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STATE HEALTH CARE REFORM

Federal Requirements Influence State Reforms

Statement for the Record
Mark V. Nadel, Associate Director
Human Resources Division



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SUMMARY OF GAO TESTIMONY BY MARK V. NADEL
ON FEDERAL BARRIERS TO COMPREHENSIVE STATE HEALTH CARE REFORMS

GAO reported in Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992) that states have taken a leadership role in devising strategies to expand access to health insurance and contain the growth of health care costs. Their approaches range from narrowly focused efforts to reform the health insurance market or contain hospital costs to comprehensive initiatives to achieve universal access to health care coverage.

States attempting comprehensive solutions are hampered by restrictions imposed by federal programs, particularly Medicaid, and by the Employee Retirement Income Security Act of 1974 (ERISA), which preempts state regulation of employee benefit plans, including health plans provided by self-insured employers.

GAO presented testimony on states whose reform plans are affected by federal laws. Hawaii, the only state requiring employers to provide health insurance, is able to enforce this mandate because the Congress exempted the state's 1974 law from certain ERISA provisions. The exemption, however, limits the law to its original form and prohibits changes state officials believe are necessary to improve the effectiveness and equity of Hawaii's system.

In enacting a health care reform package in 1992, Minnesota officials tried to design a plan that would not require relief from federal restrictions, thus limiting the state's options. To fund a state-subsidized health plan for lower-income uninsured residents, the state levied a provider tax that hospitals may pass on to all payers. The provider tax is currently being challenged on the basis of ERISA.

Florida's health plan, enacted in 1992, would require statutory changes to Medicaid and also might require an ERISA exemption. If employers do not voluntarily offer coverage to their employees by the end of 1994, the law contemplates a mandatory system, which could be affected by ERISA. State officials would also like to expand Medicaid coverage to people without employment-based insurance who are near poverty but ineligible for Medicaid.

If Congress decides that reform at the state level is an appropriate path, it should consider reducing the potential barriers to comprehensive state reform. States considering reform perceive restrictions associated with ERISA and Medicaid as potential obstacles. Congress could facilitate state reform efforts by developing approaches that provide states with early assurance that they will receive the federal cooperation necessary to implement change.

Mr. Chairman and Members of the Committee:

This statement discusses our report, Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992). Providing health care to every American has become one of the most serious problems facing the nation. The number of individuals without--or with inadequate--health insurance is increasing, while the cost of providing care is growing. Our report responded to a request from Representatives John Dingell and Ron Wyden to describe state initiatives that address the problems of access and affordability in the health care system and to report on federal barriers that limit state options for achieving universal access to health care. Recently you asked us to provide additional information about the need for states to obtain changes in federal laws to implement innovative health care reform.

Several states are developing programs designed to expand access to health insurance and contain the growth of health care costs. None has found this to be an easy process. State political leaders must assemble coalitions of supporters from the variety of interest groups involved in--or affected by--their health care systems. To do so, they must frame proposals that will win the support of--or at least be acceptable to--health care providers, employers, taxpayers, and a patient population ranging from those currently well insured through those currently underinsured to those who have no insurance at all.

One barrier these state political leaders face is the preemption provision of the Employee Retirement Income Security Act (ERISA) of 1974. Another is uncertainty over the particular terms that the federal government will require as a condition for a Medicaid waiver. Oregon's recent experience illustrates this latter problem. State officials worked for several years to develop a proposal capable of garnering the political support necessary, but their effort was recently derailed by denial of their request for a Medicaid waiver.

In my statement, I would like to provide some background information on the federal laws that might restrict state efforts to achieve comprehensive reform. Then I will present the results from our recent report describing the reform efforts of several states. I will close by updating the legislative efforts of four states in this rapidly changing health reform environment.

BACKGROUND

When enacted in 1974, ERISA was designed to correct serious problems regarding the solvency of employer-sponsored pension plans, but ERISA covers all employee welfare benefit plans, including health benefits. ERISA established federal standards for these employee benefit plans--although it imposes few requirements on health plans--and preempted their regulation by states.

Although preventing states from regulating health insurance plans, ERISA confirmed the states' authority to regulate insurance companies.

ERISA's preemption provision¹ enables employee benefit plans to serve employees in many jurisdictions without becoming subject to conflicting and inconsistent laws of various state and local governments. However, it has also produced a divided system in each state: the federal government has authority to regulate health plans provided by employers who self-insure but not health policies sold by insurance companies, and states can regulate health insurance companies and their policies but not the plans provided by employers who self-insure.

Under the Medicaid program, states receive federal funds only if they meet all relevant federal requirements, including eligibility and benefit plan standards. Medicaid eligibility is primarily tied to eligibility for the Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC) programs. Due to the eligibility restrictions of these two programs, young single people and childless couples are generally precluded from Medicaid coverage.

In addition to categorical eligibility requirements, Medicaid recipients must meet specific income and resource criteria. The income level that states set for welfare programs is usually the standard that applies to Medicaid eligibility. Medicaid eligibility levels vary across states, with only 16 states offering Medicaid to AFDC-eligible families with incomes over 50 percent of the federal poverty level.²

Some state reform plans that do not comply with existing Medicaid laws can be implemented by obtaining a waiver from the Health Care Financing Administration (HCFA). HCFA has the authority to grant Medicaid waivers and does so regularly. Some waivers, such as for managed care programs, can be renewed indefinitely. In addition, states can obtain demonstration waivers from HCFA that give them greater latitude to modify their Medicaid programs, but these waivers are for a limited duration and cannot be renewed.

¹29 U.S.C. section 1144 (1988).

²Recently Congress has passed legislation that expands and enhances Medicaid maternal and child health services. Medicaid eligibility has expanded to improve the access of low-income women, children, and infants to needed health care by not only broadening the allowable service coverage to these groups but also severing the traditional link between Medicaid and AFDC income eligibility criteria.

STATES ACTIVELY PURSUE HEALTH CARE REFORMS

State governments have a major stake in financing and providing health care. States are a major purchaser of health care services in this country. On average, over 13 percent of a state's budget is used to fund Medicaid, which, in 1990, grew by 18 percent. An average of 20 percent of a state's budget goes to fund health care programs.

This has led to state governments' taking an increasingly active role in the search for solutions to our national problems of constricted access to health care and rising health care costs. During the first few months of 1992 alone, three states--Florida, Minnesota, and Vermont--enacted ambitious plans to reform their health care systems.

In some states, debate no longer centers on whether to set a goal of ensuring universal access to health care coverage, but on how to achieve it. Hawaii was the first state to try to extend coverage to all its residents, and its uninsured rate is the lowest of all the states. The principal tool that has allowed Hawaii to approach universal access is its 1974 law requiring employers to provide health insurance for employees working at least 20 hours a week. State requirements that virtually all employers provide insurance and that insurers cover all employees result in less uncompensated care and cost shifting. For most residents not covered by employers or Medicaid, the state has a subsidized insurance program, known as the State Health Insurance Program (SHIP), with less extensive benefits.

Minnesota, Florida, and Vermont are among the most recent states to pass laws aimed at providing coverage to all state residents. Minnesota's 1992 Health Right Act phases in several programs to extend access to health insurance to many of the state's uninsured. Key features of the act include creation of a state Health Care Commission, which is responsible for devising a plan to set targets for reducing the growth of health care expenditures, and a state-subsidized, managed-care health plan for lower-income residents not eligible for Medicaid.

Florida's 1992 legislation set a December 31, 1994, goal for universal access to a basic health care benefits package. It created the Agency for Health Care Administration to develop and administer a plan with specific goals and timetables for ensuring access, cost containment, and insurance reform.

Vermont's 1992 Health Reform Act proposes to provide universal access to all state residents by October, 1994. The legislation created the Vermont Health Care Authority, which is charged with preparing two comprehensive reform proposals--one based on a single-payer system and the other based on a multiple-payer

system--to be voted on by the legislature. In addition, the Authority is responsible for administering the insurance reform, data compilation, and cost containment provisions contained in the law.

Instead of adopting comprehensive plans, some states have opted for programs targeted to specific uninsured groups, such as low-income children and adults. These states have expanded access to coverage for these populations either through state-subsidized private health insurance, such as Washington's Basic Health Plan, or expanded Medicaid eligibility, such as the Maine Health Program.

Most states have also adopted measures to make it easier for people with high-cost health conditions and for small business owners and employees to obtain affordable health insurance in the private market. Almost half the states have created high-risk pools to make insurance available to the medically uninsurable--people who cannot obtain conventional insurance because of their medical conditions--and to spread the risk of covering them among all insurers in the state.

To address problems in the small business insurance market, states have adopted a broad range of initiatives, including subsidies and regulatory reforms, that attempt to make insurance more affordable and accessible. Thus far, most of these efforts have had only a modest effect on the number of small firms newly offering health insurance to their employees.³

While most states have focused their attention on expanding access to coverage, some have made efforts to control increasing costs. Through changes in methods for reimbursing providers, these states attempt to limit the health care system's cost growth and administrative burden. For example, since 1972, Maryland has operated a hospital rate-setting system that reduces hospital costs and provides for nearly uniform payments by all insurers, both public and private. During this period, Maryland's hospital costs per admission fell from 25 percent above the national average to 10 percent below.

In an attempt to reduce administrative costs, New York State is now implementing a system to coordinate health care billing and payment procedures. The state's Single Payer Demonstration Project is expected to reduce claims-processing costs for participating hospitals.

³For a more detailed discussion of state efforts to modify the health insurance market for small businesses, see Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 1992).

FEDERAL BARRIERS HINDER STATE EFFORTS

One barrier to state health reform efforts is the budget problems experienced by many states, since many of these reform proposals require additional state resources. But states that overcome these budget problems find that their reform efforts are also hampered by federal laws and regulations. ERISA is a barrier because it preempts state authority to regulate employee health benefit plans. While ERISA was primarily intended to correct problems with the solvency of employer-sponsored pension plans, its impact on employer-provided health benefits has grown as more firms have self-insured for health benefits. Over half of U.S. workers are employed in firms that self-insure, and states cannot require such employers to provide a specific health plan or pay state-imposed premium taxes. The funding base for state-sponsored high-risk pools, for example, is limited because the insurance assessments that supplement individual premiums do not apply to self-insured companies. Without more flexibility in dealing with self-insured firms, states' reform options are limited.

On the other hand, many large employers and union groups fear that any diminution of ERISA could undermine the structure of existing employer-provided health insurance plans. Employers with operations in more than one state are concerned that alterations to ERISA might increase their administrative costs if they must comply with different requirements in different states. Some unions are also concerned that changes to ERISA may lead to limitations of their benefits plans or an increase in cost-sharing burdens.

Medicaid's rules and requirements also present obstacles to state reform efforts. States wishing to implement reforms may need waivers or legislative action to modify Medicaid requirements. Examples of such reforms are integrating the Medicaid program with a state health insurance plan or creating a single organization to administer all payments to health care providers. States find the process of obtaining Medicaid waivers and subsequent renewals to be cumbersome.

However, those administering this process have legitimate concerns that protections contained in the law not be compromised without careful thought. Medicaid regulations exist to ensure that state reform activities do not diminish minimum standards or quality of care for program recipients. In addition, the federal government is concerned that state reform efforts that expand health programs to a broader population might generate additional expenses for Medicaid. For example, some states that want to expand Medicaid to groups that are currently ineligible are seeking additional federal funds, thus increasing costs for the federal government.

In the remainder of this statement, I will discuss the experience of several states, primarily Hawaii, Minnesota, Florida,

and Vermont, whose efforts to expand access to health insurance have been affected by federal constraints.

Hawaii Needs Federal Legislation to Refine System

Hawaii is the only state that now requires employers to provide health insurance to employees. Hawaii is able to enforce this requirement because the Congress passed legislation exempting the state's 1974 law from certain ERISA provisions. In part because its law took effect before ERISA was enacted, Hawaii is the only state with such an exemption. This exemption, however, has frozen the Hawaiian law in its original form. The ERISA exemption is limited to Hawaii's Prepaid Health Care Act as it was passed in 1974; the state cannot amend the act unless specific legislation is passed by the Congress.

Hawaii officials believe they have made great progress in their quest toward achieving universal access, but they also told us that they need to improve the effectiveness and equity of the state's system. A small percentage of the population remains uninsured. The state cannot modify the mandated benefits package for employer-provided insurance, require coverage for dependents, or change the cost-sharing formula for premiums. Hawaii is currently seeking amendments to ERISA to permit it to respond to implementation problems or to improve the employer-mandate law.

Other states that have tried to move toward coverage of all their citizens have had to work within ERISA's constraints. States adopting universal access plans more recently than Hawaii did not have the option of requiring employer-provided insurance and had to devise other approaches. One strategy, enacted by Massachusetts and Oregon but not yet implemented, has been to create "play-or-pay" systems that rely on the state's power to tax. Employers are required to pay a tax to help finance state-brokered insurance; if they provide health insurance to employees, they generally receive a credit for the amount they spend on coverage. These laws, however, are expected to face legal challenges based on ERISA, and the outcome is uncertain.

Minnesota's Options Limited by Federal Constraints

When Minnesota officials considered different methods of reducing the number of uninsured residents in the state, they decided to construct a plan that would not require relief from federal restrictions. Avoiding federal constraints, however, was itself an approach that limited their options. One reason for ruling out a play-or-pay system, for example, was uncertainty about whether such a system would withstand an ERISA challenge.

A key component of the health package that Minnesota adopted is a state-subsidized, managed care health plan for lower-income residents who are not eligible for Medicaid. In addition to

collecting premiums from enrollees, the state will fund the plan with a 5-cent increase in the state cigarette tax and a phased-in provider tax: (1) a 2 percent gross revenue tax on hospitals (effective 1993) and on physicians and other health care providers (effective 1994) and (2) a 1 percent tax on HMOs and nonprofit health service companies (effective 1996). Hospitals may pass the tax through to payers during 1993, to the extent allowed under federal law.

Minnesota officials decided to use a provider tax so that financing would come from within the health care system. Because ERISA preempts states' ability to regulate employee benefit plans, other financing mechanisms, such as a premium tax, would not have reached self-insured employers.

State officials told us that ERISA precludes their taking other actions that could enhance the effectiveness and fiscal soundness of their program. For instance, they would like to discourage employers who currently provide health insurance from dropping coverage for employees who could be eligible for the program, and have discussed techniques such as taxing these employers. They are concerned, however, that ERISA may bar such an approach.

Another idea Minnesota officials are considering is collecting the premiums of program enrollees through a payroll deduction mechanism. They are not sure whether ERISA would prevent them from requiring all employers, including those who self-insure, to collect the premiums for the state. In addition, their fears that their plan might be contested were realized when a self-insured union health plan recently announced that it would bring suit under ERISA to challenge the provision allowing hospitals to pass the provider tax through to payers.

Florida Seeks Federal Action

In contrast to the Minnesota approach, Florida policymakers enacted a health reform plan whose full implementation would require statutory changes to Medicaid and also might require an ERISA exemption. Florida's Health Care Reform Act stipulates that the state's 2.5 million uninsured should be offered coverage primarily through an expansion of Medicaid and an extension of employer-based insurance. Because the expansion of employer-sponsored coverage is initially voluntary, an exemption from ERISA requirements is not needed immediately. Florida officials believe, however, that obtaining such an exemption now would provide a catalyst for voluntary expansion of coverage.

The Florida law asks employers in the state voluntarily to offer coverage to all of their employees by December 31, 1994. A newly created state agency will establish interim targets, by firm size and industry, regarding the percentage of employees and

dependents insured and the number of employers offering insurance. In this way, Florida hopes to challenge its business community to expand employee health insurance on a voluntary basis. If substantial progress has been made towards insuring all employees by the end of 1994, the state will continue this voluntary approach. However, if target levels are not met, Florida officials will consider implementing some type of mandatory employer-sponsored health insurance system.

A potential obstacle to the expansion of employer-sponsored coverage is ERISA's preemption of state regulation of employee benefit plans. ERISA precludes Florida from mandating employer-based coverage. In addition, Florida could not levy a premium tax or specify a minimum benefits package for all employers because the state could enforce these requirements only with respect to employers that purchase health insurance, not those who self-insure. Florida officials are considering a play-or-pay requirement, but recognize that employers could challenge such a system under ERISA.

State policymakers think that if the state had the ability to compel all employers to provide health insurance, employers might be more inclined to provide coverage voluntarily. Therefore, Florida officials have proposed that the Congress amend ERISA's preemption clause with respect to health plans.

Another element in Florida's strategy to provide universal coverage is to expand Medicaid to people without employment-based insurance who are near poverty but ineligible for Medicaid. Because approximately 600,000 Floridians are in this category, state officials would like to implement a Medicaid buy-in program that de-couples economic assistance from medical assistance. Medicaid coverage would then be expanded to those who may not be categorically eligible and who have incomes below 250 percent of the federal poverty level. Under this program, state officials expect that participants would share in the cost of premiums and would be offered a benefits package that is less comprehensive than Medicaid's.

It is possible, though unlikely, that this proposal could be implemented through a 5-year non-renewable demonstration waiver. Florida officials, however, told us that they need congressional legislation because limiting the duration of such a complex program to 5 years would not justify the difficulty and expense of implementing it.

Medicaid requirements also may constrain Florida's efforts to control the cost of its health care system. Part of Florida's cost containment strategy is to place its Medicaid population in managed care settings. HCFA is authorized to grant waivers that allow states to implement such programs, but the law also stipulates that Medicaid and Medicare beneficiaries cannot constitute more than 75

percent of an HMO's patient population.⁴ In some parts of Florida, this requirement is difficult to achieve, thus hampering the state's attempt to provide more care through HMOs.

Florida officials are also seeking changes to Medicare laws. They would like the Congress to amend the laws to permit wide-scale demonstrations of alternative payer systems, including state administration of all Medicare benefits through a single-payer system.

Vermont Anticipates Need for Federal Relief

Vermont's reform proposal is similar to Florida's in that it defers immediate need for relief from federal restrictions. The cornerstone of the plan is the implementation of either a single-payer or multi-payer universal system by October, 1994. The legislature will decide which system to implement after November 1, 1993. Key components of any Vermont system will include universal coverage, uniform and portable benefits, capital expenditure controls, and global budgeting for hospitals and providers.

Vermont officials believe that ERISA is the largest hurdle for implementing their universal access plan. They are concerned that as the state gains more control of the health system, more employers will self-insure, removing themselves from the system. In addition, they realize that if the state were to implement a single-payer system, at some point they may want to include Medicare within the system. State and federal officials are uncertain whether Medicare could be integrated into such a system under current law.

CONCLUSIONS AND MATTERS FOR CONGRESSIONAL CONSIDERATION

An increasing number of states are trying to expand access to health insurance while controlling increases in health care costs. Their approaches range from narrowly focused efforts to reform the health insurance market or contain hospital costs to comprehensive initiatives to achieve universal access to health care coverage.

Comprehensive state reform solutions have proved challenging to formulate and implement. States not only are having difficulty in building support for their reform efforts, but also are hampered by federal laws and regulations that make it difficult to design and implement innovative health care reforms. State officials have commented that the uncertainty associated with receiving permission

⁴A state can request a demonstration waiver that would permit them to increase this percentage.

to circumvent federal requirements has hindered comprehensive reform.

There is widespread agreement that our health care system needs major changes. Some believe that such change can be achieved most effectively through national reform. Others contend that states should take the lead on reform efforts either:

- (1) to gain information on the feasibility of incorporating such changes into a national plan, or
- (2) to permit states to design unique plans that are most appropriate for each state's particular characteristics.

If the Congress decides that reform at the state level is an appropriate path, it should consider reducing the potential federal barriers to comprehensive state reform. For a state that is pursuing the difficult process of comprehensive reform, ERISA eliminates some options, such as mandated employer coverage. Additionally, some states are struggling to implement approaches specifically designed to circumvent ERISA, but still fear that their plans might not survive a challenge based on ERISA.

Congress could facilitate state reform efforts by developing approaches that provide states early assurance that they will receive the federal cooperation necessary to implement change. For example, states would need assurance that they could obtain a limited waiver from ERISA's preemption clause in order to develop certain innovative universal access systems. The Congress could define minimum standards--governing such factors as benefits packages, extent of coverage, accountability, and terms under which the waiver application might be revoked--that a state must meet to receive and maintain such a waiver.

Additionally, if the Congress is interested in state demonstration projects that achieve universal coverage through an approach entailing the use of Medicaid funds, the Congress might consider amending or streamlining the waiver process for Medicaid restrictions. This would facilitate the integration of the Medicaid program into state comprehensive reform efforts.