

Calendar No. 205

104TH CONGRESS  
1ST SESSION

**S. 1028**

[Report No. 104-156]

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## A BILL

To provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes.

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OCTOBER 12 (legislative day, OCTOBER 10), 1995

Reported with an amendment

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IN THE SENATE OF THE UNITED STATES

JULY 13 (legislative day, JULY 10), 1995

Mrs. KASSEBAUM (for herself, Mr. KENNEDY, Mr. FRIST, Mr. DODD, Mr. JEFFORDS, Ms. MIKULSKI, Mr. GREGG, Mr. WELLSTONE, Mr. GORTON, Mr. PELL, Mr. HATCH, Mr. SIMON, Mr. CHAFEE, Mr. LIEBERMAN, Mr. COHEN, Mr. KERREY, Mr. ROCKEFELLER, Mr. SIMPSON, Mr. INOUE, Mr. DORGAN, Mr. GLENN, Ms. SNOWE, Mr. BENNETT, Mr. HATFIELD, Mr. ABRAHAM, and Mr. MCCAIN) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

OCTOBER 12 (legislative day, OCTOBER 10), 1995

Reported by Mrs. KASSEBAUM, with an amendment

[Strike out all after the enacting clause and insert the part printed in *italic*]

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A BILL

To provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes.

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

3 **SECTION 1. SHORT TITLE.**

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

6 **SEC. 2. DEFINITIONS.**

7 As used in this Act:

8 (1) **BENEFICIARY.**—The term “beneficiary” has  
9 the same meaning given such term under section  
10 3(8) of the Employee Retirement Income Security  
11 Act of 1974 (29 U.S.C. 1102(8)).

12 (2) **EMPLOYEE.**—The term “employee” has the  
13 same meaning given such term under section 3(6) of  
14 the Employee Retirement Income Security Act of  
15 1974 (29 U.S.C. 1002(6)).

16 (3) **EMPLOYER.**—The term “employer” has the  
17 same meaning given such term under section 3(6) of  
18 the Employee Retirement Income Security Act of  
19 1974 (29 U.S.C. 1002(6)), except that such term  
20 shall only include employers of two or more employ-  
21 ees.

22 (4) **FAMILY.**—

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

1           ~~(B) CHILD.~~—For purposes of subpara-  
2 graph ~~(A)~~, the term “child” means any individ-  
3 ual who is a child within the meaning of section  
4 ~~151(c)(3)~~ of the Internal Revenue Code of  
5 1986, and under 19 years of age.

6           ~~(5) GROUP HEALTH PLAN.~~—The term “group  
7 health plan” means any employee welfare benefit  
8 plan, governmental plan, or church plan (as defined  
9 under paragraphs ~~(1)~~, ~~(32)~~ and ~~(33)~~ of section 3 of  
10 the Employee Retirement Income Security Act of  
11 1974 (~~29 U.S.C. 1002(1)~~, ~~(32)~~ and ~~(33)~~)) that  
12 maintains ~~(or makes contributions to)~~ a health plan.

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

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

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

1           (C) A medicare supplemental policy (as de-  
2           fined in section 1882(g)(1) of the Social Secu-  
3           rity Act)-

4           (D) Coverage issued as a supplement to li-  
5           ability insurance.

6           (E) Workers' compensation or similar in-  
7           surance.

8           (F) Automobile medical payment insur-  
9           ance.

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

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

19          (I) Coverage provided through a State risk  
20          pool, uncompensated care pool, or similar sub-  
21          sidized program.

22          (7) INDIVIDUAL HEALTH PLAN.—The term “in-  
23          dividual health plan” means a health plan marketed  
24          to individuals.

1           ~~(8) INSURED HEALTH PLAN.—~~The term “in-  
2           sured health plan” means, with respect to an em-  
3           ployee welfare benefit plan (as defined under section  
4           3(1) of the Employee Retirement Income Security  
5           Act of 1974 (29 U.S.C. 1002(1))), a health plan  
6           that is a contract for health benefits with an insurer  
7           that is subject to State regulation in accordance  
8           with section 514(b)(2)(A) of the Employee Retire-  
9           ment Income Security Act of 1974 (29 U.S.C.  
10          1144(b)(2)(A))).

11          ~~(9) INSURER.—~~The term “insurer” means—  
12                   ~~(A) a licensed insurance company;~~  
13                   ~~(B) a prepaid hospital or medical service~~  
14                   ~~plan;~~  
15                   ~~(C) a network plan (such as a preferred~~  
16                   ~~provider organization) or health maintenance or-~~  
17                   ~~ganization; or~~  
18                   ~~(D) any other entity (other than an entity~~  
19                   ~~described in paragraph (12)), except for those~~  
20                   ~~entities described in section 514(b)(6)(A)(i) of~~  
21                   ~~the Employee Retirement Income Security Act~~  
22                   ~~of 1974 (29 U.S.C. 1144(b)(6)(A)(i)) providing~~  
23                   ~~a plan of health insurance or health benefits;~~  
24           with respect to which State insurance laws apply  
25           and are not preempted under section 514 of the Em-

1        ployee Retirement Income Security Act of 1974 (29  
2        U.S.C. 1144).

3            (10) PARTICIPANT.—The term “participant”  
4        means any person who is eligible, or is required to  
5        be eligible, to receive benefits under a group health  
6        plan.

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

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

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

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

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

4 **Subtitle A—Group Health Plan**  
5 **Rules**

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

8 (a) IN GENERAL.—

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

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

13 (B) a group health plan (whether an in-  
14 sured health plan or self-insured health plan)  
15 may not establish eligibility, continuation, en-  
16 rollment, or contribution requirements for par-  
17 ticipants or beneficiaries;

18 based on health status, medical condition, claims ex-  
19 perience, receipt of health care, medical history, evi-  
20 dence of insurability, or disability of a participant or  
21 beneficiary.

22 (3) HEALTH PROMOTION OR DISEASE PREVEN-  
23 TION.—Nothing in this subsection shall prevent a  
24 group health plan from establishing discounts for

1 participation in programs of health promotion or  
2 disease prevention.

3 ~~(b) APPLICATION OF CAPACITY LIMITS.—~~

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

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

10 ~~(B) the insurer can demonstrate to the ap-~~  
11 ~~plicable certifying authority (as defined in sec-~~  
12 ~~tion 202(d)), if required, that its financial or~~  
13 ~~provider capacity to serve previously covered~~  
14 ~~participants and beneficiaries (and additional~~  
15 ~~participants and beneficiaries who will be ex-~~  
16 ~~pected to enroll because of their affiliation with~~  
17 ~~the group health plan or such previously cov-~~  
18 ~~ered participants or beneficiaries) will be im-~~  
19 ~~paired if the insurer is required to enroll addi-~~  
20 ~~tional employers, participants and beneficiaries.~~

21 Such an insurer shall be prohibited from  
22 recommencing enrollment after a cessation in enroll-  
23 ment under this paragraph for a 6-month period  
24 after such cessation or until the insurer can dem-  
25 onstrate to the applicable certifying authority (as de-



1 with the terms of the plan or where the insurer  
2 has not received timely premium payments;

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

5 ~~(C) the termination of the plan in accord-~~  
6 ~~ance with subsection (b); or~~

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

10 ~~(2) PARTICIPANT.—Subject to subsections (b)~~  
11 ~~and (c), coverage under a group health plan (wheth-~~  
12 ~~er an insured health plan or a self-insured health~~  
13 ~~plan) shall be renewed or continued in force, if the~~  
14 ~~plan sponsor elects to continue to provide coverage~~  
15 ~~under such plan, at the option of the participant or~~  
16 ~~beneficiary, except that the requirement of this para-~~  
17 ~~graph shall not apply in the case of—~~

18 ~~(A) the nonpayment of premiums or con-~~  
19 ~~tributions by the participant or beneficiary in~~  
20 ~~accordance with the terms of the plan or where~~  
21 ~~the plan has not received timely premium pay-~~  
22 ~~ments;~~

23 ~~(B) fraud or misrepresentation of material~~  
24 ~~fact on the part of the participant or bene-~~

1            beneficiary relating to an application for coverage or  
2            claim for benefits;

3            ~~(C) the termination of the plan in accord-~~  
4            ~~ance with subsection (b); or~~

5            ~~(D) loss of eligibility for continuation cov-~~  
6            ~~erage as described in part 6 of subtitle B of~~  
7            ~~title I of the Employee Retirement Income Se-~~  
8            ~~curity Act of 1974 (29 U.S.C. 1161 et seq.).~~

9            ~~(3) CONTRIBUTION AND PARTICIPATION~~  
10          ~~RULES.—Nothing in this subsection shall be con-~~  
11          ~~strued to preclude an insurer from establishing em-~~  
12          ~~ployer contribution rules or group participation rules~~  
13          ~~for plan sponsors in connection with an insured~~  
14          ~~group health plan consistent with applicable State~~  
15          ~~law.~~

16          ~~(b) TERMINATION OF HEALTH PLANS.—~~

17            ~~(1) HEALTH PLAN NOT OFFERED.—In any case~~  
18            ~~in which an insurer is no longer going to continue~~  
19            ~~to offer a group health plan to plan sponsors, par-~~  
20            ~~ticipants or beneficiaries, the plan may be discon-~~  
21            ~~tinued by the insurer if—~~

22            ~~(A) the insurer provides notice to each~~  
23            ~~plan sponsor (and participants and beneficiaries~~  
24            ~~covered under the group health plan) of such~~

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

3 ~~(B) the insurer offers to each plan spon-~~  
4 ~~sor, the option to purchase any other group~~  
5 ~~health plan currently being offered; and~~

6 ~~(C) in exercising the option to discontinue~~  
7 ~~the group health plan and in offering one or~~  
8 ~~more replacement plans, the insurer acts uni-~~  
9 ~~formly without regard to the health status or~~  
10 ~~insurability of participants or beneficiaries, or~~  
11 ~~new participants or beneficiaries.~~

12 ~~(2) INSURER NOT OFFERING PLAN.—~~

13 ~~(A) IN GENERAL.—In any case in which~~  
14 ~~an insurer is no longer offering any group~~  
15 ~~health plan in a State, the plan may be discon-~~  
16 ~~tinued by the insurer if—~~

17 ~~(i) the insurer provides notice to the~~  
18 ~~applicable certifying authority (as defined~~  
19 ~~in section 202(d)) and to each plan spon-~~  
20 ~~sor (and participants and beneficiaries cov-~~  
21 ~~ered under such plan) of such termination~~  
22 ~~at least 180 days prior to the date of the~~  
23 ~~expiration of the plan; and~~

24 ~~(ii) all such plans issued or delivered~~  
25 ~~for issuance in the State are discontinued~~

1           and coverage under such plans is  
2           nonrenewed.

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

6                   (i) to all group health plans of small  
7                   employers (as defined under applicable  
8                   State law, or employers with not more  
9                   than 50 employees if such term is not de-  
10                  fined in State law) covering participants or  
11                  participants and beneficiaries; or

12                   (ii) to all other group health plans of-  
13                  fered by the insurer in the State.

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

21           ~~(c)~~ TREATMENT OF NETWORK PLANS.—

22                   (1) GEOGRAPHIC LIMITATIONS.—A group  
23                   health plan which is a network plan (as defined in  
24                   paragraph ~~(2)~~) or a health maintenance organization  
25                   plan may deny continued participation under the

1 plan to participants or beneficiaries who neither live,  
2 reside, nor work in an area in which the group  
3 health plan is offered, but only if such denial is ap-  
4 plied uniformly, without regard to health status or  
5 the insurability of particular participants or bene-  
6 ficiaries.

7 (2) NETWORK PLAN.—As used in paragraph  
8 (1), the term “network plan” means a health plan  
9 that arranges for the financing and delivery of  
10 health care services to participants or beneficiaries  
11 covered under such health plan, in whole or in part,  
12 through arrangements with providers to furnish  
13 health care services.

14 **SEC. 103. PORTABILITY OF HEALTH COVERAGE AND LIM-**  
15 **TATION ON PREEXISTING CONDITION EXCLU-**  
16 **SIONS.**

17 (a) IN GENERAL.—A group health plan (whether an  
18 insured health plan or a self-insured health plan) may im-  
19 pose a limitation or exclusion of benefits relating to treat-  
20 ment of a preexisting condition based on the fact that the  
21 condition existed prior to the effective date of the plan  
22 with respect to a participant or beneficiary only if—

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

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

4           (3) the limitation or exclusion does not apply to  
5           a pregnancy existing on the effective date of cov-  
6           erage.

7           (b) CREDITING OF QUALIFYING PREVIOUS COV-  
8           ERAGE.—

9           (1) IN GENERAL.—A group health plan (wheth-  
10          er an insured health plan or a self-insured health  
11          plan) shall provide that if a participant or bene-  
12          ficiary is in a period of previous qualifying coverage  
13          as of the date of enrollment under such plan, any  
14          period of exclusion or limitation of coverage with re-  
15          spect to a preexisting condition shall be reduced by  
16          1 month for each month in which the participant or  
17          beneficiary was in the period of qualifying previous  
18          coverage.

19          (2) DISCHARGE OF DUTY.—The duty of an in-  
20          surer or plan sponsor to verify previous qualifying  
21          coverage with respect to a participant or beneficiary  
22          is effectively discharged when such insurer or plan  
23          sponsor provides documentation to a participant or  
24          beneficiary at the time such participant or bene-

1        beneficiary becomes ineligible for coverage under the  
2        group health plan verifying—

3                (A) the dates that the participant or bene-  
4                ficiary was covered under such previous qualify-  
5                ing coverage; and

6                (B) the benefits and cost-sharing arrange-  
7                ment available to the participant or beneficiary  
8                under such previous qualifying coverage.

9                (3) DEFINITION.—The term “previous qualify-  
10              ing coverage” means the period beginning on the  
11              date a participant or beneficiary is enrolled under a  
12              health plan and ends on the date the participant or  
13              beneficiary is not so enrolled for a continuous period  
14              of more than 30 days (without regard to any waiting  
15              period).

16              (4) CONSTRUCTION.—Nothing in this sub-  
17              section shall be construed to prohibit a preexisting  
18              condition exclusion, subject to the limits in sub-  
19              section (a)(1), for a service or benefit related to a  
20              preexisting condition if such service or benefit was  
21              not previously covered under the health plan in  
22              which the individual was enrolled immediately prior  
23              to enrollment in the plan involved.

24              (c) LATE ENROLLEES.—With respect to a partici-  
25              pant or beneficiary enrolling in a group health plan

1 (whether an insured health plan or a self-insured health  
2 plan) during a time that is other than the first opportunity  
3 to enroll during an enrollment period of at least 30 days,  
4 the plan may exclude coverage with respect to services re-  
5 lated to the treatment of a preexisting condition in accord-  
6 ance with subsections (a) and (b), except the period of  
7 such exclusion may not exceed 18 months beginning on  
8 the date of coverage under the plan.

9 (d) WAITING PERIODS.—With respect to participants  
10 or beneficiaries who have become eligible to enroll in a  
11 group health plan (whether an insured health plan or a  
12 self-insured health plan), if such plan does not utilize a  
13 preexisting condition exclusion, such plan may impose a  
14 waiting period on such participants or beneficiaries not to  
15 exceed 60 days (or in the case of a late participant or  
16 beneficiary described in subsection (c), 90 days) prior to  
17 the date on which coverage under the plan becomes effec-  
18 tive. A group health plan may also use alternative methods  
19 to address adverse selection as approved by the applicable  
20 certifying authority (as defined in section 202(d)). During  
21 such a waiting period, the plan may not be required to  
22 provide health care services or benefits and no premium  
23 shall be charged to the participants or beneficiaries.

24 (e) PREEXISTING CONDITION.—For purposes of this  
25 section, the term “preexisting condition” means a condi-

1 tion for which medical advice, diagnosis, care, or treat-  
 2 ment was recommended or received within the 6-month  
 3 period ending on the day before the effective date of the  
 4 coverage (without regard to any waiting period).

5 (f) STATE FLEXIBILITY.—Nothing in this Act shall  
 6 be construed to preempt State laws that limit the exclu-  
 7 sions or limitations for preexisting conditions to periods  
 8 that are shorter than those provided for under this section  
 9 so long as such laws are not in violation of section 514  
 10 of the Employee Retirement Income Security Act of 1974  
 11 (29 U.S.C. 1144).

12 **SEC. 104. SPECIAL ENROLLMENT PERIODS.**

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

15 (1) through marriage, separation, divorce,  
 16 death, birth or adoption of a child, experiences a  
 17 change in family composition affecting health insur-  
 18 ance coverage;

19 (2) experiences a change in employment status  
 20 (including a significant change in the terms and con-  
 21 ditions of employment) or in continuation coverage;  
 22 or

23 (3) experiences a loss of health insurance cov-  
 24 erage because of a change in the employment status  
 25 of a family member;

1 each group health plan (whether insured or self-insured)  
2 shall provide for a special enrollment period at the time  
3 of such event which would permit the participant, bene-  
4 ficiary or family member to change the individual or fam-  
5 ily basis of coverage or to enroll in the plan if coverage  
6 would have been available to such individual but for failure  
7 to enroll during a previous enrollment period. Such a spe-  
8 cial enrollment period shall ensure that a child born or  
9 adopted shall be deemed to be covered under the plan as  
10 of the date of such birth or adoption if such child is en-  
11 rolled within 30 days of the date of such birth or adoption.

12 **SEC. 105. DISCLOSURE OF INFORMATION.**

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

20 (1) the provisions of the group health plan con-  
21 cerning the insurer's right to change premium rates  
22 and the factors that affect changes in premium  
23 rates;

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



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

13          (2) ~~HEALTH PROMOTION AND DISEASE PRE-~~  
14          ~~VENTION.~~—Nothing in this subsection shall be con-  
15          strued to prevent an insurer from establishing dis-  
16          counts for participation in programs of health pro-  
17          motion or disease prevention.

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

21          (4) ~~PREMIUMS.~~—Nothing in this subsection  
22          shall be construed to affect the determination of an  
23          insurer as to the amount of the premium payable  
24          under a health plan issued to individuals under ap-  
25          plicable State law.

1       (b) ELIGIBILITY FOR OTHER GROUP COVERAGE.—  
2 The provisions of subsection (a) shall not apply to an indi-  
3 vidual who is eligible for coverage under a group health  
4 plan, or who has had coverage terminated under a group  
5 health plan for failure to make required premium pay-  
6 ments or contributions, or for fraud or misrepresentation  
7 of material fact, or who is otherwise eligible for continu-  
8 ation coverage as described in section 602 of the Employee  
9 Retirement Income Security Act of 1974 (29 U.S.C.  
10 1162).

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

14 **SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL**  
15 **HEALTH COVERAGE.**

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

21           (1) the nonpayment of premiums or contribu-  
22 tions by the individual in accordance with the terms  
23 of the plan or where the plan has not received timely  
24 premium payments;

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

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

5           ~~(b) TERMINATION OF HEALTH PLANS.—~~

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

10           ~~(A) the insurer provides notice to each in-~~  
11           ~~dividual covered under the plan of such termi-~~  
12           ~~nation at least 90 days prior to the date of the~~  
13           ~~expiration of the plan;~~

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

18           ~~(C) in exercising the option to discontinue~~  
19           ~~the plan and in offering one or more replace-~~  
20           ~~ment plans, the insurer acts uniformly without~~  
21           ~~regard to the health status or insurability of in-~~  
22           ~~dividuals.~~

23           ~~(2) INSURER NOT OFFERING PLAN.—~~In any  
24           ~~case in which an insurer is no longer offering any~~

1 individual health plan in a State, the plan may be  
2 discontinued by the insurer if—

3 (A) the insurer provides notice to the ap-  
4 plicable certifying authority (as defined in sec-  
5 tion 202(d)) and to each individual covered  
6 under the plan of such termination at least 180  
7 days prior to the date of the expiration of the  
8 plan; and

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

12 (3) PROHIBITION ON MARKET REENTRY.—In  
13 the case of a termination under paragraph (2), the  
14 insurer may not provide for the issuance of any indi-  
15 vidual health plan in the State involved during the  
16 5-year period beginning on the date of the termi-  
17 nation of the last plan not so renewed.

18 (c) TREATMENT OF NETWORK PLANS.—

19 (1) GEOGRAPHIC LIMITATIONS.—An individual  
20 health plan which is a network plan (as defined in  
21 paragraph (2)) or a health maintenance organization  
22 plan may deny continued participation under the  
23 plan to individuals who neither live, reside, nor work  
24 in an area in which the individual health plan is of-  
25 fered, but only if such denial is applied uniformly,

1 without regard to health status or the insurability of  
2 particular individuals.

3 (2) NETWORK PLAN.—As used in paragraph  
4 (1), the term “network plan” means a health plan  
5 that arranges for the financing and delivery of  
6 health care services to individuals covered under  
7 such health plan, in whole or in part, through ar-  
8 rangements with providers to furnish health care  
9 services.

10 **SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET RE-**  
11 **FORMS.**

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

21 **SEC. 113. INDIVIDUAL HEALTH COVERAGE AVAILABILITY**  
22 **STUDY.**

23 (a) IN GENERAL.—Not later than January 1, 1997,  
24 the Secretary of Health and Human Services, in consulta-  
25 tion with the Secretary, representatives of State officials,

1 consumers, and other representatives of individuals and  
2 entities that have expertise in health insurance and em-  
3 ployee benefit issues, shall conduct a study, and prepare  
4 and submit to the appropriate committees of Congress a  
5 report, concerning—

6           (1) the most appropriate way, in light of the ex-  
7           perience of the various States, expert opinions, and  
8           such additional data as may be available, to ensure  
9           the availability of reasonably priced health insurance  
10          to individuals purchasing coverage on a non-group  
11          basis;

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

16          (3) the effectiveness of the provisions of this  
17          Act, and State insurance reform laws, in stabilizing  
18          the small group health insurance market by provid-  
19          ing for the broad pooling of risk.

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

## 1 **Subtitle C—COBRA Clarifications**

### 2 **SEC. 121. COBRA CLARIFICATIONS.**

3 (a) PUBLIC HEALTH SERVICE ACT.—

4 (1) PERIOD OF COVERAGE.—Section 2202(2) of  
5 the Public Health Service Act (42 U.S.C. 300bb-  
6 2(2)) is amended—

7 (A) in subparagraph (A)—

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

12 (ii) in the last sentence (as so trans-  
13 ferred)—

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

17 (II) by striking “at the time of a  
18 qualifying event described in section  
19 2203(2)” and inserting “at any time  
20 during the initial 18-month period of  
21 continuing coverage under this title”;  
22 and

23 (B) in subparagraph (E), by striking “at  
24 the time of a qualifying event described in sec-  
25 tion 2203(2)” and inserting “at any time dur-

1           ing the initial 18-month period of continuing  
2           coverage under this title”.

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

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

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

10                   (C) by adding at the end thereof the fol-  
11                   lowing new clause:

12                           “(iii) in the case of an individual de-  
13                           scribed in the last sentence of section  
14                           2202(2)(A), or a beneficiary family mem-  
15                           ber of the individual, the date such individ-  
16                           ual is determined to have been disabled.”.

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

23           (4) BIRTH OR ADOPTION OF A CHILD.—Section  
24           2208(3)(A) of the Public Health Service Act (42

1 U.S.C. 300bb-8(3)(A)) is amended by adding at the  
 2 end thereof the following new flush sentence:

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

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

8 (1) ~~PERIOD OF COVERAGE.—~~Section 602(2) of  
 9 the Employee Retirement Income Security Act of  
 10 1974 (29 U.S.C. 1162(2)) is amended—

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

13 (i) by inserting “, or a beneficiary-  
 14 family member of the individual,” after  
 15 “an individual”; and

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

21 (B) in subparagraph (E), by striking “at  
 22 the time of a qualifying event described in sec-  
 23 tion 603(2)” and inserting “at any time during  
 24 the initial 18-month period of continuing cov-  
 25 erage under this part”.

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

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

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

8           (C) by adding at the end thereof the fol-  
9     lowing new clause:

10           “(iii) in the case of an individual de-  
11     scribed in the last sentence of section  
12     602(2)(A), or a beneficiary family member  
13     of the individual, the date such individual  
14     is determined to have been disabled.”.

15           (3) NOTICES.—Section 606(3) of the Employee  
16     Retirement Income Security Act of 1974 (29 U.S.C.  
17     1166(3)) is amended by striking “at the time of a  
18     qualifying event described in section 603(2)” and in-  
19     serting “at any time during the initial 18-month pe-  
20     riod of continuing coverage under this part”.

21           (4) BIRTH OR ADOPTION OF A CHILD.—Section  
22     607(3)(A) of the Employee Retirement Income Secu-  
23     rity Act of 1974 (29 U.S.C. 1167(3)) is amended by  
24     adding at the end thereof the following new flush  
25     sentence:

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

4 (c) INTERNAL REVENUE CODE OF 1986.—

5 (1) PERIOD OF COVERAGE.—Section  
 6 4980B(f)(2)(B) of the Internal Revenue Code of  
 7 1986 is amended—

8 (A) in the last sentence of clause (i) by  
 9 striking “at the time of a qualifying event de-  
 10 scribed in paragraph (3)(B)” and inserting “at  
 11 any time during the initial 18-month period of  
 12 continuing coverage under this section”; and

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

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

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

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

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

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

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

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

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

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

24                  (e) NOTIFICATION OF CHANGES.—Not later than 60  
25                  days after the date of enactment of this Act, each group

1 health plan (covered under title XXII of the Public Health  
 2 Service Act, part 6 of subtitle A of title I of the Employee  
 3 Retirement Income Security Act of 1974, and section  
 4 4980B(f) of the Internal Revenue Code of 1986) shall no-  
 5 tify each qualified beneficiary who has elected continuation  
 6 coverage under such title, part or section of the amend-  
 7 ments made by this section.

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

### 10 **SEC. 131. PRIVATE HEALTH PLAN PURCHASING COALI-** 11 **TIONS.**

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

20 (b) CERTIFICATION.—

21 (1) IN GENERAL.—A State shall certify health  
 22 plan purchasing coalitions that meet the require-  
 23 ments of this section. Each coalition shall be char-  
 24 tered under State law and registered with the Sec-  
 25 retary.

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

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

13           (d) ~~BOARD OF DIRECTORS.~~—

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

24           (2) ~~LIMITATION ON COMPENSATION.~~—A health  
25 plan purchasing coalition may not provide compensa-

1       tion to members of the Board of Directors. The coa-  
2       lition may provide reimbursements to such members  
3       for the reasonable and necessary expenses incurred  
4       by the members in the performance of their duties  
5       as members of the Board.

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

17      (e) MEMBERSHIP AND MARKETING AREA.—

18           (1) MEMBERSHIP.—

19           (A) IN GENERAL.—A health plan purchas-  
20      ing coalition may establish limits on the size of  
21      employers who may become members of the coa-  
22      alition, and may determine whether to permit  
23      individuals to become members. Upon the es-  
24      tablishment of such membership requirements,  
25      the coalition shall, except as provided in sub-

1 paragraph (B), accept all employers (or individ-  
2 uals) residing within the area served by the coa-  
3 lition who meet such requirements as members  
4 on a first come, first-served basis.

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

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

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

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

1 aries may not be established on the basis of health  
2 status or insurability.

3 ~~(f) DUTIES AND RESPONSIBILITIES.—~~

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

6 ~~(A)~~ enter into agreements with insured  
7 health plans;

8 ~~(B)~~ enter into agreements with employers  
9 and individuals who become members of the co-  
10 alition;

11 ~~(C)~~ participate in any program of risk ad-  
12 justment or reinsurance, or any similar pro-  
13 gram, that is established by the State;

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

16 ~~(E)~~ prepare and disseminate comparative  
17 health plan materials (including information  
18 about cost, quality, benefits, and other informa-  
19 tion concerning health plans offered through  
20 the coalition);

21 ~~(F)~~ actively market to all eligible employ-  
22 ers and individuals residing within the service  
23 area; and

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

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

5           (A) the collection and distribution of pre-  
6 miums and the performance of other adminis-  
7 trative functions;

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

10           (C) the charging of membership fee to en-  
11 rollees (such fees may not be based on health  
12 status) and the charging of participation fees to  
13 health plans; and

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

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

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

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

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

1           (4) establish eligibility, continuation, enroll-  
 2           ment, or contribution requirements for employees or  
 3           employers and individuals based on the health sta-  
 4           tus, medical condition, claims experience, receipt of  
 5           health care, medical history, evidence of insurability,  
 6           or disability of any individual.

7           (h) LIMITED PREEMPTION OF CERTAIN STATE  
 8 LAWS.—

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

13                   (A) State fictitious group laws.

14                   (B) State rating requirement laws, except  
 15                   to the extent necessary to comply with the re-  
 16                   quirements of paragraph (2).

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

19           (2) RATING REQUIREMENT LAWS.—With re-  
 20          spect to a State rating requirement law, the coali-  
 21          tion—

22                   (A) may not permit premium rates to vary  
 23                   among employers or individuals that are mem-  
 24                   bers of a health plan purchasing coalition in ex-  
 25                   cess of the amount of such variations that

1 would be permitted under such State rating  
2 laws among employers that are not members of  
3 the coalition; and

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

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

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

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

16 ~~(3)~~ require individuals or employers to purchase  
17 health plans through a health plan purchasing coali-  
18 tion;

19 ~~(4)~~ require that a health plan purchasing coali-  
20 tion be the only type of health insurance purchasing  
21 arrangement permitted to operate in a State; or

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

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

5       **TITLE II—APPLICATION AND**  
6       **ENFORCEMENT OF STANDARDS**

7       **SEC. 201. APPLICABILITY.**

8       (a) CONSTRUCTION.—

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

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

1 **SEC. 202. ENFORCEMENT OF STANDARDS.**

2 (a) **INSURED HEALTH PLANS.**—Each State shall re-  
3 quire that each insured health plan issued, sold, renewed,  
4 offered for sale or operated in such State meet the insur-  
5 ance reform standards established under this Act pursu-  
6 ant to an enforcement plan filed by the State with the  
7 Secretary. A State shall submit such information as re-  
8 quired by the Secretary demonstrating effective implemen-  
9 tation of the State enforcement plan.

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

20 (c) **FAILURE TO IMPLEMENT PLAN.**—In the case of  
21 the failure of a State to enforce the standards and require-  
22 ments set forth in this Act, the Secretary, in consultation  
23 with the Secretary of Health and Human Services, shall  
24 implement an enforcement plan meeting the standards of  
25 this Act in such State. In the case of a State that fails  
26 to enforce the standards and requirements set forth in this

1 Act, each health plan operating in such State shall be sub-  
 2 ject to civil enforcement as provided for under section 502  
 3 of the Employee Retirement Income Security Act of 1974  
 4 (29 U.S.C. 1132) and for penalties as provided for under  
 5 paragraphs (1) and (2) of subsection (a) of such section  
 6 (relating to failure to provide requested information and  
 7 failure to file required reports).

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

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

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

14 **TITLE III—MISCELLANEOUS**  
 15 **PROVISIONS**

16 **SEC. 301. HMOS ALLOWED TO OFFER PLANS WITH**  
 17 **DEDUCTIBLES TO INDIVIDUALS WITH MEDI-**  
 18 **CAL SAVINGS ACCOUNTS.**

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

22 “(6)(A) If a member certifies that a medical  
 23 savings account has been established for the benefit  
 24 of such member, a health maintenance organization  
 25 may, at the request of such member reduce the basic

1 health services payment otherwise determined under  
2 paragraph (1) by requiring the payment of a deduct-  
3 ible by the member for basic health services.

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

10 (b) MEDICAL SAVINGS ACCOUNTS.—It is the sense  
11 of the Committee on Labor and Human Resources of the  
12 Senate that the establishment of medical savings accounts,  
13 including those defined in section 1301(b)(6)(B) of the  
14 Public Health Service Act (42 U.S.C. 300e(b)(6)(B)),  
15 should be encouraged as part of any health insurance re-  
16 form legislation passed by the Senate through the use of  
17 tax incentives relating to contributions to, the income  
18 growth of, and the qualified use of, such accounts.

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

1 **SEC. 302. EFFECTIVE DATE.**

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

5 **SEC. 303. SEVERABILITY.**

6 If any provision of this Act or the application of such  
7 provision to any person or circumstance is held to be un-  
8 constitutional, the remainder of this Act and the applica-  
9 tion of the provisions of such to any person or cir-  
10 cumstance shall not be affected thereby.

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

12 (a) *SHORT TITLE.*—This Act may be cited as the  
13 “Health Insurance Reform Act of 1995”.

14 (b) *TABLE OF CONTENTS.*—The table of contents for  
15 this Act is as follows:

*Sec. 1. Short title; table of contents.*

*Sec. 2. Definitions.*

*TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND  
RENEWABILITY*

*Subtitle A—Group Market Rules*

*Sec. 101. Guaranteed availability of health coverage.*

*Sec. 102. Guaranteed renewability of health coverage.*

*Sec. 103. Portability of health coverage and limitation on preexisting condition  
exclusions.*

*Sec. 104. Special enrollment periods.*

*Sec. 105. Disclosure of information.*

*Subtitle B—Individual Market Rules*

*Sec. 110. Individual health plan portability.*

*Sec. 111. Guaranteed renewability of individual health coverage.*

*Sec. 112. State flexibility in individual market reforms.*

*Sec. 113. Definition.*

*Subtitle C—COBRA Clarifications**Sec. 121. Cobra clarifications.**Subtitle D—Private Health Plan Purchasing Cooperatives**Sec. 131. Private health plan purchasing cooperatives.**TITLE II—APPLICATION AND ENFORCEMENT OF STANDARDS**Sec. 201. Applicability.**Sec. 202. Enforcement of standards.**TITLE III—MISCELLANEOUS PROVISIONS**Sec. 301. HMOs allowed to offer plans with deductibles to individuals with medical savings accounts.**Sec. 302. Health coverage availability study.**Sec. 303. Sense of the Committee concerning Medicare.**Sec. 304. Effective date.**Sec. 305. Severability.***1 SEC. 2. DEFINITIONS.****2 As used in this Act:**

**3 (1) BENEFICIARY.**—The term “beneficiary” has  
**4 the meaning given such term under section 3(8) of the**  
**5 Employee Retirement Income Security Act of 1974**  
**6 (29 U.S.C. 1002(8)).**

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

**11 (3) EMPLOYER.**—The term “employer” has the  
**12 meaning given such term under section 3(5) of the**  
**13 Employee Retirement Income Security Act of 1974**  
**14 (29 U.S.C. 1002(5)), except that such term shall in-**  
**15 clude only employers of two or more employees.**

**16 (4) EMPLOYEE HEALTH BENEFIT PLAN.**—

1           (A) *IN GENERAL.*—The term “employee  
2           health benefit plan” means any employee welfare  
3           benefit plan, governmental plan, or church plan  
4           (as defined under paragraphs (1), (32), and (33)  
5           of section 3 of the Employee Retirement Income  
6           Security Act of 1974 (29 U.S.C. 1002 (1), (32),  
7           and (33))) that provides or pays for health bene-  
8           fits (such as provider and hospital benefits) for  
9           participants and beneficiaries whether—

10                   (i) directly;

11                   (ii) through a group health plan of-  
12                   ferred by a health plan issuer as defined in  
13                   paragraph (8); or

14                   (iii) otherwise.

15           (B) *RULE OF CONSTRUCTION.*—An em-  
16           ployee health benefit plan shall not be construed  
17           to be a group health plan, an individual health  
18           plan, or a health plan issuer.

19           (C) *ARRANGEMENTS NOT INCLUDED.*—Such  
20           term does not include the following, or any com-  
21           bination thereof:

22                   (i) Coverage only for accident, or dis-  
23                   ability income insurance, or any combina-  
24                   tion thereof.

1           (ii) Medicare supplemental health in-  
2           surance (as defined under section  
3           1882(g)(1) of the Social Security Act).

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

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

9           (v) Workers compensation or similar  
10          insurance.

11          (vi) Automobile medical payment in-  
12          surance.

13          (vii) Coverage for a specified disease or  
14          illness.

15          (viii) Hospital or fixed indemnity in-  
16          surance.

17          (ix) Short-term limited duration insur-  
18          ance.

19          (x) Credit-only, dental-only, or vision-  
20          only insurance.

21          (xi) A health insurance policy provid-  
22          ing benefits only for long-term care, nursing  
23          home care, home health care, community-  
24          based care, or any combination thereof.

25          (5) FAMILY.—

1           (A) *IN GENERAL.*—The term “family”  
2 means an individual, the individual’s spouse,  
3 and the child of the individual (if any).

4           (B) *CHILD.*—For purposes of subparagraph  
5 (A), the term “child” means any individual who  
6 is a child within the meaning of section  
7 151(c)(3) of the Internal Revenue Code of 1986.

8           (6) *GROUP HEALTH PLAN.*—

9           (A) *IN GENERAL.*—The term “group health  
10 plan” means any contract, policy, certificate or  
11 other arrangement offered by a health plan is-  
12 suer to a group purchaser that provides or pays  
13 for health benefits (such as provider and hospital  
14 benefits) in connection with an employee health  
15 benefit plan.

16           (B) *ARRANGEMENTS NOT INCLUDED.*—Such  
17 term does not include the following, or any com-  
18 bination thereof:

19                   (i) Coverage only for accident, or dis-  
20 ability income insurance, or any combina-  
21 tion thereof.

22                   (ii) Medicare supplemental health in-  
23 surance (as defined under section  
24 1882(g)(1) of the Social Security Act).

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

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

6                   (v) Workers compensation or similar  
7 insurance.

8                   (vi) Automobile medical payment in-  
9 surance.

10                  (vii) Coverage for a specified disease or  
11 illness.

12                  (viii) Hospital or fixed indemnity in-  
13 surance.

14                  (ix) Short-term limited duration insur-  
15 ance.

16                  (x) Credit-only, dental-only, or vision-  
17 only insurance.

18                  (xi) A health insurance policy provid-  
19 ing benefits only for long-term care, nursing  
20 home care, home health care, community-  
21 based care, or any combination thereof.

22                  (7) GROUP PURCHASER.—The term “group pur-  
23 chaser” means any person (as defined under para-  
24 graph (9) of section 3 of the Employee Retirement In-  
25 come Security Act of 1974 (29 U.S.C. 1002(9)) or en-

1     *tity that purchases or pays for health benefits (such*  
2     *as provider or hospital benefits) on behalf of two or*  
3     *more participants or beneficiaries in connection with*  
4     *an employee health benefit plan. A health plan pur-*  
5     *chasing cooperative established under section 131*  
6     *shall not be considered to be a group purchaser.*

7             (8) *HEALTH PLAN ISSUER.*—*The term “health*  
8     *plan issuer” means any entity that is licensed (prior*  
9     *to or after the date of enactment of this Act) by a*  
10    *State to offer a group health plan or an individual*  
11    *health plan.*

12            (9) *PARTICIPANT.*—*The term “participant” has*  
13    *the meaning given such term under section 3(7) of the*  
14    *Employee Retirement Income Security Act of 1974*  
15    *(29 U.S.C. 1002(7)).*

16            (10) *PLAN SPONSOR.*—*The term “plan sponsor”*  
17    *has the meaning given such term under section*  
18    *3(16)(B) of the Employee Retirement Income Security*  
19    *Act of 1974 (29 U.S.C. 1002(16)(B)).*

20            (11) *SECRETARY.*—*The term “Secretary”, unless*  
21    *specifically provided otherwise, means the Secretary*  
22    *of Labor.*

23            (12) *STATE.*—*The term “State” means each of*  
24    *the several States, the District of Columbia, Puerto*  
25    *Rico, the United States Virgin Islands, Guam, Amer-*

1        *ican Samoa, and the Commonwealth of the Northern*  
2        *Mariana Islands.*

3        ***TITLE I—HEALTH CARE ACCESS,***  
4        ***PORTABILITY, AND RENEW-***  
5        ***ABILITY***

6        ***Subtitle A—Group Market Rules***

7        ***SEC. 101. GUARANTEED AVAILABILITY OF HEALTH COV-***  
8        ***ERAGE.***

9        *(a) IN GENERAL.—*

10        *(1) NONDISCRIMINATION.—Except as provided in*  
11        *subsection (b), section 102 and section 103—*

12                *(A) a health plan issuer offering a group*  
13                *health plan may not decline to offer whole group*  
14                *coverage to a group purchaser desiring to pur-*  
15                *chase such coverage; and*

16                *(B) an employee health benefit plan or a*  
17                *health plan issuer offering a group health plan*  
18                *may establish eligibility, continuation of eligi-*  
19                *bility, enrollment, or premium contribution re-*  
20                *quirements under the terms of such plan, except*  
21                *that such requirements shall not be based on*  
22                *health status, medical condition, claims experi-*  
23                *ence, receipt of health care, medical history, evi-*  
24                *dence of insurability, or disability.*

1           (2) *HEALTH PROMOTION AND DISEASE PREVEN-*  
2           *TION.—Nothing in this subsection shall prevent an*  
3           *employee health benefit plan or a health plan issuer*  
4           *from establishing premium discounts or modifying*  
5           *otherwise applicable copayments or deductibles in re-*  
6           *turn for adherence to programs of health promotion*  
7           *and disease prevention.*

8           (b) *APPLICATION OF CAPACITY LIMITS.—*

9           (1) *IN GENERAL.—Subject to paragraph (2), a*  
10          *health plan issuer offering a group health plan may*  
11          *cease offering coverage to group purchasers under the*  
12          *plan if—*

13               (A) *the health plan issuer ceases to offer*  
14               *coverage to any additional group purchasers;*  
15               *and*

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

1           the health plan issuer is required to offer cov-  
2           erage to additional group purchasers.

3           Such health plan issuer shall be prohibited from offer-  
4           ing coverage after a cessation in offering coverage  
5           under this paragraph for a 6-month period or until  
6           the health plan issuer can demonstrate to the applica-  
7           ble certifying authority (as defined in section 202(d))  
8           that the health plan issuer has adequate capacity,  
9           whichever is later.

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

18           (c) *CONSTRUCTION.*—

19           (1) *MARKETING OF GROUP HEALTH PLANS.*—  
20           Nothing in this section shall be construed to prevent  
21           a State from requiring health plan issuers offering  
22           group health plans to actively market such plans.

23           (2) *INVOLUNTARY OFFERING OF GROUP HEALTH*  
24           *PLANS.*—Nothing in this section shall be construed to  
25           require a health plan issuer to involuntarily offer

1     *group health plans in a particular market. For the*  
2     *purposes of this paragraph, the term “market” means*  
3     *either the large employer market or the small em-*  
4     *ployer market (as defined under applicable State law,*  
5     *or if not so defined, an employer with not more than*  
6     *50 employees).*

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

9     *(a) IN GENERAL.—*

10            *(1) GROUP PURCHASER.—Subject to subsections*  
11            *(b) and (c), a group health plan shall be renewed or*  
12            *continued in force by a health plan issuer at the op-*  
13            *tion of the group purchaser, except that the require-*  
14            *ment of this subparagraph shall not apply in the case*  
15            *of—*

16                    *(A) the nonpayment of premiums or con-*  
17                    *tributions by the group purchaser in accordance*  
18                    *with the terms of the group health plan or where*  
19                    *the health plan issuer has not received timely*  
20                    *premium payments;*

21                    *(B) fraud or misrepresentation of material*  
22                    *fact on the part of the group purchaser;*

23                    *(C) the termination of the group health*  
24                    *plan in accordance with subsection (b); or*

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

4           (2) *PARTICIPANT.*—Subject to subsections (b)  
5           and (c), coverage under an employee health benefit  
6           plan or group health plan shall be renewed or contin-  
7           ued in force, if the group purchaser elects to continue  
8           to provide coverage under such plan, at the option of  
9           the participant (or beneficiary where such right exists  
10          under the terms of the plan or under applicable law),  
11          except that the requirement of this paragraph shall  
12          not apply in the case of—

13                (A) the nonpayment of premiums or con-  
14                tributions by the participant or beneficiary in  
15                accordance with the terms of the employee health  
16                benefit plan or group health plan or where such  
17                plan has not received timely premium payments;

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

22                (C) the termination of the employee health  
23                benefit plan or group health plan;

24                (D) loss of eligibility for continuation cov-  
25                erage as described in part 6 of subtitle B of title

1           *I of the Employee Retirement Income Security*  
2           *Act of 1974 (29 U.S.C. 1161 et seq.); or*

3           *(E) failure of a participant or beneficiary*  
4           *to meet requirements for eligibility for coverage*  
5           *under an employee health benefit plan or group*  
6           *health plan that are not prohibited by this Act.*

7           *(3) RULES OF CONSTRUCTION.—Nothing in this*  
8           *subsection, nor in section 101(a), shall be construed*  
9           *to—*

10           *(A) preclude a health plan issuer from es-*  
11           *tablishing employer contribution rules or group*  
12           *participation rules for group health plans as al-*  
13           *lowed under applicable State law;*

14           *(B) preclude a plan defined in section 3(37)*  
15           *of the Employee Retirement Income Security Act*  
16           *of 1974 (29 U.S.C. 1102(37)) from establishing*  
17           *employer contribution rules or group participa-*  
18           *tion rules; or*

19           *(C) permit individuals to decline coverage*  
20           *under an employee health benefit plan if such*  
21           *right is not otherwise available under such plan.*

22           *(b) TERMINATION OF GROUP HEALTH PLANS.—*

23           *(1) PARTICULAR TYPE OF GROUP HEALTH PLAN*  
24           *NOT OFFERED.—In any case in which a health plan*  
25           *issuer decides to discontinue offering a particular*

1        *type of group health plan, a group health plan of such*  
2        *type may be discontinued by the health plan issuer*  
3        *only if—*

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

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

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

1           (2) *DISCONTINUANCE OF ALL GROUP HEALTH*  
2 *PLANS.—*

3           (A) *IN GENERAL.—*In any case in which a  
4 health plan issuer elects to discontinue offering  
5 all group health plans in a State, a group health  
6 plan may be discontinued by the health plan is-  
7 suer only if—

8                   (i) the health plan issuer provides no-  
9 tice to the applicable certifying authority  
10 (as defined in section 202(d)) and to each  
11 group purchaser (and participants and  
12 beneficiaries covered under such group  
13 health plan) of such discontinuation at least  
14 180 days prior to the date of the expiration  
15 of such plan; and

16                   (ii) all group health plans issued or de-  
17 livered for issuance in the State are discon-  
18 tinued and coverage under such plans is not  
19 renewed.

20           (B) *APPLICATION OF PROVISIONS.—*The  
21 provisions of this paragraph and paragraph (3)  
22 may be applied separately by a health plan is-  
23 suer—

24                   (i) to all group health plans offered to  
25 small employers (as defined under applica-

1            *ble State law, or if not so defined, an em-*  
2            *ployer with not more than 50 employees); or*

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

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

14           (c) *TREATMENT OF NETWORK PLANS.*—

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

23           (2) *NETWORK PLAN.*—*As used in paragraph (1),*  
24           *the term “network plan” means an employee health*  
25           *benefit plan or a group health plan that arranges for*



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

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

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

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

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

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

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

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

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

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

1           (A) *PREVIOUS QUALIFYING COVERAGE.*—  
2           The term “previous qualifying coverage” means  
3           the period beginning on the date—

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

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

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

17           (B) *LIMITATION OR EXCLUSION OF BENE-*  
18           *FITS RELATING TO TREATMENT OF A PREEXIST-*  
19           *ING CONDITION.*—The term “limitation or exclu-  
20           sion of benefits relating to treatment of a pre-  
21           existing condition” means a limitation or exclu-  
22           sion of benefits imposed on an individual based  
23           on a preexisting condition of such individual.

24           (4) *EFFECT OF PREVIOUS COVERAGE.*—An em-  
25           ployee health benefit plan or a health plan issuer of-

1        *fering a group health plan may impose a limitation*  
2        *or exclusion of benefits relating to the treatment of a*  
3        *preexisting condition, subject to the limits in sub-*  
4        *section (a)(1), only to the extent that such service or*  
5        *benefit was not previously covered under the group*  
6        *health plan, employee health benefit plan, or individ-*  
7        *ual health plan in which the participant or bene-*  
8        *ficiary was enrolled immediately prior to enrollment*  
9        *in the plan involved.*

10        *(c) LATE ENROLLEES.—Except as provided in section*  
11        *104, with respect to a participant or beneficiary enrolling*  
12        *in an employee health benefit plan or a group health plan*  
13        *during a time that is other than the first opportunity to*  
14        *enroll during an enrollment period of at least 30 days, cov-*  
15        *erage with respect to benefits or services relating to the*  
16        *treatment of a preexisting condition in accordance with*  
17        *subsections (a) and (b) may be excluded, except the period*  
18        *of such exclusion may not exceed 18 months beginning on*  
19        *the date of coverage under the plan.*

20        *(d) AFFILIATION PERIODS.—With respect to a partici-*  
21        *pant or beneficiary who would otherwise be eligible to re-*  
22        *ceive benefits under an employee health benefit plan or a*  
23        *group health plan but for the operation of a preexisting con-*  
24        *dition limitation or exclusion, if such plan does not utilize*  
25        *a limitation or exclusion of benefits relating to the treat-*

1 *ment of a preexisting condition, such plan may impose an*  
2 *affiliation period on such participant or beneficiary not to*  
3 *exceed 60 days (or in the case of a late participant or bene-*  
4 *ficiary described in subsection (c), 90 days) from the date*  
5 *on which the participant or beneficiary would otherwise be*  
6 *eligible to receive benefits under the plan. An employee*  
7 *health benefit plan or a health plan issuer offering a group*  
8 *health plan may also use alternative methods to address ad-*  
9 *verse selection as approved by the applicable certifying au-*  
10 *thority (as defined in section 202(d)). During such an af-*  
11 *filiation period, the plan may not be required to provide*  
12 *health care services or benefits and no premium shall be*  
13 *charged to the participant or beneficiary.*

14 *(e) PREEXISTING CONDITION.—For purposes of this*  
15 *section, the term “preexisting condition” means a condi-*  
16 *tion, regardless of the cause of the condition, for which med-*  
17 *ical advice, diagnosis, care, or treatment was recommended*  
18 *or received within the 6-month period ending on the day*  
19 *before the effective date of the coverage (without regard to*  
20 *any waiting period).*

21 *(f) STATE FLEXIBILITY.—Nothing in this section shall*  
22 *be construed to preempt State laws that —*

23 *(1) require health plan issuers to impose a limi-*  
24 *tation or exclusion of benefits relating to the treat-*

1        *ment of a preexisting condition for periods that are*  
2        *shorter than those provided for under this section; or*

3            *(2) allow individuals, participants, and bene-*  
4        *ficiaries to be considered to be in a period of previous*  
5        *qualifying coverage if such individual, participant, or*  
6        *beneficiary experiences a lapse in coverage that is*  
7        *greater than the 30-day period provided for under*  
8        *subsection (b)(3);*

9        *unless such laws are preempted by section 514 of the Em-*  
10       *ployee Retirement Income Security Act of 1974 (29 U.S.C.*  
11       *1144).*

12       **SEC. 104. SPECIAL ENROLLMENT PERIODS.**

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

15            *(1) through marriage, separation, divorce, death,*  
16        *birth or placement of a child for adoption, experiences*  
17        *a change in family composition affecting eligibility*  
18        *under a group health plan, individual health plan, or*  
19        *employee health benefit plan;*

20            *(2) experiences a change in employment status,*  
21        *as described in section 603(2) of the Employee Retire-*  
22        *ment Income Security Act of 1974 (29 U.S.C.*  
23        *1163(2)), that causes the loss of eligibility for cov-*  
24        *erage, other than COBRA continuation coverage*

1        *under a group health plan, individual health plan,*  
2        *or employee health benefit plan; or*

3            *(3) experiences a loss of eligibility under a group*  
4        *health plan, individual health plan, or employee*  
5        *health benefit plan because of a change in the employ-*  
6        *ment status of a family member;*

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

19       **SEC. 105. DISCLOSURE OF INFORMATION.**

20            *(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN*  
21        *ISSUERS.—*

22            *(1) IN GENERAL.—In connection with the offer-*  
23        *ing of any group health plan to a small employer (as*  
24        *defined under applicable State law, or if not so de-*  
25        *finied, an employer with not more than 50 employees),*

1     *a health plan issuer shall make a reasonable disclo-*  
2     *sure to such employer, as part of its solicitation and*  
3     *sales materials, of—*

4             *(A) the provisions of such group health plan*  
5             *concerning the health plan issuer's right to*  
6             *change premium rates and the factors that may*  
7             *affect changes in premium rates;*

8             *(B) the provisions of such group health plan*  
9             *relating to renewability of coverage;*

10            *(C) the provisions of such group health plan*  
11            *relating to any preexisting condition provision;*  
12            *and*

13            *(D) descriptive information about the bene-*  
14            *fits and premiums available under all group*  
15            *health plans for which the employer is qualified.*

16     *Information shall be provided to small employers*  
17     *under this paragraph in a manner determined to be*  
18     *understandable by the average small employer, and*  
19     *shall be sufficiently accurate and comprehensive to*  
20     *reasonably inform small employers, participants and*  
21     *beneficiaries of their rights and obligations under the*  
22     *group health plan.*

23            *(2) EXCEPTION.—With respect to the require-*  
24            *ment of paragraph (1), any information that is pro-*  
25            *prietary and trade secret information under applica-*

1     *ble law shall not be subject to the disclosure require-*  
2     *ments of such paragraph.*

3             (3) *CONSTRUCTION.*—*Nothing in this subsection*  
4     *shall be construed to preempt State reporting and dis-*  
5     *closure requirements to the extent that such require-*  
6     *ments are not preempted under section 514 of the*  
7     *Employee Retirement Income Security Act of 1974*  
8     *(29 U.S.C. 1144).*

9             (b) *DISCLOSURE OF INFORMATION TO PARTICIPANTS*  
10  *AND BENEFICIARIES.*—

11             (1) *IN GENERAL.*—*Section 104(b)(1) of the Em-*  
12     *ployee Retirement Income Security Act of 1974 (29*  
13     *U.S.C. 1024(b)(1)) is amended in the matter follow-*  
14     *ing subparagraph (B)—*

15             (A) *by striking “102(a)(1),” and inserting*  
16     *“102(a)(1) that is not a material reduction in*  
17     *covered services or benefits provided,”; and*

18             (B) *by adding at the end thereof the follow-*  
19     *ing new sentences: “If there is a modification or*  
20     *change described in section 102(a)(1) that is a*  
21     *material reduction in covered services or benefits*  
22     *provided, a summary description of such modi-*  
23     *fication or change shall be furnished to partici-*  
24     *pants not later than 60 days after the date of the*  
25     *adoption of the modification or change. In the*

1           *alternative, the plan sponsors may provide such*  
2           *description at regular intervals of not more than*  
3           *90 days. The Secretary shall issue regulations*  
4           *within 180 days after the date of enactment of*  
5           *the Health Insurance Reform Act of 1995, pro-*  
6           *viding alternative mechanisms to delivery by*  
7           *mail through which employee health benefit*  
8           *plans may notify participants of material reduc-*  
9           *tions in covered services or benefits.”.*

10           (2) *PLAN DESCRIPTION AND SUMMARY.—Section*  
11           *102(b) of the Employee Retirement Income Security*  
12           *Act of 1974 (29 U.S.C. 1022(b)) is amended—*

13                     (A) *by inserting “including the office or*  
14                     *title of the individual who is responsible for ap-*  
15                     *proving or denying claims for coverage of bene-*  
16                     *fits” after “type of administration of the plan”;*

17                     (B) *by inserting “including the name of the*  
18                     *organization responsible for financing claims”*  
19                     *after “source of financing of the plan”; and*

20                     (C) *by inserting “including the office, con-*  
21                     *tact, or title of the individual at the Department*  
22                     *of Labor through which participants may seek*  
23                     *assistance or information regarding their rights*  
24                     *under this Act and the Health Insurance Reform*  
25                     *Act of 1995 with respect to health benefits that*

1           are not offered through a group health plan.”  
 2           after “benefits under the plan”.

3           **Subtitle B—Individual Market**  
 4                                   **Rules**

5   **SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.**

6           (a) *LIMITATION ON REQUIREMENTS.*—

7                   (1) *IN GENERAL.*—With respect to an individual  
 8           desiring to enroll in an individual health plan, if  
 9           such individual is in a period of previous qualifying  
 10          coverage (as defined in section 103(b)(3)(A)(i)) under  
 11          one or more group health plans or employee health  
 12          benefit plans that commenced 18 or more months  
 13          prior to the date on which such individual desires to  
 14          enroll in the individual plan, a health plan issuer de-  
 15          scribed in paragraph (3) may not decline to offer cov-  
 16          erage to such individual, or deny enrollment to such  
 17          individual based on the health status, medical condi-  
 18          tion, claims experience, receipt of health care, medical  
 19          history, evidence of insurability, or disability of the  
 20          individual, except as described in subsections (b) and  
 21          (c).

22                   (2) *HEALTH PROMOTION AND DISEASE PREVEN-*  
 23          *TION.*—Nothing in this subsection shall be construed  
 24          to prevent a health plan issuer offering an individual  
 25          health plan from establishing premium discounts or

1     *modifying otherwise applicable copayments or*  
2     *deductibles in return for adherence to programs of*  
3     *health promotion or disease prevention.*

4             (3) *HEALTH PLAN ISSUER.*—A health plan is-  
5     *suer described in this paragraph is a health plan is-*  
6     *suer that issues or renews individual health plans.*

7             (4) *PREMIUMS.*—Nothing in this subsection shall  
8     *be construed to affect the determination of a health*  
9     *plan issuer as to the amount of the premium payable*  
10    *under an individual health plan under applicable*  
11    *State law.*

12            (b) *ELIGIBILITY FOR OTHER GROUP COVERAGE.*—The  
13    *provisions of subsection (a) shall not apply to an individual*  
14    *who is eligible for coverage under a group health plan or*  
15    *an employee health benefit plan, or who has had coverage*  
16    *terminated under a group health plan or employee health*  
17    *benefit plan for failure to make required premium pay-*  
18    *ments or contributions, or for fraud or misrepresentation*  
19    *of material fact, or who is otherwise eligible for continu-*  
20    *ation coverage as described in part 6 of subtitle B of title*  
21    *I of the Employee Retirement Income Security Act of 1974*  
22    *(29 U.S.C. 1161 et seq.) or under an equivalent State pro-*  
23    *gram.*

24            (c) *APPLICATION OF CAPACITY LIMITS.*—

1           (1) *IN GENERAL.*—Subject to paragraph (2), a  
2 health plan issuer offering coverage to individuals  
3 under an individual health plan may cease enrolling  
4 individuals under the plan if—

5                   (A) the health plan issuer ceases to enroll  
6 any new individuals; and

7                   (B) the health plan issuer can demonstrate  
8 to the applicable certifying authority (as defined  
9 in section 202(d)), if required, that its financial  
10 or provider capacity to serve previously covered  
11 individuals will be impaired if the health plan  
12 issuer is required to enroll additional individ-  
13 uals.

14 Such a health plan issuer shall be prohibited from of-  
15 fering coverage after a cessation in offering coverage  
16 under this paragraph for a 6-month period or until  
17 the health plan issuer can demonstrate to the applica-  
18 ble certifying authority (as defined in section 202(d))  
19 that the health plan issuer has adequate capacity,  
20 whichever is later.

21           (2) *FIRST-COME-FIRST-SERVED.*—A health plan  
22 issuer offering coverage to individuals under an indi-  
23 vidual health plan is only eligible to exercise the limi-  
24 tations provided for in paragraph (1) if the health  
25 plan issuer provides for enrollment of individuals



1 *suer at the option of the individual, except that the require-*  
2 *ment of this subsection shall not apply in the case of—*

3 *(1) the nonpayment of premiums or contribu-*  
4 *tions by the individual in accordance with the terms*  
5 *of the individual health plan or where the health plan*  
6 *issuer has not received timely premium payments;*

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

9 *(3) the termination of the individual health plan*  
10 *in accordance with subsection (b).*

11 *(b) TERMINATION OF INDIVIDUAL HEALTH PLANS.—*

12 *(1) PARTICULAR TYPE OF INDIVIDUAL HEALTH*  
13 *PLAN NOT OFFERED.—In any case in which a health*  
14 *plan issuer decides to discontinue offering a particu-*  
15 *lar type of individual health plan to individuals, an*  
16 *individual health plan may be discontinued by the*  
17 *health plan issuer only if—*

18 *(A) the health plan issuer provides notice to*  
19 *each individual covered under the plan of such*  
20 *discontinuation at least 90 days prior to the*  
21 *date of the expiration of the plan;*

22 *(B) the health plan issuer offers to each in-*  
23 *dividual covered under the plan the option to*  
24 *purchase any other individual health plan cur-*

1           rently being offered by the health plan issuer to  
2           individuals; and

3           (C) in exercising the option to discontinue  
4           the individual health plan and in offering one or  
5           more replacement plans, the health plan issuer  
6           acts uniformly without regard to the health sta-  
7           tus or insurability of particular individuals.

8           (2) *DISCONTINUANCE OF ALL INDIVIDUAL*  
9           *HEALTH PLANS.*—In any case in which a health plan  
10          issuer elects to discontinue all individual health plans  
11          in a State, an individual health plan may be discon-  
12          tinued by the health plan issuer only if—

13           (A) the health plan issuer provides notice to  
14           the applicable certifying authority (as defined in  
15           section 202(d)) and to each individual covered  
16           under the plan of such discontinuation at least  
17           180 days prior to the date of the discontinuation  
18           of the plan; and

19           (B) all individual health plans issued or de-  
20           livered for issuance in the State are discontinued  
21           and coverage under such plans is not renewed.

22           (3) *PROHIBITION ON MARKET REENTRY.*—In the  
23          case of a discontinuation under paragraph (2), the  
24          health plan issuer may not provide for the issuance  
25          of any individual health plan in the State involved



1 enrollment by one or more health plan issuers, high-risk  
2 pools, or mandatory conversion policies), such State law  
3 shall apply in lieu of the standards described in sections  
4 110 and 111 unless the Secretary of Health and Human  
5 Services determines, after considering the criteria described  
6 in subsection (b)(1), in consultation with the Governor and  
7 Insurance Commissioner or chief insurance regulatory offi-  
8 cial of the State, that such State law does not achieve the  
9 goals of providing access to affordable health care coverage  
10 for those individuals described in sections 110 and 111.

11 (b) DETERMINATION.—

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

15 (A) evaluate whether the State law or pro-  
16 gram provides guaranteed access to affordable  
17 coverage to individuals described in sections 110  
18 and 111;

19 (B) evaluate whether the State law or pro-  
20 gram provides coverage for preexisting condi-  
21 tions (as defined in section 103(e)) that were  
22 covered under the individuals' previous group  
23 health plan or employee health benefit plan for  
24 individuals described in sections 110 and 111;

1           (C) evaluate whether the State law or pro-  
2           gram provides individuals described in sections  
3           110 and 111 with a choice of health plans or a  
4           health plan providing comprehensive coverage;  
5           and

6           (D) evaluate whether the application of the  
7           standards described in sections 110 and 111 will  
8           have an adverse impact on the number of indi-  
9           viduals in such State having access to affordable  
10          coverage.

11          (2) NOTICE OF INTENT.—If, within 6 months  
12          after the date of enactment of this Act, the Governor  
13          of a State notifies the Secretary of Health and  
14          Human Services that the State intends to enact a  
15          law, or modify an existing law, described in sub-  
16          section (a), the Secretary of Health and Human Serv-  
17          ices may not make a determination under such sub-  
18          section until the expiration of the 12-month period be-  
19          ginning on the date on which such notification is  
20          made, or until January 1, 1997, whichever is later.  
21          With respect to a State that provides notice under  
22          this paragraph and that has a legislature that does  
23          not meet within the 12-month period beginning on the  
24          date of enactment of this Act, the Secretary shall not

1     *make a determination under subsection (a) prior to*  
2     *January 1, 1998.*

3             (3) *NOTICE TO STATE.—If the Secretary of*  
4     *Health and Human Services determines that a State*  
5     *law or program does not achieve the goals described*  
6     *in subsection (a), the Secretary of Health and*  
7     *Human Services shall provide the State with ade-*  
8     *quate notice and reasonable opportunity to modify*  
9     *such law or program to achieve such goals prior to*  
10    *making a final determination under subsection (a).*

11            (c) *ADOPTION OF NAIC MODEL.—If, not later than*  
12    *9 months after the date of enactment of this Act—*

13            (1) *the National Association of Insurance Com-*  
14    *missioners (hereafter referred to as the “NAIC”),*  
15    *through a process which the Secretary of Health and*  
16    *Human Services determines has included consultation*  
17    *with representatives of the insurance industry and*  
18    *consumer groups, adopts a model standard or stand-*  
19    *ards for reform of the individual health insurance*  
20    *market; and*

21            (2) *the Secretary of Health and Human Services*  
22    *determines, within 30 days of the adoption of such*  
23    *NAIC standard or standards, that such standards*  
24    *comply with the goals of sections 110 and 111;*

1 *a State that elects to adopt such model standards or sub-*  
 2 *stantially adopt such model standards shall be deemed to*  
 3 *have met the requirements of sections 110 and 111 and shall*  
 4 *not be subject to a determination under subsection (a).*

5 **SEC. 113. DEFINITION.**

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

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

14 (1) *Coverage only for accident, or disability in-*  
 15 *come insurance, or any combination thereof.*

16 (2) *Medicare supplemental health insurance (as*  
 17 *defined under section 1882(g)(1) of the Social Secu-*  
 18 *rity Act).*

19 (3) *Coverage issued as a supplement to liability*  
 20 *insurance.*

21 (4) *Liability insurance, including general liabil-*  
 22 *ity insurance and automobile liability insurance.*

23 (5) *Workers’ compensation or similar insurance.*

24 (6) *Automobile medical payment insurance.*

25 (7) *Coverage for a specified disease or illness.*

1           (8) *Hospital or fixed indemnity insurance.*

2           (9) *Short-term limited duration insurance.*

3           (10) *Credit-only, dental-only, or vision-only in-*  
4 *surance.*

5           (11) *A health insurance policy providing benefits*  
6 *only for long-term care, nursing home care, home*  
7 *health care, community-based care, or any combina-*  
8 *tion thereof.*

## 9       ***Subtitle C—COBRA Clarifications***

### 10   ***SEC. 121. COBRA CLARIFICATIONS.***

11       (a) *PUBLIC HEALTH SERVICE ACT.—*

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

15           (A) *in subparagraph (A)—*

16               (i) *by transferring the sentence imme-*  
17 *diately preceding clause (iv) so as to appear*  
18 *immediately following such clause (iv); and*

19               (ii) *in the last sentence (as so trans-*  
20 *ferred)—*

21                   (I) *by inserting “; or a bene-*  
22 *ficiary-family member of the individ-*  
23 *ual,” after “an individual”; and*

24                   (II) *by striking “at the time of a*  
25 *qualifying event described in section*

1           2203(2)” and inserting “at any time  
2           during the initial 18-month period of  
3           continuing coverage under this title”;

4           (B) in subparagraph (D)(i), by inserting  
5           before “; or” the following: “; except that the ex-  
6           clusion or limitation contained in this clause  
7           shall not be considered to apply to a plan under  
8           which a preexisting condition or exclusion does  
9           not apply to an individual otherwise eligible for  
10          continuation coverage under this section because  
11          of the provision of the Health Insurance Reform  
12          Act of 1995”; and

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

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

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

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

1           (C) by adding at the end thereof the follow-  
2           ing new clause:

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

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

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

18          “Such term shall also include a child who is born to  
19          or placed for adoption with the covered employee dur-  
20          ing the period of continued coverage under this title.”.

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

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

1 (A) in the last sentence of subparagraph

2 (A)—

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

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

11 (B) in subparagraph (D)(i), by inserting  
12 before “, or” the following: “, except that the ex-  
13 clusion or limitation contained in this clause  
14 shall not be considered to apply to a plan under  
15 which a preexisting condition or exclusion does  
16 not apply to an individual otherwise eligible for  
17 continuation coverage under this section because  
18 of the provision of the Health Insurance Reform  
19 Act of 1995”; and

20 (C) in subparagraph (E), by striking “at  
21 the time of a qualifying event described in sec-  
22 tion 603(2)” and inserting “at any time during  
23 the initial 18-month period of continuing cov-  
24 erage under this part”.

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

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

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

8           (C) by adding at the end thereof the follow-  
9     ing new clause:

10           “(iii) in the case of an individual de-  
11     scribed in the last sentence of section  
12     602(2)(A), or a beneficiary-family member  
13     of the individual, the date such individual  
14     is determined to have been disabled.”.

15           (3) *NOTICES.*—Section 606(3) of the Employee  
16     Retirement Income Security Act of 1974 (29 U.S.C.  
17     1166(3)) is amended by striking “at the time of a  
18     qualifying event described in section 603(2)” and in-  
19     serting “at any time during the initial 18-month pe-  
20     riod of continuing coverage under this part”.

21           (4) *BIRTH OR ADOPTION OF A CHILD.*—Section  
22     607(3)(A) of the Employee Retirement Income Secu-  
23     rity Act of 1974 (29 U.S.C. 1167(3)) is amended by  
24     adding at the end thereof the following new flush sen-  
25     tence:

1       *“Such term shall also include a child who is born to*  
2       *or placed for adoption with the covered employee dur-*  
3       *ing the period of continued coverage under this*  
4       *part.”.*

5       (c) *INTERNAL REVENUE CODE OF 1986.—*

6           (1)     *PERIOD OF COVERAGE.—Section*  
7       *4980B(f)(2)(B) of the Internal Revenue Code of 1986*  
8       *is amended—*

9           (A) *in the last sentence of clause (i) by*  
10       *striking “at the time of a qualifying event de-*  
11       *scribed in paragraph (3)(B)” and inserting “at*  
12       *any time during the initial 18-month period of*  
13       *continuing coverage under this section”;*

14          (B) *in clause (iv)(I), by inserting before “,*  
15       *or” the following: “, except that the exclusion or*  
16       *limitation contained in this subclause shall not*  
17       *be considered to apply to a plan under which a*  
18       *preexisting condition or exclusion does not apply*  
19       *to an individual otherwise eligible for continu-*  
20       *ation coverage under this subsection because of*  
21       *the provision of the Health Insurance Reform*  
22       *Act of 1995”;* and

23          (C) *in clause (v), by striking “at the time*  
24       *of a qualifying event described in paragraph*  
25       *(3)(B)” and inserting “at any time during the*

1           *initial 18-month period of continuing coverage*  
2           *under this section”.*

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

5                   (A) *in subclause (I), by striking “or” at the*  
6                   *end thereof;*

7                   (B) *in subclause (II), by striking the period*  
8                   *and inserting “, or”; and*

9                   (C) *by adding at the end thereof the follow-*  
10                  *ing new subclause:*

11                                   *“(III) in the case of an qualified*  
12                                   *beneficiary described in the last sen-*  
13                                   *tence of paragraph (2)(B)(i), the date*  
14                                   *such individual is determined to have*  
15                                   *been disabled.”.*

16           (3) *NOTICES.*—Section 4980B(f)(6)(C) of the In-  
17           *ternal Revenue Code of 1986 is amended by striking*  
18           *“at the time of a qualifying event described in para-*  
19           *graph (3)(B)” and inserting “at any time during the*  
20           *initial 18-month period of continuing coverage under*  
21           *this section”.*

22           (4) *BIRTH OR ADOPTION OF A CHILD.*—Section  
23           *4980B(g)(1)(A) of the Internal Revenue Code of 1986*  
24           *is amended by adding at the end thereof the following*  
25           *new flush sentence:*

1           *“Such term shall also include a child who*  
 2           *is born to or placed for adoption with the*  
 3           *covered employee during the period of con-*  
 4           *tinued coverage under this section.”.*

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

9           *(e) NOTIFICATION OF CHANGES.—Not later than 60*  
 10          *days prior to the date on which this section becomes effec-*  
 11          *tive, each group health plan (covered under title XXII of*  
 12          *the Public Health Service Act, part 6 of subtitle B of title*  
 13          *I of the Employee Retirement Income Security Act of 1974,*  
 14          *and section 4980B(f) of the Internal Revenue Code of 1986)*  
 15          *shall notify each qualified beneficiary who has elected con-*  
 16          *tinuation coverage under such title, part or section of the*  
 17          *amendments made by this section.*

18           ***Subtitle D—Private Health Plan***  
 19           ***Purchasing Cooperatives***

20          ***SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERA-***  
 21           ***TIVES.***

22          *(a) DEFINITION.—As used in this Act, the term “health*  
 23          *plan purchasing cooperative” means a group of individuals*  
 24          *or employers that, on a voluntary basis and in accordance*  
 25          *with this section, form a cooperative for the purpose of pur-*

1 *chasing individual health plans or group health plans of*  
2 *fered by health plan issuers. A health plan issuer, agent,*  
3 *broker or any other individual or entity engaged in the sale*  
4 *of insurance may not underwrite a cooperative.*

5 *(b) CERTIFICATION.—*

6 *(1) IN GENERAL.—If a group described in sub-*  
7 *section (a) desires to form a health plan purchasing*  
8 *cooperative in accordance with this section and such*  
9 *group appropriately notifies the State and the Sec-*  
10 *retary of such desire, the State, upon a determination*  
11 *that such group meets the requirements of this section,*  
12 *shall certify the group as a health plan purchasing*  
13 *cooperative. The State shall make a determination of*  
14 *whether such group meets the requirements of this sec-*  
15 *tion in a timely fashion. Each such cooperative shall*  
16 *also be registered with the Secretary.*

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

23 *(3) INTERSTATE COOPERATIVES.—For purposes*  
24 *of this section, a health plan purchasing cooperative*  
25 *operating in more than one State shall be certified by*

1        *the State in which the cooperative is domiciled. States*  
2        *may enter into cooperative agreements for the purpose*  
3        *of certifying and overseeing the operation of such co-*  
4        *operatives. For purposes of this subsection, a coopera-*  
5        *tive shall be considered to be domiciled in the State*  
6        *in which most of the members of the cooperative re-*  
7        *side.*

8        *(c) BOARD OF DIRECTORS.—*

9            *(1) IN GENERAL.—Each health plan purchasing*  
10        *cooperative shall be governed by a Board of Directors*  
11        *that shall be responsible for ensuring the performance*  
12        *of the duties of the cooperative under this section. The*  
13        *Board shall be composed of a broad cross-section of*  
14        *representatives of employers, employees, and individ-*  
15        *uals participating in the cooperative. A health plan*  
16        *issuer, agent, broker or any other individual or entity*  
17        *engaged in the sale of individual health plans or*  
18        *group health plans may not hold or control any right*  
19        *to vote with respect to a cooperative.*

20            *(2) LIMITATION ON COMPENSATION.—A health*  
21        *plan purchasing cooperative may not provide com-*  
22        *ensation to members of the Board of Directors. The*  
23        *cooperative may provide reimbursements to such*  
24        *members for the reasonable and necessary expenses in-*

1        *curred by the members in the performance of their du-*  
2        *ties as members of the Board.*

3            (3) *CONFLICT OF INTEREST.*—*No member of the*  
4        *Board of Directors (or family members of such mem-*  
5        *bers) nor any management personnel of the coopera-*  
6        *tive may be employed by, be a consultant for, be a*  
7        *member of the board of directors of, be affiliated with*  
8        *an agent of, or otherwise be a representative of any*  
9        *health plan issuer, health care provider, or agent or*  
10       *broker. Nothing in the preceding sentence shall limit*  
11       *a member of the Board from purchasing coverage of-*  
12       *fered through the cooperative.*

13        (d) *MEMBERSHIP AND MARKETING AREA.*—

14            (1) *MEMBERSHIP.*—*A health plan purchasing*  
15        *cooperative may establish limits on the maximum size*  
16        *of employers who may become members of the cooper-*  
17        *ative, and may determine whether to permit individ-*  
18        *uals to become members. Upon the establishment of*  
19        *such membership requirements, the cooperative shall,*  
20        *except as provided in subparagraph (B), accept all*  
21        *employers (or individuals) residing within the area*  
22        *served by the cooperative who meet such requirements*  
23        *as members on a first-come, first-served basis, or on*  
24        *another basis established by the State to ensure equi-*  
25        *table access to the cooperative.*

1           (2) *MARKETING AREA.*—A State may establish  
2 rules regarding the geographic area that must be  
3 served by a health plan purchasing cooperative. With  
4 respect to a State that has not established such rules,  
5 a health plan purchasing cooperative operating in the  
6 State shall define the boundaries of the area to be  
7 served by the cooperative, except that such boundaries  
8 may not be established on the basis of health status  
9 or insurability of the populations that reside in the  
10 area.

11       (e) *DUTIES AND RESPONSIBILITIES.*—

12           (1) *IN GENERAL.*—A health plan purchasing co-  
13 operative shall—

14           (A) enter into agreements with multiple,  
15 unaffiliated health plan issuers, except that the  
16 requirement of this subparagraph shall not apply  
17 in regions (such as remote or frontier areas) in  
18 which compliance with such requirement is not  
19 possible;

20           (B) enter into agreements with employers  
21 and individuals who become members of the co-  
22 operative;

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

1           (D) prepare and disseminate comparative  
2 health plan materials (including information  
3 about cost, quality, benefits, and other informa-  
4 tion concerning group health plans and individ-  
5 ual health plans offered through the cooperative);

6           (E) actively market to all eligible employers  
7 and individuals residing within the service area;  
8 and

9           (F) act as an ombudsman for group health  
10 plan or individual health plan enrollees.

11           (2) *PERMISSIBLE ACTIVITIES.*—A health plan  
12 purchasing cooperative may perform such other func-  
13 tions as necessary to further the purposes of this Act,  
14 including—

15           (A) collecting and distributing premiums  
16 and performing other administrative functions;

17           (B) collecting and analyzing surveys of en-  
18 rollee satisfaction;

19           (C) charging membership fee to enrollees  
20 (such fees may not be based on health status)  
21 and charging participation fees to health plan  
22 issuers;

23           (D) cooperating with (or accepting as mem-  
24 bers) employers who provide health benefits di-

1           *rectly to participants and beneficiaries only for*  
2           *the purpose of negotiating with providers; and*

3                   *(E) negotiating with health care providers*  
4           *and health plan issuers.*

5           *(f) LIMITATIONS ON COOPERATIVE ACTIVITIES.—A*  
6           *health plan purchasing cooperative shall not—*

7                   *(1) perform any activity relating to the licensing*  
8           *of health plan issuers;*

9                   *(2) assume financial risk directly or indirectly*  
10           *on behalf of members of a health plan purchasing co-*  
11           *operative relating to any group health plan or indi-*  
12           *vidual health plan;*

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

19                   *(4) operate on a for-profit or other basis where*  
20           *the legal structure of the cooperative permits profits*  
21           *to be made and not returned to the members of the*  
22           *cooperative, except that a for-profit health plan pur-*  
23           *chasing cooperative may be formed by a nonprofit or-*  
24           *ganization—*

1           (A) *in which membership in such organiza-*  
2           *tion is not based on health status, medical condi-*  
3           *tion, claims experience, receipt of health care,*  
4           *medical history, evidence of insurability, or dis-*  
5           *ability; and*

6           (B) *that accepts as members all employers*  
7           *or individuals on a first-come, first-served basis,*  
8           *subject to any established limit on the maximum*  
9           *size of and employer that may become a member;*

10          *or*

11          (5) *perform any other activities that conflict or*  
12          *are inconsistent with the performance of its duties*  
13          *under this Act.*

14          (g) *LIMITED PREEMPTION OF CERTAIN STATE*  
15          *LAWS.—*

16           (1) *IN GENERAL.—With respect to a health plan*  
17           *purchasing cooperative that meets the requirements of*  
18           *this section, State fictitious group laws shall be pre-*  
19           *empted.*

20           (2) *HEALTH PLAN ISSUERS.—*

21           (A) *RATING.—With respect to a health plan*  
22           *issuer offering a group health plan or individual*  
23           *health plan through a health plan purchasing co-*  
24           *operative that meets the requirements of this sec-*  
25           *tion, State premium rating requirement laws,*

1           *except to the extent provided under subpara-*  
2           *graph (B), shall be preempted unless such laws*  
3           *permit premium rates negotiated by the coopera-*  
4           *tive to be less than rates that would otherwise be*  
5           *permitted under State law, if such rating dif-*  
6           *ferential is not based on differences in health sta-*  
7           *tus or demographic factors.*

8           *(B) EXCEPTION.—State laws referred to in*  
9           *subparagraph (A) shall not be preempted if such*  
10          *laws—*

11                 *(i) prohibit the variance of premium*  
12                 *rates among employers, plan sponsors, or*  
13                 *individuals that are members of a health*  
14                 *plan purchasing cooperative in excess of the*  
15                 *amount of such variations that would be*  
16                 *permitted under such State rating laws*  
17                 *among employers, plan sponsors, and indi-*  
18                 *viduals that are not members of the cooper-*  
19                 *ative; and*

20                 *(ii) prohibit a percentage increase in*  
21                 *premium rates for a new rating period that*  
22                 *is in excess of that which would be per-*  
23                 *mitted under State rating laws.*

24           *(C) BENEFITS.—Except as provided in sub-*  
25          *paragraph (D), a health plan issuer offering a*

1           *group health plan or individual health plan*  
2           *through a health plan purchasing cooperative*  
3           *shall comply with all State mandated benefit*  
4           *laws that require the offering of any services,*  
5           *category or care, or services of any class or type*  
6           *of provider.*

7           (D) *EXCEPTION.—In those States that have*  
8           *enacted laws authorizing the issuance of alter-*  
9           *native benefit plans to small employers, health*  
10          *plan issuers may offer such alternative benefit*  
11          *plans through a health plan purchasing coopera-*  
12          *tive that meets the requirements of this section.*

13          (h) *RULES OF CONSTRUCTION.—Nothing in this sec-*  
14          *tion shall be construed to—*

15                 (1) *require that a State organize, operate, or oth-*  
16                 *erwise create health plan purchasing cooperatives;*

17                 (2) *otherwise require the establishment of health*  
18                 *plan purchasing cooperatives;*

19                 (3) *require individuals, plan sponsors, or em-*  
20                 *ployers to purchase group health plans or individual*  
21                 *health plans through a health plan purchasing coopera-*  
22                 *ative;*

23                 (4) *require that a health plan purchasing coopera-*  
24                 *ative be the only type of purchasing arrangement per-*  
25                 *mitted to operate in a State;*

1           (5) confer authority upon a State that the State  
2 would not otherwise have to regulate health plan issu-  
3 ers or employee health benefits plans; or

4           (6) confer authority upon a State (or the Federal  
5 Government) that the State (or Federal Government)  
6 would not otherwise have to regulate group purchas-  
7 ing arrangements, coalitions, or other similar entities  
8 that do not desire to become a health plan purchasing  
9 cooperative in accordance with this section.

10          (i) *APPLICATION OF ERISA.*—For purposes of enforce-  
11 ment only, the requirements of parts 4 and 5 of subtitle  
12 B of title I of the Employee Retirement Income Security  
13 Act of 1974 (29 U.S.C. 1101) shall apply to a health plan  
14 purchasing cooperative as if such plan were an employee  
15 welfare benefit plan.

## 16           **TITLE II—APPLICATION AND** 17           **ENFORCEMENT OF STANDARDS**

### 18          **SEC. 201. APPLICABILITY.**

19          (a) *CONSTRUCTION.*—

20               (1) *ENFORCEMENT.*—

21                       (A) *IN GENERAL.*—A requirement or stand-  
22                       ard imposed under this Act on a group health  
23                       plan or individual health plan offered by a  
24                       health plan issuer shall be deemed to be a re-  
25                       quirement or standard imposed on the health

1        *plan issuer. Such requirements or standards*  
2        *shall be enforced by the State insurance commis-*  
3        *sioner for the State involved or the official or of-*  
4        *icials designated by the State to enforce the re-*  
5        *quirements of this Act. In the case of a group*  
6        *health plan offered by a health plan issuer in*  
7        *connection with an employee health benefit plan,*  
8        *the requirements or standards imposed under*  
9        *this Act shall be enforced with respect to the*  
10       *health plan issuer by the State insurance com-*  
11       *missioner for the State involved or the official or*  
12       *officials designated by the State to enforce the re-*  
13       *quirements of this Act.*

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

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

25            (A) *not prescribed in this Act; or*

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

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

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

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

18          (a) *HEALTH PLAN ISSUERS.*—Each State shall require  
19          that each group health plan and individual health plan is-  
20          sued, sold, renewed, offered for sale or operated in such  
21          State by a health plan issuer meet the standards established  
22          under this Act pursuant to an enforcement plan filed by  
23          the State with the Secretary. A State shall submit such in-  
24          formation as required by the Secretary demonstrating effec-  
25          tive implementation of the State enforcement plan.

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

11           (c) *FAILURE TO IMPLEMENT PLAN.*—In the case of the  
12 failure of a State to substantially enforce the standards and  
13 requirements set forth in this Act with respect to group  
14 health plans and individual health plans as provided for  
15 under the State enforcement plan filed under subsection (a),  
16 the Secretary, in consultation with the Secretary of Health  
17 and Human Services, shall implement an enforcement plan  
18 meeting the standards of this Act in such State. In the case  
19 of a State that fails to substantially enforce the standards  
20 and requirements set forth in this Act, each health plan is-  
21 suer operating in such State shall be subject to civil enforce-  
22 ment as provided for under sections 502, 504, 506, and 510  
23 of the Employee Retirement Income Security Act of 1974  
24 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties  
25 contained in paragraphs (1) and (2) of section 502(c) of

1 *such Act (29 U.S.C. 1132(c)(1) and (2)) shall apply to any*  
2 *information required by the Secretary to be disclosed and*  
3 *reported under this section.*

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

7 *(1) health plan issuers, the State insurance com-*  
8 *missioner or official or officials designated by the*  
9 *State to enforce the requirements of this Act for the*  
10 *State involved; and*

11 *(2) an employee health benefit plan, the Sec-*  
12 *retary.*

13 *(e) REGULATIONS.—The Secretary may promulgate*  
14 *such regulations as may be necessary or appropriate to*  
15 *carry out this Act.*

16 *(f) TECHNICAL AMENDMENT.—Section 508 of the Em-*  
17 *ployee Retirement Income Security Act of 1974 (29 U.S.C.*  
18 *1138) is amended by inserting “and under the Health In-*  
19 *surance Reform Act of 1995” before the period.*

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

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

6           (a) *IN GENERAL.*—Section 1301(b) of the Public  
7   Health Service Act (42 U.S.C. 300e(b)) is amended by add-  
8   ing at the end the following new paragraph:

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

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

22           (b) *MEDICAL SAVINGS ACCOUNTS.*—It is the sense of  
23   the Committee on Labor and Human Resources of the Sen-  
24   ate that the establishment of medical savings accounts, in-  
25   cluding those defined in section 1301(b)(6)(B) of the Public

1 *Health Service Act (42 U.S.C. 300e(b)(6)(B)), should be en-*  
2 *couraged as part of any health insurance reform legislation*  
3 *passed by the Senate through the use of tax incentives relat-*  
4 *ing to contributions to, the income growth of, and the quali-*  
5 *fied use of, such accounts.*

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

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

14 (a) *IN GENERAL.—The Secretary of Health and*  
15 *Human Services, in consultation with the Secretary, rep-*  
16 *resentatives of State officials, consumers, and other rep-*  
17 *resentatives of individuals and entities that have expertise*  
18 *in health insurance and employee benefits, shall conduct a*  
19 *two-part study, and prepare and submit reports, in accord-*  
20 *ance with this section.*

21 (b) *EVALUATION OF AVAILABILITY.—Not later than*  
22 *January 1, 1997, the Secretary of Health and Human Serv-*  
23 *ices shall prepare and submit to the appropriate committees*  
24 *of Congress a report, concerning—*

1           (1) *an evaluation, based on the experience of*  
2           *States, expert opinions, and such additional data as*  
3           *may be available, of the various mechanisms used to*  
4           *ensure the availability of reasonably priced health*  
5           *coverage to employers purchasing group coverage and*  
6           *to individuals purchasing coverage on a non-group*  
7           *basis; and*

8           (2) *whether standards that limit the variation in*  
9           *premiums will further the purposes of this Act.*

10          (c) *EVALUATION OF EFFECTIVENESS.—Not later than*  
11         *January 1, 1998, the Secretary of Health and Human Serv-*  
12         *ices shall prepare and submit to the appropriate committees*  
13         *of Congress a report, concerning the effectiveness of the pro-*  
14         *visions of this Act and the various State laws, in ensuring*  
15         *the availability of reasonably priced health coverage to em-*  
16         *ployers purchasing group coverage and individuals pur-*  
17         *chasing coverage on a non-group basis.*

18         **SEC. 303. SENSE OF THE COMMITTEE CONCERNING MEDI-**  
19                 **CARE.**

20          (a) *FINDINGS.—The Committee on Labor and Human*  
21         *Resources of the Senate finds that the Public Trustees of*  
22         *Medicare concluded in their 1995 Annual Report that—*

23                 (1) *the Medicare program is clearly*  
24                 *unsustainable in its present form;*

1           (2) “the Hospital Insurance Trust Fund, which  
2           pays inpatient hospital expenses, will be able to pay  
3           benefits for only about 7 years and is severely out of  
4           financial balance in the long range”; and

5           (3) the Public Trustees “strongly recommend  
6           that the crisis presented by the financial condition of  
7           the Medicare trust fund be urgently addressed on a  
8           comprehensive basis, including a review of the  
9           programs’s financing methods, benefit provisions, and  
10          delivery mechanisms”.

11          (b) *SENSE OF THE COMMITTEE.*—It is the Sense of the  
12         Committee on Labor and Human Resources of the Senate  
13         that the Senate should take measures necessary to reform  
14         the Medicare program, to provide increased choice for sen-  
15         iors, and to respond to the findings of the Public Trustees  
16         by protecting the short-term solvency and long-term sus-  
17         tainability of the Medicare program.

18         **SEC. 304. EFFECTIVE DATE.**

19            Except as otherwise provided for in this Act, the provi-  
20            sions of this Act shall apply as follows:

21            (1) With respect to group health plans and indi-  
22            vidual health plans, such provisions shall apply to  
23            plans offered, sold, issued, renewed, in effect, or oper-  
24            ated on or after January 1, 1996; and

1           (2) *With respect to employee health benefit plans,*  
 2           *on the first day of the first plan year beginning on*  
 3           *or after January 1, 1996.*

4 **SEC. 305. SEVERABILITY.**

5           *If any provision of this Act or the application of such*  
 6           *provision to any person or circumstance is held to be uncon-*  
 7           *stitutional, the remainder of this Act and the application*  
 8           *of the provisions of such to any person or circumstance shall*  
 9           *not be affected thereby.*

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