

MEMORANDUM

TO: Carol, Laura and Gene *file*  
FR: Chris and Jen  
RE: Medical Savings Accounts (MSA's)  
cc: Jeremy and Tom

July 16, 1995

Attached is a relatively brief and quite recent Treasury Department analysis of Medical Savings Accounts (MSA's). It serves as a good updating and analytical document. Because MSAs are popping up in virtually every major health care bill, we thought you two and Gene might be interested in reviewing this information.

The Treasury Department, like us, continue to view MSA's with great skepticism. Having said this, like us again, they believe that MSA's are likely to be integrated in virtually any significant tax bill (such as reconciliation).

Treasury takes some hope from the fact that most major Republican bills are already shaving back some of the most egregious provisions of past attempts to expand in this area. However, they fear the "domino" effect; that is to say, even if the MSA's that may be presented to the President are not too problematic, their very existence will produce pressure to provide for more tax incentives and more problems. We will keep you apprised of developments beyond those outlined in the attached.

Assuming this is all right with you, we will take the liberty of forwarding this information to OMB and HHS, and ask that Nancy Ann and Judy bring Alice and Donna up-to-date.

## MEMORANDUM

TO: Nancy-Ann and Judy  
FR: Chris and Jen  
RE: Medical Savings Accounts (MSA's)

July 17, 1995

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Carol and Laura thought that Alice and Donna might like to see. I told them that we would get the information to them through you two.

## MEMORANDUM

TO: Meredith Miller  
FR: Chris and Jen  
RE: Medical Savings Accounts (MSA's)

July 17, 1995

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Hope you find this information to be useful. Now that we have the Treasury Department moving, I know we can expect great things from the Labor Department too! Talk to you soon.

## MEMORANDUM

TO: Janet Murguia  
FR: Chris and Jen  
RE: Medical Savings Accounts (MSA's)

July 17, 1995

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## MEMORANDUM

TO: Ira and Melanne  
FR: Chris  
RE: Medical Savings Accounts (MSA's)

July 17, 1995

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**DEPARTMENT OF THE TREASURY  
OFFICE OF TAX ANALYSIS  
1500 PENNSYLVANIA AVENUE, NW  
WASHINGTON, DC 20220**

Number of pages to follow: 6

Date: July 12, 1995

To: Chris Jennings

Addressee's Fax Number: 456-7431

Addressee's Confirmation Number: 456-5560

From: Eric J. Toder  
Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-8784

Sender's Confirmation Number: 622-0120

Comments/Special Instructions:

Attached is material we prepared on MSAs, plus the JCT revenue estimate of the Archer bill.

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**NOTE: THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND/OR RESTRICTED AS TO OR EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. If the recipient of this message is not the addressee (i.e., the intended recipient, you are hereby notified that you should not read this document and that any dissemination, distribution, or copying of this communication except insofar as necessary to deliver this document to the intended recipient, is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone, and you will be provided further instruction about the return or destruction of the this document. Thank you.**

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## Medical Savings Accounts

- Medical Savings Accounts (MSAs) are politically appealing. However, MSAs sound more financially appealing than they really are.
- MSAs would probably not produce much cost containment.
- MSAs may have an adverse effect on the health insurance market. Premiums for some of the less healthy may rise, while premiums for some of the healthy may fall. Higher premiums could lead to a decrease in health insurance coverage.
- Depending upon the specifics of the proposal, revenues may decrease as a result of MSAs.

### Background:

- Senators Gramm and D'Amato and Congressman Archer, Thomas, Sterns, Hoke and Porter have already introduced legislation which includes MSAs. In previous years, Dole, Chafee, Michel, Santorum, and Gephardt included variants of MSAs in their proposals. The Health Security Act did not include MSAs, but the proposal approved by the Ways and Means Committee did.
- The intent of an MSA is to encourage employers and employees to switch from "comprehensive" health insurance to "catastrophic" packages that have higher co-payments and deductibles, thereby giving employees an incentive to reduce unnecessary medical care.
- MSA proposals allow taxpayers to place funds in a special tax-preferred account. Funds from MSAs that are used for specified medical purposes are not taxed, while funds used for other purposes may or may not be taxed depending upon the proposal. Since "catastrophic" plans cost less than "comprehensive" plans, an employer might put some or all of the reduction in insured expenses into MSA accounts for their employees. Depending upon the MSA proposal, employees could use these funds on a tax-preferred basis to cover deductibles, co-payments and other out-of-pocket expenses. Some MSA proposals also allow individuals to establish and make contributions to MSAs.

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Likely Effects of MSAs:

- MSAs would reduce health insurance premiums for participants but expose them to larger out-of-pocket costs. Some individuals who unexpectedly become sick may find themselves short of funds to cover their medical expenses. MSAs produce winners and losers.
- An MSA would encourage cost containment by requiring higher deductibles, but may also discourage cost containment by enabling more individuals to pay for out-of-pocket expenses with tax-preferred dollars.
- The attractiveness of MSAs will depend upon the particular circumstances of employers and employees. Some employers may find that other forms of managed care contain costs better than MSAs. As a result, participation in MSAs may be low, producing little cost-containment. However, individuals that participate may gain from the expansion of tax-preferred out-of-pocket expenses.
- MSAs may put pressure on employers to stop their practice of community rating across all employees. Adverse selection may result in healthy and upper income individuals joining MSAs, leaving less healthy and lower income individuals in the more comprehensive Fee-For-Service plans and managed care plans. Premiums for the more comprehensive plans may rise. Higher premiums and a heightened awareness of the implicit cross-subsidies in the current health insurance system could lead to a decrease in the number of persons with private health insurance. For example, some employees in comprehensive plans may decline coverage if employers try to pass increases in premiums onto employees.
- By segmenting employee risk groups and drawing attention to high risk groups, MSAs may make some employers more hesitant to hire high risk groups of employees.
- Under some MSA proposals, some employers may find MSAs attractive because MSAs provide a mechanism for employers that currently provide family health insurance to shift some of their costs to a spouse's employer. Higher deductibles could reduce one employer's cost while increasing the cost of the secondary insurance paid by another employer. MSAs may also provide more incentive for employees to obtain coverage from both employers.
- Employers may find their costs rise if they do not risk-adjust correctly. If employers underestimate the health of MSA participants, then they are likely to contribute more to MSA accounts than they will realize in reduced insured expenses.

-3-

- MSA proposals that have few constraints on contributions or that have generous tax treatment are likely to result in substantial revenue loss in future years.
- MSA proposals add complexity to the income tax system. Compliance would be difficult to enforce. Low compliance would have an adverse effect on revenues.
- Some MSA proposals expand special tax-preferred treatment for long-term-care. Under these proposals, long-term-care is most likely to provide asset protection for upper income individuals that have lead relatively healthy lives. Expanding long-term-care tax preferences would decrease revenues.

Additional Information:

- House Ways and Means Chairman Archer's bill does not (and the Senate Finance bills may not) allow for tax-free build up on earnings on funds in the MSA. However, once MSAs are implemented there is likely to be strong pressure to allow tax-free build-up. Tax-free build-up potentially changes the nature of an MSA from a health cost-containment policy to a preferential savings vehicle. It also expands the preferential tax treatment for long-term-care expenditures.
- MSAs appeal to many individuals because they erroneously believe that the increase in the deductibles could be contributed to an MSA account without increasing employer costs. For example, they believe that employers could contribute \$2,800 to the MSA if the deductible increased from \$200 to \$3,000 for family plans. A recent report by the American Academy of Actuaries suggests that if all employees were required to join the MSA plan, an increase in the deductible of this magnitude would under specified conditions result in a contribution of only \$1,562. If employees were given a choice to join the MSA, employer contributions would be less than this amount because of adverse selection. While there is great controversy in this area, the Academy's estimates are the most plausible outside estimates that we have seen to date.

## MSA Example Under Identical Risk Pools

### Family Plan

	Comprehensive Plan	Catastrophic Plan
	\$200 Deductible; \$1,000 Maximum Out-of-Pocket	\$3,000 Deductible; \$4,000 Maximum Out-of-Pocket
Premium	\$6,567	\$5,005
MSA Contribution		\$1,562
Change in Deductible		\$2,800
Out-of-Pocket Exposure		
Deductible	\$200	\$1,438
Maximum	\$1,000	\$2,438

**Notes:**

Catastrophic premium reflects reduction in spending on physicians and hospitals due to a higher deductible. Assumes medium effect of MSAs on medical spending. Also assumes that all employees are required to join MSAs. If employees are given a choice, MSA contributions would be lower due to adverse selection. Premium amounts include administrative costs for health insurance and MSAs.

Source: American Academy of Actuaries.

## MSA Example Under Identical Risk Pools

### Individual Plan

	Comprehensive Plan	Catastrophic Plan
	\$200 Deductible; \$1,000 Maximum Out-of-Pocket	\$1,500 Deductible; \$2,500 Maximum Out-of-Pocket
Premium	\$2,699	\$2,076
MSA Contribution		\$623
Change in Deductible		\$1,300
Out-of-Pocket Exposure		
Deductible	\$200	\$877
Maximum	\$1,000	\$1877

#### Notes:

Catastrophic premium reflects reduction in spending on physicians and hospitals due to a higher deductible. Assumes medium effect of MSAs on medical spending. Also assumes that all employees are required to join MSAs. If employees are given a choice, MSA contributions would be lower due to adverse selection. Premium amounts include administrative costs for health insurance and MSAs.

Source: American Academy of Actuaries.

JCT estimates of Archer MSA bill.

Fiscal Years  
[Millions of Dollars]

<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>1996-2002</u>
-131	-230	-264	-301	-341	-358	-376	-2,001

**NOTE:** Details may not add to totals due to rounding.



**DEPARTMENT OF THE TREASURY  
OFFICE OF TAX ANALYSIS  
1500 PENNSYLVANIA AVENUE, NW  
WASHINGTON, DC 20220**

Number of pages to follow: 4

Date: 6/25/96

To: Chris Jennings  
White House

Addressee's Fax Number: 456 5542

Addressee's Confirmation Number: 456 5560

From: Eric J. Toder  
Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-8784

Sender's Confirmation Number: 622-0120

Comments/Special Instructions:

Tables you requested.

(1981) Treasury estimate of Revenue Loss from IRAs was \$7.2 billion = year; actual was \$37.3 billion → 5 times greater.

NOTE: THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND/OR RESTRICTED AS TO OR EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. If the recipient of this message is not the addressee (i.e., the intended recipient), you are hereby notified that you should not read this document and that any dissemination, distribution, or copying of this communication except insofar as necessary to deliver this document to the intended recipient, is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone, and you will be provided further instruction about the return or destruction of the this document. Thank you.

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Table 1

Revenue Estimates of Medical Savings Account Proposal -- Options  
(\$Millions)

Fiscal Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	1996-2002	1996-2006	Take up rate (000s of policies)		
													1999	2000	fully phased-in
Option (1) (with state implementation delays)	-2	-22	-58	-83	-92	-5	-7	-7	-7	-8	-262	-291	559	706	903
Option (2) (with state implementation delays)	-2	-21	-56	-81	-91	-5	-6	-6	-6	-7	-256	-281	535	678	850

Department of Treasury  
Office of Tax Analysis

Date: 06/25/96

- 1/ Option (1) includes the following specifications:
- Minimum deductibles: \$1,500/\$3,000
  - Maximum deductibles: \$2,000/\$4,000
  - Maximum stop-loss limits: \$2,000/\$4,000
  - Maximum MSA contribution: one-half of deductibles
  - Maximum employer size: 100 employees or less
  - No employee contributions
  - No nondiscrimination rule for self-employed.
  - Assume state implementation delays

2/ Same as Option (1) except limited to employers with 60 or few employees.

*self-employed →*  
*employee →*

Table 2

Revenue Estimates of Medical Savings Account Proposal -- Options (\$Millions)															
Fiscal Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	1996-2002	1996-2008	Take up rate (000s of policies)		
													1999	2000	fully phased-in
Option (1) (with state implementation delays)	-2	-23	-58	-84	-93	-5	-7	-7	-7	-8	-285	-294	564	713	910
Option (2) (with state implementation delays)	-2	-22	-56	-82	-82	-5	-6	-6	-6	-7	-259	-284	540	688	857

Department of Treasury  
Office of Tax Analysis

Date: 06/25/96

1/ Option (1) includes the following specifications:

- Minimum deductibles: \$1,500/\$3,000
- Maximum deductibles: \$2,000/\$4,000
- Maximum stop-loss limits: \$3,000/\$6,000
- Maximum MSA contribution: one-half of deductibles
- Maximum employer size: 100 employees or less
- No employee contributions
- No nondiscrimination rule for self-employed.
- Assume state implementation delays

2/ Same as Option (1) except limited to employers with 60 or few employees.

Table 3

Revenue Estimates of Medical Savings Account Proposal -- Options (\$Millions)															
Fiscal Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	1996-2002	1996-2006	Take up rate (000s of policies)		
													1999	2000 fully phased-in	
Option (1) (with state implementation delays)	-2	-21	-53	-75	-82	-5	-7	-7	-7	-8	-236	-267	545	688	883
Option (2) (with state implementation delays)	-2	-20	-51	-73	-81	-5	-6	-6	-6	-7	-232	-257	521	661	830

Department of Treasury  
Office of Tax Analysis

Date: 06/25/96

- 1/ Option (1) includes the following specifications:
  - Minimum deductibles: \$1,500/\$3,000
  - Maximum deductibles: \$2,000/\$4,000
  - Maximum stop-loss limits: \$2,000/\$4,000
  - Maximum MSA contribution: smaller of one-half of deductibles or \$900/\$1,800
  - Maximum employer size: 100 employees or less
  - No employee contributions
  - No nondiscrimination rule for self-employed.
  - Assume state implementation delays
- 2/ Same as Option (1) except limited to employers with 60 or few employees.

Table 4

Revenue Estimates of Medical Savings Account Proposal - Options (\$Millions)													Take up rate (00s of policies)		
Fiscal Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	1995-2002	1995-2006	1998	2000 fully phased-in	
Option (1) (with state implementation delays)	-2	-21	-53	-78	-83	-5	-7	-7	-7	-8	-240	-269	550	695	891
Option (2) (with state implementation delays)	-2	-20	-51	-74	-82	-5	-6	-6	-6	-7	-234	-259	526	658	836

Department of Treasury  
Office of Tax Analysis

Date: 06/25/96

1/ Option (1) includes the following specifications:  
 Minimum deductibles: \$1,500/\$3,000  
 Maximum deductibles: \$2,000/\$4,000  
 Maximum stop-loss limits: \$3,000/\$6,000  
 Maximum MSA contribution: smaller of one-half of deductibles or \$900/\$1,800  
 Maximum employer size: 100 employees or less  
 No employee contributions  
 No nondiscrimination rule for self-employed.  
 Assume state implementation delays

2/ Same as Option (1) except limited to employers with 60 or few employees.

file - MSA

# Danger Ahead on Medicare

By Alain Enthoven and Sara J. Singer

Judging by their draft proposals, Republicans in Congress are generally on the right track in their efforts to overhaul Medicare. With no change, the Medicare trust fund will go broke, perhaps as early as the year 2002. The Republicans aim to reduce projected spending by \$270 billion over the next seven years.

Unfortunately, some Republicans are contemplating adding a provision that could undo this ambitious reform.

Under the draft bill, beneficiaries would be able to choose among private insurance plans or continue under the existing Medicare, with few if any changes to their benefits.

Every year the Government would give everyone 65 and older a fixed sum (yet to be determined) for health-care coverage. Beneficiaries could use the voucher to buy any private insurance plan that contracts with Medicare. Or they could apply it toward a charge the Government would put on the existing Medicare services.

But a measure proposed by some Republicans would stymie Medicare reform.

The idea is that beneficiaries could select a plan with low premiums that required a high annual deductible, perhaps \$3,000. They would put the difference between the lump-sum payment and the cost of premiums into a personal interest-bearing medical spending account. Money drawn for health-care expenses approved by Congress would be tax free. They could withdraw the money for other purposes, but the amount would be taxable and subject to penalties.

While many healthy people might prefer the high-deductible, low-premium plan, the sickest would be more likely to choose a plan that featured a low deductible and early reimbursements of out-of-pocket expenses.

Then the cost to consumers in the low-deductible plans would go up because the insurer's costs would rise: health plans use the premiums from

healthy members to cover the cost of care for sick members. The smaller the pool of healthy individuals, the greater the per-person cost.

The high-deductible, low-deductible approach would encourage people to flip between the two kinds of plans. This is a bad idea. Healthy people would pocket the money in their medical spending accounts, at the cost of a small penalty or spend it on items not covered by insurance; if such accounts were not created for them and the money was part of the pool for all the beneficiaries, that money could pay for care for the sick.

As sick people in low-deductible plans found their insurance premiums rising, the healthiest of them might join a high-deductible plan at the first chance. The costs of the low-deductible plans would rise faster and faster; ultimately, the sick would press Congress for a larger voucher payment.

If the Republicans really want a plan that offers the option of a high deductible and a personal spending account, Congress should allow beneficiaries to choose between the plans only once, to prevent people from switching to low-deductible coverage after they get sick. Alternatively, people might be allowed to switch to low-deductible coverage once, but only after a five-year waiting period, and then be required to refund everything in their medical spending accounts so that the Government could recover dollars they would have spent on a low-deductible plan.

Some Republicans say that if everybody had high-deductible coverage, Medicare would save a lot of money. But this ignores reality: Most health-care dollars are spent on a small number of very sick people: In 1993, 80 percent of all health-care money was spent on the 15 percent of the population that had the highest medical costs.

This exceeded \$3,050 per person. Under a high-deductible plan, sick people who knew they would meet the \$3,000 deductible would have little incentive to hold down the rest of their costs because their plan would refund those expenses. Their doctors, reimbursed by the plan, would also lack incentive to hold down costs.

High-deductible coverage would discourage people from seeking preventive care or tests needed to detect illness early, when it can be treated at a lower cost. But this is exactly the life-saving, money-saving spending Congress should encourage. □

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High deductibles could destroy a good G.O.P. plan.

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Alain Enthoven is professor of public and private management at Stanford University's Graduate School of Business. Sara J. Singer is a special assistant.

## **The Church Alliance**

The Church Alliance is a coalition of church pension board executives acting on behalf of church pension and welfare benefit programs. These programs are among the oldest employee benefit programs in the United States. Several date from the 1700s, with the median age of the retirement programs represented through the Church Alliance being in excess of 50 years. These programs provide retirement and welfare benefits for approximately 261,000 ministers and 114,000 lay workers employed by thousands of churches and church ministry organizations. The 28 historic, mainline denominations served by these pensions boards minister to the spiritual needs of over 66 million members of Protestant and Jewish faiths.

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## CHURCH ALLIANCE

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### Steering Committee:

Mr. John G. Kapanke, Chair  
Mr. Alan F. Blanchard  
Ms. Barbara A. Boigegrain  
Ms. Joanne Brannick  
Mr. John J. Detterick  
Mr. James L. Hughes  
Mr. Leo J. Landes  
Mr. Dan A. Leeman  
Dr. Paul W. Powell  
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Episcopal Church

Ms. Barbara A. Boigegrain  
United Methodist Church

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The Pension Boards United Church of Christ

Mr. David J. Brown  
Reorganized Church of Jesus  
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Dr. L. Edward Davis  
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Mr. John J. Detterick  
Presbyterian Church (U.S.A.)

Mr. William W. Evans  
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Wisconsin Evangelical Lutheran Synod

Mr. Robert L. Temple  
Wesleyan Church

Dr. Anderson Todd, Jr.  
African Methodist Episcopal Church

STAT

*Pl. circulate to  
but hold close.*



MAR - 7 1995

MEMORANDUM FOR: CHRIS JENNINGS  
Senior Health Policy Analyst

FROM: OLENA BERG *Olena Berg*  
Assistant Secretary  
Pension and Welfare Benefits Administration

SUBJECT: Department of Labor Recommendations for  
Consumer Protection Reforms Affecting  
Employee Health Benefit Plans

**EXECUTIVE SUMMARY**

This memorandum describes Department of Labor recommendations for consumer protection reforms affecting employee health plans, with pertinent background for each proposal.<sup>1</sup> The background includes summaries of the current law and descriptions of other options considered. The memorandum also outlines the approach of the Administration's proposal for comprehensive health reform from the last Congress and several (mainly Republican) legislative proposals from the last and current Congresses, with respect to the issues raised. The proposals requiring more timely health plan reporting to covered individuals also will be included in the Department's reporting and disclosure proposal.

**Summary of Recommendations**

- Require all MEWAs to register initially and annually with the Department of Labor, which would share this information with the states to help them ensure that MEWAs operating in the state complied with state laws.<sup>2</sup> (The annual registration with the Department is not intended to alter the current regulatory regime of state regulation of MEWAs.)

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<sup>1</sup> Many of the recommendations are similar to provisions found in the Michel (R-Ill) bill, formally introduced in November 1994, but developed during the summer to serve as the House Republican health reform amendment during Floor consideration of health reform legislation. In this regard, the recently introduced Fawell (R-Ill) bill draws largely from the Michel proposal.

<sup>2</sup> This could be accomplished by permitting MEWAs to register by providing DOL with copies of their state licenses. DOL would provide an alternate method of registering in the event that a state does not require or grant licenses for MEWAs.

This recommendation builds on an approach agreed to by the principals' group on health care, to ensure that the federal and state governments have full information about MEWAs. Impose civil and criminal penalties on MEWAs that fail to register and provide new authority to allow the Department to ask a federal court to order a MEWA that fails to register to cease operations.

- Require the Department of Health and Human Services, in coordination with the Department of Labor, to develop guidelines for state standards for health plan grievance procedures, including a maximum turnaround time for claims consideration. Further provide that these guidelines would be enforced by the Department of Labor with respect to ERISA covered plans.
- Expand ERISA remedies so that individuals can be made whole for economic losses suffered when health benefits are wrongly denied. Permit the Secretary of Labor to impose a maximum civil penalty of \$25,000 for failure (or a maximum of \$1,000,000 for repeated failures) to provide benefits under the terms of the plan without any reasonable basis. Alternatively, make state law remedies and penalties available to all enrollees, including those in ERISA plans.
- Generally require courts to review health benefit claims de novo, on the basis of the record that existed before the administrator or fiduciary, without deference to the decision of the administrator or fiduciary. In addition, require courts to construe ambiguous terms in the plan against the insurance company or self-insured plan.
- Amend ERISA to provide for the establishment of a pilot demonstration project for handling health plan claim disputes through voluntary nonbinding mediation. The Department of Labor would assist in the identification and appointment of mediators, but the parties would divide the cost of the mediation process. Authorize funding for a Department health claims mediation project.
- Require distribution of updated summary plan descriptions every 5 years. Require health benefit plans to notify covered individuals at least 30 days before decreasing any benefit or coverage or increasing any out-of-pocket costs. For other changes, require plans to notify individuals at least 30 days before the end of the plan year (or before the date by which an individual must choose or decline coverage, if earlier). Prohibit insurance companies from letting an individual's coverage under an insured employee health plan lapse due to the plan administrator's nonpayment of premiums, unless the insurer notifies the individual at least 15 days before the coverage is to lapse.

## BACKGROUND

As background to the recommendations, this memorandum summarizes current law and describes the options considered. It also outlines the approach of last year's Health Security Act (HSA) and the bipartisan Mainstream proposal (9/16/94 draft), as well as several (mainly Republican) legislative proposals from the last and the current Congresses, with respect to the issues raised below. Since the Mainstream proposal was never introduced, it is not clear how many co-sponsors there would have been on each side of the aisle.

The other proposals from the 103d Congress generally reviewed for this paper include the Dole (R-Kan), Rowland (D-Ga)/Bilrakis (R-Fla), Gramm (R-Tx) and Michel (R-Ill) health bills. We have used the Dole and Michel bills from last August<sup>3</sup> to represent the Senate and House Republican leaders' later efforts to influence the health reform debate. Of these bills, only the Rowland bill had substantial bipartisan support, with 10 Republican and 10 Democrat co-sponsors. Senator Gramm's bill had 11 Republican co-sponsors.

The proposals from the 104th Congress generally reviewed for this paper include S. 18 (Specter, R-PA), S. 121 (Gramm, R-Tx), S. 294 (Cohen, R-ME) and H.R. 995, very recently introduced by Congressman Fawell (R-Ill). The Fawell proposal draws largely from the Michel proposal from the 103d Congress, which is also discussed herein. To our knowledge, none of these bills has significant bipartisan support.<sup>4</sup> Except as noted below, the Specter and Gramm proposals generally did not address issues relevant to the Department of Labor proposals.

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<sup>3</sup> The Michel proposal was developed during the summer to serve as the House Republican health reform amendment during Floor consideration of health reform legislation, and was printed in its entirety in the Congressional Record of August 10. Because health reform was not considered on the House Floor last summer, Michel introduced this proposal as a stand-alone bill, H.R. 5300, on November 29.

<sup>4</sup> The Specter bill has some bi-partisan support; its only co-sponsor is Mosely-Braun (D-Ill).

## MEWA PROPOSAL

### Current Law

ERISA defines "multiple employer welfare arrangement" (MEWA) as an arrangement offering benefits to employees of two or more employers. Under ERISA, the Department of Labor may regulate reporting and disclosure and fiduciary standards relating to MEWAs. States may regulate the financial solvency of these arrangements.

However, MEWAs present significant enforcement problems, which in too many cases leaves participants and employers vulnerable to fraud and abuse. Some MEWA operators attempt to avoid state regulation by claiming, albeit incorrectly, that state law is inapplicable to MEWAs because it is preempted by ERISA. According to a 1992 GAO Report, from 1988 to 1991 claims unpaid by MEWAs totalled over \$123 million and affected almost 400,000 enrollees.

### Recommendations

- Require all MEWAs to register both initially and annually with the Department of Labor<sup>5</sup>; charge a registration fee. Give the Secretary authority to determine what must be included in the registration statement. This information would then be shared with the states to help them ensure compliance with their laws.
- Provide new authority to allow the Department to seek an injunction in Federal Court to cease the operations of MEWAs that fail to register.
- Impose a civil penalty on the "administrator" of a MEWA that fails to register. Define the term MEWA "administrator" as an individual designated by the MEWA or, if no person is designated, the person responsible for managing plan assets.
- Provide that willful failure to register is subject to the criminal penalties imposed by ERISA section 501 (i.e., with respect to individuals, a fine of up to \$5,000 and/or up to a year in jail; for entities, a fine not exceeding \$100,000) and 18 USC section 1027.

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<sup>5</sup> In order to facilitate compliance, MEWAs could be permitted to register by providing DOL with copies of their state licenses. DOL could promulgate regulations providing an alternate method of registration for a MEWA operating in a state that does not require or grant licenses.

- Amend certain ERISA definitions to prevent MEWAs from trying to avoid the registration requirement (i.e., the section 3(40) regulation project).

### Previous Proposal

The previous approach was agreed to by the White House policy staff and endorsed by the principals' group on health care, which decided that it would be best to keep MEWA regulation primarily at the state level with an enhanced secondary enforcement role for the Department of Labor by requiring all MEWAs to provide copies of their state licenses to the Department. The intent of that proposal was to build on the current enforcement scheme, which generally allows states to regulate MEWAs. The principals' group believed that the proposal would give the federal government information about every MEWA, which it could share with the states to help them ensure compliance with their laws.

However, Department of Labor staff recognized that not every state currently requires MEWAs to be licensed; consequently, the proposal would not give the federal and state governments full information. Another concern was that the proposal might be construed as imposing MEWA licensing requirements on states. The consensus was that the recommended approach would best meet the principals' goal, consistent with the principle of maximum state flexibility and minimal federal involvement.

### Previous Legislative Proposals

- The HSA did not permit MEWAs to offer health benefit plans covering the prescribed benefit package. It left open the question of whether MEWAs could provide supplemental benefits.
- Many of the other comprehensive health reform proposals from last Congress included broader and more detailed proposals for regulation of health benefit plans offered by MEWAs. Except as noted below, these proposals generally provided for stronger federal regulation of MEWAs, while limiting or eliminating state regulation.
  - \* The Rowland bill included provisions requiring all MEWAs providing health benefits to register with the Department of Labor on an annual basis. A MEWA that was not fully insured also would be required to register annually with the appropriate state insurance commissioner(s). The bill eliminated state regulation of MEWAs that were not fully insured, instead providing for federal (DOL) certification and stricter regulation. The bill also imposed solvency requirements on federally certified MEWAs.

- \* The Michel bill included MEWA provisions similar to those in Rowland.
  - \* The Dole plan generally required health plans maintained by MEWAs with at least 500 participants to be certified by the Department of Labor.
  - \* The Mainstream proposal permitted MEWAs to offer only one "experience-rated" health plan (a "qualified association plan," or QAP). The proposal strengthened federal regulation of such plans, generally requiring certification of self-insured QAPs by the Department of Labor (or, for single-state self-insured QAPs, by the appropriate state). However, this proposal apparently eliminated ERISA regulation of other (community-rated) MEWA health plans.
- In addition, during the 103d Congress, Congressman Petri (R-WI) introduced a stand-alone MEWA bill, which combined elements of several bills, both Democrat-sponsored and Republican-sponsored, from the previous Congress.<sup>6</sup> Petri's bill would have provided, among many other things, registration requirements. It also would have permitted the Secretary of Labor to obtain a court order requiring an arrangement to cease activities when not licensed or operating under state insurance laws. This bill, and the bills described in the next paragraph, also provided for stricter federal regulation of MEWAs and imposed solvency requirements on federally regulated MEWAs.
  - During the 102d Congress, Republicans introduced two comprehensive MEWA proposals, the Bush Administration bill and the Petri bill. Both bills would have required, among many other things, that all MEWAs with health benefit plans register with the Department of Labor annually, and provide copies of the registration to state insurance commissioners in each state where the MEWA operated or intended to operate.
    - \* The Petri bill also provided detailed solvency standards that a MEWA would be required to meet to be certified by the Department (and exempted from state regulation).
    - \* The Bush Administration bill also would have permitted the Secretary of Labor to seek an order requiring a MEWA to cease activities immediately if a MEWA was neither licensed, registered or otherwise approved

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<sup>6</sup> The Petri bill had 19 Republican and 1 Democrat (Congressman Matthew Martinez, D-Cal.) co-sponsors.

under the insurance laws of the states in which the arrangement offered or provided benefits, nor operating in accordance with the terms of an exemption granted by the Secretary. In addition, the Bush Administration bill provided that before granting an exemption from state regulation, the Department of Labor would consider the solvency of the MEWA.

#### Current Congress

- The Specter bill would permit MEWAs to offer "qualified association plans". The proposal would strengthen federal regulation of such plans and generally would require certification by the Department of Labor of self-insured QAPs.
- Senator Kennedy (D-Mass) has introduced a comprehensive health reform bill (S. 168), which includes MEWA provisions similar to those in the Mainstream bill from the 103d Congress, except that it would permit MEWAs to maintain more than one "qualified association plan." Like the Mainstream proposal, this proposal apparently would eliminate ERISA regulation of other MEWA health plans.
- The Fawell bill includes MEWA-related provisions similar to those in the Rowland, Michel and Petri bills from the 103d Congress.

#### **SHORTENED TURNAROUND FOR BENEFIT CLAIMS**

##### Current Law

ERISA requires that employee benefit plans provide adequate notice in writing to participants and beneficiaries whose claims have been denied and afford them a reasonable opportunity for a full and fair review of the denial by the appropriate named fiduciary. Under Department of Labor regulations it will be deemed unreasonable if the claimant is notified more than 90 days after the plan receives the claim, absent special circumstances. If a claim is denied, the appropriate named fiduciary is expected to issue a decision upon a request for review within 60 days. There is no procedure in ERISA to deal specifically with urgent requests for preapproval of medical care or determinations of benefit eligibility.

##### Recommendation

- Require the Department of Health and Human Services, in conjunction with the Department of Labor, to develop guidelines for state standards for health plan grievance procedures, including a maximum turnaround time for claims

consideration. Further provide that these guidelines would be enforced by the Department of Labor with respect to ERISA covered plans.

## **Discussion**

Prior to the Administration's request for the Department of Labor's recommendations in the consumer protection area, recent discussions on this issue within the Department indicated that staff generally felt that the Department already possesses the regulatory authority to require shorter timeframes than required under the current regulation. However, while staff argued that the timeframes were, on their face, too long, concerns were raised about issuing a regulation without first establishing a public record highlighting the problem. Thus, at that time the consensus was reached that a "Request for Information" on this specific issue should be published to build the public record before any proposed regulation was put forward.

However, Department of Labor staff took the opportunity presented by the Administration's request to recommend a legislative approach, which the staff felt would address this issue in the most expedient manner. The staff agreed that building the public record necessary to propose the regulation would take some time. The staff initially suggested that a similar public record might be necessary to support a legislative proposal; however, the consensus was reached that there was a political basis for this recommendation, since most of the major legislative proposals from the 103d Congress would have addressed this issue (see below).

## Options

The following alternate approaches also were considered:

- Do not propose any new legislative language but begin proceeding with a regulatory project by issuing a Request for Information.
- Amend ERISA to include broad provisions specifying maximum allowable timeframes for initial decision and review of benefit claims, without differentiating between types of claims (e.g., claims for services rendered, requests for preauthorization). Provide separate timeframes for an expedited claims process relating to urgent requests for health benefits. As necessary, regulations can be issued by the Secretary to provide guidance for specific timeframes.
- Amend ERISA to include detailed new requirements for resolving claims disputes, including extensive and specific timeframes in legislative language for each step in the claims process. Provide specific timeframes for deciding

claims for services rendered, requests for preauthorization and requests for utilization review determinations. Provide separate timeframes for processing claims procedures involving urgent requests for preauthorization of items and services and for emergency utilization review determinations. Provide specific criteria as to when urgent claims procedures could be utilized.

#### **Comment**

The recommended option was chosen to give a clear legislative mandate for a uniform health plan benefit claims procedures without providing extensive new requirements. Department of Labor staff felt strongly that the same health plan grievance procedures should apply with respect to all health plans, ERISA covered or not, and this option was chosen to provide for such uniformity. This recommended option will serve the dual purpose of keeping the legislative requirements to a minimum, and thus appearing less like the 1994 proposals, while improving the current claims process through regulations.

#### **Previous Legislative Proposals**

The HSA and other bills in the 103rd Congress not only provided shortened timeframes in the internal plan procedures but also developed extensive requirements for an administrative process for resolving claims disputes, an alternative dispute resolution procedure, remedies, and a federal appeals board.

- The HSA would have required health plans to provide notice of their approval or denial of a claim within, at most, 30 days (24 hours for urgent requests, or the request was treated as approved). Once a determination to deny a claim had been made, the plan had to provide notice within 5 days, if earlier. If a claimant requested a reconsideration of the denial, the reconsideration decision generally was to have been made within 30 days of receipt of the request. If an urgent request was denied and a complaint was filed, the HSA required a hearing before an administrative law judge (ALJ) within 24 hours.
- The Mainstream proposal would have required health plans to provide notice of claim approval or denial within 25 days, at latest (within 3 days for urgent requests, or earlier if ordered by a hearing officer). Once a determination to deny a claim was made, the proposal required notice within 5 days, if earlier. If an individual appealed a denial, a plan generally would be required to provide notice of the plan's decision within 30 days of receipt of the request. If an urgent request was denied and a complaint filed, the proposal provided for a hearing before an ALJ within 3 days.

- The Michel bill would have required ERISA covered health plans to issue initial claims or preauthorization decisions within 30 days of filing (24 hours for certain cases involving emergency medical care), or the claim was treated as denied. If review of a denied claim were requested, a decision was due within 30 days after the request was filed (within 24 hours for certain cases involving emergency medical care).

#### Current Congress:

- The Cohen bill requires HHS to develop guidelines for state standards for health plan grievance procedures. These guidelines would be enforced by the Department of Labor with respect to any ERISA-covered health plan. It is unclear whether these guidelines would include shortened turnaround time for claims considerations.
- The Fawell bill generally would require ERISA covered health plans to issue initial claims or preauthorization decisions within 45 days of filing. If a claim were denied, a full and fair review of denied claims must be provided within 45 days of a request for review. Requests for emergency medical benefits would be required within 10 days (48 hours in cases of extreme urgency) with a full and fair review of a denied claim within 10 days (or 48 hours in case of extreme urgency).

#### **EXPANDED REMEDIES FOR DENIAL OF CLAIMS**

##### Current Law

Under ERISA, claimants bringing civil actions are limited to recovering the benefits due under the terms of the plan and, at the court's discretion, reasonable attorneys' fees and costs of action.

Participants and beneficiaries under ERISA who are harmed by a plan's decision have no opportunity to obtain compensatory, consequential or punitive damages that might be available under the laws in their respective states to individuals covered by non-ERISA health coverage. With such limited remedies it is difficult for claimants to obtain legal representation and even an eventual finding in the claimant's favor often results in the claimant bearing much of the cost of the plan's decision.

We understand that 23 states allow claimants with non-ERISA health coverage compensatory damages and that 27 states allow punitive damages. (However, the extent of overlap is unclear.)

## Recommendations

- Expand ERISA remedies to make people whole for losses suffered. Such remedies could include economic losses (such as out of pocket expenses and lost wages) sustained. No punitive damages would be allowed.
- Permit the Secretary of Labor to impose a maximum civil penalty of \$25,000 on an administrator or fiduciary for failure to provide benefits under the terms of the plan without any reasonable basis.
- Permit the Secretary of Labor to impose a maximum civil penalty of \$1,000,000 on an administrator or fiduciary for repeated failures to provide benefits under the terms of the plan without any reasonable basis.
- Alternatively, make state law remedies and penalties available to all enrollees in health plans, including those in ERISA plans.

## Options

The following alternative considered also was presented in a briefing paper to the principals' group on health care.<sup>7</sup> With other options recommended, it represented the interagency staff consensus of options; however, no decisions on these options were made at the principals' meeting.

- Allow (perhaps limited) non-economic damages (e.g., pain and suffering, emotional distress, etc.).

## Previous Legislative Proposals

- Under the HSA, the remedies available through the administrative process would have included the benefit denied, pre-judgment interest on costs incurred in obtaining the benefit, attorney's fees, expert witness fees and costs. Regional alliance claimants could bring cases in state court as contract claims and were entitled to full state remedies, including compensatory and punitive damages if available.

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<sup>7</sup> The options presented in the briefing paper for the principals' group also included several of the executive staff recommendations: to make individuals whole for economic losses suffered; to amend ERISA to include a civil penalty that may be imposed by the federal government in cases of an extensive pattern or practice of abusive denials; and to make state law remedies available to enrollees in ERISA plans.

- The Mainstream proposal would have limited remedies to the amount of the claim, pre-judgment interest and reasonable costs relating to the hearing (e.g., attorneys' fees). The proposal also would have permitted the Department of Labor to assess a civil penalty up to \$750,000 if a plan were found to have a pattern of bad-faith denial of claims.
- Under the Michel bill remedies available to individuals covered by ERISA health plans included prejudgment interest on actual costs incurred obtaining any item or service and attorneys' and expert witness' fees. The bill also permitted the Secretary of Labor to assess a civil penalty on an administrator or fiduciary for repeated failures to provide benefits under the terms of the plan without any reasonable basis.
- The Dole, Rowland and Gramm bills from the last Congress included provisions affecting medical liability actions. However, these provisions apparently would not apply to ERISA health plan benefit claims disputes.

#### Current Congress

- The Gramm bill would set certain rules for all medical malpractice liability lawsuits, including a statute of limitations and limitations on the scope of liability (including the noneconomic damages available). New rules would regulate the payment of costs and attorneys' fees in these actions. However, these provisions apparently would not apply to ERISA health plan benefit claims disputes.
- The Fawell bill addresses participant remedies in a similar manner to the approach of the Michel bill from the 103d Congress.

#### The Governors

The National Governors Association, in its Health Reform resolution, has also called for increasing the remedies available to individuals covered by ERISA plans. According to the NGA, if Congress does not enact legislation increasing consumer protections available, the Department of Labor should be given the authority to develop regulations that establish essential consumer protections and remedies.

## STANDARDS FOR REVIEW OF BENEFIT CLAIMS DENIALS

### Current Law

The U.S. Supreme Court has held that if an employee benefit plan gives an administrator (or fiduciary) discretion in determining benefit eligibility or the meaning of plan terms, a court can overturn only arbitrary and capricious decisions.<sup>8</sup> This high standard of review makes it difficult for a claimant to have the plan's decision overturned.

This standard of review is particularly significant because ERISA's remedies for claims denials are limited, as discussed above. Because there are no punitive or consequential damages available, the administrator may have an incentive to decide claims in favor of the sponsor. Similarly, a claimant has little incentive to seek legal redress, because there is limited recovery and the courts tend to favor the administrator's decision.

### Comment

Recent discussions within the Department of Labor focused on how to address this issue in the regulatory context. In these discussions, staff suggested that objective standards at the plan level of review would offer participants at least a minimum level of protection; this approach is reflected by the options listed below. However, the Administration's request for the Department of Labor's recommendations in the consumer protection area has given the agency an opportunity to propose statutory language that would affect the standard of review by a court reviewing the decision of the administrator or fiduciary.

### Recommendation

- Require trial courts to review interpretive issues associated with health benefit claims denials de novo, on the basis of the record that existed before the administrator or fiduciary, without deference to the decision of the administrator or fiduciary.
- Require courts to construe any ambiguous terms in the plan against the drafter (i.e. the insurance company or the self-insured plan) and in favor of the participant.

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<sup>8</sup> Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989).

## Discussion

The recommendation that courts review interpretive issues associated with health benefit claims denials de novo would lower the strict standard of review imposed by the Supreme Court's decision and increase the likelihood that participants and beneficiaries would be able to overturn a plan's decision to deny a claim. This expanded review would be based on the record as it existed when the fiduciary or administrator made the decision for the plan and limited to issues of legal interpretation; thus, no new factual evidence would be permitted. This should give participants and beneficiaries the benefit of de novo review without subjecting the courts to burdensome factual review.

## Options

Other alternatives considered include:

- Require fiduciaries reviewing a health benefit denial to construe any ambiguous terms in the plan against the drafter (i.e. the insurance company or the self-insured plan) and in favor of the participant.
- Clarify the circumstances under which fiduciaries reviewing a health benefit denial could consider oral statements or other extrinsic evidence (for example, written documents other than the plan document) when the plan documents are ambiguous.

## Previous Legislative Proposals

- The HSA provided for ALJs to hear complaints and motions de novo (i.e., in an original hearing) and their decisions would be based on the preponderance of the evidence. A Federal Review Board would review the ALJs' decisions under a substantial evidence standard, except for decisions involving interpretations of contractual issues in which case the decision need only be supported by a preponderance of the evidence.
- The Mainstream proposal provided standards strongly favoring the plan decision when ALJs heard claims for payment for health care services already rendered. In other disputes, the ALJ would determine all issues de novo, but the burden of proof would fall strongly on the claimant.

## Current Congress

- There appear to be no relevant provisions in the proposals reviewed from the current Congress.

## ALTERNATIVE DISPUTE RESOLUTION

### Current Law

Claimants wishing to contest a plan's decision must pursue civil actions which are commonly expensive and time-consuming.

### Recommendations

- Amend ERISA to establish a pilot demonstration project for handling health plan claim disputes through voluntary, nonbinding mediation. Mediation would be available after the claimant had exhausted all remedies under the plan, pursuant to ERISA section 503. The Department of Labor would assist in the identification and appointment of mediators, but the parties would divide the cost of the mediation process. (Note: this process is based on the ADR procedures in the Michel bill.)
- Authorize funding for a Department health claims mediation demonstration project.

### Discussion

The recommendation to adopt an ADR procedure reflects the increased emphasis on using ADR as a means to reduce the number of potential lawsuits and provide participants and beneficiaries with a less expensive and more expedient method of resolving benefit claims disputes. It was noted at the meeting that there is a directive in the Secretary of Labor's budget to utilize ADR.

The Department of Labor staff chose a course of agency action that was more than an ADR pilot project but less than a legislatively comprehensive ADR system after reaching the consensus that this might be the most politically expedient way to obtain funding for an ADR program. It was recognized that Department of Labor currently has regulatory authority to establish an ADR demonstration project. However, executive staff agreed that the program could be expensive for the Department, and would require additional appropriations.

### Options

Other legislative alternatives considered include:

- Propose new general legislative language that gives the Department of Labor statutory authority to propose an alternative dispute resolution process for plans (i.e., "The Department may (shall) issue guidance regarding appropriate ADR procedures for review of benefit claims disputes").

- Alternately, propose new legislative language with specific and detailed language like that proposed in the 103d Congress (see below), such as delineating the type of ADR procedure, the role of the facilitator, the maximum amount of time allowed for the ADR procedure and other options if the dispute is not resolved using ADR.

#### Previous Legislative Proposals

- The HSA would have permitted claimants to choose to take part in a state-maintained Early Resolution Program (ERP) (administered according to Department of Labor regulations) instead of going directly to an ALJ hearing. The ERP would use mediation and other ADR procedures. The mediation process would take no more than 120 days and if a settlement was reached the agreement between the parties would constitute a binding contract. If the parties were unable to reach a settlement the case would be referred to an ALJ for a hearing.
- Under the Mainstream proposal, health plans would have been permitted to establish alternative binding arbitration by a neutral third party arbitrator, pursuant to minimum consumer protection standards that would have been developed by the Department of Labor.
- The Michel bill would have amended ERISA to establish a voluntary, nonbinding mediation program for health plan claims. Mediation would be available after the claimant had exhausted all remedies under the plan, pursuant to ERISA section 503. The Department of Labor would appoint mediators and proscribe procedures, but the parties would divide the cost of the mediation process.

#### Current Congress

- The Cohen proposal includes provisions for ADR in case of medical malpractice liability claims; however, these provisions apparently would not apply to ERISA health plan benefit claims disputes. In addition, as noted above, the Cohen proposal requires the Department of Health and Human Services to develop guidelines for state standards for health plan grievance procedures, which would be enforced by the Department of Labor with respect to any ERISA-covered health plan. It is unclear whether these guidelines would cover ADR procedures.

## **REPORTING AND DISCLOSURE**

### Current Law

#### **Summary Plan Description (SPD)**

SPDs must be provided to each participant within 90 days after he/she becomes a participant or within 120 days after the plan becomes subject to title I of ERISA. A new SPD must be provided every 10 years if there are no plan changes and every 5 years if the plan has been amended since the last booklet was prepared. Participants and beneficiaries may, on an annual basis, obtain copies of the current SPD and all SMMs to date. Plans may charge a reasonable copying fee up to \$0.25 per page.

#### **Summary of Material Modifications (SMM)**

Material modifications must be described in a notice distributed to participants within 210 days after the end of the plan year in which the change is adopted.

#### **Other Materials Disclosed Upon Request**

Upon request, participants must be given access to and copies of the documents under which the plan is operated such as insurance contracts or Board resolutions defining benefits. Plans may charge a reasonable copying fee up to \$0.25 per page.

### Recommendations

- Require updated SPDs for employee health plans to be provided every 5 years.
- Prohibit plans from charging copying fees for providing copies of the current SPD and all SMMs to date to a participant or beneficiary who has requested such material and who has not received such materials previously in the same plan year.
- Provide that a health benefit plan may not be amended so as to decrease any benefit or coverage, or to increase any out-of-pocket costs charged to participants and beneficiaries (e.g., co-payments or deductibles), unless the plan administrator provides notice (either an SMM or some other notice) to each covered individual at least 30 days before the effective date of the amendment.

- Provide that plan sponsors must distribute SMMs for all other amendments at least 30 days before the earlier of the end of the plan year or the first date participants and beneficiaries may choose or decline coverage (open season). Examples of such amendments include a decision to self-insure a plan that previously was insured without reducing benefits, or a change in plan administrator.
- Prohibit insurance companies from letting individuals' coverage under an insured employee health plan lapse due to the plan administrator's nonpayment of premiums, unless the insurer notifies these individuals at least 15 days before the coverage is to lapse.

### **Discussion**

There was consensus that provisions similar to those described in the last recommendation were necessary to ensure that individuals were notified if their self-insured coverage were about to lapse. However, no consensus has been reached about how to accomplish this.

In addition, Department of Labor staff concurred, as a policy matter, that if the Administration proposes insurance market reforms such as administrative simplification (e.g., uniform claims forms) and/or plan reporting of price and quality-related data, these reforms should be imposed on ERISA plans, as well.

### Options

Other alternatives considered include:

- Require employer health plans that offer a choice of coverage to make available prior to "open season," sufficient information to allow individuals to make an informed choice. Such information could include whether each alternative is insured (and by which company) or self-insured (and what self-insured means), benefits (including limitations on coverage), deductibles, price and quality information.
- When there has been any material modification in the terms of a health plan, require an updated SPD more frequently (e.g., annually or every three years).
- Require plan administrators/fiduciaries to notify covered individuals of other significant events that may affect them within 10 days of when the plan administrator/fiduciary knew or should have know of the event. Such events could include (i) when a health plan failed to pay claims and (ii) when a plan sponsor of an insured health plan fails to remit premium payments to the insurance company.

### Previous Legislative Proposals

- The HSA would have amended ERISA to give the Department of Labor the authority to provide special regulations for group health plans, including rules necessary to ensure timely reporting and disclosure of information. In addition, the HSA would have required corporate alliance employers to make available to eligible enrollees before each open enrollment period information that would allow them to make valid comparisons among the health plans being offered by that alliance. Such information had to be provided in the same format for each plan.
- The Mainstream proposal would have required health plans (including ERISA covered plans) to provide information including benefits offered, premiums, cost-sharing and administrative charges, and the number, types and availability of providers. In addition, the proposal gave the Departments of Health and Human Services and Labor authority to require additional information (from insured and self-insured plans, respectively).
- The Rowland proposal would have required ERISA health plans to disclose information to enrollees and potential enrollees that related to the coverage provided and to the performance of the plan in providing coverage. Additional information would be required for any plan with an actuarial value different than the proposal's standardized plans.
- The Dole and Michel proposals each included requirements that certain plans make information available to consumers pursuant to state law requirements. These provisions apparently would not have affected ERISA plans.

### Current Congress

- The Cohen proposal requires HHS to develop guidelines for state standards for comparative standardized consumer information with respect to health plan premiums and quality measures. These guidelines would be enforced by the Department of Labor with respect to any ERISA-covered health plan.