

**THE REGULATORY
REQUIREMENTS
OF THE
HEALTH SECURITY ACT**

**VOLUME I: METHODOLOGY AND
FINDINGS**

MULTINATIONAL BUSINESS SERVICES, INC.

THE REGULATORY REQUIREMENTS OF THE HEALTH SECURITY ACT

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Volume I: Methodology and Findings

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EXECUTIVE SUMMARY

The Health Security Act ("HSA"), as proposed by the Clinton Administration, represents one of the most comprehensive policy initiatives in recent times. The HSA has the following objectives:

- to control rising health care spending through a combination of global budgets, price controls, and market incentives;
- to provide a standard package of health insurance benefits to virtually all Americans through the creation of a new entitlement program; and
- to finance this program through a combination of employer mandates, government maintenance-of-effort requirements, and increased out-of-pocket spending requirements for many Americans.

To more fully understand the implications of the HSA in terms of the new requirements it would create for government and the private sector, the Federation of American Health Systems commissioned Multinational Business Services, Inc. ("MBS") to undertake a study of the regulatory requirements of the HSA and the effect that the HSA would have on the size and structure of state and federal agencies.

Principal Findings

The HSA would substantially expand federal and state regulation of the health insurance and health care delivery systems, and would significantly increase the size of agencies at both levels of government. Specifically, the HSA would result in the following:

- Operation of the HSA would require an increase in state, federal, and health alliance payrolls of at least 98,146 full-time equivalent employees. In particular:
 - 11 percent, or 11,123, of the new employees would be required to staff new federal offices, such as the National Health Board, or expanded offices in existing agencies, including the Departments of Health and Human Services, Labor, Defense, and Veterans Affairs.

- 57 percent, or 55,623, of these new employees would be employed directly by the states, averaging 1,112 new employees per state; and
- 32 percent, or 31,400, additional employees would be required to staff the state-created and -operated health alliances, averaging 628 new employees per state. This extremely conservative estimate assumes that each state would form only one health alliance.

- Implementation of the HSA would require the establishment of 59 new offices at the federal, state, and alliance levels to oversee the new health care system and to enforce the HSA's new regulatory mandates on employers, individuals, health care providers, health plans, health alliances, and federal and state government.
- To implement the HSA, the federal and state governments would have to comply with 818 new regulatory mandates. This would result in an increase in the size of the *Code of Federal Regulations* ("CFR") by approximately 2,891 pages. An expansion of this magnitude would be equivalent to:

- approximately ten times the number of regulations required to operate the best current analog for a federal-state program, Medicaid, which provides health care coverage to low-income families with children, elderly, and disabled¹; or
- approximately 2.5 times the number of regulations required to operate the Medicare program, which is fully federal.²

The HSA would also result in the issuance of an additional 3,849 new pages of non-CFR guidance.

- In terms of staffing expenditures alone, the HSA would result in spending obligations at the combined federal, state, and health

alliance levels amounting to more than \$3.9 billion each year.³ In particular:

- Federal efforts to comply with the HSA's regulatory mandates would cost \$638,460,200 per year. This conservative estimate is based on the present average wage and benefit package for employees of the Health Care Financing Administration of \$57,400.
- State compliance would similarly require expenditures by the states of approximately \$2,117,790,100 each year. This would translate into \$42,355,802 per state, and reflects an average annual wage and benefit package for state employees of approximately \$38,074 per year.
- In order to comply with the state obligation to ensure the operation of at least one regional alliance in each state, the states would have to spend at least \$1,195,523,600 annually. This would translate into approximately \$23,910,472 annually per state.

These figures do not reflect administrative costs related to lease of office space, acquisition of furniture or other capital equipment, travel, or other expenses incidental to administration.

Limitations

Our estimates do not take into account existing governmental functions which would no longer be performed under the HSA. For example, under the HSA, Medicaid would no longer cover acute care, so that governmental activity under the HSA to address acute care matters would arguably not represent entirely new burdens on federal or state government. We believe, however, that aside from the effect on Medicaid acute care, the HSA mandates set forth in this report represent, in virtually all other instances, entirely new duties and/or new populations not at present subject to federal regulation. We also believe that any inclusion of HSA duties that

may result in a decrease in the activities of another government agency is offset by two factors. First, we have not taken into account HCFA regional office staffing in calculating our existing office figures, so that a 36.1% underestimate is built into most of the HCFA-based models. Second, we have otherwise underestimated required staffing for the reasons set forth in the individual new office descriptions in the "Guided Tour" (see Volume II, Appendix A).

¹ Medicaid program regulations require approximately 295 pages of the *Code of Federal Regulations*.

² Regulations for the Medicare program, which is entirely federally operated, require approximately 1,207 pages of the *Code of Federal Regulations*.

³ Federal estimates are based on Fiscal Year 1994 salary figures. State estimates are based on 1991 salary data. See discussion at pages 5 and 6 below.

Chapter 1 Introduction

Currently America's health care delivery system is subject to broad-reaching regulations and paperwork requirements. Although some degree of regulation and paperwork is needed for the effective operation of a quality health care system, most observers conclude that one of the objectives of health care reform must be to reduce such requirements.

The Federal Government has instituted two mechanisms which, if used to their fullest extent, could serve to keep regulations and paperwork requirements under control:

- The Paperwork Reduction Act
- Executive Order 12866—Regulatory Planning and Review

The Paperwork Reduction Act was enacted to ensure that federal government information collection requirements on private sector entities are kept to an absolutely necessary minimum. It requires that the Office of Management and Budget ("OMB"), located within the Executive Office of the President, approve all forms that must be filled out under a new health care program, as well as all mandates to the private and public sectors requiring record maintenance. The statute is so strong that if a federal agency fails to obtain OMB's approval on a form, then an outside party need not furnish the requested information.

Executive Order 12866 requires that OMB review every major regulation that will be issued by a federal agency under any health care reform plan.

Given OMB's role in the paperwork and regulatory process of the federal government, the Federation of American Health Systems asked Dr. Jim Tozzi to quantify the regulatory burden associated with the proposed Health Security Act ("HSA").

Dr. Tozzi was a career public servant whose service spanned the terms of five U.S. Presidents. He was instrumental in both the formation and implementation of the regulatory and paperwork review function at OMB. He was appointed to key positions in both Democratic and Republican Administrations.

In performing an analysis of the regulatory requirements of the proposed HSA, Dr. Tozzi relied heavily on a codification of its legal mandates prepared by Multinational Legal Services, a firm that specializes in regulatory proceedings, with a particular emphasis on health issues.

The results of the analysis are presented in two volumes:

- Volume I contains the results of MBS's analysis, *i.e.*, the increase in the number of federal and state employees and the number of pages in the Code of Federal Regulations that would result from enactment of the HSA.
- Volume II contains four appendixes documenting the findings set forth in Volume I:
 - Appendix A contains "A Guided Tour of the Health Security Act Administration," an office-by-office description of what the new health care plan administration would look like, including the functions and staffing requirements for each new office.
 - Appendix B, "A Roster of New Regulatory Mandates Under the Health Security Act," sets out each of the 818 new regulatory mandates under the HSA, including a citation to the text of S. 1757 for each new duty.
 - Appendix C, "Price Control, Employer, Alliance, and Health Plan Mandates Under the Health Security Act," categorizes the 818 new regulatory duties in terms of (i) mandates pertaining to price controls, global budgets, and premium caps, (ii) employer and individual mandates, (iii) alliance mandates, (iv) health plan mandates, and (v) other mandates.
 - Appendix D, "New Regulations Under the Health Security Act," documents the bases for MBS's findings concerning new pages of federal regulations and guidance under the proposed HSA.

Chapter 2

Findings—Government Staffing and Regulations Under the Health Security Act

In this study we have done what no other study of the HSA has done to date. We have read every provision of the proposed legislation, and asked what must happen at the federal and state government levels if the HSA were enacted into law. Specifically, we have considered three critical questions that have not been adequately addressed in the course of the national debate over health care reform:

- (1) How many new federal employees would be required to manage the new federal programs created by the HSA?
- (2) How many new state employees would be required to operate the HSA?
- (3) How many new pages of regulations would be added to the Code of Federal Regulations if the HSA were enacted?

How many new federal government employees would be required to implement the Health Security Act?

- The federal government would need to increase the federal payroll by at least 11,123 new full-time employees to operate programs mandated by the HSA (see Figure 1). Assuming a fiscal year 1994 annual salary of \$57,400 (including benefits), an annual budget allocation of \$638,460,200 would be required to maintain this staff (see Figure 2). This would represent a cost of \$1,749,206 per day.
- The organizational chart in Appendix A depicts the staffing required for each new federal and state office. The specific functions and staffing of each new federal office are set forth in the "Guided Tour" in Appendix A.

Our Methodology:

We compared the duties of the new offices that would be created if the HSA were enacted with the duties now performed by existing government offices. We then determined the staffing allocations of the existing offices. For

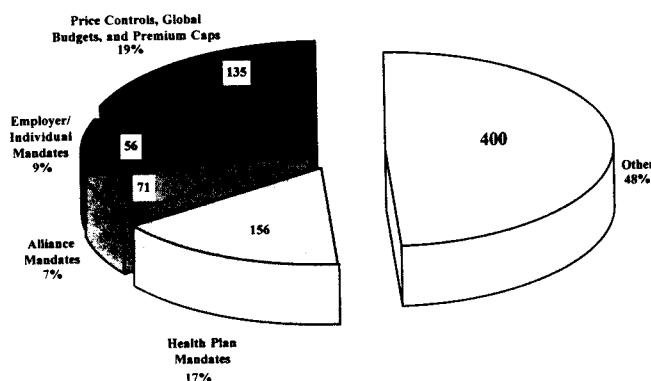
offices that would be primarily involved in rule-making, we applied the existing staffing figure to the new office. For offices whose work volume would be proportionate to the population served, we multiplied the number of existing employees by a ratio to take into account the larger population to be served under the HSA, and adjusted the result downward to take into account a presumed 30% economy of scale.

Step One—Determine Federal Duties

To determine new federal staffing requirements, we thoroughly analyzed the HSA and compiled a roster of every regulatory mandate in the Plan. (See "Appendix B: Regulatory Mandates Under the Health Security Act.") The roster enumerates more than 800 new duties (606 federal, 212 state and regional alliance), all of which would have to be performed by new and/or existing federal or state agencies.⁴ Following the exact language of the HSA, we then classified the 818 new mandates according to the specific federal or state agencies that would be responsible for implementing each. We further divided the list of regulatory mandates by subject matter into the 93 "subcategories" listed in the preface to Appendix B of this report.

Appendix B organizes all of the federal and state government mandates found in the HSA by agency and, within each agency, by the substantive area of regulation. Each duty is restated from the language of the HSA (i.e., S. 1757). Each restatement is followed by a citation to the specific section and subsection within the HSA in which the mandate is found.

Figure 1: Health Security Act Mandates by Category



Appendix C organizes all federal, state, and health alliance mandates into five categories:

- Mandates pertaining to price controls, global budgets, and premium caps,
- Employer and individual mandates,
- Alliance mandates,
- Health plan mandates, and
- Other mandates.

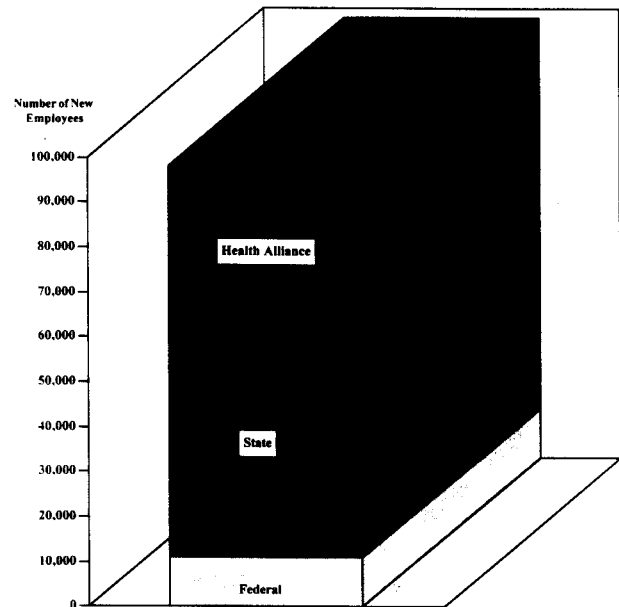
(See Figure 1.)

Step Two—Determine Staffing Levels

We then compared the duties mandated under the HSA with duties performed by existing federal health care agencies. We matched each subcategory to an analogous, existing federal or state office (“Corresponding Existing Office”) already performing functions similar to the duties in the subcategory. For each Corresponding Existing Office, we determined the function of the office, the number of actual full-time employee equivalents (“FTE’s”) in the office, and the population base served by the office. In most cases we found an existing office at the Health Care Financing Administration (“HCFA”) that performs similar duties. In a number of areas, however, the HSA would create new kinds of mandates not found in the present Medicare or Medicaid system; in these cases we sought analogous model offices in other federal and state agencies.

Based on all of the information we gathered, we “pre-created” an office-by-office organizational chart of the entire HSA administration, showing under which agency each new office would operate. This organizational chart (see “Health Security Act Administration—Table of Organization” at the end of Volume I) is reproduced in Appendix A, and shows 27 new offices within new and existing federal agencies, 15 new federal entities (i.e., commissions, advisory councils, advisory groups, consortia, etc.), nine new offices within the state agency to be designated by each state to administer the HSA, three new state entities, and five offices within each regional alliance.

Figure 2: Health Security Act Estimated Nationwide Staff Requirements



Step Three—Determine Staffing Costs:

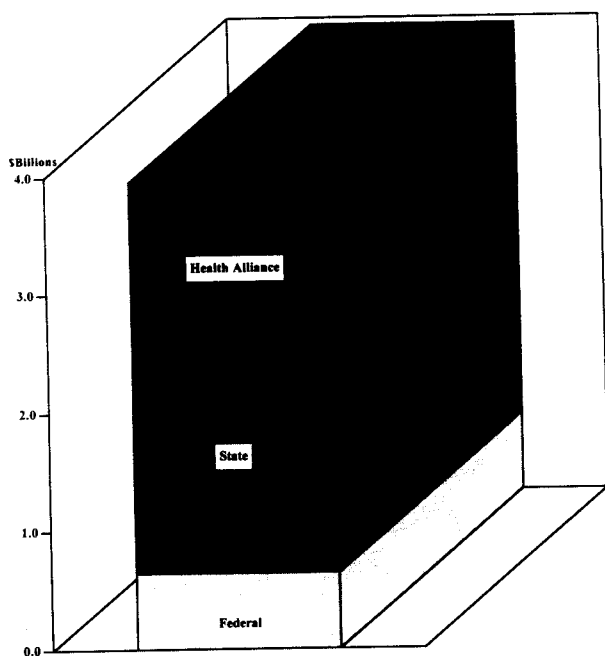
Based on the number of current FTE’s in, and the population served by, each Corresponding Existing Office, we estimated the number of FTE’s it would take to staff each of the new offices in the HSA organizational chart. For offices with purely rulemaking or inter-agency liaison duties, we did not increase the number of FTE’s to take into account the increase in population served. All of the assumptions made in estimating the number of FTE’s for each office, and all of the statistics and calculations employed in arriving at the final FTE number, are explained in detail in our “Guided Tour” of the new offices (Appendix A).

Having obtained the number of FTE’s for the employees in each new federal office in the HSA organizational chart, we estimated the total annual federal staffing costs based on HCFA’s fiscal year 1994 average annual salary (with benefits) of \$57,400.

How many new state government employees would be required to implement the HSA?

- The state governments would have to hire at least 55,623 new full-time employees nationwide (averaging 1,116 per state) to operate state health care administrations under the HSA (see Figure 2). Assuming an annual salary of \$38,074 (including benefits), the states would have to allocate \$2,117,790,100 (averaging \$42,355,802 per state) annually to comply with mandates on states under the HSA (see Figure 3).
- The states would be responsible for ensuring the establishment and operation of regional alliances. Either directly or indirectly, the states would bear responsibility for the costs of staffing these alliances. In order to operate one regional alliance per state, the states would have to hire at least 31,400 new full-time employees nationwide (averaging 628 per state) (see Figure 2). Assuming an annual salary of \$38,074 (including benefits), the states would have to allocate \$1,195,523,600 (averaging \$23,910,472 per state) to comply with the states' obligation to ensure the operation of at least one regional alliance per state (see Figure 3).

Figure 3: Health Security Act Estimated Annual Staffing Costs



- Each additional regional alliance would require the hiring of 628 new full-time employees and a corresponding annual allocation of \$23,910,472.

These state estimates are based on the duties set forth in the HSA and codified in Appendix B of this report. We prepared our state staffing estimates based on federal office models, except where indicated in Appendix A. We estimated the state and regional alliance staffing costs based on U.S. Census figures indicating an average annual state employee salary (with benefits) of approximately \$38,074.⁵

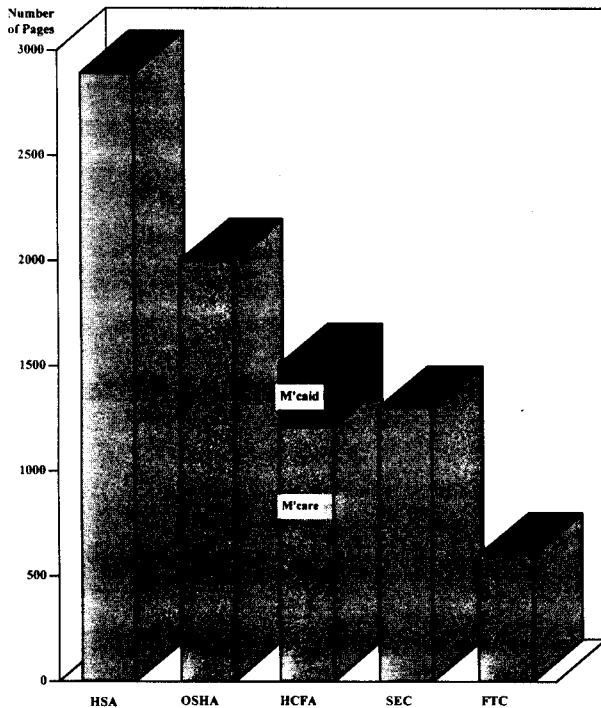
Regarding the states' financial obligations with respect to regional alliances, we note that under §1202(a) of the HSA, each state would be responsible for "establish[ing] and maintain[ing] one or more regional alliances." Moreover, "[a] State may not be a participating State for a year unless the State has established such alliances by March 1 of the previous year." § 1202(a) (p. 98). Section 1300 would provide that a regional alliance may take the form of a non-profit organization or a state agency. § 1300 (pp. 118-19). On the basis of these two provisions, it is therefore clear that each state would ultimately bear the responsibility for setting up and financing administrative structures adequate to enable the state to ensure that all regional alliance duties are carried out.

How many new pages of regulations would be added to the Code of Federal Regulations?

- At least 2,891 new pages of CFR would have to be promulgated in order to implement the HSA (see Figure 4).
- At least 3,849 new pages of additional federal guidance not for inclusion in the CFR would have to be issued in order to implement the HSA.

Implementation of the HSA would substantially expand federal regulation of the health care system. In a number of critical areas, the Plan

Figure 4: Estimated Pages of Health Security Act-Related Federal Regulations Compared to Programs Operated by Existing Federal Agencies



cannot be put into effect until such time as implementing regulations are drafted and officially promulgated by the relevant federal and state agencies.

The process of implementing regulations involves many levels of government, as well as time, effort, and expense. Proposed policies, standards, guidelines, and rules are often drafted in an office that deals routinely with the subject matter of the new regulations. The proposed regulations are then sent to an office staffed by attorneys who review and revise the proposed regulations to ensure conformity with principles of administrative law. Legal staff must then guide the proposed regulations through a public comment or hearing process, after which they may be revised yet again before publication in final form in the Federal Register.

In order to gain some understanding of the magnitude of the new rulemaking effort that would be required to implement the HSA, we

matched a number of the topical subcategories in Appendix B with existing Medicare, Medicaid, and state insurance regulations governing similar subject matter. Although we did not locate regulations corresponding to each subcategory, we found 1,865 pages of CFR and 2,483 pages of non-CFR guidance covering 60 of the 93 "subcategories" of substantive regulation set forth in Appendix B (i.e., 64.5%) that would be subject to new rulemaking under the HSA. On this basis we estimated that an additional 1,026 pages of CFR and 1,366 pages of non-CFR guidance would be required.

⁴ We did not take into account the duties found in Titles IV (amending the Medicare and Medicaid provisions of the Social Security Act) or VII (amending the Internal Revenue Code), because any new duties in these Titles would be carried out by HCFA or the Internal Revenue Service, not by the new administrative apparatus established to implement the HSA.

⁵ Specifically, an official of the U.S. Census Bureau quoted the average monthly earnings for full-time state employees for October 1991 to be \$2,565. He further quoted the benefit package for full- and part-time state employees for October 1987 to be an additional 23.7% added to the monthly salary.

Chapter 3

Guiding Principles Used in Preparing This Study

This study is an attempt to produce a neutral, objective estimate of the impact on government staffing and rulemaking that would be occasioned by the enactment of the HSA. In doing so, we have adhered to the following principles:

- (1) MBS does not take any position on the question of reform of the health care delivery system in the U.S. MBS does not endorse or reject any legislative proposal to reform that system.
- (2) All regulatory duties set forth in Appendix B were obtained from specific provisions in the HSA. All duties also are referenced, by section and page, to their sources in the HSA.
- (3) MBS modeled its "pre-construction" of HSA administration on offices of the Health Care Financing Administration, HCFA. Where the HSA calls for the performance of new functions not presently performed by HCFA, MBS sought model offices in other federal or state agencies. Each new office in the "Guided Tour" (Appendix A) is keyed to its Corresponding Existing Office, as well as to the duty subcategories and specific duties for which that new office would be responsible.
- (4) All assumptions and calculations that constitute the basis of new office FTE estimates are expressly stated in the description accompanying each new office in the Guided Tour. In sum, for each office the reader can determine the specific HSA provisions giving rise to that office's duties, as well as the complete basis for MBS's estimate of staff necessary to carry out those duties.
- (5) Staffing and cost estimates in this study are conservative. To avoid over-estimating regulatory costs, MBS under-estimated the number of employees required to perform specific functions in almost every instance. In most instances MBS counted the number of full time employees in an office, but did not count the subcontractors employed by the office to perform all of the existing office's duties.⁶ In some instances these subcontractors number in the hundreds or thousands. For each office, MBS has set forth the model office used and whether the Corresponding Existing Office figure includes subcontractors.
- (6) In determining the number of staff employed by existing offices within HCFA, we took into account only central office staff. In light of the fact that regional office FTE's account for 1,530.8 of HCFA's 4,237.4 current employees, i.e., 36.1%, all HCFA-based FTE estimates represent, on average, only 63.9% of the staffing that would actually be required to perform the office's duties on a nationwide scale.
- (7) Our estimates do not account for existing governmental functions which would no longer be performed under the HSA. For example, under the HSA, Medicaid would no longer cover acute care, so that governmental activity under the HSA to address acute care matters would arguably not represent entirely new burdens on federal or state government. We believe, however, that aside from the effect on Medicaid acute care, the HSA mandates set forth in this report represent, in virtually all other instances, entirely new duties and/or new populations not at present subject to federal regulation. We also believe that any inclusion of HSA duties that may result in a decrease in the activities of another government agency is offset by two factors. First, we have not taken into account HCFA regional office staffing in calculating our existing office figures, so that a 36.1% underestimate is built into most of the HCFA-based models. Second, we have underestimated required staffing for reasons otherwise noted in individual new office descriptions in the "Guided Tour."

⁶ Exceptions are Office Nos. 16, 17, and 22, in which subcontractors were taken into account.

Health Security Act Administration—Table of Organization

