HEALTH INSURANCE PORTABILITY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

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HEALTH INSURANCE PORTABILITY

FRIDAY, MAY 12, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:07 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 3, 1995
HL-10

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARINGS ON HEALTH INSURANCE PORTABILITY

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will hold a hearing on health insurance portability. **The hearing will take place on Friday, May 12, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include health policy experts, insurers, and employers. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Insurers and employers may choose to impose pre-existing condition exclusions on individuals when they change jobs. This has resulted in the problem for some Americans called "job lock." These Americans are reluctant to take new jobs or pursue new career opportunities because doing so would result in a loss of health insurance coverage because they or their dependents have conditions that existed prior to the change in employment.

FOCUS OF THE HEARING:

The hearing will review the impact the use of preexisting condition exclusions have had on job mobility and how a targeted approach might be designed to resolve this problem. The Subcommittee is particularly interested in technical issues involved in such a targeted approach to overcome job lock.

In announcing the hearing, Chairman Thomas stated: "A targeted portability proposal will go a long way toward eliminating the problem of job lock that has adversely affected so many Americans. Enactment of such a reform will provide peace of mind to millions of Americans."

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Friday, May 26, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. Welcome to the Health Subcommittee hearing this morning regarding health insurance portability. The hearing today will focus on the problem of "job lock" and reforms to resolve this problem for American workers. Our goal is to make sure that workers have the freedom to take their health insurance with them when they change jobs.

As the members of this subcommittee are well aware, insurers and employers may choose to impose preexisting condition exclusions on individuals when they change jobs. As a result, it has been reported that many Americans are reluctant to take new jobs or to pursue new career opportunities in part because doing so could result in a loss of health insurance coverage if they or their dependents have conditions that existed prior to the change in employment.

This subcommittee will review targeted reforms to provide individuals who play by the rules and maintain continuous coverage the peace of mind of knowing that if they decide to change jobs, they will not be penalized by the imposition of preexisting condition exclusions.

I consider the hearing today and the subject matter to be a substantial step in further reforming the health care system in this country.

No one should make the mistake about the scope of the proposal we are considering today. This legislation, H.R. 1610, and other pieces of legislation—1610, incidentally, is cosponsored by every member of this subcommittee on both sides of the aisle. This is a targeted approach. It is not intended to address every issue involved in the health care debate or in the portability debate. It focuses specifically on ensuring that individuals who participate in the group insurance system of this country are treated fairly by employers and insurers if the need to change insurance plans should arise.

It should also be pointed out that Congress this year, unlike last year, has successfully moved forward in passing health care legislation in a manner similar to the legislation we are considering today. Without the controversy that resulted from last year's effort concerning comprehensive health care reform, we have already enacted into law assistance for millions of self-employed Americans so they can obtain insurance; and the House itself has passed medical malpractice reform, tax credits for long-term care, Medicare Select; and now we are moving forward on this particular important issue of portability.

This incremental approach to health reform will give the American people what we believe to be the right dose of medicine to cure our health care problems.

Before we hear from today's witnesses, I would like to thank all of the members on the subcommittee for recognizing the importance of the problem and for cosponsoring H.R. 1610.

In addition, without objection, I would like to submit the letters of support from the National Federation of Independent Business, the Health Care Leadership Council, and the Association of Private Pension and Welfare Plans.

[The letters follow:]

May 11, 1995

Honorable Bill Thomas
Chairman
Health Subcommittee
Committee on Ways & Means
1136 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

On behalf of the 600,000 small business owners of the National Federation of Independent Business (NFIB), I am writing to express our support for your bill to bring portability to the health insurance market place.

Making it easier to go from job to job without the threat of losing health coverage has long been a goal of NFIB and the small business community. The Thomas portability bill would achieve that goal without having an adverse impact on small business premiums.

NFIB hopes that the Thomas portability bill is the first step toward additional insurance reforms, like rating reforms, guaranteed renewability, and others. We very much appreciate your leadership in making health insurance more accessible to small business owners and their employees.

Sincerely,

John J. Motley III
Vice President
Federal Governmental Relations

600 Maryland Avenue S.W. Suite 700 • Washington, D.C. 20024 • 202-554-9000 • Fax 202-484-1567

The Guardian of Small Business: for Fifty Years

HEALTHCARE
LEADERSHIP
COUNCIL

FOR IMMEDIATE RELEASE
May 12, 1995

Contact: Claire del Real
(202) 347-5731

STATEMENT BY
PAMELA G. BAILEY
PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

The Healthcare Leadership Council (HLC) is pleased to support H.R. 1610, introduced on May 11 by Representatives Thomas (R-CA) and Stark (D-CA), and commends the sponsors and cosponsors of this bipartisan effort for their leadership in finally transforming the theory of health care reform into reality.

This important market-based legislation would go a long way toward addressing the problems in the current health care delivery system by eliminating "job lock" and ensuring that American workers can change jobs without fear of losing health care coverage due to a preexisting condition or illness. The positive implications of the Thomas/Stark bill are significant and far-reaching. Their proposal would not only provide health security to America's workers, but would also extend coverage to many who are now uninsured without severely impacting health plan premium costs.

Post-election polling conducted last November by the HLC indicates that the vast majority of Americans support targeted health care reform designed to ensure portability of health care coverage between jobs. Consumers are overwhelmingly satisfied with their choice of health care coverage, and with the cost and quality of coverage. The message is clear -- keep reform simple because the market is working.

Healthcare Leadership Council
1500 K Street NW Suite 360
Washington, D.C. 20005
202 347-5731

Congress has the unique opportunity to enact targeted, consensus health care reform this year and should not get sidetracked by overly regulatory and burdensome proposals which are controversial and would threaten our market-based delivery system. The Thomas/Stark bill is a meaningful step toward enacting such common sense health reform by allowing the market to continue proving its effectiveness in health care delivery and cost containment.

The HLC is a broad coalition of 60 Chairmen and CEO's of health care companies representing all sectors of the health care industry. The HLC is firmly committed to ensuring access to quality, affordable health care through the promotion of a market-based health care delivery system. Only a system defined by market-based principles and competition can ensure health care consumers real choice in the health care marketplace while at the same time reining in costs and improving the quality of health care delivery through innovation.

Chairman THOMAS. Thank you very much, Mr. Herbert.
Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, members of the subcommittee, I am here representing the 68 independent Blue Cross & Blue Shield plans. We want to first congratulate you on identifying a strategy that can finally break this gridlock that has blocked Congress from enacting any kind of health insurance reform. This is something that is very important to prove to the American public.

You have put into practice what we all learned last year, that the only way to enact health insurance reform is to take incremental steps starting where there is widespread bipartisan agreement on what can be done.

We all found out last year that the alternative to these incremental steps, comprehensive insurance reform, is very difficult. Comprehensive reform of the insurance market involves very complex tradeoffs. It raises the whole set of issues related to subsidies between the young and the old, the healthy and the sick, those in urban areas and in rural areas, those who keep their health insurance continuously, and those who buy it only when they need it.

Your proposal breaks this gridlock by eliminating a very real concern of people who have health insurance through their jobs. That is the concern that if they change their jobs, their families will lose protection while they go through the preexisting waiting period.

There is bipartisan support in Congress to do this. There is industry-wide support to move quickly. There will be a sense of relief when families no longer have to worry about there temporary loss of coverage.

We believe that limiting insurance reforms to those in your bill are important for four reasons. No. 1, your bill, your proposal is very clear and very easily implemented. Taking one step beyond these group-to-group portability rules, for example, extending portability to the individual market, we believe, would result in a need for a major new Federal regulatory program, something this Congress may not easily accept.

No. 2, the bill applies the rules across all segments of the market. It isn't at all clear that Congress would apply rules that go beyond group-to-group portability across the market and that is very important if you want to have a stable, competitive marketplace.

No. 3, your bill is a logical division of Federal and State responsibility. It defers to the ability of States to determine what works best in their own markets. Forty-four States have already enacted various types of small group reform, and I stress various types of small group reform. However, only a Federal bill can assure portability for everyone since the States can't regulate self-funded plans with respect to waiting periods.

Finally, group-to-group portability is the only stand-alone reform. The next level of insurance reform is not a single step, it is more a complex web where one reform is meaningless without the rest of them. For example, no State has done guaranteed issue without the complex rating reforms that accompany it.

To put the benefit of your bill in human terms, if your bill is enacted, not one of the 137 million people that have health insurance through their jobs would have to turn down a job that would mean a better standard of living for their family just because changing jobs would mean a temporary loss in health insurance coverage.

Thank you.

[The prepared statement follows:]

TESTIMONY OF MARY NELL LEHNHARD
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, and members of the committee, I am Mary Nell Lehnhard, Senior Vice President, of the Blue Cross and Blue Shield Association, the coordinating organization for the 68 independent Blue Cross and Blue Shield Plans. Collectively, the Plans provide health benefits protection for 65 million people. I appreciate the opportunity to testify before you on the need to move forward with federal reform to achieve greater portability of coverage and address the important problem of job-lock.

For the past year or two, Congress and the American public have wrestled with the concept of comprehensive reform. We at the Blue Cross and Blue Shield Association, along with our member Plans, have been an active participant in that effort. This prolonged debate demonstrated that achieving comprehensive reform in a system as complex as ours is no easy task. The Chairman's bill draws on an important lesson from this experience, which is that to achieve real reform we must take an incremental approach, focusing on those problems that virtually all agree can be solved without doing damage to what is working in the current system.

We support the bill that has been proposed by Chairman Thomas as an important step that can be taken today to give the 137 million Americans covered by group health plans greater security because they will be able to maintain coverage when they change jobs. Chairman Thomas has proposed a common-sense approach that builds on the system of voluntary employer-sponsored health care coverage. It supports the revolution in health care that is already well underway in the private sector and the states. It is consistent with promoting market competition in health care. It addresses a significant concern of working Americans. It preserves an appropriate role for the states in the regulation of insurance. And it avoids the pitfalls inherent in attempting to enact grand, comprehensive, federal solutions — the reef on which health care reform foundered last year.

Federal health care reform should promote a competitive market and build on the foundation of employer-based coverage.

Health care reform is well underway in the private market and the states. Private sector innovation is the key to making affordable coverage more widely available by offering consumers a choice of health plans that effectively manage costs on behalf of their subscribers.

Private sector reforms are causing a virtual revolution in health care financing and delivery. This revolution was brought about by market competition. It builds on the foundation of employer-sponsored health benefits. And it responds to the public's demand for a choice of affordable, high quality health plans — a demand that we believe will best be met in a competitive market. The extent of this revolution is illustrated by our own experience. Enrollment in network-based health plans operated by Blue Cross and Blue Shield Plans has increased from 1% percent of total enrollment in 1982 to more than 42 percent of total enrollment in 1994. The success of these efforts to re-engineer health care coverage is illustrated by the 1994 Foster-Higgins survey of employer benefit plans, which reported that the average per-employee cost of health benefits actually declined between 1993 and 1994 as employees enrolled in record numbers in network-based health plans.

Government can support the revolution in the private sector, but it must be careful to build on the strengths of the current system by promoting and protecting a competitive market.

We believe that the current system of employer-sponsored coverage through which the vast majority of all Americans receive their coverage has served the nation well. More than 137 million employees and dependents obtain coverage for health care costs through employer-sponsored health benefit plans. The coverage available through employer-sponsored coverage has become broader and more comprehensive with each passing year.

In an effort to better manage costs, employer-sponsored health plans pioneered the development of health plans that rely on carefully selected networks of providers and well designed programs to ensure that the medical care provided to employees is necessary and appropriate. These efforts have allowed employers to offer their employees a choice of benefit plans that best suit their needs.

There are problems, certainly. The voluntary employer-based system of coverage cannot solve all problems. An employer-based system cannot make coverage available to those who are unemployed. Nor can it make coverage available to those who are employed by firms or in industries that cannot afford to pay for health benefits. As the past two years' debate demonstrated, however, these problems cannot be solved without funding significant new subsidies for those who cannot afford coverage because they lack the income to pay for it.

These problems notwithstanding, the employer-sponsored system of health insurance does a very good job of making coverage available to the vast majority of those who want, and are prepared to pay, for it. And it provides a foundation on which public sector programs to make coverage available to the most vulnerable members of society — the elderly, disabled, and poor — can build. One area in which improvement is both needed and possible is providing greater assurances to those who change jobs that they will be able to maintain their health benefits even if they have so-called "pre-existing" medical conditions.

The Thomas bill is a workable, well-designed, incremental step to increase portability of coverage for those who change jobs.

The Thomas bill addresses an issue that is of significant concern to working Americans who are currently covered by employer-sponsored health benefit plans. It would require all employer-sponsored group health plans to recognize prior group coverage when limiting coverage for pre-existing conditions.

This requirement would increase the ability of people who change jobs to maintain coverage — even if they or a family member has a chronic or pre-existing medical condition.

The approach taken by Chairman Thomas carefully defined an appropriate role for the federal government while recognizing the important role of states in developing viable, effective reforms. As discussed below, many of these state laws establish limits on pre-existing condition waiting periods for products sold to small employers. The Thomas bill would leave these requirements in place.

Under Chairman Thomas' proposal, the federal government does what only the federal government can do: it establishes standards to achieve greater portability of coverage that will apply to all group health plans. It would not mandate a specific pre-existing condition waiting period. Nor would it require an employer to offer coverage. It would require any employer who voluntarily offers a health benefit plan to apply waiting periods uniformly, without regard to the health status of an individual employee or an employee's family members. This requirement would apply to all employer health plans — including those that cannot be regulated by states.

In designing the portability bill, Chairman Thomas has been careful to address the potential abuse of pre-existing condition exclusions while avoiding the principal technical and policy problems often posed by limits on these exclusions. The principal value of pre-existing condition restrictions is their role in creating incentives for individuals to maintain continuous coverage. By discouraging individuals from going without coverage until they need medical care, the cost of coverage is reduced for both employers and for those covered under employer-sponsored health benefit plans. The proposed bill allows employers to establish the kind of pre-existing condition exclusions that are needed to encourage continuous coverage. At the same time, it prevents the selective use of such exclusions to deny coverage to those who have been continuously covered and who need medical care.

The Thomas bill builds on the success of states in reforming the small group market. Although the scope of the Chairman's bill is modest, it works in harmony with state efforts to reform the small group market. The successful track record of states that have enacted small group reform both demonstrates that reform is possible and suggests the futility of identifying 'the one best way' of making sure that consumers have a range of choices in a competitive market.

Since 1990, 45 states have enacted small group reforms. Of these:

- all 45 have adopted restrictions on rating that are designed to make sure that even those groups whose members are unfortunate enough to need substantial amounts of medical care continue to pay a reasonable amount for coverage.
- 42 limit the length of pre-existing condition exclusions.
- 35 require all carriers to make at least one product available to any group, regardless of the health status, age, or anticipated use of health services by members of the group.
- 13 require all carriers to make any of the products offered to small groups available to any small group regardless of health status or anticipated claims experience.

Generally, we believe that these state reforms have been successful. However, state reform efforts also teach another lesson: reforming the market for health care coverage is an ongoing process that requires a careful weighing of competing interests. The states are in the best position to design and implement solutions the complex and challenging task of regulating health insurers. For example, the maximum length of pre-existing condition exclusions has a significant impact on the expected cost of coverage. In general, the shorter the pre-existing condition period, the higher the cost of coverage. The limits that have been established by each state reflect the costs that employers in that state are able to bear.

Some may criticize the Chairman's bill for not addressing the problem facing individuals who lose coverage under group health plans.

We believe that the solution to this problem can and will be found in state efforts to reform the market for individual coverage. The issues that must be addressed in individual market reform are many and complex. There is little agreement on the best way of resolving these issues, and it is likely that different states will find different solutions that meet the needs of their citizens. We believe that the states are in the best position to find these solutions.

To date, 20 states have begun the difficult task of reforming the market for individuals who are not able to purchase group coverage. In addition, the National Association of Insurance Commissioners will be developing, this year, model legislation to provide states with guidance as they take up the difficult issues that individual market reform poses.

In summary, we believe that it is important to do what can be done to address significant concerns on which there is broad agreement on a clear set of solutions. The bill being proposed by Chairman Thomas is one such solution. We are prepared to work with you and other members of the committee to develop practical solutions to the most pressing problems in health care, to strengthen competitive markets, and to build on the solid foundation of employer-sponsored health coverage that serves so many so well today.

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James A. Klein
Executive Director

May 11, 1995

The Honorable William Thomas
Chairman, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

The Association of Private Pension and Welfare Plans (APPWP) commends you on the introduction of H.R. 1610, which enhances the portability of health benefits. Achieving greater portability of coverage for workers and their families while retaining appropriate incentives for individuals to purchase coverage before they become ill would be a significant accomplishment.

We are gratified that H.R. 1610 adopts a well-targeted rather than broad approach to health care legislation. The bill expands portability of coverage and reduces "job lock" while allowing employers the discretion they need to appropriately structure the health benefits that they voluntarily provide to employees. Since H.R. 1610 avoids overregulation, it will not discourage employers from voluntarily sponsoring health plans for their employees.

Again, we commend you on introducing H.R. 1610. We look forward to discussing technical issues with you in the near future and, as always, the APPWP will be pleased to work with you as H.R. 1610 moves through the legislative process.

Sincerely,

James A. Klein
Executive Director

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Chairman THOMAS. At this point, I recognize the gentleman from Wisconsin, Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Chairman, I have before me the statement from Congressman Pete Stark, who will be here shortly. I am almost tempted to deliver the statement, Mr. Chairman, because it does border on being complimentary to you. However, for the sake of brevity and to expedite the hearing today, I ask unanimous consent that the Stark statement be put in the record.

Chairman THOMAS. I thank the gentleman, I think, and I will invoke the chewing gum rule on that. If there is any flattery in it, you are supposed to enjoy it briefly and not swallow it, and we will do that.

[Mr. Stark's statement was not available at the time of printing.]

Chairman THOMAS. Thank you all once again.

Dr. Fronstin, once again, thank you. The microphone is yours. If you have any written statement, it will be made a part of the record, without objection; and you may proceed for 5 minutes to inform us in any way you see appropriate.

STATEMENT OF PAUL FRONSTIN, PH.D., RESEARCH ASSOCIATE, EMPLOYEE BENEFIT RESEARCH INSTITUTE, WASHINGTON, D.C.

Mr. FRONSTIN. Thank you.

Mr. Chairman and members of the subcommittee, I am pleased to appear before you this morning to discuss the issue of health insurance portability. My name is Paul Fronstin. I am a research associate at the EBRI, Employee Benefit Research Institute. Dallas Salisbury, the president of EBRI, asked that I thank you for the invitation to testify and he sends his regret in not being able to appear himself.

EBRI is a nonprofit, nonpartisan public policy research organization based in Washington, D.C. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research, we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

I would ask that my full statement be placed in the record.

This morning, I will cover four points relating to the issue of the portability of health insurance: Continuation of coverage issues through COBRA; preexisting condition provisions, price, and job lock; public opinion results regarding job lock; and research results regarding job lock.

COBRA's original purpose was to assure workers the ability to maintain health insurance during a transition period to other coverage. Qualified employees and their dependents may continue coverage for up to 18 or 36 months if the employment is terminated. COBRA beneficiaries may be charged 102 percent of the premium or, in the case of self-insured plans, 102 percent of the cost of the plan.

Several surveys have been conducted regarding the issues surrounding the use of COBRA. Some key results of the Charles D.

Spencer & Associates survey conducted in the spring of 1994 include the following:

Of the 14.5 percent of employees and dependents eligible for COBRA coverage, about 20 percent elected the coverage.

Average COBRA costs were approximately $5,600, as compared with $3,900 for active employees. Thus, average continuation of coverage costs were 149 percent of active employee claims costs, and, assuming employees electing coverage were paying 102 percent of the premium, employers were paying for approximately one-third of the total cost of continued coverage.

Job lock may occur for several reasons. These reasons include preexisting condition clauses in a potential employer's health plan, coverage is not offered from a potential employer, the potential employer offers less coverage than the current employer, and the potential employer does not offer health insurance coverage at all.

Selected past reform proposals have assumed that disallowing or restricting preexisting condition clauses and making health insurance more portable and personal would lessen job lock.

As of January 1994, 34 States have enacted laws that prohibit employers from imposing new waiting periods before being covered for preexisting conditions. These laws primarily pertain to the small group market. No conclusive research has been done that assesses the impact of these laws on job mobility.

In the presence of COBRA, preexisting conditions are not necessarily the primary motivating reason behind individuals choosing not to change jobs. This is because individuals can continue their current coverage after moving to a new employer, but only as long as they are willing to pay 102 percent of the premium. Thus, these individuals could carry two plans until the waiting period was satisfied. In some cases, the plan may not cover a preexisting condition at all, with or without a waiting period.

Regardless of the existence of COBRA, cost, comprehensiveness of the benefit package, and the availability of coverage remain important factors affecting job lock.

The Employee Benefit Research Institute, in conjunction with the Gallup organization, has conducted several public opinion surveys regarding the perspective and prevalence of Americans on job lock.

In 1993 we found that 20 percent of surveyed Americans indicated that they or a family member passed up a job opportunity based solely on health benefits.

When asked in further detail the reason for not changing a job based on health benefits, 33 percent cited that health benefits were not offered by the prospective employers, 20 percent cited a preexisting condition, 19 percent cited that the cost of the plan was too high, and 20 percent cited a less generous benefits package.

In addition to the public opinion surveys, several studies have been conducted regarding job mobility and health insurance. The findings are mixed and do not uniformly support or refute the existence of job lock. Studies that do support the theory of job lock show wide variation in the magnitude of its effects based on demographic and employment-based characteristics.

Thank you for the opportunity to testify this morning. I will be glad to answer any questions.

[The prepared statement and attachments follow:]

TESTIMONY OF PAUL FRONSTIN
EMPLOYEE BENEFIT RESEARCH INSTITUTE

Introduction

Mr. Chairman and members of the Committee, I am pleased to appear before you this morning to discuss the issue of health insurance portability. I am Paul Fronstin, a research associate at the Employee Benefit Research Institute (EBRI). Dallas Salisbury, the president of EBRI, asked that I thank you for the invitation to testify and send his regret at not being able to appear himself. EBRI is a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research, we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions. I would ask that my full statement be placed in the record.

The majority (57.4 percent) of Americans in 1993 received their health insurance coverage through the employment-based system (Snider and Fronstin, 1995). This connection may affect employees' compensation and, for some, their decisions about job change. The concern about the portability of health insurance may relate to the loss of health insurance benefits when a worker is offered a new job that could alter his or her insurance status. For example, if health insurance is not offered by a prospective employer, if the worker must satisfy a waiting period before becoming eligible for coverage, if the benefits package offered through the prospective employer is less generous, or if the employee has a condition that would be considered a preexisting condition and would not be covered under the new plan, the employee may opt to remain with his or her current employer. This may result in "job lock" or in employees forgoing job opportunities that could potentially increase their productivity. For employers who want employees to leave or retire and for employees who would prefer to change jobs, this job lock can be undesirable. Congress focused on portability of health insurance in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) by providing for continuation of health insurance coverage.

This morning I will cover four points relating to the issue of health insurance portability: continuation of coverage issues through COBRA; preexisting condition provisions, price, and job lock; public opinion results regarding job lock; and research results regarding job lock.

Portability and COBRA

The original purpose of the coverage continuation provisions of COBRA was to assure workers an ability to maintain health insurance during a period of transition to other coverage. COBRA requires employers to offer continued health insurance coverage to employees and their dependents when certain qualifying events occur. Qualified employees and their dependents may continue coverage up to 18 months (29 months for disabled employees) if employment is terminated (other than for gross misconduct) or if hours of work are reduced below the level at which coverage is normally provided. Dependents may continue coverage for up to 36 months if coverage is lost as a result of the employee losing coverage, cessation of dependent status, death of the employee, divorce or legal separation, or entitlement to Medicare. The charge to COBRA beneficiaries during the coverage period is limited to 102 percent of the premium (102 percent of the cost if the plan is self-insured)[1] for similarly situated employees for whom a qualifying event has not occurred. The employer may charge disabled employees 102 percent for the first 18 months and up to 150 percent during the 19th through 29th month.

Several surveys have been conducted regarding issues surrounding the use of COBRA. Some key results of the Charles D. Spencer & Associates, Inc. survey conducted in the spring of 1994 include:[2]

- Of the 14.5 percent of employees and dependents eligible for COBRA coverage, about 1 in 5 (19.6 percent) elected the coverage in 1994, up from 19.3 percent in 1993 but down from a high of 28.5 percent in 1990 (table 1).

- Among the entire 1994 surveyed population, 2.9 percent of the active employee work force elected COBRA coverage, up from 1.7 percent in 1993 (table 1).

- Average COBRA costs were $5,584 , compared with $3,903 for active employees, according to the 1994 survey. Thus, average continuation of coverage costs were 149 percent of active employee claims costs, and, assuming employees electing coverage were paying 102 percent of the premium, employers were paying for approximately one-third (32 percent) of the total costs for continued coverage. Claims cost ratios ranged from 41 percent to 500 percent. Data also indicate that within a given plan year, COBRA costs bear little relationship to active employee costs; COBRA costs more closely resemble individual (as opposed to group) plan costs in that they are not consistent from year to year.

- Among all eligibles electing coverage, 15.9 percent were spouse/dependent elections (7.9 percent selected coverage because of termination or reduction in hours, and 8.0 percent elected coverage because of death, divorce, or plan ineligibility). Employee elections accounted for 84.1 percent of all eligibles electing coverage (table 2).

- Among all spouses and dependents eligible for coverage, 9.6 percent elected coverage, compared with 37 percent in 1993, 23.4 percent in 1992, 25 percent in 1990, and 36.6 percent in 1988. Among employees eligible for coverage, 19.8 percent elected coverage in 1994.

- For 18-month qualifying events, the average length of coverage was 10.76 months. For 36-month qualifying events, the average length of coverage was 23.1 months. Among individuals electing coverage, less than 1 percent converted to an individual policy.

- Difficulties surrounding COBRA coverage according to survey respondents included adverse selection/claims cost (36 percent); difficulties in collecting premiums (36 percent); administrative difficulty such as paperwork, record keeping, etc. (30 percent); excessive time for beneficiary response, tracking eligibility (24 percent); notification from continuee of election or change in status (19 percent); and lack of final rules, complexity of law (15 percent).

Why people do not elect to take COBRA coverage has not been well documented.

Preexisting Conditions, Pricing, and Job Lock

Part of the issue of portability is the issue of job lock. Job lock may occur either because a worker cannot get health insurance coverage through a prospective position, or because while the worker can obtain coverage, the premium is higher at the prospective job than at the initial job, the benefits package is less generous, or selected conditions are not covered (i.e., a preexisting condition clause may discourage a worker from leaving the current job and health insurance plan to move to a new plan that does not cover a given health condition). Selected past health care reform proposals have assumed that disallowing or restricting preexisting condition clauses and making health insurance more portable and personal would lessen job lock.

As of January 1994, 34 states have enacted laws that prohibit employers from imposing new waiting periods on employees before they are covered for preexisting conditions. These laws primarily

pertain to the small group market (Atchison, 1994). No conclusive research has been done that assesses the impact of these laws on job mobility.[3] However, in the presence of COBRA, among plans that will cover a preexisting condition following a waiting period, preexisting conditions are not necessarily the primary motivating reason behind individuals choosing not to change jobs. This is because individuals can continue their current coverage for a maximum of 18–36 months even once moving into the new position if they are willing to pay 102 percent of the premium. Thus, these individuals could carry two plans until the waiting period was satisfied. In some cases, though, the plan may not cover a preexisting condition at all—with or without a waiting period. Regardless of the existence of COBRA, cost, comprehensiveness of the benefit package, and availability of coverage remain of importance.

Public Opinion Results on Job Lock

EBRI, in conjunction with The Gallup Organization, Inc., conducted several public opinion surveys regarding Americans' perspective on job lock. Some key findings include:[4]

- In 1993, 20 percent of surveyed Americans indicated they or a family member passed up a job opportunity based solely on health benefits, up from 11 percent in 1992 and 13 percent in 1991 (chart 1).

- In 1993, among respondents who stated they or a family member passed up a job opportunity based solely on health benefits, age, annual income, and education showed the greatest variation (chart 2), while other variables, such as occupation, sex, race, region, and marital status, showed little variation.

- Among age groups, 18–34 year olds were most likely to have passed up a job opportunity based solely on health benefits (28 percent). This compares with 21 percent among individuals aged 35–54 and 7 percent among individuals aged 55 and over (chart 2).

- Individuals with an annual income of $20,000–$75,000 were most likely to have passed up a job opportunity based solely on health insurance (23 percent) (chart 2).

- In looking at education level, individuals with some college experience were most likely to pass up a job opportunity based solely on health benefits (26 percent), compared with individuals with a high school diploma or less (16 percent) and individuals with a college or post graduate education (19 percent) (chart 2).

- When asked in further detail the reason for not changing jobs based on health benefits, the reason most often cited was that health benefits were not offered by the prospective employer (58 percent in 1991). The likelihood of this reason declined to 33 percent in 1993 yet remained the most commonly cited reason. Among other reasons cited, having a preexisting condition showed the largest increase, moving from 10 percent in 1991 to 20 percent in 1993 (chart 3).

- Individuals in 1993 most likely to respond that the reason they did not change jobs was that "the prospective employer did not offer health benefits" were individuals with less than a high school education (48 percent), individuals with a high school diploma (38 percent), and individuals with an annual income of $20,000–$75,000 (35 percent). Individuals least likely to give this reason were individuals with an annual income of $75,000 or more (16 percent).

- In 1993, individuals most likely to respond that they did not change jobs because "the prospective employer's health benefits provided less coverage than you or a family member had previously" were unmarried individuals (30 percent), college graduates (26 percent), and individuals with an annual income of less than $20,000 (26 percent). Individuals least likely to give this reason were secretarial and clerical workers (6 percent) and individuals with an annual income of $75,000 and more (7 percent).

- In 1993, individuals most likely to respond that they did not change jobs because "you or someone in your family had a medical condition the prospective employer's health plan did not cover" were individuals with an annual income of $75,000 and over (30 percent), women (27 percent), and individuals with a postgraduate degree (27 percent). Individuals least likely to give this reason were individuals aged 55 and over (8 percent), men (12 percent), and individuals with an annual income of less than $20,000 (12 percent).

- In 1993, individuals most likely to respond that they did not change jobs because "the prospective employer's health plan cost too much" were secretarial and clerical workers (41 percent) and individuals who did not graduate from high school (36 percent). Individuals least likely to give this reason were individuals with an annual income of $75,000 or more (6 percent) and individuals with a postgraduate degree (10 percent).

Research Results on Job Lock

In addition to public opinion surveys, several studies have been conducted regarding job mobility and health insurance. The findings are mixed and do not uniformly support or refute the existence of job lock. Studies that do support the theory of job lock show wide variation in the magnitude of its effects based on demographic and employment-based characteristics. Findings from these studies are summarized below and in an accompanying table I will submit for the record (table 3).

- Mitchell (1982 and 1983) conducted one of the first studies regarding the magnitude of job lock. Mitchell found evidence that the loss of a pension promise was a particularly strong deterrent to quitting. While Mitchell also found evidence that medical coverage deterred employees from quitting, it was at a fairly low level of reliability.

- Madrian (1993) and Cooper and Monheit (1993) provided the strongest evidence of job lock. Madrian estimates that job lock reduces the voluntary turnover rate of those with employer-provided health insurance by 25 percent, from 16 percent to 12 percent per year. Cooper and Monheit found that policyholders of employment-based coverage were three and one-half times less likely to change jobs than uninsured workers. However, they did not find worker or dependent health conditions associated with job mobility.

- Cooper and Monheit (1993) also indicate that mobility rates vary based on worker characteristics. Most likely to change jobs were younger workers with little job experience, part-time workers, workers with low levels of education, and workers with low hourly wages. Least likely to change jobs were full-time workers, workers with high levels of education, and workers with high hourly wages. The authors also indicate that married men who expected to lose coverage were 23 percent less likely to change jobs. Workers who were likely to gain coverage through a change in employment were 52 percent more likely to change jobs as compared with those whose insurance prospects were not expected to change.

- Madrian (1993) cites three factors to consider in evaluating the implications of job lock for economic efficiency: Does job turnover result in a better match between workers and firms and thereby increase productivity? To the extent that job lock does lower productivity, are losses temporary or permanent? and Is job lock a benefit or a cost for firms?

- Gruber and Madrian (1994) found that continuation of coverage mandates were successful in reducing job lock. They found that one year of continuation benefits was associated with a 10 percent increase in mobility among those with health insurance.

- In a later publication, Monheit and Cooper (1994) found that job lock was present in the labor market but that the proportion of workers affected and the magnitude of the welfare loss was less than generally supposed.

- Holtz-Eakin (1993) indicated that there was little evidence that health insurance provision interferes with job mobility. In his study of individuals who changed jobs as compared with those who did not he found that, in analyzing health insurance alone, there was a correlation between job mobility and health insurance. However, when looked at as part of a total compensation package, the importance of health insurance with regard to incentive to change jobs disappeared.

Conclusion

Several questions must be addressed when assessing the impact of preexisting conditions and health insurance portability on job lock. Does the issue of the portability of health insurance affect job mobility? And, if so, to what extent? Only a few studies have been done in this arena to date and results of these studies are mixed. In addition, studies that find that having employment-based health insurance impacts on job mobility indicate that there is wide variation in the magnitude of that impact. COBRA may act to reduce whatever job lock does exist. However, based on public opinion surveys, some Americans still indicate having passed up a job opportunity because health insurance was not offered in the new position (33 percent in 1993), because the new job offered less coverage (20 percent), because of a preexisting condition (20 percent) or because the new health insurance cost too much (19 percent). While preexisting conditions are indicated as a reason for not changing jobs, the existence of COBRA should mitigate this as an issue for those whose prospective employer's plan covers the preexisting condition following a waiting period.

Thank you for the opportunity to testify this morning. I'll be glad to answer any questions you may have.

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[1]The Internal Revenue Service has issued guidance for determining the premium for self-funded plans. Premiums may be based on an actuarial determination for providing benefits for active employees during the same period, or may be based on past cost. The latter is the cost equal to the plan's cost for similarly situated beneficiaries for the same period during the previous determination period adjusted by increases or decreases in the cost-of-living as measured by the gross national product. See Terry Humo and Keith C. Kakacek, "Employers Guide to Self-insuring Health Benefits" (Washington, DC: Thompson Publishing Group, 1993).

[2]A total of 270 companies responded to Spencer's 1994 survey, representing 1,527,648 employees. Data are for the 1993 plan year. Surveys have also been conducted by the International Society of Certified Employee Benefit Specialists and Towers Perrin and the National Association of Manufacturers. For a synopsis of findings from these surveys, see Paul Millholland, "Employers' COBRA Costs," *EBRI Notes* (November 1992): 1–4.

[3]In looking at the issue of limited insurance portability as a whole, Gruber and Madrian (1994) found that continuation of coverage mandates were successful in reducing job lock. They found that one year of continuation benefits was associated with a 10 percent increase in mobility among those with health insurance.

[4]EBRI/Gallup public opinion surveys are stratified random sample telephone surveys of 1,000 individuals. These surveys have a maximum expected error range at the 95 percent confidence level of ±3.1 percent.

Table 1
Entitlement and Elections for Consolidated Omnibus Budget Reconciliation Act (COBRA), Plan Years 1988–1993

Survey Year	Employees Elected as a percentage of active employees	Employees Entitled as a percentage of active employees	Employees Elected as a percentage of those entitled
1989	1.70%	16.00%	11.20%
1990	2.60	9.20	28.50
1991	2.20	10.60	20.50
1992	1.60	12.06	13.23
1993	1.68	8.71	19.30
1994	2.86	14.54	19.64

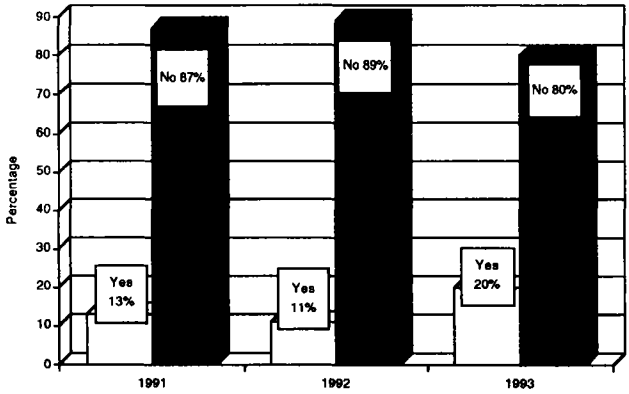
Source: Charles D. Spencer and Associates, Inc., "1994 COBRA Survey: One in Five Eligible Employees Takes COBRA; Employers Pay One-Third," *Spencer's Research Reports* (August 19, 1994).

Table 2
Reasons for Consolidated Omnibus Budget Reconciliation Act (COBRA) Elections, Plan Years 1990–1993

Survey Year	Total Electing Coverage	Spouse/Dependent Election		Employee Election
		Termination or reduction in hours	Death, divorce, plan ineligibility	Termination or reduction in hours
		(percentage)		
1991	100%	16.00%	7.60%	76.40%
1992	100	10.15	8.29	81.56
1993	100	15.00	13.50	71.50
1994	100	7.90	8.00	84.10

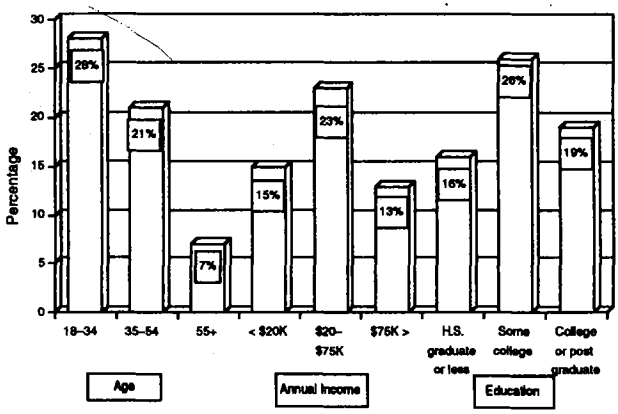
Source: Charles D. Spencer and Associates, Inc., "1994 COBRA Survey: One in Five Eligible Employees Takes COBRA; Employers Pay One-Third," *Spencer's Research Reports* (August 19, 1994).

Chart 1
Question 9: "Have you or a family member ever passed up a job opportunity or stayed in a job you would have preferred to leave solely because of health benefits?," 1991–1993



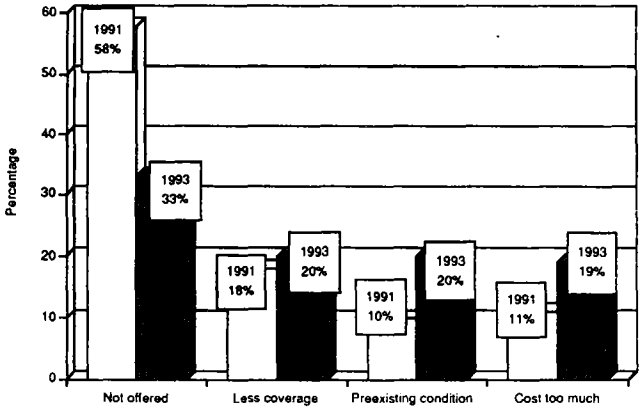
Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Benefit Trade Offs, 1991* (Washington, DC: Employee Benefit Research Institute, December 1991); and *Public Attitudes on Health Benefits, Part 1* (Washington, DC: Employee Benefit Research Institute, February 1992); and *Public Attitudes on Health Benefits, 1993* (Washington, DC: Employee Benefit Research Institute, November 1993).
Note: Asked of 1,000 individuals age 18 or older from randomly generated telephone lists.

Chart 2
Question 9: Percentage of individuals who responded yes to, "Have you or a family member ever passed up a job opportunity or stayed in a job you would have preferred to leave solely because of health benefits?," by age, annual income, and education level, 1993



Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Benefits, 1993* (Washington, DC; Employee Benefit Research Institute, November 1993).

Chart 3
Question 10: "Which of the following best describes the reason you or your family member chose not to change jobs?," 1991 and 1993



Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Benefit Trade Offs, 1991* (Washington, DC: Employee Benefit Research Institute, December 1991; and *Public Attitudes on Health Benefits, 1993* (Washington, DC: Employee Benefit Research Institute, November 1993).
Note: The balance of reasons are the following: in 1991, other (3 percent); in 1993, other (4 percent); secure at present job (3 percent); and none of these reasons (1 percent).
Refer to charts 1 and 2 for the number of individuals who responded yes to the question, "Have you or a family member ever passed up a job opportunity or stayed in a job you would have preferred to leave solely because of health benefits?"

Table 3
Employment-Related Health Insurance and Job Mobility: Alternative Estimates of Job Lock in the United States

Study	Sample/Method	Magnitude of Job Lock
Mitchell (1982)	Wage earners 18–65 years of age from the Quality of Employment Survey in 1973 and 1977. Estimated a reduced form probit equation of likelihood of job change using baseline insurance status.	Probability of job change for men reduced by 4.24 percentage points.[a] Not statistically significant.
Madrian (1994)	1987 National Medical Expenditure Survey. Sample of married men 20–55 years of age. Used a probit estimate of the likelihood of job change to derive a "difference in the difference" estimator; examined three empirical tests for job lock.	Mobility rates reduced by 30%–31% for those with employment-related coverage compared to those without such coverage; mobility rates reduced by 33%–37% for those married men with employment-related coverage and large families (proxy for medical care costs); mobility rates reduced by 67% for those with employment-related coverage and a pregnant wife (proxy for medical care costs). All statistically significant.
Holtz-Eakin (1994)	1984 wave of the Panel Study of Income Dynamics. Sample of full-time workers 25–55 years of age. Derived a "difference in the difference" estimator for job changes over one- and three-year intervals.	For job changes during 1984–1985: mobility rates for married men reduced by 1.59 percentage points (result insignificant); rates for single women reduced by 1.06 percentage points (insignificant); job lock effects for other groups not found (wrong sign and insignificant). Results for three-year intervals insignificant.
Cooper and Monheit (1993)	1987 National Medical Expenditure Survey. Sample of wage earners 25–54 years of age. Predicted whether workers would gain or lose coverage on a new job, and used the results in a structural probit model of job change. Compared their mobility rates to the mobility rates of workers whose insurance status was expected to remain the same.	Among workers likely to lose coverage: mobility for married men reduced by 24.8%; single men by 23%; married women by 34.7%; single women by 38.8%. Results significant for one- or two-tail tests.

Source: Monheit, Alan C. and Philip F. Cooper, "Health Insurance and Job Mobility: Theory and Evidence" *Industrial and Labor Relations Review* (October 1994): 68–85.

[a]This figure is based on Monheit and Coopers computation based on coefficient and mean values reported by Mitchell (1982). Mitchell (1983) did not provide an explicit estimate of job-lock.

Mr. ENSIGN [presiding]. Thank you, Doctor.

Mr. Christensen.

Mr. Crane, questions?

Mr. CRANE. No.

Mr. ENSIGN. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Fronstin, since we are only dealing with the COBRA section of the Internal Revenue Code, and that is the jurisdiction of the subcommittee, as we all know, how many employees would we be covering with this legislation and how many would still not get the benefits of this bill?

Mr. FRONSTIN. Offhand, I do not know the total number of employees covered by COBRA, but I would be glad to get that information for you.

Mr. KLECZKA. OK. Thank you very much.

[The following was subsequently received:]

In response to your question on the number of Americans covered by COBRA, I have estimated that between 110 and 120 million Americans would be eligible for continuation of coverage under COBRA. These individuals include all workers and their dependents with health insurance coverage working for public and private estabishments with 20 or more employees. Health plans located within the District of Columbia are exempt from COBRA. Our estimate reflects this exemption. However, health plans that are sponsored by churches (as defined in section 414(e) of the Internal Revenue Code) are exempt from COBRA coverage. Unfortunately, we do not have data on the number of individuals in this category.

Mr. ENSIGN. Mr. Johnson.

Mr. JOHNSON of Texas. No.

Mr. ENSIGN. OK. In your testimony, you conclude that the fact that COBRA allows individuals with preexisting conditions to carry two policies until they are eligible for full coverage suggests preexisting conditions are not necessarily the primary motivating reason behind individuals choosing not to change jobs. It is hard to imagine an individual paying 102 percent of premium for a COBRA policy plus their contribution to a second policy isn't a factor. Wouldn't you agree?

Mr. FRONSTIN. I would agree that the cost is definitely a factor contributing to job lock, especially when expecting workers to pay 102 percent of one premium and possibly pay a portion of the other.

Mr. ENSIGN. Ideally, if you had to set up a program to prevent job lock, what are some of the ideas that you would come in with?

Mr. FRONSTIN. I haven't really thought about it in that much detail. If we were to just reduce the preexisting condition clauses, we are possibly going to affect the cost of the premium, and that is going to—what may happen is we found that about 20 percent were affected by preexisting conditions and about 20 percent were affected by the cost of the new plan. If we reduce preexisting condition clauses, we may increase the price of the plans and we may just be redistributing people among reasons. We just don't know. There is not enough evidence.

Mr. ENSIGN. OK. No other?

Well, thank you very much. I guess you did such a great job that nobody else has any questions. I appreciate your testimony this morning.

I would like to call the next panel forward: Neil Trautwein, manager, Health Care Policy, U.S. Chamber of Commerce; Donald Dressler, president for Insurance Services, Western Growers Association, Newport Beach, Calif.; and W.W. "Biff" Naylor, vice president-elect, National Restaurant Association.

Mr. ENSIGN. Mr. Trautwein, why don't you proceed, the yellow light will go off when you have 1 minute left. Thank you.

STATEMENT OF E. NEIL TRAUTWEIN, MANAGER, HEALTH CARE POLICY, U.S. CHAMBER OF COMMERCE

Mr. TRAUTWEIN. Thank you.

Mr. Chairman and members of the subcommittee, my name is Neil Trautwein and I am manager of Health Care Policy for the U.S. Chamber of Commerce. The chamber is the world's largest business association representing——

Mr. CHRISTENSEN. Mr. Trautwein, would you move closer to the microphone, please?

Mr. TRAUTWEIN. Yes, sir. The chamber represents 215,000 businesses, 96 percent of which have fewer than 100 employees and 71 percent of which have fewer than 10. We also represent 3,000 State and local chambers of commerce, 1,200 trade and professional associations, and 72 American chambers of commerce abroad. We appreciate the opportunity to appear before you this morning to comment on the chairman's proposed legislation on health insurance portability.

We commend the chairman and the members of this subcommittee for supporting H.R. 1610, bipartisan legislation to address health insurance portability. Targeted reforms such as those proposed by the chairman are important and valuable steps in reforming our health care system.

Our members remain committed to this effort. In fact, health care reform was a topic of a membership survey conducted in 1994, the largest survey ever conducted by the Chamber of Commerce. Results of that survey indicated that the chamber membership overwhelmingly endorses a free market approach to health care reform.

In conjunction with that trend, 84 percent of the members who responded sought to enhance the current health care system rather than impose burdensome regulations. That survey clearly illustrated opposition to any effort to enact hasty, all-encompassing reform legislation.

The chamber advocates the following steps as being integral and achievable steps toward positive health care reform. These are:

No. 1, insurance market reform designed to address the issues of availability and portability of health insurance coverage. The chairman's proposal on portability is certainly in line with these principles.

No. 2, price and quality report cards would allow consumers to compare the performance of the health plan they select with others in the market. Such information could be used to see which plan's record had the best balance between outcomes and cost.

No. 3, consumer choice among a variety of health plan structures should be facilitated, but incentives for consumer price sensitivity should be built into the system as well.

No. 4, voluntary purchasing pools would provide small employers and individuals with the same economies of scale and market leverage enjoyed by larger companies.

No. 5, administrative simplification measures would include standardized claim forms, greater emphasis on electronic processing, and computerized patient records.

No. 6, malpractice reform should include a cap on noneconomic damages and contingency fee percentages, provision for periodic payments, and a mandatory offset of payments from collateral sources.

No. 7, for the purpose of comparison shopping only, a benchmark package that all insurers would offer. This package could be modified by agreement between the insurer and purchaser, whether individual or employer.

Finally, 100 percent deductibility for the self-employed.

The targeted legislation before the subcommittee today seeks to address the problem known as job lock. For some, a new job or change of career is out of the question because of health conditions that existed prior to the desired change of employment. These preexisting conditions might limit or bar coverage under the prospective new employer.

We support the chairman's effort to address this problem by limiting the use of preexisting exclusions where continuous coverage was maintained. This approach would seem to be an important and effective step toward unlocking the job lock barrier.

Again, Mr. Chairman, we support this subcommittee's efforts. The chamber will continue to work in support of this and other market-based reforms based on the principles I discussed earlier.

We appreciate the opportunity to work with this subcommittee, and I would be happy to answer your questions.

[The prepared statement follows:]

STATEMENT
on
HEALTH INSURANCE PORTABILITY
before the
SUBCOMMITTEE ON HEALTH
of the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
E. Neil Trautwein
May 12, 1995

Mr. Chairman and members of the Subcommittee, my name is Neil Trautwein and I am Manager of Health Care Policy for the U.S. Chamber of Commerce. The Chamber federation represents 215,000 businesses (96 percent of which have fewer than 100 employees and 71 percent of which have fewer than ten), 3,000 state and local chambers of commerce, 1,200 trade and professional associations, and 72 American Chambers of Commerce abroad. We appreciate the opportunity to appear before this Subcommittee to comment on the Chairman's proposed legislation on health insurance portability.

The Chamber commends Chairman Thomas for introducing bipartisan legislation to address health insurance portability.

The need to reform our health care system clearly is a challenge we face today. Targeted reforms such as that proposed by the Chairman are important and valuable steps in addressing this need.

Our members remain committed to improving our market-based health care system. In fact, health care reform was the topic of a membership survey conducted in April of 1994, the largest membership survey ever conducted in Chamber history.

Results of that survey indicated that Chamber membership overwhelmingly endorse the free market approach to health care reform. In conjunction with that trend, 84% of the members who responded sought to enhance the current health care system rather than sap its strengths by imposing burdensome regulations. The survey

clearly illustrated opposition to any effort to enact hasty, all-encompassing reform legislation.

The Chamber advocates the following elements as critical steps toward positive health care reform which is free of mandates, new taxes and expanded bureaucracy:

- Insurance market reform designed to address the issues of availability and portability of health insurance coverage. Insurers would be required, for example, to offer insurance to anyone who wanted it and would not be able to cancel coverage based on a person's or group's claims experience. There would also be a limit on the ability to deny coverage for pre-existing conditions. The Chairman's proposal to address portability is in line with the Chamber's views.

- Price and quality report cards would allow consumers to compare the performance of the health plan they select with others in the market. Such information could be used to see which plan's record had the best balance of successful outcomes and reasonable prices.

- Consumer choice among a variety of health plan structures (HMO, PPO, point-of-service, indemnity, etc.) should be facilitated, but incentives for consumer price sensitivity should be built into the process. That is, consumers should be able to save money for themselves by selecting a lower-cost plan, and should participate via deductibles and copayments in the cost of medical services.

- Voluntary purchasing pools would provide small employers and individuals with the same economies of scale and market leverage enjoyed by large employers.

- Administrative simplification measures would included standardized claim forms, greater emphasis on electronic processing, and computerized patient records.

- Malpractice reforms should include a cap on non-economic damages and contingency-fee percentages, provision for periodic payments, and a mandatory offset of payments received from collateral sources (e.g. health insurance and disability benefits or auto insurance).

- For the purposes of comparison-shopping only, a benchmark package that all insurers would offer. The package could be modified by agreement between the insurer and the purchaser (whether individual or employer) to suit different

needs and preferences.

- 100% deductibility of health insurance expenses by the self-employed would end an indefensible discrepancy in how different business structures are treated for tax purposes.

The targeted legislation before the subcommittee today seeks to address the problem known as "job lock." For some today, a new job or change of career is out of the question because they or their dependents have health conditions that existed prior to the change of employment. These "pre-existing" conditions might limit or bar coverage under the prospective new employer.

The Chairman's proposal will address this problem by limiting use of pre-existing condition exclusion where continuous coverage was maintained under a prior employer without a substantial break in coverage. This approach would seem an important and effective step to "unlocking" the job lock barrier. We support your efforts.

The Chamber will continue to work in support of this and other market-based reforms based on the principles discussed above. We appreciate the opportunity to work with this Subcommittee and I would be pleased to answer any of your questions.

Mr. ENSIGN. Thank you, Mr. Trautwein.
Mr. Dressler.

STATEMENT OF DONALD G. DRESSLER, PRESIDENT OF INSURANCE SERVICES, WESTERN GROWERS ASSOCIATION, IRVINE, CALIF.

Mr. DRESSLER. Mr. Chairman, members of the subcommittee, thank you for the chance to be here.

Western Growers Association is a trade association of fruit and vegetable growers in California and Arizona, and we have a seasonal work force. We supply collectively about one-half of all the fruits and vegetables grown in the United States. This legislation is particularly critical for us.

I have compiled some statistics in our own group health plan, which we administer for our members. In 1994 we had 14,915 employees who we began coverage for who were subject to preexisting conditions, and they had approximately 25,000 dependents. So we had, basically, 40,000 people who we began coverage for last year who had preexisting condition exclusions apply to them.

We think that this is an issue which will help encourage workers to seek employment, which will help in making the transition from job to job, and we support the idea as a particular benefit to those employees.

We have had small group underwriting reform in California since 1993, and we have had a form of restrictions on preexisting conditions as well as a bridging between health care plans.

When we began this, we were concerned there would be some slight increase in health care costs resulting from the portability issue because, clearly, some people will have health care coverage paid for that they hadn't had before. It has been a surprise and a pleasant one to us that there hasn't been any noticeable increase in health care costs because of bridging and/or preexisting, and I would predict that would be the result of this legislation as well. So it is definitely a win for employees, and it doesn't seem to have a significant cost, as long as it is shared universally, as long as everybody plays by the same rules.

I think the portability issue is very important to small employers. Large employers have a lot of choices in their health care plans and what they do, but small employers often find themselves subject to the equivalent of job lock. If either they or someone in their family or one of their small group of employees have a severe medical problem, they are concerned about switching group health coverage because of the starting again of a preexisting condition exclusion.

So I believe this legislation will help increase competitiveness in the small group health insurance market as well as make it easier for employers to seek coverage and competitive pricing. So I think this legislation definitely provides an advantage for small employees over the status quo.

In terms of the practicality of applying this legislation, the issue which always arises for a new health care plan or an employer who is picking up a worker: How do you determine whether the preexisting conditions are going to apply or not? Since we have a num-

ber of people who join our plan every year, we have a lot of experience with this.

There are really two ways to do it. One is at the time someone is enrolled in the plan. This is the most efficient, economical way to do it, because then the patient's records are set up and there is clear processing for handling of any claims that come in later.

The situation becomes more complicated if we don't get this preexisting condition issue resolved at the beginning of enrollment and we then have to resolve it later, when a person actually requires medical care. At that point, you are trying to look at a medical condition that looks like it had care that has been continuing for some time. You have the problem of holding up claims processing while you go back to the doctor or hospital and ask, "What is your pattern of care with this patient?" Or going back to the employee or his dependents and asking, "What is your proof of prior coverage?" So handling the determination of preexisting conditions at the time of claim, which is possible, is a complicated and expensive process.

Frankly, I would hope that when employers give their notice of COBRA rights, which they do when someone leaves health care coverage, that we could include in that COBRA notification information that could then be used to qualify the employee for the next health care plan. In that case, an employee would only have to submit, for example, a copy of his COBRA notice to his new employer or new carrier so that they could determine at the time he is enrolled his status and make it a much smoother operation.

But, in any event, we think this legislation is a wonderful step forward. We support the bill. We think it is going to be helpful to both employers and employees, and it is particularly important to agriculture.

[The prepared statement follows:]

Western Growers Association

Serving the California and Arizona Fresh Produce Industry

Statement of Donald G. Dressler

Western Growers Association

before the

Health Subcommittee

House Committee on Ways and Means

May 12, 1995

Mr. Chairman and members of the Committee, thank you for the opportunity to testify on the issue of portability of health insurance, which is very important to agricultural employers.

I am Don Dressler, President of Insurance Services for Western Growers Association, of Irvine, California. Western Growers is a non-profit trade association representing growers and shippers of fresh fruits and vegetables throughout Arizona and California. We have 2,600 members who collectively produce approximately one half of our nation's supply of fresh fruit and vegetable supply. The vast majority of our members run small businesses of less than 10 employees.

For over thirty eight years, Western Growers Association has sponsored health benefit plans for our members and their employees. We operate as an ERISA health benefit trust, and are self-funded. We began our group health benefit plan because conventional insurance companies would not cover seasonal and often migrant agricultural workers, many of whom were not fluent in English and lived in rural, hard-to-reach areas.

Today, we provide benefits for 19,000 farm employees, and the total number of beneficiaries covered by our plan, including dependents, is now over 50,000.

I want to commend Chairman Thomas and the other members of the Subcommittee who have co-sponsored the portability legislation for moving ahead with this initiative on a bi-partisan basis. I believe that the passage of this legislation would be real progress in this nation's efforts to provide health insurance that is more affordable and secure for the vast majority of Americans.

The portability legislation that the Subcommittee is considering today is of vital concern to Western Growers Association due to the seasonal employment nature of many of our agricultural workers. There is a significant transition period between employers and between health benefit plans for our workers. Our coverage is on a monthly basis, and each month we average 2,000 newly covered employees. The ability to have benefits apply without beginning the period of qualification again to satisfy pre-existing qualifications is vitally important to these workers and their families.

A large number of our beneficiaries may not be working for periods ranging from several weeks to several months during the year. With varying crop seasons, harvest peak employment needs, and changes in weather, intermittent work schedules are quite common in our industry. Currently, we reinstate employees and their beneficiaries when they return to work and regain eligibility.

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Within our plan, if someone does not have an absence of more than 90 days, we "bridge" their satisfaction of the pre-existing period, and they do not have to start the waiting period over again. This encourages workers to seek new jobs during periods of seasonable layoff, and helps our members in recruiting new employees.

When our group program competes with other plans which do not offer similar portability of coverage, costs are shifted to our members and our plan. The proposed legislation will even the playing field for us in this regard. Moreover, it will eliminate the incentive for some group plans to avoid appropriate and reasonable risk, thus expanding the availability of coverage for workers.

The limitation on how long portability is assured contained in the proposed legislation encourages workers to seek and to maintain health insurance coverage. Furthermore, the bill would deter them from waiting until they have pending medical problems.

To conclude, Western Growers Association strongly supports Chairman Thomas's legislation to provide portability of health insurance. This is a very important step along the road to providing greater access to health benefits among our nation's work force.

In your future legislative deliberations, WGA hopes that you will also address the role of association sponsored multiple employer health plans and the benefits of self-funding. These issues are also important to the goal of reducing the costs of health insurance and encouraging small employers to provide health benefits to their employees. Chairman Thomas's H.R. 1234 contains important consumer and employer projections in this regard.

Mr. ENSIGN. Thank you, Mr. Dressler.
Mr. Naylor.

STATEMENT OF W.W. "BIFF" NAYLOR, VICE PRESIDENT, NATIONAL RESTAURANT ASSOCIATION

Mr. NAYLOR. Mr. Chairman, members of the subcommittee, thank you for inviting me here today.

My name is Biff Naylor. I own the Naylor Establishment in Los Angeles. We operate Beverly Hills Cafe in California and Cindy's Coffee Shop in Idaho. I am vice president of the National Restaurant Association, the leading trade group for the U.S. food service industry. Our industry, with its over 9 million workers and its nearly 740,000 units in every town and city in the United States, is the Nation's No. 1 retail employer.

I am also a cofounder of the American Restaurant Employers Trust. Twenty years ago, a group of restaurant owners in southern California got together with the goal of making it easier to provide health benefits for both their employees and their employers.

I endorse the approach Congressman Thomas is taking in the bill he has introduced today. Reducing the waiting period for covering preexisting conditions by allowing credit for coverage under a previous employer's plan is a good deal all around for employees who won't be locked into jobs out of fear that they will lose coverage if they move on and for employers who will be part of a seamless system that results in broader health insurance coverage.

Not everybody is touched with some kind of medical condition—nearly everybody is. Employers might realize this better than most because they deal so closely with employees. If it is not the restaurateur himself, it is the chef with the heart problem or the server whose child has a chronic illness.

Employers who provide insurance to employees do all they can to keep insurance premiums reasonable. But when you ask for a policy that covers preexisting conditions from the start, you are asking for higher prices. No matter how good your intentions, it is hard to be the only employer to foot the bill.

In the American Restaurant Employers Trust, we have a little more bargaining power—which is why this year we were able to do exactly what Congress and Mr. Thomas would like us to do.

No. 1, we are providing 24-hour insurance coverage that combines Workman's Comp. with health insurance.

No. 2, each employee that enrolls in our plan gets a card that entitles him to continuous coverage with no limits on preexisting conditions if they move from one restaurant in the Trust to another. Especially in an industry that can be as transient as ours, we realize employees often have to move on, and we think they ought to be able to take their health care with them. We hope the biggest fans of our job-to-job coverage will be the employees themselves. In industries like ours, it is a big selling point.

In some cases, perhaps reducing waiting periods for coverage may increase premium costs slightly, but there is a tradeoff. Often these insurance clauses have less to do with cost and more to do with wanting some guarantee that the employee will stick around and become a valued part of our work force. Allowing seamless cov-

erage for an individual who has already qualified for coverage in one job recognizes that person has staying power.

In the case of our restaurant Trust, there is an added benefit: The new restaurant gets an employee who is already part of our system, somebody who has already been trained in workplace safety and healthy lifestyles, as our plan requires.

As Congress debates the all-important question of how to make today's health insurance system work better, I encourage Congress to pass H.R. 1610. The employees would be better off, insurance rates would be more standardized, and people would be out of the business of worrying about preexisting conditions.

As the National Restaurant Association has said for years, this is one important way to chip away at the problem of how to make health insurance more accessible. Thank you.

[The prepared statement follows:]

TESTIMONY OF W.W. BIFF NAYLOR
NATIONAL RESTAURANT ASSOCIATION

Mr. Chairman, members of the subcommittee, thank you for inviting me here today.

My name is Biff Naylor. I own The Naylor Establishment, in Los Angeles. We operate Beverly Hills Cafe in California, and Cindy's Coffee Shop in Idaho. I am Vice President of the National Restaurant Association, the leading trade group for the U.S. foodservice industry. Our industry, with its over nine million workers and its nearly 740,000 units in every town and city in the U.S., is the nation's number-one retail employer.

I am also a co-founder of the American Restaurant Employers Trust. Twenty years ago, a group of restaurant owners in southern California got together with the goal of making it easier to provide health benefits for their employees. As you know, restaurants tend to be smaller businesses and often have a hard time getting affordable coverage. We wanted to come up with a high-quality insurance plan for restaurants—something *specifically* designed with restaurant companies and their employees in mind.

Today, several hundred restaurants in four states buy their health insurance plans through the Trust. This means coverage for about 10,000 employees and their dependents.

So I'm doing double duty here today, talking both from my experience as a restaurant owner and from my experience in insurance. From both perspectives, I endorse the approach Congressman Thomas is taking in the bill he has introduced today. Reducing the waiting period for covering pre-existing conditions by allowing credit for coverage under a previous employer's plan is a good deal all around—for employees who won't be locked into jobs out of fear that they'll lose coverage if they move on, and for employers who will be part of a seamless system that results in broader health insurance coverage.

Nearly everybody is touched by some kind of medical condition. Employers may realize this better than most because they deal so closely with employees. If it's not the restaurateur himself, it's the chef with a heart problem, or the server whose child has a chronic illness. Employers who provide insurance to their employees do all they can to keep insurance premiums reasonable, but if you ask for a policy that covers pre-existing conditions from the start, you're asking for higher prices. No matter how good your intentions, it's hard to be the only employer to foot the bill.

In the American Restaurant Employers Trust, though, we have a little more bargaining power—which is why this year we were able to begin doing exactly what Congressman Thomas would like to do. First, we are providing 24-hour insurance coverage that combines workers' comp insurance with health insurance. Second, each employee who enrolls in our plan gets a card that entitles them to continuous coverage — with no limits on pre-existing conditions — if they move from one restaurant in the Trust to another. Especially in an industry that can be as transient as ours, we realize employees often have to move on — and we think they ought to be able to take their health care with them. We hope the biggest fans of our job-to-job coverage will be the employees themselves. In an industry like ours, it's a big selling point.

In some cases, perhaps reducing waiting periods for coverage may increase premiums costs slightly. But there's a tradeoff. Often these insurance clauses have less to do with costs and more to do with wanting some guarantee that the employee will stick around and become a valued part of our workforce. Allowing seamless coverage for an individual who has already qualified for coverage at one job recognizes that person's staying power. In the case of our restaurant Trust, there's an added benefit: The new restaurant gets an employee who is already a part of our system, someone who has already been trained in workplace safety and in healthy lifestyles, as our plan requires.

As Congress debates the all-important question of how to make today's health insurance system work better, I encourage Congress to pass H.R. 1610. Employees would be better off, insurance rates would be more standardized, and people would be out of the business of worrying about pre-existing conditions.

As the National Restaurant Association has said for years, this is one important way to chip away at the problem of how to make health insurance more accessible.

Mr. ENSIGN. Thank you, Mr. Naylor.

Mr. Christensen, would you care to inquire?

Mr. CHRISTENSEN. Not at this time.

Mr. ENSIGN. Mr. Kleczka.

Mr. KLECZKA. Thank you.

Mr. Trautwein, the bill is narrowly drafted because of a jurisdictional concern, and so it only covers group plans. Does the chamber support providing this type of portability legislation for all policies and all people insured with health insurance?

Mr. TRAUTWEIN. The same basic principle applies to that, and the chamber would generally support that as enhancing mobility in the marketplace. There are some technical issues that come into play, and perhaps the next panel would be better suited to discuss what that might do to prices at the one life group and individual level.

Mr. KLECZKA. I say that because our colleague on the Ways and Means Committee, Nancy Johnson, will be introducing legislation which is more comprehensive than the Thomas bill before us.

Mr. Naylor, you indicate in your testimony that there are 9 million workers in restaurants around the country working for some 740,000 restaurateurs. Do you have any idea how many of the 9 million workers are covered with some type of health insurance?

Mr. NAYLOR. Well, I would guess that virtually—I am going to say maybe 80 percent of them in some manner or fashion are covered, maybe 90 percent, somewhere in that range.

I will have to describe that a little bit to you because there are a lot of young people working in our industry that are going to college, and they are covered at their universities or with their families. There are a lot of senior people working in our industry that are covered under Medicare, Medi-Cal, and so forth. Roughly 50 percent of all the restaurant employers in California offer health care to all of their full-time employees.

Mr. KLECZKA. Do you have a figure for nationwide?

Mr. NAYLOR. I would guess it would be similar to that, but I do not. Our studies were done—Fresno is our test market, and we did our studies based on that. So the employer-based, about 50 percent. Throughout the total work force, I would guess closer to 80 or 90 percent have some coverage or other.

Mr. KLECZKA. So 50 percent for full-time employees?

Mr. NAYLOR. Right.

Mr. KLECZKA. For part-time employees, do you have any idea?

Mr. NAYLOR. The part-time employees would fall in the category of the young folks working 3 months in the summertime and be covered at home, in their colleges, or so forth.

Mr. KLECZKA. If I were working for a restaurant in Wisconsin, could I apply as an individual for coverage in your Trust?

Mr. NAYLOR. Not at this time. We are only in four States so far. But we will, hopefully, get to Wisconsin in the near future. Right now——

Mr. KLECZKA. But as an individual—it would be the individual applicant versus the establishment?

Mr. NAYLOR. I will tell you the one problem we have and haven't addressed yet but will be during the course of the year.

Because of the laws in all the different States, the company that is the sponsor of this plan—it is a large company; it is a $4 billion company—has to be established differently in each one of the States that they operate in. So while they can move from job to job in California within this Trust and within our industry quite easily, moving from California to Colorado, where we are also offering this plan, is a little more difficult.

Mr. KLECZKA. Is this a fee-for-service type of policy?

Mr. NAYLOR. It is, basically, HMO based. About 95 percent of the employees are in the HMO, a health maintenance organization, that work—out of this Trust that work in our industry. There is some indemnity. There are some PPO, preferred provider organization, aspects of it for the other 5 percent or so.

Mr. KLECZKA. Well, I hope you expand it to Wisconsin and other States, too.

Mr. Trautwein, a little off the subject of portability, one of the problems we are experiencing in Wisconsin—and I am assuming in other States—is that prior to retirement the employer has offered the employee health benefits in the retirement years. We are seeing now that employers are canceling that type of coverage, be it primary health coverage or a supplemental policy to Medicare.

What advice would you have for us as to how to curtail this practice or to ensure that companies that promise benefits to people who are working there and then retire do not stop the coverage, leaving these people out there to hang and dry?

Mr. TRAUTWEIN. Congressman, that is a very compelling problem. I would ask leave to respond to you in writing on that. I have not received instructions from our Health and Employee Benefits Committee, which formulates our policy on that, and I know of no chamber policy on that position. So if I may respond in writing to your question.

Mr. KLECZKA. But you are aware that it is happening out there in the various States?

Mr. TRAUTWEIN. I have seen reports of that, yes.

Mr. KLECZKA. OK. I think that is something that we have to look at. Some of these policies were bargains, some were not. However, after the employee leaves employment and is retired, one day they wake up to the bad news that the company, for whatever reason, has just suspended their health care coverage; and you can see the real trauma that that inflicts on a lot of our constituents. So I look forward to your written response.

Thank you, Mr. Chairman.

[The following was subsequently received:]

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

R. BRUCE JOSTEN
SENIOR VICE PRESIDENT,
MEMBERSHIP POLICY GROUP

1615 H STREET, N.W.
WASHINGTON, D.C. 20062-2000
202/463-5310

May 24, 1995

The Honorable Gerald D. Kleczka
U.S. House of Representatives
2301 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Kleczka:

The U.S. Chamber of Commerce appreciated the opportunity to testify at the May 12 hearing before the Health Subcommittee of the House Committee on Ways and Means on H.R. 1610, Chairman Thomas's health insurance portability legislation.

During the course of the hearing, you asked for the Chamber's views regarding reductions or cessation of employer-sponsored retiree health benefits. We understand and appreciate your concerns.

The provision of retiree health benefits is an issue of great concern for many employers. While companies may desire to provide health benefits to both active employees as well as retirees, unexpected financial constraints preclude many from doing so. Rather than completely foregoing retiree health benefits, many employers strive to provide scaled-back benefits to their retirees. However, others faced with mounting financial pressures and increased health care costs may have no alternative but to cease coverage for retirees.

As you know, the Employee Retirement Income Security Act of 1974 (ERISA) does not set forth the legal standards that govern modifications in retiree health benefits. However, employers faced with the difficult choice of reducing or eliminating health coverage for retirees are guided by a developing body of federal common law that outlines various rights and obligations under ERISA-regulated plans. This evolving area of federal common law provides an appropriate and adequate means for addressing the questions that arise when retiree health benefits are adversely affected by employer actions.

I hope this answers your question. Should you have any additional questions, please do not hesitate to have your office contact Neil Trautwein or David Kemps of the Chamber's Domestic Policy staff at (202) 463-5500.

Sincerely,

R. Bruce Josten

R. Bruce Josten

Mr. ENSIGN. I would just like to toss something out to the panel. The intent of this legislation is for simplification, especially for the employers.

Basically, what employers have to do is they must provide verification on length of coverage on the date the employee leaves the plan. Do you see that this is a simple enough thing for employers to go through?

Mr. DRESSLER. As far as Western Growers is concerned, we handle COBRA administration now for all of our members because of the nature of agriculture and the seasonal nature of harvesting and so on. So it would be very easy for us to do.

For those who are eligible for COBRA, as I said earlier, my preference would be that we include notification in the COBRA notice which the employee gets at the time his coverage ends, which also informs him of his rights to alternative coverage. But I think that it is a very practical thing to do, and I would hope that a new worker would go to his new job with this evidence at the time he starts coverage.

Mr. ENSIGN. Mr. Naylor, maybe you can address that. We are trying to accommodate employees and do the right thing; and, obviously, I think that it shows, by your being here today, that there are people out there that care about your employees. You are not just evil businesspeople and that type of thing. But is this something that is going to be burdensome on business or is this something that should be fairly easy to administer?

Mr. NAYLOR. I don't think so. The Trust has its own administration. We model up very much like Western Growers in the fact that we provide the COBRA, and it could be included as a part of that as well.

For the independent operators, I think that the insurance companies themselves would aid in—when they design plans and so forth, so that notification has to be given by the employer, would be a part of the package. So I don't think it would be too difficult to do. I don't see an administrative burden to this at this point.

Mr. KLECZKA. If the chairman would yield, I think Mr. Dressler makes an excellent recommendation. I don't know if it is necessary to have it part of the bill. It could be part of the regulations, although we all get nervous when we say the word regulation. But if this information on the employee's past medical history could be put on the COBRA notice, it would be very easy for the next employer.

My problem is, if we mandate that by regulation, the COBRA notice will be 10 pages long. Your suggestion is an excellent one.

Mr. ENSIGN. Thank you. Thank you for your comments.

I would like to thank the panel for your testimony this morning. I appreciate the concern you are showing, and thank you very much.

I would like to call the next panel to the table: John Troy, the executive vice president, Health Insurance Association of America; Michael Herbert, president and chief executive officer for Physicians Health Services, Inc., Trumbull, Conn., on behalf of Group Health Insurance Association of America; and Mary Nell Lehnhard, senior vice president, Blue Cross & Blue Shield Association.

Mr. Troy, why don't you go ahead and proceed.

STATEMENT OF JOHN F. TROY, EXECUTIVE VICE PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. TROY. Mr. Chairman, Bill Gradison, the president of HIAA, the Health Insurance Association of America, is sorry he is unable to be here today. Bill would have liked to have the opportunity to comment on such a positive piece of legislation.

Mr. Chairman and members of the subcommittee, I am John Troy, executive vice president of the Health Insurance Association of America. I am very pleased to be here today to discuss the critical issue of health insurance portability as it affects job mobility.

HIAA has long supported reforms to make our health insurance system more secure for Americans. We think Congress should act this year to move the Nation toward the health security goals we share. Solving the problem of job lock would be an important step, and I commend the subcommittee for addressing this early in the 104th Congress.

It is particularly appropriate that we focus our attention on employment-based coverage, for it is the backbone of America's privately financed health system.

The problem of job lock is a major concern for Americans. People are afraid to leave their jobs for fear their new employer would not provide coverage for existing health conditions.

In a survey conducted earlier this year for HIAA, 78 percent of the respondents supported the concept that once an employee has satisfied an employer's preexisting condition clause, coverage under a new plan should not be denied based on health conditions. It is clear that dealing with the job lock issue would address a major concern with the health care system.

The issue of job lock can only be addressed comprehensively through Federal legislation. States can and do regulate insurance carriers and HMOs, and HIAA has played a leading role in developing and advocating reforms for the small employer market at the State level. But only Federal action can assure consistent nationwide application of basic continuity of coverage protection for all workers.

Mr. Chairman, HIAA strongly supports H.R. 1610 as a very important first step in health care reform. H.R. 1610 would require every employer providing a group health plan to credit newly eligible employees or dependents coverage under prior group health plans toward any preexisting condition limitation the plan imposes if certain conditions are met. It would also prohibit group health plans from denying coverage to employees or dependents with qualifying prior coverage based on health condition.

The genius of H.R. 1610 is that it gets to the heart of the job lock problem and remedies it in the least intrusive way possible. It sets up the right incentives by rewarding people who maintain continuous health insurance coverage. H.R. 1610 also avoids the temptation to enact measures which appear on the surface to be reforms but which could actually increase costs and reduce access.

Recent evidence suggests that employer-sponsored health plans have made great strides in controlling costs. In 1994 total per employee costs actually fell a bit more than 1 percent. Employer sponsors deserve great credit for aggressively moving to contain health care costs. HIAA believes the private sector is better equipped than

government to control costs while maintaining quality. We are pleased that H.R. 1610 allows the private sector the flexibility it needs to continue to do so.

HIAA does believe that broader Federal action in some areas of health care reform would be beneficial. For employers with 2 to 50 employees, we endorse requirements for insurers to guarantee to issue and renew coverage, together with reasonable limitations on rating.

We also endorse a range of cost containment proposals, including simplifying the administration of claims, enacting legislation to aid in detecting and prosecuting health care fraud, and reforming medical liability rules.

In the long run, the most effective cost containment technique available to us is the continued development and evolution of managed care. For over 20 years, managed care has demonstrated its ability to restrain the growth of health care costs while maintaining or improving quality of care. HIAA believes public policy should seek to promote the refinement and effective operation of managed care plans.

That said, Mr. Chairman, we do not believe that it would be wise to delay enactment of H.R. 1610 in an attempt to achieve consensus on a broader agenda. Your bill is an important first step. It should move forward quickly. Our written testimony discusses a number of technical concerns that we believe the subcommittee should consider.

Mr. Chairman, I thank you for the opportunity to appear here today, and we stand ready to help you in any way that we can.

[The prepared statement follows:]

TESTIMONY OF JOHN F. TROY
HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Chairman and Members of the Subcommittee, I am John Troy, Executive Vice President for the Health Insurance Association of America (HIAA), a trade association which represents approximately 225 of the nation's health insurers, including managed care plans and HMOs, which in turn provide health coverage for tens of millions of Americans.

I am very pleased to be here with you today to discuss the critical issue of health insurance portability as it affects job mobility. HIAA has long sought to make our health insurance system more stable and secure for all Americans by advocating sensible reforms based on what we believe consumers want. We think the Congress should act this year to move the nation toward the health security goals we share. Solving the problem of "job lock" would be an important first step in this direction, and I commend the Subcommittee for moving to address this issue early in the 104th Congress.

It is particularly appropriate that we focus our attention on employment-based coverage; it is the backbone of America's privately financed health insurance system. About 70% of Americans under age 65 currently have private health insurance and, of these, fully 87% obtain that coverage through an employer, either directly from their own employer or indirectly through a spouse's or parent's employer.

The problem of "job lock" is a major concern that Americans have about our current health insurance system. People who have jobs that provide health coverage are afraid to leave their current jobs, for fear that their new employer would not provide coverage for medical problems they or their dependents already have.

It is difficult to estimate how large the "job lock" problem is. We do know [from analysis of the Census Bureau's Survey of Income and Program Participation] that the turnover rate for workers in jobs that provide health insurance is about 14 percent per year. That is, each year roughly 10 million U.S. workers (not counting covered spouses and children) leave jobs that provide health insurance. We do not know how many more would like to change jobs but hesitate because of concerns about losing coverage for existing medical conditions.

Even without precise estimates of the magnitude of this problem, it is clear that dealing with the "job lock" issue would go a long way toward addressing one of Americans' major concerns about their health care system. In a survey conducted earlier this year, for the HIAA by Public Opinion Strategies and Hamilton & Staff, 78 percent of respondents supported the concept that, once an employee has satisfied his employer's pre-existing condition clause, he should not be denied coverage when he changes jobs in the future, even if he is sick.

I want to emphasize that "job lock" can only be addressed comprehensively through Federal legislation. States can – and do – regulate insurance carriers and HMOs, and HIAA has proudly played a leading role over the last 5 to 7 years in developing and advocating sensible reforms for the small employer insurance market at the state level. Since 1990, 42 states have enacted laws intended to reform how medical insurance for small employers is rated and sold.

But states cannot – and should not – regulate self-insured employers, who today provide coverage to at least half of all workers with employment-based health coverage. Therefore, only Federal action can assure consistent, nationwide application of basic continuity-of-coverage protection for all U.S. workers.

For these reasons, Mr. Chairman, HIAA strongly supports your recently introduced bill as a very important first step in health care reform. It would require every employer-provided group health plan to credit a newly eligible employee's or dependent's coverage under prior group health plan(s) toward any pre-existing condition limitation the plan imposes, if certain conditions are met. It would also prohibit employer-provided group health plans from denying coverage to otherwise-eligible employees or dependents with qualifying prior coverage based on factors related to the person's medical condition or use of health care.

The technical language can get quite arcane, but it's really a very simple concept: Whenever you change from one insured job to another, you get credit for your prior coverage, as long as you haven't let your coverage lapse for more than 60 days.

The genius of this bill is that it gets to the heart of the "job lock" problem and remedies it in the least intrusive way possible. It sets up all the right incentives for the maintenance and effective operation of a voluntary, private health insurance system by rewarding people who do the right thing and maintain continuous health insurance coverage.

Another virtue of the bill is that it avoids the temptation to enact measures which appear on the surface to be "reforms" but which would, in fact, increase health insurance costs and reduce access. For example, the bill properly leaves to group health plans and insurers the flexibility to determine such matters as:

- what benefits to provide, with what cost-sharing requirements;
- how to contain costs and assure quality, including provider reimbursement, provider qualifications and network design, utilization review requirements, and other managed care features; and
- what provisions are necessary to discourage healthy workers from delaying enrollment in their employer's plan until they know they will use it, or from allowing their coverage to lapse when they are between jobs. (Simply allowing such behavior, as some earlier reform proposals have suggested, would raise premiums for all insureds, penalizing those who conscientiously maintain their coverage.)

Mr. Chairman, recent evidence suggests that employer-sponsored health plans have made great strides in controlling health care inflation. In 1994, total per-employee costs for all such plans actually fell a bit more than one percent, the first time such a year-to-year decline has been recorded. While the pressure of the health care reform debate may have had some influence on this result, I believe that employer-sponsored health plans deserve most of the credit for aggressively moving to contain their own health care costs. HIAA believes that the private sector is much better equipped than the government to determine how best to rein in costs, and I commend you, Mr. Chairman, for crafting a bill that allows the private sector the flexibility it needs to continue to do so.

Also, and again very properly in our view, the bill does not attempt to deal with the very difficult problem of how to improve availability and affordability of individually purchased medical insurance. Due to the nature of this market, regulatory approaches to improving access need to be considered very carefully. We would be happy to meet with you, Mr. Chairman, or any member of the Subcommittee or your staff, to discuss our ideas and concerns regarding the individual insurance market. But we do feel quite strongly that the bill we are discussing today is not the appropriate vehicle for addressing individual insurance.

HIAA does believe that broader Federal action in some areas of health care reform, specifically with respect to national standards for all insurers and health plans serving small employers, would be beneficial for the nation. For example, for employers with 2 to 50 employees, we endorse requirements for insurers to guarantee issue and renew medical coverage, together with reasonable limitations on rating variability across employers. We also endorse a range of cost containment proposals, including simplifying the administration of health insurance claims, enacting legislation to aid in detecting and prosecuting health care fraud, and reforming medical liability rules.

In the long run, the most effective cost containment technique available to us is the continued development and evolution of managed care. Over the past 20 years, managed care has demonstrated its ability to restrain the growth of health care costs while maintaining or improving quality of care. Even better results can be expected in the future, as managed care continues to evolve and improve. Therefore, HIAA believes public policy should seek to promote the ongoing refinement and effective operation of managed care programs. We support the repeal or pre-emption of a range of existing laws, rules and regulations that restrict the effective operation of managed care programs, at whatever level of government they may currently be imposed; and we oppose efforts to enact additional legislation that would interfere with managed care plans' ability to contract with providers or otherwise organize themselves to deliver high-quality, cost-effective medical care, such as "any-willing-provider" laws and the so-called "Patient Protection Act."

That said, Mr. Chairman, we do not believe that it would be wise to delay enactment of the bill you have proposed in an attempt to achieve consensus on a broader reform agenda.

Your bill is a very, very important and significant first step. It should move forward quickly, and should not be delayed by attempts to broaden it at this time.

Mr. Chairman, we do have three concerns about the bill that we ask you to bear in mind as Subcommittee consideration of the bill proceeds; two of them are inter-related. First, there is no requirement in the bill that, in order to be considered "qualified," a newly eligible worker's prior coverage must be substantially similar to the coverage offered by his or her new employer. In the absence of such a requirement, "gaming" of the system is possible. For example, a small employer might initially buy coverage with a very high deductible to minimize his premiums, then switch to more comprehensive coverage when the owner, the owner's child, or a particularly valued employee becomes ill. (The guarantee-issue requirements for small employer coverage in more than 30 states make this possible.) A similar dynamic could arise when workers change employers. The problem here is that it permits people to minimize their contributions to the insurance system while they are well, yet benefit from more comprehensive coverage when they become ill without having paid their fair share of the cost of the more comprehensive coverage. That will raise premiums for everyone.

The omission of a "substantially similar coverage" requirement is most likely to create problems when individuals arrange health plans for themselves (and their families) only, as self-employed people do who work alone without employees. (I'll refer to this group as the "solo self-employed"). This brings me to our second issue. Addressing concerns about the individual insurance market is much more difficult than dealing with problems in true employment-based insurance. With respect to deciding whether, when and how much medical insurance to buy, solo self-employed people behave more like individuals than like groups, so we strongly recommend that the provisions of this bill should apply only to group health plans that serve either 2 or more employees or an owner with at least one covered employee.

If this definitional problem is dealt with, the need for a "substantially similar coverage" requirement is also reduced. So long as the crediting-of-prior-coverage requirement applies only between plans in which a true employer-employee relationship exists, we feel the proposal will not result in excessive adverse selection even in the absence of a "substantially similar coverage" requirement.

Finally, we note that the bill as introduced would prohibit denial of coverage on the basis of factors related to health status <u>only</u> when the individual in question has qualifying previous coverage. While we recognize the Subcommittee's desire to focus on "job lock" and portability concerns, we see no reason to restrict this "non-discrimination" requirement. HIAA has long supported the following concept, which we call "whole group coverage": Employers should have full flexibility to determine which categories of workers they wish to cover in their group health plans (full-time v. part-time, etc.), but having once made that decision, neither employers nor their insurers should be permitted to exclude an otherwise-eligible employee or dependent based on factors related to health status, medical condition, claims experience or similar factors. This is a very popular concept with the American people -- 85 percent supported it in the recent survey I referred to earlier -- and I urge the Subcommittee to adopt such a provision.

In conclusion, Mr. Chairman, I thank you and the Subcommittee for the opportunity to testify today, I applaud you for addressing the "job lock" issue head on, and I urge the Subcommittee and the Congress to move quickly to enact the bill you have proposed.

Chairman THOMAS [presiding]. Thank you very much, Mr. Troy, I appreciate your testimony.

Mr. Herbert.

STATEMENT OF MICHAEL E. HERBERT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PHYSICIANS HEALTH SERVICES, TRUMBULL, CONN., ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA

Mr. HERBERT. Mr. Chairman and members of the subcommittee, my name is Michael E. Herbert. I am president and chief executive officer of PHS, Physicians Health Services, a 19-year-old HMO serving 200,000 members in Connecticut and New York. PHS is Connecticut's largest HMO, and I have served as its chief executive officer since its inception in the seventies.

I am testifying today on behalf of the GHAA, Group Health Association of America, the leading national association for health maintenance organizations. Actually, I am pinch-hitting for Karen Ignagni, GHAA's president who, ironically, is in Middletown, Conn., today meeting with Connecticut's HMO industry.

GHAA's 380-member HMOs serve 80 percent of the 50 million Americans who receive health care from HMOs. Our member plans started, and continue to lead, the Nation's move to high-quality, organized health care.

GHAA has long supported insurance market reforms, including State-level small group insurance market reforms and appropriate Federal-level insurance market reforms. We are pleased that the subcommittee is beginning its deliberations on insurance reform issues this year by starting with Chairman Thomas' bill to assure group-to-group portability, and we are pleased to see that every member of the subcommittee shares our support for making health care coverage portable for working Americans.

Chairman Thomas should be commended, as should the whole subcommittee, for their leadership in undertaking a small but important step toward improving the health care delivery system. In general, this bill amends COBRA to provide that individuals moving from one employer's group health plan to another would have any preexisting condition limitations in their new plan reduced by the length of their prior group health plan coverage, so long as there is no more than a 60-day break in coverage.

The bill also adds a nondiscrimination provision to the statute prohibiting discrimination against covered employees—on the basis of health status, medical condition, claims experience, medical history, disability, or evidence of uninsurability by a group health plan for purposes of determining eligibility, continuation, enrollment, or contribution requirements. Based on COBRA, the proposal applies to all individuals who are covered by an employer-sponsored insured or self-insured group health plan, down to group size of one, especially self-employed individuals and certain independent contractors.

This bill addresses a substantial part of the "job lock" problem where individuals—or their dependents—who have preexisting health conditions find it difficult to change jobs because a new employer-sponsored group health plan could require them and/or their family members to go without coverage for the treatment of their

condition for a set time period, even if they have met their former health plan's requirements for preexisting condition waiting periods.

By "crediting" the period of prior coverage in a qualified group health plan, Chairman Thomas' bill would allow individuals who have previously been covered by a group health plan to change jobs without being subject to new preexisting condition waiting periods.

The majority of HMO enrollees, roughly 80 percent, already benefit from the provisions outlined in the bill. These individuals are enrolled in federally qualified HMOs which, by law, do not apply preexisting condition waiting periods.

GHAA believes that H.R. 1610 fulfills most of the key criteria that any such portability provision must meet. The proposal applies to all employer-sponsored coverage, self-insured and fully insured; and it applies only to employment-based coverage.

Our one area of concern is that group-to-group coverage should be clearly defined to include all groups down to groups of two employees. As drafted, the bill includes groups down to group size one. While experience in the group market above group size one is extensive and supports portability among such groups, there is insufficient experience to foresee the impact of including groups of one in the bill's portability requirements. Research should be undertaken to ensure that the inclusion of groups of one will not have a detrimental impact on the group market as a whole.

Although the potential problems are less serious than those raised in providing the same portability provisions for individual-to-group coverage, they remain significant.

As you proceed with this measure, and other insurance market reforms, I would like to flag for the subcommittee some issues of particular importance to HMOs.

No. 1, in any reform related to preexisting condition waiting periods, it is important to recognize that most HMOs are not designed to administer such waiting periods. The Federal HMO Act precludes such provisions, and, for the most part, HMO systems are not structured to track or pay claims in a manner that differentiates among types of conditions for each enrollee.

No. 2, we would caution that substantial complications could arise if portability rules are extended beyond "group-to-group" coverage to include individuals moving to or from individual products, Medicaid, and high-risk pool coverage.

As I have stated before, GHAA believes that group-to-group coverage provisions are a good starting point for insurance reform. However, based on our experience in States that have adopted similar portability provisions, we believe that the market is not yet ready to extend such provisions to people moving between individual coverages or from individual-to-group—or group-to-individual—coverage.

For plans that offer comprehensive coverage, such as HMOs, serious adverse selection problems can arise if individuals can convert from high-deductible or "bare bones" coverage to comprehensive HMO plans. This issue is likely to arise in the context of any MSA, medical savings account legislation, if such proposals require MSA participants to purchase high-deductible catastrophic cov-

erage, and then allow conversion at any time to a more comprehensive policy.

If comprehensive coverage, such as that provided by HMOs, must bear the risk that individuals can select such coverage whenever a health care need is anticipated and drop the coverage as soon as the need goes away, its affordability for the vast majority of employees who maintain continuous coverage in a comprehensive plan will be diminished.

Finally, we are very concerned that any insurance reform measure such as this portability bill not become a "vehicle" for "antimanaged care" provisions, such as mandatory contracting, mandatory point-of-service, and so-called "Patient Protection Act" provisions. Such provisions will inhibit the ability of HMOs to provide high-quality, cost-effective health care. Consequently, they will also undermine the progress that is being made in holding down premium increases; a trend due in large part to the growing number of employees who are selecting HMOs and other managed care options. We would strongly oppose any bills that include such measures.

We encourage you to continue with your strategy of taking carefully studied legislative steps that promote a market-based health care delivery system and help to solve the specific problems in the current marketplace. For this approach to remain successful, the bill should remain clean of such controversial provisions.

In essence, we are saying that the market is working in health care delivery in America today, and this bill provides a small but important step forward in allowing the market to work better. GHAA would be pleased to work with you and the staff as you proceed with this bill and other insurance reforms, and I would be pleased to answer any questions.

[The prepared statement follows:]

TESTIMONY OF MICHAEL E. HERBERT
GROUP HEALTH ASSOCIATION OF AMERICA

Mr. Chairman and members of the Subcommittee, my name is Michael E. Herbert. I am President and CEO of Physicians Health Services (PHS), a 19-year old health maintenance organization (HMO) serving 200,000 members in Connecticut and New York. PHS is Connecticut's largest HMO, and I have served as its CEO since its inception in the 1970s.

I am testifying today on behalf of the Group Health Association of America (GHAA), the leading national association for health maintenance organizations (HMOs). GHAA's 380 member HMOs serve 80 percent of the 50 million Americans who receive health care from HMOs. Our member plans started -- and continue to lead -- the nation's move to high quality, organized health care.

GHAA has long supported insurance market reforms, including state-level small group insurance market reforms, and appropriate federal-level insurance market reforms in the context of last year's comprehensive health care reform debate. We are pleased that the Subcommittee is beginning its deliberations on insurance reform issues this year by starting with Chairman Thomas' bill to assure "group-to-group" portability. In general, this bill amends COBRA to provide that individuals moving from one employer's group health plan to another would have any pre-existing condition limitations in their new plan reduced by the length of their prior group health plan coverage, so long as there is no more than a 60 day break in coverage.

The bill also adds a nondiscrimination provision to the statute, prohibiting discrimination against covered employees -- on the basis of health status, medical condition, claims experience, medical history, disability, or evidence of uninsurability -- by a group health plan for purposes of determining eligibility, continuation, enrollment or contribution requirements. Based on COBRA, the proposal applies to all individuals who are covered by an employer-sponsored insured or self-insured group health plan, down to group size of one (e.g., self-employed individuals and certain independent contractors).

This bill addresses a substantial part of the "job-lock" problem, where individuals (or their dependents) who have preexisting health conditions find it difficult to change jobs because a new employer-sponsored group health plan could require them and/or their family members to go without coverage for the treatment of their condition for a set time period -- even if they have met their former health plan's requirements for preexisting condition waiting periods. By "crediting" the period of prior coverage in a qualified group health plan, Chairman Thomas' bill would allow individuals who have previously been covered by a group health plan to change jobs without being subject to new pre-existing condition waiting periods.

The majority of HMO enrollees (roughly 80 percent) already benefit from the provisions outlined in the bill. These individuals are enrolled in federally-qualified HMOs, which by law, do not apply preexisting condition waiting periods.

GHAA believes that this bill fulfills most of the key criteria that any such portability provision must meet:

- the proposal applies to all employer-sponsored coverage, self-insured and fully-insured; and
- it applies only to employment-based coverage.

Our one area of concern is that group-to-group coverage should be clearly defined to include all groups down to groups of two employees. As drafted, the bill includes groups down to group size one. While experience in the group market above group size one is extensive and supports portability among such groups; there is insufficient experience to foresee the impact of including groups of one in the bill's portability requirements. Research should be undertaken to ensure that inclusion of groups of one will not have a detrimental impact on the group market as a whole. Although the potential problems are less serious than those raised in providing the same portability provisions for individual to group coverage -- as I will describe later -- they remain significant.

Additional issues

As you proceed with this measure, and other insurance market reforms, I would like to flag for the committee some issues of particular importance to HMOs. First, in any reform related to pre-existing condition waiting periods, it is important to recognize that most HMOs are not designed to administer such waiting periods. As I mentioned before, the Federal HMO Act precludes such provisions and, for the most part, HMO systems are not structured to track or pay claims in a manner that differentiates among type of conditions for each enrollee.

Second, we would caution that substantial complications could arise if portability rules are extended beyond "group-to-group" coverage to include individuals moving to or from individual products, Medicaid, and high-risk pool coverage. As I've stated before, GHAA believes that group-to-group coverage provisions are a good starting point for insurance reform. However, based on our experience in states that have adopted similar portability provisions, we believe that the market is not yet ready to extend such provisions to people moving between individual coverages or from individual to group (or group to individual) coverage.

For plans that offer comprehensive coverage, such as HMOs, serious adverse selection problems can arise if individuals can convert from high-deductible or bare bones coverage to comprehensive HMO plans. This issue is likely to arise in the context of any Medical Savings Account (MSA) legislation if such proposals require MSA participants to purchase high-deductible, catastrophic coverage, and then allow conversion at any time to a more comprehensive policy. If comprehensive coverage, such as that provided by HMOs, must bear the risk that individuals can select such coverage whenever a health care need is anticipated and drop the coverage as soon as the need goes away, its affordability for the vast majority of employees who maintain continuous coverage in a comprehensive plan will be diminished.

Finally, we are very concerned that any insurance reform measure, such as this portability bill, not become a "vehicle" for "anti-managed care" provisions -- such as mandatory contracting, mandatory point-of-service, and so-called "Patient Protection Act" provisions. Such provisions will inhibit the ability of HMOs to provide high quality, cost effective health care. Consequently, they will also undermine the progress that is being made in holding down premium increases; a trend due in large part to the growing number of employees who are selecting HMOs and other managed care options. We would strongly oppose any bills that include such measures. We encourage you to continue with your strategy of taking carefully studied legislative steps that promote a market-based health care delivery system and help to solve the specific problems in the current marketplace. For this approach to remain successful, the bill should remain clean of such controversial provisions.

Mr. Chairman, thank-you for this opportunity to testify. GHAA would be pleased to work with you and the staff as you proceed with this bill and other insurance reforms, and I would be pleased to answer any questions that you have.

Chairman THOMAS. I want to thank all of you very much. No one thinks that this bill solves all of the problems as has been accurately and quite well stated. This is a group-to-group solution. When you get into that seamless transition for employees or the self-employed, you do run into problems.

Mr. Herbert, you outlined several gaming-the-system potentials especially between radically different insurance proposals like MSAs to a more comprehensive plan, the possibility of incompatibility between the kind of health delivery system models that start with some different basic assumptions and would be difficult to move between those.

Nevertheless, no one on this panel who cosponsored H.R. 1610 believes that that is the end of the process. Our job is to move forward and my colleague to my right, Nancy Johnson, is to be commended for introducing H.R. 1604, which goes where no one has gone before, and willingly, into answering a number of those questions.

So we are viewing this as the quite painfully obvious first step. Why it wasn't painfully obvious previously just continues to perplex me, but clearly my colleagues in supporting this step indicate why not do what we can do in a timeframe that we can do it.

But we are going to be looking forward to probing with you all of those concerns that you rightfully share with us in terms of the difficulty of moving on to the next step, because solving the group-to-group problem is not solving the job lock problem. It does help.

I want to thank you for your willingness to begin this process. This is not the end, this is the beginning.

The gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. All right.

Chairman THOMAS. If the gentlewoman would withhold for a moment, the question was obviously we have a vote on and there are a series of votes following. My intention is to try to get some testimony on a question-and-answer basis, but it may well be one-half hour or longer before we come back, with these multiple votes, and so my assumption is that when we do have to recess for the vote, the subcommittee hearing will be over.

Mrs. JOHNSON of Connecticut. I just want to take this opportunity to thank you for your testimony and I appreciate your commitment to portability. I do think that one of the reasons the American public hates the government is because it overpromises. Much as I support the Thomas bill and cosponsored it, I have put out a bill that puts forward a broader challenge and I think it is one that we must meet.

So I invite your input and normally in this process I would put it out and we would have a lot more discussion before it actually took a legislative form. There will be another evolution of this bill. Because of the nature of the first 100 days and, frankly, the project before us in the budget, we don't have the luxury of the old process, but I think guaranteed issue, for instance, without rating reform has some merit.

It is true that then a company could up the premiums and have the effect of knocking you out, but they may not up them as high as the risk pool which is the only other option for that person. I think we ought to look at what guaranteed issue offers us and

what does doing it through the Tax Code offer us, which is far easier than doing it through a mechanism that sets up a Federal level of regulation and how can we make that work. But far more important is we have to deal with this issue of portability of the individual plan and individual-to-group plan.

I simply have a hard time from the point of view of equity of dealing with somebody who paid their own insurance premiums for years and years, they have maintained their coverage, then they go to work for an employer who has his own plan and have to endure a preexisting condition exclusion. They have taken the heavy burden. They have paid the higher rates of the individual. Then they come in to a plan and that employer is covering a number of people.

At least that ought to be portable for groups larger than 25 or whatever. But we now know that when a group hits a critical mass, underwriting isn't an issue. So there is someplace that we can begin talking about individual-to-group portability.

You will notice in my bill that individual-to-individual portability is very constrained. You can only exercise that portability if your company goes out of the business or you move. In other words, you have no choice. But again, you, having taken your responsibility, ought to carry some weight in the system. I think the exposure to the adverse selection problem for those people is really minimal. But I think even my bill doesn't go far enough. We have to figure out how to do individual-to-individual portability because that is fairness.

So in the end, we really have a bigger challenge and the industry has got to help us with this because America desperately needs it and anyone who works hard and pays his way ought to have the right to make change. We now know when managed care plans get big enough, it doesn't matter to them. My people tell me, we get a certain size we don't medically underwrite. So let's figure out what is the size, how do we do it, how do we make it happen, and let's pass the Thomas bill tomorrow and the Johnson bill 1 week later.

Chairman THOMAS. Thank you. Although the gentlewoman from Connecticut did not mention, she is a cosponsor of my bill. I am a cosponsor of her bill. To underscore the fact that H.R. 1610 does not end the quest, I am looking for answers to the larger questions as well.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Just one question, Mr. Herbert brought up the issue of medical savings accounts and high deductible policies. If we were to allow medical savings accounts as a tax-favored insurance vehicle, would it not pose the potential problem of a group plan offering that vehicle to its group and then having a problem transferring from that group to another group that had low deductibles?

Mr. HERBERT. Mr. Troy, would you like to address that?

Mr. TROY. Well, the HIAA has developed criteria to measure legislation in terms of the MSA issue overall and there are a number of what we would call adverse selection issues related to the medical savings account issue. But we would hope that as the public policy debate continues on MSAs, that there would be ways to ac-

commodate the proponents, but also maintain the integrity of the insurance system.

Mr. McCrery. So you think it is possible to do that within the context of tax-favored MSAs?

Mr. Troy. I think when we flesh out the criteria, perhaps the proponents would have to measure it against their goals because there is significant adverse selection concerns. It is a matter of whether they can be circumscribed by provisions.

Mr. Herbert. Just to further comment, I think the greatest concern is you would have someone belonging to an MSA for perhaps several years while they are healthy and then when they have a significant medical experience coming up, they would then move into a more comprehensive plan like an HMO, and some way or another we need to learn how to deal with that.

Mr. McCrery. Thank you, Mr. Chairman.

Chairman Thomas. I want to thank the witnesses very much and the subcommittee is adjourned.

[Whereupon, at 11:07 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

James A. Klein
Executive Director

May 11, 1995

The Honorable William Thomas
Chairman, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

The Association of Private Pension and Welfare Plans (APPWP) commends you on the introduction of H.R. 1610, which enhances the portability of health benefits. Achieving greater portability of coverage for workers and their families while retaining appropriate incentives for individuals to purchase coverage before they become ill would be a significant accomplishment.

We are gratified that H.R. 1610 adopts a well-targeted rather than broad approach to health care legislation. The bill expands portability of coverage and reduces "job lock" while allowing employers the discretion they need to appropriately structure the health benefits that they voluntarily provide to employees. Since H.R. 1610 avoids overregulation, it will not discourage employers from voluntarily sponsoring health plans for their employees.

Again, we commend you on introducing H.R. 1610. We look forward to discussing technical issues with you in the near future and, as always, the APPWP will be pleased to work with you as H.R. 1610 moves through the legislative process.

Sincerely,

James A. Klein
Executive Director

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TESTIMONY OF A. GREG SCANDLEN
COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Full portability of health insurance coverage for American workers has always been a goal of the Council for Affordable Health Insurance's free market approach to federal health care reform. As Executive Director of the Council for Affordable Health Insurance, I am therefore pleased to provide the Ways & Means Health Subcommittee with this testimony supporting the goals and concepts of HR 1610. This legislation would require employer-provided group health plans to credit coverage under a prior group health plan against any preexisting condition limitation.

The Council for Affordable Health Insurance and the health insurance companies and several hundred individual members we represent, firmly believe that anyone who has maintained health insurance coverage without interruption in premiums should not be canceled or denied health insurance for any reason other than failure to pay premiums, or are guilty of insurance fraud and abuse.

Further, the Council maintains that if a preexisting condition limitation has been previously satisfied, there is no need actuarially to satisfy a second waiting period. By giving a credit to individuals changing jobs for their periods of continuous coverage, as HR1610 provides, there will never be a sense of fear that another period of eligibility must be met, thus successfully eliminating "job lock."

Job lock is a very real phenomenon that keeps American workers from changing jobs because of their fears of either losing coverage for themselves and members of their families, or to be forced to go without full coverage until a waiting period is satisfied.

However, the Council for Affordable Health Insurance believes that federal portability legislation cannot possibly address the "job lock" dilemma entirely. For example, a worker moving from one job to another may not have the disposable income to afford health insurance premiums under COBRA. Under the tenets of HR1610, that worker would need to maintain health insurance coverage between jobs if the hiatus in employment lasts longer than 60 days. Otherwise, the worker may be exposed to a waiting period to satisfy a preexisting condition.

Out-of-work Americans have always had difficulty making COBRA premium payments, but the Council for Affordable Health Insurance has a solution to that problem.

Medical Savings Accounts (MSAs) are tax-deferred accounts set up to pay for routine medical care and to allow for the build-up of savings to pay for future medical expenses. MSAs would allow employers, to purchase a high-deductible policy and put the premium savings into a Medical Savings Account to pay for routine medical care, until the deductible is satisfied. The funds in the MSA belong to the insured, and if not spent, accumulate over time as savings, pre-funding future health care expenses such as insurance premiums under COBRA.

If Medical Savings Accounts were enacted on the federal level, workers would have the funds available to pay their own insurance premiums under COBRA. In fact, the Council for Affordable Health Insurance believes that portability legislation such as HR 1610 would be greatly enhanced by passage of Medical Savings Account legislation.

The Council for Affordable Health Insurance also believes that premiums paid directly out of pocket should enjoy the same favorable tax treatment that employer-paid premiums enjoy. This "tax equity" is another measure that would address the "job lock" problem. Many employers do not provide health coverage at all, and tax equity would enable those workers to purchase their own insurance policy, thus keeping coverage continuous and avoiding additional underwriting.

Medical Savings Accounts and tax equity will not solve all the nation's health care woes. But coupled with legislation such as HR 1610, the U.S. Congress can begin a plan a rebuild, strengthen, and extend health insurance access to all Americans, regardless of their employment, health or economic status.

The Council for Affordable Health Insurance has developed an 8-point plan for free market reform of the American health care system. Listed here are the elements of the CAHI plan:

Tax Policy Current tax policy should be modified to equalize the tax treatment for individuals with that available to employers for health care costs.

Medical Savings Accounts CAHI supports legislation that would permit medical care savings accounts to be established by employers for their employees, and for self-employed individuals.

Universally Available Coverage CAHI supports guaranteed access for all citizens through the establishment of a national high risk pool, or a system of state-based high risk pools.

Small Group Reform CAHI endorses many features of small group reform proposals, including limited rating bands, limits on annual rate increases, full portability for those with continuous coverage, and renewability of coverage.

Tort Reform Limits on malpractice awards need to be developed, while the system of peer review and professional discipline of negligent physicians should be improved.

Price Disclosure Patients should know the cost of their treatment in advance and have a stake in paying for it, then they will act in the same manner as they would for purchasing any good or service - they will shop for the best service at the lowest price.

Patient Education Patients should be made aware of alternatives for treatment, differences in quality of services, and the importance of personal behavior on health.

Abolition of State Mandated Benefits Buyers should be able to purchase insurance policies that cover benefits they wish to have and can afford, rather than having the political system dictate a benefit structure.

By incorporating Medical Savings Accounts and full portability with other concepts that have always been the strength of our country — individual freedom and responsibility, a free market for goods, services, and ideas, a robust competitive environment, and limiting government's involvement to

protecting those who are incapable of caring for their own needs; we can fix the current health care delivery system instead of destroying it.

On behalf of the members of the Council for Affordable Health Insurance, I would like to take this opportunity to thank the chairman of the House Ways & Means Subcommittee on Health, the Honorable Bill Thomas, for introducing HR 1610 and for conducting these important hearings. The Council stands ready to assist this committee in the passage of HR 1610, and other elements of free market health care reform. Thank you, Mr. Chairman.

WALNUT 2-5252

GEORGE ROSS FISHER, M.D.
829 SPRUCE STREET
PHILADELPHIA, PA. 19107

Honorable Bill Thomas, Chairman
Subcommittee on Health,
Ways and Means Committee,
United States House of Representatives

Re: Hearing on Health Insurance Portability, May 12, 1995

The oral testimony before your committee was uniformly favorable to proposed legislation creating portability of health insurance for members of an employer group moving to another employer group. I join the employers and insurers who testified, in endorsing such legislation. However, I greatly regret the suggestions which were offered to exclude groups of one, or other definitional ways of extending the same portability to those who move from employed to self-employed status. Or from self-employed to employed status, as though an episode of self-employment were some sort of unforgivable sin.

To restrict portability to large employer groups has the effect of encouraging job leavers to enlist in post-employment COBRA plans within a brief 60-day grace period. It is easy to see why such incentive is appealing to employers who wish to augment the number of well persons in their insured pool. It is also easy to see the appeal to insurers who would envision a greater retention of their business among job-leavers. No one, however, troubled to mention the financial hardships often suffered by those who have just lost a job and may be uncertain when they will get another. Or the fact, quite apparent in the data offered in testimony, that job-leavers are typically in worse health than those whose employment is retained. In all this talk about adverse risk selection, it is well to remember who is doing the selecting.

In other words, large employer groups are a privileged class, seeking to become even more privileged. It is unbecoming for them to invoke vague unspoken dangers of extending similar privileges to self-employed persons. Employer groups enjoy total tax exemption for their health insurance, while self-employed persons have only recently been extended a 30% exclusion. For self-employed persons to come away from this legislation with an additional discrimination relating to pre-existing conditions would heighten their sense of injustice.

What might be more satisfactory would be for the legislation to focus on whether or not the individual is coming from a period of continuing coverage of comparable degree. If the individual was covered for a particular condition under the previous policy, and if a standard period of contestability had previously been satisfied, a new carrier should be precluded from imposing a pre-existing illness clause. That should be true, regardless of the number of persons in the group, including a group of only one as much as a group of a thousand.

I also urge you to consider some form of mandatory waiver of premium, or alternatively reduction to minimum coverage, for job-leavers. While this might slightly increase the costs for those who remain behind in the lifeboat, it would recognize that those who are dumped out of the lifeboat are selectively impoverished, and have selectively worse health.

Mr. Chairman, I approached these hearings with the expectation that after the group-to-group transfer issue had been addressed, the subcommittee would turn to the self-employed issue, probably through some form of Medical Savings Account. I certainly hope that is the case, and representatives of group insurance will then reflect further on the equities involved.

George Ross Fisher, MD
Trustee (for Philadelphia), Pennsylvania Medical Society

HEALTHCARE
LEADERSHIP
COUNCIL

FOR IMMEDIATE RELEASE
May 12, 1995

Contact: Claire del Real
(202) 347-5731

STATEMENT BY
PAMELA G. BAILEY
PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

The Healthcare Leadership Council (HLC) is pleased to support H R. 1610, introduced on May 11 by Representatives Thomas (R-CA) and Stark (D-CA), and commends the sponsors and cosponsors of this bipartisan effort for their leadership in finally transforming the theory of health care reform into reality.

This important market-based legislation would go a long way toward addressing the problems in the current health care delivery system by eliminating "job lock" and ensuring that American workers can change jobs without fear of losing health care coverage due to a preexisting condition or illness. The positive implications of the Thomas/Stark bill are significant and far-reaching. Their proposal would not only provide health security to America's workers, but would also extend coverage to many who are now uninsured without severely impacting health plan premium costs.

Post-election polling conducted last November by the HLC indicates that the vast majority of Americans support targeted health care reform designed to ensure portability of health care coverage between jobs. Consumers are overwhelmingly satisfied with their choice of health care coverage, and with the cost and quality of coverage. The message is clear -- keep reform simple because the market is working.

Healthcare Leadership Council
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Congress has the unique opportunity to enact targeted, consensus health care reform this year and should not get sidetracked by overly regulatory and burdensome proposals which are controversial and would threaten our market-based delivery system. The Thomas/Stark bill is a meaningful step toward enacting such common sense health reform by allowing the market to continue proving its effectiveness in health care delivery and cost containment.

The HLC is a broad coalition of 60 Chairmen and CEO's of health care companies representing all sectors of the health care industry. The HLC is firmly committed to ensuring access to quality, affordable health care through the promotion of a market-based health care delivery system. Only a system defined by market-based principles and competition can ensure health care consumers real choice in the health care marketplace while at the same time reining in costs and improving the quality of health care delivery through innovation.

TESTIMONY OF JOAN GREENE, RN, MSN, CPNP
NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES & PRACTITIONERS

The National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) is grateful for the opportunity to submit testimony on the issue of health insurance portability. NAPNAP represents over 4,400 nurse practitioners dedicated to pediatric care. We strive to enhance the quality of health care for infants, children and adolescents. Children are the nation's most valuable resource, and we believe that they need access to health care regardless of race, economic status or religious beliefs.

We find that health insurance is a critical link to health care, for children as well as the population as a whole. Uninsured children use fewer health care services than do insured children. Uninsured children are also significantly less likely than publicly insured poor children to identify a usual source of routine care.

At the same time, recent trends show a decline in health coverage for children from private insurers and an increase in coverage from publicly funded insurance, Medicaid. However, growing budget constraints point toward a decrease in Medicaid spending. This is of great concern to pediatric health care providers like us, because it is the children of low-wage working families who will lose out under this scenario. More incentives for private health insurance coverage for working families, such as improved health insurance portability, would certainly help to prevent or alleviate the lack of access to health insurance that would result from these trends.

We commend Chairman Thomas and the members of this subcommittee for taking the lead on the issue of health insurance portability. It is clear to those of us who work with children that access to primary and preventive health care is the first step toward a rewarding and valuable life. Improving the health insurance portability of families increases access to health care for children. It is good for families, good for children and good for society.

We strongly support the premise of removing pre-existing conditions barriers for workers who need or desire to move from one job to another. In fact, we believe that Congress should do everything within its power to guarantee health insurance coverage for all children. Ensuring access to primary and preventive care for children would provide all children with a healthy start in life and would reduce the costs of treatment for the uninsured. Removing pre-existing conditions barriers for working families with employer-based insurance is the first step toward ensuring care for all children.

The Thomas legislation, H.R. 1610, would reduce the waiting period for covering pre-existing conditions by allowing credit for

coverage under a previous employer's plan, so long as there is no more than a 60 day stop in coverage. It would apply to transfers from one group health plan to another group health plan. We see this is a great step forward. We would support going even further toward guaranteeing health insurance coverage protections for all children.

The subcommittee is also considering bi-partisan legislation which goes further than H.R. 1610. The Johnson plan, H.R. 1604, would apply portability protections to all group and individual plans, including self-insured plans. It would also make extension of health insurance coverage through COBRA more affordable for those who leave or lose their jobs. Simply put, the Johnson plan would apply to more workers. More families with children would be protected from loss of insurance due to job loss, pre-existing conditions barriers, or the "job lock" that often results from these harsh realities. We support this legislation because we believe it will help ensure access to health care for more children.

As health care providers for children, we continue to advocate for legislation which will increase their access to care. We believe that the health system should encourage the promotion of health and the prevention of disease. Of primary importance to us is the renewability of coverage and the continuous coverage for individuals and families when the wage earner changes jobs. Health care plans which utilize pre-existing clauses for designated diseases must be eliminated.

We strongly support the continuing bi-partisan efforts of this subcommittee to improve health insurance portability and to eliminate pre-existing conditions barriers for working families. We encourage the subcommittee to enact coverage protections for as broad a group as possible, because behind many of those wage earners are children who need primary care. Ensuring the portability of health insurance for workers who change jobs and eliminating pre-existing limitations are important steps toward removing all the barriers that stand between working families and health care coverage.

NFIB
National Federation of Independent Business

May 11, 1995

Honorable Bill Thomas
Chairman
Health Subcommittee
Committee on Ways & Means
1136 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

On behalf of the 600,000 small business owners of the National Federation of Independent Business (NFIB), I am writing to express our support for your bill to bring portability to the health insurance market place.

Making it easier to go from job to job without the threat of losing health coverage has long been a goal of NFIB and the small business community. The Thomas portability bill would achieve that goal without having an adverse impact on small business premiums.

NFIB hopes that the Thomas portability bill is the first step toward additional insurance reforms, like rating reforms, guaranteed renewability, and others. We very much appreciate your leadership in making health insurance more accessible to small business owners and their employees.

Sincerely,

John J. Motley III
Vice President
Federal Governmental Relations

600 Maryland Avenue S.W., Suite 700 • Washington, D.C. 20024 • 202-554-9000 • Fax 202-484-1567
The Guardian of Small Business for Fifty Years

Statement of
Pearl Moore, RN MN FAAN
Executive Director, Oncology Nursing Society

The Oncology Nursing Society is pleased to have this opportunity to submit testimony for the written record to the House Ways and Means Committee, Subcommittee on Health.

The Oncology Nursing Society is a national specialty organization of more than 25,000 registered nurses dedicated to excellence in patient care, teaching, research and education in the field of oncology.

The American health care system is the most expensive in the industrialized world; yet, it is a system that delivers inconsistent quality of care and distributes benefits unequally. As nurses, we provide a unique perspective on the health care system. Working in a variety of settings provides us with the opportunity to interact with patients who benefit from the health care system's most sophisticated services as well as those individuals seriously compromised by the system's inefficiencies.

Millions of Americans have medical histories that include cancer and they face problems in obtaining adequate health insurance due to ineligibility, unaffordable premiums, and/or pre-existing conditions exclusion clauses.

The Oncology Nursing Society strongly supports health insurance reform legislation that eliminates pre-existing condition restrictions, addresses out-of-pocket deductible and co-payment expenses and restricts risk rating.

We applaud Chairman Thomas for holding hearings as they relate to the issue of health insurance portability and encourage the introduction of legislation which would eliminate the use of pre-existing condition exclusions.

On behalf of our members and the patient population we serve, we thank you for this opportunity to address this committee. We would welcome the opportunity to appear before you and provide more extensive testimony as the health care debate continues.

STATEMENT OF THE
SUSAN G. KOMEN BREAST CANCER FOUNDATION
ON
PORTABILITY AND PRE-EXISTING CONDITION PROVISION
HOUSE WAYS & MEANS SUBCOMMITTEE ON HEALTH

The Susan G. Komen Breast Cancer Foundation of Dallas, Texas, is an organization dedicated to the eradication of breast cancer and carries out this mission by raising private funds for research, education, screening and treatment of breast cancer. Started in 1982 in Texas, the Foundation now has a network of volunteer affiliates in 32 states and 57 cities in which it sponsors the RACE FOR THE CURE®, a 5k and 1k running/walking race to raise awareness of breast cancer. In 1995, 235,000 people are expected to participate in the RACE events. The Foundation uses 75% of the funds raised in each city to fund breast cancer programs in the specific cities. These programs include providing education programs, free or underwritten mammograms, and attendant services for patients undergoing treatment. The remaining race funds are used for the Foundation's National Grants Program to fund important and cutting-edge research on breast cancer. Currently, the Foundation is the largest private sector funder of research solely dedicated to breast cancer.

The Foundation wishes to comment on the policies and insurance requirements that affect approximately 2 million survivors of breast cancer, and the 46,000 women per year who will be diagnosed with breast cancer. The insurance policies of many major health insurers exclude coverage for "pre-existing conditions". Women who have been diagnosed with breast cancer are, in many instances, denied coverage for treatment because they are deemed to have a "pre-existing condition". This exclusion varies from one insurance company to another, but can apply to any number of treatments, including the potentially life-saving and costly bone marrow transplant. In the 1990s alone, close to 1.8 million women will be afflicted with breast cancer and many will be denied coverage for treatment if the current insurance policies are continued. The financial impact on these women and their families is substantial, and in some instances, so costly that some families resort to near bankruptcy to pay bills.

In addition, breast cancer survivors and/or their spouses may be precluded from making job changes because new employers carry insurance that exclude "pre-existing conditions". Often women with breast cancer or survivors change jobs in response to the disease. These women may be unable to do so, or risk losing insurance coverage if they do. A spouse may be precluded from changing jobs because his wife has breast cancer and the new employer's insurance has a "pre-existing condition" provision. In many instances, a spouse may lose a job due to corporate down-sizing or reorganization and will find that a new job has insurance with "pre-existing condition" exclusions.

A change in insurance policies that would eliminate abuses of "pre-existing condition" provisions and would allow for "portability" of insurance policies would assist the millions of women in getting coverage for needed treatments, or in changing jobs, and would save many families from job or financial problems caused by lack of coverage.

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