

103^D CONGRESS
2^D SESSION

H. R. 4410

To provide for universal affordable access to health care and health insurance through tax and savings incentives, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 12, 1994

Mr. JACOBS (for himself and Mr. INHOFE) introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, and Education and Labor

A BILL

To provide for universal affordable access to health care and health insurance through tax and savings incentives, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Bipartisan Health Security Reform Act of 1994”.

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

TITLE I—AMENDMENTS OF INTERNAL REVENUE CODE OF 1986

Subtitle A—Tax Incentives for Purchase of Health Care Coverage

Sec. 101. Refundable credit for purchase of health care coverage.

Subtitle B—Medical Care Savings Accounts

Sec. 111. Medical care savings accounts.

Sec. 112. Unused amounts in flexible spending accounts transferable to medical care savings accounts.

Subtitle C—Expansion of COBRA Continuation Coverage

Sec. 121. Expansion of COBRA continuation coverage.

TITLE II—INSURANCE REFORM

Subtitle A—Employer Insurance Protections

Sec. 201. Small group employer insurance protections.

Sec. 202. General portability requirement for employer-based health insurance.

Sec. 203. Exemption from certain State mandates.

Sec. 204. Enforcement.

Sec. 205. Definitions.

Sec. 206. Effective date.

Subtitle B—Guaranteeing Portability of Health Insurance for Individuals

Sec. 211. Coverage of individual health benefit plans.

Sec. 212. Portability protections.

Sec. 213. Definitions.

Sec. 214. Effective date.

Subtitle C—Assuring Health Insurance Coverage for Uninsurable Individuals

Sec. 221. Establishment of programs by States.

Sec. 222. Uninsurable individuals eligible for coverage.

Sec. 223. Qualified health insurance coverage under program.

Sec. 224. Funding of program.

Sec. 225. Administration.

TITLE III—MEDICAID REFORM

Sec. 301. Providing coverage for out-of-pocket expenses under private health plans.

TITLE IV—MEDICAL CHARGE DISCLOSURE

Sec. 401. Requiring providers of medical services to disclose maximum charges.

1 **TITLE I—AMENDMENTS OF IN-**
2 **TERNAL REVENUE CODE OF**
3 **1986**

4 **Subtitle A—Tax Incentives for**
5 **Purchase of Health Care Coverage**

6 **SEC. 101. REFUNDABLE CREDIT FOR PURCHASE OF**
7 **HEALTH CARE COVERAGE.**

8 (a) ALLOWANCE OF CREDIT.—Subpart C of part IV
9 of subchapter A of chapter 1 of the Internal Revenue Code
10 of 1986 (relating to refundable credits) is amended by re-
11 designating section 35 as section 36 and by inserting after
12 section 34 the following new section:

13 **“SEC. 35. PURCHASE OF HEALTH CARE COVERAGE.**

14 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
15 dividual, there shall be allowed as a credit against the tax
16 imposed by this subtitle for the taxable year an amount
17 equal to 30 percent of the sum of—

18 “(1) the amount paid by the taxpayer during
19 the taxable year for health care coverage for the tax-
20 payer, the spouse of the taxpayer, and any depend-
21 ent (as defined in section 152) of the taxpayer, and

22 “(2) if the individual is an eligible individual,
23 the amount contributed by the taxpayer for the tax-
24 able year to a medical care savings account of such
25 individual.

1 “(b) LIMITATION ON CONTRIBUTIONS TO MEDICAL
2 CARE SAVINGS ACCOUNTS.—

3 “(1) IN GENERAL.—The amount taken into ac-
4 count under subsection (a)(2) for any taxable year
5 for contributions to a medical care savings account
6 of an individual shall not exceed the amount of pa-
7 tient cost-sharing required under the high deductible
8 health plan or the health maintenance organization
9 covering the individual. In the case of a husband
10 and wife, the excess described in the preceding sen-
11 tence shall be divided equally between such spouses.

12 “(2) PRORATION OF LIMITATION IF PART-YEAR
13 ELIGIBILITY.—In the case of an individual who is an
14 eligible individual only for a portion (but not all) of
15 the calendar year ending with or within the taxable
16 year, the limitation under this subsection for such
17 taxable year shall be an amount which bears the
18 same ratio to such limitation (determined without
19 regard to this paragraph) as such portion bears to
20 the entire calendar year.

21 “(c) DEFINITIONS.—For purposes of this section—

22 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
23 individual’ means any individual who is covered
24 under a high deductible health plan or by a health
25 maintenance organization. Such term shall not in-

1 clude an individual with respect to whom a deduc-
2 tion under section 151 is allowable to another tax-
3 payer for a taxable year beginning in the calendar
4 year in which the individual's taxable year begins.

5 “(2) HIGH DEDUCTIBLE HEALTH PLAN.—The
6 term ‘high deductible health plan’ means insurance
7 which constitutes medical care (as defined in section
8 213(d)), but only if such insurance requires patient
9 cost-sharing of at least \$1,000 per year but not
10 more than \$5,000 per year.

11 “(3) HEALTH CARE COVERAGE.—The term
12 ‘health care coverage’ means—

13 “(A) coverage under insurance which con-
14 stitutes medical care (as defined in section
15 213(d)),

16 “(B) coverage under an accident or health
17 plan, and

18 “(C) coverage by a health maintenance or-
19 ganization.

20 Such term does not include excluded coverage.

21 “(4) EXCLUDED COVERAGE.—The term ‘ex-
22 cluded coverage’ means—

23 “(A) any coverage providing wages or pay-
24 ments in lieu of wages for any period during

1 which the employee is absent from work on ac-
2 count of sickness or injury,

3 “(B) any coverage providing for payments
4 referred to in section 105(c),

5 “(C) any coverage provided to an employee
6 or former employee after such employee has at-
7 tained age 65, unless such coverage is provided
8 by reason of the current employment of the in-
9 dividual (within the meaning of section
10 1862(b)(1)(A)(i)(I) of the Social Security Act)
11 with the employer providing the coverage,

12 “(D) any coverage provided under Federal
13 law to any individual (or spouse or dependent
14 thereof) by reason of such individual being—

15 “(i) a member of the Armed Forces of
16 the United States, or

17 “(ii) a veteran, and

18 “(E) any other coverage to the extent that
19 the Secretary determines that the continuation
20 of an exclusion for such coverage is not incon-
21 sistent with the purposes of this section.”

22 “(d) SPECIAL RULES.—

23 “(1) COORDINATION WITH MEDICAL EXPENSE
24 DEDUCTION.—Any amount which is taken into ac-

1 count in determining the credit under this section
2 shall not be taken into account under section 213.

3 “(2) COORDINATION WITH FLEXIBLE SPENDING
4 ACCOUNTS.—Any amount paid from a flexible spend-
5 ing account shall be treated as not paid by the tax-
6 payer.”

7 (b) REPEAL OF DEDUCTION OF HEALTH INSURANCE
8 COSTS FOR SELF-EMPLOYED INDIVIDUALS.—Subsection
9 (l) of section 162 is hereby repealed.

10 (c) TECHNICAL AMENDMENTS.—

11 (1) The table of sections for such subpart C is
12 amended by striking the last item and inserting the
13 following new items:

“Sec. 35. Purchase of health care coverage.
“Sec. 36. Overpayments of tax.”

14 (2) Paragraph (2) of section 1324(b) of title
15 31, United States Code, is amended by inserting be-
16 fore the period “or from section 35 of such Code”.

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to taxable years beginning after
19 December 31, 1995.

20 **Subtitle B—Medical Care Savings** 21 **Accounts**

22 **SEC. 111. MEDICAL CARE SAVINGS ACCOUNTS.**

23 (a) IN GENERAL.—Subpart A of part I of subchapter
24 D of chapter 1 of the Internal Revenue Code of 1986 is

1 amended by inserting after section 408 the following new
2 section:

3 **“SEC. 408A. MEDICAL CARE SAVINGS ACCOUNTS.**

4 “(a) GENERAL RULE.—For purposes of this title, the
5 term ‘medical care savings account’ (which may also be
6 referred to as a ‘Medical IRA’) means a trust created or
7 organized in the United States for the exclusive benefit
8 of an individual and the individual’s spouse and depend-
9 ents (as defined in section 152), but only if the written
10 instrument creating the trust meets the following require-
11 ments:

12 “(1) Except in the case of a rollover contribu-
13 tion described in subsection (c)(5), no contribution
14 will be accepted unless it is in cash and contribu-
15 tions will not be accepted during any calendar year
16 in excess of the limitation applicable to the individ-
17 ual under section 35(b)(2).

18 “(2) The trustee is a bank (as defined in sec-
19 tion 408(n)), insurance company (as defined in sec-
20 tion 816), or such other person who demonstrates to
21 the satisfaction of the Secretary that the manner in
22 which such other person will administer the trust
23 will be consistent with the requirements of this
24 section.

1 “(3) No part of the trust funds will be invested
2 in life insurance contracts.

3 “(4) The interest of an individual in the bal-
4 ance of the account is nonforfeitable.

5 “(5) The assets of the trust will not be commin-
6 gled with other property except in a common trust
7 fund or common investment fund.

8 “(b) TAX TREATMENT OF ACCOUNTS.—

9 “(1) ACCOUNT TAXED AS GRANTOR TRUST.—

10 The account beneficiary of a medical care savings
11 account shall be treated for purposes of this title as
12 the owner thereof and shall be subject to tax thereon
13 in accordance with subpart E of part I of subchapter
14 J of this chapter (relating to grantors and others
15 treated as substantial owners).

16 “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-
17 GAGES IN PROHIBITED TRANSACTION.—

18 “(A) IN GENERAL.—If, during any taxable
19 year of the account beneficiary, such beneficiary
20 engages in any transaction prohibited by section
21 4975 with respect to the account, the account
22 ceases to be a medical care savings account as
23 of the first day of that taxable year.

24 “(B) ACCOUNT TREATED AS DISTRIBUTING
25 ALL ITS ASSETS.—In any case in which any ac-

1 count ceases to be a medical care savings ac-
2 count by reason of subparagraph (A) on the
3 first day of any taxable year, subsection (c)
4 shall be applied as if—

5 “(i) there were a distribution on such
6 first day in an amount equal to the fair
7 market value (on such first day) of all as-
8 sets in the account (on such first day), and

9 “(ii) no portion of such distribution
10 were used to pay qualified expenses.

11 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
12 RITY.—If, during any taxable year, the account ben-
13 eficiary uses the account or any portion thereof as
14 security for a loan, the portion so used is treated as
15 distributed and not used to pay qualified expenses.

16 “(c) TAX TREATMENT OF DISTRIBUTIONS.—

17 “(1) IN GENERAL.—Any amount paid or dis-
18 tributed out of a medical care savings account shall
19 be included in the gross income of the account bene-
20 ficiary unless such amount is used exclusively to pay
21 the qualified expenses of such beneficiary or of the
22 spouse and dependents (as defined in section 152) of
23 such beneficiary.

24 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
25 FORE DUE DATE OF RETURN.—Paragraph (1) shall

1 not apply to the distribution of any contribution paid
2 during a taxable year to a medical care savings ac-
3 count to the extent that such contribution exceeds
4 the limitation applicable under section 35(b)(2) if—

5 “(A) such distribution is received by the
6 individual on or before the last day prescribed
7 by law (including extensions of time) for filing
8 such individual’s return for such taxable year,
9 and

10 “(B) such distribution is accompanied by
11 the amount of net income attributable to such
12 excess contribution.

13 Any net income described in subparagraph (B) shall
14 be included in the gross income of the individual for
15 the taxable year in which it is received.

16 “(3) PENALTY FOR DISTRIBUTIONS NOT USED
17 FOR QUALIFIED EXPENSES.—

18 “(A) IN GENERAL.—The tax imposed by
19 this chapter for any taxable year in which there
20 is a payment or distribution from a medical
21 care savings account which is includible in gross
22 income under paragraph (1) shall be increased
23 by 10 percent of the amount which is so includ-
24 ible.

1 “(B) EXCEPTION FOR DISTRIBUTIONS
2 AFTER AGE 59½.—Subparagraph (A) shall not
3 apply to any distribution or payment after the
4 date on which the account beneficiary attains
5 age 59½.

6 “(C) DISABILITY OR DEATH CASES.—Sub-
7 paragraph (A) shall not apply if the payment or
8 distribution is made after the account bene-
9 fiary becomes disabled within the meaning of
10 section 72(m)(7) or dies.

11 “(4) ROLLOVER CONTRIBUTION.—An amount is
12 described in this paragraph as a rollover contribu-
13 tion if it meets the requirements of subparagraphs
14 (A) and (B).

15 “(A) IN GENERAL.—Paragraph (1) does
16 not apply to any amount paid or distributed out
17 of a medical care savings account to the ac-
18 count beneficiary if the entire amount received
19 is paid into a medical care savings account for
20 the benefit of such beneficiary not later than
21 the 60th day after the day on which he receives
22 the payment or distribution.

23 “(B) LIMITATION.—This paragraph does
24 not apply to any amount described in subpara-
25 graph (A) received by an individual from a

1 medical care savings account if at any time dur-
2 ing the one-year period ending on the day of
3 such receipt such individual received any other
4 amount described in subparagraph (A) from a
5 medical care savings account which was not in-
6 cludible in his gross income because of the ap-
7 plication of this paragraph.

8 “(C) DENIAL OF ROLLOVER TREATMENT
9 FOR INHERITED ACCOUNTS, ETC.—

10 “(i) IN GENERAL.—In the case of an
11 inherited medical care savings account—

12 “(I) this paragraph shall not
13 apply to any amount received by an
14 individual from such an account (and
15 no amount transferred from such ac-
16 count to another medical care savings
17 account shall be excluded from gross
18 income by reason of such transfer),
19 and

20 “(II) such inherited account shall
21 not be treated as a medical care sav-
22 ings account for purposes of determin-
23 ing whether any other amount is a
24 rollover contribution.

1 “(ii) INHERITED MEDICAL CARE SAV-
2 INGS ACCOUNT.—A medical care savings
3 account shall be treated as inherited if—

4 “(I) the account beneficiary ac-
5 quired such account by reason of the
6 death of another individual, and

7 “(II) the account beneficiary was
8 not the surviving spouse of such other
9 individual.

10 “(d) DEFINITIONS.—For purposes of this section—

11 “(1) QUALIFIED EXPENSES.—The term ‘quali-
12 fied expenses’ means any of the following expenses
13 which are incurred for the benefit of the account
14 beneficiary or the spouse or dependents (as defined
15 in section 152) of such beneficiary:

16 “(A) Expenses for medical care (as defined
17 in section 213(d)).

18 “(B) Expenses for long-term care services
19 (or premiums for long-term care insurance).

20 “(C) Expenses for work-related training,
21 education, and child care.

22 “(2) ACCOUNT BENEFICIARY.—The term ‘ac-
23 count beneficiary’ means the individual for whose
24 benefit the medical care savings account is estab-
25 lished.

1 “(e) CUSTODIAL ACCOUNTS.—For purposes of this
2 section, a custodial account shall be treated as a trust if—

3 “(1) the assets of such account are held by a
4 bank (as defined in section 408(n)), insurance com-
5 pany (as defined in section 816), or another person
6 who demonstrates to the satisfaction of the Sec-
7 retary that the manner in which he will administer
8 the account will be consistent with the requirements
9 of this section, and

10 “(2) the custodial account would, except for the
11 fact that it is not a trust, constitute a medical care
12 savings account described in subsection (a).

13 For purposes of this title, in the case of a custodial ac-
14 count treated as a trust by reason of the preceding sen-
15 tence, the custodian of such account shall be treated as
16 the trustee thereof.

17 “(f) REPORTS.—The trustee of a medical care sav-
18 ings account shall make such reports regarding such ac-
19 count to the Secretary and to the account beneficiary with
20 respect to contributions, distributions, and such other
21 matters as the Secretary may require under regulations.
22 The reports required by this subsection shall be filed at
23 such time and in such manner and furnished to such indi-
24 viduals at such time and in such manner as may be re-
25 quired by those regulations.”

1 (b) EMPLOYER PAYMENTS EXCLUDED FROM EM-
2 PLOYMENT TAX BASE.—

3 (1) SOCIAL SECURITY TAXES.—

4 (A) Subsection (a) of section 3121 of such
5 Code is amended by striking “or” at the end of
6 paragraph (20), by striking the period at the
7 end of paragraph (21) and inserting “; or”, and
8 by inserting after paragraph (21) the following
9 new paragraph:

10 “(22) any payment made to or for the benefit
11 of an employee if at the time of such payment it is
12 reasonable to believe that the employee will be able
13 to exclude such payment from income under section
14 106.”

15 (B) Subsection (a) of section 209 of the
16 Social Security Act is amended by striking “or”
17 at the end of paragraph (18), by striking the
18 period at the end of paragraph (19) and insert-
19 ing “; or”, and by inserting after paragraph
20 (19) the following new paragraph:

21 “(20) any payment made to or for the benefit
22 of an employee if at the time of such payment it is
23 reasonable to believe that the employee will be able
24 to exclude such payment from income under section
25 106 of the Internal Revenue Code of 1986.”

1 (2) RAILROAD RETIREMENT TAX.—Subsection
2 (e) of section 3231 of such Code is amended by add-
3 ing at the end the following new paragraph:

4 “(10) MEDICAL CARE SAVINGS ACCOUNT CON-
5 TRIBUTIONS.—The term ‘compensation’ shall not in-
6 clude any payment made to or for the benefit of an
7 employee if at the time of such payment it is reason-
8 able to believe that the employee will be able to ex-
9 clude such payment from income under section
10 106.”

11 (3) UNEMPLOYMENT TAX.—Subsection (b) of
12 section 3306 of such Code is amended by striking
13 “or” at the end of paragraph (15), by striking the
14 period at the end of paragraph (16) and inserting “;
15 or”, and by inserting after paragraph (16) the fol-
16 lowing new paragraph:

17 “(17) any payment made to or for the benefit
18 of an employee if at the time of such payment it is
19 reasonable to believe that the employee will be able
20 to exclude such payment from income under section
21 106.”

22 (4) WITHHOLDING TAX.—Subsection (a) of sec-
23 tion 3401 of such Code is amended by striking “or”
24 at the end of paragraph (19), by striking the period
25 at the end of paragraph (20) and inserting “; or”,

1 and by inserting after paragraph (20) the following
2 new paragraph:

3 “(21) any payment made to or for the benefit
4 of an employee if at the time of such payment it is
5 reasonable to believe that the employee will be able
6 to exclude such payment from income under section
7 106.”

8 (c) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
9 of such Code (relating to tax on excess contributions to
10 individual retirement accounts, certain section 403(b) con-
11 tracts, and certain individual retirement annuities) is
12 amended—

13 (1) by inserting “**MEDICAL CARE SAVINGS**
14 **ACCOUNTS,**” after “**ACCOUNTS,**” in the heading
15 of such section,

16 (2) by redesignating paragraph (2) of sub-
17 section (a) as paragraph (3) and by inserting after
18 paragraph (1) the following:

19 “(2) a medical care savings account (within the
20 meaning of section 408A),”,

21 (3) by striking “or” at the end of paragraph
22 (1) of subsection (a), and

23 (4) by adding at the end thereof the following
24 new subsection:

1 “(d) EXCESS CONTRIBUTIONS TO MEDICAL CARE
2 SAVINGS ACCOUNTS.—For purposes of this section, in the
3 case of a medical care savings account (within the mean-
4 ing of section 408A), the term ‘excess contributions’
5 means the amount by which the amount contributed for
6 the taxable year to the account exceeds the limitation ap-
7 plicable under section 35(b)(2) for such taxable year. For
8 purposes of this subsection, any contribution which is dis-
9 tributed out of the medical care savings account in a dis-
10 tribution to which section 408A(c)(2) applies shall be
11 treated as an amount not contributed.”

12 (d) TAX ON PROHIBITED TRANSACTIONS.—Section
13 4975 of such Code (relating to prohibited transactions)
14 is amended—

15 (1) by adding at the end of subsection (c) the
16 following new paragraph:

17 “(4) SPECIAL RULE FOR MEDICAL CARE SAV-
18 INGS ACCOUNTS.—An individual for whose benefit a
19 medical care savings account (within the meaning of
20 section 408A) is established shall be exempt from
21 the tax imposed by this section with respect to any
22 transaction concerning such account (which would
23 otherwise be taxable under this section) if, with re-
24 spect to such transaction, the account ceases to be
25 a medical care savings account by reason of the ap-

1 plication of section 408A(b)(2)(A) to such account.”,
2 and

3 (2) by inserting “or a medical care savings ac-
4 count described in section 408A” in subsection
5 (e)(1) after “described in section 408(a)”.

6 (e) FAILURE TO PROVIDE REPORTS ON MEDICAL
7 CARE SAVINGS ACCOUNTS.—Section 6693 of such Code
8 (relating to failure to provide reports on individual retire-
9 ment account or annuities) is amended—

10 (1) by inserting “**OR ON MEDICAL CARE**
11 **SAVINGS ACCOUNTS**” after “**ANNUITIES**” in the
12 heading of such section, and

13 (2) by adding at the end of subsection (a) the
14 following: “The person required by section 408A(f)
15 to file a report regarding a medical care savings ac-
16 count at the time and in the manner required by
17 such section shall pay a penalty of \$50 for each fail-
18 ure unless it is shown that such failure is due to rea-
19 sonable cause.”

20 (f) CLERICAL AMENDMENTS.—

21 (1) The table of sections for subpart A of part
22 I of subchapter D of chapter 1 of such Code is
23 amended by inserting after the item relating to sec-
24 tion 408 the following:

“Sec. 408A. Medical care savings accounts.”

1 (2) The table of sections for chapter 43 of such
2 Code is amended by striking the item relating to sec-
3 tion 4973 and inserting the following:

 “Sec. 4973. Tax on excess contributions to individual retirement
 accounts, medical care savings accounts, certain
 403(b) contracts, and certain individual retirement
 annuities.”

4 (3) The table of sections for subchapter B of
5 chapter 68 of such Code is amended by inserting “or
6 on medical care savings accounts” after “annuities”
7 in the item relating to section 6693.

8 (g) EFFECTIVE DATE.—The amendments made by
9 this section shall take effect on January 1, 1996.

10 **SEC. 112. UNUSED AMOUNTS IN FLEXIBLE SPENDING AC-**
11 **COUNTS TRANSFERABLE TO MEDICAL CARE**
12 **SAVINGS ACCOUNTS.**

13 (a) IN GENERAL.—Subsection (d) of section 125 of
14 the Internal Revenue Code of 1986 (relating to cafeteria
15 plans) is amended by adding at the end thereof the follow-
16 ing new paragraph:

17 “(3) UNUSED AMOUNTS TRANSFERABLE TO
18 MEDICAL CARE SAVINGS ACCOUNTS.—Subsection (a)
19 shall not fail to apply to a participant in a plan, and
20 a plan shall not fail to be treated as a cafeteria plan,
21 solely because under the plan amounts not paid out
22 as reimbursements under a flexible spending ar-
23 rangement for medical care (as defined in section

1 213(d)) for an individual or such individual's spouse
2 and dependents) are contributed on the last day of
3 the plan year of the cafeteria plan to a medical care
4 savings account (as defined in section 408A) of such
5 individual.”

6 (b) EFFECTIVE DATE.—The amendment made by
7 this section shall apply to cafeteria plan years ending after
8 December 31, 1995.

9 **Subtitle C—Expansion of COBRA**
10 **Continuation Coverage**

11 **SEC. 121. EXPANSION OF COBRA CONTINUATION COV-**
12 **ERAGE.**

13 (a) AMENDMENTS TO INTERNAL REVENUE CODE.—

14 (1) SMALLER EMPLOYERS SUBJECT TO RE-
15 QUIREMENTS.—Paragraph (1) of section 4980B(d)
16 of the Internal Revenue Code of 1986 (relating to
17 tax not to apply to certain plans) is amended by
18 striking “20 employees” and inserting “4 employ-
19 ees”.

20 (2) PERIOD OF COVERAGE EXTENDED TO 36
21 MONTHS.—

22 (A) IN GENERAL.—Clause (i) of section
23 4980B(f)(2)(B) of such Code (relating to period
24 of coverage) is amended to read as follows:

25 “(i) MAXIMUM REQUIRED PERIOD.—

1 “(I) IN GENERAL.—The date
2 which is 36 months after the date of
3 the qualifying event.

4 “(II) SPECIAL RULE FOR CER-
5 TAIN BANKRUPTCY PROCEEDINGS.—
6 In the case of a qualifying event de-
7 scribed in paragraph (3)(F) (relating
8 to bankruptcy proceedings), the date
9 of the death of the covered employee
10 or qualified beneficiary (described in
11 subsection (g)(1)(D)(iii)), or in the
12 case of the surviving spouse or de-
13 pendent children of the covered em-
14 ployee, 36 months after the date of
15 the death of the covered employee.

16 “(III) QUALIFYING EVENT IN-
17 VOLVING MEDICARE ENTITLEMENT.—
18 In the case of an event described in
19 paragraph (3)(D) (without regard to
20 whether such event is a qualifying
21 event), the period of coverage for
22 qualified beneficiaries other than the
23 covered employee for such event or
24 any subsequent qualifying event shall
25 not terminate before the close of the

1 36-month period beginning on the
2 date the covered employee becomes
3 entitled to benefits under title XVIII
4 of the Social Security Act.”

5 (B) TECHNICAL AMENDMENT.—The last
6 sentence of section 4980B(f)(2)(C) of such
7 Code is amended to read as follows: “In the
8 case of a qualified beneficiary who is deter-
9 mined, under title II or XVI of the Social Secu-
10 rity Act, to have been disabled at the time of
11 a qualifying event described in paragraph
12 (3)(B), any reference in clause (i) to ‘102 per-
13 cent’ is deemed a reference to ‘150 percent’ for
14 any month after the 36th month of continu-
15 ation coverage.”

16 (b) AMENDMENTS TO EMPLOYEE RETIREMENT IN-
17 COME SECURITY ACT OF 1974.—

18 (1) SMALLER EMPLOYERS SUBJECT TO RE-
19 QUIREMENTS.—Subsection (b) of section 601 of the
20 Employee Retirement Income Security Act of 1974
21 (29 U.S.C. 1161) (relating to exception for certain
22 plans) is amended by striking “20 employees” and
23 inserting “4 employees”.

24 (2) PERIOD OF COVERAGE EXTENDED TO 36
25 MONTHS.—

1 (A) IN GENERAL.—Subparagraph (A) of
2 section 602(2) of such Act (29 U.S.C. 1161(2))
3 (relating to period of coverage) is amended to
4 read as follows:

5 “(A) MAXIMUM REQUIRED PERIOD.—

6 “(i) IN GENERAL.—The date which is
7 36 months after the date of the qualifying
8 event.

9 “(ii) SPECIAL RULE FOR CERTAIN
10 BANKRUPTCY PROCEEDINGS.—In the case
11 of a qualifying event described in section
12 603(6) (relating to bankruptcy proceed-
13 ings), the date of the death of the covered
14 employee or qualified beneficiary (described
15 in section 607(3)(C)(iii)), or in the case of
16 the surviving spouse or dependent children
17 of the covered employee, 36 months after
18 the date of the death of the covered
19 employee.

20 “(iii) QUALIFYING EVENT INVOLVING
21 MEDICARE ENTITLEMENT.—In the case of
22 an event described in section 603(4) (with-
23 out regard to whether such event is a
24 qualifying event), the period of coverage
25 for qualified beneficiaries other than the

1 covered employee for such event or any
2 subsequent qualifying event shall not ter-
3minate before the close of the 36-month
4 period beginning on the date the covered
5 employee becomes entitled to benefits
6 under title XVIII of the Social Security
7 Act.”

8 (B) TECHNICAL AMENDMENT.—The last
9 sentence of section 602(3) of such Act is
10 amended to read as follows: “In the case of an
11 individual who is determined, under title II or
12 XVI of the Social Security Act, to have been
13 disabled at the time of a qualifying event de-
14 scribed in section 603(2), any reference in sub-
15 paragraph (A) to ‘102 percent’ is deemed a ref-
16 erence to ‘150 percent’ for any month after the
17 36th month of continuation coverage.”

18 (c) AMENDMENTS TO PUBLIC HEALTH SERVICE
19 ACT.—

20 (1) SMALLER EMPLOYERS SUBJECT TO RE-
21 QUIREMENTS.—Paragraph (1) of section 2201(b) of
22 the Public Health Service Act (42 U.S.C. 300bb-
23 1(b)) (relating to exception for certain plans) is
24 amended by striking “20 employees” and inserting
25 “4 employees”.

1 (2) PERIOD OF COVERAGE EXTENDED TO 36
2 MONTHS.—

3 (A) IN GENERAL.—Subparagraph (A) of
4 section 2202(2) of such Act (42 U.S.C. 300bb-
5 2(2)) (relating to period of coverage) is amend-
6 ed to read as follows:

7 “(A) MAXIMUM REQUIRED PERIOD.—

8 “(i) IN GENERAL.—The date which is
9 36 months after the date of the qualifying
10 event.

11 “(ii) QUALIFYING EVENT INVOLVING
12 MEDICARE ENTITLEMENT.—In the case of
13 an event described in section 2203(4)
14 (without regard to whether such event is a
15 qualifying event), the period of coverage
16 for qualified beneficiaries other than the
17 covered employee for such event or any
18 subsequent qualifying event shall not ter-
19minate before the close of the 36-month
20 period beginning on the date the covered
21 employee becomes entitled to benefits
22 under title XVIII of the Social Security
23 Act.”

24 (B) TECHNICAL AMENDMENT.—The last
25 sentence of section 2202(3) of such Act is

1 amended to read as follows: “In the case of an
2 individual who is determined, under title II or
3 XVI of the Social Security Act, to have been
4 disabled at the time of a qualifying event de-
5 scribed in section 2203(2), any reference in
6 subparagraph (A) to ‘102 percent’ is deemed a
7 reference to ‘150 percent’ for any month after
8 the 36th month of continuation coverage.”

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to—

11 (1) qualifying events occurring after December
12 31, 1995, and

13 (2) qualifying events occurring on or before
14 such date if the period of continuation coverage re-
15 quired under section 4980B of the Internal Revenue
16 Code of 1986 (determined without regard to the
17 amendments made by this section) has not expired
18 on or before such date.

19 **TITLE II—INSURANCE REFORM**
20 **Subtitle A—Employer Insurance**
21 **Protections**

22 **SEC. 201. SMALL GROUP EMPLOYER INSURANCE PROTEC-**
23 **TIONS.**

24 (a) REQUIREMENTS FOR INSURERS.—Any health
25 benefit insurer that provides or offers a small group health

1 benefit plan within a State (in this subtitle referred to as
2 a “covered insurer”) must meet the requirements specified
3 in this section with respect to such a plan.

4 (b) SMALL EMPLOYER PROTECTION AGAINST TER-
5 MINATION OR NON-RENEWAL OR INDUSTRY BLACKLIST-
6 ING.—

7 (1) IN GENERAL.—A covered insurer may not—

8 (A) cancel or nonrenew an individual small
9 employer group because of high claims costs or
10 the health of the group, or

11 (B) refuse to provide coverage to such a
12 group based solely on the nature of the employ-
13 er’s business or industry.

14 (2) PERMISSIBLE TERMINATION.—A covered in-
15 surer may cancel or nonrenew a small group health
16 benefit plan for an individual small employer group
17 for any of the following:

18 (A) Failure to make premium payments.

19 (B) Failure to remain eligible for inclusion
20 in the class of business by which its coverage
21 was provided.

22 (C) Failure to comply with the insurer’s
23 minimum participation requirements.

24 (D) Fraud or misrepresentation by the
25 employer.

1 (3) CANCELLATION OF CLASS OF BUSINESS.—

2 (A) IN GENERAL.—A covered insurer may
3 cancel or nonrenew an entire class of business
4 with respect to a small group health benefit
5 plan.

6 (B) LIMITATION ON MARKET REENTRY.—

7 In the case of such a cancellation or
8 nonrenewal, the insurer may not write new
9 business with the same or similar class of small
10 group employers for a period of 5 years begin-
11 ning on the date of termination of the last plan
12 so cancelled or not renewed.

13 (c) LIMITS ON PREMIUM RATES.—The annual in-
14 crease in the premium rate charged to a small employer
15 group by a covered insurer may not exceed the sum of
16 the following:

17 (1) The percentage change in the premium rate
18 for new business for employers with similar case
19 characteristics, as measured between the first day of
20 the year in which the new rates take effect and the
21 first day of the previous year.

22 (2) A percentage (not to exceed 15 percent)
23 based on claims experience, health status, or dura-
24 tion of coverage.

1 (3) Any adjustment due to changes in the cov-
2 erage provided or changes in the case characteristics
3 of the small employer group.

4 (d) LIMIT ON VARIATION IN PREMIUMS.—

5 (1) ACROSS CLASSES OF BUSINESS.—The index
6 rate for a rating period for any class of business
7 shall not exceed the index rate for any other class
8 of business by more than 20 percent.

9 (2) WITHIN A CLASS OF BUSINESS.—For a
10 class of business, the premium rates charged during
11 a rating period to small employer groups with simi-
12 lar case characteristics for the same or similar cov-
13 erage (or rates that could be charged to such em-
14 ployers under the rating system for that class of
15 business) shall not vary from the index rate for such
16 class by more than 25 percent of the index rate.

17 (3) USE OF INDUSTRY AS A CASE CHAR-
18 ACTERISTIC.—

19 (A) IN GENERAL.—Subject to subpara-
20 graph (B), a covered insurer may utilize indus-
21 try as a case characteristic in establishing pre-
22 mium rates.

23 (B) LIMITATION ON VARIATION.—If a cov-
24 ered insurer that utilizes industry as a case
25 characteristic in establishing premium rates,

1 the highest rate factor associated with an in-
2 dustry classification may not exceed the lowest
3 rate associated with any industry classification
4 by more than 15 percent.

5 **SEC. 202. GENERAL PORTABILITY REQUIREMENT FOR EM-**
6 **PLOYER-BASED HEALTH INSURANCE.**

7 (a) LIMITATIONS ON USE OF PREEXISTING CONDI-
8 TIONS.—

9 (1) IN GENERAL.—A group health benefit plan
10 of an employer shall not deny, exclude, or limit bene-
11 fits for a covered individual for losses incurred more
12 than 12 months following the effective date of the
13 individual's coverage due to a preexisting condition.

14 (2) RESTRICTIONS ON DEFINITION OF PRE-
15 EXISTING CONDITION.—For purposes of paragraph
16 (1), such a plan shall not define a preexisting condi-
17 tion more restrictively than the following:

18 (A) A condition that would have caused an
19 ordinarily prudent person to seek medical ad-
20 vice, diagnosis, care, or treatment during the 6
21 months immediately preceding the effective date
22 of coverage.

23 (B) A condition for which medical advice,
24 diagnosis, care, or treatment was recommended

1 or received during the 6 months immediately
2 preceding the effective date of coverage.

3 (C) A pregnancy existing on the effective
4 date of coverage.

5 (b) LIMITATION ON UNDERWRITING.—

6 (1) IN GENERAL.—In the case of a previously
7 covered individual who becomes an employee of an
8 employer, the group health plan of (or contributed to
9 by) the employer shall accept the individual for cov-
10 erage upon the date of application for coverage on
11 the basis relating to the individual's health status as
12 of the date the individual applied for employment
13 with the previous employer.

14 (2) PREVIOUSLY COVERED INDIVIDUAL DE-
15 FINED.—For purposes of paragraph (1), the term
16 “previously covered individual” means, with respect
17 to an employer, an individual who before employ-
18 ment by the employer was an employee of another
19 employer and was provided coverage under a group
20 health plan of (or contributed to by) the previous
21 employer.

22 (c) RESTRICTIONS FOR SMALL EMPLOYER HEALTH
23 PLANS.—

24 (1) IN GENERAL.—No insurer offering a health
25 benefit plan to a small employer shall refuse to ac-

1 cept under the plan any individual who, on the date
2 of the application for such coverage, has been con-
3 tinuously covered (as defined in paragraph (2)) and
4 would be eligible for such coverage except for under-
5 writing considerations relating to the individual's
6 health status.

7 (2) CONTINUOUS COVERAGE.—

8 (A) IN GENERAL.—For purposes of this
9 subsection, an individual is deemed to be con-
10 tinuously covered as of a date if the individual
11 is covered under any employee health benefit
12 plan or other health insurance policy at the be-
13 ginning and end of the 1-year period ending
14 with such date and has not had any lapse in
15 such coverage during such period totalling more
16 than 31 days, not including as such a lapse any
17 applicable employment waiting or probationary
18 period.

19 (B) SPECIAL RULE.—For purposes of sub-
20 paragraph (A), there shall not be taken into ac-
21 count coverage provided by or in connection
22 with any State high risk insurance pool.

23 (d) CONSTRUCTION.—Nothing in this section shall be
24 construed as requiring an insurer or health benefit plan
25 to provide benefits greater than those provided to an indi-

1 vidual insured as a standard risk had the previous cov-
2 erage remained in force.

3 (e) DEFINITIONS.—For purposes of this section:

4 (1) COVERED INDIVIDUAL.—The term “covered
5 individual” means—

6 (A) an individual who is (or will be) pro-
7 vided coverage under a group health plan by
8 virtue of the performance of services by the in-
9 dividual for 1 or more persons maintaining the
10 plan (including as an employee defined in sec-
11 tion 401(c)(1) of the Internal Revenue Code of
12 1986), and

13 (B) the spouse or any dependent child of
14 such individual.

15 (2) GROUP HEALTH PLAN.—The term “group
16 health plan” has the meaning given such term by
17 section 5000(b)(1) of the Internal Revenue Code of
18 1986.

19 **SEC. 203. EXEMPTION FROM CERTAIN STATE MANDATES.**

20 An covered insurer that complies with the require-
21 ments of sections 201 and 202 with respect to a small
22 employer group is exempt from State law requirements
23 concerning the providing of specified health insurance ben-
24 efits or laws which prohibit the use of managed care net-
25 works.

1 **SEC. 204. ENFORCEMENT.**

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

6 **“SEC. 5000A. ENFORCEMENT OF REQUIREMENTS FOR EM-
7 PLOYER HEALTH BENEFIT PLANS.**

8 “(a) GENERAL RULE.—There is hereby imposed a
9 tax on the failure of an insurer or group health plan to
10 meet the applicable requirements of section 201 or 202
11 of the Bipartisan Health Security Reform Act of 1994
12 with respect to any covered individual.

13 “(b) AMOUNT OF TAX.—

14 “(1) IN GENERAL.—The amount of the tax im-
15 posed by subsection (a) on any failure with respect
16 to—

17 “(A) a requirement in such section 201
18 shall be \$100 for each day in the noncompli-
19 ance period with respect to such failure; or

20 “(B) a requirement in such section 202
21 with respect to a covered individual shall be
22 \$100 for each day in the noncompliance period
23 with respect to such failure.

24 “(2) NONCOMPLIANCE PERIOD.—For purposes
25 of this section, the term ‘noncompliance period’
26 means, with respect to any failure, the period—

1 “(A) beginning on the date such failure
2 first occurs, and

3 “(B) ending on the date such failure is
4 corrected.

5 “(3) CORRECTION.—A failure of a group health
6 plan to meet the requirements of section 202 of the
7 Bipartisan Health Security Reform Act of 1994 with
8 respect to any covered individual shall be treated as
9 corrected if—

10 “(A) such failure is retroactively undone to
11 the extent possible, and

12 “(B) the covered individual is placed in a
13 financial position which is as good as such indi-
14 vidual would have been in had such failure not
15 occurred.

16 For purposes of applying subparagraph (B), the cov-
17 ered individual shall be treated as if the individual
18 had elected the most favorable coverage in light of
19 the expenses incurred since the failure first oc-
20 curred.

21 “(c) LIMITATIONS ON AMOUNT OF TAX.—

22 “(1) TAX NOT TO APPLY WHERE FAILURE NOT
23 DISCOVERED EXERCISING REASONABLE DILI-
24 GENCE.—No tax shall be imposed by subsection (a)
25 on any failure during any period for which it is es-

1 established to the satisfaction of the Secretary that
2 none of the persons referred to in subsection (d)
3 knew, or exercising reasonable diligence would have
4 known, that such failure existed.

5 “(2) TAX NOT TO APPLY TO FAILURES COR-
6 RECTED WITHIN 30 DAYS.—No tax shall be imposed
7 by subsection (a) on any failure if—

8 “(A) such failure was due to reasonable
9 cause and not to willful neglect, and

10 “(B) such failure is corrected during the
11 30-day period beginning on the first date any of
12 the persons referred to in subsection (d) knew,
13 or exercising reasonable diligence would have
14 known, that such failure existed.

15 “(3) WAIVER BY SECRETARY.—In the case of a
16 failure which is due to reasonable cause and not to
17 willful neglect, the Secretary may waive part or all
18 of the tax imposed by subsection (a) to the extent
19 that the payment of such tax would be excessive re-
20 lative to the failure involved.

21 “(d) LIABILITY FOR TAX.—

22 “(1) IN GENERAL.—Except as otherwise pro-
23 vided in this subsection, the following shall be liable
24 for the tax imposed by subsection (a) on a failure:

1 “(A) In the case of a group health plan
2 other than a self-insured group health plan, the
3 issuer.

4 “(B)(i) In the case of a self-insured group
5 health plan other than a multiemployer group
6 health plan, the employer.

7 “(ii) In the case of a self-insured group
8 health multiemployer plan, the plan.

9 “(C) Each person who is responsible (other
10 than in a capacity as an employee) for admin-
11 istering or providing benefits under the group
12 health plan, health insurance plan, or other
13 health benefit arrangement (including a self-in-
14 sured plan) and whose act or failure to act
15 caused (in whole or in part) the failure.

16 “(2) SPECIAL RULES FOR PERSONS DESCRIBED
17 IN PARAGRAPH (1)(C).—A person described in sub-
18 paragraph (C) (and not in subparagraphs (A) and
19 (B)) of paragraph (1) shall be liable for the tax im-
20 posed by subsection (a) on any failure only if such
21 person assumed (under a legally enforceable written
22 agreement) responsibility for the performance of the
23 act to which the failure relates.”.

24 (b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of
25 section 275(a) of such Code (relating to nondeductibility

1 of certain taxes) is amended by inserting “47,” after
2 “46,”.

3 (c) CLERICAL AMENDMENTS.—The table of sections
4 for such chapter 47 is amended by adding at the end
5 thereof the following new item:

“Sec. 5000A. Enforcement of requirements for employer health
benefit plans.”

6 (d) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to taxable years beginning after
8 December 31, 1995.

9 **SEC. 205. DEFINITIONS.**

10 In this subtitle:

11 (1) CASE CHARACTERISTICS.—The term “case
12 characteristics” means demographic, geographic, and
13 other relevant characteristics as determined by the
14 insurer that are considered by the insurer in the de-
15 termination of premium rates for a small employer,
16 but not including—

17 (A) claims experience,

18 (B) health status, and

19 (C) duration of coverage since date of
20 issue.

21 (2) INSURER.—The term “insurer” means an
22 entity that provides health insurance in a State.

23 (3) SMALL EMPLOYER.—The term “small em-
24 ployer” means a business that, during the most re-

1 cent calendar year, employed at least 3, but not
2 more than 25, employees who are eligible for cov-
3 erage under a health benefit plan on at least 50 per-
4 cent of that business' working days.

5 (4) HEALTH BENEFIT PLAN.—The term
6 "health benefit plan" means any employee welfare
7 benefit plan (as defined in the Employee Retirement
8 Income Security Act of 1974) that is insured by an
9 insurer that provides medical, surgical, or hospital
10 care or benefits to employees of a small employer
11 and their dependents and to which the employer con-
12 tributes 50 percent or more of the single coverage
13 cost at the time of purchase. Such term does not in-
14 clude any individual major medical policies and
15 group insurance that are not designed or adminis-
16 tered as a health benefit plan to be provided by an
17 employer for its employees.

18 (5) INDEX RATE.—The term "index rate"
19 means, for a class of business as to a small employ-
20 er's rating period with similar case characteristics,
21 the arithmetic average of the applicable base pre-
22 mium rate and the corresponding highest premium
23 rate.

24 (6) CLASS OF BUSINESS.—The term "class of
25 business" means each separate class of business es-

1 established by an insurer to reflect substantial dif-
 2 ferences in expected claims experience or administra-
 3 tive costs related only to one or more of the follow-
 4 ing:

5 (A) The insurer's use of more than one
 6 type of system for the marketing and sale of
 7 health benefit plans to small employers.

8 (B) The insurer's acquisition of a class of
 9 business from another insurer.

10 (C) The insurer providing coverage to one
 11 or more association groups.

12 **SEC. 206. EFFECTIVE DATE.**

13 This title shall take effect on January 1, 1996.

14 **Subtitle B—Guaranteeing Port-**
 15 **ability of Health Insurance for**
 16 **Individuals**

17 **SEC. 211. COVERAGE OF INDIVIDUAL HEALTH BENEFIT**
 18 **PLANS.**

19 (a) IN GENERAL.—This subtitle applies only to
 20 health benefit plans delivered or issued for delivery to indi-
 21 viduals in a State and does not apply to—

22 (1) any employer-based health benefit plan, or

23 (2) any eligible individual whose prior similar
 24 health benefit plan was provided by—

1 (A) a State high risk pool (as defined by
2 the Secretary of Health and Human Services),

3 (B) under title XVIII or XIX of the Social
4 Security Act, or

5 (C) under another State or Federal pro-
6 gram, unless the eligible individual was pre-
7 viously covered as an employee of the State or
8 Federal Government.

9 (b) INDIVIDUAL HEALTH BENEFIT PLAN.—In this
10 subtitle, the term “individual health benefit plan” means
11 a health benefit plan described in subsection (a).

12 **SEC. 212. PORTABILITY PROTECTIONS.**

13 (a) CONSIDERATION OF APPLICATIONS.—If an eligi-
14 ble individual or eligible family applies for an individual
15 health benefit plan, the insurer offering the plan must ei-
16 ther—

17 (1) offer coverage to all eligible individuals ap-
18 plying on the same application, or

19 (2) deny coverage to all eligible individuals ap-
20 plying on the application.

21 (b) PREEXISTING CONDITION PERIOD LIMITA-
22 TION.—No policy provision of an individual health benefit
23 plan shall exclude or limit coverage for a preexisting condi-
24 tion for a period beyond 12 months following the effective
25 date of the individual’s coverage.

1 (c) PORTABILITY OF COVERAGE.—The preexisting
2 condition limitation period under any individual health
3 benefit plan shall be reduced by one month for each month
4 of continuous coverage the eligible individual had under
5 a prior health benefit plan.

6 (d) LIMITATION ON RIDERS.—

7 (1) IN GENERAL.—Except as provided in para-
8 graph (2), an insurer issuing an individual health
9 benefit plan may not modify the plan with respect
10 to an eligible individual.

11 (2) RELATION TO PREEXISTING CONDITION EX-
12 CLUSION PERIOD.—

13 (A) IN GENERAL.—To the extent that a
14 preexisting condition limitation applies, an in-
15 surer may restrict or exclude coverage or bene-
16 fits for a specific condition for a maximum pe-
17 riod of 12 months from the effective date of
18 coverage of an eligible individual by way of
19 rider or endorsement.

20 (B) NO ADDITION RIDERS.—No other rider
21 or endorsement may be placed on the health
22 benefit plan to restrict further coverage.

23 (C) COMBINATION.—If both a rider and a
24 preexisting condition exclusion period are used,

1 the combined limitation period may not exceed
2 12 months.

3 (e) NO DISCLOSURE OF CONDITION REQUIRED.—A
4 preexisting condition limitation period may be applied
5 whether or not the specific condition has been disclosed
6 on the application for coverage under the individual health
7 benefit plan.

8 **SEC. 213. DEFINITIONS.**

9 In this subtitle:

10 (1) ELIGIBLE FAMILY.—The term “eligible
11 family” means an applicant, an applicant’s spouse,
12 and any eligible individual who is a dependent child
13 of the applicant.

14 (2) ELIGIBLE INDIVIDUAL.—The term “eligible
15 individual” means an individual who was insured
16 under a prior similar health benefit plan which was
17 continuous to a date not more than 30 days prior
18 to the effective date of the new health benefit plan
19 for that individual.

20 (3) HEALTH BENEFIT PLAN.—

21 (A) IN GENERAL.—The term “health bene-
22 fit plan” means any hospital or medical expense
23 insured policy or certificate, hospital or medical
24 service plan contract, or health maintenance or-
25 ganization subscriber contract.

1 (B) EXCLUSION.—Such term does not in-
2 clude any of the following:

3 (i) short-term limited duration insur-
4 ance,

5 (ii) accident-only, credit-only, dental-
6 only, vision-only insurance,

7 (iii) medicare supplement insurance,

8 (iv) hospital indemnity insurance,

9 (v) long-term care or disability income
10 insurance,

11 (vi) coverage issued as a supplement
12 to liability insurance,

13 (vii) workmen’s compensation or simi-
14 lar insurance, or

15 (viii) automobile medical-payment in-
16 surance.

17 (4) PREEXISTING CONDITION.—The term “pre-
18 existing condition” means any injury or illness—

19 (A) for which the covered individual re-
20 ceived medical advice or treatment within 12
21 months immediately preceding the applicable ef-
22 fective date the covered individual became in-
23 sured under the policy, or

24 (B) which in the opinion of a qualified doc-
25 tor—

1 (i) probably began prior to the appli-
2 cable effective date the covered individual
3 became insured under the policy, and

4 (ii) manifested symptoms which would
5 cause an ordinarily prudent individual to
6 seek diagnosis or treatment within 12
7 months immediately preceding the applica-
8 ble effective date the covered individual be-
9 cause insured under the policy.

10 (5) PRIOR SIMILAR HEALTH BENEFIT PLAN.—

11 The term “prior similar health benefit plan” means
12 a health benefit plan under which an eligible individ-
13 ual was previously covered and which provides bene-
14 fits who do not materially differ from the new health
15 benefit plan in any of the following respects:

16 (A) The type of medical benefits provided.

17 (B) The level of medical benefits available
18 based on deductibles, coinsurance, or
19 copayments, or any combination thereof.

20 (C) The maximum benefits available for
21 specific services.

22 (D) Cost containment provisions.

1 **SEC. 214. EFFECTIVE DATE.**

2 This subtitle shall apply to each health benefit plan
3 that is delivered or issued for delivery to an individual on
4 or after January 1, 1996.

5 **Subtitle C—Assuring Health Insur-**
6 **ance Coverage for Uninsurable**
7 **Individuals**

8 **SEC. 221. ESTABLISHMENT OF PROGRAMS BY STATES.**

9 (a) **IN GENERAL.**—For years beginning with 1997,
10 each State shall establish, administer, and fund a high
11 risk health insurance pool (in this subtitle referred to as
12 a “State high risk program”) that assures, in accordance
13 with this subtitle, the availability of qualified health insur-
14 ance coverage to uninsurable individuals.

15 (b) **DEADLINE.**—Each State shall comply with sub-
16 section (a) by not later than January 1, 1997.

17 (c) **WAIVER.**—Subsection (a) shall not apply in the
18 case of a State that has established a comprehensive
19 health insurance program that assures the availability of
20 qualified health insurance coverage to all eligible individ-
21 uals residing in the State.

22 (d) **RECOMMENDATION FOR COMPLIANCE REQUIRE-**
23 **MENT.**—Not later than January 1, 1996, the Secretary
24 of Health and Human Services shall submit to Congress
25 a recommendation on appropriate sanctions for States
26 that fail to meet the requirement of subsection (a).

1 **SEC. 222. UNINSURABLE INDIVIDUALS ELIGIBLE FOR COV-**
2 **ERAGE.**

3 (a) UNINSURABLE AND ELIGIBLE INDIVIDUAL DE-
4 FINED.—In this subtitle:

5 (1) UNINSURABLE INDIVIDUAL.—The term
6 “uninsurable individual” means, with respect to a
7 State, an eligible individual who presents proof of
8 uninsurability by 2 private insurers in accordance
9 with subsection (b).

10 (2) ELIGIBLE INDIVIDUAL.—The term “eligible
11 individual” means, with respect to a State, a citizen
12 or national of the United States (or an alien lawfully
13 admitted for permanent residence) who is a resident
14 of the State for at least 90 days.

15 (b) PROOF OF UNINSURABILITY.—

16 (1) IN GENERAL.—The proof of uninsurability
17 for an individual shall be in the form of—

18 (A) a notice of rejection or refusal to issue
19 substantially similar insurance for health rea-
20 sons, or

21 (B) a notice of refusal to insure except at
22 a rate in excess of the plan rate,

23 (C) an offer to insure but only subject to
24 a reduction or an exclusion of coverage for a
25 preexisting condition for a period exceeding 6
26 months.

1 (2) EXCEPTION.—A State may waive the re-
2 quirement of proof described in paragraph (1) in the
3 case of an individual who demonstrates a provable
4 medical or health condition.

5 **SEC. 223. QUALIFIED HEALTH INSURANCE COVERAGE**
6 **UNDER PROGRAM.**

7 In this subtitle, the term “qualified health insurance
8 coverage” means health insurance coverage that—

9 (1) provides benefits typical of major medical
10 insurance available in the individual health insur-
11 ance market, and

12 (2) may include coinsurance (in a percentage
13 not to exceed 20 percent) and a stop loss on out-of-
14 pocket expenses of not to exceed—

15 (A) for 1997, \$5,000, or

16 (B) for a subsequent year, the dollar
17 amount specified in this paragraph for the pre-
18 vious year increased by the percentage increase
19 in the medical care component of the consumer
20 price index for all urban consumers (United
21 States city average, as published by the Bureau
22 of Labor Statistics) for the 12-month period
23 ending with September of the preceding cal-
24 endar year.

1 In applying subparagraph (B) for a year, if the dol-
2 lar amount computed under such subparagraph is
3 not a multiple of \$10, it shall be rounded to the next
4 highest multiple of \$10.

5 **SEC. 224. FUNDING OF PROGRAM.**

6 (a) LIMITATIONS ON PREMIUMS.—

7 (1) IN GENERAL.—The applicable premium es-
8 tablished under a State high-risk program may not
9 exceed 135 percent of the applicable standard risk
10 rate, except as provided in paragraph (2).

11 (2) SURCHARGE FOR AVOIDABLE HEALTH
12 RISKS.—A State high-risk program may impose a
13 surcharge on premiums for individuals with avoid-
14 able high risks, such as smoking.

15 (b) FLEXIBILITY IN ADDITIONAL FUNDING.—A
16 State high-risk program shall provide for additional fund-
17 ing through other means specified under State law. Such
18 means may include—

19 (1) an assessment on all insurers in the State
20 through a nonprofit association consisting of all
21 health benefits insurers doing business in the State
22 on an equitable and pro rata basis,

23 (2) a designated tax source, or

24 (3) general revenues of the State.

1 **SEC. 225. ADMINISTRATION.**

2 A State high-risk program shall be administered
3 through a contract with one or more insurers operating
4 in the State.

5 **TITLE III—MEDICAID REFORM**

6 **SEC. 301. PROVIDING COVERAGE FOR OUT-OF-POCKET EX-**
7 **PENSES UNDER PRIVATE HEALTH PLANS.**

8 (a) STATE OPTION.—Section 1902(a) of the Social
9 Security Act (42 U.S.C. 1396a(a)) is amended—

10 (1) by striking “and” at the end of paragraph
11 (61);

12 (2) by striking the period at the end of para-
13 graph (62) and inserting “; and”; and

14 (3) by adding at the end the following new
15 paragraph:

16 “(63) at the option of the State, provide that
17 an individual eligible for medical assistance under
18 the State plan has the option to receive medical as-
19 sistance through enrollment with a health plan
20 under a program described in section 1931.”.

21 (b) PROGRAM FOR ENROLLMENT DESCRIBED.—Title
22 XIX of such Act (42 U.S.C. 1396 et seq.) is amended by
23 redesignating section 1931 as section 1932 and by insert-
24 ing after section 1930 the following new section:

1 “OPTIONAL STATE PROGRAM TO ENROLL INDIVIDUALS IN
2 PRIVATE HEALTH PLANS

3 “SEC. 1931. (a) IN GENERAL.—For purposes of sec-
4 tion 1902(a)(63), a program under this section is a pro-
5 gram under which the State makes payments to health
6 plans that provide qualified health insurance coverage
7 under section 223 of the Bipartisan Health Security Re-
8 form Act for enrolling individuals for coverage under such
9 plans, including all necessary payments of premiums,
10 copayments, and deductibles applicable under such a plan
11 on behalf of such an individual.

12 “(b) TREATMENT OF PAYMENTS AS MEDICAL AS-
13 SISTANCE.—Subject to paragraph (3), for purposes of de-
14 termining the amount of Federal financial participation
15 for a State under section 1903 in a quarter, any payments
16 made by a State under the program under this section
17 shall be treated as expenditures for medical assistance
18 under the State plan for such quarter.

19 “(c) OPTIONAL USE OF CONTRIBUTIONS TO MEDI-
20 CAL SAVINGS ACCOUNTS OR VOUCHERS TO OBTAIN COV-
21 ERAGE.—Under a program under this section, a State
22 may provide for the enrollment of individuals in health
23 plans—

1 “(1) by making contributions to an individual’s
2 medical savings account established under section
3 220 of the Internal Revenue Code of 1986; or

4 “(2) by providing the individual with a voucher
5 that may be used toward the payment of the costs
6 of enrollment in a health plan (as determined under
7 an agreement between the State and the plan).”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 subsections (a) and (b) shall apply to quarters beginning
10 on or after January 1, 1996.

11 **TITLE IV—MEDICAL CHARGE** 12 **DISCLOSURE**

13 **SEC. 401. REQUIRING PROVIDERS OF MEDICAL SERVICES** 14 **TO DISCLOSE MAXIMUM CHARGES**

15 (a) REQUIREMENT DESCRIBED.—Each individual or
16 entity providing a medical procedure or diagnostic test
17 shall post (at a place and in a manner that will be visible
18 to the individuals receiving the procedures or tests)—

19 (1) the maximum charge assessed for the proce-
20 dure or test; and

21 (2) the costs to the individual or entity that are
22 associated with the procedure or test.

23 (b) PROHIBITION AGAINST CHARGING IN EXCESS OF
24 POSTED MAXIMUM CHARGE.—An individual or entity may
25 not charge an amount for a medical procedure or diag-

1 nostic test in excess of the maximum charge posted for
2 the procedure or test pursuant to paragraph (1).

3 (c) RECOMMENDATIONS FOR ENFORCEMENT.—Not
4 later than April 1, 1995, the Secretary of Health and
5 Human Services shall submit to Congress specific rec-
6 ommendations for sanctions that should be imposed on in-
7 dividuals and entities that fail to meet the requirements
8 of this section.

9 (d) EFFECTIVE DATE.—This section shall apply to
10 medical procedures and diagnostic tests provided on or
11 after January 1, 1996.

○

HR 4410 IH—2

HR 4410 IH—3

HR 4410 IH—4

HR 4410 IH—5