

WAIVER OF 75/25 MEDICAID ENROLLMENT RULE FOR  
CERTAIN MANAGED CARE ORGANIZATIONS

AUGUST 2, 1996.—Committed to the Committee of the Whole House on the State  
of the Union and ordered to be printed

Mr. BLILEY, from the Committee on Commerce,  
submitted the following

R E P O R T

[To accompany H.R. 3871]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 3871) to waive temporarily the Medicaid enrollment composition rule for certain health maintenance organizations, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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PURPOSE AND SUMMARY

This measure extends three existing waivers to Section 1903(m)(2)(A)(ii) of the Social Security Act. Section 1903(m)(2)(A)(ii) requires that Medicaid beneficiaries constitute less than 75 percent of the membership of any prepaid health

maintenance organization. At present, a number of plans are operating under Federally-approved waivers of this section. Three of these plans—Health Partners of Philadelphia, Inc., Fidelis Health Plan of New York, and Managed Healthcare Systems of New York, Inc.—are granted extensions of the so-called “75–25” waiver by this measure.

#### BACKGROUND AND NEED FOR LEGISLATION

State experimentation with health maintenance organizations (HMOs) began shortly after the implementation of Medicaid. The origin of the 75/25 rule arose out of concerns relating to certain managed care companies. These concerns included inaccurate information dissemination to enrollees, restricted access to non-participating providers, inconsistent provision of benefits, and, in certain cases, financial instability of the enrolling plan.

Reports of these irregularities led to Congressional action that has spanned the last twenty years. The first Federal action addressing Medicaid HMO contracts came with the Health Maintenance Organization Amendments of 1976 (P.L. 94–46). This measure, the predecessor of the current 75–25 rule, limited the percentage of Medicaid and Medicare beneficiaries enrolled in risk contracts to 50 percent. An exception applied to Federally-funded centers and pre-1970 contractors. New contractors had up to three years to meet the requirement if they could show that they were making satisfactory progress towards compliance. The 1976 measure also limited new State prepaid initiatives to established organizations which could meet the Federal qualifications.

The 1976 measure had the unintended effect of sharply limiting managed care enrollment by Medicaid beneficiaries. As of 1981, scarcely more than 1 percent of the Medicaid population (281,926 beneficiaries) were enrolled in HMOs. Of that number, fully 85 percent were located in just four States: California, Maryland, Michigan, and New York.

In light of this experience, Congress again addressed managed care enrollment by Medicaid beneficiaries in the Omnibus Budget Reconciliation Act of 1981. Among the changes made by OBRA81 (P.L. 97–35) to Federal Medicaid HMO contracting rules were the following. The allowable percentage of Medicaid beneficiaries that could be enrolled in HMOs was increased to 75 percent from 50 percent. This permitted plans to tailor their services to Medicaid beneficiaries and the communities in which they reside. In addition, Medicaid contracts were no longer limited to Federally qualified HMOs, allowing States to determine the qualified status of plans if they demonstrated an ability to provide covered services and if they could protect beneficiaries from financial liability should the organization become insolvent.

Despite these advances, current Medicaid law creates significant obstacles for plans that focus on the needs of low-income communities. Although these plans have achieved notable success in enhancing the quality of care received by area Medicaid beneficiaries, they have been less successful in attracting commercial clients from outlying areas. The requirement that one-quarter of their enrolled population consist of such customers, therefore, often places them in the difficult position of having to choose between devoting

resources to their Medicaid-funded enrollees or to the expense of competing against broader-based firms for commercial clients.

In light of the burdens created by this situation, this measure extends the existing waivers of the "75-25" requirement of Section 1903(m)(2)(A)(ii) for three health plans. A description of these plans follows.

Health Partners of Philadelphia, Inc. is a not-for-profit voluntary health maintenance organization comprised of local teaching hospitals. It is independently licensed by the Commonwealth of Pennsylvania and fully accredited by the National Committee for Quality Assurance. It serves approximately 87,000 Medicaid recipients and 250 commercially-enrolled individuals in Philadelphia and the surrounding region. While Health Partners' chief focus is on primary care, health education, and prevention, it also provides transportation services, expanded vision and dental benefits, multi-lingual capability, 24-hour access to mental health and substance abuse treatment, and home visits for new and expectant mothers and fathers.

Fidelis Health Plan, operated by the Catholic Health Services Plan of Brooklyn and Queens, was established by the Catholic Medical Center which serves those two boroughs. The principal focus of the care provided by Fidelis to its 19,960 Medicaid recipients is primary and preventive care as well as health education. An enrollee selects his or her own primary care practitioner who serves as his or her personal provider and coordinates the primary and specialty care received through the plan.

Managed Healthcare Systems of New York, Inc., a minority-controlled managed care company founded in 1994, serves nearly 39,000 enrollees in Brooklyn and Queens. Managed Healthcare Systems' primary and preventive care and health education services are conducted through the use of mobile health vans, a school-based health center, an after-school Learning Center, newly established primary care clinics, and community outreach efforts for pregnancy, asthma, diabetes, sickle cell anemia, tuberculosis, and HIV/AIDS.

#### HEARINGS

The Committee on Commerce has not held hearings on this legislation.

#### COMMITTEE CONSIDERATION

On July 24, 1996, the Committee on Commerce met in open markup session and ordered H.R. 3871 reported to the House, without amendment, by a voice vote, a quorum being present.

#### ROLLCALL VOTES

Clause 2(1)(2)(B) of rule XI of the Rules of the House requires the Committee to list the recorded votes on the motion to report legislation and amendments thereto. There were no recorded votes taken in connection with ordering H.R. 3871 reported. An amendment by Mr. Upton to provide an additional waiver from the Medicare and Medicaid enrollment requirements for Comprehensive Health Services, Inc. was offered, and then withdrawn by unani-

mous consent. A motion by Mr. Bliley to order H.R. 3871 reported to the House, without amendment, was agreed to by a voice vote, a quorum being present.

#### COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this legislation.

#### COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

#### NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(1)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee states that H.R. 3871 would result in no new or increased budget authority or tax expenditures or revenues.

#### COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974.

#### CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974:

U.S. CONGRESS,  
CONGRESSIONAL BUDGET OFFICE,  
*Washington, DC, August 1, 1996.*

Hon. THOMAS J. BLILEY, Jr.,  
*Chairman, Committee on Commerce, House of Representatives,  
Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 3871, a bill to waive the Medicaid enrollment composition rule for certain health maintenance organizations, as ordered reported on July 24, 1996. CBO estimates that enactment of H.R. 3871 would not significantly increase or decrease federal spending. However, because the bill could affect direct spending, it would be subject to pay-as-you-go procedures under Section 252 of the Balanced Budget Amendment and Emergency Deficit Control Act of 1985.

The enrollment composition rule in Title XIX of the Social Security Act requires that no more than 75 percent of the enrollees of a Medicaid health maintenance organization (HMO) may be Medicaid or Medicare beneficiaries. H.R. 3871 would allow the following plans to waive the enrollment rule: Catholic Health Services Plan of Brooklyn and Queens, Inc. and Managed Healthcare Systems of

New York, Inc., through January 1, 1999; and Health Partners of Philadelphia, Inc. through December 31, 1999.

Without waivers of the enrollment rule, Medicaid beneficiaries would be required to enroll in alternate plans. We expect the cost of enrolling beneficiaries in such plans would not differ significantly from the costs of providing their care in the HMOs described above, however, because of competitive pressures and because plans in New York City are required to bid within a very small range of a state-promulgated community rate.

H.R. 3871 contains no intergovernmental or private sector mandates as defined in the Unfunded Mandates Reform Act of 1995 (P.L. 104-4). Because the States of New York and Pennsylvania pay about half of Medicaid costs, they would accrue about half of the savings or bear about half of the costs that would result from this bill. Any cost or savings would total less than \$500,000 annually.

If you wish further details on this estimate, we will be pleased to provide them. The Federal cost estimate was prepared by Jean Hearne, the State and local cost estimate by John Patterson, and the private sector mandate estimate by Linda Bilheimer.

Sincerely,

JUNE E. O'NEILL, *Director.*

#### INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that H.R. 3871 would have no inflationary impact.

#### ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

#### SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

##### *Section 1. Waiver of 75/25 Medicaid enrollment rule for certain managed care organizations*

This section waives the requirement of Section 1903(m)(2)(A)(ii) of the Social Security Act with respect to Catholic Health Services Plan of Brooklyn and Queens, Inc. (doing business as Fidelis Health Plan) and Managed Healthcare Systems of New York, Inc., for contract periods through January 1, 1999, and with respect to Health Partners of Philadelphia, Inc., for contract periods through December 31, 1999.

#### CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

This legislation does not amend any existing Federal statute.