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ISSUE BRIEF
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The Effects of Proposed Patient Protection Legislation on Managed Care

Over the past few years, Congress and a number of state legislatures have considered "patient protection" legislation to regulate the use of managed care strategies in health insurance and self-insured employer health plans. These bills have included provisions allowing greater patient access to medical providers, clarifying the application of specific managed care rules such as coverage for emergency room services and giving health plan enrollees the ability to appeal decisions made by their health plan to an outside appeals board. In 1999, the American Academy of Actuaries' Managed Care Reform Work Group published a paper ("Patient Protection and Managed Care," Winter 1999) to address some of the issues common to the various patient protection proposals.

As the debate over patient protection legislation continues in Congress and the states, two key issues have emerged – the scope of applicability of proposed legislation and the ability of enrollees to file legal action against their health plan. The purpose of this issue brief is to assist policy-makers in their understanding of these two issues. Briefly, this paper concludes that:

1. Legislative proposals with the broadest applicability provide the greatest uniformity, especially when an employer's plan provides coverage to employees in more than one state. Only federal legislation could apply uniformly to both "self-insured" and "fully insured" health plans. Congress will need to decide if legislative changes will affect only self-insured plans, or will also preempt state insurance laws.

2. Although the ultimate effects of allowing enrollees to sue their health plans may not be felt for some time, most health actuaries believe such legislation would ultimately lead to increases in health insurance premiums as well as higher health plan costs. In fact, many actuaries believe such increases would be substantial. In addition, they believe that a good portion of the savings that have been achieved from the introduction of managed health care may eventually be lost.

3. Employers could respond to the threat of increased litigation by health plan enrollees in a number of ways, including:

a.) Trying to offset rising costs by increasing cost sharing with employees (i.e., higher deductibles, coinsurance, premiums, etc.);
b.) Attempting to eliminate or avoid corporate liability;
c.) Adopting defined contribution approaches to providing health care benefits; and
d.) Dropping health coverage altogether.

SCOPE OF APPLICABILITY

Approximately 160 million Americans are covered by some type of health plan. This coverage includes various types of employer-sponsored programs and government plans such as Medicaid and Medicare, as well as health insurance purchased on an individual basis. Employee benefit plans, including group health plans, are considered "employee welfare benefit plans" under the Employee Retirement Income Security Act (ERISA), and are subject to federal rules concerning such things as reporting and disclosure,fiduciary standards, claims and grievances, and continuation of coverage.

Employers typically provide health benefits to their employees by either purchasing health insurance from a health insurance issuer, or by providing benefits on a self-insured basis. When employers utilize insured arrangements, they purchase insurance from a health insurance issuer such as an insurance company or health maintenance organization (HMO), in exchange for a premium. In doing so, they transfer the insurance risk to the issuer of the policy or contract.

Under self-insured health plans, the insurance risk is held by the employer who ultimately retains financial liability for claim payments. Claims may be paid directly by the employer, or through the use of a trust. Employers can adjudicate the claims themselves, but they commonly utilize an independent organization such as an insurer, HMO or third party administrator to determine whether a medical service is medically necessary and covered by the plan.

The distinction between fully insured and self-insured health plans is important. Fully insured health plans are generally subject to state regulations that apply to health insurers and HMOs and to the products they issue, addressing items such as the inclusion of state-mandated benefits,and approvals of insurance contract forms and rates. However, self-insured employer health plans (which cover approximately 48 million people), are covered by a federal law known as the Employee Retirement Income Security Act (ERISA).

The managed care reform proposals introduced in Congress over the last few years have differed in the scope of how their various provisions would apply. For example, the bill sponsored in 1999 by Rep. Charlie Norwood (R-Ga.) and Rep. John Dingell (D-Mich.) ("The Bipartisan Consensus Managed Care Improvement Act of 1999"; H.R. 2723; August, 1999) applied its patient protection provisions to all plans — insured and self-funded plans under ERISA, group and individual insured plans issued by health insurance carriers, and government plans. This bill would cover approximately 160 million people.

In contrast, legislation proposed by Senator Don Nickles (R-Okl.) and Senator Trent Lott (R. Miss.) ("The Patients' Bill of Rights Act of 1999"; S. 1344; July 1999) applied most of its key protection provisions (e.g., access to OB-GYN, pediatric care and specialists; continuity of care; emergency care rules; availability of point-of-service; and drug formulary rules) only to self-insured ERISA plans. Plan information disclosure rules and grievance appeal requirements and procedures, would apply to all employer-sponsored plans. Other provisions, such as rules for breast cancer hospitalization length-of-stay and the use of genetic information, would apply to all group and individual health insured plans as well.

Any patient protection bill approved by Congress must address the scope of applicability of the legislation. It will be important to decide if the proposal applies only to self-insured health plans or if it will be expanded to include coverage offered by health insurers and HMOs. Similarly, the legislation might also be applied to individual health insurance policies.

Another consideration is the extent to which any congressional patient protection proposal allows states to enact similar laws. For example, the federal law passed by Congress may require all health plans (fully insured and self-insured, employer coverage and individual health insurance) to cover emergency room procedures in certain situations. In one approach, the federal rules would apply in all cases, and states would not be permitted to enact additional legislation.

As an alternative, the federal statute might be considered a "floor" and states would be allowed to legislate additional emergency room coverage requirements so long as the minimum federal standards were maintained. In this case, any state mandates would apply only to health plans subject to its jurisdiction (i.e. fully insured employer plans and individual health insurance policies).

Broad federal applicability of patient protection laws would provide the greatest uniformity, especially when an employer's plan provides coverage in more than one state. This uniformity is also enhanced to the extent that

states are not permitted to approve additional managed care requirements. Many states have adopted managed care laws, but there is a wide degree of variation in these regulatory patient protections from state to state.

To the extent that health insurers and HMOs do business in more than one state, uniform federal requirements would lessen the administrative burden of complying with differing state laws. However, it must also be recognized that many in Congress as well as state regulators argue it is important to preserve the rights delegated to the states to regulate insurance, and believe that federal regulation should apply only where the states cannot regulate coverage (i.e., where the ERISA preemption applies).

It should also be noted that the potential for new patient protection standards is not limited to legislative action. The Department of Labor recently finalized new ERISA rules which set minimum standards for claims handling procedures, tighten decision making deadlines and require quicker responses by health plans on claim appeals. Although it is too early to tell the impact these regulations will have on health plan operations and costs, the potential effects and any employer reaction should be watched.

HEALTH PLAN LIABILITY

Employer-sponsored self-insured health plans have generally been protected from enrollee lawsuits under state law by the ERISA preemption. This preemption means that enrollees of employer-sponsored self-insured plans are unable to sue their health plan under state law for damages resulting from the actions or decisions of the plan. Rather, these causes of action must be brought in federal courts where damages are limited to the cost of the plan benefits (most claims, to date, relate to coverage disputes) and costs of the litigation. Recovery of punitive damages is not permitted. In addition, ERISA rules governing lawsuits are generally more restrictive than those in most state courts. While ERISA preemptions have been the subject of numerous court challenges in recent years,most disputes regarding plan benefits and administration continue to be resolved under the federal rules.

Legislation allowing enrollees to sue their health plans has been enacted in a few states, and has been proposed in a number of other states and at the federal level. Typically, the legislation permits enrollees to recover damages resulting from personal injury or wrongful death in connection with the provision of insurance, administrative services or medical services by or to a group health plan or that arise out of an arrangement to provide such services. These proposals protect health plan sponsors and/or employers as long as the allegation does not relate to their exercise of discretionary authority regarding plan coverage.

The bills introduced in Congress range from proposals that would continue to limit lawsuits against self-insured plans to federal courts (but with expanded remedies), to eliminating the ERISA preemption thereby exposing such plans to litigation in state courts. The legislative proposals that have been considered at the state level allow enrollees to sue fully insured employer health plans in state court. Probably the most extreme change involves a complete elimination of the ERISA preemption. In either venue, legislative changes could include limits on remedies (e.g. reduction or elimination of economic, non-economic or punitive damages).

One additional issue that arises with legislation permitting health plan enrollee law suits is how it affects any existing state statutory limits on damages that can be recovered in litigation, such as medical malpractice statutes or restrictions on punitive damages. Another consideration is whether the health plan enrollee must first exhaust any dispute resolution measures, either through an appeal to the health plan or to an outside state entity.

Proposals allowing enrollees to sue their health plans are controversial, primarily because of the uncertain financial impact on health plans and self-insured employers and, ultimately, on the enrollees who will bear the burden of any cost increases. The ERISA preemption, which provided uniformity in interstate rules and more predictable dispute resolution, encouraged cost efficient employer-sponsored, self-insured health coverage. The elimination of the ERISA preemption, allowing plan lawsuits to be brought in state court, exposes these plans to unknown higher costs, which may ultimately cause plans to reduce coverage and/or increase enrollee charges, co-payments or deductibles. The impact of these higher costs will also be felt by health insurers and HMOs in those states that permit enrollees to sue their health plans over decisions about the provision of medical care.

There are both direct and indirect cost increases that must be considered. Direct costs are the costs of additional lawsuits that arise from an increase in both the number and average cost of these suits. These higher costs

are expected because there are new causes of action, there are more potential defendants (such as managed care organizations and/or employers), and those additional defendants have "deeper pockets" than individual medical providers, who might otherwise be the ones subject to legal action. There is also a potential for class action suits. Some would argue that the cost of individual class action suits could be very substantial,and that these suits will have the potential to financially impair managed care organizations subject to the suits.

The indirect cost of legislation allowing enrollees to sue their health plan is the higher cost of health care resulting from the increase in lawsuits. Managed care organizations,health insurers and self-insured health plans may change their operations to reduce the potential for lawsuits. For example,plans may begin to cover new technologies and drugs more quickly, and might be less likely to encourage effective lower cost medical treatment methods in order to avoid litigation. Additional staff may be added to perform utilization review and credentialling. Further, plans might relax their active medical management initiatives because increased lawsuits could have an adverse impact on a managed care organization's public image, resulting in loss of customers.

A substantial part of the increase could be expected over two to three years or more as plans, providers, and lawyers react to the new legal environment. But a compounding of effects would likely emerge over a longer time period as part of the annual increases in the cost of health insurance. The magnitude of these increased costs, and the cost/benefit tradeoff is the subject of much debate.

Additionally, there are potential nonfinancial effects relating to defensive changes in plan operations. If appropriate medical management promotes better health—and plans diminish active medical management to avoid litigation or expend limited resources on ineffective health care—there may be an adverse impact on the health plan enrollees. Conversely, fewer denials of treatments may reduce the incidence of personal injury.

There is not sufficient data available at this time to accurately determine the direct and indirect costs of allowing lawsuits against health plans in state court. Most actuaries who have reviewed proposed legislation believe costs will increase, but the amount of that increase is uncertain. Most actuaries believe that indirect cost impacts are likely to exceed direct cost impacts because plans will attempt to avoid the potential for large court judgements and associated negative publicity. It is still too early to tell whether there will be large cost increases in those states where enrollees are permitted to sue their health plans because the courts have not yet decided a large number of cases interpreting such legislation. The learning curve associated with filing new types of liability claims is lengthy, and there are even longer delays in their resolution.

Considering these significant time lags and recognizing that insurance premiums are generally based on historical data and that most applicable insurance coverage is written on a claims-made basis, it will probably take a number of years for newly emerging trends in liability costs to be accurately reflected in insurance premium data. At this point,however, there does not appear to be evidence of significant increases in liability costs in states where enrollee lawsuits are allowed.

Although the ultimate effects of allowing enrollees to sue their health plans may not be felt for some time, many health actuaries believe the current legislative proposals would ultimately lead to increases in health insurance premiums, which they feel could be substantial. In addition, they believe that a good portion of the gains achieved in lower utilization from the introduction of managed care in plans based on contracted independent providers could eventually be lost.

EMPLOYER RESPONSE

Employer response to enactment of health plan liability can be considered in two areas: reaction to increased costs and actions to avoid corporate liability.

Employer response to increased direct and indirect costs of health plan liability is difficult to predict in the current economy and labor market because large employers, especially in certain industries, must balance the need to deal with increased cost of employee benefits with the need to attract and retain workers. Employers are likely to offset rising costs resulting from reductions in cost-saving measures, such as precertification, length-of-stay approval and referral processes. Such actions are likely to include increased cost sharing with employees through changes to benefits (higher deductibles, coinsurance, etc.) and/or increased employee contributions. It is also possible that companies, especially small employers, will be unable to deal with the increased costs and

choose to not provide coverage.

In addition to actions based on cost concerns, employers are likely to take steps to avoid corporate liability. One of the issues that is still being resolved with legislation allowing enrollees to sue their health plans is the extent to which employers are liable for actions by the health plan. Companies will seek to insulate themselves from liability in providing health care to their employees.

Self-insured employers may choose to insure their health benefit programs or name the administrator as claim fiduciary rather than risk lawsuits based on coverage decisions. Either action would likely subject such employers to additional program costs. Insuring the benefit program would require compliance with state-mandated benefits, and subject the program to risk charges and profit margins inherent in insured arrangements. Administrators are likely to charge for assuming the role of claim fiduciary.

Another possible reaction to both cost and liability concerns could be an increase in the number of employers adopting defined contribution approaches to health care benefits. Under a defined contribution approach, the employer provides a fixed dollar amount or credit to the employee to be used as partial or full payment of premiums for a health plan chosen by the employee. Such an approach controls employers' cost increases by passing costs above the fixed amount on to the employees. It also places more plan choice decisions with the employees rather than the employer. However, depending on how such arrangements are structured,some proposed patient protection provisions may still apply.

CONCLUSION

The American Academy of Actuaries formed the Managed Care Reform Work Group to explore the actuarial issues in a number of managed care bills being considered by Congress and state legislatures. As stated in the Work Group's earlier issue brief, managed care has resulted in dramatic changes in how health care is utilized by consumers. These changes have resulted in lower costs and better coordination of care. However, there have also been concerns about shifting control over health care decisions from patients and providers to the health plans.

In considering patient protection legislation, policy-makers must weigh the intended benefits with the potential cost implications for health plans. The impact of such costs will vary greatly depending on the scope of any legislation. Regardless of the scope, the affected plans are likely to experience (possibly significant) cost increases resulting from increased liability exposure as well as from expanded administrative and operational requirements.

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