104TH CONGRESS
2D SESSION

H. R. 3130

To assure availability and continuity of health insurance and to simplify the administration of health coverage.

IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 1996

Mr. PETERSON of Florida (for himself, Mr. MORAN, Mr. DOOLEY of California, Mr. BAESLER, Mr. BERMAN, Ms. BROWN of Florida, Mr. CLEMENT, Mr. COLEMAN, Mr. DELLUMS, Mr. DIXON, Mr. FATTAH, Mr. FAZIO of California, Mr. FRAZER, Mr. HASTINGS of Florida, Mr. HEFNER, Mr. HILLIARD, Mr. HINCHEY, Ms. KAPTUR, Mr. LAFALCE, Mrs. LINCOLN, Mr. LEWIS of Georgia, Ms. LOFGREN, Ms. MCKINNEY, Mrs. MEEK of Florida, Mr. MINGE, Mr. NADLER, Ms. NORTON, Mr. OBERSTAR, Ms. PELOSI, Mr. POSHARD, Ms. ROYBAL-ALLARD, Mr. SABO, Mr. SANDERS, Mrs. SCHROEDER, Mr. STENHOLM, Mr. STUPAK, Mr. TORRES, Ms. VELÁZQUEZ, Mr. YATES, Mr. CLYBURN, Mr. JEFFERSON, Mr. PASTOR, Mr. CRAMER, Mr. ROSE, Mrs. THURMAN, Mr. PAYNE of Virginia, Ms. JACKSON-LEE of Texas, and Mr. PALLONE) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, the Judiciary, and Economic and Educational Opportunities, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To assure availability and continuity of health insurance and to simplify the administration of health coverage.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 "Health Insurance Affordability Act of 1996".

4 (b) TABLE OF CONTENTS.—The table of contents of
5 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—ASSURING AVAILABILITY AND CONTINUITY OF HEALTH COVERAGE

Subtitle A—Guaranteed Access to Health Coverage

Sec. 101. Guaranteed offer by carriers.
Sec. 102. Guaranteed issue by carriers.
Sec. 103. Guaranteed renewal.
Sec. 104. Restricting preexisting condition exclusions.
Sec. 105. Enrollment periods.

Subtitle B—Provision of Benefits

Sec. 111. Standards for managed care arrangements.
Sec. 112. Report on utilization review standards.

Subtitle C—Fair Rating Practices

Sec. 121. Use of fair rating practices.
Sec. 122. Establishment of risk adjustment mechanisms.

Subtitle D—Consumer Protections

Sec. 131. Requirement for provision of information.
Sec. 132. Prohibition of improper incentives.
Sec. 133. Written policies and procedures respecting advance directives.

Subtitle E—Benefits

Sec. 141. Qualified health coverage.
Sec. 142. Standard coverage.
Sec. 143. High-deductible coverage.
Sec. 144. Actuarial valuation of benefits.
Sec. 145. Limitation on offering supplemental benefits.
Sec. 146. Family coverage option; supplemental coverage.
Sec. 147. Level playing field for providers.

Subtitle F—Standards and Certification; Enforcement; Preemption; General Provisions

Sec. 151. Establishment of standards.
Sec. 152. Application of standards to carriers through States.
Sec. 153. Application to group health plans.
Sec. 154. Enforcement.
Sec. 155. Limitation on self insurance for small employers.

Subtitle G—Definitions; General Provisions

Sec. 191. General definitions.
Sec. 192. Definitions relating to employment.
Sec. 193. Definitions relating to health coverage, plans, and carriers.
Sec. 194. Definitions relating to residence and immigration status.
Sec. 195. Effective dates.

TITLE II—ADMINISTRATIVE SIMPLIFICATION

Sec. 200. Purpose.
Sec. 201. Definitions.

Subtitle A—Standards for Data Elements and Transactions

Sec. 211. General requirements on Secretary.
Sec. 212. Standards for data elements of health information.
Sec. 213. Information transaction standards.
Sec. 214. Health information network privacy standards.
Sec. 215. Timetables for adoption of standards.

Subtitle B—Requirements with Respect to Certain Transactions and Information

Sec. 221. Standard transactions and information.
Sec. 222. Accessing health information for authorized purposes.
Sec. 223. Ensuring availability of information.
Sec. 224. Timetables for compliance with requirements.

Subtitle C—Miscellaneous Provisions

Sec. 231. Standards and certification for health information network services.
Sec. 232. Imposition of additional requirements.
Sec. 233. Effect on State law.

TITLE III—ANTITRUST

Sec. 301. Publication of antitrust guidelines on activities of health plans.

1 # TITLE I—ASSURING AVAILABIL-
2 # ITY AND CONTINUITY OF
3 # HEALTH COVERAGE

4 ## Subtitle A—Guaranteed Access to
5 ## Health Coverage

6 **SEC. 101. GUARANTEED OFFER BY CARRIERS.**

7 (a) IN GENERAL.—Each carrier that offers health in-
8 surance coverage in the individual/small group market in
9 a fair rating area (as defined in section 193) shall make

1 available, to each qualifying individual (as defined in sec-
2 tion 194(3)) or small employer (covered in such market)
3 in such fair rating area—

4 (1) qualified standard coverage consistent with
5 section 142, and

6 (2) subject to subsection (b), qualified high-de-
7 ductible coverage consistent with section 143.

8 (b) HIGH-DEDUCTIBLE COVERAGE.—

9 (1) EXCEPTION FOR HEALTH MAINTENANCE
10 ORGANIZATIONS.—The requirement of subsection
11 (a)(2) shall not apply with respect to health insur-
12 ance coverage that—

13 (A) is provided by a Federally qualified
14 health maintenance organization (as defined in
15 section 1301(a) of the Public Health Service
16 Act), or

17 (B) is not provided by such an organiza-
18 tion but is provided by an organization recog-
19 nized under State law as a health maintenance
20 organization or managed care organization or a
21 similar organization regulated under State law
22 for solvency.

23 (2) LIMITATION ON OFFER OF HIGH-DEDUCT-
24 IBLE COVERAGE.—Qualified high-deductible coverage
25 may not be made available by a carrier to a qualify-

1 ing individual (or to a small employer with respect
2 to an employee) unless the carrier also makes avail-
3 able qualified standard coverage that has identical
4 benefits (other than the amount of the deductible)
5 and the individual or employee demonstrates to the
6 carrier that the individual or employee has available
7 assets (as defined by the Secretary) equal to at least
8 the deductible amount established under section
9 144(b)(1) applicable to the high-deductible coverage.
10 A carrier may not make available to an individual
11 health coverage (other than coverage for supple-
12 mental benefits) the actuarial value of which is less
13 than the actuarial value of qualified high-deductible
14 coverage, unless the individual has available assets
15 (as defined by the Secretary) equal to at least the
16 deductible amount of the coverage offered.
17 (c) COVERAGE OF ENTIRE RATING AREA.—
18 (1) IN GENERAL.—With respect to each fair
19 rating area for which a carrier offers health insur-
20 ance coverage, the carrier shall provide for coverage
21 of benefits for items and services furnished through-
22 out the fair rating area.
23 (2) SPECIAL RULE FOR CARRIERS OFFERING
24 COVERAGE IN MULTI-STATE METROPOLITAN STATIS-
25 TICAL AREAS.—In the case of a carrier that offers

1 qualified health insurance coverage in the individual/
2 small employer market in a portion of a State that
3 is located in an interstate metropolitan statistical
4 area, the carrier may not provide such coverage with
5 respect to an individual or employer in such metro-
6 politan statistical area unless the carrier also offers
7 such coverage in other portions of the area located
8 in other States.

9 (3) SPECIAL RULE FOR COVERAGE THROUGH
10 MANAGED CARE ARRANGEMENT.—In the case of cov-
11 erage offered by a carrier or under a group health
12 plan to the extent that it provides benefits through
13 a managed care arrangement in a fair rating area,
14 this subsection shall not be construed as requiring
15 the establishment of facilities throughout the area, if
16 the facilities are located consistent with section
17 102(b)(1).

18 (d) FAMILY COVERAGE OPTION.—The offer of cov-
19 erage under this section with respect to an individual shall
20 include the option of coverage of family members of the
21 individual.

22 (e) LIMITATION ON CARRIERS.—A carrier may not
23 require an employer under a group health plan to impose
24 through a waiting period for health coverage under a plan

1 or similarly require a limitation or condition on health cov-
2 erage or benefits based on—
3 (1) the health status of an individual,
4 (2) claims experience of an individual,
5 (3) receipt of health care by an individual,
6 (4) medical history of an individual,
7 (5) receipt of public subsidies by an individual,
8 or
9 (6) lack of evidence of insurability of an individ-
10 ual.
11 (f) CONSTRUCTION FOR MEWAS.—Nothing in this
12 section shall be construed as requiring a multiple employer
13 welfare arrangement that provides health coverage other
14 than through a carrier to meet the requirements of this
15 section.

16 **SEC. 102. GUARANTEED ISSUE BY CARRIERS.**

17 (a) IN GENERAL.—Subject to subsections (b) and (c)
18 and section 103, each carrier that offers health insurance
19 coverage in the individual/small group market in a fair rat-
20 ing area—
21 (1) must accept every small employer in the
22 area that applies for such coverage during an enroll-
23 ment period provided under section 105; and
24 (2) must accept for enrollment under such cov-
25 erage every qualifying individual (and family mem-

1 ber of such an individual) who applies for enrollment
2 during an enrollment period provided under section
3 105 and may not place any restriction on the eligi-
4 bility of an individual to enroll so long as such indi-
5 vidual is a qualifying individual.

6 (b) SPECIAL RULES FOR MANAGED CARE ARRANGE-
7 MENTS.—In the case of coverage offered by a carrier or
8 under a group health plan that provides benefits through
9 a managed care arrangement in a fair rating area, the
10 carrier or plan—

11 (1) need not establish facilities for the delivery
12 of health care services throughout the area so long
13 as such facilities are located in a manner that does
14 not discriminate on the basis of health status of in-
15 dividuals residing in proximity to such facilities, and

16 (2) may deny such coverage in a fair rating
17 area to employers or individuals if the organization
18 demonstrates to the applicable regulatory authority
19 that—

20 (A) it will not have the capacity to deliver
21 services adequately to enrollees of any addi-
22 tional groups or additional enrollees because of
23 its obligations to existing group contract hold-
24 ers and enrollees, and

(B) it is applying this paragraph uniformly to all employers and individuals without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

Coverage may be denied under paragraph (2) only if the denial is applied during a consecutive period of at least 180 days.

(c) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—In addition to the authority provided under subsection (b)(2), in the case of coverage offered by any carrier, the carrier may deny coverage to a small employer or individual if the carrier demonstrates to the applicable regulatory authority that—

(1) it does not have the financial reserves necessary to underwrite additional coverage, and

(2) it is applying this subsection uniformly to all employers and individuals without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

Coverage may be denied under this subsection only if the denial is applied during a consecutive period of at least 180 days.

(d) TREATMENT OF CERTAIN MEWAS.—Subsection (a) shall not apply to a carrier if the only coverage offered

by the carrier in the individual/small group market is through one or more multiple employer welfare arrangements. In the case of coverage offered by a carrier in the individual/small group market through a multiple employer welfare arrangement and to which the previous sentence does not apply, the requirements of subsection (a) shall apply to the carrier and not to the arrangement.

SEC. 103. GUARANTEED RENEWAL.

(a) LIMITATION ON TERMINATION BY CARRIERS.—A carrier may not deny, cancel, or refuse to renew health coverage of a qualifying individual or eligible employer within a type of coverage option described in section 193(13) except—

(1) on the basis of nonpayment of premiums,

(2) on the basis of fraud or misrepresentation, or

(3) subject to subsection (b), in a fair rating area because the carrier is ceasing to provide any health insurance coverage in the individual/small group market within such type of coverage option in the area.

(b) LIMITATIONS ON MARKET EXIT BY CARRIERS.—

(1) NOTICE, ETC.—Subsection (a)(3) shall not apply to a carrier ceasing to provide health insurance coverage unless—

1 (A) such termination of coverage takes ef-
2 fect at the end of a contract year, and
3 (B) the carrier provides notice of such ter-
4 mination to employers and individuals covered
5 at least 30 days before the date of an annual
6 open enrollment period established with respect
7 to the employer or individual under section 105.
8 (2) LIMITATION ON REENTRY IN INDIVIDUAL/
9 SMALL GROUP MARKET.—If a carrier ceases to offer
10 or provide health insurance coverage in an area with
11 respect to the individual/small group market for a
12 type of coverage option, the insurer may not offer
13 health insurance coverage in the area in such market
14 within such type of coverage option until 5 years
15 after the date of the termination.
16 (c) RULE FOR MULTIEMPLOYER PLANS AND MUL-
17 TIPLE EMPLOYER HEALTH.—A multiemployer plan and
18 a multiple employer health plan may not cancel coverage
19 or deny renewal of coverage under such a plan with re-
20 spect to an employer other than—
21 (1) for nonpayment of contributions,
22 (2) for fraud or other misrepresentation by the
23 employer, or
24 (3) because the plan is ceasing to provide any
25 coverage in a geographic area.

1 **SEC. 104. RESTRICTING PREEXISTING CONDITION EXCLU-**
2 **SIONS.**

3 (a) IN GENERAL.—Except as provided in this section,
4 a carrier or group health plan providing health coverage
5 may not exclude health coverage with respect to services
6 related to treatment of a condition based on the fact that
7 the condition of an individual existed before the effective
8 date of coverage of the individual.

9 (b) LIMITED 6-MONTH EXCLUSION PERMITTED.—

10 (1) IN GENERAL.—Subject to paragraph (2)
11 and subsections (c) through (e), a carrier or group
12 health plan providing health coverage may exclude
13 health coverage with respect to services related to
14 treatment of a condition of an individual based on
15 the fact that the condition existed before the effec-
16 tive date of coverage of the individual only if the pe-
17 riod of the exclusion does not exceed 6 months be-
18 ginning on the date of coverage.

19 (2) CREDITING OF PREVIOUS COVERAGE.—

20 (A) IN GENERAL.—A carrier or group
21 health plan providing health coverage shall pro-
22 vide that if a covered individual is in a period
23 of continuous coverage (as defined in subpara-
24 graph (C)) as of a date upon which coverage is
25 initiated or reinitiated, any period of exclusion
26 of coverage with respect to a preexisting condi-

1 tion (as defined in subparagraph (B)) for such
2 services or type of services shall be reduced by
3 1 month for each month in the period of contin-
4 uous coverage.

5 (B) PREEXISTING CONDITION DEFINED.—
6 In this paragraph, the term ''preexisting condi-
7 tion'' means, with respect to health coverage, a
8 condition which has been diagnosed or treated
9 during the 6-month period ending on the day
10 before the first date of such coverage (without
11 regard to any waiting period).

12 (C) PERIOD OF CONTINUOUS COVERAGE.—
13 In this part, the term ''period of continuous
14 coverage'' means the period beginning on the
15 date an individual has health coverage (or cov-
16 erage under a public plan providing medical
17 benefits) and ends on the date the individual
18 does not have such coverage for a continuous
19 period of more than 3 months (or 6 months in
20 the case of an individual who loses coverage due
21 to involuntary termination of employment, other
22 than by reason of an employee's gross mis-
23 conduct).

1 (c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—
2 Any exclusion of coverage under subsection (b)(1) shall
3 not apply if the exclusion relates to pregnancy.

4 (d) EXCLUSION NOT APPLICABLE TO NEWBORNS
5 AND ADOPTED CHILDREN.—

6 (1) NEWBORNS.—Any exclusion of coverage
7 under subsection (b)(1) shall not apply to a child
8 who is covered at the time of birth and remains in
9 a period of continuous coverage after such time.

10 (2) ADOPTED CHILDREN.—Any exclusion of
11 coverage under subsection (b)(1) shall not apply (be-
12 ginning on the date of adoption) to an adopted child
13 who is covered at the time of adoption and remains
14 in a period of continuous coverage after such time.

15 (e) EXCLUSION NOT APPLICABLE TO INDIVIDUALS
16 ENROLLED OR ENROLLING DURING CERTAIN OPEN EN-
17 ROLLMENT PERIODS.—

18 (1) INDIVIDUALS ENROLLING DURING PE-
19 RIOD.—In the case of an individual who enrolls and
20 obtains coverage during an open enrollment period
21 described in section 105(b), any exclusion of cov-
22 erage under subsection (b)(1) shall not apply so long
23 as the individual remains in a period of continuous
24 coverage.

(2) INDIVIDUALS ENROLLED AT BEGINNING OF PERIOD.—In the case of an individual who has health coverage as of the first day of the initial open enrollment period described in section 105(b)(1), any exclusion of coverage under subsection (b)(1) shall not apply as of such date and so long as the individual is in a period of continuous coverage.

(f) APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization that provides health insurance coverage shall not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwithstanding that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provisions of this subtitle so long as such exclusion is applied consistent with the provisions of this part.

SEC. 105. ENROLLMENT PERIODS.

(a) IN GENERAL.—Each carrier and each group health plan providing health coverage in the individual/small group market shall permit qualifying individuals and eligible employers to obtain health coverage from the carrier or group health plan during each enrollment period provided under this section.

(b) OPEN ENROLLMENT PERIODS FOR WHICH PRE-EXISTING CONDITION EXCLUSIONS WAIVED.—

1 (1) INITIAL PERIOD.—There shall be an initial
2 open enrollment period, with respect to individuals
3 and employees who are residents of a State, during
4 the 60-day period beginning on January 1, 1997.
5 (2) INDIVIDUALS ELIGIBLE FOR SUBSIDIES.—
6 There shall be an individual open enrollment period
7 with respect to an individual at the time the individ-
8 ual first becomes eligible for any premium assistance
9 under part A of title XXI of the Social Security Act,
10 during the 60-day period beginning on the first date
11 the individual meets eligibility criteria within any
12 12-month period.
13 (3) COURT ORDERS.—If a court has ordered
14 that coverage be provided for a spouse or child of an
15 employee or individual under health coverage of the
16 employee or individual, there shall be an open enroll-
17 ment period during the 30-day period beginning on
18 the date of issuance of the court order.
19 (4) ENROLLMENT OF NEWBORNS AND NEWLY
20 ADOPTED CHILDREN.—There shall be an open en-
21 rollment period with respect to a newborn child and
22 a newly adopted child during the 30-day period be-
23 ginning on the date of the birth or adoption of a
24 child, if family coverage is available as of such date.

1 (c) ANNUAL OPEN ENROLLMENT PERIODS FOR
2 WHICH PREEXISTING CONDITION EXCLUSIONS MAY
3 APPLY.—
4 (1) IN GENERAL.—Each carrier and each group
5 health plan providing health coverage in the individ-
6 ual/small group market shall provide for at least one
7 annual open enrollment period (of not less than 30
8 days) each year. Such period shall be in addition to
9 the open enrollment periods described in subsection
10 (b).
11 (2) COORDINATION.—
12 (A) CARRIERS IN INDIVIDUAL/SMALL
13 GROUP MARKET.—Such annual open enrollment
14 periods with respect to carriers in the individ-
15 ual/small group market are subject to coordina-
16 tion by States.
17 (d) OTHER OPEN ENROLLMENT PERIODS FOR
18 WHICH PREEXISTING CONDITION EXCLUSIONS MAY
19 APPLY.—
20 (1) TERMINATION OF RESIDENCE AREA.—For
21 each qualifying individual, at the time the individual
22 terminates residence in the service area of coverage
23 provided by a carrier to the individual, there shall be
24 an open enrollment period (of not less than 30 days)

1 during which the individual may enroll in health cov-
2 erage.

3 (2) FAMILY OR EMPLOYMENT CHANGES.—In
4 the case of a qualifying individual who—

5 (A) through divorce or death of a family
6 member experiences a change in family com-
7 position, or

8 (B) experiences a change in employment
9 status (including a significant change in the
10 terms and conditions of employment or the
11 terms and conditions of employment of a
12 spouse),

13 there shall be an open enrollment period (of at least
14 30 days) in which the individual is permitted to
15 change the individual or family basis of coverage or
16 the health coverage in which the individual is en-
17 rolled. The circumstances under which such enroll-
18 ment periods are required and the duration of such
19 periods shall be specified by the Secretary.

20 (3) ENROLLMENT DUE TO LOSS OF PREVIOUS
21 COVERAGE.—In the case of a qualifying individual
22 who—

23 (A) had health coverage at the time of an
24 individual's enrollment period,

1 (B) stated at the time of such period that
2 having other health coverage was the reason for
3 declining enrollment, and
4 (C) lost the other health coverage as a re-
5 sult of the termination of the coverage, termi-
6 nation or reduction of employment, or other
7 reason, except termination at the option of the
8 individual,
9 there shall be an open enrollment period during the
10 30-day period beginning on the date of termination
11 of the other coverage.
12 (4) ENROLLMENT AT TIME OF MARRIAGE.—
13 There shall be an open enrollment period with re-
14 spect to the spouse of an individual (including chil-
15 dren of the spouse) during the 30-day period begin-
16 ning on the date of the marriage, if family coverage
17 is available as of such date.
18 (5) NO EFFECT ON COBRA CONTINUATION BEN-
19 EFITS.—Nothing in this subsection shall be con-
20 strued as affecting rights of individuals to continu-
21 ation coverage under section 4980B of the Internal
22 Revenue Code of 1986, part 6 of subtitle B of title
23 I of the Employee Retirement Income Security Act
24 of 1974, or title XXII of the Public Health Service
25 Act.

1 (e) PERIOD OF COVERAGE.—
2 (1) IN GENERAL.—In the case of a qualifying
3 individual who enrolls under health coverage during
4 an open enrollment period under this section, cov-
5 erage shall begin on such date (not later than the
6 first day of the first month that begins at least 15
7 days after the date of enrollment) as the Secretary
8 shall specify, consistent with this subsection.
9 (2) COVERAGE OF FAMILY MEMBERS.—In the
10 case of an open enrollment period described in sub-
11 section (b)(3), (b)(4), or (d)(4), the Secretary shall
12 provide for coverage of family members to begin as
13 soon as possible on or after the date of the event
14 that gives rise to the special enrollment period (or,
15 in the case of birth or adoption, as of the date of
16 birth or adoption).

17 Subtitle B—Provision of Benefits

18 SEC. 111. STANDARDS FOR MANAGED CARE ARRANGE-
19 MENTS.

20 (a) APPLICATION OF REQUIREMENTS.—Each group
21 health plan, and each carrier providing health insurance
22 coverage, that provides for health care through a managed
23 care arrangement (as defined in section 193(10)(A)) shall
24 comply with the applicable requirements of this section.
25 (b) CONSUMER DISCLOSURE.—

1 (1) In general.—The group health plan, or
2 carrier providing health insurance coverage, that
3 provides for health care shall assure that, before an
4 individual is enrolled with the plan or carrier, the in-
5 dividual is provided with information about the ar-
6 rangements between the entity providing for the
7 managed care arrangement and health care provid-
8 ers for the provision of covered benefits, including
9 the following:
10 (A) Emergency services.—Arrange-
11 ments for access to emergency care services in-
12 side and outside the provider network (includ-
13 ing designated trauma centers), including any
14 requirements for prior authorization.
15 (B) Specialized treatment.—Arrange-
16 ments for access to specialized treatment pro-
17 viders (such as centers of excellence).
18 (C) Choice of personal physician.—
19 Ability of enrollees to choose (and change the
20 selection of) a personal physician from among
21 available participating physicians and change
22 that selection as appropriate.
23 (D) Essential community providers.—
24 Arrangements for access to essential community
25 providers, including disproportionate share hos-

1 pitals, sole community hospitals, medicare-de-
2 pendent, small rural hospitals, Federally quali-
3 fied health centers, rural health clinics, local
4 health departments, and children's hospitals.
5 (2) DESIGNATION OF CENTERS OF EXCEL-
6 LENCE.—The Secretary shall establish a process for
7 the designation of facilities, including children's hos-
8 pitals and other pediatric facilities, as centers of ex-
9 cellence for purposes of this subsection. A facility
10 may not be designated unless the facility is deter-
11 mined—
12 (A) to provide specialty care,
13 (B) to deliver care for complex cases re-
14 quiring specialized treatment and for individ-
15 uals with chronic diseases, and
16 (C) to meet other requirements that may
17 be established by the Secretary relating to spe-
18 cialized education and training of health profes-
19 sionals, participation in peer-reviewed research,
20 or treatment of patients from outside the geo-
21 graphic area of the facility.
22 (c) PROVIDER DISCLOSURE AND DUE PROCESS RE-
23 LATING TO PROVIDER NETWORKS.—
24 (1) DISCLOSURE.—The entity providing for a
25 managed care arrangement under which health cov-

1 erage shall provide that before entering into a con-
2 tract with health care providers with respect to the
3 entity's provider network, the provider is given infor-
4 mation concerning the terms and conditions of the
5 provider's involvement with the network, including
6 the following:
7 (A) STANDARDS FOR SELECTION OF PRO-
8 VIDERS FOR NETWORK.—Information concern-
9 ing the standards (including criteria for quality,
10 efficiency, credentialing, and services) to be
11 used by the entity for contracting with health
12 care providers with respect to the entity's pro-
13 vider network.
14 (B) REVIEW PROCESS.—Information con-
15 cerning the process under which a provider may
16 request a review of the entity's decision to ter-
17 minate or refuse to renew the provider's partici-
18 pation agreement.
19 (2) WRITTEN NOTICE OF DENIALS.—The entity
20 providing for the managed care arrangement shall
21 provide written notice to the provider of any denial
22 of an application to participate in the provider net-
23 work.
24 (3) TERMINATION PROCESS.—

(A) IN GENERAL.—The entity may not terminate or refuse to renew a participation agreement with a provider in the entity's provider network unless the entity provides written notification to the provider of the entity's decision to terminate or refuse to renew the agreement. The notification shall include a statement of the reasons for the entity's decision, consistent with any standards described in paragraph (1)(A).

(B) TIMING OF NOTIFICATION.—The entity shall provide the notification required under subparagraph (A) at least 30 days prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of a covered individual.

(d) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—A carrier or group health plan may not require an individual to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

(e) PREEMPTION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.—

1 (1) LIMITATION ON RESTRICTIONS ON NET-
2 WORK PLANS.—Effective as of January 1, 1997—
3 (A) a State may not prohibit or limit a
4 carrier or group health plan providing health
5 coverage from including incentives for enrollees
6 to use the services of participating providers;
7 (B) a State may not prohibit or limit such
8 a carrier or plan from limiting coverage of serv-
9 ices to those provided by a participating pro-
10 vider;
11 (C) a State may not prohibit or limit the
12 negotiation of rates and forms of payments for
13 providers by such a carrier or plan with respect
14 to health coverage;
15 (D) a State may not prohibit or limit such
16 a carrier or plan from limiting the number of
17 participating providers;
18 (E) a State may not prohibit or limit such
19 a carrier or plan from requiring that services be
20 provided (or authorized) by a practitioner se-
21 lected by the enrollee from a list of available
22 participating providers or, except as provided in
23 subsection 111(d), from requiring enrollees to
24 obtain referral in order to have coverage for

1 treatment by a specialist or health institution;
2 and
3 (F) a State may not prohibit or limit the
4 corporate practice of medicine.
5 (2) DEFINITIONS.—In this subsection:
6 (A) MANAGED CARE COVERAGE.—The
7 term ''manageds care coverage'' means health
8 coverage to the extent the coverage is provided
9 through a managed care arrangement (as de-
10 fined in section 193(10)(A)) that meets the ap-
11 plicable requirements of this section.
12 (B) PARTICIPATING PROVIDER.—The term
13 ''participating provider'' means an entity or in-
14 dividual which provides, sells, or leases health
15 care services as part of a provider network (as
16 defined in section 193(10)(B)).

17 **SEC. 112. REPORT ON UTILIZATION REVIEW STANDARDS.**

18 (a) STUDY.—The Secretary shall provide for a study
19 on the feasibility and appropriateness of—
20 (1) establishing standards for utilization review
21 programs, and
22 (2) prohibiting group health plans and carriers
23 providing health insurance coverage from denying
24 coverage of or payment for items and services on the

1 basis of a utilization review program unless the pro-
2 gram meets such standards.
3 (b) REPORT.—Not later than 18 months after the
4 date of the enactment of this Act, the Secretary shall sub-
5 mit to Congress a report on the study under subsection
6 (a). The Secretary shall include the report recommenda-
7 tions regarding the application of standards for utilization
8 review programs to group health plans and carriers pro-
9 viding health insurance coverage.
10 (c) PREEMPTION.—For provision preempting State
11 laws relating to utilization review, see section 6103.

12 Subtitle C—Fair Rating Practices

13 SEC. 121. USE OF FAIR RATING PRACTICES.

14 (a) USE OF FAIR RATING PRACTICES.—The pre-
15 mium rate established by a carrier for health insurance
16 coverage in the individual/small group market (including
17 the premium rate for coverage for a small employer
18 through a multiple employer welfare arrangement that is
19 fully-insured) may not vary except by the following:
20 (1) AGE.—By age, based on classes of age es-
21 tablished by the Secretary, in consultation with the
22 NAIC, consistent with subsection (b).
23 (2) GEOGRAPHIC AREA.—By geographic area,
24 as identified by a State consistent with subsection
25 (c).

1 (3) FAMILY CLASS.—By family class, based on
2 the following 4 classes of family coverage: individual,
3 individual with one or more children, married couple
4 without a child, and married couple with one or
5 more children.
6 (4) BENEFIT DESIGN.—By benefit design of
7 coverage, including by type of coverage, such as
8 standard coverage and high-deductible coverage, and
9 by type of coverage option (described in section
10 193(13)) with respect to standard coverage.
11 (5) ADMINISTRATIVE CATEGORIES.—By per-
12 mitted expense category, based on differences in ex-
13 penses among such categories, consistent with sub-
14 section (d).
15 The premiums shall be established for the different benefit
16 designs (including standard coverage and high-deductible
17 coverage) based on the actuarial value of the coverage for
18 the population of the individual/small group market in the
19 fair rating area, without regard to the distribution of such
20 population among the types of coverage or type of cov-
21 erage options.
22 (b) LIMITATION ON VARIATION BY AGE.—
23 (1) IN GENERAL.—Any variation in premium
24 rates by age under subsection (a)(1) for age classes
25 of individuals under 65 years of age may not result

1 in the ratio of the highest age rate to the lowest age
2 rate exceeding the limiting ratio described in para-
3 graph (2).
4 (2) LIMITING RATIO.—For purposes of para-
5 graph (1), the limiting ratio described in this para-
6 graph is—
7 (A) 4-to-1, for premiums for months in
8 1997,
9 (B) 3.67-to-1, for premiums for months in
10 1998,
11 (C) 3.33-to-1, for premiums for months in
12 1999, and
13 (D) 3-to-1, for premiums for months in
14 2000 and any succeeding year.
15 (3) SEPARATE AGE CLASSES FOR INDIVIDUALS
16 65 YEARS OF AGE OR OLDER.—The Secretary shall
17 establish one or more separate age classes for indi-
18 viduals 65 years of age or older.
19 (c) GEOGRAPHIC AREA VARIATIONS.—For purposes
20 of subsection (a)(2), a State—
21 (1) may not identify an area that divides a 3-
22 digit zip code, a county, or all portions of a metro-
23 politan statistical area,
24 (2) shall not permit premium rates for coverage
25 offered in a portion of an interstate metropolitan

1 statistical area to vary based on the State in which
2 the coverage is offered, and
3 (3) may, upon agreement with one or more ad-
4 jacent States, identify multi-state geographic areas
5 consistent with paragraphs (1) and (2).
6 (d) ADMINISTRATIVE VARIATIONS.—
7 (1) EXPENSE CATEGORIES.—Expense cat-
8 egories shall be established under subsection (a)(5)
9 by a carrier in a manner that only reflects dif-
10 ferences based on marketing, commissions, and simi-
11 lar expenses. Such categories shall take into account
12 health plan purchasing organizations.
13 (2) LIMITATION ON VARIATIONS.—The vari-
14 ation provided among expense categories under sub-
15 section (a)(5) may not result in a premium for the
16 highest expense category exceeding 120 percent of
17 the premium for the lowest expense category.
18 (e) PREMIUM RATING IN GROUP HEALTH PLANS.—
19 The premium rate established under a group health plan
20 for health insurance coverage may not vary within a bene-
21 fit design except by the factors described in subsection (a)
22 and subject to the limitation specified in subsection (b).
23 (f) ACTUARIAL CERTIFICATION.—Each carrier that
24 offers health insurance coverage in a State shall file annu-
25 ally with the State commissioner of insurance a written

1 statement by a member of the American Academy of Actu-
2 aries (or other individual acceptable to the commissioner)
3 that, based upon an examination by the individual which
4 includes a review of the appropriate records and of the
5 actuarial assumptions of the carrier and methods used by
6 the carrier in establishing premium rates for applicable
7 health insurance coverage—

8 (1) the carrier is in compliance with the appli-
9 cable provisions of this section, and

10 (2) the rating methods are actuarially sound.

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

13 (g) CONSTRUCTION.—The provisions of this section
14 shall apply to premium rates established by carriers for
15 multiple employer welfare arrangements that are fully in-
16 sured or for fully-insured coverage offered with respect to
17 individuals and small employers in the individual/small
18 group market. Such premium rates shall apply based on
19 the fair rating area in which the covered individual or em-
20 ployee resides to reflect the population in the individual/
21 small group market.

22 **SEC. 122. ESTABLISHMENT OF RISK ADJUSTMENT MECHA-**
23 **NISMS.**

24 (a) ESTABLISHMENT OF STANDARDS.—

25 (1) DEVELOPMENT OF MODELS.—

1 (A) IN GENERAL.—The Secretary shall re-
2 quest the NAIC to develop, within 9 months
3 after the date of the enactment of this Act and
4 in consultation with the American Academy of
5 Actuaries, a model risk adjustment system com-
6 posed of one or more risk adjustment mecha-
7 nisms under which premiums applicable to
8 health insurance coverage in the individual/
9 small group market and coverage under mul-
10 tiple employer welfare arrangements that are
11 fully insured (without regard to whether such
12 an arrangement is offered through an associa-
13 tion) would be adjusted to take into account
14 such factors as may be appropriate to predict
15 the future need and the efficient use of services
16 by covered individuals in the market. Such fac-
17 tors may include the age, gender, geographic
18 residence, health status, or other demographic
19 characteristics of individuals enrolled in such
20 plans and shall include consideration of enroll-
21 ment of a disproportionate share of individuals
22 who enroll during the initial open enrollment
23 period under section 105(b)(1).
24 (B) PROMULGATION AS PROPOSED
25 RULE.—If the NAIC develops such model with-

1 in such period, the Secretary shall publish the
2 model as a proposed rule under section 553 of
3 title 5, United States Code. If the NAIC has
4 not developed such model within such period,
5 the Secretary shall publish (not later than 60
6 days after the end of such period) a proposed
7 rule that specifies a proposed model that pro-
8 vides for effective risk adjustment mechanisms.
9 (2) RULE MAKING PROCESS.—The Secretary
10 shall provide for a period (described in section
11 553(c) of title 5, United States Code) of not less
12 than 30 days for public comment on a proposed rule
13 published under paragraph (1)(B). The Secretary
14 shall publish a final rule, by not later than January
15 1, 1996, that specifies risk adjustment mechanisms
16 that the Secretary finds are effective for purposes of
17 carrying out this section. Such rule shall include
18 models developed by the NAIC if the Secretary finds
19 that such models provide for effective risk adjust-
20 ment mechanisms.
21 (3) MODIFICATION.—The Secretary, at the re-
22 quest of the NAIC or otherwise, may by regulation
23 modify the model risk adjustment system established
24 under this subsection.

1 (b) IMPLEMENTATION OF RISK ADJUSTMENT SYS-
2 TEM.—Each State shall establish and maintain a risk ad-
3 justment system that conforms with the model established
4 under this section by not later than January 1, 1997. A
5 State may establish and maintain such a system jointly
6 with one or more other States.

7 Subtitle D—Consumer Protections

8 SEC. 131. REQUIREMENT FOR PROVISION OF INFORMA-
9 TION.

10 (a) CARRIERS.—
11 (1) IN GENERAL.—Each carrier that offers
12 health insurance coverage to small employers (or eli-
13 gible employees of small employers) or qualifying in-
14 dividuals must disclose to such prospective enrollees,
15 to brokers, and to health plan purchasing organiza-
16 tions the information that the Secretary may specify
17 relating to the performance of the carrier in provid-
18 ing such coverage and relating to differences be-
19 tween the coverage provided and the most similar
20 model benefit package established under section
21 144(b)(2). If a carrier offers to individuals or em-
22 ployers coverage the actuarial value of which is more
23 than the actuarial value for high-deductible coverage
24 but less than such value for standard coverage, the
25 carrier must disclose to such employers or individ-

1 uals detailed information on how the coverage of-
2 fered compares to any standard and high-deductible
3 coverage offered by the carrier to such individuals
4 and employers.

5 (2) MARKETING MATERIAL.—Each carrier that
6 provides any health insurance coverage in a State
7 shall file with the State those marketing materials
8 relating to the offer and sale of health insurance
9 coverage to be used for distribution before the mate-
10 rials are used. Such materials shall be in a uniform
11 format specified under the standards established
12 under section 1301.

13 (b) GROUP HEALTH PLANS.—Each group health
14 plan that provides health coverage must disclose to enroll-
15 ees and potential enrollees information, similar to the in-
16 formation described in subsection (a), relating to perform-
17 ance of the plan in providing such coverage and relating
18 to differences between the coverage provided and the most
19 similar model benefit package established under section
20 144(b)(2).

21 (c) INFORMATION RELATING TO RISK ADJUST-
22 MENT.—Each carrier or group health plan providing cov-
23 erage in the individual/small group market (including mul-
24 tiple employer health plans that are fully insured, without
25 regard to whether such an arrangement or plan is offered

through an association) shall provide to the State such information as the State may require in order to carry out section 122 (relating to risk adjustment mechanisms).

SEC. 132. PROHIBITION OF IMPROPER INCENTIVES.

(a) LIMITATION ON FINANCIAL INCENTIVES.—No carrier that provides health insurance coverage may vary the commission or financial or other remuneration to a person based on the claims experience or health status of individuals enrolled by or through the person.

(b) NONDISCRIMINATION IN AGENT COMPENSATION.—A carrier—

(1) may not vary or condition the compensation provided to an agent or broker related to the sale or renewal of health insurance coverage because of the health status or claims experience of any individuals enrolled with the carrier through the agent or broker; and

(2) may not terminate, fail to renew, or limit its contract or agreement of representation with an agent or broker for any reason related to the health status or claims experience of any individuals enrolled with the carrier through the agent or broker.

(c) PROHIBITION OF TIE-IN ARRANGEMENTS.—No carrier that offers health insurance coverage may require

1 the purchase of any other insurance or product as a condi-
2 tion for the purchase of such coverage.

3 **SEC. 133. WRITTEN POLICIES AND PROCEDURES RESPECT-**
4 **ING ADVANCE DIRECTIVES.**

5 A carrier and a group health plan offering health cov-
6 erage shall meet the requirements of section 1866(f) of
7 the Social Security Act (relating to maintaining written
8 policies and procedures respecting advance directives), in-
9 sofar as such requirements would apply to the carrier or
10 plan if the carrier or plan were an eligible organization.

11 # Subtitle E—Benefits

12 **SEC. 141. QUALIFIED HEALTH COVERAGE.**

13 In this Act, the term ‘‘qualified health coverage’’
14 means health coverage that—
15 (1) provides—
16 (A) standard coverage consistent with sec-
17 tion 142(a), or
18 (B) high-deductible coverage consistent
19 with section 143; and
20 (2) meets other requirements of subtitles A
21 through D applicable to the coverage and the carrier
22 or group health plan providing the coverage.

23 **SEC. 142. STANDARD COVERAGE.**

24 (a) IN GENERAL.—Health insurance coverage is con-
25 sidered to provide standard coverage consistent with this

1 subsection and for preventive benefits under subsection
2 (b)(4) if—
3 (1) benefits under such coverage are provided
4 within at least each of the required categories of
5 benefits described in paragraph (1) of subsection (b)
6 and consistent with such subsection;
7 (2) the actuarial value of the benefits meets the
8 requirements of subsection (c), and
9 (3) the benefits comply with the minimum re-
10 quirements specified in subsection (d).
11 (b) REQUIRED CATEGORIES OF COVERED BENE-
12 FITS.—
13 (1) IN GENERAL.—The categories of covered
14 benefits described in this paragraph are the types of
15 benefits specified in each of subparagraphs (A), (B),
16 (C), (D), (E), and (F) of paragraph (1), and sub-
17 paragraphs (E) and (F) of paragraph (2), of section
18 8904(a) of title 5, United States Code (relating to
19 types of benefits required to be in health insurance
20 offered to Federal employees).
21 (2) COVERAGE OF TREATMENTS IN APPROVED
22 RESEARCH TRIALS.—
23 (A) IN GENERAL.—Coverage of the routine
24 medical costs (as defined in subparagraph (B))
25 associated with the delivery of treatments shall

1 be considered to be medically appropriate if the
2 treatment is part of an approved research trial
3 (as defined in subparagraph (C)).
4 (B) ROUTINE MEDICAL COSTS DEFINED.—
5 In subparagraph (A), the term "routine medical
6 costs" means the cost of health services re-
7 quired to provide treatment according to the de-
8 sign of the trial, except those costs normally
9 paid for by other funding sources (as defined by
10 the Secretary). Such costs do not include the
11 cost of the investigational agent, devices or pro-
12 cedures themselves, the costs of any nonhealth
13 services that might be required for a person to
14 receive the treatment, or the costs of managing
15 the research.
16 (C) APPROVED RESEARCH TRIAL DE-
17 FINED.—In subparagraph (A), the term "ap-
18 proved research trial" means a trial—
19 (i) conducted for the primary purpose
20 of determining the safety, effectiveness, ef-
21 ficacy, or health outcomes of a treatment,
22 compared with the best available alter-
23 native treatment, and
24 (ii) approved by the Secretary.

1 A trial is deemed to be approved under clause
2 (ii) if it is approved by the National Institutes
3 of Health, the Food and Drug Administration
4 (through an investigational new drug exemp-
5 tion), the Department of Veterans Affairs, or
6 by a qualified nongovernmental research entity
7 (as identified in guidelines issued by one or
8 more of the National Institutes of Health).
9 (3) COVERAGE OF OFF-LABEL USE.—An off-
10 label use for a drug that has been found to be safe
11 and effective under section 505 of the Federal Food,
12 Drug, and Cosmetic Act shall be covered if the medi-
13 cal indication for which it is used is listed in one of
14 the following 3 compendia: the American Hospital
15 Formulary Service-Drug Information, the American
16 Medical Association Drug Evaluations, and the
17 United States Pharmacopeia-Drug Information.
18 (4) PREVENTIVE BENEFITS.—The following are
19 preventive benefits that shall be covered without any
20 deductibles, copayment, coinsurance, or other cost-
21 sharing:
22 (A) NEWBORN, WELL-BABY AND WELL-
23 CHILD CARE.—Newborn care, well-baby care,
24 and well-child care for individuals under 19
25 years of age, including routine physical exami-

nations, routine immunizations, and routine tests, as specified by the Secretary based on the schedule recommended by the American Academy of Pediatricians.

(B) MAMMOGRAMS.—Routine screening mammograms (including their interpretation), limited to 1 mammogram for a woman who is at least 35 (but less than 40) years of age, 1 mammogram every 2 years for a woman who is at least 40 (but less than 50) years of age, and 1 mammogram every year for a woman who is at least 50 years of age.

(C) SCREENING PAP SMEARS AND PELVIC EXAMS.—Screening pap smears and pelvic exams for women over 17 years of age, limited to 1 each year.

(D) COLORECTAL SCREENING.—Colorectal screening for individuals over 18 years of age at high risk, consisting of 1 fecal occult blood screening test every year, 1 screening sigmoidoscopy every 5 years, and 1 screening colonoscopy every 4 years.

(E) SCREENING TUBERCULIN TESTS.—Screening tuberculin tests annually for individuals at risk of contracting tuberculosis.

1 (F) PRENATAL CARE.—Prenatal care.
2 (G) ADULT IMMUNIZATIONS.—Routine im-
3 munizations for an individual over 17 years of
4 age (including booster immunizations against
5 tetanus and diphtheria, but limited to 1 such
6 immunization every 10 years).
7 (H) PROSTATE CANCER SCREENING.—
8 Routine cancer screening for a man who is at
9 least 40 years of age through a prostate specific
10 antigen test, limited to 1 test each year.
11 (c) STANDARD ACTUARIAL VALUE.—
12 (1) IN GENERAL.—The actuarial value of the
13 benefits under standard coverage in a fair rating
14 area meets the requirements of this subsection if
15 such value is equivalent to the standard actuarial
16 value described in paragraph (2) for the area. The
17 actuarial value of benefits under standard coverage
18 shall be determined using the adjustment under
19 paragraph (3) for a standardized population and set
20 of standardized utilization and cost factors.
21 (2) STANDARD ACTUARIAL VALUE DE-
22 SCRIBED.—The standard actuarial value described
23 in this paragraph for coverage in a geographic area
24 is the actuarial value of benchmark coverage during
25 1994 in such area. Such actuarial value shall be de-

1 termined using the adjustment under paragraph (3)
2 for a standardized population and set of standard-
3 ized utilization and cost factors and updated annu-
4 ally in accordance with section 144(a).

5 (3) ADJUSTMENTS FOR STANDARDIZED POPU-
6 LATION, STANDARDIZED UTILIZATION AND COST
7 FACTORS, AND GEOGRAPHIC AREA.—The adjustment
8 under this paragraph—

9 (A) for a standardized population shall be
10 made by not taking into account individuals 65
11 years of age or older, employees of the United
12 States Postal Service, retirees, and annuitants;
13 and

14 (B)(i) except as provided in clause (ii), for
15 a geographic area shall be made in a manner
16 that reflects the ratio of the actuarial value of
17 benchmark coverage in such geographic area
18 (as adjusted under subparagraph (A)) to such
19 actuarial value for such benchmark coverage for
20 the United States as a whole, taking into ac-
21 count standardized actuarial utilization and
22 cost factors, and

23 (ii) in the case of a group health plan oper-
24 ating in more than one geographic area, the
25 ratio described in clause (i) shall be determined

in accordance with regulations promulgated by the Secretary.

At the election of a group health plan under subparagraph (B)(ii), the ratio under such subparagraph shall be 1.

(d) MINIMUM REQUIREMENTS WITHIN A CATEGORY.—Benefits offered in any standard coverage within any category of benefits shall be not less than the narrowest scope and shortest duration of benefits within that category in any of the approved health benefits plans offered under chapter 89 of title 5, United States Code (relating to the Federal Employees Health Benefits Program) in 1994. Benefits offered in the standard plan within the category of preventive services shall not require payment of cost-sharing for covered items and services.

(e) NO COVERAGE OF SPECIFIC TREATMENT, PROCEDURES, OR CLASSES REQUIRED.—Nothing in this section (or section 143) may be construed to require the coverage of any specific procedure or treatment or class of service in health coverage under this Act or through regulation.

(f) CONSTRUCTION.—Nothing in this section (or section 143) shall be construed as requiring coverage to include benefits for items and services that are not medically necessary or appropriate.

1 **SEC. 143. HIGH-DEDUCTIBLE COVERAGE.**

2 Health insurance coverage is considered to provide
3 high-deductible coverage consistent with this section if—
4 (1) benefits under such coverage comply with—
5 (A) the requirements described in section
6 142(b) (relating to required categories of cov-
7 ered benefits), and
8 (B) the requirements described in section
9 142(d) (relating to minimum requirements
10 within a category);
11 (2) the deductible amount is the amount estab-
12 lished under section 144(b)(1);
13 (3) benefits under the coverage in any year
14 (other than preventive benefits described in section
15 142(b)(4)) are covered only to the extent expenses
16 incurred for items and services included in the cov-
17 erage for the year exceed the deductible amount
18 specified in paragraph (2); and
19 (4) the actuarial value of the coverage (as de-
20 termined under rules consistent with section 142(c))
21 is equivalent to 80 percent of the actuarial value es-
22 tablished under such section for standard coverage.

23 **SEC. 144. ACTUARIAL VALUATION OF BENEFITS.**

24 (a) IN GENERAL.—The Secretary, in consultation
25 with the NAIC and the American Academy of Actuaries,
26 shall establish (and may from time to time modify) proce-

dures by which health insurance benefits are valued for purposes of this subtitle.

(b) DEDUCTIBLE; MODEL BENEFIT PACKAGES.—The Secretary, in consultation with the NAIC and the American Academy of Actuaries, shall establish—

(1) the deductible amount for high-deductible coverage for the purposes of section 143(2) such that the actuarial value of high-deductible coverage described in section 143 is 20 percent less than the actuarial value of standard coverage described in section 142(a); and

(2) model benefit packages that may be treated, for purposes of this title, as meeting the requirements for standard or high-deductible coverage under sections 142(a) and 143, respectively, and which shall include model cost sharing arrangements for fee-for-service options, managed care options, and point-of-service options.

SEC. 145. LIMITATION ON OFFERING SUPPLEMENTAL BENEFITS.

A carrier or group health plan offering qualified health coverage may offer coverage of items and services only in addition to the qualified standard coverage offered (whether in the form of coverage of additional items and services or a reduction in cost sharing) and only if—

1 (1) such supplemental coverage is offered and
2 priced separately from the standard coverage offered
3 and is only made available to individuals who obtain
4 qualified standard coverage through the carrier or
5 plan;

6 (2) the purchase of the qualified health cov-
7 erage is not conditioned upon the purchase of such
8 supplemental coverage; and

9 (3) in the case of supplemental coverage that
10 consists of a reduction in the cost-sharing otherwise
11 applicable, the premium for the supplemental cov-
12 erage takes into account any expected increase in
13 utilization of items and services included in the
14 qualified health coverage resulting from obtaining
15 the supplemental coverage.

16 **SEC. 146. FAMILY COVERAGE OPTION; SUPPLEMENTAL**
17 **COVERAGE.**

18 (a) FAMILY COVERAGE OPTION.—Each carrier and
19 group health plan that offers health insurance coverage
20 shall provide for an option under which children under 26
21 years of age (without regard to whether they are full-time
22 students or disabled) will be treated (with respect to fam-
23 ily coverage) as family members. The carrier or plan may
24 impose an additional premium for such option.

1 (b) CONSTRUCTION.—Nothing in this title shall be
2 construed as limiting the benefits that may be offered as
3 part of a group health plan or health insurance coverage.

4 **SEC. 147. LEVEL PLAYING FIELD FOR PROVIDERS.**

5 Nothing in this subtitle may be construed to require
6 or prohibit the use of a particular class of provider, among
7 the providers that are legally authorized to provide such
8 treatment.

9 Subtitle F—Standards and Certifi-
10 cation; Enforcement; Preemp-
11 tion; General Provisions

12 **SEC. 151. ESTABLISHMENT OF STANDARDS.**

13 (a) ROLE OF NAIC.—

14 (1) IN GENERAL.—The Secretary shall request
15 the NAIC to develop, within 9 months after the date
16 of the enactment of this Act, model regulations that
17 specify standards with respect to the requirements of
18 this subtitle as applicable to carriers and health in-
19 surance coverage.

20 (2) REVIEW OF STANDARDS.—If the NAIC de-
21 velops recommended regulations specifying such
22 standards within such period, the Secretary shall re-
23 view the standards. Such review shall be completed
24 within 60 days after the date the regulations are de-
25 veloped. Unless the Secretary determines within

such period that the standards do not meet the requirements, such standards shall serve as the standards under this subtitle, with such amendments as the Secretary deems necessary.

(b) CONTINGENCY.—If the NAIC does not develop such model regulations within such period or the Secretary determines that such regulations do not specify standards that meet the requirements described in subsection (a), the Secretary shall specify, within 15 months after the date of the enactment of this Act, standards to carry out those requirements.

SEC. 152. APPLICATION OF STANDARDS TO CARRIERS THROUGH STATES.

(a) APPLICATION OF STANDARDS.—

(1) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in paragraph (2), a report on steps the State is taking to implement and enforce the standards established under section 151 with respect to carriers and health insurance coverage offered or renewed not later than such deadline.

(2) DEADLINE FOR REPORT.—The deadline under this paragraph is 1 year after the date the standards are established under section 151.

(b) FEDERAL ROLE.—

1 (1) NOTICE OF DEFICIENCY.—If the Secretary
2 determines that a State has failed to submit a report
3 by the deadline specified under subsection (a)(2) or
4 finds that the State has not implemented and pro-
5 vided adequate enforcement of the standards estab-
6 lished under section 151, the Secretary shall notify
7 the State and provide the State a period of 60 days
8 in which to submit such report or to implement and
9 enforce such standards.
10 (2) IMPLEMENTATION OF ALTERNATIVE.—
11 (A) IN GENERAL.—If, after such 60-day
12 period, the Secretary finds that such a failure
13 has not been corrected, the Secretary shall pro-
14 vide for such mechanism for the implementation
15 and enforcement of such standards in the State
16 as the Secretary determines to be appropriate.
17 (B) EFFECTIVE PERIOD.—Such implemen-
18 tation and enforcement shall take effect with
19 respect to carriers, and health insurance cov-
20 erage offered or renewed, on or after 3 months
21 after the date of the Secretary's finding under
22 subparagraph (A), and until the date the Sec-
23 retary finds that such a failure has been cor-
24 rected.

SEC. 153. APPLICATION TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Subject to subsection (b), sections 151 and 152 shall apply to group health plans providing health coverage in the same manner as they apply to carriers providing health insurance coverage.

(b) SUBSTITUTION OF REFERENCES.—For purposes of subsection (a), any reference in section 151 or 152 to—

(1) a State or the Secretary of Health and Human Services is deemed a reference to the Secretary of Labor, and

(2) a carrier or health insurance coverage is deemed a reference to a group health plan and health coverage, respectively.

SEC. 154. ENFORCEMENT.

(a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR EMPLOYERS AND GROUP HEALTH PLANS.—

(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of this title insofar as they relate to group health plans or employers shall be deemed to be provisions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor under this subtitle pursuant to paragraph (1), sec-

1 tion 505 of the Employee Retirement Income Secu-
2 rity Act of 1974 (29 U.S.C. 1135) shall apply.
3 (b) ENFORCEMENT BY EXCISE TAX FOR CAR-
4 RIERS.—
5 (1) IN GENERAL.—Chapter 43 of the Internal
6 Revenue Code of 1986 (relating to qualified pension
7 plans, etc.) is amended by adding at the end thereof
8 the following new section:
9 **"SEC. 4980C. FAILURE OF CARRIER TO COMPLY WITH**
10 **HEALTH INSURANCE STANDARDS.**
11 "(a) IMPOSITION OF TAX.—
12 "(1) IN GENERAL.—There is hereby imposed a
13 tax on the failure of a carrier to comply with the re-
14 quirements applicable to the carrier under parts 1
15 through 4 of subtitle A and subtitle B of title I of
16 the Health Insurance Affordability Act of 1996.
17 "(2) EXCEPTION.—Paragraph (1) shall not
18 apply to a failure by a carrier in a State if the Sec-
19 retary of Health and Human Services determines
20 that the State has in effect a regulatory enforcement
21 mechanism that provides adequate sanctions with re-
22 spect to such a failure by such a carrier.
23 "(b) AMOUNT OF TAX.—
24 "(1) IN GENERAL.—Subject to paragraph (2),
25 the amount of the tax imposed by subsection (a)

1 shall be $100 for each day during which such failure
2 persists for each individual to which such failure re-
3 lates. A rule similar to the rule of section
4 4980B(b)(3) shall apply for purposes of this section.
5 ''(2) LIMITATION.—The amount of the tax im-
6 posed by subsection (a) for a carrier with respect to
7 health insurance coverage shall not exceed 25 per-
8 cent of the amounts received for such coverage dur-
9 ing the period such failure persists.
10 ''(c) LIABILITY FOR TAX.—The tax imposed by this
11 section shall be paid by the carrier.
12 ''(d) EXCEPTIONS.—
13 ''(1) CORRECTIONS WITHIN 30 DAYS.—No tax
14 shall be imposed by subsection (a) by reason of any
15 failure if—
16 ''(A) such failure was due to reasonable
17 cause and not to willful neglect, and
18 ''(B) such failure is corrected within the
19 30-day period beginning on the earliest date the
20 carrier knew, or exercising reasonable diligence
21 would have known, that such failure existed.
22 ''(2) WAIVER BY SECRETARY.—In the case of a
23 failure which is due to reasonable cause and not to
24 willful neglect, the Secretary may waive part or all
25 of the tax imposed by subsection (a) to the extent

that payment of such tax would be excessive relative to the failure involved.

"(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance coverage' and 'carrier' have the respective meanings given such terms in section 193 of the Health Insurance Affordability Act of 1996."

(2) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end thereof the following new item:

"Sec. 4980C. Failure of carrier to comply with health insurance standards."

SEC. 155. LIMITATION ON SELF INSURANCE FOR SMALL EMPLOYERS.

A single employer plan (as defined in section 3(40)(B) of the Employee Retirement Income Security Act of 1974) may not offer health coverage other than through a carrier unless the plan has at least 100 eligible employees.

Subtitle G—Definitions; General Provisions

SEC. 191. GENERAL DEFINITIONS.

For purposes of this Act:

(1) APPLICABLE REGULATORY AUTHORITY.—The term "applicable regulatory authority" means, with respect to a carrier operating in a State—

(A) the State insurance commissioner, or

1 (B) the Secretary, in the case described in
2 section 152(b)(2).
3 (2) FAMILY MEMBER.—
4 (A) IN GENERAL.—Individuals are consid-
5 ered to be members of a family if—
6 (i) they are married, or
7 (ii) they have a legal parent-to-child
8 relationship (whether by natural birth or
9 adoption), if the child is—
10 (I) under 19 years of age,
11 (II) is under 25 years of age and
12 a full-time student, or
13 (III) an unmarried dependent re-
14 gardless of age who is incapable of
15 self-support because of mental or
16 physical disability which existed before
17 age 22.
18 (B) SPECIAL RULES.—Family members—
19 (i) include an adopted child and a rec-
20 ognized natural child;
21 (ii) include a stepchild or foster child
22 with respect to an individual but only if
23 the child lives with the individual in a reg-
24 ular parent-child relationship; and

1 (iii) include such other children as the
2 Secretary may specify, but shall not in-
3 clude an emancipated minor.
4 (3) PRISONER.—The term ''prisoner'' means,
5 as specified by the Secretary, an individual during a
6 period of imprisonment under Federal, State, or
7 local authority after conviction as an adult.
8 (4) SECRETARY.—The term ''Secretary'' means
9 the Secretary of Health and Human Services.
10 (5) STATE.—The term ''State'' means the 50
11 States, the District of Columbia, Puerto Rico, the
12 Virgin Islands, Guam, American Samoa, and the
13 Northern Mariana Islands.

14 **SEC. 192. DEFINITIONS RELATING TO EMPLOYMENT.**

15 (a) APPLICATION OF ERISA DEFINITIONS.—Except
16 as otherwise provided in this Act, terms used in this Act
17 shall have the meanings applicable to such terms under
18 section 3 of the Employee Retirement Income Security Act
19 of 1974 (29 U.S.C. 1002).
20 (b) ADDITIONAL DEFINITIONS.—For purposes of this
21 title:
22 (1) COUNTABLE EMPLOYEE.—The term ''count-
23 able employee'' means, with respect to an employer
24 for a month, any employee other than an employee
25 whose normal work week is less than 10 hours.

1 (2) LARGE EMPLOYER.—The term ''large em-
2 ployer'' means an employer that is not a small em-
3 ployer (as defined in paragraph (4)).
4 (3) QUALIFYING EMPLOYEE.—
5 (A) IN GENERAL.—The term ''qualifying
6 employee'' means, with respect to an employer
7 for a month, any employee other than—
8 (i) a part-time, seasonal, or temporary
9 employee (as defined in subparagraph
10 (B)); or
11 (ii) an employee who is a child de-
12 scribed in section 191(2)(A)(ii).
13 (B) PART-TIME, SEASONAL, OR TEM-
14 PORARY EMPLOYEE DEFINED.—For purposes of
15 subparagraph (A), the term ''part-time, sea-
16 sonal, or temporary employee'' means any of
17 the following employees with respect to a
18 month:
19 (i) CERTAIN PART-TIME EMPLOY-
20 EES.—Any employee whose normal work
21 week is reasonably expected as of the first
22 day of such month to be less than 20
23 hours.
24 (ii) SEASONAL OR TEMPORARY EM-
25 PLOYEES.—Any employee who is not rea-

1 sonably expected as of the first day of such
2 month to be employed by the employer for
3 a period of 120 consecutive days during
4 any 365-day period that includes such first
5 day.

6 (iii) DELAY FOR CERTAIN PART-TIME
7 EMPLOYEES.—Any employee whose normal
8 work week is reasonably expected as of the
9 first day of such month to be at least 20
10 hours, but less than 35 hours, and the nor-
11 mal work week of the employee during the
12 preceding 3 months was less than 20
13 hours.

14 (4) SMALL EMPLOYER.—The term ''small em-
15 ployer'' means, with respect to a calendar year, an
16 employer that normally employs more than 1 but
17 less than 100 countable employees on a typical busi-
18 ness day. For the purposes of this paragraph, the
19 term ''employee'' includes a self-employed individual.
20 For purposes of determining if an employer is a
21 small employer, rules similar to the rules of sub-
22 section (b) and (c) of section 414 of the Internal
23 Revenue Code of 1986 shall apply.

1 **SEC. 193. DEFINITIONS RELATING TO HEALTH COVERAGE,**
2 **PLANS, AND CARRIERS.**

3 Except as otherwise provided, for purposes of this
4 Act:

5 (1) BENCHMARK COVERAGE.—The term
6 ''benchmark coverage'' means the standard option of
7 the Blue Cross-Blue Shield plan offered under the
8 Federal Employees Health Benefits Program under
9 chapter 89 of title 5, United States Code, as in ef-
10 fect during 1994.

11 (2) CARRIER.—The term ''carrier'' means a li-
12 censed insurance company, an entity offering pre-
13 paid hospital or medical services, and a health main-
14 tenance organization, and includes a similar organi-
15 zation regulated under State law for solvency.

16 (3) CLASS OF FAMILY COVERAGE.—The term
17 ''class of family coverage'' means the 4 classes de-
18 scribed in section 121(a)(3).

19 (4) FAIR RATING AREA.—The term ''fair rating
20 area'' means a geographic area identified by a State
21 for purposes of section 121(a)(2).

22 (5) GROUP HEALTH PLAN.—The term ''group
23 health plan'' means an employee welfare benefit plan
24 providing medical care (as defined in section 213(d)
25 of the Internal Revenue Code of 1986) to partici-
26 pants or beneficiaries directly or through insurance,

1 reimbursement, or otherwise, but does not include
2 any type of coverage excluded from the definition of
3 a health insurance coverage under paragraph (7)(B).
4 (6) HEALTH COVERAGE.—The term ''health
5 coverage'' means health insurance coverage provided
6 by a carrier or medical care provided under a group
7 health plan.
8 (7) HEALTH INSURANCE COVERAGE.—
9 (A) IN GENERAL.—Except as provided in
10 subparagraph (B), the term ''health insurance
11 coverage'' means any hospital or medical service
12 policy or certificate, hospital or medical service
13 plan contract, or health maintenance organiza-
14 tion group contract offered by a carrier.
15 (B) EXCEPTION.—Such term does not in-
16 clude any of the following (or any combination
17 of the following):
18 (i) Coverage only for accident, dental,
19 vision, disability income, or long-term care
20 insurance, or any combination thereof.
21 (ii) Medicare supplemental health in-
22 surance.
23 (iii) Coverage issued as a supplement
24 to liability insurance.

1 (iv) Liability insurance, including gen-
2 eral liability insurance and automobile li-
3 ability insurance.
4 (v) Workers' compensation or similar
5 insurance.
6 (vi) Automobile medical-payment in-
7 surance.
8 (vii) Coverage for a specified disease
9 or illness.
10 (viii) A hospital or fixed indemnity
11 policy.
12 (ix) Coverage provided exclusively to
13 individuals who are not eligible individuals.
14 (8) HEALTH MAINTENANCE ORGANIZATION.—
15 The term ''health maintenance organization'' in-
16 cludes, as defined in standards established under
17 section 143, an organization that provides health in-
18 surance coverage which meets specified standards
19 and under which health services are offered to be
20 provided on a prepaid, at-risk basis primarily
21 through a defined set of providers.
22 (9) INDIVIDUAL/SMALL GROUP MARKET.—The
23 term ''individual/small group market'' means the in-
24 surance market offered—

(A) to individuals seeking health insurance coverage on behalf of themselves (and their dependents) insofar as no employer is seeking such coverage on behalf of the individual, and

(B) to small employers seeking health insurance coverage on behalf of their employees (and their dependents),

regardless of whether or not such coverage is made available directly or through a multiple employer welfare arrangement, association, or otherwise.

(10) MANAGED CARE ARRANGEMENTS.—

(A) MANAGED CARE ARRANGEMENT.—The term ''managed care arrangement'' means, with respect to a group health plan or under health insurance coverage, an arrangement under such plan or coverage under which providers agree to provide items and services covered under the arrangement to individuals covered under the plan or who have such coverage.

(B) PROVIDER NETWORK.—The term ''provider network'' means, with respect to a group health plan or health insurance coverage, providers who have entered into an agreement described in subparagraph (A).

1 (11) MULTIPLE EMPLOYER WELFARE AR-
2 RANGEMENT.—The term ''multiple employer welfare
3 arrangement'' shall have the meaning applicable
4 under section 3(40) of the Employee Retirement In-
5 come Security Act of 1974.
6 (12) NAIC.—The term ''NAIC'' means the Na-
7 tional Association of Insurance Commissioners.
8 (13) OPTIONS.—Each of the following is a
9 ''type of coverage option'' in relation to standard
10 coverage:
11 (A) FEE-FOR-SERVICE OPTION.—Standard
12 coverage is considered to provide a ''fee-for-
13 service option'' if, regardless of whether covered
14 individuals may receive benefits through a pro-
15 vider network, benefits with respect to the cov-
16 ered items and services in the coverage are
17 made available for such items and services pro-
18 vided through any lawful provider of such cov-
19 ered items and services and payment is made to
20 such a provider whether or not there is a con-
21 tractual arrangement between the provider and
22 the carrier or plan.
23 (B) MANAGED CARE OPTION.—Standard
24 coverage is considered to provide a ''managed
25 care option'' if benefits with respect to the cov-

1 ered items and services in the coverage are
2 made available exclusively through a provider
3 network, except in the case of emergency serv-
4 ices and as otherwise required under law.
5 (C) POINT-OF-SERVICE OPTION.—Standard
6 coverage is considered to provide a ''point-of-
7 service option'' if the benefits with respect to
8 covered items and services in the coverage are
9 made available principally through a managed
10 care arrangement, with the choice of the en-
11 rollee to obtain such benefits for items and
12 services provided through any lawful provider of
13 such covered items and services. The coverage
14 may provide for different cost sharing schedules
15 based on whether the items and services are
16 provided through such an arrangement or out-
17 side such an arrangement.
18 (14) QUALIFIED HEALTH COVERAGE.—The
19 term ''qualified health coverage'' has the meaning
20 given such term in section 141.
21 (15) STANDARD COVERAGE.—The term ''stand-
22 ard coverage'' means coverage provided consistent
23 with section 142(a).

1 (16) STATE COMMISSIONER OF INSURANCE.—
2 The term ''State commissioner of insurance'' in-
3 cludes a State superintendent of insurance.

4 **SEC. 194. DEFINITIONS RELATING TO RESIDENCE AND IM-**
5 **MIGRATION STATUS.**

6 Except as otherwise provided, for purposes of this
7 Act:

8 (1) ALIEN PERMANENTLY RESIDING IN THE
9 UNITED STATES UNDER COLOR OF LAW.—The term
10 ''alien permanently residing in the United States
11 under color of law'' means an alien lawfully admitted
12 for permanent residence (within the meaning of sec-
13 tion 101(a)(20) of the Immigration and Nationality
14 Act), and includes any of the following (such status
15 not having changed):

16 (A) An alien who is admitted as a refugee
17 under section 207 of the Immigration and Na-
18 tionality Act.

19 (B) An alien who is granted asylum under
20 section 208 of such Act.

21 (C) An alien whose deportation is withheld
22 under section 243(h) of such Act.

23 (D) An alien whose deportation is sus-
24 pended pursuant to section 244 of such Act.

1 (E) An alien who is granted conditional
2 entry pursuant to section 203(a)(7) of such Act
3 as in effect before April 1, 1980.

4 (F) An alien who is admitted for tem-
5 porary residence under section 210, 210A, or
6 245A of such Act.

7 (G) An alien who is within a class of aliens
8 lawfully present in the United States pursuant
9 to any other provision of such Act, if (i) the At-
10 torney General determines that the continued
11 presence of such class of aliens serves a human-
12 itarian or other compelling public interest, and
13 (ii) the Secretary determines that such interest
14 would be further served by treating each such
15 alien within such class as a ''legal permanent
16 resident'' for purposes of this Act or who has
17 been granted extended voluntary departure as a
18 member of a nationality group.

19 (H) An alien who is the spouse or unmar-
20 ried child under 21 years of age of a citizen of
21 the United States, or the parent of such a citi-
22 zen if the citizen is over 21 years of age, and
23 with respect to whom an application for adjust-
24 ment to lawful permanent residence is pending.

1 (I) An alien within such other classification
2 of permanent resident aliens as the Secretary
3 may establish by regulation.

4 (2) LONG-TERM NONIMMIGRANT.—The term
5 ''long-term nonimmigrant'' means a nonimmigrant
6 described in subparagraph (E), (H), (I), (K), (L),
7 (N), (O), (Q), or (R) of section 101(a)(15) of the
8 Immigration and Nationality Act.

9 (3) QUALIFYING INDIVIDUAL.—The term
10 ''qualifying individual'' means, an individual who is
11 a resident of the United States, who is not a pris-
12 oner, and is—

13 (A) a citizen or national of the United
14 States;

15 (B) an alien permanently residing in the
16 United States under color of law (as defined in
17 paragraph (1)); or

18 (C) a long-term nonimmigrant (as defined
19 in paragraph (2)).

20 **SEC. 195. EFFECTIVE DATES.**

21 The requirements of this title shall apply with respect
22 to—

23 (1) group health plans for plan years beginning
24 on or after January 1, 1997, and

(2) carriers (with respect to coverage other than under a group health plan) as of January 1, 1997.

TITLE II—ADMINISTRATIVE SIMPLIFICATION

SEC. 200. PURPOSE.

It is the purpose of this title to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act, by encouraging the development of a health information network through the adoption of standards and the establishment of requirements for the electronic transmission of certain health information.

SEC. 201. DEFINITIONS.

For purposes of this title:

(1) CODE SET.—The term "code set" means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(2) COORDINATION OF BENEFITS.—The term "coordination of benefits" means determining and coordinating the financial obligations of plan sponsors when health care benefits are payable by more than one such sponsor.

1 (3) HEALTH INFORMATION.—The term ''health
2 information'' means any information that relates to
3 the past, present, or future physical or mental health
4 or condition or functional status of an individual,
5 the provision of health care to an individual, or pay-
6 ment for the provision of health care to an individ-
7 ual.
8 (4) HEALTH INFORMATION NETWORK.—The
9 term ''health information network'' means the health
10 information system that is formed through the appli-
11 cation of the requirements and standards established
12 under this title.
13 (5) HEALTH INFORMATION NETWORK SERV-
14 ICE.—The term ''health information network serv-
15 ice''—
16 (A) means a private entity or an entity op-
17 erated by a State that enters into contracts—
18 (i) to process or facilitate the process-
19 ing of nonstandard data elements of health
20 information into standard data elements;
21 (ii) to provide the means by which
22 persons are connected to the health infor-
23 mation network for purposes of meeting
24 the requirements of this title, including the

1 holding of standard data elements of
2 health information;
3 (iii) to provide authorized access to
4 health information through the health in-
5 formation network; or
6 (iv) to provide specific information
7 processing services, such as automated co-
8 ordination of benefits and claims trans-
9 action routing; and
10 (B) includes a health information security
11 organization.
12 (6) HEALTH INFORMATION SECURITY ORGANI-
13 ZATION.—The term ''health information security or-
14 ganization'' means a private entity or an entity oper-
15 ated by a State that accesses standard data elements
16 of health information through the health information
17 network, processes such information into non-identi-
18 fiable health information, and may store such infor-
19 mation.
20 (7) HEALTH PROVIDER.—The term ''health
21 provider'' includes a provider of services (as defined
22 in section 1861(u) of the Social Security Act), a pro-
23 vider of medical or other health services (as defined
24 in section 1861(s) of such Act), and any other per-

1 son (other than a plan sponsor) furnishing health
2 care items or services.
3 (8) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
4 FORMATION.—The term ''individually identifiable
5 health information'' means health information in the
6 health information network—
7 (A) that identifies an individual who is the
8 subject of the information; or
9 (B) with respect to which there is a rea-
10 sonable basis to believe that the information
11 can be used to identify such an individual.
12 (9) NONIDENTIFIABLE HEALTH INFORMA-
13 TION.—The term ''nonidentifiable health informa-
14 tion'' means health information that is not individ-
15 ually identifiable health information.
16 (10) PLAN SPONSOR.—The term ''plan spon-
17 sor'' means—
18 (A) a carrier (as defined in section 193(2))
19 providing health insurance coverage (as defined
20 in section 193(7));
21 (B) a group health plan;
22 (C) an association or other entity which es-
23 tablishes or maintains a multiple employer wel-
24 fare arrangement (as defined in section
25 193(11)) providing benefits consisting of medi-

cal care described in section 607(1) of the Employee Retirement Income Security Act of 1974; and

(D) a State, or the Federal Government, acting in a capacity as a provider of health benefits to eligible individuals that is equivalent to that of a carrier.

(11) STANDARD.—The term ''standard'', when used with reference to a transaction or to data elements of health information, means that the transaction or data elements meet any standard adopted by the Secretary under subtitle A that applies to the transaction or data elements.

Subtitle A—Standards for Data Elements and Transactions

SEC. 211. GENERAL REQUIREMENTS ON SECRETARY.

(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this subtitle that are—

(1) consistent with the objective of reducing the costs of providing and paying for health care; and

(2) in use and generally accepted, developed, or modified by the standard-setting organizations accredited by the American National Standard Institute.

1 (b) INITIAL STANDARDS.—The Secretary may de-
2 velop an expedited process for the adoption of initial
3 standards under this part.
4 (c) PROTECTION OF COMMERCIAL INFORMATION.—
5 In adopting standards under this part, the Secretary may
6 not require disclosure of trade secrets or confidential com-
7 mercial information by any person.

8 **SEC. 212. STANDARDS FOR DATA ELEMENTS OF HEALTH IN-**
9 **FORMATION.**

10 (a) IN GENERAL.—The Secretary shall adopt stand-
11 ards necessary to make uniform and compatible for elec-
12 tronic transmission through the health information net-
13 work the data elements of any health information that the
14 Secretary determines is appropriate for transmission in
15 connection with a transaction described in section 221.
16 (b) ADDITIONS.—The Secretary may make additions
17 to any set of data elements adopted under subsection (a)
18 as the Secretary determines appropriate in a manner that
19 minimizes the disruption and cost of compliance with such
20 additions.
21 (c) CERTAIN DATA ELEMENTS.—
22 (1) UNIQUE HEALTH IDENTIFIERS.—The Sec-
23 retary shall establish a system to provide for a
24 standard unique health identifier for each individual,

employer, plan sponsor, and health provider for use in the health care system.

(2) CODE SETS.—

(A) IN GENERAL.—The Secretary, in consultation with experts from the private sector and Federal agencies, shall—

(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution of code sets and modifications to code sets.

SEC. 213. INFORMATION TRANSACTION STANDARDS.

(a) IN GENERAL.—The Secretary shall adopt technical standards that are consistent with the health information network privacy standards adopted under section 214 relating to the method by which standard data elements of health information may be transmitted electronically, including standards with respect to the format in which such data elements may be transmitted.

1 (b) SPECIAL RULE FOR COORDINATION OF BENE-
2 FITS.—Any standard adopted by the Secretary under
3 paragraph (1) that relates to coordination of benefits shall
4 provide that a claim for reimbursement for health services
5 furnished shall be tested, by an algorithm specified by the
6 Secretary, against all records of enrollment and eligibility
7 for the individual who received such services that are avail-
8 able to the recipient of the claim through the health infor-
9 mation network to determine any primary and secondary
10 obligors for payment.

11 (c) ELECTRONIC SIGNATURE.—The Secretary, in co-
12 ordination with the Secretary of Commerce, shall promul-
13 gate regulations specifying procedures for the electronic
14 transmission and authentication of signatures, compliance
15 with which shall be deemed to satisfy State and Federal
16 statutory requirements for written signatures with respect
17 to transactions described in section 221 and written signa-
18 tures on health records and prescriptions.

19 (d) STANDARDS FOR CLAIMS FOR CLINICAL LABORA-
20 TORY TESTS.—The standards under this section shall pro-
21 vide that claims for clinical laboratory tests for which ben-
22 efits are payable by a plan sponsor shall be submitted di-
23 rectly by the person or entity that performed (or super-
24 vised the performance of) the tests to the sponsor in a
25 manner consistent with (and subject to such exceptions

1 as are provided under) the requirement for direct submis-
2 sion of such claims under the medicare program.

3 **SEC. 214. HEALTH INFORMATION NETWORK PRIVACY**
4 **STANDARDS.**

5 The Secretary shall adopt standards respecting the
6 privacy of individually identifiable health information that
7 is in the health information network. Such standards shall
8 include standards concerning at least the following:

9 (1) The rights of an individual who is the sub-
10 ject of such information.

11 (2) The procedures to be established for the ex-
12 ercise of such rights.

13 (3) The uses and disclosures of such informa-
14 tion that are authorized or required.

15 (4) Safeguards for the security of such informa-
16 tion and adequate security practices.

17 **SEC. 215. TIMETABLES FOR ADOPTION OF STANDARDS.**

18 (a) INITIAL STANDARDS FOR DATA ELEMENTS.—
19 The Secretary shall adopt standards relating to—

20 (1) the data elements for the information de-
21 scribed in section 212(a) not later than 9 months
22 after the date of the enactment of this Act (except
23 in the case of standards with respect to data ele-
24 ments for claims attachments, which shall be adopt-

1 ed not later than 24 months after the date of the
2 enactment of this Act); and
3 (2) any addition to a set of data elements, in
4 conjunction with making such an addition.
5 (b) INITIAL PRIVACY STANDARDS.—The Secretary
6 shall adopt standards relating to the privacy of individ-
7 ually identifiable health information in the health informa-
8 tion network under section 214 not later than 12 months
9 after the date of the enactment of this Act.
10 (c) INITIAL STANDARDS FOR INFORMATION TRANS-
11 ACTIONS.—The Secretary shall adopt standards relating
12 to information transactions under section 213 not later
13 than 18 months after the date of the enactment of this
14 Act (except in the case of standards for claims attach-
15 ments, which shall be adopted not later than 24 months
16 after the date of the enactment of this Act).
17 (d) MODIFICATIONS TO STANDARDS.—
18 (1) IN GENERAL.—Except as provided in para-
19 graph (2), the Secretary shall review the standards
20 adopted under this subtitle and shall adopt modified
21 standards as determined appropriate, but not more
22 frequently than once every 6 months. Any modifica-
23 tion to standards shall be completed in a manner
24 which minimizes the disruption to, and costs of com-
25 pliance incurred by, a plan sponsor, health provider,

1 or health plan purchasing organization that is re-
2 quired to comply with subtitle B.
3 (2) SPECIAL RULES.—
4 (A) MODIFICATIONS DURING FIRST 12-
5 MONTH PERIOD.—Except with respect to addi-
6 tions and modifications to code sets under sub-
7 paragraph (B), the Secretary may not adopt
8 any modification to a standard adopted under
9 this subtitle during the 12-month period begin-
10 ning on the date the standard is adopted, un-
11 less the Secretary determines that the modifica-
12 tion is necessary in order to permit a plan spon-
13 sor, a health provider, or a health plan purchas-
14 ing organization to comply with subtitle B.
15 (B) ADDITIONS AND MODIFICATIONS TO
16 CODE SETS.—
17 (i) IN GENERAL.—The Secretary shall
18 ensure that procedures exist for the rou-
19 tine maintenance, testing, enhancement,
20 and expansion of code sets.
21 (ii) ADDITIONAL RULES.—If a code
22 set is modified under this subsection, the
23 modified code set shall include instructions
24 on how data elements that were encoded
25 prior to the modification are to be con-

verted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption to, and costs of compliance incurred by, a plan sponsor, health provider, or health plan purchasing organization that is required to comply with subtitle B.

(e) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this part. Such process may include demonstration projects and analyses of the cost of implementing such standards and modifications.

Subtitle B—Requirements with Respect to Certain Transactions and Information

SEC. 221. STANDARD TRANSACTIONS AND INFORMATION.

(a) TRANSACTIONS BY SPONSORS.—

(1) TRANSACTIONS WITH PROVIDERS.—If a plan sponsor conducts any of the transactions described in paragraph (3) with a health provider—

(A) the transaction shall be a standard transaction; and

1 (B) the health information transmitted by
2 the sponsor to the provider or by the provider
3 to the sponsor in connection with the trans-
4 action shall be in the form of standard data ele-
5 ments.
6 (2) TRANSACTIONS WITH SPONSORS.—If a plan
7 sponsor conducts any of the transactions described
8 in paragraph (3) with another plan sponsor—
9 (A) the transaction shall be a standard
10 transaction; and
11 (B) the health information transmitted by
12 either sponsor in connection with the trans-
13 action shall be in the form of standard data ele-
14 ments.
15 (3) TRANSACTIONS.—The transactions referred
16 to in paragraphs (1) and (2) are the following:
17 (A) Verification of eligibility for benefits.
18 (B) Coordination of benefits.
19 (C) Claim submission.
20 (D) Claim attachment submission.
21 (E) Claim status notification.
22 (F) Claim status verification.
23 (G) Claim adjudication.
24 (H) Payment and remittance advice.

1 (I) Certification or authorization of a re-
2 ferral to a health provider who is not part of a
3 provider network.

4 (b) USE OF HEALTH INFORMATION NETWORK SERV-
5 ICES.—A plan sponsor, a health provider, or a health plan
6 purchasing organization may comply with any provision
7 of this section by entering into an agreement or other ar-
8 rangement with a health information network service cer-
9 tified under section 231 pursuant to which the service un-
10 dertakes the duties applicable to the sponsor, provider, or
11 organization under the provision.

12 **SEC. 222. ACCESSING HEALTH INFORMATION FOR AUTHOR-**
13 **IZED PURPOSES.**

14 (a) PROCUREMENT RULE FOR GOVERNMENT AGEN-
15 CIES.—

16 (1) IN GENERAL.—A health information secu-
17 rity organization that is certified under section 231
18 shall make available to a Federal or State agency,
19 pursuant to a cost-type contract (as defined under
20 the Federal Acquisition Regulation), any non-identi-
21 fiable health information, including non-identifiable
22 health information that is derived from individually
23 identifiable health information, that—

1 (A) is held by the service or may be ob-
2 tained by the service under paragraph (2) or
3 subsection (b);
4 (B) consists of data elements that are sub-
5 ject to a standard under subtitle A; and
6 (C) is requested by the agency to fulfill a
7 requirement under this Act.
8 (2) CERTAIN INFORMATION AVAILABLE AT LOW
9 COST.—If a health information security organization
10 requires health information consisting of data ele-
11 ments that are subject to a standard under subtitle
12 A from a plan sponsor or a health provider in order
13 to comply with a request made by a Federal or State
14 agency under paragraph (1), the sponsor or provider
15 shall make such information available to such orga-
16 nization for a charge that does not exceed the rea-
17 sonable cost of transmitting the information.
18 (b) PROCUREMENT RULE FOR INFORMATION SECU-
19 RITY ORGANIZATIONS.—A health information security or-
20 ganization that makes non-identifiable health information
21 available to a Federal or State agency under subsection
22 (a) shall make such non-identifiable information available,
23 for a charge that does not exceed the reasonable cost of
24 transmitting the information, to any other health informa-
25 tion security organization that—

1 (A) is certified under section 231; and
2 (B) requests the information.

3 **SEC. 223. ENSURING AVAILABILITY OF INFORMATION.**

4 The Secretary shall establish a procedure under
5 which a plan sponsor or health provider that does not have
6 the ability to transmit standard data elements directly,
7 and does not have access to a health information network
8 service certified under section 231, may comply with the
9 provisions of this part.

10 **SEC. 224. TIMETABLES FOR COMPLIANCE WITH REQUIRE-**
11 **MENTS.**

12 (a) INITIAL COMPLIANCE.—
13 (1) IN GENERAL.—Not later than 12 months
14 after the date on which standards are adopted under
15 subtitle A with respect to a type of transaction, or
16 data elements for a type of health information, a
17 plan sponsor, health provider, or health plan pur-
18 chasing organization shall comply with the require-
19 ments of this subtitle with respect to such trans-
20 action or information.
21 (2) ADDITIONAL DATA ELEMENTS.—Not later
22 than 12 months after the date on which the Sec-
23 retary adopts an addition to a set of data elements
24 for health information under section 212, a plan
25 sponsor, health provider, or health plan purchasing

1 organization shall comply with the requirements of
2 this subtitle using such data elements.

3 (b) COMPLIANCE WITH MODIFIED STANDARDS.—

4 (1) IN GENERAL.—If the Secretary adopts a
5 modified standard under section 215(c), a plan
6 sponsor, health provider, or health plan purchasing
7 organization shall comply with the modified standard
8 at such time as the Secretary determines appro-
9 priate, taking into account the time needed to com-
10 ply due to the nature and extent of the modification.

11 (2) SPECIAL RULE.—In the case of a modifica-
12 tion to a standard that does not occur within the 12-
13 month period beginning on the date the standard is
14 adopted, the time determined appropriate by the
15 Secretary under paragraph (1) may not be—

16 (A) earlier than the last day of the 90-day
17 period beginning on the date the modified
18 standard is adopted; or

19 (B) later than the last day of the 12-
20 month period beginning on the date the modi-
21 fied standard is adopted.

Subtitle C—Miscellaneous Provisions

SEC. 231. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK SERVICES.

(a) STANDARDS FOR OPERATION.—The Secretary shall establish standards with respect to the operation of health information network services, including standards ensuring that such services—

(1) develop, operate, and cooperate with one another to form the health information network;

(2) meet all of the standards adopted under subtitle A that are applicable to the services;

(3) make public information concerning their performance, as measured by uniform indicators such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicator determined appropriate by the Secretary; and

(4) if they are part of a larger organization, have policies and procedures in place which isolate their activities with respect to processing information in a manner that prevents access to such information by such larger organization.

(b) CERTIFICATION BY THE SECRETARY.—

1 (1) ESTABLISHMENT.—Not later than 18
2 months after the date of the enactment of this Act,
3 the Secretary shall establish a certification proce-
4 dure for health information network services which
5 ensures that certified services are qualified to meet
6 the requirements of this title and the standards es-
7 tablished by the Secretary under this section. Such
8 certification procedure shall be implemented in a
9 manner that minimizes the costs and delays of oper-
10 ations for such services.
11 (2) APPLICATION.—Each entity desiring to be
12 certified as a health information network service
13 shall apply to the Secretary for certification in a
14 form and manner determined appropriate by the
15 Secretary.
16 (3) AUDITS AND REPORTS.—The procedure es-
17 tablished under paragraph (1) shall provide for au-
18 dits by the Secretary and reports by an entity cer-
19 tified under this section as the Secretary determines
20 appropriate in order to monitor such entity's compli-
21 ance with the requirements of this title and the
22 standards established by the Secretary under this
23 section.

1 (4) RECERTIFICATION.—A health information
2 network service shall be recertified under this sub-
3 section at least every 3 years.
4 (c) LOSS OF CERTIFICATION.—
5 (1) MANDATORY TERMINATION.—Except as
6 provided in paragraph (2), if a health information
7 network service violates a health information net-
8 work privacy standard adopted under section 214
9 that is applicable to the service, its certification
10 under this section shall be terminated unless the
11 Secretary determines that appropriate corrective ac-
12 tion has been taken.
13 (2) CONDITIONAL CERTIFICATION—The Sec-
14 retary may establish a procedure under which a
15 health information network service may remain cer-
16 tified on a conditional basis if the service is operat-
17 ing consistently with a plan intended to correct any
18 violations described in paragraph (1). Such proce-
19 dure may provide for the appointment of a trustee
20 to continue operation of the service until the require-
21 ments for full certification are met.
22 (d) CERTIFICATION BY PRIVATE ENTITIES.—The
23 Secretary may designate private entities to conduct the
24 certification procedures established by the Secretary under
25 this section. A health information network service certified

by such an entity in accordance with such designation shall be considered to be certified by the Secretary.

(e) INFORMATION HELD BY HEALTH INFORMATION NETWORK SERVICES.—If a health information network service certified under this section loses its certified status or takes any action that would threaten the continued availability of the standard data elements of health information held by such service, such data elements shall be transferred to another health information network service certified under this section that has been designated by the Secretary.

SEC. 232. IMPOSITION OF ADDITIONAL REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (c), after the Secretary has established standards under section 212 that are necessary to make uniform and compatible for electronic transmission the data elements that the Secretary determines are appropriate for transmission in connection with a transaction described in subtitle B, an individual or entity may not require an individual or entity, to provide in any manner any additional data element in connection with—

(1) the transaction; or

(2) an inquiry with respect to the transaction.

(b) TRANSMISSION METHOD.—Except as provided in subsection (c), after the Secretary has established stand-

1 ards under section 213 relating to the method by which
2 data elements that the Secretary determines are appro-
3 priate for transmission in connection with a transaction
4 described in subtitle B may be transmitted electronically,
5 an individual or entity may not require an individual or
6 entity to transmit any data element in a manner inconsist-
7 ent with the standards in connection with—
8 (1) the transaction; or
9 (2) an inquiry with respect to the transaction.
10 (c) EXCEPTION.—Subsections (a) and (b) do not
11 apply if—
12 (1) an individual or entity voluntarily agrees to
13 provide the additional data element; or
14 (2) a waiver is granted under subsection (d) to
15 permit the requirement to be imposed.
16 (d) CONDITIONS FOR WAIVERS.—
17 (1) IN GENERAL.—An individual or entity may
18 request a waiver from the Secretary in order to im-
19 pose on an individual or entity a requirement other-
20 wise prohibited under subsection (a) or (b). Subject
21 to paragraph (2), the Secretary may grant such a
22 waiver.
23 (2) CONSIDERATION OF WAIVER REQUESTS.—A
24 waiver may not be granted under this subsection to
25 impose an otherwise prohibited requirement unless

1 the Secretary determines that the value of any additional information to be provided under the require-
3 ment for research or other purposes significantly
4 outweighs the administrative cost of the imposition
5 of the requirement, taking into account the burden
6 of the timing of the imposition of the requirement.

7 (e) ANONYMOUS REPORTING.—If an individual or en-
8 tity attempts to impose on an individual or entity a re-
9 quirement prohibited under subsection (a) or (b), the indi-
10 vidual or entity on whom the requirement is being imposed
11 may contact the Secretary. The Secretary shall develop a
12 procedure under which an individual or entity that con-
13 tacts the Secretary under the preceding sentence shall re-
14 main anonymous. The Secretary shall notify the individual
15 or entity imposing the requirement that the requirement
16 may not be imposed unless the other individual or entity
17 voluntarily agrees to such requirement or a waiver is ob-
18 tained under subsection (d).

19 **SEC. 233. EFFECT ON STATE LAW.**

20 (a) IN GENERAL.—Except as otherwise provided in
21 this section, a provision, requirement, or standard under
22 this title shall supersede any contrary provision of State
23 law.

24 (b) STATE ''QUILL AND PEN'' LAWS.—A State may
25 not establish, continue in effect, or enforce any provision

1 of State law that requires medical or health plan records
2 (including billing information) to be maintained or trans-
3 mitted in written rather than electronic form, except
4 where the Secretary determines that the provision is nec-
5 essary to prevent fraud and abuse, with respect to con-
6 trolled substances, or for other purposes.

7 (c) PUBLIC HEALTH REPORTING.—Nothing in this
8 title shall be construed to invalidate or limit the authority,
9 power, or procedures established under any law providing
10 for the reporting of disease or injury, child abuse, birth,
11 or death, public health surveillance, or public health inves-
12 tigation or intervention.

13 (d) PUBLIC USE FUNCTIONS.—Nothing in this title
14 shall be construed to limit the authority of a Federal or
15 State agency to make non-identifiable health information
16 available for public use.

17 (e) PAYMENT FOR HEALTH CARE SERVICES OR PRE-
18 MIUMS.—Nothing in this title shall be construed to pro-
19 hibit a consumer from paying for health care items or
20 services, or plan or health insurance coverage premiums,
21 by debit, credit, or other payment cards or numbers or
22 other electronic payment means.

TITLE III—ANTITRUST

SEC. 301. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF HEALTH PLANS.

(a) IN GENERAL.—The Attorney General shall provide for the development and publication of explicit guidelines on the application of antitrust laws to the activities of health plans. The guidelines shall be designed to facilitate development and operation of plans, consistent with the antitrust laws.

(b) REVIEW PROCESS.—The Attorney General shall establish a review process under which the administrator or sponsor of a health plan (or organization that proposes to administer or sponsor a health plan) may submit a request to the Attorney General to obtain a prompt opinion (but in no event later than 90 days after the Attorney General receives the request) from the Department of Justice on the plan's conformity with the Federal antitrust laws.

(c) DEFINITIONS.—In this section—

(1) the term "antitrust laws"—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act

1 (15 U.S.C. 45) to the extent such section ap-
2 plies to unfair methods of competition, and
3 (B) includes any State law similar to the
4 laws referred to in subparagraph (A); and
5 (2) the term "health plan" means any contract
6 or arrangement under which an entity bears all or
7 part of the cost of providing health care items and
8 services, including a hospital or medical expense in-
9 curred policy or certificate, hospital or medical serv-
10 ice plan contract, or health maintenance subscriber
11 contract, but does not include—
12 (A) coverage only for accident, dental, vi-
13 sion, disability, or long term care, medicare
14 supplemental health insurance, or any combina-
15 tion thereof,
16 (B) coverage issued as a supplement to li-
17 ability insurance,
18 (C) workers' compensation or similar in-
19 surance, or
20 (D) automobile medical-payment insur-
21 ance.

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