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# THE HEALTH INSURANCE REFORM ACT OF 1995

OCTOBER 12 (legislative day, OCTOBER 10), 1995.—Ordered to be printed

Mrs. KASSEBAUM, from the Committee on Labor and Human Resources, submitted the following

## REPORT

[To accompany S. 1028, "The Health Insurance Reform Act of 1995"]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1028, "The Health Insurance Reform Act of 1995") having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill, as amended, do pass.

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## I. PURPOSE AND SUMMARY OF THE LEGISLATION

The current health insurance market provides too little protection for individuals and families with significant health problems and makes it too difficult for employers—particularly small employers—to obtain adequate coverage for their employees. The Health Insurance Reform Act of 1995 (S. 1028) will reduce many of the current barriers to obtaining health coverage by making it easier for people who change jobs or lose their jobs to maintain adequate coverage, and by providing increased purchasing power to small businesses and individuals.

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The legislation builds upon successful State reforms and strengthens the private market by requiring health plans to compete based on quality, price, and service instead of refusing to offer coverage to those who are in poor health and who need it the most. The General Accounting Office estimates that passage of S. 1028 would help at least 25 million Americans each year.

1. *The legislation limits exclusions for preexisting conditions.*—The bill prohibits health plans from limiting or denying coverage for more than 12 months for a medical condition that was diagnosed or treated during the previous 6 months. Once the 12-month limit expires, no new preexisting condition limit may ever be imposed on people maintaining their coverage, even if they change jobs or health plans.

The bill provides that coverage of less than 12 months may be credited against any preexisting condition exclusion under a new health plan. For example, an individual who has had coverage for 6 months when he or she changes jobs or health plans would face a maximum additional exclusion of 6 months, rather than the normal 12 months.

2. *The legislation guarantees availability of health coverage.*—The bill prohibits insurance carriers, health maintenance organizations and other entities issuing health coverage from denying coverage to employers with two or more employees. It also prevents employment-based health plans from excluding any employee from coverage based on health status.

3. *The legislation guarantees renewability of health coverage to employers and individuals.*—Except in the case of fraud or misrepresentation by the policy holder, the bill generally requires health plans to renew coverage for groups and individuals as long as premiums are paid.

4. *The legislation ends "job lock" by making health coverage portable.*—Because the bill limits preexisting condition exclusions and provides credit for prior continuous coverage, workers will no longer be locked into jobs or prevented from starting their own businesses for fear of losing their health coverage.

5. *The legislation promotes group purchasing.*—The bill assists employers and individuals in forming private, voluntary coalitions to purchase health insurance and negotiate with providers and health plans. State laws prohibiting such associations or excessively restricting their ability to bargain with health plans are preempted. These coalitions can provide small employers and individuals the kind of clout in the marketplace currently enjoyed by large employers.

6. *The legislation improves COBRA coverage for disabled individuals and newborns.*—Under current law, the Consolidated Omnibus Reconciliation Act of 1986 (COBRA) allows disabled workers to extend their employment-based coverage for an additional 11 months (beyond the original 18 months available to all workers) if they become disabled during the course of employment with that employer. This law is designed to allow disabled individuals to maintain private health coverage until they are eligible for Medicare. Senate bill 1028 would allow individuals who have disabled family members or who become disabled during the original 18-month period of COBRA coverage to take advantage of the additional ex-

tended coverage currently available only to workers who already are disabled at the time they leave employment.

In addition, the legislation also allows newborns and adopted children to have access to their parents COBRA coverage immediately, instead of waiting until the health plan's next open enrollment period.

7. *The legislation helps individuals leaving group coverage maintain health coverage.*—The bill guarantees the availability of individual health coverage to individuals who have had employment-based coverage for at least 18 months and who are ineligible for or have exhausted COBRA coverage. Because the States are experimenting with methods of guaranteeing individual coverage and the National Association of Insurance Commissioners (NAIC) is developing a model law in this area, the legislation provides maximum flexibility for the States to address the issue of group-to-individual portability and directs the Secretary of Health and Human Services (HHS) to study current State efforts.

8. *The legislation applies to all employment-based health plans.*—The reforms contained in S. 1028 generally apply to all group health plans sponsored by employers and unions, including self-insured plans, and to all employers with two or more employers.

9. *The legislation promotes state flexibility.*—With respect to policies offered by insurance carriers, health maintenance organizations and other entities that currently may be regulated by the States, the bill allows States to enact insurance reforms providing additional protection for consumers beyond the minimum requirements contained in the legislation.

## II. Background and Need for the Legislation

### A. Overview

An estimated 43 million Americans (18.7 percent of the nonelderly population) will be without health insurance coverage for some period of time in 1995, one million more than in 1994.[1] In addition, an estimated 81 million Americans suffer from some type of preexisting medical condition that could make it difficult for them to obtain health coverage, especially for that condition.[2]

There are two principle barriers to obtaining health coverage: affordability and availability. Underwriting and rating practices utilized by insurers and some employer-sponsored health plans restrict the availability of coverage for people with preexisting medical conditions and other characteristics associated with above-average utilization of health care.[3] These practices make it particularly difficult for small businesses and individuals to obtain affordable health coverage.

In 1994, 61 percent of Americans under the age of 65 received health coverage through the employment-based system.[4] However, the current market provides too little protection for individuals and families with significant health problems. Because of the preva-

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[1] New York Times, August 27, 1995, page 1.
[2] Citizens Fund, "Health Insurance at Risk," June 1991, page 8.
[3] Congressional Research Service Report for Congress, "Health Insurance: Reforming the Private Market," August 3, 1995.
[4] The Urban Institute, February 1995.

lence of participation requirements, preexisting condition clauses, and discriminatory enrollment practices, many workers have had to limit their employment choices to hold on to their health coverage while others live with the fear of knowing that a job layoff could mean a total loss of health coverage.

In fact, millions of Americans are at risk of becoming uninsured or subject to preexisting condition exclusions under the current system because they change jobs, lose jobs, or work for employers who change insurance policies. According to the General Accounting Office (GAO), 25 million Americans would be helped by Federal portability reforms contained in S. 1028; roughly 12 million workers with employer-based health care coverage leave their jobs every year and millions more lose their jobs.[5] In addition, employers that provide health coverage to their employees often change health insurance plans, further exposing those with medical conditions to gaps in coverage. Small employers generally change policies every 3 to 4 years.[6]

Small employers face some distinct problems in trying to provide health coverage for their workers. Statistically, small businesses are more likely to be low-wage firms for whom health insurance coverage may represent a substantial increase in total compensation costs. In addition, small employers sometimes are more economically fragile than medium-sized and large-sized businesses. A major cause of the difficulties faced by small businesses, however, lies in the nature of the private insurance market itself. Because they have less purchasing power, small firms often are unable to buy coverage at any price, must pay more for coverage when they are able to obtain it, and cannot count on stable premiums.

### B. EVOLUTION OF THE PRIVATE HEALTH INSURANCE MARKET

The private health insurance system has evolved gradually over the course of this century, largely in response to competitive pressures. One important trend has been a gradual move away from cross-subsidization of the costs of health care coverage. In the 1930's, the original Blue Cross plans, along with similar plans developed by providers and consumers of care, offered insurance at standard rates to all purchasers. Under this community-rating system, low-risk, low-cost individuals and groups subsidized the costs for the higher-risk segments of the insured population.

The rise in competition from commercial insurance companies in the 1940's led to "experience rating" for large groups and, as a result, increasing segmentation of the private insurance market. Low-cost groups demanded that the rates they paid for coverage be related to the costs incurred for their group alone, and the commercial insurers met this demand. Ultimately, the Blues were obliged to follow their lead and to offer experience rated insurance to large groups. Some groups found that they had sufficient resources to withdraw from the insurance market altogether and insure themselves, further reducing the pool of firms seeking coverage—and further increasing costs—in the community-rated market. A combination of high administrative costs charged by insurance carriers,

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[5] GAO, "National Portability Standards Would Facilitate Changing Health Plans," July 18, 1995.

[6] American Academy of Actuaries (staff discussion).

State mandates, and medical inflation contributed to this withdrawal. The resulting market segmentation has exacerbated the difficulties many small employers face in obtaining affordable coverage.

As health care costs continued to climb, insurance carriers also began to utilize experience rating and increasingly aggressive underwriting practices in the small group market. As a result, competition among insurers in today's small group insurance market is based largely on risk selection and not on the basis of efficiency or service to the customer. The logic of a competitive insurance market has thus worked to reduce the degree of cross-subsidy in the cost of health insurance, as insurers compete for the business of groups representing the most favorable or predictable risks. Attempts to remedy this situation have proven difficult because of the division of roles between the Federal and State governments in regulating health plans.

### C. REGULATION OF HEALTH PLANS

Currently, responsibility for regulating health plans is divided between the Federal Government and the States. Under the Employee Retirement Income Security Act [ERISA], the Federal Government regulates private health plans offered by employers and unions. The States are responsible for regulating health coverage sold by insurance carriers. Today, self-funded employer plans cover 40–50 percent of the privately insured population,[7] and data shows that self-funding is increasing, particularly among smaller firms.[8]

According to the Employee Benefit Research Institute (EBRI), 74 percent of employers with 500 or more employees self-funded their health plans in 1994, up from 63 percent in 1993. EBRI also reports that an estimated 22 million full-time employees in private industry and State and local governments participated in self-funded employment-based health plans in 1994. Because ERISA prohibits States from regulating self-insured health plans provided by employers and unions, States are not able to control the health care coverage offered to at least half of the employed population. Preemption has fostered innovation and efficiency, particularly by large employers, but also has left many employees vulnerable to potential abuse and has allowed job lock to perpetuate in the majority of the work force.

#### *1. Self-funded plans*

Currently, many employers retain the risk for paying the cost of claims directly out of company assets rather than purchasing commercial health insurance. In addition, multiemployer plans established pursuant to collective bargaining agreements (known as "Taft Hartley" plans) between workers' unions and workers' employers also may be self-funded.

Although the terms "self-funded" and "self-insured" have become synonymous with ERISA plans, these terms are not found in ERISA. Instead, they have been created and applied by the courts and, as a result, there is ambiguity and uncertainty among many

[7] CRS, "Health Insurance: Reforming the Private Market," August 3, 1995.
[8] GAO, "ERISA and Health Reform," July 1995.

employers and employees as to the status of certain employee benefit plans. Much of the current ambiguity is fostered by the practice of purchasing stop-loss coverage by employers and unions who cannot, or choose not to, bear the entire risk or providing benefits to plan participants.[9] In testimony before this committee in July 1995, several witnesses told the committee that the use of increasingly lower stop-loss levels has increased confusion about the legal status of self-insured plans and resulted in further segmentation of the insurance market.

Under current law, these ''self-funded'' or ''self-insured'' health plans are preempted from State regulation under ERISA. ERISA was crafted to leave the content and design of employer health plans to employers in negotiation with their work force, without requiring employers and multiemployer plans to comply with numerous, conflicting State laws. While ERISA does establish certain regulations for health benefit plans in the area of reporting and disclosure, fiduciary standards, claims review, and enforcement, these regulations do little to assure the portability of health benefits. For example, Federal law currently does not place any limitations on the use or definition of preexisting condition limitations by employer-sponsored, self-funded health plans.

Under ERISA, employers and unions that operate health benefit plans on a self-funded basis restrict coverage for preexisting medical conditions in the same manner as insurance carriers. Studies show that at least 60 percent of non–Health Maintenance Organization (HMO) plans offered by firms with 100 or more full-time employees had preexisting condition clauses in 1993.[10] Some employers deny health insurance altogether to individual employees or their dependents due to their current or past health problems.

*2. Group health insurance market*

The group health insurance market, regulated by the States, is typically divided into two separate markets: the large group insurance market and small group insurance market. Traditionally, State regulation of the health insurance industry has focused on such areas as financial stability, marketing practices, covered services, and policy forms. Recently, however, as small employers faced special problems in trying to provide health insurance for their workers, States initiated broader sets of reforms in the small group insurance market (typically defined as 2 or 3 to 25 or 50 employees).

In recent years, the majority of States have passed laws: (1) requiring carriers to sell health insurance without regard to the medical history or health status of employers or individual employees on a guaranteed renewable basis; (2) limiting the amount that insurance carriers may charge for their policies; (3) guaranteeing renewability of insurance policies; and (4) guaranteeing portability of

[9] As the United States' General Accounting Office stated in a recent report: ''Accurately assessing [the degree to which firms are self-funding] is difficult given the dynamic nature of the health market and the increasingly blurred distinctions between self-funded and insured plans. In many cases, employees do not know whether their employer-based health plan is self funded or purchased through an insurer. This results partly because employers are increasingly adopting funding arrangements that are neither fully insured or self-insured.'' GAO Report, ''ERISA and Health Reform,'' July 1995, page 3.

[10] See CRS ''Health Insurance: Reforming the Private Market,'' August 3, 1995.

insurance by limiting preexisting condition exclusions and crediting waiting periods satisfied under previous coverage.

Currently, 45 States have passed some type of small group health insurance reform law in an attempt to level the playing field within the insured marketplace. However, these State reforms vary in their ability to guarantee renewability and portability of health insurance coverage, and a handful of States have not addressed these issues at all. Moreover, because only a limited number of States have extended similar reforms to larger employers and State reforms do not apply to self-funded ERISA plans, a majority of workers still lack access to reliable health coverage.

*3. Individual insurance market*

Recognizing the interaction between the small group and individual insurance markets, several States recently have begun to turn their attention to reforming the individual insurance market, and the National Association of Insurance Commissioners (NAIC) plans to propose a model law on individual market reform within the next few months.

There are an estimated 10 million to 20 million individuals who currently purchase health insurance in the individual insurance market. Individuals seeking coverage in the individual health insurance market are much less likely to have access to affordable and guaranteed renewable coverage than those purchasing insurance in the group market. Moreover, these individuals generally face higher premium costs than those covered under a group plan, they are subject to discriminatory rating practices (such as tier rating), and they lack portability of coverage. States also are finding that there is increasing risk segmentation between the individual and small group markets, as employers and group insurance carriers sometimes force unhealthy employees to purchase coverage in the individual market rather than covering them under a group health plan.

In order to provide access to insurance coverage for individuals, States have historically relied on limited mechanisms such as high risk pools and special State legislation that enables Blue Cross/Blue Shield plans to avoid some of the requirements ordinarily imposed on commercial insurers in exchange for providing coverage to individuals on an open enrollment basis. Only 20 States have individual market reform laws, and these laws have thus far been relatively limited in scope. Therefore, the majority of individuals may face barriers to obtaining health coverage if they lose their job, are hired by an employer that does not offer coverage, or leave a job with health coverage to become self-employed.

## D. LACK OF DEPENDABLE HEALTH COVERAGE

*1. Denial and cancellation of coverage*

In the current market, many health plans attempt to avoid enrolling older or sicker individuals and groups. In considering what employer groups to accept, insurers consider characteristics of the entire group, such as the type of business in which the firm is engaged, as well as characteristics of individual members of the group that may predict their future need for health services. Whole in-

dustries have been redlined out of coverage because they are thought to employ people who are likely to get sick. A study by the Congressional Research Service (CRS) found that one typical insurer routinely denied coverage to 35 separate types of businesses, ranging from auto dealers to restaurants.[11]

Even businesses and individuals with health insurance cannot be sure of maintaining their coverage if illness strikes. Insurers can collect premiums for years—and then suddenly refuse to renew coverage if individuals or employees begin to incur large health costs. For example, during his testimony before the committee on July 18, Mr. Tom Hall of Oklahoma City, Oklahoma, explained that when he bought out his partners and started his own business, he was denied individual insurance coverage because of his preexisting heart condition by the same insurance carrier that had provided him coverage under a group policy for nearly 30 years.

*2. Exclusions for preexisting conditions and lack of portability*

Health plans often deny coverage for the very conditions most likely to require insurance. As many as 81 million Americans have preexisting medical conditions that could affect their insurability.[12] Preexisting condition limits are routinely imposed in plans offered to small and large businesses, and to individuals. More than half of all workers are enrolled in employment-based plans that impose some form of preexisting condition exclusion or limitation.[13]

Such limitations are often justified as a means of preventing people from gaming the system and buying insurance only when they become sick. But those who have bought insurance and faithfully paid premiums for years can find themselves subjected to exclusions if their employer changes insurance carriers or if they change jobs or lose their jobs.

An estimated 23 million people lose insurance coverage annually;

Eighteen million Americans change insurance policies annually when someone in their family changes jobs;

Small businesses providing insurance to their employees typically change policies every 3 to 4 years.

Because health plans impose exclusions for preexisting conditions and deny coverage for those considered poor health risks, millions of Americans are caught in "job lock." They would like to change jobs or start their own business to advance their careers and improve their family's standard of living—but the risk of losing their health coverage is too great. A Washington Post/CBS News survey found that one-quarter of all American workers stay in jobs they otherwise would leave because they fear losing their health coverage.

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[11] "Insuring the Uninsured: Options and Analysis," Congressional Research Service, Library of Congress, October 1988.

[12] Citizens Fund, "Health Insurance at Risk" June 1991, page 8.

[13] Gabel, Liston, Jensen and Marsteller, "The Health Insurance Picture in 1993: Some Rare Good News" Health Affairs, Spring (I) 1994, page 328.

### E. LACK OF PURCHASING POWER FOR INDIVIDUALS AND SMALL BUSINESSES

In recent years, large businesses have been able to use their purchasing power to promote competition among health plans and providers, improve the quality of health care for their employees, and negotiate more favorable rates. For small businesses, however, the cost of health insurance continues to climb. According to a recent survey, health costs for large employers declined 1.9 percent in 1994, while small employers experienced an average increase of 6.5 percent. Firms with fewer than 10 workers were not included in the survey, and probably experienced even higher increases. Small businesses also pay more in administrative costs and contribute more to insurance company profits for the insurance they are able to purchase—as much as 40 or even 50 percent of the amount paid out in medical claims, compared to just 5 percent for the largest firms.

### F. FEDERAL AND STATE INSURANCE REFORM EFFORTS

Congress has wrestled with insurance reform legislation with little success since the early part of this decade. The last several Congresses repeatedly have considered legislation that would limit the ability of health plans to deny or restrict coverage, or to vary premium rates, on the basis of health status. In the 102d Congress, the Senate twice passed a small group insurance reform proposal developed by Senator Bentsen, first as part of the Senate amendment to H.R. 4210, the Tax Fairness and Economic Growth Act of 1992, and again in the Senate amendment to H.R. 11, the Revenue Act of 1992. However, the health insurance provisions were dropped in conference on both bills.

In the absence of congressional action, the States have taken the lead in reforming the health insurance market. In 1992, the NAIC, representing the insurance commissioners of the 50 States, issued a model law for reform of the small group insurance market. By the end of 1994, 45 States had adopted similar or identical reforms. Most commonly, such reforms require carriers to sell health insurance to small employers without regard to the medical history or health status of the group or individual members of the group on a guaranteed renewable basis. These reforms also establish limits on how much premiums may differ among businesses insured by the same carrier. As of mid-1995, about 20 States had extended some type of underwriting and rating restrictions to health insurance policies sold to individuals. In 1995, the NAIC approved a revised small group health insurance model law that, among other changes, would expand small group reforms to firms with only one employee and further tighten premium rating restrictions. In addition, the NAIC is expected to adopt an individual insurance reform model later this year.

However, State insurance reforms are inherently limited. First, by definition, most State reforms are targeted to small employers. According to EBRI, 70 percent of workers with health coverage work for firms with more than 100 employees. Moreover, State reforms cannot affect a large portion of the market because "self-insured" health benefit plans sponsored by employers and unions are

beyond the reach of State regulators because of the preemption provisions of the Employee Retirement Income Security Act (ERISA). Finally, individual States are powerless to ensure portability of health coverage to individuals who move from one State to another or cross State borders to obtain health care services.

## III. Legislative Consideration and Votes in Committee

The Health Insurance Reform Act of 1995, S. 1028, was introduced on July 13, 1995, by Senators Kassebaum, Kennedy, Frist, Dodd, Jeffords, Mikulski, Gregg, Wellstone, Gorton, Pell, Hatch, Simon, Chafee, and Lieberman. The bill was referred to the Senate Committee on Labor and Human Resources, which held a hearing to consider the legislation on July 18. Prior to the drafting of the legislation, the committee held two days of hearings on March 14 and 15 of this year, entitled ''Effective Health Care Reform in a Changing Marketplace,'' to examine changes in the health care market and possible directions for reform.

On August 2, 1995, the committee held an executive session to consider S. 1028. An amendment in the nature of a substitute was brought up for consideration by Chairman Kassebaum, and Senators Kennedy, Frist, Dodd, Jeffords, Mikulski, Gregg, Wellstone, Gorton, Pell, and Simon. Five amendments were adopted in executive session, including two ''sense of the committee amendments,'' and S. 1028 was reported favorably by a unanimous roll call vote of 16 to 0.

### A. Amendments Adopted by Voice Vote During Executive Session

Three amendments were adopted in executive session by voice vote.

1. Senator Jeffords and Senator Kassebaum offered an amendment that amended section 104(b)(1) of the Employee Retirement Income Security Act (ERISA) to require employer-sponsored health plans to provide timely notice to participants of material reductions in covered services. The amendment, which was adopted by voice vote, requires plan sponsors to provide notice to participants within 60 days of the adoption of such material reductions or, in the alternative, at regular intervals of 90 days. Under current law, notice of material modifications to a plan (including material reductions in covered services) must be provided to participants within 210 days of the close of the plan year.

The Jeffords-Kassebaum amendment also amended section 102(b) of ERISA to require plan sponsors to provide more specific information to participants regarding the administration, financing, and resolution of claims under the plan. More specifically, the amendment requires plan sponsors to notify participants of the plan's financing arrangements. In the case of a self-funded employer plan, for example, the employer would be identified as the source of financing. In the case of a plan that is financed through arrangements with stop-loss carriers or carriers offering fully insured group health plans, the carrier also should be identified. In addition, the amendment requires plan sponsors to notify participants of the office, contact or title of the individual at the United

States Department of Labor from whom participants may obtain information regarding their rights under this act and ERISA.

2. Senator Jeffords also offered an amendment to modify section 131(h) of the legislation. The amendment would have preempted State benefit mandates to allow health plan purchasing cooperatives (HPPC's) formed under the bill to design their own benefit packages or, in those States that have adopted scaled-back benefit designs for small employers, to utilize those small group plan designs. After a brief colloquy, Senator Jeffords agreed to modify his amendment, and the modified amendment was subsequently adopted by voice vote. The modified Jeffords amendment allows HPPC's to offer scaled-back benefit packages in those States that have allowed such packages to be sold to small employers. Unlike the original amendment, State mandates of general applicability are not preempted except under these conditions.

3. Senator Wellstone offered an amendment to clarify the definition of "preexisting condition" in section 103(e) of the legislation. The amendment, which was adopted by voice vote, clarifies that the term "preexisting condition" as used in the legislation means "a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received" during the 6-month period prior to an individual's enrollment in a health plan. While the language of the Wellstone amendment would require that preexisting condition exclusions be applied equally to similar medical conditions without regard to the cause of such conditions (i.e., subject to a maximum exclusion of 12 months), this amendment was designed primarily to prohibit the use by insurance companies of preexisting medical conditions to deny or limit coverage to victims of domestic abuse.

### B. THREE ROLLCALL VOTES TAKEN DURING EXECUTIVE SESSION

Rollcall votes were taken on three "sense of the committee" amendments during the August 2 executive session.

1. Senators Frist, Coats, Gregg, and Abraham offered an amendment to include language in the legislation stating that it is the "sense of the committee" that medical savings accounts "should be encouraged as part of any health insurance reform legislation passed by the Senate * * *." The amendment was adopted by a roll call vote of 9 yeas to 7 nays.

| YEAS | NAYS |
|---|---|
| Kassebaum | Kennedy |
| Jeffords | Pell |
| Coats | Dodd |
| Gregg | Simon |
| Frist | Harkin |
| DeWine | Mikulski |
| Ashcroft | Wellstone |
| Abraham | |
| Gorton | |

2. Senator Harkin offered an amendment stating that it was the "sense of the committee" that the Senate should not adopt any legislation that: (1) would have the impact of increasing the number of uninsured Americans or (2) would require middle and low-in-

come senior citizens to pay a larger share of Medicare program costs than they pay now. The Harkin amendment was defeated by a roll call vote of 7 yeas to 9 nays.

| YEAS | NAYS |
|---|---|
| Kennedy | Kassebaum |
| Pell | Jeffords |
| Dodd | Coats |
| Simon | Gregg |
| Harkin | Frist |
| Mikulski | DeWine |
| Wellstone | Ashcroft |
| | Abraham |
| | Gorton |

3. In response to the Harkin amendment, Senators Kassebaum and Abraham offered an amendment stating that it was the ''sense of the committee'' that the Senate ''should take measures necessary to reform the Medicare program, to provide increased choice for seniors, and to respond to the findings of the public trustees by protecting the short-term solvency and long-term sustainability of the Medicare program.'' The Kassebaum–Abraham amendment noted that the public trustees of Medicare had concluded in their 1995 annual report that: (1) ''the Medicare program is clearly unsustainable in its present form''; (2) ''the Hospital Insurance Trust Fund, which pays inpatient hospital expenses, will be able to pay benefits for only about 7 years and is severely out of financial balance in the long range''; and (3) the trustees ''strongly recommend that the crisis presented by the financial condition of the Medicare trust funds be urgently addressed on a comprehensive basis, including a review of the programs' financing methods, benefit provisions, and delivery mechanisms.'' The Kassebaum–Abraham amendment was adopted by a roll call vote of 9 yeas to 7 nays.

| YEAS | NAYS |
|---|---|
| Kassebaum | Kennedy |
| Jeffords | Pell |
| Coats | Dodd |
| Gregg | Simon |
| Frist | Harkin |
| DeWine | Mikulski |
| Ashcroft | Wellstone |
| Abraham | |
| Gorton | |

### C. TWO AMENDMENTS OFFERED AND SUBSEQUENTLY WITHDRAWN WITHOUT CONSIDERATION DURING EXECUTIVE SESSION

Three amendments were offered, and then withdrawn without consideration, during the executive session on August 2.

1. Senator Harkin offered, and then withdrew, an amendment to add the term ''genetic information'' to the list of factors upon which employment-based and individual health plans may not base the establishment of eligibility, continuation, enrollment or premium contribution requirements. During a brief colloquy, the committee agreed that the terms ''health status'' and ''medical history'' as used

in both section 101(a)(1)(B) relating to employment-based health plans and 110(a) relating to individual health plans were intended to be broad enough to include "genetic information." Therefore, the chairman indicated that this report would reflect the committee's intention in that regard.

2. Senator Wellstone offered, and then withdrew, an amendment to prohibit insurance carriers from declining to offer coverage or imposing preexisting condition limitations based on the cause of a condition for which medical advice, diagnosis, care, or treatment was recommended or received.

3. Senator Jeffords offered, and then withdrew, an amendment to prohibit the imposition of lifetime limits in all health plans.

## IV. Explanation of the Legislation and Committee Views

### A. General Overview of S. 1028

The primary purpose of the reforms contained in the Health Insurance Reform Act of 1995, S. 1028, is to provide greater access, security, and portability of health benefits. The legislation is designed to curtail the most common abuses in the current system by requiring health plans to compete based on quality, price, service, and efficiency, instead of refusing to offer coverage to those who are in poor health and who need health coverage the most.

Senate bill 1028 encourages private market forces to help restrain health care costs by empowering more individuals and employers to become active purchasers of health care services. The committee's unanimous approval of S. 1028 should not be read as a sign that certain members of the committee have surrendered the goal of universal coverage. Instead, it should be viewed as a recognition that many positive changes short of universal coverage can significantly increase the availability, portability, and security of health coverage.[14]

The committee is very concerned about the affordability of health coverage. It recognizes, however, that a majority of State small group reform laws include rating restrictions which limit the amount by which insurance companies and HMO's may vary premiums. Moreover, the committee anticipates that States may adjust their rating laws to take into consideration the broader group of employers and individuals who will be covered by this legislation. In addition, many States are in the process of adopting new rating standards recently recommended by the NAIC. Therefore, the committee believes it is not appropriate to enact federal rating standards at this time. As a result, S. 1028 requires the Secretary of Health and Human Services (HHS) to evaluate and report on the

[14] Several witnesses commented during the committee's July 18 hearing that the scope of S. 1028 was appropriate, and the design of its provisions was sound. For example, Kevin Haugh from the Institute for Health Policy Solutions testified:

> I believe what distinguishes this bill from many other pieces of legislation is its coherency of purpose. The bill establishes a clear set of reasonable objectives and holds to them. The bill avoids provisions which prey on each other, and in the process compromise the whole. The bill also importantly recognizes and utilizes the various different parties necessary to effectively carry out its objectives—the private sector, States and the Federal Government.

Testimony of Kevin Haugh, Institute for Health Policy Solutions, before the Senate Committee on Labor and Human Resources, July 18, 1995.

various mechanisms used by States to ensure the availability of reasonably priced health insurance to employers purchasing small-group coverage as well as individuals purchasing coverage on a nongroup basis.

While some of the more comprehensive reforms contained in past legislation have not been included, S. 1028 nevertheless contains many important consumer protections that will benefit millions of Americans. Perhaps most significantly, the reforms in S. 1028 extend to self-insured ERISA plans, to policies offered to large and medium-sized employers, and to individuals leaving group coverage. As the NAIC testified during the July 18 hearing: ''Since portability is a prime concern among consumers regarding insurance, and since State regulators cannot affect portability with respect to ERISA plans, we are pleased you have taken this step with your bill.'' Testimony of the Special Committee on Health Care Reform of the National Association of Insurance Commissioners before the Senate Committee on Labor and Human Resources, Josephine Musser, Recording Secretary, NAIC, July 18, 1995, pages 2–3.[15]

At the same time, as testimony by the NAIC reflected, the legislation does not preempt many of the innovative and effective protections which the States have developed and implemented, and encourages further innovations with regard to State insurance reforms.[16] For example, as of May 1995, 14 States had passed laws that define small groups down to a single life, while 17 States define small groups as two or more employees. With respect to the number of days necessary to satisfy continuous coverage requirements, 19 States allow individuals a gap of more than 30 days and one State allows a 9-month gap in coverage.

The committee acknowledges that S. 1028 will not cure all of the ills in the Nation's health insurance system. But, as the General Accounting Office (GAO) testified before the committee in July 1995, it will help at least 25 million Americans each year by making it easier for employers and individuals to buy and keep health insurance—even when an employee or family member becomes ill. And it will allow people to change jobs without fear of losing their health insurance. As one witness testified during the committee's July 18 hearing, S. 1028 will immediately give the 137 million Americans covered by group health plans greater assurance that they will be able to maintain coverage when they change jobs. *See* Testimony of Blue Cross and Blue Shield Association, page 2.

### B. OVERVIEW OF SUBSTANTIVE CHANGES TO S. 1028 CONTAINED IN LEGISLATION ADOPTED BY THE COMMITTEE

In addition to the amendments discussed in section III above, the substitute amendment proposed by the chairman contained several substantive modifications to the original legislation.

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[15] See also Testimony of Blue Cross and Blue Shield, page 4 (''[o]nly the Federal Government can establish these portability standards for all groups, both large and small''); Testimony of Kevin Haugh, Institute for Health Policy Solutions, page 4 (''[p]roviding continuity of coverage across the large employer market and between the large and small employer markets requires Federal action.'').

[16] Testimony of the National Association of Insurance Commissioners, before the Committee on Labor and Human Resources, United States Senate, pre-sented by Josephine Musser, Wisconsin Commissioner of Insurance, July 1, 1995, page 2.

*1. Major modifications to individual market portability provisions*

The main substantive difference between the bill that was introduced July 13 and the chairman's substitute amendment for S. 1028 are the provisions on individual market reform. Section 112 of the original bill made clear that State individual market reforms, including guarantee issue, open enrollment, conversion policies, and high risk pools, would apply in lieu of the group-to-individual portability and individual renewability provisions of section 110 and 111 of the legislation unless the Secretary of HHS determined that those State reforms were not "at least as effective" as the individual reforms contained in S. 1028. This approach was fully embraced by the NAIC and the National Governors Association. See Testimony of Josephine Musser, page 7; August 1 letter from Governor Howard Dean and Governor Tommy G. Thompson on behalf of the National Governors' Association to the Honorable Nancy Kassebaum, August 1, 1995, page 2 ("[w]e believe * * * that there is value in a federal standard [for individual market reform] as long as States have some latitude within that standard. Toward that end, your bill recognizes the advances made by States in the individual market by including a carefully crafted test for Federal preemption.").

Despite this presumption in favor of State reforms, there was some concern that the language in the original legislation was too open-ended and granted the Secretary of HHS too much authority to override State individual market reforms. The bill, as reported, clearly responds to these concerns by clarifying further that deference should be given by the Secretary to State programs achieving the goals of the bill through alternative mechanisms.

Second, in response to concern about adverse selection among those who move from group to individual coverage, the substitute requires individuals to maintain group coverage for 18 months and to exhaust eligibility for COBRA before becoming eligible for individual coverage on a guaranteed issue basis. The original legislation required continuous group coverage for only 12 months.

Recognizing that affordability is a major concern in the individual insurance market, the legislation provides a limited continuity of coverage right for individuals leaving the group market. Clearly, these requirements do not go nearly as far as the "guaranteed issue" requirements that are in effect in some States. Under State-guaranteed issue requirements, insurance companies are required to sell policies to individuals, regardless of whether they have maintained prior coverage. In addition, the legislation does not require portability between individual policies. The legislation leaves to the States decisions as to whether to enact broader reforms such as individual guarantee issue and individual-to-individual portability. As described in section 302 of the legislation, the committee has asked for a report to evaluate the effectiveness of the provisions of the legislation, and the various State insurance reforms, in ensuring the availability of reasonably priced health insurance to employers and individuals purchasing coverage.

The committee believes that any increased costs associated with the group-to-individual portability provisions of S. 1028 will be minimal. Moreover, the legislation provides States with ample flexibility to spread any increased costs more broadly and to adopt

alternative individual market reforms that may be more appropriate in a particular locale.[17]

Moreover, an independent analysis by the American Academy of Actuaries determined that if the group-to-individual portability provisions of S. 1028 were enacted they could cause a premium increase of as little as 3 percent.[18] This is supported by an actuarial analysis by the accounting firm of Coopers & Lybrand, which found that individual market reforms contemplated in the State of California that are much broader than those contained in S. 1028 would cause premiums to rise by only 4 percent and have a minimal impact on coverage.[19]

*2. COBRA provisions slightly modified*

Because S. 1028 limits the use of preexisting condition exclusions for individuals who maintain continuous coverage, it seemed feasible to amend COBRA to avoid unnecessary duplicative coverage in the case of persons who are now eligible for direct employment-based coverage without preexisting condition exclusions. Therefore, section 121 of the legislation was modified slightly from the original legislation.

*3. Study modified*

The study contained in section 302 of the legislation was modified to require that the Secretary of HHS conduct a two-part study on the effectiveness of State laws and the Health Insurance Reform Act of 1995. As a result, the Secretary is no longer directed to submit a legislative proposal. By January 1, 1997, the Secretary of HHS must provide to Congress: (1) an evaluation of the various mechanisms used to ensure the availability of reasonably priced health insurance to employers and individuals; and (2) an evaluation of whether standards that limit the variation in health insurance premiums will further the purposes of this act. The Secretary must submit a second report by January 1, 1998, evaluating the effectiveness of the provisions of the legislation, and the various State insurance reform laws, in ensuring the availability of reasonably priced health insurance to employers and individuals.

*4. Definitions and preemption language modified*

While not a substantive change, it should be noted that the legislation as reported by the committee contains modifications to several definitions and the preemption language. These changes were intended primarily to make clear that self-insured ERISA plans

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[17] The testimony of several witnesses at the committee's July 18 hearing support this point. For example Kevin Haugh of the Institute for Health Policy Solutions testified at the committee's July 18 hearing that "[i]n my opinion, the very limited nature of this provision will minimize the potential financial impact * * * on the individual market. Evidence from employer surveys and insurer experience in the States suggests that a small percent of individuals leaving an employer elect COBRA or other continuation and a *very, very* small percent of individuals eligible for individual conversion following continuation choose to convert * * * In addition, the bill, in my opinion, strikes a nice State-Federal balance by allowing States to meet the bill's requirements to the extent they have measures in place which achieve similar goals. See Statement of Kevin Haugh, at page 6 (italic in original).

[18] American Academy of Actuaries, August 2, 1995, correspondence to the Senate Committee on Labor and Human Resources.

[19] Coopers & Lybrand, internal memorandum dated March 6, 1995, on "Estimating the Effects of Guaranteed Issue for Individuals and Groups of Two on the Current California Small Group Insurance Market.

continue to be governed by uniform, Federal standards and are subject to oversight by the Federal Government, not the States. It is the intent of the committee that the bill not alter in any way the current preemption language of ERISA.

## C. DETAILED EXPLANATION OF KEY PROVISIONS OF THE LEGISLATION ADOPTED BY THE COMMITTEE

### *1. Structure of the legislation*

Senate bill 1028 is divided into three titles: Title I—Health Care Access, Portability, and Renewability; Title II—Application and Enforcement; and Title III—Miscellaneous. Title I contains the four main subtitles of the legislation: Subtitle A—Group Market Rules; Subtitle B—Individual Market Rules; Subtitle C—COBRA Clarifications; and Subtitle D—Private Health Plan Purchasing Cooperatives. Title II delineates State and Federal Government responsibilities for enforcement of the provisions of the legislation. Finally, Title III amends the Public Health Service Act to allow federally qualified health maintenance organizations to charge a deductible in connection with medical savings accounts and contains several ''sense of the committee'' provisions relating to matters outside of the committee's jurisdiction.

## SECTION 2—DEFINITIONS

The legislation reported by the committee contains several modifications of note in the definition section.

### *2. Definition of Health Plan Issuer*

Rather than the term ''insurance carrier'' or ''insurer'', as used in S. 1028 as introduced, the legislation reported by the committee contains a definition of the term ''Health Plan Issuer.'' The committee intends for the reforms contained in this legislation to extend to entities beyond traditional insurers and therefore believes that the term ''insurer'' may have been too narrow for purposes of this legislation. For example, HMO's and other entities that offer health coverage in the group market and individual market are not necessarily considered insurance carriers and are not always regulated under State insurance laws. Nevertheless, the legislation clearly is designed to extend reforms to HMO's and other entities issuing group and individual health plans. The term ''health plan issuer'' therefore is designed to be broad enough to cover traditional insurance carriers, as well as HMO's and other entities subject to State regulation that offer group health plans and individual health plans, as defined in the legislation.

### *3. Definition of Employee Health Benefit Plan and Group Health Plan*

One of the challenges of constructing the legislation was to extend Federal portability reforms to both the insured and the self-insured market without further blurring the lines of State and Federal responsibility for regulating health plans. To more clearly delineate the roles of the States and the Federal Government, as well as the requirements placed by this legislation on health plan issuers and on health plans offered by employers and unions, the legis-

lation reported by the committee uses two separate terms to describe the types of health coverage offered by these separate entities.

The term "group health plan" is meant to define an insured product, subject to State regulation, that is offered by a health plan issuer to employers or others purchasing on behalf of a group. The term "employee health benefit plan" is meant to define a range of employment-based health benefit plans, whether fully insured or self-insured, that are offered by employers, unions, State governments and churches. Therefore, while an employee health benefit plan should not be construed to be a group health plan or health plan issuer, an employee health benefit plan offering fully-insured health benefits to participants would be providing benefits to participants through a group health plan offered by a health plan issuer. The requirements in the legislation relating to these employee health benefit plans generally are enforced by the Secretary of Labor.

These definitions are designed to be both functional and forward-looking. The committee recognizes that currently there is uncertainty about the legal status of certain arrangements providing health care benefits. This legislation is not designed to settle such issues. However, it is the intent of the committee that as the health care market continues to evolve and the courts further illuminate the reaches of section 514 of ERISA, such arrangements will be covered by the reforms contained in this legislation in one way or another—they will be considered either health plan issuers or employee health benefit plans.

## Title I—Health Care Access, Portability, and Renewability

### *Subtitle A—Group Market Rules*

#### *4. Guaranteed availability and nondiscrimination in the group market*

*Guaranteed availability.*—Section 101(a)(1)(A) of the legislation prohibits insurance carriers, HMO's and other entities issuing health coverage ("health plan issuers") from declining to offer coverage to any employer with two or more employees desiring to purchase coverage. In the current market, insurers and HMO's may refuse to offer coverage to employers that they consider to have an unhealthy work force, or they may offer coverage only to healthy employees. The committee intends for the term "whole group coverage" to require health plan issuers to offer coverage to any employee or dependent whom the employer wishes to cover under the terms of its employee health benefit plan, and to prohibit health plan issuers from excluding any eligible employee or dependent from coverage based on his or her health status.

While this section requires health plan issuers to offer coverage to certain employers, neither this section nor any other provision of the legislation should be construed to require employers to offer or provide health coverage to their employees.

*All-markets requirement.*—The chairman's substitute added the construction clause contained in section 101(c)(2) to make clear that section 101(a) does not require health plan issuers to offer cov-

erage involuntarily in a particular market (defined as the large employer or small employer market). For example, an insurance carrier that sells policies only to large employers would not be required by this legislation to sell policies to small employers.

*Capacity limits*.—Health plan issuers may decline to offer coverage to employers only if the health plan issuer: (1) generally offers coverage on a first-come, first-served basis; (2) ceases to enroll any new employers; and (3) demonstrates to the State insurance commissioner that its financial or provider capacity will be impaired if it is required to enroll additional employers. A health plan issuer that ceases enrollment under this section may not begin enrolling new employers for at least 6 months. This provision is intended to balance the desire to maintain quality service to current enrollees while prohibiting health plan issuers from engaging in "cherry-picking" by offering coverage only to healthy groups.

*Nondiscrimination*.—Section 101(a)(1)(B) prohibits all employee health benefit plans, whether insured or self-insured, and group health plans offered by health plan issuers from establishing eligibility, enrollment, continuation, or premium contribution requirements based on health status, medical condition, claims experience, medical history, evidence of insurability or disability. The legislation does not preclude such health plans from establishing eligibility, enrollment, continuation or contribution rules based on other factors, such as the number of hours per week that an individual works, length of employment, or other factors unrelated to health status, medical condition, claims experience, medical history, evidence of insurability or disability.

The committee recognizes that employer-sponsored group health plans and multiemployer plans have adopted many innovative techniques and programs to control costs. In some cases, such plans actually provide greater benefits or medical services to those in poor health. The committee wishes to make clear that it does not intend for section 101(a)(1)(B) to preclude such practices.

The purpose of section 101(a)(1)(B) is to establish a fair and nondiscriminatory right to participation in a group health plan or employee health benefit plan. The committee does not intend for the language in section 101(a)(1)(B) to prohibit plans from setting uniformly applicable limits on coverage of particular or aggregate benefits, inhibit case-management and other techniques to control improper utilization of covered services, or change rights under the continuation of coverage rules established by COBRA or under the Americans with Disabilities Act. Of course, the committee does not intend to allow such rules if they are merely a subterfuge for discrimination based on health status. For example, a change in eligibility that clearly was directed at one sick employee would not be permissible under this legislation.

*Health promotion and disease prevention*.—Because of the difficulty of constructing language which allows such beneficial practices to continue, while prohibiting plan designs and practices that are intended to discriminate based on health status or other related factors, section 101(a)(2) of the legislation expressly allows employee health benefit plans and health plan issuers offering group health plans to modify premiums, copayments, and deductibles in return for adherence to programs of health promotion and disease

prevention. For example, an employer could offer a reduced premium to non-smokers.

*Genetic information*.—As medical science continues to develop more advanced tests for analyzing and deciphering genetic information, the committee is concerned about individuals being denied access to health care coverage based on genetic information that may be available to insurance carriers, employers, and others offering health coverage. Recent advances have allowed researchers to identify a growing number of genetic characteristics that place individuals at higher-than-average risk of developing disease. Genetic information is unique because it is potentially powerful information not only about an individual's medical future, but also about the medical future of an individual's family members. While genetic information about a person's risk for future disease may help to avoid or manage illness better, it also may put certain individuals at a disadvantage in obtaining health coverage.

Therefore, it is the committee's intent that the terms "health status" and "medical history" as used in section 101(a)(1)(B) of the legislation be interpreted to include information about past, present, or future health status and medical history, including genetic information. The terms "health status" and "medical history" in section 110(a)(1) of subtitle B also should be read to prohibit discrimination based on the use of genetic information in individual health plans. Therefore, the provisions of the bill forbidding group health plans and individual health plans from discriminating based on health status and medical history also should be read to prohibit such plans from establishing eligibility, enrollment, continuation, or premium contribution requirements based on genetic information.

The committee acknowledges that a generally recognized definition of "genetic information" does not exist and that the term may be defined differently under different circumstances. For purposes of this legislation, however, the committee generally intends for the term "genetic information" to mean information about the genes, gene products, or inherited characteristics of an individual covered under the terms of a plan, or about his or her family members. This construction is intended to protect individuals who have, or whose family members have, a gene associated with a genetic disorder. It also is intended to protect couples who are healthy, but have the gene or genes for a recessive disorder that might affect their children.

*5. Guaranteed renewability of group coverage*

*Renewal and reasons for nonrenewal*.—Section 102(a)(1) of the legislation requires health plan issuers to renew group health plans sold to employers with two or more employees at the option of the employer. Health plan issuers may refuse to renew group health plans only for four specified reasons: (1) nonpayment of premiums or untimely payment of premiums; (2) fraud or misrepresentation of material fact; (3) termination of the plan; and (4) failure to meet contribution and participation requirements. Employers who provide coverage for their employees under a contract or policy with a health plan issuer may not be denied renewal by the health plan

issuer for any reason other than those specified in this section of the legislation.[20]

This section does not require employers or unions to continue to provide health coverage to employees or group members. Where an employer elects to continue offering coverage under an employee health benefit plan or group health plan, however, section 102(a)(2) requires that coverage be renewed at the option of participants who were covered under the plan. Employee health benefit plans and health plan issuers renewing group health plans may decline to cover previously covered participants and beneficiaries only for five specified reasons: (1) nonpayment of premiums or untimely payment of premiums; (2) fraud or misrepresentation of material fact; (3) termination of the plan; (4) loss of eligibility for COBRA continuation coverage; and (5) failure to meet eligibility requirements not prohibited by this legislation. Participants and beneficiaries who are covered under an employee health benefit plan or group health plan may not be denied renewal for any reasons other than those specified in this section of the legislation.

*Plan modifications.*—Section 102(b)(1) provides rules which health plan issuers must follow in order to modify the terms of a policy or to discontinue a specific policy and replace it with another. For example, this provision would allow insurance carriers or HMO's to modify the applicable copayment under the plan or to reduce the number of inpatient hospital days covered by the plan if the carrier or HMO provided notice of those changes 90 days prior to the discontinuation of the current plan and offered each plan sponsor or individual purchasing on behalf of a group the option to purchase any other group health plan offered by the carrier.

*Plan termination.*—Section 102(b)(2) provides rules which health plan issuers must follow if they decide to discontinue group health plans and not to replace them. Under this scenario, health plan issuers may discontinue a group health plan only if they discontinue coverage to all employers, participants, and beneficiaries covered under the plan in the State, and provide at least 180 days notice of the discontinuation to the State Insurance Commissioner and to each employer, participant, and beneficiary covered under the plan. Moreover, this section provides that health plan issuers that discontinue a group health plan without replacing such plan may not sell any group plans in the State for 5 years. Health plan issuers may choose to terminate all group health plans offered in the State, or all group health plans offered to small employers only.

*6. Portability of health coverage and limitations on preexisting condition exclusions*

*Limits on preexisting conditions.*—Section 103 of the legislation provides that employee health benefit plans and health plan issuers offering group health plans may not limit or exclude coverage under such plan for more than 12 months for a health condition for which medical advice, diagnosis, care, or treatment was rec-

[20] Health maintenance organizations and other network plans may refuse to renew coverage to individuals for an additional reason. Section 102(c) allows health maintenance organizations and network plans to deny renewal to individuals who neither live nor work in the group health plan's service area, but only if the denial is applied uniformly and without regard to health status.

ommended or received during the 6-month period prior to an individual's enrollment in the plan (without regard to waiting periods). The 12-month preexisting condition limitation does not apply to newborns covered within 30 days of birth, or to pregnancy.

*Cause of the condition irrelevant.*—An amendment offered by Senator Wellstone, and accepted by voice vote during the executive session on August 2, clarifies the intent of the legislation that preexisting conditions are to be treated equally under the terms of the legislation, regardless of their cause. This modification is not intended to prohibit employee health benefit plans and group health plans from applying any preexisting condition limitations to victims of domestic abuse. It is the committee's understanding that most employer-sponsored plans, whether insured or self-insured, generally do not vary the length of preexisting condition periods or limit benefits during a period of exclusion based on the cause of a medical condition. While the language of the provision is broad and applies to all causes of preexisting conditions, the major purpose of Senator Wellstone's amendment was to end the egregious practice by some health plans of denying or limiting health coverage to individuals—particularly women—simply because they have been the victim of domestic abuse.

*Employee benefits remain voluntary.*—The committee wishes to emphasize that nothing in this legislation changes the voluntary nature of employee benefits. This point is emphasized by section 201(c) of the legislation. For example, if an employer-sponsored group health plan or multiemployer plan does not ordinarily provide certain benefits or services under the terms of the plan, or if the plan provides services that are less comprehensive than those available under an individual's prior health coverage, it will not be required by this legislation to provide more comprehensive benefits or services. Similarly, section 103(a)(3) of the legislation should not be read to require an employee health benefit plan or group health plan to provide any benefits relating to pregnancy that the plan does not provide voluntarily or to require a group health plan to provide any benefits relating to pregnancy not otherwise required by applicable State or Federal law.

*Similar coverage standard.*—Section 103(b)(4) allows employee health benefit plans and health plan issuers offering group health plans to exclude coverage for preexisting conditions "only to the extent" that a service or benefit was not covered under the plan in which the individual was enrolled immediately prior to enrollment in the employee health benefit plan or group health plan. For example, if an individual was covered under a catastrophic health plan immediately prior to enrollment in a more comprehensive employee health benefit plan or group health plan and that catastrophic plan had a deductible of $3,000, the current plan could require the individual to cover the first $3,000 of treatments necessitated by a preexisting medical condition, even though the health plan otherwise provides first dollar coverage. This provision is intended to prevent individuals from waiting to obtain comprehensive coverage until they are sick and to protect more comprehensive health plans from adverse selection.

*Late enrollees.*—To encourage individuals to obtain coverage at the first available opportunity, employee health benefit plans and

group health plans offered by health plan issuers may exclude coverage for preexisting health conditions for 18 months for those individuals who enroll in a the plan at a time other than their first opportunity to enroll, except as provided in section 104 of the legislation (special enrollment periods). In order for a longer waiting period to be imposed, the enrollment period during which such individual declined coverage must have lasted for at least 30 days.

*Affiliation periods.*—Under section 103(d) of the legislation, network plans that do not utilize preexisting condition limitations may substitute a 60-day affiliation period (90 days for late enrollees), during which the plan may not be required to provide health benefits and no premium shall be charged to an individual. The purpose of section 103(d) is to provide equitable treatment for plans, such as HMO's, that do not wish to address adverse selection by imposing preexisting condition exclusions.

*Credit for prior coverage.*—Section 103(b) of the legislation provides that the 12-month maximum preexisting condition period allowed under section 103(a) of the bill shall be reduced by one month for each month that an individual was continuously covered under a prior health plan. An individual is considered ''continuously covered'' if he or she has maintained coverage under a group or individual health plan without a break in coverage of greater than 30 days.

Therefore, an individual who has maintained continuous coverage during the year immediately prior to his or her enrollment in a new employee health benefit plan or group health plan (i.e., coverage for at least 11 of the last 12 months) may not be denied coverage for a preexisting condition under a new employee health benefit plan or group health plan. Furthermore, the individual will receive one month of credit against any preexisting condition exclusion under the new plan for each month he or she was covered under the previous plan, even if the individual had been covered under the previous plan for less than 12 months. This provision is the key to providing portability of health coverage and providing incentives for individuals voluntarily to purchase health coverage in a voluntary, employment-based system.

Neither section 103(d) nor any other provision of the legislation should be construed to limit waiting periods that may be applied by employers or unions, as long as such periods are applied uniformly and without regard to health status. For example, an employer-sponsored plan would not be prohibited by this legislation from denying health coverage to all employees, or to all part-time employees, until they have been with the firm for 3 months.

The committee wishes to emphasize, however, that a waiting period cannot be counted against the time an individual is considered to be continuously covered. Therefore, if an individual has otherwise maintained continuous coverage as provided in section 103(b)(3) of the legislation, the individual should be considered to have maintained continuous coverage if he or she enrolls in a new plan within 30 days of the time he or she becomes eligible for such coverage, regardless of the length of any waiting period.

The following examples are designed to illustrate how the provisions of section 103 will work to provide continuity of coverage.

*Example 1: Full 12-month exclusion applied:* Derek is hired by the XYZ corporation and wants to enroll in the group health plan offered to all XYZ employees. XYZ offers a group health plan through an insurance policy with the Safe & Secure Insurance Corporation, which uses a 12-month preexisting condition exclusion (with a 6-month look-back). Derek did not enroll in the group health plan offered by his previous employer, the ABC corporation (or alternatively, ABC did not offer coverage to its employees). Derek is treated for a back condition 2 months before taking the job with XYZ corporation. The Safe & Secure Insurance Corporation may deny coverage for Derek's back condition for up to 12 months.

*Example 2: 12-month exclusion partially reduced:* In the example above, Derek was covered under the ABC corporations's health plan for 9 months prior to taking his new job with the XYZ corporation. Safe & Secure may deny payments for Derek's back treatments for only 3 months.

*Example 3: 12-month exclusion completely reduced:* Same as Example 2, except Derek was covered under ABC corporation's health plan for 12 months or more. Safe & Secure may not deny coverage for Derek's preexisting back condition.

During the committee's hearing on July 18, Mrs. Susan Rogan from Herndon, Virginia, provided a real-life example of how the portability provisions contained in S. 1028 bill will help families who face insurmountable barriers to maintaining health insurance coverage under the current system. Mrs. Rogan testified that her husband changed jobs five times during a ten-year period. Each time, he had to maintain the COBRA coverage available from his previous employer for at least one year, in addition to contributing towards the group health plan offered by his new employer. The family essentially was required to maintain double coverage during these periods because the health coverage offered through each new employer did not cover their daughter's preexisting medical condition. Mrs. Rogan described her family's efforts to maintain continuous coverage as "a nightmare." See testimony of Susan M. Rogan, before the Senate Committee on Labor and Human Resources, July 18, 1995.

The committee wishes to emphasize that, under the provisions of S. 1028, it would be unnecessary for the Rogans to maintain dual coverage because their daughter could not be excluded from coverage under a new group health plan once she was covered under a prior plan for 12 months.

*Portability from individual, group, and governmental plans.*— The committee intends for this section to require employee health benefit plans and group health plans to credit prior continuous coverage obtained under a group health plan, an employee health benefit plan, an individual health plan, or a health plan established under State or Federal law, such as Medicaid. The committee believes that requiring employment-based health plans to credit previous continuous coverage under governmental programs like Medicaid and high-risk pools, will provide additional incentives for individuals to move into the work force without the fear of losing their health coverage.

*Protection for children under the age of one.*—The chairman's substitute added a provision to section 103(b) of the legislation to make clear that newborns who are enrolled in a group health plan within 30 days of birth may not be excluded from coverage under a group or individual health plan during the child's first 12 months of life. Also, as is the case with individuals who are previously enrolled, children cannot be subject to a preexisting condition exclusion once the condition has been diagnosed, if the condition was previously covered. This provision is intended to ensure that children under the age of one are not subjected to new preexisting condition exclusions when their parents change jobs or health plans simply because of their age.

*Administrative burden.*—Section 103(b)(2) of the legislation requires that employee health benefit plans provide participants and beneficiaries with information about benefits, cost-sharing, and dates of coverage after they become ineligible for coverage under the employee health benefit plan. It then becomes the responsibility of the participant or beneficiary to carry this information forward to his or her new employer so that the subsequent plan can readily determine whether the individual is eligible for coverage or whether he or she will face any exclusions or limitations of coverage. This provision is intended to avoid any administrative burden and potential confusion by clearly delineating responsibilities for certifying previous coverage.

*State flexibility.*—The committee bill provides a 12-month exclusion period and 18-month exclusion period for late enrollees in order to eliminate possible abuses of preexisting condition exclusions and to provide incentives in a voluntary market for individuals to obtain coverage at the earliest possible opportunity.

A majority of States utilize a 12-month exclusion period in the small group market. Recognizing, however, that some State laws allow for shorter periods and some States may want to adopt shorter periods in the future, the standards set forth in section 103 of the legislation represent minimum Federal standards with regard to group health plans offered by health plan issuers. Section 103(f) of the legislation specifically permits States to establish shorter preexisting condition limitation periods for group health plans offered by insurance carriers, HMO's and other State-regulated entities that issue contracts or policies of health benefits and to allow individuals to be considered to be in a period of "qualifying previous coverage" if an individual experiences a gap in coverage of greater than 30 days. The committee wishes to emphasize that States may not alter the standards contained in section 103 (or in any other section of this legislation) with regard to self-insured ERISA plans.

*7. Special enrollment periods*

Section 104 of the legislation allows individuals enrolled in an employee health benefit plan or group health plan, including COBRA beneficiaries, to change their enrollment status, under certain circumstances, without being subject to penalties for late enrollment or experiencing gaps in coverage. Section 104 would, for example, allow a recently married individual to change his or her enrollment status from "single" to "family". This section of the leg-

islation also would allow a participant to add a newborn or adopted child to his or her policy as a beneficiary if the employee health benefit plan or group health plan provides coverage for newborns and adopted children. Section 104 also would provide protection in the situation where a married couple elected family coverage under the health plan offered by one spouse's employer and that spouse subsequently lost his or her job or otherwise lost eligibility for coverage through that employer. In that case, the provision would allow the couple to enroll under the other health plan sponsored by the other employer.

*8. Disclosure of information*

Section 105 of the legislation requires health plan issuers to disclose their rating, renewal, and preexisting condition practices to small employers, and to provide information about the benefits and premiums offered under all group health plans available to small employers. States which have adopted provisions requiring health plan issuers to provide this type of information have found that it has had the effect of empowering employer purchasers by providing them with more comparable and easily understood health plan choices.

*Notice of material reductions in covered services.*—An amendment by Senators Jeffords and Kassebaum, accepted by voice vote at the executive session on August 2, amends section 104(b)(1) of ERISA to require plans to notify plan participants of "material reductions in covered services" within 60 days of such reductions or, in the alternative, at 90-day intervals. The Secretary of Labor is directed to issue regulations providing for a list of alternative, cost-effective means of notifying plan participants of such changes.

The provision was added because the committee was concerned that current law, which requires plan sponsors to notify participants of material modifications to a plan (including material reductions in covered services) must be provided to participants within 210 days of the close of the plan year, does not provide sufficient protection to consumers. Because participants in some cases may not receive notice of reductions in covered benefits or services for over a year after such modifications are made, they may unknowingly incur health costs for which they are fully responsible.

The Jeffords-Kassebaum amendment also amended section 102(b) of ERISA to require plan sponsors to provide more specific information to participants in the summary plan description regarding the administration, financing, and resolution of claims. The amendment requires plan sponsors to notify participants of the plan's financing arrangements. In the case of a self-funded employer plan, for example, the employer would be identified as the source of financing. In the case of a plan that is financed through arrangements with stop-loss carriers or carriers offering fully insured group health plans, the carrier also should be identified. In addition, the amendment requires plan sponsors to notify participants of the office, contact, or title of the individual at the United States Department of Labor from whom participants may obtain information regarding their rights under this act and ERISA.

As the health care market continues to evolve, the functions of many health plans are becoming increasingly diversified and

spread among various individuals and entities that fall within different regulatory schemes. As a result, plan participants may turn to a State insurance commissioner for assistance when, in fact, the plan falls under Federal authority. Therefore, the committee believes this provision will help clarify some existing confusion regarding the administration and enforcement of rights under this legislation and ERISA.

*Subtitle B—Individual Market Rules*

*9. Individual health plan portability*

Section 110 of the legislation requires insurance carriers, HMO's and other health plan issuers offering individual health policies to provide coverage to individuals wishing to purchase coverage under certain circumstances. To be eligible for individual coverage under this provision, an individual: (1) must have had continuous coverage for at least 18 months under an employee health benefit plan or group health plan; (2) must not be eligible for coverage under an employee health benefit plan or group health plan or have been terminated from such plan for fraud or failure to make required payments; and (3) must be ineligible for COBRA continuation coverage or must have exhausted eligibility for COBRA continuation coverage.

This section is designed to allow individuals who have maintained employment-based health coverage for at least 18 months (without a break in coverage of more than 30 days) and who have exhausted or are not eligible for COBRA continuation coverage to have access to individual insurance coverage without regard to health status when they lose their job, leave their job to start their own business, or take a job with an employer who does not offer group health coverage.

As discussed in more detail in section IV.B.1. above, this provision was carefully crafted to guarantee access to individuals who make an effort to maintain continuous coverage while addressing the concerns of those who fear that premiums might rise from broader availability of guaranteed coverage in the individual market.

*10. Guaranteed renewability of individual health coverage*

*Renewability.*—Section 111 is nearly identical to the provisions contained in section 102 of the legislation governing renewal of group health plans. It requires health plan issuers to renew individual health policies at the option of the individual, unless: (1) the individual fails to pay premiums or fails to pay premiums in a timely fashion; (2) there is fraud or misrepresentation of material fact on the part of the individual; or (3) the policy is terminated under the procedures specified in the legislation.

*Plan termination.*—The provisions regarding termination of individual insurance policies also are nearly identical to those contained in section 102 of the legislation governing group policies.

*11. State flexibility in individual market reforms*

The committee recognizes that States are experimenting with different methods of making coverage available in the individual mar-

ket and will, in some cases, go further than the committee proposal in guaranteeing affordable coverage. Accordingly, the committee wanted to provide maximum flexibility for States to experiment with different methods of achieving the goals of the legislation. In particular, the committee wished to respond to constructive suggestions made by the National Governors Association (NGA) and the NAIC and to criticisms from the insurance industry, that, unless carefully crafted, the bill would hinder desirable State experimentation.[21]

Specifically, the section now provides that State reforms of the individual market will apply rather than the rules contained in Section 110 and 111 of the legislation, if they achieve the objectives of the legislation.

In evaluating State reforms under this more lenient standard, the legislation requires the Secretary of HHS to consult with a State's governor and insurance commissioner and to consider only those four criteria set forth in section 112(b)(1).

It is the committee's strong intent: (1) that this section provide the framework for a collaborative and consultative process between the Secretary of HHS and the State governor and insurance commissioner; (2) that the Secretary of HHS grant substantial deference to State solutions in evaluating whether a State law meets the goals of providing access to affordable coverage for individuals; and (3) that the Secretary consider only the four factors in section 112(b)(1) in arriving at a determination.

In addition to providing substantial deference to alternative State solutions, the committee intends that, in making a determination under this section, the Secretary of HHS will take a common-sense, flexible approach to determining whether a State plan achieves the broad goals of this bill and will place greater weight on some of the factors specified in subsection 112(b)(1) than on others.

Thus, the committee intends that a program which limits choice of plan beyond what otherwise would be provided in the bill, e.g., through a high-risk pool with only a few coverage options rather than through a guaranteed issue program, would not necessarily be inconsistent with the goals of the bill, particularly if such an approach would keep insurance premiums for all participants in the individual market more affordable than would otherwise be the case. Similarly, a State plan which met the minimum requirements of guaranteed access to affordable coverage but used an entirely different mechanism for achieving this goal than the one provided in the bill, such as participation in a Medicaid buy-in, could also be acceptable if it would result in more affordable coverage for the individual market as a whole, as provided under criterion (b)(1)(D).

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[21] During her testimony before the committee on July 18, Mary Nell Lehnhard from the Blue Cross-Blue Shield Association stated that the NAIC "has taken as its number one priority the development of several model acts to provide options and guidance to States as they attempt to solve the problem of group-to-individual portability. We believe these efforts should be allowed to evolve—and not be cut short by Federal legislation." She added that Blue Cross-Blue Shield hoped the committee would determine "how the Federal Government could best support state reform efforts." Testimony of Mary Nell Lehnhard, Blue Cross-Blue Shield Association, page 11.

With regard to subsection 112(b)(1)(C), the committee's intent is to assure that individuals are not faced with a choice of plans so limited that they would be unable to obtain a comprehensive plan.

With regard to subsection 112(b)(1)(D), the committee's intent is that the Secretary of HHS weigh heavily the impact that requiring a State to modify or replace a current program would have on overall affordability and access for all those who may wish to purchase individual insurance coverage in the State. Moreover, the committee emphasizes that neither this provision nor any of the four factors outlined in section 112(b)(1) are intended to be dispositive, or considered alone. Rather, the Secretary of HHS is expected to consider the totality of the State program with respect to the goals of the legislation, as expressed in the four factors listed in this subsection.

Section 112 is intended to provide substantial leeway for States to craft individualized solutions. State reforms need not be identical to the provisions of section 110 or 111. In this regard, the committee notes that, currently, 20 States have enacted some type of individual insurance market reform. Fourteen States have enacted guaranteed renewability in the individual market, and 18 States have extended some portability reforms to the individual market. Nine States have enacted guaranteed issue requirements in the individual market and Blue Cross-Blue Shield provides guaranteed issue in an additional eight.

In addition, approximately 25 States offer individuals access to high-risk pools, so that people unable to buy insurance in the private individual market can buy from the pool. States use a variety of different mechanisms to subsidize the excess costs of the pools in order to keep insurance affordable. While such programs would not automatically satisfy the criteria set forth in the legislation, many may provide an adequate substitute for the requirements of sections 110 and 111.

Finally, to assure maximum State flexibility, the committee provides a "safe harbor" for any State plan that meets model standards adopted by the NAIC, if the Secretary determines that such standards meet the goals of sections 110 and 111.

### *Subtitle C—COBRA Clarifications*

#### *12. COBRA clarifications*

Section 121 of the legislation contains two modifications to COBRA designed to minimize gaps in health coverage for newborns and adopted children, and individuals with disabilities.

*Modifications improving access for disabled individuals.*—Under current rules, individuals who have coverage through firms with 20 or more workers and lose their coverage because they leave their job, or for certain other reasons, may extend their coverage for an additional 18 months by paying 102 percent of the normal premium. Disabled workers may extend their coverage for an additional 11 months if they pay up to 150 percent of the premium for coverage beyond the initial 18 months. The modification contained in section 121 would allow individuals who have disabled family members or who became disabled at any time during their coverage under an initial COBRA extension period to extend their coverage

for the additional 11-month period currently granted only to workers who are disabled at the time they lose their coverage.

*Modifications improving access for newborns and adopted children*.—In addition, the committee intends for section 121 to clarify that newborns and adopted children may be covered immediately under a parent's COBRA policy. As COBRA currently is interpreted, newborns and adopted children are not eligible for coverage until the group health plan's next open enrollment period.

*Subtitle D—Private Health Plan Purchasing Cooperatives*

*13. Section 131. Health plan purchasing cooperatives*

Because small employers and individuals are at a significant disadvantage in terms of access to affordable health insurance, section 131 of the legislation creates incentives for individuals and employers to form private, voluntary cooperatives to purchase health insurance and negotiate with providers and health plans.

The provisions of subtitle D are intended to create special benefits for cooperatives meeting the standards of this subtitle. It is not intended to affect in any way the legal status or rights of purchasing cooperatives, employer coalitions, multi-employer plans, multiple employer welfare arrangements, or similar arrangements not meeting the standards of subtitle D. States are not required to establish cooperatives. Individuals and employers are not required to purchase health insurance through cooperatives, and the legislation does not prohibit or preclude any other type of group purchasing arrangements from existing.

Health plan purchasing cooperatives under this legislation are certified under State law and registered with the Secretary of Labor. They must purchase insured products, may not bear risk, or be controlled by, or affiliated with, health plan issuers. Cooperatives must be governed by a board of directors representing a broad cross-section of employers, employees, and individuals participating in the cooperative. Individuals associated with health plan issuers may not underwrite cooperatives nor serve on their board of directors. In addition, cooperatives must contract with multiple, unaffiliated health plans. The purpose of these requirements is to ensure that cooperatives are employer-controlled and to prevent against the possibility that they become captives of any health plan issuer. However, the committee does not intend by these provisions to prohibit a cooperative from contracting with insurance companies, brokers, or others with appropriate expertise to provide administrative or consultative services.

Moreover, it should be emphasized that the rules regarding individual health plans and group health plans established elsewhere in the legislation (e.g., guaranteed renewal, nondiscrimination, portability), or by State laws not preempted by the legislation, also apply to health plans offered by health plan issuers to a cooperative.

Cooperatives may determine the maximum size of the employer they wish to include, whether they wish to include individuals as well as groups, or individuals or groups alone, and the marketing area they wish to serve (unless a State requires a cooperative to serve a specific geographic area). They must then accept all em-

ployers and individuals who meet these requirements, regardless of health status, on a first-come, first-served basis. The committee anticipates that cooperatives will compete, in part, on the basis of membership fees charged to enrollees. The legislation permits cooperatives to charge enrollment fees and allows such fees to vary based on factors—such as the size of an employer—that are not based on ''health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability'' as prohibited by section 131(g)(3). Nothing in the legislation should be read to prohibit organizations sponsoring cooperatives, such as chambers of commerce, from charging one fee to cover both membership in the cooperative and in the sponsoring organization, as long as such fee is not based on health status or the other factors listed in section 131(g)(3).

In order to facilitate the formation of health plan purchasing cooperatives and allow them to be active purchasers in the health care market, Section 131(h) of the legislation preempts certain State laws that prevent groups of employers from joining together to purchase insurance (''fictitious group laws'') and negotiate with health plans and providers. In addition, pursuant to an amendment offered by Senator Jeffords and accepted by voice vote during the executive session on August 2, this section allows health plan issuers to offer less-costly, scaled-back benefit packages to cooperatives in those States that have adopted such packages for small employers. Cooperatives operating in States that have not adopted such benefit packages as part of their small group insurance reforms must continue to comply with all State-mandated benefits, if any.

## Title II—Application and Enforcement of Standards

### *Applicability, preemption, and enforcement*

*Applicability.*—Section 201 of the bill provides that nothing in the legislation shall be construed to prevent States from establishing, implementing, or continuing in effect health insurance standards and requirements not prescribed in the legislation or standards and requirements that are related to the issuance, renewal, or portability of health insurance, or the establishment or operation of group purchasing arrangements, that are consistent with and are not in direct conflict with the provisions of this legislation, and provide greater protection or benefit to individuals.

For example, States may require insurance companies to publish report cards or other types of consumer information other than what is required under this bill. In addition, States may require that insurance companies wait more than 5 years before reentering a particular market, as specified in this legislation. In both of these cases, State regulation provides greater protection or benefit to individuals and is not in direct conflict with the provisions of this legislation.

Section 201(b) emphasizes again that nothing in the legislation shall be construed to affect or modify ERISA's preemption provisions. It is the intent of the committee that the bill not alter in any way the current preemption language of ERISA. The States traditionally have regulated the business of insurance. Health benefit plans offered by employers and unions have been governed by a na-

tional scheme under ERISA for over two decades. Senate bill 1028 builds upon and enhances that structure; it should not be read to modify it.

*Enforcement.*—Section 202 of the legislation provides that requirements or standards imposed on health plan issuers offering group health plans or individual health plans shall be enforced by the State insurance commissioner for the State involved, or the official or officials designated by the State to enforce the requirements of this act. It also requires States to file an enforcement plan with the Secretary. The legislation does not mandate the type of enforcement mechanisms States must use. Instead, it allows each State the flexibility to adopt whatever sanction or allow whatever remedy a State believes necessary to carry out the purposes of this legislation.

The Secretary of Labor will enforce the requirements of the legislation with regard to employee health benefit plans, and the legislation provides specific enforcement authority for this purpose. If a State fails to substantially enforce the standards contained in the legislation, the Secretary of Labor will enforce those standards directly against health plan issuers. While the NAIC and NGA support the division of authority provided in this section of the legislation, and the committee does not envision a State surrendering its authority and responsibility for the regulation of health insurance, the committee believes that this provision is necessary to avoid the current prohibition on Federal legislation containing unfunded State mandates.

The committee intends for the enforcement provisions to build upon and maintain, to the extent possible, the current division of enforcement authority between the States and the Federal Government. Therefore, except in the case of a substantial State failure to enforce the provisions of this act under section 202(c), the Secretary shall not enforce the standards of the act with respect to health plan issuers and, in no case, shall a State enforce the standards of the act relating to employee health benefit plans.

## Title III—Miscellaneous Provisions

### *15. HMO's allowed to offer plans with deductibles to individuals with medical savings accounts*

Section 301 of the legislation amends the Public Health Service Act to allow health maintenance organizations to charge deductibles to an HMO member if the member has a medical savings account. The Public Health Service Act currently does not allow HMO's to charge deductibles in connection with medical savings accounts. This provision would clear away the one Federal legal hurdle to HMO's offering medical savings accounts. The committee emphasizes that the decision of an HMO to offer such an option would be voluntary.

Section 301 also contains language stating that it is the "sense of the Senate that Congress should take measures to further the purposes of this act, including any necessary changes to the Internal Revenue Code of 1986, to encourage groups and individuals to obtain health coverage, and to promote access, equity, portability, affordability, and security of health benefits." This represents the

recognition that many desirable tax code changes are outside this committee's jurisdiction.

*MSA amendment.*—An amendment to this section offered by Senators Frist, Coats, Gregg, and Abraham during the committee's executive session on August 2, which passed by a roll call vote of 9 yeas to 7 nays, states that it is the "sense of the Committee on Labor and Human Resources that the establishment of medical savings accounts * * * should be encouraged as part of any health insurance reform legislation passed by the Senate" through the use of tax incentives. Members of the committee supporting the Frist amendment believe that medical savings accounts offer an important opportunity to reduce health care costs and expand choices for individuals. While such accounts are not under the jurisdiction of the Committee on Labor and Human Resources, they wished to express their support for inclusion of such a proposal in reform legislation.

## V. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
*Washington, DC, September 22, 1995.*

Hon. NANCY LANDON KASSEBAUM,
*Chairman, Committee on Labor and Human Resources, U.S. Senate, Washington, DC.*

DEAR MADAM CHAIRMAN: The Congressional Budget Office [CBO] has reviewed S. 1028, the Health Insurance Reform Act of 1995, as ordered reported by the Senate Committee on Labor and Human Resources on August 2, 1995. CBO estimates that enactment of S. 1028 would not significantly affect the federal budget. (Each state's insurance commissioner would ensure that the requirements of this legislation are carried out by health insurance carriers in their state; CBO has not attempted to estimate the amount by which state government spending could be changed.) Pay-as-you-go procedures would apply because the bill could affect direct spending and receipts. The estimated change in direct spending and receipts, however, is not significant.

This bill would create uniform national standards intended to improve the portability of private health insurance policies. For example, these standards would allow workers with employment-based policies to continue their coverage more easily when changing or leaving jobs. Because most private insurance plans require a waiting period before new enrollees become eligible for coverage, especially for preexisting medical conditions, workers with chronic conditions or other health risks may face gaps in their coverage when they change jobs. Alternatively, such workers may be hesitant to change jobs because they fear the temporary loss of coverage, a situation known as "job-lock."

S. 1028 would reduce the effective length of exclusions for preexisting conditions by crediting enrollees for continuous coverage by a previous insurer. Insurance companies would be prohibited from denying certain coverages based on the medical status or experience of individuals or groups and would be required to renew coverage in most cases. Insurers could not deny coverage to individ-

uals who have exhausted their continuing coverage from a previous employer. This bill would allow individuals to change their enrollment status without being subject to penalties for late enrollment if their family or employment status changes during the year. To the extent that states have not already implemented similar rules, these changes would clarify the insurance situation and possibly reduce gaps in coverage for many people.[1]

Because the bill would not regulate the premiums that plans could charge, the net number of people covered by health insurance and the premiums that they pay would continue to be influenced primarily by current market forces. In other words, although insurance would become more portable for some people under this bill, it would not become any more or less available in general.

S. 1028 could affect the federal budget in two primary ways. First, if the bill changed the amount of employer-paid health premiums, total federal tax revenues could change. For example, if the amount employers paid for premiums rose, cash wages would probably fall, thereby reducing income and payroll tax revenues. If individuals paid more for individually-purchased insurance, they could increase their itemized deductions for health expenses. Second, if the bill caused people insured by Medicaid or government health programs to purchase private coverage, then federal outlays for those programs could change.

According to the General Accounting Office [GAO], 38 states have enacted legislation to improve the portability and renewability of health plans among small employers.[2] The state laws do not apply to employees of larger firms with self-funded insurance plans, however, and the GAO report finds that state laws generally do not apply to the market for individually-purchased insurance.

Because many insurance reforms have already been implemented by the states, GAO assumes that the new national standards created by S. 1028 would not significantly change the insurance market for most people. Although the national standards created by S. 1028 would improve the portability of health insurance for some additional groups or individuals, GAO assumes that the incremental change in the insurance marketplace would be minor. Any changes to overall insurance coverage or premiums caused by the bill would probably be small, and the direction of the change is uncertain. Most people subject to the new insurance rules would have had coverage under the old rules, so their total health spending would probably not be noticeably different. Therefore federal revenues would be unlikely to change.[3]

CBO estimates that federal outlays for Medicaid would not change because any persons eligible for free coverage from Medicaid under current law would also seek out Medicaid coverage if S. 1028 was enacted. CBO also estimates that the bill would cause no

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[1] For additional discussion, see GAO testimony "Health Insurance Regulations, National Portability Standards Would Facilitate Changing Health Plans," July 18, 1995, before the Senate Committee on Labor and Human Resources.

[2] Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GAO/HEHS–95–161FS, June 12, 1995).

[3] CBO cooperates with the Joint Committee on Taxation to produce estimates of revenue changes under proposals that would change the private health insurance market. Following CBO's estimate that S. 1028 would not significantly change spending for private health insurance, the Joint Committee assumes that federal revenues would not change.

appreciable changes to federal outlays for Medicare, Federal Employees Health Benefits, or other federal programs.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Jeff Lemieux.

Sincerely,

JAMES L. BLUM
(For June E. O'Neill, *Director*).

## VI. REGULATORY IMPACT STATEMENT

The committee has determined there will be only a negligible increase in the regulatory burden of paperwork as the result of this legislation.

## VII. SECTION-BY-SECTION ANALYSIS

*Sec. 1. Short title; Table of contents*

Section 1 provides that the Act be cited as the "Health Insurance Reform Act of 1995".

Section 1(b) contains the table of contents.

*Sec. 2. Definitions*

Subsection (1) defines "beneficiary" as that term is defined under section 3(8) of the Employee Retirement Income Security Act of 1974.

Subsection (2) defines "employee" as that term is defined under section 3(6) of the Employee Retirement Income Security Act of 1974.

Subsection (3) defines "employer" as that term is defined under section 3(5) of the Employee Retirement Income Security Act, except that the term includes only employers of two or more employees.

Subsection (4) defines "employee health benefit plan" as any employee welfare benefit plan, governmental plan, or church plan (as defined under the Employee Retirement Income Security Act of 1974) that provides or pays for health benefits, such as provider and hospital benefits, for participants and beneficiaries whether directly, through a group health plan, or otherwise.

An "employee health benefit plan" does not include the following or any combination of the following: (1) coverage only for accident, or disability income insurance, or any combination thereof; (2) Medicare supplemental health insurance; (3) coverage issued as a supplement to liability insurance; (4) liability insurance, including general liability insurance and automobile liability insurance; (5) workers compensation or similar insurance; (6) automobile medical payment insurance; (7) coverage for a specified disease or illness; (8) hospital or fixed indemnity insurance; (9) short-term limited duration insurance; (10) credit-only, dental-only, or vision-only insurance; (11) a health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subsection (5) defines a "family" as an individual, the individual's spouse, and the child of the individual, if any and defines "child" as any individual who is a child within the meaning of the Internal Revenue Code of 1986.

Subsection (6) defines ''group health plan'' as any contract, policy, certificate, or other arrangement offered by a health plan issuer to a group purchaser that provides or pays for health benefits, such as provider and hospital benefits, in connection with an employee health benefit plan.

A ''group health plan'' does not include the following or any combination of the following: (1) coverage only for accident, or disability income insurance, or any combination thereof; (2) Medicare supplemental health insurance; (3) coverage issued as a supplement to liability insurance; (4) liability insurance, including general liability insurance and automobile liability insurance; (5) workers compensation or similar insurance; (6) automobile medical payment insurance; (7) coverage for a specified disease or illness; (8) hospital or fixed indemnity insurance; (9) short-term limited duration insurance; (10) credit-only, dental-only, or vision-only insurance; (11) a health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subsection (7) defines ''group purchaser'' as any person or entity that purchases or pays for health benefits, such as provider or hospital benefits, on behalf of two or more participants or beneficiaries in connection with an employee health benefit plan. However, a health plan purchasing cooperative defined under section 131 shall not be considered to be a group purchaser.

Subsection (8) defines ''health plan issuer'' as any entity that is licensed by a State to offer a group health plan or an individual health plan.

Subsection (9) defines ''participant'' as that term is defined under section 3(7) of the Employee Retirement Income Security Act of 1974.

Subsection (10) defines ''plan sponsor'' as that term is defined under section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

Subsection (11) defines ''Secretary'' as the Secretary of Labor, unless otherwise specified.

Subsection (12) defines ''State'' as each of the several States, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

## Title I—Health Care Access, Portability, and Renewability

### *Subtitle A—Group Market Rules*

#### *Sec. 101. Guaranteed availability of health coverage*

Section 101(a)(1)(A) requires health plan issuers to offer whole group coverage to any group purchaser desiring to purchase coverage. Section 101(a)(1)(B) prohibits employee health benefit plans and health plan issuers offering group health plans from establishing eligibility, continuation of eligibility, enrollment, or premium contribution requirements based on health status, medical conditions, claims experience, receipt of health care, medical history, evidence of insurability, or disability.

Section 101(a)(2) allows an employee health benefit plan or a health plan issuer to offer premium discounts or modify copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Section 101(b)(1) allows a health plan issuer offering a group health plan to cease offering coverage to group purchasers only where the health issuer ceases to offer coverage to any additional group purchasers or where the health plan issuer can demonstrate that its financial or provider capacity to serve previously covered participants and beneficiaries will be impaired if the health plan issuer is required to offer coverage to additional group purchasers. Once a health plan issuer ceases to offer coverage to group purchasers, that health plan issuer is prohibited from offering coverage for a 6-month period or until the health plan issuer can demonstrate adequate capacity, whichever is later.

Section 101(b)(2) requires health plan issuers that want to begin offering health plans after a period of cessation as described in section 101(b)(1) to offer coverage on a first-come first-served basis or other basis determined by the State to assure a fair opportunity to enroll in the plan and avoid risk selection.

*Sec. 102. Guaranteed renewability of health coverage*

Section 102(a)(1) requires that health plan issuers renew group health plans at the option of group purchasers, except in the case of nonpayment or untimely payment of premiums or contributions, fraud or misrepresentation of material fact on the part of the group purchaser, the termination of the group health plan, or the failure of the group purchaser to meet contribution or participation requirements. Subsection 102(a)(2) allows participants to renew coverage under an employee health benefit plan or group health plan if the group purchaser elects to continue to provide coverage under a group health plan, except under certain circumstances.

Section 102(b) defines the terms under which a health plan issuer may discontinue a particular type of group health plan or all group health plans in a State. If a health plan issuer discontinues all group health plans in a State, the health plan issuer may not issue any group health plan in the State for a 5-year period beginning on the date of the discontinuation of the last group health plan.

Section 102(c) permits network plans to deny continued participation to participants or beneficiaries who neither live, reside, nor work in an area in which the network plan is offered, but only if the denial is applied uniformly and without regard to health status or the insurability of particular participants.

*Sec. 103. Portability of health coverage and limitation on preexisting condition exclusions*

Section 103(a) allows an employee health benefit plan and a health plan issuer offering a group health plan to impose a limitation or exclusion of benefits relating to treatment of a preexisting condition only if the limitation or exclusion: (1) extends for not more than 12 months after the date of enrollment in the plan; (2) is not applicable to an individual who within 30 days of the date

of birth or placement for adoption, was covered under the plan; and (3) is not applicable to a pregnancy.

Section 103(b) requires crediting of previous qualifying coverage for individuals. Under this provision, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month of previous qualifying coverage. Previous qualifying coverage means the period beginning on the date the participant or beneficiary is enrolled in a group health plan or an employee health benefit plan, and ending on the date not enrolled. It also means the period beginning on the date an individual is enrolled under an individual health plan or under a public or private plan established under State or Federal law, and ending on the date the individual is not enrolled.

Under Section 103(b)(2), an employee health benefit plan shall provide documentation of coverage to participants and beneficiaries whose coverage is terminated under the plan. The documentation shall include the dates of coverage and the benefits and cost-sharing arrangements available.

With respect to late enrollees in a group health plan or an employee health benefit plan, section 103(c) allows for a preexisting condition exclusion that does not exceed 18 months beginning on the date of coverage under the plan.

Section 103(d) allows a group health plan or employee health benefit plan to apply a 60-day affiliation period if the plan does not utilize a preexisting condition limitation or exclusion, and a 90-day affiliation period for late enrollees.

Section 103(e) defines "preexisting condition" as a condition, regardless of the cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior to coverage.

Section 103(f) clarifies that nothing in this section should be construed to preempt State laws that require health plan issuers to impose a preexisting condition limitation or exclusion period that is shorter than provided for under this section, and that nothing in this section shall be construed to preempt State laws that allow individuals, participants, and beneficiaries to be considered in a period of previous qualifying coverage if there is a lapse of greater than the 30-day period provided for in this act.

*Sec. 104. Special enrollment periods*

Section 104 provides that in the case of a participant, beneficiary or family member who, under a group health plan, an individual health plan, or an employee health benefit plan, experiences a change in family composition affecting eligibility, experiences a loss of eligibility or experiences a change in employment status, each group health plan and employee health benefit shall provide for a special enrollment period that would permit the participant to change the individual or family basis of coverage or to enroll in the plan under certain circumstances.

*Sec. 105. Disclosure of information*

Section 105(a) requires health plan issuers offering group health plans to small employers to make a reasonable disclosure to such employers of: (1) the provisions of a group health plan concerning

the health plan issuer's right to change premium rates and factors that may affect changes in premium rates; (2) the provisions of a group health plan relating to renewability of coverage; (3) the provisions of a group health plan relating to any preexisting condition provision; and (4) descriptive information about the benefits and premiums available under all group health plans for which the employer is qualified.

Section 105(b)(1) amends section 104(b)(1) of the Employee Retirement Income Security Act to require ERISA plans to notify plan participants of ''material reductions in covered services'' within 60 days of such reductions or, in the alternative, at 90-day intervals. The Secretary of Labor is directed to issue regulations providing for a list of alternative, cost-effective means of notifying plan participants of such changes.

Section 105(b)(2) amends section 102(b) of the Employee Retirement Income Security Act to require plan sponsors to provide more specific information to participants in the summary plan description regarding the administration, financing, and resolution of claims.

*Subtitle B—Individual Market Rules*

*Section 110. Individual health plan portability*

Section 110(a) requires health plan issuers offering individual health plans to provide coverage to individuals wishing to purchase coverage under certain circumstances. Section 110(a) also allows health plan issuers to offer premium discounts or modify copayments or deductibles in return for adherence to programs of health promotion and disease prevention. To be eligible for individual coverage under this provision, an individual: (1) must have had continuous coverage for at least 18 months under an employee health benefit plan or group health plan; (2) must not be eligible for coverage under an employee health benefit plan or group health plan or have been terminated from such plan for fraud or failure to make required payments; and (3) must be ineligible for COBRA continuation coverage or must have exhausted eligibility for COBRA continuation coverage.

Section 110(c) allows a health plan issuer offering an individual health plan to cease offering coverage to individuals only where the health issuer ceases to offer coverage to any additional individuals or where the health plan issuer can demonstrate that its financial or provider capacity to serve previously covered individuals will be impaired if the health plan issuer is required to offer coverage to additional individuals purchasers. Once a health plan issuer ceases to offer coverage under this section, that health plan issuer is prohibited from offering coverage for a 6-month period or until the health plan issuer can demonstrate adequate capacity, whichever is later. At that time, the health plan issuer must offer coverage on a first-come first-served basis or other basis determined by the State to assure a fair opportunity to enroll in the plan and avoid risk selection.

*Section 111. Guaranteed renewability of individual health coverage*

Section 111 is nearly identical to the provisions contained in section 102 of the legislation governing renewal of group health plans. It requires health plan issuers to renew individual health plans at the option of the individual, unless: (1) the individual fails to pay premiums or fails to pay premiums in a timely fashion; (2) there is fraud or misrepresentation of material fact on the part of the individual; or (3) the health plan is terminated under the procedures specified in the legislation.

The provisions regarding termination of individual health plans also are nearly identical to those contained in section 102 of the legislation governing group health plans.

*Section 112. State flexibility in individual market reforms*

Section 112 provides that State reforms of the individual market will apply in lieu of the provisions contained in sections 110 and 111 of the act, unless the Secretary of HHS determines that such State reforms do not achieve the goals of providing access to affordable coverage for individuals described in sections 110 and 111 of the act.

The Secretary of HHS must consult with a State's governor and insurance commissioner and consider only those four criteria set forth in section 112(b)(1): (1) whether the State law or program provides access to affordable coverage; (2) whether the State law or program provides coverage for preexisting conditions; (3) whether the State law or program provides individuals with a choice of health plans or comprehensive coverage; and (2) whether the State law or program will have an adverse impact on the number of individuals having access to affordable coverage.

In addition, if a State plan meets model individual market reform standards adopted by the NAIC and approved by the Secretary of HHS, a State shall be deemed to have met the requirements of sections 110 and 111 of the act without further review.

*Section 113. Definition*

Section 113 defines an individual health plan as a contract, policy, certificate, or other arrangement offered by a health plan issuer to individuals that provides or pays for health benefits, such as provider and hospital benefits. An individual health plan does not include the following or any combination of the following: (1) coverage only for accident, or disability income insurance, or any combination thereof; (2) Medicare supplemental health insurance; (3) coverage issued as a supplement to liability insurance; (4) liability insurance, including general liability insurance and automobile liability insurance; (5) workers compensation or similar insurance; (6) automobile medical payment insurance; (7) coverage for a specified disease or illness; (8) hospital or fixed indemnity insurance; (9) short-term limited duration insurance; (10) credit only, dental-only, or vision-only insurance; (11) a health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

*Subtitle C—COBRA Clarifications*

*Sec. 121. COBRA clarifications*

Section 121 amends the Consolidated Omnibus Budget Reconciliation Act (COBRA) to allow individuals who have disabled family members or who become disabled at any time during their coverage under an initial COBRA extension period to extend their coverage for the additional 11-month period currently available only to workers who are disabled at the time they lose their coverage.

Section 121 also amends COBRA to clarify that newborns and adopted children may be covered immediately under a parent's COBRA policy.

*Subtitle D—Private Health Plan Purchasing Cooperatives*

*Section 131. Private health plan purchasing cooperatives*

Section 131(a) defines a health plan purchasing cooperative as a group of individuals or employers that form a cooperative on a voluntary basis to purchase individual or group health plans.

Section 131(b) provides that a group desiring to form a health plan purchasing cooperative under this act be certified by a State and registered with the Secretary and that, in the case of a State refusal to certify, the Secretary shall certify cooperatives.

Section 131(c) requires each health plan purchasing cooperative to have a board of directors and provides requirements for such board.

Section 131(d) allows health plan purchasing cooperatives to establish limits on the size of employers and decide whether to accept individuals as members. Once membership criteria are set, a health plan purchasing cooperative must accept members on a first come, first-served basis. Section 131(d) also allows health plan purchasing cooperatives to establish a marketing area in those States that do not define such marketing areas.

Section 131(e) provides certain mandatory and permissible health plan purchasing cooperative activities and section 131(f) provides certain limitations on activities of a health plan purchasing cooperative.

Section 131(g)(1) preempts State fictitious group laws with respect to health plan purchasing cooperatives meeting the requirements of this section. Section 131(g)(2) provides for limited preemption of State rating laws and benefit mandates with respect to group health plans and individual health plans offered by health plan issuers to a health plan purchasing cooperative meeting the requirements of this section.

Title II—Application and Enforcement of Standards

*Sec. 201. Applicability*

Section 201(a) provides that: (1) requirements or standards imposed under the act on group health plans and individual health plans shall be deemed to be requirements imposed on health plan issuers; (2) requirements or standards imposed under the act on group health plans offered by health plan issuers in connection with employee health benefit plans shall be enforced by the State

insurance commissioner for the State involved or other official designated by the State to enforce the requirements of the Act; and (3) except in the case of a substantial State failure to enforce the provisions of this act under section 202(c), the Secretary shall not enforce the standards of the act with respect to health plan issuers and, in no case, shall a State enforce the standards of the act relating to employee health benefit plans.

Section 201(a) also provides that nothing in the legislation shall be construed to prevent States from establishing, implementing, or continuing in effect health insurance standards and requirements not prescribed in the legislation or standards and requirements that are related to the issuance, renewal, or portability of health insurance, or the establishment or operation of group purchasing arrangements, that are consistent with and are not in direct conflict with the provisions of this legislation, and provide greater protection or benefit to individuals.

Section 201(b) provides that nothing in the legislation shall be construed to affect or modify the preemption provisions of the Employee Retirement Income Security Act.

*Sec. 202. Enforcement of standards*

Section 202 requires each State to file an enforcement plan with the Secretary of Labor. The Secretary will enforce the requirements of the legislation with regard to employee health benefit plans. If a State fails to substantially enforce the standards contained in the legislation, the Secretary of Labor will enforce those standards directly against health plan issuers.

Section 202(e) allows the Secretary to promulgate regulations necessary or appropriate to carry out this act. Section 202(f) amends the Employee Retirement Income Security Act to allow the Secretary to use appropriated funds to enforce the requirements of this act.

Title III—Miscellaneous Provisions

*Sec. 301. HMO's allowed to offer plans with deductibles to individuals with medical savings accounts*

Section 301(a) amends section 1301(b) of the Public Health Service Act to allow health maintenance organizations to charge deductibles to an HMO member if the member has a medical savings account.

Section 301(b) states that it is the "sense of the Committee on Labor and Human Resources" that the establishment of medical savings accounts should be encouraged as part of any health insurance reform legislation passed by the Senate through the use of tax incentives.

Section 301(c) further states that it is the "sense of the Senate" that Congress should take measures to further the purposes of this act, including any necessary changes to the Internal Revenue Code of 1986, to encourage groups and individuals to obtain health coverage, and to promote access, equity, portability, affordability, and security of health benefits.

*Sec. 302. Health coverage availability study*

Section 302 requires the Secretary of HHS conduct a two-part study on the effectiveness of State laws and the Health Insurance Reform Act of 1995. By January 1, 1997, the Secretary of HHS must provide to Congress: (1) an evaluation of the various mechanisms used to ensure the availability of reasonably priced health insurance to employers and individuals; and (2) an evaluation of whether standards that limit the variation in health insurance premiums will further the purposes of this act. The Secretary must submit a second report by January 1, 1998, evaluating the effectiveness of the provisions of the legislation, and the various State insurance reform laws, in ensuring the availability of reasonably priced health insurance to employers and individuals.

*Sec. 303. Sense of the committee concerning Medicare*

Section 303 states that it is the "sense of the Committee on Labor and Human Resources" that the Senate should take measures necessary to reform the Medicare program, to provide increased choice for seniors, and to respond to the findings of the Public Trustees by protecting the short-term solvency and long-term sustainability of the Medicare program.

*Sec. 304. Effective date*

Section 304 provides that the provisions of the act, except where otherwise provided, shall apply to all group health plans and individual health plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1996, and shall apply to all employee health benefit plans on the first day of the first plan year beginning on or after January 1, 1996.

*Sec. 305. Severability*

Section 305 provides that if any provision of the act or application of such provision is held to be unconstitutional, the remainder of the act shall not be affected.

## VIII. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

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### HEALTH INSURANCE REFORM ACT OF 1995

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### TITLE 29, U.S. CODE

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SEC. 1024 * * *

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(b) * * *

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(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary plan description, and all modifications and changes referred to in section [102(a)(1)] *102(a)(1) that is not a material reduction in covered services or benefits provided,*

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(B) * * *

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*If there is a modification or change described in section 102(a)(1) that is a material reduction in covered services or benefits provided, a summary description of such modification or changes shall be furnished to participants not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Reform Act of 1995, providing alternative mechanisms to delivery by mail through which employee health benefit plans may notify participants of material reductions in covered services or benefits.*

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(c) Statement of rights. The Secretary may by regulation require that the administrator of any employee benefit plan furnish to each participant and to each beneficiary receiving benefits under the plan a statement of the rights of participants and beneficiaries under this title. *Such statement may include information regarding the extent to which benefits under such plan are provided through arrangements with insurance or financed by the plan sponsor, and information regarding the enforcement of the rights of participants and beneficiaries under this title or under the laws of any State.*

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SEC. 1022 * * *

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(b) The plan description and summary plan description shall contain the following information: The name and type of administration of the plan *including the office or title of the individual who is responsible for approving or denying claims for coverage of benefits* ; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan *including the name of the organization responsible for financing claims* and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the

records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan *including the office, contact, or title of the individual at the Department of Labor through which participants may seek assistance or information regarding their rights under this Act and the Health Insurance Reform Act of 1995 with respect to health benefits that are not offered through a group health plan* and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of this Act).

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TITLE 42, U.S. CODE

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SEC. 300bb–2 * * *

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(2) * * *

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(A) * * *

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(iv) * * *

In the case of an individual, *or a beneficiary-family member of the individual,* who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 2203(2)

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(D) * * *

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(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion *except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1995* or limitation with respect to any preexisting condition of such beneficiary, or

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(E) Termination of extended coverage for disability. In the case of a qualified beneficiary who is disabled ⌊at the time of a qualifying event described in section 2203(2)⌋ *at any time during the initial 18-month period of continuing coverage under this title,* the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

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SEC. 300bb–5 * * *

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(1) * * *

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(C) * * *

(i) the date described in subparagraph (A), [or]

(ii) in the case of any qualified beneficiary who receives notice under section 2206(4), the date of such notice[.] *or,*

*(iii) in the case of an individual described in the last sentence of section 2202(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.*

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*(3) LIMITATION.—To the extent that an individual is enrolled in a group health plan and a limitation or exclusion of benefits relating to the treatment of a preexisting condition (as defined in section 103(e) of the Health Insurance Reform Act of 1995) would not apply to such individual, such individual shall not be entitled to elect continuation coverage under this title, except that nothing in this paragraph shall be construed to require continuation coverage under this title for an individual who is not subject to a preexisting condition exclusion as a result of the enactment of the Health Insurance Reform Act of 1995.*

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SEC. 300bb–6 * * *

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(3) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 2203 within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled [at the time of a qualifying event described in section 2203(2)] *at any time during the initial 18-month period of continuing coverage under this title* is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled, and

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SEC. 300bb–8 * * *

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(3) * * *

(A) * * *

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(ii) * * *

*Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this title.*

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TITLE 29, U.S. CODE

SEC. 1162 * * *

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(2) * * *

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(v) * * *

In the case of an individual *or a beneficiary-family member of the individual,* who is determined, under title II or XVI of the Social Security Act, to have been disabled [at the time of a qualifying event described in section 603(2)] *at any time during the initial 18-month period of continuing coverage under this part,* any reference in clause (i) or (ii) to 18 months with respect to such event is deemed a reference to 29 months, but only if the qualified beneficiary has provided notice of such determination under section 603(3) before the end of such 18 months.

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(D) * * *

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(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion *except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1995* or limitation with respect to any preexisting condition of such beneficiary, or

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(E) Termination of extended coverage for disability. In the case of a qualified beneficiary who is disabled [at the time of a qualifying event described in section 603(2)], *at any time during the initial 18-month period of continuing coverage under this part* the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

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SEC. 1165 * * *

(1) * * *

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(C) * * *

(i) the date described in subparagraph (A), [or]

(ii) in the case of any qualified beneficiary who receives notice under section 606(4), the date of such notice[.], *or*

*(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.*

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*(3) LIMITATION.—To the extent that an individual is enrolled in a group health plan and a limitation or exclusion of benefits relating to the treatment of a preexisting condition (as defined in section 103(e) of the Health Insurance Reform Act of 1995) would not apply to such individual, such individual shall not be entitled to elect continuation coverage under this part, except that nothing in this paragraph shall be construed to require continuation coverage under this part for an individual who is not subject to a preexisting condition exclusion as a result of the enactment of the Health Insurance Reform Act of 1995.*

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SEC. 1166 * * *

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(a) * * *

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(3) each covered employee or qualified beneficiary is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 603 within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled [at the time of a qualifying event described in section 603(2)] *at any time during the initial 18-month period of continuing coverage under this part* is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled, and

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SEC. 1167 * * *

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(5) * * *

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(B) * * *

*Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this part.*

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# INTERNAL REVENUE CODE OF 1986

TITLE 26, U.S. CODE

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SEC. 4980B * * *

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(f) * * *

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(i) * * *

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(V) * * *

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In the case of a qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled [at the time of a qualifying event described in paragraph (3)(B)] *at any time during the initial 18-month period of continuing coverage under this section*, any reference in subclause (I) or (II) to 18 months with respect to such event is deemed a reference to 29 months, but only if the qualified beneficiary has provided notice of such determination under paragraph (6)(C) before the end of such 18 months.

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(iv) * * *

(I) covered under any other group health plan (as an employee or otherwise), which does not contain any exclusion *except that the exclusion or limitation contained in this subclause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this subsection because of the provision of the Health Insurance Reform Act of 1995* or limitation with respect to any preexisting condition of such beneficiary, or

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(v) Termination of extended coverage for disability. In the case of a qualified beneficiary who is disabled [at the time of a qualifying event described in paragraph (3)(B)], *at any time during the initial 18-month period of continuing coverage under this section* the month that begins more than 30 days after the date of the final determination under title II or XVI of the

Social Security Act that the qualified beneficiary is no longer disabled.

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(5) * * *

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(A) * * *

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(iii) * * *

(I) the date described in clause (i), [or]

(II) in the case of any qualified beneficiary who receives notice under paragraph (6)(D), the date of such notice[.], *or*

*(III) in the case of a qualified beneficiary described in the last sentence of paragraph (2)(B)(i), the date such individual is determined to have been disabled.*

*(iv) LIMITATION.—To the extent that an individual is enrolled in a group health plan and a limitation or exclusion of benefits relating to the treatment of a preexisting condition (as defined in section 103(e) of the Health Insurance Reform Act of 1995) would not apply to such individual, such individual shall not be entitled to elect continuation coverage under this part, except that nothing in this clause shall be construed to require continuation coverage under this subsection for an individual who is not subject to a preexisting condition exclusion as a result of the enactment of the Health Insurance Reform Act of 1995.*

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(6) * * *

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(C) Each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in subparagraph (C) or (E) of paragraph (3) within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled [at the time of a qualifying event described in paragraph (3)(B)] *at any time during the initial 18-month period of continuing coverage under this section* is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days of the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled.

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(g) * * *

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(1) * * *

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(A) * * *

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(ii) * * *

*Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this section.*

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TITLE 29, U.S. CODE

SEC. 1138. APPROPRIATIONS—There are hereby authorized to be appropriated such sums as may be necessary to enable the Secretary to carry out his functions and duties under this Act *and under the Health Insurance Reform Act of 1995.*

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TITLE 42, U.S. CODE

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SEC. 300e * * *

(b) * * *

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(5) * * *

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*(6)(A) If a member certifies that a medical savings account has been established for the benefit of such member, a health maintenance organization may, at the request of such member reduce the basic health services payment otherwise determined under paragraph (1) by requiring the payment of a deductible by the member for basic health services.*

*(B) For purposes of this paragraph, the term "medical savings account" means an account which, by its terms, allows the deposit of funds and the use of such funds and income derived from the investment of such funds for the payment of the deductible described in subparagraph (A).*

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