To: Chris Jennings
Fr: Larry Levitt

This is the amendment Sarah Fox was talking about. Gary + I think it doesn't cost ~~federal~~ $ (and could save). Len is looking at it.

[illegible committee member roster]

United States Senate
COMMITTEE ON LABOR AND HUMAN RESOURCES
WASHINGTON, DC 20510-6[illegible]

FACSIMILE COVER SHEET

TO: Larry Levitt

FAX NUMBER: 456-7431

FROM: Sarah Fox

DATE: 6/6/94

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OPTIONAL FORM 99 (7-90)

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To Len Nichols	From Larry Levitt
Dept./Agency	Phone #
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Thanks.

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

Amendments to Sec. 1901 (Definitions Relating to Employment and Income)

In subsection (b)(2), following the definition of "full-time employee" in subparagraph (C), add a new subparagraph (D) as follows:

> **(D) PART-TIME EMPLOYEE. -- For purposes of this Act, the term "part-time employee" means, with respect to an employer, an employee who is employed on a part-time basis (as specified in subparagraph (A)) by the employer.**

Reletter subparagraph (D) as subparagraph (E) and revise as follows:

> "(E) CONSIDERATION OF INDUSTRY PRACTICE. -- As provided under Rules established by the Board, an employee who is not described in subparagraph (C) **or (D)** shall be considered to be employed on a full-time **or part-time** basis by an employer (and to be a full-time **or part-time employee of an employer**) for a month (or for all months in a 12-month period) if the employee is employed by that employer on a continuing basis that, taking into account the structure or nature of ~~the~~ employment in the industry, represents full **or part**-time employment.

[NOTE: Insertions are indicated in boldface; deletions are indicated by strikeout marks.]

Chris -
We are not supposed to copy -

DRAFT

May 24, 1994

PROPOSED AMENDMENTS

A. AMENDMENT TO TITLE I, SUBTITLE A, PART 1.

1. Insert new Sec. 1004 relating to Health Plan Principles to read as follows:

SEC. 1004. HEALTH PLAN PRINCIPLES.

In accordance with this Act, the following principles shall apply to all health plans:

(1) No health plan may discriminate on the basis of medical history, pre-existing medical conditions, or genetic predisposition to medical conditions.

(2) A health plan-

(A) shall accept all applicants for coverage;

(B) shall not impose a rider that services to exclude coverage to an individual.

(3) A health plan shall ensure that all medically necessary services can be obtained, including access to specialty care.

(4) Health benefits coverage shall be portable from one health plan to another.

(5) A health plan shall offer a community rated premium.

(6) A health plan shall offer an annual open enrollment period of at least 30 days.

2. Renumber sections 1004, 1005, and 1006 to read as sections 1005, 1006, and 1007.

3. Amend section 1005 (previously 1004) as follows:

   "(c) Access to FEHBP for Any Individual.-The Federal Employees Health Benefits Program (FEHBP) is amended to permit any individual to purchase health care coverage offered through the program. The Federal Office of Personnel Management is hereby authorized to take such actions as are appropriate to fulfill its responsibilities under this part."

B. AMENDMENTS TO SUBTITLE C - STATE RESPONSIBILITIES.

1. Strike sections 1202, 1203, 1204, 1205, 1206, and 1209 of Part 1.

2. Strike sections 1231 through and including section 1237 of Part B.

3. Strike sections 1251 through and including section 1262 of Part 4.

4. Strike section 1271 of Part 5.

5. Amend "Part 6" to read as "Part 3 - Reductions in Cost Sharing; Income Determinations."

C. AMENDMENTS TO SUBTITLE D - CONSUMER PURCHASING COOPERATIVES.

1. Amend Subtitle D to read as "Subtitle D - Individual and Small Employer Health Plan Purchasing Groups."

2. Strike sections 1301 through and including section 1321.

3. Insert substitute language for Subtitle D.

D. AMENDMENTS TO SUBTITLE E - LARGE GROUP SPONSORS.

1. Insert substitute language for Subtitle E.

E. AMENDMENTS TO SUBTITLE F - HEALTH PLANS.

1. Insert substitute language for Subtitle F.

SUBTITLE D-INDIVIDUAL AND SMALL EMPLOYER HEALTH PLAN PURCHASING GROUPS

SEC. 1301. ESTABLISHMENT AND ORGANIZATION; HEALTH CARE COVERAGE AREAS.
SEC. 1302. AGREEMENTS WITH HEALTH PLANS.
SEC. 1303. AGREEMENTS WITH SMALL EMPLOYERS.
SEC. 1304. ENROLLING INDIVIDUALS IN HEALTH PLANS THROUGH A PURCHASING GROUP.
SEC. 1305. RECEIPT OF PREMIUMS.
SEC. 1306. COORDINATION AMONG PURCHASING GROUPS.
SEC. 1307. HEALTH PLAN MARKETING ACTIVITIES.
SEC. 1308. THIRD-PARTY CONTRACTING TO PERFORM DUTIES.

SUBTITLE E-LARGE EMPLOYER HEALTH PLANS

PART 1-REQUIREMENTS ON LARGE EMPLOYER PLANS

SEC. 1401. STANDARDS APPLIED TO LARGE EMPLOYER SPONSOR
SEC. 1402. ESTABLISHMENT OF STANDARDS APPLICABLE TO LARGE EMPLOYER PLANS.
SEC. 1403. OFFER OF DIFFERENT BENEFIT PACKAGES REQUIRED.
SEC. 1404. ENROLLMENT IN LARGE EMPLOYER PLANS IN SATISFACTION OF ENROLLMENT REQUIREMENT.
SEC. 1405. DEVELOPMENT OF LARGE OR MULTIPLE EMPLOYER PURCHASING GROUPS.
SEC. 1406. CORRECTIVE ACTIONS.

PART 2-AMENDMENTS TO ERISA

SEC. 1421. LIMITATION ON COVERAGE OF GROUP HEALTH PLANS UNDER TITLE I OF ERISA.

PART 3-REVISION OF COBRA CONTINUATION COVERAGE REQUIREMENTS

SEC. 1431. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.
SEC. 1432. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

SUBTITLE F-HEALTH PLANS

PART 1-REQUIREMENTS FOR HEALTH PLANS

SEC. 1501. STATE PLANS; REGISTRATION PROCESS; QUALIFICATIONS.
SEC. 1502. SPECIFIED STANDARD BENEFITS; COST-SHARING; SUPPLEMENTAL BENEFITS.
SEC. 1503. COLLECTION, PROVISION OF STANDARDIZED INFORMATION, AND CONFIDENTIALITY.
SEC. 1504. PROHIBITION OF DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN CONDITIONS; LIMITATION ON PRE-EXISTING CONDITION EXCLUSIONS.
SEC. 1505. USE OF STANDARD PREMIUMS.
SEC. 1506. FINANCIAL SOLVENCY REQUIREMENTS.
SEC. 1507. COORDINATION OF COVERAGE.
SEC. 1508. GRIEVANCE MECHANISMS; ENROLLEE PROTECTIONS; WRITTEN POLICIES AND PROCEDURES RESPECTING ADVANCE DIRECTIVES.
SEC. 1509. ADMINISTRATIVE STANDARDS.
SEC. 1510. QUALITY ASSURANCE STANDARDS.
SEC. 1511. UTILIZATION MANAGEMENT PROTOCOLS.
SEC. 1512. ACCESS TO CARE; ESSENTIAL COMMUNITY PROVIDERS; POINT OF SERVICE OPTION.
SEC. 1513. MONITORING ACCESS.
SEC. 1514. MARKETING STANDARDS.
SEC. 1515. OPEN ENROLLMENT; AVAILABILITY, AND RENEWABILITY.
SEC. 1516. RURAL AND MEDICALLY UNDERSERVED AREAS.
SEC. 1517. RISK ADJUSTMENT.

Senate Labor
5/24/94

1 **SUBTITLE D-INDIVIDUAL AND SMALL EMPLOYER HEALTH PLAN**
2 **PURCHASING GROUPS**

3 **SEC. 1301. ESTABLISHMENT AND ORGANIZATION; HEALTH CARE**
4 **COVERAGE AREAS.**

5 (a) HEALTH CARE COVERAGE AREAS.-
6 (1) IN GENERAL.-For purposes of carrying out this
7 subtitle, subject to paragraphs (2) and (3), each State
8 shall be considered a Health Care Coverage Area
9 (hereinafter referred to as "HCCA").
10 (2) ALTERNATIVE, INTRASTATE AREAS.-Each State shall
11 provide for the division of the State into HCCAs so
12 that-
13 (A) each metropolitan statistical area in a
14 State shall be a separate HCCA;
15 (B) with respect to areas that are not within
16 a metropolitan statistical area --
17 (1) eligible individuals shall be grouped
18 into contiguous regions of not less than
19 250,000; or
20 (2) where the number of eligible
21 individuals residing in an area or a
22 contiguous region is less than 250,000, those
23 individuals shall be assigned to a HCCA
24 established pursuant to another metropolitan
25 statistical area within the State.

1 (3) ALTERNATIVE, INTERSTATE AREAS.-One or more
2 contiguous States may provide for the establishment of a
3 HCCA in accordance with rules established by the Board
4 that includes adjoining portions of the States so long
5 as such area, if it includes any part of a metropolitan
6 statistical area, includes all of such area.
7 (4) DEFINITION OF METROPOLITAN STATISTICAL AREA.-
8 For purposes of this subsection the term "metropolitan
9 statistical area" is defined as a city or an urbanized
10 area and the surrounding county or counties with a total
11 population that meets the most recent revised standards
12 for defining metropolitan areas as published by the
13 Office of Management and Budget.
14 (b) ESTABLISHMENT OF PURCHASING GROUPS.-
15 (1) IN GENERAL.-A State shall establish individual
16 and small employer purchasing groups (in this Act
17 referred to as "Purchasing Groups") in accordance with
18 this part. Each purchasing group shall be chartered
19 under State law and operated as a not-for-profit
20 corporation. An insurer may not form, underwrite, or
21 possess a majority vote of a purchasing group, but may
22 administer such a group (pursuant to section 1308).
23 (2) COORDINATING MULTIPLE HCCA AREAS.-Nothing in
24 this subsection shall be construed as preventing a State
25 from coordinating the activities of one or more HCCAs in
26 the State.

1 (3) INTERSTATE HCCA AREAS.-HCCAs with respect to
2 interstate areas specified under subsection (a)(3) shall
3 be established in accordance with rules of the Board.
4 (4) FEDERAL TAX STATUS OF PURCHASING GROUPS.-
5 Section 501(c) of the Internal Revenue Code of 1986
6 (relating to exempt organizations) is amended by adding
7 the following new paragraph:
8 "(26) Any corporation organized for the
9 exclusive purpose of carrying out the function
10 of an Individual and Small Employer Health
11 Plan Purchasing Group and established pursuant
12 to Title I, Subtitle D of the Health Security
13 Act of 1994."
14 (c) BOARD OF DIRECTORS.-Each Purchasing Group shall be
15 governed by a Board of Directors as follows:
16 (1) INITIAL BOARD OF DIRECTORS.-The initial Board
17 of Directors shall be comprised of seven members, who
18 have knowledge of health care delivery and benefit plans
19 or experience as administrators of health benefit plans,
20 and at least three of whom are small employers, and who
21 are appointed by the Governor or other chief executive
22 officer of the State (or otherwise provided under State
23 law in the case of a HCCA described in subsection
24 (b)(3)) for a term of two years.
25 (2) ELECTED BOARD OF DIRECTORS.-Each State shall
26 provide by legislation or otherwise, for a process of

1 electing the Board of Directors after the terms of the
2 initial Board has expired. After the terms of the
3 initial Board of Directors has expired, the Board of
4 Directors shall be composed of both employers and
5 individuals participating in the Purchasing Group, and
6 be elected for staggered terms by vote of all
7 individuals enrolled in health plans through the
8 Purchasing Group in a HCCA, in accordance with the
9 process established by the State.
10 (3) MEMBERSHIP.-A Purchasing Group shall accept all
11 small employers, eligible employees, and eligible
12 individuals residing within the HCCA served by the group
13 as members if such employers, employees or individuals
14 request such membership.
15 (4) VOTING.-Members of a purchasing group shall
16 have voting rights consistent with the rules established
17 by the State.
18 (d) DUTIES OF PURCHASING GROUPS.-Each Purchasing Group
19 shall-
20 (1) enter into agreements with health plans under
21 section 1302;
22 (2) enter into agreements with small employers
23 under section 1303;
24 (3) enroll only eligible individuals and
25 coordinating coverage in health plans, in accordance
26 with section 1304;

1 (4) compute the enrollment charge, in accordance
2 with section 1305;
3 (5) provide for coordination with other Purchasing
4 Groups, in accordance with section 1306;
5 (6) provide for marketing requirements of health
6 plans, in accordance with section 1307;
7 (7) contract with third parties where necessary, in
8 accordance with section 1308; and
9 (8) carry out other functions provided for under
10 this title.
11 (e) LIMITATION ON ACTIVITIES.-A Purchasing Group shall
12 not-
13 (1) perform any activity (including review,
14 approval, or enforcement)relating to payment rates for
15 providers;
16 (2) perform any activity (including certification
17 or enforcement) relating to compliance of health plans
18 with the requirements this Act;
19 (3) assume financial risk in relation to any such
20 health plan; or
21 (4) perform other activities identified by the
22 State as being inconsistent with the performance of its
23 duties under this Act.
24 (f) RULES OF CONSTRUCTION.-

1 (1) ESTABLISHMENT NOT REQUIRED.-Nothing in this
2 section shall be construed as requiring that a
3 Purchasing Group be established in each HCCA; and
4 (2) SINGLE ORGANIZATION SERVING MULTIPLE HCCAS.-
5 Nothing in this section shall be construed as preventing
6 a single not-for-profit corporation from being the
7 Purchasing Group for more than one HCCA.
8 (3) VOLUNTARY PURCHASING GROUP PARTICIPATION.-
9 Nothing in this section shall be construed as requiring
10 any individual or small employer to purchase a health
11 plan exclusively through a Purchasing Group.
12 **SEC. 1302. AGREEMENTS WITH HEALTH PLANS.**
13 (a) AGREEMENTS.-
14 (1) IN GENERAL.-Each Purchasing Group for a HCCA
15 shall enter into an agreement under this section with
16 each certified health plan that services residents of
17 the HCCA and that elects to offer coverage to eligible
18 individuals through the Purchasing Group. Each such
19 agreement under this section, between a health plan and
20 a Purchasing Group shall include provisions consistent
21 with the requirements of this section. Except as
22 provided in paragraph (2)(A), a Purchasing Group may not
23 refuse to enter into such an agreement with a health
24 plan which is registered with a State as offering
25 coverage in the HCCA.

1 (2) TERMINATION OF AGREEMENT.-The State shall
2 establish a process for the termination of agreements
3 and a process for appealing such termination under this
4 paragraph. In accordance with regulations of the State-
5 (A) the Purchasing Group may terminate an
6 agreement if the health plan's registration for
7 that HCCA is terminated or if the health plan fails
8 to fulfill the requirements of an agreement,
9 (B) the health plan may terminate an agreement
10 with or without cause upon sufficient notice in
11 order to provide for the orderly enrollment of
12 enrollees under other health plans. Termination of
13 an agreement between a health plan and a Purchasing
14 Group terminates the rights of persons enrolled in
15 the health plan through the Purchasing Group in
16 accord with rules established by the State ensuring
17 continuity of enrollee coverage under another
18 health plan.
19 (C) The health plan may appeal the termination
20 of its agreement by the Purchasing Group to the
21 State in accordance with rules and procedures
22 established by the State.
23 (b) RECEIPT OF GROSS PREMIUMS.-
24 (1) IN GENERAL.-Under an agreement under this
25 section between a Purchasing Group and a health plan,
26 payment of premiums shall be made, by individuals or

1 employers on their behalf, or by both, directly to the
2 Purchasing Group for the benefit of the health plan.
3 (2) TIMING OF PAYMENT OF PREMIUMS.-Premiums shall
4 be payable on a monthly basis. The Purchasing Group may
5 provide for penalties and grace periods for late
6 payment.
7 (3) PURCHASING GROUPS RETAIN RISK OF NONPAYMENT.-
8 Nothing in this subsection shall be construed as placing
9 upon a health plan any risk associated with failure of a
10 Purchasing Group to make prompt payment of premiums.
11 Each eligible individual and each small employer who
12 pays on behalf of its employees to enroll in a health
13 plan through a Purchasing Group shall remain directly
14 liable to the Purchasing Group for payment of premiums,
15 and the Purchasing Group shall be directly liable to the
16 health plan for payment of premiums collected from
17 enrollees.
18 (c) FORWARDING OF ADJUSTED PREMIUMS.-
19 (1) IN GENERAL.-Under an agreement under this
20 section between a health plan and a Purchasing Group,
21 the Purchasing Group shall forward to each health plan
22 in which an eligible individual has been enrolled
23 through the Purchasing Group an amount equal to the sum
24 of-
25 (A) the health plan's standard premium rate
26 charged for the premium class, and

1 (B) a risk-adjustment factor (if any)
2 established by the State.
3 (2) PAYMENTS.-Payments shall be made by the
4 Purchasing Group under this subsection within a period
5 (specified by the State and not to exceed 7 days) after
6 receipt of the premium from the employer of the eligible
7 individual or the eligible individual, as the case may
8 be.
9 **SEC. 1303. AGREEMENTS WITH SMALL EMPLOYERS.**
10 (a) IN GENERAL.-The Purchasing Group for each HCCA shall
11 offer to enter into an agreement under this section with each
12 small employer that employs individuals in the area. Each
13 agreement under this section between a small employer and a
14 Purchasing Group shall include provisions consistent with the
15 requirements specified in the succeeding subsections of this
16 section.
17 (b) FORWARDING INFORMATION ON ELIGIBLE EMPLOYEES.-
18 (1) IN GENERAL.-Under an agreement under this
19 section between a small employer and a Purchasing Group,
20 the employer must forward to the appropriate Purchasing
21 Group --
22 (A) the name, address, and social security
23 number (and other identifying information required
24 by the Purchasing Group) of each eligible employee
25 (including part-time and seasonal employees) and
26 covered dependents;

1 (B) the percent of contribution (if any) that
2 the employer will make for coverage of such
3 individuals under a health plan; and
4 (C) information with respect to any change in
5 the employment status of each eligible employee
6 whose name is forwarded to the appropriate
7 Purchasing Group.
8 (2) APPROPRIATE PURCHASING GROUP.-In this
9 subsection, the term "appropriate Purchasing Group"
10 means the Purchasing Group for the principal place of
11 business of the employer.
12 (c) PAYROLL DEDUCTION.-
13 (1) IN GENERAL.-Under an agreement under this
14 section between a small employer and a Purchasing Group,
15 if the Purchasing Group indicates to the employer that
16 an eligible employee is enrolled in health plan through
17 the Purchasing Group, the employer shall provide at the
18 option of the employee for the deduction, from the
19 employee's wages or other compensation, of the amount of
20 the enrollment charge (as defined in section 1305(a))
21 due (less any employer contribution). In the case of an
22 employee who is paid wages or other compensation on a
23 monthly or more frequent basis, an employer shall not be
24 required to provide for payment of amounts to a
25 Purchasing Group other than at the same time at which
26 the amounts are deducted from wages or other

1 compensation. In the case of an employee who is paid
2 wages or other compensation less frequently than
3 monthly, an employer may be required to provide for
4 payment of amounts to a Purchasing Group on a monthly
5 basis.
6 (2) ADDITIONAL PREMIUMS.-If the amount withheld
7 under paragraph (1) is not sufficient to cover the
8 entire cost of the premiums, the employee shall be
9 responsible for paying directly to the Purchasing Group
10 the difference between the amount of such premiums and
11 the amount withheld.
12 **SEC. 1304. ENROLLING INDIVIDUALS IN HEALTH PLANS THROUGH A**
13 **PURCHASING GROUP.**
14 (a) IN GENERAL.-Each Purchasing Group shall offer
15 eligible individuals the opportunity to enroll in any health
16 plan which has an agreement with the Purchasing Group for the
17 HCCA in which the individual resides.
18 (b) COORDINATING ENROLLMENT IN MULTIPLE PLANS.-Each
19 Purchasing Group shall establish a procedure for the
20 coordination of standard benefits which provides for the
21 orderly payment of claims where eligible individuals (and
22 dependents) may be enrolled in more than one health plan for
23 the coverage of standard benefits. Coordination of benefits
24 under this paragraph shall ensure that such persons will
25 receive no greater coverage than that which is required under
26 the standard benefit plan.

1 (c) ENROLLMENT PROCESS.-
2 (1) IN GENERAL.-Each Purchasing Group shall
3 establish an enrollment process in accordance with rules
4 consistent with this subsection.
5 (2) INITIAL ENROLLMENT PERIOD.-Each eligible
6 individual, at the time the individual first becomes an
7 eligible individual in a HCCA, have an initial
8 enrollment period (of not less than 30 days) in which to
9 enroll in a health plan.
10 (3) GENERAL ENROLLMENT PERIOD.-Each Purchasing
11 Group shall establish an annual period, of not less than
12 30 days, during which eligible individuals may enroll in
13 a health plan or change the health plan in which the
14 individual is enrolled.
15 (4) SPECIAL ENROLLMENT PERIODS.-In the case of
16 individuals who-
17 (A) through marriage, divorce, separation,
18 birth or adoption of a child, death or other
19 circumstances, experience a change in family
20 situation, or
21 (B) experience a change in employment status
22 (including a significant change in the terms and
23 conditions of employment),
24 each Purchasing Group shall provide for a special
25 enrollment period in which the individual is permitted
26 to change the individual or family basis of coverage in

1 the health plan in which the individual is enrolled.
2 The circumstances under which such special enrollment
3 periods are required and the duration of such periods
4 shall be specified by the State.
5 (5) TRANSITIONAL ENROLLMENT PERIOD.- Each
6 Purchasing Group shall provide for a special
7 transitional enrollment period during which eligible
8 individuals may first enroll.
9 (d) PERIOD OF COVERAGE.-
10 (1) INITIAL ENROLLMENT PERIOD.-In the case of an
11 eligible individual who enrolls with a health plan
12 through a Purchasing Group during an initial enrollment
13 period, coverage under the plan shall begin on such date
14 (not later than the first day of the first month that
15 begins at least 15 days after the date of enrollment) as
16 the Purchasing Group shall specify.
17 (2) GENERAL ENROLLMENT PERIODS.-In the case of an
18 eligible individual who enrolls with a health plan
19 through a Purchasing Group during a general enrollment
20 period, coverage under the plan shall begin on the 1st
21 day of the 1st month beginning at least 15 days after
22 the end of such period.
23 (3) SPECIAL ENROLLMENT PERIODS.-
24 (A) IN GENERAL.-In the case of an eligible
25 individual who enrolls with a health plan during a
26 special enrollment period described in subsection

1 (c)(4), coverage under the plan shall begin on such
2 date (not later than the first day of the first
3 month that begins at least 15 days after the date
4 of enrollment) as the Purchasing Group shall
5 specify, except that coverage of family members
6 shall begin on or after the date of the event that
7 gives rise to the special enrollment period.
8 (B) TRANSITIONAL SPECIAL ENROLLMENT PERIOD.-In
9 the case of an eligible individual who enrolls with
10 a health plan during the transitional special
11 enrollment period described in subsection (c)(5),
12 coverage under the plan shall begin on the date
13 established by the Purchasing Group.
14 (4) MINIMUM PERIOD OF ENROLLMENT.-In order to avoid
15 adverse selection, each Purchasing Group may require,
16 that enrollments with all health plans through the
17 Purchasing Group be for not less than a specified
18 minimum enrollment period (with exceptions permitted for
19 such exceptional circumstances as the Purchasing Group
20 may recognize). Persons whose enrollment is terminated
21 or which lapses, and who are not covered by a health
22 plan within 60 days of such termination or lapse, may
23 not re-enroll in a health plan through a Purchasing
24 Group for a period of at least twelve months.
25 **SEC. 1305. RECEIPT OF PREMIUMS.**

1 (a) ENROLLMENT CHARGE.-The amount charged by a
2 Purchasing Group for coverage under a health plan in a HCCA
3 is equal to the sum of-
4 (1) the standard premium rate established by the
5 health plan for such coverage, and
6 (2) the Purchasing Group overhead amount
7 established under subsection (b)(3) for enrollment of
8 individuals in the HCCA.
9 (b) OVERHEAD AMOUNT.-
10 (1) PURCHASING GROUP BUDGET.-Each Purchasing Group
11 shall establish a budget for administrative costs (which
12 includes a reserve for any shortfall in premiums due to
13 nonpayment) for each year in accordance with regulations
14 established by the State.
15 (2) OVERHEAD PERCENTAGE.-The Purchasing Group shall
16 compute an overhead percentage which, when applied to
17 the standard premium amount for individual coverage for
18 each enrollee unit, will provide for revenues equal to
19 the Purchasing Group budget for the year.
20 (3) OVERHEAD AMOUNT.-The Purchasing Group overhead
21 amount for enrollment, whether on an individual or
22 family basis, in a health plan for a HCCA for a month is
23 equal to the applicable overhead percentage (computed
24 under paragraph (2)) multiplied by the standard premium
25 amount for individual coverage under the health plan for
26 the month.

1 (4) DISCLOSURE OF OVERHEAD AMOUNT.-Each Purchasing
2 Group shall, prior to the time of enrollment, provide to
3 enrollees and other interested parties a copy of its
4 budget and disclose the percentage of the enrollment
5 charge that the overhead amount represents in addition
6 to the standard premium amount charged by a health plan.
7 (5) REPORT TO THE STATE.-Each Purchasing Group
8 shall provide a report annually to the State which
9 describes the specific costs and method employed by the
10 Purchasing Group to determine the overhead amount. The
11 State shall review these costs to ensure that
12 appropriate overhead amounts are maintained by each
13 Purchasing Group. States may establish additional
14 uniform reporting requirements and uniform methods of
15 reporting.
16 **SEC. 1306. COORDINATION AMONG PURCHASING GROUPS.**
17 (a) IN GENERAL-The State shall establish rules
18 consistent with this section for-
19 (1) coordination among Purchasing Groups, in cases
20 where small employers are located in HCCA and any of
21 their employees reside in a different HCCA (and are
22 eligible for enrollment with health plans located in the
23 other area);
24 (2) coordination among Purchasing Groups for the
25 provision of out-of-HCCA area benefits and services; and

1 (3) ensuring consistency and coordination of data
2 collection systems, standard electronic format and
3 recordkeeping requirements.
4 (b) COORDINATION RULES.-Under the rules established
5 under subsection (a)(1)-
6 (1) PURCHASING GROUP FOR EMPLOYER.-The Purchasing
7 Group for the principal place of business of a small
8 employer shall be responsible-
9 (A) for providing information to the
10 employer's employees on health plans for areas in
11 which employees reside;
12 (B)(i) for enrolling employees under the
13 health plan selected (even if the health plan
14 selected is not in the same HCCA as the Purchasing
15 Group) and (ii) if the health plan chosen is not in
16 the same HCCA as the Purchasing Group, for
17 forwarding the enrollment information to the
18 Purchasing Group for the area in which the health
19 plan selected is located;
20 (C) in the case of premiums to be paid through
21 payroll deduction, to receive such premiums and
22 forward them to the Purchasing Group for the area
23 in which the health plan selected is located; and
24 (D) ensuring compliance with health plan
25 marketing rules established in Section 1306.

1 (2) PURCHASING GROUP FOR EMPLOYEE RESIDENCE.-The
2 Purchasing Group for the HCCA in which an employee
3 resides shall be responsible for providing other
4 Purchasing Groups with information concerning health
5 plans offered in its area.

6 **SEC. 1307. HEALTH PLAN MARKETING ACTIVITIES.**

7 (a) IN GENERAL.-Each Purchasing Group shall market
8 health plans to members through the entire HCCA served by the
9 Purchasing Group. A Purchasing Group shall provide to each
10 small employer that employs individuals in the HCCA and to
11 each eligible individuals who resides in the HCCA information
12 pursuant to this section.

13 (b) DESCRIPTIVE SUMMARY INFORMATION.-Each Purchasing
14 Group shall make available to eligible employers, employees,
15 and individuals, summaries of appropriate marketing materials
16 provided to the Purchasing Group by a health plan which meet
17 the requirements of (c). Each Purchasing Group shall
18 distribute, to eligible individuals, employers, and other
19 interested persons, information, in standardized comparative
20 form, on the prices, outcomes, enrollee satisfaction, and
21 other information pertaining to the quality of all of the
22 different health plans in its HCCA. The health plan's annual
23 registration fee required by the Purchasing Group and the
24 Purchasing Group overhead amount shall be itemized separately
25 in the comparative information. Prior to such distribution,
26 each Purchasing Group shall provide to each health plan an

1 adequate notice and reasonable opportunity to review and
2 comment on such information proposed to be distributed.
3 (c) NAIC MODEL REQUIRED.-Each State shall adopt
4 requirements equal to model requirements promulgated by the
5 National Association of Insurance Commissioners (hereinafter
6 referred to as the "NAIC") for the uniform description of
7 benefit plans, rates, prices and accreditation information on
8 health plans offered through a Purchasing Group. The
9 Secretary shall request the NAIC to develop and promulgate
10 such standards within six months after the date of enactment
11 of this Act.
12 **SEC. 1308. THIRD-PARTY CONTRACTING TO PERFORM DUTIES.**
13 (a) IN GENERAL.-Each Purchasing Group may contract with
14 qualified, independent third parties for any service
15 necessary to carry out the powers and duties of the
16 Purchasing Group pursuant to the requirements established
17 under this section.
18 (b) RESTRICTION ON INFORMATION USE BY THIRD PARTY.-
19 Unless permission is granted specifically by a Purchasing
20 Group, a third party hired by a Purchasing Group may not
21 release, publish, or otherwise use any information to which
22 the third party has access under its contract.
23 (c) RESTRICTION ON PERSONS ELIGIBLE FOR THIRD-PARTY
24 CONTRACT.-No person may act, directly or through an
25 affiliated company, both as a health plan serving the

1 Purchasing Group and as an independent third party contractor
2 as described in (a) within a given HCCA.

3 **Subtitle E-Large Employer Health Plans**

4 **PART 1-REQUIREMENTS ON LARGE EMPLOYER PLANS**

5 **SEC. 1401. STANDARDS APPLIED TO LARGE EMPLOYER SPONSOR.**

6 (a) IN GENERAL.-Each large employer sponsor shall meet
7 the applicable standards developed under section 1402.

8 (b) DEFINITION.-As used in this subtitle:

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

18 (2) LARGE GROUP SPONSOR.-The term "large group
19 sponsor" means an eligible sponsor that elects, in a
20 form and manner specified by the Secretary of Labor,
21 consistent with this subpart, to be treated as a large
22 group sponsor under this title and that does not have
23 such and election terminated under section 1405. A
24 large group sponsor may offer a State qualified health
25 plan or a self-insured plan that maintains enrollment of
26 at least 500 individuals.

1 (3) MULTIEMPLOYER PLAN.-The term "multiemployer
2 plan" has the meaning given such term in section 3(37)
3 of the Employee Retirement Income Security Act of 1974,
4 and includes any plan that is treated as such a plan
5 under title I of such Act.
6 (4) PLAN SPONSOR OF A MULTIEMPLOYER PLAN.-The term
7 "plan sponsor of a multiemployer plan" means a plan
8 sponsor described in section 3(16)(B)(iii) of the
9 Employee Retirement Income Security Act of 1974, but
10 only with respect to a group health plan that is a
11 multiemployer plan and only if-
12 (A) such plan provided health benefits as of
13 September 1, 1993; and
14 (B) such plan is maintained by one or more
15 affiliates of labor organizations representing
16 employees in the same industry.
17 Each large employer plan shall meet the applicable
18 standards developed under section 1402.
19 **SEC. 1402. ESTABLISHMENT OF STANDARDS APPLICABLE TO**
20 **LARGE EMPLOYER PLANS.**
21 (a) ESTABLISHMENT OF STANDARDS BY SECRETARY OF HEALTH
22 AND HUMAN SERVICES.-
23 (1) IN GENERAL.-The Secretary of Health and Human
24 Services, in consultation with the Secretary of Labor,
25 shall develop and publish standards applicable to large
26 employer plans relating to the requirements described in

1 paragraph (2). The Secretary shall develop and publish
2 such standards by not later than the date that is six
3 months after the date of enactment of this Act. Such
4 standards shall be the certified health plan standards
5 applicable under this part.

6 (2) REQUIREMENTS SPECIFIED.-Subject to paragraph
7 (3), the requirements referred to in paragraph (1) are
8 requirements specified in the following provisions:

9 (A) Section 1515 (relating to guaranteed
10 eligibility), except that such subsection shall be
11 applied (for purposes of this subsection) only with
12 respect to eligible employees of the large
13 employer.

14 (B) Section 1504 (relating to non-
15 discrimination based on health status).

16 (C) Section 1502 (relating to benefits).

17 (D) Section 1515 (relating to enrollment) or
18 establish such comparable enrollment procedures as
19 the Secretary of Labor specifies.

20 (E) Section 1503 (relating to collection and
21 provision of standardized information).

22 (F) Section 1510 (relating to quality
23 assurance).

24 (3) COLLECTIVE BARGAINING EXCEPTION.-Paragraph
25 (2)(A) shall not apply to a large employer plan that is

1 providing benefits pursuant to a collective bargaining
2 agreement.
3 (b) ESTABLISHMENT OF STANDARDS BY SECRETARY OF LABOR.-
4 (1) IN GENERAL.-The Secretary of Labor, in
5 consultation with the Secretary of Health and Human
6 Services, shall develop and publish standards applicable
7 to large employer plans relating to the requirements
8 specified in paragraph (2). The Secretary shall develop
9 and publish such standards by not later than the date
10 that is six months after the date of enactment of this
11 Act. Such standards shall be the certified health plan
12 standards applicable under this part.
13 (2) REQUIREMENTS SPECIFIED.-Subject to paragraph
14 (3), the requirements referred to in paragraph (1) are
15 comparable to requirements specified in the following
16 provisions:
17 (A) Section 1506 (relating to financial
18 solvency) or such standards similar to the
19 standards established under such section as the
20 Secretary of Labor specifies, except that such
21 standards shall be consistent with the applicable
22 rules under section 414 of the Employee Retirement
23 Income Security Act of 1974.
24 (B) Section 1505 (relating to use of standard
25 premiums) except that large employer groups may
26 utilize experience-rating.

1 (C) Section 1508 (relating to grievance
2 procedures).
3 (D) Section 1403 (relating to required offer
4 of different benefit packages).
5 (3) COLLECTIVE BARGAINING EXCEPTION.-Paragraph
6 (2)(A) shall not apply to a large employer plan that is
7 providing benefits pursuant to a collective bargaining
8 agreement.
9 (c) CONSIDERATION OF NAIC STANDARDS.-In establishing
10 standards under this section, the Secretary of Health and
11 Human Services and the Secretary of Labor shall take into
12 account standards established under section 1501 of Subtitle
13 F relating to comparable requirements.
14 (d) APPLICATION OF STANDARDS TO HEALTH PLANS OFFERED
15 UNDER FEHBP.-Notwithstanding any other provision of law, each
16 health plan offered under chapter 89 of title 5, United
17 States Code, shall meet the standards applicable to large
18 employer plans under this Subtitle, in the same manner and as
19 of the same date such standards first apply to such plans.
20 **SEC. 1403. OFFER OF DIFFERENT BENEFIT PACKAGES REQUIRED.**
21 (a) IN GENERAL.-Each large employer shall make available
22 to each eligible employee at least 3 health plans-
23 (1) a qualified large employer plan that includes
24 at least one fee-for-service plan, and

1 (2) a qualified large employer plan that includes
2 at least two health plans that are not fee-for-service
3 plans.
4 (b) SELECTION OF PLANS BY MAJORITY OF EMPLOYEES.-
5 (1) IN GENERAL.-The large employer shall make the
6 selections of qualified large employer plans under
7 subparagraphs (1) and (2) of subsection (a) on an annual
8 basis. In making each such selection, the large
9 employer shall comply with any selection of a qualified
10 large employer plan made by at least 50 percent of the
11 eligible employees of the large employer. The Secretary
12 of Labor shall prescribe rules which shall govern the
13 manner in which employees may make such a selection.
14 Nothing in this subsection shall be construed to require
15 an employer to make a qualified large employer plan or
16 for such an employer to refuse to offer such a plan for
17 good cause.
18 (2) LIMITATION.-Paragraph (1) shall not apply in
19 the case of a large employer that contributes to the
20 cost of the qualified large employer plan.
21 (c) CONTRACTS WITH PLANS.-Each large group sponsor may-
22 (1) negotiate with a State qualified health plan to
23 enter into a contract with the plan for the enrollment
24 of such individuals under the plan; or
25 (2) offer to individuals an appropriate self-
26 insured plan.

1 (d) In the case of an individual who qualifies for
2 coverage under large employer plan (and is not eligible for
3 coverage under an equivalent health care program or under a
4 qualified health plan that is not a large employer plan), the
5 individual shall satisfy the requirement of this Act
6 (relating to universal coverage) through enrollment in the
7 large employer plan.

8 **SEC. 1404. DEVELOPMENT OF LARGE OR MULTIPLE EMPLOYER**
9 **PURCHASING GROUPS.**

10 (a) IN GENERAL.-Nothing in this subtitle shall be
11 construed as prohibiting two or more large employers from
12 forming a purchasing group with respect to the employees of
13 such employer or employers. Such entities shall comply with
14 the requirements applicable to large group sponsors under
15 this subtitle.

16 (b) NO USE OF INDIVIDUAL AND SMALL EMPLOYER PURCHASING
17 GROUPS.-A large employer shall be ineligible to purchase
18 health insurance through an individual and small employer
19 Purchasing Group (defined in Subtitle D).

20 **SEC. 1405. CORRECTIVE ACTIONS.**

21 (a) IN GENERAL.-The plan sponsor of each large employer
22 plan shall determine semiannually whether the requirements of
23 this part are met. In any case in which the plan sponsor
24 determines that there is reason to believe that there is or
25 will be a failure to meet such requirements, or the Secretary
26 or the Secretary of Labor makes such a determination and so

1 notifies the plan sponsor, the plan sponsor shall, within 90
2 days after making such determination or receiving such
3 notification, notify such Secretary (in such form and manner
4 as such Secretary may prescribe by regulation) of a
5 description of the corrective actions (if any) that the plan
6 sponsor has taken or plans to take in response to such
7 recommendations. The plan sponsor shall thereafter report to
8 such Secretary, in such form and frequency as such Secretary
9 may specify to the plan sponsor, regarding corrective action
10 taken by the plan sponsor until such requirements are met.
11 Either such Secretary may make a determination that a large
12 employer plan has ceased to be a qualified large employer
13 plan only if such Secretary is satisfied that the necessary
14 corrective action cannot reasonably be expected to occur on a
15 timely basis necessary to avoid failure to provide benefits
16 of which the plan is obligated.
17 (b) DISQUALIFIED OR TERMINATION OF PLAN.-
18 (1) IN GENERAL.-In any case in which the plan
19 sponsor of a large employer plan determines that there
20 is reason to believe that the plan will cease to be a
21 qualified large employer plan or will terminate, the
22 plan sponsor shall so inform the Secretary and the
23 Secretary of Labor, shall develop a plan for winding up
24 the affairs of the plan in connection with such
25 disqualification or termination in a manner which will
26 result in timely payment of all benefits for which the

1 plan is obligated, and shall submit such plan in writing
2 to such Secretaries. Actions required under this
3 subparagraph shall be taken in such form and manner as
4 may be prescribed in regulations jointly prescribed by
5 such Secretaries.

6 (2) ACTIONS REQUIRED IN CONNECTION WITH
7 DISQUALIFICATION OR TERMINATION.-

8 (A) IN GENERAL.-In any case in which-

9 (i) the Secretary or the Secretary of
10 Labor has been notified under paragraph (1) of
11 a failure of a large employer plan to meet the
12 requirements of this part and has not been
13 notified by the plan sponsor that corrective
14 action has restored compliance with such
15 requirements, and

16 (ii) such Secretary determines, in
17 consultation with the other Secretary referred
18 to in clause (i), that the continuing failure
19 to meet such requirements can be reasonably
20 expected to result in a continuing failure to
21 pay benefits for which the plan is obligated,

22 the plan sponsor and the large employer shall
23 comply with the requirements of subparagraph (B) or
24 (C), as applicable.

25 (B) ACTIONS BY PLAN SPONSOR.-Upon a
26 determination by the Secretary or the Secretary of

1 Labor under subparagraph (A)(ii), the plan sponsor
2 shall, at the direction of such Secretary,
3 terminate the plan and, in the course of the
4 termination, take such actions as such Secretary,
5 in consultation with the other Secretary referred
6 to in subparagraph (A)(i), may require as necessary
7 to ensure that the affairs of the plan will be, to
8 the maximum extent possible, wound up in a manner
9 which will result in timely payment of all benefits
10 for which the plan is obligated.
11 (C) ACTIONS BY LARGE EMPLOYER.-Upon a
12 determination by the Secretary or the Secretary of
13 Labor under subparagraph (A)(ii), the large
14 employer shall provide for such contingency
15 coverage for all eligible employees of the employer
16 in accordance with regulations which shall be
17 prescribed in joint regulations of such
18 Secretaries. Such regulations may provide for
19 temporary coverage of such employees under a plan
20 provided by a purchasing group in the appropriate
21 HCCA, a plan provided under chapter 89 of title 5,
22 United States Code, or other appropriate means
23 established in such regulations.".
24 **PART 2-AMENDMENTS TO ERISA**
25 **SEC. 1421. LIMITATION ON COVERAGE OF GROUP HEALTH PLANS**
26 **UNDER TITLE I OF ERISA.**

1 (a) IN GENERAL.-Section 4 of the Employee Retirement
2 Income Security Act of 1974 (29 U.S.C. 1003) is amended-
3 (1) in subsection (a), by striking "subsection (b)"
4 and inserting "subsections (b) and (c)";
5 (2) in subsection (b), by striking "The provisions"
6 and inserting "Except as provided in subsection (c), the
7 provisions"; and
8 (3) by adding at the end the following new
9 subsection:
10 "(c) COVERAGE OF GROUP HEALTH PLANS.-
11 "(1) LIMITED INCLUSION.-This title shall apply to a
12 group health plan to the extent provided in this
13 subsection. For purposes of this title, a plan, fund,
14 or program shall not be treated as a group health plan
15 solely because an employer makes the plan available (and
16 takes related actions) in compliance with the applicable
17 requirements of the Health Security Act of 1994.
18 "(2) COVERAGE UNDER CERTAIN PROVISIONS WITH RESPECT
19 TO LARGE EMPLOYER PLANS.-
20 "(A) IN GENERAL.-Except as provided in
21 subparagraph (B), parts 1 (relating to reporting
22 and disclosure) and 4 (relating to fiduciary
23 responsibility) of subtitle B shall apply to a
24 large employer plan.
25 "(B) IN APPLICABILITY WITH RESPECT TO INSURED
26 QUALIFIED HEALTH PLANS.-Subparagraph (A) shall not

1 apply with respect to any employee welfare benefit
2 plan to the extent such plan provides for health
3 benefits under or through a qualified insured
4 health plan.
5 "(3) CLAIMS PROCEDURES.-Section 503 shall apply the
6 case of any large employer plan.
7 "(4) CIVIL ACTIONS BY PARTICIPANTS, BENEFICIARIES,
8 AND FIDUCIARIES AND BY THE SECRETARY.-Section 502 shall
9 apply in the case of any large employer plan and any
10 other group health plan for which the plan sponsor makes
11 a contribution.
12 "(5) DEFINITIONS AND ENFORCEMENT PROVISIONS.-
13 Sections 3, 501, 504, 505, 506, 510, and 511 and the
14 preceding provisions of this section shall apply to a
15 group health plan to the extent necessary to effectively
16 carry out, and enforce the requirements under, the
17 provisions of this title as they apply pursuant to this
18 subsection.
19 "(6) APPLICABILITY OF PREEMPTION RULES.-Section 514
20 shall apply in the case of any group health plan to the
21 extent that parts 1 (relating to reporting and
22 disclosure) and 4 (relating to fiduciary responsibility)
23 of subtitle B apply to such plan under paragraph (2).".
24 (b) REPORTING AND DISCLOSURE REQUIREMENTS APPLICABLE TO
25 GROUP HEALTH PLANS.-

1 (1) IN GENERAL.-Part 1 of subtitle B of title I of
2 such Act is amended-
3 (A) in the heading for section 110, by adding
4 "BY PENSION PLANS" at the end;
5 (B) by redesignating section 111 as section
6 112; and
7 (C) by inserting after section 110 the
8 following new section:
9 "SPECIAL RULES FOR GROUP HEALTH PLANS
10 "SEC. 111. IN GENERAL.-The Secretary may by regulation
11 provide special rules for the application of this part to
12 group health plans which are consistent with the purposes of
13 this title and the Health Security Act of 1994 and which take
14 into account the special needs of participants,
15 beneficiaries, and health care providers under such plans.
16 "(b) EXPEDITIOUS REPORTING AND DISCLOSURE.-Such special
17 rules may include rules providing for-
18 "(1) reductions in the periods of time referred to
19 in this part,
20 "(2) increases in the frequency of reports and
21 disclosures required under this part, and
22 "(3) such other changes in the provisions of this
23 part as may result in more expeditious reporting and
24 disclosure of plan terms and changes in such terms to
25 the Secretary and to plan participants and
26 beneficiaries,

1 to the extent that the Secretary determines that the rules
2 described in this subsection are necessary to ensure timely
3 reporting and disclosure of information consistent with the
4 purposes of this part and the Health Security Act of 1994 as
5 they relate to group health plans.
6 "(c) ADDITIONAL REQUIREMENTS.-Such special rules may
7 include rules providing for reporting and disclosure to the
8 Secretary and to participants and beneficiaries of additional
9 information or at additional times with respect to group
10 health plans to which this part applies under section
11 4(c)(2), if such reporting and disclosure would be comparable
12 to and consistent with similar requirements applicable under
13 the Health Security Act of 1994 with respect to small
14 employer plans and applicable regulations of the Secretary of
15 Health and Human Services prescribed thereunder.".
16 (2) CLERICAL AMENDMENT.-The table of contents in
17 section 1 of such Act is amended by striking the items
18 relating to sections 110 and 111 and inserting the
19 following new items:
20 "Sec. 110. Alternative methods of compliance by pension
21 plans.
22 "Sec. 111. Special rules for group health plans.
23 "Sec. 112. Repeal and effective date.".
24 (c) TREATMENT OF MULTIPLE EMPLOYER WELFARE
25 ARRANGEMENTS.-

1 (1) INAPPLICABILITY OF PREEMPTION RULES.-Section
2 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is
3 amended by adding at the end (after and below clause
4 (ii)) the following new sentence:
5 "This paragraph shall not apply in the case of a group health
6 plan.".
7 (2) TRANSITIONAL RULES FOR EXISTING MULTIPLE
8 EMPLOYER WELFARE ARRANGEMENT PROVIDING HEALTH BENEFITS.
9 (A) IN GENERAL.-Subject to subparagraph (B),
10 any multiple employer welfare arrangement which has
11 commenced operations on or before January 1, 1994,
12 and with respect to which there is in effect a
13 certification by the Secretary of Labor under this
14 paragraph shall be treated for purposes of this
15 title as a large employer plan.
16 (B) REQUIREMENTS.-Subparagraph (A) shall apply
17 to a multiple employer welfare arrangement only if-
18 (i) the benefits provided under the
19 arrangement consist solely of medical care (as
20 defined in section 213(d) of the Internal
21 Revenue Code of 1986),
22 (ii) such arrangement meets the
23 requirements of clause (i) of section
24 514(b)(6)(A) of the Employee Retirement Income
25 Security Act of 1974 (as in effect immediately
26 before the amendment made by paragraph (1)),

1 (iii) the sponsoring entity is organized
2 and maintained in good faith, with a
3 constitution and bylaws specifically stating
4 its purpose, as a trade association, an
5 industry association, a professional
6 association, or a chamber of commerce or other
7 business group, for substantial purposes other
8 than that of obtaining or providing medical
9 care described in section 213(d) of the
10 Internal Revenue Code of 1986, and the
11 applicant demonstrates to the satisfaction of
12 the Secretary that the sponsoring entity is
13 established as a permanent entity which
14 receives the active support of its members,
15 and
16 (iv) the sponsoring entity is not
17 enrolling members in a manner that
18 discriminates on the basis of health status.
19 (C) PROHIBITION ON COMMENCEMENT OF NEW
20 ARRANGEMENTS.-No multiple employer welfare
21 arrangement providing benefits which consist of
22 medical care (as defined in section 213(d) of the
23 Internal Revenue Code of 1986) which has not
24 commenced operations as of January 1, 1994, may
25 operate after such date.

1 (D) CERTIFICATION PROCEDURE.-The Secretary of
2 Labor shall certify, for a period of five-years
3 only, a multiple employer welfare arrangement under
4 this paragraph if-
5 (i) an application for such certification
6 with respect to such arrangement, identified
7 individually or by class, has been duly filed
8 in complete form with the Secretary of Labor
9 in accordance with this paragraph,
10 (ii) such application demonstrates
11 compliance with the requirements of section
12 1401, and
13 (iii) the Secretary of Labor finds that
14 such certification is -
15 (I) administratively feasible,
16 (II) not adverse to the interests of
17 the individuals covered under the
18 arrangement, and
19 (III) protective of the rights and
20 benefits of the individuals covered under
21 the arrangement.
22 In the case of an arrangement which has commenced
23 operations as of January 1, 1994, an application under
24 this paragraph must be filed not later than January 1,
25 1996.

1 (E) DESIGNATION OF PLAN SPONSOR.-The Secretary of
2 Labor shall provide by regulation for designation of the
3 entities to be treated as the plan sponsor.
4 (F) REVOCATION OF CERTIFICATION.-The Secretary of
5 Labor may revoke a certification under this paragraph
6 for any cause that may serve as the basis for the denial
7 of an initial application for such a certification under
8 this paragraph.
9 (G) REVIEW OF ACTIONS BY SECRETARY OF LABOR.-Any
10 decision by the Secretary of Labor which involves the
11 denial of an application by a multiple employee welfare
12 arrangement for certification under this paragraph or
13 the revocation of such a certification shall contain a
14 statement of the specific reason or reasons supporting
15 the Secretary's action, including reference to the
16 specific terms of the certification and the statutory
17 provision or provisions relevant to the determination.
18 Any such denial or revocation shall be subject to review
19 as provided in section 502 of the Employee Retirement
20 Income Security Act of 1974.

21 **PART 3-REVISION OF COBRA CONTINUATION**
22 **COVERAGE REQUIREMENTS**

23 **SEC. 1431. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME**
24 **SECURITY ACT OF 1974.**

1 (a) PERIOD OF COVERAGE.-Subparagraph (D) of section
2 602(2) of the Employee Retirement Income Security Act of
3 1974(29 U.S.C. 1161(2)) is amended-
4 (1) by striking "or" at the end of clause (i), by
5 striking the period at the end of clause (ii) and
6 inserting ", or", and by adding at the end the following
7 new clause:
8 "(iii) eligible for coverage under a
9 qualified health plan in accordance with title
10 I of the Health Security Act.";
11 (2) by adding at the end thereof the following:
12 An individual terminated by a large group sponsor
13 must elect by the date of the termination to either
14 remain in the plan of the sponsor for a period of
15 not to exceed 12 months or until the individual is
16 reemployed, whichever is less, or has purchased
17 coverage from another plan in the marketplace.";
18 and
19 (3) by striking "OR MEDICARE ENTITLEMENT" in the
20 heading and inserting", MEDICARE ENTITLEMENT; OR
21 QUALIFIED HEALTH PLAN ELIGIBILITY".
22 (b) QUALIFIED BENEFICIARY.-Section 607(3) of such Act
23 (29 U.S.C. 1167(2)) is amended by adding at the end the
24 following new subparagraph:
25 "(D) SPECIAL RULE FOR INDIVIDUALS COVERED BY
26 HEALTH SECURITY ACT.-The term 'qualified

1 beneficiary' shall not include any individual who,
2 upon termination of coverage under a group health
3 plan, is eligible for coverage under a qualified
4 health plan in accordance with title I of the
5 Health Security Act."
6 (c) REPEAL UPON IMPLEMENTATION OF ACT.-
7 (1) IN GENERAL.-Part 6 of subtitle B of title I of
8 such Act (29 U.S.C. 601 et seq.) is amended by striking
9 sections 601 through 608 and by redesignating section
10 609 as section 601.
11 (2) CONFORMING AMENDMENTS.-
12 (A) Section 502(a)(7) of such Act (29 U.S.C.
13 1132(a)(7)) is amended by striking "609(a)(2)(A)"
14 and inserting "601(a)(2)(A)".
15 (B) Section 502(c)(1) is amended by striking
16 "paragraph (1) or (4) of section 606".
17 (C) Section 514 of such Act (29 U.S.C. 1144)
18 is amended by striking "609" each place it appears
19 in subsections (b)(7) and (b)(8) and inserting
20 "601".
21 (D) The table of contents in section 1 of such
22 Act is amended by striking the items relating to
23 sections 601 through 609 and inserting the
24 following new item:
25 "Sec. 601. Additional standards for group health plans."
26 (d) EFFECTIVE DATE.-

1 (1) SUBSECTIONS (a) AND (b).-The amendments made by
2 subsections (a) and (b) shall take effect on the date of
3 the enactment of this Act.
4 (2) SUBSECTION (c).-The amendments made by
5 subsection (c) shall take effect on the first January 1
6 following the deadline specified in section of this Act.
7 **SEC. 1432. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.**
8 (a) PERIOD OF COVERAGE.-Subparagraph (D) of section
9 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-
10 2(2)) is amended-
11 (1) by striking "or" at the end of clause (i), by
12 striking the period at the end of clause (ii) and
13 inserting ", or", and by adding at the end the following
14 new clause:
15 "(iii) eligible for coverage under a
16 qualified health plan in accordance with title
17 I of the Health Security Act,", and
18 (2) by striking "OR MEDICARE ENTITLEMENT" in the
19 heading and inserting ", MEDICARE ENTITLEMENT, OR
20 QUALIFIED HEALTH PLAN ELIGIBILITY".
21 (b) QUALIFIED BENEFICIARY.-Section 2208(3) of such Act
22 (42 U.S.C. 300bb-8(3)) is amended by adding at the end the
23 following new subparagraph:
24 "(c) SPECIAL RULE FOR INDIVIDUALS COVERED BY
25 ACT.-The term 'qualified beneficiary' shall not
26 include any individual who, upon termination of

1 coverage under a group health plan, is eligible
2 for coverage under a qualified health plan in
3 accordance with title I of the Health Security
4 Act.".
5 (c) REPEAL UPON IMPLEMENTATION OF HEALTH SECURITY ACT.-
6 (1) IN GENERAL.-Title XII of such Act (42 U.S.C.
7 300bb-1 et seq.) is hereby repealed.
8 (2) CONFORMING AMENDMENT.-The table of contents of
9 such Act is amended by striking the item relating to
10 title XXII.
11 (d) EFFECTIVE DATE.-
12 (1) SUBSECTIONS (a) AND (b).-The amendments made by
13 subsections (a) and (b) shall take effect on the date of
14 the enactment of this Act.
15 (2) SUBSECTION (c).-The amendments made by
16 subsection (c) shall take effect on the first January 1
17 following the deadline specified in section of this Act.

18 **Subtitle F-Health Plans**

19 **PART 1-REQUIREMENTS FOR HEALTH PLANS**

20 **SEC. 1501. STATE PLANS; REGISTRATION PROCESS; QUALIFICATIONS.**

21 (a) IN GENERAL.-The National Health Board (hereinafter
22 referred to as "the Board") shall provide a process for
23 development and approval of State plans (as established in
24 subsection (c)) whereby a State may register a health plan
25 (as defined in subsection (b)) as certified health plan. The
26 health plan shall remain registered unless and until the

1 health plan's registration as an certified health plan is
2 revoked by the State pursuant to subsection (f) or the health
3 plan withdraws its registration for any service area.
4 (b) HEALTH PLAN DEFINED.-The term "health plan" means a
5 plan that provides comprehensive health benefits delivered
6 through an open-network, or closed-network, or non-network
7 system, whether directly, through insurance or otherwise, and
8 includes a policy of health insurance, a contract of a
9 service benefit organization, or a membership agreement with
10 a health maintenance organization or other prepaid health
11 plan, and also includes any self-insured employee welfare
12 benefit plan, a multiple employer welfare plan, a
13 governmental plan, or a church plan (as such terms are
14 defined in section 3 of the Employee Retirement Income
15 Security Act of 1974).
16 (c) STATE PLAN REQUIREMENTS.-
17 (1) IN GENERAL.- The Board shall adopt and publish
18 within eighteen months after enactment of this Act a
19 Model State Plan to Implement Certified Health Plan
20 Registration (hereinafter referred to as "Model State
21 Plan") that meets the requirements of this subtitle.
22 No health plan may be registered as a certified health
23 plan under this subtitle in any State unless the Board
24 has certified that an approved State plan is effective
25 in such State. The Board shall regularly review State
26 plans to determine if they continue to meet the

1 standards and requirements of this subtitle and, where
2 the Board finds that a State plan no longer meets the
3 standards and requirements, before making a final
4 determination, the Board shall provide the State an
5 opportunity to adopt a plan of correction.
6 (2) NAIC MODEL PLAN.- The Board shall request the
7 National Association of Insurance Commissioners
8 (hereinafter referred to as "NAIC") to develop such a
9 Model State Plan for its consideration. The Board may
10 adopt, reject, or modify any Model State Plan submitted
11 to it by the NAIC. If the NAIC fails to develop and
12 report a Model State Plan to the Board within twelve
13 months after enactment of this Act, the Board shall
14 develop its own Federal Model State Plan that meets the
15 requirements of this subtitle.
16 (3) EFFECTIVE STATE PLAN REQUIRED.- A State shall adopt
17 the Model State Plan published by the Board, except that a
18 State may adopt such modifications as it determines are
19 necessary and appropriate, and which are consistent with this
20 subtitle, subject to the approval of the Board. If by
21 January 1, 1997, a State does not adopt the Model State Plan
22 published by the Board, or a modification thereof which has
23 been approved by the Board; or where a State Plan fails to
24 continue to meet the standards and requirements of this
25 subtitle, and a State fails to correct such State Plan after
26 the Board has provided an opportunity for correction, the

1 Board shall adopt a Federal Model State Plan which shall be
2 effective in such State as if it had been adopted by the
3 State.
4 (d) QUALIFICATIONS.-In order for a health plan to be
5 eligible to be registered as a certified health plan under a
6 State plan, the health plan must-
7 (1) provide, in accordance with section 1515(b)(4),
8 for health plan items and services throughout each
9 designated service area for which it is registered;
10 (2) provide, in accordance with section 1502, for
11 coverage the standard benefits specified by the Board;
12 (3) provide, in accordance with section 1503, for
13 the collection and reporting to the State and each
14 appropriate Purchasing Group of certain information
15 regarding its enrollees and provision of services;
16 (4) not discriminate in enrollment or benefits, as
17 required under section 1504;
18 (5) establish standard premiums for the standard
19 benefits, in accordance with section 1505;
20 (6) meet financial solvency requirements, in
21 accordance with section 1506;
22 (7) facilitate the coordination of benefits among
23 other health plans in accordance with rules established
24 under section 1507;
25 (8) provide for effective grievance procedures in
26 accordance with section 1508;

1 (9) demonstrate ability to administer the health
2 benefit plan, in accordance with section 1509;
3 (10) demonstrate ability to assure the delivery of
4 the appropriate level and type of health care service
5 and to monitor and evaluate the quality and cost
6 effectiveness of care in accordance with section 1510;
7 (11) demonstrate ability to conduct utilization
8 management in accordance with section 1511;
9 (12) demonstrate ability to assure enrollees with
10 adequate access to providers of health care, including
11 geographic availability and adequate numbers and types
12 in accordance with section 1512;
13 (13) demonstrate ability to monitor access in
14 accordance with section 1513;
15 (14) meet the marketing requirements, in accordance
16 with section 1514;
17 (15) meet requirements for open enrollment,
18 availability, and renewability, in accordance with
19 section 1515;
20 (16) meet requirements, where appropriate, with
21 respect to rural and underserved areas in accordance
22 with section 1516; and
23 (17) meet requirements, where appropriate, with
24 respect to participation in a risk adjustment program in
25 accordance with section 1517.

1 (e) RECOGNITION OF ACCREDITATION BY NATIONAL
2 ORGANIZATIONS.-A State is authorized to use as a basis of
3 qualification under subsection (d), the accreditation by
4 nationally recognized accreditation organizations, such as
5 the National Committee on Quality Assurance (NCQA) and the
6 Joint Commission on Accreditation of Health Care
7 Organizations (JCAHO), or other organization where the Board
8 finds that a national accreditation body establishes
9 requirements equal to or more stringent than requirements
10 established under subsection (d).
11 (f) REVOCATION OF HEALTH PLAN REGISTRATION.-The State
12 may revoke a plan's registration as an certified health plan
13 for any HCCA only upon determination that the health plan no
14 longer meets the requirements of subsection (d). The State
15 shall establish a procedure for revocation of a health plan's
16 registration that includes adequate written notice and an
17 opportunity to be heard prior to revocation on the specific
18 basis of the Board's determination that a plan no longer
19 complies with the requirements of subsection (d).
20 **SEC. 1502. SPECIFIED STANDARD BENEFITS; COST-SHARING;**
21 **SUPPLEMENTAL BENEFITS.**
22 (a) STANDARD BENEFITS AND OTHER REQUIREMENTS.-A State
23 shall not accept the registration of a health plan as an
24 certified health plan unless the plan-
25 (1) offers one or more of the standard benefit
26 packages as specified by Board under section _____;

1 (2) has entered into arrangements with a sufficient
2 number and variety of network providers to provide for
3 its enrollees the standard benefits without imposing
4 cost-sharing in excess of the cost-sharing which meets
5 the requirements of section ________; and
6 (3) provides, in the case of individuals covered
7 under more than one certified health plan, for
8 coordination of coverage under such plans in accord with
9 section 1108.
10 (b) TREATMENT OF SUPPLEMENTARY HEALTH BENEFITS.-
11 (1) IN GENERAL.-Subject to paragraphs (2), (3), and
12 (4), subsection (a) shall not be construed as preventing
13 a health plan or any other health plan, carrier, or
14 insurer from offering to the general public insurance
15 policies or plans for health benefits supplementary to
16 the standard benefits or for reducing the cost-sharing
17 below the maximum cost-sharing, if such policies or
18 plans for supplementary health benefits or reductions in
19 cost-sharing are offered and priced separately from the
20 standard health benefits described in subsection (a).
21 (2) SUPPLEMENTAL POLICIES OR PLANS DEFINED.-For
22 purposes of this subsection --
23 (A) The term "supplemental health benefit
24 policy" means a health insurance policy or health
25 benefit plan that is approved by a State in which
26 it is offered and which only provides--

1 (i) coverage for services and items not
2 included in the standard benefit package, or
3 that are not covered because of a limitation
4 in amount, duration, scope, or circumstances;
5 or
6 (ii) coverage for deductibles, coinsurance,
7 and copayments imposed as part of the standard
8 benefit package; or
9 (iii) both.
10 (B) Such term does not include the following
11 types of policies--
12 (i) a long-term care insurance policy;
13 (ii) insurance that limits benefits with
14 respect to specific diseases (or conditions);
15 (iii) hospital or nursing home indemnity
16 insurance;
17 (iv) a Medicare supplemental policy (as
18 defined in section 1882 of the Social Security
19 Act);
20 (v) insurance with respect to only accidents.
21 (3) NO DUPLICATIVE HEALTH BENEFITS.-A health plan
22 or any other health plan, carrier, or insurer may not
23 offer under paragraph (1) any policy for supplementary
24 health benefits that duplicates standard benefits by
25 providing payment for any medical expenses that are paid
26 for under the standard benefits required under

1 subsection (a). Policies meeting the requirements of
2 paragraph (2)(A) shall be deemed to be nonduplicative;
3 and the types of policies specified in paragraph (2)(B)
4 that pay benefits regardless of other coverage shall be
5 deemed to be nonduplicative.
6 (4) RESTRICTIONS ON MARKETING.-A health plan or any
7 other health plan, carrier, or insurer may not offer a
8 supplemental health benefit policy (defined in
9 subparagraph (2)) using marketing practices that
10 involve--
11 (a) providing monetary incentives for or otherwise
12 conditioning the sale of the policy to enrollment
13 in a standard benefit health plan of such entity;
14 or
15 (b) using or disclosing to any party information
16 about the health status or claims experience of
17 participants in a standard health benefit plan for
18 purposes of marketing such a policy.
19 (5) STATE PLAN REQUIRED.-The NAIC shall include in
20 its Model State Plan (required under section 1101),
21 appropriate rules for the regulation of supplemental
22 health benefit policies and plans that meet the
23 requirements of this paragraph.
24 (c) LIMITATION ON IMPOSITION OF COST-SHARING.-A health
25 plan may not provide payment for services (other than
26 emergency services) furnished by a provider with whom it has

entered into an arrangement described in subsection (a)(2) unless the provider has agreed (in a manner specified by the State) not to impose cost-sharing in excess of that so specified. Nothing in this subsection shall be construed as requiring or prohibiting health plans from paying for services provided by out-of-network providers.

SEC. 1503. COLLECTION, PROVISION OF STANDARDIZED INFORMATION, AND CONFIDENTIALITY.

(a) PROVISION OF INFORMATION.-

(1) IN GENERAL.-Each health plan must provide the State and each Purchasing Group with which it has contracted (at a time, not less frequently than annually, and in an electronic, standardized form and manner specified by the National Health Board) information required in this subsection, to evaluate the performance of the health plan in providing the standard benefits to its enrollees.

(2) INFORMATION TO BE INCLUDED.-Subject to paragraph (3), information to be reported under this subsection shall include the following:

(A) Information on the types of treatments and outcomes of treatments with respect to the clinical health of enrollees.

(B) Information on enrollee satisfaction, based on standard surveys prescribed by the Board.

1 (C) Information on aggregate health care
2 expenditures by the plan.
3 (D) Information on the standard premium
4 charged for each premium class in each service area
5 in which the plan is offered.
6 (3) PROTECTION OF PROPRIETARY INFORMATION.-
7 Notwithstanding the requirements of paragraph (a), the
8 Board shall not release or make available to the public
9 or any other person not authorized by this Act any
10 privileged and confidential information, actuarial
11 certifications, or other information that is marked
12 "proprietary" and which is submitted to the Board under
13 authority of this section by a health plan.
14 (4) HOLD HARMLESS PROVISION.-A health plan required
15 to provide information to the Board pursuant to this
16 section, and that provides such information, shall not
17 be held liable by any person for such disclosure or for
18 the use or disclosure of that information by the Board,
19 any Purchasing Group, or any agency of government.
20 (b) CONDITIONING CERTAIN PROVIDER PAYMENTS.-In order to
21 assure the collection of all information required from the
22 direct providers of services for which benefits are available
23 through a health plan, a health plan may not provide payment
24 for services covered by the standard benefit package (other
25 than emergency services) furnished by a provider unless the
26 provider has agreed in writing to give the health plan the

1 information necessary to fulfill its obligations under this
2 section.
3 (c) ACCURACY AND CONFIDENTIALITY OF PATIENT SPECIFIC
4 INFORMATION.-A health plan shall take such measures as may be
5 necessary to ensure that health care information is accurate
6 and reliable. Any data or information pertaining to the
7 diagnosis, treatment or health of any enrollee obtained from
8 such person or from any provider shall be held in confidence
9 in accord with applicable State or Federal law and shall not
10 be disclosed to any person except to the extent that may be
11 necessary to carry out the requirements of this section and
12 in a manner specified by the Board to ensure enrollee
13 confidentiality.
14 **SEC. 1504. PROHIBITION OF DISCRIMINATION BASED ON HEALTH**
15 **STATUS FOR CERTAIN CONDITIONS; LIMITATION ON**
16 **PRE-EXISTING CONDITION EXCLUSIONS.**
17 (a) IN GENERAL.-Except as provided under subsection (b),
18 an health plan may not deny, limit, or condition the
19 enrollment in the plan based on the health status, claims
20 experience, receipt of health care, medical history, or lack
21 of evidence of insurability, of an eligible individual
22 enrolling for coverage in that health plan.
23 (b) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR
24 SERVICES.-Except as provided under subsection (c) an health
25 plan may not exclude coverage of an eligible individual
26 because of existing medical conditions provided that, persons

1 whose enrollment is terminated or which lapses, and who are
2 not covered by a health plan within 60-days of such
3 termination or lapse, may be subject to an exclusion of
4 coverage for up to 12 months with respect to services related
5 to treatment of a preexisting condition which has been
6 diagnosed or treated during the 12-month period ending on the
7 day before the first date of coverage under the plan.

8 (c) TRANSITIONAL LIMITS ON TREATMENT OF PREEXISTING
9 CONDITION EXCLUSIONS FOR SERVICES.-Effective upon date of
10 enactment and for the period until universal coverage is
11 effective under section 1501 the following limitations shall
12 apply with respect to exclusions of coverage--

13 (1) IN GENERAL.-Subject to the succeeding
14 provisions of this subsection, and except as provided in
15 subparagraphs (3) and (4), a health plan may exclude
16 coverage with respect to services related to treatment
17 of a preexisting condition, but the period of such
18 exclusion may not exceed 6 months beginning on the date
19 of coverage under the plan. The exclusion of coverage
20 shall not apply to services furnished to newborns or to
21 pregnant women.

22 (2) CREDITING OF PREVIOUS COVERAGE.-

23 (A) IN GENERAL.-A health plan shall provide
24 that if an enrollee is in a period of continuous
25 coverage (as defined in subparagraph (B)(i)) as of
26 the date of initial coverage under such plan, any

1 period of exclusion of coverage with respect to a
2 preexisting condition for such services or type of
3 services shall be reduced by 1 month for each month
4 in the period of continuous coverage.
5 (B) DEFINITIONS.-As used in this paragraph:
6 (i) PERIOD OF CONTINUOUS COVERAGE.-The
7 term "period of continuous coverage" means the
8 period beginning on the date an individual is
9 enrolled in a health plan offering a benefits
10 package that covers the preexisting condition,
11 and ends on the date the individual is not so
12 enrolled for a continuous period of more than
13 3 months.
14 (ii) PREEXISTING CONDITION.-Except as
15 provided in (3), the term "preexisting
16 condition" means, with respect to coverage
17 under a health plan, a condition which has
18 been diagnosed before or during, or treated
19 during, the 3-month period ending on the day
20 before the first date of such coverage
21 (without regard to any waiting period).
22 (3) LATE ENROLLEES.-With respect to persons
23 enrolling in a health plan during a time other than
24 during an open or special enrollment period, a health
25 plan may exclude coverage with respect to services
26 related to treatment of a preexisting condition, but the

1 period of such exclusion may not exceed 18-months
2 beginning on the date of coverage under the plan.
3 (4) WAITING PERIODS.-A health plan that does not
4 utilize a preexisting condition exclusion may impose a
5 waiting period on enrollees not to exceed 30 days,
6 before coverage under the plan becomes effective.
7 During the waiting period, the health plan is not
8 required to provide health care services or benefits and
9 no premium shall be charged to the enrollee.
10 (d) LIMITATION.-The requirements of subsections (a) and
11 (b) shall not apply to treatment which is not within the
12 standard benefits (as defined in this Act).
13 **SEC. 1505. USE OF STANDARD PREMIUMS.**
14 (a) IN GENERAL.-Each health plan shall establish a
15 standard premium that meets the requirements of this section.
16 (b) ADJUSTMENT FOR PURCHASING GROUP AGREEMENT.-Each
17 health plan that has in effect an agreement with an
18 individual and small employer health plan Purchasing Group
19 (pursuant to section
20 1302) may adjust the standard premium to reflect any
21 additional administrative costs or savings, as the case may
22 be, associated with offering health plans through such
23 Purchasing Group. Any adjustment made to the standard
24 premium pursuant to this paragraph shall be calculated and
25 applied uniformly, and disclosed in a manner prescribed by
26 the State.

1 (c) TREATMENT OF AFFILIATED HEALTH PLANS.-For purposes
2 of this section, health plans (as defined in section 1501(b))
3 offering the standard benefit packages and that are operated
4 by the same or affiliated companies or that are eligible to
5 file a consolidated federal income tax return shall be
6 treated as one health plan, and any requirements,
7 restrictions or limitations imposed by this section shall
8 apply as if all affiliated health plans were issued by one
9 health plan.
10 (d) PREEMPTION OF INCONSISTENT STATE OR FEDERAL PREMIUM
11 RATING REQUIREMENTS.-In addition to the provisions of Part 2
12 of this Subtitle, the requirements of this section shall
13 supersede any inconsistent federal or State premium rating
14 requirements applicable to organizations registered as health
15 plans.
16 **SEC. 1506. FINANCIAL SOLVENCY REQUIREMENTS.**
17 (a) IN GENERAL.-In order for a health plan to be
18 registered by a State under this subtitle, the Board must
19 find that a State has established financial solvency
20 requirements at least equal to the requirements of this
21 section to ensure that the health plan provides evidence of
22 adequate capitalization and has established satisfactory
23 protection of enrollees with respect to potential insolvency.
24 Each health plan shall have a fiscally sound operation as
25 demonstrated to a State by having: (1) total assets being
26 greater than total unsubordinated liabilities; (2) sufficient

1 cash flow and adequate liquidity to meet obligations as they
2 become due; (3) a net operating surplus; (4) a plan for
3 handing insolvency which allows for continuation of benefits;
4 (5) insurance or other arrangements to protect the plan
5 against losses arising from professional liability claims,
6 fire, theft, fraud, embezzlement, and other casualty risks;
7 and (6) any other additional requirements adopted pursuant to
8 subsection (i).
9 (b) FINANCIAL PLAN REQUIRED.-Each health plan shall
10 provide the State with a financial plan that includes
11 information with respect to marketing, revenue and expense
12 (on an accrual basis), sources and uses of funds' statements,
13 and balance sheets, and a plan that enrollee benefits under
14 the health plan's plan are continued for a reasonable
15 transition period necessary to obtain other health plan
16 replacement coverage and obligations incurred prior to
17 insolvency are satisfied if the plan becomes insolvent.
18 (c) CAPITAL REQUIREMENTS FOR INSURED PLANS.-In the case
19 of an health plan that is an insured plan (as defined by the
20 Board) and is offered in a State, the plan shall be required
21 by the State to have an initial net worth of $1,500,000, and
22 must maintain thereafter a minimum net worth equal to the sum
23 of (1) and (2):
24 (1) the greater of--(A) $1,000,000; or (B) 2%
25 of the plan's annual premium revenues, as reported
26 on the plan's most recent annual financial

1 statement filed with the State, on the first
2 $150,000,000 of premium and 1% of the plan's annual
3 premium on the premium in excess of $150,000,000;
4 or (C) an amount equal to the sum of 8% of the
5 plan's total annual health care expenditures on the
6 first $150,000,000, and 4% of the plan's total
7 annual health care expenditures in excess of
8 $150,000,000 (except those paid on a capitated
9 basis or on a managed hospital payment basis or
10 those expenditures made for self-referral non-
11 emergency services) plus 4% of annual hospital
12 expenditures (paid on a managed hospital payment
13 basis); and
14 (2) an amount equal to the sum of 15% of the
15 plan's health care expenditures up to $50,000,000
16 for self-referred non-emergency services and 8% of
17 the plan's health care expenditures for such
18 services in excess of $50,000,000.
19 (d) CAPITAL REQUIREMENTS FOR OTHER PLANS.-In the case of
20 an health plan that is not an insured plan or is an insured
21 plan in a State that fails to meet the requirements of this
22 section, the Board shall require the plan to maintain
23 sufficient capital by providing a bond or other satisfactory
24 assurances consistent with subparagraph (c).
25 (e) DEPOSIT REQUIREMENT FOR ALL PLANS.-For the purpose
26 of demonstrating a good faith commitment to be an established

1 health plan, each health plan shall deposit with the State
2 cash, securities, or any combination of these or other
3 measures specified as acceptable by the Board which, at all
4 times, shall have a value of not less than $300,000. The
5 deposit shall be deemed to be an admitted asset of the health
6 plan in the determination of net worth. A health plan may
7 withdraw any deposit instrument after making a substitute
8 deposit of cash, securities, or any combination of equal
9 amount and value if approved by the State.
10 (f) FINANCIAL GUARANTEES.-A health plan may meet the
11 requirements of this section and other State requirements
12 through a guarantor. For purposes of this subparagraph, a
13 guarantor must be a legal entity which--
14 (1) agrees to submit to the jurisdiction of the
15 State for purposes of enforcing the guarantee; and
16 (2) owns or controls, directly or indirectly, the
17 majority of voting power in, or is under common control
18 with, the health plan or the legal entity of which the
19 health plan is a part; and
20 (3) has a net worth, including land, buildings, and
21 equipment legally available to be pledged to cover
22 operating expenses, equal to the greater of either--
23 (A) $5 million; or
24 (B) net worth in an amount needed to bring the
25 health plan's net worth to the amount required
26 to meet the net worth test and to assure

1 sufficient cash flow and adequate liquidity to
2 meet current obligations.
3 (g) REINSURANCE.-An health plan may utilize reinsurance,
4 provider risk sharing and other appropriate mechanisms to
5 share a portion of the risk.
6 (h) PROTECTION AGAINST PROVIDER CLAIMS.-In the case of a
7 failure of an health plan to make payments with respect to
8 the standard benefits for any reason, an individual who is
9 enrolled under the plan is not liable to any health care
10 provider or practitioner with respect to the provision of
11 health services within such set of standard benefits for
12 payments in excess of the amount for which the enrollee would
13 have been liable if the plan were to have made payments in a
14 timely manner.
15 (i) ADDITIONAL STATE PLAN REQUIREMENTS.-The Model State
16 Plan (required under Section 1501) shall include financial
17 solvency provisions that meet the requirements of this
18 section, and may include any additional requirements
19 consistent with the minimum standards established in this
20 section (including any special rules that may be required for
21 network plans offering out-of-network coverage). Each health
22 plan shall meet such other requirements (including any
23 capital requirements in addition to those specified in
24 subsection (c)) as may be adopted by a State in its State
25 Plan pursuant to the standards and requirements established
26 under Section 1101.

1 **SEC. 1507. COORDINATION OF COVERAGE.**
2 Each health plan shall provide for the coordination of
3 standard benefits in accordance with rules established by the
4 Board. Coordination of benefits shall ensure that persons
5 who may be enrolled in more than one health plan will receive
6 no greater coverage than that which is required under the
7 standard benefit plan.
8 **SEC. 1508. GRIEVANCE MECHANISMS; ENROLLEE PROTECTIONS;**
9 **WRITTEN POLICIES AND PROCEDURES RESPECTING**
10 **ADVANCE DIRECTIVES.**
11 (a) EFFECTIVE GRIEVANCE PROCEDURES.-Each health plan
12 shall provide for effective procedures meeting standards
13 specified by the Board for hearing and resolving grievances
14 between the plan, its staff and participating providers, and
15 between the plan and individuals enrolled under the plan.
16 Standards issued by the Board shall preempt any applicable
17 State provisions and must assure that: (1) grievances and
18 complaints will be transmitted in a timely manner to
19 appropriate decision making levels within the plan which have
20 authority to take corrective action; and (2) appropriate
21 action will be taken promptly, including a full investigation
22 if necessary and notification of concerned parties as to the
23 results of the plan's investigation.
24 (b) WRITTEN POLICIES AND PROCEDURES RESPECTING ADVANCE
25 DIRECTIVES.-A health plan may not be registered as an health
26 plan unless the plan meets the requirements of section

1 1866(f) of the Social Security Act (relating to maintaining
2 written policies and procedures respecting advance
3 directives), insofar as such requirements would apply to the
4 plan if the plan were an eligible organization.
5 **SEC. 1509. ADMINISTRATIVE STANDARDS.**
6 Each health plan shall demonstrate the capability to
7 administer the health benefit plan. For purposes of this
8 section, a health plan must: provide for adequate numbers
9 and type of staff; communicate procedures to enrollees and
10 participating providers; establish procedures for input from
11 enrollees on covered services; provide mechanisms for
12 appropriate participation by physicians in policies affecting
13 patient care; and meet specifications for administrative
14 simplification adopted pursuant to Subtitle ____, Title ____
15 of this Act.
16 **SEC. 1510. QUALITY ASSURANCE STANDARDS.**
17 (a) IN GENERAL.-Each health plan shall establish
18 procedures to assure that the health care services provided
19 to enrollees shall be rendered under reasonable standards of
20 quality of care consistent with prevailing professionally
21 recognized standards of medical practice. Such procedures
22 shall include mechanisms to assure availability,
23 accessibility and continuity of care and which: (1) stress
24 health outcomes; (2) provide review by health professionals
25 of the process followed in the provision of health services;
26 (3) use systematic data collection of performance and patient

1 results, provide interpretation of these data to its
2 practitioners, and institute needed change; and (4) include
3 written procedures for taking appropriate remedial action
4 whenever, as determined under the program, inappropriate or
5 substandard services have been provided or services which
6 should have been furnished have not been provided.
7 (b) INTERNAL QUALITY ASSURANCE PROGRAM.-Each health plan
8 shall establish, and communicate to its enrollees and its
9 providers, an ongoing internal program and periodic reporting
10 to monitor and evaluate the quality and cost effectiveness of
11 its health care services, including primary and specialist
12 physician services, and ancillary and preventive health care
13 services, and to coordinate care across all institutional and
14 non-institutional settings and with other medical management
15 activities. For purposes of this section, a health plan's
16 quality assurance program shall include, at a minimum, the
17 following:
18 (1) A written statement of goals and objectives
19 which emphasizes improved health status in
20 evaluating the quality of care rendered to
21 enrollees;
22 (2) A written quality assurance plan which
23 describes the following:
24 (a) The plan's scope and purpose in quality
25 assurance;

1 (b) The organizational structure responsible
2 for quality assurance activities;
3 (c) Contractual arrangements, where
4 appropriate, for delegation of quality
5 assurance activities;
6 (d) Confidentiality policies and procedures;
7 (e) A system of ongoing evaluation
8 activities;
9 (f) A system of focused evaluation
10 activities;
11 (g) A system for credentialing providers and
12 performing peer review activities;
13 (h) A system for ensuring that providers and
14 facilities are appropriately licensed,
15 certified, or accredited as required by
16 applicable laws and regulations; and
17 (i) Duties and responsibilities of the
18 designated physician responsible for the
19 quality assurance activities.
20 (3) A written statement describing the system of
21 ongoing quality assurance activities including:
22 (a) Problem assessment, identification,
23 selection and study;
24 (b) Corrective action, monitoring, evaluation
25 and reassessment; and

1 (c) Interpretation and analysis of patterns
2 of care rendered to individual patients
3 by individual providers.
4 (4) A written statement describing the system of
5 focused quality assurance activities based on
6 representative samples of the enrolled population
7 which identifies method of topic selection, study,
8 data collection, analysis, interpretation and
9 report format; and
10 (5) Written plans for taking appropriate
11 corrective action whenever, as determined by the
12 quality assurance program, inappropriate or
13 substandard services have been provided or services
14 which should have been furnished have not been
15 provided.
16 (c) CONFIDENTIALITY OF RECORDS.-The health plan shall
17 record proceedings of formal quality assurance program
18 activities and maintain documentation in a confidential
19 manner in accordance with applicable Federal or State laws.
20 (d) REPORTING PLAN PERFORMANCE.-Each health plan shall
21 report annually on the plan's performance in a manner
22 specified by the State which provides for uniform reporting
23 to facilitate comparison of performance with other health
24 plans. For purposes of establishing such requirements the
25 State may utilize the standards specified by the Health Plan
26 Employer Data Information Set ("HEDIS"), based upon the most

1 recent model, and shall incorporate any subsequent and
2 generally accepted changes reflecting improvements in
3 performance measurements.

4 **SEC. 1511. UTILIZATION MANAGEMENT PROTOCOLS.**

5 (a) IN GENERAL.-Each health plan shall establish written
6 management procedures used by the plan for controlling
7 utilization and costs that meets certification standards
8 established by a State. For purposes of this section, such
9 procedures may include a system of reviewing medical
10 necessity and appropriateness of patient services using
11 specific guidelines.

12 (b) STATE STANDARD.-A State may certify utilization
13 management standards either directly or may deem such
14 standards to meet the requirements of this section through
15 accreditation by a private organization whose standards are
16 recognized by the State as meeting such requirements.

17 (c) PROPRIETARY NATURE.-Written management standards and
18 procedures used by an health plan for controlling utilization
19 and costs are deemed to be proprietary information and no
20 State law or regulation may require public disclosure of such
21 standards and procedures.

22 **SEC. 1512. ACCESS TO CARE; ESSENTIAL COMMUNITY PROVIDERS;**
23 **POINT OF SERVICE OPTION.**

24 (a) IN GENERAL.-Each health plan shall establish and
25 maintain adequate arrangements with health care providers or
26 have such other arrangements as may be necessary to provide

1 required health services for its enrollees that recognize
2 their diverse needs including: a sufficient number and
3 distribution of participating providers to assure that
4 standard benefits are available and accessible to each
5 enrollee within the area served by the plan and within
6 reasonable proximity to the business or personal residences
7 of the enrollees; reasonable hours of operation and after-
8 hours services; emergency and urgent care services when
9 medically necessary, available and accessible within the
10 service area twenty-four hours a day, seven days a week.
11 Each plan shall permit each enrollee to choose a personal
12 physician from among participating primary care physicians
13 and to change that selection as appropriate.
14 (b) ESSENTIAL COMMUNITY PROVIDERS.- If a State
15 determines that an health plan has not met the standards of
16 subsection (a) it may, after written notice and an
17 opportunity to be heard with respect to the basis of such a
18 determination, require the health plan to offer to contract
19 with any essential community provider but only to the extent
20 necessary to assure adequate access for such individuals.
21 Such agreements with an essential community provider shall be
22 on the same basis generally, including payments, as the terms
23 and conditions that may be specified for any other contract
24 entered into by the health plan with providers that are not
25 essential community providers. Authorization for a State to
26 require an health plan to enter into an agreement with an

1 essential community provider shall be effective for the
2 three-year period beginning with the date of enactment of
3 this Act. For purposes of this subparagraph the term
4 "essential community provider" shall include only federally
5 qualified health centers and rural health clinics. The terms
6 "rural health clinic" and "federally qualified health center"
7 mean a facility that meets the standards and requirements of
8 such facility as specified under Section 1861(aa) of the
9 Social Security Act (42 U.S.C. 1395x(aa)).
10 (c) POINT-OF-SERVICE OPTION.-Each health plan that is a
11 network plan shall offer enrollees the opportunity to obtain
12 coverage for out-of-network items and services, provided that
13 such point-of-service option is offered, and priced
14 separately from the benefits offered through the plan's
15 network. An health plan providing coverage to an enrollee
16 for out-of-network items and services may charge an
17 alternative premium and require alternative cost-sharing to
18 take into account such coverage; and the terms and conditions
19 of payment to out-of-network providers shall be determined by
20 the health plan in the manner specified in the health plan's
21 written description of plan benefits. An health plan may
22 suspend the offering of out-of-network coverage upon approval
23 by a State.
24 **SEC. 1513. MONITORING ACCESS.**
25 Each health plan shall establish procedures for
26 monitoring enrollee access to assure that all services

1 contracted for will be accessible to enrollees on an
2 appropriate basis without delays. The plan shall ensure the
3 use and maintenance of an adequate patient record system
4 which will facilitate documentation and retrieval of clinical
5 information for the purpose of evaluating continuity and
6 coordination of patient care and assessing the quality of
7 health and medical care provided to enrollees.

8 **SEC. 1514. MARKETING STANDARDS.**

9 (a) IN GENERAL.-Each health plan shall provide to each
10 enrollee written descriptions of plan premium costs,
11 benefits, covered services and items, and procedures that
12 clearly and fully describe any and all limitations of
13 coverage, exclusions, and out-of-pocket costs including
14 copayments, deductibles, co-insurance, and aggregate maximums
15 on out-of-pocket costs. Such materials shall also provide
16 information with respect to the identity, locations,
17 qualifications, availability of participating providers, out-
18 of-area and out-of-network benefits and services, grievance
19 procedures, and the financial condition of the plan.

20 (b) MARKETING METHODS; ADVERTISING MATERIALS.-A health
21 plan may utilize direct marketing, agency, or other
22 arrangements to distribute health plan information subject to
23 applicable state fair marketing practices laws. All
24 advertising, promotional materials, and other communications
25 with health plan members and the general public must be
26 factually accurate and responsive to the needs of served

1 populations. A health plan may not distribute marketing
2 materials to an area smaller than the entire designated
3 service area of the plan.
4 (c) PAYMENT OF AGENT COMMISSIONS.- A health plan-
5 (1) may pay a commission or other remuneration to
6 an agent or broker in marketing the plan to individuals
7 or groups, but
8 (2) may not vary such remuneration based, directly
9 or indirectly, on the anticipated or actual claims
10 experience associated with the group or individuals to
11 which the plan was sold.
12 **SEC. 1515. OPEN ENROLLMENT; AVAILABILITY, AND**
13 **RENEWABILITY.**
14 (a) REQUIREMENT OF INDIVIDUAL OFFERING; NETWORK PLANS.-
15 In the case of a health plan that offers coverage to small
16 employers, the Health plan must also offer such coverage to
17 individuals and may satisfy this requirement by having in
18 effect an agreement (described in section 1302) with each
19 Purchasing Group in each HCCA in which it is offered. If a
20 health plan offers a network plan (as defined in section
21 1522(b)) to small employers, the Health plan must make such
22 plan available to individuals.
23 (b) REQUIREMENT OF OPEN ENROLLMENT.-
24 (1) IN GENERAL.-Each Health plan shall establish an
25 enrollment process consistent with this subparagraph.
26 In the case of a health plan which is a health plan in

1 order to be registered as a health plan the plan must,
2 subject to paragraphs (2), (3), (4) and (5) accept the
3 enrollment of any eligible individual (including
4 enrollees of an insolvent Health plan registered in the
5 same State or HCCA) either directly or through a
6 Purchasing Group authorized to enroll individuals under
7 an agreement referred to in subsection (a) if the
8 individual applies for enrollment during an annual 30-
9 day open enrollment period or other special enrollment
10 period authorized by a State.
11 (2) ENROLLMENT PROCESS; SPECIAL RULES.-
12 (A) INITIAL ENROLLMENT PERIOD.-Each eligible
13 individual, at the time the individual first
14 becomes an eligible individual in a HCCA, shall
15 have an initial enrollment period (of not less than
16 30 days) in which to enroll in a health plan.
17 (B) GENERAL ENROLLMENT PERIOD.-Each Health
18 plan shall establish an annual period, of not less
19 than 30 days, during which eligible individuals may
20 enroll in a health plan or change the health plan
21 in which the individual is enrolled.
22 (C) SPECIAL ENROLLMENT PERIODS.-In case of
23 individuals who-
24 (i) through marriage, divorce,
25 separation, birth or adoption of a child,

1 death or other circumstances, experience a
2 change in family situation, or
3 (ii) experience a change in employment
4 status (including a significant change in the
5 terms and conditions of employment), or
6 (iii) changes residence to another HCCA;
7 each Health plan shall provide for a special
8 enrollment period in which the individual is
9 permitted to change the individual or family
10 basis of coverage in the health plan in which
11 the individual is enrolled. The circumstances
12 under which such special enrollment periods
13 are required and the duration of such periods
14 shall be specified by the State.
15 (D) TRANSITIONAL ENROLLMENT PERIOD.-Each
16 Health plan shall provide for a special
17 transitional enrollment period during which
18 eligible individuals may first enroll.
19 (E) PERIOD OF COVERAGE.-
20 (i) INITIAL ENROLLMENT PERIOD.-In the
21 case of an eligible individual who enrolls
22 with a health plan during an initial
23 enrollment period, coverage under the plan
24 shall begin on such date (not later than the
25 first day of the first month that begins at

1 least 15 days after the date of enrollment) as
2 the State shall specify.
3 (ii) GENERAL ENROLLMENT PERIODS.-In the
4 case of an eligible individual who enrolls
5 with a health plan during a general enrollment
6 period, coverage under the plan shall begin on
7 the 1st day of the 1st month beginning at
8 least 15 days after the end of such period.
9 (iii) SPECIAL ENROLLMENT PERIODS.-
10 (A) IN GENERAL.-In the case of an
11 eligible individual who enrolls with a
12 health plan during a special enrollment
13 period, coverage under the plan shall
14 begin on such date (not later than the
15 first day of the first month that begins
16 at least 15 days after the date of
17 enrollment) as the State shall specify,
18 except that coverage of family members
19 shall begin on or after the date of the
20 event that gives rise to the special
21 enrollment period.
22 (B) TRANSITIONAL SPECIAL ENROLLMENT
23 PERIOD.-In the case of an eligible
24 individual who enrolls with a health plan
25 during the transitional special
26 enrollment period, coverage under the

1 plan shall begin on January 1 of the
2 first certification year.
3 (3) RENEWABILITY; LIMITATION ON TERMINATION.-
4 Subject to paragraphs (4) and (5), coverage of eligible
5 individuals under a health plan in a HCCA shall be
6 renewed at the option of such eligible individuals, and
7 coverage may not be terminated except for-
8 (A) where a health plan has not received
9 timely premium payments on behalf of such
10 individuals,
11 (B) fraud or misrepresentation,
12 (C) change of residence to an area not served
13 by the plan,
14 (D) termination of the plan, after notice and
15 in accordance with paragraph (4).
16 (4) TREATMENT OF NETWORK PLANS.-
17 (A) GEOGRAPHIC LIMITATIONS.-
18 (i) IN GENERAL.-A health plan which is a
19 network plan (as defined in subparagraph (D))
20 may deny enrollment under the plan to an
21 eligible individual who is located outside a
22 service area of the plan, but only if such
23 denial is applied uniformly, without regard to
24 health status or insurability of individuals.
25 (ii) SERVICE AREAS.-The State shall
26 establish standards for the designation by

1 network plans of service areas in order to
2 prevent discrimination based on health status
3 of individuals or their need for health
4 services.
5 (B) CAPACITY LIMITS.-Subject to subparagraph
6 (C), a health plan which is a network plan may
7 apply to the State to uniformly cease enrolling
8 eligible groups or individuals under the Health
9 plan (or in a service area of the plan) if-
10 (i) it ceases to accept any enrollments
11 in that service area, and
12 (ii) it can demonstrate to the State that
13 its financial or administrative capacity to
14 serve previously covered groups or individuals
15 (and additional individuals who will be
16 expected to enroll because of affiliation with
17 such previously covered groups or individuals)
18 will be impaired if it is required to accept
19 enrollments.
20 (C) FIRST-COME-FIRST-SERVED.-A network plan is
21 only eligible to exercise the limitations provided
22 for in subparagraph (B) if it accepts enrollments
23 of eligible individuals up to a stated limit
24 (approved by the State) on a first-come-first-
25 served basis.

1 (D) NETWORK PLAN.-In this paragraph, the term
2 "network plan" has the same meaning as provided in
3 section 1522(b)(1).
4 (5) TERMINATION OF PLANS.-A health plan may elect
5 not to renew or make available a health plan in a HCCA,
6 or not to utilize a particular type of delivery system
7 in a HCCA, but only if the Health plan --
8 (a) elects not to renew all of its health
9 plans in such HCCA or not to use the delivery
10 system in such HCCA; and
11 (b) provides notice to the State and each
12 individual covered under the plan of such
13 termination at least 180 days before the date of
14 expiration of either the plan or use of the
15 delivery system.
16 In such case, a health plan may not provide for the
17 issuance of any health plan in such HCCA, or to utilize
18 such delivery system in that HCCA during a 5-year period
19 beginning on the date of the termination of the last
20 plan not so renewed. For purposes of this subparagraph
21 the term "delivery system" means an open-network, closed
22 network, or non-network health care delivery system.
23 **SEC. 1516. RURAL AND MEDICALLY UNDERSERVED AREAS.**
24 (a) IN GENERAL.-If, after notice and public hearing, and
25 in accord with appropriate rules established by the Board, a
26 State determines that there is inadequate access in the

1 factors to be used for risk adjustment of premiums paid to a
2 health plan.