★★★ THE POLICY PAGE ★★★

An update on state and federal action from

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THE KASSEBAUM-KENNEDY HEALTH INSURANCE ACT: WHAT WOULD IT DO?

The U.S. Senate and House have passed different versions of an insurance bill under the same number, H.R. 3103. The Senate bill is referred to as the Kassebaum-Kennedy bill after its sponsors, Senators Nancy Kassebaum (R-Kansas) and Edward Kennedy (D-Massachusetts). The bills do not address the problem of affordability, which is the primary barrier preventing 4.5 million Texans -- over 26% of the population under age 65 -- from getting health coverage. These uninsured Texans do not qualify for Medicaid. The bills would create market reforms designed to ensure that Americans who can afford average-priced health insurance do not lose their coverage or face permanent limits on coverage when they change jobs. There is strong bipartisan support for the core elements of the two bills.

Controversial amendments added to the bill by members of both parties have threatened to doom the bill. As we write, a conference committee has not been named. Delay is due in part to a push by Senator Dole to ensure inclusion of a Medical Savings Account (MSA) amendment which he favors -- against the wishes of Sen. Kassebaum. Sen. Dole indicated that passage of the bill before his June 11 departure was a top priority, but this did not occur. New negotiations are underway to craft modifications to the MSA provision and to an amendment requiring coverage of mental health services to be equal to coverage of physical health conditions. This *Policy Page* summarizes key provisions of the bills and issues surrounding some of the controversial provisions.

GENERAL INSURANCE REFORMS

General Pre-Existing Condition Exclusion Rules. A pre-existing condition is defined as any medical condition for which a person has been treated, or for which treatment was recommended, during the 6-month period prior to when a health insurance or HMO policy takes effect Under both bills, insurers would be able to exclude coverage of a pre-existing condition for up to 12 months for persons who enrolled in a plan at their first possible opportunity, or for up to 18 months for those who do not (e.g., for an employee who does not opt for health benefits when first offered by his employer).

"Portability" Rules. Both bills would set special standards for coverage of pre-existing conditions when a person changes jobs without an interruption in health coverage. **The Senate bill** prohibits insurers from applying any such limits *if the service in question* (e.g., outpatient mental health, physical therapy, physician services*) was covered under the old plan.* For any benefits that were not covered by the previous plan, exclusion periods would be allowed, but would be reduced (from the 12 months) by 1 month for each month the person was covered under the old plan. Thus, a person continuously covered by an employer-sponsored health plan for a year or more who subsequently changed jobs and immediately enrolled in his new employer's health plan could not be subject to any delay or limit on coverage of a pre-existing condition. **The House bill** is a bit less consumer-friendly; health plans would only have to reduce the 12-month exclusion period for those services covered by the enrollee's old health plan. Any "new" services would be subject to the full 12- or 18-month exclusion.

Special Exceptions. Both bills prohibit plans from treating **pregnancy** as a pre-existing condition. Both bills would also prohibit plans from imposing pre-existing condition exclusions on **adopted children and newborns** who are enrolled immediately following their adoption or birth. **HMOs** and other health plans that do not impose pre-existing condition waiting periods would be allowed to impose waiting periods for new enrollees in which no premiums would be charged and no coverage rendered. These so-called "affiliation periods" would be capped at 60 days for persons who enrolled in a plan at their first possible opportunity (90 days for those who enroll later).

GROUP COVERAGE PROVISIONS

Discrimination Prohibitions. Both bills would prohibit health plans from refusing to accept any individual in a group health policy based on their historical, current, or anticipated health status. The plans could not require that any **individual** make a higher contribution or pay a higher premium than other group members; however, the plan could charge the **group** a higher overall premium reflecting the health status of its members. This means that group health premiums would still be heavily influenced by the makeup of the group, and would in some cases be unaffordable.

Guaranteed Availability. In the **Senate bill,** every group health plan would have to offer coverage for sale to all takers in its geographic area. The only exceptions would be for fraud or failure to pay premiums by the purchaser, or if a plan had stopped selling new coverage completely. Insurers could set standards for what percentages of employees must participate, or for what percentage of the premium must be paid by an employer (as opposed to the employees). In the **House version**, these requirements would apply only to insurers and HMOs in the small group market (up to 50 employees).

Guaranteed Renewability. The **Senate bill** would require all health plans to renew existing group plans, with the exceptions again being for fraud or failure to pay premiums by the purchaser, or if a plan had stopped selling new coverage completely. The **House bill** would apply to HMOs only, with the same exceptions.

INDIVIDUAL COVERAGE PROVISIONS

Guaranteed Availability. Under both bills, any health plan in the business of selling individual coverage would have to offer coverage to any individual who met all the following conditions:

1. had been insured for 18 continuous months,
2. had lost access to coverage under any employer or other group plan,
3. was not eligible for COBRA continuation coverage, **and**
4. had not lost coverage due to non-payment of premiums or fraud.

The House bill would deny this protection to any persons who had a break of 60 or more days in coverage during the 18-month period; the Senate bill disqualifies anyone with a break of 30 days or more. Neither bill would place any limit on the premiums that insurers could "offer" for individual coverage; individual health insurance premiums have historically been significantly more expensive on the average than group policy premiums.

Guaranteed Renewability. Both bills would require health plans selling individual coverage to renew existing policies, with the exceptions again being for fraud or failure to pay premiums by the purchaser, if a plan had stopped selling new coverage completely, or if the individual had moved out of the health plan's service area.

State Regulation. Both bills would allow states to adopt their own laws and rules regarding individual health policies, as long as they offered the same or greater protection against pre-existing condition exclusions, and "similar opportunities" to purchase individual coverage.

SANCTIONS FOR HEALTH PLANS

Both bills define the conditions under which a health plan could temporarily suspend offering new or renewed coverage. The **Senate bill** would allow such a suspension only if state Insurance authorities certified that a plan was financially unable to serve additional clients. A plan could not resume selling coverage until at least 6 months had passed **and** state insurance authorities certified the plan's as financially sound. The **House version** does not appear to require a role by state regulators; it simply allows plans with fiscal capacity concerns to suspend operations, and requires them to wait at least 6 months before resuming sales. Both bills require any plan ceasing sales on a long-term basis to be banned from selling coverage in that state for 5 years.

MOST CONTROVERSIAL PROVISIONS

Repeal Truth in Advertising for MediGap Policies. Current law requires that any health insurance policy that duplicates Medicare benefits **must** disclose that fact. The **House bill** would eliminate this disclosure requirement for "dread disease" (e.g., cancer-only) and hospital indemnity policies -- policies which consumer experts say are of little value to any consumer.

Medical Savings Accounts. The **House bill** would allow uninsured persons and those with high-health

insurance deductibles ($1,500 individual, $3,000 family) to deposit up to $2,000 ($4,000 family) annually into a Medical Savings Account (MSA). Funds deposited in these accounts (and interest earned) would be tax exempt, as long as they were used to pay for medical expenses. Unused funds at year-end could be carried over for medical use, or withdrawn for non-medical use with a 10% penalty and taxes withheld.

Critics of MSAs predict that MSAs could provide incentives for further segmentation of the health insurance market, attracting the healthy to leave more comprehensive insurance and thus driving up the cost of the remaining pool. Experts do not agree on the impact MSAs might have. The Congressional Budget Office (CBO) recently estimated that MSAs would **increase** the cost of Medicare. A recent RAND study predicted that MSAs would **not** have a catastrophic impact on health costs if widely adopted, but neither would they reduce health spending significantly; in fact, the authors predict that MSAs are as likely to increase costs as they are to reduce them (plus or minus 2%).

One thing that is sure about MSAs is that they offer little hope to uninsured Americans. Their employers are not likely to purchase a high-deductible health policy and to deposit thousands of dollars in an MSA on the worker's behalf. An MSA with no money in it cannot help a family, and a high-deductible health policy is little help if they cannot pay the deductible.

Both Senators Kassebaum and Kennedy opposed the MSA amendments because they threatened the bill's viability. Compromise around a pilot approach for MSAs for small businesses or self-employed persons is being discussed.

Parity In Mental Health Coverage. The **Senate bill** would prohibit both self-insured plans and commercial insurers from imposing limits on benefits or payments for mental health services that are different from those imposed for other conditions. Clearly, more equitable coverage of mental health could confer major long-term benefits to society, but would increase average health coverage costs in the short term. This provision has strong opposition from powerful business interests including the National Association of Manufacturers, the Business Roundtable, and the Association of Private Pension and Welfare Plans.

Health Plan Purchasing Co-Ops & MEWAs. The **Senate bill** would allow businesses and individuals to band together to form "Health Plan Purchasing Cooperatives" that could operate like large self-insured businesses under ERISA. These "Co-Ops" would have to register with the state, and states would be allowed to require the entities to carry reinsurance. Co-Ops could not assume risk, must be non-profit, must offer open enrollment, and may not exclude persons or groups due to health status.

The **House bill** would re-create Multiple Employer Welfare Arrangements (MEWAs) for small business and individuals to purchase insurance. Unlike the Senate bill, this provision would allow states to impose no regulations, including no solvency protections whatever for persons enrolled in these MEWAs. MEWAs have had a long history of solvency problems, and state insurance regulators have been struggling for years to ensure that MEWAs would be subject to the same fiscal oversight as other insurers.

Limits on Malpractice Awards. The **House bill** would cap non-economic (at $250,000) and punitive damages (at 3 times actual damages) in medical malpractice cases. It would abolish joint liability and mandate structured settlements in state and federal courts. It would also make drug and medical device manufacturers immune from liability if their product had ever been approved by the FDA.

Criminal Penalties for Medicaid Asset Transfers. The **House bill** would make it a misdemeanor crime to knowingly dispose of assets in order to become eligible for Medicaid benefits, i.e., nursing home or community care.