AGENDA
November 21, 1994

I. BACKGROUND ON ERISA

II. THE PROBLEM

III. THE PROBLEM WITH THE PROBLEM: POLITICS

IV. POSSIBLE OPTIONS

V. RECAP AND CONCLUSION

ERISA

I. BACKGROUND

II. THE PROBLEM

A. INSURANCE REFORMS CANNOT BE EXTENDED TO SELF-INSURED PLANS

B. ENROLLEES IN MEWAS ARE INSUFFICIENTLY PROTECTED

C. ERISA AS A POTENTIAL ROADBLOCK TO REFORM

D. REMEDIES MAY BE INSUFFICIENT

III. THE PROBLEM WITH THE PROBLEM: INTEREST GROUP POLITICS

IV. POSSIBLE OPTIONS

OPTION 1: To continue the present structure of having federal and state regulation of health insurance bought from insurance companies and only federal regulation of self-insured employment-based health plans.

POSSIBLE INITIATIVES

RETAIN CURRENT ERISA PREEMPTION: STATUS QUO

OPTION 2: To apply minimum federal insurance reforms to all health plans with options for additional state regulation.
(NOTE: Administration-wide staff agreement on this matter -- as was the case in almost every bill last year; no consensus on appropriate state role beyond minimum standards, however.)

POSSIBLE INITIATIVES

A. APPLY HEALTH INSURANCE REFORMS THROUGH FEDERAL REQUIREMENTS FOR ALL HEALTH INSURANCE PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD NOT BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON ANY PLANS.

B. APPLY HEALTH INSURANCE REFORMS THROUGH FEDERAL REQUIREMENTS FOR ALL HEALTH INSURANCE PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON FULLY-INSURED PLANS.

C. APPLY MINIMUM FEDERAL HEALTH INSURANCE REFORM TO ALL HEALTH PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON PLANS BELOW A CERTAIN THRESHOLD NUMBER OF EMPLOYEES (i.e., 5000, 1000, 500, etc.)

D. APPLY FEDERAL INSURANCE REFORMS AND REQUIRE STATES TO REQUEST WAIVERS TO IMPOSE FURTHER REQUIREMENTS ON PLANS BELOW THE THRESHOLD NUMBER

OPTION 3: To facilitate state and federal enforcement of existing regulations of MEWAs.

POSSIBLE INITIATIVES

CLARIFY EXISTING LAW AND, IN ADDITION, REQUIRE MEWAS TO FILE COPIES OF THEIR STATE LICENSES WITH THE DEPARTMENT OF LABOR (NOTE: Administration-wide staff agreement on this compromise initiative).

OPTION 4: To allow states to implement their own health care reforms by promoting express legislative waivers of ERISA preemption.

POSSIBLE INITIATIVES

A. RETAIN CURRENT ERISA PREEMPTION WITH A LIMITED EXCEPTION FOR STATE LAWS ON COST CONTAINMENT

B. RETAIN CURRENT ERISA PREEMPTION WITH AN EXCEPTION FOR CERTAIN STATE LAWS RELATING TO FINANCING AND COST CONTAINMENT

C. RETAIN CURRENT ERISA PREEMPTION WITH BROAD LEGISLATIVE EXCEPTION FOR STATES THAT ENACT LAWS WITH EXTENSIVE COVERAGE EXPANSION

D. RETAIN CURRENT ERISA PREEMPTION BUT GRANT A LIMITED NUMBER OF INDIVIDUAL STATE WAIVERS THROUGH A LEGISLATIVE OR ADMINISTRATIVE PROCESS

OPTION 5: To enhance the remedies available to enrollees in ERISA plans.

POSSIBLE INITIATIVES

A. EXPAND FEDERAL REMEDIES AVAILABLE TO PARTICIPANTS FOR "BAD FAITH" CLAIM DENIAL

B. PROVIDE FOR FEDERAL CIVIL PENALTIES FOR CASES OF BAD FAITH DENIALS

C. MAKE STATE LAW REMEDIES AVAILABLE TO ERISA PLAN PARTICIPANTS

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ERISA applies to all private employment-related group health plans, of which there are currently more than 3 million, covering over 120 million Americans. ERISA does not apply to church plans, governmental plans and most workers' compensation plans.

PROBLEMS

1. INSURANCE REFORMS CANNOT BE EXTENDED TO SELF-INSURED PLANS:

background: ERISA allows states to regulate health insurance carriers and the group health policies they sell to employers but prevents states from regulating self-insured employee benefit plans.

problems: In order to assure that all individuals with employer-based health coverage benefit from "basic" insurance reforms (e.g., requiring guaranteed issue and renewal, prohibiting pre-existing conditions exclusions), federal legislation is necessary. Even if the decision to establish these reforms at the federal level is made, the question remains whether to accord states the flexibility to go beyond the federal reforms by enacting their own reforms.

Currently, insurance reforms enacted at the state level cannot be applied to self-insured plans. Many argue that firms choose self-insurance not because it is the most efficient way to provide health care to its employees but because they wish to evade state regulation.

2. ENROLLEES IN MEWAS ARE INSUFFICIENTLY PROTECTED:

background: MEWAs, or Multiple Employer Welfare Arrangements, are arrangements in which two or more employers pool their resources to purchase health plans for their employees. In many places, self-funded MEWAs (sponsored by stable trade associations) are an alternative source of health coverage. Under ERISA, fully-insured MEWAs are subject to state insurance laws that regulate solvency and self-insured MEWAs

are subject to state insurance laws that are "not inconsistent" with the rest of ERISA.

problems: MEWAs frequently lack financial stability because they are often without a stable funding source, adequate reserves, or actuarially sound contribution levels.

According to a 1992 GAO Report MEWAs were operating in 46 states. The report estimated that from 1988 to 1991, unpaid claims by MEWAs totalled over $123 million and affected almost 400,000 enrollees.

The Department of Labor is currently investigating 70 MEWA civil cases and 36 criminal cases. Since the Department began its nationwide criminal MEWA effort in the late 1980s, it has obtained 77 criminal indictments and 70 convictions.

Federal authorities are often unaware of an insolvent MEWA's existence until enrollees begin to complain that they have been denied benefits. The time it takes the authorities to investigate and litigate a case against a MEWA is long enough to allow many enrollees to be defrauded. The lack of effective enforcement on the federal level is detrimental to effective regulation of MEWAs in general because a MEWA will often operate in several states at once. This means that federal authorities would be able to shut down an insolvent MEWA by themselves; a MEWA challenged by authorities in one state would be able to continue operations in other states unless and until the authorities in those states took action.

State authorities are hindered in their attempts to enforce their insurance laws against MEWAs by the MEWAs' argument that state licensing requirements are "inconsistent with", and thus preempted by, ERISA. Although most courts eventually reject the MEWAs' argument, they do not do so promptly because (1) the statute is worded in a confusing way and (2) it is not easily apparent, especially to judges who are not familiar with ERISA, whether a state regulation is consistent with ERISA.

3. ERISA AS A POTENTIAL ROADBLOCK TO REFORM:

background: ERISA preempts state regulation that "relates to" health plans except that states may impose insurance regulations on fully-insured plans.

problem: This regime hampers state attempts to reform health care because regulations involving cost containment (e.g. provider rate setting), plan administration (e.g. uniform claims procedures), and coverage expansion and financing (e.g. employer "pay-or-play" taxes) are either clearly preempted by ERISA or likely to provoke a time-consuming and costly court battle because they are vulnerable to a claim of ERISA preemption. For example, the United States Supreme Court has recently agreed to review an appellate court decision invalidating a New York law that imposed varying surcharges on hospital care over the basic rate depending on the patient's type of coverage.

4. REMEDIES MAY BE INSUFFICIENT:

background: The remedies and claims procedures provided by ERISA are severely limited.

problems: The only remedy provided by ERISA for enrollees in ERISA plans (whether self-insured or fully-insured) whose benefit claims are denied in bad faith is recovery of the initial cost of the benefit denied. Even enrollees in fully-insured plans cannot recover for bad faith claim denials under state tort or contract law. This is because laws applied to insurance companies in state courts "regulate insurance" under ERISA only if they are specifically directed at the insurance industry.

A recent case in the Court of Appeals for the Fifth Circuit involved a self-funded health plan that required enrollees to obtain precertification for certain procedures. The organization hired to perform the precertification review denied a hospitalization request for a woman experiencing a high-risk pregnancy despite her doctor's recommendation and the independent recommendation of an expert hired by the review organization. Instead, the organization authorized 10 hours per day of in-home care for the woman. At a time when no nurse was on duty, the fetus became distressed and died. The court held that the woman could not recover against the organization under state law and noted that she had neither a state nor a federal remedy.

OPTIONS

OPTION 1: To continue the present structure of having federal and state regulation of health insurance bought from insurance companies and only federal regulation of self-insured employment-based health plans.

POSSIBLE INITIATIVES

RETAIN CURRENT ERISA PREEMPTION: STATUS QUO

In this scenario, states would continue to regulate health insurance companies but be prevented from implementing laws concerning other aspects of health care reform and self-funded plans would remain subject only to ERISA's limited requirements. Under this system, states' ability to achieve state-wide insurance reform is limited because employers have the option of choosing to self-insure, thus escaping state regulation entirely.

OPTION 2: To apply minimum federal insurance reforms to all health plans with options for additional state regulation.

The staff members have agreed that federal insurance reforms should be applied to both fully-insured and self-insured plans. We have not reached consensus on the appropriate level of flexibility to be accorded the states to go beyond federal standards.

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All state insurance laws would be preempted, but new federal insurance reforms would be applied uniformly to both fully-insured and self-insured plans.

B. APPLY HEALTH INSURANCE REFORMS THROUGH FEDERAL REQUIREMENTS FOR ALL HEALTH INSURANCE PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON FULLY-INSURED PLANS.

This initiative would lessen the incentive for employers to self-insure in order to evade state regulation because an escape from state regulation would no longer be an escape from all regulation.

C. APPLY MINIMUM FEDERAL HEALTH INSURANCE REFORM TO ALL HEALTH PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON PLANS BELOW A CERTAIN THRESHOLD NUMBER OF EMPLOYEES (i.e., 5000, 1000, 500, etc.)

This initiative resolves the issue whether only federal rules apply according to the criteria of plan size; currently the determining factor is whether the plan is fully-insured or self-insured.

D. APPLY FEDERAL INSURANCE REFORMS AND REQUIRE STATES TO REQUEST WAIVERS TO IMPOSE FURTHER REQUIREMENTS ON PLANS BELOW THE THRESHOLD NUMBER

Under this initiative, states would be able to regulate small employers only by receiving an administrative waiver from the federal government. This initiative may accomplish more uniformity among state programs by requiring states to meet certain criteria before a waiver is granted.

OPTION 3: To facilitate state and federal enforcement of existing regulations of MEWAs.

The staff members have agreed on the following approach to addressing the problems caused by MEWAs.

POSSIBLE INITIATIVES

CLARIFY EXISTING LAW AND, IN ADDITION, REQUIRE MEWAS TO FILE COPIES OF THEIR STATE LICENSES WITH THE DEPARTMENT OF LABOR

Under this initiative, ERISA would be changed to indicate clearly that the application of state insurance regulations to MEWAs is not inconsistent with ERISA. This clarification would aid states in enforcing their own laws by making it more difficult for MEWAs to hinder state enforcement actions by claiming ERISA preemption.

In addition, this initiative would require that MEWAs provide copies of their state licenses to federal authorities prior to beginning operation so that the MEWAs can be monitored for compliance with federal law. The DOL would be given authority to cease the operation of a MEWA that refused to file the required license.

Federal action against MEWAs may be desirable because many MEWAs operate in more than one state. Federal action could shut down the entire MEWA in one proceeding; without federal action, proceedings would be required in each state in

which the MEWA was operating before a multi-state MEWA's entire operation could be stopped.

OPTION 4: To allow states to implement their own health care reforms by promoting express legislative waivers of ERISA preemption.

The state waiver option could be employed alone or in combination with other options.

Many of the initiatives discussed below would permit states to institute laws concerning the financing of health care. It is important to remember that in any such ERISA waiver approach, the waiver could be structured in a way that would make it more acceptable to the affected parties. For example, the permissible financing options could be limited to specific mechanisms -- e.g., provider taxes but not mandates. Alternatively, certain sized firms could be exempted altogether from state financing regulations as long as the firms provided a suitable benefit package for their employees.

POSSIBLE INITIATIVES

A. RETAIN CURRENT ERISA PREEMPTION WITH A LIMITED EXCEPTION FOR STATE LAWS ON COST CONTAINMENT

This initiative is limited and thus would cause less disruption of the current market. It will, however, also be less effective in expanding coverage and other reforms. Financing will be improved only to the extent that cost savings are used to extend coverage. This initiative would clarify federal law with regard to states such as Maryland that need a waiver for their all-payer cost-containment statute.

B. RETAIN CURRENT ERISA PREEMPTION WITH AN EXCEPTION FOR CERTAIN STATE LAWS RELATING TO FINANCING AND COST CONTAINMENT

Under this initiative, state laws financing health care and promoting cost containment would apply to both self-insured and fully-insured plans. This would allow states to implement financial regulation to contain costs, expand coverage, raise revenue or achieve other health care reform goals.

C. RETAIN CURRENT ERISA PREEMPTION WITH BROAD LEGISLATIVE EXCEPTION FOR STATES THAT ENACT LAWS WITH EXTENSIVE COVERAGE EXPANSION

This initiative would allow states to enact more comprehensive reforms (e.g., "pay or play" taxes, single-payer systems, etc.). This initiative essentially exempts from ERISA preemption state laws that are part of a comprehensive reform system and that would not be exempt under the more limited exceptions for cost containment and financing listed in initiatives 3(A) and 3(B).

D. RETAIN CURRENT ERISA PREEMPTION BUT GRANT A LIMITED NUMBER OF INDIVIDUAL STATE WAIVERS THROUGH A LEGISLATIVE OR ADMINISTRATIVE PROCESS

Under this initiative, waivers would be granted on a state-by-state basis rather than categorically. Individual state waivers could be granted on a limited basis -- e.g. to a given number of states as part of a research or demonstration project to be carried on for a certain number of years. Specific statutory criteria would need to be established against which the states seeking waivers would be measured. An executive branch interagency commission could be established to grant the waivers.

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background: ERISA allows states to regulate health insurance carriers and the group health policies they sell to employers but prevents states from regulating self-insured employee benefit plans.

problems: This means that basic insurance reforms enacted at the state level, such as requiring guaranteed issue and renewal and prohibiting pre-existing conditions exclusions, cannot be applied to self-insured plans.

Many argue that firms choose self-insurance not because it is the most efficient way to provide health care to its employees but because they wish to evade state regulation. To whom do apply the minimal insurance reforms → State or Fed.

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National Health Expenditures

1960 to 1993

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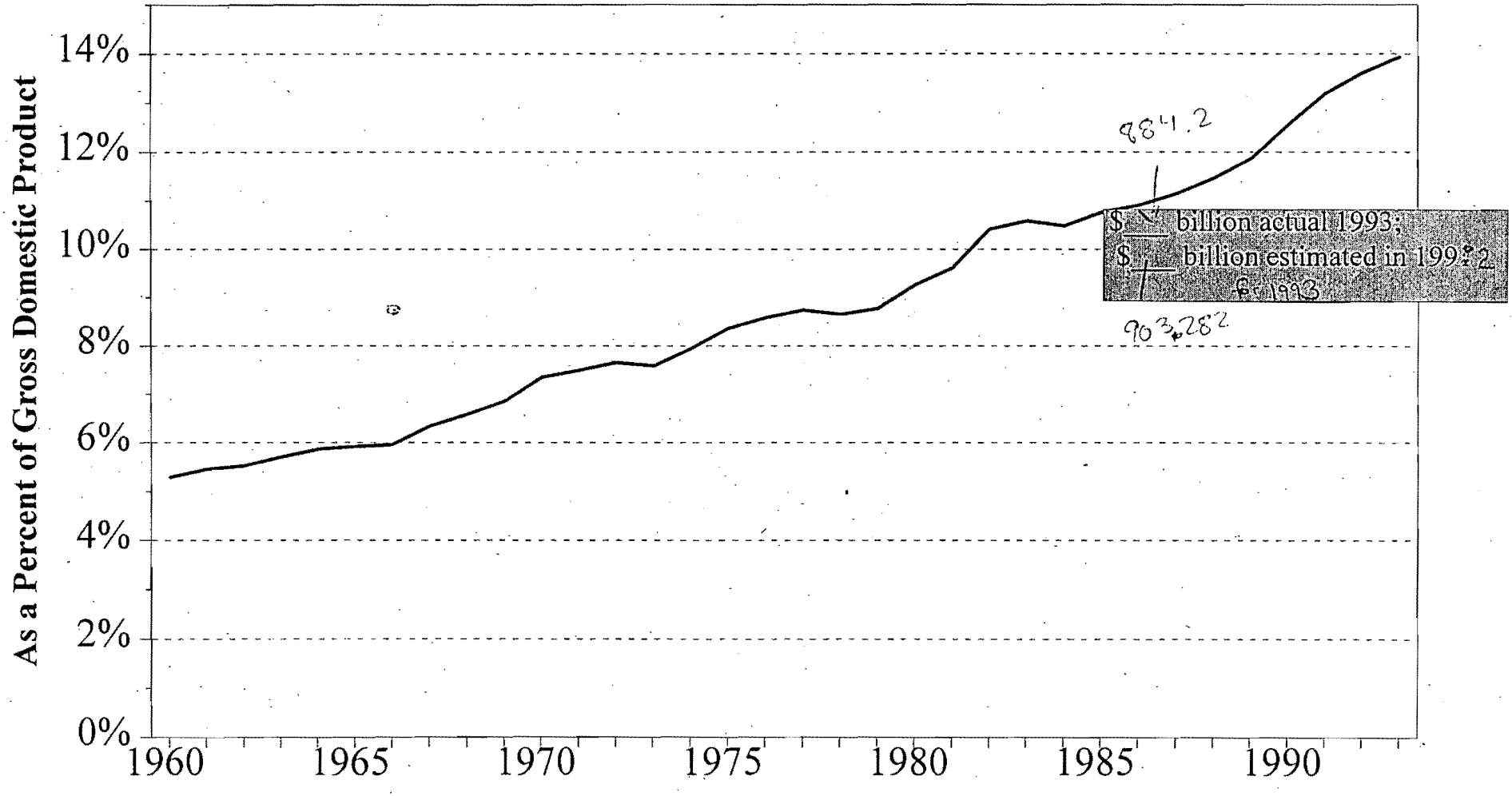
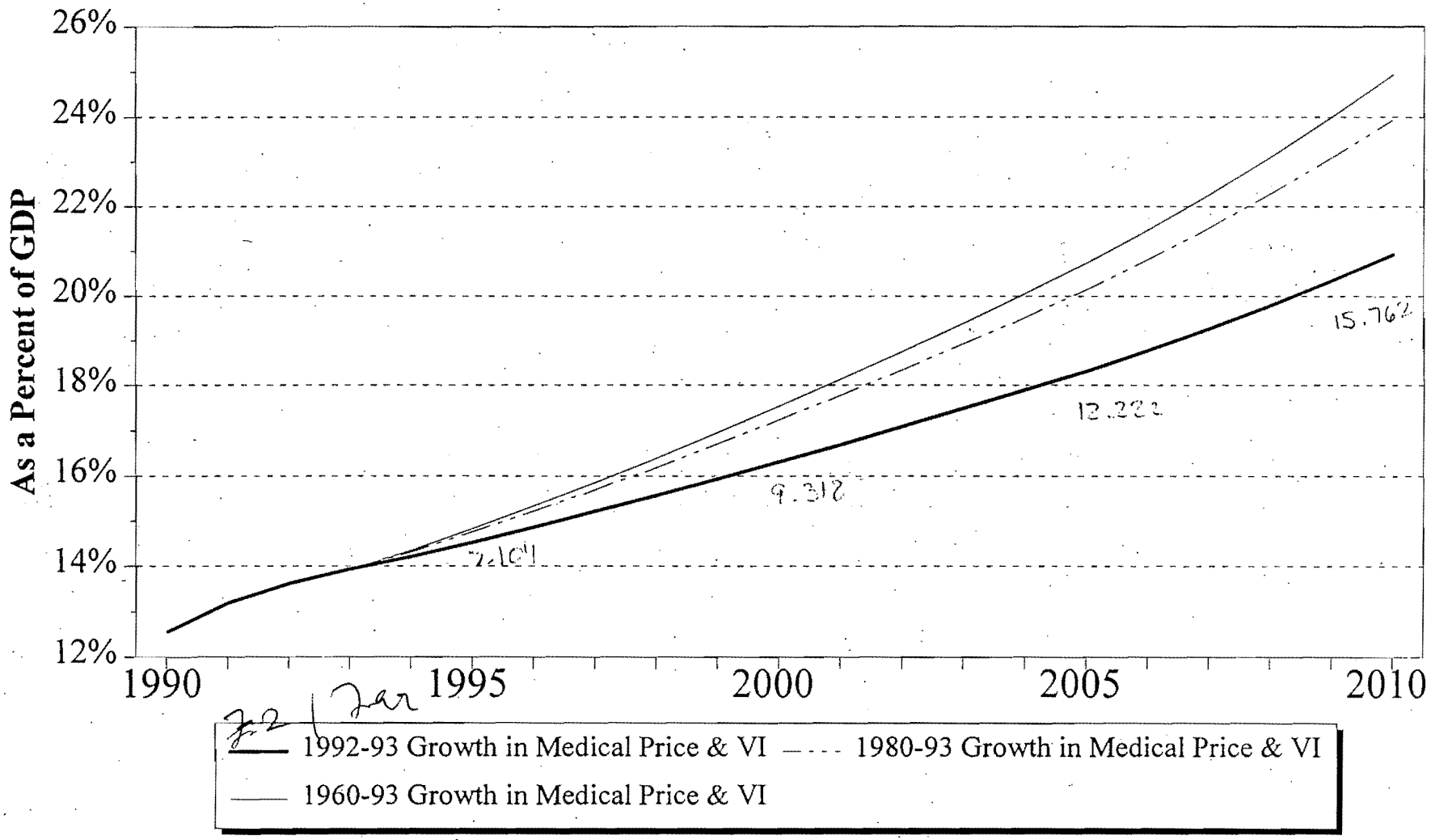


Source: HCFA/Office of the Actuary & OMB; Analysis: OMB

Growth in National Health Expenditures

DRAFT

Three Possible Scenarios



Source: HCFA/Office of the Actuary & OMB; Analysis: OMB

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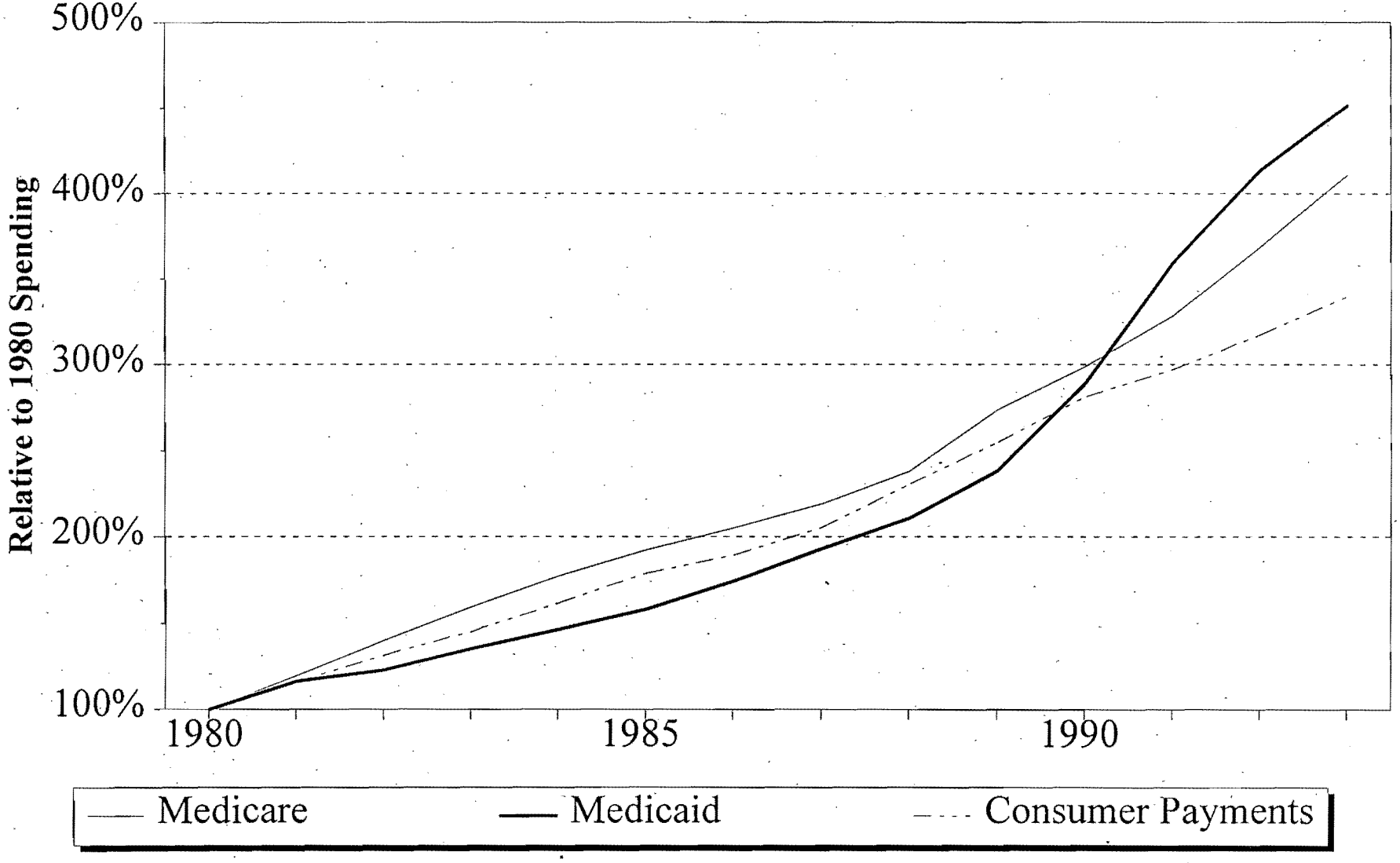
Private & Public Health Spending

Relative to their 1980 Levels



Source: HCFA/Office of the Actuary; Analysis: OMB

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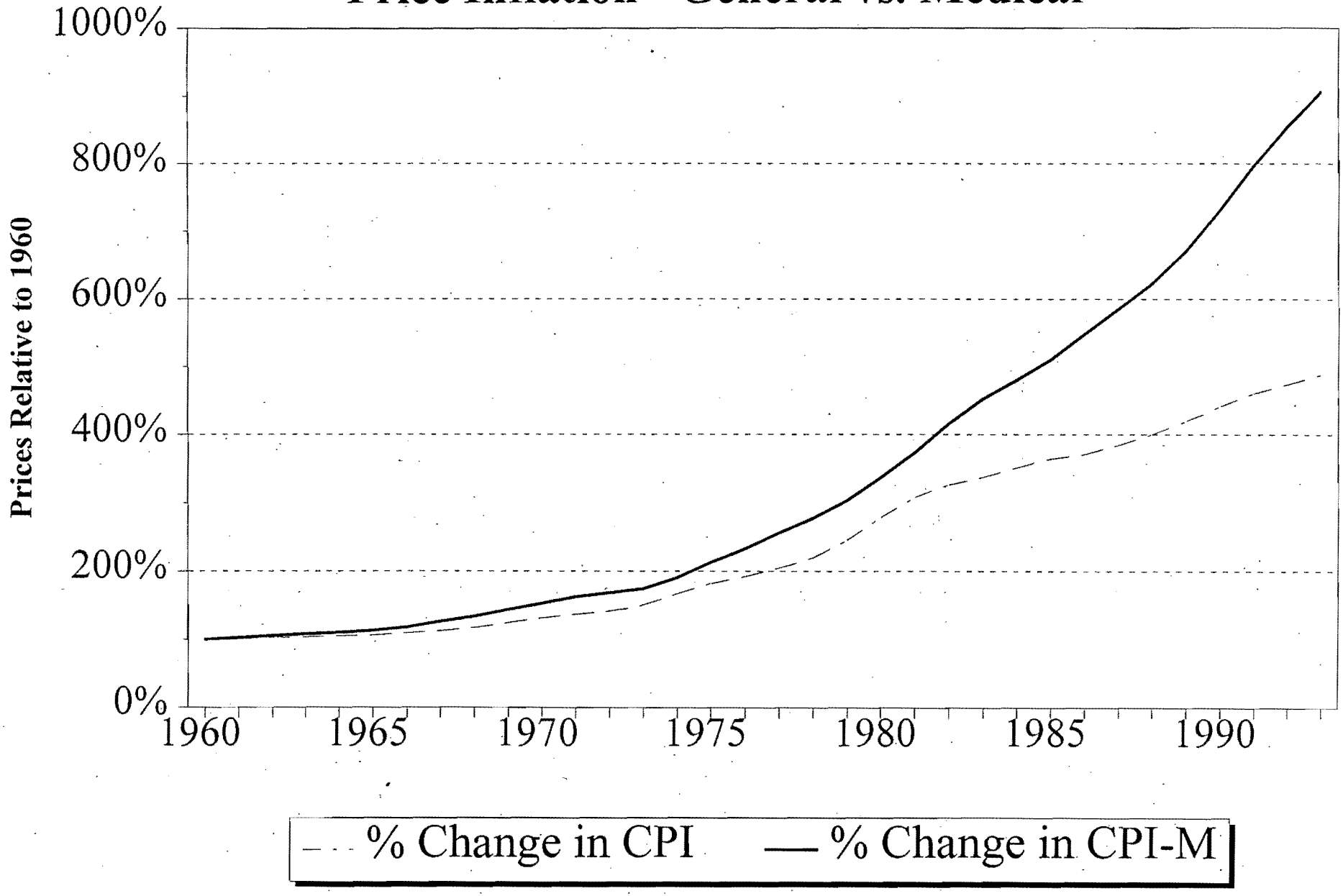
Price Inflation - General vs. Medical



Source: OMB

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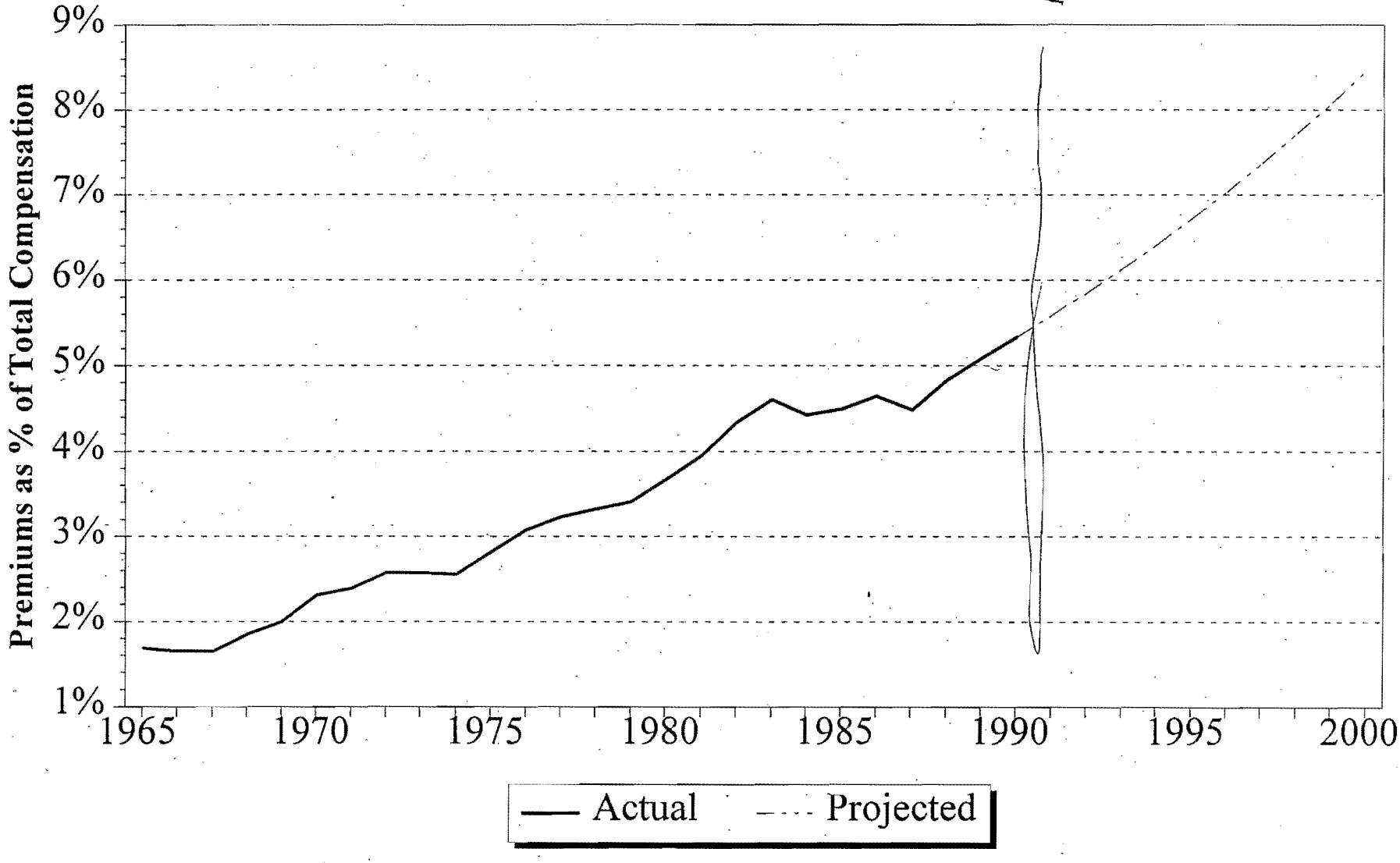
Ratio of Employer Paid Premiums to Compensation of PrivateWorkers



Source: HCFA/Office of the Actuary; Analysis: OMB

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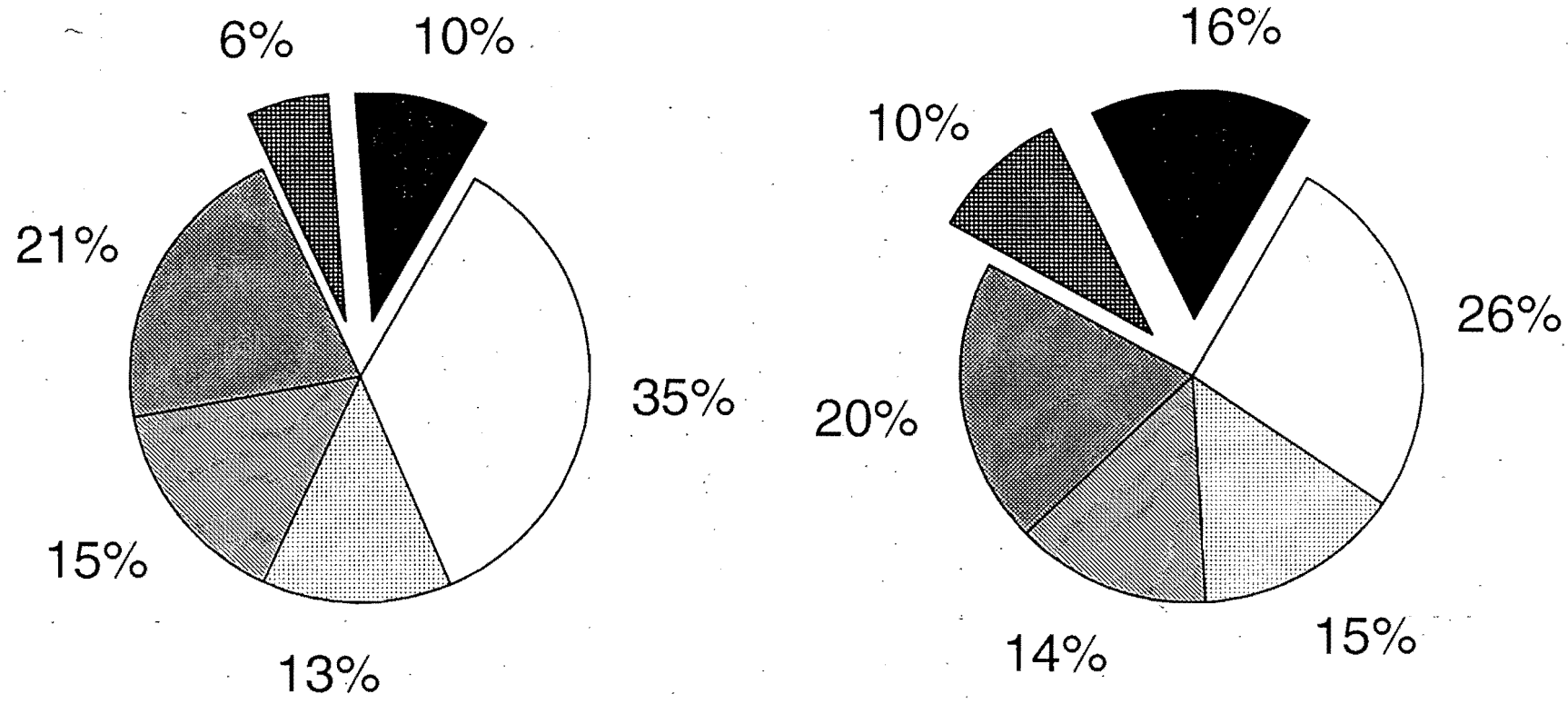
Medicare & Medicaid Growth Crowds Out Discretionary Spending, FY 1994 - FY 2004



Data: CBO, "Economic and Budget Outlook: An Update", August 1994. Analysis: Health Financing Branch

From the 1994 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund

"Under the Trustees' intermediate assumptions, the present financing schedule for the HI program is sufficient to ensure benefit payments only over the next 7 years."

Under intermediate assumptions, the HI Trust Fund is exhausted in 2001.

DRAFT

From the 1994 Annual Report of the Board of Trustees of the Supplementary Medical Insurance Trust Fund [emphasis added]

"Although the SMI program is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. **In spite of the evidence of slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past.** Growth rates have been so rapid that **outlays of the program have increased 59 percent in the aggregate and 45 percent per enrollee in the last 5 years.** For the same time period, **the program grew 23 percent faster than the economy despite recent efforts to control the cost of the program."**

DRAFT

DEPARTMENT OF THE TREASURY
OFFICE OF TAX ANALYSIS
1500 PENNSYLVANIA AVENUE, NW
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Number of Pages: 1+3 Date: 11/21/94

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Comments/Special Instructions: Here are Eric Toder's outlines for Wednesday's NEC meetings. He has approved these outlines.

UNCLASSIFIED

TAX CAP AND HIGH COST PLAN ASSESSMENTS

I. Background.

A. Current law for employer-provided health insurance.

B. Other tax preferences for medical expenditures.

1. 25% deduction for self-employed.
2. Itemized deduction for medical expenses above 7.5% of adjusted gross income.

II. Reasons to tighten current law treatment of employer contributions for health insurance.

A. Cost containment.
B. Revenue.

III. Tax cap options.

A. Supplementals.

B. Co-payments and deductibles.

C. Dollar caps.

1. Equity issues.
2. Administrative issues.

D. Additional issues.

1. Need for basic benefit package.
2. Employer vs. employee cap.

IV. High cost plan assessment.

A. 1994 Senate proposals.
B. Similar problems in designing base.
C. Additional concerns.

V. Conclusions.

MEDICAL SAVINGS ACCOUNTS

I. Overview of why we are considering Medical Savings Accounts (MSAs).

- A. On the surface they sound good even though they may have undesirable effects that outweigh their desirable effects.
- B. Support in Congress for MSAs.
- C. Need for cost-containment.

II. What is an MSA?

- A. Description of how it works in general.
- B. Variety of proposals.
- C. Different designs lead to different magnitudes of effects.

III. What is the problem that supporters claim MSAs will solve?

- A. Bias against catastrophic plans.
  1. Tax-exclusion of employer-provided health insurance.
  2. Limited deductibility of out-of-pocket health costs.
- B. Do catastrophic plans reduce costs?
  1. Empirical evidence.
  2. Catastrophic plans vs. HMO type managed care.
  3. Total spending vs. out-of-pocket costs.

IV. Effects of MSAs.

- A. Expansion of coverage.
- B. Cost containment.
- C. Impact on health insurance market and distributional effects.
  1. Healthy and upper income benefit.
  2. Less healthy and lower income lose.
- D. Tradeoff between cost containment and distributional effects.
  1. Outcomes depend on participation rates.
  2. Examples.

V. Ways to minimize adverse effects.

A. Risk adjustors.

1. Political feasibility.
2. Likely effectiveness.

B. Tax instead of, or in conjunction with, risk adjustors.

1. Political feasibility.
2. Likely effectiveness.

C. Other design features.

1. Contribution limits.
2. Tax treatment of earnings in MSAs.
3. Availability of funds for nonmedical purposes and tax treatment.
4. Definition of medical withdrawals.

VI. Alternatives to MSAs.

A. Tax caps.
B. Small market and other health insurance reforms.
C. Subsidies, tax credits and deductions for purchase of catastrophic plans.

JIN

NOV 15 '94

STATE HEALTH NOTES

INTERGOVERNMENTAL HEALTH POLICY PROJECT

The George Washington University WASHINGTON DC

ERISA: States Push to Raze the Biggest Barrier to Health Reform

For the last 20 years, Congress has managed to duck ERISA. But with the death of federal health care reform, the day of reckoning may be at hand. ERISA—short for the Employee Retirement Income Security Act of 1974—was, as its name suggests, designed to protect worker pensions. But a one-paragraph section that preempts state regulation of employee benefit plans, including self-insured health plans, has effectively tied the hands of states seeking to reform their health care financing and delivery systems in order to expand access and contain costs.

Given the pervasiveness of self-insurance—relatively few businesses took that route in 1974, compared to about 60 percent today—almost any scheme states devise to broaden insurance coverage and spread risk appears subject to challenge on ERISA grounds. That means everything, from risk pools and mandated benefits, already ruled inapplicable to self-insured plans by the courts, to the later generation of employer mandates, insurance reforms like guaranteed issue and community rating and even the seemingly innocuous task of data collection, is off the table.

This year, several bills surfaced on Capitol Hill proposing to give ERISA waivers to a handful of states taking the lead on reform. Because federal action seemed in the offing, they went nowhere. Now, state officials plan to step up pressure on Congress to amend the law or otherwise give them flexibility to pursue reforms, including ways to broaden the revenue base.

Although no one approach has yet emerged as a favorite, MAINE Rep. Charlene Rydell said it's important to begin a dialogue with the various interest groups as a first step towards achieving consensus. Rydell, who chairs an *ad hoc* group of health policy leaders from 25 'reforming states,' said "Congress will respond" if a coalition that includes business and labor can make a case change is needed to make the system more equitable. Employers who provide generous benefits are not being served by a law that offers equal protection to less conscientious companies, she argued.

But an early sounding suggests that selling business and labor on change could be tough. "We don't see any need for ERISA reform that permits states to regulate employer plans," said Chris Bowlin, associate director of employee benefits for the National Association of Manufacturers (NAM). In NAM's view, he said, the issue is preserving the "voluntary environment" in which companies design benefit plans that best meet the needs of their workers.

The Courts: Piecemeal Policy

Congress's reluctance to wade into the ERISA quagmire means "policy" changes have been made largely by the courts. The track record has been inconsistent at best. A case in point: two recent federal appeals court rulings that reached opposite conclusions about similar rate-setting schemes in NEW JERSEY and NEW YORK.

The New York case was decided in October 1993, when the U.S. Court of Appeals for the 2nd Circuit affirmed a district court decision that three state-imposed

("ERISA," next page.)

IN THIS ISSUE

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STATE HEALTH NOTES

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ERISA (from pg. 1)

surcharges on hospital rates to finance indigent care violated ERISA's preemption clause. Just six months earlier, a 3d Circuit Court of Appeals panel had reversed a lower court ruling to the same effect on New Jersey's uncompensated care surtax.

It now falls to the U.S. Supreme Court, which announced in October that it would hear the New York Case (*Travelers Insurance Co. v. Cuomo*), to resolve the matter. In New Jersey, legislators had scrapped the surtax by the time the 3rd Circuit ruled, so except for the issue of union-escrowed funds, the disposition is mostly moot.

But in New York, concerns about the case run high. Should the state lose, Assembly Health Committee chairman Richard Gottfried told *SHN* in a late September interview, its entire financing system "could be lying in wreckage all around us." Officials of the state hospital association, which has weighed in on the government's side, say an adverse ruling could cost hospitals as much as $200 million a year.

The outcome of the case will also hold meaning for CONNECTICUT, where, like New Jersey, the legislature replaced an uncompensated care pool in the wake of a February federal district court decision that said ERISA preempted the pool. But the replacement system, which keeps a sales tax on hospital services and imposes a new tax on hospital gross earnings, is now being challenged by the state hospital association—again on ERISA grounds.

Though the Court may clear up some issues on rate-setting, observers say it's apt to leave other ERISA-related questions open. "I'm assuming the decision will be pretty narrow," said Patricia Butler, a COLORADO-based lawyer-consultant. "It might provide a few principles, but it certainly won't address the broader questions" facing states crafting universal access plans. Still, she said, "We'll eke out every bit of logic and guidance we can."

Looming Barriers

Unless the Court goes farther than expected, states undertaking more comprehensive system reforms will be stopped in their tracks without relief from Congress. Both OREGON and WASHINGTON, for instance, have pegged their universal access plans to an employer mandate—a strategy certain to provoke an ERISA challenge.

Oregon's mandate doesn't start until 1997, but Washington's kicks in next July 1 for companies with 500 or more employees. "We need an ERISA modification to implement the mandate," said Bill Hagans, the House Health Care Committee's senior policy analyst. If large firms are exempt from the uniform benefits package, premium cap and community rating, he said, more than half of the insured population will be outside the system, creating a situation ripe for adverse selection.

MINNESOTA officials are also running into ERISA challenges—or what the Health Department's acting director for health care delivery policy, Mary Kennedy, calls "policy impediments"—as they try to design a uniform benefits package to comply with the 1992-93 reform laws. Pricing of the package is "already a problem," Kennedy said. "The price we put on it reflects the fact that it's spread over a smaller population," in the absence of self-insured firms. And the fact that ERISA plans are exempt from insurance reforms gives other companies "a tremendous incentive to self-insure," she said, shrinking the pool even more.

(The state won the first round on financing for its MinnesotaCare plan for low-income residents; in April, a federal district court upheld the 2 percent tax on hospitals and physicians, saying the economic impact on challenging self-insured union trusts was "too tenuous" to negate the law. The unions have appealed.)

Legislative Options

In a report written for the National Governor's Association earlier this year, Butler spelled out three basic options, short of outright repeal of the preemption clause, that Congress might consider to give states ERISA

("ERISA," back cover)

States' Reactions (from pg. 2)

elbow room: exempting specific types of activities like data collection; empowering a federal agency to review individual state waiver requests; and authorizing waivers state-by-state.

There's a precedent for the third option: HAWAII, which won a waiver in 1983—the only state ever granted one—to implement its 1974 employer mandate, on grounds that it predated ERISA. A provision in this year's federal budget bill picked up that theme, proposing narrow exemptions for four existing programs: New York's and MARYLAND's rate-setting laws; Minnesota's provider tax; and 1983 amendments to Hawaii's law. It was scrapped as nongermane.

A possible vehicle for 1995 is legislation introduced on September 22—days before congressional leaders pulled the plug on federal reform—by Sens. Bob Graham (D-FL) and Mark Hatfield (R-OR). Though it doesn't cite ERISA by name, it proposes giving waivers to FLORIDA, Hawaii, Maryland, New York, Oregon and Washington to "remove federal obstacles" that would otherwise jeopardize their reforms.

To Rydell, the state-by-state approach "stops the clock"— witness Hawaii, which is locked into the 1974 version of its law. And "what happens when the next group of states comes up?" she asked. Instead, her group calls for "narrowly crafted changes" to require businesses that want continued ERISA protection to meet minimum federal standards. States that met those standards would get "expedited consideration" of their reform plans.

Right now, she noted, "there are no standards for what companies have to do, and plans that offer few benefits get the same treatment as more generous plans. We recognize that self-insuring entities don't want 50 different standards. This is intended to provide protection, not to be punitive."

Taxes and Other Thorny Issues

An important part of the discussion, Rydell stressed, is the financing of reform. "We're not looking for the authority to tax ERISA plans," she said, "but we do want an examination of broad-based financing mechanisms, so that costs are borne on equal basis."

The NAM's Bowlin agreed reforms should build on as broad a tax base as possible. If health care "is important to citizens," he said, "states have several options for raising revenue" beyond the "narrow population of employers."

But Butler said there are few tax schemes states can float that won't trigger an ERISA challenge—though some things, like an individual mandate and perhaps a play-or-pay plan, "stand a greater chance of success."

(A long-awaited test of MASSACHUSETTS' play-or-pay plan, enacted in 1988 and delayed several times, will likely be delayed again. Officially, it takes effect January 1 but legislators are expected to defer in the face of a major campaign by businesses.)

Even a single-payer plan like the one on CALIFORNIA's November ballot, which uses a payroll-income tax combination, "will most likely be challenged," meaning years of delay and legal costs, Butler said. "If a state can't frame its own system with a tax-based approach, it can't do anything." Moreover, ERISA "affects almost anything a state might want to do"—even something as "seemingly benign" as collecting information on utilization review activities of self-insured plans.

Two other things for Congress to chew on: a September 'white paper' from the National Association of Insurance Commissioner (NAIC) highlighting consumer protection loopholes in the law and a draft NAIC standard addressing an increasingly common industry practice: the sale of stop loss insurance, designed to protect employers against higher than expected losses, as health insurance, with ERISA as a dodge to escape state regulation.

Fred Nepple, general counsel to WISCONSIN's Insurance Commission, said the stop-loss scheme "is a couple of years old"—as old as state moves to reform the insurance market. The stop-loss scheme is "a huge temptation for segments of the industry," he said. They can select healthy customers, keep them from being put in a larger pool and offer a "tremendously profitable product." NAIC wants to define parameters to distinguish "true stop loss from stop loss that's a subterfuge."

How the pieces of the ERISA issue will be packaged remains to be seen, though the imperative to give states maneuvering room on reform is likely to take precedence over other issues. But Butler cautioned that "in the end, business and labor are so powerful, I'm skeptical anything can pass." *• LD*

Of Interest... Gains for Minority Physicians

Two items of note in the quest to produce more minority physicians:

•Admission of "underrepresented minorities" to U.S. medical schools reached a record this year, according to the Association of American Medical Colleges: 12.4 percent of incoming students were black, Hispanic or Native American/Alaska Native. (Asian/Pacific Islanders, who took 17.4 percent of the 1994 slots, are not counted as underrepresented minorities.) The 2,014 minority freshmen move AAMC a step closer to its 'year 2000' goal of enrolling 3,000 underrepresented minorities annually.

•Responding to an Institute of Medicine report released last spring that offered strategies for increasing minority representation in the health professions, the Josiah Macy, Jr. Foundation, has announced creation of a Minorities in Medicine Program. Backed by $2.7 million in foundation funds, the program will work to identify minority high school students with talent and interest in the sciences and link them with one of six medical schools for educational guidance and curriculum planning through their undergraduate years. Taking part are: Baylor College of Medicine; Boston University School of Medicine; Cornell University Medical College; UMDNJ-**NEW JERSEY** Medical School; the University of **MICHIGAN** Medical School; and the University of Southern **CALIFORNIA** School of Medicine.

(DRAFT) EXPANDING COVERAGE THROUGH STATE FLEXIBILITY

OVERVIEW

In the absence of significant coverage expansions at the federal level, one option for expanding coverage is to provide states with greater flexibility and resources to pursue health care reform.

The federal government has two levers to encourage state coverage expansions:

- Providing greater flexibility to states in administering health care programs (e.g., Medicaid).
- Providing additional funding to states to help pay for new coverage.

Providing flexibility to states can lead to some expansions of coverage. However, there are limits to how far existing resources can be extended, and expanding coverage is not necessarily the primary state interest in pursuing flexibility or additional funding.

- Many states are interested in pursuing flexibility as a way to reduce costs -- not expand coverage.

ADMINISTRATIVE FLEXIBILITY

There are several areas in which providing flexibility to states could produce savings that could be channeled into expanded coverage:

- Encouraging or requiring greater use of managed care organizations;
- Permitting benefit reductions; and
- Reducing administrative complexity (which can reduce administrative costs).

There are limits, however, on how far existing resources can be extended to provide new coverage. Medicaid is not a generous payer, so there are limits to amount of savings that managed care can achieve (estimates from 0 to 10%). In addition, reductions in the projected Medicaid baseline will make it harder for states to produce "savings" through state health care reform initiatives.

ADDITIONAL FINANCING

The Federal government could encourage states to expand coverage by extending additional financial resources to states, either as matching funds or as a direct grant program.

To protect the federal budget, caps on new federal spending for the program may be necessary.

GENERAL CONSIDERATIONS

- States will want greater administrative flexibility under Medicaid program without expanding coverage to new populations.

- States are unlikely to make new money available for coverage expansions, so any additional financing will probably come from redirecting existing state resources or from the federal government.

- States may be more interested in fiscal relief than coverage expansion. If new federal financing is made available, the challenge will be to assure that it is used to expand coverage rather than to substitute for existing state or private spending.

- Increasing state flexibility reduces the ability of the federal government to influence health care policy and decisions. The ability to protect consumers would necessarily be diminished.

OPTIONS

Option 1 Streamlining Medicaid Waivers for States that Expand Coverage

Provide presumptive waivers for specified Medicaid requirements (e.g., managed care flexibility) to states that propose significant coverage expansions. States would be able to modify their Medicaid programs within bounds without prior federal approval. However, the federal government would have authority to verify that states meet waiver requirements.

Key Considerations:

- Budget neutrality is difficult to achieve.

- Retains some of the federal guarantees and consumer protections.

- Loosening Medicaid requirements without prior review of state programs may lead to problems with access and quality.

Option 2 Providing Additional Funds to States for Expanding Coverage

Additional Federal funds would be provided to States that expand coverage of the uninsured. States could be provided with substantial flexibility under this new program, but Medicaid would remain as under current law.

Funds could be provided to states on a matching basis or as a direct grant. The Federal contribution to the program would be capped.

Key Considerations:

- If funds are provided on a matching basis, the States most likely to participate are those that already cover a significant portion of the poor through Medicaid or state-financed programs. Poorer states with the most needy populations may be financially unable to participate in the program.

Option 3 Maximum State Flexibility/Medicaid Block Grant

The current Medicaid financing arrangements would be replaced with Federal block grant payments to States. Payments would include the Federal share of the Medicaid program and any new Federal funding. States would be given substantial flexibility in using these Federal payments -- and any required or optional State contributions -- to finance health services for low-income residents.

Key Considerations:

- A block grant program would cap federal spending on Medicaid. If the Federal grant is insufficient, states would need to either expand state funding or cut services or eligible populations.

- Uncertainty for future program growth would be borne by the states and program recipients.

- States may reduce eligibility or benefits for groups now covered under the program.

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of Pages: Cover + _____ DATE: _____

TO: Chris Jennings

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REMARKS:

These are being circulated with HCFA & OS.

Debbie

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

SPECIAL

HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF LEGISLATIVE AND INTER-GOVERNMENTAL AFFAIRS

M E M O R A N D U M

TO: Bruce Vladeck
Helen Smits
Jerry Klepner
Ken Apfel
Judy Feder
David Ellwood
Kathy Buto
Steve Pelovitz
Rodney Armstead
Sally Richardson

FROM: Debbie Chang

DATE: November 21

RE: Materials for Medicaid and Medicare Cost Containment and Managed care

Attached are 3 documents for your review and comment. These were prepared over the weekend with Bruce to respond to a request from the White House. These are intended to be used for a presentation by Bruce on cost controls on Wednesday.

Due to time pressures imposed by others, we are distributing this simultaneously and would appreciate your comments by COB Monday. Please call the following people to provide your comments.

On Medicaid Managed Care - Don Johnson, 690-7762
On Medicare Managed Care - Peter Hickman, 690-5950
on Cost Controls - Debbie Chang, 690-5960 or Tom Gustafson, 690-5500

DRAFT

Medicare and Medicaid
Cost Containment Legislative Proposals

MEDICARE

A range of Medicare reforms could help to control costs in the short term and in the future. Some would have significant scorable budget savings. Others would reform various aspects of the program that would improve our ability to control costs in the future, even though they might not be scored as having significant savings within the budget window. Medicare managed care options are addressed in a separate paper.

Major proposals could include:

1. Reform payment procedures

Over a period of years, we have moved large portions of the Medicare program onto payment methods that are designed to control Federal costs: prospective payment (for inpatient hospital services) and fee schedules (for physicians and most other Part B services). Payment methods for two additional areas are now ready for reform: hospital outpatient services and skilled nursing facilities.

- Prospective payment systems in these areas will reform incentives that now tend to increase costs and put the Federal budget at risk.

- Outpatient prospective payment will reverse the scandalous growth in co-insurance charges to beneficiaries: OPD coinsurance has now grown to about 50 percent, as opposed to 20 percent elsewhere in the program.

Graduate Medical Education payment reform can:

- Achieve budgetary savings while changing a number of payment parameters to

- Increase emphasis on training of primary care practitioners and

- Permit payments to recognize the major shift of medical training to ambulatory care.

Savings in the physician area have been a significant source of savings in the past and may be again, although lower baselines will lead to lower savings from particular proposals as well. Insofar as savings are required, it would be desirable to achieve them in ways that contribute to containing costs in the future.

- Remove the upward bias now inherent in the statutory formula for setting the annual physician growth target

(the Medicare Volume Performance Standard).

In addition, Medicare payment for durable medical equipment (DME) can be reformed to reflect market rates, thus lowering Medicare costs. HCFA could take advantage of market rates in local areas by simplifying and changing the current inherent reasonableness authority.

2. Promote Competition

Relying more heavily on market forces to establish how much Medicare pays is attractive in general and responds to the current climate.

- Competitive bidding for Part B services would permit the market in local areas set our payment rates.

- Several other changes would "level the playing field" between Medicare managed care plans and Medigap plans, leading to sharpened competition and improved performance.

3. Combat Fraud and Abuse

- A major funding reform, the Benefit Quality Assurance Program, will permit adequate funding for payment integrity activities of Medicare carriers and intermediaries. We expect a 8-to-one return for these activities.

- Medicare secondary payer reforms will emphasize paying the claim right in the first place through improved coordination of benefits, rather than costly pay-and-chase approaches.

- Medicare can follow the lead of the private sector in adopting certain "good business" practices governing overpayments and other aspects of our business relations with physicians and providers.

4. Simplify and Streamline Program Management

Various program reforms can tighten up administration, reduce vulnerabilities, improve information flows, and eliminate certain unnecessary practices.

- "One-stop Billing" will use electronic transmittal of claims information from Medicare to secondary payers.

- Changes relating to the Medicare Transaction System now under development would increase the flexibility of our contracting authority and simplify claims processing.

MEDICAID

Medicaid changes could emphasize similar themes, but reflect differences in a joint Federal-State program.

1. State Financing Reform

To prevent abuses relating to intergovernmental transfers:

- Medicaid payments to government-owned facilities would be limited to costs
- Rules relating to payments to hospitals serving a "disproportionate share" of the poor would be tightened.

2. Promote Competition

A series of proposals could give States greater flexibility to operate cost-effective managed care programs. For instance,

- Permit limited waivers of enrollment composition rules, with quality assurances.
- Permit States to adopt primary care case management programs without requiring a waiver from HCFA.

3. Combat Fraud and Abuse

- Several proposals could improve States' ability to ensure payments from third parties liable to pay medical bills for Medicaid beneficiaries.
- Statutory improvements could increase the effectiveness of existing provisions assuring medical support from absent parents.

4. Simplify Administration

- To remove requirements now largely redundant as a result of nursing home reform, mandated annual mental health screenings of nursing home residents could be replaced with reviews on an as-needed basis.

Medicare Managed Care

I. Growth in Managed Care

Medicare has experienced significant growth in managed care enrollment as well as managed care contracts for the past four years.

Enrollment: In 1994, Medicare enrollment grew by 12 percent. As of September of this year, 9 percent of all Medicare beneficiaries were enrolled in managed care plans. (6 percent in risk plans, 2 percent in Health Care Prepayment Plans (HCPPs), with the remainder in cost plans and Medicare SELECT).

Contracts: As of September of this year, Medicare had 235 total prepaid contracts (145 risk contracts, 29 cost contracts, 57 HCPP contracts, and 4 Demo contracts). This is an increase from 188 in 1993 and from 165 in 1990.

II. Issues in Medicare Managed Care

Historically, the following issues have been raised as problematic in Medicare managed care:

Medicare Payment. Managed care organizations with Medicare risk contracts receive a per capita payment of 95% of Medicare's projected fee-for-service cost for each enrollee (referred to as adjusted average per capita costs (AAPCC)). Rates are adjusted by demographic factors such as age and sex and by a geographic factor based on county of enrollee residence. According to Mathematica Policy Research (MPR), even though Medicare's payment is 95% rather than 100% of the AAPCC, the program is still not achieving savings because of favorable selection. In fact MPR found that Medicare's payments to risk contracting HMOs were approximately 6 percent higher than the costs of covering the same beneficiaries in fee-for-service.

The managed care industry has traditionally been critical of Medicare's payment methodology for risk contracts. Among the concerns are that payment levels are too low, county rates are unstable and that plans in areas with relatively low payment are disadvantaged compared to plans in areas with relatively high payment (for example, the monthly rate in Hennepin, Minnesota is $362, while in Dade, Florida it is $615).

Marketing. There have been continual problems and complaints in the way managed care plans market to Medicare beneficiaries, particularly in some regions of the country. Deceptive practices such as enrolling beneficiaries without their consent and agents not fully explaining critical managed care provisions, for example, the lock-in, have resulted in expensive mistakes and

bureaucratic hassles for beneficiaries.

Beneficiary Confusion. The ever-increasing number of managed care options for Medicare beneficiaries makes choosing a plan very confusing and may even deter beneficiaries from choosing managed care altogether. Widely varying plan benefits and enrollment periods make comparison shopping almost impossible.

Uneven Playing Field With Medigap. While Medicare managed care plan are prohibited from health screening, imposing pre-existing condition exclusion periods or charging differential premiums based on health status or age, the same requirements do not apply to Medigap policies. As a result, the competition between Medicare managed care and Medigap does not take place on a level playing field.

Limited Beneficiary Choice. A relatively small percentage of Federally Qualified HMOs participate in Medicare's managed care program. Only a handful of these plans offer a point-of-service option to enrollees. While Medicare SELECT holds the promise of expanding choice through the creation of managed care/Medigap hybrid products, plans under the existing demonstration are not required to manage care. As a result, the majority of SELECT enrollees are in plans that achieve Medigap savings only through discount arrangements and selection. SELECT enrollees also do not have the same assurances as to access and quality as do enrollees in Medicare risk plans.

Quality Assurance. HCFA currently has certain process requirements for HMOs which are meant to assure quality of care. Work is in process on a new generation of quality measurement systems that will focus on patterns of care, but full implementation is still several years away. Thus, while there is evidence from research studies that quality of care in HMOs is comparable to that in Medicare's fee-for-service sector, HCFA does not yet have systems to adequately measure, monitor and assure quality on an ongoing basis. Such systems are especially important when dealing with capitated systems because capitation provides financial incentives to minimize care.

III. Options

Option 1) Reduce benefits in fee-for-service Medicare as an incentive for beneficiaries to enter HMOs

In addition to the current Part B premium, require beneficiaries who do not enroll in a managed care plan to pay the difference between the average per capita fee-for-service costs in their area and the lowest premium for a managed care plan with a Medicare contract.

- All managed care plans in an area that wish to participate in the Medicare program would submit bids.

- Medicare's contribution for all beneficiaries in that area would be based on the lowest bid.

- The "bid" for regular fee-for-service Medicare (91 % of all Medicare Beneficiaries) would be based on average per capita Medicare costs in the area.

- If the "bid" for regular Medicare was not the lowest, beneficiaries choosing fee-for-service would have to pay the difference between Medicare's contribution and the "bid".

Option 2) Strengthen Current Risk and Cost Contract Program and Create Additional Incentives for Participation

Under this option a variety of measures would be taken to strengthen Medicare's risk and cost contract program.

- HMO payment
  - + Impose upper limits and floors on regional payment variation and create outlier pools for high cost cases.
  - + Conduct demonstrations of competitive rate setting.
- Simplify Beneficiary Choice
  - + Create a standard core benefit for all Medicare managed care plans.
  - + Establish a coordinated open enrollment process for Medicare managed care plans and for Medigap.
  - + Prohibit Medigap plans from health screening, imposing pre-existing condition exclusion periods or charging differential premiums based on health status or age.
- Increase Availability of Managed Care Option
  - + Authorize the Secretary to contract with purchasing coalitions for the provision of Medicare benefits on a capitated basis.
  - + Increase payment to managed care plans operating in rural areas and modify the requirement that commercial enrollment equal or exceed Medicare and Medicaid enrollment (50/50 requirement) to encourage participation.

Option 3) Create More Flexible Managed Care Options

Under this option, Medicare would move to create more flexible managed care options for beneficiaries.

- Medicare SELECT - Make a restructured Medicare SELECT available to all beneficairies. The SELECT program would become a federal contracting option subject to similar safeguards as now apply to risk and cost contractors. In addition, entities wishing to obtain a Medicare SELECT contract would have to be actively involved in managing care.

- Expand Availability of Point-of-Service Options - Encourage Medicare risk plans to offer point-of-service options as an additional benefit to enrollees.

- Medicare Point-of-Service - Authorize the Medicare to contract with entities to create comprehensive preferred provider networks in areas where this option would not be otherwise available.

MEDICAID MANAGED CARE

I. Current Law and Growth in Managed Care

Current law: States may implement Medicaid managed care through voluntary enrollment programs or mandatory programs under Freedom of Choice waivers (under 1915(b) waiver authority) and section 1115 demonstration waivers. Managed care arrangements under waiver programs include capitated, HMO-like programs and primary care case management (PCCM) programs.

Enrollment: Enrollment in Medicaid managed care has been dramatically increasing in both actual numbers and as a proportion of Medicaid beneficiaries over the last several years. Managed care enrollment grew by 63 percent between 1993 and 1994. Because States generally leave elderly and disabled Medicaid beneficiaries -- particularly nursing home residents -- in fee-for-service, current enrollment represents approximately one-third of the target population. We anticipate that this proportion will continue to grow, and approach full enrollment in managed care, without changes to current law.

II. Issues in Medicaid Managed Care

- Managed care expansions should represent an effort to develop more efficient health care delivery systems.

- Managed care arrangements should ensure accountability across all elements of the system. In particular, financial accountability, public oversight and quality of care should be emphasized, and the necessary data must be collected and furnished to permit such accountability.

- In the absence of a Federal mandate, proposed options must appeal enough to States to induce their participation. Providing program design flexibility and additional Federal dollars would appeal to States.

State Impact: Changes should provide flexibility for States to develop their own time-frame for managed care and target managed care programs to the populations and provider markets most appropriate for their State. While current law incentives have provided an effective avenue for managed care expansions, States have expressed interest in having more flexibility.

Managed care systems require considerable administrative "infra-structure" to be successfully implemented. Many States or portions of States may not be ready from a management perspective for managed care.

Budget Impact: The fiscal benefits of managed care will continue to hold down the rate of growth in Medicaid spending. Effective proposals would provide new incentives or new methods for States to develop cost-effective managed care programs.

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Reduced Pressure for 1115 Waivers: The Federal government has allowed States to implement managed care systems through 1115 demonstration waivers, but budget neutrality continues to be problematic. Legislative proposals to ease managed care implementation without an 1115 waiver would both reduce administrative problems and allow the waiver program to focus on innovative approaches rather than only managed care expansions.

Beneficiary Impact: Proposals to give States broad latitude to mandate managed care and establish enrollment lock-ins have been very controversial in the past, because of their anticipated impact on Medicaid beneficiaries. Quality of care measures are still developing, yet the incentives to "underserve" patients in managed care need to be closely monitored.

III. Options

The following options emphasize flexibility rather than new providing new Federal funds to the States.

Option 1) Increase State Flexibility

Targeted legislation would be proposed to reform the current Medicaid managed care program to provide States with additional flexibility within their regular Medicaid programs. These proposals would encourage the use of managed care and simplify Medicaid administration.

Legislative changes that would provide States with new latitude to establish managed care programs include:

- Permitting limited waivers of enrollment composition rules when States establish quality assurance systems.
- Permitting States to develop primary care case management programs without a waiver.
- Permitting six-month enrollment lock-ins for all managed care plans.
- Permitting States to contract with a single HMO in rural areas.

HCFA could also establish Federal 1115 waiver policies that would give greater priority to programs that would increase the use of managed care.

Option 2) Remove Current Prior Approval Barriers

Permit States to develop mandatory Medicaid managed care programs as state plan options. States would not need Federal waivers to develop primary care case management programs or enter into risk contracts. Current statutory requirements that serve as barriers

to Medicaid managed care would be eliminated.

In order to take advantage of this enhanced flexibility, States would be required to play an active role in quality oversight and require health plans to meet new, more stringent quality assurance requirements. (This approach is similar to the 1992 Moynihan managed care bill.)

Option 3) Mandate Managed Care

Require that States develop Medicaid managed care programs for all beneficiaries. Quality assurance monitoring would be particularly critical if all States are required to implement managed care, regardless of previous experience with capitation and beneficiary protections. Therefore, States could be required to implement Federally-defined quality assurance programs; in return, current statutory quality proxies could be eased.

Typically, managed care programs save approximately five percent from Medicaid fee-for-service spending. Proponents of this approach have used this statistic to develop savings estimates. If a mandate generated this level of savings nationwide, total additional Medicaid savings would be between $1 and $2 billion a year -- or $10 to $20 billion over ten years.

States would be able to apply for waivers to continue fee-for-service (FFS) service delivery in geographic areas that cannot sustain a managed care system. The State would have to stay within a FFS payment limit based on managed care rates. These waivers would last for three years; to renew the waiver, States would have to demonstrate again why managed care would not be successful.