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Federal Regulations Affecting Health Benefits

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The federal government has become more active regulating health plans. Recently effective laws—the Health Insurance Portability and Accountability Act of 1996, the Mental Health Parity Act, the Newborn's and Mother's Health Protection Act, and the Balanced Budget Act of 1997 have cost implications to many group health plans. The prospects for future legislation this year based on the Norwood Bill and the President's proposed "Consumer Bill of Rights" appear excellent. The panelists explore key aspects of each law and cost and design implications on group health plans. They also discuss the expected direction of future federal legislative actions affecting group health plans.

Mr. Thomas G. Ruehle: The subject and nature of our federal regulations have changed significantly over the past few years. This session will address the nature of these regulations and how they affect insurance companies and employers who provide health benefits. We're going to start with Gordon Trapnell, who will provide an overview on recent legislation. Gordon is president of Actuarial Research in the Washington, D.C. area. He consults primarily to government agencies and organizations and is a frequent speaker at the Society meetings. We're then going to follow with discussion on how insurance companies respond to this new environment of federal regulations. This will be led by Geoff Sandler, assistant vice president and actuary for Empire Blue Cross/Blue Shield in New York. He's a past chairperson of the Academy Committee for Federal Health Insurance. We're

Note: The chart referred to in the text can be found at the end of the manuscript.

going to then continue with Mark Olson, who will discuss how employers are affected by the federal health regulations. Mark is a principal with Towers Perrin. He's a health practice leader in the St. Louis office who consults to several large companies, including some *Fortune* 500 companies. We're then going to finish with Gordon Trapnell commenting on the likely direction of future federal legislation on health benefits.

Mr. Gordon R. Trapnell: Actuaries are used to dealing with individual states on regulation of health insurance and life insurance. But in recent years, the federal legislature has started to act more and more like a grand state legislature, with all of the same pressures and activities. In fact, there seems to be no limit on what they will get involved in, if they sense some votes, publicity, or money. The reason is ERISA's preemption of the regulation of employee benefits by the states, as long as they're provided by an employer benefit plan that is a single employer, self-insured, or the result of collective bargaining agreements. The sense is that the federal government is just getting started going through the types of legislation that have appeared in practically every state, and that has become the target of every consumer lobby, which the consumers have always been more comfortable with at the federal level, increasingly supported by a coalition of providers who have joined together in a massive lobbying effort. We have already seen some significant interventions. First came the Health Insurance Portability Act (HIPAA), with its 48-hour minimum maternity stays, mental-health (MH) parity, and registration of multiple employer welfare associations. Next came the Balanced Budget Act (BBA), which really should be called the Unbalanced Budget Act, since the budget would have been balanced a lot better without it, with its introduction of a gag rule and strong provisions affecting retiree medical benefits and Medicare supplemental policies. Next, we seem to be getting something called consumer protection legislation, which the cynics call provider protection legislation. There are so many different facets to it that it's almost unlimited, the ways in which it may interfere in the operation of not only HMOs and other integrated health plans, but health insurance policies as well.

In response to all of this increased interest in the Congress and the Administration in regulation of health insurance, the government has already undergone change. In particular, I think you'll see a new player at the Department of Labor (DOL), known as the Pension and Welfare Benefits Administration. The DOL has traditionally limited its interest and its responsibilities under ERISA to matters of the integrity of pensions, disclosure of financial arrangements, and similar legal issues. However, it has now beefed up its economic and health services research staff and is taking a great interest in consumer protection legislation and regulation. I will return later to talk about what I think actually may come out of all of current legislative initiatives.

Mr. Geoffrey C. Sandler: Gordon Trapnell has provided an overview of the regulatory environment at the federal level. I'll address the impact these regulations have on insurers from the point of view of pricing and premium levels, product design, administrative recordkeeping and claims processing, and marketing. From an insurance company point of view, regulation affects one or more of three broad areas, (1) benefits and coverage, (2) administration and internal operations, and (3) products and markets. I'd like to address each of these in turn and give some examples of how we at Empire would view the potential impact of regulatory changes in general. I'll also share some details on how we responded to some specific pieces of legislation.

With respect to changes affecting benefits or coverage, some examples are the Mental Health Parity Act passed in 1996 and effective January 1998, the Patient Access to Responsible Care Act, (PARCA), which has been introduced in the House by Representative Charles Norwood (R-GA) and various proposals that affect the definition of medical necessity.

The Mental Health Parity Act affects all groups with at least 50 employees, including ASO groups and applies to MH benefits only. Treatment of substance abuse and chemical dependency is not considered MH service under this act. Additionally, if the application of the law results in greater than a 1% increase in the group's premium, the group will be exempt from the law. Under the Mental Health Parity Act, health plans can no longer have annual or lifetime limits on MH that are less than for other types of benefits. If a group health plan has an aggregate lifetime or annual dollar limit on medical and surgical services, the plan must do one of two things: Count mental health in any medical and surgical services aggregate limit or it must establish a separate limit that is no less for MH than for the medical surgical limit. If a group health plan has no aggregate lifetime or annual dollar limit for medical and surgical services, then the plan may not have an aggregate limit for MH services. The group health plan may still use cost sharing, such as deductibles and copay limits, on the number of visits or days, and requirements related to medical necessity, such as preauthorization.

At Empire, we had to do a number of steps to implement MH parity. First, we had to identify which of our benefit plan designs had inside limits on inpatient or outpatient MH. Second, we had to identify which of our customers had any of the plans with these benefit structures. Third, sales staff had to be trained about the new requirements under the Mental Health Parity Act. Fourth, our sales representatives then had to go to each affected group and explain their options, either to remove the lifetime maximums, resulting in a possible rate increase, or to keep the same rate, but impose an inpatient day limit and outpatient limits on the

number of visits or the cost per visit. Fifth, we had to do internal training of our customer service staff to acquaint them with the new requirements so that they would be able to respond to customer questions. Sixth, we had to make changes in our claims systems to remove lifetime maximums from our adjudication logic. Seventh, claims processing staff had to be trained on the provisions of the Act, and more specifically, how they affect claims adjudication calculations so no inside limits would be applied to MH benefits after the effective date of the Act when individual claims are processed manually. Eighth, still to be determined are the internal procedures that we will use next year to capture actual claims data and summarize it to demonstrate to affected customers whether their claim costs have changed by more than 1%.

Turning now to PARCA, this bill contains a number of provisions affecting benefits, and some of these affect administrative requirements as well. I'll run through some of PARCA's major provisions. Health insurers must cover emergency room (ER) and urgent care services without a preauthorization requirement if the symptoms would suggest an emergency medical condition to a prudent lay person. The prudent lay person rule and the restrictions on preauthorization requirements affect the way we process ER claims and could result in higher claim costs for most insurance carriers. Health insurance plans offering network coverage must cover specialty referrals when such treatment is deemed medically necessary in the professional judgment of the physician, in combination with the enrollee. Therefore, those referrals cannot be subject to prior authorization by the insurer. This reduces the insurer's ability to apply medical management to its managed care plans. There cannot be specific direct or indirect payments to health care providers under the plan that would be considered an inducement to reduce or limit medically necessary services. In general, this requirement would not apply to reasonable managed care capitations, but could apply to other risk-sharing or risk-transfer arrangements, and other forms of provider reimbursement. This will affect the way we contract with our managed care providers.

Health insurers offering network coverage also must offer enrollees, at the time of enrollment, the option of health coverage on a non-network basis, effectively mandating a point-of-service option. Some HMOs may have difficulty providing this indemnity coverage, because claim processing and provider reimbursement are very different in managed care. Health insurance coverage must reimburse for covered services nonparticipating health providers, at the reimbursement rate offered for participating providers. Health insurers cannot discriminate in participation, reimbursement, or indemnification against a health professional who is acting within the scope of the professional's license or certification under the applicable state law solely on the basis of that license or certification. This provision could eliminate certain inside limits on, for example, chiropractic

services, and may also require covering services of such providers who ordinarily might be excluded from the benefit plan. PARCA and other proposals would eliminate the ERISA preemption of state law and increase the exposure of health plans to malpractice liability. This affects benefit delivery, through possible defensive changes in utilization and review practices and also has administrative implications, which I'll address a little later.

As you consider each of these above provisions, it should be easy to understand how they would affect medical claim costs, either the utilization of services or the cost of services—as well as operations such as utilization review procedures—documentation and the claims adjudication process. Insurers also will need to make sure that their customer service and provider service staff will be able to respond to any concerns raised by the customers or the providers. All of these items, through their effect on claim costs or administrative expenses, will have an impact on the premium rate charged to customers for health coverage. We, as actuaries, will face the challenge to evaluate these cost implications.

Let's move to the impact of regulations on administrative and internal operations. Gordon pointed out that HIPAA, also known as the Kennedy-Kassebaum bill, imposed a minimum length-of-stay requirement for maternity. It also imposed a number of requirements affecting insurers or self-funded group health plans, as well as the individual health insurance market. For group health plans, the limit on preexisting conditions is 12 months, or 18 months for late enrollees. They can't apply to pregnancy, newborns, and adoptees or to coverages of prior plans. Certification of coverage must be provided when individuals are no longer covered by the plan. There must be guaranteed renewability for small and large employers covered under the insured plans. It must be guaranteed issue for small groups of 2 to 50. In the individual market, portability means no preexisting conditions limitations. If there were 18 months of prior coverage under a group plan, the enrollee is not now eligible for a group, and COBRA benefits have been exhausted. There must be guaranteed renewability for all individuals. These provisions have some benefit implications because of the preexisting conditions provisions. There are also significant administrative and record-keeping implications because of the need to determine the applicability of preexisting conditions provisions and the requirement to document and provide certification of coverage when the individuals are no longer covered under the plan.

PARCA and other proposals affect health plan liability exposure. PARCA eliminates the ERISA preemption, thereby increasing the exposure of health plans to being sued. This could directly increase an insurer's liability costs. Other proposals effectively deem utilization review to be the practice of medicine and, thereby,

expose health insurers to additional vicarious liabilities. Proposals such as the Patient's Bill of Rights contain a number of requirements affecting data and record-keeping requirements. Many seek to establish how well plans prevent or treat certain illnesses, for example, the frequency that children get vaccinations or that diabetics are checked for high blood pressure. Requirements such as PARCA's imposition of a time limit on improving preauthorization requests create additional record-keeping requirements. External review requirements for appeals create additional administrative requirements, additional recordkeeping, and may add additional expenses and timing considerations in the claim adjudication process.

PARCA would require managed care plans to establish quality assurance programs to assess enrollee health status, patient outcomes, processes of care, and enrollee satisfaction. Insurers must also assess their administration and funding capacity to support preventative care, utilization, access and availability, cost-effectiveness, acceptable treatment modalities, specialty referrals, the peer process, and administrative efficiency. Because of my involvement with managed care plans, I have a pretty good sense of how difficult it would be to comply with many of these requirements in a managed care environment. Other proposals apply some similar provisions to nonmanaged care plans. And this would be an even more daunting challenge to health insurers, especially when there's no primary care physician to centralize an enrollee's medical records.

Finally, I'd like to turn to how regulations can affect products and markets. The Family Medical Savings and Investment Act of 1995 created a pilot program for medical savings accounts (MSAs). These are similar to flexible spending accounts. The Act permitted individuals to set up tax-favored accounts under specific conditions:

- The individual would have to be covered by a catastrophic health plan with a deductible of $1,800.
- The individual or his or her employer could contribute an amount up to the deductible, but no more than $2,500 a year.
- Contributions to the account would not be taxed, but investment income earned by the account would be.
- Disbursements from the account would not be taxed if they were used to pay unreimbursed medical expenses or long-term-care insurance premiums.
- Any unused funds in the account would remain the property of the individual.

From an insurer's point of view, the first question to address was whether it was worthwhile to create an MSA product. From my company's point of view, this meant the catastrophic coverage that operates alongside the medical savings

account. As with any potential new product, we had to evaluate the potential market for the product and the internal resources necessary to create the product, develop the benefit design, work out internal administrative procedures, price and even come up with the name for the product, which involved extensive service mark searches so that we didn't violate some other company's work. All of this took resources away from other corporate initiatives. In the end, I think it's not overstating the case to say that the MSA pilot program has not been very popular nationwide, but we spend considerable resources to develop a product that we brought to market.

The BBA affects the health benefit marketplace through its enabling of new competitors in the form of provider-sponsored organizations (PSOs). The PSOs function very much like an HMO, but essentially the provider organization would be taking the insurance risk directly. To the extent that PSOs are subject to different requirements than HMOs or other health carriers, the playing field is not as level as it once was.

I'd like to make some additional comments concerning Medicare. Federal regulations affect Medicare in various ways just about every year. In the simplest sense, annual changes in Medicare reimbursement levels, the resource-based relative value schedules (RBRVS), affect how indemnity insurers and claim administrators pay claims under indemnity coverages. Many negotiated managed care fee schedules are tied to Medicare RBRVS and there are many other changes that affect Medicare as well. The BBA created the Medicare Plus Choice program, creating possible new alternatives to traditional indemnity Medicare coverage, and the more recent Medicare risk HMOs. For example, we may, in the near future, begin to see Medicare PPOs. The BBA also had other direct effects on Medicare HMOs, affecting capitation payments by the Health Care Financing Administration (HCFA) to the HMO plans for covering Medicare HMO enrollees, and the structure and timing of the Medicare risk rate filings. The act also introduces risk adjustors into the Medicare risk HMOs in the year 2000.

These are just a few examples of how federal regulations affect health insurers. Each change has some impact on the cost of benefits, internal administrative expenses, or products and markets. Regulation can have a direct or indirect effect on plan costs or premiums, and on the products offered in the marketplace. As actuaries, we can play important roles in evaluating the effects of regulations on products and markets to help ensure appropriate responses that comply with the regulations and at the same time, to meet the needs of our customers and clients. Now I'll turn the program over to Mark, who will address the employer perspective.

Mr. Mark F. Olson: I want to give you the perspective of how employers typically respond to legislation, regardless of whether it's at the state or the federal level, although we're primarily focused on the federal level. It's important to keep in mind the perspective of the employer, because a vice president of human resources or a benefits manager is going to have a lot of different things going on. This is just going to be one small piece of what they do and what their responsibilities are. They have year 2000 problems that they're dealing with and a lot of them are being asked to reduce staff and do more with less.

Where do all the regulations come from? Chart 1 shows that the federal government, since it wasn't able to pass comprehensive health care reform legislation a couple years ago, has jumped on the incremental bandwagon. When the 30 or 40 states actually pass some type of legislation, the federal government says, "Gee, that's a good idea, let's pass it too." That way they can say, "Look constituents, we did something." It usually gets passed with a lot of fanfare. There might be pictures in the rose garden. You'll read about it in the paper and it'll be on TV and other high-visibility type things. This includes the Mental Health Parity Act, mandatory minimum maternity stays, and some things that were mentioned that will probably be coming up, such as the ER-prudent lay-person definition. The lower left-hand corner of the chart shows the agencies that unfortunately have to deal with the regulations once they're passed. The DOL and the IRS have to figure out what it really means and clarify some of the verbiage that's included in the legislation. A lot of this is low visibility; employers really have to look out for this stuff. If they're not keeping up to date with legislative reporting, the agency, or something like that, some of this can sneak by, so it's important to be aware that this is another area of concern.

In the lower right-hand corner are the courts. If the employer and an employee don't like what the governing agencies have decided it means, or what the legislature or Congress has decided it means, they'll mount a legal challenge, and either try to overturn it, change it, or say that it doesn't meet the spirit of the law. A good example of this is the recent Supreme Court ruling on a case with respect to COBRA eligibility. I had an employer call me about a month ago and ask if he should change his plan. We told him, "You can go ahead and change your plan if you want to, but right now, this is our position." When the legislation passed, he wasn't even aware of it. It was four or five pages into the newspaper, and he wasn't really of it.

Once the vice president of HR learns about potential legislation or anything that's been passed already—and he may hear about this from some type of legislative reporting service, the trade journals or from some administrator or a consulting firm—a series of questions that come up. What are the requirements? What do I

really have to do here? If those are the requirements, then which plans are affected? How many of the plans that I deal with are affected? Are my union plans affected? Are the nonunion plans affected? They actually have to go down the list and figure out which plans they may have to deal with. Some of it will be fairly obvious, but some won't be so obvious, and there have been some recent instances where seemingly medical legislation affecting primarily medical plans trailed into dental plans, depending on how the employer's plan was actually set up.

Some of the legislation will have a direct impact, and some of it may be more indirect. I'm primarily discussing the direct impact here. The effective dates will be important. Typically, there are differences here between when union plans have to comply with the law. They're always more favorable and try to factor in the lag between when it gets passed and what employers have to do to meet collective bargaining agreements. Then there's also the issue of whether or not there are any penalties.

Depending on the risk tolerance of the employer, they'll actually look at what the penalties might be. Are they just fines? If I don't comply, I can I change it and not be penalized, or will criminal penalties apply? And should I try to do something as soon as possible? These will all have some bearing in terms of how HR will respond to the legislation.

There's also a series of specific issues that employers need to look at with respect to their plan. How they deal with these issues may depend on how the employer has set up his or her plan and what the corporate strategy and objectives are. There'll be financing and funding methodology. If it's a fully insured plan, they may rely on the administrator to say, "This is what we're doing to the plan as a result of this legislation." You're really at the mercy of the administrator to see what's going on, and you probably aren't going to be able to change things much. If it's a self-insured plan, you have more flexibility. You may be able to talk to the administrator about what you might want to do. However, you may still be constrained by what the administrator can actually do in terms of administrating any changes that come through.

There'll be reporting, disclosure, communication requirements, a summary of material modifications, and changes to your summary plan description or your plan document amendments that need to be done. And if there are plan changes, you'll need a report on the impact of what the plan changes mean. Typically, employers will have some level of control. If the plan change is only worth $100,000, the vice president of HR can go ahead and approve it. If it's more than that, maybe he or

she has to go to the benefits committee, the CEO, the chief financial officer, or somebody else at a senior level.

The other issue here is that if the legislation is significant enough, it may actually cause employers to rethink their health plan. A good example of this is what Gordon had mentioned earlier, the presence of the BBA and the Medicare provisions. As a result of what HCFA is trying to do with the enrollment process, a lot of employers are asking, "If the government's going to get in the enrollment business, then why am I offering retiree medical coverage to individuals after age 65? I'll just either provide a flat dollar amount to everybody and they can go buy what they want. Or I'm just going to get out of it altogether, and let them enroll with whatever's available in the marketplace." However, I think that may be somewhat premature. I've had several employers express great skepticism that the government will actually be able to pull this off, but it looks like they're at least headed that way. It may get delayed, but they're trying very hard to get there.

When you look at the strategy development process overview in its total, the first thing that happens is there's a notification or recognition that something's passed. This is the employer or the vice president of HR finally saying, "Oh, no, it's passed, I've got to do something now." Then they'll need to assess this against other priorities. Where does this fit in the big scheme of things? Some employers are so focused on growth or income targets that responding to some type of legislation may be way down on the list. And, if it doesn't support their overall business strategy, even though there might be penalties associated with it, trying to actually implement any changes might fall way down on the list of priorities. They may just take a chance and say, "I'm not going to worry about this until somebody comes after me and says I have to change it."

In recognizing which plans it actually affects, the employer may pick up the phone and call ABC Company down the street, talk to a buddy, and ask, "What are you doing about this?" I think this happens more than it probably should, but it's prevalent even with the large employers. There are several large employer groups that actually get together on a weekly or monthly basis and discuss how they're handling certain issues. A good example of this is, when the Mental Health Parity Act was passed, a lot of the health plans said, "We're going to claim 1%." And this was before they had decided that, you had to do your retrospective review after the legislation was passed. Once the health plans said that, a lot of employers jumped on the bandwagon and said, "If it's good enough for them, I'll do it too. OK, we're all set, and we cruise on down the road." Then the government came out and said, "Here are the rules. This is how we're playing. You're going to have to go back and actually do something, then demonstrate it retrospectively, after the legislation's been passed and it has been effective."

The next step is what I would call the preliminary evaluation, in which employers would actually try to assess the situation and develop some alternatives. What can I do? What types of things will actually help me comply with this legislation? It may be relatively minor plan changes because the plan already complies or they think it complies. They may say, "I'm not worried and, I'm not going to do anything with it. Yes, there are some implications here, but I'll worry about it next year or at some future point when I'm questioned by the DOL or whomever."

In developing the financial assessment one of the things that they'll do is look at the plan design changes, and determine the financial impact, if any, and make sure the administrator can actually administer this. Then there's the issue of making sure it's consistent. If you have a series of HMOs and your own self-funded point-of-service (POS) or PPO plan, you'll want to make sure that some of the changes are at least consistent across the board—as consistent as you can make them. Then revise and develop whatever recommendations might go up to either your boss or the benefits committee. This just lays out the pros and cons, why we're doing these things, the alternatives that we considered, the decisions, and the path that we took to get those decisions.

Beyond that, I guess the last resort here is for an employer to implement a legal challenge against whatever the legislation might be. This is pretty rare. I don't know many employers who do this on their own, but there are groups of employers that will periodically say, "This is crazy, we're going to jump in and try to make sure that this doesn't happen, or at least challenge it in court and see if we can get it overturned." There also is a group of employers who are pretty active in lobbying and will try to stop things, or at least make employers aware of what's going on before things happen. A good example of this is the ERISA preemption that's being bandied about now. There's fairly good employer support, and most employers are aware of it. It remains to be seen whether they can stop it or not. That's a different question.

Mr. Trapnell: There are literally dozens of bills in Congress, and some with hundreds of sponsors, which may or may not mean anything. The action that counts is in the House. The Norwood Bill has gotten the most attention and publicity, first with PARCA and recently with a revised version that Representative Norwood introduced just recently, that's referred to in Washington as PARCA Lite, which I will be talking about later. He has also introduced a series of clauses that addressed criticisms of his bills, which he maintains proves that the bill can have the effect that a lot of the opponents have been ascribing to it.

The other most influential bill is the Dingell Bill, sponsored by Rep. John D. Dingell (D-MI) and Senator Edward M. Kennedy (D-MA). This Democratic proposal has literally dozens of provisions, all overlapping in interesting ways. Another influential bill was the one introduced by Sen. James Jeffords (R-VT) called The Health Care QUEST Act which has been largely limited to types of things such as disclosure and due process, particularly appeals, review of quality, transferring a review to some external authority, which would probably reduce a lot of administrative costs and chill effects on use of judgment, but otherwise would not have the kind of direct interventions sought by the provider community.

Another bill that's still alive is the Fawell Bill to enfranchise association health plans by exempting them from state rate regulations, state mandates, taxes, and assessments. Perhaps the most interesting thing about that for me is it's being pushed by a well-known pension actuary, Harris W. Fawell (R-IL) who works on the Hill. The bill to watch is being put together by Representative J. Dennis Hastert (R-IL.) who is leading a task force designated by the Republican leadership to decide what they really want to do. As far as I can make out, they've been sitting on it to see how it's going to play in the next election. But the expectation is that they will gather together the less-controversial provisions that have been in most of the consumer protection bills, particularly those that have been pretty much conceded by the American Association of Health Plans as too difficult to fight. The real struggle then would be whether some of the more controversial provisions either appear or get attached as a result of the legislative process. There's also some chance that the new version of the Fawell Bill will come back. Association health plans have been resurrected as Health Marts, to make them sound more like things that are regarded in health services research as good, such as purchasing alliances. The competition has already progressed to the point where it's not really between different bills, but over specific provisions that have been identified in the bills, many of which Geoff mentioned, because PARCA contains a good number of them. But most of these pieces are vaguely drafted, and some of them are downright schizophrenic. A good example is the one about physician incentives. The bill has two principle provisions affecting financial incentives. One says that you cannot make a payment to a provider as an inducement to reduce or limit medically necessary services. The other requires that if you include in your payment to providers, payment for services that the provider doesn't provide directly (i.e., there are financial incentives), that then you must provide a stop-loss under standards developed by the Secretary. You must also survey current enrollees and former enrollees concerning their access to care. Think about the administrative costs of surveying former enrollees.

But then it goes on with a revision that says, "Nothing in this subsection shall be construed as prohibiting all capitation and similar provider discount arrangements."

That was where you said "responsible," but the new version of the legislation uses the word "all" so that, literally, it would be fulfilled if the Department of Health and Human Services (HHS) could come up with one satisfactory capitation arrangement such as a staff model with no incentive bonuses.

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The word "responsible" was much more waffle-able. But of course, before anybody panics about that, go back and read the Stark Amendment to the Medicare program contracts. It delayed the enforcement and allowed the secretary to determine whether there was risk or not. That's where we got these minimum stop-losses. It was about $5,000, and minimum withholds of 30%. That's where these things came from. The HCFA's response was, "When were physicians really at risk? Of course, the ultimate risk is putting somebody at capitation. How can they say that nothing in this bill is going to prohibit you? You can't give them any inducement, but, it doesn't prohibit *all* capitation arrangements. You have to devise a capitation arrangement that doesn't involve risk, and I'm not sure if anybody knows how to do that. But this is a good illustration of how vaguely worded these things are, and how unpredictable the actual impact is. The meat is going to have to be in the regulations that are written. The regulations will try to incorporate the spirit. They may try to blunt the spirit, as they did with the Stark Amendment. The HCFA staff was appalled at the Stark Amendments and tried to find some way around them, because it pretty much would have precluded risk contracting.

You can group these consumer protection provisions, and I've tried to group them into not exactly benign, but at least regarded as either too difficult to fight at the slogan level, and have been pretty much conceded by the lobbyists for the health plans. That would include things like the disclosure provisions, although some of those can be pretty onerous, especially for administrative expenses. With typical schizophrenia, it virtually tells you how to fully disclose every arrangement, utilization review procedure, and claim procedure you have. You don't have to disclose any proprietary secrets. Another one is the definition of "emergency," which Geoff talked about a bit. The consensus of the health plan seems to be that it's a dumb idea to legislate it. They would like to tinker with the definition a bit and to prevent routine approval as meeting the layperson rule of conditions as just a way around to use the ER when it's convenient. However, they've given up and said, "We hope to influence the regulations." One of the provisions that is in practically every bill requires fairly elaborate internal and external appeals processes. And the fact that Medicare risk contracts have contracted out an external appeals process at relative low cost and with little controversy, has pretty much forced the health plan representatives, the association, to concede that there are going to be external appeals, so it's too difficult to fight. There could be considerable administrative expense involved in that, though, and a lot of it in

tighter time frames. It's just one more area in which you will probably have to demonstrate that you've dotted all the I's and crossed all the t's for very exacting regulations.

The other thing along the same lines are disclosing utilization review (UR) standards and having physicians develop them. A few areas make me nervous as to what they might mean. Another one is the direct access to specialists in the network, without having to go through a gatekeeper. There are provisions for a regulatory process through which someone in the government will decide that you must cover certain drugs, which, of course, would immediately become the targets of lobbying efforts from those people who need them and those companies who would profit from them. UR standards, direct access to network, drug formulary, and reconstructive surgery, especially breast reconstruction, are some of the things that all have a definite cost, but something that health plans could probably live with. For some the administrative costs will probably outweigh the claims costs.

But then we come to the more onerous provisions. I've had a hard time trying to decide what I think about the effect of liability provisions. I've always thought that the legal establishment of this country would catch up with managed care and gut it in time. But it may take a number of years for them to do it, whereas these provisions would speed up the process and guarantee what the result is. Certainly, as far as what the effects could be in the immediate future, that tops my list. The second is the area of financial incentives. It's one of the few ways health plans can really get at what occurs in a doctor's office, unless they want to have their own doctor monitor each doctor on their panel. Giving at least some financial incentive is just about the only way to get at large proportions of the services that health plans provide. These provisions have the potential, certainly, to undermine financial incentives. It's always amazing to me that consumers don't worry about financial incentives to overprovide services; they just worry about the incentives to underprovide services.

There are provisions that are generally referred to as provider protections, and it's hard to figure out what they really will do. At one extreme, they will tell health plans that if you cover a doctor, you have to cover everybody else if that doctor is licensed under state law. That wouldn't be too bad, but the other one appears to be any willing provider within each of those nonphysician specialties or practitioners, which would undermine any control a health plan could have over what it pays for. The bills, as drafted, don't appear to do that, but this, of course, is exactly what the nonphysician provider coalition is pushing for. When a provision like that's going to be attached to something, you never know what's going to be in the final legislative language until you read it the next morning or maybe two weeks later. Of course, people vote on these things without having actually read them.

Then there are things like maintaining adequate networks. This could be reasonably implemented, and it could already be required for National Committee for Quality Assurance (NCQA) accreditation. But if you read those words, some clauses are very onerous, they say that you must have a practitioner who's "reasonably close to every enrollee's residence." What does that mean? One of the nearest 10? I don't know.

Then there's the provision for the Pharmaceutical Research Manufacturer's Association that would require covering experimental therapies—that's drugs and devices—in clinical trials, so expenditures per capita for drugs could go up at an even sharper exponential curve. Then there's the mandatory POS in PARCA. It's not so much that you have to offer a POS option to every single enrollee—and I hope enrollee would mean the employee and not each family member—but even that's not clear. Then there's another provision saying that you have to charge a fair premium. It's fairly explicit what a fair premium is. Now, either you're not going to offer many POS plans, or you're going to have such an enormous regulatory cost to establish that you're charging a fair premium, to say nothing of how state authorities will decide how a fair premium ought to be determined. And this is one where it might go through a process where they took the 1% limit pretty lightly, until the regulations appeared and said, "No, we're serious. You have to get your data out and show it." Can you imagine what their POS premiums would be like?

What can pass? As I see the situation, the Democrats have largely been successful in bringing health care issues to public attention this year, and getting a lot of publicity. The Republicans wanted a quiet, uneventful legislative session leading to winning enough of their marginal races to retain control of the House. They thought they could just ride the economy, keep things quiet, and not let anything interfere. But the ruckus that's already occurred over the tobacco bill has probably changed that situation. You have to think about how all of this is playing out in a couple of dozen House races, where the politics are very different from what they are on the national level. But the Republicans and Democrats are both keenly aware that the control of the House depends on the outcome of those races. And these issues, apparently, are playing strongly. The Democratic candidates are talking about the tobacco bill and the consumer protection. I think there's at least a 50:50 probability that the House leadership will pass a consumer protection bill late in the session to provide cover for its candidates, especially given the way the newspapers have been playing the demise of the tobacco settlement with headlines such as, "Republican Senators Kill Tobacco Bill" in the *Washington Post*. It's a little more complex than that, but slogans count in these marginal races. By the way, I think there are two ways some of these provisions could pass, either as a bill, in circumstances that I've described, or by taking one or two of the more popular

provisions and attaching them to something else. The Democrats will try to attach them to everything coming through the Senate and the House because their game plan is to attract as much attention to these issues as they can and to get as much unfavorable publicity for the Republicans opposing them.

What might be included in a composite bill? It'll probably have most of the items that were in the Patient's Bill of Rights. That would include the prudent lay person, the disclosure provisions, and the appeals provisions. Then it gets more difficult to predict. I'd say the POS option has a very good chance of making it, largely because the opposition has been muted by being attracted to the more onerous provisions.

There are things that are so much worse that the opponents of the various provisions haven't been able to concentrate on what is onerous in some of these provisions for them. I don't think anybody is really thinking about the administrative costs associated with what I call the benign provisions. The handicapping appears to be that the liability change won't make it. The Republicans really are dead-set against that and they'll pass everything else first. After all, their political enemies are the trial lawyers. But one of the things to consider, if something doesn't pass this year, and especially if the Republicans lose seats and are tagged with not having been responsive to health issues, as is already happening in the House races, it's almost certain that something like this will happen next year. Of course, it could come rushing through this year.

One final player that will be very influential in this debate has yet to be heard from, and that's the Congressional Budget Office (CBO). The CBO hasn't come out with their set of cost estimates for these provisions, and that will be very influential. I've been watching the CBO for about 15 or 20 years, as a very unusual act in the context of our national legislature. If you ask people who work on the Hill, and that includes Congressional Research Service, with the exception of CBO, who they work for, they'll tell you. If they're on congressional staff, they won't mention the staff as being the employer, but what congressman or representative is their real patron. If that patron turns over, they turn over, regardless of what their responsibilities are, what their records are, and what they know. The one act that has appeared to be impervious to this has been CBO. It has had genuine integrity and the Congress has responded to this with typical schizophrenia. On the one hand, it was delighted to put CBO up as being something objective, to counter these manipulated administration budget numbers. On the other hand, members of Congress can't resist telling them what to do. And they're intensely frustrated with CBO's economic forecasts, which have been much better than any reasonable person would have projected, including probably everybody in this room, unless there's somebody here who doesn't belong in an actuarial association because

they're much too optimistic. If we have such a person, I think we'd better revise our educational procedures to make sure we don't have them in the future.

Anyway, the economy has constantly exceeded CBO's projections, and the Republican leadership is furious. You have to understand that when you make a cost estimate for a legislature, and this is true for state legislatures as much as the federal, as actuaries, with our clients being insurance employers, they're payers in most cases. Conservative means you estimated high and if things go better, that's great; there's some money left over. But if you're working for a legislator, it's exactly reversed. If you overestimate, that's money the legislator can't spend on his or her constituents. And they're furious about that. That's the situation with CBO now. CBO's been so beaten up over this that I don't know what to expect, but it is a major player.

Mr. Ruehle: There's a lot of activity and there can be a lot of problems with what might be passed.

Mr. Jay C. Miniati: I've been working out of the country for a little while, so I'm using this session to get current again. On the surface, it sounds like we're legislating our way right out of managed care, if not just outwardly jeopardizing the affordability of those kind of plans. If that's not the case, then with the legislation that's being passed, or prospectively going to be passed, where do you think we're going to bottom out in five years?

Mr. Trapnell: I thought a lot about this when I first read through these bills. I said, "My God, they're going to eliminate managed care." They're not going to eliminate it, but make it infinitely more complicated and introduce a very strong bias toward one particular kind of managed care. That's going to be intermediate-sized multispecialty physician practices, where they can, through internal means and collective interest in their financial outcome, accomplish a lot of the things that are being banned, or made very difficult, in the context of independent physicians who are not controlled by the plan. In other words, the attacks on financial incentives won't eliminate all financial incentives. The regulation of precertification and UR is not going to eliminate case management, as I learned yesterday. Disease management is taking over. There will still be ways to manage care. It will be more difficult. It will be much more open. You'll have to comply with far more procedures. Administrative expenses are going to go way up, if these things pass, but before panicking, you should still consider the experience with the Stark Amendments. When they came out in the late 1980s, they could have virtually eliminated risk contracting, but insurers found ways around it. As I said, it's going to become a much more regulated atmosphere, but not an impossible one.

Mr. Ruehle: I'd like to add one more point, from an insurer's point of view. I agree with what Gordon said in terms of the effect on managed care plans, but one of the complicating issues is that, as you make managed care plans more expensive, they start to get closer and closer to the cost of nonmanaged care plans. And, as you compress the premium differentials between managed care and nonmanaged care plans, the buyers start thinking less about managed care. As the prices get closer together, they say, "For a little bit more, I can have an indemnity plan with all the kinds of freedoms that I always liked."

Mr. Olson: Or a PPO.

Mr. Ruehle: Yes. So, in a theoretical sense, the movement will be toward more complicated and costly managed care plans that are, more highly structured internally have more administrative procedures, more benefit claim adjudication, and so on. But it's not quite clear how those plans will play out in the marketplace because of what's going to happen to the premium relativities among the different kinds of products, both managed care and nonmanaged care.

Mr. Sandler: I might add that there will be a chilling of judgment, because of the need to justify everything, and particularly in something that's evolving as rapidly as health care, you'll always be practicing. Your procedures will be based on medicine as it was five or ten years ago, as documented in research that's been published one or two years ago. You can't take advantage of expert judgment to tell you where things are right now, and are likely to be in the immediate future.

Mr. Olson: I want to throw my two cents in here too. It will create an enormous challenge for the health plans to try to manage risk in a better fashion. I think we're seeing some of this, at least with the Medicare plans and health-style and life-risk assessments, where they actually identify the risks when the person signs on and try to manage it in a better fashion than they are currently.

Ms. Jean Wodarczyk: Being a health actuary today is kind of fun because they continue to pay us to look in a crystal ball and be wrong. With that as a backdrop, I'm going to ask you to look in your crystal ball. We're staring right down the barrel of some new Medicare options that appear to me to be not only wide-ranging, but a psychotic response to trying to save money in the Medicare environment. You all must be placing your bets today on how the market's going to respond to these options with your companies and your clients. I'd be interested in what your thoughts are and how this significant population is going to respond to the offerings that Medicare has laid out.

Mr. Trapnell: There are many facets to that question, but let me make an observation about the legislative process in general. Cost estimates can influence the legislative process. They don't always. Frequently, they're totally irrelevant. The decisions are made on completely different grounds. But to the extent they do influence them, you have to understand the terminology on the Hill. When they get a cost estimate from the CBO that they, by law, must take into account, they refer to it as "scoring." That's precisely the right word—it's a game. First you persuade them you're going to do something benign, get a cost estimate, and then do what you wanted to do. But you keep the cost estimate. A lot of this would explain how the Congress, having placed the future of Medicare's financial basis on the savings they got out of CBO for the managed care, can turn around and pass a set of legislative rules that will take a lot of that away. That's typical schizophrenia—they have them scored separately.

I guess I view what passed in the BBA differently, because they have provided a financially feasible path for Medicare in the next century, when we can't possibly afford the level of resources that we've been willing to devote to Medicare when there were fewer eligibles. And the future looks like one in which, if you are poor, you'll have access to Medicare fee-for-service or a managed care plan that doesn't provide a very appealing set of providers, and that the participation in Medicare fee-for-service won't fall as low as it is in Medicaid, but it'll be well along a process that I would call the Medicaidation of Medicare, as they let the fee levels fall to the point where the providers who are willing to take those, or practice geriatric medicine, will begin to dwindle.

However, they've provided these other options. Risk contracts, fee-for-service options, and Metropolitan Statistical Areas (MSAs) will disappear unless they find a way to risk-adjust them. But, in the future, if you want medicine at a standard similar to what people have largely enjoyed since Medicare was passed, you'll have to pay a premium for it, in addition to your Part B premium, and this is just to get what Medicare now provides. If you want a Medicare supplement, you'll have to pay a third premium. This is how the country will afford the Medicare program. It'll collect large amounts of premium from middle-class and upper-income people for the medicine of their choice. At least, that's how I view the future.

Mr. Olson: I'd like to add from an employer perspective that employers have been struggling with how to get rid of *Financial Accounting Standard (FAS) No. 106 l*iability and expense for quite a while, and some of them have been taking different tactics. But the BBA certainly created an opportunity for them to get into a defined contribution game, similar to the way the government has gotten into a defined contribution game, or is trying to get into the defined contribution game. The other

point that I would make is that the BBA really is a shell game; it's just buying some time until they can figure out what to do. Unless the CBO or whoever made the assessment about how much time they actually bought is way off again, there are going to be more changes coming down the road. It's just a question of what they are, and what the shape of those might look like. But it's going to continue to evolve, and more changes will be coming.

Mr. Trapnell: I'll add to that. My favorite one is the way they plan to balance the budget in 2002 in part by moving all of the payments for the prepaid health plans, that is, the risk contracts and the fee-for-service plans, up to September, so they go into the previous fiscal year. They're then going to move the ones for the following September forward to October and make a double payment in 2003. That's known as balancing the budget.

Mr. Harry L. Sutton Jr.: There was a discussion about PARCA, surveying terminated HMO members, which is already in the rules for Medicare and Medicaid. The physician incentive rules, which also include a new term called "intermediaries," is also used in risk-based capital. The physicians are at risk, even if a clinic or a large multispecialty group refers one patient a year; therefore, they have to survey, each year, active Medicare, or Medicaid members and terminating members when they leave, to find out if they left because they were denied health care. Those are already in place, and they have been since the beginning of 1997. HCFA is are auditing the Personal Injury Protection (PIP) rules for physician contracts. The question I had was on the Mental Health Parity Act. Geoff and Mark, in some states that don't have mandated health benefits, are employers thinking of dropping them? And what if the employer has a medical plan that does not include MH, but subcontracts with a different entity for MH services, such as a separate HMO, or a health plan for mental health? Do these rules about maximum limits and so on still apply if the plans are not integrated into one benefit plan? And could you eliminate MH benefits completely? If you don't have any, the rules don't apply.

Mr. Sandler: Harry, you're right, the rules don't apply. The Mental Health Parity Act does not require plans to add MH benefits if they don't already have them. If the plan doesn't have them, you're not required to add them. If you do have them, you have to treat them, under the parity rules, like other kinds of benefits. I believe that the answer to your other question is that, from a regulatory point of view, the regulations don't care whether your benefits are integrated or not. They don't look at it in terms of the structure of your benefit contracts; they look at it in terms of the benefits that are provided to the covered employees. In that sense, it doesn't make any difference whether you have a MH carve-out under a separate free-standing arrangement or whether it's integrated into your basic health plan.

Mr. Olson: I would agree with everything that he said. The only other thing I'd add is that I only know of one employer who actually talked about just getting rid of MH and chemical dependency altogether. I don't think it's something that would be very attractive to employees in representing that you provide full coverage to everybody.

Mr. Sutton: Yes, I felt that the government has slapped actuaries in the face; of course, they have estimates that the cost would go up 20%, 2%, or 0.5%, from segmented actuaries, I guess. Do you think employers will have to live with this? When they fatten their MH benefits or whatever they have to do to comply, and it goes up more than 1%, will they cut it back? Or is the government figure too complicated, and once they go, they won't go back?

Mr. Olson: My impression is that once the employer has made the change, they probably aren't going to go back. There are only a couple I've talked to that actually even have the mechanism or the data where they're going to be able to go back and say, "Here's what happened, we made the change, and here's what it was before that." There aren't many employers who really have the data, so I think you're right. The other thing is, with the managed MH care industry, with the way trends have gone, costs have come down so much that employers, when they assessed them, realized these changes didn't have much of an impact.

Mr. Ruehle: Also, the restrictions on the law are so specific that there are many other ways you can put limitations in your benefits. Most of the employers I've seen have switched around their limitations and tried to have the same total amount of benefits. I don't know if that's what you've been seeing, Mark.

Mr. Olson: Yes. There are other ways to put limits in here, and what I would be more concerned with is that they'll look at what's actually been done and come back and say, "No, we don't want any limits at all, and you have got to get rid of the day limits," or whatever. I think there's a real potential for that.

Mr. Ruehle: Some employers are looking at their whole plan and saying, "Well, this isn't what I wanted." They're taking an opportunity to reevaluate their benefits and change them. And some of them are improving them because they didn't think they offered adequate coverage.

Mr. Chris Sykes: Under HIPAA, how are people treating late applicants, whether they have a qualifying event or not, and whether they have prior coverage or not? It seems there are some gray areas as to what you can and cannot do with a late applicant, not in terms of the preexisting condition so much as whether or not you

have to take them on, if they don't have a qualifying event—or how long you can delay taking them on. I'm curious as to which administrative procedures people are following regarding late applicants under HIPAA.

Mr. Olson: Most of the employers that I'm dealing with have said, "Forget preexisting conditions altogether, we don't want to issue certificates of creditable coverage. We don't even want to be in the game." A lot of them have said, "It just isn't worth the hassle." And I don't know if that's your experience or not, but very, very few employers have gone through the process of setting it up, issuing, and getting these things out. I only know one or two employers who are issuing them, or have somebody issuing them, but I'm sure there are others.

Mr. Sandler: From an insurer's point of view, we have to gear up to be able to do it, whether anybody wants it or not, but I agree with Mark. It's simpler for most larger employees to avoid the issue altogether. The administrative costs they'll end up paying are probably going to outweigh the costs of providing the additional coverage, so they tend to not deal with it at all.

Mr. Olson: There are some employers with very high turnover where it's an issue, and I think those are the ones that have said, "I have to do this just to protect myself."

Mr. Trapnell: One possible insight into trying to figure out how similar provisions, or provisions that look similar, may be implemented and actually affect health plans in the future is one that had the full sympathy of the administration's political leadership, especially Tipper Gore, for whom MH parity has been one of her key issues. As a practical matter, forcing the plans to keep the data and proving it was likely to lead to large numbers by simply implementing it and being done with it, was probably regarded very favorably. That's the impact that they wanted. When it comes to many of these other provisions, there's recognition that they're undermining the potential for the savings that are associated with managed care, which they don't want to do. So, there may be much less sympathy and fewer onerous regulations from the point of view of just making sure it happens.

CHART 1
THE LEGAL ENVIRONMENT OF WELFARE PLANS: PUTTING IT IN CONTEXT