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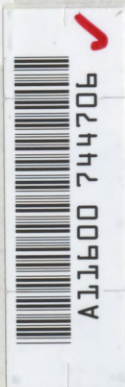
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EXEMPTION OF FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM FROM CERTAIN STATE LAWS

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HEARINGS BEFORE THE SUBCOMMITTEE ON GOVERNMENT AND EMPLOYEE BENEFITS OF THE COMMITTEE ON POST OFFICE AND CIVIL SERVICE HOUSE OF REPRESENTATIVES NINETY-FOURTH CONGRESS

SECOND SESSION

ON

H. R. 12114

A BILL TO AMEND CHAPTER 89 OF TITLE 5, UNITED STATES CODE, TO ESTABLISH UNIFORMITY IN FEDERAL EMPLOYEE HEALTH BENEFITS AND COVERAGE PROVIDED PURSUANT TO CONTRACTS MADE UNDER SUCH CHAPTER BY PREEMPTING STATE OR LOCAL LAWS PERTAINING TO SUCH BENEFITS AND COVERAGE WHICH ARE INCONSISTENT WITH SUCH CONTRACTS

MARCH 23 AND 25, 1976

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EXEMPTION OF FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM FROM CERTAIN STATE LAWS

TUESDAY, MARCH 23, 1976

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS,
Washington, D.C.

The subcommittee met at 9:30 a.m., in room 304, Cannon House Office Building, Hon. Norman Y. Mineta (acting chairman) presiding.

Mr. MINETA. The subcommittee will come to order.

The subcommittee has convened this morning to begin its hearings and deliberations on H.R. 12114, a bill introduced by Congressman Richard C. White. This bill is a direct result of a General Accounting Office study, requested by this subcommittee, entitled "Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees' Health Benefits Carriers," issued October 17, 1975.

As I understand the situation, a number of State health insurance laws, regulations, and attorneys general opinions are beginning to have an impact on the coverage provided under the FEHB program. It can reasonably be expected that if these State requirements were publicized and strictly enforced by the States, the subscription costs of the FEHB program could be increased substantially.

To date, the existing conflicts between the FEHB carriers' contract with CSC and the State requirements have not had a great impact on the FEHB program costs, primarily because many States that have insurance requirements that apparently conflict with benefits and services provided by FEHB plans have not attempted to enforce their requirements. In other States, the FEHB carriers have been successful in convincing the States that they are exempt from State requirements.

Finally, there are some States that have enforced their requirements, but have not done so uniformly to all FEHB plans in those States.

Needless to say then, there is some doubt and considerable confusion among the carriers and the States regarding the applicability of various State health insurance laws to the FEHB contracts.

This subcommittee feels that the contracts negotiated between the Civil Service Commission and the various FEHB carriers are meant to require uniform coverage for all enrollees in each option of each plan. This bill, H.R. 12114, would establish that uniformity in Federal employee health benefits coverage, by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with FEHB contracts.

Our first witness today will be Mr. Thomas A. Tinsley, Director of the Bureau of Retirement, Insurance and Occupational Health, U.S. Civil Service Commission.

STATEMENT OF THOMAS A. TINSLEY, DIRECTOR, BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH, U.S. CIVIL SERVICE COMMISSION

Mr. TINSLEY. Thank you.

Mr. MINETA. Just as a note, prior to your presenting your testimony: I have been informed that this morning is the third time in a row for the Civil Service Commission; and, as I recall the rules, they state that the testimony is to be received at least 24 hours in advance of your appearance. This would be helpful to us and we would appreciate it. If I understand correctly, you are aware of the hearings before or when they are scheduled, at least 2 or 3 weeks in advance. It is awfully hard for the staff and the committee to be properly prepared for these hearings without having that testimony before us.

I would appreciate the ability to have this for the subcommittee staff prior to the hearings.

Mr. TINSLEY. I appreciate the committee's concern and I apologize to the committee for the delay here. At times it is beyond the control of the Civil Service Commission. In many instances, in fact in this particular instance, it required clearance of the Department of Justice as well as the Office of Management and Budget and other agencies involved.

However, that does not excuse the Commission or the executive branch from not complying with the committee's rules and for that I apologize and I assure you that I will do my best in the future to comply with that rule.

Mr. MINETA. Thank you, Mr. Tinsley.

Mr. TINSLEY. Mr. Chairman, you have my prepared statement which I assume will be placed in the record. I believe your opening statement very clearly outlined the problem and I will just briefly comment on the contents of the statement.

Mr. MINETA. Without objection the statement will be entered in the record at this point.

[The prepared statement follows:]

STATEMENT BY THOMAS A. TINSLEY, DIRECTOR, BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH, U.S. CIVIL SERVICE COMMISSION

Mr. Chairman and Members of the subcommittee; I appreciate this opportunity to appear before your Subcommittee to give the Commission's views on H.R. 12114. This bill would amend the Federal Employees Health Benefits (or FEHB) law so that the provisions of a health benefits contract made under that law which concerns benefits or coverage would preempt any State and local insurance laws and regulations which deal with benefits or coverage.

The problem of the applicability of state or local insurance laws to the FEHB program has been steadily growing in recent years. The problem often manifests itself in state or local laws that require insurance carriers doing business in their jurisdictions to provide benefits for which they did not contract with the Commission. H.R. 12114 would, in effect, exempt from state or local insurance laws and regulations, relating to benefits or contracts, insurance carriers in their administration of FEHB contracts.

Let me explain the background of this problem in more detail. While the FEHB law gives the Civil Service Commission the sole authority to negotiate contracts with participating carriers and to prescribe regulations to implement that law, the law does not give the Commission clear authority to issue regulations restricting the application of state laws when their provisions contradict provisions in the Commission's health benefits contracts. For all practical purposes the legislative history of the FEHB law is silent on this problem.

Initially, state laws offered few if any, problems to the FEHB Program. All states regulate the insurance business in various ways and state insurance laws have historically dealt with such matters as premium taxes, reserves, who is a covered family member and when persons are eligible to enroll in group coverage. It is apparent that either state laws excluded FEHB plans, or FEHB plans were in compliance with these laws, or the states decided not to enforce laws that conflicted with the provisions of FEHB contracts.

For the last several years, however, more and more states have been enacting legislation which provides for the kinds of benefits, to whom they will be provided, in what period of time, and who will provide them that insurance carriers doing business in the state must include in their plans. Failure to comply with State law even though it is in conflict with our contract results in the carrier not being permitted to do business in the State.

The loss of a license to provide health insurance in any state would render the two governmentwide carriers ineligible to be the Indemnity Benefit and Service Benefit Plan carriers under the FEHB program since the law requires the carrier for these plans to be licensed in all 50 states and the District of Columbia.

Although a few states (for example, Florida) have openly acknowledged that their laws do not apply to Commission contracts issued pursuant to the FEHB law, numerous others are more aggressively pursuing the preemption problem. In fact, states are now enacting insurance laws affecting not only specific types of care, extent of benefits, and specific types of providers, but also family members covered, age limits for family members, extension of coverage, and conversion contracts. Furthermore, a number of states are making their laws extra-territorial to overcome the argument of FEHB carriers that contracts between them and the Commission are made in D.C. rather than in any state.

A major beneficial feature in the FEHB program is a requirement that each FEHB plan must provide the same uniform benefits at the same premium for all enrollees in the plan. This uniformity would be threatened by carriers being forced to pay extra-contractual benefits in some states in compliance with state or local law. This would also result in FEHB plan enrollees in some States; paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

Aetna has contended that state laws contradicting the provisions in plans under the FEHB programs are preempted by the FEHB law. They asked the Commission's Office of General Counsel whether the McCarran-Ferguson Act established this preemption because the McCarran-Ferguson law which recognizes the authority of the states to retain the power to regulate the business of insurance makes an exception where an Act of Congress (for example, the FEHB law) "specifically relates to the business of insurance". However, our General Counsel's opinion was that although the FEHB law authorized the Commission to enter into contracts with insurance, it did not provide for the Commission to actually conduct insurance business. In other words, our General Counsel's opinion was that the states could, in effect, regulate FEHB plans.

Accordingly, it would appear that states have the authority and are beginning to welcome the *authority* to change provisions in otherwise uniform health benefits plans. Some action must be quickly taken to deal with what is rapidly becoming a serious problem. If no action is taken, it is only logical to assume that the states rather than the Federal Government will become the final arbiters of what is or is not covered by the FEHB program.

We have studied various solutions to this problem. It is our opinion that legislation such as H.R. 12114 preempting the FEHB Program from the benefit and contractual provisions of state or local law offers the only permanent solution. Furthermore, it is the only solution which would not result in additional cost to the Federal Government and which would preserve the principle of uniformity of benefits for enrollees in each FEHB plan. We do not believe that Federal fringe benefits enacted by the Congress for Federal employees should be subject to change or regulation by state legislatures or state insurance boards.

Accordingly, the Commission strongly urges the enactment of H.R. 12114.

Mr. MINETA. You may continue.

Mr. TINSLEY. This problem is one that has become increasingly more important to the program although some of these situations have existed for a number of years. It wasn't until the last few years that the States became more aggressive in terms of the enactment of these State laws and State insurance regulations, and began to enforce

their application in terms of the Federal employees health benefits program.

As pointed out the real problem here is one in which State laws are in conflict with the contracts we have with carriers. This produces a situation where the benefits are no longer uniform for Federal employees throughout the country. In fact, in many instances they are dependent entirely on the location in which the employee lives, that is the State in which the employee lives.

The benefits since the States have begun to enforce these laws, have become costly to the Federal employee and to the Government. As a result you have employees who are paying for benefits that they themselves do not have the opportunity of receiving.

One solution to this would be to negotiate contracts that would use the State benefit provision as a base which would mean we would have a fantastic program involving all types of benefits geared to the State laws. That would be extremely costly and I am not sure it would be in the best interest of the program.

This particular bill that is before the committee asks for nothing more than to preempt State laws and insurance regulations insofar as they apply primarily to the benefit structure. It is not asking for complete preemption in this instance.

We do feel, and feel rather strongly, that in addition to the other undesirable features here, that the Federal Government as an employer should have the right to determine what benefits its own employees will receive and that these benefits should be uniform, that they should not be left to the States, either their legislatures, or State insurance commissioners, or attorneys general to decide.

That very briefly, Mr. Chairman, is the Commission's position on this bill and we strongly urge its enactment.

Mr. MINETA. Thank you, Mr. Tinsley. What kind of specific benefits or coverages would be affected by various State laws?

Mr. TINSLEY. There are a number of various State laws.

Mr. MINETA. Would you take the example of one State?

Mr. TINSLEY. All right. These laws involve benefits, types of providers who will be covered, who won't be covered, what periods of time they will be covered for, and for what benefits. For example, in Connecticut they have a law that requires that an employee or dependent, if the employee becomes ineligible for continued participation in the plan for any reason including death, be allowed to continue the insurance for up to 39 weeks or until covered by another group plan after insurance would otherwise cease upon payment of premiums to the policyholder.

Under the Federal contracts there is an extension of coverage after termination of employment of up to 30 days with the conversion contract. If the individual remains in employment but is in a leave-without-pay status, we continue the coverage for up to a year. In the event of death of an individual the coverage would go to his survivors. That is one type of conflict.

Some States require that the contracts provide for specific type of services. The most common one is services to be provided by chiropractors. Many of our plans do not provide for the services provided by chiropractors.

Mr. MINETA. Because of State laws?

Mr. TINSLEY. Because of the contract.

In States where the carriers are required to provide the benefit they are undoubtedly providing the benefit, otherwise they would lose their license in the State. The loss of a license in a State by one of the nationwide carriers would be tantamount to losing the contract under the law because the law requires that they be licensed in all 50 States. So they don't have much choice.

The Connecticut law also requires home health care benefits. The only plan we now have that provides any home health care benefit is the service benefit plan, the Blue Cross, Blue Shield plan. The other plans for the most part either do not provide or provide very limited benefits in that area. In Connecticut they even stipulate the number of home visits. I believe it is 80 a year.

The Maryland Insurance Department has a number that are in conflict. One is a regulation which would prohibit coordination of benefits between no-fault automobile insurance and medical insurance policies. They can be paid under both. In most of our contracts we normally by coordination try to prohibit the dual payments for any benefit. These are the types of laws, Mr. Chairman.

Mr. MINETA. Mr. Tinsley, Mr. Taylor is going to have to be leaving for another meeting. So, if I could ask him to proceed, he has an inquiry of you. Go ahead, Mr. Taylor.

Mr. TAYLOR. If this bill were enacted into law would it result in a reduction of premium rates?

Mr. TINSLEY. I am always reluctant to talk about a reduction in premium rates since that's only happened about once in the last, I guess since the beginning of the program. It would be a lessening in the increase of the rates. We have been given estimates that these State laws are costing us a minimum of about 5 percent of premium. If that were the case and I had a \$2½ billion premium that would be about \$125 million a year. And the chances are with the States moving more and more into the regulation of insurance down to the point of specifying benefits, the cost would go up.

Mr. TAYLOR. It would be a suppressing effect?

Mr. TINSLEY. Yes.

Mr. TAYLOR. You say it is about a 5-percent increase?

Mr. TINSLEY. That is the estimate that the carriers have given us.

Mr. TAYLOR. Have you had an opportunity to look at some of the contracts that Blue Cross and Blue Shield have with hospitals throughout the country?

In my district I have received a lot of complaints especially from Government employees who just received notice from Blue Cross and Blue Shield that they would only pay 75 percent of the cost of their room. This was because of some disagreement that Blue Cross and Blue Shield had in negotiating the contract with the hospitals.

Now, this was in the St. Louis area. In the Kansas City area where room rates are higher than they are in St. Louis they don't have this problem, and I assume the rates are the same on both sides. For some reason they negotiate with hospitals on one side and not on the other side. What causes this?

Mr. TINSLEY. The situation you are referring to is a situation that has been prevalent in southwest Missouri for the last 2 years. The Blues have been attempting to negotiate with the hospitals for 2 years down there. The hospitals in some areas of the country have been refusing to agree to some of the contract provisions that they had

agreed to in the past with Blue Cross, Blue Shield. It involves a problem that is normally referred to as the Blues' discount. However, it goes really to the issue of the manner in which the Blues negotiate or agree with an institution in terms of defining what the cost will be that they will pay.

As a result in southwest Missouri since these hospitals do not have a contract with Blue Cross, Blue Shield they are considered nonmember hospitals. In a nonmember hospital most Blue Cross, Blue Shield contracts will not pay the full rate. They pay a nonmember hospital rate.

Mr. TAYLOR. The Blue Cross, Blue Shield policyholders, if they are policyholders, have just received a notice that they are going to be cut even further than what they have been.

The question that is asked me so often is why this for us when my brother-in-law who lives in Kansas City pays the same premium I pay, the hospital's rates there are higher than in Springfield, Mo., and they don't tell him this.

Mr. TINSLEY. We have this situation in a number of areas in the country. We have found in recent years that hospitals and doctors are not knuckling under to the Blues to the extent they used to in the past. They will not contract with the Blues except on their own terms. You cannot, and I don't think we would want to force Blue Cross, Blue Shield to pay to a nonmember hospital full rates. If you were to do that, Blue Cross, Blue Shield would become nothing more than an indemnity plan and for all practical purposes you are losing the benefit, so-called benefit, of the Blues' capability in the past of reaching agreements with hospitals and providers of health care that actually gave an advantage, supposedly, to their members.

The interesting part of this is what happens to us when this occurs, even though our members are free to move to another carrier, they are not captives of the Blues, the reaction we usually get is that we should do something to make the Blues contract with the hospital or make the hospital do something to contract with the Blues.

We don't view our role as moving into the middle of a contractual argument to force anybody to contract with anybody else. For all I know the hospitals are justified in southwest Missouri in not wanting to agree to whatever terms it is the Blues want them to agree to.

In answer to your other question we have from time to time taken a look at the arrangements that Blue Cross, Blue Shield has with hospitals. There have been some very serious questions raised about some of their contracting practices with the hospitals. The Blues feel very strongly that their relationships with the hospitals are in the area of trade secrets and that any publication or widespread publication or challenge in any area would do more harm than good to the Blue Cross, Blue Shield arrangements with hospitals throughout the country, because these hospital arrangements are not uniform.

Mr. TAYLOR. They certainly aren't. The lack of uniformity is what concerns me. Many members of Blue Cross, Blue Shield are not getting the benefits for their dollar that they are in other parts of the State because of their reluctance or the failure of the hospitals and the Blues to get together on the contract. And the policyholders or the members are certainly the victims of this.

Mr. TINSLEY. This can be extremely difficult for most people. I think to some extent in our program it is offset by the fact that they can move to another carrier.

Mr. TAYLOR. Thank you.

Mr. MINETA. Mr. Harris?

Mr. HARRIS. It is nice to see you again, Mr. Tinsley. I wanted to pursue that question a little bit. I remember receiving testimony in this subcommittee that in fact hospitals at times do have different rates for those patients under Blue Cross, Blue Shield contracts than those patients, for example, under another. Is that correct?

Mr. TINSLEY. Yes. Most other carriers have argued from time to time, and I think one carrier in particular who has gone to court claims, that they are subsidizing Blue Cross, Blue Shield customers which has an adverse effect on their rate.

Mr. HARRIS. We do have a situation where the hospitals may be charging a noncovered patient more than the Blue-covered patient and you would have the question of the noncovered patient may be subsidizing the Blue patient?

Mr. TINSLEY. Yes; very definitely.

Mr. HARRIS. When it was originally brought before this subcommittee it had elements in it that disturbed me a little bit and quite frankly I want to admit openly that I did not realize that Blue contracts with hospitals were considered trade secrets.

Mr. TINSLEY. Well, I don't know how far——

Mr. HARRIS. I'm an advocate of open covenants openly arrived at, that sort of thing.

Mr. TINSLEY. I think in my discussion with some of the officials of Blue Cross, Blue Shield, I think what they are fearful of is that if hospital A finds out what hospital B has that there would be more hospitals that would give Blue Cross, Blue Shield a tussle in terms of the contractual arrangement.

Mr. HARRIS. I am sure that is one of the reasons. But I would be surprised if hospital D and hospital C weren't talking already. I think this area is a matter of some concern, Mr. Chairman. I think it deserves some study here because in many localities the Blues are by far the predominant coverer and I think it is something that we ought to look at as far as the total cost of hospital care is concerned.

Thank you, Mr. Chairman.

Mr. TINSLEY. If I may comment on that, Mr. Harris, several years ago we ran into a major problem with Blue Cross, Blue Shield in term of audits when we began to challenge a hospital contract in a certain area of the country. And that to this date has never been clarified.

It is part of one of the audit issues I mentioned at an earlier hearing where we are at loggerheads with Blue Cross, Blue Shield and one which hopefully will be resolved by the Armed Services Board of Contract Appeals, if not there, in court in the near future.

Mr. MINETA. Counsel?

Mr. McCLUSKEY. As I understand it, though, doesn't each local plan contract with its own hospital?

Mr. TINSLEY. Yes. These hospital contracts are not under the control of the national associations. The hospital contracts are under the control of the local Blue Cross plan.

Mr. McCLUSKEY. Then we have the further problem of the FEP program under Blue Cross, Blue Shield having its own board and its own body just for the Federal employees and yet it has no clout apparently.

Mr. TINSLEY. With the locals?

Mr. McCLUSKEY. Yes.

Mr. TINSLEY. The clout it would have varies throughout the country. It certainly has no clout where the FEP is a small percentage of the business.

Mr. McCLUSKEY. Generally speaking overall as far as policymaking and so forth it seems like this whole setup is just to run the Federal employees program but what power it has within the Blue Cross, Blue Shield overall structure is somewhat nebulous if any.

Mr. TINSLEY. Well, to the extent that the top officials of Blue Cross-Blue Shield National Associations and to the extent, and I can't remember the new name they tacked onto it, it used to be called the board of managers, to the extent that that board is composed primarily of the heads of the local Blue Cross, Blue Shield plans from various parts of the country, it does not have that much influence at the local level.

I do believe that men like Mr. McNerney, president of the Blue Cross Association and some of the other top officials in the national associations do exert a great deal of influence throughout the Blue Cross, Blue Shield organization.

I don't think they are without power or influence. That naturally would vary from section to section of the country. But I think it would be an understatement to say they have no influence just as it would be to say this program has no influence. I don't think it has all the influence some people think it has, but I think it has some influence.

Mr. MINETA. Just one quick question. When did we have our first conflict with the State or local law?

Mr. TINSLEY. Confrontation between a carrier and a State?

Mr. MINETA. Yes.

Mr. TINSLEY. This probably was back 5 or 6 years ago. Many States haven't bothered to try to enforce this. In some States where the carrier has gone to the State and said, "Look, you know this is a Federal contract."

And the State insurance commissioner in some instances has said, "We won't bother with this." In recent years with the spread of State legislation in this area the problem has become more acute.

Mr. MINETA. Any further questions?

Mr. HARRIS. No.

Mr. MINETA. Thank you very much, Mr. Tinsley.

Mr. TINSLEY. Thank you.

Mr. MINETA. Our next witness this morning is Daniel W. Pettengill, vice president of the Group Division of Aetna Life and Casualty, accompanied by Mr. Peter Connell, Washington counsel.

STATEMENT OF DANIEL W. PETTENGILL, VICE PRESIDENT, GROUP DIVISION, AETNA LIFE AND CASUALTY, ACCOMPANIED BY PETER CONNELL, COUNSEL

Mr. PETTENGILL. Mr. Chairman, members of the subcommittee, my name is Daniel W. Pettengill; I am vice president, Group Division of Aetna Life and Casualty. I am accompanied by Peter J. Connell, our Washington counsel.

As you know, Aetna administers the Governmentwide indemnity benefit plan on behalf of 104 other insurance carriers. It is a pleasure for us to appear before you today to provide you with our views on H.R. 12114.

This bill would amend the Federal Employees' Health Benefits Act (FEHBA) to provide that the provisions of contracts made pursuant to that act would supersede and preempt conflicting State or local laws or regulations dealing with benefits or coverage. We support the enactment of this legislation.

We support H.R. 12114, first, because we are convinced that its enactment is necessary to clarify the authority of the Congress and the Civil Service Commission to control the costs and quality of the Federal employees' health benefits program; second, because it would promote equity among program participants in any given plan; third, because it would serve to stabilize or reduce future costs; and fourth because it would enhance the efficiency of the administration of the program. Permit me to expand on these four points.

H.R. 12114 WOULD CLARIFY THE AUTHORITY OF THE CONGRESS AND THE CIVIL SERVICE COMMISSION

At the request of Chairman White, the Comptroller General of the United States submitted to this subcommittee on October 17, 1975, a report entitled "Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees' Health Benefits Carriers." This report pointed out that,

A number of state health insurance laws, regulations and (State) Attorneys General opinions are beginning to have an impact on the coverage provided under the FEHB plans.

And concluded that doubt exists regarding the applicability of various State health insurance requirements to the contracts the several carriers have with the Civil Service Commission.

This uncertainty arises in instances wherein State laws or regulations conflict with the Federal statute enacted by the Congress—5 U.S.C. 8901 et seq.—or with the provisions of Civil Service Commission contracts. When faced with a conflict of this sort, the question arises as to whether Federal law and contracts prevail or whether State law prevails.

I should point out that this situation developed only recently, as the result of a trend of States' assertion of jurisdiction over health insurance policies covering all residents of the particular State, regardless of site in which the insurance policies were issued and delivered. Traditionally the law of the State where a group policy is delivered is considered to govern its validity and effect for all persons insured under the contract, regardless of their place of residence.

However, over the last 5 years or so, there has been a discernible trend away from this traditional approach. In some instances the States have expressly legislated that certain laws will have extraterritorial effect. In other instances, the State insurance commissioners have interpreted State statutes to apply extraterritorially by issuing regulations or orders that govern such policies as they apply to State residents.

For example, several States have enacted freedom of choice laws which extend extracontractually certain benefits and coverage. Such laws generally provide that notwithstanding any provisions of any insurance policy, whenever such policy provides for reimbursements for any service which may be legally performed by a person licensed

in the State for the practice of medicine, surgery, dentistry, osteopathy, chiropractic or podiatric, reimbursement under such policy shall not be denied when such service is rendered by a person so licensed.

Some of the States having such provisions, such as Nevada and Maryland—among others—have taken the position that their laws apply to benefits and coverage offered under contracts written pursuant to the Federal act, notwithstanding the fact that such contracts are issued and delivered to the U.S. Civil Service Commission in Washington, D.C. Other States, such as California and Florida, which have similar provisions, have taken a contrary position.

It is not my purpose, this morning, to assess the relative merits of these essentially legal conclusions. Rather, I want to underscore the point made by the Comptroller General that confusion does exist; that our best efforts to resolve this issue have not borne fruit; and that legislation is required to clarify the authority of the Congress and the Commission.

I would emphasize that this clarification is required if the Congress and the Commission are to have the authority to control the costs and the quality of a Federal program—a program designed for Federal employees and their families and paid for by them and by the Federal Government. It is axiomatic that the costs of this program are directly related to the benefits. To the extent that the Congress and the Commission do not control the benefits, they cede control over the associated costs.

The quality of the program is also very much at issue. For example, 2 years ago the Congress amended the FEHBA to provide for payment of services rendered by clinical psychologists without the need for referral and supervision by physicians. I emphasize the word “clinical” psychologists because the Congress quite deliberately decided to enact an amendment which—in the words of Mr. Dulski, then Chairman of your committee—

Has the effect of excluding certain licensed psychologists who are not qualified and trained as clinical psychologists. [Congressional Record, July 17, 1974, p. H 6599]

So, while the Congress was concerned with reducing the costs associated with physician referral and supervision, it was also very much concerned with the quality of care to be provided to Federal employees and their families. And congressional concern for that quality was deliberately and carefully reflected by the limited nature of the liberalization.

But that care and deliberation exercised by the Congress can be undermined—in fact, completely gutted—by conflicting State laws. This is not a hypothetical problem: The State insurance laws of at least a half dozen jurisdictions including New York, California, Michigan, New Jersey, North Carolina, and Maryland, conflict with this clear congressional directive.

For example, Maryland law requires direct access to any licensed or certified psychologist, regardless of whether that person is a clinical psychologist.

Cases may be expected to arise in the future, in Maryland and in other such jurisdictions which, if State law should take precedence, will require the Commission to direct the carrier to pay for services

rendered directly by a class of psychologists—that is, nonclinical psychologists—when the Congress specifically decided that services provided by such a class should not be reimbursed in the absence of an appropriate referral. This, of course, would vitiate congressional efforts to control the quality of this program.

Additional illustrations of recently enacted conflicting State laws are set forth in a letter prepared by Mr. McIntyre, of my staff, to the GAO. The letter is set forth as appendix III to the Comptroller General's report; for your convenience I have attached a copy to my testimony.

H.R. 12114 WOULD PROMOTE EQUITY AMONG PARTICIPANTS IN A GIVEN HEALTH PLAN

The Congress can resolve the uncertainties I have discussed in one of two ways: You can decide that, in the event of conflict, the Federal statute and contract take precedence, or you can decide that the State laws and regulations should prevail. We can administer our plan either way. But we would point out that uniformity in Federal benefits and coverage under any given option cannot be achieved if such benefits and coverage are to be subject to the insurance laws and regulations of the several States. Such a decision would subject the health insurance benefits and coverage of Federal employees to a substantial degree of variation.

As the Comptroller General noted, accession to:

Conflicting requirements can be expected to result in increased premium costs to both the Government and the program enrollees and a lack of uniformity of benefits for all enrollees in the same plan, which results in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States. Clearly, this would not be an equitable solution.

H.R. 12114 WOULD SERVE TO STABILIZE OR REDUCE FUTURE COSTS

While the Comptroller General concluded that a nonuniform program could be expected to lead to increased premium costs, he also stated that the necessary data was not available to determine the magnitude of those increases, or conversely, the savings which would be realized by the enactment of legislation such as H.R. 12114. But a decision to accord precedence to conflicting State laws and regulations would certainly increase claim benefits payable. It would also increase the administrative costs incurred in tracking the various State laws and amendments to those laws, and in printing separate brochures for participants residing in each State.

Our actuaries have told us that a rough estimate of the increased costs which would attend a decision to vary these benefits and coverage on a State-by-State basis, would be about 5 percent of premiums. If this is accurate, and if it were true for other plans as well, the annual increased costs—which could be averted by the enactment of H.R. 12114—would be about \$100 million, assuming, as did the Comptroller General, that “the total cost of the program for fiscal year 1976 will be about \$2 billion.”

I will not belabor our fourth and final point: That the enactment of H.R. 12114 would enhance the efficiency of the administration of the Government-wide indemnity benefit plan. As it is now, we have no

clear guidance on whether to pay claims in a variety of instances in which conflicts are possible. Decisions are necessarily made on a claim-by-claim, ad hoc, basis. We would welcome a definitive resolution of this matter, and, clearly, a resolution establishing uniformity of benefits and coverage within various options of a plan would permit much greater efficiency of administration, with corresponding cost savings.

Mr. Chairman, members of the subcommittee, that concludes my statement. I appreciate your courtesy in inviting us to testify today. If you have any questions, Mr. Connell and I will be pleased to entertain them at this point.

Mr. MINETA. Thank you very much, Mr. Pettengill. When was the first time that Aetna ran into any kind of a conflict under your contracts with State or local law?

Mr. PETTENGILL. I believe, sir, that it was in the State of Nevada when the insurance commissioner got an opinion from his attorney general that the coverage of chiropractors applied to all contracts regardless of where they were issued. We raised the point that this was a Federal, special Federal, contract and that we thought the Federal law preempted the State law requiring the coverage of chiropractors.

The Nevada attorney general at that time ruled to the contrary. We asked the Commission what they wished us to do since, as Mr. Tinsley pointed out earlier, for us to refuse to pay them could result in the commissioner lifting our license and making us ineligible to be the carrier of the plan.

We were advised that we were to pay chiropractic benefits in Nevada only for as long as the commissioner so required it, and we have done so since that time.

Mr. MINETA. How many of these conflicts have you had in other States since this initial experience in Nevada, and how much in dollars have you paid out in claims outside your plans?

Mr. PETTENGILL. Fortunately, to date the dollar amount has not been that significant basically because in each instance we have taken the matter up with the insurance commissioner and, as I pointed out in my testimony, some insurance commissioners have decided that the Federal law does override the State law and have told us to go ahead and enforce the contract as we read it.

Others, on the other hand, have come back as did Commissioner Rottman in Nevada, and said, "No, we believe the State law overrides the Federal law and you must pay."

We have been, as I indicated, handling these things on an each-situation basis so that, to date, the amounts of money we have had to pay have not been substantial. But the number of laws being enacted is increasing, and their scope is increasing. I feel very strongly that unless the Congress settles this issue by passing a law such as H.R. 12114, you are going to have a situation where more and more States will say that their laws override and you will then have complete nonuniformity throughout the country.

Mr. MINETA. Am I correct in assuming that, in the construction of rates for your plans, there are savings that are being affected, since there are certain benefits that are not being paid for, or are not covered even though they are taken into consideration in the construction of the rate?

Mr. PETTENGILL. Our rate is based on the benefits which we intend to pay for all employees in all States. At the present time, the payment of a chiropractic claim, for example, in Nevada would be taken out of our contingency reserve. And so it is not in the premium rate itself. Now, obviously, how long this can go on is——

Mr. MINETA. That is a benefit that goes beyond the terms of the contract. What about benefits that are provided by contract but are not being provided because of some conflict with State law?

Mr. PETTENGILL. We do not consider that any of the conflicts are contractual benefits so that any time we pay one of these States that override the Federal law, that is a separate payment, as I said earlier, that comes out of the contingency.

Mr. CONNELL. Is your question whether we deny benefits?

Mr. MINETA. That is right. Where the benefit is being provided, but because of State or local law——

Mr. CONNELL. I don't think we have that situation.

Mr. MINETA. You don't have that situation?

Mr. CONNELL. No, sir.

Mr. HARRIS. The State gives them but doesn't take away.

Mr. MINETA. What about the case in terms of cost control measures? What is Aetna doing with that, in terms of that area?

Mr. PETTENGILL. Well, we do have a requirement that all expenses must be medically necessary for the condition being treated and we have a fairly capable staff of both home office physicians and consultants throughout the country to which we refer cases where we have doubts as to the necessity of the treatment or as to whether the charge is reasonable in relation to the treatment.

We do make full use of review committees that have been established by the various professions. But I am sure you appreciate that those do not exist in all jurisdictions so that in some cases we are forced to use either our own medical staff or the opinion of the consultants whom we obtain. We are endeavoring to do as much of that as we possibly can and we believe that within those constraints we do a fairly good job.

We also endeavor to look at those areas of health care where, quite frankly, review is not yet effective and to place internal limits on the benefits we provide in order to assure that the portion of the health care dollar of the Government-wide indemnity plan that goes for that particular service does not become an unduly large percentage of the benefits. We are trying to present a balanced plan so that it will be attractive to a wide range of Federal employees.

Mr. MINETA. Mr. Harris?

Mr. HARRIS. Thank you, Mr. Chairman.

I want to thank you for your testimony. Just one quick question. I think you make an impressive case for the rather chaotic situation that exists with different regulations in each State, and what have you.

H.R. 12114 seems to be very sweeping and I would like to ask if you have looked at something less sweeping that would still accomplish the main purpose here. Right now we are really saying whatever we put in the contract is going to override any State law in almost any element of health coverage and I just wondered if a law somewhat less sweeping would not accomplish a similar purpose.

Mr. CONNELL. I think the term "coverage" as used in that bill refers to eligibility as to who is eligible to participate.

Mr. PETTENGILL. And for how long.

Mr. CONNELL. Our feeling is that the bill is appropriate because the Congress really ought to be the institution that determines who is eligible for this Federal program and that the Congress ought to be the institution that determines what the benefits will be.

Mr. HARRIS. "Any contract under this chapter which relates to the payment, nature, or extent of benefits or coverage shall supersede and preempt any State and local law." In my mind that seems to do more than what you just said. "Any provision or contract which relates to the payment, nature, or extent of benefits."

Mr. CONNELL. I think the nature of benefits—one example of that would be chiropractic services or services by clinical, as opposed to nonclinical, psychologists. Payment I think is obvious. The word "coverage" as used in the contract relates to the question of eligibility under the plan.

Mr. PETTENGILL. We are of the opinion, sir, and admittedly I am not a lawyer, that this has been thoughtfully considered because it doesn't conflict in any way with a State's right to regulate reserves that a carrier is required to hold in order to be a licensed carrier in that State.

It doesn't infringe upon a State's right to assess premium taxes on a carrier or other types of taxes. It limits itself solely to who is eligible for this Federal plan and what benefits are provided.

Mr. HARRIS. I think that is very helpful. I think this is important to get that into the record. This, I think, is the main point we have before us, the need for this type of legislation is very evident and I think we ought to make sure we don't get into the business of just overriding willy-nilly today or in the future the States' rights as far as the regulation of the industry is concerned.

Mr. MINETA. Yes. I think the fact that this amends the basic provision, where we are dealing with the contractual relationship between the health carriers and the Federal employees, is the thing that would limit the nature of the amendment.

Counsel, did you have a question?

Mr. McCLUSKEY. Yes. I would like to follow up with a couple quick questions. What year was this Nevada ruling?

Mr. PETTENGILL. I would have to refresh my memory. I think it was 3 years ago but I would want to check on that.

Mr. McCLUSKEY. So there have been payments being made for at least 3 years?

Mr. PETTENGILL. Correct.

Mr. McCLUSKEY. Could you submit the dates of these various rulings in the States where you have had to pay for the record?

Mr. PETTENGILL. We will do so.

Mr. McCLUSKEY. And if possible, the total amounts paid out?

Mr. PETTENGILL. That unfortunately is not possible because it was not until this year that we started keeping precise records. I regret that situation. But those are the facts of the case.

[The following information was furnished:]

STATES DEFINITELY MAINTAINING THEIR LAWS OVERRIDE FEHBA

(Year of definite decision is shown in parentheses)

Nevada (1973).

STATES WHICH HAVE RAISED THE ISSUE BUT NOT YET DEFINITELY MAINTAINED
THAT THEIR LAWS OVERRIDE FEHBA

(Year issue was first raised is shown in parentheses)

Ohio (1971).

South Dakota (1972).

Oklahoma (1972).

Missouri (1972).

Maryland (1974).

Michigan (1976).

Arkansas (1976).

STATES WHICH HAVE TENTATIVELY DECIDED THAT THEIR LAWS DO NOT
OVERRIDE FEHBA

(Year of tentative decision is shown in parentheses)

California (1973).

Florida (1974).

Washington (1976).

Wisconsin (1976).

Mr. McCLUSKEY. You said that you pay these out of the contingency reserve; but aren't contingency reserves required by the contract?

Mr. PETTENGILL. Starting this year we are paying them out of the contingency. In prior years they were paid out of our premiums.

Mr. McCLUSKEY. So it did affect the premiums slightly?

Mr. PETTENGILL. Yes.

Mr. MINETA. Mr. Harris?

Mr. HARRIS. I have no further questions.

Mr. MINETA. Mr. Pettengill and Mr. Connell, we thank you very much for your contribution toward the work of the committee.

Mr. McCLUSKEY. Mr. Chairman, I would like to submit to the subcommittee that the staff has asked Aetna for its cost control measures and what it is doing to review and expand these measures and Aetna has been very cooperative on this.

Mr. MINETA. Very fine. Thank you very much.

Mr. PETTENGILL. Thank you.

[Whereupon, at 10:20 a.m., the subcommittee adjourned.]

[The attachment to Mr. Pettengill's statement follows:]

151 Farmington Avenue
Hartford, Connecticut 06115

Malcolm McIntyre
Manager
Government Relations
Group Division

September 23, 1975

Mr. Gerald Miller
Supervisory Auditor
Government Accounting Office
Audit Site, Room 2456
U.S. Civil Service Commission
1200 E Street, N.W.
Washington, D.C. 20415

Dear Mr. Miller:

In accordance with your most recent request, I have reviewed some state laws enacted recently and inasmuch as these new statutes could impact on the payment of benefits and the implementation of the Federal Personnel Manual 890.1 regulations, as they relate to health benefits, I will give you a short resume of each law and regulation.

Arkansas has a law which became effective June, 1975, which requires recognition of chiropractors' charges if such services would have been payable if rendered by a physician.

In Colorado, a law will become effective on January 1, 1976 which will require basic coverages to include benefits for at least 45 days of in-patient care or 90 days partial hospitalization (3-12 hours in hospital or licensed psychiatric hospital) for mental illness treatment. Comprehensive medical policies must include out-patient services for treatment of mental and nervous conditions which may be limited to \$1,000 in a 12-month period. Also, coinsurance may not exceed 50%.

Another law in Colorado which will also be effective January 1, 1976 requires insurers to offer for inclusion in group health policies coverage for treatment of alcoholism. Minimum benefits required to be offered include 45 days in-patient care in a licensed hospital or a facility licensed by the Department of Health, and out-patient benefits to the extent of \$500 in a 12-month period.

Effective October 1, 1975, a law in Connecticut will require that an employee or dependent, if the employee becomes ineligible for continued participation in a plan for any reason including death, be allowed to continue insurance for up to 39 weeks or until covered by another group plan after insurance would otherwise cease, upon payment of premiums to the policyholder.

Another law, which became effective on May 28, 1975 in Connecticut, amends the Mental Illness Law to make it applicable to renewed

contracts to increase the covered period of confinement for mental and nervous conditions from 30 to 60 days, and to increase the level of coverage for out-patient treatment from \$500 to \$1,000.

Effective October 1, 1975, another law will become applicable in Connecticut which mandates home health care benefits. The maximum offered cannot be less than 80 visits in a calendar year or in any continuous period of 12 months. Of concern to us is the fact that such care could be rendered by a person who does not meet the requirements for coverage under the provisions of the Indemnity Benefit Plan or the Uniform Plan.

In Idaho, a new law became effective on July 1, 1975. One of the provisions of this law is that any medical policy which includes maternity benefits must, upon discontinuance, provide the maternity benefits that would have been payable to persons pregnant at the time of discontinuance had the policy remained in force for a period of 12 months following discontinuance.

Effective October 1, 1975, a law will go into effect in Illinois which will require group coverage to continue for a period not to exceed six months from an employee's "termination date" (date employee fired, laid off, etc.), provided the employee agrees to pay the premium at the previous rate. The employer must meet special notice requirements to permit the terminated employee the option to elect the continued coverage. This law will only be effective until July 1, 1977.

In Louisiana, effective November 1, 1975, a new law will require recognition of a chiropractor's charges if such services would have been payable if rendered by a physician.

The Maryland Insurance Department has a proposed regulation which would prohibit coordination of benefits between "no-fault" automobile insurance and medical insurance policies. This proposed regulation would also be extraterritorial in nature. Of course, this would impact directly on the "double coverage" provision contained in the Indemnity Benefit Plan.

A law becomes effective in Massachusetts on January 1, 1976 requiring that all group hospital and surgical expense policies covering Massachusetts residents, and to individual policies issued in Massachusetts, offer benefits for expenses arising for treatment of mental illness at least equal to requirements that in-patient benefits for treatment in a mental hospital will be provided for at least 60 days in a calendar year if the hospital is under the supervision of the Department of Mental Health, or licensed by that Department, and for confinement in a licensed general hospital, benefits are to be provided on the same basis as for any other illness. For out-patient benefits for treatment of mental and nervous disorders, they are to be covered to the extent of \$500 over a 12-month period if services are provided by a comprehensive health service organization, by a licensed or accredited hospital, by a community mental health clinic or day-care center providing mental

health services as approved by the Department of Mental Health, or by consultations, diagnostic or treatment sessions when administered by a licensed psychotherapist or psychologist.

In Minnesota, a law was effective July 1, 1975 which requires coverage for in-patient hospital and medical expenses on the same basis as other benefits for the treatment of emotionally handicapped children in a residential treatment facility licensed by the Commissioner of Public Welfare.

Also in Minnesota, a law became effective on August 1, 1975 which requires coverage of at least 90% of the first \$600 in any 12-month period for consultation, diagnosis and treatment for mental and nervous disorders while the insured is not a bed patient in a hospital.

Another Minnesota law, which was effective May 15, 1975, requires that coverage under a group health insurance policy, upon termination of employment, must be continued until either the employee is reemployed and eligible for another group health care coverage or for six months.

In Nevada, a law became effective July 1, 1975 which requires benefits for home health care or health-supportive services. On this same date, another law became applicable in Nevada which requires recognition of the charges made by a licensed doctor of traditional Chinese Medicine (acupuncture).

Effective January 1, 1976, New Hampshire will have a new law which requires benefits for losses arising from mental or nervous conditions to be at least equivalent to 45 days of in-patient confinement, and 100% of the first five visits (80% thereafter) for out-patient coverage limited to \$500 in a calendar year.

On June 5, 1975, a law became effective in New Jersey which requires recognition of a chiropractor's charges if such services would have been payable if rendered by a physician.

In Oklahoma, there is a new law requiring that group health policies issued or delivered on or after January 1, 1976 provide for continuation of coverage for 30 days after termination of such policy, and requires specified extended benefits to employees who have been covered under the policy for at least six months, for a continuous loss which commenced while the insurance was in force.

On July 31, 1975, a law became effective in Wisconsin which requires coverage for out-patient services at a hospital or out-patient treatment facility, including services of a physician in connection with alcoholism or drug abuse to the extent of the first \$500 in any calendar year. The law, however, makes a distinction in mandating the level of coverage for mental illness. Out-patient treatment for mental illness which is rendered at any place other than under a community mental health program established by Section 51.42 of the Wisconsin Statutes, need only be covered to the extent of \$500 in a

calendar year. However, out-patient mental illness treatment rendered under a community mental health program must be paid for the first \$500 in any calendar year. The effect of this is that no deductible or coinsurance is permitted until the \$500 limit is reached in connection with out-patient alcoholic treatment of mental illness, no matter where the treatment is rendered, and in connection with the treatment of mental illness, no deductible or coinsurance is permitted until the \$500 limit is reached if the out-patient care is rendered under a community mental health program. However, if the out-patient mental health care is rendered somewhere other than under the community mental health program, a deductible and coinsurance is permitted.

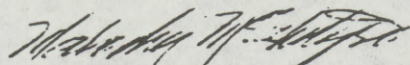
Of course, I am sure you realize that there are many other statutes effective in various states which would impact on the benefit provisions of both the Indemnity Benefit Plan and the Uniform Plan, as well as the Federal Employees Health Benefits regulations. I have pointed out the foregoing laws and regulations just to give an indication of how the additional benefits, for which premiums have not been considered under these plans, would increase the claim benefits payable. One must also consider the implications on the increased administrative costs inherent to us in tracking and providing coverage under all of the various state laws under these plans, and the implied necessity of having to, in the future, print brochures for each state showing the various coverages which would be in effect and the benefits which would be payable in each state.

As relates to the regulations and laws of the states concerning continuation of coverage, etc., it would be necessary for the Civil Service Commission to make a determination as to whether or not the states' laws or regulations would apply, or whether the Federal Employees Health Benefits regulations would apply under these circumstances.

All in all, I am sure that you realize our assumption that a 5% premium increase would be necessary for the Indemnity Benefit Plan for 1976 in order to pay benefits for services required by the various states is only for a one-year period, and that the cost would escalate in the future as more and more of the states' laws became applicable to these plans, or the states passed laws which would impact on the benefit structures of these plans.

I very much appreciate your request for this additional information, and please be assured that if I may be of further assistance to you, you need only call upon me.

Sincerely,



Malcolm McIntyre, Manager
Group Government Relations

MM/cb

EXEMPTION OF FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM FROM CERTAIN STATE LAWS

THURSDAY, MARCH 25, 1976

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS,
Washington, D.C.

The subcommittee met at 9:17 a.m. in room 304A, Cannon House Office Building, Hon. Herbert E. Harris II (acting chairman) presiding. Mr. HARRIS. The subcommittee will come to order please.

The subcommittee has reconvened this morning to continue its hearings and deliberations on H.R. 12114, a bill introduced by Congressman Richard C. White. This bill is a direct result of a General Accounting Office study requested by this subcommittee, entitled, 'Conflicts between State Health Insurance Requirements and Contracts of the Federal Employees' Health Benefits Carriers,' issued October 17, 1975.

To date, the existing conflicts between the FEHB carriers' contract with CSC and the state requirements have not had a great impact on the FEHB program costs, primarily because many States that have insurance requirements that apparently conflict with benefits and services provided by FEHB plans have not attempted to enforce their requirements. In other States, the FEHB carriers have been successful in convincing the States that they are exempt from State requirements.

Finally, there are some States that have enforced their requirements, but have not done so uniformly to all FEHB plans in those States. Needless to say then, there is some doubt and considerable confusion among the carriers and the States regarding the applicability of various State health insurance laws to the FEHB contracts.

It can reasonably be expected that if those State requirements were publicized and strictly enforced by the States, the subscription costs of the FEHB program could be increased substantially.

This subcommittee feels that the contracts negotiated between the Civil Service Commission and the various FEHB carriers are meant to require uniform coverage for all enrollees in each option of each plan. This bill, H.R. 12114, would establish that uniformity in Federal employee health benefits coverage by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with FEHB contracts.

Our witness this morning is Nathan T. Wolkomir, president, National Federation of Federal Employees, accompanied by George Tilton.

**STATEMENT OF GEORGE TILTON, ASSOCIATE GENERAL COUNSEL,
NATIONAL FEDERATION OF FEDERAL EMPLOYEES**

Mr. TILTON. For the record, I am George Tilton, associate general counsel for the National Federation of Federal Employees. Dr. Wolkomir was unable to attend today. He sends his apologies to the chairman.

Mr. HARRIS. Do you intend to give Mr. Wolkomir's statement?

Mr. TILTON. No; Mr. Chairman, I would prefer that it simply be incorporated into the record, and I will speak briefly on our position if that is agreeable to the Chair.

Mr. HARRIS. Very good. I notice the statement is fairly brief. I hope as you indicate, your comments will be briefer.

Mr. TILTON. I think they will be at least as brief if not briefer.

Mr. HARRIS. Very good. Mr. Wolkomir's statement will be placed in the record at this point.

[The statement of Nathan T. Wolkomir follows:]

STATEMENT OF NATHAN T. WOLKOMIR, PRESIDENT OF THE NATIONAL FEDERATION OF FEDERAL EMPLOYEES

Mr. Chairman and Members of the subcommittee, my name is Nathan T. Wolkomir, President of the National Federation of Federal Employees. The NFFE is the largest independent union in the Federal sector, representing both at home and overseas over 150,000 persons throughout the Government.

We appreciate this opportunity to testify on H.R. 12114 which will establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts established under Chapter 89 of Title 5 by preempting State or local laws pertaining to these benefits and coverage which are inconsistent with such contracts.

This bill is the result of a recommendation made to the Subcommittee by the General Accounting Office that the Subcommittee consider legislation to clarify its intent as to whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employee Health Benefits Act (FEHBA). The recommendation is made in a report on the conflicts between State Health Insurance requirements and the contracts of the FEHB program requested by Chairman White.

The report stated that in many instances State laws concerning health insurance waivers have created inequities in the administration of the FEHB programs. These laws, in many instances, require the carrier to provide services in addition to those enumerated in their contracts. For example, the report states that in Nevada, under the Aetna Indemnity Benefit Plan, there is a requirement that the plan cover chiropractor services while those services are not reimbursable in any other State under that particular plan. Needless to say, this case, and the numerous others cited by the report, create confusion and misunderstanding for the insurance enrollees and the carriers.

The report asserts that these conflicting requirements can be expected to result in both increased premium costs and lack of uniformity of benefits for all enrollees in the same plan. This requires enrollees in some States to pay a premium based, in part, on the cost of benefits provided only to enrollees in other States.

Mr. Chairman, we support this legislation insofar as it will assist in holding down the costs of health insurance in the Federal sector. We believe the skyrocketing of costs of the health insurance programs is one of the major, if not the major, concerns of the Federal employees today. However, in studying the GAO report concerning the various State requirements we question whether or not some of those services should not be provided under all the various FEHB plans. Some are important and would be an asset to any health insurance program.

We believe the whole subject of what is contained in these contracts should be reviewed by the Congress. More and more we are receiving complaints from our members stating that their health insurance program did not cover this hospitalization or that bill, and they were forced to pay the bill.

The NFFE believes it is time that the Congress examine these contracts to determine whether they are economical or fair. We believe they are not. It is true

that the employees have a choice but it is not a real choice. Every program is similar and each one's costs are increasing. We assert, again, our proposal that the Congress make the Federal Government a self-insurer in the area of health insurance. We believe that an examination of the facts will demonstrate the Federal Government can efficiently and effectively administer a nationwide Government insurance program, non-contributory, that will surpass any offered programs currently available under the FEHBA. The responsibility for the operation of such a program could be placed in the Office of Worker's Compensation or the Social Security Administration.

We are well aware that our proposal requires a fundamental change in the delivery of health care to Federal employees. But we believe that such a change is necessary if Federal employees are to receive the best health insurance available. We firmly believe that the Federal Government can run a more effective program at a lesser cost.

In conclusion, we do support H.R. 12114. But we also believe that instead of piecemeal attempts to correct what is a bad situation, a major overhaul of the program ought to be done. We believe that we have suggested a feasible method. What is needed now is the will.

Mr. TILTON. Thank you, Mr. Chairman.

Essentially, we are in agreement with the intent of this bill which is to hold down insurance costs and preserve uniformity. I think our testimony over the years will demonstrate we have always been interested in uniformity and holding down insurance costs.

The question this bill raises in our mind, though, is whether or not this is an appropriate method of preserving uniformity. The question that should be asked—and we submit this committee should consider—is whether or not some or all of these benefits should be incorporated into all plans. That is, perhaps some of the benefits are necessary and good benefits, and perhaps rather than excluding them from one State, they should be included in all States.

The effect of this bill, however, would be to prohibit that. Well, it would not exactly prohibit it, but would be to discourage that.

There is a certain amount of leverage involved when a State, or group of States, provide extra coverage. And if the coverage is good, we think there ought to be some mechanism whereby this particular bit of coverage might be incorporated in the other plan.

Finally, Mr. Chairman, we think this particular set of circumstances also points up the necessity of a complete review of the entire Government health insurance program. The contracts insofar as we are aware have never really been reviewed by the Congress. We think perhaps the Congress should review these contracts and determine whether or not this is exactly what is necessary for Federal employees.

We think that perhaps an indepth review would indicate that there are many changes that can and should be made. We also think, Mr. Chairman, that it is time to consider, or at least to initiate a feasibility study of a Government health insurance program. We are convinced that a Government health insurance program would result in substantial savings and would reduce premiums substantially.

I would point out just one area where we think it would do so. And that is at the present time, the health insurance carriers are entitled to a so-called 1-percent risk factor. Essentially, this is a cost-plus contract. We think this could be eliminated and would be eliminated if the Government ran the program. By eliminating this 1-percent risk factor, premiums should go down or at least should be stabilized.

I won't belabor it any longer, Mr. Chairman, but we would ask that the committee consider that possibility. And that will conclude my remarks.

Mr. HARRIS. Very good. Thank you.

I have one question. If you speak of the Government in the sense of setting up a program of self-insurance, would you view that as an exclusive program?

Mr. TILTON. Well, I don't think it would necessarily have to be an exclusive type of program. But I believe the benefits would be so obvious to most employees that it would rapidly become an exclusive type of program.

Mr. HARRIS. In other words, my specific question is: if in fact the Government developed a program like that, does it make sense to present it to the employees with the option of taking on a private program if they wanted to?

Mr. TILTON. I think, Mr. Chairman, this would be a policy decision Congress would have to make. I would see no problem, no conflict, with an employee being permitted to choose between one or the other. The only difficulty that I would foresee would be that if you had many, many programs, the efficiency that would be gained by having one single program, the efficiency of operation would be lost. And that would be the only difficulty that I would see and perhaps would make it again more expensive in the long run.

Mr. HARRIS. Obviously, one program would make it a lot simpler in figuring out what the Federal share and employees' share is. It would not be as complicated as it is now.

Mr. TILTON. Surely, Mr. Chairman, it would be a very easy and simple program as far as we see now. We think there are existing mechanisms that could be adopted for this purpose.

To name two, the Social Security Administration already has a nationwide network of offices and local offices as does the Office of Workmen's Compensation. We think that either one or the other of these existing organizations could be expanded to cover a Government health insurance program.

Mr. HARRIS. I note here on page 3 of the testimony submitted by Dr. Wolkomir, you state that your organization does not believe that the health contracts negotiated under the FEHB programs are economical or fair. Do you have any statistics or comparisons available on which you base this assumption?

Mr. TILTON. I am not certain we have hard statistics. We have over the years received many, many complaints about the coverage. We have received many, many complaints where employees thought they were covered and later learned to their economic detriment that they were not covered. And we think in terms of economics, the premiums are high, Mr. Chairman, and they are going up all the time. And we think that fact speaks for itself.

Mr. HARRIS. Yes, of course. We have gone through the premium thing, and I agree with you on that point. When we get to investigating it, though, we find medical care has gone up also; that the premiums are not necessarily disproportionate to the cost of medical care.

Mr. TILTON. That may well be the case, Mr. Chairman. In which case, I would again suggest it is all the more reason to provide a mechanism to hold it down. And we think the Government health insurance program would do so.

Mr. HARRIS. What kind of record do we have of the Government programs being effective in this regard? How about medicare and medicaid? Have they met with uniform accolade as to the manner in which they have been administered?

Mr. TILTON. No; they have not, Mr. Chairman. But I believe that—and I must confess to you now—I sometimes confuse medicare and medicaid, the terms are so similar. But medicare, I believe has been a largely efficiently-run program. Medicaid, if my terminology is correct, is primarily the welfare one whereas medicare is the social security side.

Medicaid, I believe, has had some problems. I also believe that there are private carriers associated with medicaid.

On the other hand, I think the Government has run other insurance programs. And although this is not completely in point, I would mention just one that I am familiar with. And that is Government indemnity bonds. And it is my recollection that when Mr. Connally was Secretary of the Treasury, he determined that it would be cheaper for the Government to be a self-insurer than it was to obtain this type of insurance from private carriers.

Now, Mr. Connally, I am sure you will agree, is not willing to give away the Government's money for anything, nor I think is he the type of a person that would establish a new program.

Mr. HARRIS. I am not sure that is necessarily so. If in fact your theory is right with regard to Government employees, why not just eliminate all the confusion, just have a nationwide medical care insurance program?

Mr. TILTON. Perhaps, Mr. Chairman, that would be the ultimate answer to health insurance programs. And this might well be a good test program. It is on a relatively small number of employees, some 2.5 million. I would think that this would be an excellent way to find out whether or not national health insurance is a good idea.

Mr. HARRIS. The organization doesn't have any position on an over-all nationwide medical insurance program?

Mr. TILTON. Well, we have, of course, been concerned primarily with Federal employees. But if such a program proved—our members are also taxpayers—economically feasible and provided a substantial savings to the taxpayers as a whole, I would think that we would support such a program.

Mr. HARRIS. Thank you very much.

Counsel, do you have questions?

Mr. McCLUSKEY. Yes. You stated in your testimony that on the basis of the risk charge, there would be a specific savings if the Government were to be self-insured. Are you aware that risk charge is less than 1 percent right now?

Mr. TILTON. I believe it is precisely 1 percent. But 1 percent on a—

Mr. McCLUSKEY. It is less than 1 percent.

Mr. TILTON. Still, when one multiplies that times many, many millions of dollars, it is a substantial sum of money. I think the 1 percent risk factor is in a sense inflationary.

Moreover, there is no incentive to save money. It is essentially a cost plus contract. And when you say 1 percent in addition to everything, there is no incentive to save.

Mr. McCLUSKEY. Concerning your statement that your members are also taxpayers, of course, you are aware that if the Government becomes a self-insurer, the Government takes over all costs and that becomes part of the overall budget, and taxes go up again?

Mr. TILTON. They may not.

Mr. McCLUSKEY. The chances are that they will.

Mr. TILTON. They may not. This was in reference to the national health care program, and I just don't think the jury is in on the national health care idea. And this is why I was very tentative about what we would do.

I believe that this would be useful pilot project. It would determine how feasible it was. It would determine whether or not the quality of health care did in fact increase and whether or not premiums did in fact stabilize or perhaps decrease which would in effect be a—if it stabilized, that would be a decrease.

Mr. McCLUSKEY. But I don't understand what you are saying about premiums. If the Government becomes a self-insurer, the Government will take over the total cost.

Mr. TILTON. This is what we would prefer. On the other hand, other questions, other persons, have suggested it might be a contributory plan. We would prefer to see the Government pay all of the premiums. But if it were a contributory plan as other people have suggested, then that would stabilize the premiums.

Mr. McCLUSKEY. Are you familiar with any other multi-State contracts?

Mr. TILTON. No; I don't believe I am. You mean besides insurance?

Mr. McCLUSKEY. Besides the FEHB program. In other words, are you familiar with any companies that have multi-State health insurance contracts?

Mr. TILTON. We once looked at that, and it is my recollection that some of the larger companies do have such contracts. I believe that United States Steel still has one. But this is based on my recollection so I could not say that I was familiar with any other multi-State health insurance contract.

Mr. McCLUSKEY. The point of the question is I am just wondering if there are indeed other companies or places that have these multi-State insurance contracts, whether or not they have to follow these conflicts in each State, running into the same problems we are.

Mr. TILTON. I am sure they would. In that instance, they would have less of an excuse to avoid following the State law than would the Federal Government. At least in this case of FEHB contracts, one can say there is a certain preemption because it is the Federal Government.

I couldn't imagine a private company using the same argument. They simply wouldn't have the legal basis to make such an argument. And in view of the traditional strong interest that a State has in preserving the health of the citizens, I don't think any private company could make that argument.

Mr. McCLUSKEY. And the argument would be in a legal sense that the contract was made in State "a" and the laws of that State would pertain to it.

Mr. TILTON. Well, except for the very strong interest that a State has in the health of its citizens. You present an interesting question,

but I don't think it would work. I think that a multi-State insurance contract entered into by a private company would of necessity have to follow the laws of the State where it was enforced.

Mr. McCLUSKEY. Thank you, Mr. Chairman.

Mr. HARRIS. Thank you very much for your testimony. There are no additional witnesses today. We will adjourn subject to the call of the Chair.

[Whereupon, at 9:35 a.m., the meeting was adjourned, subject to the call of the Chair.]

[The letters which follow were ordered placed in the record:]



NATIONAL TREASURY EMPLOYEES UNION

Suite 1101 — 1730 K Street, N. W.
Washington, D.C. 20006 (202) 785-4411

April 6, 1976

The Honorable Richard C. White
Chairman, Subcommittee on Retirement
and Employee Benefits
Suite 2423, Rayburn House Office Building
Washington, D. C. 20510

Dear Chairman White:

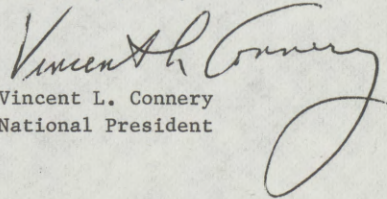
The National Treasury Employees Union supports H.R. 12114 to establish uniformity in Federal employee health benefits and coverage by preempting state and local laws which are inconsistent with the contracts negotiated between the carriers and the Civil Service Commission.

Under present circumstances, some states have enacted laws requiring insurance plans to contain benefits not included in the Federal contract. As a result, all Federal employees are assessed higher premiums in order to provide extra benefits to a few who happen to reside in these states. This is caused by the carrier increasing costs to the Federal plans in order to cover these state mandated services.

H.R. 12114, by exempting the carriers from paying for these special services in a few states, will lower premiums for all Federal employees by an average of about 5%. In light of the exorbitant premiums currently paid by Federal employees for health insurance, we agree that this is a step in the right direction.

We commend you for your continuing concern for Federal employees' rights and benefits as evidenced by your sponsorship of many measures to improve employment conditions for the Federal work force.

Sincerely yours,


Vincent L. Connery
National President

VLC:b11

**Blue Cross
Blue Shield**
Federal Employee Program



1800 M Street, N.W.
Washington, D.C. 20036
202/785-7950

19 March 1976

Honorable Richard C. White, Chairman
Subcommittee on Retirement and
Employee Benefits
Post Office and Civil Service Committee
U.S. House of Representatives
Washington, D.C. 20515

Re: Federal Employees Health Benefits Act
Preemption of State Laws Affecting Benefits and Coverage

Dear Mr. Chairman:

This replies to your request that the Blue Cross and Blue Shield organizations comment on H.R. 12114. H.R. 12114, which you introduced, would preempt state or local laws or regulations insofar as such laws affect the payment, nature, or extent of benefits or coverage under a plan established pursuant to the Federal Employees Health Benefits Act (FEHBA).

It is our understanding that the Federal government, acting as an employer, wishes to assure that uniformity of health benefits for its employees will be maintained, and that it is to this end that the Bill is addressed.

Although the laws of several states conflict with the benefits of the Government-wide Service Benefit Plan offered under Blue Cross and Blue Shield programs, the present scope of this conflict is minor in relation to the total package of benefits being offered. However, the Blue Cross and Blue Shield organizations would not object if Congress were to enact a statute preempting state law as it relates to the health benefits of Federal employees. If such legislation were to be enacted, we have no changes to suggest with respect to H.R. 12114.

We appreciate very much being given the opportunity to offer our comments on your Bill.

Sincerely,

Robert J. Laur
Vice President

RJL/jg

NATIONAL ASSOCIATION OF LETTER CARRIERS

LETTER CARRIERS' BUILDING
100 INDIANA AVENUE, N.W.
WASHINGTON, D. C. 20001

JAMES H. RADEMACHER
PRESIDENT

March 18, 1976

AREA CODE 202
EXECUTIVE 3-4695

Honorable Richard C. White
Chairman, Subcommittee on
Retirement and Insurance
Post Office and Civil Service
Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to express the views of the National Association of Letter Carriers on your bill H.R. 12114.

I would like first to establish our credentials to comment on the bill. The NALC Health Benefit Plan, which is sponsored by the National Association of Letter Carriers for its members, has participated in the Federal Employees Health Benefits Program since the inception of the Program in 1960. We have nearly 160,000 letter carriers and retired letter carriers enrolled in our plan. Together with their family members, we insure about 600,000 people. And, it is important to keep in mind for purposes of H.R. 12114, that these people are located in each of the 50 states, Puerto Rico, and the Virgin Islands.

We like to think that we know and understand the health insurance business. This is evidenced by the fact that we have as few or fewer complaints than any similar plan in the Federal Employee Program and also a lower operating cost than any other plan. (Our operating costs amount to only 4.1% of premium compared to about 5.1% for the next lowest plan and over 12% for the highest.)

I would next like to commend the Chairman for recognizing the problem that H.R. 12114 is intended to solve, and for introducing this bill because the problem is a most serious one and keeps growing worse as time goes on.

Honorable Richard C. White
March 18, 1976
Page Two

Briefly stated, the problem is that there is a multiplicity of state laws, nearly all different, which mandate health benefit plans, under varying conditions, to provide certain benefits or observe certain procedures in paying claims or providing coverage. Additional such laws are pending in different state legislatures.

I am not detailing these laws here because they are too numerous and varied. However, only a partial listing of the subjects of these laws would include: coverage of newborn children, alcoholism, tax supported institutions, mental illness, benefits for various practitioners of the healing arts, coverage of handicapped children, conversion rights, and even the content of claim forms a plan must use.

We do not question the good intentions of the various state legislators in enacting these laws. Our main problem is their proliferation, and the fact that hardly any two of them are the same. In a plan such as ours, which insures people throughout the country and is supposed to provide the same benefits for everyone at the same premium, it is impossible to comply with all the state laws except at great expense, which would significantly and needlessly increase premiums. Compliance would also result in inequities against people who happen to live in a state which does not mandate a benefit for a particular service.

Another problem is that some of the state laws contravene the Civil Service Commission's regulations. For example, the regulations require an employee to convert to an individual contract no later than 31 days after employment ends. The State of Minnesota, for one, allows six months for the exercise of the conversion right---and it requires the employer to collect premiums during this period, which the Government will not do.

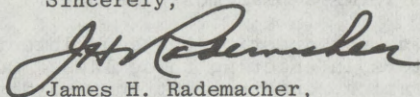
We are of the considered opinion that the Federal Employees Health Benefit law is, and always has been, paramount to state laws and we have been operating accordingly. However, the Civil Service Commission has neither agreed nor disagreed with us on a formal basis. Their official position since about 1963 has been that they neither interpret nor enforce state laws. The question, to my knowledge, has not been tested in court but we have yet to see a notice from a state insurance commissioner to the effect that we are in violation of a state law.

Honorable Richard C. White
March 18, 1976
Page Three

Meanwhile, state laws are proliferating and the contention that benefits should be paid in accordance with state law, more and more, is becoming a source of complaint. It, therefore, most urgently needs to be resolved. In my opinion, H.R. 12114, if enacted, would resolve the matter as it should be, by simply saying that the provisions of our contract with the Civil Service Commission supersede and preempt any state law or regulation.

Therefore, on behalf of the National Association of Letter Carriers, I urge the Committee to promptly and favorably report on this bill and, further, that it be enacted.

Sincerely,

A handwritten signature in dark ink, appearing to read "J. H. Rademacher", written in a cursive style.

James H. Rademacher,
President

JHR:clg

94TH CONGRESS
2D SESSION

H. R. 12114

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 25, 1976

Mr. WHITE introduced the following bill; which was referred to the Committee on Post Office and Civil Service

A BILL

To amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

That section 8902 of title 5, United States Code, relating to contracts for Federal employee health benefits plans, is amended by adding at the end thereof the following new subsection:

“(1) The provisions of any contract under this chapter which relate to the payment, nature, or extent of benefits or coverage shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.”.

UNITED STATES CIVIL SERVICE COMMISSION

WASHINGTON, D.C. 20415

March 22, 1976

Honorable David N. Henderson
Chairman, Committee on Post Office
and Civil Service
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in further reply to your request for the Commission's views on H.R. 12114, a bill "To amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts."

H.R. 12114 would, in effect, exempt the Federal Employees Health Benefits (FEHB) Program from any State or local law or regulation to the extent that such law or regulation conflicted with the provisions of the FEHB contract. This would statutorily establish uniformity of benefits and coverage under the FEHB Program and the Commission strongly urges favorable consideration of the bill.

The Federal Employees Health Benefits Act, now codified in chapter 89 of title 5, United States Code, gives the Commission sole authority to negotiate contracts with participating carriers, and to prescribe regulations to implement its provisions. However, the FEHB law contains no clear statement which would authorize the Commission to prescribe regulations restricting the application of state laws in relation to the Commission's health benefits contracts.

All states regulate the insurance business in various (and varying) ways. Apparently, in the early years of the FEHB Program, FEHB plans were either in compliance with these laws, or the laws excluded FEHB plans, or the states elected not to enforce laws that conflicted with FEHB plans. Whatever the reason, state laws offered few if any problems for our program.

In the past several years, however, more and more states have legislated the kinds of benefits and medical practitioners that carriers doing business in these states must cover. This presents a very real danger to the uniformity of benefits under the FEHB program. For example, the Aetna Life and Casualty (carrier of the Governmentwide Indemnity Benefit Plan) is currently being compelled to pay for the services of chiropractors in several states, even though our contract with Aetna does not recognize these practitioners as covered providers. If they refused to comply they would lose their license to provide health insurance in those states and would no longer be eligible as the Indemnity Benefit carrier under the FEHB Program, since the law (5 U.S.C. 8902(b)) requires them to be licensed in all 50 states and the District of Columbia.

Aetna contended that such state laws are preempted by the FEHB Act, and asked the Commission's Office of General Counsel to concur in their position that the McCarran-Ferguson Act establishes the preemption inasmuch as McCarran-Ferguson recognizes the authority of the states to retain the power to regulate the business of insurance, except where an Act of Congress (i.e., 5 U.S.C. chapter 89) "specifically relates to the business of insurance." However, the General Counsel's response to Aetna noted that the FEHB Act, although it authorizes the Commission to enter into contracts with insurers, does not provide that the Commission actually conducts insurance business. They therefore found no legal merit in Aetna's position but, instead, found that the states could indeed regulate our plans.

As a result, numerous states, including some which have previously acknowledged that their laws do not apply to our contracts, are more aggressively pursuing the preemption problem. States are enacting insurance laws affecting not only specific types of care, extent of benefits and specific types of providers, but also family members covered, age limits for family members, extension of coverage, and conversion contracts. Additionally, numerous state laws are being made extra-territorial to overcome our carriers' argument that our contracts are made in the District of Columbia and not in the state.

One of the most beneficial features of our FEHB plans is the requirement that they provide the same uniform benefits for the same premium for all enrollees in a plan. This can no longer be enforced if carriers are compelled to pay extra-contractual benefits in some of the states in compliance with state or local laws.

Presumably, the states have (and now seem to want to exercise) the authority to determine what benefits will or will not be paid, who is a covered medical practitioner, and who is an eligible family member. It is imperative that some action be taken to deal with what is becoming a serious problem. If nothing is done, it is logical to assume that the states rather than the Federal Government will become the final arbiters of what is and is not covered by the FEHB Program.

The Commission has studied various possible solutions to this problem. It is our belief that legislation such as H.R. 12114 preempting the FEHB Program from state or local law offers the only permanent solution. Additionally this appears to be the only solution which would not compromise the principle of uniform benefits for all enrollees in a plan, and which would not result in additional cost to the Government.

For these reasons the Commission strongly urges enactment of H.R. 12114.

The Office of Management and Budget advises that from the standpoint of the Administration's program there is no objection to the submission of this report.

By direction of the Commission:

Sincerely yours,

Georgiana Sheldon
ACTING Chairman

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

MAR 23 1976

Honorable David N. Henderson
Chairman, Committee on Post Office
and Civil Service
House of Representatives
Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

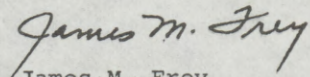
This is in reply to the Committee's request for the views of this Office on H.R. 12114, "To amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts."

The purpose of this bill is to exempt the Federal Employees Health Benefits (FEHB) program from State or local laws or regulations to the extent they conflict with the provisions of an FEHB contract, in order to ensure that benefits and coverage under the program will be uniform.

In its report and testimony, the Civil Service Commission states a number of reasons for supporting enactment of this bill.

We concur in the views expressed by the Civil Service Commission and, accordingly, recommend enactment of H.R. 12114.

Sincerely,


James M. Frey
Assistant Director for
Legislative Reference

STATEMENT OF THE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
ON H.R. 12114

SUBMITTED TO
THE SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS
OF THE COMMITTEE ON POST OFFICE AND CIVIL SERVICE

BY

DICK L. ROTTMAN
INSURANCE COMMISSIONER OF THE STATE OF NEVADA
AND
PRESIDENT OF THE NAIC

and

LESTER L. RAWLS
INSURANCE COMMISSIONER OF THE STATE OF OREGON
AND
VICE PRESIDENT AND CHAIRMAN OF THE EXECUTIVE COMMITTEE
OF THE NAIC

April 2, 1976

The National Association of Insurance Commissioners (NAIC) is pleased to provide this statement to the House Subcommittee on Retirement and Employee Benefits of the Committee on Post Office and Civil Service regarding the proposed preemption of state laws for Federal Employee Health Benefit programs. This statement is made on behalf of the NAIC which is a voluntary organization with membership consisting of the chief insurance regulatory officials in the fifty states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The NAIC has been in existence since 1871 in order to integrate the regulatory activities of the states and to prevent regulatory conflict which would hamper the national operation of the insurance business.

A significant and fundamental strength of coordinated state regulation is its ability to bring to bear the efforts, talents, and drives of 50 state insurance departments and the U.S. insular possessions on the various insurance regulatory problems. This fosters independent innovation and flexibility in the development and application of regulatory techniques. At the same time, the NAIC recognizes that the insurance business has nationwide characteristics. If each state moved in divergent ways, it would be difficult for the insurance industry to properly function. Thus, it is essential that there be a compromise between necessary uniformity and the innovative ability of the states to flexibly act in response to their own particular problems. The NAIC has proved to be an effective forum for dealing with the regulatory concerns shared among the states.

1. H.R. 12114

It is our understanding that H.R. 12114 was drafted upon the recommendation of the Comptroller General of the United States and GAO to clarify whether state requirements can alter the terms of contracts negotiated under the Federal Employees Health Benefits Act. The effect of the bill would be to preempt any state law relating to the

payment, nature or extent of benefits or coverage which is inconsistent with the contractual provisions of Federal employee health benefit programs. It is the position of the NAIC that such legislation is both unnecessary and undesirable.

2. Overview of State Insurance Regulation

Federal jurisdiction over insurance regulation was affirmed in 1944 with the Supreme Court's decision in *U.S. v. Southeastern Underwriters Association* (322 U.S. 533) that the insurance business is conducted in interstate commerce. The insurance business was not, however, subject to any new and detailed federal regulation because Congress returned to the states the authority to continue almost exclusive jurisdiction with the enactment of the McCarran Ferguson Act in 1945.

In the interval of time since the McCarran Act, the states have continued the orderly development of state regulation. But state regulation of the insurance business is not an end in and of itself. Its justification rests upon the protection which it affords the insurance consuming public, consistent with other goals of public policy. The state-by-state system of regulation is far from perfect, but the history of federal regulatory agencies reveals a lack of perfection at that level as well.

The scope of state regulation is broad and detailed. Insurers and agents are subject to licensing requirements. Insurers must file periodic reports in each state in which they do business. State examinations are conducted to review the insurer's financial condition and claims processing. The states set standards for policy content and approval, thereby enabling insurance commissioners to eliminate a source of misrepresentation or other unfair practices in advance. Rates are reviewed or controlled, and specifically in the health area, premiums must be reasonable in relation to benefits. Insurers' marketing practices are also controlled by advertising regulations, laws governing the

qualifications of agents and brokers, and the uniformly enacted NAIC Unfair Trade Practices Act. In addition, the states have broad enforcement powers including criminal and civil penalties, cease and desist orders, fines, etc.

The effect of H.R. 12114 would be to carve out a large group of policyholders or beneficiaries from the state protections and controls over policies and their contents. It would preempt the laws of the several states that are alleged to pose conflict problems and the laws of the state where the master contract is delivered. This would eliminate not only the alleged conflicts but also the protections available in the state that would otherwise have control over the policies. The Report of the Comptroller General of the United States on Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefit Carriers, dated October 17, 1975, reveals that there are 9 million program participants covered under the federal employee health plans.

Before Congress exempts this class of consumers from the protections of state insurance regulation, it should consider the case for maintaining state regulation.

3. Health Insurance Policy Provisions

Insurance policies issued to individuals and the certificates or information materials provided to group members under a group policy may be difficult for the layman to understand. For this reason, states regulate policy terms. In 1950, the NAIC developed and adopted the Uniform Individual Accident and Sickness Policy Provisions Law. Every state has enacted this uniform law. In addition, in 1973 the NAIC adopted a Minimum Standards Act for Individual Policies setting categories of coverage to facilitate comparisons, specify benefits and compel disclosure.

Regulation of group policy provisions and benefits has typically not been as stringent as individual policies because of greater compe-

tition, greater consumer awareness, and a more nearly equal position of bargaining strength. Nevertheless, the broad scope of state insurance regulation impacts on group policies, and certain areas have been singled out in the past for specific and uniform protection.

In 1972, the NAIC adopted the Group Coverage Discontinuance and Replacement Regulation which details the liability of carriers on claims arising during discontinuance of group coverage, appropriate notice to group members, extension of benefits, and replacement. Further, in late 1975, the NAIC adopted a Group Health Insurance Mandatory Conversion Privilege Model Act. This act provides detailed requirements for conversion coverage whenever group coverage terminates for any reason. Finally, some states have developed other specific requirements for group policy provisions in accordance with the perceived public need. Indeed, insurance regulation is not static but rather continues to evolve in response to identified problem areas and public needs. Protection of the public interest through state-by-state regulation and through the coordinated effort of the NAIC should not be foreclosed capriciously by the federal government, either for the large group of federal employees or the public at large.

4. Multi-state Group Contracts

The problems often associated with mass-marked health insurance -- such as deceptive advertising; premiums which are unreasonable in relation to benefits; unfair claim or settlement practices -- do not generally present the same problems in bona fide group insurance coverages as with individual policies. The general rule has consequently evolved that conventional group insurance is regulated by one state -- the state in which the master policy is delivered.

However, each state is charged with identifying the public need and providing the relevant policyholder protections. With respect to multi-state group policies, in fact, several states do impose specific

requirements for coverage regardless of where the master contract is located. Groups formed primarily for the purpose of obtaining group insurance and trustee health benefit plans have presented certain problems to the states in adequately protecting participants. The resulting lack of uniformity has been challenged by the Comptroller General of the United States and others. But absolute uniformity for itself is a questionable goal. The health insurance business has numerous logical ties to the geographic, economic and political structures of the states. For example, risk analysis, coverage, and rating are related to local conditions and needs. Marketing methods, company size, structure and orientation have evolved from and exist within state and regional circumstances. While there are some matters where uniformity is helpful, in some areas this is not the case.

Diversity is advantageous where local conditions vary or experimentation is desirable. For example, if a particular state has a relatively high concentration of osteopaths or chiropractors, as opposed to medical doctors, it probably reflects the reliance of the population on these practitioners for health maintenance. It may be perfectly appropriate for this state to require standard health insurance coverage for such care where another state would not.

However, this is not to say that the NAIC ignores the desirability of uniform regulation of multi-state group contracts and the ability of the group sponsors to provide uniform benefit packages. As a matter of fact, the NAIC is currently reviewing the problem in its Task Force on Trustee Group Insurance. A balance between necessary uniformity and local problems and needs is obviously desirable. Congress should not lightly tamper with the ongoing process of state health insurance regulation.

5. Considerations for Rejecting H.R. 12114

A. Advantages of State Regulation

The foremost reason for rejecting the proposal to preempt state re-

gulation of federal employee health insurance plans has already been alluded to. With the enactment of the McCarran Act, Congress recognized that it was in the public interest to preserve state regulation. Local public policy is advantageously protected by state regulation.

The history of federal and state government demonstrates that government cannot always be relied upon to perform in the public interest. An important guardian of such interest is the dispersion of power between the state and federal governments, enabling each to exercise a discipline over the other. If problems can be dealt with adequately at the state level, they should be handled there rather than in Washington.

The report of the U.S. Comptroller General on conflicts between state law and federal employee plans does not detail specific costs or savings that would result from compliance with varying state requirements on federal group coverages. Emphasized in the report is the fact of increased state activity that might generate future problems for the federal plans. The concern of the states with developing public needs is not a sign of arbitrary state exercise of power. Rather, these state activities signify a concrete virtue of state regulation. The pluralism, experimentation, and vitality of regulation evident in the several states provides a fertile environment for innovation and creative leadership.

The supposed compounded future problems for the federal employee benefit plans are not certain to materialize. As already indicated, the desirability of uniformity in multi-state group contracts is an active subject of interest for the NAIC. Congress should not invade this area of insurance regulation that has traditionally been preserved for the states absent clear and compelling reasons.

B. Unfair Discrimination

The federal government is not the only multi-state employer with master health insurance policies covering employees in several states.

In fact, there is no apparent reason why federal employee health insurance contracts should be subject to different state insurance requirements than other group employee contracts.

Absent distinguishing characteristics of federal employees or federal health insurance plans, Congress should respect the ability of the states to regulate insurance in the best interests of the public at large, including federal employees.

C. False Expectations Among Federal Employees

Not only would H.R. 12114 set the stage for inapplicability of state laws to federal employees health plans, eliminating relevant, state perceived protections, but it would also provide the potential for misunderstanding among federal employees. Employees located in a state which undertakes progressive reform of health insurance practices may be misled into believing they will be the beneficiaries of new state mandated coverages when, in fact, Congress has rejected this result in advance.

D. Inaccurate Assumptions Underlying the Proposed Preemption

The report of the Comptroller General on conflicts between state law and the federal employee health plans appears to endorse the desirability of uniform benefits and premiums for federal employee plans.

Indeed, one of the primary conclusions of the report is that the

"conflicting requirements (of the states) can be expected to result in -- increased premium costs to both the Government and FEHB plan enrollees and -- a lack of uniformity of benefits for all enrollees in the same plan, which results in enrollees in some states paying a premium based, in part, on the cost of benefits provided only to enrollees in other states."

The first point concerning increased premium costs is not supported in the Comptroller General's report. The letter of transmittal to the Subcommittee on Retirement and Employee Benefits in fact acknowledges that there is a lack of cost data with which increased costs can be determined. The increased cost problem is merely an alleged possibility rather than a present fact or reliable prediction.

Nevertheless, as already expressed, the NAIC is mindful of the jurisdictional concerns associated with the operation of multi-state employee health insurance plans and is reviewing this matter wholly apart from H.R. 12114 and the CAO report. Most states do not impose additional benefit requirements on coverages extended from a master employee health insurance contract delivered in another state. Even in those states that do impose such requirements, the requirements are a result of deliberate legislative determinations that such coverage is in the best interests of the public at large. If uniform or single state regulation of group employee contracts is demonstrated to be appropriate, the NAIC is a proven, effective mechanism for coordinating state insurance regulation.

The second part of the Comptroller General's conclusion appears to challenge the varying state requirements that would, in effect, create a subsidy for enrollees in states with broader state mandated coverages by enrollees in states without the additional benefits. The alleged result is an unfair lack of uniform benefits and premiums.

However, the point made is superficial and simplistic. First of all, the availability of four types of health plans for federal employees defies uniformity itself (i.e. service benefit plans, indemnity benefit plans, employee organization plans, and comprehensive medical plans). Furthermore, Comptroller General's report notes that

"the benefits and premium costs may differ among various plans -- and between various options available under the same plan -- (but) all those enrolled under a particular plan and option are entitled to receive the same benefits and pay the same premiums."

Clearly, there is no true uniformity and, in any event, there is a subsidy within plans if premiums are "the same" on a countrywide basis. The subsidy exists simply because of the great variation in the cost of medical treatment throughout the United States. Charges are not uniform for hospital rooms, treatments and procedures, and lengths of stay for the same surgical procedure. Likewise, health insurance is more expensive in some states than in others. Recognition of these facts should underscore both the point that complete and equitable uniformity is difficult if not

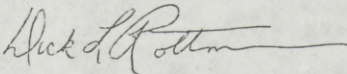
impossible to achieve and that uniformity for the sake of uniformity is a questionable objective.

E. Notice

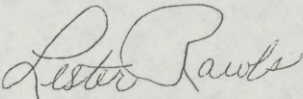
While the Federal Civil Service Commission, GAO, or the U.S. Comptroller General may have brought the problems of conflicts of state laws with uniform benefits and provisions to the attention of individual states, no notice of these concerns has ever been expressed directly to the NAIC nor, upon request, did the GAO provide the NAIC with a copy of the Comptroller General's report outlining its concerns. As already expressed, the NAIC provides a flexible means for the states to encourage uniformity while at the same time leaving each state with the authority to act in a manner best suited to its own particular problems.

6. Conclusion

Coordinated state regulation of insurance has existed for over a century. The states have proved themselves competent and responsive to the regulatory needs of the evolving interstate insurance business. Congress has recognized the desirability and public interest in maintaining state insurance regulation. Absent compelling need for federal reform, Congress should refrain from altering the on-going process of state insurance regulation in both limited circumstances and broad areas of such regulation. We are not aware of the full details nor have we been afforded an opportunity to be responsive to the alleged compelling need for enactment of H.R. 12114.



Dick L. Rottman
President



Lester L. Rawls
Chairman of the Executive Committee

151 Farmington Avenue
Hartford, Connecticut 06156



Malcolm McIntyre
Director
Government Relations
Group Division

April 13, 1976

Mr. Ronald P. McCluskey
Director and Counsel
Subcommittee on Retirement and Employee Benefits
of the Committee on Post Office and Civil Service
U. S. House of Representatives
B-345-D Rayburn House Office Building
Washington, D. C. 20515

Dear Mr. McCluskey:

GOVERNMENT-WIDE INDEMNITY BENEFIT PLAN

Subsequent to the March 23 hearing on H.R. 12114, you asked Mr. Peter J. Connell how much we have drawn from the Contin-
gency Reserve to pay claims for services rendered by
practitioners as mandated by a state law instead of under
the provisions of our Plan.

While the Subcommittee is welcome to this information, it should appreciate that this data is not at all indicative of what the ultimate cost would be. This is so both because only one state, Nevada, has as yet definitely decided to apply extraterritoriality to FEHBA and because no notice has been given federal employees that benefits are available, temporarily at least, in that one state.

The amount of such benefits paid in Nevada between July 1975 and March 1976 was \$5,105.73.

Sincerely,

A handwritten signature in dark ink, appearing to read "Malcolm McIntyre". The signature is written in a cursive, flowing style.

Malcolm McIntyre
Director
Group Government Relations

MM/cb



151 Farmington Avenue
Hartford, Connecticut 06156

D. W. Pettengill
Vice President
Group Division

April 9, 1976

The Honorable Richard C. White
Chairman
Subcommittee on Retirement and Employee Benefits
of the Committee on Post Office and Civil Service
United States House of Representatives
B-345-D Rayburn House Office Building
Washington, D. C. 20515

Dear Congressman White:

Thank you for sending Mr. Peter J. Connell, our Washington Counsel, a copy of the NAIC's April 2 testimony on H.R. 12114 and for giving us an opportunity to comment thereon.

I notice that the NAIC's testimony argues that H.R. 12114 would completely usurp state regulation of insurance as far as federal employees and their dependents are concerned. Nowhere, however, do they cite the specific wording of the bill that would do this. Indeed, the very second sentence of their testimony contradicts this argument by admitting that H.R. 12114 relates only "to the payment, nature or extent of benefits or coverage."

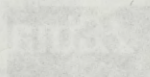
As I mentioned in response to a question from Mr. Harris at the March 23 hearing of your Subcommittee, "...it (H.R. 12114) doesn't conflict in any way with a state's right to regulate reserves that a carrier is required to hold in order to be a licensed carrier in that state. It doesn't infringe upon a state's right to assess premium taxes on a carrier or other types of taxes. It limits itself solely to who is eligible for this federal plan and what benefits are provided."

The Aetna supports state regulation of the insurance business and endeavors to assist the NAIC in its efforts to improve the quality of such regulation. Actually, the NAIC has already done what it could with respect to this problem of conflicting state laws and regulations. NAIC has by long tradition recommended that the state in which a group contract is issued be the one that shall regulate the eligibility and benefit provisions of that contract. As I mentioned in my March 23 testimony, it is only recently that a few states, including Mr. Rottman's own state of Nevada, have broken with this sound and long-established practice. Thus, there would seem to be little hope that the NAIC can come up with any workable alternative that all states would accept. Hence, the urgent need for enactment of H.R. 12114.

Again, our thanks for this opportunity to comment on the NAIC's testimony. If you have any questions concerning our comments, please telephone either Mr. Connell or myself.

Sincerely,

Daniel W. Pettengill
Vice President, Group Division



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