104TH CONGRESS
1ST 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.

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.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Insurance Reform Act of 1995''.

SEC. 2. DEFINITIONS.

As used in this Act:

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

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

(3) EMPLOYER.—The term ''employer'' has the same meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)), except that such term shall only include employers of two or more employees.

(4) FAMILY.—

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

(B) CHILD.—For purposes of subparagraph (A), the term ''child'' means any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986, and under 19 years of age.

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

(6) HEALTH PLAN.—The term ''health plan'' means any plan or arrangement that provides, or pays for health benefits (such as physician and hospital benefits) directly or through insurance, reimbursement, or otherwise. Such term does not include the following, or any combination thereof:

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

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

(C) A medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act).

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

(E) Workers' compensation or similar insurance.

(F) Automobile medical payment insurance.

(G) A long-term care insurance policy, including a nursing home fixed indemnity policy.

(H) Any plan or arrangement not described in any preceding subparagraph that provides for benefit payments, on a periodic basis, for a specified disease or illness or period of hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate.

(I) Coverage provided through a State risk pool, uncompensated care pool, or similar subsidized program.

(7) INDIVIDUAL HEALTH PLAN.—The term ''individual health plan'' means a health plan marketed to individuals.

(8) INSURED HEALTH PLAN.—The term ''insured health plan'' means, with respect to an employee welfare benefit plan (as defined under section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1))), a health plan that is a contract for health benefits with an insurer

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

(9) INSURER.—The term ''insurer'' means—

(A) a licensed insurance company;

(B) a prepaid hospital or medical service plan;

(C) a network plan (such as a preferred provider organization) or heath maintenance organization; or

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

with respect to which State insurance laws apply and are not preempted under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(10) PARTICIPANT.—The term ''participant'' means any person who is eligible, or is required to be eligible, to receive benefits under a group health plan.

(11) PLAN SPONSOR.—The term ''plan sponsor'' has the same meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(16)(B)).

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

(13) SELF-INSURED HEALTH PLAN.—The term ''self-insured health plan'' means a group health plan that is not an insured health plan.

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

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Health Plan Rules

SEC. 101. GUARANTEED AVAILABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) GROUP HEALTH PLANS.—Except as provided in subsection (b) and section 103—

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

(B) a group health plan (whether an insured health plan or self-insured health plan) may not establish eligibility, continuation, enrollment, or contribution requirements for participants or beneficiaries;

based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability of a participant or beneficiary.

(3) HEALTH PROMOTION OR DISEASE PREVENTION.—Nothing in this subsection shall prevent a group health plan from establishing discounts for participation in programs of health promotion or disease prevention.

(b) APPLICATION OF CAPACITY LIMITS.—

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

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

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

Such an insurer shall be prohibited from recommencing enrollment after a cessation in enrollment under this paragraph for a 6-month period after such cessation or until the insurer can demonstrate to the applicable certifying authority (as defined in section 202(d)) that the insurer has adequate capacity, whichever is later.

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

ers, participants and beneficiaries described in paragraph (1)(B)).

(c) CONSTRUCTION.—Nothing in this section shall be construed to prevent a State from requiring insurers offering group health plans to actively market such plans.

SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

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

(A) the nonpayment of premiums or contributions by the plan sponsor in accordance with the terms of the plan or where the insurer has not received timely premium payments;

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

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

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

(2) PARTICIPANT.—Subject to subsections (b) and (c), coverage under a group health plan (whether an insured health plan or a self-insured health plan) shall be renewed or continued in force, if the plan sponsor elects to continue to provide coverage under such plan, at the option of the participant or beneficiary, except that the requirement of this paragraph shall not apply in the case of—

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

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

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

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

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

strued to preclude an insurer from establishing employer contribution rules or group participation rules for plan sponsors in connection with an insured group health plan consistent with applicable State law.

(b) TERMINATION OF HEALTH PLANS.—

(1) HEALTH PLAN NOT OFFERED.—In any case in which an insurer is no longer going to continue to offer a group health plan to plan sponsors, participants or beneficiaries, the plan may be discontinued by the insurer if—

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

(B) the insurer offers to each plan sponsor, the option to purchase any other group health plan currently being offered; and

(C) in exercising the option to discontinue the group health plan and in offering one or more replacement plans, the insurer acts uniformly without regard to the health status or insurability of participants or beneficiaries, or new participants or beneficiaries.

(2) INSURER NOT OFFERING PLAN.—

(A) IN GENERAL.—In any case in which an insurer is no longer offering any group health plan in a State, the plan may be discontinued by the insurer if—

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

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

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

(i) to all group health plans of small employers (as defined under applicable State law, or employers with not more than 50 employees if such term is not defined in State law) covering participants or participants and beneficiaries; or

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

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

(c) TREATMENT OF NETWORK PLANS.—

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

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

through arrangements with providers to furnish health care services.

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

(a) IN GENERAL.—A group health plan (whether an insured health plan or a self-insured health plan) may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition based on the fact that the condition existed prior to the effective date of the plan with respect to a participant or beneficiary only if—

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

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

(3) the limitation or exclusion does not apply to a pregnancy existing on the effective date of coverage.

(b) CREDITING OF QUALIFYING PREVIOUS COVERAGE.—

(1) IN GENERAL.—A group health plan (whether an insured health plan or a self-insured health plan) shall provide that if a participant or bene-

ficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of qualifying previous coverage.

(2) DISCHARGE OF DUTY.—The duty of an insurer or plan sponsor to verify previous qualifying coverage with respect to a participant or beneficiary is effectively discharged when such insurer or plan sponsor provides documentation to a participant or beneficiary at the time such participant or beneficiary becomes ineligible for coverage under the group health plan verifying—

(A) the dates that the participant or beneficiary was covered under such previous qualifying coverage; and

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

(3) DEFINITION.—The term ''previous qualifying coverage'' means the period beginning on the date a participant or beneficiary is enrolled under a health plan and ends on the date the participant or

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

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

(c) LATE ENROLLEES.—With respect to a participant or beneficiary enrolling in a group health plan (whether an insured health plan or a self-insured health plan) during a time that is other than the first opportunity to enroll during an enrollment period of at least 30 days, the plan may exclude coverage with respect to services related to the treatment of a preexisting condition in accordance with subsections (a) and (b), except the period of such exclusion may not exceed 18 months beginning on the date of coverage under the plan.

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

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

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

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

SEC. 104. SPECIAL ENROLLMENT PERIODS.

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

(1) through marriage, separation, divorce, death, birth or adoption of a child, experiences a change in family composition affecting health insurance coverage;

(2) experiences a change in employment status (including a significant change in the terms and conditions of employment) or in continuation coverage; or

(3) experiences a loss of health insurance coverage because of a change in the employment status of a family member;

each group health plan (whether insured or self-insured) shall provide for a special enrollment period at the time of such event which would permit the participant, beneficiary or family member to change the individual or family basis of coverage or to enroll in the plan if coverage would have been available to such individual but for failure to enroll during a previous enrollment period. Such a special enrollment period shall ensure that a child born or adopted shall be deemed to be covered under the plan as of the date of such birth or adoption if such child is enrolled within 30 days of the date of such birth or adoption.

SEC. 105. DISCLOSURE OF INFORMATION.

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

(1) the provisions of the group health plan concerning the insurer's right to change premium rates and the factors that affect changes in premium rates;

(2) the provisions of such plan relating to renewability of policies and contracts;

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

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

Information shall be provided under this subsection in a manner determined to be understandable by the average small employer or plan sponsor, and shall be sufficiently accurate and comprehensive to reasonably inform employers, participants and beneficiaries of their rights and obligations under the plan.

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

(c) CONSTRUCTION.—Nothing in this section shall be construed to preempt State reporting and disclosure requirements or reporting and disclosure requirements under the Employee Retirement Income Security Act of 1974.

Subtitle B—Individual Health Plan Rules

SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.

(a) LIMITATION ON REQUIREMENTS.—

(1) IN GENERAL.—With respect to an individual desiring to enroll in an individual health plan, if such individual is in a period of previous qualifying coverage (as defined in section 103(b)(3)) under a group health plan that commenced 12 or more months prior to the date on which such individual desires to enroll in such a plan, an insurer described in paragraph (3) may not establish eligibility, continuation, or enrollment requirements based on the health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability of the individual.

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall be construed to prevent an insurer from establishing discounts for participation in programs of health promotion or disease prevention.

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

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

(b) ELIGIBILITY FOR OTHER GROUP COVERAGE.—The provisions of subsection (a) shall not apply to an individual who is eligible for coverage under a group health plan, or who has had coverage terminated under a group health plan for failure to make required premium payments or contributions, or for fraud or misrepresentation of material fact, or who is otherwise eligible for continuation coverage as described in section 602 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162).

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

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE.

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

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

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

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

(b) TERMINATION OF HEALTH PLANS.—

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

(A) the insurer provides notice to each individual covered under the plan of such termi-

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

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

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

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

(A) the insurer provides notice to the applicable certifying authority (as defined in section 202(d)) and to each individual covered under the plan of such termination at least 180 days prior to the date of the expiration of the plan; and

(B) all such plans issued or delivered for issuance in the State are discontinued and coverage under such plans is nonrenewed.

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

(c) TREATMENT OF NETWORK PLANS.—

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

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means a health plan that arranges for the financing and delivery of health care services to individuals covered under such health plan, in whole or in part, through arrangements with providers to furnish health care services.

SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

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

SEC. 113. INDIVIDUAL HEALTH COVERAGE AVAILABILITY STUDY.

(a) IN GENERAL.—Not later than January 1, 1997, the Secretary of Health and Human Services, in consultation with the Secretary, representatives of State officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefit issues, shall conduct a study, and prepare and submit to the appropriate committees of Congress a report, concerning—

(1) the most appropriate way, in light of the experience of the various States, expert opinions, and such additional data as may be available, to ensure the availability of reasonably priced health insurance

to individuals purchasing coverage on a non-group basis;

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

(3) the effectiveness of the provisions of this Act, and State insurance reform laws, in stabilizing the small group health insurance market by providing for the broad pooling of risk.

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

Subtitle C—COBRA Clarifications

SEC. 121. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

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

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to ap-

pear immediately following such clause (iv); and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

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

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

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

(c) INTERNAL REVENUE CODE OF 1986.—

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

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

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

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

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

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

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

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

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

(3) NOTICES.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time dur-

ing the initial 18-month period of continuing coverage under this section''.

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

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

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

(e) NOTIFICATION OF CHANGES.—Not later than 60 days after the date of enactment of this Act, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle A of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

Subtitle D—Private Health Plan Purchasing Coalitions

SEC. 131. PRIVATE HEALTH PLAN PURCHASING COALITIONS.

(a) DEFINITION.—As used in this Act, the term ''health plan purchasing coalition'' means a group of individuals or employers that, on a voluntary basis and in accordance with this section, form an entity for the purpose of purchasing insured health plans or negotiating with insured health plans and providers. An insurer, agent, broker or any other individual or entity engaged in the sale of insurance may not form or underwrite a coalition.

(b) CERTIFICATION.—

(1) IN GENERAL.—A State shall certify health plan purchasing coalitions that meet the requirements of this section. Each coalition shall be chartered under State law and registered with the Secretary.

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

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

(d) BOARD OF DIRECTORS.—

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

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

(3) CONFLICT OF INTEREST.—No member of the Board of Directors (or family members of such members) nor any management personnel of the coalition may be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representative of any health plan or other insurer, health care provider, or agent or broker. Nothing in the preceding sentence shall limit a member of the Board from purchasing coverage from a health plan offered through the coalition.

(e) MEMBERSHIP AND MARKETING AREA.—

(1) MEMBERSHIP.—

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

(B) CAPACITY LIMITS.—A health plan purchasing coalition may cease accepting employers or individuals as members of the coalition if—

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

(ii) the coalition can demonstrate to the State (or the Secretary in the case of coalitions certified by the Secretary) that the financial or other capacity of the coalition to serve current members will be impaired if the coalition is required to accept other members.

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

(f) DUTIES AND RESPONSIBILITIES.—

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

(A) enter into agreements with insured health plans;

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

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

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

(E) prepare and disseminate comparative health plan materials (including information about cost, quality, benefits, and other information concerning health plans offered through the coalition);

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

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

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

(A) the collection and distribution of premiums and the performance of other administrative functions;

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

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

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

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

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

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

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

(4) establish eligibility, continuation, enrollment, or contribution requirements for employees or employers and individuals based on the health status, medical condition, claims experience, receipt of

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

(h) LIMITED PREEMPTION OF CERTAIN STATE LAWS.—

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

(A) State fictitious group laws.

(B) State rating requirement laws, except to the extent necessary to comply with the requirements of paragraph (2).

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

(2) RATING REQUIREMENT LAWS.—With respect to a State rating requirement law, the coalition—

(A) may not permit premium rates to vary among employers or individuals that are members of a health plan purchasing coalition in excess of the amount of such variations that would be permitted under such State rating laws among employers that are not members of the coalition; and

(B) with respect to premium rates negotiated by the coalition, may permit such rates to be less than rates that would otherwise be permitted under State law if such rating differential is not based on differences in health status or demographic factors.

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

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

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

(3) require individuals or employers to purchase health plans through a health plan purchasing coalition;

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

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

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

TITLE II—APPLICATION AND ENFORCEMENT OF STANDARDS

SEC. 201. APPLICABILITY.

(a) CONSTRUCTION.—

(1) IN GENERAL.—A requirement or standard imposed on an insured health plan under this Act shall be deemed to be a requirement or standard imposed on the insurer. A requirement or standard imposed on a self-insured health plan under this Act shall be deemed to be a requirement or standard imposed on the plan sponsor.

(2) PREEMPTION OF STATE LAW.—Nothing in this Act shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements related to the issuance, renewal, or rating of health insurance, or other standards or requirements related to health insurance, unless such standards are in direct conflict with the standards or requirements established under this Act.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) INSURED HEALTH PLANS.—Each State shall require that each insured health plan issued, sold, renewed, offered for sale or operated in such State meet the insurance reform standards established under this Act pursu-

ant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the State enforcement plan.

(b) SELF-INSURED HEALTH PLANS.—In the case of self-insured health plans, the Secretary shall enforce the reform standards established under this Act. A plan failing to meet such standards shall be subject to civil enforcement as provided for under section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) and for penalties as provided for under paragraphs (1) and (2) of section 502(a) of such Act (relating to failure to provide requested information and failure to file required reports).

(c) FAILURE TO IMPLEMENT PLAN.—In the case of the failure of a State to enforce the standards and requirements set forth in this Act, the Secretary, in consultation with the Secretary of Health and Human Services, shall implement an enforcement plan meeting the standards of this Act in such State. In the case of a State that fails to enforce the standards and requirements set forth in this Act, each health plan operating in such State shall be subject to civil enforcement as provided for under section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) and for penalties as provided for under

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

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

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

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

TITLE III—MISCELLANEOUS PROVISIONS

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

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

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

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

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

SEC. 302. EFFECTIVE DATE.

The provisions of this Act shall apply to health plans offered, sold, issued, renewed, or operated on or after January 1, 1996.

SEC. 303. SEVERABILITY.

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

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