

104<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 2220

To provide for portability of health insurance, guaranteed renewability, high risk pools, medical care savings accounts, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

AUGUST 4, 1995

Mr. JACOBS (for himself, Mr. LIPINSKI, and Mr. INGLIS of South Carolina) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, 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 provide for portability of health insurance, guaranteed renewability, high risk pools, medical care savings accounts, 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 “Health Insurance Portability and Guaranteed Renewabil-  
6 ity Act of 1995”.

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

Sec. 1. Short title; table of contents.

TITLE I—AMENDMENTS OF INTERNAL REVENUE CODE OF 1986

Subtitle A—Medical Care Savings Accounts

- Sec. 101. Medical care savings benefits.
- Sec. 102. Medical care savings accounts.
- Sec. 103. Unused amounts in flexible spending accounts transferable to medical care savings accounts.

Subtitle B—Expansion of COBRA Continuation Coverage

- Sec. 111. Expansion of COBRA continuation coverage.
- Sec. 112. Expansion of COBRA options and continuation coverage requirements.
- Sec. 113. Continuation coverage must offer conversion option at end of required coverage period.

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. Enforcement.
- Sec. 204. Definitions.
- Sec. 205. 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. Limitations on nonrenewal and premium increases.
- Sec. 214. Definitions.
- Sec. 215. Effective date.

Subtitle C—Assuring Health Insurance Coverage for Uninsurable Individuals

- Sec. 221. Establishment of high risk health insurance pools.
- Sec. 222. Uninsurable individuals eligible for coverage.
- Sec. 223. Qualified health insurance coverage under pool.
- Sec. 224. Funding of pool.
- Sec. 225. Administration.

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

4 **Subtitle A—Medical Care Savings**  
5 **Accounts**

6 **SEC. 101. MEDICAL CARE SAVINGS BENEFITS.**

7 (a) IN GENERAL.—Part III of subchapter B of chap-  
8 ter 1 of the Internal Revenue Code of 1986 is amended  
9 by inserting after section 125 the following new section:

10 **“SEC. 125A. MEDICAL CARE SAVINGS BENEFITS.**

11 “(a) IN GENERAL.—A medical care savings benefit  
12 is a qualified benefit which consists of a health plan meet-  
13 ing the requirements of this section that includes, as part  
14 thereof, a medical care savings account, as set forth in  
15 section 408A.

16 “(b) ESTABLISHMENT OF MEDICAL CARE SAVINGS  
17 BENEFIT.—A medical care savings benefit shall be estab-  
18 lished as a health plan which provides that all or part of  
19 the premium differential realized by instituting a qualified  
20 higher deductible health plan is credited to a participating  
21 employee during a plan year to pay for medical care de-  
22 scribed in section 213(d) subject to the limitations set  
23 forth in subsection (e) hereof. To the extent that any  
24 amount remains credited to that participant at the end  
25 of each plan year, such amount shall be deposited to a

1 section 408A medical care savings account (which may  
2 also be referred to as a ‘Medical IRA’) for that partici-  
3 pant.

4 “(c) PAYMENTS FROM ACCOUNT BALANCE.—If the  
5 plan provides for level installment payments, the plan may  
6 also provide that the maximum amount of reimbursement  
7 at a particular time during the period of coverage may  
8 be limited to the amount of actual contributions to the  
9 participant’s benefit account. A participant may be ad-  
10 vanced, interest free, such amounts necessary to cover in-  
11 curred medical expenses which exceed the amount then  
12 credited to the participant’s benefit account, upon the par-  
13 ticipant’s agreement to repay such advancement from fu-  
14 ture installments or upon ceasing to be a participant.

15 “(d) REPORTING.—Employers shall cause to be is-  
16 sued to participating employees, not less frequently than  
17 quarterly, a statement setting forth amounts remaining in  
18 their accounts.

19 “(e) LIMITATIONS ON MEDICAL CARE SAVINGS BEN-  
20 EFITS.—For purposes of this section—

21 “(1) IN GENERAL.—In the case of an employer  
22 who has a health plan in existence immediately prior  
23 to the adoption of the medical care savings benefit,  
24 the maximum amount that may be contributed an-

1 nually to a participant's benefit account shall be  
2 equal to—

3 “(A) the cost of that health plan for that  
4 participant's type of coverage; plus

5 “(B) a cost of living adjustment for the  
6 calendar year in which the plan year begins, de-  
7 termined under section 1(f)(3) as adjusted an-  
8 nually based on the CPI-medical cost of living  
9 component.

10 “(2) OTHER EMPLOYERS.—In the case of an  
11 Employer to whom paragraph (1) does not apply,  
12 the contribution limit shall be equal to the excess of  
13 the annual cost of the catastrophic health plan cov-  
14 ering the individual (whether or not such cost is  
15 borne by the employer or the employee) over the an-  
16 nual aggregate cost (including the government and  
17 employee share) of the standard option of the Blue  
18 Cross-Blue Shield plan offered under the Federal  
19 Employees Health Benefits Program under chapter  
20 89 of title 5, United States Code for the same type  
21 of family coverage.

22 “(3) OVERALL LIMITATION.—In no event may  
23 any contribution described above exceed the deduct-  
24 ible amount of the qualified higher deductible plan.

1       “(f) HEALTH PLAN.—The term ‘health plan’ means  
2 an employee welfare benefit plan providing medical care  
3 (as defined in section 213(d)) to participants or bene-  
4 ficiaries directly or through insurance, reimbursement, or  
5 otherwise.

6       “(g) QUALIFIED HIGHER DEDUCTIBLE PLAN.—The  
7 term ‘qualified higher deductible plan’ is a health plan  
8 which provides for payment of covered benefits in excess  
9 of the higher deductible, which higher deductible shall not  
10 exceed \$5,000 in 1996 and, adjusted annually thereafter  
11 for increases in the cost of living in accordance with regu-  
12 lations prescribed by the Secretary.

13       “(h) COORDINATION WITH HEALTH FLEXIBLE  
14 SPENDING ACCOUNTS.—If, during a plan year, a partici-  
15 pating employee has a medical care savings benefit in ef-  
16 fect and a health flexible spending account established  
17 under section 125, coverage under the health flexible  
18 spending account, for the type of medical expenses that  
19 may be reimbursed under the medical care savings benefit,  
20 would be limited to 100 percent of the deductible under  
21 the qualified higher deductible plan, less the amount cred-  
22 ited in the current year to the employee’s medical care  
23 savings account. For purposes of section 125, a medical  
24 care savings benefit is not considered to involve the defer-  
25 ral of compensation for purposes of this title.

1       “(i) SEPARATE DETERMINATIONS FOR CATEGORIES  
2 OF EMPLOYEES AND SEPARATE LINES OF BUSINESS.—  
3 Contributions to Health Plans established by an Employer  
4 may be separately determined on the basis of:

5           “(1) Types of coverage.

6           “(2) Reasonable classifications of employees  
7 based on such classifications as hours of work per  
8 week, retirement status, coverage by a collective bar-  
9 gaining agreement.

10          “(3) Employees within separate lines of busi-  
11 ness, within the meaning of section 414(r).

12       “(j) OTHER DEFINITIONS FOR PURPOSES OF THIS  
13 SECTION.—

14           “(1) EMPLOYEE.—The term ‘employee’ means  
15 any individual employed by an employer, including—

16           “(A) an individual who is an employee  
17 within the meaning of section 401(c)(1); and

18           “(B) former employees.

19           “(2) TYPES OF COVERAGE.—The types of cov-  
20 erage are—

21           “(A) self-only coverage; and

22           “(B) coverage other than self-only cov-  
23 erage.

24       “(k) PREVENTATIVE HEALTH CARE.—By allowing  
25 medical expenses payable from a medical care savings ben-

1 efit to be those permitted under section 213(d), participat-  
2 ing employees are encouraged to use this benefit to pro-  
3 mote good health, to use preventative medical and health  
4 procedures, and to seek appropriate consultative and sec-  
5 ond opinions.

6 “(l) NONDUPLICATION OF BENEFITS.—Policies is-  
7 sued as a part of a medical care savings benefit shall not  
8 be required to duplicate expenses that may be proper ex-  
9 penses covered by the medical care savings benefit. Addi-  
10 tionally, the qualified higher deductible plan may provide  
11 that the deductible specified in the insurance policy may  
12 be increased by the amount of any benefits payable by any  
13 other health benefits program or plan.”.

14 (b) CLERICAL AMENDMENT.—The table of sections  
15 for part III of subchapter B of chapter 1 of such Code  
16 is amended by inserting after the item relating to section  
17 125 the following new item:

“Sec. 125A. Medical care savings benefits.”

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

21 **SEC. 102. MEDICAL CARE SAVINGS ACCOUNTS.**

22 (a) IN GENERAL.—Subpart A of part I of subchapter  
23 D of chapter 1 of the Internal Revenue Code of 1986 is  
24 amended by inserting after section 408 the following new  
25 section:

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

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

10           “(1) Except in the case of a rollover contribu-  
11 tion described in subsection (c)(3), no contribution  
12 will be accepted unless it is in cash and contribu-  
13 tions will not be accepted during any calendar year  
14 in excess of the amount permitted under section  
15 125A(b).

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

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

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

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

4           “(b) TAX TREATMENT OF ACCOUNTS.—

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

6           “(A) IN GENERAL.—Except as provided in  
7           subparagraph (B), the account beneficiary of a  
8           medical care savings account shall be treated  
9           for purposes of this title as the owner of such  
10          account and shall be subject to tax thereon in  
11          accordance with subpart E of part I of sub-  
12          chapter J of this chapter (relating to grantors  
13          and others treated as substantial owners).

14          “(B) TREATMENT OF CAPITAL LOSSES.—

15          With respect to assets held in a medical care  
16          savings account, any capital loss for a taxable  
17          year from the sale or exchange of such an asset  
18          shall be allowed only to the extent of capital  
19          gains from such assets for such taxable year.  
20          Any capital loss which is disallowed under the  
21          preceding sentence shall be treated as a capital  
22          loss from the sale or exchange of such an asset  
23          in the next taxable year. For purposes of this  
24          subparagraph, all medical care savings accounts

1 of the account beneficiary shall be treated as 1  
2 account.

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

5 “(A) IN GENERAL.—If, during any taxable  
6 year of the account beneficiary, such beneficiary  
7 engages in any transaction prohibited by section  
8 4975 with respect to the account, the account  
9 ceases to be a medical care savings account as  
10 of the first day of that taxable year.

11 “(B) ACCOUNT TREATED AS DISTRIBUTING  
12 ALL ITS ASSETS.—In any case in which any ac-  
13 count ceases to be a medical care savings ac-  
14 count by reason of subparagraph (A) on the  
15 first day of any taxable year, subsection (c)  
16 shall be applied as if—

17 “(i) there were a distribution on such  
18 first day in an amount equal to the fair  
19 market value (on such first day) of all as-  
20 sets in the account (on such first day), and

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

23 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-  
24 RITY.—If, during any taxable year, the account ben-  
25 eficiary uses the account or any portion thereof as

1 security for a loan, the portion so used is treated as  
2 distributed and not used to pay qualified expenses.

3 “(c) TAX TREATMENT OF DISTRIBUTIONS.—

4 “(1) INCLUSION OF AMOUNTS NOT USED FOR  
5 QUALIFIED MEDICAL EXPENSES.—

6 “(A) IN GENERAL.—Any amount paid or  
7 distributed out of a medical care savings ac-  
8 count which is not used exclusively to pay the  
9 qualified medical expenses of the account bene-  
10 ficiary or of the spouse or dependents of such  
11 beneficiary shall be included in the gross in-  
12 come of such beneficiary to the extent such  
13 amount does not exceed the excess of—

14 “(i) the aggregate contributions by  
15 the employer to such account which were  
16 not includible in gross income, over

17 “(ii) the aggregate prior payments or  
18 distributions from such account which were  
19 includible in gross income under this para-  
20 graph.

21 “(B) SPECIAL RULES.—For purposes of  
22 subparagraph (A)—

23 “(i) all medical care savings accounts  
24 of the account beneficiary shall be treated  
25 as 1 account,

1           “(ii) all payments and distributions  
2           during any taxable year shall be treated as  
3           1 distribution, and

4           “(iii) any distribution of property  
5           shall be taken into account at its fair mar-  
6           ket value on the date of the distribution.

7           “(2) PENALTY FOR DISTRIBUTIONS NOT USED  
8           FOR QUALIFIED EXPENSES.—

9           “(A) IN GENERAL.—The tax imposed by  
10          this chapter for any taxable year in which there  
11          is a payment or distribution from a medical  
12          care savings account which is includible in gross  
13          income under paragraph (1) shall be increased  
14          by 10 percent of the amount which is so includ-  
15          ible.

16          “(B) EXCEPTION FOR DISTRIBUTIONS  
17          AFTER AGE 59½.—Subparagraph (A) shall not  
18          apply to any distribution or payment after the  
19          date on which the account beneficiary attains  
20          age 59½.

21          “(C) DISABILITY OR DEATH CASES.—Sub-  
22          paragraph (A) shall not apply if the payment or  
23          distribution is made after the account bene-  
24          ficiary becomes disabled within the meaning of  
25          section 72(m)(7) or dies.

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

5           “(A) IN GENERAL.—Paragraph (1) does  
6 not apply to any amount paid or distributed out  
7 of a medical care savings account to the ac-  
8 count beneficiary if the entire amount received  
9 is paid into a medical care savings account for  
10 the benefit of such beneficiary not later than  
11 the 60th day after the day on which he receives  
12 the payment or distribution.

13           “(B) LIMITATION.—This paragraph does  
14 not apply to any amount described in subpara-  
15 graph (A) received by an individual from a  
16 medical care savings account if at any time dur-  
17 ing the one-year period ending on the day of  
18 such receipt such individual received any other  
19 amount described in subparagraph (A) from a  
20 medical care savings account which was not in-  
21 cludible in his gross income because of the ap-  
22 plication of this paragraph.

23           “(C) TREATMENT AFTER DEATH OF AC-  
24 COUNT BENEFICIARY.—

1           “(i) IN GENERAL.—After the death of  
2           the account beneficiary, the assets in such  
3           beneficiary’s medical care savings account  
4           may continue to be used for the benefit of  
5           the beneficiary’s spouse and dependents if,  
6           not more than 60 days after the bene-  
7           ficiary’s death—

8                     “(I) the beneficiary’s medical  
9                     care savings account is transferred to  
10                    a new account administrator; or

11                   “(II) the legatee requests in writ-  
12                   ing that the account administrator re-  
13                   main the administrator of the ac-  
14                   count, and the account administrator  
15                   agrees to retain the account.

16           “(ii) FAILURE TO GIVE NOTICE.—If  
17           the former account administrator of a  
18           medical care savings account of a deceased  
19           beneficiary is not informed, within 90 days  
20           after the beneficiary’s death, of the name  
21           and address of an account administrator to  
22           which the medical care savings account has  
23           been transferred under clause (i), the  
24           former account administrator shall liq-  
25           uidate the assets in such account and pay

1 the proceeds to the estate of the bene-  
2 ficiary.

3 “(iii) ACCOUNT ADMINISTRATOR UN-  
4 WILLING TO MAINTAIN ACCOUNT.—If—

5 “(I) the legatee makes a request  
6 described in clause (i)(II); and

7 “(II) the account administrator  
8 does not agree to retain the account;  
9 the account administrator shall, within 90  
10 days after the beneficiary’s death, liquidate  
11 the assets in such account and pay the  
12 proceeds to the estate of the beneficiary.

13 “(iv) TREATMENT OF TRANSFERS TO  
14 ESTATE.—Any transfer to the estate of a  
15 decedent under clause (ii) or (iii) shall not  
16 be includible in the gross income of the  
17 beneficiary or of the estate.

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

19 “(1) QUALIFIED EXPENSES.—The term ‘quali-  
20 fied expenses’ means any of the following expenses  
21 which are incurred for the benefit of the account  
22 beneficiary or the spouse or dependents (as defined  
23 in section 152) of such beneficiary:

24 “(A) Expenses for medical care (as defined  
25 in section 213(d)).

1           “(B) Expenses for long-term care services  
2           (or premiums for long-term care insurance).

3           “(2) ACCOUNT BENEFICIARY.—The term ‘ac-  
4           count beneficiary’ means the individual for whose  
5           benefit the medical care savings account is estab-  
6           lished.

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

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

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

19          For purposes of this title, in the case of a custodial ac-  
20          count treated as a trust by reason of the preceding sen-  
21          tence, the custodian of such account shall be treated as  
22          the trustee thereof.

23          “(f) REPORTS.—The trustee of a medical care sav-  
24          ings account shall make such reports regarding such ac-  
25          count to the Secretary and to the account beneficiary with

1 respect to contributions, distributions, and such other  
2 matters as the Secretary may require under regulations.  
3 The reports required by this subsection shall be filed at  
4 such time and in such manner and furnished to such indi-  
5 viduals at such time and in such manner as may be re-  
6 quired by those regulations.”

7 (b) EMPLOYER PAYMENTS EXCLUDED FROM EM-  
8 PLOYMENT TAX BASE.—

9 (1) SOCIAL SECURITY TAXES.—

10 (A) Subsection (a) of section 3121 of such  
11 Code is amended by striking “or” at the end of  
12 paragraph (20), by striking the period at the  
13 end of paragraph (21) and inserting “; or”, and  
14 by inserting after paragraph (21) the following  
15 new paragraph:

16 “(22) any payment made to or for the benefit  
17 of an employee if at the time of such payment it is  
18 reasonable to believe that the employee will be able  
19 to exclude such payment from gross income under  
20 chapter 1.”

21 (B) Subsection (a) of section 209 of the  
22 Social Security Act is amended by striking “or”  
23 at the end of paragraph (18), by striking the  
24 period at the end of paragraph (19) and insert-

1           ing “; or”, and by inserting after paragraph  
2           (19) the following new paragraph:

3           “(20) 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 gross income under  
7           chapter 1 of the Internal Revenue Code of 1986.”

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

11          “(10) MEDICAL CARE SAVINGS ACCOUNT CON-  
12          TRIBUTIONS.—The term ‘compensation’ shall not in-  
13          clude any payment made to or for the benefit of an  
14          employee if at the time of such payment it is reason-  
15          able to believe that the employee will be able to ex-  
16          clude such payment from gross income under chap-  
17          ter 1.”

18          (3) UNEMPLOYMENT TAX.—Subsection (b) of  
19          section 3306 of such Code is amended by striking  
20          “or” at the end of paragraph (15), by striking the  
21          period at the end of paragraph (16) and inserting “;  
22          or”, and by inserting after paragraph (16) the fol-  
23          lowing new paragraph:

24          “(17) any payment made to or for the benefit  
25          of an employee if at the time of such payment it is

1 reasonable to believe that the employee will be able  
2 to exclude such payment from gross income under  
3 chapter 1.”

4 (4) WITHHOLDING TAX.—Subsection (a) of sec-  
5 tion 3401 of such Code is amended by striking “or”  
6 at the end of paragraph (19), by striking the period  
7 at the end of paragraph (20) and inserting “; or”,  
8 and by inserting after paragraph (20) the following  
9 new paragraph:

10 “(21) 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 gross income under  
14 chapter 1.”

15 (c) TAX ON PROHIBITED TRANSACTIONS.—Section  
16 4975 of such Code (relating to prohibited transactions)  
17 is amended—

18 (1) by adding at the end of subsection (c) the  
19 following new paragraph:

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

1 otherwise be taxable under this section) if, with re-  
2 spect to such transaction, the account ceases to be  
3 a medical care savings account by reason of the ap-  
4 plication of section 408A(b)(2)(A) to such account.”,  
5 and

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

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

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

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

23 (e) CLERICAL AMENDMENTS.—

24 (1) The table of sections for subpart A of part  
25 I of subchapter D of chapter 1 of such Code is

1 amended by inserting after the item relating to sec-  
2 tion 408 the following:

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

3 (2) The table of sections for chapter 43 of such  
4 Code is amended by striking the item relating to sec-  
5 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.”

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

10 (f) EFFECTIVE DATE.—The amendments made by  
11 this section shall take effect on January 1, 1996.

12 **SEC. 103. UNUSED AMOUNTS IN FLEXIBLE SPENDING AC-**  
13 **COUNTS TRANSFERABLE TO MEDICAL CARE**  
14 **SAVINGS ACCOUNTS.**

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

19 “(3) UNUSED AMOUNTS TRANSFERABLE TO  
20 MEDICAL CARE SAVINGS ACCOUNTS.—Subsection (a)  
21 shall not fail to apply to a participant in a plan, and  
22 a plan shall not fail to be treated as a cafeteria plan,

1 solely because under the plan amounts not paid out  
2 as reimbursements under a flexible spending ar-  
3 rangement for medical care (as defined in section  
4 213(d)) for an individual or such individual's spouse  
5 and dependents) are contributed on the last day of  
6 the plan year of the cafeteria plan to a medical care  
7 savings account (as defined in section 408A) of such  
8 individual.”

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

12 **Subtitle B—Expansion of COBRA**  
13 **Continuation Coverage**

14 **SEC. 111. EXPANSION OF COBRA CONTINUATION COV-**  
15 **ERAGE.**

16 (a) AMENDMENTS TO INTERNAL REVENUE CODE.—

17 (1) SMALLER EMPLOYERS SUBJECT TO RE-  
18 QUIREMENTS.—Paragraph (1) of section 4980B(d)  
19 of the Internal Revenue Code of 1986 (relating to  
20 tax not to apply to certain plans) is amended by  
21 striking “20 employees” and inserting “2 employ-  
22 ees”.

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

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

4 “(i) MAXIMUM REQUIRED PERIOD.—

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

8 “(II) SPECIAL RULE FOR CER-  
9 TAIN BANKRUPTCY PROCEEDINGS.—

10 In the case of a qualifying event de-  
11 scribed in paragraph (3)(F) (relating  
12 to bankruptcy proceedings), the date  
13 of the death of the covered employee  
14 or qualified beneficiary (described in  
15 subsection (g)(1)(D)(iii)), or in the  
16 case of the surviving spouse or de-  
17 pendent children of the covered em-  
18 ployee, 36 months after the date of  
19 the death of the covered employee.

20 “(III) QUALIFYING EVENT IN-  
21 VOLVING MEDICARE ENTITLEMENT.—

22 In the case of an event described in  
23 paragraph (3)(D) (without regard to  
24 whether such event is a qualifying  
25 event), the period of coverage for

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

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

20 (3) SUBSTANTIALLY SIMILAR COVERAGE UNDER  
21 NEW EMPLOYER’S HEALTH PLAN TO TERMINATE  
22 CONTINUATION COVERAGE OBLIGATION OF PRIOR  
23 EMPLOYER.—Clause (iv) of section 4980B(f)(2)(B)  
24 of such Code is amended by striking “or” at the end  
25 of subclause (I), by redesignating subclause (II) as

1 subclause (III), and by inserting after subclause (I)  
2 the following new subclause:

3 “(II) covered under any other  
4 group health plan by reason of the re-  
5 employment of the covered employee if  
6 such coverage is substantially similar  
7 to (or in all respects greater than) the  
8 coverage provided by reason of this  
9 section, or”.

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

12 (1) SMALLER EMPLOYERS SUBJECT TO RE-  
13 QUIREMENTS.—Subsection (b) of section 601 of the  
14 Employee Retirement Income Security Act of 1974  
15 (29 U.S.C. 1161) (relating to exception for certain  
16 plans) is amended by striking “20 employees” and  
17 inserting “2 employees”.

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

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

24 “(A) MAXIMUM REQUIRED PERIOD.—

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

4           “(ii) SPECIAL RULE FOR CERTAIN  
5           BANKRUPTCY PROCEEDINGS.—In the case  
6           of a qualifying event described in section  
7           603(6) (relating to bankruptcy proceed-  
8           ings), the date of the death of the covered  
9           employee or qualified beneficiary (described  
10          in section 607(3)(C)(iii)), or in the case of  
11          the surviving spouse or dependent children  
12          of the covered employee, 36 months after  
13          the date of the death of the covered  
14          employee.

15          “(iii) QUALIFYING EVENT INVOLVING  
16          MEDICARE ENTITLEMENT.—In the case of  
17          an event described in section 603(4) (with-  
18          out regard to whether such event is a  
19          qualifying event), the period of coverage  
20          for qualified beneficiaries other than the  
21          covered employee for such event or any  
22          subsequent qualifying event shall not ter-  
23          minate before the close of the 36-month  
24          period beginning on the date the covered  
25          employee becomes entitled to benefits



1 coverage provided by reason of this  
2 section, or”.

3 (c) AMENDMENTS TO PUBLIC HEALTH SERVICE  
4 ACT.—

5 (1) SMALLER EMPLOYERS SUBJECT TO RE-  
6 QUIREMENTS.—Paragraph (1) of section 2201(b) of  
7 the Public Health Service Act (42 U.S.C. 300bb-  
8 1(b)) (relating to exception for certain plans) is  
9 amended by striking “20 employees” and inserting  
10 “4 employees”.

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

13 (A) IN GENERAL.—Subparagraph (A) of  
14 section 2202(2) of such Act (42 U.S.C. 300bb-  
15 2(2)) (relating to period of coverage) is amend-  
16 ed to read as follows:

17 “(A) MAXIMUM REQUIRED PERIOD.—

18 “(i) IN GENERAL.—The date which is  
19 36 months after the date of the qualifying  
20 event.

21 “(ii) QUALIFYING EVENT INVOLVING  
22 MEDICARE ENTITLEMENT.—In the case of  
23 an event described in section 2203(4)  
24 (without regard to whether such event is a  
25 qualifying event), the period of coverage

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

9 (B) TECHNICAL AMENDMENT.—The last  
10 sentence of section 2202(3) of such Act is  
11 amended to read as follows: “In the case of an  
12 individual who is determined, under title II or  
13 XVI of the Social Security Act, to have been  
14 disabled at the time of a qualifying event de-  
15 scribed in section 2203(2), any reference in  
16 subparagraph (A) to ‘102 percent’ is deemed a  
17 reference to ‘150 percent’ for any month after  
18 the 36th month of continuation coverage.”

19 (3) SUBSTANTIALLY SIMILAR COVERAGE UNDER  
20 NEW EMPLOYER’S HEALTH PLAN TO TERMINATE  
21 CONTINUATION COVERAGE OBLIGATION OF PRIOR  
22 EMPLOYER.—Subparagraph (D) of section 2202(2)  
23 of such Act is amended by striking “or” at the end  
24 of clause (i), by redesignating clause (ii) as clause

1 (iii), and by inserting after clause (i) the following  
2 new clause:

3 “(ii) covered under any other  
4 group health plan by reason of the re-  
5 employment of the covered employee if  
6 such coverage is substantially similar  
7 to (or in all respects greater than) the  
8 coverage provided by reason of this  
9 section, or”.

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

12 (1) qualifying events occurring after December  
13 31, 1995, and

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

20 **SEC. 112. EXPANSION OF COBRA OPTIONS AND CONTINU-**  
21 **ATION COVERAGE REQUIREMENTS.**

22 (a) AMENDMENTS TO INTERNAL REVENUE CODE.—  
23 Subparagraph (A) of section 4980B(f)(2) of the Internal  
24 Revenue Code of 1986 (relating to continuation coverage

1 requirements of group health plans) is amended to read  
2 as follows:

3 “(A) TYPE OF BENEFIT COVERAGE.—The  
4 coverage must consist of coverage which, as of  
5 the time the coverage is being provided—

6 “(i) is identical to the coverage pro-  
7 vided under the plan to similarly situated  
8 beneficiaries under the plan with respect to  
9 whom a qualifying event has not occurred,

10 “(ii) is so identical, except such cov-  
11 erage is offered with an annual \$1,000 de-  
12 ductible, or

13 “(iii) is so identical, except such cov-  
14 erage is offered with an annual \$3,000 de-  
15 ductible.

16 If coverage under the plan is modified for any  
17 group of similarly situated beneficiaries, the  
18 coverage shall also be modified in the same  
19 manner for all individuals who are qualified  
20 beneficiaries under the plan pursuant to this  
21 subsection in connection with such group.”

22 (b) AMENDMENTS TO EMPLOYEE RETIREMENT IN-  
23 COME SECURITY ACT OF 1974.—Paragraph (1) of section  
24 602 of the Employee Retirement Income Security Act of  
25 1974 (29 U.S.C. 1162) is amended to read as follows:

1           “(1) TYPE OF BENEFIT COVERAGE.—The cov-  
2           erage must consist of coverage which, as of the time  
3           the coverage is being provided—

4                   “(A) is identical to the coverage provided  
5                   under the plan to similarly situated bene-  
6                   ficiaries under the plan with respect to whom a  
7                   qualifying event has not occurred,

8                   “(B) is so identical, except such coverage  
9                   is offered with an annual \$1,000 deductible, or

10                   “(C) is so identical, except such coverage is  
11                   offered with an annual \$3,000 deductible.

12           If coverage under the plan is modified for any group  
13           of similarly situated beneficiaries, the coverage shall  
14           also be modified in the same manner for all individ-  
15           uals who are qualified beneficiaries under the plan  
16           pursuant to this part in connection with such  
17           group.”

18           (c) AMENDMENTS TO PUBLIC HEALTH SERVICE  
19           ACT.—Paragraph (1) of section 2202 of the Public Health  
20           Service Act (42 U.S.C. 300bb-2) is amended to read as  
21           follows:

22                   “(1) TYPE OF BENEFIT COVERAGE.—The cov-  
23                   erage must consist of coverage which, as of the time  
24                   the coverage is being provided—

1           “(A) is identical to the coverage provided  
2           under the plan to similarly situated bene-  
3           ficiaries under the plan with respect to whom a  
4           qualifying event has not occurred,

5           “(B) is so identical, except such coverage  
6           is offered with an annual \$1,000 deductible, or

7           “(C) is so identical, except such coverage is  
8           offered with an annual \$3,000 deductible.

9           If coverage under the plan is modified for any group  
10          of similarly situated beneficiaries, the coverage shall  
11          also be modified in the same manner for all individ-  
12          uals who are qualified beneficiaries under the plan  
13          pursuant to this part in connection with such  
14          group.”

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

17               (1) qualifying events occurring after December  
18               31, 1996, and

19               (2) qualifying events occurring on or before  
20               such date if the period of continuation coverage re-  
21               quired under section 4980B of the Internal Revenue  
22               Code of 1986 (determined without regard to the  
23               amendments made by this Act) has not expired on  
24               or before such date.

1 **SEC. 113. CONTINUATION COVERAGE MUST OFFER CON-**  
2 **VERSION OPTION AT END OF REQUIRED COV-**  
3 **ERAGE PERIOD.**

4 (a) AMENDMENTS TO INTERNAL REVENUE CODE.—

5 Paragraph (1) of section 4980B(f) of the Internal Reve-  
6 nue Code of 1986 is amended to read as follows:

7 “(1) IN GENERAL.—A group health plan meets  
8 the requirements of this subsection only if—

9 “(A) the coverage of the costs of pediatric  
10 vaccines (as defined under section 2162 of the  
11 Public Health Service Act) is not reduced below  
12 the coverage provided by the plan as of May 1,  
13 1993,

14 “(B) each qualified beneficiary who would  
15 lose coverage under the plan as a result of a  
16 qualifying event is entitled to elect, within the  
17 election period, continuation coverage under the  
18 plan, and

19 “(C) in the case of a group health plan  
20 provided through insurance, at the termination  
21 of the continuation coverage period with respect  
22 to any qualified beneficiary (other than a period  
23 which terminates by reason of paragraph  
24 (2)(B)(iv)), such beneficiary has the option to  
25 be covered under another health plan provided

1 through insurance issued by such the insurer  
2 (or an affiliated insurer)—

3 “(i) which does not contain any exclu-  
4 sion or limitation with respect to any pre-  
5 existing condition of such beneficiary,

6 “(ii) which provides coverage which is  
7 substantially similar to (or in all respects  
8 greater than) the coverage being termi-  
9 nated, and

10 “(iii) the premium for which is based  
11 on the new, normal business rate within  
12 the class of business involved for individ-  
13 uals with similar demographic characteris-  
14 tics and which is adjusted only for age and  
15 sex.”

16 (b) AMENDMENTS TO EMPLOYEE RETIREMENT IN-  
17 COME SECURITY ACT OF 1974.—Subsection (a) of section  
18 601 of such Act is amended to read as follows:

19 “(a) IN GENERAL.—The plan sponsor of each group  
20 health plan shall provide, in accordance with this part,  
21 that—

22 “(1) each qualified beneficiary who would lose  
23 coverage under the plan as a result of a qualifying  
24 event is entitled, under the plan, to elect, within the

1 election period, continuation coverage under the  
2 plan, and

3 “(2) in the case of such a group health plan  
4 provided through insurance, at the termination of  
5 the continuation coverage period with respect to any  
6 qualified beneficiary (other than a period which ter-  
7 minates by reason of section 602(2)(D)), such bene-  
8 ficiary has the option to be covered under another  
9 health plan provided through insurance issued by  
10 such the insurer (or an affiliated insurer) which does  
11 not contain any exclusion or limitation with respect  
12 to any preexisting condition of such beneficiary and  
13 which provides coverage which is substantially simi-  
14 lar to (or in all respects greater than) the coverage  
15 being terminated.”.

16 (c) AMENDMENTS TO PUBLIC HEALTH SERVICE  
17 ACT.—Subsection (a) of section 2201 of the Public Health  
18 Service Act is amended to read as follows:

19 “(a) IN GENERAL.—In accordance with regulations  
20 which the Secretary shall prescribe, each group health  
21 plan that is maintained by any State that receives funds  
22 under this Act, by any political subdivision of such a State,  
23 or by any agency or instrumentality of such a State or  
24 political subdivision, shall provide, in accordance with this  
25 title, that—

1           “(1) each qualified beneficiary who would lose  
2 coverage under the plan as a result of a qualifying  
3 event is entitled, under the plan, to elect, within the  
4 election period, continuation coverage under the  
5 plan, and

6           “(2) in the case of such a group health plan  
7 provided through insurance, at the termination of  
8 the continuation coverage period with respect to any  
9 qualified beneficiary (other than a period which ter-  
10 minates by reason of section 2202(2)(D)), such ben-  
11 eficiary has the option to be covered under another  
12 health plan provided through insurance issued by  
13 such the insurer (or an affiliated insurer) which does  
14 not contain any exclusion or limitation with respect  
15 to any preexisting condition of such beneficiary and  
16 which provides coverage which is substantially simi-  
17 lar to (or in all respects greater than) the coverage  
18 being terminated.”

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

21           (1) qualifying events occurring after December  
22 31, 1996, and

23           (2) qualifying events occurring on or before  
24 such date if the period of continuation coverage re-  
25 quired under section 4980B of the Internal Revenue

1 Code of 1986 (determined without regard to the  
2 amendments made by this Act) has not expired on  
3 or before such date.

4 **TITLE II—INSURANCE REFORM**  
5 **Subtitle A—Employer Insurance**  
6 **Protections**

7 **SEC. 201. SMALL GROUP EMPLOYER INSURANCE PROTEC-**  
8 **TIONS.**

9 (a) REQUIREMENTS FOR INSURERS.—Any health  
10 benefit insurer that provides or offers a small group health  
11 benefit plan within a State (in this subtitle referred to as  
12 a “covered insurer”) must meet the requirements specified  
13 in this section with respect to such a plan.

14 (b) SMALL EMPLOYER PROTECTION AGAINST TER-  
15 MINATION OR NON-RENEWAL OR INDUSTRY BLACKLIST-  
16 ING.—

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

18 (A) cancel or nonrenew an individual small  
19 employer group except for a reason specified in  
20 paragraph (2), or

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

24 A covered insurer may not single out and cancel a  
25 small group health benefit plan for an individual

1 small employer group because of claims experience  
2 relating to the group.

3 (2) PERMISSIBLE TERMINATION.—A covered in-  
4 surer may cancel or nonrenew a small group health  
5 benefit plan for an individual small employer group  
6 for any of the following:

7 (A) Nonpayment of required premium.

8 (B) Fraud or misrepresentation on the  
9 part of the employer.

10 (C) Noncompliance with provisions of the  
11 plan.

12 (D) Nonrenewal upon 90 days written no-  
13 tice with respect to all persons insured under  
14 the small group health benefit plan in a State.

15 (3) LIMITATION ON MARKET REENTRY.—A cov-  
16 ered insurer that exercises its right of nonrenewal as  
17 provided under paragraph (2)(D) may not accept  
18 any new health business of the type it nonrenewed  
19 for a period of 5 years, after the date it provides no-  
20 tice of such nonrenewal.

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

1           (1) The percentage change in the premium rate  
2           for new business for employers with similar case  
3           characteristics, as measured between the first day of  
4           the year in which the new rates take effect and the  
5           first day of the previous year.

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

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

12          (d) LIMIT ON VARIATION IN PREMIUMS.—

13           (1) ACROSS CLASSES OF BUSINESS.—The index  
14           rate for a rating period for any class of business  
15           shall not exceed the index rate for any other class  
16           of business by more than 20 percent.

17           (2) WITHIN A CLASS OF BUSINESS.—For a  
18           class of business, the premium rates charged during  
19           a rating period to small employer groups with simi-  
20           lar case characteristics for the same or similar cov-  
21           erage (or rates that could be charged to such em-  
22           ployers under the rating system for that class of  
23           business) shall not vary from the index rate for such  
24           class by more than 25 percent of the index rate.

1           (3) USE OF INDUSTRY AS A CASE CHAR-  
2           ACTERISTIC.—

3           (A) IN GENERAL.—Subject to subpara-  
4           graph (B), a covered insurer may utilize indus-  
5           try as a case characteristic in establishing pre-  
6           mium rates.

7           (B) LIMITATION ON VARIATION.—If a cov-  
8           ered insurer that utilizes industry as a case  
9           characteristic in establishing premium rates,  
10          the highest rate factor associated with an in-  
11          dustry classification may not exceed the lowest  
12          rate associated with any industry classification  
13          by more than 15 percent.

14 **SEC. 202. GENERAL PORTABILITY REQUIREMENT FOR EM-**  
15 **EMPLOYER-BASED HEALTH INSURANCE.**

16          (a) LIMITATIONS ON USE OF PREEXISTING CONDI-  
17          TIONS.—

18           (1) IN GENERAL.—A group health benefit plan  
19           of an employer shall not exclude or limit coverage  
20           for a preexisting condition for a covered individual  
21           for a period beyond 12 months following the effec-  
22           tive date of the individual's coverage.

23           (2) RESTRICTIONS ON DEFINITION OF PRE-  
24           EXISTING CONDITION.—For purposes of paragraph

1 (1), such a plan shall not define a preexisting condi-  
2 tion more restrictively than the following:

3 (A) A condition that would have caused an  
4 ordinarily prudent person to seek medical ad-  
5 vice, diagnosis, care, or treatment during the 6  
6 months immediately preceding the effective date  
7 of coverage.

8 (B) A condition for which medical advice,  
9 diagnosis, care, or treatment was recommended  
10 or received during the 6 months immediately  
11 preceding the effective date of coverage.

12 (C) A pregnancy existing on the effective  
13 date of coverage.

14 (b) LIMITATIONS ON RIDERS.—

15 (1) IN GENERAL.—Except as provided in para-  
16 graph (2), an insurer issuing a group health plan  
17 may not modify the plan with respect to an eligible  
18 individual, eligible employee, or dependent.

19 (2) RELATION TO PREEXISTING CONDITION EX-  
20 CLUSION PERIOD.—

21 (A) IN GENERAL.—To the extent that a  
22 preexisting condition limitation applies, an in-  
23 surer may restrict or exclude coverage or bene-  
24 fits for a specific condition for a maximum pe-  
25 riod of 12 months from the effective date of

1 coverage of an eligible individual by way of  
2 rider or endorsement.

3 (B) NO ADDITION RIDERS.—No other rider  
4 or endorsement may be placed on the group  
5 health plan to restrict further coverage.

6 (C) COMBINATION.—If both a rider and a  
7 preexisting condition exclusion period are used,  
8 the combined limitation period may not exceed  
9 12 months.

10 (3) NO DISCLOSURE OF CONDITION RE-  
11 QUIRED.—A preexisting condition limitation period  
12 may be applied whether or not the specific condition  
13 has been disclosed on the application for coverage  
14 under the individual health benefit plan.

15 (4) PORTABILITY OF COVERAGE.—The preexist-  
16 ing condition limitation period under any group  
17 health plan with respect to particular services shall  
18 be reduced by one month for each month of continu-  
19 ous coverage the eligible individual had under prior  
20 similar coverage.

21 (c) LIMITATION ON UNDERWRITING.—

22 (1) IN GENERAL.—In the case of a previously  
23 covered individual who becomes an employee of an  
24 employer, the group health plan of the employer  
25 shall accept the individual for coverage upon the

1 date of application for coverage on the basis relating  
2 to the individual's health status as of the date the  
3 individual applied for employment with the previous  
4 employer.

5 (2) PREVIOUSLY COVERED INDIVIDUAL DE-  
6 FINED.—For purposes of paragraph (1), the term  
7 “previously covered individual” means, with respect  
8 to an employer, an individual who before employ-  
9 ment by the employer was an employee of another  
10 employer and was provided coverage under a group  
11 health plan of (or contributed to by) the previous  
12 employer.

13 (d) RESTRICTIONS FOR SMALL EMPLOYER HEALTH  
14 PLANS.—If a small employer insurer offers coverage to  
15 a small employer, the small employer insurer shall offer  
16 coverage to all of the eligible employees of the small em-  
17 ployer and their dependents. A small employer insurer  
18 shall not offer coverage to only certain individuals in a  
19 small employer group or to only part of the group, except  
20 in the case of late enrollees.

21 (e) CONSTRUCTION.—Nothing in this section shall be  
22 construed as requiring an insurer or health benefit plan  
23 to provide benefits greater than those provided to an indi-  
24 vidual insured as a standard risk had the previous cov-  
25 erage remained in force.

1 (f) DEFINITIONS.—For purposes of this section:

2 (1) COVERED INDIVIDUAL.—The term “covered  
3 individual” means—

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

11 (B) the spouse or any dependent child of  
12 such individual.

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

17 **SEC. 203. ENFORCEMENT.**

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

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

24 “(a) GENERAL RULE.—There is hereby imposed a  
25 penalty on the failure of an insurer or group health plan

1 to meet the applicable requirements of section 201 or 202  
2 of the Health Insurance Portability and Guaranteed Re-  
3 newability Act of 1995 with respect to any covered individ-  
4 ual.

5 “(b) AMOUNT OF PENALTY.—

6 “(1) IN GENERAL.—The amount of the penalty  
7 imposed by subsection (a) on any failure with re-  
8 spect to—

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

12 “(B) a requirement in such section 202  
13 with respect to a covered individual shall be  
14 \$100 for each day in the noncompliance period  
15 with respect to such failure.

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

19 “(A) beginning on the date such failure  
20 first occurs, and

21 “(B) ending on the date such failure is  
22 corrected.

23 “(3) CORRECTION.—A failure of a group health  
24 plan to meet the requirements of section 202 of the  
25 Health Insurance Portability and Guaranteed Re-

1 newability Act of 1995 with respect to any covered  
2 individual shall be treated as corrected if—

3 “(A) such failure is retroactively undone to  
4 the extent possible, and

5 “(B) the covered individual is placed in a  
6 financial position which is as good as such indi-  
7 vidual would have been in had such failure not  
8 occurred.

9 For purposes of applying subparagraph (B), the cov-  
10 ered individual shall be treated as if the individual  
11 had elected the most favorable coverage in light of  
12 the expenses incurred since the failure first oc-  
13 curred.

14 “(c) LIMITATIONS ON AMOUNT OF PENALTY.—

15 “(1) PENALTY NOT TO APPLY WHERE FAILURE  
16 NOT DISCOVERED EXERCISING REASONABLE DILI-  
17 GENCE.—No penalty shall be imposed by subsection  
18 (a) on any failure during any period for which it is  
19 established to the satisfaction of the Secretary that  
20 none of the persons referred to in subsection (d)  
21 knew, or exercising reasonable diligence would have  
22 known, that such failure existed.

23 “(2) PENALTY NOT TO APPLY TO FAILURES  
24 CORRECTED WITHIN 30 DAYS.—No penalty shall be  
25 imposed by subsection (a) on any failure if—

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

3           “(B) such failure is corrected during the  
4           30-day period beginning on the first date any of  
5           the persons referred to in subsection (d) knew,  
6           or exercising reasonable diligence would have  
7           known, that such failure existed.

8           “(3) WAIVER BY SECRETARY.—In the case of a  
9           failure which is due to reasonable cause and not to  
10          willful neglect, the Secretary may waive part or all  
11          of the penalty imposed by subsection (a) to the ex-  
12          tent that the payment of such penalty would be ex-  
13          cessive relative to the failure involved.

14          “(d) LIABILITY FOR PENALTY.—

15                 “(1) IN GENERAL.—Except as otherwise pro-  
16                 vided in this subsection, the following shall be liable  
17                 for the penalty imposed by subsection (a) on a fail-  
18                 ure:

19                         “(A) In the case of a group health plan  
20                         other than a self-insured group health plan, the  
21                         issuer.

22                         “(B)(i) In the case of a self-insured group  
23                         health plan other than a multiemployer group  
24                         health plan, the employer.

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

3           “(C) Each person who is responsible (other  
4 than in a capacity as an employee) for admin-  
5 istering or providing benefits under the group  
6 health plan, health insurance plan, or other  
7 health benefit arrangement (including a self-in-  
8 sured plan) and whose act or failure to act  
9 caused (in whole or in part) the failure.

10          “(2) SPECIAL RULES FOR PERSONS DESCRIBED  
11 IN PARAGRAPH (1)(C).—A person described in sub-  
12 paragraph (C) (and not in subparagraphs (A) and  
13 (B)) of paragraph (1) shall be liable for the penalty  
14 imposed by subsection (a) on any failure only if such  
15 person assumed (under a legally enforceable written  
16 agreement) responsibility for the performance of the  
17 act to which the failure relates.

18          “(e) PENALTY TREATED AS TAX.—For purposes of  
19 subtitle F, any penalty imposed by this section shall be  
20 treated as a tax.”

21          (b) NONDEDUCTIBILITY OF PENALTY.—Paragraph  
22 (6) of section 275(a) of such Code (relating to  
23 nondeductibility of certain taxes) is amended by inserting  
24 “47,” after “46,”.

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

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

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

7 **SEC. 204. DEFINITIONS.**

8 In this subtitle:

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

15 (A) claims experience,

16 (B) health status, and

17 (C) duration of coverage since date of  
18 issue.

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

21 (3) SMALL EMPLOYER.—The term “small em-  
22 ployer” means a business that, during the most re-  
23 cent calendar year, employed at least 2, but not  
24 more than 25, employees who are eligible for cov-

1 erage under a health benefit plan on at least 50 per-  
2 cent of that business' working days.

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

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

22 (6) CLASS OF BUSINESS.—The term “class of  
23 business” means each separate class of business es-  
24 tablished by an insurer to reflect substantial dif-  
25 ferences in expected claims experience or administra-

1       tive costs related only to one or more of the follow-  
2       ing:

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

6               (B) The insurer's acquisition of a class of  
7               business from another insurer.

8               (C) The insurer providing coverage to one  
9               or more association groups.

10              (7) ELIGIBLE EMPLOYEE.—The term “eligible  
11              employee” means a permanent employee who has a  
12              normal work week of 30 hours or more. Such term  
13              includes a sole proprietor or a general partner of a  
14              partnership.

15              (8) DEPENDENT.—The term “dependent”  
16              means, in relation to an individual—

17                      (A) the spouse of the individual,

18                      (B) an unmarried child of the individual if  
19                      the child (i) is under 19 years of age or (ii) is  
20                      a full-time student, under 23 years of age, and  
21                      financially dependent upon the individual, and

22                      (C) an unmarried child of the individual of  
23                      age if the child is medically certified as disabled  
24                      and the child is financially dependent upon the  
25                      individual.

1 **SEC. 205. EFFECTIVE DATE.**

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

3 **Subtitle B—Guaranteeing Port-**  
4 **ability of Health Insurance for**  
5 **Individuals**

6 **SEC. 211. COVERAGE OF INDIVIDUAL HEALTH BENEFIT**  
7 **PLANS.**

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

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

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

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

16 (B) under title XVIII or XIX of the Social  
17 Security Act, or

18 (C) under another State or Federal pro-  
19 gram, unless the eligible individual was pre-  
20 viously covered as an employee of the State or  
21 Federal Government.

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

1 **SEC. 212. PORTABILITY PROTECTIONS.**

2 (a) CONSIDERATION OF APPLICATIONS.—If an eligi-  
3 ble individual or eligible family applies for an individual  
4 health benefit plan, the insurer offering the plan must ei-  
5 ther—

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

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

10 (b) LIMITATIONS ON USE OF PREEXISTING CONDI-  
11 TIONS.—

12 (1) IN GENERAL.—No policy provision of an in-  
13 dividual health benefit plan shall exclude or limit  
14 coverage for a preexisting condition for a covered in-  
15 dividual for a period beyond 12 months following the  
16 effective date of the individual's coverage.

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

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

1           (B) A condition for which medical advice,  
2           diagnosis, care, or treatment was recommended  
3           or received during the 6 months immediately  
4           preceding the effective date of coverage.

5           (C) A pregnancy existing on the effective  
6           date of coverage.

7           (c) PORTABILITY OF COVERAGE.—The preexisting  
8           condition limitation period under any individual health  
9           benefit plan with respect to particular services shall be re-  
10          duced by one month for each month of continuous cov-  
11          erage the eligible individual had under prior similar cov-  
12          erage.

13          (d) LIMITATION ON RIDERS.—

14           (1) IN GENERAL.—Except as provided in para-  
15           graph (2), an insurer issuing an individual health  
16           benefit plan may not modify the plan with respect  
17           to an eligible individual or eligible family member.

18           (2) RELATION TO PREEXISTING CONDITION EX-  
19           CLUSION PERIOD.—

20           (A) IN GENERAL.—To the extent that a  
21           preexisting condition limitation applies, an in-  
22           surer may restrict or exclude coverage or bene-  
23           fits for a specific condition for a maximum pe-  
24           riod of 12 months from the effective date of

1 coverage of an eligible individual or eligible  
2 family member by way of rider or endorsement.

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

6 (C) COMBINATION.—If both a rider and a  
7 preexisting condition exclusion period are used,  
8 the combined limitation period may not exceed  
9 12 months.

10 (e) NO DISCLOSURE OF CONDITION REQUIRED.—A  
11 preexisting condition limitation period may be applied  
12 whether or not the specific condition has been disclosed  
13 on the application for coverage under the individual health  
14 benefit plan.

15 (f) OFFER OF CONTINUED COVERAGE FOR CERTAIN  
16 DEPENDENTS.—An insurer shall offer to a person who  
17 was covered as a dependent under an individual health  
18 benefit plan who would otherwise lose eligibility for such  
19 coverage because the person is a child and has attained  
20 the termination age under the policy, because of the death  
21 of the primary insured, or because of the divorce from the  
22 primary insured, identical coverage to that which was pre-  
23 viously issued the individual by that insurer. The insurer  
24 may not apply additional underwriting, waiting periods,  
25 or preexisting condition limitations to such coverage if the

1 person requests such coverage not later than 31 days after  
2 the date of loss of coverage.

3 **SEC. 213. LIMITATIONS ON NONRENEWAL AND PREMIUM**  
4 **INCREASES.**

5 (a) IN GENERAL.—An insurer issuing an individual  
6 health benefit plan may not—

7 (1) cancel or nonrenew an individual health  
8 benefit plan except for a reason specified in sub-  
9 section (b),

10 (2) single out and cancel an individual health  
11 benefit plan of an individual because of claims expe-  
12 rience relating to the individual, and

13 (3) single out an individual for a rate increase  
14 upon renewal because of claims experience relating  
15 to the individual.

16 (b) PERMISSIBLE NONRENEWAL.—An insurer may  
17 cancel or nonrenew an individual health benefit plan for  
18 any of the following:

19 (1) Nonpayment of required premium.

20 (2) Fraud or misrepresentation on the part of  
21 the individual.

22 (3) Noncompliance with provisions of the plan.

23 (4) Nonrenewal upon 90 days written notice  
24 with respect to all individuals insured under the in-  
25 dividual health benefit plans in a State.

1 An insurer may not cancel or nonrenew

2 (c) LIMITATION ON MARKET REENTRY.—An insurer  
3 that exercises its right of nonrenewal as provided under  
4 subsection (b)(4) may not accept any new health business  
5 of the type it nonrenewed for a period of 5 years, after  
6 the date it provides notice of such nonrenewal.

7 **SEC. 214. DEFINITIONS.**

8 In this subtitle:

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

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

19 (3) HEALTH BENEFIT PLAN.—

20 (A) IN GENERAL.—The term “health bene-  
21 fit plan” means any hospital or medical expense  
22 insured policy or certificate, hospital or medical  
23 service plan contract, or health maintenance or-  
24 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) PRIOR SIMILAR HEALTH BENEFIT PLAN.—

18 The term “prior similar health benefit plan” means  
19 a health benefit plan under which an eligible individ-  
20 ual was previously covered and which provides bene-  
21 fits who do not materially differ from the new health  
22 benefit plan in any of the following respects:

23 (A) The type of medical benefits provided.

1 (B) The level of medical benefits available  
2 based on deductibles, coinsurance, or  
3 copayments, or any combination thereof.

4 (C) The maximum benefits available for  
5 specific services.

6 (D) Cost containment provisions.

7 **SEC. 215. EFFECTIVE DATE.**

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

11 **Subtitle C—Assuring Health Insur-**  
12 **ance Coverage for Uninsurable**  
13 **Individuals**

14 **SEC. 221. ESTABLISHMENT OF HIGH RISK HEALTH INSUR-**  
15 **ANCE POOLS.**

16 (a) IN GENERAL.—

17 (1) REQUIREMENT.—For years beginning with  
18 1997, each health insurer, health service organiza-  
19 tion, and health maintenance organization shall be a  
20 participant in a high risk health insurance pool (in  
21 this subtitle referred to as a “high risk pool”) in  
22 each State in which it operates. Such a pool may be  
23 established by the State or, if not so established,  
24 shall be established by such insurers and organiza-  
25 tions.

1           (2) FUNCTIONS.—Any such pool shall assure,  
2           in accordance with this subtitle, the availability of  
3           qualified health insurance coverage to uninsurable  
4           individuals.

5           (3) FUNDING.—Any such pool shall be funded  
6           by an assessment against health insurers, health  
7           service organizations, and health maintenance orga-  
8           nizations on a pro rata basis of “lives covered” in  
9           the State. The costs of the assessment may be added  
10          by a health insurer, health service organization, or  
11          health maintenance organization to the costs of its  
12          health insurance or health coverage provided in the  
13          State.

14          (b) DEADLINE.—Pools required under subsection (a)  
15          shall be established by not later than January 1, 1997.

16          (c) WAIVER.—Subsection (a) shall not apply in the  
17          case of insurers and organizations operating in a State  
18          if the State has established a comprehensive health insur-  
19          ance program that assures the availability of qualified  
20          health insurance coverage to all eligible individuals resid-  
21          ing 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 insurers

1 and organizations that fail to meet the requirement of sub-  
2 section (a).

3 **SEC. 222. UNINSURABLE INDIVIDUALS ELIGIBLE FOR COV-**  
4 **ERAGE.**

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

7 (1) UNINSURABLE INDIVIDUAL.—The term  
8 “uninsurable individual” means, with respect to a  
9 State, an eligible individual who presents proof of  
10 uninsurability by a private insurer in accordance  
11 with subsection (b) or proof of a condition previously  
12 recognized as uninsurable by the State.

13 (2) ELIGIBLE INDIVIDUAL.—

14 (A) IN GENERAL.—The term “eligible indi-  
15 vidual” means, with respect to a State, a citizen  
16 or national of the United States (or an alien  
17 lawfully admitted for permanent residence) who  
18 is a resident of the State for at least 90 days.

19 (B) EXCEPTION.—An individual is not an  
20 “eligible individual” if the individual—

21 (i) is covered by or eligible for benefits  
22 under a State medicaid plan approved  
23 under title XIX of the Social Security Act,

24 (ii) has voluntarily terminated plan  
25 coverage,

1 (iii) has received the maximum benefit  
2 payable under the plan, or

3 (iv) is an inmate in a public institu-  
4 tion or is eligible for other public programs  
5 or has the individual's premium paid for or  
6 reimbursed under any government-spon-  
7 sored program or by any government agen-  
8 cy or health care provider.

9 (b) PROOF OF UNINSURABILITY.—

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

12 (A) a notice of rejection or refusal to issue  
13 substantially similar insurance for health rea-  
14 sons,

15 (B) a notice of refusal to insure except at  
16 a rate in excess of the plan rate, or

17 (C) an offer to insure but only subject to  
18 a reduction or an exclusion of coverage for a  
19 preexisting condition for a period exceeding 12  
20 months.

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

1 **SEC. 223. QUALIFIED HEALTH INSURANCE COVERAGE**  
2 **UNDER POOL.**

3 In this subtitle, the term “qualified health insurance  
4 coverage” means health insurance coverage that provides  
5 benefits typical of major medical insurance available in the  
6 individual health insurance market.

7 **SEC. 224. FUNDING OF POOL.**

8 (a) LIMITATIONS ON PREMIUMS.—

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

13 (2) SURCHARGE FOR AVOIDABLE HEALTH  
14 RISKS.—A high risk pool may impose a surcharge on  
15 premiums for individuals with avoidable high risks,  
16 such as smoking.

17 (b) ADDITIONAL FUNDING.—A high risk pool shall  
18 provide for additional funding through an assessment on  
19 all health insurers, health service organizations, and  
20 health maintenance organizations in the State through a  
21 nonprofit association consisting of all such insurers and  
22 organizations doing business in the State on an equitable  
23 and pro rata basis consistent with section 221.

1 **SEC. 225. ADMINISTRATION.**

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

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