103D CONGRESS
2D SESSION

S. 1978

To amend part III of title 5, United States Code, to provide for participation by non-Federal employees in health benefits plans under the Federal Employees Health Benefits Program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 24 (legislative day, FEBRUARY 22), 1994

Mr. ROTH introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

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A BILL

To amend part III of title 5, United States Code, to provide for participation by non-Federal employees in health benefits plans under the Federal Employees Health Benefits Program, 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 ''Federal Health Care
5 Expansion Act of 1994''.

6 **SEC. 2. FINDINGS.**

7 The Congress finds that—

1 (1) the United States spends more on health
2 care than any other nation in the world, and costs
3 continue to increase at double digit rates;
4 (2) more than 35,000,000 people in the United
5 States do not have basic health care insurance;
6 (3) small businesses and the self-employed find
7 it particularly difficult to obtain affordable health in-
8 surance because of the small-risk pools in which they
9 are grouped; and
10 (4) the Federal Employees Health Benefits
11 Program provides quality health care coverage na-
12 tionwide while providing enrollees with a large de-
13 gree of choice.

14 **SEC. 3. PURPOSES.**

15 The purposes of this Act are to—
16 (1) reduce the rising cost of health care
17 through the use of market forces;
18 (2) increase access to affordable health care to
19 millions of individuals who do not have health insur-
20 ance;
21 (3) make available to millions of Americans the
22 health care coverage that is available to the Presi-
23 dent, Members of Congress, Supreme Court Jus-
24 tices, members of the President's Cabinet, and mil-
25 lions of Federal employees and retirees;

1 (4) accomplish these purposes without the use
2 of global spending caps, employer mandates, or the
3 establishment of a huge Government bureaucracy;
4 and
5 (5) strengthen the Federal Employees Health
6 Benefits Program by introducing greater competi-
7 tion into the Federal employee plan so that the Gov-
8 ernment can use its power as a major purchaser of
9 health care to drive down the costs of care for Fed-
10 eral enrollees while maintaining high quality care
11 and service.

12 TITLE I—SMALL BUSINESS PAR- 13 TICIPATION IN FEDERAL EM- 14 PLOYEES HEALTH BENEFITS 15 PLANS

16 SEC. 101. SMALL BUSINESS PARTICIPATION IN FEDERAL 17 EMPLOYEES HEALTH BENEFITS PLANS.

18 Part III of title 5, United States Code, is amended
19 by inserting after chapter 89 the following new chapter:

20 "CHAPTER 90—SMALL BUSINESS PARTICI- 21 PATION IN FEDERAL EMPLOYEE 22 HEALTH BENEFITS PLANS

''Sec.
''9001. Definition.
''9002. Application to small business participants.
''9003. Small business participation.
''9004. Contributions.
''9005. Continued coverage.

"9006. Schedule of small business participation.

1 **"§ 9001. Definition**

2 "For purposes of this chapter, the term 'small busi-
3 ness' means any business entity which employs 100 or less
4 employees (including businesses with one self-employed in-
5 dividual).

6 **"§ 9002. Application to small business participants**

7 "(a) The Office of Personnel Management shall pro-
8 mulgate regulations to apply the provisions of chapter 89,
9 relating to health benefits plans, to the greatest extent
10 practicable to small businesses and individuals covered
11 under the provisions of this chapter.

12 "(b) Notwithstanding the provisions of subsection
13 (a), carriers shall offer the same health benefits plans for
14 the same premiums as are offered under chapter 89.

15 "(c) Notwithstanding subsection (a), the provisions
16 of section 8907 shall not apply to individuals covered
17 under this chapter, except the Office of Personnel Man-
18 agement shall establish a method to disseminate informa-
19 tion relating to health benefits plans (including informa-
20 tion concerning periods of open enrollment and a summary
21 of the information described in section 8908) to such indi-
22 viduals through small business participants and carriers.

23 **"§ 9003. Small business participation**

24 "Any small business which desires to participate in
25 a health benefits plan under this chapter may enter into

1 a contract with a carrier in accordance with this chapter.
2 Such contract shall be for a term of no less than 1 year.
3 **"§ 9004. Contributions**
4 "(a) Subject to the provisions of subsection (b), an
5 individual enrolled in a health benefits plan under this
6 chapter shall make contributions equal to the amount of
7 contributions made by—
8 "(1) a Federal enrollee in such plan under indi-
9 vidual, or self and family coverage, as the case may
10 be, as determined under section 8906; and
11 "(2) the Federal agency making Government
12 contributions determined under section 8906 for
13 such Federal enrollee.
14 "(b)(1) A small business may by contract agree to
15 make any amount of the contribution required under sub-
16 section (a) on behalf of an enrollee under such subsection.
17 "(2) An agency of a State government may provide
18 any amount of the contribution required under subsection
19 (a) on behalf of an enrollee under such subsection.
20 "(3) The Secretary of Health and Human Services
21 (HHS) may subsidize any amount of the contribution re-
22 quired by subsection (a) or section 9005(a) for any quali-
23 fied enrollee of any small business participating in a health
24 benefits plan under this chapter. For purposes of the pre-
25 ceding sentence, the term 'qualified enrollee' will be deter-

mined by the Secretary of HHS according to the number of individuals apply and the budget neutrality requirement in section 105 of this Act.

''(c) A small business participating under this chapter shall—

''(1) collect contributions from employees by withholdings from pay or by another method or schedule;

''(2) make payments of such contributions to the contracted carrier;

''(3) maintain and make available such records as the Office, applicable State insurance authority, or carrier may require; and

''(4) provide any other related administrative service in carrying out the provisions of this chapter.

''§ 9005. Continued coverage

''(a) Subject to subsection (b), the provisions of section 8905a shall be made applicable to enrollees and individuals covered by such enrollments under this chapter through section 9002 and the carrier contract entered into under section 9003, except the enrollee shall pay all contributions for continued coverage and the applicable amount for administrative expenses unless the applicable small business by contract agrees to pay any part of such contributions or expenses.

1 ‘‘(b) An individual may be covered under continued
2 coverage as provided under subsection (a), only if such in-
3 dividual remains in the same plan during the period of
4 continued coverage as such individual was enrolled in im-
5 mediately before such period of continued coverage.

6 **“§ 9006. Schedule of small business participation**

7 ‘‘(a) Subject to the provisions of subsections (b), (c),
8 (d), (e), and (f), each carrier enrolling individuals of small
9 business participants under this chapter shall ensure
10 that—

11 ‘‘(1) in the first contract year after the date of
12 the enactment of the Federal Health Care Expan-
13 sion Act of 1994, the number of enrollees from small
14 businesses as provided under this chapter shall be no
15 less than 5 percent of the number of Federal enroll-
16 ees enrolled under chapter 89;

17 ‘‘(2) in the second such year, the number of
18 small business enrollees shall be no less than 20 per-
19 cent of the number of such Federal enrollees;

20 ‘‘(3) in the third such year, the number of
21 small business enrollees shall be no less than 40 per-
22 cent of the number of such Federal enrollees;

23 ‘‘(4) in the fourth such year, the number of
24 small business enrollees shall be no less than 60 per-
25 cent of the number of such Federal enrollees; and

1 ''(5) in the fifth such year and in each year
2 thereafter, the number of small business enrollees
3 shall be no less than 80 percent of the number of
4 such Federal enrollees.
5 ''(b) Beginning in the contract year described under
6 subsection (a)(1) and in each contract year thereafter, in
7 no event shall a carrier enroll enrollees from less than 1
8 small business.
9 ''(c)(1) In the contract year described under sub-
10 section (a)(1), a small business may participate if such
11 business—
12 ''(A) has between 75 and 100 employees; and
13 ''(B) shall ensure that at least 80 percent of
14 such employees shall enroll.
15 ''(2) In the contract year described under subsection
16 (a)(2) small businesses with between 50 and 74 employees
17 may additionally participate.
18 ''(3) In the contract year described under subsection
19 (a)(3), small businesses with between 1 and 49 employees
20 may additionally participate.
21 ''(4) In the contract year described under subsection
22 (a)(4) and each year thereafter, all small businesses may
23 participate.
24 ''(d) If during any contract year described under sub-
25 section (a) (1) through (5), more small businesses apply

1 for participation than are required to participate under
2 such subsection, the carrier shall—
3 ''(1) subject to paragraph (2), randomly select
4 small businesses for participation from all applica-
5 tions; and
6 ''(2) ensure that from such randomly selected
7 small businesses, at least 50 percent of such busi-
8 nesses are not offering any type of health insurance
9 benefits to its employees.
10 ''(e) In the administration of subsection (a) (2)
11 through (5) each carrier enrolling individuals of small
12 business participants shall ensure that no less than 50
13 percent of small business enrollees in each contract year
14 shall be individuals who had no health insurance coverage
15 in the previous year.
16 ''(f) A small business may participate in a health ben-
17 efits plan as provided under this section if such business
18 meets all such requirements otherwise provided under this
19 chapter.
20 ''(g) The Office may waive the requirements under
21 subsection (a) but only after making a determination that
22 there is insufficient interest in small businesses within the
23 region in participating under this chapter.''.

1 **SEC. 102. EXTENSION OF CONTINUED COVERAGE.**

2 Section 8905a of title 5, United States Code, is
3 amended—
4 (1) in subsection (e)—
5 (A) in paragraph (1)(A) by striking out
6 ''18 months'' and inserting in lieu thereof ''36
7 months''; and
8 (B) in paragraph (2)(C) by striking out
9 ''18-month period'' and inserting in lieu thereof
10 ''36-month period''; and
11 (2) in subsection (f)(3)(B) by striking out ''18-
12 month period'' and inserting in lieu thereof ''36-
13 month period.

14 **SEC. 103. COST EXPERIENCE COMPARISON REPORT.**

15 No later than January 30 following the first contract
16 year implementing the amendments made by section 101
17 of this Act, and on January 30 of each 4 years thereafter,
18 each carrier contracting under chapter 89 or 90 of title
19 5, United States Code, shall submit a report to the Office
20 of Personnel Management that compares the aggregate
21 cost experiences with respect to coverage between—
22 (1) Federal employees and other individuals
23 covered under chapter 89 of title 5, United States
24 Code; and
25 (2) individuals covered under chapter 90 of
26 such title.

1 **SEC. 104. RISK ADJUSTMENT STUDY.**

2 No later than 2 years after the date of the enactment
3 of this Act, the Office of Personnel Management shall con-
4 duct a study and submit a health benefits plan risk adjust-
5 ment report to the Congress. Such report shall examine
6 in the administration of chapters 89 and 90 of title 5,
7 United States Code (as amended and added by this Act)—

8 (1) the feasibility of risk adjusting premiums,
9 by the use of subsidies and surcharges to hold car-
10 riers harmless for enrollment risks, based on demo-
11 graphic variables;

12 (2) the risk adjustment factors that are cor-
13 related with increased or diminished risk for con-
14 sumption of the type of health services included in
15 the standardized level of benefits established under
16 such chapters;

17 (3) a formula for assigning numerical risk fac-
18 tors for lower than average risk for consumption of
19 services, the average risk for consumption of serv-
20 ices, and higher than average risk factors, and a
21 methodology for the adjustment of such factors; and

22 (4) any recommendations for the enactment of
23 legislation.

1 **SEC. 105. ELIMINATION OF MEDICARE AND MEDICAID DIS-**
2 **PROPORTIONATE SHARE HOSPITAL PAY-**
3 **MENTS TO FINANCE SELF-EMPLOYED DEDUC-**
4 **TION AND BUY-IN SUBSIDY.**

5 (a) PHASE-OUT OF DISPROPORTIONATE SHARE HOS-
6 PITAL PAYMENTS.—The Secretary of Health and Human
7 Services shall phase-out over a 5-fiscal-year period begin-
8 ning with the first fiscal year following the second January
9 1 described in section 107, the disproportionate share hos-
10 pital payments under sections 1886(d)(5)(F) and
11 1902(a)(13)(A) of the Social Security Act (42 U.S.C.
12 1395ww(d)(5)(F) and 1396a(a)(13)(A)).

13 (b) BUDGET NEUTRAL MANNER.—The phase-out de-
14 scribed in subsection (a) shall be accomplished in a Fed-
15 eral budget neutral manner such that the savings for each
16 fiscal year resulting from such phase-out are fully used
17 to offset the additional costs resulting from the amend-
18 ments made by section 301 and section 201 of this Act
19 and such costs resulting from the premium subsidy pro-
20 gram for low-income workers of participating small busi-
21 nesses described in section 9003(b)(3) of title 5, United
22 States Code (as added by section 101 of this Act).

23 (c) CONFORMING AMENDMENTS.—

24 (1) Clause (i) of section 1886(d)(5)(F) of the
25 Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) is
26 amended by striking "For discharges" and inserting

1 "Except as provided in section 105 of the Federal
2 Health Care Expansion Act of 1994, for dis-
3 charges".

4 (2) Subparagraph (A) of section 1902(a)(13) of
5 the Social Security Act (42 U.S.C. 1396a(a)(13)) is
6 amended by striking "take into account the situation
7 of hospitals" and inserting "take into account, ex-
8 cept as provided in section 105 of the Federal
9 Health Care Expansion Act of 1994, the situation of
10 hospitals".

11 **SEC. 106. STUDY REGARDING NONWORKER AND**
12 **NONCOVERED EMPLOYEE BUY-INS.**

13 The Secretary of Health and Human Services shall
14 study by what method nonworkers and employees of em-
15 ployers not covered under chapter 90 of title 5, United
16 States Code (as added by section 101 of this Act), may
17 be incorporated into the buy-in for coverage under the
18 Federal Employees Health Benefits Plan. The Secretary
19 shall report the results of such study and any appropriate
20 legislative recommendations to the Congress not later than
21 2 years after the date of the enactment of this Act.

22 **SEC. 107. EFFECTIVE DATE.**

23 (a) IN GENERAL.—Except as provided under sub-
24 section (b), the provisions of this Act and the amendments
25 made by this Act shall be effective on and after the first

January 1, occurring after the date of the enactment of this Act.

(b) EXCEPTION.—The provisions of chapters 89 and 90 of title 5, United States Code, as amended and added by this title, relating to the establishment of or exercise of authority (including the promulgation of regulations) by the Office of Personnel Management, the Secretary of Health and Human Services, the President, or any other applicable Federal officer shall take effect on the date of the enactment of this Act in order to establish health benefits plans and fully implement the provisions and amendments made by this Act no later than the first January 1 occurring after the date of the enactment of this Act.

TITLE II—BETTER ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Improvements in Health Insurance Affordability for Small Employers

SEC. 201. GRANTS TO STATES FOR SMALL EMPLOYER HEALTH INSURANCE PURCHASING PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter in this section referred to as the "Secretary") shall make grants to States that submit applications meeting the requirements of this section for

1 the establishment and operation of small employer health
2 insurance purchasing programs.
3 (b) USE OF FUNDS.—Grant funds awarded under
4 this section to a State may be used to finance administra-
5 tive costs associated with developing and operating a
6 group purchasing program for small employers, such as
7 the costs associated with—
8 (1) engaging in marketing and outreach efforts
9 to inform small employers about the group purchas-
10 ing program, which may include the payment of
11 sales commissions;
12 (2) negotiating with insurers to provide health
13 insurance through the group purchasing program; or
14 (3) providing administrative functions, such as
15 eligibility screening, claims administration, and cus-
16 tomer service.
17 (c) APPLICATION REQUIREMENTS.—An application
18 submitted by a State to the Secretary must describe—
19 (1) whether the program will be operated di-
20 rectly by the State or through one or more State-
21 sponsored private organizations and the details of
22 such operation;
23 (2) any participation requirements for small
24 employers;

1 (3) the extent of insurance coverage among the
2 eligible population, projections for change in the ex-
3 tent of such coverage, and the price of insurance
4 currently available to these small employers;
5 (4) program goals for reducing the price of
6 health insurance for small employers and increasing
7 insurance coverage among employees of small em-
8 ployers and their dependents;
9 (5) the approaches proposed for enlisting par-
10 ticipation by insurers and small employers, including
11 any plans to use State funds to subsidize the cost
12 of insurance for participating employers; and
13 (6) the methods proposed for evaluating the ef-
14 fectiveness of the program in reducing the number
15 of uninsured in the State and on lowering the price
16 of health insurance to small employers in the State.
17 (d) GRANT CRITERIA.—In awarding grants, the Sec-
18 retary shall consider the potential impact of the State's
19 proposal on the cost of health insurance for small employ-
20 ers and on the number of uninsured, and the need for re-
21 gional variation in the awarding of grants. To the extent
22 the Secretary deems appropriate, grants shall be awarded
23 to fund programs employing a variety of approaches for
24 establishing small employer health insurance group pur-
25 chasing programs.

1 (e) PROHIBITION ON GRANTS.—No grant funds shall
2 be paid to States that do not meet the requirements of
3 title XXI of the Social Security Act with respect to small
4 employer health insurance plans, or to States with group
5 purchasing programs involving small employer health in-
6 surance plans that do not meet the requirements of such
7 title.

8 (f) ANNUAL REPORT BY STATES.—States receiving
9 grants under this section must report to the Secretary an-
10 nually on the numbers and rates of participation by eligi-
11 ble insurers and small employers, on the estimated impact
12 of the program on reducing the number of uninsured, and
13 on the price of insurance available to small employers in
14 the State.

15 (g) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated for each of fiscal years
17 1995, 1996, and 1997, such sums as may be necessary
18 for the purposes of awarding grants under this section.

19 (h) SECRETARIAL REPORT.—The Secretary shall re-
20 port to Congress by no later than January 1, 1997, on
21 the number and amount of grants awarded under this sec-
22 tion, and include with such report an evaluation of the
23 impact of the grant program on the number of uninsured
24 and price of health insurance to small employers in partici-
25 pating States.

Subtitle B—Improvements in Health Insurance for Small Employers

PART I—STANDARDS AND REQUIREMENTS OF SMALL EMPLOYER HEALTH INSURANCE REFORM

SEC. 211. STANDARDS AND REQUIREMENTS OF SMALL EMPLOYER HEALTH INSURANCE.

The Social Security Act is amended by adding at the end the following new title:

"TITLE XXI—STANDARDS FOR SMALL EMPLOYER HEALTH INSURANCE AND CERTIFICATION OF MANAGED CARE PLANS

"PART A—GENERAL STANDARDS; DEFINITIONS

"APPLICATION OF REQUIREMENTS TO SMALL EMPLOYER HEALTH INSURANCE PLANS

"SEC. 2101. (a) PLAN UNDER STATE REGULATORY PROGRAM OR CERTIFIED BY THE SECRETARY.—An insurer offering a health insurance plan to a small employer in a State on or after the effective date applicable to the State under subsection (b) shall be treated as meeting the requirements of this title if—

"(1) the Secretary determines that the State has established a regulatory program that provides for the application and enforcement of standards

1 meeting the requirements under section 2102 to
2 meet the requirements of part B of this title; and
3 "(2) if the State has not established such a pro-
4 gram or if the program has been decertified by the
5 Secretary under section 2102(b), the health insur-
6 ance plan has been certified by the Secretary (in ac-
7 cordance with such procedures as the Secretary es-
8 tablishes) as meeting the requirements of part B of
9 this title.
10 "(b) EFFECTIVE DATES.—
11 "(1) IN GENERAL.—Except as specified in
12 paragraph (2) and provided in paragraph (3), the
13 standards established under section 2102 to meet
14 the requirements of part B of this title shall apply
15 to health insurance plans offered, issued, or renewed
16 to a small employer in a State on or after January
17 1, 1995.
18 "(2) EXCEPTION FOR LEGISLATION.—In the
19 case of a State which the Secretary identifies, in
20 consultation with the NAIC, as—
21 "(A) requiring State legislation (other than
22 legislation appropriating funds) in order for in-
23 surers and health insurance plans offered to
24 small employers to meet the standards under

1 the program established under subsection (a),
2 or
3 ''(B) having a legislature which does not
4 meet in 1995 in a legislative session in which
5 such legislation may be considered,
6 the date specified in this paragraph is the first day
7 of the first calendar quarter beginning after the
8 close of the first regular legislative session of the
9 State legislature that begins on or after January 1,
10 1996. For purposes of the previous sentence, in the
11 case of a State that has a 2-year legislative session,
12 each year of such session shall be deemed to be a
13 separate regular legislative session of the State legis-
14 lature.
15 ''(3) REQUIREMENTS APPLIED TO EXISTING
16 POLICIES.—In the case of a health insurance plan in
17 effect before the applicable effective date specified in
18 paragraph (1) or (2), the requirements referred to in
19 subsections (a) and (b) of section 2112 shall not
20 apply to any such plan, or any renewal of such plan,
21 before the date which is 2 years after such effective
22 date.
23 ''(c) REPORTING REQUIREMENTS OF STATES.—Each
24 State shall submit to the Secretary, at intervals estab-
25 lished by the Secretary, a report on the implementation

1 and enforcement of the standards under the program es-
2 tablished under subsection (a)(1) with respect to health
3 insurance plans offered to small employers.

4 ‘‘(d) MORE STRINGENT STATE STANDARDS PER-
5 MITTED.—Except as provided in subsections (b)(8) and
6 (c)(4) of section 2113, a State may implement standards
7 that are more stringent than the standards established to
8 meet the requirements of part B of this title.

9 ‘‘(e) LIMITED WAIVER OF RATING REQUIRE-
10 MENTS.—The Secretary may waive requirements with re-
11 spect to subsections (b) and (e) of section 2112 in the
12 case of a State with equally stringent but not identical
13 standards in effect prior to January 1, 1994.

14 ‘‘ESTABLISHMENT OF STANDARDS

15 ‘‘SEC. 2102. (a) ESTABLISHMENT OF STANDARDS.—

16 ‘‘(1) ROLE OF THE NAIC.—The Secretary shall
17 request that the NAIC—

18 ‘‘(A) develop specific standards, in the
19 form of a model Act and model regulations, to
20 implement the requirements of part B of this
21 title; and

22 ‘‘(B) report to the Secretary on such
23 standards,

24 by not later than September 30, 1994. If the NAIC
25 develops such standards within such period and the
26 Secretary finds that such standards implement the

1 requirements of part B of this title, such standards
2 shall be the standards applied under section 2101.
3 "(2) ROLE OF THE SECRETARY.—If the NAIC
4 fails to develop and report on the standards de-
5 scribed in paragraph (1) by the date specified in
6 such paragraph or the Secretary finds that such
7 standards do not implement the requirements under
8 part B of this title, the Secretary shall develop and
9 publish such standards, by not later than December
10 31, 1994. Such standards shall then be the stand-
11 ards applied under section 2101.
12 "(3) STANDARDS ON GUARANTEED AVAILABIL-
13 ITY.—The standards developed under paragraphs
14 (1) and (2) shall provide alternative standards for
15 guaranteeing availability of health insurance plans
16 for all small employers in a State as provided in sec-
17 tion 2111(c).
18 "(4) GUIDELINES FOR DEMOGRAPHIC RATING
19 FACTORS.—The standards developed under para-
20 graphs (1) and (2) shall include guidelines with re-
21 spect to rating factors used by insurers to adjust
22 premiums to reflect demographic characteristics of a
23 small employer group.
24 "(b) PERIODIC SECRETARIAL REVIEW OF STATE
25 REGULATORY PROGRAM.—The Secretary periodically

1 shall review State regulatory programs to determine if
2 they continue to meet and enforce the standards referred
3 to in subsection (a). If the Secretary initially determines
4 that a State regulatory program no longer meets and en-
5 forces such standards, the Secretary shall provide the
6 State an opportunity to adopt a plan of correction that
7 would bring such program into compliance with such
8 standards. If the Secretary makes a final determination
9 that the State regulatory program fails to meet and en-
10 force such standards and requirements after such an op-
11 portunity, the Secretary shall decertify such program and
12 assume responsibility under section 2101(a)(2) with re-
13 spect to plans in the State.

14 ‘‘(c) GAO AUDITS.—The Comptroller General of the
15 United States shall conduct periodic reviews on a sample
16 of State regulatory programs to determine their compli-
17 ance with the standards and requirements of this title.
18 The Comptroller General of the United States shall report
19 to the Secretary and Congress on the findings of such re-
20 views.

21 ‘‘DEFINITIONS

22 ‘‘SEC. 2103. (a) HEALTH INSURANCE PLAN.—As
23 used in this title, the term ‘health insurance plan’ means
24 any hospital or medical service policy or certificate, hos-
25 pital or medical service plan contract, health maintenance

1 organization group contract, or a multiple employer wel-
2 fare arrangement, but does not include—
3 ‘‘(1) a self-insured group health plan;
4 ‘‘(2) a self-insured multiemployer group health
5 plan; or
6 ‘‘(3) any of the following offered by an in-
7 surer—
8 ‘‘(A) accident only, dental only, vision only,
9 disability only insurance, or long-term care only
10 insurance,
11 ‘‘(B) coverage issued as a supplement to li-
12 ability insurance,
13 ‘‘(C) medicare supplemental insurance as
14 defined in section 1882(g)(1),
15 ‘‘(D) workmen's compensation or similar
16 insurance, or
17 ‘‘(E) automobile medical-payment insur-
18 ance.
19 In the case of a multiple employer welfare arrangement
20 that is fully insured, the requirements of this Act shall
21 only apply to the insurer of the arrangement.
22 ‘‘(b) INSURER.—As used in this title the term ‘in-
23 surer' means any person that offers a health insurance
24 plan to a small employer.
25 ‘‘(c) GENERAL DEFINITIONS.—As used in this title:

1 "(1) APPLICABLE REGULATORY AUTHORITY.—
2 The term 'applicable regulatory authority' means—
3 "(A) in the case of a health insurance plan
4 offered in a State with a program meeting the
5 requirements of part B of this title, the State
6 commissioner or superintendent of insurance or
7 other State authority responsible for regulation
8 of health insurance; or
9 "(B) in the case of a health insurance plan
10 certified by the Secretary under section
11 2101(a)(2), the Secretary.
12 "(2) SMALL EMPLOYER.—The term 'small em-
13 ployer' means, with respect to a calendar year, an
14 employer that normally employs more than 1 but
15 less than 101 eligible employees on a typical busi-
16 ness day. For the purposes of this paragraph, the
17 term 'employee' includes a self-employed individual.
18 "(3) ELIGIBLE EMPLOYEE.—The term 'eligible
19 employee' means, with respect to an employer, an
20 employee who normally performs on a monthly basis
21 at least 30 hours of service per week for that em-
22 ployer.
23 "(4) NAIC.—The term 'NAIC' means the Na-
24 tional Association of Insurance Commissioners.

1 "(5) STATE.—The term 'State' means each of
2 the several States, the District of Columbia, and the
3 Commonwealth of Puerto Rico.

4 "PART B—SMALL EMPLOYER HEALTH INSURANCE
5 REFORM

6 "GENERAL REQUIREMENTS FOR HEALTH INSURANCE
7 PLANS ISSUED TO SMALL EMPLOYERS

8 "SEC. 2111. (a) REGISTRATION WITH APPLICABLE
9 REGULATORY AUTHORITY.—Each insurer shall register
10 with the applicable regulatory authority for each State in
11 which it issues or offers a health insurance plan to small
12 employers.

13 "(b) GUARANTEED ELIGIBILITY.—

14 "(1) IN GENERAL.—No insurer may exclude
15 from coverage any eligible employee, or the spouse
16 or any dependent child of the eligible employee, to
17 whom coverage is made available by a small em-
18 ployer.

19 "(2) WAITING PERIODS.—Paragraph (1) shall
20 not apply to any period an eligible employee is ex-
21 cluded from coverage under the health insurance
22 plan solely by reason of a requirement imposed by
23 an employer applicable to all employees that a mini-
24 mum period of service with the small employer is re-

1 quired before the employee is eligible for such cov-
2 erage.

3 ''(c) GUARANTEED AVAILABILITY.—

4 ''(1) IN GENERAL.—Subject to the succeeding
5 provisions of this subsection, an insurer that offers
6 a health insurance plan to small employers located
7 in a State must meet the standards adopted by the
8 State described in paragraph (2).

9 ''(2) STANDARDS ON GUARANTEED AVAILABIL-
10 ITY.—

11 ''(A) IN GENERAL.—In order to implement
12 the requirements of this title, the standards de-
13 veloped under paragraphs (1) and (2) of section
14 2102(a) shall—

15 ''(i) require that a State adopt a
16 mechanism for guaranteeing the availabil-
17 ity of health insurance plans for all small
18 employers in the State,

19 ''(ii) specify alternative mechanisms,
20 including at least the alternative mecha-
21 nisms described in subparagraph (B), that
22 a State may adopt, and

23 ''(iii) prohibit marketing or other
24 practices by an insurer intended to dis-
25 courage or limit the issuance of a health

1 insurance plan to a small employer on the
2 basis of size, industry, geographic area, ex-
3 pected need for health services, or other
4 risk factors.
5 "(B) ALTERNATIVE MECHANISMS.—The
6 alternative mechanisms described in this sub-
7 paragraph are:
8 "(i) A mechanism under which the
9 State—
10 "(I) requires that any insurer of-
11 fering a health insurance plan to a
12 small employer in the State shall offer
13 the same plan to all other small em-
14 ployers in the State or in the portion
15 of the State established as the insur-
16 er's geographic service area (as ap-
17 proved by the State), and
18 "(II) requires the participation of
19 all such insurers in a small employer
20 reinsurance program established by
21 the State.
22 "(ii) A mechanism under which the
23 State—
24 "(I) requires that any insurer of-
25 fering a health insurance plan to a

1 small employer in the State shall offer
2 the same plan to all other small em-
3 ployers in the State or in the portion
4 of the State established as the insur-
5 er's geographic service area (as ap-
6 proved by the State), and
7 ''(II) permits any such insurer to
8 participate in a small employer rein-
9 surance program established by the
10 State.
11 ''(iii) A mechanism under which the
12 State requires that any insurer offering a
13 health insurance plan to a small employer
14 in the State shall participate in a program
15 for assigning high-risk groups among all
16 such insurers.
17 ''(iv) A mechanism under which the
18 State requires that any insurer that—
19 ''(I) offers a health insurance
20 plan to a small employer in the State,
21 and
22 ''(II) does not agree to offer the
23 same plan to all other small employers
24 in the State or in the portion of the
25 State established as the insurer's geo-

1 graphic service area (as approved by
2 the State),
3 shall participate in a program for assign-
4 ing high-risk groups among all such insur-
5 ers.
6 ''(C) STATE ADOPTION OF CERTAIN
7 STANDARDS.—A regulatory program adopted by
8 the State under section 2101 must provide—
9 ''(i) for the adoption of one of the
10 mechanisms described in clauses (i)
11 through (iv) of subparagraph (B), or
12 ''(ii) for such other program that
13 guarantees availability of health insurance
14 to all small employers in the State and is
15 approved by the Secretary.
16 ''(D) STANDARDS FOR NONCOMPLYING
17 STATES.—The Secretary, in consultation with
18 the Secretary of the Treasury, shall develop re-
19 quirements with respect to guaranteed availabil-
20 ity to apply with respect to insurers located in
21 a State that has not adopted the standards
22 under section 2102 and who wish to apply for
23 certification under section 2101(a)(2).
24 ''(3) GROUNDS FOR REFUSAL TO RENEW.—

1 ''(A) IN GENERAL.—An insurer may refuse
2 to renew, or (except with respect to clause (iii))
3 may terminate, a health insurance plan under
4 this part only for—
5 ''(i) nonpayment of premiums,
6 ''(ii) fraud or misrepresentation,
7 ''(iii) failure to maintain minimum
8 participation rates (consistent with sub-
9 paragraph (B)), or
10 ''(iv) repeated misuse of a provider
11 network provision.
12 ''(B) MINIMUM PARTICIPATION RATES.—
13 An insurer may require, with respect to a
14 health insurance plan issued to a small em-
15 ployer, that a minimum percentage of eligible
16 employees who do not otherwise have health in-
17 surance are enrolled in such plan if such per-
18 centage is applied uniformly to all plans offered
19 to employers of comparable size.
20 ''(d) GUARANTEED RENEWABILITY.—
21 ''(1) IN GENERAL.—An insurer shall ensure
22 that a health insurance plan issued to a small em-
23 ployer be renewed, at the option of the small em-
24 ployer, unless the plan is terminated for a reason
25 specified in paragraph (2) or in subsection (c)(3)(A).

1 "(2) TERMINATION OF SMALL EMPLOYER BUSI-
2 NESS.—An insurer is not required to renew a health
3 insurance plan with respect to a small employer if
4 the insurer—
5 "(A) elects not to renew all of its health
6 insurance plans issued to small employers in a
7 State; and
8 "(B) provides notice to the applicable regu-
9 latory authority in the State and to each small
10 employer covered under a plan of such termi-
11 nation at least 180 days before the date of expi-
12 ration of the plan.
13 In the case of such a termination, the insurer may
14 not provide for issuance of any health insurance plan
15 to a small employer in the State during the 5-year
16 period beginning on the date of termination of the
17 last plan not so renewed.
18 "(e) NO DISCRIMINATION BASED ON HEALTH STA-
19 TUS FOR CERTAIN SERVICES.—
20 "(1) IN GENERAL.—Except as provided under
21 paragraph (2), a health insurance plan offered to a
22 small employer by an insurer may not deny, limit, or
23 condition the coverage under (or benefits of) the
24 plan based on the health status, claims experience,

1 receipt of health care, medical history, or lack of evi-
2 dence of insurability, of an individual.

3 ''(2) TREATMENT OF PREEXISTING CONDITION
4 EXCLUSIONS FOR ALL SERVICES.—

5 ''(A) IN GENERAL.—Subject to the suc-
6 ceeding provisions of this paragraph, a health
7 insurance plan offered to a small employer by
8 an insurer may exclude coverage with respect to
9 services related to treatment of a preexisting
10 condition, but the period of such exclusion may
11 not exceed 6 months. The exclusion of coverage
12 shall not apply to services furnished to
13 newborns.

14 ''(B) CREDITING OF PREVIOUS COV-
15 ERAGE.—

16 ''(i) IN GENERAL.—A health insur-
17 ance plan issued to a small employer by an
18 insurer shall provide that if an individual
19 under such plan is in a period of continu-
20 ous coverage (as defined in clause (ii)(I))
21 with respect to particular services as of the
22 date of initial coverage under such plan,
23 any period of exclusion of coverage with re-
24 spect to a preexisting condition for such
25 services or type of services shall be reduced

1 by 1 month for each month in the period
2 of continuous coverage.
3 ''(ii) DEFINITIONS.—As used in this
4 subparagraph:
5 ''(I) PERIOD OF CONTINUOUS
6 COVERAGE.—The term 'period of con-
7 tinuous coverage' means, with respect
8 to particular services, the period be-
9 ginning on the date an individual is
10 enrolled under a health insurance
11 plan, title XVIII, title XIX, or other
12 health benefit arrangement including
13 a self-insured plan which provides
14 benefits with respect to such services
15 and ends on the date the individual is
16 not so enrolled for a continuous period
17 of more than 3 months.
18 ''(II) PREEXISTING CONDI-
19 TION.—The term 'preexisting condi-
20 tion' means, with respect to coverage
21 under a health insurance plan issued
22 to a small employer by an insurer, a
23 condition which has been diagnosed or
24 treated during the 3-month period
25 ending on the day before the first date

of such coverage (without regard to any waiting period).

''REQUIREMENTS RELATED TO RESTRICTIONS ON RATING PRACTICES

''SEC. 2112. (a) LIMIT ON VARIATION OF PREMIUMS BETWEEN BLOCKS OF BUSINESS.—

''(1) IN GENERAL.—The base premium rate for any block of business of an insurer (as defined in section 2103(b)(1)) may not exceed the base premium rate for any other block of business by more than 20 percent.

''(2) EXCEPTIONS.—Paragraph (1) shall not apply to a block of business if the applicable regulatory authority determines that—

''(A) the block is one for which the insurer does not reject, and never has rejected, small employers included within the definition of employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claims experience, health status, industry, or occupation,

''(B) the insurer does not transfer, and never has transferred, a health insurance plan involuntarily into or out of the block of business, and

1 ''(C) health insurance plans offered under
2 the block of business are currently available for
3 purchase by small employers at the time an ex-
4 ception to paragraph (1) is sought by the in-
5 surer.

6 ''(b) LIMIT ON VARIATION IN PREMIUM RATES
7 WITHIN A BLOCK OF BUSINESS.—For a block of business
8 of an insurer, the highest premium rates charged during
9 a rating period to small employers with similar demo-
10 graphic characteristics (limited to age, sex, family size,
11 and geography and not relating to claims experience,
12 health status, industry, occupation, or duration of cov-
13 erage since issue) for the same or similar coverage, or the
14 highest rates which could be charged to such employers
15 under the rating system for that block of business, shall
16 not exceed an amount that is 1.5 times the base premium
17 rate for the block of business for a rating period (or por-
18 tion thereof) that occurs in the first 3 years in which this
19 section is in effect, and 1.35 times the base premium rate
20 thereafter.

21 ''(c) CONSISTENT APPLICATION OF RATING FAC-
22 TORS.—In establishing premium rates for health insur-
23 ance plans offered to small employers—

24 ''(1) an insurer making adjustments with re-
25 spect to age, sex, family size, or geography must

1 apply such adjustments consistently across small
2 employers (as provided in guidelines developed under
3 section 2102(a)(4)), and
4 ‘‘(2) no insurer may use a geographic area that
5 is smaller than a county or smaller than an area
6 that includes all areas in which the first three digits
7 of the zip code are identical, whichever is smaller.
8 ‘‘(d) LIMIT ON TRANSFER OF EMPLOYERS AMONG
9 BLOCKS OF BUSINESS.—
10 ‘‘(1) IN GENERAL.—An insurer may not trans-
11 fer a small employer from one block of business to
12 another without the consent of the employer.
13 ‘‘(2) OFFERS TO TRANSFER.—An insurer may
14 not offer to transfer a small employer from one
15 block of business to another unless—
16 ‘‘(A) the offer is made without regard to
17 age, sex, geography, claims experience, health
18 status, industry, occupation or the date on
19 which the policy was issued, and
20 ‘‘(B) the same offer is made to all other
21 small employers in the same block of business.
22 ‘‘(e) LIMITS ON VARIATION IN PREMIUM IN-
23 CREASES.—The percentage increase in the premium rate
24 charged to a small employer for a new rating period (de-
25 termined on an annual basis) may not exceed the sum of

1 the percentage change in the base premium rate plus 5
2 percentage points.
3 ‘‘(f) DEFINITIONS.—In this section:
4 ‘‘(1) BASE PREMIUM RATE.—The term ‘base
5 premium rate’ means, for each block of business for
6 each rating period, the lowest premium rate which
7 could have been charged under a rating system for
8 that block of business by the insurer to small em-
9 ployers with similar demographic or other relevant
10 characteristics (limited to age, sex, family size, and
11 geography and not relating to claims experience,
12 health status, industry, occupation or duration of
13 coverage since issue) for health insurance plans with
14 the same or similar coverage.
15 ‘‘(2) BLOCK OF BUSINESS.—
16 ‘‘(A) IN GENERAL.—Except as provided in
17 subparagraph (B), the term ‘block of business’
18 means, with respect to an insurer, all of the
19 small employers with a health insurance plan is-
20 sued by the insurer (as shown on the records of
21 the insurer).
22 ‘‘(B) DISTINCT GROUPS.—
23 ‘‘(i) IN GENERAL.—Subject to clause
24 (ii), a distinct group of small employers
25 with health insurance plans issued by an

1 insurer may be treated as a block of busi-
2 ness by such insurer if all of the plans in
3 such group—
4 ‘‘(I) are marketed and sold
5 through individuals and organizations
6 that do not participate in the market-
7 ing or sale of other distinct groups by
8 the insurer,
9 ‘‘(II) have been acquired from
10 another insurer as a distinct group, or
11 ‘‘(III) are provided through an
12 association with membership of not
13 less than 25 small employers that has
14 been formed for purposes other than
15 obtaining health insurance.
16 ‘‘(ii) LIMITATION.—An insurer may
17 not establish more than six distinct groups
18 of small employers.
19 ‘‘(f) FULL DISCLOSURE OF RATING PRACTICES.—
20 ‘‘(1) IN GENERAL.—At the time an insurer of-
21 fers a health insurance plan to a small employer, the
22 insurer shall fully disclose to the employer all of the
23 following:
24 ‘‘(A) Rating practices for small employer
25 health insurance plans, including rating prac-

1 tices for different populations and benefit de-
2 signs.
3 ‘‘(B) The extent to which premium rates
4 for the small employer are established or ad-
5 justed based upon the actual or expected vari-
6 ation in claims costs or health condition of the
7 employees of such small employer and their de-
8 pendents.
9 ‘‘(C) The provisions concerning the insur-
10 er's right to change premium rates, the extent
11 to which premiums can be modified, and the
12 factors which affect changes in premium rates.
13 ‘‘(2) NOTICE ON EXPIRATION.—An insurer pro-
14 viding health insurance plans to small employers
15 shall provide for notice, at least 60 days before the
16 date of expiration of the health insurance plan, of
17 the terms for renewal of the plan. Such notice shall
18 include an explanation of the extent to which any in-
19 crease in premiums is due to actual or expected
20 claims experience of the individuals covered under
21 the small employer's health insurance plan contract.
22 ‘‘(g) ACTUARIAL CERTIFICATION.—Each insurer
23 shall file annually with the applicable regulatory authority
24 a written statement by a member of the American Acad-
25 emy of Actuaries (or other individual acceptable to such

authority) certifying that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for small employer health insurance plans—

"(1) the insurer is in compliance with the applicable provisions of this section, and

"(2) the rating methods are actuarially sound.

Each insurer shall retain a copy of such statement for examination at its principal place of business.

"REQUIREMENTS FOR SMALL EMPLOYER HEALTH INSURANCE BENEFIT PACKAGE OFFERINGS

"SEC. 2113. (a) BASIC AND STANDARD BENEFIT PACKAGES.—

"(1) IN GENERAL.—If an insurer offers any health insurance plan to small employers in a State, the insurer shall also offer a health insurance plan providing for the standard benefit package defined in subsection (b) and a health insurance plan providing for the basic benefit package defined in subsection (c).

"(2) MANAGED CARE OPTION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), if an insurer offers any health insurance plan to small employers in a State and also offers a managed care plan in

1 the State or a geographic area within the State
2 to employers that are not small employers, the
3 insurer must offer a similar managed care plan
4 to small employers in the State or geographic
5 area.

6 ''(B) SIZE LIMITS.—An insurer may cease
7 enrolling new small employer groups in all or a
8 portion of the insurer's service area for a man-
9 aged care plan if it ceases to enroll any new
10 employer groups within the service area or
11 within a portion of a service area of such plan.

12 ''(b) STANDARD BENEFIT PACKAGE.—

13 ''(1) IN GENERAL.—

14 ''(A) PACKAGE DEFINED.—Except as oth-
15 erwise provided in this section, a health insur-
16 ance plan providing for a standard benefit
17 package shall be limited to payment for—

18 ''(i) inpatient and outpatient hospital
19 care, except that treatment for a mental
20 disorder, as defined in subparagraph
21 (B)(i), is subject to the special limitations
22 described in clause (v)(I);

23 ''(ii) inpatient and outpatient physi-
24 cian services, as defined in subparagraph
25 (B)(ii), except that psychotherapy or coun-

1 seling for a mental disorder is subject to
2 the special limitations described in clause
3 (v)(II);
4 ''(iii) diagnostic tests;
5 ''(iv) preventive services limited to—
6 ''(I) prenatal care and well-baby
7 care provided to children who are 1
8 year of age or younger;
9 ''(II) well-child care;
10 ''(III) Pap smears;
11 ''(IV) mammograms; and
12 ''(V) colorectal screening services;
13 and
14 ''(v)(I) inpatient hospital care for a
15 mental disorder for not less than 45 days
16 per year, except that days of partial hos-
17 pitalization or residential care may be sub-
18 stituted for days of inpatient care; and
19 ''(II) outpatient psychotherapy and
20 counseling for a mental disorder for not
21 less than 20 visits per year provided by a
22 provider who is acting within the scope of
23 State law and who—
24 ''(aa) is a physician; or

1 ''(bb) is a duly licensed or cer-
2 tified clinical psychologist or a duly li-
3 censed or certified clinical social work-
4 er, a duly licensed or certified equiva-
5 lent mental health professional, or a
6 clinic or center providing duly licensed
7 or certified mental health services.
8 ''(B) DEFINITIONS.—For purposes of this
9 paragraph:
10 ''(i) MENTAL DISORDER.—The term
11 'mental disorder' has the same meaning
12 given such term in the International Clas-
13 sification of Diseases, 9th Revision, Clini-
14 cal Modification.
15 ''(ii) PHYSICIAN SERVICES.—The term
16 'physician services' means professional
17 medical services lawfully provided by a
18 physician under State medical practice
19 acts, and includes professional services
20 provided by a dentist, licensed advanced-
21 practice nurse, physician assistant, optom-
22 etrist, podiatrist, or chiropractor acting
23 within the scope of their practices (as de-
24 termined under State law) if such services

1 would be treated as physician services if
2 furnished by a physician.
3 ''(2) AMOUNT, SCOPE, AND DURATION OF CER-
4 TAIN BENEFITS.—
5 ''(A) IN GENERAL.—Except as provided in
6 subparagraph (B) and in paragraph (3), a
7 health insurance plan providing for a standard
8 benefit package shall place no limits on the
9 amount, scope, or duration of benefits described
10 in subparagraphs (A) through (C) of paragraph
11 (1).
12 ''(B) PREVENTIVE SERVICES.—A health
13 insurance plan providing for a standard benefit
14 package may limit the amount, scope, and du-
15 ration of preventive services described in sub-
16 paragraph (D) of paragraph (1) provided that
17 the amount, scope, and duration of such serv-
18 ices are reasonably consistent with rec-
19 ommendations and periodicity schedules devel-
20 oped by appropriate medical experts.
21 ''(3) EXCEPTIONS.—Paragraph (1) shall not be
22 construed as requiring a plan to include payment
23 for—
24 ''(A) items and services that are not medi-
25 cally necessary;

1 ‘‘(B) routine physical examinations or pre-
2 ventive care (other than care and services de-
3 scribed in subparagraph (D) of paragraph (1));
4 or
5 ‘‘(C) experimental services and procedures.
6 ‘‘(4) LIMITATION ON PREMIUMS.—
7 ‘‘(A) IN GENERAL.—Except as provided in
8 subparagraph (B), an insurer issuing a health
9 insurance plan providing for a standard benefit
10 package shall not require an employee to pay a
11 monthly premium which exceeds 20 percent of
12 the total monthly premium.
13 ‘‘(B) PART-TIME EMPLOYEE EXCEPTED.—
14 In the case of a part-time employee, an insurer
15 issuing a health insurance plan providing for a
16 standard benefit package may require that such
17 an employee pay a monthly premium that does
18 not exceed 50 percent of the total monthly pre-
19 mium.
20 ‘‘(5) LIMITATION ON DEDUCTIBLES.—
21 ‘‘(A) IN GENERAL.—Except as permitted
22 under subparagraph (B), a health insurance
23 plan providing for a standard benefit package
24 shall not provide a deductible amount for bene-
25 fits provided in any plan year that exceeds—

1 ‘‘(i) with respect to benefits payable
2 for items and services furnished to any em-
3 ployee with no family member enrolled
4 under the plan, for a plan year beginning
5 in—
6 ‘‘(I) a calendar year prior to
7 1995, $400; or
8 ‘‘(II) for a subsequent calendar
9 year, the limitation specified in this
10 clause for the previous calendar year
11 increased by the percentage increase
12 in the consumer price index for all
13 urban consumers (United States city
14 average, as published by the Bureau
15 of Labor Statistics) for the 12-month
16 period ending on September 30 of the
17 preceding calendar year; and
18 ‘‘(ii) with respect to benefits payable
19 for items and services furnished to any em-
20 ployee with a family member enrolled
21 under the standard benefit package plan,
22 for a plan year beginning in—
23 ‘‘(I) a calendar year prior to
24 1995, $400 per family member and
25 $700 per family; or

1 "(II) for a subsequent calendar
2 year, the limitation specified in this
3 clause for the previous calendar year
4 increased by the percentage increase
5 in the consumer price index for all
6 urban consumers (United States city
7 average, as published by the Bureau
8 of Labor Statistics) for the 12-month
9 period ending on September 30 of the
10 preceding calendar year.

11 If the limitation computed under clause (i)(II)
12 or (ii)(II) is not a multiple of $10, it shall be
13 rounded to the next highest multiple of $10.

14 "(B) WAGE-RELATED DEDUCTIBLE.—A
15 health insurance plan may provide for any other
16 deductible amount instead of the limitations
17 under—

18 "(i) subparagraph (A)(i), if such
19 amount does not exceed (on an annualized
20 basis) 1 percent of the total wages paid to
21 the employee in the plan year; or

22 "(ii) subparagraph (A)(ii), if such
23 amount does not exceed (on an annualized
24 basis) 1 percent per family member or 2

1 percent per family of the total wages paid
2 to the employee in the plan year.
3 ''(6) LIMITATION ON COPAYMENTS AND COIN-
4 SURANCE.—
5 ''(A) IN GENERAL.—Subject to subpara-
6 graphs (B) through (D), a health insurance
7 plan providing for a standard health benefit
8 package may not require the payment of any
9 copayment or coinsurance for an item or service
10 for which coverage is required under this sec-
11 tion—
12 ''(i) in an amount that exceeds 20
13 percent of the amount payable for the item
14 or service under the plan; or
15 ''(ii) after an employee and family
16 covered under the plan have incurred out-
17 of-pocket expenses under the plan that are
18 equal to the out-of-pocket limit (as defined
19 in subparagraph (E)(ii)) for a plan year.
20 ''(B) EXCEPTION FOR MANAGED CARE
21 PLANS.—A health insurance plan that is a man-
22 aged care plan may require payments in excess
23 of the amount permitted under subparagraph
24 (A) in the case of items and services furnished
25 by nonparticipating providers.

1 “(C) EXCEPTION FOR IMPROPER UTILIZA-
2 TION.—A health insurance plan may provide for
3 copayment or coinsurance in excess of the
4 amount permitted under subparagraph (A) for
5 any item or service that an individual obtains
6 without complying with procedures established
7 by a managed care plan or under a utilization
8 program to ensure the efficient and appropriate
9 utilization of covered services.
10 “(D) EXCEPTIONS FOR MENTAL HEALTH
11 CARE.—In the case of care described in para-
12 graph (1)(E)(ii), a health insurance plan shall
13 not require payment of any copayment or coin-
14 surance for an item or service for which cov-
15 erage is required by this part in an amount that
16 exceeds 50 percent of the amount payable for
17 the item or service.
18 “(7) LIMIT ON OUT-OF-POCKET EXPENSES.—
19 “(A) OUT-OF-POCKET EXPENSES DE-
20 FINED.—As used in this section, the term ‘out-
21 of-pocket expenses’ means, with respect to an
22 employee in a plan year, amounts payable under
23 the plan as deductibles and coinsurance with re-
24 spect to items and services provided under the
25 plan and furnished in the plan year on behalf

1 of the employee and family covered under the
2 plan.
3 "(B) OUT-OF-POCKET LIMIT DEFINED.—
4 As used in this section and except as provided
5 in subparagraph (C), the term 'out-of-pocket
6 limit' means for a plan year beginning in—
7 "(i) a calendar year prior to 1995,
8 $3,000; or
9 "(ii) for a subsequent calendar year,
10 the limit specified in this subparagraph for
11 the previous calendar year increased by the
12 percentage increase in the consumer price
13 index for all urban consumers (United
14 States city average, as published by the
15 Bureau of Labor Statistics) for the 12-
16 month period ending on September 30 of
17 the preceding calendar year.
18 If the limit computed under clause (ii) is not a
19 multiple of $10, it shall be rounded to the next
20 highest multiple of $10.
21 "(C) ALTERNATIVE OUT-OF-POCKET
22 LIMIT.—A health insurance plan may provide
23 for an out-of-pocket limit other than that de-
24 fined in subparagraph (B) if, for a plan year
25 with respect to an employee and the family of

1 the employee, the limit does not exceed (on an
2 annualized basis) 10 percent of the total wages
3 paid to the employee in the plan year.
4 ''(8) LIMITED PREEMPTION OF STATE MAN-
5 DATED BENEFITS.—No State law or regulation in
6 effect in a State that requires health insurance plans
7 offered to small employers in the State to include
8 specified items and services other than those speci-
9 fied by this subsection shall apply with respect to a
10 health insurance plan providing for a standard bene-
11 fit package offered by an insurer to a small em-
12 ployer. A State law or regulation requiring the cov-
13 erage of newborns, adopted children or other speci-
14 fied categories of dependents shall continue to apply.
15 ''(c) BASIC BENEFITS PACKAGE.—
16 ''(1) IN GENERAL.—A health insurance plan
17 providing for a basic benefit package shall be limited
18 to payment for—
19 ''(A) inpatient and outpatient hospital
20 care, including emergency services;
21 ''(B) inpatient and outpatient physicians'
22 services;
23 ''(C) diagnostic tests; and
24 ''(D) preventive services (which may in-
25 clude one or more of the following services)—

1 ''(i) prenatal care and well-baby care
2 provided to children who are 1 year of age
3 or younger;
4 ''(ii) well-child care;
5 ''(iii) Pap smears;
6 ''(iv) mammograms; and
7 ''(v) colorectal screening services.
8 Nothing in this paragraph shall prohibit a basic
9 health benefit package from including coverage for
10 treatment of a mental disorder.
11 ''(2) COST-SHARING.—Each health insurance
12 plan providing for the basic benefit package issued
13 to a small employer by an insurer may impose pre-
14 miums, deductibles, copayments, or other cost-shar-
15 ing on enrollees of such plan.
16 ''(3) OUT-OF-POCKET LIMIT.—Each health in-
17 surance plan providing for a basic benefit package
18 shall provide for a limit on out-of-pocket expenses.
19 ''(4) LIMITED PREEMPTION OF STATE MAN-
20 DATED BENEFITS.—No State law or regulation in
21 effect in a State that requires health insurance plans
22 offered to small employers in the State to include
23 specified items and services other than those de-
24 scribed in this subsection shall apply with respect to
25 a health insurance plan providing for a basic benefit

1 package offered by an insurer to a small employer.
2 A State law or regulation requiring the coverage of
3 newborns, adopted children or other specified cat-
4 egories of dependents shall continue to apply.''.

5 **PART II—TAX PENALTY ON NONCOMPLYING**
6 **INSURERS**

7 **SEC. 221. EXCISE TAX ON PREMIUMS RECEIVED ON**
8 **HEALTH INSURANCE POLICIES WHICH DO**
9 **NOT MEET CERTAIN REQUIREMENTS.**

10 (a) IN GENERAL.—Chapter 47 of the Internal Reve-
11 nue Code of 1986 (relating to taxes on group health plans)
12 is amended by adding at the end thereof the following new
13 section:

14 **"SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS**
15 **FOR HEALTH INSURANCE.**

16 ''(a) GENERAL RULE.—In the case of any person is-
17 suing a health insurance plan to a small employer, there
18 is hereby imposed a tax on the failure of such person to
19 meet at any time during any taxable year the applicable
20 requirements of title XXI of the Social Security Act. The
21 Secretary of Health and Human Services shall determine
22 whether any person meets the requirements of such title.
23 ''(b) AMOUNT OF TAX.—
24 ''(1) IN GENERAL.—The amount of tax imposed
25 by subsection (a) by reason of 1 or more failures

1 during a taxable year shall be equal to 25 percent
2 of the gross premiums received during such taxable
3 year with respect to all health insurance plans issued
4 to a small employer by the person on whom such tax
5 is imposed.

6 ''(2) GROSS PREMIUMS.—For purposes of para-
7 graph (1), gross premiums shall include any consid-
8 eration received with respect to any accident and
9 health insurance contract.

10 ''(3) CONTROLLED GROUPS.—For purposes of
11 paragraph (1)—

12 ''(A) CONTROLLED GROUP OF CORPORA-
13 TIONS.—All corporations which are members of
14 the same controlled group of corporations shall
15 be treated as 1 person. For purposes of the pre-
16 ceding sentence, the term 'controlled group of
17 corporations' has the meaning given to such
18 term by section 1563(a), except that—

19 ''(i) 'more than 50 percent' shall be
20 substituted for 'at least 80 percent' each
21 place it appears in section 1563(a)(1), and

22 ''(ii) the determination shall be made
23 without regard to subsections (a)(4) and
24 (e)(3)(C) of section 1563.

1 "(B) PARTNERSHIPS, PROPRIETORSHIPS,
2 ETC., WHICH ARE UNDER COMMON CONTROL.—
3 Under regulations prescribed by the Secretary,
4 all trades or business (whether or not incor-
5 porated) which are under common control shall
6 be treated as 1 person. The regulations pre-
7 scribed under this subparagraph shall be based
8 on principles similar to the principles which
9 apply in the case of subparagraph (A).
10 "(c) LIMITATION ON TAX.—
11 "(1) TAX NOT TO APPLY WHERE FAILURE NOT
12 DISCOVERED EXERCISING REASONABLE DILI-
13 GENCE.—No tax shall be imposed by subsection (a)
14 with respect to any failure for which it is established
15 to the satisfaction of the Secretary that the person
16 on whom the tax is imposed did not know, and exer-
17 cising reasonable diligence would not have known,
18 that such failure existed.
19 "(2) TAX NOT TO APPLY WHERE FAILURES
20 CORRECTED WITHIN 30 DAYS.—No tax shall be im-
21 posed by subsection (a) with respect to any failure
22 if—
23 "(A) such failure was due to reasonable
24 cause and not to willful neglect, and

1 ''(B) such failure is corrected during the
2 30-day period beginning on the 1st date any of
3 the persons on whom the tax is imposed knew,
4 or exercising reasonable diligence would have
5 known, that such failure existed.

6 ''(3) WAIVER BY SECRETARY.—In the case of a
7 failure which is due to reasonable cause and not to
8 willful neglect, the Secretary may waive part or all
9 of the tax imposed by subsection (a) to the extent
10 that the payment of such tax would be excessive rel-
11 ative to the failure involved.

12 ''(d) DEFINITIONS.—For purposes of this section:

13 ''(1) HEALTH INSURANCE PLAN.—The term
14 'health insurance plan' means any hospital or medi-
15 cal service policy or certificate, hospital or medical
16 service plan contract, health maintenance organiza-
17 tion group contract, or a multiple employer welfare
18 arrangement, but does not include—

19 ''(A) a self-insured group health plan;

20 ''(B) a self-insured multiemployer group
21 health plan; or

22 ''(C) any of the following:

23 ''(i) accident only, dental only, vision
24 only, disability only, or long-term care only
25 insurance,

1 ‘‘(ii) coverage issued as a supplement
2 to liability insurance,
3 ‘‘(iii) medicare supplemental insur-
4 ance as defined in section 1882(g)(1),
5 ‘‘(iv) workmen’s compensation or
6 similar insurance, or
7 ‘‘(v) automobile medical-payment in-
8 surance.
9 In the case of a multiple employer welfare arrange-
10 ment that is fully insured, this Act shall only apply
11 to the insurer of the arrangement.
12 ‘‘(2) SMALL EMPLOYER.—The term ‘small em-
13 ployer’ means, with respect to a calendar year, an
14 employer that normally employs more than 1 but
15 less than 101 eligible employees on a typical busi-
16 ness day. For the purposes of this paragraph, the
17 term ‘employee’ includes a self-employed individual.
18 ‘‘(3) ELIGIBLE EMPLOYEE.—The term ‘eligible
19 employee’ means, with respect to an employer, an
20 employee who normally performs on a monthly basis
21 at least 30 hours of service per week for that em-
22 ployer.
23 ‘‘(4) PERSON.—The term ‘person’ means any
24 person that offers a health insurance plan to a small
25 employer, including a licensed insurance company, a

1 prepaid hospital or medical service plan, a health
2 maintenance organization, or in States which have
3 distinct insurance licensure requirements, a multiple
4 employer welfare arrangement.''.

5 (b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of
6 section 275(a) of the Internal Revenue Code of 1986 (re-
7 lating to nondeductibility of certain taxes) is amended by
8 inserting ''47,'' after ''46,''.

9 (c) CLERICAL AMENDMENTS.—The table of sections
10 for such chapter 47 of the Internal Revenue Code of 1986
11 is amended by adding at the end thereof the following new
12 item:

''Sec. 5000A. Failure to satisfy certain standards for health insurance.''.

13 (d) EFFECTIVE DATES.—

14 (1) IN GENERAL.—The amendments made by
15 subsections (a) and (c) shall take effect on the date
16 of the enactment of this Act.

17 (2) NONDEDUCTIBILITY OF TAX.—The amend-
18 ment made by subsection (b) shall apply to taxable
19 years beginning after December 31, 1993.

1 **PART III—STUDIES AND REPORTS**

2 **SEC. 231. GAO STUDY AND REPORT ON RATING REQUIRE-**
3 **MENTS AND BENEFIT PACKAGES FOR SMALL**
4 **GROUP HEALTH INSURANCE.**

5 (a) IN GENERAL.—The Comptroller General of the
6 United States shall study and report to the Congress by
7 no later than January 1, 1996, on—
8 (1) the impact of the standards for rating prac-
9 tices for small group health insurance established
10 under section 2112 of the Social Security Act and
11 the requirements for benefit packages established
12 under section 2113 of such Act on the availability
13 and price of insurance offered to small employers,
14 differences in available benefit packages, the number
15 of small employers choosing standard or basic pack-
16 ages, and the impact of the standards on the num-
17 ber of small employers offering health insurance to
18 employees through a self-funded employer welfare
19 benefit plan; and
20 (2) differences in State laws and regulations af-
21 fecting the availability and price of health insurance
22 plans sold to individuals and the impact of such laws
23 and regulations, including the extension of require-
24 ments for health insurance plans sold to small em-
25 ployers in the State to individual health insurance

1 and the establishment of State risk pools for individ-
2 ual health insurance.

3 (b) RECOMMENDATIONS.—The Comptroller General
4 shall include in the report to Congress under this section
5 recommendations with respect to adjusting rating stand-
6 ards under section 2112 of the Social Security Act—

7 (1) to eliminate variation in premiums charged
8 to small employers resulting from adjustments for
9 such factors as claims experience and health status,
10 and

11 (2) to eliminate variation in premiums associ-
12 ated with age, sex, and other demographic factors.

13 Subtitle C—Improvements in Port-
14 ability of Private Health Insur-
15 ance

16 SEC. 241. EXCISE TAX IMPOSED ON FAILURE TO PROVIDE
17 FOR PREEXISTING CONDITION.

18 (a) IN GENERAL.—Chapter 47 of the Internal Reve-
19 nue Code of 1986 (relating to taxes on group health
20 plans), as amended by section 221, is amended by adding
21 at the end thereof the following new section:

1 **"SEC. 5000B. FAILURE TO SATISFY PREEXISTING CONDI-**
2 **TION REQUIREMENTS OF GROUP HEALTH**
3 **PLANS.**

4 ''(a) GENERAL RULE.—There is hereby imposed a
5 tax on the failure of—

6 ''(1) a group health plan to meet the require-
7 ments of subsection (e), or

8 ''(2) any person to meet the requirements of
9 subsection (f),

10 with respect to any covered individual.

11 ''(b) AMOUNT OF TAX.—

12 ''(1) IN GENERAL.—The amount of the tax im-
13 posed by subsection (a) on any failure with respect
14 to a covered individual shall be $100 for each day
15 in the noncompliance period with respect to such
16 failure.

17 ''(2) NONCOMPLIANCE PERIOD.—For purposes
18 of this section, the term 'noncompliance period'
19 means, with respect to any failure, the period—

20 ''(A) beginning on the date such failure
21 first occurs, and

22 ''(B) ending on the date such failure is
23 corrected.

24 ''(3) CORRECTION.—A failure of a group health
25 plan to meet the requirements of subsection (e) with

1 respect to any covered individual shall be treated as
2 corrected if—
3 ''(A) such failure is retroactively undone to
4 the extent possible, and
5 ''(B) the covered individual is placed in a
6 financial position which is as good as such indi-
7 vidual would have been in had such failure not
8 occurred.
9 For purposes of applying subparagraph (B), the cov-
10 ered individual shall be treated as if the individual
11 had elected the most favorable coverage in light of
12 the expenses incurred since the failure first oc-
13 curred.
14 ''(c) LIMITATIONS ON AMOUNT OF TAX.—
15 ''(1) TAX NOT TO APPLY WHERE FAILURE NOT
16 DISCOVERED EXERCISING REASONABLE DILI-
17 GENCE.—No tax shall be imposed by subsection (a)
18 on any failure during any period for which it is es-
19 tablished to the satisfaction of the Secretary that
20 none of the persons referred to in subsection (d)
21 knew, or exercising reasonable diligence would have
22 known, that such failure existed.
23 ''(2) TAX NOT TO APPLY TO FAILURES COR-
24 RECTED WITHIN 30 DAYS.—No tax shall be imposed
25 by subsection (a) on any failure if—

1 ''(A) such failure was due to reasonable
2 cause and not to willful neglect, and
3 ''(B) such failure is corrected during the
4 30-day period beginning on the first date any of
5 the persons referred to in subsection (d) knew,
6 or exercising reasonable diligence would have
7 known, that such failure existed.
8 ''(3) WAIVER BY SECRETARY.—In the case of a
9 failure which is due to reasonable cause and not to
10 willful neglect, the Secretary may waive part or all
11 of the tax imposed by subsection (a) to the extent
12 that the payment of such tax would be excessive rel-
13 ative to the failure involved.
14 ''(d) LIABILITY FOR TAX.—
15 ''(1) IN GENERAL.—Except as otherwise pro-
16 vided in this subsection, the following shall be liable
17 for the tax imposed by subsection (a) on a failure:
18 ''(A) In the case of a group health plan
19 other than a self-insured group health plan, the
20 issuer.
21 ''(B)(i) In the case of a self-insured group
22 health plan other than a multiemployer group
23 health plan, the employer.
24 ''(ii) In the case of a self-insured multiem-
25 ployer group health plan, the plan.

1 "(C) Each person who is responsible (other
2 than in a capacity as an employee) for admin-
3 istering or providing benefits under the group
4 health plan, health insurance plan, or other
5 health benefit arrangement (including a self-in-
6 sured plan) and whose act or failure to act
7 caused (in whole or in part) the failure.
8 "(2) SPECIAL RULES FOR PERSONS DESCRIBED
9 IN PARAGRAPH (1)(C).—A person described in sub-
10 paragraph (C) (and not in subparagraphs (A) and
11 (B)) of paragraph (1) shall be liable for the tax im-
12 posed by subsection (a) on any failure only if such
13 person assumed (under a legally enforceable written
14 agreement) responsibility for the performance of the
15 act to which the failure relates.
16 "(e) NO DISCRIMINATION BASED ON HEALTH STA-
17 TUS FOR CERTAIN SERVICES.—
18 "(1) IN GENERAL.—Except as provided under
19 paragraph (2), group health plans may not deny,
20 limit, or condition the coverage under (or benefits
21 of) the plan based on the health status, claims expe-
22 rience, receipt of health care, medical history, or
23 lack of evidence of insurability, of an individual.
24 "(2) TREATMENT OF PREEXISTING CONDITION
25 EXCLUSIONS FOR ALL SERVICES.—

1 "(A) IN GENERAL.—Subject to the suc-
2 ceeding provisions of this paragraph, group
3 health plans may exclude coverage with respect
4 to services related to treatment of a preexisting
5 condition, but the period of such exclusion may
6 not exceed 6 months. The exclusion of coverage
7 shall not apply to services furnished to
8 newborns.

9 "(B) CREDITING OF PREVIOUS COV-
10 ERAGE.—

11 "(i) IN GENERAL.—A group health
12 plan shall provide that if an individual
13 under such plan is in a period of continu-
14 ous coverage (as defined in clause (ii)(I))
15 with respect to particular services as of the
16 date of initial coverage under such plan
17 (determined without regard to any waiting
18 period under such plan), any period of ex-
19 clusion of coverage with respect to a pre-
20 existing condition for such services or type
21 of services shall be reduced by 1 month for
22 each month in the period of continuous
23 coverage without regard to any waiting pe-
24 riod.

1 "(ii) DEFINITIONS.—As used in this
2 subparagraph:
3 "(I) PERIOD OF CONTINUOUS
4 COVERAGE.—The term 'period of con-
5 tinuous coverage' means, with respect
6 to particular services, the period be-
7 ginning on the date an individual is
8 enrolled under a health insurance
9 plan, title XVIII or XIX of the Social
10 Security Act, or other health benefit
11 arrangement (including a self-insured
12 plan) which provides benefits with re-
13 spect to such services and ends on the
14 date the individual is not so enrolled
15 for a continuous period of more than
16 3 months.
17 "(II) PREEXISTING CONDI-
18 TION.—The term 'preexisting condi-
19 tion' means, with respect to coverage
20 under a group health plan, a condition
21 which has been diagnosed or treated
22 during the 3-month period ending on
23 the day before the first date of such
24 coverage without regard to any wait-
25 ing period.

1 "(f) DISCLOSURE OF COVERAGE, ETC.—Any person
2 who has provided coverage (other than under title XVIII
3 or XIX of the Social Security Act) during a period of con-
4 tinuous coverage (as defined in subsection (e)(2)(B)(ii)(I))
5 with respect to a covered individual shall disclose, upon
6 the request of a group health plan subject to the require-
7 ments of subsection (e), the coverage provided the covered
8 individual, the period of such coverage, and the benefits
9 provided under such coverage.
10 "(g) DEFINITIONS.—For purposes of this section—
11 "(1) COVERED INDIVIDUAL.—The term 'cov-
12 ered individual' means—
13 "(A) an individual who is (or will be) pro-
14 vided coverage under a group health plan by
15 virtue of the performance of services by the in-
16 dividual for 1 or more persons maintaining the
17 plan (including as an employee defined in sec-
18 tion 401(c)(1)), and
19 "(B) the spouse or any dependent child of
20 such individual.
21 "(2) GROUP HEALTH PLAN.—The term 'group
22 health plan' has the meaning given such term by
23 section 5000(b)(1).".
24 (b) CLERICAL AMENDMENT.—The table of sections
25 for such chapter 47 of the Internal Revenue Code of 1986

is amended by adding at the end thereof the following new item:

"Sec. 5000B. Failure to satisfy preexisting condition requirements of group health plans.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 1994.

Subtitle D—Health Care Cost Containment

SEC. 251. FEDERAL CERTIFICATION OF MANAGED CARE PLANS AND UTILIZATION REVIEW PROGRAMS.

Title XXI of the Social Security Act, as added by section 211, is amended by adding at the end the following part:

"PART C—FEDERAL CERTIFICATION OF MANAGED CARE PLANS

"FEDERAL CERTIFICATION OF MANAGED CARE PLANS AND UTILIZATION REVIEW PROGRAMS

"SEC. 2114. (a) VOLUNTARY CERTIFICATION PROCESS.—

"(1) CERTIFICATION.—The Secretary shall establish a process for certification of managed care plans meeting the requirements of subsection (b)(1) and of utilization review programs meeting the requirements of subsection (b)(2).

1 ''(2) QUALIFIED MANAGED CARE PLAN.—For
2 purposes of this title, the term 'qualified managed
3 care plan' means a managed care plan that the Sec-
4 retary certifies, upon application by the program, as
5 meeting the requirements of this section.
6 ''(3) QUALIFIED UTILIZATION REVIEW PRO-
7 GRAM.—For purposes of this title, the term 'quali-
8 fied utilization review program' means a utilization
9 review program that the Secretary certifies, upon
10 application by the program, as meeting the require-
11 ments of this section.
12 ''(4) UTILIZATION REVIEW PROGRAM.—For
13 purposes of this title, the term 'utilization review
14 program' means a system of reviewing the medical
15 necessity, appropriateness, or quality of health care
16 services and supplies covered under a health insur-
17 ance plan or a managed care plan using specified
18 guidelines. Such a system may include preadmission
19 certification, the application of practice guidelines,
20 continued stay review, discharge planning,
21 preauthorization of ambulatory procedures, and ret-
22 rospective review.
23 ''(5) MANAGED CARE PLAN.—
24 ''(A) IN GENERAL.—For purposes of this
25 title the term 'managed care plan' means a plan

1 operated by a managed care entity as described
2 in subparagraph (B), that arranges for the fi-
3 nancing and delivery of health care services to
4 persons covered under such plan through—
5 ‘‘(i) arrangements with participating
6 providers to furnish health care services;
7 ‘‘(ii) explicit standards for the selec-
8 tion of participating providers;
9 ‘‘(iii) organizational arrangements for
10 ongoing quality assurance and utilization
11 review programs; and
12 ‘‘(iv) financial incentives for persons
13 covered under the plan to use the partici-
14 pating providers and procedures provided
15 for by the plan.
16 ‘‘(B) MANAGED CARE ENTITY DEFINED.—
17 For purposes of this title, a managed care en-
18 tity includes a licensed insurance company, hos-
19 pital or medical service plan, health mainte-
20 nance organization, an employer, or employee
21 organization, or a managed care contractor as
22 described in subparagraph (C), that operates a
23 managed care plan.

1 "(C) MANAGED CARE CONTRACTOR DE-
2 FINED.—For purposes of this title, a managed
3 care contractor means a person that—
4 "(i) establishes, operates or maintains
5 a network of participating providers;
6 "(ii) conducts or arranges for utiliza-
7 tion review activities; and
8 "(iii) contracts with an insurance
9 company, a hospital or medical service
10 plan, an employer, an employee organiza-
11 tion, or any other entity providing coverage
12 for health care services to operate a man-
13 aged care plan.
14 "(6) PARTICIPATING PROVIDER.—The term
15 'participating provider' means a physician, hospital,
16 pharmacy, laboratory, or other appropriately licensed
17 provider of health care services or supplies, that has
18 entered into an agreement with a managed care en-
19 tity to provide such services or supplies to a patient
20 covered under a managed care plan.
21 "(7) REVIEW AND RECERTIFICATION.—The
22 Secretary shall establish procedures for the periodic
23 review and recertification of qualified managed care
24 plans and qualified utilization review programs.

1 "(8) TERMINATION OF CERTIFICATION.—The
2 Secretary shall terminate the certification of a quali-
3 fied managed care plan or a qualified utilization re-
4 view program if the Secretary determines that such
5 plan or program no longer meets the applicable re-
6 quirements for certification. Before effecting a ter-
7 mination, the Secretary shall provide the plan notice
8 and opportunity for a hearing on the proposed ter-
9 mination.

10 "(9) CERTIFICATION THROUGH ALTERNATIVE
11 REQUIREMENTS.—

12 "(A) CERTAIN ORGANIZATIONS RECOG-
13 NIZED.—An eligible organization as defined in
14 section 1876(b), shall be deemed to meet the
15 requirements of subsection (b) for certification
16 as a qualified managed care plan.

17 "(B) RECOGNITION OF ACCREDITATION.—
18 If the Secretary finds that a State licensure
19 program or a national accreditation body estab-
20 lishes a requirement or requirements for accred-
21 itation of a managed care plan or utilization re-
22 view program that are at least equivalent to a
23 requirement or requirements established under
24 subsection (b), the Secretary may, to the extent
25 he finds it appropriate, treat a managed care

plan or a utilization review program thus accredited as meeting the requirement or requirements of subsection (b) with respect to which he made such finding.

"(b) REQUIREMENTS FOR CERTIFICATION.—

"(1) MANAGED CARE PLANS.—The Secretary, in consultation with the Health Care Cost Commission, shall establish Federal standards for the certification of qualified managed care plans, including standards related to—

"(A) the qualification and selection of participating providers;

"(B) the number, type, and distribution of participating providers necessary to assure that all covered items and services are available and accessible to persons covered under a managed care plan in each service area;

"(C) the establishment and operation of an ongoing quality assurance program, which includes procedures for—

"(i) evaluating the quality and appropriateness of care;

"(ii) using the results of quality evaluations to promote and improve quality of care; and

1 ''(iii) resolving complaints from enroll-
2 ees regarding quality and appropriateness
3 of care;
4 ''(D) the provision of benefits for covered
5 items and services not furnished by participat-
6 ing providers if the items and services are medi-
7 cally necessary and immediately required be-
8 cause of an unforeseen illness, injury, or condi-
9 tion;
10 ''(E) the qualifications of individuals per-
11 forming utilization review activities;
12 ''(F) procedures and criteria for evaluating
13 the necessity and appropriateness of health care
14 services;
15 ''(G) the timeliness with which utilization
16 review determinations are to be made;
17 ''(H) procedures for the operation of an
18 appeals process which provides a fair oppor-
19 tunity for individuals adversely affected by a
20 managed care review determination to have
21 such determination reviewed;
22 ''(I) procedures for ensuring that all appli-
23 cable Federal and State laws designed to pro-
24 tect the confidentiality of individual medical
25 records are followed; and

1 ‘‘(J) payment of providers for the expenses
2 associated with responding to requests for in-
3 formation needed to conduct a utilization re-
4 view.
5 ‘‘(2) QUALIFIED UTILIZATION REVIEW PRO-
6 GRAMS.—The Secretary, in consultation with the
7 Health Care Cost Commission, shall establish Fed-
8 eral standards for the certification of qualified utili-
9 zation review programs, including standards related
10 to—
11 ‘‘(A) the qualifications of individuals per-
12 forming utilization review activities;
13 ‘‘(B) procedures and criteria for evaluating
14 the necessity and appropriateness of health care
15 services;
16 ‘‘(C) the timeliness with which utilization
17 review determinations are to be made;
18 ‘‘(D) procedures for the operation of an
19 appeals process which provides a fair oppor-
20 tunity for individuals adversely affected by a
21 utilization review determination to have such
22 determination reviewed;
23 ‘‘(E) procedures for ensuring that all ap-
24 plicable Federal and State laws designed to pro-

1 tect the confidentiality of individual medical
2 records are followed; and
3 ''(F) payment of providers for the expenses
4 associated with responding to requests for in-
5 formation needed to conduct a utilization re-
6 view.
7 ''(3) APPLICATION OF STANDARDS.—
8 ''(A) IN GENERAL.—Standards shall first
9 be established under this subsection by not later
10 than 24 months after the date of the enactment
11 of this section. In developing standards under
12 this subsection, the Secretary shall—
13 ''(i) review standards in use by na-
14 tional private accreditation organizations
15 and State licensure programs;
16 ''(ii) recognize, to the extent appro-
17 priate, differences in the organizational
18 structure and operation of managed care
19 plans; and
20 ''(iii) establish procedures for the
21 timely consideration of applications for cer-
22 tification by managed care plans and utili-
23 zation review programs.
24 ''(B) REVISION OF STANDARDS.—The Sec-
25 retary shall periodically review the standards

1 established under this subsection, taking into
2 account recommendations by the Health Care
3 Cost Commission, and may revise the standards
4 from time to time to assure that such standards
5 continue to reflect appropriate policies and
6 practices for the cost-effective and medically ap-
7 propriate use of services within managed care
8 plans and utilization review programs.

9 ''(c) LIMITATION ON STATE RESTRICTIONS ON
10 QUALIFIED MANAGED CARE PLANS AND UTILIZATION
11 REVIEW PROGRAMS.—

12 ''(1) IN GENERAL.—No requirement of any
13 State law or regulation shall—

14 ''(A) prohibit or limit a qualified managed
15 care plan from including financial incentives for
16 covered persons to use the services of partici-
17 pating providers;

18 ''(B) prohibit or limit a qualified managed
19 care plan from restricting coverage of services
20 to those—

21 ''(i) provided by a participating pro-
22 vider; or

23 ''(ii) authorized by a designated par-
24 ticipating provider;

25 ''(C) subject to paragraph (2)—

1 ''(i) restrict the amount of payment
2 made by a qualified managed care plan to
3 participating providers for items and serv-
4 ices provided to covered persons; or
5 ''(ii) restrict the ability of a qualified
6 managed care plan to pay participating
7 providers for items and services provided
8 to covered persons on a per capita basis;
9 ''(D) prohibit or limit a qualified managed
10 care plan from restricting the location, number,
11 type, or professional qualifications of participat-
12 ing providers;
13 ''(E) prohibit or limit a qualified managed
14 care plan from requiring that items and services
15 be authorized by a primary care physician se-
16 lected by the covered person from a list of avail-
17 able participating providers;
18 ''(F) prohibit or limit the use of utilization
19 review procedures or criteria by a qualified uti-
20 lization review program or a qualified managed
21 care plan;
22 ''(G) require a qualified utilization review
23 program or a qualified managed care plan to
24 make public utilization review procedures or cri-
25 teria;

1 ‘‘(H) prohibit or limit a qualified utiliza-
2 tion review program or a qualified managed
3 care plan from determining the location or
4 hours of operation of a utilization review, pro-
5 vided that emergency services furnished during
6 the hours in which the utilization review pro-
7 gram is not open are not subject to utilization
8 review;

9 ‘‘(I) require a qualified utilization review
10 program or a qualified managed care plan to
11 pay providers for the expenses associated with
12 responding to requests for information needed
13 to conduct utilization review, other than as pro-
14 vided in standards for qualified managed care
15 plans and qualified utilization review programs;

16 ‘‘(J) restrict the amount of payment made
17 to a qualified utilization review program or a
18 qualified managed care plan for the conduct of
19 utilization review;

20 ‘‘(K) restrict access by a qualified utiliza-
21 tion review program or a qualified managed
22 care plan to medical information or personnel
23 required to conduct utilization review;

1 ''(L) define utilization review as the prac-
2 tice of medicine or another health care profes-
3 sion; or
4 ''(M) require that utilization review be con-
5 ducted (i) by a resident of the State in which
6 the treatment is to be offered or by an individ-
7 ual licensed in such State, or (ii) by a physician
8 in any particular specialty or with any board
9 certified specialty of the same medical specialty
10 as the provider whose services are being ren-
11 dered.
12 ''(2) EXCEPTIONS TO CERTAIN REQUIRE-
13 MENTS.—
14 ''(A) SUBPARAGRAPH (C).—Subparagraph
15 (C) shall not apply where the amount of pay-
16 ments with respect to a block of services or pro-
17 viders is established under a statewide system
18 applicable to all non-Federal payors with re-
19 spect to such services or providers.
20 ''(B) SUBPARAGRAPHS (L) AND (M).—
21 Nothing in subparagraphs (L) or (M) shall be
22 construed as prohibiting a State from (i) re-
23 quiring that utilization review be conducted by
24 a licensed health care professional or (ii) requir-
25 ing that any appeal from such a review be made

by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

''(3) RELATIONSHIP TO MEDICAID PROGRAM.—Nothing in paragraph (1) shall be construed as prohibiting a State from imposing requirements on managed care plans or utilization review programs that are necessary to conform with the requirements of title XIX of the Social Security Act with respect to services provided to, or with respect to, individuals receiving medical assistance under such title.''.

TITLE III—HEALTH INSURANCE COSTS FOR SELF-EMPLOYED

SEC. 301. HEALTH INSURANCE COSTS FOR SELF-EMPLOYED.

(a) PERMANENT EXTENSION.—Section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(b) INCREASE IN DEDUCTION.—Section 162(l)(1) of the Internal Revenue Code of 1986 is amended by striking ''25 percent of''.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1994.

○

S 1978 IS——2

S 1978 IS——3

S 1978 IS——4

S 1978 IS——5

S 1978 IS——6