March 22, 1996

A GUIDE TO KASSEBAUM-KENNEDY

INTRODUCTION

Both houses of Congress soon will consider sweeping legislation affecting the way millions of Americans get their health insurance. In the Senate, the chief sponsors of the Health Insurance Reform Act of 1995 (S. 1028) are Senators Nancy Kassebaum (R-KS) and Edward Kennedy (D-MA).[1] In the House, Representative Dennis Hastert (R-IL) is coordinating the efforts to introduce an improved version of the Kassebaum-Kennedy bill.[2] Both bills are intended to address a recurring and legitimate concern among millions of working Americans who currently have employment-based health insurance: the threat of losing private health insurance when they lose or change their jobs, or try to obtain coverage when they have a pre-existing medical condition. But while the Kassebaum-Kennedy bill contains some useful provisions, it also contains serious flaws—many of which would be corrected by incorporating language based on the House proposal.

Anxiety about health insurance coverage stems from the very nature of today's employment-based system. Typically, workers and their dependents are covered by an employer-based health insurance policy only as long as they remain with the same employer, and for just a short time afterwards. If a worker is laid off or takes a job with a different employer, the family may encounter pre-existing condition exclusions or different health care providers. If the worker joins a firm with no group insurance plan and buys his own coverage, he receives no tax breaks for purchasing

1 Senator Kassebaum is the Chairwoman of the Senate Committee on Labor and Human Resources. S. 1028 was reported out of the full committee by a unanimous, bipartisan vote of 16-0 on August 2, 1995. At this time, S. 1028 has 51 cosponsors.

2 The committees of jurisdiction are the House Committees on Commerce, Ways and Means, and Economic and Educational Opportunities. The Economic and Educational Opportunities Committee reported out H.R. 995 on March 6, 1996. The Committee on Commerce reported out H.R. 3070 on March 20, 1996. The Committee on Ways and Means reported out H.R. 3103 on March 19, 1996. The House of Representatives is expected to vote on a final version combining specific provisions from these three bills on March 28, 1996.

that policy—compared with generous tax relief if an employer obtains and owns the coverage. Lawmakers thus need to address two fundamental problems in trying to fix the broken health insurance market:

❶ **Health insurance is the only type of insurance tied to the place of employment.** Other major forms of insurance such as homeowners, mortgage, and life are not normally tied to a worker's place of employment. The reason health insurance is employer-based today is that federal tax relief for insurance is available only to workers who obtain insurance through their place of work.

❷ **The tax code effectively limits workers and their families to only one type of insurance option: employer-based health insurance.** Insurance market reforms do not resolve this underlying problem with a distorted health insurance market.

The Kassebaum-Kennedy bill (S. 1028), as reported out of committee, is flawed legislation. While S. 1028 avoids the price controls and huge tax increases found in both the Clinton plan and other bills introduced in the last Congress, it contains vague provisions for federal regulation of the health insurance market, a responsibility traditionally left to the states. S. 1028 gives the Secretary of Health and Human Services disturbingly broad powers in this area.

Instead of just trying to guarantee Americans the right to purchase health insurance, Congress should take careful steps to make sure that Americans of all incomes, health status, and employment status have the ability to buy into the health care market.[3] Therefore, Congress should focus on:

✓ **Group to group portability;**

✓ **Limiting pre-existing condition exclusions upon losing employer-based coverage;**

✓ **Reasonable mechanisms to allow small employers and legitimate associations to pool together to get better prices;**

✓ **Tax equity for individuals and families seeking health insurance outside an employer setting; and**

✓ **Full income tax deductibility for the self-employed increased to 100 percent.**

In his 1996 State of the Union message, President Bill Clinton emphasized that the goal of S. 1028 is to end the loss of portable health insurance among millions of workers and their dependents.[4] The issue of portability of insurance is a broad concern among Republicans and Democrats alike. S. 1028 is a well-intentioned attempt to address it, as well as the problem of pre-existing conditions. The bill also makes improvements in the areas of guaranteed availability and portability of group cover-

3 Edmund F. Haislmaier, "A Policy Maker's Guide to the Health Care Crisis: Part IV, The Right Road to Health Insurance Reform," Heritage Foundation *Talking Points*, November 5, 1992, p. 17.

4 President Bill Clinton, State of the Union Address, January 23, 1996.

age. Unfortunately, for jurisdictional and procedural reasons, Senate rules have prevented the addition of several key health care reform components necessary to allow individuals, rather than the companies they work for, to own their health insurance policies. If it is Congress's intention to give workers and their families true portability of health insurance, lawmakers must correct the inherent flaws and inequities that are the unintended consequences of an inequitable federal tax code that penalizes the working poor and self-employed.

Thus, even though the Senate measure does contain extensive federal regulation of the individual health insurance market, intended to address portability, it lacks the key financial incentive to persuade healthy individuals to purchase health insurance in a timely fashion. Unless Congress is willing to address the core problem of today's health insurance system—the federal tax code—health insurance reform will fall far short of its goals.

The widespread fear of losing employment-based health insurance emerged as the driving force behind the health care debate during the 103rd Congress. An analysis of the March 1994 Current Population Survey showed that 55.3 percent of the uninsured population in 1993 were uninsured because they had lost their jobs or changed jobs.[5] That insecurity stems from the design of today's employer-based health insurance system, itself the product of perverse incentives created by the federal tax code.[6] Others worry about not having any form of insurance from their current employer.

The best way to achieve portability is to give Americans ownership and control of the financing of health benefits. Where appropriate, financial assistance should be given to low-income working families to help pay for basic care in the form of vouchers or tax credits. If individuals and families are allowed to comparison shop among a variety of health plans and benefit levels offered through their employer, a private organization, or an individual policy, costs can be controlled. True portability also can be achieved, because Americans will no longer face the possibility of losing their health insurance based on a change in job, loss of job, or pre-existing condition.

WHAT S. 1028 WOULD DO

The Kassebaum-Kennedy bill would create a uniform federal standard for health insurance that is intended to increase the portability of private health insurance policies. Under the legislation, individuals with employment-based health insurance would be able to maintain coverage while changing jobs. In the area of group coverage, the bill would reduce the length of exclusions for pre-existing conditions by crediting enrollees for maintaining continuous coverage through a previous employer. Furthermore, insurers and employers would be prevented from excluding em-

5 Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1994 Current Population Survey," EBRI *Special Report and Issue Brief* No. 158, February 1995, p. 10.

6 Stuart M. Butler and Edmund F. Haislmaier, "The Consumer Choice Health Security Act (S. 1743/H.R. 3698)," Heritage Foundation *Issue Bulletin* No. 186, December 23, 1993, p. 18.

ployees from an employer's group health plan based on their medical status or experience.

The proposal also would create a new state-based system of health plan purchasing cooperatives (HPPCs) intended to give small businesses and individuals greater purchasing power in negotiating more favorable rates from insurance carriers and other health plan providers.

A Limit on Pre-Existing Conditions

The Kassebaum-Kennedy bill places a restriction on the ability of health plans and employers to limit or deny coverage in group health insurance plans to 12 months for medical conditions diagnosed in the previous 6 months. A time credit is applied against the preexisting condition period by reducing it one month for each month that a worker and his dependents were continuously covered under a previous group health plan. In addition, the bill:

- ✓ **Places** a ban on further preexisting condition exclusions by any insurer once a worker has been continuously insured for a minimum of 12 months. Thus, workers who change jobs or insurance plans would no longer be subject to waiting periods.
- ✓ **Prohibits** health plans and employers from canceling or providing coverage to any employee in the employer group plan based on a preexisting condition or health status.
- ✓ **Promotes** wellness programs by allowing employers and group health plans to provide discounts to employees who participate in activities (approved by state insurance regulators) designed to promote healthy behavior, prevent or delay the onset of illness, or provide for screening or early detection of an illness.

The guaranteed availability and renewability of health insurance in S. 1028 would alleviate the portability problem facing workers who want to change jobs. This is a welcome and long-overdue improvement in today's health insurance market.

Group Purchasing Arrangements (Health Plan Purchasing Cooperatives)

S. 1028 attempts to make health insurance more affordable for small employers and self-employed workers by enabling them to purchase coverage as part of a larger group. The rationale is that small businesses generally pay higher per capita premiums than larger businesses because they lack economies of scale and the power to bargain. Under current law, when an employee or dependent incurs expensive claims, typically the employer's premiums increase sharply the following year, in many cases pricing that group out of the insurance market. The danger to the worker and his family occurs when a health plan provider drops the small employer from coverage, or the employer excludes the particular employee from the group plan due to his previous year's claims experience.

The bill attempts to correct this problem by promoting small group purchasing arrangements. Referred to as Health Plan Purchasing Cooperatives (HPPCs), they are private, voluntary coalitions/alliances developed to purchase health insurance and ne-

gotiate with providers and health plans. State laws prohibiting the formation of such HPPCs are preempted. Under the bill, HPPCs would require state certification and would have to be registered with the U.S. Department of Labor. In addition to purchasing insured products on behalf of members, HPPCs would not be permitted to bear risk,[7] although they would be given discretion in determining the eligibility requirements for employers and whether or not to include individuals—as long as the individual's health status is not a factor.

To facilitate the formation of HPPCs, and to get them to be active participants in the health insurance market, S. 1028 provides for a limited preemption of state insurance rating laws with respect to group health plans and individual health plans offered by health insurance carriers through HPPCs.[8] Health plans purchased through other avenues, however, would remain subject to state small group rating requirements, which require carriers to pool all small group businesses for rating purposes. Thus, the Senate bill creates different rules for different insurance arrangements.

An Uneven Playing Field. By exempting HPPCs from state small employer group rating laws, Congress would be creating an incentive for small businesses with healthier than average employees to seek out coverage under a HPPC that has procured rate discounts: Businesses could do this on any basis other than the health status and demographics of the HPPC's members. But there is a significant problem: Without the premium payments from these healthy employer groups, others seeking coverage through non-HPPC arrangements could face higher than normal rates in a pool dominated by unhealthy employer groups. The Senate bill, in other words, could end up compounding the market distortions in a sector already distorted by an inequitable federal tax code.

Unfortunately, the legislative language creating HPPCs would lead to an uneven playing field against commercial insurance companies not selling products through HPPCs. While insurance premiums in the non-HPPC market no doubt would be higher than those in the HPPCs as a result of this provision, it is not definite how severe the impact would be. Congress would be wise to ensure that an even playing field exists in the health insurance market so that competition among health plan providers is fair. At a minimum, Congress should amend S. 1028 so that all health plans, whether issued through a HPPC or though a non-HPPC, are exempted from state rating requirements. Members of Congress should not worsen the distortions in health insurance markets through federal legislation.

Some in Congress have expressed an interest in enacting a blanket federal preemption of any state-mandated benefit laws that would apply solely to HPPCs. State-mandated benefit laws have added to the cost of insurance, rendering policies unaffordable for many small businesses and individuals. While it is perfectly understandable that Members would want to protect small businesses and individuals purchasing insurance through a HPPC from burdensome and costly state mandates, any

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7 This helps ensure that HPPCs will not be controlled by or affiliated with health insurance carriers. Any appearance of impropriety is therefore avoided.

8 S. 1028 [Report No. 104-156], Calendar No. 205, 104th Cong., 1st Sess., October 12, 1995, Subtitle D, Sec. 131(g)(2).

preemption of state mandated benefit laws, however well-intentioned, should be applied to all forms of health coverage, HPPCs and non-HPPCs alike. A better approach would be to preempt state laws which:

- **Require** health insurance policies to cover specific diseases, services, or providers;
- **Limit** the ability of managed care plans to contract selectively with health care providers; or
- **Limit** the ability of managed care plans to impose higher cost-sharing provisions on treatment obtained from providers outside a plan's network.[9]

Lower premiums are a desirable goal. However, it would be extremely unwise of Congress to distort the health insurance market further by placing HPPC plans at a marketing advantage over non-HPPC plans. As drafted, the potential for HPPCs' gaining monopoly status is very real because of the legislative language creating these new entities. Although not theoretically exclusive, as under the Clinton health plan, these geographically based HPPCs might become the exclusive means for individuals and employers to obtain fully insured health coverage, if premium rates negotiated by the HPPC are less than those otherwise permitted under state law.

In this respect, Members of Congress should recall the ill-fated "managed competition" legislation introduced in 1994 by former Congressmen Jim Cooper (D-TN) and Fred Grandy (R-IA).[10] Among other things, this health insurance reform proposal also would have established state-based health insurance purchasing cooperatives.[11] While individual and family enrollment in these HPPCs supposedly would have been voluntary, the regulatory infrastructure and tax code revisions set up in the Cooper-Grandy plan eventually would have forced small businesses and individuals into such entities. Consistent with the managed competition model in the Cooper-Grandy plan, HPPCs under S. 1028 would be required to enroll all employers and individuals within a geographic area as determined by the state. If S. 1028 were enacted into law as reported out of the Senate Labor Committee, the combination of new federal rules with existing state insurance rules could make employee enrollment in HPPCs the only practical choice for insurance coverage. Workers and their families therefore would lose a large measure of personal choice in health plans.

Most significantly, current ERISA regulations do not prohibit states from establishing voluntary purchasing cooperatives.[12] Congress should not create a regulatory infrastructure that could establish the groundwork for making such HPPCs manda-

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9 Butler and Haislmaier, "The Consumer Choice Health Security Act (S. 1743, H.R. 3698)," p. 14.

10 For a detailed explanation of both the Clinton and Cooper-Grandy health plans, see Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993; Robert E. Moffit, "A Guide To 'Clinton-Lite": The Cooper-Grandy Managed Competition Health Care Reform Proposal," Heritage Foundation *Talking Points*, March 28, 1994.

11 The Clinton plan called such arrangements Health Insurance Purchasing Cooperatives (HIPCs).

12 The Employee Retirement Income Security Act (ERISA, P.L. 93-406) prohibits states from treating self-insured firms as insurance carriers and making them subject to state insurance regulations. By establishing a self-insured plan which meets

tory within a state. The danger is that the instability created by the federally designed HPPCs would lead to further federal regulation to "correct" the problem—resulting in still further problems. The result: Congress, by degrees, would create a system of purchasing cooperatives similar to those found in the Clinton Health Security Act, which required every American to obtain health insurance through these alliances.

Group-to-Individual Coverage

S. 1028 does take some of the first steps needed to construct a consumer-based health insurance framework—even though other provisions conflict with this goal. Subtitle B does this by setting up an infrastructure to facilitate individual health plan portability. Insurance carriers that sell individual health plans are required to issue individual coverage when the following criteria have been met:

❶ **Individuals** a) must have been covered previously under an employment-based health plan, b) must have paid health insurance premiums on a continuous basis without a gap in coverage of 30 days or more, and c) must have been covered for at least 18 months;

❷ **Individuals** must not be eligible for coverage under an employee health benefit plan or group health plan, such as one offered by a new employer or by a parent's or spouse's employer;

❸ **Individuals** must have exhausted their eligibility for COBRA[13] continuation coverage (which is available for a minimum of 18 months to over 80 percent of individuals receiving employment-based coverage); and

❹ **Individuals** must not reside in a state which has adopted a high-risk pool or other means of covering individuals unable to maintain health coverage.

Guaranteed issue and the availability of insurance in the individual market are addressed by forbidding insurance carriers to determine coverage or establish eligibility, continuation, or enrollment requirements based on health status, medical condition, claims experience, or medical history. Without these rules governing the group-to-individual conversion, the portability of health insurance will not be achieved. Under current law, individuals switching from an employer who offers insurance coverage to an employer who does not offer coverage would simply lose this benefit.

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federal ERISA standards, a firm can avoid state insurance regulations, such as requirements that insurers maintain reserve funds of a specified size, pay state insurance premium taxes, or comply with state-mandated benefits.

13 Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 requires employers with 20 or more employees that offer a group health insurance plan to offer qualified employees and their families the option of continued health insurance at group rates when faced with loss of their coverage because of certain events. Self-insured firms (ones which assume the risk of paying for their employees' health care costs rather than passing that risk onto insurers) also are covered under Title X. The events that trigger continuation of COBRA coverage are defined to include: 1) termination of employment, 2) death of the employee, 3) divorce or legal separation from the employee, 4) the employee becomes eligible for Medicare, and 5) the end of a child's dependency under a parent's health insurance policy. Beth Fuchs, "Health Insurance Continuation Coverage under COBRA," CRS Issue Brief, December 1, 1993, p. 7.

The bill also puts rules in place for health insurance carriers to ensure their financial stability and solvency. An insurance carrier or other health plan provider offering coverage to individuals under an individual health plan may deny applicants if the health plan ceases to enroll any new individuals. A carrier also may do so if it can demonstrate to the state that its financial or provider capacity to serve previously covered individuals will be impaired if the state requires it to enroll additional individuals.

Concerns have been raised about how these provisions would affect premium costs.[14] Some critics of S. 1028's group-to-individual portability provision say that insurance premiums in the individual market would increase sharply, perhaps in the range of 10 to 15 percent.[15] But the American Academy of Actuaries, the national organization representing actuaries of all specialties in the United States, says the increase in premiums would be quite small, ranging between 2 and 5 percent.[16]

Since S. 1028 does not impose strict community rating requirements, or otherwise impose price caps on the premiums that insurers may charge individuals,[17] some insurance executives, such as those with one of the leading insurance trade associations, fear that the guaranteed-issue requirement for individuals with prior coverage would "make individual health insurance unaffordable over time."[18] This concern is premised upon two assumptions: 1) that only unhealthy individuals will purchase health insurance, thereby increasing the likelihood of adverse selection in the individual market; and 2) that absent significant public subsidies, healthy individuals will not purchase insurance before they need it.

Because both consumer choice and competition are frustrated in a health insurance system that is predominantly employment-based, these concerns about insurance costs in the individual market are legitimate in today's tax climate. Since health insurance is entirely optional, those who purchase health insurance on their own must pay the entire cost of the premiums with after-tax dollars. Thus, healthier than average individuals would be more likely to decline insurance in a voluntary market, while unhealthy persons could see an economic benefit in getting coverage. A guaranteed-issue requirement in the individual market would lead to higher premiums since unhealthy people would comprise a disproportionate share of the market. While concerns about rising premiums in the individual insurance market are justified, Congress can and should address this potential problem by providing consumers with financial assistance to help offset any possible increase.

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14 See Merrill Matthews, Jr., "Portability: Is Kassebaum/Kennedy the Answer?" National Center for Policy Analysis *Brief Analysis* No. 196, February 19, 1996.

15 Mary N. Lehnhard, Senior Vice President, Blue Cross and Blue Shield Association, testimony before the Committee on Labor and Human Resources, U.S. Senate, July 18, 1995.

16 Thomas J. Stoiber, FSA, MAAA, written communication to Committee on Labor and Human Resources, U.S. Senate, August 2, 1995, p. 2.

17 Under a community rating requirement, all enrollees in a given area are charged the same rate (premium) for health insurance, regardless of the potential cost to the insurer covering the pool.

18 Health Insurance Association of America, "The Health Insurance Reform Act of 1995," HIAA Policy Statement, January 1996.

How Congress Can Improve S. 1028

While the Kassebaum-Kennedy bill makes improvements in the existing health insurance system, there are several provisions which should be strengthened. Without further changes, the laudable intentions of this legislation will not be realized in good public policy. Millions of Americans are painfully aware of the weaknesses in the current system. The Senate Committee on Labor correctly diagnosed the problem: "[M]illions 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."[19]

Certain key policy changes can improve insurance reform legislation and better achieve the goal of portability and security in health insurance. These changes, as proposed in the House legislation, include tax equity for non-employer-based health insurance, medical savings accounts (MSAs), increased deductibility for purchasing health insurance for the self-employed, a clarification of the ERISA laws making it easier for smaller employers and individuals to pool and gain leverage in the insurance market, and medical malpractice reforms.

Tax Equity Would Offset Most Adverse Effects in the Individual Market

As noted, policy analysts and insurance industry executives have raised concerns over the effects that guaranteed issue and guaranteed renewability could have on premiums in the individual insurance market. Under the current system, unhealthy individuals leaving employment-based coverage find COBRA either the preferable or perhaps the only alternative to being uninsured. Healthy individuals have the luxury of making an economic decision to go with no coverage or purchase an individual-based policy with after-tax income.

To the extent that Members of Congress remain concerned about a potential increase in premiums, they should re-examine the core problem behind today's health insurance system—the federal tax code. Congress should provide an incentive for healthy employees to enroll in the individual market by giving them tax equity. This means giving individuals who purchase their own health insurance policies the same tax treatment as workers who get their health insurance through their employers. As drafted, the Kassebaum-Kennedy bill would not help college graduates entering the job market for the first time who end up working for small start-up businesses unable to offer health insurance. To fix this problem, Members of Congress need to look no further than the health-related tax provisions passed overwhelmingly by both Houses of Congress in the Balanced Budget Act of 1995. A majority of today's uninsured population is made up of the self-employed, those working for small firms, or young individuals. These groups are affected by the distortions in an employer-based health insurance system and are the ones typically suffering from the absence of portability and ownership.

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19 U.S. Senate Committee on Labor and Human Resources, Committee Report to accompany S.1028, "The Health Insurance Reform Act of 1995," Report 104-156, October 12, 1995, p.4.

❶ Introduce medical savings accounts (MSAs).

MSAs would enable group-to-individual conversions to have a widespread impact on today's uninsured population. While there are other comprehensive forms of tax equity Congress could consider (such as tax credits and 100 percent deductions for the self-employed), MSAs would be a good start. They would provide sufficient incentive for healthy individuals to purchase insurance, thereby creating a solid and solvent risk pool that offsets the claims of future unhealthy enrollees. MSAs could be constructed as passed earlier this Congress:

- ✦ Contributions of up to $2,000 for individuals and $4,000 for families, including employer contributions, would be 100 percent deductible from adjusted gross income;
- ✦ Interest earned on the income would be subject to taxation;
- ✦ Withdrawals made for non-medical expenditures would be included in the individual's gross income and subject to a 10 percent tax prior to age 59-and-a-half;
- ✦ Upon reaching age 59-and-a-half, the individual could make withdrawals for any purpose without the 10 percent tax;
- ✦ In order for a health plan to be classified as such, at a minimum it would have to provide catastrophic coverage in which the minimum deductible for individuals is $1,500 and $3,000 for families.

❷ Increase and expand tax deductions.

Under current law, self-employed individuals are permitted to deduct 30 percent of the amount paid for health insurance for themselves and their dependents. While a 30 percent deduction provides some tax relief for the nation's self-employed, the federal tax code still provides significant tax advantages for employees by exempting company-sponsored benefits from any federal income or payroll taxes (FICA), as well as from state and local taxes. In addition to pre-existing condition exclusion barriers, the availability of this tax exclusion for workers is one of the major impediments facing employees seeking to leave and start their own businesses. Congress should remove this bias, and also encourage creation of a sound individual-based health insurance market, by increasing the deduction for health insurance of self-employed individuals and their families.

Earlier this year, Congress passed legislation which would have increased the 30 percent deduction to 50 percent between 1996 and 2002. This proposal was vetoed by President Clinton. While a 100 percent deduction would provide tax fairness for all individuals and the self-employed, even a compromise of 50 percent would represent substantial progress.

❸ As a condition of regulating private insurance at the federal level, consider pre-empting state mandated benefit laws.

The health insurance industry is one of the most highly regulated sectors of the American economy. Before an insurance carrier or health plan provider is allowed to enter and do business within a state, it must satisfy a litany of state requirements and

regulations. Regulation of health insurance is usually within the jurisdiction of the states, not the federal government. A key component of state regulation is the imposition of mandated benefits on insurance carriers licensed to do business within their jurisdictions. These mandates are the product of intense special-interest lobbying at the state level, where medical specialists, marriage and family counselors, therapists, and other professionals have succeeded in imposing coverage requirements. Over the years, the number and scope of these benefits have grown substantially, adding to the cost of insurance plans sold to employers and individuals. Nationwide, there are over 1,000 such state mandates, ranging from in vitro fertilization to chiropractic care and psychological counseling.

In principle, Congress should refrain from regulating health insurance at the federal level. But with S. 1028, Congress is doing precisely that, arguing that the weaknesses of the current insurance market (the absence of portability and the growing numbers of uninsured) outweigh adherence to the principles of federalism. If Congress decides to regulate the individual health insurance market, sponsors of S. 1028 should seek at least a net deregulation of the market by preempting state mandated benefit laws. In return for preemption, Congress may seek to require catastrophic coverage as a consumer protection measure. This would substantially reduce both the regulatory burden and the cost of insurance for small businesses which employ a majority of the uninsured population.

❹ Avoid a Clinton-style standardized benefits package.

Congress should refrain from imposing any requirements that health plans cover a particular benefit, medical procedure, or service. Several Senators favor requiring health plans to cover specifically defined medical benefits. But while such a proposal is appealing on a superficial level, this approach guarantees higher costs and unintended long-term consequences. Like the Clinton plan, a standardized benefits package forces all individuals to buy benefits they neither want nor need. It does not take into account the different medical needs and desires of individuals and families. While some Americans may want and can afford the inclusion of comprehensive and expensive benefits, millions of others—especially younger, less well off, and healthier individuals—may not. If a worker or family member suffers from a particular disease that is not included in the standardized benefits package, that person could be medically worse off if the required extra service he needs is unaffordable.

Specific benefits invariably are required if a Hollywood movie star or celebrity is willing to take up the cause of persons with a particular disease, replete with an appropriately colored ribbon.[20] During the debate over the Clinton health plan and its variants in 1994, congressional staff, Representatives, and Senators were inundated with office visits, mail, faxes, and phone calls asking that a particular benefit or service be covered. If the group of patients is large and powerful enough, perhaps with the aid of a celebrity, it is likely that the benefit will be added by Congress. Supporters of mandated benefits should be honest about the unintended consequences that

20 John C. Liu, "Clinton Heavy: The Kennedy Health Bill," Heritage Foundation *Issue Bulletin* No. 197, July 21, 1994, p. 13.

come with a mandated benefits package—higher premiums and the politicization of diseases.

❺ Do not remove "lifetime limits" from employer-sponsored health benefit plans.

Some Members of Congress are considering a prohibition on "lifetime limit" provisions in private health insurance plans as a way to protect patients facing high medical expenses due to catastrophic illnesses. The danger is that such a rule would raise employers' health care costs. For some companies, the extra cost could be severe enough to prevent a plan from being offered or continued, thus exposing the patient to 100 percent of all medical bills, including catastrophic claims.

Lifetime limits are necessary to help private insurance companies meet solvency standards required by the states. The same principle already applies to government health programs. For example, the Medicare Hospital Insurance (HI) Part A Trust Fund imposes a lifetime limit on two major services: hospitalization (150 days) and skilled nursing facility care (100 days). It is all but certain that if such a rule were applied to Medicare Part A, the Trust Fund would be insolvent long before the projected date of 2002.

While studies have estimated the cost of eliminating lifetime caps would be an additional 2.3 percent for employers,[21] the findings do not take into account the added cost of prohibiting separate "inside limits" on specific categories of services already contained within existing policies. Without lifetime and inside limitations in health insurance policies, many small to mid-sized employers would be unable to purchase any type of health plan for their employees. As pointed out by the Association of Private Pension and Welfare Plans (APPWP), a majority of employer-based health benefit plans include "inside limits" on certain benefits and services:[22]

> The Standard Option benefit package offered to federal government employees enrolled in the Federal Employees Health Benefits Program (FEHBP) includes a limit of one hospital inpatient treatment program per lifetime for alcohol, drug, and substance abuse.
>
> The Segal Company's "1994 Survey of State Employee Health Benefit Plans" also reports that 35 states included "separate annual/lifetime maximums" for mental health and/or substance abuse treatment.

The strongest cost argument in favor of outlawing lifetime limits is that average increases in premiums for employers would be modest. But the American Academy of Actuaries (AAA) has cited several consequences that make the removal of lifetime limitation provisions financially unattractive. One is the "[p]otential for increased

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21 Jack Rodgers, Director of Health Policy Economics, Price Waterhouse, LLP, written communication to William Aliski, Vice President, Product and Patient Services, Genzyme Corporation, November 8, 1995, p. 4.

22 Association of Private Pension and Welfare Plans, "Congress Should Reject Prohibitions or Restrictions on Lifetime Limits in Employer-Sponsored Health Benefit Plans," *Legislative Action*, July 26, 1995, pp. 1-2.

health care inflation, potential pressure to liberalize limited benefit structures in public programs, and the potential impact on reinsurance companies and insurer premiums."[23] Another unintended consequence of repealing lifetime limits would be the added cost taxpayers would be forced to bear for the approximately 18.2 million federal, state, and local government employees. A majority of health plans covering government employees already have lifetime limit provisions, and many also contain additional inside limits. While lifetime caps appear onerous, they give employers who voluntarily offer health benefit plans reason to believe that these plans will remain affordable.

Lifetime caps are but one health benefit design feature that allows employers to offer the level of benefits they can afford. During consideration of the Clinton plan, Congress and the American people rejected mandating the level of benefits that employers must provide to their employees. The issue of employer-provided health benefits is a matter best left to employers and employees. Private employers and employees, not Congress, should decide what level of benefits they can afford. Congress should avoid piecemeal additions to benefit packages based on pressure from health industry groups. If Congress bows to pressure from such groups, employers will be forced to scale back or drop the benefits they provide to accommodate a repeal of lifetime limits. Employees and their families will receive fewer benefits, and this will lead to calls for additional mandated benefits, further increasing health care costs. This unnecessary yet inevitable circle of events is sure to be triggered if Congress gets into the perennially unfinished business of benefit setting.

❻ Consider medical malpractice reform.

While there are federalism concerns involved in legislating malpractice reforms at the federal level, an urgent need exists to confront the liability problem. The federal government funds approximately half the nation's health care expenditures through Medicare, Medicaid, Veterans Administration, Indian, and Public Health programs; and medical malpractice and other liability costs, driven by pro-plaintiff state laws, have contributed to these already large costs. In fact, medical malpractice costs have contributed greatly to increased medical costs in both the public and private sectors.

In connection with medical malpractice litigation, the current legal system allows unlimited compensation for non-economic damages. Non-economic damages are separate from, and do not include compensation for, medical costs, rehabilitative costs, foregone wages, or other out-of-pocket expenses. During the first session of the 104th Congress, the House of Representatives passed legislation to limit non-economic damages associated with medical malpractice. Significant provisions of the reform included a $250,000 limit on non-economic damages and the option to pay future losses exceeding $50,000 in periodic increments. The Senate should carefully consider the House medical malpractice reform provisions while encouraging substantive reforms at the state level.

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23 Henry S. Sutton, American Academy of Actuaries, written communication to Ms. Elaina Goldstein, Office of U.S. Senator Jeffords, August 3, 1995, p. 1.

❼ Place no more power and control in the hands of the Secretary of Health and Human Services.

Section 110 of S. 1028 requires insurance companies and other health plan issuers to guarantee issue coverage, without any exclusion of coverage for pre-existing conditions, to individuals who meet certain requirements related to prior group coverage. Section 111 requires guaranteed renewal of all individual health plans. Section 112 allows states to be exempt from the requirements of Sections 110 and 111 if, and only if, they have in place (or subsequently put in place) an alternative law or program that meets the same goals and is approved by the Secretary of Health and Human Services.

In evaluating whether a state meets the goals, the Secretary of HHS is to evaluate state programs according to the four criteria:

- ☞ Whether the state law or program provides coverage to individuals leaving group coverage;
- ☞ Whether the state law or program provides coverage for preexisting conditions for individuals leaving group coverage;
- ☞ Whether the state law or program provides individuals leaving group coverage with a choice of health plans or a health plan providing comprehensive coverage; and
- ☞ Whether requiring a state to comply with Sections 110 and 111 would have an adverse impact on the number of individuals in the state who have access to affordable health insurance coverage.

Among insurance experts, there is a wide range of estimates on how much premiums in the individual health insurance market actually would increase under S. 1028. Rather than mandate a single uniform approach, as called for in Section 112, Congress should allow the various states to experiment with alternative approaches and methods. States should determine for themselves the best way to guarantee continued availability of health coverage to their residents leaving the group market. To date, 11 states already have enacted guaranteed issue requirements in the individual market.

Section 112 vests enormous power in the Secretary of Health and Human Services. The Secretary, in effect, can disapprove legitimate state initiatives that address the problem of how to guarantee continuation of coverage for individuals and families. For instance, the Secretary could rule that state high-risk pools are not "affordable" because their premiums are higher than prevailing market rates, even though significant subsidies are required to cover the true costs of enrollees. Under this scenario, most states' high-risk pools could be found "unaffordable" and unacceptable to the Secretary.

Instead of allowing the Secretary to control how states regulate their individual insurance markets (a traditional state function), S. 1028 should allow the state insurance commissioner (or the official or officials designated by the state to enforce the goals of this legislation) to determine whether the alternative state law or program

meets the goals of S. 1028. No review or approval by the Secretary of HHS should be required.

❽ Reject Section 121's extension of COBRA.

Section 121 of S. 1028 changes COBRA (P.L. 99-272) by allowing 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 months. Currently, this extension is available only to workers who are disabled at the time they lose their coverage.[24] Today, coverage under COBRA may last from 18 to 36 months, depending on the circumstances of the event leading to loss of health insurance. Under current law, covered employees and dependents are required to pay up to 102 percent of the total premium during the 18-month period. Disabled employees and dependents are eligible for 29 months of continued coverage but then must pay up to 150 percent of the total premium during the additional 11 months.

While the extension of COBRA sounds appealing to Members of Congress and the public, the reality is that employers, and ultimately workers, are required to pay the actual claims costs incurred by employees opting for coverage under COBRA. In short, such a change is another employer mandate. This extra expense has been particularly burdensome on employers already struggling to give health benefits to their current employees. According to the Employee Benefit Research Institute, a nonpartisan public policy research organization specializing in employee benefits, "many employers consider COBRA to be a costly mandate. Any expansion of COBRA would almost certainly increase employer cost for health insurance."[25] And according to the Blue Cross/Blue Shield Association, "Claims costs for COBRA subscribers, on average, are typically 40 percent to 60 percent higher than the costs of active employees. Those people who seek COBRA coverage are people who need, but cannot obtain, affordable coverage as individuals, and their high use of medical services is directly reflected in the unusually high COBRA claims costs."[26] These higher than average costs, which must be borne by employers, will lead inevitably to a reduction in employee benefits and compensation, or to withdrawal from the market.

Suggestions have been made that S. 1028's COBRA provision be extended to all companies. Placing additional mandates on small employers (less than 20 employees) could jeopardize protections for beneficiaries of self-funded ERISA health plans. For example, small employers who insure their employees under federal ERISA requirements have been able to avoid costly state-mandated benefits and taxes on their health plans. It would be ironic for Members of Congress to impose a new layer of federal mandates on a class of employers who have sought protection and relief from state mandates. Furthermore, such an unprecedented reach of federal

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24 S. 1028 [Report No. 104-156], Calendar No. 205, 104th Cong., 1st Sess., October 12, 1995, Subtitle C, Sec. 121, COBRA Clarification, p. 41.

25 Employee Benefit Research Institute, "Portability of Health Insurance, COBRA Expansions and Small Group Market Reform," *Issue Brief* No. 166, October 1995.

26 Mary N. Lehnhard, testimony of Blue Cross and Blue Shield Association before the Committee on Labor and Human Resources.

regulatory power would preempt many of the innovative and effective health reform measures that states have developed and implemented themselves. Finally, the costs associated with such an extension would be too large for small businesses operating on a slim profit margin to bear.[27]

❾ Replace the Senate HPPCs with House provisions encouraging multiple employer health plans.

The HPPCs in the Kassebaum-Kennedy bill as drafted are vague and will generate intrusive and burdensome federal regulations. Congress should strike this newly created infrastructure and replace it with provisions that would encourage the use of multiple employer health plans, voluntary health insurance associations, and other fully insured arrangements. Legislation to accomplish this (HR. 995) has been proposed by Representative Harris Fawell (R-IL).[28]

The goal of giving small businesses and individuals increased purchasing power in the health insurance market is shared by a vast majority of Members of Congress. Unfortunately, S. 1028 creates an additional federal regulatory framework in setting up its HPPCs while simultaneously placing them at a competitive advantage over non-HPPC plans in the health insurance market. Lawmakers should be cautious in supporting legislation which, in its present form, easily could turn the health insurance market into a government-run entity at either the state or federal levels, reproducing something that looks and works like President Clinton's Health Security Act.

In stark contrast, Title III of the Fawell bill would allow smaller businesses to join together under the auspices of ERISA to purchase fully insured coverage or to cover their employees under self-insured multiple employer health plans (MEHPs).[29] Since 85 percent of the uninsured population are in families headed by a worker,[30] it is significant that Title III of the Fawell proposal seeks to use ERISA to preempt state laws that prohibit two or more employers from obtaining fully insured health insurance coverage under any fully insured multiple employer arrangement.

In addition to providing smaller employers and individuals with increased purchasing power, the Fawell proposal eliminates the confusion surrounding the responsibilities of the states and the U.S. Department of Labor under ERISA. This confusion has led to a cottage industry of fly-by-night insurance swindlers who hide behind the ERISA preemption clause. Ironically, states that have enacted statutes regulating legitimate self-insured multiple employer plans often have hurt legitimate arrange-

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27 "COBRA has turned into a nuisance for corporate financial officers...and a mother lode for lawyers and consultants.... Because of suits and a higher claim rate, health costs to companies for former employees and their eligible relatives on COBRA have jumped to $5,301 per worker per year vs. $3,420 for employees still on payrolls—even as overall corporate health costs are going down." John S. DeMott, "Beware COBRA's Bite," *CFO Magazine*, January 1996.

28 See Title III of H.R. 995, the ERISA Targeted Health Insurance Reform Act, sponsored by Representative Harris Fawell (R-IL). H.R. 995 was marked up by the full Committee on Economic and Educational Opportunities and passed on March 6, 1996.

29 Representative Harris Fawell, statement before House Economic and Educational Opportunities Committee, March 6, 1996.

30 Employee Benefits Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1994 Current Population Survey," EBRI *Special Report and Issue Brief* No. 158, February 1995, p. 10.

ments meeting the ERISA plan definitions and caused such arrangements to dissolve. These state actions have been arbitrary and do not follow any consistent pattern of reasoning, either within a state or among states. To remedy this situation, Title III of the Fawell proposal would give states a consistent guideline for the regulation of legitimate ERISA multiple employer plans wishing to continue their operations.

Title III also would give legitimate self-insured associations (including but not limited to church plans, franchise networks, associations, certain large employers, and collectively bargained plans) two clear and distinct regulatory options. First, legitimate associations could maintain or establish multiple employer health plans by seeking licensure in the states permitting such practices. Alternatively, these plans could seek federal certification pursuant to the "exemption" provision in current ERISA law. Under Title III of the Fawell proposal, entities that are created for the express purpose of purchasing health insurance would automatically be subject to the laws of the state in which they seek to do business. In turn, the states could make these groups meet any state-defined insurance or multiple employer plan licensing requirements state.

While smaller employers and individuals are at a disadvantage as they attempt to negotiate premium rates with insurance carriers, this does not necessitate the creation of new entities and additional federal regulations as prescribed in the Kassebaum-Kennedy bill. Accordingly, the Fawell proposal gives smaller employers and the self-employed the right to take advantage of the "[e]conomies of scale that large employers and multi-union employer plans have had for years under ERISA [to gain] access to affordable insurance."[31] Unlike the uneven playing field created in S. 1028, the Fawell proposal would help ensure the ability of traditional insurance carriers to compete with self-insured plans for the small employer, self-employed, and individual market.

CONCLUSION

S. 1028 enjoys broad bipartisan support in the Senate. In Congress, there is a strong desire to reform the broken health insurance market. S. 1028 is a well-intentioned effort to address the portability problem that confronts millions of workers and their families. While the creation of group-to-individual conversion is a positive step toward making health insurance more portable, its impact is diminished by the creation of additional regulatory distortions in the health insurance market. It is unfortunate that S. 1028 fails to address the tax system that currently impedes the ability of the market to function, and that it opens up the dangers of new distortions and sources of instability.

Over 80 percent of Americans under age 65 are covered by health insurance. While they generally are satisfied with their coverage, a genuine fear exists that this security could be lost. Reform of the health insurance market should address the source of this fear—the fact that health insurance is predominantly employment-

31 Fawell, statement before House Economic and Educational Opportunities Committee, March 6, 1996.

based and that federal tax policy exclusively favors this type of arrangement. This Senate bill does not address the key problems confronting the millions of Americans seeking to gain access to the health insurance market. The sponsors of S. 1028 attempt, instead, to create a transitional phase from group (employer-based) to individual coverage through federal regulation. Despite its drawbacks, however, S. 1028 could be the vehicle for significant health insurance reform, including the individual ownership of health insurance plans. By incorporating the improvements offered in the House proposal, S. 1028 could advance the security of health insurance for millions of working families. Instead of distorting the health insurance market with unnecessary and detrimental regulations, Members of Congress should promote a free-market policy by creating a health insurance system that is driven by consumer choice and genuine competition.

The health insurance market is one that traditionally has been regulated at the state level. Any congressional reform should not hamper the successes and innovations produced by state initiatives. To its sponsors' credit, S. 1028 challenges the false presumption that health insurance should be exclusively employment-based, and even more important, highlights the problems of portability and affordability that are inherent consequences of such a restrictive system. Members of Congress should build on the positive features of S. 1028 while making improvements that will give working Americans what they want from health insurance reform: true portability and individual policies that give them long-term health insurance protection against the financial devastation of catastrophic illness.

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