115TH CONGRESS
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Part 1

SELF-INSURANCE PROTECTION ACT

MARCH 20, 2017.—Ordered to be printed

Ms. FOXX, from the Committee on Education and the Workforce, submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 1304]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 1304) to amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to exclude from the definition of health insurance coverage certain medical stop-loss insurance obtained by certain plan sponsors of group health plans, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Self-Insurance Protection Act".

SEC. 2. CERTAIN MEDICAL STOP-LOSS INSURANCE OBTAINED BY CERTAIN PLAN SPONSORS OF GROUP HEALTH PLANS NOT INCLUDED UNDER THE DEFINITION OF HEALTH INSURANCE COVERAGE.

(a) ERISA.—Section 733(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)(1)) is amended by adding at the end the following sentence: "Such term shall not include a stop-loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.".

(b) PHSA.—Section 2791(b)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(1)) is amended by adding at the end the following new sentence: "Such term shall not include a stop-loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs

in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.".

(c) IRC.—Section 9832(b)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: "Such term shall not include a stop-loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.".

H.R. 1304, SELF-INSURANCE PROTECTION ACT

PURPOSE

H.R. 1304, the *Self-Insurance Protection Act,* amends the *Employee Retirement Income Security Act of 1974* (ERISA),[1] the *Public Health Services Act of 1968* (PHSA),[2] and the Internal Revenue Code of 1986 (Code)[3] to clarify that federal regulators cannot redefine stop-loss insurance as traditional health insurance. By providing legal certainty, the bill will help ensure workers and families continue to have access to affordable, flexible self-insured health plans.

COMMITTEE ACTION

112TH CONGRESS

Full Committee hearing examining the Impact of the Health Care Law on the Economy, Employers, and the Workforce

On February 9, 2011, the Committee on Education and the Workforce (Committee) held a hearing entitled "The Impact of the Health Care Law on the Economy, Employers, and the Workforce" to discuss, among other things, the benefits of self-insuring. The witnesses before the Committee were Dr. Paul Howard, Senior Fellow, Manhattan Institute, New York, New York; Ms. Gail Johnson, President and CEO, Rainbow Station, Inc., Glenn Allen, Virginia; Dr. Paul Van de Water, Senior Fellow, Center on Budget and Policy Priorities, Washington, D.C.; and Mr. Neil Trautwein, Vice President and Employee Benefits Policy Counsel, National Retail Federation, Washington, D.C.

Subcommittee hearing examining the Pressures of Rising Costs on Employer Provided Health Care

On March 10, 2011, the Health, Employment, Labor and Pensions (HELP) Subcommittee held a hearing entitled "The Pressures of Rising Costs on Employer Provided Health Care" to discuss, among other things, the benefits of self-insurance. The witnesses were Mr. Tom Miller, Resident Fellow, American Enterprise Institute, Washington, D.C.; Mr. Brett Parker, Vice Chairman and Chief Financial Officer, Bowlmor Lanes, New York, New York; Mr. Jim Houser, Owner, Hawthorne Auto, Portland, Oregon; and Mr. J. Michael Brewer, President, Lockton Benefit Group, Lockton Companies, LLC, Kansas City, Missouri.

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[1] 29 U.S.C. § 1001 *et seq.* [hereinafter *ERISA*].
[2] 42 U.S.C. § 201 *et seq.* [hereinafter *PHSA*].
[3] 26 U.S.C. § 1 *et seq.* [hereinafter *the Code*].

Subcommittee hearing examining the Recent Health Care Law: Consequences for Indiana Families and Workers

On June 7, 2011, the HELP Subcommittee held a field hearing in Evansville, Indiana, entitled "The Recent Health Care Law: Consequences for Indiana Families and Workers" to examine, among other things, the impact of the law on self-funded plans. The witnesses were the Honorable Mark Messmer, Indiana House of Representatives, Messmer Mechanical, Jasper, Indiana; Ms. Robyn Crosson, Company Compliance Services, State of Indiana Department of Insurance, Indianapolis, Indiana; Ms. Sherry Lang, Human Resources Director, Womack Restaurants, Terre Haute, Indiana; Mr. Denis Johnson, VP of Operations, Boston Scientific, Spencer, Indiana; Mr. David J. Carlson, M.D., General Surgeon, Deaconess Hospital, Evansville, Indiana; and Mr. Glen Graber, President, Graber Post Building, Inc., Odon, Indiana.

Subcommittee hearing examining Regulations, Costs, and Uncertainty in Employer Provided Health Care

On October 13, 2011, the HELP Subcommittee held a hearing entitled "Regulations, Costs, and Uncertainty in Employer Provided Health Care," which examined, among other things, the characteristics and attributes of self-funded plans. The witnesses were Ms. Grace-Marie Turner, President, Galen Institute, Alexandria, Virginia; Mr. Dennis M. Donahue, Managing Director, Wells Fargo Insurance Services USA, Inc., Chicago, Illinois; Mr. Ron Pollack, Executive Director, Families USA, Washington, D.C.; and Ms. Robyn Piper, President, Piper Jordan, San Diego, California.

Subcommittee hearing examining Health Care: Challenges Facing Pennsylvania's Workers and Job Creators

On February 22, 2012, the HELP Subcommittee held a field hearing in Butler, Pennsylvania, entitled "Health Care: Challenges Facing Pennsylvania's Workers and Job Creators" to discuss, among other things, the benefits of self-insuring. The witnesses were the Honorable Donald C. White, Senator, Pennsylvania State Senate, Harrisburg, Pennsylvania; Ms. Kathleen Bishop, President and CEO, Meadville-Western Crawford, County Chamber of Commerce, Meadville, Pennsylvania; Ms. Georgeanne Koehler, Pittsburg, Pennsylvania; Ms. Lori Joint, Director of Government Affairs, Manufacturer & Business Association, Erie, Pennsylvania; Ms. Patti-Ann Kanterman, Chief Financial Officer, Associated Ceramics & Technology, Inc., Sarver, Pennsylvania; Mr. Paul T. Nelson, Owner and CEO, Waldameer Park, Inc., Erie, Pennsylvania; Mr. Ralph Vitt, Owner, Vitt Insure, Pittsburg, Pennsylvania; and Mr. Will Knecht, President, Wendell August Forge; Grove City, Pennsylvania.

Subcommittee hearing examining Barriers to Lower Health Care Costs for Workers and Employers

On May 31, 2012, the HELP Subcommittee held a hearing entitled "Barriers to Lower Health Care Costs for Workers and Employers" to examine rising health care costs facing employers and employees, including the destructive impact of the *Affordable Care*

Act (ACA or Obamacare).[4] The witnesses were Mr. Ed Fensholt, Senior Vice President, Lockton Companies, LLC, Kansas City, Missouri; Mr. Roy Ramthun, President, HAS Consulting Services, Washington, D.C.; Ms. Jody Hall, Founder & Owner, Cupcake Royale, Seattle, Washington; and Mr. Bill Streitberger, Vice President of Human Resources, Red Robin, Greenwood Village, Colorado.

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Subcommittee hearing examining Health Care Challenges Facing North Carolina's Workers and Job Creators

On April 30, 2013, the HELP Subcommittee held a field hearing in Concord, North Carolina, entitled "Health Care Challenges Facing North Carolina's Workers and Job Creators," during which witnesses discussed the negative impact of the ACA, including on businesses that self-insure. The witnesses were Mr. Chuck Horne, President, Hornwood Inc., Lilesville, North Carolina; Ms. Tina Haynes, Chief Human Resource Officer, Rowan-Cabarrus Community College, Salisbury, North Carolina; Mr. Adam Searing, Director, Health Access Coalition, Raleigh, North Carolina; Mr. Ken Conrad, Chairman, Libby Hill Seafood Restaurants, Greenboro, North Carolina; Mr. Dave Bass, Vice President, Compensation and Associate Wellness, Delhaize America, Concord, North Carolina; Mr. Ed Tubel, Founder and CEO, Tricor Inc., Charlotte, North Carolina; Dr. Olson Huff, Pediatrician, Asheville, North Carolina; and Mr. Bruce Silver, President and CEO, Racing Electronics, Concord, North Carolina.

Full Committee hearing reviewing the President's Fiscal Year 2014 Budget Proposal for the U.S. Department of Health and Human Services

On June 4, 2013, the Committee held a hearing entitled "Reviewing the President's Fiscal Year 2014 Budget Proposal for the U.S. Department of Health and Human Services," during which members discussed the experiences of employers that self-insure. The sole witness at the hearing was The Honorable Kathleen Sebelius, then-Secretary of the U.S. Department of Health and Human Services, Washington, D.C.

Subcommittee hearing regarding the Employer Mandate: Examining the Delay and Its Effect on Workplaces

On July 23, 2013, the HELP Subcommittee and the Workforce Protections Subcommittee jointly held a hearing entitled "The Employer Mandate: Examining the Delay and Its Effect on Workplaces" to review, among other things, the impact of the ACA on the self-insured market. Witnesses before the subcommittees were Ms. Grace-Marie Turner, President, Galen Institute, Alexandria, Virginia; Mr. Jamie T. Richardson, Vice President, White Castle System, Inc., Columbus, Ohio; Mr. Ron Pollack, Executive Director, Families USA, Washington, D.C.; and Dr. Douglas Holtz-Eakin, President, American Action Forum, Washington, D.C.

[4] Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (2010), and Health and Education Reconciliation Act, Pub. L. No. 111–152 (2010) [hereinafter Affordable Care Act, Obamacare, or ACA].

Subcommittee hearing regarding Health Care Challenges Facing Kentucky's Workers and Job Creators

On August 27, 2013, the HELP Subcommittee held a field hearing in Lexington, Kentucky entitled "Health Care Challenges Facing Kentucky's Workers and Job Creators," which included an examination of the harmful impact of the ACA on Kentucky's employers and their employees and a discussion about self-insurance. Witnesses before the subcommittee were Mr. Tim Kanaly, Owner and President, Gary Force Honda, Bowling Green, Kentucky; Mr. Joe Bologna, Owner, Joe Bologna's—Italian Pizzeria & Restaurant, Lexington, Kentucky; Ms. Carrie Banahan, Executive Director, Office of the Kentucky Health Benefit Exchange, Frankfort, Kentucky; Mr. John Humkey, President, Employee Benefit Associates, Inc., Lexington, Kentucky; Ms. Janey Moores, President and CEO, BJM & Associates, Inc., Lexington, Kentucky; Mr. Donnie Meadows, Vice President of Human Resources, K–VA–T Food Stores, Inc., Abingdon, VA; Ms. Debbie Basham, Southwest Breast Cancer Awareness Group, Louisville, Kentucky; and Mr. John McPhearson, CEO, Lectrodryer, Richmond, Kentucky.

Subcommittee hearing on Providing Access to Affordable, Flexible Health Plans through Self-Insurance

On February 26, 2014, the HELP Subcommittee held a hearing entitled "Providing Access to Affordable, Flexible Health Plans through Self-Insurance" to examine self-insurance and stop-loss insurance. The witnesses were Mr. Michael Ferguson, President and CEO, Self-Insurance Institute of America, Simpsonville, South Carolina; Mr. Wes Kelley, Executive Director, Columbia Power and Water Systems, Columbia, Tennessee; Ms. Maura Calsyn, Director of Health Policy, Center for American Progress, Washington, D.C.; and Mr. Robert Melillo, National Vice President of Risk Financing Solutions, USI Insurance, Glastonbury, Connecticut.

Full Committee hearing reviewing the President's Fiscal Year 2015 Budget Proposal for the Department of Labor

On March 26, 2014, the Committee held a hearing entitled "Reviewing the President's Fiscal Year 2015 Budget Proposal for the Department of Labor," during which the Secretary of Labor was questioned about whether the Department had plans to regulate stop-loss. The sole witness was the Honorable Thomas E. Perez, then-Secretary of the U.S. Department of Labor, Washington, D.C.

Subcommittee hearing examining the Effects of the President's Health Care Law on Indiana's Classrooms and Workplaces

On September 4, 2014, the HELP Subcommittee held a field hearing in Greenfield, Indiana, entitled "The Effects of the President's Health Care Law on Indiana's Classrooms and Workplaces," during which witnesses testified about employer-provided health coverage and self-insured plans. The witnesses were Mr. Mike Shafer, Chief Financial Officer, Zionsville Community Schools, Zionsville, Indiana; Mr. Tom Snyder, President, Ivy Tech Community College, Indianapolis, Indiana; Mr. Danny Tanoos, Superintendent, Vigo County School Corporation, Terre Haute, Indiana; Mr. Tom Forkner, President, Anderson Federation of Teachers, AFT Local 519, Anderson, Indiana; Mr. Mark DeFabis, President

and Chief Executive Officer, Integrated Distribution Services, Plainfield, Indiana; Mr. Nate LaMar, International Regional Manager, Draper, Inc., Spiceland, Indiana; Mr. Dan Wolfe, Owner, Wolfe's Auto Auction, Terre Haute, Indiana; and Mr. Robert Stone, Director of Palliative Care, IU Health Bloomington Hospital, Bloomington, Indiana.

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H.R. 1423, Self-Insurance Protection Act, introduced

On March 18, 2015, Rep. David "Phil" Roe (R–TN), then-Chairman of the HELP Subcommittee, introduced the Self-Insurance Protection Act (H.R. 1423).[5] He introduced the bill to ensure employees and employers could continue to have access to affordable, flexible health care plans by having the option to self-fund those plans.

Full Committee hearing reviewing the President's Fiscal Year 2016 Budget Proposal for the Department of Labor

On March 18, 2015, the Committee held a hearing entitled "Reviewing the President's Fiscal Year 2016 Budget Proposal for the Department of Labor," during which the Secretary of Labor was questioned about the Department's plans to regulate stop-loss. The sole witness was the Honorable Thomas E. Perez, then-Secretary of the U.S. Department of Labor, Washington, D.C.

Subcommittee hearing on Five Years of Broken Promises: How the President's Health Care Law is Affecting America's Workplaces

On April 14, 2015, the HELP Subcommittee held a hearing entitled "Five Years of Broken Promises: How the President's Health Care Law is Affecting America's Workplaces," which examined the continuing negative impact of the ACA on employer-sponsored health coverage. Witnesses before the Subcommittee were former Deputy Secretary of the Department of Health and Human Services the Honorable Tevi Troy, Ph.D., President, American Health Policy Institute, Washington, D.C.; Mr. Rutland Paal, Jr., President, Rutland Beard Floral Group, Scotch Plains, New Jersey; Michael Brev, President, Brev Corp. t/a Hobby Works, WingTOTE Manufacturing, LLC, Laurel, Maryland; and Ms. Sally Roberts, Human Resources Director, Morris Communications Company, LLC, Augusta, Georgia.

Full Committee hearing on examining the Policies and Priorities of the U.S. Department of Health and Human Services

On March 15, 2016, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services," during which self-insured plans were discussed. The sole witness at the hearing was the Honorable Sylvia Mathews Burwell, then-Secretary of the U.S. Department of Health and Human Services, Washington, D.C.

[5] H.R. 1423, 114th Cong. (2015).

Subcommittee hearing on Innovations in Health Care: Exploring Free-Market Solutions for a Healthy Workforce

On April 14, 2016, the HELP Subcommittee held a hearing entitled "Innovations in Health Care: Exploring Free-Market Solutions for a Healthy Workforce," which examined, among other things, the benefits of self-insuring. Witnesses before the subcommittee were Ms. Sabrina Corlette, J.D., Senior Research Professor, Center on Health Insurance Reforms, Georgetown University's Health Policy Institute, Washington, D.C.; Ms. Tresia Franklin, Director, Total Rewards and Employee Relations, Hallmark Cards, Inc. Kansas City, Missouri; Ms. Amy McDonough, Vice President and General Manager of Corporate Wellness, Fitbit, San Francisco, California; and Mr. John Zern, Executive Vice President and Global Health Leader, Aon, Chicago, Illinois.

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Full Committee hearing on Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions

On February 1, 2017, the Committee held a hearing entitled "Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions," which examined failures of the ACA. Witnesses before the Committee included Mr. Scott Bollenbacher, CPA, Managing Partner, Bollenbacher & Associates, LLC, Portland, Indiana; Mr. Joe Eddy, President and Chief Executive Officer, Eagle Manufacturing Company, Wellsburg, West Virginia; Ms. Angela Schlaack, St. Joseph, Michigan; and Dr. Tevi Troy, Chief Executive Officer, American Health Policy Institute, Washington, D.C.

Full Committee hearing on Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families

On March 1, 2017, the Committee held a hearing entitled "Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families," which examined H.R. 1304, among other proposals. Witnesses before the Committee included Mr. Jon B. Hurst, President, Retailers Association of Massachusetts, Boston, Massachusetts; Ms. Allison R. Klausner, J.D., Principal, Government Relations Leader, Conduent, Secaucus, New Jersey; Ms. Lydia Mitts, Associate Director of Affordability Initiatives, Families USA, Washington, D.C.; and Mr. Jay Ritchie, Executive Vice President, Tokio Marine HHC, Kennesaw, Georgia.

Introduction of H.R. 1304, Self-Insurance Protection Act

On March 2, 2017, Rep. Roe introduced the *Self-Insurance Protection Act* (H.R. 1304), along with HELP Subcommittee Chairman Tim Walberg (R–MI).[6] Rep. Roe reintroduced the bill to ensure self-funding remains an option for employee and employers offering health care coverage.

[6] H.R. 1304, 115th Cong. (2017).

Full Committee passes H.R. 1304, Self-Insurance Protection Act

On March 8, 2017, the Committee considered H.R. 1304, the *Self-Insurance Protection Act*.[7] Rep. Roe offered an amendment in the nature of a substitute, making a technical change to the introduced bill. The Committee voted to adopt the amendment in the nature of a substitute by voice vote. Rep. Jared Polis (D–CO) offered an amendment that was ruled non-germane, and the ruling of the Chair was upheld by a vote of 22 to 17 on a motion to table the appeal of the ruling of the Chair. Rep. Bonamici (D–OR) offered a clarifying amendment to ensure that the legislation would not be construed to restrict the ability of states to regulate stop-loss policies. H.R. 1304 does not preempt states from regulating stop-loss coverage. At the request of Ranking Member Robert C. "Bobby" Scott (D–VA), Committee Chairwoman Virginia Foxx (R–NC) agreed to include such clarifying language in the Committee report. This clarification ensures that nothing in the bill is erroneously construed to restrict states' ability to regulate stop-loss policies. Based on the understanding between Chairwoman Foxx and Ranking Member Scott that this clarification would be included in the Committee's official report, Rep. Bonamici withdrew her amendment. The Committee favorably reported H.R. 1304, as amended, to the House of Representatives by voice vote.

SUMMARY OF H.R. 1304

On March 2, 2017, Rep. Roe introduced H.R. 1304, which would amend ERISA, PHSA, and the Code to clarify that federal regulators cannot redefine stop-loss insurance as "health insurance coverage" under federal law, thereby ensuring employers can continue to utilize this important financial risk-management tool when offering employees health care coverage through a self-funded plan.

COMMITTEE VIEWS

Background on employer-sponsored insurance coverage

Since World War II, employers have offered health care benefits as a way to recruit and retain talent and ensure a healthy and productive workforce. Employer-sponsored insurance is one of the primary means by which Americans obtain health care coverage. According to the Kaiser Family Foundation, more than 150 million Americans, or 55.5 percent of working Americans, are covered by a health benefit plan offered by their employer.[8] A report by the American Health Policy Institute found that employers spent $578.6 billion in 2012 providing health coverage for 168.6 million employees, retirees, and dependents.[9] Almost all businesses with at least 200 or more employees offer health benefits, and just over half of smaller businesses with 3–199 employees offer health benefits.[10]

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[7] *H.R. 1304, Self-Insurance Protection Act: Markup Before the H. Comm. on Educ. and the Workforce,* 115th Cong. (2017).

[8] Kaiser Family Found., *Employer Health Benefits Survey* (2016), *http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey.*

[9] Troy, T., and Wilson, D.M., *Health Coverage Cost Per Covered Life: Government vs. Employment-Sponsored Programs,* AMERICAN HEALTH POLICY INST. (2014), *http://www.americanhealthpolicy.org/Content/documents/resources/AHPI*_STUDY_Cost_Per_Covered_Life.pdf.

[10] Kaiser Family Found., *supra* note 7.

Employer-provided health benefits are regulated by a number of laws, including ERISA as amended by the ACA. The Department of Labor (DOL) implements and enforces ERISA. By virtue of its jurisdiction over ERISA, the Committee has jurisdiction over employer-provided health coverage.

Self-insured health plans

Small and large employers offer health care coverage to employees in self-funded arrangements (self-insurance) or purchase fully-insured plans. ERISA regulates both fully-insured and self-insured plans, but only self-insured plans are exempt from a patchwork of benefit mandates and regulations imposed under state insurance law. Employers sponsoring self-insured plans are not subject to the same requirements under the ACA as those with fully-insured plans. Some employers that self-insure purchase "stop-loss" insurance as a financial risk management tool to protect against catastrophic claims. Therefore, employer-provided plans have different requirements and costs depending on funding arrangements. Last year, approximately 61 percent of workers with coverage were enrolled in a self-funded plan, up from 49 percent in 2000 and 54 percent in 2005.[11] Fifty-seven percent of workers enrolled in self-funded plans are in plans backed by stop-loss insurance coverage.[12]

An employer can provide health insurance to employees either by fully-insuring or self-insuring. An employer who is fully-insured enters into a contractual agreement with a health insurer to purchase a product for his or her employees. The employer and employees pay a fixed, monthly premium to the insurance company. This is what many consider "traditional" insurance. An employer who self-funds provides for employees' medical costs by paying providers directly or reimbursing employees as claims arise, instead of paying a fixed premium to an insurance company. Typically, a trust is set up to fund such claims. Self-insured employers are responsible for employees' health care expenses, and they have the flexibility to customize the design of their health plans to meet the specific needs of their workforce.

A self-insured employer can either administer the employee claims in-house or subcontract the administrative services to a third party administrator (TPA). The employer or TPA then coordinates provider network contracts and stop-loss insurance coverage for unexpected high claims.[13] By making a conscious choice to bear the financial risk of an employee's health care expenses, employers can experience cost savings that are not available from a plan purchased in the fully-insured market. Mr. Jay Ritchie, Executive Vice President, Tokio Marino HCC Stop-Loss Group, testifying before the Committee on behalf of the Self-Insurance Institute of America, Inc., discussed the value of self-funding:

> If you're a health insurer, you're going to take the increasing cost of medical insurance and, due to our new medical loss ratio law, get a profit percentage on the rising increase of that cost. So, you take it into a self-insured model[,] and you're not paying the health insurer's profits

[11] *Id.*
[12] *Id.*
[13] SELF-INSURED INST. OF AMERICA, *http://www.siia.org/i4a/pages/Index.cfm?pageID=4546* (last visited Mar. 15, 2017).

> on top of your rising costs. That's the value of self-insurance. You're taking it and controlling your own destination, and keeping it at a true costs basis.[14]

The more employees an employer has, the more likely that employer is to self-insure. Of employers who self-insure, 82 percent are businesses with 200 or more employees.[15] Small businesses are less likely to self-insure because, unlike their larger counterparts, they often have fewer employees to spread the risk and smaller margins to pay claims. In 2016, 13 percent of firms with fewer than 200 employees self-insured.[16] The top industries with self-insured firms include transportation, manufacturing, retail, finance, state and local government, and health care.[17]

Many employers choose to self-insure because they can customize their plans to their workforce. For example, self-insured plans are not required to cover all categories of essential health benefits mandated by the ACA, so employers can structure their plans to meet the specific needs of their employees instead of paying for a more costly "one-size-fits-all" traditional insurance policy. Mr. Michael Ferguson, President and CEO, Self-Insurance Institute of America, Inc. testified before the subcommittee about the benefits of self-funded plans:

> Federal law provides self-insured plans greater flexibility in designing benefits packages that better meet the specific needs of their plan participants. . . . Self-insurance plans can also structure more innovative reimbursement arrangements with health care providers. . . . As medical costs have skyrocketed, self-insured plan sponsors have been taking steps to reduce medical costs by emphasizing prevention and maintenance care for chronic diseases.[18]

Self-insurance is also attractive to employers due to the long-term financial savings it may provide. Mr. Ritchie acknowledged these savings in his testimony before the Committee, saying:

> . . . over a 3- to 5-year period, we see that self-insurance is generally cheaper than health insurance. Now, on a year-to-year basis, that may be very different because the health insurance is prospectively priced where the self-insurance is actually priced. Whatever you actually spend that year is your cost, where for health insurance they're predicting that.[19]

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[14] *Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families: Hearing Before the H. Comm. on Educ. and the Workforce,* 115th Cong. (2017) (statement of Jay Ritchie, Executive Vice President, Tokio Marine HHC).

[15] Kaiser Family Found., *supra* note 7 (finding 83 percent of covered workers in firms with 1,000 to 4,999 workers and 94 percent of covered workers in firms with 5,000 or more workers are in self-funded plans. In 2006, 78 percent of large firms with 200 or more workers were self-insured).

[16] *Id.*

[17] *Id.*

[18] *Providing Access to Affordable, Flexible Health Plans Through Self-Insurance: Hearing Before the Subcomm. on Health, Emp't, Labor, and Pensions of the H. Comm. on Educ. and the Workforce,* 113th Cong., 46 (2014) (statement of Michael Ferguson, President and CEO, Self-Insurance Inst. of America, Inc.).

[19] Ritchie, *supra* note 13.

Under a self-insured plan, the dollars that are not spent on claims costs can be saved in the plan's reserves to help cover the future health care needs of workers and their families.

Stop-loss insurance

Many self-insured employers also purchase stop-loss insurance, a financial risk-management tool designed to protect against catastrophic claims expenses. Stop-loss coverage reimburses a self-insured plan sponsor for medical claims that exceed a certain pre-established level of liability; it does not insure employees, nor does it reimburse medical providers for care. As Mr. Ritchie stated in his testimony, "stop-loss does not insure employees nor do we reimburse medical providers for care, but rather stop-loss reimburses a self-insured entity for health care payments they have made that exceed certain, pre-determined level similar to a liability product." [20]

The point at which the stop-loss carrier begins to pay claims is known as the "attachment point." There are two types of stop-loss insurance: "specific" and "aggregate." Specific stop-loss insurance protects against a high claim of a single employee, while aggregate stop-loss insurance institutes a maximum dollar amount of claims paid during a certain period of time. Most employers who purchase stop-loss insurance purchase both specific and aggregate stop-loss coverage. In 2016, the average attachment point was $160,000 for small businesses and $330,000 for large businesses that carry specific stop-loss coverage.

Traditionally, stop-loss plans are purchased by small- and medium-sized employers who want to offer employees the flexibility of a self-insured health plan while being safe-guarded against unusually high claims. In testimony before the Committee, Mr. Ritchie described how small businesses benefit from stop-loss insurance:

> What we see is once you get about 5,000 lives, claims become pretty predictable and, therefore, there is no reason to purchase stop-loss insurance anymore. You don't need that risk transfer mechanism. Who does need that risk transfer mechanism are those as you get smaller, so the smaller an employer gets, the more risk transfer they need to support their self-funded plan.[21]

In 2016, 72 percent of covered workers in a small firm's (3–199 workers) partially or fully self-funded plan were also covered by stop-loss insurance, compared to 56 percent of workers covered in a large firm's (200 or more workers) partially or fully self-funded plan. The larger the employer, the more liability they are able to bear on their own without the need for stop-loss coverage.

Stop-loss insurance is sometimes regulated at the state level but not the federal level. However, the Obama administration repeatedly signaled interest in regulating stop-loss insurance as health insurance. Mr. Ferguson testified that the industry understood this possible intent:

> . . . the [Obama] administration has at least an interest . . . in making it more difficult for employers to obtain

[20] *Id.*
[21] *Id.*

> stop-loss insurance as a way to sort of control a migration towards self-insurance. So, to the extent that [obtaining] stop-loss insurance is made more difficult through a regulatory process, it will dissuade more employers from being able—or make it difficult for those employers to operate self-insured plans.[22]

In November 2014, DOL made clear that a state law would not be preempted by ERISA, thus formally notifying states of their ability to regulate employer stop-loss coverage. Stakeholders feared this guidance was a precursor to federal regulation that would have a negative effect on employers' ability to self-insure. Mr. Jay Ritchie, Executive Vice President, Tokio Marine HCC Stop-Loss Group, testified during the Committee's hearing about the consequence of regulating stop-loss coverage at the federal level:

> If stop loss is defined as health insurance coverage, it will dramatically change the nature of stop loss coverage, potentially leading to few or no carriers in the market, which will drive up the cost and threaten the existence of self-insured plans. By limiting the availability of stop loss, employer sponsored would be forced to move back to a more expensive fully-insured model, passing those costs on to employees and restricting their ability to offer more customized benefits and access to data.[23]

Stop-loss coverage is not and should not be defined as health insurance coverage under ERISA, the PHSA, or the Code. Stop-loss differs from health insurance in that it is priced to cover only one to three claims a year,[24] and it does not insure employees or reimburse medical providers for care.

Support for maintaining self-funding as an option for all businesses

The Self-Insurance Institute of America, Inc. and the U.S. Chamber of Commerce support this legislation because it protects a funding mechanism option businesses should be permitted to consider when offering a self-insured health plan to their employees. Moreover, the legislation ensures that thousands of employers—large and small—who currently self-insure their health plans will be able to continue providing affordable benefits that best meet the needs of their workers and their families.

CONCLUSION

Plan sponsors that choose to self-fund are able to offer their employees tailored benefits based on their specific needs. Self-funding also allows for cost reductions because the employer pays claims when they actually are incurred, and it eliminates paying for marketing and profits of the insurer under a fully-insured plan. When offering health care coverage, plan sponsors should be permitted to consider if self-funding is appropriate for them. Stop-loss policies are essential to ensuring self-funding is still an option by giving plan sponsors a tool to manage the financial risk and ensure employees claims are paid. H.R. 1304 amends ERISA, the PHSA, and

[22] Ferguson, *supra* note 17.
[23] Ritchie, *supra* note 13.
[24] *Id.*

the Code to clarify that federal regulators cannot redefine stop-loss insurance as "health insurance coverage," therefore preserving the option of self-funding. Stop-loss coverage should not be regulated at the federal level, and the bill leaves regulation of these policies to the states. H.R. 1304 is one part of a broader effort to ensure all Americans have access to affordable health care coverage that meets their needs.

SECTION-BY-SECTION

The following is a section-by-section analysis of the Amendment in the Nature of a Substitute offered by Rep. Roe and reported favorably by the Committee.

Section 1. Short title

Section 1 provides the short title is the "Self-Insurance Protection Act."

Section 2. Certain medical stop-loss insurance obtained by certain plan sponsors of group health plans not included under the definition of health insurance coverage

Subsection (a) amends the definition of health insurance coverage under ERISA to explicitly state that a stop-loss policy is not health insurance coverage.

Subsection (b) amends the definition of health insurance coverage under PHSA to explicitly state that a stop-loss policy is not health insurance coverage.

Subsection (c) amends the definition of health insurance coverage under the Code to explicitly state that a stop-loss policy is not health insurance coverage.

EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the body of this report.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104–1 requires a description of the application of this bill to the legislative branch. H.R. 1304 will help ensure workers and families continue to have access to affordable, flexible self-insured health plans.

UNFUNDED MANDATE STATEMENT

With respect to the requirements of Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104–4), the Committee has requested but not received from the Director of the Congressional Budget Office a statement as to whether the provisions of the reported bill include unfunded mandates.

EARMARK STATEMENT

H.R. 1304 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of House Rule XXI.

ROLL CALL VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee Report to include for each record vote on a motion to report the measure or matter and on any amendments offered to the measure or matter the total number of votes for and against and the names of the Members voting for and against.

Date: March 8, 2017

COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE

Roll Call: 1 Bill: H.R. 1304 Amendment Number: 4

Disposition: Adopted by a vote of 22 yeas and 17 nays.

Sponsor/Amendment: Mr. Thompson - motion to table the appeal of the ruling of the chair on the Polis amendment (creates a public option)

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs. FOXX (NC) (Chairwoman)	X			Mr. SCOTT (VA) (Ranking)		X	
Mr. WILSON (SC)	X			Mrs. DAVIS (CA)		X	
Mr. HUNTER (CA)	X			Mr. GRIJALVA (AZ)		X	
Mr. ROE (TN)	X			Mr. COURTNEY (CT)		X	
Mr. THOMPSON (PA)	X			Ms. FUDGE (OH)		X	
Mr. WALBERG (MI)	X			Mr. POLIS (CO)		X	
Mr. GUTHRIE (KY)	X			Mr. SABLAN (MP)		X	
Mr. ROKITA (IN)	X			Ms. WILSON (FL)		X	
Mr. BARLETTA (PA)	X			Ms. BONAMICI (OR)		X	
Mr. MESSER (IN)	X			Mr. TAKANO (CA)		X	
Mr. BYRNE (AL)	X			Ms. ADAMS (NC)		X	
Mr. BRAT (VA)	X			Mr. DeSAULNIER (CA)		X	
Mr. GROTHMAN (WI)	X			Mr. NORCROSS (NJ)		X	
Mr. RUSSELL (OK)	X			Ms. BLUNT ROCHESTER (DE)		X	
Ms. STEFANIK (NY)	X			Mr. KRISHNAMOORTHI (IL)		X	
Mr. ALLEN (GA)	X			Ms. SHEA-PORTER (NH)		X	
Mr. LEWIS (MN)	X			Mr. ESPAILLAT (NY)		X	
Mr. ROONEY (FL)	X						
Mr. MITCHELL (MI)	X						
Mr. GARRETT (VA)	X						
Mr. SMUCKER (PA)	X						
Mr. FERGUSON (GA)	X						
vacancy							

TOTALS: Aye: 22 No: 17 Not Voting:

Total: 40 / Quorum: 14 / Report: 21

(23 R - 17 D)

CORRESPONDENCE

Exchange of letters with the Committee on Energy and Commerce and the Committee on Ways and Means.

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

March 20, 2017

The Honorable Virginia Foxx
Chairwoman
Committee on Education and Workforce
2176 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Foxx:

I write in regard to H.R. 1304, Self-Insurance Protection Act, which was referred the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and the Workforce. I wanted to notify you that the Committee will forgo action on the bill so that it may proceed expeditiously to the House floor for consideration.

The Committee on Energy and Commerce takes this action with our mutual understanding that by foregoing consideration of H.R. 1304, the Committee does not waive any jurisdiction over the subject matter contained in this or similar legislation and will be appropriately consulted and involved as this or similar legislation moves forward to address any remaining issues within the Committee's jurisdiction. The Committee also reserves the right to seek appointment of an appropriate number of conferees to any House-Senate conference involving this or similar legislation and asks that you support any such request.

I would appreciate your response confirming this understanding with respect to H.R. 1304 and ask that a copy of our exchange of letters on this matter be included in your committee's report on the legislation or the Congressional Record during its consideration on the House floor.

Sincerely,

Greg Walden
Chairman

COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

March 20, 2017

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter regarding the Committee on Energy and Commerce jurisdictional interest in H.R. 1304, *Self-Insurance Protection Act*, as amended. I appreciate your willingness to forgo further consideration of H.R. 1304 by your committee.

I agree that the Committee on Energy and Commerce has a valid jurisdictional interest in certain provisions of H.R. 1304 and that the committee's jurisdiction will not be adversely affected by your decision to forgo further consideration of the bill. Your committee will be appropriately consulted and involved as this or similar legislation moves forward. As you have requested, I will include a copy of your letter and this response in the committee report for H.R. 1304 and in the Congressional Record during the Floor consideration of this bill. As always, thank you for your cooperation.

Sincerely,

Virginia Foxx

Virginia Foxx
Chairwoman

CC: The Honorable Paul Ryan
The Honorable Bobby Scott
The Honorable Frank Pallone
Mr. Thomas J. Wickham, Jr., Parliamentarian

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

March 16, 2017

The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
2176 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairwoman Foxx,

I am writing with respect to H.R. 1304, the "Self-Insurance Protection Act," on which the Committee on Ways and Means was granted an additional referral.

In order to allow H.R. 1304 to move expeditiously to the House floor, I agree to waive formal consideration of this bill. The Committee on Ways and Means takes this action with the mutual understanding that by forgoing formal consideration of H.R. 1304, we do not waive any jurisdiction over the subject matter contained in this or similar legislation, and the Committee will be appropriately consulted and involved as the bill or similar legislation moves forward so that we may address any remaining issues that fall within our Rule X jurisdiction. The Committee also reserves the right to seek appointment of an appropriate number of conferees to any House-Senate conference involving this or similar legislation, and requests your support for such request.

Finally, I would appreciate your response to this letter confirming this understanding, and would ask that a copy of our exchange of letters on this matter be included in the *Congressional Record* during floor consideration of this measure.

Sincerely,

Kevin Brady
Chairman

cc: The Honorable Paul Ryan
The Honorable Bobby Scott
The Honorable Richard Neal
Mr. Tom Wickham, Jr.

March 20, 2017

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter regarding the Committee on Ways and Means jurisdictional interest in H.R. 1304, *Self-Insurance Protection Act*, as amended. I appreciate your willingness to forgo further consideration of H.R. 1304 by your committee.

I agree that the Committee on Ways and Means has a valid jurisdictional interest in certain provisions of H.R. 1304 and that the committee's jurisdiction will not be adversely affected by your decision to forgo further consideration of the bill. Your committee will be appropriately consulted and involved as this or similar legislation moves forward. As you have requested, I will include a copy of your letter and this response in the committee report for H.R. 1304 and in the Congressional Record during the Floor consideration of this bill. As always, thank you for your cooperation.

Sincerely,

Virginia Foxx

Virginia Foxx
Chairwoman

CC: The Honorable Paul Ryan
The Honorable Bobby Scott
The Honorable Richard Neal
Mr. Thomas J. Wickham, Jr., Parliamentarian

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House Rule XIII, the goal of H.R. 1304 is to help ensure workers and families continue to have access to affordable, flexible self-insured health plans.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 1304 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULE MAKINGS

The committee estimates that enacting H.R. 1304 does not specifically direct the completion of any specific rule makings within the meaning of 5 U.S.C. 551.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the body of this report.

NEW BUDGET AUTHORITY AND CBO COST ESTIMATE COMMITTEE COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause (3)(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee has requested but not received a cost estimate for this bill from the Director of Congressional Budget Office. The Committee has requested but not received from the Director of the Congressional Budget Office a statement as to whether this bill contains any new budget authority, spending authority, credit authority, or an increase or decrease in revenues or tax expenditures.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

* * * * * * *

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

* * * * * * *

SUBTITLE B—REGULATORY PROVISIONS

* * * * * * *

PART 7—GROUP HEALTH PLAN REQUIREMENTS

* * * * * * *

SUBPART C—GENERAL PROVISIONS

* * * * * * *

SEC. 733. DEFINITIONS.

(a) GROUP HEALTH PLAN.—For purposes of this part—

(1) IN GENERAL.—The term "group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).

(2) MEDICAL CARE.—The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this part—

(1) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. *Such term shall not include a stop-loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.*

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term "group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(c) EXCEPTED BENEFITS.—For purposes of this part, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Se-

curity Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—For purposes of this part—

(1) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Part 6 of this subtitle.

(B) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(C) Title XXII of the Public Health Service Act.

(2) HEALTH STATUS-RELATED FACTOR.—The term "health status-related factor" means any of the factors described in section 702(a)(1).

(3) NETWORK PLAN.—The term "network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(4) PLACED FOR ADOPTION.—The term "placement", or being "placed", for adoption, has the meaning given such term in section 609(c)(3)(B).

(5) FAMILY MEMBER.—The term "family member" means, with respect to an individual—

(A) a dependent (as such term is used for purposes of section 701(f)(2)) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(6) GENETIC INFORMATION.—

(A) IN GENERAL.—The term "genetic information" means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term "genetic information" shall not include information about the sex or age of any individual.

(7) GENETIC TEST.—

(A) IN GENERAL.—The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term "genetic test" does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(8) GENETIC SERVICES.—The term "genetic services" means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(9) UNDERWRITING PURPOSES.—The term "underwriting purposes" means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

* * * * * * *

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

* * * * * * *

PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 2791. DEFINITIONS.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. Except for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).

(2) MEDICAL CARE.—The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(3) TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701(e).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

(1) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. *Such term shall not include a stop-loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.*

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a)),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term "group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(5) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term "individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) EXCEPTED BENEFITS.—For purposes of this title, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—

(1) APPLICABLE STATE AUTHORITY.—The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such issuer.

(2) BENEFICIARY.—The term "beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974.

(3) BONA FIDE ASSOCIATION.—The term "bona fide association" means, with respect to health insurance coverage offered in a State, an association which—

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual

(including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

(4) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of such Act.

(C) Title XXII of this Act.

(5) EMPLOYEE.—The term "employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(6) EMPLOYER.—The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two or more employees.

(7) CHURCH PLAN.—The term "church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(8) GOVERNMENTAL PLAN.—(A) The term "governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal governmental plan.

(B) FEDERAL GOVERNMENTAL PLAN.—The term "Federal governmental plan" means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(C) NON-FEDERAL GOVERNMENTAL PLAN.—The term "non-Federal governmental plan" means a governmental plan that is not a Federal governmental plan.

(9) HEALTH STATUS-RELATED FACTOR.—The term "health status-related factor" means any of the factors described in section 2702(a)(1).

(10) NETWORK PLAN.—The term "network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(11) PARTICIPANT.—The term "participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(12) PLACED FOR ADOPTION DEFINED.—The term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(13) PLAN SPONSOR.—The term "plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(14) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(15) FAMILY MEMBER.—The term "family member" means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 2701(f)(2)) of such individual; and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(16) GENETIC INFORMATION.—

(A) IN GENERAL.—The term "genetic information" means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term "genetic information" shall not include information about the sex or age of any individual.

(17) GENETIC TEST.—

(A) IN GENERAL.—The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term "genetic test" does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(18) GENETIC SERVICES.—The term "genetic services" means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(19) UNDERWRITING PURPOSES.—The term "underwriting purposes" means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(20) QUALIFIED HEALTH PLAN.—The term "qualified health plan" has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

(21) EXCHANGE.—The term "Exchange" means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—For purposes of this title:

(1) INDIVIDUAL MARKET.—

(A) IN GENERAL.—The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) TREATMENT OF VERY SMALL GROUPS.—

(i) IN GENERAL.—Subject to clause (ii), such terms includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) LARGE EMPLOYER.—The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) LARGE GROUP MARKET.—The term "large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) SMALL EMPLOYER.—The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average

of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.

(5) SMALL GROUP MARKET.—The term "small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(7) STATE OPTION TO EXTEND DEFINITION OF SMALL EMPLOYER.—Notwithstanding paragraphs (2) and (4), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

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INTERNAL REVENUE CODE OF 1986

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Subtitle K—Group Health Plan Requirements

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CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

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Subchapter C—General Provisions

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SEC. 9832. DEFINITIONS.

(a) GROUP HEALTH PLAN.—For purposes of this chapter, the term "group health plan" has the meaning given to such term by section 5000(b)(1).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this chapter—

(1) HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. *Such term shall not include a stop-loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.*

(B) NO APPLICATION TO CERTAIN EXCEPTED BENEFITS.—In applying subparagraph (A), excepted benefits described in subsection (c)(1) shall not be treated as benefits consisting of medical care.

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(c) EXCEPTED BENEFITS.—For purposes of this chapter, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—For purposes of this chapter—

(1) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Section 4980B, other than subsection (f)(1) thereof insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609 of such Act.

(C) Title XXII of the Public Health Service Act.

(2) GOVERNMENTAL PLAN.—The term "governmental plan" has the meaning given such term by section 414(d).

(3) MEDICAL CARE.—The term "medical care" has the meaning given such term by section 213(d) determined without regard to—

(A) paragraph (1)(C) thereof, and

(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.

(4) NETWORK PLAN.—The term "network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(5) PLACED FOR ADOPTION DEFINED.—The term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption

of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(6) FAMILY MEMBER.—The term "family member" means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 9801(f)(2)) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(7) GENETIC INFORMATION.—

(A) IN GENERAL.—The term "genetic information" means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term "genetic information" shall not include information about the sex or age of any individual.

(8) GENETIC TEST.—

(A) IN GENERAL.—The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term "genetic test" does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(9) GENETIC SERVICES.—The term "genetic services" means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(10) UNDERWRITING PURPOSES.—The term "underwriting purposes" means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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MINORITY VIEWS

INTRODUCTION

Committee Democrats are concerned about H.R. 1304, the *Self-Insurance Protection Act* and were also troubled by the Majority's insistence on considering health-related legislation while two other Committees (Energy and Commerce and Ways and Means) simultaneously considered legislation to gut the Affordable Care Act (ACA).

PROGRESS OF THE ACA HELPS SMALL BUSINESSES & WORKING FAMILIES

The ACA took steps to level the playing field for small businesses and workers. The ACA added reforms to ensure that one small business with an older or sick employee or owner is not disadvantaged compared to other small businesses. The medical loss ratio provision of the ACA requires insurance, including plans that cover small businesses, to spend at least 80% of premiums on health care claims and quality improvement, ensuring that premium dollars go toward the actual health costs of covering the small business and its employees, and not just profits. Further, the ACA created more options for employers and workers through the creation of the Small Business Health Options Program (SHOP) and included a tax credit to defray the cost of health insurance for their employees. The ACA also establishes several safeguards for workers and families. Thanks to the ACA, most insurance plans must now provide coverage without cost sharing for certain preventive health services, including pap smears and mammograms for women, well-child visits, flu shots, and more. Early estimates, after the ACA's passage, showed that there were around 129 million Americans with a pre-existing condition, 82 million of whom were enrolled in employer-based coverage.[1] For these millions of American workers, the ACA means that losing a job does not mean losing health insurance coverage.

THE REPUBLICAN REPLACEMENT PLAN THREATENS THE HEALTH INSURANCE SECURITY OF AMERICAN FAMILIES

Two days prior to the Committee's consideration of the three bills, Republicans released their ACA replacement plan, the *American Health Care Act.* At the same time, a recent poll shows public

[1] Department of Health and Human Services, At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could be Denied Affordable Coverage Without Health Reform, (November 1, 2011) available at: *https://aspe.hhs.gov/sites/default/files/pdf/76376/index.pdf.*

support for the ACA has reached its highest level on record.[2] The Ways and Means and Energy and Commerce Committees moved the bill forward through the Committee process, despite the fact that the Congressional Budget Office had not yet released estimates on the legislation's impact on coverage or cost. Committee Democrats expressed their concern about the lack of transparency in moving the bill forward and also further expressed concern that the markup in the Education and the Workforce Committee occurred simultaneous to this process—essentially forcing the Committee to consider legislation that represents a moving target.

SELF-INSURANCE CAN POSE RISKS TO SMALL BUSINESSES AND WORKERS

A self-insured group health plan (or a 'self-funded' plan) is one in which the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for each out-of-pocket claim as it is incurred instead of paying a fixed premium to an insurance carrier, like a fully-insured plan. Both fully insured and self-insured plans are regulated by the Employee Retirement Income Security Act of 1974 (ERISA). However, self-insured plans are not required to cover health care services for state-mandated benefits, as fully insured plans are, and they are exempt from certain provisions of the ACA (e.g., the medical loss ratio and the health insurer fee). Because self-insurance may offer advantages—such as greater flexibility in benefit design and lower costs—they are especially attractive to large firms with enough employees to spread risk adequately to avoid the financial fallout from potentially catastrophic medical costs of a single employee or a few employees.

It is common for self-insured plans to purchase stop-loss insurance which protects plans from catastrophic financial losses. Stop-loss is not regulated at the federal level and enjoys limited and varied regulation at the state level. In many cases, the lines are blurred between stop-loss insurance and conventional insurance; a self-insured plan with a specific attachment point (the point in which the stop-loss begins coverage) of $5,000 functions in the same way as a plan with a $5,000 deductible.[3]

All employers face risks when self-insuring, but small employers run the risk of incurring unmanageable losses if an employee suffers an unexpected injury or illness. Although some risk can be mitigated by obtaining stop-loss insurance, stop-loss coverage also presents its own risks. While these policies can be cheaper for employers with a healthier and younger workforce, the premiums can be increased or workers can be denied renewal if their health declines or they become more expensive to cover. Stop-loss insurance can pick its market and its availability is not guaranteed for an employer.

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[2] Pew Research Center, *Support for 2010 Health Care Law Reaches New High,* (February 23, 2017) available at: *http://www.pewresearch.org/fact-tank/2017/02/23/support-for-2010-health-care-law-reaches-new-high/*.

[3] Center for American Progress, *"The Threat of Self-Insured Plans Among Small Businesses"*, (June 19, 2013) available at: *https://www.americanprogress.org/issues/healthcare/reports/2013/06/19/65790/the-threat-of-self-insured-plans-among-small-businesses/*.

Stop-loss policies also often engage in lasering. Lasering is the practice of assigning a different attachment point or denying coverage altogether for an employee based on health status, allowing stop-loss insurers to set higher attachment points for employees with costly pre-existing conditions, which then transfers the liability for these employees' costs back to the employer and employee.[4] While the ACA explicitly prevents this discriminatory practice, this protection does not apply to self-funded plans.[5] Stop-loss also often requires notification if "new risk" is incurred. Employers are legally prohibited from discriminating on the basis of health status, but stop-loss insurers are not, and many of the policies have provisions that will trigger immediate, or even retroactive, increased premiums when the stop-loss insurer receives greater-than-expected claims.[6] For these and other reasons, the National Association of Insurance Commissioners has indicated that, ". . . because stop loss insurance products are not generally required to conform to state or federal health insurance law, including the ACA, there may be exposure to additional risk in some stop loss insurance products that is not immediately apparent."[7]

COMMITTEE CONSIDERATION OF H.R. 1304

Committee Democrats do not oppose the use of stop-loss insurance to help employers mitigate their risk when they choose to self-insure; Democrats also want to make certain that both employers and employees are protected when self-insuring and purchasing stop-loss and are aware of the risks of doing so.

The *Self-Insurance Protection Act*, introduced by Representative Roe, would provide that stop-loss insurance is not health insurance coverage for the purposes of ERISA, the Public Health Service Act, and the Internal Revenue Code. Due to a "Request for Information Regarding Stop Loss Insurance" issued in 2012 by the Departments of Treasury/Labor/Health and Human Services,[8] there was concern that the administration would regulate stop-loss insurance. This legislation was previously introduced largely in response to that concern. There has been no recent indication that the federal government is seeking to regulate stop-loss insurance, though some consumer groups and researchers have expressed concern about the inadequacy of the current regulatory framework for stop-loss.

Some states have taken action to address the concerns and threats that stop-loss insurance can pose to employers and workers, particularly small businesses. For example, Connecticut issued guidance to insurers prohibiting them from imposing an attachment point for a single enrollee that is greater than three times the

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[4] Center on Health Insurance Reform Blog Post, *As Self-Funding Increases in Popularity, Two States Step up to Address Potential Stop-Loss Policy Concerns*, (March 11, 2016) available at: *http://chirblog.org/as-self-funding-increases-in-popularity-two-states-step-up/*.

[5] *Id.*

[6] National Association of Insurance Commissioners, *White Paper: Stop Loss Insurance, Self-funding and the ACA*, (2015) available at: *http://www.naic.org/documents/SLI_SF.pdf.*

[7] *Id.*

[8] Departments of the Treasury, Labor, and Health and Human Services, *Request for Information Regarding Stop Loss Insurance,* (May 1, 2012) available at: *http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=26054&AgencyId=8&DocumentType=3.*

attachment point for the overall policy.[9] Some states, including Delaware, New York, and Oregon, have prohibited the sale of stop-loss to small employers.[10] North Carolina permits stop-loss insurance, but regulates it as if it were normal health insurance when it is provided to small employers.[11]

Democrats offered a number of amendments to make improvements to the bill. The first amendment, offered by Representative Takano, expressed a sense of Congress that any health care insurance legislation should build on the current progress of the ACA, as measured by CBO analysis that demonstrates improvements in cost and coverage. That amendment was withdrawn.

Representative Bonamici offered a clarifying amendment to ensure that the legislation would not be construed to restrict the ability of states to regulate stop-loss policies. She explained, "Several states, including my home state of Oregon, have regulations in place to protect consumers, both business owners and employees, when it comes to stop-loss insurance. I am concerned that the bill before us may preempt those consumer protections and prevent a State from determining how to best regulate the stop-loss insurance being offered within its borders." At the request of Ranking Member Scott, Chairwoman Foxx agreed to include such clarifying language in the Committee report, accepting and agreeing with the intent of Representative Bonamici's amendment. This clarification is vital to ensuring that nothing in the bill is erroneously construed to preempt or restrict states' ability to regulate stop-loss policies as states see fit or otherwise restrict effective oversight and regulation of these policies at the state level. Based on the understanding between Chairwoman Foxx and Ranking Member Scott that this clarification would be included in the Committee's official report, Representative Bonamici withdrew her amendment.

Representative Polis offered an amendment to create a public insurance option, which was ruled not germane. Committee Democrats remain committed to building on the progress of the ACA and proposing constructive measures, such as the public option, that will increase competition and help drive down costs for working families.

While Democrats continue to be concerned about the lack of clarity of the legislation and the possible unintended consequences, Committee Democrats have worked with the Majority to ensure that report language addresses some of these concerns, particularly those raised by the Bonamici amendment.

H.R. 1304 was favorably reported, as amended, by voice vote.

CONCLUSION

After seven years of disparaging the ACA, Republicans released a repeal and replacement plan that will leave millions of Americans worse off. Meanwhile, legislation considered in the Committee would not work to build on the progress of the ACA or improve and

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[9] Center on Health Insurance Reform Blog Post, *As Self-Funding Increases in Popularity, Two States Step up to Address Potential Stop-Loss Policy Concerns,* (March 11, 2016) available at: *http://chirblog.org/as-self-funding-increases-in-popularity-two-states-step-up/*.

[10] Mark Hall, *Regulating Stop-Loss Coverage May Be Needed To Deter Self-Insuring Small Employers From Undermining Market Reforms, Health Affairs,* (February 2012), available at: *http://content.healthaffairs.org/content/31/2/316.full#ref-16.*

[11] *Id.*

expand coverage. Committee Democrats continue to express concerns about the ambiguity of H.R. 1304, the *Self-Insurance Protection Act* and its impact on current and future state regulation of stop-loss insurance, particularly as Republicans seek to dismantle the entirety of the ACA. Committee Democrats are committed to health care as a right, not a privilege for only the healthiest and wealthiest Americans.

ROBERT C. "BOBBY" SCOTT,
Ranking Member.
SUSAN A. DAVIS.
RAÚL M. GRIJALVA.
JOE COURTNEY.
MARCIA L. FUDGE.
JARED POLIS.
GREGORIO KILILI CAMACHO SABLAN.
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ALMA S. ADAMS.
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