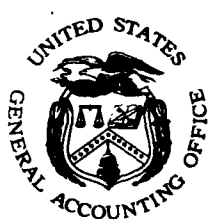


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REPORT OF THE COMPTROLLER GENERAL OF THE UNITED STATES

Conflicts Between State Health Insurance Requirements And Contracts Of The Federal Employees Health Benefits Carriers

U.S. Civil Service Commission

Many States have health insurance requirements that conflict with provisions of the contracts negotiated by the Civil Service Commission and the Federal Employees Health Benefits carriers. Some doubt and confusion exists on the part of the Federal health insurance carriers and the States regarding the applicability of State requirements to these contracts. GAO believes the Subcommittee on Retirement and Employee Benefits, Committee on Post Office and Civil Service, should consider legislation to clarify whether State requirements can alter the terms of contracts negotiated under the Federal Employees Health Benefits Act.

MWD-76-49

OCT. 17, 1975

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COMPTROLLER GENERAL OF THE UNITED STATES

WASHINGTON, D.C. 20548

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B-164562

The Honorable Richard C. White
Chairman, Subcommittee on Retirement
and Employee Benefits
Committee on Post Office and Civil Service
House of Representatives

42906

Dear Mr. Chairman:

Your February 20, 1975, letter asked for information on State health insurance requirements which conflict with contracts negotiated between the Federal Employees Health Benefits carriers and the Civil Service Commission. You asked that we identify those State health insurance requirements which conflict with contracts of these carriers, and if feasible, determine (1) what the increase in costs would be to the Federal Employees Health Benefits program if the contracts were changed to include all benefits required by the States and (2) what the savings would be if these State requirements were preempted by Federal statute.

The report discusses various State conflicts, the carriers' methods of dealing with these conflicts, and the position of the Civil Service Commission and certain carriers regarding the applicability of State requirements to the Commission's health insurance contracts. Because of an absence of cost data, we could not determine what the increased cost to the Federal Employees Health Benefits program would be if the contracts were changed to include all benefits required by the States, nor could we determine what the savings would be if the State requirements were preempted by Federal statute.

We found that (1) some doubt and confusion exists among the carriers and the States regarding the applicability of State requirements to these contracts and (2) the States are becoming increasingly active in establishing and enforcing health insurance requirements. Accordingly, we believe that the Subcommittee should consider legislation to clarify whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act.

B-164562

As your office requested, we did not obtain the Commission's or the carriers' formal comments on this report, but the contents of the report were discussed with Commission officials.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Thomas A. Stearns".

Comptroller General
of the United States

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ABBREVIATIONS

CSC	Civil Service Commission
FEHB	Federal Employees Health Benefits
GAO	General Accounting Office
NALC	National Association of Letter Carriers
GEHA	Government Employees Hospital Association

D I G E S T

The Federal Employees Health Benefits program provides health insurance coverage to program participants through contracts negotiated between the Civil Service Commission and health plan carriers. These contracts specify the benefits to be provided by the plans and the premium cost which is shared by the Government and enrollees. (See p. 1.)

Some States have established health insurance requirements that conflict with the provisions of these contracts, such as requiring recognition of certain practitioners not covered by Federal Employees Health Benefit plans. These conflicting requirements have not, to date, greatly increased the costs of the Federal Employees Health Benefits program. (See p.5.)

Many States have not attempted to enforce their requirements that conflict with these health plans. In other States, the carriers have been successful in convincing the States that the Federal employees' plans are exempt from State requirements. Other States have enforced their requirements but have not done so uniformly for all carriers in the Federal program. (See p. 5.)

For example, the Indemnity Benefit Plan pays for chiropractic services in Nevada, as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractic services only in New York and Montana where State laws require coverage for such services. The Service Benefit Plan has been required to pay for these services only in Maryland and Oklahoma. Even in the States that have enforced conflicting requirements, few Federal enrollees are aware of the States' requirements, and, as a result, most enrollees do not attempt to obtain reimbursement for chiropractic services. (See p. 9.)

The cost of revising the carriers' contracts with the Civil Service Commission to include all benefits required by States is difficult to estimate because of such unknown factors as the potential utilization of these benefits. However, the Indemnity Benefit Plan believes they would have to increase their premiums by as much as five percent. (See p.13.)

Some plans have requested the assistance of the Commission in obtaining exemptions from the State requirements, but the Commission has consistently taken the position that the States have the authority to regulate the plans. (See p.16.)

Because of the large number of State requirements that conflict with the plans, and indications that States are becoming more active in enforcing them, it appears that such requirements could increasingly affect the benefits and costs of the program. (See p. 16.)

CONCLUSIONS

There is some doubt and confusion on the part of the carriers and the States regarding the applicability of various State health insurance requirements to the Federal Employees Health Benefits program contracts.

As a result, decisions regarding health benefits or services required by States, but not covered under the Federal Employees Health Benefits program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Because the States are becoming more active in establishing and enforcing health insurance requirements which conflict with the carriers' contracts with the Commission, these conflicting requirements can be expected to result in:

- increased premium costs to both the Government and the program enrollees and
- a lack of uniformity of benefits for all enrollees in the same plan, which results in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States. (See p. 16.)

RECOMMENDATION TO THE SUBCOMMITTEE

In view of (1) the doubt and confusion that exists among the health benefit carriers and some States and (2) the increased activity of the States in establishing and enforcing health insurance requirements, GAO recommends that the Subcommittee consider legislation to clarify its intent as to whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act. (See p. 17.)

CHAPTER 1
INTRODUCTION

We reviewed the problems resulting from conflicts between the benefits and services provided under the Federal Employees Health Benefits (FEHB) program and various State requirements in response to a February 20, 1975, request from the Chairman, Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service. (See app. I .)

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The Federal Employees Health Benefits program, established by the FEHB Act of 1959, provides health insurance coverage for about 3 million Government employees and annuitants and 6 million dependents. The cost of the program, which is shared by participating employees and the Government, was about \$1.6 billion for fiscal year 1974, of which the Government's share was estimated at \$960 million. The total cost of the program for fiscal year 1976 will be about \$2 billion.

The program is administered by the Civil Service Commission (CSC) which contracts for coverage through the following four types of health plans:

- Service Benefit Plan: A Government-wide plan under which the carrier, Blue Cross/Blue Shield, generally provides benefits through direct payments to physicians and hospitals. About 5.6 million of the 9 million program participants are covered by this plan.

- Indemnity Benefit Plan: A Government-wide plan under which the carrier, Aetna Life Insurance Company, provides benefits by either reimbursements to the employees or, at their request, direct payments to physicians and hospitals. About 1.3 million program participants are covered by this plan.
- Employee Organization Plans: These plans, available only to individuals and members of their families who are members of the sponsoring organizations, provide benefits either by reimbursing employees or, at their request, by paying physicians and hospitals. Twelve such plans provide coverage to about 1.5 million program participants.
- Comprehensive Medical Plans: These plans, available only in certain localities, provide (1) comprehensive medical services by teams of physicians and technicians practicing in common medical centers or (2) benefits in the form of direct payments to physicians with whom the plans have agreements. Thirty-two such plans provide benefits to about 600,000 program participants.

The premium costs to the Government and enrollees and the benefits provided by each of the FEHB plans are specified in contracts negotiated each year by CSC and the carriers. Although the benefits and premium costs may differ among the various plans--and between various options available under the same plan--all those enrolled under a particular plan and option are entitled to receive the same benefits and pay the same premiums.

Even though the contracts between CSC and the various FEHB carriers require uniform coverage for all enrollees in each option of each plan, a few States have required certain FEHB carriers to provide benefits or services not covered in the contracts with CSC.

In addition, some FEHB carriers are being taxed by States while others are not, which affects the premium rates. For example, some States require certain FEHB carriers to pay premium taxes while other FEHB carriers are exempt and some States require reserves for contingencies and epidemics, in addition to the reserves required by CSC. We have previously reported on the tax and reserve issues (B-164562, Oct. 20, 1970, May 22, 1972, and Nov. 7, 1974). The premium taxes paid by the various FEHB carriers in calendar year 1974 are shown in appendix II.

SCOPE OF REVIEW

The objective of our review was to obtain information on the conflicts between State health insurance requirements and the FEHB program and the effect such conflicts have on the cost of the program.

The review included an examination of records and discussions with officials at CSC headquarters, Washington, D.C., and at the offices of the carriers for the Service Benefit Plan, the Indemnity Benefit Plan, and several of the employee organization plans. We did not visit all of the States or review all State laws and regulations; rather, we obtained most of our information on actual and potential conflicts in

benefits and services from the FEHB carriers. Also, because of the absence of cost data pertaining to benefits or services required by States but not included in FEHB carriers' contracts with CSC, we could not determine (1) the cost to the program if all such benefits were included in the FEHB plans' contracts or (2) the savings if such State insurance requirements were preempted by Federal law.

CHAPTER 2

CONFLICTS BETWEEN STATE HEALTH INSURANCE REQUIREMENTS AND FEHB CONTRACT PROVISIONS

A number of State health insurance laws, regulations, and Attorney Generals' opinions are beginning to have an impact on the coverage provided under the FEHB plans. It can reasonably be expected that if these State requirements were publicized and strictly enforced by the States, the costs of the FEHB program could be increased substantially.

The existing conflicts between the FEHB carriers' contracts with CSC and the State requirements have, to date, not had a great impact on the FEHB program costs, primarily because

--even when the States have ruled that conflicting State health benefit requirements are applicable (even if not provided in the FEHB contract), the FEHB enrollees do not usually know about the State laws and regulations and therefore do not pursue their claims with the carriers and
--both the States and the carriers are unsure of the States' rights to impose State requirements on Federal contracts.

In connection with the latter point, many States that have insurance requirements that apparently conflict with benefits and services provided by FEHB plans have not attempted to enforce their requirements. In other States, the FEHB carriers have been successful in convincing the States that they are exempt from State requirements.

Some States that have enforced their requirements, have not done so uniformly to all FEHB plans in those States. This could be, however, because enrollees in some plans are not aware of State requirements.

CSC's position on this matter has been that (1) the States have the authority to regulate and tax FEHB carriers, (2) it neither interprets nor enforces State laws, and (3) the FEHB carriers are free to take whatever steps are available to test the applicability of State laws.

There is some doubt and considerable confusion among the carriers and the States regarding the applicability of various State health insurance laws to the FEHB contracts.

As a result, decisions regarding the health benefits or services allowed under the FEHB program are, to a large extent, made on a State-by-State and a claim-by-claim basis. Descriptions of conflicts that the individual carriers have experienced with various State requirements follow.

INDEMNITY BENEFIT PLAN

Although Aetna has usually been successful in convincing State insurance commissions that the Indemnity Benefit Plan is exempt from State laws and regulations, there have been exceptions.

Aetna has established standard responses to satisfy various States on the applicability of State insurance laws and regulations to the Indemnity Benefit Plan contracts. If a State asks why Aetna has denied

a claim for a certain expense not covered by the plan, but required by the State, Aetna's first response has been that the plan is a group policy issued in the District of Columbia and is, therefore, not subject to the laws of that State. Until recent years, the States generally accepted this response.

According to Aetna officials, however, a few States have recently passed laws applicable to all group contracts regardless of where the policy was issued. In addition, Aetna stated that a few States have taken the position that, regardless of the wording of the State law, it applies to all contracts regardless of where they were issued. In these instances, Aetna tells the State that its plan is written pursuant to a special act of the Federal government and is not subject to State law or regulation. According to Aetna, this reply was accepted by all States until 1973.

In 1973, however, Nevada refused to recognize this argument and directed Aetna to pay for chiropractic services which were not included in its FEHB contract.

In June 1973, Nevada officials informed Aetna that in 1970 the State Legislature amended Nevada statutes to require coverage of chiropractic services and that Nevada's Attorney General had rendered an opinion in February 1973 which stated, in part, that:

"Nevada law currently requires coverage for chiropractic services in all individual, group or blanket health policies used in this State, regardless of the effective date or date of issuance to any such policy."

In September 1973, Nevada told Aetna that whenever the Indemnity Benefit Plan covers Nevada residents it is subject to State law. Nevada further stated that unless Federal legislation expressly preempted the Indemnity Benefit Plan from State law, Aetna's contention of Federal preemption would not be considered valid.

As a result, Aetna proposed to CSC that it either (1) join Aetna in court action to contest Nevada's requirements or (2) allow Aetna to include chiropractors in the plan's definition of doctors. Aetna estimated the additional premium necessary to cover this inclusion would range from 1 to 2 percent (about \$2-4 million).

CSC declined to participate in a suit over this matter, but authorized Aetna to pay claims for services provided by chiropractors in Nevada. Aetna accepted CSC's decision, with the understanding that the cost of such claims be paid by CSC from its contingency reserve. This understanding was subsequently incorporated into the Indemnity Benefit Plan contract.

Aetna has successfully contested claims for chiropractic services in Missouri, Ohio, South Dakota, and Washington. In all cases, Aetna convinced the States that since the Indemnity Benefit Plan was under the FEHB program, it is exempt from State requirements. Beneficiaries in California and Florida have also had disputes with Aetna over claims for chiropractic services. The insurance commissioners in these States, however, ruled that they lacked jurisdiction over FEHB plans.

In addition, Aetna has been involved in a dispute with Maryland concerning services provided by certain psychologists. Maryland law requires payment for services provided by licensed or certified psychologists, regardless of whether they are clinical psychologists. Aetna denied a claim in Maryland on the grounds that a licensed psychologist was not a clinical psychologist as defined in its contract. However, Aetna subsequently paid this claim as directed by the State.

According to Aetna officials, they have also disputed claims involving various State requirements in Montana, North Dakota, and Texas. Aetna did not give us details on these disputes but said no payments have been made for the disputed claims.

Aetna provided us examples of recent actions by States that may increasingly affect the FEHB plans (see app. III). In one example, the Nevada legislature enacted a law, effective July 1, 1975, requiring health insurance policies to include coverage for services by persons licensed in Nevada to practice traditional oriental medicine, including acupuncture. According to Aetna officials, payment may have to be made for these services, which are not included in its FEHB contract.

Aetna officials told us that annual premium fees for the Indemnity Benefit Plan would have to be increased by 5 percent or about \$11 million, to cover all benefits required by States but not included in the FEHB contract. Aetna believes that FEHB plan carriers should be exempt from State requirements on the grounds that the FEHB Act preempts State regulations.

SERVICE BENEFIT PLAN

The Service Benefit Plan, provided by the National Associations of Blue Cross and Blue Shield plans, has also experienced conflicts with States involving practitioners and benefits. We were told by an association official that State conflicts have been discussed with CSC, but the associations have not formally requested CSC to help them contest the right of States to enforce their requirements.

Although freestanding surgical facilities are not covered under the Service Benefit Plan, because these facilities do not meet the plan's criteria for hospitals, information provided by CSC indicates that the plan makes payments for services of such facilities in 21 States. An association representative said recognizing these facilities was a management decision, since recognition is required by law in some States. CSC has not objected to the plan's coverage of treatment in these facilities, because it is less expensive than providing similar services in regular hospitals and, therefore, does not adversely affect the cost to the FEHB program.

Chiropractic services are not a covered benefit under the Service Benefit Plan. However, according to the carrier for the plan, payment is made for these services in Maryland and Oklahoma at the insistence of these States. The Service Benefit Plan has not been required to make payment for chiropractic services by any other State, including Nevada, which has required payment for these services by Aetna's Indemnity Benefit Plan. This could be because enrollees of the Service Benefit Plan are unaware of the State's requirements.

Other State regulations which conflict with the Service Benefit Plan, but have not been contested as yet, involve treatment for nervous and mental conditions, alcoholism, and drug addiction. For example, North Dakota recently passed a law requiring health insurance coverage for persons suffering from mental illness, alcoholism, and drug addiction. This law requires that benefits be provided for treatment by partial hospitalization which is defined as "that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment." However, the Service Benefit Plan does not cover such partial hospitalization.

Similarly, the Massachusetts legislature has passed a law--to become effective on January 1, 1976--which provides guidelines on benefits for nervous and mental conditions and alcoholism. The law requires that a group medical service agreement in that State include provisions for payment of benefits for inpatient confinement in a mental hospital for at least 60 days of any calendar year. The Service Benefit Plan, however, has a lifetime maximum of \$50,000 for benefits provided for nervous conditions and mental illness.

Also under Massachusetts law, coverage of at least \$500 will be required for outpatient services at any licensed alcoholism treatment facility. The Service Benefit Plan recognizes only a facility meeting its definition of hospital.

EMPLOYEE ORGANIZATION PLANS

A National Association of Letter Carriers (NALC) official stated their plan is not paying for any benefits or services not covered in their FEHB contract. Accordingly, NALC has refused to pay claims for chiropractic services in Oklahoma; the State has not contested NALC's action.

NALC was the only employee organization plan that provided us estimates of the cost to cover those benefits required by States but not covered in its FEHB contract. NALC estimated that its annual premium fees would have to be increased by \$4 million to cover the services of chiropractors and by \$3 million to cover the services of general psychologists.

This position contrasts to that of the Mutual of Omaha Insurance Company, which underwrites six FEHB employee organization plans. A Company official said New York and Montana require coverage of chiropractic services and the six FEHB plans which it underwrites are complying with these requirements.

The Government Employees Hospital Association (GEHA) cited several instances where it believed conflicts existed between State requirements and its FEHB contract. One of these involved the recognition of psychologists, which, at one time, were not covered under GEHA's FEHB contract.

A conflict occurred in Missouri where GEHA was directed to--and did--pay for psychiatric services rendered by an osteopath. GEHA denied the claim because osteopaths were not licensed to provide psychiatric services.

The State's basis for directing payment was that GEHA's contract provided for services rendered by doctors of medicine and licensed doctors of osteopathy.

GEHA officials also stated that in some cases they were required by Illinois and Nevada to pay for certain chiropractic services which were not provided for in their FEHB contract; however, in other similar cases in the same States, GEHA was not required to recognize or pay for these services.

GEHA currently has a lawsuit pending in California concerning the payment of chiropractic services. The suit was filed by a chiropractor who was refused payment for services required by State health insurance laws, but not covered under GEHA's FEHB contract.

CARRIERS' CONTACTS WITH CSC
REGARDING CONFLICTS

Several of the FEHB carriers--principally Aetna and NALC--have sought CSC assistance in attempting to resolve the conflicts between State health insurance requirements and FEHB contract requirements.

As previously mentioned (see p. 6), Aetna's position is that FEHB carriers should be exempt from State requirements because the FEHB Act preempts State regulations. Aetna bases its position on the McCarran-Ferguson Act (15 U.S.C. 1012(b)), which states, in part, that:

"No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance * * *." (Emphasis added)

Aetna points out that the FEHB Act states that "each contract shall contain a detailed statement of benefits offered and shall include such maximum, limitations, exclusions, and other definitions of benefits as the Commission considers necessary or desirable." Therefore, according to Aetna, the FEHB Act specifically relates to the "business of insurance" and clearly comes within the exception section of the McCarran-Ferguson Act and should not be subject to State regulations.

Aetna informed CSC of its opinion that the terms of the FEHB contract must take precedence over State regulations, to protect the FEHB program from conflicting regulations and to permit uniform coverage for all Federal employees enrolled in the Indemnity Benefit Plan.

NALC has attempted to obtain exemption from State insurance regulations since Wisconsin, in December 1968 (1) required NALC to pay approximately \$207,000 in premium taxes, penalty assessments, and penalty interest because NALC had not obtained a State license and (2) had, according to Wisconsin, engaged in unauthorized transaction of insurance business.

In August 1970, NALC requested CSC to support NALC's position that the FEHB Act supersedes State licensing of health benefits plans such as NALC's, and that the taxes, penalties, and interest payments imposed by Wisconsin conflict with the FEHB Act.

NALC's legal opinion submitted to CSC stated that Wisconsin's application of State insurance licensing requirements to an employee organization plan established under the FEHB Act violates the Supremacy Clause (Clause 2 of Article VI) of the United States Constitution, since "it intrudes upon an area preempted by federal law, obstructs and

impairs the operation of an Act of Congress and frustrates effectuation of its policy."

In December 1970 and January 1971, two other employee organization plans--the United Federation of Postal Clerks and Rural Carrier Benefit Plan--joined NALC in seeking an amendment to the FEHB Act so that FEHB contracts would supersede, or take precedence over, State laws which conflict with FEHB contracts.

CSC's POSITION

CSC's position has been that "the States have the authority to both regulate and tax health insurance carriers operating under the Federal Employees Health Benefits Program of chapter 89 of title 5 of the United States Code." In response to the FEHB carriers' requests, CSC told the carriers that

- the FEHB Act was not designed to regulate the insurance business or to override any State regulatory scheme,
- no legal basis exists for CSC to issue a regulation restricting the applicability of State laws to FEHB contracts,
- CSC neither interprets nor enforces State laws, and
- the carriers are free to pursue whatever steps are available to them to test the applicability of a State law in a given situation.

In this regard, CSC's General Counsel has not agreed with the carriers' contention that the FEHB Act is exempt from State regulation because of the McCarran-Ferguson Act. Moreover, he does not believe the "supremacy clause," also known as the preemption doctrine, could be used

as a legal basis for issuing a regulation restricting the applicability of State laws with regard to FEHB contracts.

In a June 1975 letter to Aetna, CSC's Deputy General Counsel said the legislative history of the FEHB Act is nearly devoid of references to the relationship between the FEHB Act and State laws regulating the business of insurance. He pointed out that the House Committee on Post Office and Civil Service stated in a 1970 report that:

"it is recommended that the Civil Service Commission take appropriate action to inform carriers that the fact they are administering a Federal contract is no reason for circumventing compliance with applicable State laws."

The Deputy General Counsel concluded that this remark, along with others, indicates that State law should be controlling. Furthermore, he said there is no mention of the McCarran-Ferguson Act in the legislative history of the original FEHB laws or subsequent amendments to it. Therefore, he does not view the history of the FEHB Act as supporting Aetna's position that the act was intended to constitute a specific and explicit congressional enactment regulating the business of insurance.

On June 26, 1975, Aetna requested CSC's official position of the applicability of State requirements to FEHB carriers. As of October 9, 1975, CSC had not responded.

CONCLUSIONS

There is some doubt and confusion on the part of the FEHB carriers and the States regarding the applicability of various State health insurance requirements to the FEHB contracts. As a result, decisions

regarding health benefits or services required by States, but not covered under the Federal Employees Health Benefits program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Because the States are becoming more active in establishing and enforcing health insurance requirements which conflict with the carriers' contracts with CSC, these conflicting requirements can be expected to result in

- increased premium costs to both the Government and FEHB plan enrollees and
- a lack of uniformity of benefits for all enrollees in the same plan, which results in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

RECOMMENDATION TO THE SUBCOMMITTEE

In view of (1) the doubt and confusion that exists among the health benefit carriers and some States and (2) the increased activity of the States in establishing and enforcing health insurance requirements, we recommend that the Subcommittee consider legislation to clarify its intent as to whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act.

RICHARD C. WHITE, TEX., CHAIRMAN
 DOMINICK V. DANIELS, N.J.
 HERBERT E. HARRIS, VA.
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GENE TAYLOR, MO.
 ROBIN L. BEARD, TENN.

EX OFFICIO:
 DAVID N. HENDERSON, N.C.
 EDWARD J. DERWINSKI, ILL.

U.S. House of Representatives

SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE
 BENEFITS

OF THE

COMMITTEE ON POST OFFICE AND CIVIL SERVICE

B-345-B RAYBURN HOUSE OFFICE BUILDING

Washington, D.C. 20515

February 20, 1975

B-164562

The Honorable Elmar B. Staats
 Comptroller General of the
 United States
 U.S. General Accounting Office
 441 G Street, NW.
 Washington, D.C. 20548

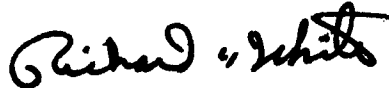
Dear Mr. Staats:

It has recently come to our attention that certain inequities exist in the Federal Employees Health Benefits (FEHB) program due to conflicts between the FEHB contracts and various State statutes. For instance, in Arizona, benefits for chiropractic services are paid under the service benefit plan because such benefits are required by State statute even though they are not paid for Federal employees in all States. In addition, certain States have statutes which require health benefit plans to maintain special contingency reserves in addition to the reserves held under the FEHB program.

I would like the General Accounting Office to identify those State health insurance requirements which are in conflict with contracts of the FEHB carriers. If feasible, I would also like to know (1)

what the increase in costs would be to the FEHB program if the contracts with the FEHB carriers were changed to include all benefits required by such State statutes and (2) what the savings would be if such State statutes were preempted by Federal statute. I would also be interested in any legislative changes that you believe might improve this situation.

Sincerely yours,

A handwritten signature in black ink that reads "Richard C. White". The signature is written in a cursive style with a large, prominent initial "R".

Richard C. White
Chairman

PREMIUM TAX EXPENSES
FOR CALENDAR YEAR 1974
BY FEHB CARRIER

<u>Plan</u>	<u>Premium tax expense in 1974</u>	<u>Number of enrollees</u>	<u>Per enrollee (annual)</u>
Service Benefit Plan	\$1,063,982	1,844,309	\$ 0.58
Indemnity Benefit Plan	5,367,212	475,118	11.30
American Federation of Government Employees	149,914	15,317	9.79
Government Employees Hospital Association	-0-	23,067	-0-
National Association of Letter Carriers	-0-	147,964	-0-
Postmasters Benefit Plan	118,561	8,574	13.83
Rural Letter Carriers	337,501	28,836	11.70
American Foreign Service	86,837	10,031	8.66
Government Employees Benefit Association	99,184	8,486	11.69
Canal Zone	200,151	17,865	11.20
Special Agents Mutual Benefit Association	173,135	17,842	9.70
Mail Handlers	256,062	23,596	10.85
National Alliance	40,209	3,866	10.40
American Postal Workers	-0-	158,194	-0-



151 Farmington Avenue
Hartford, Connecticut 06115

Malcolm McIntyre
Manager
Government Relations
Group Division

September 23, 1975

Mr. Gerald Miller
Supervisory Auditor
Government Accounting Office
Audit Site, Room 2456
U.S. Civil Service Commission
1900 E Street, N.W.
Washington, D.C. 20415

Dear Mr. Miller:

In accordance with your most recent request, I have reviewed some state laws enacted recently and inasmuch as these new statutes could impact on the payment of benefits and the implementation of the Federal Personnel Manual 890.1 regulations, as they relate to health benefits, I will give you a short resume of each law and regulation.

Arkansas has a law which became effective June, 1975, which requires recognition of chiropractors' charges if such services would have been payable if rendered by a physician.

In Colorado, a law will become effective on January 1, 1976 which will require basic coverages to include benefits for at least 45 days of in-patient care or 90 days partial hospitalization (3-12 hours in hospital or licensed psychiatric hospital) for mental illness treatment. Comprehensive medical policies must include out-patient services for treatment of mental and nervous conditions which may be limited to \$1,000 in a 12-month period. Also, coinsurance may not exceed 50%.

Another law in Colorado which will also be effective January 1, 1976 requires insurers to offer for inclusion in group health policies coverage for treatment of alcoholism. Minimum benefits required to be offered include 45 days in-patient care in a licensed hospital or a facility licensed by the Department of Health, and out-patient benefits to the extent of \$500 in a 12-month period.

Effective October 1, 1975, a law in Connecticut will require that an employee or dependent, if the employee becomes ineligible for continued participation in a plan for any reason including death, be allowed to continue insurance for up to 39 weeks or until covered by another group plan after insurance would otherwise cease, upon payment of premiums to the policyholder.

Another law, which became effective on May 28, 1975 in Connecticut, amends the Mental Illness Law to make it applicable to renewed

Mr. Miller
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contracts to increase the covered period of confinement for mental and nervous conditions from 30 to 60 days, and to increase the level of coverage for out-patient treatment from \$500 to \$1,000.

Effective October 1, 1975, another law will become applicable in Connecticut which mandates home health care benefits. The maximum offered cannot be less than 80 visits in a calendar year or in any continuous period of 12 months. Of concern to us is the fact that such care could be rendered by a person who does not meet the requirements for coverage under the provisions of the Indemnity Benefit Plan or the Uniform Plan.

In Idaho, a new law became effective on July 1, 1975. One of the provisions of this law is that any medical policy which includes maternity benefits must, upon discontinuance, provide the maternity benefits that would have been payable to persons pregnant at the time of discontinuance had the policy remained in force for a period of 12 months following discontinuance.

Effective October 1, 1975, a law will go into effect in Illinois which will require group coverage to continue for a period not to exceed six months from an employee's "termination date" (date employee fired, laid off, etc.), provided the employee agrees to pay the premium at the previous rate. The employer must meet special notice requirements to permit the terminated employee the option to elect the continued coverage. This law will only be effective until July 1, 1977.

In Louisiana, effective November 1, 1975 a new law will require recognition of a chiropractor's charges if such services would have been payable if rendered by a physician.

The Maryland Insurance Department has a proposed regulation which would prohibit coordination of benefits between "no-fault" automobile insurance and medical insurance policies. This proposed regulation would also be extraterritorial in nature. Of course, this would impact directly on the "double coverage" provision contained in the Indemnity Benefit Plan.

A law becomes effective in Massachusetts on January 1, 1976 requiring that all group hospital and surgical expense policies covering Massachusetts residents, and to individual policies issued in Massachusetts, offer benefits for expenses arising for treatment of mental illness at least equal to requirements that in-patient benefits for treatment in a mental hospital will be provided for at least 60 days in a calendar year if the hospital is under the supervision of the Department of Mental Health, or licensed by that Department, and for confinement in a licensed general hospital, benefits are to be provided on the same basis as for any other illness. For out-patient benefits for treatment of mental and nervous disorders, they are to be covered to the extent of \$500 over a 12-month period if services are provided by a comprehensive health service organization, by a licensed or accredited hospital, by a community mental health clinic or day-care center providing mental

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health services as approved by the Department of Mental Health, or by consultations, diagnostic or treatment sessions when administered by a licensed psychotherapist or psychologist.

In Minnesota, a law was effective July 1, 1975 which requires coverage for in-patient hospital and medical expenses on the same basis as other benefits for the treatment of emotionally handicapped children in a residential treatment facility licensed by the Commissioner of Public Welfare.

Also in Minnesota, a law became effective on August 1, 1975 which requires coverage of at least 90% of the first \$600 in any 12-month period for consultation, diagnosis and treatment for mental and nervous disorders while the insured is not a bed patient in a hospital.

Another Minnesota law, which was effective May 15, 1975, requires that coverage under a group health insurance policy, upon termination of employment, must be continued until either the employee is reemployed and eligible for another group health care coverage or for six months.

In Nevada, a law became effective July 1, 1975 which requires benefits for home health care or health-supportive services. On this same date, another law became applicable in Nevada which requires recognition of the charges made by a licensed doctor of traditional Chinese Medicine (acupuncture).

Effective January 1, 1976, New Hampshire will have a new law which requires benefits for losses arising from mental or nervous conditions to be at least equivalent to 45 days of in-patient confinement, and 100% of the first five visits (80% thereafter) for out-patient coverage limited to \$500 in a calendar year.

On June 5, 1975, a law became effective in New Jersey which requires recognition of a chiropractor's charges if such services would have been payable if rendered by a physician.

In Oklahoma, there is a new law requiring that group health policies issued or delivered on or after January 1, 1976 provide for continuation of coverage for 30 days after termination of such policy, and requires specified extended benefits to employees who have been covered under the policy for at least six months, for a continuous loss which commenced while the insurance was in force.

On July 31, 1975, a law became effective in Wisconsin which requires coverage for out-patient services at a hospital or out-patient treatment facility, including services of a physician in connection with alcoholism or drug abuse to the extent of the first \$500 in any calendar year. The law, however, makes a distinction in mandating the level of coverage for mental illness. Out-patient treatment for mental illness which is rendered at any place other than under a community mental health program established by Section 51.42 of the Wisconsin Statutes, need only be covered to the extent of \$500 in a

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calendar year. However, out-patient mental illness treatment rendered under a community mental health program must be paid for the first \$500 in any calendar year. The effect of this is that no deductible or coinsurance is permitted until the \$500 limit is reached in connection with out-patient alcoholic treatment of mental illness, no matter where the treatment is rendered, and in connection with the treatment of mental illness, no deductible or coinsurance is permitted until the \$500 limit is reached if the out-patient care is rendered under a community mental health program. However, if the out-patient mental health care is rendered somewhere other than under the community mental health program, a deductible and coinsurance is permitted.

Of course, I am sure you realize that there are many other statutes effective in various states which would impact on the benefit provisions of both the Indemnity Benefit Plan and the Uniform Plan, as well as the Federal Employees Health Benefits regulations. I have pointed out the foregoing laws and regulations just to give an indication of how the additional benefits, for which premiums have not been considered under these plans, would increase the claim benefits payable. One must also consider the implications on the increased administrative costs inherent to us in tracking and providing coverage under all of the various state laws under these plans, and the implied necessity of having to, in the future, print brochures for each state showing the various coverages which would be in effect and the benefits which would be payable in each state.

As relates to the regulations and laws of the states concerning continuation of coverage, etc., it would be necessary for the Civil Service Commission to make a determination as to whether or not the states' laws or regulations would apply, or whether the Federal Employees Health Benefits regulations would apply under these circumstances.

All in all, I am sure that you realize our assumption that a 5% premium increase would be necessary for the Indemnity Benefit Plan for 1976 in order to pay benefits for services required by the various states is only for a one-year period, and that the cost would escalate in the future as more and more of the states' laws became applicable to these plans, or the states passed laws which would impact on the benefit structures of these plans.

I very much appreciate your request for this additional information, and please be assured that if I may be of further assistance to you, you need only call upon me.

Sincerely,



Malcolm McIntyre, Manager
Group Government Relations

MM/cb