EXPANDING HEALTH COVERAGE FOR UNINSURED AMERICANS

Over 43 million Americans are uninsured and that number is rising. Over most of the past decade we have seen a return of double digit health care inflation, making it increasingly difficult for many employers to keep affordable health coverage available for their employees. President Bush proposed the enactment of new refundable health credits for means-tested individuals ($1,000) and families ($3,000) that would be used to purchase health insurance in the private market or split between cash contributions to a health savings account and the payment of a premium for high deductible health insurance. The health tax credits could be "advanced" by individuals who qualify for the new federal assistance to an insurance company, which would then redeem the value of the advanced credit from the U.S. Treasury.

In addition, the President has proposed to expand the availability of health savings accounts (HSAs) by providing tax rebates to small businesses for the contributions they make to employees' accounts, up to $200 per employee with individual coverage and $500 for those with family coverage. The President has also proposed allowing individuals who participate in HSAs to take a tax deduction for the cost of the premiums they pay for high deductible coverage purchased in conjunction with HSAs, similar to the deduction already available for self-employed individuals and employees who pay insurance premiums through their employer's cafeteria plan arrangement.

The President is likely to propose similar initiatives and possibly additional ones this year as part of his proposed fiscal year 2005 budget.

The Senate Republican Task Force on Health Care Costs and the Uninsured also released a report that included several additional recommendations to help make health care coverage more affordable and accessible. For example the Senate GOP task force report proposed efforts to empower consumers to make better health care decisions, improve patient safety and quality, promote the efficient use of technology, curtail waste, fraud and abuse and reform the medical liability system, including requiring responsible third parties to pay the medical expenses of an injured individual and avoiding double recovery of medical expenses. The efforts of the task force were intended to set the stage for further consideration of legislation in 2005 to address the needs of the uninsured and are likely to be influential in shaping future debate in this area.

(more on next page)

(continued from previous page)

ACTIONS RECOMMENDED:

- The Council recommends that Congress consider supporting legislation to expand health coverage on an incremental basis, starting with those most in need, such as the millions of Americans, including retirees, who may have no connection to employer-sponsored health coverage or who are low-income and are unable to afford health care coverage available to them.

- The Council urges that any changes in existing tax policy for health coverage -- including new health tax credits likely to soon be considered by the 109th Congress -- must be carefully designed so they do not undermine the current employer-based system that serves over 100 million Americans.

- The Council supports legislation to encourage employers to establish more consumer-driven health plan designs (such as health savings accounts or other similar innovative plan designs) as a way to provide more affordable plan choices to millions of Americans over the next several years. Expanded tax preferences to encourage the establishment of HSAs and efforts to allow greater flexibility in the design of HSAs should be approved by the 109th Congress.

- The Council also urges Congress to allow insurers to offer health coverage free of state mandated benefits so that more affordable health coverage options may enter the marketplace. At the same time, the Council believes Congress should firmly resist further efforts to impose mandated health benefits at the federal level.

MEDICARE REFORM AND PRESCRIPTION DRUG COVERAGE

Immediately following the 2002 mid-term elections, President Bush and GOP leaders of Congress made enactment of a prescription drug benefit for seniors and reform of the Medicare program a top domestic priority. After long and often contentious consideration by Congress, President Bush signed the Medicare Modernization Act (MMA) into law (Pub. L. 108-173) on December 8, 2003, which adds a voluntary prescription drug benefit to Medicare beginning in 2006. The Medicare drug benefit will be offered either through private prescription drug plans (PDPs) established under the new Medicare Part D program or through Medicare Advantage plans, which integrate Medicare's Parts A and B benefits with the new Part D drug benefit and replace Medicare+Choice plans. The Medicare program will contract with claims administration companies on a non-risk basis to make drug coverage available in any part of the country where at least two private plan options are not available in a given geographic region.

The drug coverage includes a $250 deductible after which Medicare will pay 75 percent of costs between $251 and $2,250. The beneficiary then pays any further drug expenses until out-of-pocket costs reach $3,600, when the catastrophic benefit begins and Medicare pays 95 percent of any additional drug costs for the year. This gap in coverage between $2,250 and $3,600 is commonly referred to as the "doughnut hole." Any drug costs paid by an employer's retiree health plan do not count toward the $3,600 out-of-pocket limit.

The new law also includes a tax-free direct subsidy for employers choosing to offer actuarially equivalent prescription drug coverage to their retirees and dependents. For employer-sponsored plans that qualify for the subsidy in 2006, Medicare will pay 28 percent of allowable costs for prescription drug claims above $250 and below $5,000 that are incurred by Medicare-eligible individuals enrolled in the employer's plan. Employers will also have the option of supplementing or "wrapping" around the new drug benefit or coordinating their retiree drug benefits with the new expanded coverage under Medicare by contracting with health plans participating in the new Medicare Advantage program to exclusively serve the employer's own retirees.

ACTIONS RECOMMENDED:

- The Council supports the Medicare Modernization Act as well as further efforts to modernize Medicare, making it more competitive and more reflective of innovative employers' value-based purchasing practices designed to encourage health care providers to more consistently deliver efficient, high quality health services.

(more on next page)

(continued from previous page)

- The Council strongly urges that any proposals to modify the Medicare Modernization Act not include mandates on employers that now provide retiree health coverage, including for prescription drugs. Rather, employers should have the choice of either voluntarily accepting a financial incentive to continue the prescription drug coverage provided to their retirees or should be able to redesign their plans to supplement any coverage made available by Medicare.

- The Council will continue to provide policy and technical advice to the Centers for Medicare and Medicaid Services (CMS) as they work to develop guidance on the implementation of the Medicare Modernization Act, particularly on areas relating to the subsidy of employer-sponsored retiree prescription drug plans and other coverage options available to employers and retirees under the new legislation.

- Finally, the Council recommends that Medicare's current eligibility age be maintained. Since many employers provide early retirees with valuable health benefits until they reach eligibility for Medicare, expansions in the eligibility age would force these employers to pay for additional years of benefits that they did not intend to pay for when the original commitment was made. In addition, there can be no guarantee that health benefits will be extended in all cases to fill the expanded gap between early retirement and any increase in the Medicare eligibility age, leaving more Americans without health coverage during this period.

HEALTH SAVINGS ACCOUNTS/ CONSUMER DRIVEN HEALTH CARE

Health Savings Accounts (HSAs) were created as part of the Medicare Modernization Act of 2003 (MMA) and took effect on January 1, 2004. HSAs are a new form of consumer driven health plan that shares some, but not all, of the features of Flexible Spending Arrangements (FSAs), Health Reimbursement Arrangements (HRAs), and Archer Medical Savings Accounts (MSAs). HSAs must be offered with a qualified High Deductible Health Plan (HDHP), all contributions, interest, and distributions for qualified medical expenses are free of federal income tax, both the employer and employee may contribute to the HSA, and the account is fully portable.

The Department of Treasury was quick to issue several comprehensive rounds of guidance that allowed employers to seriously consider implementing an HSA, or other consumer driven health plan, for 2005 or 2006. Treasury does not currently have any plans to issue additional guidance on HSAs.

President Bush has been a strong advocate of HSAs. During the 2004 presidential campaign he discussed three tax proposals to help make HSAs more widely available. The proposals included tax credits for small-employer contributions to HSAs applied to the first $500 for family coverage and $200 for individual coverage; for low-income families, a $1,000 HSA contribution and $2,000 refundable tax credit to purchase a qualified HDHP; and an individual federal tax deduction for purchase of an HDHP.

Employers have been very enthusiastic about HSAs, either as a new option for employees or as a complete replacement of their former health coverage. In a survey by Mercer Human Resource Consulting, 73 percent of employers who responded said it is either very or somewhat likely that they will offer an HDHP with an HSA by 2006. Large employers and health plans are just now beginning to receive feedback from the market regarding what, if anything, might stimulate even more employers to offer HSAs and more employees to enroll in them. Examples of structural changes that could be made to improve HSAs include allowing HSAs to be used to pay for retiree health insurance for individuals who are not yet eligible for Medicare and allowing more flexibility in using HSAs in combination with other forms of health coverage, such as FSAs and HRAs.

ACTIONS RECOMMENDED

- The Council supports legislation providing a tax deduction and/or credits to individuals who purchase a qualified HDHP or small employers who offer a HDHP and/or make contributions to employees' HSAs.

(more on next page)

(continued from previous page)

- The Council supports efforts to make consistent comparative information available to health care purchasers and consumers on the quality, performance, and efficiency of health care providers and services. Health care costs and quality can both be significantly improved by increased transparency in the health care marketplace. The federal government can help lead this effort by the appropriate disclosure of non-patient identifiable claims data from programs such as Medicare so that employers and consumers have better information on the relative performance of health care providers.

- The Council encourages Congress to monitor the emerging consumer driven health care market and to consider legislative changes that could help make HSAs even more attractive to employers and employees.

FLEXIBLE SPENDING ARRANGEMENTS (FSAS)

Flexible spending arrangements (FSAs) allow employees to set aside money on a pre-tax basis to be used for health care expenses that are not covered by their health plans including co-pays, deductibles, and other out-of-pocket health care expenses. The benefit of an FSA comes with the "use it or lose it" price tag; at the end of the year the employee loses any amount he contributed to his account but did not spend. Approximately 22.5 million workers have access to an FSA, but only 20 to 30 percent of those (approximately 4.5 to 6.8 million workers) participate. Many employees cite fear of losing their unspent FSA money at the end of the year as a major reason whey they elect not to participate. Modifying the "use it or lose it" rule would encourage millions of workers to participate in health FSAs and enable them to better afford their rising health care expenses.

On August 23, 2004, Chairman of the Senate Finance Committee Charles Grassley (R-IA) sent a letter to Treasury Secretary John Snow stating that the Treasury Department has the authority to eliminate the FSA "use it or lose it" rule without additional legislation from Congress. According to the letter, "since the 'use it or lose it' rule was created administratively – and was done so through proposed regulations that have never been finalized – it would seem that the Treasury Department does have the authority."

Senator Grassley cited three primary policy reasons for the elimination of the rule: (1) There is "no other area of benefit law in which [Congress] allows – let alone mandates – that employee dollars set aside for benefit expenses revert back to the employer; (2) the "use it or lose it" rule causes "inefficient allocation of health care dollars by providing an incentive for employees to incur unnecessary health care expenses at the end of the year to use up the account; and, (3) the "use it or lose it" rule has the effect of "dramatically reducing employee participation in FSAs because employees do not want to risk forfeiting or wasting their hard-earned money."

During the 108th Congress, the House of Representatives approved legislation to allow employees to take up to $500 in unused year-end flexible spending arrangement (FSA) funds and carry them over to the following year or transfer them to a health savings account (HSA). The Council endorsed the proposal along with other FSA rollover bills but none of the bills were considered by the Senate.

(more on next page)

(continued from previous page)

ACTIONS RECOMMENDED:

- The Council strongly supports elimination of the "use is or lose it rule" and has provided technical assistance and comments to support the recent efforts by Senator Grassley to raise this issue with the Treasury Department.

- If the Treasury Department does not modify or eliminate the "use it or lose it" rule by administrative action, the Council also supports legislative efforts to permit a limited rollover of unspent FSA funds. A provision of the House-passed Medicare Modernization Act of 2003 would have permitted a $500 rollover of unspent FSA funds, but the provision was dropped by the Medicare conferees prior to enactment.

RETIREE HEALTH COVERAGE

Over the past 15 years, there has been a well-documented decline in the percentage of employers offering retiree health benefits, dropping from 66 percent in 1988 to 38 percent in 2003. This trend is likely to continue. Retiree health plan costs increased 16 percent between 2001 and 2002, while costs increased 13.7 percent for active employees, and many employers are quickly reaching the caps they imposed on their retiree health spending following the adoption of Financial Accounting Standards Board (FASB) Statement No. 106 on "Employers' Accounting for Post-retirement Benefits Other Than Pensions."

Retiree health benefits sponsored by employers are generally in one of two forms. This coverage serves either as a "bridge" benefit available to early retirees that terminates once the person reaches Medicare's eligibility age, or for those who are age 65 or older, as a supplement to Medicare benefits. These plans are intended to meet distinctly different retiree health care needs and are not generally intended, or required, to provide the "same" benefits to early retirees as they do to post-65 retirees.

On April 22, 2004, the Equal Employment Opportunity Commission (EEOC) finalized its rule on retiree health benefits to clarify that an employer-sponsored retiree health plan would not violate the Age Discrimination in Employment Act (ADEA) even if it does not provide the same level of benefits to early retirees as to older retirees who are eligible for coverage under Medicare. The EEOC rule specifically cited the *Erie County Retirees Association v. County of Erie* decision in the Third Circuit that held that an employer who voluntarily provides retiree health benefits may be prohibited from reducing health benefits for individuals who are eligible for Medicare.

ACTIONS RECOMMENDED:

- The Council strongly supports the EEOC's decision to finalize its July 2003 proposed rule. The rule is currently undergoing interagency review. The rule is needed to clarify that it is not a violation of the Age Discrimination in Employment Act (ADEA) to provide a higher level of health care coverage to early retirees than is provided after an individual reaches eligibility for Medicare, which then becomes their primary source of health coverage. Such a clarification is needed because of the *Erie County* decision that would cause nearly all retiree health plans to be found in violation of federal law if this court's reasoning were applied more broadly. The Council will continue its efforts with Congress and the Administration and, if necessary, the courts to support this important clarification of the age discrimination law.

(more on next page)

(continued from previous page)

- The Council urges Congress to resist any proposals that would mandate employers that currently provide retiree health coverage to continue these plans in perpetuity. Such mandates would impose an unfair burden on employers who have worked hard to voluntarily continue health coverage for their retirees compared to others who have discontinued similar plans or never offered this benefit at all. Moreover, any such mandates would have an immediate chilling effect on the willingness of any other employers to establish retiree health plans for future retirees.

- The Council supports new savings mechanisms that would encourage a more defined contribution approach to retiree medical coverage including the establishment of Retiree Medical Benefit Accounts (RMBAs), which would use existing individual and workplace savings systems to allow individuals and workers to elect annually to allocate a portion of their pre-tax retirement contributions into a separate RMBA within their retirement plan. Distributions from a RMBA would be tax-free and penalty-free if made after a certain age and use for "medical care" as defined in section 213(d) of the Internal Revenue Code.

- The Council also supports proposals to allow retirees to use retirement plan distributions on a pre-tax basis to pay their share of the cost of retiree health plan coverage. Legislation introduced by Representatives Rob Portman (R-OH) and Ben Cardin (D-MD) during the 108th Congress would expand section 401(h) accounts to fund retiree health benefits through profit-sharing or stock bonus plans and not just as a part of a defined benefit or money purchase pension plan, as is the case under current law.

- The new Health Savings Accounts (HSAs) created under the Medicare Modernization Act of 2003 are also tax-preferred savings vehicles that may be used for retiree health. One means to encourage greater savings for future health care needs would be to permit early retirees to use funds from their HSA accounts to purchase retiree health insurance, rather than prohibiting the availability of HSA funds for this purpose, as under current law, for those who have not yet reached age 65.

HEALTH CARE LIABILITY REFORM

Sharply increased medical malpractice premiums have forced physicians and hospitals in some parts of the country to either limit their case loads or close their doors altogether. Physicians and insurers blame rising court awards for the current crisis in the medical malpractice system. The American Medical Association (AMA) says jury awards in medical malpractice cases increased by 43 percent between 1999 and 2000 alone, from an average of $700,000 to about $1 million. The impact of the crisis on already rising health care costs is a key concern to employers and employees, along with the impact on access to health care services for patients in high-risk practice areas such as obstetrics and trauma surgery in some states.

Three times since 2002 the House of Representatives has passed a bill that would have established a $250,000 cap on non-economic damages and allowed punitive damages only under a strict statutory standard for malicious actions limited to $250,000 or twice the amount of economic damages. (See H.R. 5 and H.R. 4280 from the 108th Congress.) The Senate has considered but failed to approve a similar bill. In addition during 2004, Senate Republicans held votes on several bills that would have limited the scope of reform to certain medical specialties and services such as OB-GYN, but none of the bills has succeeded in overcoming procedural hurdles raised by opponents. This issue will continue to be a key health care priority for House and Senate Republicans in the 109th Congress and will continue to face stiff opposition from the plaintiffs' trial bar and their allies in Congress. Because the cap on damages has been such a contentious issue, we may see the Senate pursue other types of tort reform to address the overall problem.

President Bush supports federal medical liability reform saying a Health and Human Services (HHS) study shows that a federal standard for liability in medical malpractice cases could alone lower federal government costs by $30 billion or more per year and save Americans $60 billion on health care premium costs. Achieving medical liability reform is reportedly one of the President's top priority issues for the 109th Congress.

ACTIONS RECOMMENDED

- The Council supports legislation akin to the House-passed bills from the 108th Congress to limit medical malpractice awards and make other important tort reforms in cases including health care services.

- The Council believes any federal medical liability/ tort reform legislation should apply equally to health plan actions determined by the courts to be subject to state law that might also be applicable to the actions of a health care provider.

- The Council also believes appropriate reform of the medical liability system would include provisions requiring responsible third parties to pay the medical expenses of an injured individual and avoiding double recovery of medical expenses.

January 2005

MENTAL HEALTH PARITY

Congress has once again approved a one-year extension of the current mental health parity law that mandates parity in annual and lifetime dollar limits between medical and surgical benefits covered by a health plan and any mental health benefits covered by the same plan. The law was originally set to sunset in 2001. Proponents of expanded mental health parity benefits are not satisfied with an extension of current law and will likely continue to press for an expansion of the mandate.

Senators Pete Domenici (R-NM) and Edward Kennedy (D-MA) have proposed legislation to significantly expand the requirements and will likely reintroduce their bill in the 109th Congress. During the 108th Congress, they drafted a compromise version of their proposal that would have eliminated the requirement that all mental health diagnoses in the "DSM-IV," the compendium of mental health disorders, be covered by a health plan and included in the parity requirement. The compromise plan would have permitted financial or treatment limits on mental health benefits only if the health plan includes these same limits on "substantially all" medical and surgical benefits.

House GOP leaders, particularly House Speaker Dennis Hastert (R-IL) and Ways & Means Committee Chairman Bill Thomas (R-CA), are opposed to *any* expansion of current mental health parity requirements because any health benefit mandates, no matter how well-intentioned, will increase rapidly rising health care costs. In the past, President Bush has said he would work to pass legislation to "prevent (health) plans from applying less generous treatment or financial limitations on mental health benefits than are imposed on medical and surgical benefits." As Governor of Texas, President Bush signed a bill mandating parity for severe mental health illnesses.

ACTIONS RECOMMENDED:

- The Council recommends extending current federal mental health parity standards – now set to expire on December 31, 2005 – rather than expanding current law by imposing numerous detailed restrictions on employer-sponsored health plans that provide coverage for mental health care services. Under current law if a health plan has an annual or lifetime maximum dollar limit for covered medical and surgical benefits, the total dollar limits for any mental health services covered by the plan may be no less.

- The Council believes that current federal parity law strikes an appropriate balance between the need to ensure basic fairness in the health plans that provide coverage for vitally important mental health care services without overly restricting the ability to carefully manage the coverage for these services so that they will remain as comprehensive and affordable as possible for all plan participants.