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Micromanaging Americans' Health Insurance: The Impact of House and Senate Bills

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Both the pending House health care bill and Senate HELP Committee bill include provisions that would, if enacted, result in sweeping, complex, and highly discretionary new federal regulation of health insurance. Yet virtually all of the proposed new health insurance requirements are completely unnecessary to achieving the legislation's intended objectives of expanding health insurance coverage and reducing health care costs.

Indeed, many of the provisions would make the current situation worse either by driving costs higher or by encouraging more employers and individuals to drop coverage.

Federal Health Insurance Benefit Standards. The Senate bill would actually result in three different sets of health insurance regulations. The bill reported out by the Senate Health, Education, Labor and Pensions Committee would:

- Impose new federal benefit mandates on existing state-regulated health insurance and federally regulated employer-sponsored self-insured plans;
- Authorize the Department of Health and Human Services (HHS) to establish a second set of insurance regulations on policies offered through new state "gateways" as well as on the insurers offering those policies; and
- Specify yet another set of rules for HHS to implement for the new "community health insurance option," or public plan, to also be offered through the gateways.[1]

The House bill proposes a single minimum coverage standard that will eventually apply to nearly all health plans and establishes a new "Health Benefits Advisory Committee" within HHS to make detailed recommendations, which the secretary of HHS would then impose through regulation.[2]

Indeed, both bills set forth the basic components of a standardized benefit package while giving HHS the task of promulgating further specific requirements under each of the basic categories. This grant of authority is broad enough that the secretary of HHS would be able to specify through federal regulations not only specific items and services than must be covered but also the minimum frequency or duration of a required covered service and the maximum allowable patient cost sharing.

Gutting State Authority. In effect, HHS would supplant both existing state insurance regulation of commercial health insurance and existing Department of Labor regulation of employer self-insured health plans. HHS would become the *de facto* national regulator of all health insurance, both private and public.

Furthermore, HHS would be given authority to continually update and revise its promulgations of

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health insurance regulations, with the likely result that all health insurance coverage, both private and public, would need to be annually revised to conform to the latest versions of what will become a constantly evolving set of comprehensive and detailed coverage requirements.

Highly Prescriptive. For example, the legislation would require plans to cover "preventive services," with plans prohibited from charging patients more than nominal cost sharing (in the Senate bill) or any cost sharing at all (in the House bill) for those services. Among the "preventive services" that both bills would require health plans to cover are those "recommended with a grade of A or B by the Task Force on Clinical Preventive Services."[3] Currently, that task force has 30 separate such recommendations and would be expected to issue many more in the future.

Many of the current recommendations are fairly specific and already included in most existing health insurance plans, such as mammographies for women over age 40 every one to two years. However, some are more general, such as the recommendation of "intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians."[4]

Nor are the preventive health requirements in the bills limited to just this list. The legislation goes on to specify additional sets of required preventive services. Again, some are fairly specific, such as "vaccines recommended for use by the Director of the Centers for Disease Control and Prevention." Others are broader and will require detailed regulations to further define and implement, such as, "maternity care" and "well baby and well child care and oral health, vision, and hearing services, equipment, and supplies at least for children under 21 years of age."[5]

The problem is that the legislation would require HHS to turn these *recommendations*—which health plans are now free to adopt and tailor as they see fit—into minimum benefit *requirements* for which all health plans must pay. So, for example, in the case of the "behavioral dietary counseling" recommendation, HHS would need to draft and promulgate regulations detailing the type, scope, frequency, and duration of the specific services that must be covered, along with rules on which providers must be paid for providing which services, and the criteria under which specific patients qualify for specific services.

The same would be true for the rest of the "minimum benefit" requirements for physician, hospital, and other services, as well as drugs and medical devices.

Furthermore, the House bill also instructs HHS to set limits on the patient cost sharing that health plans could apply to the required services, and even the form of such cost sharing, specifying: "In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance."[6]

Killing Existing Coverage. The vast majority of Americans already have health insurance. A major concern for them with any new health care legislation is whether they will be able to keep their cur-

1. Senate bill, Sections 101, 3101, and 3106. All citations of the "Senate bill" refer to the Senate HELP Committee's "additional Chairman's mark on coverage" at *http://help.senate.gov/BAI09F54_xml.pdf* (July 22, 2009). As of this writing, the Senate HELP Committee has not yet released a version incorporating amendments adopted by the committee during its markup of the bill.
2. America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong., 1st Sess., Sections 123–124.
3. *Ibid.*, Section 122(a)8. Similar language is included in the Senate bill in § 2708(a)1.
4. U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, "Guide to Clinical Preventive Services, 2008: Metabolic, Nutritional, and Endocrine Conditions: Behavioral Counseling in Primary Care to Promote a Healthy Diet," at *http://www.ahrq.gov/clinic/pocketgd08/gcp08s2d.htm#Diet* (July 22, 2009).
5. America's Affordable Health Choices Act, Section 122(a)8, 9, and 10.
6. *Ibid.*, Section 122(c)(2)C.

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rent coverage, something that both the President and congressional leaders have repeatedly promised. So, not surprisingly, the heading for Section 102 of the House bill reads; "Protecting the Choice to Keep Current Coverage," while the heading for Section 131 of the Senate bill proclaims, "No Changes to Existing Coverage."

However, the truth is that, while both those sections would "grandfather" existing individual and employment-based coverage, both bills also include other provisions that would eventually lead to nearly all current plans either adopting the new federal coverage standards or being replaced by new coverage that meets those standards.

The Senate bill stipulates that any "significant" subsequent modification of the "benefits or cost sharing requirements" of a prior plan would trigger the loss of its grandfathered status.[7] Also, within five years all Americans would be subject to the individual mandate to either purchase "qualifying coverage" or pay a fine.[8] The Senate bill neither permits grandfathered plans to count as qualifying coverage nor exempts individuals enrolled in grandfathered plans from the individual mandate.[9]

Thus, under the Senate bill, beginning in 2014 anyone retaining prior individual or employer-group coverage would be fined annually for not obtaining new coverage that meets the new requirements.

In contrast, the House bill *does* allow grandfathered coverage to count as "acceptable coverage" for purposes of the individual mandate, but it gives grandfathered employer-sponsored plans only a five-year "grace period"—after which those plans would also be required to meet the new coverage standards.[10] Thus, under the House bill, after 2017 the only prior coverage that would be left unchanged would be individual policies—but only so long as insurers continued to renew them.[11]

Soaking the Young through Community Rating. Both bills would also limit age rating of premiums to no more than a two-to-one difference between highest and lowest.[12] Thus, a 64-year-old could not be charged more than twice the premium of an 18-year-old. The effect is that younger individuals will be required to heavily subsidize older individuals, creating both social inequities and practical problems.

Younger individuals consume less medical care than older ones, while younger workers generally earn less than older (more skilled and experienced) workers in almost any given occupation. Significantly increasing the cost to younger individuals will encourage more of them to avoid coverage, thus necessitating higher fines and penalties to get them to comply with the individual mandate in the legislation, as well as greater subsidies to make coverage "affordable" for them.

Consequently, significant funding that could be better targeted to a relatively small population of older workers with low incomes will instead be diverted to subsidizing younger, healthier individuals to buy overpriced coverage.

Nullifying the ERISA Preemption. It should be of particular concern to employers that, in both bills, the new insurance regulations are not limited to only commercial insurers but would also be imposed on employer self-insured plans as well. For the past 35 years, most large employers have relied on provisions of the 1974 Employee Retirement

7. Senate bill Section 131(e). The language of this section goes on to also require HHS to define what the term *significant* means by specifying that "[t]he Secretary shall by regulation establish criteria to determine whether a plan or health insurance coverage has been modified to a significant extent under the preceding sentence."
8. *Ibid.*, Section 161.
9. *Ibid.*
10. America's Affordable Health Choices Act, Sections 401 and 102(b).
11. While an insurer could not decline to renew any particular individual's existing policy, it could opt to discontinue offering individual coverage. Under such circumstances, affected individuals could obtain only new coverage that met the new federal standards. The mandate provisions would take effect in 2013, and the grace period for grandfathered employer coverage would apply from 2013 to 2017.
12. America's Affordable Health Choices Act, Section 113(a)1, and Senate bill, Section 2701(a)(1)D.

Income Security Act (ERISA) to design and manage their own customized health benefit plans for their employees—exempted by ERISA from state insurance regulations imposed on commercial insurers.

In 2008, among all workers with health insurance, 45 percent were covered by commercial group insurance (also known as "fully insured" plans), and 55 percent were covered by employer self-insured plans. Among firms with 5,000 or more employees, 89 percent of workers with health insurance received it through an employer self-insured plan.[13]

However, both bills would effectively nullify the value to employers of that "ERISA preemption" by placing self-insured plans under the same new, sweeping, *federal* health insurance regulatory regime as commercial insurers.

The House bill would require that within five years every employer-sponsored plan become a "qualified health benefits plan," or QHBP, making the sponsoring employer a "QHBP-offering entity" under the legislation.[14] As a result, the federal micromanagement of employer-sponsored plans under the House bill would be far greater than anything previously attempted by state governments, whose insurance regulations employers have used the ERISA preemption to avoid.

For example, only the 1993 Maryland law establishing a standard benefit package for small group health insurance in that state—together with a commission to annually modify that benefit package—even comes close to the kind of broad, discretionary authority that the House bill would grant HHS to define and continually revise the specific requirements of a federal standardized benefits package.[15]

The House legislation would also require all "QHBP offering entities" (including employers) to comply with the prompt payment of claims statutes and regulations currently imposed on Medicare Advantage plans and the private vendors who contract with HHS to process claims for fee-for-service Medicare.[16]

More Bureaucracy. In addition, the House bill would establish the "Health Choices Administration" as a new, independent federal agency under the direction of a commissioner.[17] Among the commissioner's duties will be to "promote accountability of QHBP offering entities in meeting Federal health insurance requirements, regardless of whether such accountability is with respect to qualified health benefits plans offered through the Health Insurance Exchange or outside of such Exchange."[18]

The commissioner will have the authority to assess civil monetary penalties on both commercial insurers and employer-sponsors of plans that fail to comply with the new federal requirements.[19] In addition, the legislation also gives the commissioner the power to "conduct audits of qualified health benefits plans compliance with Federal requirements. Such audits may include random compliance audits and targeted audits in response to complaints or other suspected non-compliance."[20] The legislation goes on to further provide that "[t]he Commissioner is authorized to recoup from qualified health benefits plans reimbursement for the costs of such examinations and audit of such QHBP offering entities."

13. Employee Benefit Research Institute, "Health Plan Differences: Fully-Insured vs. Self-Insured," February 11, 2009, at *http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf* (July 22, 2009).
14. America's Affordable Health Choices Act, Section 100(c)19.
15. A brief overview of Maryland's approach, and a summary of the current standard benefit requirements, can be found at *http://mhcc.maryland.gov/smallgroup/cshbp_brochure.htm* (July 22, 2009).
16. America's Affordable Health Choices Act, Section 135.
17. *Ibid.*, Section 141.
18. *Ibid.*, Section 142(b)1.
19. *Ibid.*, Section 142(d)(2)A. This section authorizes the imposition of fines "applicable under similar circumstances for similar violations under section 1857(g) of the Social Security Act," which applies to insurers offering Medicare+ Choice plans (42 U.S. Code §1395w–27(g)). That statute specifies penalties of "not more than $25,000 for each determination" but also specifies a number of exceptions under which the fines could be significantly higher.
20. *Ibid.*, Section 142(b)(2)A.

Thus, after 2017, any private employer still willing to offer its workers a heath benefit plan can expect to also pay for the privilege of being harassed by federal bureaucrats seeking to determine if it is in compliance with all federal rules micromanaging the operations of its plan—and to be fined for any failures that may be discovered in the process.

The Wrong Direction. Both of the pending House and Senate health care bills would establish new, federal health insurance regulatory regimes that are needlessly complicated, needlessly burdensome, needlessly invasive, needlessly regulatory, and needlessly expensive.

The insurance regulation sections of the bills, as currently drafted, are utterly superfluous and even contrary to the legitimate objectives of sensible health care reform—namely, expanding health insurance coverage and reducing health care costs. Congress should simply delete those provisions from its proposed legislation.

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