

# Washington Business Health Update

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- **COMPANY CHALLENGES VERMONT'S ATTEMPTS TO OBTAIN SELF-INSURED PLAN HEALTH DATA**

Recently, Vermont's Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) issued a subpoena to a self-insured employer-sponsored group health plan's third-party administrator (TPA) after the employer refused to permit the TPA to turn over plan data to the agency. The agency attempted to enforce a regulation requiring all plans, including employer plans in the state, to submit health plan claims and eligibility data to the state.

The employer-sponsored plan filed for an injunction in Vermont's U.S. District Court to stop the agency on the grounds that the action would regulate self-insured plans and violate the Employee Retirement Income Security Act of 1974 (ERISA). ERISA is the federal law which generally prevents states from applying state laws to self-insured employer-sponsored plans. The case will move forward if the U.S. District Court does not grant the injunction.

**IMPACT ON EMPLOYERS AND EMPLOYEES:** Vermont's state law could force self-insured plans to provide highly sensitive, confidential health plan information to the state. If successful, Vermont (and perhaps other states using Vermont's law as a precedent) could regulate self-insured plans through their TPAs and weaken ERISA preemption of state laws.

**OUTLOOK:** *The U.S. District Court for the District of Vermont may rule on the injunction in the next few months.*

**BACKGROUND:** In 2008, Vermont's BISHCA issued [Regulation H-2008-01](#), which requires health insurers, managed care organizations, TPAs, pharmacy benefit managers (PBMs), and other parties to submit health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities to the state. Under this

regulation, TPAs must submit health plan claims and eligibility data—including data from self-insured plans—to BISHCA.

Vermont's BISHCA has authority to collect eligibility and claims data for Vermont residents from health insurers under a 1991 state law through the Vermont Healthcare Claims Uniform Reporting and Evaluation System.

**NATIONAL BUSINESS GROUP ON HEALTH VIEW ON THESE ISSUES:** The National Business Group on Health strongly supports ERISA, which provides the national framework that enables self-insured employers to provide innovative health care and benefits solutions on a national, uniform basis efficiently, which benefits us all. If the courts allow states to subject employer plans to state laws beyond the regulations of the federal Department of Labor, it could prevent plans from offering uniform benefits and operating plans efficiently, stifling innovation, raising costs and harming quality.

### ➤ MICHIGAN'S 1% TAX ON PAID HEALTH CLAIMS MAY VIOLATE ERISA

Recently, Michigan lawmakers passed a [bill](#) that would require health insurers, Health Maintenance Organizations (HMOs), and TPAs for both insured and self-insured plans to pay a quarterly 1% tax on paid claims for health care services provided to Michigan residents in the state, for 2 years, beginning on January 1, 2012.

**IMPACT ON EMPLOYERS AND EMPLOYEES:** Unless successfully challenged in court, TPAs may attempt to pass on the costs from this new tax to both insured and self-insured plans either through direct payments or higher fees. The bill could also weaken ERISA preemption of state laws.

**OUTLOOK:** *Michigan's Governor will likely sign the bill into law soon.*

**BACKGROUND:** Michigan's lawmakers intend to raise revenue for Michigan's Medicaid program by taxing paid health claims. The bill would cap the 1% tax at \$10,000 per individual, and does not include out-of-pocket expenditures by individuals (e.g., copayments, coinsurance, and deductibles); medical coverage for automobile insurance; or workers' compensation. It is highly likely that the bill, as applied to self-insured plans, violates ERISA.

**NATIONAL BUSINESS GROUP ON HEALTH VIEW ON THESE ISSUES:** The National Business Group on Health strongly supports ERISA, which provides the national framework that enables self-insured employers to provide innovative health care and benefits solutions on a national, uniform basis efficiently, which benefits us all. If the courts allow states to subject employer plans to state laws beyond the regulations of the federal Department of Labor, it will likely prevent plans from offering uniform benefits and operating plans efficiently, stifling innovation, raising costs and harming quality.

### ➤ HOUSE COMMITTEES TO CONSIDER REPEALING RULES ON LOSS OF GRANDFATHERED PLAN STATUS

Recently, House Majority Leader Eric Cantor (R-VA) stated that the House Education and Labor; Energy and Commerce; and Ways and Means Committees will draft

legislation to repeal the health care law's rules on the loss of grandfathered plan status. The rules describe benefit changes that group health plans can make without triggering a number of benefit mandates and plan requirements, such as providing government-recommended preventive services at no cost to plan participants and complying with new internal appeals requirements and independent review of challenges to denied claims.

Majority Leader Cantor included the repeal effort in a [memo](#) targeting several Administration rules "negatively affecting wages and job growth."

**IMPACT ON EMPLOYERS AND EMPLOYEES:** Allowing existing employer plans to maintain grandfathered status will help employers make common benefit design changes to help control costs while avoiding some of the costs associated with the requirements for non-grandfathered plans. The flexibility afforded to grandfathered plans will help keep coverage affordable for employees and their families.

**OUTLOOK:** *The House committees will consider bills to repeal the grandfathered plan rules in late November/early December. The House will likely pass the bill, but it is unlikely to pass the Senate.*

**BACKGROUND:** Grandfathered plans have some advantages over non-grandfathered plans. They automatically satisfy the health care law's requirements to provide "minimum essential coverage," they do not have to adopt all of the plan requirements and mandates that other plans do such as:

- Eliminating cost sharing for government-required preventive services, beginning in 2011;
- Implementing Department of Health and Human Services (HHS)-approved internal review and external appeals processes, beginning in 2011;
- Applying nondiscrimination rules (Insured plans only), beginning in 2011;
- Prohibiting prior authorization or higher out-of-network cost-sharing for emergency care, beginning in 2011;
- Prohibiting prior authorization for Ob/Gyn, and pediatric services, beginning in 2011;
- Filing financial reports with HHS/State insurance departments, beginning in 2011;
- Filing quality of care reports with HHS, beginning in 2012;
- Covering people in clinical trials, beginning in 2014; and
- Prohibiting cost-sharing limits that exceed HSA maximums (Currently \$5,950 individual, \$11,900 family), beginning in 2014.

Last year, the Senate defeated an amendment by Senator Michael Enzi (R-WY) to repeal the grandfathered plan rules.

**NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THESE ISSUES:** The National Business Group on Health believes that employers should continue to have the flexibility to determine the types of benefits they voluntarily offer

and to tailor benefit plans to the specific needs of their employees and the circumstances of their companies. We believe the federal government should allow all plans in existence prior to the health care law's enactment date to maintain grandfathered plan status no matter what routine plan design changes they make. At the very least, employer-sponsored plans that adopt proven, evidence-based plan changes that enhance quality and value, make plan changes to comply with other federal laws, eliminate coverage for ineffective services or treatments, or make benefit changes that do not change the actuarial value of their plans by more than 5%, should not lose their grandfathered plan status

Link to the Business Group's comment letter to the Departments of Labor, Health and Human Services and Treasury on the grandfathered plan rules:

<http://www.businessgrouphealth.org/pdfs/081610%20Letter%20to%20HHS,%20DoL%20and%20IRS%20on%20Grandfathered%20Plan%20Regulations.pdf>

Link to the Business Group's Public Policy Alerts on the grandfathered plan rules:

<http://www.businessgrouphealth.org/members/secureDocument.cfm?docID=2962>

<http://www.businessgrouphealth.org/members/secureDocument.cfm?docID=2777>

➤ **CONGRESSIONAL “SUPER” COMMITTEE WILL ATTEMPT TO CUT \$1.5 TRILLION TO AVOID ACROSS-THE-BOARD FEDERAL SPENDING CUTS**

Representative Jeb Hensarling (R-TX) and Senator Patty Murray (D-WA) co-chair a [12-member](#), bipartisan congressional “super” committee tasked with finding up to \$1.5 trillion in federal savings by November 23. Congress created the “super” committee under a law to increase the \$14.3 trillion federal debt ceiling in two stages by up to \$2.4 trillion—enough to keep borrowing into 2013 (past the presidential election)—while cutting an equal \$2.4 trillion in federal spending over 10 years.

In the second stage, the “super” committee must recommend further deficit reductions totaling \$1.5 trillion or more, with Congress obligated to vote on the panel's proposals by the end of the year.

To put pressure on the members of the “super” committee, the law also includes a “trigger” of across-the-board cuts matching the size of the debt ceiling increase in military spending, education, transportation and Medicare payments (capped at 2%) to health care providers if Congress fails to act. The “trigger” does not include Medicaid cuts.

The “super” committee's members face the difficult task of considering politically sensitive reforms to the tax code and federal entitlement programs as well as additional cuts in other federal spending. Members of Congress and the Administration state that everything is on the table: including \$300 billion in federal health care expenditure cuts previously agreed to by Vice-President Joe Biden and House Majority Leader Eric Cantor (R-VA).

A few of the options on the table include:

- **Medicare**
  - Cutting payments to hospitals (payments for services and medical education), clinical labs, skilled nursing facilities, home health care agencies, durable medical equipment (DME) companies (wheel chairs, etc.); and Medigap plans;
  - Reforming physician payments;
  - Expanding the Independent Payment Advisory Board's powers to include hospital payment reform and possibly before its start date of 2014;
  - Holding total federal health spending to Gross Domestic Product (GDP) growth + 1% per beneficiary and requiring action if this amount is exceeded;
  - Raising Medicare's eligibility age;
  - Raising beneficiaries' cost sharing; and
  - Means testing or raising Medicare Part B (medical insurance) premiums.
- **Affordable Care Act**
  - Reducing federal subsidies to individuals in the exchanges;
  - Repealing the CLASS (Community Living Assistance Benefit) program; and
  - Reducing the excise or "Cadillac" Tax to 12% or moving up its start date from 2018.
- **Tax Treatment of Health Benefits**
  - Reforming or possibly capping, but not eliminating the favorable tax treatment of employer-sponsored coverage.

Democrats on the "super" committee continue to push for additional taxes to offset some of the recommended cuts, which the "super" committee's Republican members strongly oppose. Republicans want entitlement cuts and changes to Medicare and Social Security that Democrats oppose.

**IMPACT ON EMPLOYERS AND EMPLOYEES:** Reforming our nation's expensive entitlement programs (Medicare, Medicaid and Social Security) will save the federal government from fiscal ruin and our economy too, before the Medicaid expansion begins in 2014, and both Medicare and Social Security run out of money, respectively, beginning in [2020](#) and 2036. Increasing the federal debt without reforming entitlements would cause interest rates to increase dramatically and damage America's economic recovery.

**OUTLOOK:** *The "super" committee must report out its recommendations by November 23 with an up-or-down vote without amendments by December 23. The President can veto any recommended cuts, but Congress can also override his veto. Hospitals, skilled nursing facilities and home health care agencies will likely face additional cuts in the "super" committee's final recommendations.*

**BACKGROUND:** The “super” committee has already started to discuss potential cuts, hire committee staff, schedule public hearings and create a template for a national website to gather additional input from the public.

In its first stage, the legislation that authorized an increase in the federal debt ceiling and created the “super” committee raised the debt ceiling (the amount the government can borrow to pay for programs passed by Congress) by \$917 billion in August , accompanied by \$917 billion in federal spending cuts, mostly to discretionary spending over 10 years (\$420 billion from the national security budget).

Standard and Poor’s recently downgraded the U.S.’s AAA credit rating for the first time, citing the nation’s political process and criticizing lawmakers for failing to cut spending or raise revenue enough to reduce record budget deficits which caused the U.S. stock market to plunge.

In June, the House rejected a bill that would raise the debt ceiling by the \$2.4 trillion requested by the President without any spending cuts.

In May, the Senate rejected Representative Paul Ryan’s (R-WI) House-passed budget bill that would cut about \$4 trillion in federal spending over 10 years and convert Medicare into a health insurance subsidy for people currently 55 or younger, beginning in 2022.

The federal government reached the debt ceiling on May 16, 2011 and took administrative measures to delay a default until August 2.

The federal government’s debt is \$13.5 trillion and rising. The U.S. currently borrows \$125 billion per month to pay for all of commitments, including Medicare. In January, the CBO raised its estimate for the annual deficit (spending more than it takes in on revenues) from \$1.1 trillion to \$1.5 trillion. Spending on the government’s major mandatory health care programs—Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), and future health insurance subsidies provided through the insurance exchanges in 2014—along with Social Security will increase from roughly 10% of Gross Domestic Product (GDP) in 2011 to about 16% over the next 25 years. Medicare, Medicaid, and SCHIP together account for 21% of total federal spending.

In April, the President signed legislation that cut \$41 billion across a variety of government programs while funding the federal government until September 30, 2011. The President also made a [speech](#) calling for up to \$4 trillion in savings over 12 years, but did not release many details.

**NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THESE ISSUES:** The National Business Group on Health believes that we need to put our government’s fiscal house in order and invest in high value services and programs in order to strengthen our economy. We also believe that we need a long term solution to the country’s unsustainable entitlement spending.

The National Business Group on Health believes the federal government should maintain the current favorable tax treatment of employer-sponsored coverage because it is a key reason that so many families have affordable coverage. The National Business Group on Health opposes capping or eliminating the current tax exclusion for employer

contributions to employee health benefits and capping or eliminating the current ability of employers to fully deduct their expenses for employee health care. We also support the federal government allowing everyone to pay for out-of-pocket health care expenses on a pre-tax basis.

The Institute of Medicine (IOM) has listed ways to save hundreds of billions of dollars annually in the health care system by reducing medical errors, overuse or patient safety problems without hurting the quality and safety of health care.

Link to the IOM's list of excess cost domains:

[http://books.nap.edu/openbook.php?record\\_id=12750&page=52](http://books.nap.edu/openbook.php?record_id=12750&page=52)

The Business Group believes Congress needs to tie physician payments to performance on quality and safety in any reform of Medicare's physician payment system and with any restoration of planned payment cuts.

If you would like more details on these or other issues or would like a phone briefing on legislation, or want to express concerns about specific issues, please contact Steven Wojcik, Vice President, Public Policy at [wojcik@businessgrouphealth.org](mailto:wojcik@businessgrouphealth.org) or 202-558-3012. **Also, as part of our "Ask a Benefits Question" service, we are happy to respond within 24 hours to any health benefits question on policy, regulations or legislation.**

*This material is provided for information purposes only and is not a substitute for legal advice.*

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