(7) prior authorization for the delivery of services shall not be permitted in inappropriate circumstances.

SEC. 5015. ACCEPTANCE OF PREMIUM CERTIFICATES.

(a) IN GENERAL.—If an individual covered under an insured health benefit plan offered by a carrier tenders to the carrier a premium certificate issued under part A of title XXII of the Social Security Act, the carrier shall reduce by the value of the certificate the amount of any premium required to be paid by the individual for periods beginning after the date of tender of the certificate unless otherwise provided by the Secretary.

(b) TENDER OF CERTIFICATE.—

(1) IN GENERAL.—If an individual tenders to a carrier a premium certificate under subsection (a), the carrier may tender such a certificate to the Secretary, in a manner specified by the Secretary, and, upon such tender, is entitled to receive the value of the certificate so tendered.

(2) TENDER THROUGH UNIVERSAL FEHBP OR COOPERATIVES.—Paragraph (1) shall apply with respect to an individual on whose behalf a premium certificate is tendered by the Director of the Office of Universal FEHBP under subtitle D or a consumer purchasing cooperative under subtitle E.

SEC. 5016. ADDITIONAL REQUIREMENTS FOR INSURED HEALTH BENEFIT PLANS.

In addition to the requirements imposed by the preceding provisions of this part, each carrier providing an insured health benefit plan shall meet the following additional requirements:

(1) ISSUANCE OF HEALTH SECURITY CARDS; COORDINATION OF INDIVIDUAL ENTITLEMENT.—The carrier shall issue health security cards and carry out other administrative functions in accordance with regulations developed by the Secretary including the issuance of an annual written statement to enrollees verifying enrollment in a private health plan and the provision of information on enrollees to the Secretary which the Secretary may forward to the Secretary of the Treasury.

(2) COMPLIANCE WITH PAYMENT RULES.—The carrier provides for payment for items and services consistent with any State system approved under title IV.

(3) OTHER REQUIREMENTS.—The carrier shall meet the applicable requirements of the following provisions of this Act:

(A) Subtitle A of title IX (relating to grievance and appeals procedures, participation in the National Quality Management Program, and the privacy of information on enrollees).

(B) Subtitle B of title IX (relating to data management and reporting and administrative simplification).

# Subtitle B—Standards for Sponsors and Self-Insured Health Benefit Plans

## PART 1—GENERAL REQUIREMENTS

SEC. 5101. REQUIREMENT FOR CERTIFICATION OF SPONSORS AND PLANS.

(a) IN GENERAL.—No sponsor may offer a self-insured health benefit plan (as defined in section 5504(11)) during a year on or after the effective date specified in subsection (b) (or enroll any individual under such a plan beginning on or after such effective date) unless the sponsor and the plan have been certified for the year by the Secretary of Labor (in accordance with such procedures as the Secretary of Labor establishes) as meeting the applicable standards established under section 5501(a)(2) consistent with this subtitle.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to contracts under a self-insured health benefit plan sold, issued, or renewed on or after January 1, 1997.

SEC. 5102. LIMITATION ON ELIGIBLE SPONSORS.

(a) IN GENERAL.—No entity may serve as the sponsor of a self-insured health benefit plan unless the entity is an eligible sponsor (as defined in subsection (b)) who elects, in a form and manner specified by the Secretary of Labor consistent with this subtitle, to be treated as the sponsor of such a plan and to be subject to the standards established by the Secretary of Health and Human Services for such plans under section 5501(a)(2).

(b) ELIGIBLE SPONSORS.—

(1) IN GENERAL.—In this section, each of the following is an eligible sponsor:

(A) LARGE EMPLOYER.—An employer that is a large employer as of the date of an election under subsection (a), with respect to employees, former employees, and family members.

(B) PLAN SPONSOR OF A MULTIEMPLOYER PLAN.—A plan sponsor described in section 3(16)(B)(iii) of Employee Retirement Income Security Act of 1974, but only with respect to participants and beneficiaries (as defined in section 3 of such Act) covered under a group health plan that is a multiemployer plan (as defined in subsection (c)(3)) maintained by the sponsor and only if (as of the date of an election under subsection (a)) such plan—

(i) covers more than 100 full-time employees in the United States, or

(ii) the plan is maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering more than 100 full-time employees.

(C) RURAL ELECTRIC COOPERATIVE AND RURAL TELEPHONE COOPERATIVE ASSOCIATION.—A rural electric cooperative or a rural telephone cooperative association, but only with respect to employees, former employees, and family members covered under a group health plan that is maintained by such cooperative or association (or members of such cooperative or association) and only if such plan has more than 100 employees in the United States entitled to benefits under the plan.

(2) EXCLUSION OF SPONSORS OF MEWAS.—The plan sponsor of a multiple employer welfare arrangement may not be considered an eligible sponsor under this subsection.

(c) DEFINITIONS.—In this section, except as otherwise provided:

(1) GROUP HEALTH PLAN.—The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries (as defined in section 3 of the Employee Retirement Income Security Act of 1974) directly or through insurance, reimbursement, or otherwise.

(2) LARGE EMPLOYER.—The term "large employer" has the meaning given such term in section 1106(b)(1)(A).

(3) MULTIEMPLOYER PLAN.—The term "multiemployer plan" has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such Act.

(4) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—The term "multiple employer welfare arrangement" has the meaning given such term in section 3(40) of the Employee Retirement Income Security Act of 1974 (as in effect on the day before the date of the enactment of this Act).

(5) RURAL ELECTRIC COOPERATIVE.—The term "rural electric cooperative" has the meaning given such term in section

## "Subpart II—NATIONAL PUBLIC HEALTH EMERGENCY ACCOUNT

"SEC. 1910. NATIONAL EMERGENCY ACCOUNT.

"(a) ESTABLISHMENT OF ACCOUNT.—There is established an account to be known as the National Public Health Emergency Account (in this section referred to as the 'Account'). The Account shall consist of the amounts transferred under section 1901(c).

"(b) EXPENDITURES FROM ACCOUNT.—

"(1) IN GENERAL.—Subject to paragraph (2), upon the Secretary submitting to the Congress a written declaration that a public health emergency exists, amounts in the Account are available to the Secretary for the purpose of responding to the emergency.

"(2) CERTAIN CONDITIONS.—With respect to the availability to the Secretary of amounts in the Account, a declaration under paragraph (1) is effective only if in the declaration the Secretary provides that the Secretary has determined that—

"(A) the emergency involved poses a significant threat to the health of individuals in the community involved;

"(B) the resources of the State involved (including Federal funds provided to the State) that are otherwise available to the State for responding to the emergency are insufficient; and

"(C) the circumstances constituting the emergency are other than chronic conditions.

"(c) ALLOCATION TO STATES OF UNOBLIGATED AMOUNTS.—With respect to amounts that are transferred under 1901(c) for a fiscal year and that are unobligated as of September 30 of the fiscal year (referred to in this subsection as the 'unobligated balance'), the Secretary shall pay to a State, from the unobligated balance, an amount equal to the product of such balance and the percentage constituted by the ratio of the amount of the grant under section 1901 to the State for the fiscal year to the total amount of such grants for the year. The amount paid to a State under the preceding sentence shall be considered by the Secretary to be part of the grant made to the State under section 1901 for such fiscal year.

## PART 3—HEALTH CENTERS FOR POPULATIONS LACKING ACCESS TO SERVICES

**SEC. 7121. PURPOSE OF PROGRAM.**

The purpose of the program under title XXVII of the Public Health Service Act (added by section 7123 of this Act) is to achieve the goal that federally qualified health centers in operation as of the date of the enactment of this Act, and such centers developed and placed into operation pursuant to such title XXVII, will have sufficient capacity to provide the required services of the centers to all rural and urban medically underserved populations that, as of December 31, 1995, were designated by the Secretary as such a population.

**SEC. 7122. TABLE OF CONTENTS REGARDING NEW TITLE XXVII OF PUBLIC HEALTH SERVICE ACT.**

A table describing the contents of title XXVII of the Public Health Service Act, as added by section 7123 of this Act, is as follows:

**SEC. 7123. DIRECT SPENDING REGARDING FEDERALLY QUALIFIED HEALTH CENTERS; TEMPORARY PROGRAM FOR DEVELOPMENT OF ADDITIONAL CENTERS.**

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following title:

# "TITLE XXVII—FEDERALLY QUALIFIED HEALTH CENTERS

## "Subtitle A—Unfunded Portion of Operational Costs of Rural and Urban Centers

### "PART 1—GRANTS REGARDING UNFUNDED PORTION OF OPERATIONAL COSTS

**"SEC. 2701. CAPPED ENTITLEMENT REGARDING UNFUNDED PORTION OF OPERATIONAL COSTS.**

"(a) IN GENERAL.—In the case of any public or nonprofit private entity that in accordance with section 2716 submits to the Secretary an application for a fiscal year demonstrating that the entity is a federally qualified health center, the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make a grant to the entity for such year for the purposes determined under section 2721. The grant shall be made in an amount determined under section 2741, subject to subsections (b) through (e). Grants under this subsection may only be made for fiscal year 1996 and subsequent fiscal years.

"(b) DIRECT SPENDING.—For carrying out this title, there are hereby appropriated, out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

"(1) For fiscal year 1996, $1,325,000,000.

"(2) For fiscal year 1997, $1,630,000,000.

"(3) For fiscal year 1998, $1,750,000,000.
"(4) For fiscal year 1999, $1,750,000,000.
"(5) For fiscal year 2000, $1,800,000,000.
"(6) For fiscal year 2001, $1,850,000,000.
"(7) For fiscal year 2002, $1,950,000,000.
"(8) For fiscal year 2003, $1,850,000,000.
"(9) For fiscal year 2004, $1,950,000,000.
"(10) For fiscal year 2005, the amount specified in paragraph (9) multiplied by an amount equal to the product of—
"(A) 1 plus the national medicare growth factor (as defined in section 8201(c) of the Guaranteed Health Insurance Act of 1994); and
"(B) 1 plus the annual percentage increase projected by the Secretary to occur during such year in the populations served by federally qualified health centers.
"(11) For fiscal year 2006 and each subsequent fiscal year, the amount determined under this subsection for the preceding fiscal year multiplied by an amount equal to the product of subparagraphs (A) and (B) of paragraph (10) (as such subparagraphs are applied for the fiscal year involved).
"(c) ENTITLEMENT STATUS OF GRANTS.—
"(1) IN GENERAL.—Effective on and after October 1, 1995, in the case of a federally qualified health center, the requirement established in subsection (a) for the Secretary (relating to making a grant)—
"(A) is an entitlement in the center on behalf of individuals served by the center (but is not an entitlement in any such individual); and
"(B) represents the obligation of the Federal Government, subject to paragraph (2), to make a grant under subsection (a) to the center in the amount determined for the center under section 2741.
"(2) CAPPED ENTITLEMENT.—With respect to making grants under subsection (a) to federally qualified health centers in the amounts determined under section 2741, the entitlement established in paragraph (1) for such centers is subject to the extent of the amount appropriated in subsection (b) for the fiscal year and to allocations under subsections (d) and (e).
"(3) PRO RATA REDUCTIONS UNDER CAP AMOUNT.—With respect to making grants under subsection (a) for a fiscal year to federally qualified health centers in the amounts determined under section 2741, if the Secretary determines that the budget authority provided in subsection (b) is insufficient to both provide the amounts under section 2741 and make the allocations under subsections (d) and (e), the Secretary shall first make the allocation under subsection (e) and then reduce each amount determined under section 2741 for such year on a pro rata basis to the extent necessary for the grants under subsection (a) to be provided in an aggregate amount equal to the balance of the budget authority.
"(4) NATURE OF ENTITLEMENT.—With respect to the purposes for which a grant under subsection (a) is authorized to be expended, modifications in such purposes enacted after the date of the enactment of the Guaranteed Health Insurance Act of 1994 do not affect the amount of budget authority provided in subsection (b) for any fiscal year.
"(d) ALLOCATIONS REGARDING DEVELOPMENT OF ADDITIONAL CENTERS.—Of the budget authority provided in subsection (b) for a fiscal year, the Secretary shall, for the purpose of making grants under section 2751 (relating to the development of federally qualified health centers), reserve the following amount, as applicable to the fiscal year involved:
"(1) For fiscal year 1996, $75,000,000.
"(2) For fiscal year 1997, $80,000,000.
"(3) For fiscal year 1998, $100,000,000.
"(4) For fiscal year 1999, $100,000,000.

"(5) For fiscal year 2000, $100,000,000.
"(6) For fiscal year 2001, $100,000,000.
"(7) For fiscal year 2002, $150,000,000.

"(e) ALLOCATIONS FOR UNANTICIPATED NEEDS.—

"(1) IN GENERAL.—Of the budget authority provided in subsection (b) for a fiscal year, the Secretary shall reserve 2 percent for—

"(A) making grants to any federally qualified health center that, in the determination of the Secretary, has a need for such a grant to assist the center in responding to unanticipated needs for required services or additional services that have arisen in the service area of the center, or in responding to other unanticipated circumstances that have arisen in the provision by the center of required services or additional services; and

"(B) making grants to any grantee under section 2751 that, in the determination of the Secretary, has a need for a such a grant to assist the grantee in responding to unanticipated circumstances that have arisen in carrying out the project under such section.

"(2) ALLOCATION TO GRANTEES OF UNOBLIGATED AMOUNTS.—With respect to amounts that are reserved under paragraph (1) for a fiscal year and that are unobligated as of September 30 of the fiscal year (referred to in this subsection as the 'unobligated balance'), the Secretary shall pay to each federally qualified health center and to each grantee under section 2751, from the unobligated balance, an amount equal to the product of such balance and the percentage constituted by the ratio of the amount of the grant for the fiscal year for such center or grantee (made under subsection (a) or section 2751, respectively) to the sum of the total amount of grants under subsection (a) for the year and the total amount of grants under section 2751 for the year. The amount paid to such center or grantee under the preceding sentence shall be considered by the Secretary to be part of the grant made for such fiscal year to the center or grantee under subsection (a) or section 2751, respectively.

"(f) DEFINITION OF FEDERALLY QUALIFIED HEALTH CENTER.—

"(1) IN GENERAL.—For purposes of this title, the term 'federally qualified health center' means a public or nonprofit private entity that is described in paragraph (2) or (3), and that operates a health center that—

"(A) serves any medically underserved populations (as defined in section 2752(b)) in the service area designated for the center under section 2743;

"(B) meets each of the conditions described in part 2 (relating to current status);

"(C) meets each of the conditions described in part 3 (relating to agreements on future status); and

"(D) meets each of the conditions described in sections 2741 and 2742 of part 4 (relating to general provisions).

"(2) RELATIONSHIP TO STATUS IN FISCAL YEAR 1995.—For purposes of paragraph (1), an entity described in this paragraph is an entity that met one or more of the following conditions for fiscal year 1995:

"(A) The entity received a grant under section 329, 330, 340, or 340A, as in effect for such year.

"(B) The entity applied for such a grant and was approved by the Secretary as meeting the requirements for such a grant, but the entity did not receive a grant because the amount of funding available to the Secretary for such grants was insufficient to make a grant to all entities so approved.

"(C) The entity was certified by the Secretary as a Federally-qualified health center under section 1905(l)(2)(B) of the Social Security Act.

"(3) RELATIONSHIP TO DEVELOPMENT GRANTS.—For purposes of paragraph (1), an entity described in this paragraph is an entity that, for fiscal year 1996 or any subsequent fiscal year, received a grant under section 2751 of subtitle B (relating to the development of centers).

## "PART 2—SERVICES AND STRUCTURE OF CENTERS; OTHER CONDITIONS REGARDING CURRENT STATUS

### "SEC. 2711. REQUIRED SERVICES OF CENTERS; ADDITIONAL SERVICES.

"(a) SERVICES GENERALLY; AVAILABILITY.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is as follows:

"(1) The center involved (directly or through contracts or cooperative agreements with public or private entities)—

"(A) provides the required services (as defined in subsection (b)); and

"(B) provides any additional service (as defined in section 2722) that is included for the center in the plan in effect for the center under section 2721(d).

"(2) The center makes the required and additional services available to all individuals (subject to the extent of the capacity of the center), unless the Secretary provides a waiver for the entity under which the center provides the services principally to migratory or seasonal agricultural workers and related individuals, or principally to Indians. The Secretary shall provide such a waiver upon request of the center regarding the individuals involved if, for fiscal year 1995, the center principally served such individuals. Before making a grant under section 2701 for a fiscal year to a center for which such a waiver was in effect for the previous fiscal year, the Secretary shall review the circumstances involved to determine whether the waiver should remain in effect.

"(b) REQUIRED SERVICES.—

"(1) IN GENERAL.—For purposes of this title, the term 'required services' means the following:

"(A) Basic health services.

"(B) Referrals to providers of medical services and other health-related services.

"(C) Patient case management services.

"(D) Required enabling services, subject to subsection (c).

"(2) BASIC HEALTH SERVICES.—For purposes of this title, the term 'basic health services' means the following:

"(A) Services of health professionals.

"(B) Diagnostic laboratory and radiologic services.

"(C) Preventive health services.

"(D) Emergency medical services.

"(E) Preventive dental services, subject to subsection (c).

"(F) Pharmaceutical services, subject to subsection (c).

"(3) PREVENTIVE HEALTH SERVICES.—With respect to the definition of the term 'preventive health services' for purposes of this title—

"(A) for each of the fiscal years 1996 through 1998, such term includes prenatal and perinatal services; screening for breast and cervical cancer (including mammography); well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, for communicable diseases, and for cholesterol; pediatric eye and ear examinations to determine the need for vision and hearing correction; and voluntary family planning services; and

"(B) for fiscal year 1999 and subsequent fiscal years, such term means services specified in subparagraph (A), and in addition, any preventive or screening service included in the guaranteed national benefit package under subtitle A of title III of the Guaranteed Health Insurance Act of 1994.

"(4) PATIENT CASE MANAGEMENT SERVICES.—For purposes of this title, the term 'patient case management services' means services that will assist patients of a center in gaining access to needed medical, social, educational, and other services.

"(5) REQUIRED ENABLING SERVICES.—

"(A) For purposes of this title, the term 'required enabling services' means services specified in subparagraph (B) that are provided for the purpose of enabling individuals to utilize the services of the center involved.

"(B) The services referred to in subparagraph (A) are (as necessary in the service area of the center involved) transportation, community and patient outreach, patient education, and translation services.

"(c) APPLICABILITY OF CERTAIN REQUIREMENTS.—

"(1) IN GENERAL.—If, for fiscal year 1995, a center did not provide a service specified in paragraph (2), the requirement under subsection (a) to provide the service is effective for fiscal year 1999 and subsequent fiscal years, except as provided in subparagraph (B). With respect to the fiscal years 1996 through 1998, the following applies to the center:

"(A) If, for such a fiscal year, the center (at the option of the center) includes the service in the proposed plan submitted under 2721(a)(1), the Secretary shall include the service in the plan in effect for the center under 2721(d) for the year.

"(B) Upon the service being so included in the plan, the center is subject to the requirement under subsection (a) to provide the service each fiscal year.

"(2) RELEVANT SERVICES.—A service referred to in paragraph (1) is any required enabling service, any preventive dental service, and any pharmaceutical service.

"(d) OTHER DEFINITIONS.—For purposes of this title:

"(1) The term 'Indian' means an individual who, under section 4 of the Indian Health Care Improvement Act, is an Indian or an urban Indian.

"(2)(A) The term 'migratory or seasonal agricultural worker, or related individual' means each of the following:

"(i) A migratory agricultural worker.

"(ii) A seasonal agricultural worker.

"(iii) A member of the family of a migratory or seasonal agricultural worker.

"(iv) An individual who previously was such a worker, but who no longer meets the definition under subparagraph (B) or (C) because of age or disability.

"(v) A member of the family of an individual described in clause (iv).

"(B) The term 'migratory agricultural worker' means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.

"(C) The term 'seasonal agricultural worker' means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

"(D) The term 'agriculture' means farming in all its branches, including—

"(i) cultivation and tillage of the soil;

"(ii) the production, cultivation, growing, and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on, the land; and

"(iii) any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described in clause (i).

"SEC. 2712. ACTIVITIES FOR SPECIAL POPULATIONS.

"(a) DEFINITION OF SPECIAL POPULATIONS.—For purposes of this title, the term 'special population' means each of the following populations:

"(1) Homeless individuals.

"(2) Residents of public housing.

"(3) Individuals with HIV disease, tuberculosis, or other communicable diseases.

"(4) Such other populations as the Secretary may identify as having significant particularized difficulties in obtaining the services of federally qualified health centers.

"(b) RULE OF CONSTRUCTION.—The activities carried out under subsection (c) for special populations are in addition to the services carried out for such populations under section 340 and 340A.

"(c) REQUIRED ACTIVITIES.—Effective for fiscal year 1996 and subsequent fiscal years, a condition under section 2701(f) for status as a federally qualified health center is that the center involved carries out, for each special population activities to overcome the particularized difficulties experienced by the population in obtaining the services of the center.

"(d) DEFINITIONS.—For purposes of this title:

"(1) The term 'homeless individual' means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

"(2) The term 'resident of public housing' means a resident of housing that is public housing as defined in section 3(b)(1) of the United States Housing Act of 1937.

"SEC. 2713. GOVERNING BOARD.

"(a) REQUIREMENTS.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved has established a governing board meeting the following requirements:

"(1) Except as provided in subsection (b), such board is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center.

"(2) The board establishes general policies for the center, except as provided in subsection (c).

"(3) The board reviews the application to be submitted by the center under section 2716, including the proposed plan for the center developed under section 2721(a)(1), and approves or disapproves the application.

"(4) The board approves the selection of a director for the center.

"(5) The board meets at least once quarterly.

"(b) INDIAN TRIBES AND ORGANIZATIONS.—The requirement of subsection (a)(1) does not apply to the governing board of a center if the center is operated by an Indian tribe or tribal organization under the Indian Self-Determination Act.

"(c) CENTERS OF CERTAIN PUBLIC ENTITIES; MODIFIED BOARDS.—

"(1) IN GENERAL.—In the case of a center operated by a public entity, the requirement of subsection (a)(2) does not apply to the personnel policies of the center, or the fiscal policies of the center (subject to paragraph (2)), if—

"(A) the center is operated by an entity described in section 2701(f)(2), and for fiscal year 1994 was not required to permit the governing board of the center to establish personnel or fiscal policies for the center; or

"(B) for fiscal year 1996 or any subsequent fiscal year, the center received a grant under subtitle B (relating to the development of centers) and, under section 2753, was not so required.

"(2) RULE OF CONSTRUCTION.—The requirements of subsection (a)(3), including with respect to the proposed plan under section 2721, apply to a center notwithstanding the provisions of paragraph (1) regarding fiscal policies.

"SEC. 2714. SCHEDULE OF FEES AND DISCOUNTS.

"A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved is in compliance with the following:

"(1) The center has maintained and is maintaining a schedule of fees for the provision of the services of the center, and the schedule has been and is consistent with locally prevailing rates or charges.

"(2) In the case of any portion of a fee for which a patient of the center has the responsibility of making payment (including amounts owed pursuant to requirements of health plans regarding copayments and deductibles), the center has maintained and is maintaining a schedule of discounts to be applied to the payment of such portion, and the discounts have been and are being adjusted in accordance with section 303(f) of part 51c of title 42, Code of Federal Regulations (42 CFR 51c.303(f)), as in effect for fiscal year 1994.

"(3) With respect to the schedule of fees under paragraph (1) and the schedule of discounts under paragraph (2), the center has made and is making every reasonable effort to secure in accordance with the schedules payments from patients, subject to paragraph (4).

"(4) In the case of an individual seeking a service of the center, the center has not conditioned and is not conditioning the provision of the service on payment for the service, and the center has provided and is providing the service without regard to whether the individual has paid the portions of fees imposed by the center for which the individual has the responsibility of making payments (including amounts owed pursuant to requirements of health plans regarding copayments and deductibles).

"SEC. 2715. ADDITIONAL CONDITIONS.

"A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved is in compliance with the following:

"(1) The services of the center have been and are available and accessible in the service area of the center promptly, as appropriate, and in a manner that assures continuity.

"(2) The center has maintained and is maintaining organizational arrangements that provide for—

"(A) an ongoing quality assurance program regarding the services of the center; and

"(B) procedures to maintain the confidentiality of patient records.

"(3) The center has maintained and is maintaining an ongoing referral relationship with one or more hospitals.

"(4) The center has maintained and is maintaining compliance with applicable Federal law on accounting procedures, including such requirements on accounting procedures as the Secretary may establish specifically for the expenditure of a grant under section 2701.

"(5) The center has provided and is providing the services of the center in the language and cultural context that is most appropriate for the patients involved.

"SEC. 2716. APPLICATION FOR GRANT.

"(a) IN GENERAL.—For purposes of section 2701(a), an application for a grant under such section for a fiscal year for a center is in accordance with this section if the application—

"(1) is submitted not later than the date specified by the Secretary;

"(2) contains the proposed plan required in section 2721(a)(1);

"(3) demonstrates that the application, including such plan, has been approved by the governing board of the center;

"(4) contains the agreements required in this subtitle, and otherwise demonstrates that the center meets the conditions established in this subtitle regarding status as a federally qualified health center; and

"(5) is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subtitle.

"(b) AGREEMENT REGARDING CONTINUANCE OF CURRENT STATUS.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved agree to continue serving any medically underserved populations in the service area of the center, and to continue meeting each of the conditions described in this part.

## "PART 3—REQUIRED AGREEMENTS

"SEC. 2721. EXPENDITURE OF GRANT; OPERATIONAL COSTS.

"(a) IN GENERAL.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is as follows:

"(1) The center involved submits to the Secretary, in accordance with subsection (d), a proposed plan for the expenditure by the center of a grant under section 2701 for the fiscal year.

"(2) The center agrees to expend the grant only for costs that are specified in subsection (b) and only in accordance with the plan in effect for the center for the year under subsection (d).

"(b) OPERATIONAL COSTS.—

"(1) IN GENERAL.—For purposes of subsection (a)(2), the costs specified in this subsection regarding the expenditure by a federally qualified health center of a grant under section 2701 are the costs of providing the required services; the costs of providing any additional services (as defined in section 2722) that are included for the center in the plan in effect under subsection (d); and the costs of otherwise operating the center involved in accordance with the conditions established in this subtitle.

"(2) REQUIRED ALLOWANCE OF CERTAIN COSTS.—The Secretary shall under paragraph (1) authorize each federally qualified health center to expend a grant under section 2701 for the following costs:

"(A) The costs of providing the required services and the additional services involved.

"(B) The costs of recruiting, training, and compensating the staff of the center.

"(C) The costs of administering the center, including the costs of participating as a provider in one or more health plans.

"(D) The costs of carrying out offsite activities with respect to the required and additional services.

"(3) DISCRETIONARY ALLOWANCE OF CERTAIN COSTS.—In the case of the center involved, the Secretary may under paragraph (1) authorize the expenditure of a grant under section 2701 for any or all of the following costs (in addition to expenditures authorized under paragraph (2)):

3(40)(A)(iv) of the Employee Retirement Income Security Act of 1974.

(6) RURAL TELEPHONE COOPERATIVE ASSOCIATIONS.—The term "rural telephone cooperative association" has the meaning given such term in section 3(40)(A)(v) of the Employee Retirement Income Security Act of 1974.

**SEC. 5103. NON-DISCRIMINATION.**

(a) IN GENERAL.—Section 5002 shall apply with respect to a sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

(b) PROHIBITING OFFERING INDUCEMENT TO ENROLL IN INSURED HEALTH BENEFIT PLANS.—A sponsor of a self-insured health benefit plan may not offer any inducement to any individual eligible to seek coverage through the sponsor to seek coverage elsewhere.

**SEC. 5104. REQUIREMENTS RELATING TO ENROLLMENT.**

(a) ENROLLMENT IN CHOSEN PLAN.—The sponsor of a self-insured health benefit plan shall enroll an individual eligible to seek coverage through the sponsor in the plan chosen by the individual from among the plans offered by the sponsor (in accordance with the requirements of section 5107).

(b) ANNUAL OPEN ENROLLMENT PERIOD.—The sponsor of a self-insured health benefit plan shall provide for an annual open enrollment period of at least 45 days during which individuals eligible to enroll in the plan may change the health benefit plan under which they are provided coverage.

(c) CHANGES IN ENROLLMENT DURING 1ST YEAR OF ENROLLMENT.—Once during the first year for which an individual is enrolled in a plan offered by the sponsor of a self-insured health benefit plan, the individual may change the health benefit plan in which the individual is enrolled. Such a change shall be effective on the first day of the first month beginning at least 45 days after the date the sponsor receives a notice of change of coverage.

(d) ENROLLMENT OF NEWLY ELIGIBLE INDIVIDUALS.—The sponsor of a self-insured health benefit plan may not refuse to enroll an individual who is eligible to enroll in a health benefit plan offered by the sponsor and is not enrolled in such a plan.

**SEC. 5105. PROHIBITION ON PRE-EXISTING CONDITION EXCLUSIONS.**

The provisions of section 5004(a) shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

**SEC. 5106. PROHIBITION ON WAITING PERIODS.**

(a) IN GENERAL.—The provisions of section 5005(a) shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

(b) COVERAGE AFTER ENROLLMENT DURING ANNUAL OPEN ENROLLMENT PERIOD.—In the case of an individual who enrolls in a self-insured health benefit plan during an open enrollment period described in section 5104(b), the sponsor shall provide coverage of the individual under the plan effective as of such date as the sponsor may establish with respect to enrollments made during such period (consistent with the standards established by the Secretary of Health and Human Services under section 5501(c)).

**SEC. 5107. BENEFIT REQUIREMENTS.**

(a) OFFER OF PLAN CONSISTING OF GUARANTEED NATIONAL BENEFIT PACKAGE.—Each sponsor of a self-insured health benefit plan—

(1) shall offer all enrollees a health benefit plan consisting only of coverage for the benefits (including cost-sharing) contained in the guaranteed national benefit package, and

(2) may offer a health benefit plan consisting of coverage for the benefits described in paragraph (1) and (subject to subsection (d)) additional benefits.

(b) OFFER OF PLAN PROVIDING UNLIMITED CHOICE OF PROVIDERS.—Each sponsor of a self-insured health benefit plan shall assure that all enrollees are offered coverage in—

(1) at least one managed care plan (unless there is no such plan available in the area); and

(2) at least one unlimited-choice-of-provider plan, which may be a point-of-service plan.

(c) SPECIAL RULE FOR ENROLLEES COVERED UNDER STATE MANAGED MENTAL HEALTH PROGRAMS.—The provisions of section 5007(c) shall apply to sponsors of self-insured health benefit plans in the same manner as they apply to carriers providing insured health benefit plans.

(d) NON-DISCRIMINATION IN ADDITIONAL BENEFITS FOR NON-EMPLOYER PLANS.—In the case of a self-insured health benefit plan with an eligible sponsor described in subparagraph (B) or (C) of section 5102(b)(1), if the sponsor offers additional benefits pursuant to subsection (a)(2) that consist of a reduction in the cost-sharing imposed under a plan, the sponsor shall provide such additional benefits to all enrollees in the same manner as an employer would be required under 1112.

**SEC. 5108. REQUIREMENTS RELATING TO RATING OF PREMIUMS.**

(a) CHARGING RATES BY CLASS OF ENROLLMENT.—The sponsor of a self-insured health benefit plan shall establish separate premium rates for each of the three classes of enrollment described in section 3(b) of the Guaranteed Health Insurance Act of 1994.

(b) VARIATIONS ONLY BY ACTUARIAL VALUE.—

(1) IN GENERAL.—The differences among premium rates established under subsection (a) shall reflect only differences in the actuarial value of the guaranteed national benefit package among the classes of enrollment, consistent with standards established by the Secretary of Health and Human Services.

(2) PERMITTING VARIATION BY GEOGRAPHIC AREA OF ENROLLMENT.—At the option of the sponsor of a self-insured health benefit plan, in applying paragraph (1) the sponsor may vary premium rates based on differences in the actuarial value of the package among classes of enrollment in geographic areas, but only if the geographic areas applied are the same as the community-rating areas established under section 5008(d) with respect to insured health benefit plans offered in the State.

(c) EXCEPTION FOR SPONSORS PAYING ENTIRE PREMIUM.—Subsections (a) and (b) shall not apply in the case of a self-insured health benefit plan offered by a sponsor for which the sponsor does not require the enrollee to contribute any portion of the applicable premium.

**SEC. 5109. ADDITIONAL STANDARDS FOR MANAGED CARE PLANS AND POINT-OF-SERVICE PLANS.**

The provisions of section 5009 shall apply with respect to a managed care plan and a point-of-service plan provided by the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a managed care plan and point-of-service plan provided by the carrier providing an insured health benefit plan.

**SEC. 5110. PROVISION OF PLAN INFORMATION.**

(a) IN GENERAL.—The sponsor of a self-insured health benefit plan shall annually prepare and make available to individuals eligible to enroll in the plan, in a uniform format, information on the plans offered by the sponsor.

(b) INFORMATION DESCRIBED.—The information required to be provided under subsection (a) shall include summary information described in section 5011(b)(2) (other than information described in subparagraph (A)(vi)).

(c) DISCLOSURE OF UTILIZATION REVIEW AND QUALITY STANDARDS.—Upon the request of any individual eligible to enroll in a self-insured health benefit plan offered by a sponsor, the sponsor shall make available information on—

(1) procedures used by the plan to control utilization of services and expenditures, and

(2) procedures used by the plan to assure quality of care.

**SEC. 5111. REQUIREMENTS FOR ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.**

The provisions of section 5012 shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

**SEC. 5112. UTILIZATION REVIEW.**

The provisions of section 5014 shall apply with respect to a utilization review program of a self-insured health benefit plan in the same manner as such provisions apply with respect to a utilization review program of an insured health benefit plan.

**SEC. 5113. ACCEPTANCE OF PREMIUM CERTIFICATES.**

The provisions of section 5015 shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

**SEC. 5114. ADDITIONAL REQUIREMENTS FOR SELF-INSURED HEALTH BENEFIT PLANS.**

The additional requirements described in section 5016 shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such additional requirements apply with respect to a carrier providing an insured health benefit plan, except that the requirements of paragraph (2) of such section shall not apply in the case of a sponsor who is not required to participate in a State system approved under title IV.

## PART 2—RESPONSIBILITIES RELATING TO FINANCING

**SEC. 5121. RESERVE REQUIREMENTS.**

(a) IN GENERAL.—The Secretary of Labor shall ensure that each sponsor of a self-insured health benefit plan maintains plan assets in trust as provided in section 403 of the Employee Retirement Income Security Act of 1974—

(1) without any exemption under section 403(b)(4) of such Act, and

(2) in amounts which the Secretary of Labor determines are sufficient to provide at any time for payment to health care providers of all outstanding balances owed by the plan at such time.

The requirements of the preceding sentence may be met through letters of credit, bonds, or other appropriate security to the extent provided in regulations of the Secretary of Labor.

(b) SOLVENCY REQUIREMENTS.—The Secretary of Labor shall—

(1) prescribe such additional financial reserve requirements (which may include requirements relating to the use of aggregate and specific stop-loss insurance, reinsurance, or any other insurance requirement), and

(2) establish such limits on the amount of risk such a plan may retain,

as may be appropriate to assure the solvency of a self-insured health benefit plan. The requirements and limits shall take into account the number of lives covered and other appropriate risk-related factors identified by the Secretary of Labor.

(c) DISCLOSURE.—The sponsor of a self-insured health benefit plan shall notify the Secretary of Labor at such time as the financial reserve requirements of this section are not being met. The Secretary of Labor may assess a civil money penalty of not more

than $100,000 against any sponsor for any failure to provide such notification in such form and manner and within such time periods as such Secretary may prescribe by regulation.

SEC. 5122. TRUSTEESHIP OF INSOLVENT PLANS BY SECRETARY OF LABOR.

(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary of Labor determines that self-insured health benefit plan will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of such Secretary, the Secretary of Labor shall, upon notice to the plan, apply to the appropriate United States district court for appointment of such Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the enrolled individuals or health care providers or to avoid any unreasonable deterioration of the financial condition of the plan or any unreasonable increase in the liability of the Self-Insured Plan Insolvency Fund. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

(b) POWERS AS TRUSTEE.—The Secretary of Labor, upon appointment as trustee under subsection (a), shall have the power—

(1) to do any act authorized by the plan, this Act, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

(3) to invest any assets of the plan which such Secretary holds in accordance with the provisions of the plan, regulations of such Secretary, and applicable provisions of law,

(4) to do such other acts as such Secretary deems necessary to continue operation of the plan without increasing the potential liability of the Self-Insured Plan Insolvency Fund, if such acts may be done under the provisions of the plan,

(5) to require the plan sponsor, the plan administrator, any contributing employer, and any employee organization representing covered individuals to furnish any information with respect to the plan which such Secretary as trustee may reasonably need in order to administer the plan,

(6) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

(7) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

(8) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

(9) to terminate the plan and liquidate the plan assets in accordance with applicable provisions of this Act and other provisions of law, to restore the plan to the responsibility of the large group sponsor, or to continue the trusteeship,

(10) to take such steps as may be necessary to ensure the continuation of the individual's enrollment in a plan providing coverage of the guaranteed national benefit package, and

(11) to do such other acts as may be necessary to comply with this Act or the Employee Retirement Income Security Act of 1974 or any order of the court and to protect the interests of enrolled individuals and health care providers.

(c) NOTICE OF APPOINTMENT.—As soon as practicable after such Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

(1) the plan administrator,

(2) each enrolled individual,

(3) each employer who may be liable for contributions to the plan, and

(4) each employee organization which, for purposes of collective bargaining, represents enrolled individuals.

(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this Act or title I of the Employee Retirement Income Security Act of 1974, the Secretary of Labor, upon appointment as trustee under this section, shall have the same rights, powers, and duties as those of a trustee under chapters 1, 3 (other than the right to compensation under section 330), and 5, and subchapters I and II of chapter 7, of title 11, United States Code, and shall have the duties of a fiduciary for purposes of such title I.

(e) OTHER PROCEEDINGS.—An application by the Secretary of Labor under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

(f) JURISDICTION OF COURT.—

(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this subsection, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this subsection, of a court of the United States having jurisdiction over cases under title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary of Labor as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the large group sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of such Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

(2) VENUE.—An action under this subsection may be brought in the judicial district where the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

(g) PERSONNEL.—In accordance with regulations of the Secretary of Labor, such Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with such Secretary's service as trustee under this section.

**SEC. 5123. PROVISION OF AMOUNTS DUE PROVIDERS FROM INSOLVENT PLANS.**

(a) IN GENERAL.—To the extent that amounts are available in the Fund established under subsection (b), the Secretary of Labor shall make payment from such Fund of outstanding amounts due to providers under a self-insured health benefit plan while such plan is under such Secretary's trusteeship under section 5122.

(b) SELF-INSURED PLAN INSOLVENCY FUND.—

(1) ESTABLISHMENT.—The Secretary of Labor shall establish a Self-Insured Plan Insolvency Fund (hereinafter in this part referred to as the "Fund") from which the Secretary shall authorize payment of the amounts described in subsection (a).

(2) BORROWING AUTHORITY.—At the direction of the Secretary of Labor, the Fund may, to the extent necessary to carry out this section, issue to the Secretary of the Treasury notes or other obligations, in such forms and denominations, bearing

such maturities, and subject to such terms and conditions as may be prescribed by the Secretary of the Treasury. The total balance of the Fund obligations outstanding at any time shall not exceed $500,000,000. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of such notes or other obligations by the Fund. The Secretary of the Treasury shall purchase any notes or other obligations issued by the Fund under this paragraph, and for that purpose the Secretary of the Treasury may use as a public debt transaction the proceeds from the sale of any securities issued under chapter 31 of title 31, United States Code and the purposes for which securities may be issued under such chapter are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by such Secretary under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States.

(3) PROTECTION FOR ENROLLEES.—The Secretary of Labor shall take such actions as may be necessary to assure that health care providers continue to care for eligible individuals enrolled in such a plan while the plan is under trusteeship.

**SEC. 5124. IMPOSITION AND COLLECTION OF PERIODIC ASSESSMENTS ON PLAN SPONSORS.**

(a) IMPOSITION OF ASSESSMENTS.—The Secretary of Labor may impose assessments under this section to enable the Fund to repay amounts borrowed by the Fund while maintaining a balance sufficient to ensure the Fund's solvency.

(b) LIMITATION ON AMOUNT OF ASSESSMENT.—The total amount assessed against a plan under this section during a year may not exceed two percent of the total amount contributed to the plan toward the enrollment of individuals under the plan during the year.

(c) PAYMENT OF ASSESSMENTS.—

(1) OBLIGATION TO PAY.—The designated payor of each plan shall pay the assessments imposed by the Secretary of Labor under this section with respect to that plan when they are due. Assessments under this section are payable at the time, and on an estimated, advance, or other basis, as determined by such Secretary. Assessments shall continue to accrue until the plan's assets are distributed pursuant to a termination procedure or such Secretary is appointed to serve as trustee of the plan under section 5122.

(2) LATE PAYMENT CHARGES AND INTEREST.—

(A) LATE PAYMENT CHARGES.—If any assessment is not paid when it is due, the Secretary of Labor may assess a late payment charge plus interest, as prescribed by such Secretary in regulations.

(B) WAIVERS.—Late payment charges and interest under subparagraph (A) shall not apply to any assessment payment made within 60 days after the date on which payment is due, if before such date, the designated payor obtains a waiver from the Secretary of Labor based upon a showing of substantial hardship arising from the timely payment of the assessment.

(d) CIVIL ACTION UPON NONPAYMENT OR LATE PAYMENT.—If any designated payor fails to pay an assessment when due, the Secretary of Labor may bring a civil action in any district court of the United States within the jurisdiction of which the plan assets are located, the plan is administered, or in which a defendant resides or is found, for the recovery of the amount of the unpaid assessment, reasonable interest, any late payment charge, and inter-

est, and process may be served in any other district. The district courts of the United States shall have jurisdiction over actions brought under this subsection by the Secretary of Labor without regard to the amount in controversy.

(e) DESIGNATED PAYOR DEFINED.—

(1) IN GENERAL.—For purposes of this section, the term "designated payor" means—

(A) the employer or plan administrator in any case in which the eligible sponsor of the plan is described in subparagraph (A) of section 5101(b)(1); and

(B) the contributing employers or the plan administrator in any case in which the eligible sponsor of the large group sponsor is described in subparagraph (B) or (C) of section 5101(b)(1).

(2) CONTROLLED GROUPS.—If an employer is a member of a controlled group, each member of such group shall be jointly and severally liable for any assessments required to be paid by such employer. For purposes of the preceding sentence, the term "controlled group" means any group treated as a single employer under subsection (b) or (c) of section 414 of the Internal Revenue Code of 1986.

SEC. 5125. MANAGEMENT OF FUNDS; RELATIONS WITH EMPLOYEES.

(a) MANAGEMENT OF FUNDS.—The management of funds by the sponsor of a self-insured health benefit plan shall be subject to the applicable fiduciary requirements of title I of the Employee Retirement Income Security Act of 1974.

(b) MANAGEMENT OF FINANCES AND RECORDS; ACCOUNTING SYSTEM.—Each sponsor of a self-insured health benefit plan shall comply with standards relating to the management of finances and records and accounting systems as the Secretary of Labor shall specify.

## Subtitle C—Standards for Supplemental Health Plans

SEC. 5201. REQUIREMENT FOR CERTIFICATION OF CARRIERS AND POLICIES.

(a) CERTIFICATION REQUIRED.—

(1) IN GENERAL.—No carrier may sell, issue, or renew a contract under a supplemental health benefit policy (as defined in section 5504(11)) with respect to any individual or group in a State, unless the carrier, in relation to the plan, and the plan have been certified as meeting the applicable standards established under section 5501 consistent with this subtitle—

(A) by a State regulatory program of the State (approved under section 5502), or

(B) in the case of a State without such an approved program, by the Secretary (in accordance with such procedures as the Secretary establishes).

(2) POLICY DISAPPROVED.—If the applicable regulatory authority determines that a carrier with respect to a supplemental health benefit policy does not meet the applicable standards of this title on or after the effective date described in subsection (d), the carrier may not provide coverage under the policy to individuals not enrolled as of the date of the determination and may not continue to provide the policy for policy years beginning after the date of such determination until the authority determines that such carrier and policy are in compliance with such standards.

(3) SPECIAL RULE FOR CARRIERS OFFERING POLICIES IN MULTI-STATE METROPOLITAN STATISTICAL AREAS.—In the case of a carrier offering or selling a supplemental health benefit policy in a portion of a State that is located in a metropolitan statistical area, the carrier may not sell, issue, or renew a contract under the policy with respect to an individual or em-

ployer in such metropolitan statistical area unless the carrier, in relation to the policy, and the policy have been certified as meeting the applicable standards established under section 5501 by the State regulatory program of each State in which the metropolitan statistical area is located. The Secretary may waive the application of this paragraph to a carrier under extraordinary circumstances.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subsection (a) shall apply to contracts under supplemental health benefit policies sold, issued, or renewed on or after January 1, 1997.

(2) EXCEPTION FOR PLANS OFFERED IN STATES REQUIRING LEGISLATION.—In the case of a supplemental health benefit policy sold, issued, or renewed in a State which the Secretary identifies, in consultation with the NAIC, as—

(A) requiring State legislation (other than legislation appropriating funds) in order for carriers and plans to meet the requirements of this subtitle, but

(B) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,

the date specified in this subsection is January 1, 1998, or, if earlier, the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1998. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

**SEC. 5202. STANDARDIZED BENEFITS.**

(a) LIMITATION ON POLICIES PERMITTED.—An carrier may not offer or sell a supplemental health benefit policy unless the benefits covered by the policy meet the requirements for one of the standard benefit packages established by the Secretary under subsection (b).

(b) ESTABLISHMENT OF STANDARDIZED PACKAGES.—

(1) IN GENERAL.—Not later than July 1, 1995, the Secretary shall establish not more than 10 standardized benefit packages for supplemental health benefit policies under this subtitle. Of such packages—

(A) the Secretary shall designate one as a core supplemental benefit package consisting of a reasonable combination of benefits typical of such policies; and

(B) at least one shall be designed to supplement a managed care plan.

(2) CRITERIA USED IN ESTABLISHING PACKAGES.—In establishing standardized benefit packages under paragraph (1), the Secretary shall take into account State laws that mandate the inclusion of particular benefits and providers of services, and the benefits typically offered or sold by health plans that are not included in the guaranteed national benefit package.

**SEC. 5203. REQUIREMENTS FOR OFFERING OF PACKAGES.**

(a) REQUIRING OFFER OF CORE SUPPLEMENTAL BENEFIT PACKAGE.—An carrier may not offer or sell any supplemental health benefit policy unless the carrier offers or sells one such policy that provides only for coverage of the core supplemental benefit package described in section 5202(b)(1)(A).

(b) PROHIBITING OFFER OF MULTIPLE PACKAGES TO AN INDIVIDUAL.—An carrier may not offer or sell a supplemental health benefit policy to an individual who is covered under another such policy, unless the individual's coverage under the new policy begins only after the individual's coverage under the original policy is terminated.

**SEC. 5204. NON-DISCRIMINATION REQUIREMENTS.**

(a) DISCRIMINATION BASED ON HEALTH STATUS.—The provisions of section 5002(a) shall apply during the annual open enroll-

ment period established under section 5205 with respect to a carrier offering or selling a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

(b) DISCRIMINATION BASED ON OTHER FACTORS.—The provisions of section 5002(b) shall apply with respect to a carrier offering or selling a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

**SEC. 5205. OPEN ENROLLMENT.**

The State shall establish an annual open enrollment period of at least 30 days during which a carrier offering or selling a supplemental health benefit policy may not refuse to enroll an individual who seeks coverage under the policy.

**SEC. 5206 PROHIBITION ON PRE-EXISTING CONDITION EXCLUSIONS.**

(a) DURING ANNUAL OPEN ENROLLMENT PERIOD.—A carrier offering or selling a supplemental health benefit policy may not exclude or limit coverage under the policy during the annual open enrollment period established under section 5105 with respect to services covered under the policy related to treatment of a pre-existing condition.

(b) DURING OTHER PERIODS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier offering or selling a supplemental health benefit policy may exclude coverage during any period other than the annual open enrollment period established under section 5105 with respect to services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months and shall not apply to services furnished to newborns or pregnancy-related services.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A carrier offering or selling a supplemental health benefit policy shall provide that if an individual covered under such a policy is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under such policy, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(B) DEFINITIONS.—As used in this paragraph:

(i) PERIOD OF CONTINUOUS COVERAGE.—The term "period of continuous coverage" means, with respect to particular services, the period beginning on the date an individual is enrolled under any plan or policy which provides benefits with respect to the same or substantially similar services (as determined in accordance with criteria established by the Secretary) and ends on the date the individual is not so enrolled for a continuous period of more than 3 months (or for a longer period with respect to individuals who lose employment and meet such other conditions as the Secretary may specify).

(ii) PREEXISTING CONDITION.—The term "preexisting condition" means a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of the individual's coverage (without regard to any waiting period).

**SEC. 5207. CONTINUATION OF COVERAGE REQUIREMENT.**

The provisions of section 5006 (other than subsection (b) of such section) shall apply with respect to a carrier offering or selling a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier offering an insured health benefit plan.

SEC. 5208. COMMUNITY RATING REQUIREMENTS.

(a) IN GENERAL.—The premium rate charged by a carrier for a supplemental health benefit policy consisting of a standard benefit package established by the Secretary under section 5202 in a community-rating area for a class of enrollment shall be the same for all such enrollments.

(b) REFERENCES TO COMMUNITY AND ENROLLMENT.—The "community-rating area" and "class of enrollment" applicable under subsection (a) are the community and class of enrollment applicable to the community rating of premiums for insured health benefit plans required under section 5008.

SEC. 5209. STANDARDS FOR MARKETING.

(a) RESTRICTIONS ON TIE-INS WITH HEALTH BENEFIT PLANS.—

(1) IN GENERAL.—A carrier offering or selling a supplemental health benefit policy may not condition the offer or sale of a health benefit plan to an individual on the purchase of the supplemental health benefit policy by the individual.

(2) RESTRICTION ON AUTHORITY OF MANAGED CARE PLANS TO OFFER SUPPLEMENTAL POLICIES.—A carrier providing a managed care plan which provides for coverage of the guaranteed national benefit package may not offer or sell a supplemental health benefit policy to any individual unless the individual is enrolled in such managed care plan.

(b) APPLICABILITY OF OTHER REQUIREMENTS.—The provisions of section 5010 shall apply with respect to a carrier offering or selling a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

## Subtitle D—Universal FEHBP

SEC. 5301. PURPOSE.

The purpose of this subtitle is to ensure that individuals seeking health insurance coverage in the community-rated market sector may enroll in the same range of health plans providing the same guaranteed national benefits as are provided to Members of Congress and Federal employees.

SEC. 5302. CONTRACTS WITH CARRIERS.

(a) IN GENERAL.—

(1) CARRIERS SERVING THE COMMUNITY-RATED MARKET SECTOR.—The Office of Universal FEHBP (established under section 5307(a), in this subtitle referred to as the "Office") shall enter into such contracts with carriers who, beginning on January 1, 1997, shall offer insured health benefit plans certified under this title in the community-rated market sector and who shall meet standards prescribed under subsection (c).

(2) ASSURING RANGE OF PLANS AVAILABLE.—To the maximum extent practicable, the Office shall assure with respect to each community-rating area the offering of such a range of types of health benefit plans in the area under this subtitle as is (or was) provided under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code).

(3) CONDITIONS.—The Office may enter into contracts with carriers under this subtitle under the same conditions (in relation to bidding and duration of contract) as are provided for contracts under section 8902(a) of title 5, United States Code. The Office is not required to enter into such a contract with any particular carrier. Each such contract under this subtitle shall be consistent with the provisions of this subtitle and this Act.

(b) OFFERING OF SUPPLEMENTAL POLICIES.—To the extent practicable, the Office may provide for the offering of supplemental health benefit policies that meet the applicable requirements of subtitle C of this title to individuals who are enrolled under this subtitle in an insured health benefit plan certified under this title.

The Office shall take such actions as may be appropriate to permit the offering of a supplemental health benefit policy that has the same benefits as those in a maintenance of effort policy described in section 8904a of title 5, United States Code.

(c) STANDARDS FOR CARRIERS, PLANS, AND POLICIES.—The Office may prescribe reasonable standards for carriers seeking to offer insured health benefit plans under this subtitle in the community-rated market sector, including standards relating to quality, price, administration, and other matters. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

(d) INFORMATION TO THE PUBLIC.—The Office shall disseminate general information to the public (especially to individuals and employers of individuals eligible to enroll under this subtitle) on the availability of insured health benefit plans under this subtitle, enrollment and premium payment procedures, and such other related information as the Office considers appropriate. Such information shall meet the standards specified in section 5011(c)(2).

(e) RISK.—Neither the Office nor the United States Government may bear insurance risk under this subtitle, and the Office may not bear any financial, fiduciary, or other responsibility for any VA health plan in which veterans may enroll under title 38, United States Code, pursuant to an agreement under subsection (f). The Office may not collect premiums with respect to the enrollment in any such VA health plan.

(f) AGREEMENT REGARDING VA HEALTH PLANS.—The Office shall enter into an agreement with the Secretary of Veterans Affairs to provide for disseminating information and the enrollment of veterans who are eligible to be enrolled both—

(1) in an insured health benefit plan offered under this subtitle, and

(2) in a VA health plan under chapter 18 of title 38, United States Code,

in such a VA health plan certified pursuant to section 5501(c) of this title. Such a VA health plan is an experienced-rated plan whose premiums are established under section 1831(d)(2) of title 38, United States Code, and shall not be treated as part of a community-rating area for any purpose relating to risk or the establishment of premiums for the purposes of this subtitle. The Secretary of Veterans Affairs shall reimburse the Office for any expense incurred in disseminating information on the availability of VA health plans and enrolling in such a plan pursuant to such agreement.

SEC. 5303. ELIGIBILITY.

(a) IN GENERAL.—Individuals in the community-rated market sector (described in section 5003(e)(1)) are eligible to be enrolled in an insured health benefit plan certified under this title that is offered under this subtitle. The enrollment may include family members based on an appropriate class of enrollment.

(b) CERTAIN INDIVIDUALS NOT INCLUDED IN COMMUNITY-RATED MARKET SECTOR.—The following individuals are not included in the community-rated market sector:

(1) IN GENERAL.—Subject to paragraphs (2) and (3) of this subsection, any individual described in section 5003(f).

(2) CHAPTER 89 ELIGIBLES.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), an individual who is eligible to enroll in an approved health benefit plan under chapter 89 of title 5, United States Code.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply to any individual—

(i) who makes an effective election under section 8905b of such title (relating to elections of coverage during the FEHBP transition period (within the mean-

ing of section 8903b(a)(1) of title 5, United States Code));

(ii) who is a full-time employee and is not eligible to enroll (other than as a family member) under chapter 89 of such title; or

(iii) who is a family member of an individual described in clause (ii).

(C) TERMINATION.—The previous provisions of this paragraph shall not be effective with respect to any period of coverage which begins after the end of the FEHBP transition period.

(3) FULL-TIME EMPLOYEE OF LARGE EMPLOYERS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), an individual who is a full-time employee of a large employer.

(B) EXCEPTION FOR FAMILY MEMBERS.—Subparagraph (A) shall not apply to an employee who is—

(i) a spouse of an individual who is a employee of an employer that is not a large employer, or

(ii) a dependent child.

(C) EXCEPTION FOR POSTAL WORKERS.—Subparagraph (A) shall not apply to a full-time employee of the United States Postal Service.

(c) TREATMENT OF FEDERAL GOVERNMENT.—For purposes of this section, the Government of the United States (excluding the United States Postal Service) shall not be treated as a large employer.

**SEC. 5304. PREMIUMS FOR COVERAGE.**

(a) AMOUNT OF PREMIUMS.—

(1) IN GENERAL.—Premiums charged individuals in a community-rating area enrolled in insured health benefit plans under this subtitle shall be the premiums established under section 5008 for the plan for the area.

(2) NEGOTIATION OF ADMINISTRATIVE DISCOUNT.—The Office may negotiate with a carrier seeking to offer an insured health benefit plan under this subtitle a dollar or percentage discount from the amount of the premiums otherwise applicable. Such a discount—

(A) shall be applied uniformly to all enrollees of the plan;

(B) may vary only by class of enrollment;

(C) shall only reflect administrative savings to such a carrier from marketing such a plan through the Office under this subtitle instead of other means of marketing such a plan; and

(D) may not relate to differences in anticipated claims, costs, or utilization.

(b) PAYMENT PROCEDURES.—The Office shall develop and implement procedures for the payment of premiums by enrolling individuals and by employers offering health coverage through insured health benefit plans under this subtitle. The procedures shall provide for the acceptance and forwarding of premium certificates issued under part A of title XXII of the Social Security Act toward payment of the premiums owed.

**SEC. 5305. GENERAL ADMINISTRATIVE PROVISIONS.**

(a) TERMS OF OFFERING AND ENROLLMENT.—Plans and policies shall be offered under this subtitle in a manner consistent with the requirements of this title for the offering of such plans and policies other than under this subtitle. The Office shall develop and implement procedures for the enrollment, directly or by contract, of individuals under this subtitle during an annual open enrollment period and at such other special enrollment periods as may be appropriate and consistent with the requirements of this Act based on changes in employment, family status, or otherwise.

(b) AUDIT.—Each contract entered into with a carrier under this subtitle shall contain provisions requiring the carrier to—

(1) furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this subtitle; and

(2) permit the Office and representatives of the General Accounting Office to examine records of the carriers as may be necessary to carry out the purposes of this subtitle.

(c) TREATMENT OF CERTAIN ORGANIZATIONS AS CARRIERS.—

An organization which is a bargaining representative recognized under section 1203 of title 39, United States Code, which at any time during the 24-month period ending on the date of the enactment of this Act, was under contract with the Office of Personnel Management under section 8902 of title 5, United States Code, for a health benefits plan that was self-insured, shall be treated as a carrier for purposes of this subtitle, and may provide health benefits only to full members of such organization (determined in a manner consistent with section 8903a(d) of such title 5), including annuitants (as defined in section 8901(3) of such title 5) by reason of separating from a position in such a bargaining unit.

SEC. 5306. UNIVERSAL FEHBP HEALTH BENEFITS FUND.

(a) ESTABLISHMENT.—The Secretary of the Treasury shall establish, at the request of the Office, in the Treasury of the United States, a Universal FEHBP Health Benefits Fund. The Fund shall be administered by the Office.

(b) DEPOSITS INTO FUND.—If the Fund is established, there shall be deposited into the Fund—

(1) premiums paid to the Office under this subtitle;

(2) administrative fees and such other payments as are prescribed by the Office;

(3) moneys and the proceeds from the sale of gifts, devises, and bequests of property received under subsection (f).

(c) AVAILABILITY OF AMOUNTS IN FUND.—

(1) IN GENERAL.—Amounts in the Fund shall be available—

(A) without fiscal year limitation for payments to insured health benefit plans under this subtitle; and

(B) to pay expenses for administering this subtitle within the limitations that may be specified annually by Congress.

(2) USE OF LETTER-OF-CREDIT ARRANGEMENTS.—Payments from the Fund to a plan participating in a letter-of-credit arrangement under this subtitle shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

(d) SET-ASIDE FOR ADMINISTRATIVE EXPENSES.—

(1) FUND.—If the Fund is established, a percentage (specified under paragraph (3)) of the amounts deposited into the Fund as premiums shall be regularly set aside in the Fund to pay administrative expenses described in subsection (c)(1)(B).

(2) PREMIUMS NOT PAID INTO FUND.—In the case of premiums payable to a carrier for coverage under this subtitle which are not deposited into the Fund, the Office shall assess an administrative fee against the carrier in an amount equal to a percentage (specified under paragraph (3)) of such premiums.

(3) PERCENTAGE.—For purposes of this subsection, the Office shall establish a percentage that, when applied under this subsection, is reasonably adequate to pay such administrative expenses. Beginning with the fourth full contract year under this subtitle, such percentage may not exceed 1 percent.

(e) INVESTMENT AUTHORITY.—The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the pro-

ceeds from the sale of these obligations shall be added to and become a part of the Fund.

(f) GIFTS.—The Office may accept, hold, administer, and utilize gifts, devises, and bequests of property, both real and personal, made unconditionally for the purpose of carrying out this subtitle. Conditional gifts may be accepted and used in accordance with their provisions, except that no gift may be accepted which is conditioned on any expenditure not to be met therefrom or from the income thereof unless such expenditure has been approved by Act of Congress.

(g) AUTHORIZATION OF APPROPRIATION OF AMOUNT FOR START-UP EXPENSES.—There are authorized to be appropriated to the Office such sums as may be necessary for the initial implementation of this subtitle. The Office shall provide for repayments to the General Fund of the Treasury, during a period of not longer than 10 years beginning with the second full contract year during which insured health benefit plans are offered under this subtitle and from the premiums paid for coverage under such plans, of the amounts appropriated pursuant to this subsection.

**SEC. 5307. ESTABLISHMENT OF OFFICE OF UNIVERSAL FEHBP.**

(a) ESTABLISHMENT OF OFFICE.—There is established in the Office of Personnel Management an office to be known as the "Office of Universal FEHBP" to be headed by a Director appointed by the President.

(b) FUNCTIONS.—The Office shall be responsible for the administration of the program under this subtitle.

(c) TRANSFER.—The President shall transfer to the Office such functions, personnel, and other resources (and may transfer such authority) of the Office of Personnel Management or any other department or agency as the Office may require to carry out its responsibilities under this subtitle.

(d) DETAIL AUTHORITY.—Agencies may detail to the Office, with or without reimbursement, such personnel as the Office may require to carry out such responsibilities.

(e) REGULATIONS.—The Office may prescribe regulations necessary to carry out this subtitle.

**SEC. 5308. STUDIES; ANNUAL REPORT.**

(a) STUDIES.—The Office shall make a continuing study of the operation and administration of this subtitle, including surveys and reports on insured health benefit plans available to individuals eligible to enroll under this subtitle and on the experience of the plans.

(b) ANNUAL REPORT.—Not later than April 1 of each year, the Office shall transmit to Congress an annual report on the operation of this subtitle for the preceding contract year. Such report shall include an assessment of any circumstances in the universal FEHBP market that would adversely affect the operation of this subtitle. The report submitted under this subsection before the first full contract year under this subtitle shall include a description of the procedures developed and intended to be implemented for enrollment of individuals in insured health benefit plans under this subtitle.

# Subtitle E—Consumer Purchasing Cooperatives

## PART 1—ESTABLISHMENT BY STATES

**SEC. 5401. ESTABLISHMENT OF COOPERATIVES.**

(a) IN GENERAL.—For purposes of this title, a "consumer purchasing cooperative" or "cooperative" is an entity which is established by a State in accordance with this part and—

(1) which meets the governance requirements of part 2; and

(2) which carries out functions in accordance with part 3.

(b) ESTABLISHMENT OF COOPERATIVES BY UNITS OF LOCAL GOVERNMENT.—A unit of local government may establish a cooperative under this subtitle in the same manner as a State, but only if—

(1) the geographic area over which the unit has jurisdiction is included in a metropolitan statistical area with a population not less than 1,000,000; and

(2) the cooperative established by the unit covers the entire geographic area over which the unit has jurisdiction.

(c) ADMINISTRATION OF COOPERATIVE BY STATE.—A State may operate a consumer purchasing cooperative through a State agency or a unit of local government or may contract with a nonprofit organization for the operation of the cooperative.

SEC. 5402. DESIGNATION OF COOPERATIVE BOUNDARIES AND SERVICE AREA.

In establishing the boundaries of a consumer purchasing cooperative—

(1) a State may not discriminate on the basis of or otherwise take into account race, age, gender, sexual orientation, language, religion, national origin, socioeconomic status, or health status; or

(2) if a cooperative area includes any portion of a metropolitan statistical area located in the State, the State shall include the entire portion of such metropolitan statistical area located in the State in the cooperative area; and

(3) if the State establishes more than one cooperative under this subpart—

(A) no area of the State may be included in more than one cooperative area, and

(B) each area of the State shall be included in a cooperative area.

## PART 2—GOVERNANCE REQUIREMENTS

SEC. 5411. BOARD OF DIRECTORS.

(a) IN GENERAL.—A consumer purchasing cooperative must be governed by a Board of Directors appointed or elected consistent with the provisions of this section. All powers vested in a consumer purchasing cooperative under this subtitle shall be vested in the Board of Directors.

(b) MEMBERSHIP; CHAIRMAN.—

(1) MEMBERSHIP.—Such a Board of Directors shall consist of 13 members as follows:

(A) REPRESENTATIVES OF EMPLOYERS.—6 members who represent employers whose employees purchase health coverage through the cooperative, including self-employed individuals who purchase such coverage.

(B) REPRESENTATIVES OF CONSUMERS.—6 members who represent individuals who purchase such coverage, including employees who purchase such coverage.

(C) CHIEF HEALTH OFFICER.—The chief health officer of the State (or such officer's designee).

The members of the Board of Directors described in subparagraphs (A) and (B) are referred to in this section as "elected" Board members.

(2) CHAIR.—The Board of Directors shall elect a member to serve as the chair of the Board.

(3) APPOINTMENT AND ELECTION.—

(A) INITIAL APPOINTMENT.—The State shall provide, in accordance with rules established by the Secretary, for the appointment of initial members to the Board of Directors.

(B) SUBSEQUENT ELECTION.—Subsequent elected members of the Board of Directors of a cooperative shall be elected by individuals enrolled in plans through the cooperative. Such elections shall occur annually for Board members whose terms expire in the following year.

(C) VACANCIES.—A vacancy of an elected Board member shall be filled through election within 30 days after the date of the vacancy. A vacancy in the Board of Directors shall not affect the ability of the remaining Board members to govern the cooperative.

(4) NOMINATION PROCESS.—

(A) IN GENERAL.—Each cooperative shall provide a process for nominating individuals to serve as members of the Board. Under the process, the individuals nominated shall be broadly representative of the interests and backgrounds (including ethnic and racial backgrounds and gender) of the cooperative members.

(B) QUALIFICATIONS OF MEMBERS NOMINATED.—No cooperative member shall be nominated unless the member—

(i) has been a member of the cooperative for at least 6 months,

(ii) has presented a petition signed by 250 cooperative members, and

(iii) has submitted a written nominating statement, pursuant to the rules of the cooperative.

(5) TERMS OF MEMBERS.—

(A) IN GENERAL.—Elected Board members shall serve for a term of 3 years, except that such members initially elected shall serve for staggered terms.

(B) REMOVAL FOR CAUSE.—Each cooperative shall establish procedures for the removal of an elected Board member for cause. Such procedure shall assure adequate due process.

(6) COMPENSATION OF MEMBERS.—No member of the Board of Directors shall receive compensation for service as a member of the Board, except that such a member may receive reimbursement for expenses incurred while performing official functions as member of the Board.

(c) REQUIREMENTS ON BOARD MEMBERS.—

(1) NO CONFLICT OF INTEREST PERMITTED.—An individual may not serve as an elected Board member (or as a member appointed under subsection (b)(3)) if the individual is one of the following (or an immediate family member of one of the following):

(A) A health care provider.

(B) An individual who is an employee or member of the board of directors of, has a substantial ownership in, or derives substantial income from, a health care provider, health plan, pharmaceutical company, or a supplier of medical equipment, devices, or services.

(C) A person who derives substantial income from the provision of health care.

(D)(i) A member or employee of an association, law firm, or other institution or organization that represents the interests of one or more health care providers, health plans or others involved in the health care field, or (ii) an individual who practices as a professional in an area involving health care.

(2) PROHIBITING DISCRIMINATION BASED ON POLITICAL AFFILIATION.—Members of the Board may not engage in any activity that constitutes discrimination on the basis of political affiliation.

(3) FIDUCIARY STANDARDS.—Members of the Board of Directors and other officers and employees of a consumer purchasing cooperative shall comply with the requirements of part 4 of title I of the Employee Retirement Income Security Act of 1974.

(4) LIMITATION ON GIFTS.—Members of the Board of Directors of a cooperative may not receive gifts (other than of nominal value, from immediate families, or under other cir-

cumstances explicitly permitted by the State) from any entity that has a financial interest in activities conducted by the Board.

(d) MEETINGS OF THE BOARD.—

(1) IN GENERAL.—Meetings of the Board of Directors shall be called by the Chairman or a majority of its members.

(2) OPEN MEETINGS.—Meetings of the Board of Directors shall be open to cooperative members and the public, except that, under rules established by the State, the Board may meet in executive session that is not open to the public.

(3) QUORUM.—A majority of the serving members of the Board of Directors shall constitute a quorum for the purposes of conducting its business, but 4 members of the Board constitute a quorum for purposes of holding hearings or gathering information.

**SEC. 5412. PROVIDER ADVISORY BOARDS.**

Each consumer purchasing cooperative must establish a provider and technical advisory board consisting of representatives of health care providers and professionals who provide covered items and services through plans offered in the community-rated market sector served by the cooperative and including other professionals. Such advisory board shall provide the Board of Directors of the cooperative with medical, technical, and policy advice on various issues relating to the cooperative. To the greatest extent feasible, the membership of such advisory board shall represent the various geographic regions of the area served by the cooperative and shall reflect the racial, ethnic, and gender composition of the health care providers and professionals who provide covered items and services through health plans offered by the cooperative.

## PART 3—RESPONSIBILITIES AND AUTHORITIES OF COOPERATIVES

**SEC. 5421. CONTRACTS WITH CARRIERS.**

(a) CONTRACTS WITH CARRIERS.—Each cooperative may enter into a contract under this part with a carrier that seeks to offer an insured health benefit plan certified under this title in the community-rated market sector through the cooperative.

(b) DEVELOPMENT OF STANDARDS.—The cooperative shall develop standards for carriers seeking to offer plans through the cooperative, including standards relating to quality, price, administration, and other matters.

**SEC. 5422. SERVICES FOR PARTICIPANTS.**

(a) OFFERING CHOICE OF PLANS.—

(1) NO LIMITATION ON CHOICE OF PLANS OFFERED.—Each consumer purchasing cooperative shall permit each individual eligible to seek coverage in the community-rated market sector through an insured health benefit plan offered through the cooperative to seek coverage through any such plan offered through the cooperative.

(2) REQUIREMENTS FOR OFFERING CERTAIN PLANS.—The cooperative shall assure that each individual eligible to seek coverage through a plan offered through the cooperative is offered—

(A) at least one managed care plan (unless there is no such plan available in the area served by the cooperative); and

(B) at least one unlimited-choice-of-provider plan, which may be a point-of-service plan.

(b) INFORMATION.—In conjunction with the offering of plans to individuals and employers, the cooperative shall make available the information described in section 5011(c)(2) and such other information as it deems appropriate about such plans.

(c) OUTREACH.—Each cooperative shall provide for appropriate outreach programs to underserved populations.

(d) ADDITIONAL SERVICES.—Each cooperative shall carry out the following additional functions:

(1) The notification of the availability of medicare part C for certain individuals

(2) The enrollment of individuals during an annual open enrollment period and at such other special enrollment periods as may be appropriate and consistent with the requirements of this Act based on changes in employment, family status, or otherwise.

(3) In accordance with requirements of section 5414, the collection of premium contributions, the forwarding of such contributions to the plans in which the individuals are enrolled, and the acceptance and forwarding of premium certificates issued under part A of title XXII of the Social Security Act toward payment of the premiums owed.

**SEC. 5423. REQUIREMENTS RELATING TO COLLECTION OF PREMIUMS AND ACCOUNTING.**

(a) ADMINISTRATIVE DISCOUNT PERMITTED FOR PLANS OFFERED THROUGH COOPERATIVES.—A cooperative may negotiate with a carrier seeking to offer a plan through the cooperative a dollar or percentage discount from the amount of the premiums otherwise applicable. Such a discount—

(1) shall be applied uniformly to all enrollees of the plan;

(2) may vary only by class of enrollment;

(3) shall only reflect administrative savings to such a carrier from marketing such a plan through the cooperative instead of other means of marketing such a plan; and

(4) may not relate to differences in anticipated claims, costs, or utilization.

(b) LIABILITY FOR PAYMENTS OF PREMIUMS TO PLAN SPONSORS.—Under rules established by the State—

(1) IN GENERAL.—The cooperative has a duty—

(A) to account for the receipt of payments for premiums and premium certificates issued under part A of title XXII of the Social Security Act, and

(B) to coordinate such payments in a manner consistent with this Act.

(2) LIABILITY.—The cooperative is liable to the parties involved for breach of the duty described in paragraph (1)(A).

(c) ACCOUNTING SYSTEM.—The cooperative shall establish an accounting system that meets standards established by the Secretary of Health and Human Services (in consultation with the Secretary of Labor) for purposes of carrying out this subtitle. Such a system shall collect such information on a timely basis as may be required to ascertain the individuals (including family members) covered under plans offered through the cooperative, the applicable premium, and premium payments (including employer contributions towards enrollment and reductions in premiums owed pursuant to premium certificates issued under part A of title XXII of the Social Security Act) and to provide periodic reports on premiums imposed, amounts collected, and remaining amount owing by such individuals.

(d) COMPLIANCE WITH FIDUCIARY STANDARDS.—The cooperative shall comply with standards and duties relating to administration, management, and distribution of premium payments and other funds provided under this subtitle. The standards shall be specified by the Secretary of Labor, in consultation with the Secretary of Health and Human Services. The standards shall include at least protections of the type applicable to fiduciaries under part 4 of title I and under title V of the Employee Retirement Income Security Act of 1974.

**SEC. 5424. COOPERATIVE FEE.**

(a) IN GENERAL.—A consumer purchasing cooperative may require a carrier that offers a plan through the cooperative to pay a fee in an amount equal to a uniform percentage (not to exceed one

percent) of the premiums paid by individuals enrolled in the plan through the cooperative.

(b) USE OF FUNDS.—A cooperative shall use the funds under subsection (a) only for activities described in this subtitle.

SEC. 5425. ANTIDISCRIMINATION.

No cooperative may discriminate, or engage (directly or through contractual arrangements) in any activity, including marketing, that has the effect of discriminating against an individual on the basis of race, national origin, sex, religion, language, socioeconomic status, age, disability, sexual orientation, health status, anticipated need for health services, or location of residence within the service area of a plan of a carrier. However, this section shall not be construed as preventing a cooperative from engaging in activities to encourage the enrollment of individuals eligible to enroll in plans through the cooperative who reside in underserved areas.

## PART 4—GRANTS FOR ESTABLISHMENT AND OPERATION OF COOPERATIVES

SEC. 5431. ESTABLISHMENT OF GRANT PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a program under which the Secretary shall make grants to eligible States for the planning, development, and initial operation of consumer purchasing cooperatives.

(c) ELIGIBILITY OF STATE.—A State is eligible to receive a grant under this subpart if the State submits to the Secretary (at such time and in such form as the Secretary may require) an application containing—

(1) assurances that the State has established (or is in the process of establishing) one or more cooperatives in accordance with this subtitle);

(2) assurances that the State and each such cooperative meet the applicable requirements of this subtitle; and

(3) such other information and assurances as the Secretary may require.

(g) GRANTS TO CONTIGUOUS STATES ESTABLISHING JOINT COOPERATIVES.—In the case of contiguous States each of which is eligible to receive a grant under this part, the Secretary may make grants to the States for the establishment and operation of a consumer purchasing cooperative operated jointly by the States and serving areas in each of the States.

(f) LIMIT ON TOTAL PROVIDED TO STATE.—The total amount of funds provided to a State under this part may not exceed $5,000,000 for a 5-year period.

SEC. 5432. USE OF GRANT FOR PARTICIPATION OF COOPERATIVE IN CAPITAL REVIEW PROGRAM.

(a) IN GENERAL.—A State (or unit of local government) receiving a grant for the operation of a consumer purchasing cooperative under this subtitle may use funds provided under the grant for the participation of the cooperative in a program of the State to review and approve capital expenditures in the State (meeting the requirements of subsection (b)).

(b) REQUIREMENTS FOR PROGRAM.—A capital review program meets the requirements of this subsection if the program—

(A) is designed to assure that the needs of the State's residents for health care services are met;

(B) includes and enforces occupancy targets for inpatient hospital facilities;

(C) includes and enforces utilization targets for services subject to review under the plan;

(D) identifies where appropriate which facilities (and parts of facilities) would be consolidated in order to reach the occupancy and utilization targets for health care services; and

(E) provides an opportunity for review and comment by interested parties.

SEC. 5433. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $150,000,000 for the 5-year period beginning with fiscal year 1996 for grants under this part.

## Subtitle F—General Provisions

SEC. 5501. ESTABLISHMENT OF FEDERAL STANDARDS.

(a) ESTABLISHMENT OF GENERAL STANDARDS FOR HEALTH BENEFIT PLANS.—

(1) STANDARDS FOR CARRIERS PROVIDING INSURED HEALTH BENEFIT PLANS.—Not later than July 1, 1995, the Secretary shall establish standards for carriers providing insured health benefit plans consistent with this section and the requirements described in subtitle A.

(2) STANDARDS FOR SPONSORS OF SELF-INSURED HEALTH BENEFIT PLANS.—Not later than July 1, 1995, the Secretary of Health and Human Services (in consultation with the Secretary of Labor) shall establish and publish standards for self-insured health benefit plans and the sponsors of such plans consistent with this section and the requirements of subtitle B. Under such standards, the Secretary of Labor would annually certify (for years beginning with 1997) each self-insured health benefit plan found by the Secretary of Labor to be in compliance with such standards, based on information provided by the plans in such manner and format as the Secretary of Labor considers appropriate.

(3) STANDARDS FOR PLANS THAT SUPPLEMENT THE GUARANTEED NATIONAL BENEFIT PACKAGE.—Not later than July 1, 1995, the Secretary shall establish standards for supplemental health benefit policies in accordance with the requirements for such policies (and the entities offering such policies) consistent with this section and the requirements described in subtitle C.

(b) SPECIAL RULES FOR PROGRAMS OF THE INDIAN HEALTH SERVICE.—

(1) IN GENERAL.—The standards established under subsection (a) apply with respect to the certification of health programs of the Indian Health Service (as used in section 901 of the Indian Health Care Improvement Act), except as provided in paragraph (3).

(2) APPLICABLE REGULATORY AUTHORITY.—The applicable regulatory authority with respect to the certification of health programs of the Indian Health Service under this title shall be the Secretary. The Secretary may not delegate the responsibility for certification.

(3) EXCEPTED STANDARDS.—The Secretary shall, after consulting with Indian tribes, tribal organizations, and urban Indian organizations, promulgate regulations describing the standards or elements of standards which the Secretary finds are not appropriate to health programs of the Indian Health Service. In carrying out this subsection, the Secretary shall apply the same standards in the same manner to health programs operated directly by the Indian Health Service as the Secretary applies to health programs operated by tribes, tribal organizations, and urban Indian organizations.

(4) REPORT.—The Secretary shall submit a report to the Congress describing the standards which the Secretary finds are not appropriate and the reasons therefore.

(5) REGULATIONS.—Regulations promulgated under this section shall be promulgated no later than 3 months after the date that standards are established and published under subsection (a).

(c) SPECIAL RULES FOR PROGRAMS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The standards established under subsection (a) apply with respect to the certification of health plans of the Department of Veterans Affairs, except as provided in paragraph (3).

(2) APPLICABLE REGULATORY AUTHORITY.—The applicable regulatory authority with respect to the certification of health plans of the Department of Veterans Affairs under this title shall be the Secretary. The Secretary may not delegate the responsibility for certification.

(3) SPECIAL RULES.—The Secretary shall, after consulting with the Secretary of Veterans Affairs, promulgate regulations describing the standards or elements of standards which the Secretary finds are not appropriate to health plans of the Department of Veterans Affairs. Under such regulations, the Secretary shall assure that premium charged for enrollment in such a plan may not be less than the actuarial value of the benefits provided to enrollees under the plan.

(4) REPORT.—The Secretary shall submit a report to the Congress describing the standards which the Secretary finds are not appropriate and the reasons therefore.

(5) REGULATIONS.—Regulations promulgated under this section shall be promulgated no later than 3 months after the date that standards are established and published under subsection (a).

(d) ROLE OF NAIC IN RELATION TO SOLVENCY STANDARDS.—

(1) REQUEST.—The Secretary shall request the NAIC (in consultation with the American Society of Actuaries) within 6 months after the date of the enactment of this title—

(A) to develop model regulations that specify standards with respect to the solvency requirements described in section 5013 (consistent with paragraph (2)), and

(B) to submit such model regulations to the Secretary.

(2) SPECIFICATIONS FOR STANDARDS.—The standards specified by the model regulations under paragraph (1)(A) shall include the following:

(A) Capital requirements for carriers, based on financial analysis, appropriate for maintaining reasonable net worth for the type of carrier (and plan) involved, including a requirement for additional capital in the case of factors likely to adversely affect the carrier's financial stability and solvency as measured by the following:

(i) Projected plan enrollment.

(ii) The number of participating providers.

(iii) The extent and nature of risk-sharing with participating providers.

(iv) Prior performance of the carrier and its plans and liquidity of the carrier's assets.

(B) Procedures for financial review of carriers.

(C) Procedures for ongoing monitoring and enforcement of compliance with the standards.

(D) Standards for the oversight and regulation of financial transactions between the carrier and its parent or affiliate organizations.

(E) Criteria for determining whether a carrier is in a financially impaired condition.

(F) Standards for health plan guaranty funds described in section 5013(d), including standards with respect to premium assessments.

(3) USE OF MODEL REGULATION.—If the NAIC develops and submits model regulations on a timely basis under paragraph (1) and the Secretary determines that the model regulations incorporates such solvency requirements, the Secretary shall incorporate such model regulations within the standards established under this section.

(e) STANDARDS RELATING TO COORDINATION OF ENROLLMENT AND COVERAGE.—

(1) IN GENERAL.—In establishing standards for health benefit plans under this section, the Secretary shall establish rules concerning when changes in enrollment become effective under health benefit plans in relation to changes in the status of an individual enrolled in a health benefit plan.

(2) MONTHLY CHANGES.—Such rules shall be designed—

(A) to provide automatic coverage to newborns as of the date of birth,

(B) in the case of an individual provided coverage through employment, to provide for coverage through the end of the month in which the employment is terminated, and

(C) to prevent eligible individuals from having any periods of noncoverage when changing enrollment among health benefit plans.

(3) SPECIAL RULES FOR COORDINATION OF COVERAGE.—The Secretary shall provide for such rules as may be necessary to provide for the allocation of responsibility among certified health plans (and the medicare program and medicare part C) in the case of an inpatient hospital stay, or in the case in which a single payment amount is made for other services provided over a period of time, that begins during the period of coverage under one such health benefit plan and ends during a period of coverage under another such certified health plan or program.

**SEC. 5502. ENFORCEMENT THROUGH APPROVED STATE PROGRAMS.**

(a) IN GENERAL.—If the Secretary determines that a State has in effect an effective regulatory program—

(1) for the application of the standards established under section 5501(a)(1) to carriers providing insured health benefit plans (including provisions imposing penalties under the same conditions and in the same amounts as provided for under section 5503(a), and other provisions to monitor and enforce such standards), and for providing for collecting and disseminating information under section 5009, the Secretary may approve such program for purposes of certification of carriers and insured health benefit plans under subtitle A; and

(2) for the application of the standards established under section 5501(a)(3) to carriers providing supplemental health benefit policies (including provisions imposing penalties under the same conditions and in the same amounts as provided for under section 5503(a), and other provisions to monitor and enforce such standards), and for providing for collecting and disseminating information with respect to such policies under section 5106(b), the Secretary may approve such program for purposes of certification of carriers and supplemental health benefit policies under subtitle C.

(b) ANNUAL REPORTS.—As a condition for the continued approval of such a regulatory program, the State shall report to the Secretary annually such information as the Secretary may require with respect to the performance of the program. Such information shall include a list of the carriers and insured health benefit plans or supplemental health benefit policies (as the case may be) certified under the program, the compliance of such carriers and plans with the applicable standards established under section 5501, and monitoring and enforcement actions taken to ensure such compliance.

(c) PERIODIC SECRETARIAL REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary annually shall review State regulatory programs approved under subsection (a) to determine if they adequately continue to apply, monitor, and enforce the standards. If the Secretary initially determines that a State regulatory program no longer is applying and enforcing such standards, the Secretary shall provide the State an opportunity to adopt such a plan of cor-

rection that would bring such program into compliance. If the Secretary makes a final determination that the State regulatory program fails to apply and enforce such standards after such an opportunity, the Secretary shall disapprove such program and assume responsibility for certification of all carriers and insured health benefit plans or supplemental health benefit policies (as the case may be) in that State, for establishing enrollment periods under section 5003(b), and for providing for collecting and disseminating information under section 5011.

(d) GAO AUDITS.—The Comptroller General shall conduct periodic reviews on a sample of State regulatory programs approved under subsection (a) to determine their compliance with the requirements of such subsection. The Comptroller General shall report to the Secretary and Congress on the findings of such reviews.

(e) EFFECT ON SECRETARIAL RESPONSIBILITIES.—Nothing in this section may be construed to restrict the Secretary's ability to obtain such information and carry out such activities as may be necessary to impose the Federal penalties described in section 5503 or to otherwise carry out duties and responsibilities under this title in a State with an approved program under this section.

SEC. 5503. FEDERAL PENALTIES.

(a) APPLICATION OF FEDERAL CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Any person who sells or issues a health plan—

(A) that is not certified in accordance with this title is subject to a civil money penalty not to exceed $25,000 for each such violation,

(B) in violation of the requirements of part 2 of subtitle B (relating to financial requirements for self-insured health benefit plans) is subject to the civil money penalty applicable under such part, and

(C) in violation of any other requirement under subtitle A, B, or C is subject to a civil money penalty not to exceed $25,000 for each such violation.

(2) PROCEDURES FOR IMPOSITION.—Except as provided in subsection (d), the provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A of such Act.

(3) IMPOSITION OF PENALTIES BY APPROPRIATE SECRETARY.—The civil money penalties referred to in paragraph (1) shall be imposed by the Secretary of Health and Human Services (in the case of penalties relating to an insured health benefit plan or a supplemental health benefit policy) or the Secretary of Labor (in the case of penalties relating to a self-insured health benefit plan).

(4) AVAILABILITY OF INJUNCTIVE RELIEF.—The Secretary of Health and Human Services (in cases relating to an insured health benefit plan or a supplemental health benefit policy) or the Secretary of Labor (in cases relating to a self-insured health benefit plan) may obtain injunctive relief to enjoin any act or omission which may be subject to a civil money penalty under this subsection.

(5) APPLICATION OF FEDERAL PENALTIES.—A person is subject to a penalty under this section without regard to whether the applicable regulatory authority with respect to the person is the Secretary or the State.

(b) WITHHOLDING FEDERAL FINANCIAL ASSISTANCE TO STATES NOT ENFORCING ANTI-DISCRIMINATION REQUIREMENTS.—If the Secretary finds that a State has not adopted and is not enforcing the requirements described in section 5002 (relating to anti-discrimination requirements for carriers providing insured health benefit plans) with respect to insured health benefit plans in the State, the Secretary may—

(1) withhold Federal financial assistance payments to the State; and

(2) refer any findings to the Attorney General for further action pursuant to subtitle A of title IX.

(c) PENALTY FOR CERTAIN POLICIES DUPLICATING COVERAGE.—

(1) IN GENERAL.—Any person who sells or issues a health plan described in paragraph (4) that duplicates coverage of any item or service covered under the guaranteed national benefit package is subject to a civil money penalty not to exceed $25,000 for each such violation. Paragraph (2) of subsection (a) shall apply with respect to a penalty under the previous sentence in the same manner as such paragraph applies to penalties under such subsection.

(2) EXCEPTION FOR PLANS PROVIDING BENEFITS WITHOUT REGARD TO OTHER COVERAGE.—Paragraph (1) shall not apply with respect to any health plan that provides benefits to an enrollee without regard to any benefits provided to the enrollee under another plan.

(3) EXCEPTION FOR LIABILITY INSURANCE COVERAGE.—Paragraph (1) shall not apply with respect to any health plan described in clause (iv) or (v) of section 5504(15)(B) that provides benefits to an enrollee without regard to any benefits provided to the enrollee under a plan other than a plan described in such clause.

(4) PLANS DESCRIBED.—The health plans described in this paragraph are the plans described in section 5504(15)(B), but do not include a maintenance of effort policy provided under section 8904a of title 5, United States Code.

(d) PROCEDURES FOR IMPOSITION OF PENALTIES FOR VIOLATION OF FINANCIAL REQUIREMENTS FOR SELF-INSURED PLANS.—

(1) APPLICABILITY.—The procedures described in this subsection shall apply with respect to the imposition of a civil money penalty against the sponsor of a self-insured health benefit plan for violations of any requirements described in part 2 of subtitle B (relating to financial requirements).

(2) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under the procedures established under this section, the Secretary of Labor shall take into account the previous record of compliance of the person being assessed with the applicable requirements for sponsors of self-insured health benefit plans under subtitle B and the gravity of the violation.

(3) ADMINISTRATIVE REVIEW.—

(A) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an opportunity for hearing by the Secretary of Labor upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing all evidence shall be determined on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(B) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary of Labor modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under paragraph (4).

(4) JUDICIAL REVIEW.—

(A) FILING OF ACTION FOR REVIEW.—Any person against whom an order imposing a civil money penalty has been entered after an agency hearing under this subsection may obtain review by the United States district

court for any district in which such person is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice be registered mail to the Secretary of Labor.

(B) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary of Labor shall promptly certify and file in such court the record upon which the penalty was imposed.

(C) STANDARD FOR REVIEW.—The findings of the Secretary of Labor shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(D) APPEAL.—Any final decision, order, or judgment of such district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28 of such Code.

(5) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(A) FAILURE TO PAY ASSESSMENT.—If any person fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary of Labor, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(B) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(6) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this subsection shall be paid to the Secretary of Labor (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(e) AVAILABILITY OF PRIVATE RIGHT OF ACTION FOR AGGRIEVED INDIVIDUALS.—

(1) IN GENERAL.—Any person aggrieved by an act or omission of an individual or entity which constitutes a failure to comply with an applicable requirement of this title may obtain from such individual or entity in any court of competent jurisdiction appropriate relief, including actual, compensatory, and punitive damages and equitable relief.

(2) EXCEPTION FOR CERTAIN VIOLATIONS.—Paragraph (1) does not apply in the case of an act or omission upon which a complaint may be filed in a complaint review office pursuant to section 9304 or for which a remedy may be sought under section 9333.

(3) ATTORNEY'S FEES AND COSTS.—In any action under paragraph (1) in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(4) EXHAUSTION OF REMEDIES.—In an action under paragraph (1), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

**SEC. 5504. DEFINITIONS.**

In this title:

(1) APPLICABLE REGULATORY AUTHORITY.—The term "applicable regulatory authority" means—

(A) the Secretary, or

(B) in the case of a State that has assumed responsibility for enforcement of standards under subtitle A pursuant to a State program approved under section 5502, the

authority of the State that is exercising such responsibility.

(2) CARRIER.—The term 'carrier' means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of section 833(c)(2) of the Internal Revenue Code of 1986), a health maintenance organization, or other entity licensed or certified by a State to provide health insurance or health benefits. The Secretary may issue regulations that provide for affiliated carriers to be treated as a single carrier where appropriate under this title.

(3) HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term "health benefit plan" means a health plan, other than a plan described in subparagraph (B).

(B) EXCEPTION.—The term "health benefit plan" does not include any of the following (or any combination thereof):

(i) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

(ii) Medicare supplemental health insurance.

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

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

(v) Worker's compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital or fixed indemnity policy.

(ix) Coverage provided exclusively to individuals who are not eligible individuals under this Act.

(4) HEALTH PLAN.—The term "health plan" means—

(A) any contract of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, that is provided by a carrier, or

(B) an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits and is funded in a manner other than through the purchase of one or more policies or contracts described in subparagraph (A).

(5) HIGH DEDUCTIBLE PLAN.—The term "high deductible plan" means an insured health benefit plan (other than a plan that provides services through a provider network) that provides for cost-sharing using the standard cost-sharing schedule under section 3013(a) for which the carrier establishes the deductible in accordance with paragraph (4) of such section.

(6) INSURED.—The term "insured" means, with respect to a plan, a plan that is provided by a carrier.

(7) MANAGED CARE PLAN.—The term "managed care plan" means a health benefit plan that provides for services included in the guaranteed national benefit package under the plan (other than services described in subsections (c) and (d) of section 5009) primarily through providers in the provider network of the plan.

(8) MARKET SECTOR.—The term "market sector" means a market sector described in section 5003(e)(2).

(9) NAIC.—The term "NAIC" means the National Association of Insurance Commissioners.

(10) POINT-OF-SERVICE PLAN.—The term "point-of-service plan" means an unlimited-choice-of-provider plan that also permits an enrollee to receive benefits through a provider network.

(11) PROVIDER NETWORK.—The term "provider network" means, with respect to a health plan, providers who have en-

tered into an agreement with the plan under which such providers are obligated to provide items and services covered under the plan to individuals enrolled in the plan subject to the managed care cost-sharing schedule established under section 3014.

(12) SELF-INSURED.—The term "self-insured" means, with respect to a plan, a plan that is described in paragraph (4)(B).

(13) SPONSOR.—The term "sponsor" means, in relation to a health plan that—

(A) is insured, the carrier providing the plan, or

(B) is self-insured, the entity that sponsors the plan.

(14) STATE.—The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(15) SUPPLEMENTAL HEALTH BENEFIT POLICY.—

(A) IN GENERAL.—The term "supplemental health benefit policy" means a health insurance policy or health benefit plan which provides—

(i) coverage for items and services not included in the guaranteed national benefit package, or

(ii) coverage for items and services included in such package but not covered because of a limitation in amount, duration, or scope of benefits (including coverage for cost-sharing),

or both.

(B) EXCLUSIONS.—Such term does not include the following:

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

(ii) Medicare supplemental health insurance.

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

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

(v) Worker's compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital or fixed indemnity policy.

(ix) Coverage provided exclusively to individuals who are not eligible individuals under this Act.

(C) EXCEPTION FOR SERVICES COVERED UNDER CERTIFIED SELF-INSURED PLAN.—Such term does not include any self-insured health benefit plan certified by the Secretary under section 5501(a)(1)(B) as meeting the standards applicable to such a plan under subtitle B, notwithstanding that the plan provides coverage for any item or service described in subparagraph (A).

(16) TYPE OF PLAN.—Each of the following is considered to be a separate "type" of plan:

(A) A managed care plan.

(B) A point-of-service plan.

(C) A high deductible plan.

(D) An unlimited-choice-of-provider plan that is not a point-of-service plan or a high deductible plan.

(16) UNLIMITED-CHOICE-OF-PROVIDER PLAN.—

(A) IN GENERAL.—The term "unlimited-choice-of-provider plan" means a health benefit plan that, regardless of whether it permits enrollees to receive benefits through a provider network—

(i) provides coverage for all items and services included in the guaranteed national benefit package that are furnished by any lawful health care provider, subject to permissible coverage limitations (described in subparagraph (B)), and

(ii) makes payment to such a provider whether or not there is a contractual arrangement between the

plan and the provider subject to cost sharing at the standard cost-sharing schedule (described in section 3013).

(B) PERMISSIBLE COVERAGE LIMITATIONS DESCRIBED.—The permissible coverage limitations are (as specified by the Secretary) the following:

(i) Utilization review.

(ii) Prior approval for specified services (not including routine prior approval for services), other than services provided for the treatment of an emergency medical condition (as defined in section 1867(e)(1) of the Social Security Act).

(iii) Exclusion of providers on the basis of poor quality of care, based on evidence obtainable by the plan.

**SEC. 5505. PREEMPTION OF STATE LAW.**

No State may enforce any law or regulation that is inconsistent with any standard established under this title.

**SEC. 5506. CONSTRUCTION OF REFERENCES.**

In this title, except as otherwise specifically provided, any references to provisions of the Social Security Act or the Employee Retirement Income Security Act of 1974 are deemed to be references to such provisions as in effect on the day after the date of the enactment of this Act, taking into account the amendments made to such provisions by this Act.

## Subtitle G—Transitional Insurance Reforms

**SEC. 5601. ESTABLISHMENT OF STANDARDS.**

(a) IN GENERAL.—The Secretary of Health and Human Services (in consultation with the Secretary of Labor) shall establish standards to carry out the requirements of this subtitle.

(b) CERTIFICATION OF COMPLIANCE.—For each 6-month period in which this subtitle is effective, each health plan sponsor shall file a certification with the Secretary (or with a State with which the Secretary has entered into an arrangement under subsection (c)(2)) that the sponsor is in compliance with the requirements of this subtitle.

(c) ENFORCEMENT.—

(1) ISSUANCE OF REGULATIONS.—The Secretary shall issue regulations to carry out this subtitle, and is authorized to issue such regulations on an interim basis that become final on the date of publication, subject to change based on subsequent public comment. The Secretary may consult with States and the National Association of Insurance Commissioners in issuing regulations and guidelines under this subtitle.

(2) ARRANGEMENTS WITH STATES.—The Secretary may enter into arrangements with a State to enforce the requirements of this subtitle with respect to insured health benefit plans issued or sold, or established and maintained, in the State.

(d) SANCTIONS AND REMEDIES.—

(1) IN GENERAL.—Any health plan sponsor that violates a requirement of this subtitle shall be subject to a civil money penalty of not more than $25,000 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) EQUITABLE REMEDIES.—A civil action may be brought by the Secretary—

(A) to enjoin any act or practice which violates any provision of this subtitle, or

(B) to obtain other appropriate equitable relief (I) to redress such violations, or (II) to enforce any provision of this subtitle, including, in the case of a wrongful termination of (or refusal to renew) coverage, reinstating coverage effective as of the date of the violation.

(e) CONSTRUCTION.—The provisions of this subtitle shall be construed in a manner that assures, to the greatest extent practicable, continuity of health benefits under health benefit plans in effect on the effective date of this Act.

(f) SPECIAL RULES FOR ACQUISITIONS AND TRANSFERS.—The Secretary may issue regulations regarding the application of this subtitle in the case of insured health benefit plans (or groups of such plans) which are transferred from one carrier to another carrier through assumption, acquisition, or otherwise, and in the case of plans terminated pursuant to a joint marketing agreement entered into prior to January 1, 1994.

**SEC. 5602. CONTINUATION OF COVERAGE.**

(a) PROHIBITION OF TERMINATION.—

(1) GROUP HEALTH INSURANCE PLANS.—Each health plan sponsor that provides a group health insurance plan for a group of employees may not terminate (or fail to renew) coverage for the group, or for any covered individual, if the employer of the employees continues the plan, except in the case of—

(A) nonpayment of required premiums, or

(B) fraud or misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(2) INDIVIDUAL HEALTH INSURANCE PLANS.—Each carrier providing an individual health insurance plan may not terminate (or fail to renew) coverage for an individual covered under the plan (or a covered dependent), except in the case of—

(A) nonpayment of required premiums,

(B) fraud, or

(C) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(3) SELF-INSURED HEALTH BENEFIT PLANS.—Each sponsor of a self-insured health benefit plan may not terminate (or fail to renew) coverage for an individual covered under the plan (or a covered dependent), except in the case of—

(A) nonpayment of required premiums,

(B) fraud, or

(C) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(b) ACCEPTANCE OF NEW MEMBERS IN A GROUP HEALTH INSURANCE PLAN.—

(1) IN GENERAL.—In the case of a health plan sponsor that provides a group health insurance plan that is in effect on the effective date of this subtitle, the sponsor is required—

(A) to accept all individuals, and their eligible dependents, who become full-time employees (as defined in section 3467(b)(1) of the Internal Revenue Code of 1986) of an employer covered after such effective date;

(B) to establish and apply premium rates that are consistent with section 5605; and

(C) to limit the application of pre-existing condition restrictions in accordance with section 5603.

(2) CONSISTENT APPLICATION OF RULES RELATING TO DEPENDENTS AND WAITING PERIODS.—In this subsection, the term "eligible dependent", with respect to a group health insurance plan, has the meaning provided under the plan as of June 29, 1994, or, in the case of a plan not established as of such date, as of the date of establishment of the plan.

SEC. 5603. LIMITS ON PRE-EXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—Subject to the succeeding provisions of this section, a carrier providing an insured health benefit plan may exclude coverage with respect to services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months and such exclusion shall not apply with respect to services furnished to newborns, pregnancy-related services, or to a plan for which such exclusion did not apply as of the effective date of this subtitle.

(b) CREDITING OF PREVIOUS COVERAGE.—

(1) IN GENERAL.—A carrier providing an insured health benefit plan shall provide that if an individual covered under such a plan is in a period of continuous coverage (as defined in paragraph (2)(A)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a pre-existing condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(2) DEFINITIONS.—As used in this subsection:

(A) PERIOD OF CONTINUOUS COVERAGE.—The term "period of continuous coverage" means, with respect to particular services, the period beginning on the date an individual is enrolled under a health benefit plan, the medicare program, a State medicaid plan, or other health benefit arrangement which provides benefits with respect to the same or substantially similar services (as determined in accordance with criteria established by the Secretary) and ends on the date the individual is not so enrolled for a continuous period of more than 3 months (or for a longer period with respect to individuals who lose employment and meet such other conditions as the Secretary may specify).

(B) PRE-EXISTING CONDITION.—The term "pre-existing condition" means, with respect to coverage under a health benefit plan, a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

SEC. 5604. PREMIUM CHANGES TO REFLECT CHANGES IN GROUP OR INDIVIDUAL CHARACTERISTICS OR TERMS OF COVERAGE.

(a) APPLICATION.—The provisions of this section shall apply to changes in premiums under insured health benefit plans that reflect—

(1) changes in the number of individuals covered under such a plan;

(2) changes in the group or individual characteristics (including age, gender, family composition or geographic area but not including health status, claims experience or duration of coverage under the plan) of individuals covered under such a plan;

(3) changes in the level of benefits (including changes in cost-sharing) under the plan; and

(4) changes in any material terms and conditions of the health benefit plan (other than factors related to health status, claims experience, and duration of coverage under the plan).

(b) DIVISION OF HEALTH INSURANCE PLANS BY SECTOR.—For purposes of this section, each health plan sponsor shall divide its health insurance business into the following 3 sectors:

(1) Health insurance for groups with at least 100 covered lives (in this subsection referred to as the "large group sector").

(2) Health insurance for groups with fewer than 100 covered lives (in this subsection referred as the "small group sector").

(3) Health insurance for individuals, and not for groups (in this subsection referred to as the "individual sector").

(c) SINGLE SET OF RATE FACTORS.—

(1) IN GENERAL.—Each health plan sponsor shall develop a single set of rate factors which will be used to calculate any changes in premium within a sector described in subsection (b) that relate to the reasons described in paragraphs (1) through (4) of subsection (a).

(2) STANDARDS.—Such rate factors—

(A) shall relate to reasonable and objective differences in demographic characteristics, in the design and in levels of coverage, and in other terms and conditions of a contract,

(B) shall not relate to expected health status, claims experience, or duration of coverage of the one or more groups or individuals, and

(C) shall comply with regulations established under section 5606.

(d) COMPUTATION OF PREMIUM CHANGES.—

(1) IN GENERAL.—Changes in premium rates within a sector that relate to the reasons described in subsection (a) shall be calculated using the rate factors developed pursuant to subsection (c).

(2) APPLICATION OF FACTORS.—

(A) IN GENERAL.—The change in premium rates with respect to each health benefit plan shall reflect the rate factors specified under subsection (c) applicable to the reason as applied to the current premium charged for the plan. Such rate factors shall be applied in a manner so that the resulting adjustment, to the extent possible, reflects the premium that would have been charged under the plan if the reason for the change in premium had existed at the time that the current premium rate was calculated.

(B) NO REFLECTION OF CHANGE IN HEALTH STATUS.—In applying the rate factors under this paragraph, the adjustment shall not reflect any change in the health status, claims experience or duration of coverage with respect to any employer or individual covered under the plan.

(e) LIMITATION ON APPLICATION.—This section shall only apply—

(1) to changes in premiums occurring on or after the date of the enactment of this Act to groups and individuals covered as of such date, and

(2) with respect to groups and individuals subsequently covered, to changes in premiums subsequent to such coverage.

(f) APPLICATION TO COMMUNITY-RATED PLANS.—Nothing in this section shall require the application of rate factors related to individual or group characteristics with respect to any health benefit plan that, as of the date of the enactment of this Act, does not use such factors in the determination of premiums under the plan.

**SEC. 5605. LIMITATIONS ON CHANGES IN PREMIUMS FOR PLANS IN INDIVIDUAL SECTOR AND SMALL GROUP SECTOR RELATED TO INCREASES IN HEALTH CARE COSTS AND UTILIZATION.**

(a) APPLICATION.—The provisions of this section shall apply to changes in premiums for insured health benefit plans in the individual sector and the small group sector (as such terms are defined in section 5604(b)) that reflect increases in health care costs and utilization.

(b) EQUAL INCREASE FOR ALL PLANS WITHIN EACH SECTOR.—

(1) IN GENERAL.—To the extent that any increase in premiums by a health plan sponsor for insured health benefit plans reflect increases in health care costs and utilization—

(A) the annual percentage increase for plans within the individual sector shall be the same for all such plans in the sector; and

(B) the annual percentage increase for plans within the small group sector shall be the same for all such plans in the sector.

(2) GEOGRAPHIC APPLICATION.—Paragraph (1)—

(A) may be applied on a national level, or

(B) may vary based on geographic area, but only if (i) such areas are sufficiently large to provide credible data on which to calculate the variation and (ii) the variation is due to reasonable factors related to the objective differences among such areas in costs and utilization of health services.

(3) EXCEPTIONS TO ACCOMMODATE STATE RATE REFORM EFFORTS.—Paragraph (1) shall not apply, in accordance with guidelines of the Secretary, to the extent necessary to permit a State to narrow the variations in premiums among insured health benefit plans offered by health plan sponsors to similarly situated groups or individuals within a sector.

(4) OTHER REASONS SPECIFIED BY THE SECRETARY.—The Secretary may specify through regulations such other exceptions to the provisions of this subsection as the Secretary determines are required to enhance stability of the health insurance market and continued availability of coverage.

(c) EVEN APPLICATION THROUGHOUT A YEAR.—In applying the provisions of this section to an insured health benefit plan that are renewed in different months of a year, the annual percentage increase shall be applied in a consistent, even manner so that any variations in the rate of increase applied in consecutive months are even and continuous during the year.

(d) PETITION FOR EXCEPTION.—A health plan sponsor may petition the Secretary (or a State acting under a contract with the Secretary under section 5601(c)(3)) for an exception from the application of the provisions of this section. The Secretary may approve such an exception if—

(1) the sponsor demonstrates that the application of this section would threaten the financial viability of the sponsor, and

(2) the sponsor offers an alternative method for increasing premiums that is not substantially discriminatory to any sector or to any group or individual covered by an insured health benefit plan offered by the sponsor.

**SEC. 5606. MORE STRINGENT STATE LAWS NOT PREEMPTED.**

The requirements of this subtitle do not preempt any State law unless the State law directly conflicts with such requirements. The provision of additional protections under State law shall not be considered to directly conflict with such requirements.

**SEC. 5607. LIMIT ON CHANGES IN SELF-INSURED HEALTH BENEFIT PLANS.**

(a) IN GENERAL.—A sponsor of a self-insured health benefit plan may not make a modification of benefits described in subsection (b).

(b) MODIFICATION OF BENEFITS DESCRIBED.—

(1) IN GENERAL.—A modification of benefits described in this subsection is any reduction or limitation in coverage, effected on or after the effective date of this subtitle, with respect to any medical condition or course of treatment for which the anticipated cost for any individual enrollee is likely to exceed $5,000 in any 12-month period.

(2) TREATMENT OF TERMINATION.—A modification of benefits includes the termination of a plan if the sponsor, within a period (specified by the Secretary) establishes a substitute plan that reflects the reduction or limitation described in paragraph (1).

(c) REMEDY.—Any modification made in violation of this subsection shall not be effective and the sponsor of the self-insured health benefit plan shall continue to provide benefits as though the modification (described in subsection (b)) had not occurred.

SEC. 5608. DEFINITIONS.

In this subtitle:

(1) COVERED EMPLOYEE.—The term "covered employee" means an employee (or dependent of such an employee) covered under a group health insurance plan.

(2) COVERED INDIVIDUAL.—The "covered individual" means, with respect to a health plan, an individual insured, enrolled, eligible for benefits, or otherwise covered under the plan.

(3) GROUP HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—The term "group health insurance plan" means a health benefit plan offered primarily to employers for the purpose of providing health insurance to the employees (and dependents) of the employer.

(B) INCLUSION OF ASSOCIATION PLANS AND MEWAS.—Such term includes—

(i) any arrangement in which coverage for health benefits is offered to employers through an association, trust, or other arrangement, and

(ii) a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974), whether funded through insurance or otherwise.

(4) INDIVIDUAL HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—The term "individual health insurance plan" means any health benefit plan directly purchased by an individual or offered primarily to individuals (including families) for the purpose of permitting individuals (without regard to an employer contribution) to purchase health insurance coverage.

(B) INCLUSION OF ASSOCIATION PLANS.—Such term includes any arrangement in which coverage for health benefits is offered to individuals through an association, trust, list-billing arrangement, or other arrangement in which the individual purchaser is primarily responsible for the payment of any premium associated with the contract.

(C) TREATMENT OF CERTAIN ASSOCIATION PLANS.—In the case of a health benefit plan sponsored by an association, trust, or other arrangement that provides health insurance coverage both to employers and to individuals, the plan shall be treated as—

(i) a group health insurance plan with respect to such employers, and

(ii) an individual health insurance plan with respect to such individuals.

(5) STATE COMMISSIONER OF INSURANCE.—The term "State commissioner of insurance" includes a State superintendent of insurance.

SEC. 5609. EFFECTIVE DATE.

(a) INSURED HEALTH BENEFIT PLANS.—The provisions of this subtitle—

(1) shall first apply to insured health benefit plans provided in a State on or after January 1, 1995, except that section 5602 shall apply to such plans on or after the date of the enactment of this Act; and

(2) shall not apply to an insured health benefit plan provided in a State on and after the first day of the first year during which the standards established by the Secretary under section 5501 for insured health benefit plans sold to individuals and employers are in effect in the State (in accordance with such section).

(b) SELF-INSURED HEALTH BENEFIT PLANS.—The provisions of this subtitle—

(1) shall first apply to self-insured health benefit plans provided on or after January 1, 1995, except that section 5602 shall apply to such plans on or after the date of the enactment of this Act; and

(2) shall not apply as of the first day of the first year during which the standards established by the Secretary under section 5501 for self-insured health benefit plans and the sponsors of such plans are in effect.