

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.

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## 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.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Health Insurance Reform Act of 1996”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Definitions.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

- Sec. 101. Guaranteed availability of health coverage.
- Sec. 102. Guaranteed renewability of health coverage.
- Sec. 103. Portability of health coverage and limitation on preexisting condition exclusions.
- Sec. 104. Special enrollment periods.
- Sec. 105. Disclosure of information.

Subtitle B—Individual Market Rules

- Sec. 110. Individual health plan portability.
- Sec. 111. Guaranteed renewability of individual health coverage.
- Sec. 112. State flexibility in individual market reforms.
- Sec. 113. Definition.

Subtitle C—COBRA Clarifications

- Sec. 121. Cobra clarifications.

Subtitle D—Private Health Plan Purchasing Cooperatives

- Sec. 131. Private health plan purchasing cooperatives.

TITLE II—APPLICATION AND ENFORCEMENT OF STANDARDS

- Sec. 201. Applicability.
- Sec. 202. Enforcement of standards.

TITLE III—MISCELLANEOUS PROVISIONS

- Sec. 301. HMOs allowed to offer plans with deductibles to individuals with medical savings accounts.
- Sec. 302. Health coverage availability study.
- Sec. 303. Effective date.
- Sec. 304. Severability.

3 **SEC. 2. DEFINITIONS.**

4 As used in this Act:

5 (1) **BENEFICIARY.**—The term “beneficiary” has  
6 the meaning given such term under section 3(8) of

1 the Employee Retirement Income Security Act of  
2 1974 (29 U.S.C. 1002(8)).

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

7 (3) EMPLOYER.—The term “employer” has the  
8 meaning given such term under section 3(5) of the  
9 Employee Retirement Income Security Act of 1974  
10 (29 U.S.C. 1002(5)), except that such term shall in-  
11 clude only employers of two or more employees.

12 (4) EMPLOYEE HEALTH BENEFIT PLAN.—

13 (A) IN GENERAL.—The term “employee  
14 health benefit plan” means any employee wel-  
15 fare benefit plan, governmental plan, or church  
16 plan (as defined under paragraphs (1), (32),  
17 and (33) of section 3 of the Employee Retire-  
18 ment Income Security Act of 1974 (29 U.S.C.  
19 1002 (1), (32), and (33))) that provides or pays  
20 for health benefits (such as provider and hos-  
21 pital benefits) for participants and beneficiaries  
22 whether—

23 (i) directly;

1 (ii) through a group health plan of-  
2 fered by a health plan issuer as defined in  
3 paragraph (8); or

4 (iii) otherwise.

5 (B) RULE OF CONSTRUCTION.—An em-  
6 ployee health benefit plan shall not be con-  
7 strued to be a group health plan, an individual  
8 health plan, or a health plan issuer.

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

12 (i) Coverage only for accident, or dis-  
13 ability income insurance, or any combina-  
14 tion thereof.

15 (ii) Medicare supplemental health in-  
16 surance (as defined under section  
17 1882(g)(1) of the Social Security Act).

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

20 (iv) Liability insurance, including gen-  
21 eral liability insurance and automobile li-  
22 ability insurance.

23 (v) Workers compensation or similar  
24 insurance.

1 (vi) Automobile medical payment in-  
2 surance.

3 (vii) Coverage for a specified disease  
4 or illness.

5 (viii) Hospital or fixed indemnity in-  
6 surance.

7 (ix) Short-term limited duration in-  
8 surance.

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

11 (xi) A health insurance policy provid-  
12 ing benefits only for long-term care, nurs-  
13 ing home care, home health care, commu-  
14 nity-based care, or any combination there-  
15 of.

16 (5) FAMILY.—

17 (A) IN GENERAL.—The term “family”  
18 means an individual, the individual’s spouse,  
19 and the child of the individual (if any).

20 (B) CHILD.—For purposes of subpara-  
21 graph (A), the term “child” means any individ-  
22 ual who is a child within the meaning of section  
23 151(c)(3) of the Internal Revenue Code of  
24 1986.

25 (6) GROUP HEALTH PLAN.—

1 (A) IN GENERAL.—The term “group  
2 health plan” means any contract, policy, certifi-  
3 cate or other arrangement offered by a health  
4 plan issuer to a group purchaser that provides  
5 or pays for health benefits (such as provider  
6 and hospital benefits) in connection with an em-  
7 ployee health benefit plan.

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

11 (i) Coverage only for accident, or dis-  
12 ability income insurance, or any combina-  
13 tion thereof.

14 (ii) Medicare supplemental health in-  
15 surance (as defined under section  
16 1882(g)(1) of the Social Security Act).

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

19 (iv) Liability insurance, including gen-  
20 eral liability insurance and automobile li-  
21 ability insurance.

22 (v) Workers compensation or similar  
23 insurance.

24 (vi) Automobile medical payment in-  
25 surance.

1 (vii) Coverage for a specified disease  
2 or illness.

3 (viii) Hospital or fixed indemnity in-  
4 surance.

5 (ix) Short-term limited duration in-  
6 surance.

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

9 (xi) A health insurance policy provid-  
10 ing benefits only for long-term care, nurs-  
11 ing home care, home health care, commu-  
12 nity-based care, or any combination there-  
13 of.

14 (7) GROUP PURCHASER.—The term “group  
15 purchaser” means any person (as defined under  
16 paragraph (9) of section 3 of the Employee Retirement  
17 Income Security Act of 1974 (29 U.S.C.  
18 1002(9)) or entity that purchases or pays for health  
19 benefits (such as provider or hospital benefits) on  
20 behalf of two or more participants or beneficiaries in  
21 connection with an employee health benefit plan. A  
22 health plan purchasing cooperative established under  
23 section 131 shall not be considered to be a group  
24 purchaser.

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

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

10          (10) PLAN SPONSOR.—The term “plan spon-  
11 sor” has the meaning given such term under section  
12 3(16)(B) of the Employee Retirement Income Secu-  
13 rity Act of 1974 (29 U.S.C. 1002(16)(B)).

14          (11) SECRETARY.—The term “Secretary”, un-  
15 less specifically provided otherwise, means the Sec-  
16 retary of Labor.

17          (12) STATE.—The term “State” means each of  
18 the several States, the District of Columbia, Puerto  
19 Rico, the United States Virgin Islands, Guam,  
20 American Samoa, and the Commonwealth of the  
21 Northern Mariana Islands.



1 **TITLE I—HEALTH CARE ACCESS,**  
2 **PORTABILITY, AND RENEW-**  
3 **ABILITY**

4 **Subtitle A—Group Market Rules**

5 **SEC. 101. GUARANTEED AVAILABILITY OF HEALTH COV-**  
6 **ERAGE.**

7 (a) IN GENERAL.—

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

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

14 (B) an employee health benefit plan or a  
15 health plan issuer offering a group health plan  
16 may establish eligibility, continuation of eligi-  
17 bility, enrollment, or premium contribution re-  
18 quirements under the terms of such plan, ex-  
19 cept that such requirements shall not be based  
20 on health status, medical condition, claims ex-  
21 perience, receipt of health care, medical history,  
22 evidence of insurability, or disability.

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

1       suer from establishing premium discounts or modify-  
2       ing otherwise applicable copayments or deductibles  
3       in return for adherence to programs of health pro-  
4       motion and disease prevention.

5       (b) APPLICATION OF CAPACITY LIMITS.—

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

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

13            (B) the health plan issuer can demonstrate  
14       to the applicable certifying authority (as defined  
15       in section 202(d)), if required, that its financial  
16       or provider capacity to serve previously covered  
17       participants and beneficiaries (and additional  
18       participants and beneficiaries who will be ex-  
19       pected to enroll because of their affiliation with  
20       a group purchaser or such previously covered  
21       participants or beneficiaries) will be impaired if  
22       the health plan issuer is required to offer cov-  
23       erage to additional group purchasers.

24       Such health plan issuer shall be prohibited from of-  
25       fering coverage after a cessation in offering coverage

1 under this paragraph for a 6-month period or until  
2 the health plan issuer can demonstrate to the appli-  
3 cable certifying authority (as defined in section  
4 202(d)) that the health plan issuer has adequate ca-  
5 pacity, whichever is later.

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

14 (c) CONSTRUCTION.—

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

19 (2) INVOLUNTARY OFFERING OF GROUP  
20 HEALTH PLANS.—Nothing in this section shall be  
21 construed to require a health plan issuer to involun-  
22 tarily offer group health plans in a particular mar-  
23 ket. For the purposes of this paragraph, the term  
24 “market” means either the large employer market or  
25 the small employer market (as defined under appli-

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

3 **SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COV-**  
4 **ERAGE.**

5 (a) IN GENERAL.—

6 (1) GROUP PURCHASER.—Subject to sub-  
7 sections (b) and (c), a group health plan shall be re-  
8 newed or continued in force by a health plan issuer  
9 at the option of the group purchaser, except that the  
10 requirement of this subparagraph shall not apply in  
11 the case of—

12 (A) the nonpayment of premiums or con-  
13 tributions by the group purchaser in accordance  
14 with the terms of the group health plan or  
15 where the health plan issuer has not received  
16 timely premium payments;

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

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

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

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

1 plan or group health plan shall be renewed or con-  
2 tinued in force, if the group purchaser elects to con-  
3 tinue to provide coverage under such plan, at the op-  
4 tion of the participant (or beneficiary where such  
5 right exists under the terms of the plan or under ap-  
6 plicable law), except that the requirement of this  
7 paragraph shall not apply in the case of—

8 (A) the nonpayment of premiums or con-  
9 tributions by the participant or beneficiary in  
10 accordance with the terms of the employee  
11 health benefit plan or group health plan or  
12 where such plan has not received timely pre-  
13 mium payments;

14 (B) fraud or misrepresentation of material  
15 fact on the part of the participant or bene-  
16 ficiary relating to an application for coverage or  
17 claim for benefits;

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

20 (D) loss of eligibility for continuation cov-  
21 erage as described in part 6 of subtitle B of  
22 title I of the Employee Retirement Income Se-  
23 curity Act of 1974 (29 U.S.C. 1161 et seq.); or

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

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

3           (3) RULES OF CONSTRUCTION.—Nothing in  
4           this subsection, nor in section 101(a), shall be con-  
5           strued to—

6                   (A) preclude a health plan issuer from es-  
7                   tablishing employer contribution rules or group  
8                   participation rules for group health plans as al-  
9                   lowed under applicable State law;

10                   (B) preclude a plan defined in section  
11                   3(37) of the Employee Retirement Income Se-  
12                   curity Act of 1974 (29 U.S.C. 1102(37)) from  
13                   establishing employer contribution rules or  
14                   group participation rules; or

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

18           (b) TERMINATION OF GROUP HEALTH PLANS.—

19                   (1) PARTICULAR TYPE OF GROUP HEALTH  
20                   PLAN NOT OFFERED.—In any case in which a health  
21                   plan issuer decides to discontinue offering a particu-  
22                   lar type of group health plan, a group health plan  
23                   of such type may be discontinued by the health plan  
24                   issuer only if—

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

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

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

22 (2) DISCONTINUANCE OF ALL GROUP HEALTH  
23 PLANS.—

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

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

4 (i) the health plan issuer provides no-  
5 tice to the applicable certifying authority  
6 (as defined in section 202(d)) and to each  
7 group purchaser (and participants and  
8 beneficiaries covered under such group  
9 health plan) of such discontinuation at  
10 least 180 days prior to the date of the ex-  
11 piration of such plan; and

12 (ii) all group health plans issued or  
13 delivered for issuance in the State are dis-  
14 continued and coverage under such plans is  
15 not renewed.

16 (B) APPLICATION OF PROVISIONS.—The  
17 provisions of this paragraph and paragraph (3)  
18 may be applied separately by a health plan is-  
19 suer—

20 (i) to all group health plans offered to  
21 small employers (as defined under applica-  
22 ble State law, or if not so defined, an em-  
23 ployer with not more than 50 employees);  
24 or



1 (ii) to all other group health plans of-  
2 fered by the health plan issuer in the  
3 State.

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

13 (c) TREATMENT OF NETWORK PLANS.—

14 (1) GEOGRAPHIC LIMITATIONS.—A network  
15 plan (as defined in paragraph (2)) may deny contin-  
16 ued participation under such plan to participants or  
17 beneficiaries who neither live, reside, nor work in an  
18 area in which such network plan is offered, but only  
19 if such denial is applied uniformly, without regard to  
20 health status or the insurability of particular partici-  
21 pants or beneficiaries.

22 (2) NETWORK PLAN.—As used in paragraph  
23 (1), the term “network plan” means an employee  
24 health benefit plan or a group health plan that ar-  
25 ranges for the financing and delivery of health care

1 services to participants or beneficiaries covered  
2 under such plan, in whole or in part, through ar-  
3 rangements with providers.

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

9 **SEC. 103. PORTABILITY OF HEALTH COVERAGE AND LIM-**  
10 **TATION ON PREEXISTING CONDITION EXCLU-**  
11 **SIONS.**

12 (a) **IN GENERAL.**—An employee health benefit plan  
13 or a health plan issuer offering a group health plan may  
14 impose a limitation or exclusion of benefits relating to  
15 treatment of a preexisting condition based on the fact that  
16 the condition existed prior to the coverage of the partici-  
17 pant or beneficiary under the plan only if—

18 (1) the limitation or exclusion extends for a pe-  
19 riod of not more than 12 months after the date of  
20 enrollment in the plan;

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

1 ment Income Security Act of 1974 (29 U.S.C.  
2 1169(c)(3)(B)), was covered under the plan; and

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

5 (b) CREDITING OF PREVIOUS QUALIFYING COV-  
6 ERAGE.—

7 (1) IN GENERAL.—Subject to paragraph (4), an  
8 employee health benefit plan or a health plan issuer  
9 offering a group health plan shall provide that if a  
10 participant or beneficiary is in a period of previous  
11 qualifying coverage as of the date of enrollment  
12 under such plan, any period of exclusion or limita-  
13 tion of coverage with respect to a preexisting condi-  
14 tion shall be reduced by 1 month for each month in  
15 which the participant or beneficiary was in the pe-  
16 riod of previous qualifying coverage. With respect to  
17 an individual described in subsection (a)(2) who  
18 maintains continuous coverage, no limitation or ex-  
19 clusion of benefits relating to treatment of a pre-  
20 existing condition may be applied to a child within  
21 the child's first 12 months of life or within 12  
22 months after the placement of a child for adoption.

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

1 terminated under the plan. Pursuant to regulations  
2 promulgated by the Secretary, the duty of an em-  
3 ployee health benefit plan to verify previous qualify-  
4 ing coverage with respect to a participant or bene-  
5 ficiary is effectively discharged when such employee  
6 health benefit plan provides documentation to a par-  
7 ticipant or beneficiary that includes the following in-  
8 formation:

9 (A) the dates that the participant or bene-  
10 ficiary was covered under the plan; and

11 (B) the benefits and cost-sharing arrange-  
12 ment available to the participant or beneficiary  
13 under such plan.

14 An employee health benefit plan shall retain the doc-  
15 umentation provided to a participant or beneficiary  
16 under subparagraphs (A) and (B) for at least the  
17 12-month period following the date on which the  
18 participant or beneficiary ceases to be covered under  
19 the plan. Upon request, an employee health benefit  
20 plan shall provide a second copy of such documenta-  
21 tion to such participant or beneficiary within the 12-  
22 month period following the date of such ineligibility.

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

1 (A) PREVIOUS QUALIFYING COVERAGE.—

2 The term “previous qualifying coverage” means  
3 the period beginning on the date—

4 (i) a participant or beneficiary is en-  
5 rolled under an employee health benefit  
6 plan or a group health plan, and ending on  
7 the date the participant or beneficiary is  
8 not so enrolled; or

9 (ii) an individual is enrolled under an  
10 individual health plan (as defined in sec-  
11 tion 113) or under a public or private  
12 health plan established under Federal or  
13 State law, and ending on the date the indi-  
14 vidual is not so enrolled;

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

17 (B) LIMITATION OR EXCLUSION OF BENE-

18 FITS RELATING TO TREATMENT OF A PRE-

19 EXISTING CONDITION.—The term “limitation or

20 exclusion of benefits relating to treatment of a

21 preexisting condition” means a limitation or ex-

22 clusion of benefits imposed on an individual

23 based on a preexisting condition of such individ-

24 ual.

1           (4) EFFECT OF PREVIOUS COVERAGE.—An em-  
2           ployee health benefit plan or a health plan issuer of-  
3           fering a group health plan may impose a limitation  
4           or exclusion of benefits relating to the treatment of  
5           a preexisting condition, subject to the limits in sub-  
6           section (a)(1), only to the extent that such service  
7           or benefit was not previously covered under the  
8           group health plan, employee health benefit plan, or  
9           individual health plan in which the participant or  
10          beneficiary was enrolled immediately prior to enroll-  
11          ment in the plan involved.

12          (c) LATE ENROLLEES.—Except as provided in sec-  
13          tion 104, with respect to a participant or beneficiary en-  
14          rolling in an employee health benefit plan or a group  
15          health plan during a time that is other than the first op-  
16          portunity to enroll during an enrollment period of at least  
17          30 days, coverage with respect to benefits or services relat-  
18          ing to the treatment of a preexisting condition in accord-  
19          ance with subsections (a) and (b) may be excluded, except  
20          the period of such exclusion may not exceed 18 months  
21          beginning on the date of coverage under the plan.

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

1 condition limitation or exclusion, if such plan does not uti-  
2 lize a limitation or exclusion of benefits relating to the  
3 treatment of a preexisting condition, such plan may im-  
4 pose an affiliation period on such participant or bene-  
5 ficiary not to exceed 60 days (or in the case of a late par-  
6 ticipant or beneficiary described in subsection (c), 90  
7 days) from the date on which the participant or bene-  
8 ficiary would otherwise be eligible to receive benefits under  
9 the plan. An employee health benefit plan or a health plan  
10 issuer offering a group health plan may also use alter-  
11 native methods to address adverse selection as approved  
12 by the applicable certifying authority (as defined in section  
13 202(d)). During such an affiliation period, the plan may  
14 not be required to provide health care services or benefits  
15 and no premium shall be charged to the participant or  
16 beneficiary.

17 (e) PREEXISTING CONDITION.—For purposes of this  
18 section, the term “preexisting condition” means a condi-  
19 tion, regardless of the cause of the condition, for which  
20 medical advice, diagnosis, care, or treatment was rec-  
21 ommended or received within the 6-month period ending  
22 on the day before the effective date of the coverage (with-  
23 out regard to any waiting period).

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

1           (1) require health plan issuers to impose a limi-  
2           tation or exclusion of benefits relating to the treat-  
3           ment of a preexisting condition for periods that are  
4           shorter than those provided for under this section;  
5           or

6           (2) allow individuals, participants, and bene-  
7           ficiaries to be considered to be in a period of pre-  
8           vious qualifying coverage if such individual, partici-  
9           pant, or beneficiary experiences a lapse in coverage  
10          that is greater than the 30-day period provided for  
11          under subsection (b)(3);

12 unless such laws are preempted by section 514 of the Em-  
13 ployee Retirement Income Security Act of 1974 (29  
14 U.S.C. 1144).

15 **SEC. 104. SPECIAL ENROLLMENT PERIODS.**

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

18           (1) through marriage, separation, divorce,  
19           death, birth or placement of a child for adoption, ex-  
20           periences a change in family composition affecting  
21           eligibility under a group health plan, individual  
22           health plan, or employee health benefit plan;

23           (2) experiences a change in employment status,  
24           as described in section 603(2) of the Employee Re-  
25           tirement Income Security Act of 1974 (29 U.S.C.



1 1163(2)), that causes the loss of eligibility for cov-  
2 erage, other than COBRA continuation coverage  
3 under a group health plan, individual health plan, or  
4 employee health benefit plan; or

5 (3) experiences a loss of eligibility under a  
6 group health plan, individual health plan, or em-  
7 ployee health benefit plan because of a change in the  
8 employment status of a family member;

9 each employee health benefit plan and each group health  
10 plan shall provide for a special enrollment period extend-  
11 ing for a reasonable time after such event that would per-  
12 mit the participant to change the individual or family basis  
13 of coverage or to enroll in the plan if coverage would have  
14 been available to such individual, participant, or bene-  
15 ficiary but for failure to enroll during a previous enroll-  
16 ment period. Such a special enrollment period shall ensure  
17 that a child born or placed for adoption shall be deemed  
18 to be covered under the plan as of the date of such birth  
19 or placement for adoption if such child is enrolled within  
20 30 days of the date of such birth or placement for adop-  
21 tion.

22 **SEC. 105. DISCLOSURE OF INFORMATION.**

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

1           (1) IN GENERAL.—In connection with the offer-  
2           ing of any group health plan to a small employer (as  
3           defined under applicable State law, or if not so de-  
4           fined, an employer with not more than 50 employ-  
5           ees), a health plan issuer shall make a reasonable  
6           disclosure to such employer, as part of its sollicita-  
7           tion and sales materials, of—

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

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

14                  (C) the provisions of such group health  
15                  plan relating to any preexisting condition provi-  
16                  sion; and

17                  (D) descriptive information about the ben-  
18                  efits and premiums available under all group  
19                  health plans for which the employer is qualified.

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

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

3 (2) EXCEPTION.—With respect to the require-  
4 ment of paragraph (1), any information that is pro-  
5 prietary and trade secret information under applica-  
6 ble law shall not be subject to the disclosure require-  
7 ments of such paragraph.

8 (3) CONSTRUCTION.—Nothing in this sub-  
9 section shall be construed to preempt State report-  
10 ing and disclosure requirements to the extent that  
11 such requirements are not preempted under section  
12 514 of the Employee Retirement Income Security  
13 Act of 1974 (29 U.S.C. 1144).

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

16 (1) IN GENERAL.—Section 104(b)(1) of the  
17 Employee Retirement Income Security Act of 1974  
18 (29 U.S.C. 1024(b)(1)) is amended in the matter  
19 following subparagraph (B)—

20 (A) by striking “102(a)(1),” and inserting  
21 “102(a)(1) that is not a material reduction in  
22 covered services or benefits provided,”; and

23 (B) by adding at the end thereof the fol-  
24 lowing new sentences: “If there is a modifica-  
25 tion or change described in section 102(a)(1)

1           that is a material reduction in covered services  
2           or benefits provided, a summary description of  
3           such modification or change shall be furnished  
4           to participants not later than 60 days after the  
5           date of the adoption of the modification or  
6           change. In the alternative, the plan sponsors  
7           may provide such description at regular inter-  
8           vals of not more than 90 days. The Secretary  
9           shall issue regulations within 180 days after the  
10          date of enactment of the Health Insurance Re-  
11          form Act of 1996, providing alternative mecha-  
12          nisms to delivery by mail through which em-  
13          ployee health benefit plans may notify partici-  
14          pants of material reductions in covered services  
15          or benefits.”.

16           (2) PLAN DESCRIPTION AND SUMMARY.—Sec-  
17          tion 102(b) of the Employee Retirement Income Se-  
18          curity Act of 1974 (29 U.S.C. 1022(b)) is amend-  
19          ed—

20                   (A) by inserting “including the office or  
21                   title of the individual who is responsible for ap-  
22                   proving or denying claims for coverage of bene-  
23                   fits” after “type of administration of the plan”;

24                   (B) by inserting “including the name of  
25                   the organization responsible for financing

1 claims” after “source of financing of the plan”;  
2 and

3 (C) by inserting “including the office, con-  
4 tact, or title of the individual at the Depart-  
5 ment of Labor through which participants may  
6 seek assistance or information regarding their  
7 rights under this Act and the Health Insurance  
8 Reform Act of 1996 with respect to health ben-  
9 efits that are not offered through a group  
10 health plan.” after “benefits under the plan”.

## 11 **Subtitle B—Individual Market** 12 **Rules**

### 13 **SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.**

14 (a) LIMITATION ON REQUIREMENTS.—

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

1 cal condition, claims experience, receipt of health  
2 care, medical history, evidence of insurability, or dis-  
3 ability of the individual, except as described in sub-  
4 sections (b) and (c).

5 (2) HEALTH PROMOTION AND DISEASE PRE-  
6 VENTION.—Nothing in this subsection shall be con-  
7 strued to prevent a health plan issuer offering an in-  
8 dividual health plan from establishing premium dis-  
9 counts or modifying otherwise applicable copayments  
10 or deductibles in return for adherence to programs  
11 of health promotion or disease prevention.

12 (3) HEALTH PLAN ISSUER.—A health plan is-  
13 suer described in this paragraph is a health plan is-  
14 suer that issues or renews individual health plans.

15 (4) PREMIUMS.—Nothing in this subsection  
16 shall be construed to affect the determination of a  
17 health plan issuer as to the amount of the premium  
18 payable under an individual health plan under appli-  
19 cable State law.

20 (b) ELIGIBILITY FOR OTHER GROUP COVERAGE.—  
21 The provisions of subsection (a) shall not apply to an indi-  
22 vidual who is eligible for coverage under a group health  
23 plan or an employee health benefit plan, or who has had  
24 coverage terminated under a group health plan or em-  
25 ployee health benefit plan for failure to make required pre-

1 mium payments or contributions, or for fraud or misrepre-  
2 sentation of material fact, or who is otherwise eligible for  
3 continuation coverage as described in part 6 of subtitle  
4 B of title I of the Employee Retirement Income Security  
5 Act of 1974 (29 U.S.C. 1161 et seq.) or under an equiva-  
6 lent State program.

7 (c) APPLICATION OF CAPACITY LIMITS.—

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

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

14 (B) the health plan issuer can demonstrate  
15 to the applicable certifying authority (as defined  
16 in section 202(d)), if required, that its financial  
17 or provider capacity to serve previously covered  
18 individuals will be impaired if the health plan  
19 issuer is required to enroll additional individ-  
20 uals.

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

1 202(d)) that the health plan issuer has adequate ca-  
2 pacity, whichever is later.

3 (2) FIRST-COME-FIRST-SERVED.—A health plan  
4 issuer offering coverage to individuals under an indi-  
5 vidual health plan is only eligible to exercise the lim-  
6 itations provided for in paragraph (1) if the health  
7 plan issuer provides for enrollment of individuals  
8 under such plan on a first-come-first-served basis or  
9 other basis established by a State to ensure a fair  
10 opportunity to enroll in the plan and avoid risk se-  
11 lection.

12 (d) MARKET REQUIREMENTS.—

13 (1) IN GENERAL.—The provisions of subsection  
14 (a) shall not be construed to require that a health  
15 plan issuer offering group health plans to group pur-  
16 chasers offer individual health plans to individuals.

17 (2) CONVERSION POLICIES.—A health plan is-  
18 suer offering group health plans to group purchasers  
19 under this Act shall not be deemed to be a health  
20 plan issuer offering an individual health plan solely  
21 because such health plan issuer offers a conversion  
22 policy.

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



1 individuals under an individual health plan to actively  
2 market such plan.

3 **SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL**  
4 **HEALTH COVERAGE.**

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

11 (1) the nonpayment of premiums or contribu-  
12 tions by the individual in accordance with the terms  
13 of the individual health plan or where the health  
14 plan issuer has not received timely premium pay-  
15 ments;

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

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

20 (b) TERMINATION OF INDIVIDUAL HEALTH  
21 PLANS.—

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

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

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

7 (B) the health plan issuer offers to each  
8 individual covered under the plan the option to  
9 purchase any other individual health plan cur-  
10 rently being offered by the health plan issuer to  
11 individuals; and

12 (C) in exercising the option to discontinue  
13 the individual health plan and in offering one or  
14 more replacement plans, the health plan issuer  
15 acts uniformly without regard to the health sta-  
16 tus or insurability of particular individuals.

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

22 (A) the health plan issuer provides notice  
23 to the applicable certifying authority (as defined  
24 in section 202(d)) and to each individual cov-  
25 ered under the plan of such discontinuation at

1           least 180 days prior to the date of the dis-  
2           continuation of the plan; and

3           (B) all individual health plans issued or  
4           delivered for issuance in the State are discon-  
5           tinued and coverage under such plans is not re-  
6           newed.

7           (3) PROHIBITION ON MARKET REENTRY.—In  
8           the case of a discontinuation under paragraph (2),  
9           the health plan issuer may not provide for the issu-  
10          ance of any individual health plan in the State in-  
11          volved during the 5-year period beginning on the  
12          date of the discontinuation of the last plan not so  
13          renewed.

14          (c) TREATMENT OF NETWORK PLANS.—

15           (1) GEOGRAPHIC LIMITATIONS.—A health plan  
16          issuer which offers a network plan (as defined in  
17          paragraph (2)) may deny continued participation  
18          under the plan to individuals who neither live, re-  
19          side, nor work in an area in which the individual  
20          health plan is offered, but only if such denial is ap-  
21          plied uniformly, without regard to health status or  
22          the insurability of particular individuals.

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

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

4 **SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET RE-**  
5 **FORMS.**

6 (a) IN GENERAL.—With respect to any State law  
7 with respect to which the Governor of the State notifies  
8 the Secretary of Health and Human Services that such  
9 State law will achieve the goals of sections 110 and 111,  
10 and that is in effect on, or enacted after, the date of enact-  
11 ment of this Act (such as laws providing for guaranteed  
12 issue, open enrollment by one or more health plan issuers,  
13 high-risk pools, or mandatory conversion policies), such  
14 State law shall apply in lieu of the standards described  
15 in sections 110 and 111 unless the Secretary of Health  
16 and Human Services determines, after considering the cri-  
17 teria described in subsection (b)(1), in consultation with  
18 the Governor and Insurance Commissioner or chief insur-  
19 ance regulatory official of the State, that such State law  
20 does not achieve the goals of providing access to affordable  
21 health care coverage for those individuals described in sec-  
22 tions 110 and 111.

23 (b) DETERMINATION.—

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

4           (A) evaluate whether the State law or pro-  
5 gram provides guaranteed access to affordable  
6 coverage to individuals described in sections  
7 110 and 111;

8           (B) evaluate whether the State law or pro-  
9 gram provides coverage for preexisting condi-  
10 tions (as defined in section 103(e)) that were  
11 covered under the individuals' previous group  
12 health plan or employee health benefit plan for  
13 individuals described in sections 110 and 111;

14           (C) evaluate whether the State law or pro-  
15 gram provides individuals described in sections  
16 110 and 111 with a choice of health plans or  
17 a health plan providing comprehensive coverage;  
18 and

19           (D) evaluate whether the application of the  
20 standards described in sections 110 and 111  
21 will have an adverse impact on the number of  
22 individuals in such State having access to af-  
23 fordable coverage.

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

1 of a State notifies the Secretary of Health and  
2 Human Services that the State intends to enact a  
3 law, or modify an existing law, described in sub-  
4 section (a), the Secretary of Health and Human  
5 Services may not make a determination under such  
6 subsection until the expiration of the 12-month pe-  
7 riod beginning on the date on which such notifica-  
8 tion is made, or until January 1, 1998, whichever is  
9 later. With respect to a State that provides notice  
10 under this paragraph and that has a legislature that  
11 does not meet within the 12-month period beginning  
12 on the date of enactment of this Act, the Secretary  
13 shall not make a determination under subsection (a)  
14 prior to January 1, 1998.

15 (3) NOTICE TO STATE.—If the Secretary of  
16 Health and Human Services determines that a State  
17 law or program does not achieve the goals described  
18 in subsection (a), the Secretary of Health and  
19 Human Services shall provide the State with ade-  
20 quate notice and reasonable opportunity to modify  
21 such law or program to achieve such goals prior to  
22 making a final determination under subsection (a).

23 (c) ADOPTION OF NAIC MODEL.—If, not later than  
24 9 months after the date of enactment of this Act—

1           (1) the National Association of Insurance Com-  
2           missioners (hereafter referred to as the “NAIC”),  
3           through a process which the Secretary of Health and  
4           Human Services determines has included consulta-  
5           tion with representatives of the insurance industry  
6           and consumer groups, adopts a model standard or  
7           standards for reform of the individual health insur-  
8           ance market; and

9           (2) the Secretary of Health and Human Serv-  
10          ices determines, within 30 days of the adoption of  
11          such NAIC standard or standards, that such stand-  
12          ards comply with the goals of sections 110 and 111;  
13          a State that elects to adopt such model standards or sub-  
14          stantially adopt such model standards shall be deemed to  
15          have met the requirements of sections 110 and 111 and  
16          shall not be subject to a determination under subsection  
17          (a).

18          **SEC. 113. DEFINITION.**

19          (a) IN GENERAL.—As used in this title, the term “in-  
20          dividual health plan” means any contract, policy, certifi-  
21          cate or other arrangement offered to individuals by a  
22          health plan issuer that provides or pays for health benefits  
23          (such as provider and hospital benefits) and that is not  
24          a group health plan under section 2(6).

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

3 (1) Coverage only for accident, or disability in-  
4 come insurance, or any combination thereof.

5 (2) Medicare supplemental health insurance (as  
6 defined under section 1882(g)(1) of the Social Secu-  
7 rity Act).

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

10 (4) Liability insurance, including general liabil-  
11 ity insurance and automobile liability insurance.

12 (5) Workers' compensation or similar insurance.

13 (6) Automobile medical payment insurance.

14 (7) Coverage for a specified disease or illness.

15 (8) Hospital or fixed indemnity insurance.

16 (9) Short-term limited duration insurance.

17 (10) Credit-only, dental-only, or vision-only in-  
18 surance.

19 (11) A health insurance policy providing bene-  
20 fits only for long-term care, nursing home care,  
21 home health care, community-based care, or any  
22 combination thereof.

## 23 **Subtitle C—COBRA Clarifications**

### 24 **SEC. 121. COBRA CLARIFICATIONS.**

25 (a) PUBLIC HEALTH SERVICE ACT.—



1           (1) PERIOD OF COVERAGE.—Section 2202(2) of  
2 the Public Health Service Act (42 U.S.C. 300bb-  
3 2(2)) is amended—

4           (A) in subparagraph (A)—

5           (i) by transferring the sentence imme-  
6 diately preceding clause (iv) so as to ap-  
7 pear immediately following such clause  
8 (iv); and

9           (ii) in the last sentence (as so trans-  
10 ferred)—

11           (I) by inserting “, or a bene-  
12 ficiary-family member of the individ-  
13 ual,” after “an individual”; and

14           (II) by striking “at the time of a  
15 qualifying event described in section  
16 2203(2)” and inserting “at any time  
17 during the initial 18-month period of  
18 continuing coverage under this title”;

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

1 cause of the provision of the Health Insurance  
2 Reform Act of 1996”; and

3 (C) in subparagraph (E), by striking “at  
4 the time of a qualifying event described in sec-  
5 tion 2203(2)” and inserting “at any time dur-  
6 ing the initial 18-month period of continuing  
7 coverage under this title”.

8 (2) ELECTION.—Section 2205(1)(C) of the  
9 Public Health Service Act (42 U.S.C. 300bb-  
10 5(1)(C)) is amended—

11 (A) in clause (i), by striking “or” at the  
12 end thereof;

13 (B) in clause (ii), by striking the period  
14 and inserting “, or”; and

15 (C) by adding at the end thereof the fol-  
16 lowing new clause:

17 “(iii) in the case of an individual de-  
18 scribed in the last sentence of section  
19 2202(2)(A), or a beneficiary-family mem-  
20 ber of the individual, the date such individ-  
21 ual is determined to have been disabled.”.

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

1 “at any time during the initial 18-month period of  
2 continuing coverage under this title”.

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

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

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

13 (1) PERIOD OF COVERAGE.—Section 602(2) of  
14 the Employee Retirement Income Security Act of  
15 1974 (29 U.S.C. 1162(2)) is amended—

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

18 (i) by inserting “, or a beneficiary-  
19 family member of the individual,” after  
20 “an individual”; and

21 (ii) by striking “at the time of a  
22 qualifying event described in section  
23 603(2)” and inserting “at any time during  
24 the initial 18-month period of continuing  
25 coverage under this part”;

1 (B) in subparagraph (D)(i), by inserting  
2 before “, or” the following: “, except that the  
3 exclusion or limitation contained in this clause  
4 shall not be considered to apply to a plan under  
5 which a preexisting condition or exclusion does  
6 not apply to an individual otherwise eligible for  
7 continuation coverage under this section be-  
8 cause of the provision of the Health Insurance  
9 Reform Act of 1996”; and

10 (C) in subparagraph (E), by striking “at  
11 the time of a qualifying event described in sec-  
12 tion 603(2)” and inserting “at any time during  
13 the initial 18-month period of continuing cov-  
14 erage under this part”.

15 (2) ELECTION.—Section 605(1)(C) of the Em-  
16 ployee Retirement Income Security Act of 1974 (29  
17 U.S.C. 1165(1)(C)) is amended—

18 (A) in clause (i), by striking “or” at the  
19 end thereof;

20 (B) in clause (ii), by striking the period  
21 and inserting “, or”; and

22 (C) by adding at the end thereof the fol-  
23 lowing new clause:

24 “(iii) in the case of an individual de-  
25 scribed in the last sentence of section

1           602(2)(A), or a beneficiary-family member  
2           of the individual, the date such individual  
3           is determined to have been disabled.”.

4           (3) NOTICES.—Section 606(3) of the Employee  
5           Retirement Income Security Act of 1974 (29 U.S.C.  
6           1166(3)) is amended by striking “at the time of a  
7           qualifying event described in section 603(2)” and in-  
8           serting “at any time during the initial 18-month pe-  
9           riod of continuing coverage under this part”.

10          (4) BIRTH OR ADOPTION OF A CHILD.—Section  
11          607(3)(A) of the Employee Retirement Income Secu-  
12          rity Act of 1974 (29 U.S.C. 1167(3)) is amended by  
13          adding at the end thereof the following new flush  
14          sentence:

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

19          (c) INTERNAL REVENUE CODE OF 1986.—

20           (1) PERIOD OF COVERAGE.—Section  
21           4980B(f)(2)(B) of the Internal Revenue Code of  
22           1986 is amended—

23           (A) in the last sentence of clause (i) by  
24           striking “at the time of a qualifying event de-  
25           scribed in paragraph (3)(B)” and inserting “at

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

3 (B) in clause (iv)(I), by inserting before “,  
4 or” the following: “, except that the exclusion  
5 or limitation contained in this subclause shall  
6 not be considered to apply to a plan under  
7 which a preexisting condition or exclusion does  
8 not apply to an individual otherwise eligible for  
9 continuation coverage under this subsection be-  
10 cause of the provision of the Health Insurance  
11 Reform Act of 1996”; and

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

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

19 (A) in subclause (I), by striking “or” at  
20 the end thereof;

21 (B) in subclause (II), by striking the pe-  
22 riod and inserting “, or”; and

23 (C) by adding at the end thereof the fol-  
24 lowing new subclause:

1                   “(III) in the case of an qualified  
2                   beneficiary described in the last sen-  
3                   tence of paragraph (2)(B)(i), the date  
4                   such individual is determined to have  
5                   been disabled.”.

6                   (3) NOTICES.—Section 4980B(f)(6)(C) of the  
7                   Internal Revenue Code of 1986 is amended by strik-  
8                   ing “at the time of a qualifying event described in  
9                   paragraph (3)(B)” and inserting “at any time dur-  
10                  ing the initial 18-month period of continuing cov-  
11                  erage under this section”.

12                  (4) BIRTH OR ADOPTION OF A CHILD.—Section  
13                  4980B(g)(1)(A) of the Internal Revenue Code of  
14                  1986 is amended by adding at the end thereof the  
15                  following new flush sentence:

16                         “Such term shall also include a child who  
17                         is born to or placed for adoption with the  
18                         covered employee during the period of con-  
19                         tinued coverage under this section.”.

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

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

1 tive, each group health plan (covered under title XXII of  
2 the Public Health Service Act, part 6 of subtitle B of title  
3 I of the Employee Retirement Income Security Act of  
4 1974, and section 4980B(f) of the Internal Revenue Code  
5 of 1986) shall notify each qualified beneficiary who has  
6 elected continuation coverage under such title, part or sec-  
7 tion of the amendments made by this section.

## 8 **Subtitle D—Private Health Plan** 9 **Purchasing Cooperatives**

### 10 **SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERA-** 11 **TIVES.**

12 (a) DEFINITION.—As used in this Act, the term  
13 “health plan purchasing cooperative” means a group of  
14 individuals or employers that, on a voluntary basis and  
15 in accordance with this section, form a cooperative for the  
16 purpose of purchasing individual health plans or group  
17 health plans offered by health plan issuers. A health plan  
18 issuer, agent, broker or any other individual or entity en-  
19 gaged in the sale of insurance may not underwrite a coop-  
20 erative.

21 (b) CERTIFICATION.—

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



1       retary of such desire, the State, upon a determina-  
2       tion that such group meets the requirements of this  
3       section, shall certify the group as a health plan pur-  
4       chasing cooperative. The State shall make a deter-  
5       mination of whether such group meets the require-  
6       ments of this section in a timely fashion. Each such  
7       cooperative shall also be registered with the Sec-  
8       retary.

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

15              (3) INTERSTATE COOPERATIVES.—For purposes  
16       of this section, a health plan purchasing cooperative  
17       operating in more than one State shall be certified  
18       by the State in which the cooperative is domiciled.  
19       States may enter into cooperative agreements for the  
20       purpose of certifying and overseeing the operation of  
21       such cooperatives. For purposes of this subsection, a  
22       cooperative shall be considered to be domiciled in the  
23       State in which most of the members of the coopera-  
24       tive reside.

25       (c) BOARD OF DIRECTORS.—

1           (1) IN GENERAL.—Each health plan purchasing  
2 cooperative shall be governed by a Board of Direc-  
3 tors that shall be responsible for ensuring the per-  
4 formance of the duties of the cooperative under this  
5 section. The Board shall be composed of a broad  
6 cross-section of representatives of employers, em-  
7 ployees, and individuals participating in the coopera-  
8 tive. A health plan issuer, agent, broker or any other  
9 individual or entity engaged in the sale of individual  
10 health plans or group health plans may not hold or  
11 control any right to vote with respect to a coopera-  
12 tive.

13           (2) LIMITATION ON COMPENSATION.—A health  
14 plan purchasing cooperative may not provide com-  
15 pensation to members of the Board of Directors.  
16 The cooperative may provide reimbursements to  
17 such members for the reasonable and necessary ex-  
18 penses incurred by the members in the performance  
19 of their duties as members of the Board.

20           (3) CONFLICT OF INTEREST.—No member of  
21 the Board of Directors (or family members of such  
22 members) nor any management personnel of the co-  
23 operative may be employed by, be a consultant for,  
24 be a member of the board of directors of, be affili-  
25 ated with an agent of, or otherwise be a representa-

1       tive of any health plan issuer, health care provider,  
2       or agent or broker. Nothing in the preceding sen-  
3       tence shall limit a member of the Board from pur-  
4       chasing coverage offered through the cooperative.

5       (d) MEMBERSHIP AND MARKETING AREA.—

6           (1) MEMBERSHIP.—A health plan purchasing  
7       cooperative may establish limits on the maximum  
8       size of employers who may become members of the  
9       cooperative, and may determine whether to permit  
10      individuals to become members. Upon the establish-  
11      ment of such membership requirements, the coopera-  
12      tive shall, except as provided in subparagraph (B),  
13      accept all employers (or individuals) residing within  
14      the area served by the cooperative who meet such re-  
15      quirements as members on a first-come, first-served  
16      basis, or on another basis established by the State  
17      to ensure equitable access to the cooperative.

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

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

3 (e) DUTIES AND RESPONSIBILITIES.—

4 (1) IN GENERAL.—A health plan purchasing co-  
5 operative shall—

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

12 (B) enter into agreements with employers  
13 and individuals who become members of the co-  
14 operative;

15 (C) participate in any program of risk-ad-  
16 justment or reinsurance, or any similar pro-  
17 gram, that is established by the State;

18 (D) prepare and disseminate comparative  
19 health plan materials (including information  
20 about cost, quality, benefits, and other informa-  
21 tion concerning group health plans and individ-  
22 ual health plans offered through the coopera-  
23 tive);

1           (E) actively market to all eligible employ-  
2           ers and individuals residing within the service  
3           area; and

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

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

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

12           (B) collecting and analyzing surveys of en-  
13           rollee satisfaction;

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

18           (D) cooperating with (or accepting as  
19           members) employers who provide health bene-  
20           fits directly to participants and beneficiaries  
21           only for the purpose of negotiating with provid-  
22           ers; and

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

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

3 (1) perform any activity relating to the licens-  
4 ing of health plan issuers;

5 (2) assume financial risk directly or indirectly  
6 on behalf of members of a health plan purchasing  
7 cooperative relating to any group health plan or in-  
8 dividual health plan;

9 (3) establish eligibility, continuation of eligi-  
10 bility, enrollment, or premium contribution require-  
11 ments for participants, beneficiaries, or individuals  
12 based on health status, medical condition, claims ex-  
13 perience, receipt of health care, medical history, evi-  
14 dence of insurability, or disability;

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

21 (A) in which membership in such organiza-  
22 tion is not based on health status, medical con-  
23 dition, claims experience, receipt of health care,  
24 medical history, evidence of insurability, or dis-  
25 ability; and

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

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

9 (g) LIMITED PREEMPTION OF CERTAIN STATE  
10 LAWS.—

11 (1) IN GENERAL.—With respect to a health  
12 plan purchasing cooperative that meets the require-  
13 ments of this section, State fictitious group laws  
14 shall be preempted.

15 (2) HEALTH PLAN ISSUERS.—

16 (A) RATING.—With respect to a health  
17 plan issuer offering a group health plan or indi-  
18 vidual health plan through a health plan pur-  
19 chasing cooperative that meets the requirements  
20 of this section, State premium rating require-  
21 ment laws, except to the extent provided under  
22 subparagraph (B), shall be preempted unless  
23 such laws permit premium rates negotiated by  
24 the cooperative to be less than rates that would  
25 otherwise be permitted under State law, if such

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

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

6 (i) prohibit the variance of premium  
7 rates among employers, plan sponsors, or  
8 individuals that are members of a health  
9 plan purchasing cooperative in excess of  
10 the amount of such variations that would  
11 be permitted under such State rating laws  
12 among employers, plan sponsors, and indi-  
13 viduals that are not members of the coop-  
14 erative; and

15 (ii) prohibit a percentage increase in  
16 premium rates for a new rating period that  
17 is in excess of that which would be per-  
18 mitted under State rating laws.

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



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

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

10 (h) RULES OF CONSTRUCTION.—Nothing in this sec-  
11 tion shall be construed to—

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

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

16 (3) require individuals, plan sponsors, or em-  
17 ployers to purchase group health plans or individual  
18 health plans through a health plan purchasing coop-  
19 erative;

20 (4) require that a health plan purchasing coop-  
21 erative be the only type of purchasing arrangement  
22 permitted to operate in a State;

23 (5) confer authority upon a State that the State  
24 would not otherwise have to regulate health plan is-  
25 suers or employee health benefits plans; or

1           (6) confer authority upon a State (or the Fed-  
2           eral Government) that the State (or Federal Govern-  
3           ment) would not otherwise have to regulate group  
4           purchasing arrangements, coalitions, or other similar  
5           entities that do not desire to become a health plan  
6           purchasing cooperative in accordance with this sec-  
7           tion.

8           (i) APPLICATION OF ERISA.—For purposes of en-  
9           forcement only, the requirements of parts 4 and 5 of sub-  
10          title B of title I of the Employee Retirement Income Secu-  
11          rity Act of 1974 (29 U.S.C. 1101) shall apply to a health  
12          plan purchasing cooperative as if such plan were an em-  
13          ployee welfare benefit plan.

## 14           **TITLE II—APPLICATION AND** 15           **ENFORCEMENT OF STANDARDS**

### 16           **SEC. 201. APPLICABILITY.**

17           (a) CONSTRUCTION.—

18           (1) ENFORCEMENT.—

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

1           missioner for the State involved or the official  
2           or officials designated by the State to enforce  
3           the requirements of this Act. In the case of a  
4           group health plan offered by a health plan is-  
5           suer in connection with an employee health ben-  
6           efit plan, the requirements or standards im-  
7           posed under this Act shall be enforced with re-  
8           spect to the health plan issuer by the State in-  
9           surance commissioner for the State involved or  
10          the official or officials designated by the State  
11          to enforce the requirements of this Act.

12                   (B) LIMITATION.—Except as provided in  
13                   subsection (c), the Secretary shall not enforce  
14                   the requirements or standards of this Act as  
15                   they relate to health plan issuers, group health  
16                   plans, or individual health plans. In no case  
17                   shall a State enforce the requirements or stand-  
18                   ards of this Act as they relate to employee  
19                   health benefit plans.

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

24                           (A) not prescribed in this Act; or

1 (B) related to the issuance, renewal, or  
2 portability of health insurance or the establish-  
3 ment or operation of group purchasing arrange-  
4 ments, that are consistent with, and are not in  
5 direct conflict with, this Act and provide greater  
6 protection or benefit to participants, bene-  
7 ficiaries or individuals.

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

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

17 **SEC. 202. ENFORCEMENT OF STANDARDS.**

18 (a) HEALTH PLAN ISSUERS.—Each State shall re-  
19 quire that each group health plan and individual health  
20 plan issued, sold, renewed, offered for sale or operated in  
21 such State by a health plan issuer meet the standards es-  
22 tablished under this Act pursuant to an enforcement plan  
23 filed by the State with the Secretary. A State shall submit  
24 such information as required by the Secretary demonstrat-

1 ing effective implementation of the State enforcement  
2 plan.

3 (b) EMPLOYEE HEALTH BENEFIT PLANS.—With re-  
4 spect to employee health benefit plans, the Secretary shall  
5 enforce the reform standards established under this Act  
6 in the same manner as provided for under sections 502,  
7 504, 506, and 510 of the Employee Retirement Income  
8 Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and  
9 1140). The civil penalties contained in paragraphs (1) and  
10 (2) of section 502(c) of such Act (29 U.S.C. 1132(c)(1)  
11 and (2)) shall apply to any information required by the  
12 Secretary to be disclosed and reported under this section.

13 (c) FAILURE TO IMPLEMENT PLAN.—In the case of  
14 the failure of a State to substantially enforce the stand-  
15 ards and requirements set forth in this Act with respect  
16 to group health plans and individual health plans as pro-  
17 vided for under the State enforcement plan filed under  
18 subsection (a), the Secretary, in consultation with the Sec-  
19 retary of Health and Human Services, shall implement an  
20 enforcement plan meeting the standards of this Act in  
21 such State. In the case of a State that fails to substan-  
22 tially enforce the standards and requirements set forth in  
23 this Act, each health plan issuer operating in such State  
24 shall be subject to civil enforcement as provided for under  
25 sections 502, 504, 506, and 510 of the Employee Retire-

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

7 (d) APPLICABLE CERTIFYING AUTHORITY.—As used  
8 in this title, the term “applicable certifying authority”  
9 means, with respect to—

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

14 (2) an employee health benefit plan, the Sec-  
15 retary.

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

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

1           **TITLE III—MISCELLANEOUS**  
2                           **PROVISIONS**

3   **SEC. 301. HMOS ALLOWED TO OFFER PLANS WITH**  
4                           **DEDUCTIBLES TO INDIVIDUALS WITH MEDI-**  
5                           **CAL SAVINGS ACCOUNTS.**

6           Section 1301(b) of the Public Health Service Act (42  
7 U.S.C. 300e(b)) is amended by adding at the end the fol-  
8 lowing new paragraph:

9                   “(6)(A) If a member certifies that a medical  
10           savings account has been established for the benefit  
11           of such member, a health maintenance organization  
12           may, at the request of such member reduce the basic  
13           health services payment otherwise determined under  
14           paragraph (1) by requiring the payment of a deduct-  
15           ible by the member for basic health services.

16                   “(B) For purposes of this paragraph, the term  
17           ‘medical savings account’ means an account which,  
18           by its terms, allows the deposit of funds and the use  
19           of such funds and income derived from the invest-  
20           ment of such funds for the payment of the deduct-  
21           ible described in subparagraph (A).”.

22   **SEC. 302. HEALTH COVERAGE AVAILABILITY STUDY.**

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

1 representatives of individuals and entities that have expertise  
2 in health insurance and employee benefits, shall conduct  
3 a two-part study, and prepare and submit reports, in ac-  
4 cordance with this section.

5 (b) EVALUATION OF AVAILABILITY.—Not later than  
6 January 1, 1998, the Secretary of Health and Human  
7 Services shall prepare and submit to the appropriate com-  
8 mittees of Congress a report, concerning—

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

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

18 (c) EVALUATION OF EFFECTIVENESS.—Not later  
19 than January 1, 1999, the Secretary of Health and  
20 Human Services shall prepare and submit to the appro-  
21 priate committees of Congress a report, concerning the ef-  
22 fectiveness of the provisions of this Act and the various  
23 State laws, in ensuring the availability of reasonably  
24 priced health coverage to employers purchasing group cov-



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

3 **SEC. 303. EFFECTIVE DATE.**

4 Except as otherwise provided for in this Act, the pro-  
5 visions of this Act shall apply as follows:

6 (1) With respect to group health plans and in-  
7 dividual health plans, such provisions shall apply to  
8 plans offered, sold, issued, renewed, in effect, or op-  
9 erated on or after January 1, 1997; and

10 (2) With respect to employee health benefit  
11 plans, on the first day of the first plan year begin-  
12 ning on or after January 1, 1997.

13 **SEC. 304. SEVERABILITY.**

14 If any provision of this Act or the application of such  
15 provision to any person or circumstance is held to be un-  
16 constitutional, the remainder of this Act and the applica-  
17 tion of the provisions of such to any person or cir-  
18 cumstance shall not be affected thereby.

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