

104<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# S. 1028

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 SENATE OF THE UNITED STATES

JULY 13 (legislative day, JULY 10), 1995

Mrs. KASSEBAUM (for herself, Mr. KENNEDY, Mr. FRIST, Mr. DODD, Mr. JEFFORDS, Ms. MIKULSKI, Mr. GREGG, Mr. WELLSTONE, Mr. GORTON, Mr. PELL, Mr. HATCH, Mr. SIMON, Mr. CHAFEE, and Mr. LIEBERMAN) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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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.**

4       This Act may be cited as the “Health Insurance Re-  
5       form Act of 1995”.

1 **SEC. 2. DEFINITIONS.**

2 As used in this Act:

3 (1) **BENEFICIARY.**—The term “beneficiary” has  
4 the same meaning given such term under section  
5 3(8) of the Employee Retirement Income Security  
6 Act of 1974 (29 U.S.C. 1102(8)).

7 (2) **EMPLOYEE.**—The term “employee” has the  
8 same meaning given such term under section 3(6) of  
9 the Employee Retirement Income Security Act of  
10 1974 (29 U.S.C. 1002(6)).

11 (3) **EMPLOYER.**—The term “employer” has the  
12 same meaning given such term under section 3(6) of  
13 the Employee Retirement Income Security Act of  
14 1974 (29 U.S.C. 1002(6)), except that such term  
15 shall only include employers of two or more employ-  
16 ees.

17 (4) **FAMILY.**—

18 (A) **IN GENERAL.**—The term “family” in-  
19 cludes an individual, the individual’s spouse,  
20 and the child of the individual (if any).

21 (B) **CHILD.**—For purposes of subpara-  
22 graph (A), the term “child” means any individ-  
23 ual who is a child within the meaning of section  
24 151(c)(3) of the Internal Revenue Code of  
25 1986, and under 19 years of age.

1           (5) GROUP HEALTH PLAN.—The term “group  
2 health plan” means any employee welfare benefit  
3 plan, governmental plan, or church plan (as defined  
4 under paragraphs (1), (32) and (33) of section 3 of  
5 the Employee Retirement Income Security Act of  
6 1974 (29 U.S.C. 1002(1), (32) and (33))) that  
7 maintains (or makes contributions to) a health plan.

8           (6) HEALTH PLAN.—The term “health plan”  
9 means any plan or arrangement that provides, or  
10 pays for health benefits (such as physician and hos-  
11 pital benefits) directly or through insurance, reim-  
12 bursement, or otherwise. Such term does not include  
13 the following, or any combination thereof:

14           (A) Coverage only for accidental death,  
15 dismemberment, dental, or vision.

16           (B) Coverage providing wages or payments  
17 in lieu of wages for any period during which the  
18 employee is absent from work on account of  
19 sickness or injury.

20           (C) A medicare supplemental policy (as de-  
21 fined in section 1882(g)(1) of the Social Secu-  
22 rity Act).

23           (D) Coverage issued as a supplement to li-  
24 ability insurance.

1 (E) Workers' compensation or similar in-  
2 surance.

3 (F) Automobile medical payment insur-  
4 ance.

5 (G) A long-term care insurance policy, in-  
6 cluding a nursing home fixed indemnity policy.

7 (H) Any plan or arrangement not de-  
8 scribed in any preceding subparagraph that  
9 provides for benefit payments, on a periodic  
10 basis, for a specified disease or illness or period  
11 of hospitalization without regard to the costs in-  
12 curred or services rendered during the period to  
13 which the payments relate.

14 (I) Coverage provided through a State risk  
15 pool, uncompensated care pool, or similar sub-  
16 sidized program.

17 (7) INDIVIDUAL HEALTH PLAN.—The term “in-  
18 dividual health plan” means a health plan marketed  
19 to individuals.

20 (8) INSURED HEALTH PLAN.—The term “in-  
21 sured health plan” means, with respect to an em-  
22 ployee welfare benefit plan (as defined under section  
23 3(1) of the Employee Retirement Income Security  
24 Act of 1974 (29 U.S.C. 1002(1))), a health plan  
25 that is a contract for health benefits with an insurer

1 that is subject to State regulation in accordance  
2 with section 514(b)(2)(A) of the Employee Retirement  
3 Income Security Act of 1974 (29 U.S.C.  
4 1144(b)(2)(A)).

5 (9) INSURER.—The term “insurer” means—

6 (A) a licensed insurance company;

7 (B) a prepaid hospital or medical service  
8 plan;

9 (C) a network plan (such as a preferred  
10 provider organization) or health maintenance or-  
11 ganization; or

12 (D) any other entity (other than an entity  
13 described in paragraph (12)), except for those  
14 entities described in section 514(b)(6)(A)(i) of  
15 the Employee Retirement Income Security Act  
16 of 1974 (29 U.S.C. 1144(b)(6)(A)(i)) providing  
17 a plan of health insurance or health benefits;

18 with respect to which State insurance laws apply  
19 and are not preempted under section 514 of the Em-  
20 ployee Retirement Income Security Act of 1974 (29  
21 U.S.C. 1144).

22 (10) PARTICIPANT.—The term “participant”  
23 means any person who is eligible, or is required to  
24 be eligible, to receive benefits under a group health  
25 plan.

1 (11) PLAN SPONSOR.—The term “plan spon-  
 2 sor” has the same meaning given such term under  
 3 section 3(16)(B) of the Employee Retirement In-  
 4 come Security Act of 1974 (29 U.S.C.  
 5 1002(16)(B)).

6 (12) SECRETARY.—The term “Secretary”, un-  
 7 less specifically provided otherwise, means the Sec-  
 8 retary of Labor.

9 (13) SELF-INSURED HEALTH PLAN.—The term  
 10 “self-insured health plan” means a group health  
 11 plan that is not an insured health plan.

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

17 **TITLE I—HEALTH CARE ACCESS,**  
 18 **PORTABILITY, AND RENEW-**  
 19 **ABILITY**

20 **Subtitle A—Group Health Plan**  
 21 **Rules**

22 **SEC. 101. GUARANTEED AVAILABILITY OF HEALTH COV-**  
 23 **ERAGE.**

24 (a) IN GENERAL.—

1 (1) GROUP HEALTH PLANS.—Except as pro-  
2 vided in subsection (b) and section 103—

3 (A) an insurer may not decline to provide  
4 whole group coverage to employers; and

5 (B) a group health plan (whether an in-  
6 sured health plan or self-insured health plan)  
7 may not establish eligibility, continuation, en-  
8 rollment, or contribution requirements for par-  
9 ticipants or beneficiaries;

10 based on health status, medical condition, claims ex-  
11 perience, receipt of health care, medical history, evi-  
12 dence of insurability, or disability of a participant or  
13 beneficiary.

14 (3) HEALTH PROMOTION OR DISEASE PREVEN-  
15 TION.—Nothing in this subsection shall prevent a  
16 group health plan from establishing discounts for  
17 participation in programs of health promotion or  
18 disease prevention.

19 (b) APPLICATION OF CAPACITY LIMITS.—

20 (1) IN GENERAL.—Subject to paragraph (2), an  
21 insurer offering coverage in connection with a group  
22 health plan may cease enrolling employers under the  
23 plan if—

24 (A) the insurer ceases to enroll any new  
25 employers, participants and beneficiaries; and

1 (B) the insurer can demonstrate to the ap-  
2 plicable certifying authority (as defined in sec-  
3 tion 202(d)), if required, that its financial or  
4 provider capacity to serve previously covered  
5 participants and beneficiaries (and additional  
6 participants and beneficiaries who will be ex-  
7 pected to enroll because of their affiliation with  
8 the group health plan or such previously cov-  
9 ered participants or beneficiaries) will be im-  
10 paired if the insurer is required to enroll addi-  
11 tional employers, participants and beneficiaries.

12 Such an insurer shall be prohibited from  
13 recommencing enrollment after a cessation in enroll-  
14 ment under this paragraph for a 6-month period  
15 after such cessation or until the insurer can dem-  
16 onstrate to the applicable certifying authority (as de-  
17 fined in section 202(d)) that the insurer has ade-  
18 quate capacity, whichever is later.

19 (2) FIRST-COME-FIRST-SERVED.—An insurer  
20 offering coverage in connection with a group health  
21 plan is only eligible to exercise the limitations pro-  
22 vided for in paragraph (1) if the insurer provides for  
23 enrollment of employers (including participants and  
24 beneficiaries) under such plan on a first-come-first-  
25 served basis (except in the case of additional employ-



1       ers, participants and beneficiaries described in para-  
2       graph (1)(B)).

3       (c) CONSTRUCTION.—Nothing in this section shall be  
4       construed to prevent a State from requiring insurers offer-  
5       ing group health plans to actively market such plans.

6       **SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COV-**  
7       **ERAGE.**

8       (a) IN GENERAL.—

9           (1) PLAN SPONSOR.—Subject to subsections (b)  
10       and (c), a group health plan that is an insured  
11       health plan shall be renewed or continued in force at  
12       the option of the plan sponsor, except that the re-  
13       quirement of this subparagraph shall not apply in  
14       the case of—

15           (A) the nonpayment of premiums or con-  
16       tributions by the plan sponsor in accordance  
17       with the terms of the plan or where the insurer  
18       has not received timely premium payments;

19           (B) fraud or misrepresentation of material  
20       fact on the part of the plan sponsor;

21           (C) the termination of the plan in accord-  
22       ance with subsection (b); or

23           (D) the failure of the plan sponsor to meet  
24       contribution or participation requirements in  
25       accordance with paragraph (3).

1           (2) PARTICIPANT.—Subject to subsections (b)  
2 and (c), coverage under a group health plan (wheth-  
3 er an insured health plan or a self-insured health  
4 plan) shall be renewed or continued in force, if the  
5 plan sponsor elects to continue to provide coverage  
6 under such plan, at the option of the participant or  
7 beneficiary, except that the requirement of this para-  
8 graph shall not apply in the case of—

9           (A) the nonpayment of premiums or con-  
10 tributions by the participant or beneficiary in  
11 accordance with the terms of the plan or where  
12 the plan has not received timely premium pay-  
13 ments;

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 plan in accord-  
19 ance with subsection (b); or

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.).

24           (3) CONTRIBUTION AND PARTICIPATION  
25 RULES.—Nothing in this subsection shall be con-

1       strued to preclude an insurer from establishing em-  
2       ployer contribution rules or group participation rules  
3       for plan sponsors in connection with an insured  
4       group health plan consistent with applicable State  
5       law.

6       (b) TERMINATION OF HEALTH PLANS.—

7           (1) HEALTH PLAN NOT OFFERED.—In any case  
8       in which an insurer is no longer going to continue  
9       to offer a group health plan to plan sponsors, par-  
10      ticipants or beneficiaries, the plan may be discon-  
11      tinued by the insurer if—

12           (A) the insurer provides notice to each  
13      plan sponsor (and participants and beneficiaries  
14      covered under the group health plan) of such  
15      termination at least 90 days prior to the date  
16      of the expiration of such plan;

17           (B) the insurer offers to each plan spon-  
18      sor, the option to purchase any other group  
19      health plan currently being offered; and

20           (C) in exercising the option to discontinue  
21      the group health plan and in offering one or  
22      more replacement plans, the insurer acts uni-  
23      formly without regard to the health status or  
24      insurability of participants or beneficiaries, or  
25      new participants or beneficiaries.

1 (2) INSURER NOT OFFERING PLAN.—

2 (A) IN GENERAL.—In any case in which  
3 an insurer is no longer offering any group  
4 health plan in a State, the plan may be discon-  
5 tinued by the insurer if—

6 (i) the insurer provides notice to the  
7 applicable certifying authority (as defined  
8 in section 202(d)) and to each plan spon-  
9 sor (and participants and beneficiaries cov-  
10 ered under such plan) of such termination  
11 at least 180 days prior to the date of the  
12 expiration of the plan; and

13 (ii) all such plans issued or delivered  
14 for issuance in the State are discontinued  
15 and coverage under such plans is  
16 nonrenewed.

17 (B) APPLICATION OF PROVISIONS.—The  
18 provisions of this paragraph and paragraph (3)  
19 may be applied separately by an insurer—

20 (i) to all group health plans of small  
21 employers (as defined under applicable  
22 State law, or employers with not more  
23 than 50 employees if such term is not de-  
24 fined in State law) covering participants or  
25 participants and beneficiaries; or

1 (ii) to all other group health plans of-  
2 ferred by the insurer in the State.

3 (3) PROHIBITION ON MARKET REENTRY.—In  
4 the case of a termination under paragraph (2), the  
5 insurer may not provide for the issuance of any in-  
6 sured group health plan that was terminated in the  
7 State involved during the 5-year period beginning on  
8 the date of the termination of the last plan not so  
9 renewed.

10 (c) TREATMENT OF NETWORK PLANS.—

11 (1) GEOGRAPHIC LIMITATIONS.—A group  
12 health plan which is a network plan (as defined in  
13 paragraph (2)) or a health maintenance organization  
14 plan may deny continued participation under the  
15 plan to participants or beneficiaries who neither live,  
16 reside, nor work in an area in which the group  
17 health plan is offered, but only if such denial is ap-  
18 plied uniformly, without regard to health status or  
19 the insurability of particular participants or bene-  
20 ficiaries.

21 (2) NETWORK PLAN.—As used in paragraph  
22 (1), the term “network plan” means a health plan  
23 that arranges for the financing and delivery of  
24 health care services to participants or beneficiaries  
25 covered under such health plan, in whole or in part,

1 through arrangements with providers to furnish  
2 health care services.

3 **SEC. 103. PORTABILITY OF HEALTH COVERAGE AND LIM-**  
4 **TATION ON PREEXISTING CONDITION EXCLU-**  
5 **SIONS.**

6 (a) IN GENERAL.—A group health plan (whether an  
7 insured health plan or a self-insured health plan) may im-  
8 pose a limitation or exclusion of benefits relating to treat-  
9 ment of a preexisting condition based on the fact that the  
10 condition existed prior to the effective date of the plan  
11 with respect to a participant or beneficiary only if—

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

15 (2) the limitation or exclusion does not apply to  
16 an individual who, within 30 days of the date of  
17 birth, was covered under the plan; and

18 (3) the limitation or exclusion does not apply to  
19 a pregnancy existing on the effective date of cov-  
20 erage.

21 (b) CREDITING OF QUALIFYING PREVIOUS COV-  
22 ERAGE.—

23 (1) IN GENERAL.—A group health plan (wheth-  
24 er an insured health plan or a self-insured health  
25 plan) shall provide that if a participant or bene-

1        ficiary is in a period of previous qualifying coverage  
2        as of the date of enrollment under such plan, any  
3        period of exclusion or limitation of coverage with re-  
4        spect to a preexisting condition shall be reduced by  
5        1 month for each month in which the participant or  
6        beneficiary was in the period of qualifying previous  
7        coverage.

8            (2) DISCHARGE OF DUTY.—The duty of an in-  
9        surer or plan sponsor to verify previous qualifying  
10       coverage with respect to a participant or beneficiary  
11       is effectively discharged when such insurer or plan  
12       sponsor provides documentation to a participant or  
13       beneficiary at the time such participant or bene-  
14       ficiary becomes ineligible for coverage under the  
15       group health plan verifying—

16            (A) the dates that the participant or bene-  
17       ficiary was covered under such previous qualify-  
18       ing coverage; and

19            (B) the benefits and cost-sharing arrange-  
20       ment available to the participant or beneficiary  
21       under such previous qualifying coverage.

22            (3) DEFINITION.—The term “previous qualify-  
23       ing coverage” means the period beginning on the  
24       date a participant or beneficiary is enrolled under a  
25       health plan and ends on the date the participant or

1 beneficiary is not so enrolled for a continuous period  
2 of more than 30 days (without regard to any waiting  
3 period).

4 (4) CONSTRUCTION.—Nothing in this sub-  
5 section shall be construed to prohibit a preexisting  
6 condition exclusion, subject to the limits in sub-  
7 section (a)(1), for a service or benefit related to a  
8 preexisting condition if such service or benefit was  
9 not previously covered under the health plan in  
10 which the individual was enrolled immediately prior  
11 to enrollment in the plan involved.

12 (c) LATE ENROLLEES.—With respect to a partici-  
13 pant or beneficiary enrolling in a group health plan  
14 (whether an insured health plan or a self-insured health  
15 plan) during a time that is other than the first opportunity  
16 to enroll during an enrollment period of at least 30 days,  
17 the plan may exclude coverage with respect to services re-  
18 lated to the treatment of a preexisting condition in accord-  
19 ance with subsections (a) and (b), except the period of  
20 such exclusion may not exceed 18 months beginning on  
21 the date of coverage under the plan.

22 (d) WAITING PERIODS.—With respect to participants  
23 or beneficiaries who have become eligible to enroll in a  
24 group health plan (whether an insured health plan or a  
25 self-insured health plan), if such plan does not utilize a



1 preexisting condition exclusion, such plan may impose a  
2 waiting period on such participants or beneficiaries not to  
3 exceed 60 days (or in the case of a late participant or  
4 beneficiary described in subsection (c), 90 days) prior to  
5 the date on which coverage under the plan becomes effec-  
6 tive. A group health plan may also use alternative methods  
7 to address adverse selection as approved by the applicable  
8 certifying authority (as defined in section 202(d)). During  
9 such a waiting period, the plan may not be required to  
10 provide health care services or benefits and no premium  
11 shall be charged to the participants or beneficiaries.

12 (e) PREEXISTING CONDITION.—For purposes of this  
13 section, the term “preexisting condition” means a condi-  
14 tion for which medical advice, diagnosis, care, or treat-  
15 ment was recommended or received within the 6-month  
16 period ending on the day before the effective date of the  
17 coverage (without regard to any waiting period).

18 (f) STATE FLEXIBILITY.—Nothing in this Act shall  
19 be construed to preempt State laws that limit the exclu-  
20 sions or limitations for preexisting conditions to periods  
21 that are shorter than those provided for under this section  
22 so long as such laws are not in violation of section 514  
23 of the Employee Retirement Income Security Act of 1974  
24 (29 U.S.C. 1144).

1 **SEC. 104. SPECIAL ENROLLMENT PERIODS.**

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

4 (1) through marriage, separation, divorce,  
5 death, birth or adoption of a child, experiences a  
6 change in family composition affecting health insur-  
7 ance coverage;

8 (2) experiences a change in employment status  
9 (including a significant change in the terms and con-  
10 ditions of employment) or in continuation coverage;  
11 or

12 (3) experiences a loss of health insurance cov-  
13 erage because of a change in the employment status  
14 of a family member;

15 each group health plan (whether insured or self-insured)  
16 shall provide for a special enrollment period at the time  
17 of such event which would permit the participant, bene-  
18 ficiary or family member to change the individual or fam-  
19 ily basis of coverage or to enroll in the plan if coverage  
20 would have been available to such individual but for failure  
21 to enroll during a previous enrollment period. Such a spe-  
22 cial enrollment period shall ensure that a child born or  
23 adopted shall be deemed to be covered under the plan as  
24 of the date of such birth or adoption if such child is en-  
25 rolled within 30 days of the date of such birth or adoption.

1 **SEC. 105. DISCLOSURE OF INFORMATION.**

2 (a) IN GENERAL.—In connection with the offering  
3 for sale of any group health plan to a small employer (as  
4 defined under applicable State law, or employers with not  
5 more than 50 employees if such term is not defined in  
6 State law), an insurer shall make a reasonable disclosure  
7 to the employer, as part of its solicitation and sales mate-  
8 rials, of—

9 (1) the provisions of the group health plan con-  
10 cerning the insurer's right to change premium rates  
11 and the factors that affect changes in premium  
12 rates;

13 (2) the provisions of such plan relating to re-  
14 newability of policies and contracts;

15 (3) the provisions of such plan relating to any  
16 preexisting condition provision; and

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

20 Information shall be provided under this subsection in a  
21 manner determined to be understandable by the average  
22 small employer or plan sponsor, and shall be sufficiently  
23 accurate and comprehensive to reasonably inform employ-  
24 ers, participants and beneficiaries of their rights and obli-  
25 gations under the plan.

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

5 (c) CONSTRUCTION.—Nothing in this section shall be  
6 construed to preempt State reporting and disclosure re-  
7 quirements or reporting and disclosure requirements  
8 under the Employee Retirement Income Security Act of  
9 1974.

## 10 **Subtitle B—Individual Health Plan** 11 **Rules**

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

13 (a) LIMITATION ON REQUIREMENTS.—

14 (1) IN GENERAL.—With respect to an individ-  
15 ual desiring to enroll in an individual health plan, if  
16 such individual is in a period of previous qualifying  
17 coverage (as defined in section 103(b)(3)) under a  
18 group health plan that commenced 12 or more  
19 months prior to the date on which such individual  
20 desires to enroll in such a plan, an insurer described  
21 in paragraph (3) may not establish eligibility, con-  
22 tinuation, or enrollment requirements based on the  
23 health status, medical condition, claims experience,  
24 receipt of health care, medical history, evidence of  
25 insurability, or disability of the individual.

1           (2) HEALTH PROMOTION AND DISEASE PRE-  
2           VENTION.—Nothing in this subsection shall be con-  
3           strued to prevent an insurer from establishing dis-  
4           counts for participation in programs of health pro-  
5           motion or disease prevention.

6           (3) INSURER.—An insurer described in this  
7           paragraph is an insurer that issues or renews any  
8           type or form of health plan to individuals.

9           (4) PREMIUMS.—Nothing in this subsection  
10          shall be construed to affect the determination of an  
11          insurer as to the amount of the premium payable  
12          under a health plan issued to individuals under ap-  
13          plicable State law.

14          (b) ELIGIBILITY FOR OTHER GROUP COVERAGE.—  
15          The provisions of subsection (a) shall not apply to an indi-  
16          vidual who is eligible for coverage under a group health  
17          plan, or who has had coverage terminated under a group  
18          health plan for failure to make required premium pay-  
19          ments or contributions, or for fraud or misrepresentation  
20          of material fact, or who is otherwise eligible for continu-  
21          ation coverage as described in section 602 of the Employee  
22          Retirement Income Security Act of 1974 (29 U.S.C.  
23          1162).

1 (c) MARKET REQUIREMENTS.—The provisions of  
2 subsection (a) shall not be construed to require that an  
3 insurer be an insurer of individuals.

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

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

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

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

17 (3) the termination of the plan in accordance  
18 with subsection (b).

19 (b) TERMINATION OF HEALTH PLANS.—

20 (1) HEALTH PLAN NOT OFFERED.—In any case  
21 in which an insurer is no longer going to continue  
22 to offer an individual health plan to individuals, the  
23 plan may be discontinued by the insurer if—

24 (A) the insurer provides notice to each in-  
25 dividual covered under the plan of such termi-

1 nation at least 90 days prior to the date of the  
2 expiration of the plan;

3 (B) the insurer offers to each individual  
4 covered under the plan the option to purchase  
5 any other health plan currently being offered to  
6 individuals; and

7 (C) in exercising the option to discontinue  
8 the plan and in offering one or more replace-  
9 ment plans, the insurer acts uniformly without  
10 regard to the health status or insurability of in-  
11 dividuals.

12 (2) INSURER NOT OFFERING PLAN.—In any  
13 case in which an insurer is no longer offering any  
14 individual health plan in a State, the plan may be  
15 discontinued by the insurer if—

16 (A) the insurer provides notice to the ap-  
17 plicable certifying authority (as defined in sec-  
18 tion 202(d)) and to each individual covered  
19 under the plan of such termination at least 180  
20 days prior to the date of the expiration of the  
21 plan; and

22 (B) all such plans issued or delivered for  
23 issuance in the State are discontinued and cov-  
24 erage under such plans is nonrenewed.

1           (3) PROHIBITION ON MARKET REENTRY.—In  
2           the case of a termination under paragraph (2), the  
3           insurer may not provide for the issuance of any indi-  
4           vidual health plan in the State involved during the  
5           5-year period beginning on the date of the termi-  
6           nation of the last plan not so renewed.

7           (c) TREATMENT OF NETWORK PLANS.—

8           (1) GEOGRAPHIC LIMITATIONS.—An individual  
9           health plan which is a network plan (as defined in  
10          paragraph (2)) or a health maintenance organization  
11          plan may deny continued participation under the  
12          plan to individuals who neither live, reside, nor work  
13          in an area in which the individual health plan is of-  
14          fered, but only if such denial is applied uniformly,  
15          without regard to health status or the insurability of  
16          particular individuals.

17          (2) NETWORK PLAN.—As used in paragraph  
18          (1), the term “network plan” means a health plan  
19          that arranges for the financing and delivery of  
20          health care services to individuals covered under  
21          such health plan, in whole or in part, through ar-  
22          rangements with providers to furnish health care  
23          services.



1 **SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET RE-**  
2 **FORMS.**

3 With respect to any State law in effect on, or enacted  
4 after, the date of enactment of this Act, such as guarantee  
5 issue, open enrollment, high-risk pools, or mandatory con-  
6 version policies, such State law shall apply in lieu of the  
7 standards described in sections 110 and 111 unless the  
8 Secretary of Health and Human Services determines that  
9 such State law is not as effective in providing access to  
10 affordable health care coverage as the standards described  
11 in sections 110 and 111.

12 **SEC. 113. INDIVIDUAL HEALTH COVERAGE AVAILABILITY**  
13 **STUDY.**

14 (a) IN GENERAL.—Not later than January 1, 1997,  
15 the Secretary of Health and Human Services, in consulta-  
16 tion with the Secretary, representatives of State officials,  
17 consumers, and other representatives of individuals and  
18 entities that have expertise in health insurance and em-  
19 ployee benefit issues, shall conduct a study, and prepare  
20 and submit to the appropriate committees of Congress a  
21 report, concerning—

22 (1) the most appropriate way, in light of the ex-  
23 perience of the various States, expert opinions, and  
24 such additional data as may be available, to ensure  
25 the availability of reasonably priced health insurance

1 to individuals purchasing coverage on a non-group  
2 basis;

3 (2) the need for Federal standards that limit  
4 the variation in health insurance premiums charged  
5 to individuals and groups of different characteristics  
6 in order to achieve the purposes of this Act; and

7 (3) the effectiveness of the provisions of this  
8 Act, and State insurance reform laws, in stabilizing  
9 the small group health insurance market by provid-  
10 ing for the broad pooling of risk.

11 (b) RECOMMENDATIONS.—The report submitted  
12 under subsection (a) shall contain the recommendations  
13 of the Secretary of Health and Human Services and the  
14 Secretary for additional Federal legislation, if any, that  
15 is needed to ensure the availability of reasonably priced  
16 health insurance for individuals and employers.

## 17 **Subtitle C—COBRA Clarifications**

### 18 **SEC. 121. COBRA CLARIFICATIONS.**

19 (a) PUBLIC HEALTH SERVICE ACT.—

20 (1) PERIOD OF COVERAGE.—Section 2202(2) of  
21 the Public Health Service Act (42 U.S.C. 300bb-  
22 2(2)) is amended—

23 (A) in subparagraph (A)—

24 (i) by transferring the sentence imme-  
25 diately preceding clause (iv) so as to ap-

1           pear immediately following such clause  
2           (iv); and

3           (ii) in the last sentence (as so trans-  
4           ferred)—

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

8           (II) by striking “at the time of a  
9           qualifying event described in section  
10          2203(2)” and inserting “at any time  
11          during the initial 18-month period of  
12          continuing coverage under this title”;  
13          and

14          (B) in subparagraph (E), by striking “at  
15          the time of a qualifying event described in sec-  
16          tion 2203(2)” and inserting “at any time dur-  
17          ing the initial 18-month period of continuing  
18          coverage under this title”.

19          (2) ELECTION.—Section 2205(1)(C) of the  
20          Public Health Service Act (42 U.S.C. 300bb-  
21          5(1)(C)) is amended—

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

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

1 (C) by adding at the end thereof the fol-  
2 lowing new clause:

3 “(iii) in the case of an individual de-  
4 scribed in the last sentence of section  
5 2202(2)(A), or a beneficiary-family mem-  
6 ber of the individual, the date such individ-  
7 ual is determined to have been disabled.”.

8 (3) NOTICES.—Section 2206(3) of the Public  
9 Health Service Act (42 U.S.C. 300bb-6(3)) is  
10 amended by striking “at the time of a qualifying  
11 event described in section 2203(2)” and inserting  
12 “at any time during the initial 18-month period of  
13 continuing coverage under this title”.

14 (4) BIRTH OR ADOPTION OF A CHILD.—Section  
15 2208(3)(A) of the Public Health Service Act (42  
16 U.S.C. 300bb-8(3)(A)) is amended by adding at the  
17 end thereof the following new flush sentence:

18 “Such term shall also include a child who is born to  
19 or adopted by the covered employee during the pe-  
20 riod of continued coverage under this title.”.

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

23 (1) PERIOD OF COVERAGE.—Section 602(2) of  
24 the Employee Retirement Income Security Act of  
25 1974 (29 U.S.C. 1162(2)) is amended—

1 (A) in the last sentence of subparagraph

2 (A)—

3 (i) by inserting “, or a beneficiary-  
4 family member of the individual,” after  
5 “an individual”; and

6 (ii) by striking “at the time of a  
7 qualifying event described in section  
8 603(2)” and inserting “at any time during  
9 the initial 18-month period of continuing  
10 coverage under this part”; and

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

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

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

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

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

1           “(iii) in the case of an individual de-  
2           scribed in the last sentence of section  
3           602(2)(A), or a beneficiary-family member  
4           of the individual, the date such individual  
5           is determined to have been disabled.”.

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

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

17          “Such term shall also include a child who is born to  
18          or adopted by the covered employee during the pe-  
19          riod of continued coverage under this part.”.

20          (c) INTERNAL REVENUE CODE OF 1986.—

21                  (1) PERIOD OF COVERAGE.—Section  
22                  4980B(f)(2)(B) of the Internal Revenue Code of  
23                  1986 is amended—

24                          (A) in the last sentence of clause (i) by  
25                          striking “at the time of a qualifying event de-

1 scribed in paragraph (3)(B)” and inserting “at  
2 any time during the initial 18-month period of  
3 continuing coverage under this section”; and

4 (B) in clause (v), by striking “at the time  
5 of a qualifying event described in paragraph  
6 (3)(B)” and inserting “at any time during the  
7 initial 18-month period of continuing coverage  
8 under this section”.

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

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

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

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

17 “(III) in the case of an qualified  
18 beneficiary described in the last sen-  
19 tence of paragraph (2)(B)(i), the date  
20 such individual is determined to have  
21 been disabled.”.

22 (3) NOTICES.—Section 4980B(f)(6)(C) of the  
23 Internal Revenue Code of 1986 is amended by strik-  
24 ing “at the time of a qualifying event described in  
25 paragraph (3)(B)” and inserting “at any time dur-

1 ing the initial 18-month period of continuing cov-  
2 erage under this section”.

3 (4) BIRTH OR ADOPTION OF A CHILD.—Section  
4 4980B(g)(1)(A) of the Internal Revenue Code of  
5 1986 is amended by adding at the end thereof the  
6 following new flush sentence:

7 “Such term shall also include a child who is  
8 born to or adopted by the covered employee  
9 during the period of continued coverage under  
10 this section.”.

11 (d) EFFECTIVE DATE.—The amendment made by  
12 this section shall apply to qualifying events occurring on  
13 or after the date of the enactment of this Act for plan  
14 years beginning after December 31, 1996.

15 (e) NOTIFICATION OF CHANGES.—Not later than 60  
16 days after the date of enactment of this Act, each group  
17 health plan (covered under title XXII of the Public Health  
18 Service Act, part 6 of subtitle A of title I of the Employee  
19 Retirement Income Security Act of 1974, and section  
20 4980B(f) of the Internal Revenue Code of 1986) shall no-  
21 tify each qualified beneficiary who has elected continuation  
22 coverage under such title, part or section of the amend-  
23 ments made by this section.



1     **Subtitle D—Private Health Plan**  
2             **Purchasing Coalitions**

3     **SEC. 131. PRIVATE HEALTH PLAN PURCHASING COALI-**  
4             **TIONS.**

5             (a) DEFINITION.—As used in this Act, the term  
6 “health plan purchasing coalition” means a group of indi-  
7 viduals or employers that, on a voluntary basis and in ac-  
8 cordance with this section, form an entity for the purpose  
9 of purchasing insured health plans or negotiating with in-  
10 sured health plans and providers. An insurer, agent,  
11 broker or any other individual or entity engaged in the  
12 sale of insurance may not form or underwrite a coalition.

13             (b) CERTIFICATION.—

14                 (1) IN GENERAL.—A State shall certify health  
15 plan purchasing coalitions that meet the require-  
16 ments of this section. Each coalition shall be char-  
17 tered under State law and registered with the Sec-  
18 retary.

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

1           (3) MULTI-STATE COALITIONS.—For purposes  
2 of this section, a health plan purchasing coalition  
3 operating in more than one State shall be certified  
4 by the State in which the coalition is domiciled, pur-  
5 suant to an agreement between the States in which  
6 the coalition conducts business.

7           (d) BOARD OF DIRECTORS.—

8           (1) IN GENERAL.—Each health plan purchasing  
9 coalition shall be governed by a Board of Directors  
10 that shall be responsible for ensuring the perform-  
11 ance of the duties of the coalition under this section.  
12 The Board shall be composed of a broad cross-sec-  
13 tion of representatives of employers, employees, and  
14 individuals participating in the coalition. An insurer,  
15 agent, broker or any other individual or entity en-  
16 gaged in the sale of insurance may not hold or con-  
17 trol any right to vote with respect to a coalition.

18           (2) LIMITATION ON COMPENSATION.—A health  
19 plan purchasing coalition may not provide compensa-  
20 tion to members of the Board of Directors. The coa-  
21 lition may provide reimbursements to such members  
22 for the reasonable and necessary expenses incurred  
23 by the members in the performance of their duties  
24 as members of the Board.

1           (3) CONFLICT OF INTEREST.—No member of  
2 the Board of Directors (or family members of such  
3 members) nor any management personnel of the coa-  
4 lition may be employed by, be a consultant for, be  
5 a member of the board of directors of, be affiliated  
6 with an agent of, or otherwise be a representative of  
7 any health plan or other insurer, health care pro-  
8 vider, or agent or broker. Nothing in the preceding  
9 sentence shall limit a member of the Board from  
10 purchasing coverage from a health plan offered  
11 through the coalition.

12           (e) MEMBERSHIP AND MARKETING AREA.—

13           (1) MEMBERSHIP.—

14           (A) IN GENERAL.—A health plan purchas-  
15 ing coalition may establish limits on the size of  
16 employers who may become members of the coa-  
17 lition, and may determine whether to permit  
18 individuals to become members. Upon the es-  
19 tablishment of such membership requirements,  
20 the coalition shall, except as provided in sub-  
21 paragraph (B), accept all employers (or individ-  
22 uals) residing within the area served by the coa-  
23 lition who meet such requirements as members  
24 on a first come, first-served basis.

1 (B) CAPACITY LIMITS.—A health plan pur-  
2 chasing coalition may cease accepting employers  
3 or individuals as members of the coalition if—

4 (i) the coalition ceases to permit any  
5 new employers or individuals to become  
6 members; and

7 (ii) the coalition can demonstrate to  
8 the State (or the Secretary in the case of  
9 coalitions certified by the Secretary) that  
10 the financial or other capacity of the coali-  
11 tion to serve current members will be im-  
12 paired if the coalition is required to accept  
13 other members.

14 (2) MARKETING AREA.—A State may establish  
15 rules regarding the geographic area that must be  
16 served by a health plan purchasing coalition. With  
17 respect to a State that has not established such  
18 rules, a health plan purchasing coalition operating in  
19 the State shall define the boundaries of the area to  
20 be served by the coalition, except that such bound-  
21 aries may not be established on the basis of health  
22 status or insurability.

23 (f) DUTIES AND RESPONSIBILITIES.—

24 (1) IN GENERAL.—A health plan purchasing co-  
25 alition shall—

1 (A) enter into agreements with insured  
2 health plans;

3 (B) enter into agreements with employers  
4 and individuals who become members of the co-  
5 alition;

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

9 (D) contract and negotiate with health  
10 care providers and health plans;

11 (E) prepare and disseminate comparative  
12 health plan materials (including information  
13 about cost, quality, benefits, and other informa-  
14 tion concerning health plans offered through  
15 the coalition);

16 (F) actively market to all eligible employ-  
17 ers and individuals residing within the service  
18 area; and

19 (G) act as an ombudsman for health plan  
20 enrollees.

21 (2) PERMISSIBLE ACTIVITIES.—A health plan  
22 purchasing coalition may perform such other func-  
23 tions as necessary to further the purposes of this  
24 Act, including—

1 (A) the collection and distribution of pre-  
2 miums and the performance of other adminis-  
3 trative functions;

4 (B) the collection and analysis of surveys  
5 of health plan enrollee satisfaction;

6 (C) the charging of membership fee to en-  
7 rollees (such fees may not be based on health  
8 status) and the charging of participation fees to  
9 health plans; and

10 (D) cooperating with (or accepting as  
11 members) employers who self-insure for the  
12 purpose of negotiating with providers.

13 (g) LIMITATIONS ON COALITION ACTIVITIES.—A  
14 health plan purchasing coalition shall not—

15 (1) perform any activity relating to the licens-  
16 ing of health plans;

17 (2) assume financial risk in relating to any  
18 health plan;

19 (3) perform any other activities that conflict or  
20 are inconsistent with the performance of its duties  
21 under this Act; or

22 (4) establish eligibility, continuation, enroll-  
23 ment, or contribution requirements for employees or  
24 employers and individuals based on the health sta-  
25 tus, medical condition, claims experience, receipt of

1 health care, medical history, evidence of insurability,  
2 or disability of any individual.

3 (h) LIMITED PREEMPTION OF CERTAIN STATE  
4 LAWS.—

5 (1) IN GENERAL.—With respect to a health  
6 plan purchasing coalition that meets the require-  
7 ments of this section, the following State laws shall  
8 be preempted:

9 (A) State fictitious group laws.

10 (B) State rating requirement laws, except  
11 to the extent necessary to comply with the re-  
12 quirements of paragraph (2).

13 (C) Other State laws that directly conflict  
14 with the requirements in this section.

15 (2) RATING REQUIREMENT LAWS.—With re-  
16 spect to a State rating requirement law, the coali-  
17 tion—

18 (A) may not permit premium rates to vary  
19 among employers or individuals that are mem-  
20 bers of a health plan purchasing coalition in ex-  
21 cess of the amount of such variations that  
22 would be permitted under such State rating  
23 laws among employers that are not members of  
24 the coalition; and

1 (B) with respect to premium rates nego-  
2 tiated by the coalition, may permit such rates  
3 to be less than rates that would otherwise be  
4 permitted under State law if such rating dif-  
5 ferential is not based on differences in health  
6 status or demographic factors.

7 (i) RULES OF CONSTRUCTION.—Nothing in this sec-  
8 tion shall be construed to—

9 (1) require that a State organize, operate, or  
10 otherwise create health care purchasing coalitions;

11 (2) otherwise require the establishment of  
12 health care purchasing coalitions;

13 (3) require individuals or employers to purchase  
14 health plans through a health plan purchasing coali-  
15 tion;

16 (4) require that a health plan purchasing coali-  
17 tion be the only type of health insurance purchasing  
18 arrangement permitted to operate in a State; or

19 (5) confer authority upon a State that the State  
20 would not otherwise have to regulate health plans  
21 (whether insured or self-insured).

22 (j) APPLICATION OF ERISA.—The requirements of  
23 parts 4 and 5 of subtitle B of title I of the Employee Re-  
24 tirement Income Security Act of 1974 (29 U.S.C. 1101)  
25 shall apply to a health plan purchasing coalition.



1       **TITLE II—APPLICATION AND**  
2       **ENFORCEMENT OF STANDARDS**

3       **SEC. 201. APPLICABILITY.**

4       (a) CONSTRUCTION.—

5               (1) IN GENERAL.—A requirement or standard  
6       imposed on an insured health plan under this Act  
7       shall be deemed to be a requirement or standard im-  
8       posed on the insurer. A requirement or standard im-  
9       posed on a self-insured health plan under this Act  
10      shall be deemed to be a requirement or standard im-  
11      posed on the plan sponsor.

12              (2) PREEMPTION OF STATE LAW.—Nothing in  
13      this Act shall be construed to prevent a State from  
14      establishing, implementing, or continuing in effect  
15      standards and requirements related to the issuance,  
16      renewal, or rating of health insurance, or other  
17      standards or requirements related to health insur-  
18      ance, unless such standards are in direct conflict  
19      with the standards or requirements established  
20      under this Act.

21      **SEC. 202. ENFORCEMENT OF STANDARDS.**

22              (a) INSURED HEALTH PLANS.—Each State shall re-  
23      quire that each insured health plan issued, sold, renewed,  
24      offered for sale or operated in such State meet the insur-  
25      ance reform standards established under this Act pursu-

1 ant to an enforcement plan filed by the State with the  
2 Secretary. A State shall submit such information as re-  
3 quired by the Secretary demonstrating effective implemen-  
4 tation of the State enforcement plan.

5 (b) SELF-INSURED HEALTH PLANS.—In the case of  
6 self-insured health plans, the Secretary shall enforce the  
7 reform standards established under this Act. A plan fail-  
8 ing to meet such standards shall be subject to civil en-  
9 forcement as provided for under section 502 of the Em-  
10 ployee Retirement Income Security Act of 1974 (29  
11 U.S.C. 1132) and for penalties as provided for under para-  
12 graphs (1) and (2) of section 502(a) of such Act (relating  
13 to failure to provide requested information and failure to  
14 file required reports).

15 (c) FAILURE TO IMPLEMENT PLAN.—In the case of  
16 the failure of a State to enforce the standards and require-  
17 ments set forth in this Act, the Secretary, in consultation  
18 with the Secretary of Health and Human Services, shall  
19 implement an enforcement plan meeting the standards of  
20 this Act in such State. In the case of a State that fails  
21 to enforce the standards and requirements set forth in this  
22 Act, each health plan operating in such State shall be sub-  
23 ject to civil enforcement as provided for under section 502  
24 of the Employee Retirement Income Security Act of 1974  
25 (29 U.S.C. 1132) and for penalties as provided for under

1 paragraphs (1) and (2) of subsection (a) of such section  
2 (relating to failure to provide requested information and  
3 failure to file required reports).

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

7 (1) insured health plans, the State insurance  
8 commissioner for the State involved; and

9 (2) a self-insured health plan, the Secretary.

## 10 **TITLE III—MISCELLANEOUS** 11 **PROVISIONS**

### 12 **SEC. 301. HMOS ALLOWED TO OFFER PLANS WITH** 13 **DEDUCTIBLES TO INDIVIDUALS WITH MEDI-** 14 **CAL SAVINGS ACCOUNTS.**

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

18 “(6)(A) If a member certifies that a medical  
19 savings account has been established for the benefit  
20 of such member, a health maintenance organization  
21 may, at the request of such member reduce the basic  
22 health services payment otherwise determined under  
23 paragraph (1) by requiring the payment of a deduct-  
24 ible by the member for basic health services.

1           “(B) For purposes of this paragraph, the term  
 2           ‘medical savings account’ means an account which,  
 3           by its terms, allows the deposit of funds and the use  
 4           of such funds and income derived from the invest-  
 5           ment of such funds for the payment of the deduct-  
 6           ible described in subparagraph (A).”.

7           (b) SENSE OF THE SENATE.—It is the sense of the  
 8           Senate that the Congress should take measures to further  
 9           the purposes of this Act, including any necessary changes  
 10          to the Internal Revenue Code of 1986 to encourage groups  
 11          and individuals to obtain health coverage, and to promote  
 12          access, equity, portability, affordability, and security of  
 13          health benefits.

14          **SEC. 302. EFFECTIVE DATE.**

15          The provisions of this Act shall apply to health plans  
 16          offered, sold, issued, renewed, or operated on or after Jan-  
 17          uary 1, 1996.

18          **SEC. 303. SEVERABILITY.**

19          If any provision of this Act or the application of such  
 20          provision to any person or circumstance is held to be un-  
 21          constitutional, the remainder of this Act and the applica-  
 22          tion of the provisions of such to any person or cir-  
 23          cumstance shall not be affected thereby.

○

S 1028 IS—2

S 1028 IS—3

S 1028 IS—4