I

104TH CONGRESS
2D SESSION

H. R. 2893

To provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 25, 1996

Mrs. ROUKEMA introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means and Economic and Educational Opportunities, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Reform Act of 1996''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. DEFINITIONS.

As used in this Act:

(1) BENEFICIARY.—The term ''beneficiary'' has the meaning given such term under section 3(8) of

the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(8)).

(2) EMPLOYEE.—The term ''employee'' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)).

(3) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

(4) EMPLOYEE HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ''employee health benefit plan'' means any employee welfare benefit plan, governmental plan, or church plan (as defined under paragraphs (1), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002 (1), (32), and (33))) that provides or pays for health benefits (such as provider and hospital benefits) for participants and beneficiaries whether—

(i) directly;

(ii) through a group health plan offered by a health plan issuer as defined in paragraph (8); or

(iii) otherwise.

(B) RULE OF CONSTRUCTION.—An employee health benefit plan shall not be construed to be a group health plan, an individual health plan, or a health plan issuer.

(C) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

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

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

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

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

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(5) FAMILY.—

(A) IN GENERAL.—The term ''family'' means an individual, the individual's spouse, and the child of the individual (if any).

(B) CHILD.—For purposes of subparagraph (A), the term ''child'' means any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986.

(6) GROUP HEALTH PLAN.—

(A) IN GENERAL.—The term ''group health plan'' means any contract, policy, certificate or other arrangement offered by a health plan issuer to a group purchaser that provides or pays for health benefits (such as provider and hospital benefits) in connection with an employee health benefit plan.

(B) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

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

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

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

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

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(7) GROUP PURCHASER.—The term ''group purchaser'' means any person (as defined under paragraph (9) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(9)) or entity that purchases or pays for health benefits (such as provider or hospital benefits) on behalf of two or more participants or beneficiaries in connection with an employee health benefit plan. A health plan purchasing cooperative established under section 131 shall not be considered to be a group purchaser.

(8) HEALTH PLAN ISSUER.—The term ''health plan issuer'' means any entity that is licensed (prior to or after the date of enactment of this Act) by a State to offer a group health plan or an individual health plan.

(9) PARTICIPANT.—The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(7)).

(10) 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 (29 U.S.C. 1002(16)(B)).

(11) SECRETARY.—The term ''Secretary'', unless specifically provided otherwise, means the Secretary of Labor.

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

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

SEC. 101. GUARANTEED AVAILABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) NONDISCRIMINATION.—Except as provided in subsection (b), section 102 and section 103—

(A) a health plan issuer offering a group health plan may not decline to offer whole group coverage to a group purchaser desiring to purchase such coverage; and

(B) an employee health benefit plan or a health plan issuer offering a group health plan may establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements under the terms of such plan, except that such requirements shall not be based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability.

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall prevent an employee health benefit plan or a health plan is-

suer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(b) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering a group health plan may cease offering coverage to group purchasers under the plan if—

(A) the health plan issuer ceases to offer coverage to any additional group purchasers; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)), if required, that its financial or provider capacity to serve previously covered participants and beneficiaries (and additional participants and beneficiaries who will be expected to enroll because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer is required to offer coverage to additional group purchasers.

Such health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage

under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering a group health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer offers coverage to group purchasers under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(c) CONSTRUCTION.—

(1) MARKETING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering group health plans to actively market such plans.

(2) INVOLUNTARY OFFERING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to require a health plan issuer to involuntarily offer group health plans in a particular market. For the purposes of this paragraph, the term ''market'' means either the large employer market or the small employer market (as defined under appli-

cable State law, or if not so defined, an employer with not more than 50 employees).

SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) GROUP PURCHASER.—Subject to subsections (b) and (c), a group health plan shall be renewed or continued in force by a health plan issuer at the option of the group purchaser, except that the requirement of this subparagraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the group purchaser in accordance with the terms of the group health plan or where the health plan issuer has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the group purchaser;

(C) the termination of the group health plan in accordance with subsection (b); or

(D) the failure of the group purchaser to meet contribution or participation requirements in accordance with paragraph (3).

(2) PARTICIPANT.—Subject to subsections (b) and (c), coverage under an employee health benefit

plan or group health plan shall be renewed or continued in force, if the group purchaser elects to continue to provide coverage under such plan, at the option of the participant (or beneficiary where such right exists under the terms of the plan or under applicable law), except that the requirement of this paragraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the participant or beneficiary in accordance with the terms of the employee health benefit plan or group health plan or where such plan has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the participant or beneficiary relating to an application for coverage or claim for benefits;

(C) the termination of the employee health benefit plan or group health plan;

(D) loss of eligibility for continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.); or

(E) failure of a participant or beneficiary to meet requirements for eligibility for coverage

under an employee health benefit plan or group health plan that are not prohibited by this Act.

(3) RULES OF CONSTRUCTION.—Nothing in this subsection, nor in section 101(a), shall be construed to—

(A) preclude a health plan issuer from establishing employer contribution rules or group participation rules for group health plans as allowed under applicable State law;

(B) preclude a plan defined in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1102(37)) from establishing employer contribution rules or group participation rules; or

(C) permit individuals to decline coverage under an employee health benefit plan if such right is not otherwise available under such plan.

(b) TERMINATION OF GROUP HEALTH PLANS.—

(1) PARTICULAR TYPE OF GROUP HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of group health plan, a group health plan of such type may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each group purchaser covered under a group health plan of this type (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 90 days prior to the date of the discontinuation of such plan;

(B) the health plan issuer offers to each group purchaser covered under a group health plan of this type, the option to purchase any other group health plan currently being offered by the health plan issuer; and

(C) in exercising the option to discontinue a group health plan of this type and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status or insurability of participants or beneficiaries covered under the group health plan, or new participants or beneficiaries who may become eligible for coverage under the group health plan.

(2) DISCONTINUANCE OF ALL GROUP HEALTH PLANS.—

(A) IN GENERAL.—In any case in which a health plan issuer elects to discontinue offering

all group health plans in a State, a group health plan may be discontinued by the health plan issuer only if—

(i) the health plan issuer provides notice to the applicable certifying authority (as defined in section 202(d)) and to each group purchaser (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 180 days prior to the date of the expiration of such plan; and

(ii) all group health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(B) APPLICATION OF PROVISIONS.—The provisions of this paragraph and paragraph (3) may be applied separately by a health plan issuer—

(i) to all group health plans offered to small employers (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees); or

(ii) to all other group health plans offered by the health plan issuer in the State.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any group health plan in the market sector (as described in paragraph (2)(B)) in which issuance of such group health plan was discontinued in the State involved during the 5-year period beginning on the date of the discontinuation of the last group health plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A network plan (as defined in paragraph (2)) may deny continued participation under such plan to participants or beneficiaries who neither live, reside, nor work in an area in which such network plan is offered, but only if such denial is applied uniformly, without regard to health status or the insurability of particular participants or beneficiaries.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an employee health benefit plan or a group health plan that arranges for the financing and delivery of health care

services to participants or beneficiaries covered under such plan, in whole or in part, through arrangements with providers.

(d) COBRA COVERAGE.—Nothing in subsection (a)(2)(E) or subsection (c) shall be construed to affect any right to COBRA continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

SEC. 103. PORTABILITY OF HEALTH COVERAGE AND LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition based on the fact that the condition existed prior to the coverage of the participant or beneficiary under the plan only if—

(1) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan;

(2) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth or placement for adoption (as determined under section 609(c)(3)(B) of the Employee Retire-

ment Income Security Act of 1974 (29 U.S.C. 1169(c)(3)(B)), was covered under the plan; and

(3) the limitation or exclusion does not apply to a pregnancy.

(b) CREDITING OF PREVIOUS QUALIFYING COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (4), an employee health benefit plan or a health plan issuer offering a group health plan shall provide that if a participant or beneficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of previous qualifying coverage. With respect to an individual described in subsection (a)(2) who maintains continuous coverage, no limitation or exclusion of benefits relating to treatment of a preexisting condition may be applied to a child within the child's first 12 months of life or within 12 months after the placement of a child for adoption.

(2) DISCHARGE OF DUTY.—An employee health benefit plan shall provide documentation of coverage to participants and beneficiaries whose coverage is

terminated under the plan. Pursuant to regulations promulgated by the Secretary, the duty of an employee health benefit plan to verify previous qualifying coverage with respect to a participant or beneficiary is effectively discharged when such employee health benefit plan provides documentation to a participant or beneficiary that includes the following information:

(A) the dates that the participant or beneficiary was covered under the plan; and

(B) the benefits and cost-sharing arrangement available to the participant or beneficiary under such plan.

An employee health benefit plan shall retain the documentation provided to a participant or beneficiary under subparagraphs (A) and (B) for at least the 12-month period following the date on which the participant or beneficiary ceases to be covered under the plan. Upon request, an employee health benefit plan shall provide a second copy of such documentation to such participant or beneficiary within the 12-month period following the date of such ineligibility.

(3) DEFINITIONS.—As used in this section:

(A) PREVIOUS QUALIFYING COVERAGE.—The term ''previous qualifying coverage'' means the period beginning on the date—

(i) a participant or beneficiary is enrolled under an employee health benefit plan or a group health plan, and ending on the date the participant or beneficiary is not so enrolled; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) or under a public or private health plan established under Federal or State law, and ending on the date the individual is not so enrolled;

for a continuous period of more than 30 days (without regard to any waiting period).

(B) LIMITATION OR EXCLUSION OF BENEFITS RELATING TO TREATMENT OF A PREEXISTING CONDITION.—The term ''limitation or exclusion of benefits relating to treatment of a preexisting condition'' means a limitation or exclusion of benefits imposed on an individual based on a preexisting condition of such individual.

(4) EFFECT OF PREVIOUS COVERAGE.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition, subject to the limits in subsection (a)(1), only to the extent that such service or benefit was not previously covered under the group health plan, employee health benefit plan, or individual health plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(c) LATE ENROLLEES.—Except as provided in section 104, with respect to a participant or beneficiary enrolling in an employee health benefit plan or a group health plan during a time that is other than the first opportunity to enroll during an enrollment period of at least 30 days, coverage with respect to benefits or services relating to the treatment of a preexisting condition in accordance with subsections (a) and (b) may be excluded, except the period of such exclusion may not exceed 18 months beginning on the date of coverage under the plan.

(d) AFFILIATION PERIODS.—With respect to a participant or beneficiary who would otherwise be eligible to receive benefits under an employee health benefit plan or a group health plan but for the operation of a preexisting

condition limitation or exclusion, if such plan does not utilize a limitation or exclusion of benefits relating to the treatment of a preexisting condition, such plan may impose an affiliation period on such participant or beneficiary not to exceed 60 days (or in the case of a late participant or beneficiary described in subsection (c), 90 days) from the date on which the participant or beneficiary would otherwise be eligible to receive benefits under the plan. An employee health benefit plan or a health plan issuer offering a group health plan may also use alternative methods to address adverse selection as approved by the applicable certifying authority (as defined in section 202(d)). During such an affiliation period, the plan may not be required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

(e) PREEXISTING CONDITION.—For purposes of this section, the term ''preexisting condition'' means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before the effective date of the coverage (without regard to any waiting period).

(f) STATE FLEXIBILITY.—Nothing in this section shall be construed to preempt State laws that—

(1) require health plan issuers to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods that are shorter than those provided for under this section; or

(2) allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 30-day period provided for under subsection (b)(3);

unless such laws are preempted by section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 104. SPECIAL ENROLLMENT PERIODS.

In the case of a participant, beneficiary or family member who—

(1) through marriage, separation, divorce, death, birth or placement of a child for adoption, experiences a change in family composition affecting eligibility under a group health plan, individual health plan, or employee health benefit plan;

(2) experiences a change in employment status, as described in section 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C.

1163(2)), that causes the loss of eligibility for coverage, other than COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan; or

(3) experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan because of a change in the employment status of a family member;

each employee health benefit plan and each group health plan shall provide for a special enrollment period extending for a reasonable time after such event that would permit the participant to change the individual or family basis of coverage or to enroll in the plan if coverage would have been available to such individual, participant, or beneficiary but for failure to enroll during a previous enrollment period. Such a special enrollment period shall ensure that a child born or placed for adoption shall be deemed to be covered under the plan as of the date of such birth or placement for adoption if such child is enrolled within 30 days of the date of such birth or placement for adoption.

SEC. 105. DISCLOSURE OF INFORMATION.

(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.—

(1) IN GENERAL.—In connection with the offering of any group health plan to a small employer (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees), a health plan issuer shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of—

(A) the provisions of such group health plan concerning the health plan issuer's right to change premium rates and the factors that may affect changes in premium rates;

(B) the provisions of such group health plan relating to renewability of coverage;

(C) the provisions of such group health plan relating to any preexisting condition provision; and

(D) descriptive information about the benefits and premiums available under all group health plans for which the employer is qualified.

Information shall be provided to small employers under this paragraph in a manner determined to be understandable by the average small employer, and shall be sufficiently accurate and comprehensive to reasonably inform small employers, participants and

beneficiaries of their rights and obligations under the group health plan.

(2) EXCEPTION.—With respect to the requirement of paragraph (1), any information that is proprietary and trade secret information under applicable law shall not be subject to the disclosure requirements of such paragraph.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to preempt State reporting and disclosure requirements to the extent that such requirements are not preempted under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(b) DISCLOSURE OF INFORMATION TO PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) is amended in the matter following subparagraph (B)—

(A) by striking ''102(a)(1),'' and inserting ''102(a)(1) that is not a material reduction in covered services or benefits provided,''; and

(B) by adding at the end thereof the following new sentences: ''If there is a modification or change described in section 102(a)(1)

that is a material reduction in covered services or benefits provided, a summary description of such modification or change shall be furnished to participants not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Reform Act of 1996, providing alternative mechanisms to delivery by mail through which employee health benefit plans may notify participants of material reductions in covered services or benefits.''.

(2) PLAN DESCRIPTION AND SUMMARY.—Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended—

(A) by inserting ''including the office or title of the individual who is responsible for approving or denying claims for coverage of benefits'' after ''type of administration of the plan'';

(B) by inserting ''including the name of the organization responsible for financing

claims'' after ''source of financing of the plan''; and

(C) by inserting ''including the office, contact, or title of the individual at the Department of Labor through which participants may seek assistance or information regarding their rights under this Act and the Health Insurance Reform Act of 1996 with respect to health benefits that are not offered through a group health plan.'' after ''benefits under the plan''.

Subtitle B—Individual Market Rules

SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.

(a) LIMITATION ON REQUIREMENTS.—

(1) IN GENERAL.—With respect to an individual desiring to enroll in an individual health plan, if such individual is in a period of previous qualifying coverage (as defined in section 103(b)(3)(A)(i)) under one or more group health plans or employee health benefit plans that commenced 18 or more months prior to the date on which such individual desires to enroll in the individual plan, a health plan issuer described in paragraph (3) may not decline to offer coverage to such individual, or deny enrollment to such individual based on the health status, medi-

cal condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability of the individual, except as described in subsections (b) and (c).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall be construed to prevent a health plan issuer offering an individual health plan from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion or disease prevention.

(3) HEALTH PLAN ISSUER.—A health plan issuer described in this paragraph is a health plan issuer that issues or renews individual health plans.

(4) PREMIUMS.—Nothing in this subsection shall be construed to affect the determination of a health plan issuer as to the amount of the premium payable under an individual health plan under applicable State law.

(b) ELIGIBILITY FOR OTHER GROUP COVERAGE.—The provisions of subsection (a) shall not apply to an individual who is eligible for coverage under a group health plan or an employee health benefit plan, or who has had coverage terminated under a group health plan or employee health benefit plan for failure to make required pre-

mium payments or contributions, or for fraud or misrepresentation of material fact, or who is otherwise eligible for continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) or under an equivalent State program.

(c) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering coverage to individuals under an individual health plan may cease enrolling individuals under the plan if—

(A) the health plan issuer ceases to enroll any new individuals; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 202(d)), if required, that its financial or provider capacity to serve previously covered individuals will be impaired if the health plan issuer is required to enroll additional individuals.

Such a health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section

202(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering coverage to individuals under an individual health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer provides for enrollment of individuals under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(d) MARKET REQUIREMENTS.—

(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals.

(2) CONVERSION POLICIES.—A health plan issuer offering group health plans to group purchasers under this Act shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

(3) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering coverage to in-

dividuals under an individual health plan to actively market such plan.

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE.

(a) IN GENERAL.—Subject to subsections (b) and (c), coverage for individuals under an individual health plan shall be renewed or continued in force by a health plan issuer at the option of the individual, except that the requirement of this subsection shall not apply in the case of—

(1) the nonpayment of premiums or contributions by the individual in accordance with the terms of the individual health plan or where the health plan issuer has not received timely premium payments;

(2) fraud or misrepresentation of material fact on the part of the individual; or

(3) the termination of the individual health plan in accordance with subsection (b).

(b) TERMINATION OF INDIVIDUAL HEALTH PLANS.—

(1) PARTICULAR TYPE OF INDIVIDUAL HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of individual health plan to individuals, an

individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each individual covered under the plan of such discontinuation at least 90 days prior to the date of the expiration of the plan;

(B) the health plan issuer offers to each individual covered under the plan the option to purchase any other individual health plan currently being offered by the health plan issuer to individuals; and

(C) in exercising the option to discontinue the individual health plan and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status or insurability of particular individuals.

(2) DISCONTINUANCE OF ALL INDIVIDUAL HEALTH PLANS.—In any case in which a health plan issuer elects to discontinue all individual health plans in a State, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to the applicable certifying authority (as defined in section 202(d)) and to each individual covered under the plan of such discontinuation at

least 180 days prior to the date of the discontinuation of the plan; and

(B) all individual health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any individual health plan in the State involved during the 5-year period beginning on the date of the discontinuation of the last plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan issuer which offers a network plan (as defined in paragraph (2)) may deny continued participation under the plan to individuals who neither live, reside, nor work in an area in which the individual health plan is offered, but only if such denial is applied uniformly, without regard to health status or the insurability of particular individuals.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an individual health plan that arranges for the financing and de-

livery of health care services to individuals covered under such health plan, in whole or in part, through arrangements with providers.

SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

(a) IN GENERAL.—With respect to any State law with respect to which the Governor of the State notifies the Secretary of Health and Human Services that such State law will achieve the goals of sections 110 and 111, and that is in effect on, or enacted after, the date of enactment of this Act (such as laws providing for guaranteed issue, open enrollment by one or more health plan issuers, high-risk pools, or mandatory conversion policies), such State law shall apply in lieu of the standards described in sections 110 and 111 unless the Secretary of Health and Human Services determines, after considering the criteria described in subsection (b)(1), in consultation with the Governor and Insurance Commissioner or chief insurance regulatory official of the State, that such State law does not achieve the goals of providing access to affordable health care coverage for those individuals described in sections 110 and 111.

(b) DETERMINATION.—

(1) IN GENERAL.—In making a determination under subsection (a), the Secretary of Health and Human Services shall only—

(A) evaluate whether the State law or program provides guaranteed access to affordable coverage to individuals described in sections 110 and 111;

(B) evaluate whether the State law or program provides coverage for preexisting conditions (as defined in section 103(e)) that were covered under the individuals' previous group health plan or employee health benefit plan for individuals described in sections 110 and 111;

(C) evaluate whether the State law or program provides individuals described in sections 110 and 111 with a choice of health plans or a health plan providing comprehensive coverage; and

(D) evaluate whether the application of the standards described in sections 110 and 111 will have an adverse impact on the number of individuals in such State having access to affordable coverage.

(2) NOTICE OF INTENT.—If, within 6 months after the date of enactment of this Act, the Governor

of a State notifies the Secretary of Health and Human Services that the State intends to enact a law, or modify an existing law, described in subsection (a), the Secretary of Health and Human Services may not make a determination under such subsection until the expiration of the 12-month period beginning on the date on which such notification is made, or until January 1, 1998, whichever is later. With respect to a State that provides notice under this paragraph and that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act, the Secretary shall not make a determination under subsection (a) prior to January 1, 1998.

(3) NOTICE TO STATE.—If the Secretary of Health and Human Services determines that a State law or program does not achieve the goals described in subsection (a), the Secretary of Health and Human Services shall provide the State with adequate notice and reasonable opportunity to modify such law or program to achieve such goals prior to making a final determination under subsection (a).

(c) ADOPTION OF NAIC MODEL.—If, not later than 9 months after the date of enactment of this Act—

(1) the National Association of Insurance Commissioners (hereafter referred to as the ''NAIC''), through a process which the Secretary of Health and Human Services determines has included consultation with representatives of the insurance industry and consumer groups, adopts a model standard or standards for reform of the individual health insurance market; and

(2) the Secretary of Health and Human Services determines, within 30 days of the adoption of such NAIC standard or standards, that such standards comply with the goals of sections 110 and 111;

a State that elects to adopt such model standards or substantially adopt such model standards shall be deemed to have met the requirements of sections 110 and 111 and shall not be subject to a determination under subsection (a).

SEC. 113. DEFINITION.

(a) IN GENERAL.—As used in this title, the term ''individual health plan'' means any contract, policy, certificate or other arrangement offered to individuals by a health plan issuer that provides or pays for health benefits (such as provider and hospital benefits) and that is not a group health plan under section 2(6).

(b) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

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

(2) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

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

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

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Coverage for a specified disease or illness.

(8) Hospital or fixed indemnity insurance.

(9) Short-term limited duration insurance.

(10) Credit-only, dental-only, or vision-only insurance.

(11) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subtitle C—COBRA Clarifications

SEC. 121. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by inserting ", or a beneficiary-family member of the individual," after "an individual"; and

(II) by striking "at the time of a qualifying event described in section 2203(2)" and inserting "at any time during the initial 18-month period of continuing coverage under this title";

(B) in subparagraph (D)(i), by inserting before ", or" the following: ", except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section be-

cause of the provision of the Health Insurance Reform Act of 1996''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(2) ELECTION.—Section 2205(1)(C) of the Public Health Service Act (42 U.S.C. 300bb-5(1)(C)) is amended—

(A) in clause (i), by striking ''or'' at the end thereof;

(B) in clause (ii), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new clause:

''(iii) in the case of an individual described in the last sentence of section 2202(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 2206(3) of the Public Health Service Act (42 U.S.C. 300bb-6(3)) is amended by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting

''at any time during the initial 18-month period of continuing coverage under this title''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 2208(3)(A) of the Public Health Service Act (42 U.S.C. 300bb-8(3)(A)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this title.''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) PERIOD OF COVERAGE.—Section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended—

(A) in the last sentence of subparagraph (A)—

(i) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(ii) by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part'';

(B) in subparagraph (D)(i), by inserting before ‘‘, or’’ the following: ‘‘, except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1996’’; and

(C) in subparagraph (E), by striking ‘‘at the time of a qualifying event described in section 603(2)’’ and inserting ‘‘at any time during the initial 18-month period of continuing coverage under this part’’.

(2) ELECTION.—Section 605(1)(C) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(1)(C)) is amended—

(A) in clause (i), by striking ‘‘or’’ at the end thereof;

(B) in clause (ii), by striking the period and inserting ‘‘, or’’; and

(C) by adding at the end thereof the following new clause:

‘‘(iii) in the case of an individual described in the last sentence of section

602(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 606(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(3)) is amended by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this part.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i) by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at

any time during the initial 18-month period of continuing coverage under this section'';

(B) in clause (iv)(I), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this subclause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this subsection because of the provision of the Health Insurance Reform Act of 1996''; and

(C) in clause (v), by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(2) ELECTION.—Section 4980B(f)(5)(A)(iii) of the Internal Revenue Code of 1986 is amended—

(A) in subclause (I), by striking ''or'' at the end thereof;

(B) in subclause (II), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new subclause:

''(III) in the case of an qualified beneficiary described in the last sentence of paragraph (2)(B)(i), the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 4980B(g)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring on or after the date of the enactment of this Act for plan years beginning after December 31, 1997.

(e) NOTIFICATION OF CHANGES.—Not later than 60 days prior to the date on which this section becomes effec-

tive, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

Subtitle D—Private Health Plan Purchasing Cooperatives

SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERATIVES.

(a) DEFINITION.—As used in this Act, the term ''health plan purchasing cooperative'' means a group of individuals or employers that, on a voluntary basis and in accordance with this section, form a cooperative for the purpose of purchasing individual health plans or group health plans offered by health plan issuers. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of insurance may not underwrite a cooperative.

(b) CERTIFICATION.—

(1) IN GENERAL.—If a group described in subsection (a) desires to form a health plan purchasing cooperative in accordance with this section and such group appropriately notifies the State and the Sec-

retary of such desire, the State, upon a determination that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall make a determination of whether such group meets the requirements of this section in a timely fashion. Each such cooperative shall also be registered with the Secretary.

(2) STATE REFUSAL TO CERTIFY.—If a State fails to implement a program for certifying health plan purchasing cooperatives in accordance with the standards under this Act, the Secretary shall certify and oversee the operations of such cooperatives in such State.

(3) INTERSTATE COOPERATIVES.—For purposes of this section, a health plan purchasing cooperative operating in more than one State shall be certified by the State in which the cooperative is domiciled. States may enter into cooperative agreements for the purpose of certifying and overseeing the operation of such cooperatives. For purposes of this subsection, a cooperative shall be considered to be domiciled in the State in which most of the members of the cooperative reside.

(c) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each health plan purchasing cooperative shall be governed by a Board of Directors that shall be responsible for ensuring the performance of the duties of the cooperative under this section. The Board shall be composed of a broad cross-section of representatives of employers, employees, and individuals participating in the cooperative. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of individual health plans or group health plans may not hold or control any right to vote with respect to a cooperative.

(2) LIMITATION ON COMPENSATION.—A health plan purchasing cooperative may not provide compensation to members of the Board of Directors. The cooperative may provide reimbursements to such members for the reasonable and necessary expenses incurred by the members in the performance of their duties as members of the Board.

(3) CONFLICT OF INTEREST.—No member of the Board of Directors (or family members of such members) nor any management personnel of the cooperative may be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representa-

tive of any health plan issuer, health care provider, or agent or broker. Nothing in the preceding sentence shall limit a member of the Board from purchasing coverage offered through the cooperative.

(d) MEMBERSHIP AND MARKETING AREA.—

(1) MEMBERSHIP.—A health plan purchasing cooperative may establish limits on the maximum size of employers who may become members of the cooperative, and may determine whether to permit individuals to become members. Upon the establishment of such membership requirements, the cooperative shall, except as provided in subparagraph (B), accept all employers (or individuals) residing within the area served by the cooperative who meet such requirements as members on a first-come, first-served basis, or on another basis established by the State to ensure equitable access to the cooperative.

(2) MARKETING AREA.—A State may establish rules regarding the geographic area that must be served by a health plan purchasing cooperative. With respect to a State that has not established such rules, a health plan purchasing cooperative operating in the State shall define the boundaries of the area to be served by the cooperative, except that such boundaries may not be established on the basis of

health status or insurability of the populations that reside in the area.

(e) DUTIES AND RESPONSIBILITIES.—

(1) IN GENERAL.—A health plan purchasing cooperative shall—

(A) enter into agreements with multiple, unaffiliated health plan issuers, except that the requirement of this subparagraph shall not apply in regions (such as remote or frontier areas) in which compliance with such requirement is not possible;

(B) enter into agreements with employers and individuals who become members of the cooperative;

(C) participate in any program of risk-adjustment or reinsurance, or any similar program, that is established by the State;

(D) prepare and disseminate comparative health plan materials (including information about cost, quality, benefits, and other information concerning group health plans and individual health plans offered through the cooperative);

(E) actively market to all eligible employers and individuals residing within the service area; and

(F) act as an ombudsman for group health plan or individual health plan enrollees.

(2) PERMISSIBLE ACTIVITIES.—A health plan purchasing cooperative may perform such other functions as necessary to further the purposes of this Act, including—

(A) collecting and distributing premiums and performing other administrative functions;

(B) collecting and analyzing surveys of enrollee satisfaction;

(C) charging membership fee to enrollees (such fees may not be based on health status) and charging participation fees to health plan issuers;

(D) cooperating with (or accepting as members) employers who provide health benefits directly to participants and beneficiaries only for the purpose of negotiating with providers; and

(E) negotiating with health care providers and health plan issuers.

(f) LIMITATIONS ON COOPERATIVE ACTIVITIES.—A health plan purchasing cooperative shall not—

(1) perform any activity relating to the licensing of health plan issuers;

(2) assume financial risk directly or indirectly on behalf of members of a health plan purchasing cooperative relating to any group health plan or individual health plan;

(3) establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements for participants, beneficiaries, or individuals based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability;

(4) operate on a for-profit or other basis where the legal structure of the cooperative permits profits to be made and not returned to the members of the cooperative, except that a for-profit health plan purchasing cooperative may be formed by a nonprofit organization—

(A) in which membership in such organization is not based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability; and

(B) that accepts as members all employers or individuals on a first-come, first-served basis, subject to any established limit on the maximum size of and employer that may become a member; or

(5) perform any other activities that conflict or are inconsistent with the performance of its duties under this Act.

(g) LIMITED PREEMPTION OF CERTAIN STATE LAWS.—

(1) IN GENERAL.—With respect to a health plan purchasing cooperative that meets the requirements of this section, State fictitious group laws shall be preempted.

(2) HEALTH PLAN ISSUERS.—

(A) RATING.—With respect to a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative that meets the requirements of this section, State premium rating requirement laws, except to the extent provided under subparagraph (B), shall be preempted unless such laws permit premium rates negotiated by the cooperative to be less than rates that would otherwise be permitted under State law, if such

rating differential is not based on differences in health status or demographic factors.

(B) EXCEPTION.—State laws referred to in subparagraph (A) shall not be preempted if such laws—

(i) prohibit the variance of premium rates among employers, plan sponsors, or individuals that are members of a health plan purchasing cooperative in excess of the amount of such variations that would be permitted under such State rating laws among employers, plan sponsors, and individuals that are not members of the cooperative; and

(ii) prohibit a percentage increase in premium rates for a new rating period that is in excess of that which would be permitted under State rating laws.

(C) BENEFITS.—Except as provided in subparagraph (D), a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative shall comply with all State mandated benefit laws that require the offering of any services,

category or care, or services of any class or type of provider.

(D) EXCEPTION.—In those States that have enacted laws authorizing the issuance of alternative benefit plans to small employers, health plan issuers may offer such alternative benefit plans through a health plan purchasing cooperative that meets the requirements of this section.

(h) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to—

(1) require that a State organize, operate, or otherwise create health plan purchasing cooperatives;

(2) otherwise require the establishment of health plan purchasing cooperatives;

(3) require individuals, plan sponsors, or employers to purchase group health plans or individual health plans through a health plan purchasing cooperative;

(4) require that a health plan purchasing cooperative be the only type of purchasing arrangement permitted to operate in a State;

(5) confer authority upon a State that the State would not otherwise have to regulate health plan issuers or employee health benefits plans; or

(6) confer authority upon a State (or the Federal Government) that the State (or Federal Government) would not otherwise have to regulate group purchasing arrangements, coalitions, or other similar entities that do not desire to become a health plan purchasing cooperative in accordance with this section.

(i) APPLICATION OF ERISA.—For purposes of enforcement only, the requirements of parts 4 and 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101) shall apply to a health plan purchasing cooperative as if such plan were an employee welfare benefit plan.

TITLE II—APPLICATION AND ENFORCEMENT OF STANDARDS

SEC. 201. APPLICABILITY.

(a) CONSTRUCTION.—

(1) ENFORCEMENT.—

(A) IN GENERAL.—A requirement or standard imposed under this Act on a group health plan or individual health plan offered by a health plan issuer shall be deemed to be a requirement or standard imposed on the health plan issuer. Such requirements or standards shall be enforced by the State insurance com-

missioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act. In the case of a group health plan offered by a health plan issuer in connection with an employee health benefit plan, the requirements or standards imposed under this Act shall be enforced with respect to the health plan issuer by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this Act.

(B) LIMITATION.—Except as provided in subsection (c), the Secretary shall not enforce the requirements or standards of this Act as they relate to health plan issuers, group health plans, or individual health plans. In no case shall a State enforce the requirements or standards of this Act as they relate to employee health benefit plans.

(2) PREEMPTION OF STATE LAW.—Nothing in this Act shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements—

(A) not prescribed in this Act; or

(B) related to the issuance, renewal, or portability of health insurance or the establishment or operation of group purchasing arrangements, that are consistent with, and are not in direct conflict with, this Act and provide greater protection or benefit to participants, beneficiaries or individuals.

(b) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(c) CONTINUATION.—Nothing in this Act shall be construed as requiring a group health plan or an employee health benefit plan to provide benefits to a particular participant or beneficiary in excess of those provided under the terms of such plan.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) HEALTH PLAN ISSUERS.—Each State shall require that each group health plan and individual health plan issued, sold, renewed, offered for sale or operated in such State by a health plan issuer meet the standards established under this Act pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrat-

ing effective implementation of the State enforcement plan.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—With respect to employee health benefit plans, the Secretary shall enforce the reform standards established under this Act in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c)(1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(c) FAILURE TO IMPLEMENT PLAN.—In the case of the failure of a State to substantially enforce the standards and requirements set forth in this Act with respect to group health plans and individual health plans as provided for under the State enforcement plan filed under subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, shall implement an enforcement plan meeting the standards of this Act in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this Act, each health plan issuer operating in such State shall be subject to civil enforcement as provided for under sections 502, 504, 506, and 510 of the Employee Retire-

ment Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c)(1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(d) APPLICABLE CERTIFYING AUTHORITY.—As used in this title, the term ''applicable certifying authority'' means, with respect to—

(1) health plan issuers, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this Act for the State involved; and

(2) an employee health benefit plan, the Secretary.

(e) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this Act.

(f) TECHNICAL AMENDMENT.—Section 508 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1138) is amended by inserting ''and under the Health Insurance Reform Act of 1996'' before the period.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. HMOS ALLOWED TO OFFER PLANS WITH DEDUCTIBLES TO INDIVIDUALS WITH MEDICAL SAVINGS ACCOUNTS.

Section 1301(b) of the Public Health Service Act (42 U.S.C. 300e(b)) is amended by adding at the end the following new paragraph:

''(6)(A) If a member certifies that a medical savings account has been established for the benefit of such member, a health maintenance organization may, at the request of such member reduce the basic health services payment otherwise determined under paragraph (1) by requiring the payment of a deductible by the member for basic health services.

''(B) For purposes of this paragraph, the term 'medical savings account' means an account which, by its terms, allows the deposit of funds and the use of such funds and income derived from the investment of such funds for the payment of the deductible described in subparagraph (A).''.

SEC. 302. HEALTH COVERAGE AVAILABILITY STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary, representatives of State officials, consumers, and other rep-

resentatives of individuals and entities that have expertise in health insurance and employee benefits, shall conduct a two-part study, and prepare and submit reports, in accordance with this section.

(b) EVALUATION OF AVAILABILITY.—Not later than January 1, 1998, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning—

(1) an evaluation, based on the experience of States, expert opinions, and such additional data as may be available, of the various mechanisms used to ensure the availability of reasonably priced health coverage to employers purchasing group coverage and to individuals purchasing coverage on a non-group basis; and

(2) whether standards that limit the variation in premiums will further the purposes of this Act.

(c) EVALUATION OF EFFECTIVENESS.—Not later than January 1, 1999, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning the effectiveness of the provisions of this Act and the various State laws, in ensuring the availability of reasonably priced health coverage to employers purchasing group cov-

erage and individuals purchasing coverage on a non-group basis.

SEC. 303. EFFECTIVE DATE.

Except as otherwise provided for in this Act, the provisions of this Act shall apply as follows:

(1) With respect to group health plans and individual health plans, such provisions shall apply to plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1997; and

(2) With respect to employee health benefit plans, on the first day of the first plan year beginning on or after January 1, 1997.

SEC. 304. SEVERABILITY.

If any provision of this Act or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this Act and the application of the provisions of such to any person or circumstance shall not be affected thereby.

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