''(B) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium.

''(C) The health benefit plan is treated by the employer, or any of the eligible employees or dependents, as part of a plan or program for the purposes of section 162, section 25, or section 106 of the Internal Revenue Code of 1986.

''(4) STATE.—The term 'State' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to individuals who commence health insurance coverage or coverage under a group health plan after the first day of the first month beginning more than 6 months after the date of the enactment of this Act.

(2) PLAN YEAR EXCEPTION.—Such amendments shall not apply to plan years ending before the first day referred to in paragraph (1).

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D is amended by inserting after the item relating to chapter 44 the following new item:

''CHAPTER 45. Continuity and portability of health coverage.''

SEC. 3. CHANGES IN COBRA CONTINUATION REQUIREMENTS.

(a) MORE AFFORDABLE COVERAGE THROUGH REQUIREMENT OF LOWER-COST HEALTH PLAN CHOICES.—

(1) IN GENERAL.—Section 4980B(f) of the Internal Revenue Code of 1986 is amended—

(A) in paragraph (1), by striking '', continuation coverage under the plan'' and inserting ''and as selected by the qualified beneficiary under this subsection, continuation coverage of the type described in subparagraph (A), (F)(i), or (F)(ii) of paragraph (2)'';

(B) in paragraph (2)(A), by striking ''The coverage'' and inserting ''Unless the coverage is the type of coverage described in clause (i) or (ii) of subparagraph (F), the coverage'';

(C) in paragraph (2)(C)—

(i) in clause (i), by inserting ''(or in the case of alternative continuation coverage described in clause (i) or (ii) of subparagraph (F), 69 percent or 52 percent, respectively, of such applicable premium)'' after ''for such period'', and

(ii) in the last sentence by inserting '', '69 percent', or '52 percent'" after '' '102 percent'" and by inserting '', '100 percent', or '75 percent', respectively,'';

(D) by adding at the end of paragraph (2) the following new subparagraph:

''(F) TYPES OF ALTERNATIVE CONTINUATION COVERAGE REQUIRED.—

''(i) COVERAGE WITH TWO-THIRDS ACTUARIAL VALUE.—The type of coverage described in this clause is coverage which—

''(I) has an actuarial value (determined with respect to the similarly situated beneficiaries referred to in subparagraph (A)) of not less than ⅔ of the actuarial value (determined with respect to such beneficiaries) of the reference coverage, and

''(II) meets the requirements of clause (iii).

''(ii) COVERAGE WITH ONE-HALF ACTUARIAL VALUE.—The type of coverage described in this clause is coverage which—

''(I) has an actuarial value (determined with respect to the similarly situated beneficiaries referred to in subparagraph (A)) of not less than ½ of the actuarial value (determined with respect to such beneficiaries) of the reference coverage, and

''(II) meets the requirements of clause (iii).

''(iii) REQUIREMENTS RELATING TO GENERAL AVAILABILITY AND PREEXISTING CONDITIONS.—Coverage meets the requirements of this clause if the coverage—

''(I) is made available to all qualified beneficiaries who become eligible for coverage under this subsection after the effective date of this subparagraph, and

''(II) does not impose any restriction or limitation on coverage based on a preexisting condition unless such restriction or limitation could be imposed under the coverage described in subparagraph (A).

''(iv) REFERENCE COVERAGE DEFINED.—For purposes of this subparagraph, the term 'reference coverage' means, with respect to a group health plan, the costliest continuation coverage available under subparagraph (A) under the plan, excluding coverage in which an insignificant proportion of the eligible individuals is enrolled.''; and

(E) by adding at the end of paragraph (4) the following new subparagraph:

''(D) COMPUTATION BASED ON FULL COVERAGE.—For purposes of this section, the applicable premium shall be computed based on the type of coverage described in paragraph (2)(A).''

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after the first day of the first month beginning at least 6 months after the date of the enactment of this Act.

(b) CONTINUATION COVERAGE FOR CERTAIN FORMERLY COVERED DEPENDENT SPOUSES AND CHILDREN.—

(1) IN GENERAL.—Section 4980B(f) of such Code is amended by adding at the end the following new paragraph:

''(9) CAPTURE OF DELAYED DIVORCE OR SEPARATION.—

''(A) IN GENERAL.—For purposes of this section, if a covered employee disenrolls from coverage (or fails to renew coverage of) a qualified beneficiary within the 12-month period preceding the date of the divorce or legal separation of the employee from the employee's spouse, the divorce or separation shall be treated as a qualifying event described in paragraph (3)(C) and the loss of coverage shall be considered to be a result (and by reason) of such event.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to a qualified beneficiary if—

''(i) the beneficiary waives the rights under such subparagraph, or

''(ii) the qualified beneficiary at the time of the qualifying event or at the time of the disenrollment or failure to renew coverage has coverage under a group health plan (other than by reason of this paragraph) if the plan does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary.''

(2) TREATMENT OF PERIOD BEFORE DELAYED DIVORCE OR SEPARATION.—Subparagraph (D) of section 4980B(f)(2) of such Act is amended by adding at the end the following new sentence: ''For purposes of applying any preexisting condition limitation or restriction, any period beginning on the date of the disenrollment or failure to renew coverage referred to in paragraph (9)(A) and ending on the date of the divorce or separation referred to in such paragraph shall not be treated as a break in coverage if such paragraph applies to the qualified beneficiary.''.

(3) TREATMENT OF ANNULMENTS.—Section 4980B(g) of such Code is amended by adding at the end the following new paragraph:

''(5) TREATMENT OF ANNULMENT AS DIVORCE.—The term 'divorce' includes an annulment.''.

(4) EFFECTIVE DATE.—The amendments made by this section shall apply to divorces, legal separations, and annulments occurring more than 60 days after the date of the enactment of this Act.

(c) ELIMINATION OF TERMINATION OF CONTINUATION COVERAGE BY REASON OF MEDICARE ELIGIBILITY THROUGH END STAGE RENAL DISEASE.—

(1) IN GENERAL.—Subclause (II) of section 4980B(f)(2)(B)(iv) of such Code is amended by inserting ''other than by reason of section 226A of such Act'' after ''the Social Security Act''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to covered employees and qualified beneficiaries who become entitled to benefits under title XVIII of the Social Security Act pursuant to section 226A of such Act on or after the first day of the first month that begins after the date of the enactment of this Act.

THE MEDIGAP CONSUMER PROTECTION ACT OF 1995

HON. RICHARD J. DURBIN

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 11, 1995

Mr. DURBIN. Mr. Speaker, today I am introducing the Medigap Consumer Protection Act of 1995, which will help millions of seniors hang on to the private health insurance they purchase to pay for the deductibles and services which are not covered by Medicare.

In recent years, insurance companies have increasingly sold Medigap policies whose premiums are determined using a method known as ''attained age rating''. An attained age policy offers the buyer lower premiums at an early age but its premiums increase as a result of the aging of the policyholder. At various age thresholds the insurer raises premiums to reflect the expected greater use of health care by older policyholders. Due to the high inflation rate in the cost of health care, all Medigap policy premiums increase with time, but the premiums of attained age policies increase much more sharply.

The Medigap Consumer Protection Act would prohibit annual Medigap premium increases from being based on the age or aging of the policyholder. This would prohibit insurance companies from selling any more attained age Medigap policies. Ten States already prohibit attained age rating for Medigap: Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington. The bill would allow people who have already purchased attained age policies to keep them if they choose to do so. However, insurance companies would have to offer these policyholders the option of changing their insurance coverage to a policy not based on attained age rating, for example, a community rated or issue age rated policy.

Most Medigap purchasers, and many insurance agents, do not understand how attained age rating works, so prospective policy buyers often have a difficult time in making an informed decision. Senior citizens who purchase attained age policies and later face unexpectedly large premium increases as they age find it difficult to change policies because they usually must face a 6-month waiting period for pre-existing health conditions. When seniors enter the Medicare system—usually at age 65—they have a 6-month window of opportunity during which they can sign up for Medigap insurance without being denied coverage because of pre-existing conditions. At all other times they are subject to such a preexisting condition waiting period.

The Medigap Consumer Protection Act would direct the National Association of Insurance Commissioners [NAIC] to develop guidelines to eliminate attained age rating which would then be implemented in all States. The NAIC, founded in 1871, is the Nation's oldest association of State public officials. It is composed of the chief insurance regulators of all 50 States, the District of Columbia and the 4 U.S. territories. In the past, Congress has requested similar action from the NAIC, which has successfully completed these requests.

For instance, the Omnibus Budget Reconciliation Act of 1990 instructed NAIC to develop model standardized benefit packages for the Medigap market. After holding public hearings, and consulting with interested parties, the NAIC completed the standards, which were approved by the Secretary of Health and Human Services and became law.

I would like to include in the RECORD the following excerpt from a Consumer Reports article of August 1994 which describes the attained-age pricing problem in the Medigap market:

Many companies have changed the way they price policies so they can bait consumers with low premiums at the outset and trap them with very high increases later on.

In 1989, most carriers used either ''community rates'' or ''issue-age rates'' to price their policies. With community rates, all policyholders, young or old, pay the same premium. With issue-age rates, premiums will vary depending on the age of the buyer. But in either case, the annual premium will go up only to reflect inflation in the cost of benefits; it will not rise because you get older. Both community and issue-age rates protect policyholders from steep annual increases.

Now, however, more and more insurance companies are restoring to a less benign strategy as ''attained-age'' pricing. It allows companies to gain a competitive advantage by selling cheap policies to 65-year-olds when they enter the Medicare-supplement market. With attained-age pricing, the initial premiums, especially for those between 65 and 69, are usually lower than for issue-age or community-rated policies. But there's a catch: Premiums will rise steeply as the policyholder gets older.

In 1990, 31 percent of all Blue Cross-Blue Shield affiliates sold policies with attained-age rates. In 1993, 55 percent did. At the same time, the proportion of Blue Cross-Blue Shield plans offering community rates has dropped from 51 percent to 21 percent. AARP/Prudential still offers community rates but finds its initial premiums have become less competitive for policyholders age 65 to 69.

Attained-age policies are hazardous to policyholders. By age 75, 80, or 85, a policyholder may find that coverage has become unaffordable—just when the onset of poor health could make it impossible to buy a new, less expensive policy. Take, for example, an attained-age Plan F offered by New York Life and an issue-age Plan F offered by United American. For someone age 65, the New York Life policy is about $114 a year cheaper. But by age 80, the New York Life policyholder would have spent a total of $5000 more than the buyer of the United American policy.

Buyers are rarely warned of these consequences. Neither insurers nor agents are required to tell consumers how expensive attained-age policies will become over time. A sales brochure from California Blue Cross, which boasts one of the state's hottest-selling Medicare supplements, says nothing about rate increases; it doesn't even mention that rates are calculated on an attained-age basis. Of the 17 agents our reporter heard, only one discussed the way his company's rates were set—and he thoroughly confused the three methods. ''The vast majority of agents don't understand attained-age pricing, so they can't possibly explain it to their customers,'' says Mark McAndrew, president of United American.

Only 10 states—Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington—either require that insurers use community rates or specifically ban attained-age policies. In most other states, insurers are shifting to attained-age policies. United American, a large seller of Medicare-supplement policies, has just notified state insurance regulators that it plans to switch from issue-age to attained-age rates. ''We think attained-age rates are a bad thing, but our agents had to eat,'' explains Joyce Lane, a United American Vice president.

Mr. Speaker, Bonnie Burns, a private contractor for California's Health Insurance Counseling and Advocacy Program delivered the following testimony before the House Health and Environment Subcommittee earlier this year:

The danger [with attained age rating] is that just when people begin to need more and more medical care, they will also be hit with much higher premiums. Alternative methods of calculating premiums mean that older beneficiaries will almost always pay less than with attained age rates. The impact of sharply increased premiums is minimized.

Most seniors are in the middle class or below and are already spending about 23 percent of their income on health care expenses according to the AARP, while those under 65 spend about 8 percent. As people age their income and resources go down over time, particularly for older widowed women, and out of pocket costs for health care consume an increasingly larger part of their income. Their ability to absorb additional costs in premiums, deductibles and coinsurance is limited.

Mr. Speaker, affordable premiums and reliable health care coverage are crucial issues for millions of elderly Americans on fixed incomes. At age 65, virtually all Americans recognize the importance of good health coverage. Seniors face rapidly increasing health costs as they reach their seventies and eighties. It is inappropriate to lure seniors into attained age policies which they will not be able to afford if they live for a decade or two. That is why Consumers' Union and the National Council of Senior Citizens have written letters strongly supporting the Medigap Consumer Protection Act.

I would like to close, Mr. Speaker, by describing a few of the things the Medigap Consumer Protection Act will not do:

The Medigap Consumer Protection Act does not place price controls on the insurance industry. Under this bill each insurance carrier will continue to set its own rates and can charge as much or as little as it feels is prudent as long as it continues to meet the loss ratio requirements which are already in place under current law.

The Medigap Consumer Protection Act does not diminish valuable consumer choice. Attained age rating makes it more difficult and confusing for consumers to make price comparisons and compare different policies. Attained age rating confuses prospective policybuyers and insurance agents. Attained age rating deceives the average Medigap purchaser into purchasing coverage which they may not be able to afford later in life. This bill only prohibits the sale of any more of those policies that Consumer Reports correctly described as bait and trap policies.

The Medigap Consumer Protection Act will not force insurance carriers out of business. Under current law, insurance carriers must meet loss ratio requirements of 65 percent for the individual market and 75 percent for the group market. Loss ratios represent how much an insurance company must spend on benefits for each dollar it collects in premiums. For instance, a carrier selling Medigap policies to individuals must offer an average of at least 65 cents in benefits for each dollar it collects in premiums. This bill will still allow insurance carriers to clear up to 35 cents on each dollar in premiums they collect.

I hope that my colleagues on both sides of the aisle will join me in cosponsoring the Medigap Consumer Protection Act and in working toward its enactment so we can help seniors retain affordable, private Medigap coverage as they grow older. This legislation simply eliminates a type of policy that ropes seniors into policies with deceptively low initial premiums followed by sharp increases when those consumers may no longer have the option of switching to a competing policy.

PASSAIC HIGH SCHOOL INDIANS

HON. WILLIAM J. MARTINI

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 11, 1995

Mr. MARTINI. Mr. Speaker, I would like to take this opportunity to commemorate one of the greatest high school basketball teams of all time, the 1919–25 Passaic High School Indians. Over that 6-year stretch, the Indians enjoyed the longest winning streak ever for a high school, college, or professional team. They won an incredible 159 games in a row.

From December 17, 1919, to February 6, 1925, Passaic High was unbeatable. In an era of low-scoring basketball, they outscored their opponents by an average of 39 points, topping 100 points a dozen times. They once crushed an opponent 145 to 5.

While these teams were blessed with great players, such dominance transcends individual stars and usually begins with the coach. It was Prof. Ernest Blood that led the charge for these young men for so many years. Blood began playing basketball just a year after it was invented, and soon after he stopped playing he was coaching. In Potsdam, NY, his high school team did not lose to another high school team from 1906 to 1915.

A move to Passaic. NJ, in 1918 brought him to the job that would make him famous. Although his first season was marred by a defeat in the State championship, the streak began on the first day of the 1919 season. Win after win turned into State championship after State championship. As the streak progressed, the team became the center of attention for this industrial city: A factory whistle would indicate the results of the game, two loud blasts for a win, one long blast for a loss. Blood's foresight and desire kept the team ahead of its time, and he eventually led them