

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

# H. R. 995

To amend the Employee Retirement Income Security Act of 1974 to provide new portability, participation, solvency, claims, and other consumer protections and freedoms for workers in a mobile workforce; to increase purchasing power for employers and employees by removing barriers to the voluntary formation of multiple employer health plans and fully-insured multiple employer arrangements; to increase health plan competition providing more affordable choice of coverage by removing restrictive State laws relating to provider health networks, employer health coalitions, and insured plans and the offering of medisave plans; to expand access to fully-insured coverage for employees of small employers through fair rating standards and open markets, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 21, 1995

Mr. FAWELL (for himself, Mr. GOODLING, Mr. ARMEY, Mr. PETRI, Mrs. ROUKEMA, Mr. BALLENGER, Mr. HOEKSTRA, Mr. MCKEON, Mrs. MEYERS of Kansas, Mr. TALENT, Mr. GREENWOOD, Mr. HUTCHINSON, Mr. KNOLLENBERG, Mr. GRAHAM, Mr. WELDON of Florida, and Mr. MCINTOSH) introduced the following bill; which was referred to the Committee on Economic and Educational Opportunity and, in addition, to the Committee on Commerce, 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

MARCH 21, 1995

Additional sponsors: Mr. CUNNINGHAM, Mr. WELLER, Mr. MCHUGH, and Mr. CALVERT

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## A BILL

To amend the Employee Retirement Income Security Act of 1974 to provide new portability, participation, solvency, claims, and other consumer protections and free-

doms for workers in a mobile workforce; to increase purchasing power for employers and employees by removing barriers to the voluntary formation of multiple employer health plans and fully-insured multiple employer arrangements; to increase health plan competition providing more affordable choice of coverage by removing restrictive State laws relating to provider health networks, employer health coalitions, and insured plans and the offering of medisave plans; to expand access to fully-insured coverage for employees of small employers through fair rating standards and open markets, and for other purposes.

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

3 **SECTION 1. SHORT TITLE.**

4        This Act may be cited as the “ERISA Targeted  
 5 Health Insurance Reform Act of 1995”.

6 **TITLE I—IMPROVED ACCESS TO**  
 7 **AFFORDABLE HEALTH PLAN**  
 8 **COVERAGE**

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Sec. 1002. Effective date.

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#### Subtitle E—Funding and Plan Termination Requirements for Self-Insured Group Health Plans

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1 **Subtitle A—Increased Availability**  
2 **and Continuity of Group Health**  
3 **Plan Coverage for Employees**  
4 **and Their Families**

5 **SEC. 1001. ACCESS TO AFFORDABLE GROUP HEALTH PLAN**  
6 **COVERAGE.**

7 (a) IN GENERAL.—Subtitle B of title I of the Em-  
8 ployee Retirement Income Security Act of 1974 is amend-  
9 ed by adding at the end the following:

10 **“PART 8—ACCESS TO, AND CONTINUITY OF,**  
11 **HEALTH PLAN COVERAGE**

12 **“SEC. 800. DEFINITIONS AND SPECIAL RULES.**

13 “(a) IN GENERAL.—For purposes of this part:

14 “(1) COVERAGE: GENERAL COVERAGE, CATA-  
15 STROPHIC COVERAGE, AND MEDISAVE COVERAGE.—

16 The terms ‘general coverage’, ‘catastrophic cov-  
17 erage’, and ‘medisave coverage’ have the meanings  
18 given such terms in subsections (a), (b), and (c), re-  
19 spectively, of section 833.

20 “(2) DEPENDENT.—The term ‘dependent’  
21 means, with respect to any individual, any person  
22 who is—

23 “(A) the spouse or surviving spouse of the  
24 individual, or

1           “(B) a child (including an adopted child)  
2 of such individual and—

3                   “(i) under 19 years of age, or

4                   “(ii) under 25 years of age and a full-  
5 time student.

6           “(3) ELIGIBLE EMPLOYEE.—

7                   “(A) IN GENERAL.—The term ‘eligible em-  
8 ployee’ means, with respect to an employer  
9 maintaining a plan (or making contributions to  
10 a plan) for any plan year, an employee who,  
11 upon the commencement of service during any  
12 plan year, would normally perform during the  
13 plan year a year of service (within the meaning  
14 of section 202(a)(3)) under the plan.

15                   “(B) TREATMENT OF PARTNERSHIPS AND  
16 SELF-EMPLOYED INDIVIDUALS.—Such term in-  
17 cludes—

18                           “(i) in connection with a group health  
19 plan maintained by a partnership, a part-  
20 ner in relation to the partnership, and

21                           “(ii) in connection with a group health  
22 plan maintained by a self-employed individ-  
23 ual who has one or more employees who  
24 are eligible employees (as defined in sub-

1 paragraph (A)), the self-employed individ-  
2 ual.

3 “(4) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
4 individual’ means, with respect to an eligible em-  
5 ployee, such eligible employee and any dependent of  
6 such eligible employee.

7 “(5) EMPLOYER.—The term ‘employer’ shall  
8 have the meaning applicable under section 3(5), ex-  
9 cept that such term includes the partnership in rela-  
10 tion to any partner.

11 “(6) EXEMPTED MULTIPLE EMPLOYER HEALTH  
12 PLAN.—The term ‘exempted multiple employer  
13 health plan’ means a multiple employer welfare ar-  
14 rangement treated as an employee welfare benefit  
15 plan by reason of an exemption under part 7.

16 “(7) GROUP HEALTH PLAN; PLAN.—(A) The  
17 term ‘group health plan’ means a group health plan  
18 (as defined in section 3(42)), but does not include  
19 any type of coverage excluded from the definition of  
20 health insurance coverage under paragraph (8)(B).

21 “(B) The term ‘plan’ means a group health  
22 plan (including any such plan which is a multiem-  
23 ployer plan) and an exempted multiple employer  
24 health plan.

25 “(8) HEALTH INSURANCE COVERAGE.—

1           “(A) IN GENERAL.—Except as provided in  
2           subparagraph (B), the term ‘health insurance  
3           coverage’ means any hospital or medical service  
4           policy or certificate, hospital or medical service  
5           plan contract, or health maintenance organiza-  
6           tion group contract offered by an insurer.

7           “(B) EXCEPTION.—Such term does not in-  
8           clude any of the following:

9                   “(i) Coverage only for accident, den-  
10                  tal, vision, disability income, or long-term  
11                  care insurance, or any combination thereof.

12                  “(ii) Medicare supplemental health in-  
13                  surance.

14                  “(iii) Coverage issued as a supplement  
15                  to liability insurance.

16                  “(iv) Liability insurance, including  
17                  general liability insurance and automobile  
18                  liability insurance.

19                  “(v) Worker’s compensation or similar  
20                  insurance.

21                  “(vi) Automobile medical-payment in-  
22                  surance.

23                  “(vii) Coverage for a specified disease  
24                  or illness.

1                   “(viii) A hospital fixed indemnity pol-  
2                   icy or other fixed indemnity policy.

3                   “(9) FULLY INSURED.—The term ‘fully in-  
4                   sured’ shall have the meaning applicable under sec-  
5                   tion 701(8).

6                   “(10) INSURER.—(A) The term ‘insurer’  
7                   means—

8                   “(i) an insurance company, insurance serv-  
9                   ice, or insurance organization licensed to en-  
10                  gage in the business of insurance in a State, or

11                  “(ii) a health maintenance organization (as  
12                  defined in subparagraph (B)) licensed to do  
13                  business in a State.

14                  (B) HEALTH MAINTENANCE ORGANIZATION.—  
15                  The term ‘health maintenance organization’ means a  
16                  Federally qualified health maintenance organization  
17                  (as defined in section 1301(a) of the Public Health  
18                  Service Act), an organization recognized under State  
19                  law as a health maintenance organization, or a simi-  
20                  lar organization regulated under State law for sol-  
21                  vency in the same manner and to the same extent  
22                  as such a health maintenance organization.

23                  “(11) MULTIPLE EMPLOYER WELFARE AR-  
24                  RANGEMENT.—The term ‘multiple employer welfare

1 arrangement' shall have the meaning applicable  
2 under section 3(40).

3 “(12) NAIC.—The term ‘NAIC’ means the Na-  
4 tional Association of Insurance Commissioners.

5 “(13) NETWORK PLAN.—The term ‘network  
6 plan’ includes, as defined in standards established  
7 under section 835, an arrangement of an insurer  
8 under which health services are offered to be pro-  
9 vided primarily through a defined set of providers  
10 who have contracts with the insurer.

11 “(14) OPTIONS.—

12 “(A) FEE-FOR-SERVICE OPTION.—General  
13 coverage is considered to provide a ‘fee-for-serv-  
14 ice option’ if benefits with respect to the cov-  
15 ered items and services in the coverage are  
16 made available for such items and services pro-  
17 vided through any lawful provider of such cov-  
18 ered items and services.

19 “(B) MANAGED CARE OPTION.—General  
20 coverage is considered to provide a ‘managed  
21 care option’ if benefits with respect to the cov-  
22 ered items and services in the coverage are  
23 made available exclusively through a managed  
24 care arrangement, except in the case of emer-

1 agency and urgent services and as otherwise re-  
2 quired under law.

3 “(C) POINT-OF-SERVICE OPTION.—General  
4 coverage is considered to provide a ‘point-of-  
5 service option’ if the benefits with respect to  
6 covered items and services in the coverage are  
7 made available principally through a managed  
8 care arrangement, with the choice of the cov-  
9 ered individual to obtain such benefits for items  
10 and services provided through any lawful pro-  
11 vider of such covered items and services. The  
12 coverage may provide for different cost sharing  
13 schedules based on whether the items and serv-  
14 ices are provided through such an arrangement  
15 or outside such an arrangement.

16 “(b) HIGHLY COMPENSATED EMPLOYEE.—

17 “(1) IN GENERAL.—In this part, the term  
18 ‘highly compensated employee’ means any employee  
19 who—

20 “(A) was a 5-percent owner at any time  
21 during the year or the preceding year, or

22 “(B) had compensation for the preceding  
23 year from the employer in excess of \$50,000.

24 Under regulations the \$50,000 amount under sub-  
25 paragraph (B) shall be adjusted for increases in the

1 cost of living. Such regulations shall provide for ad-  
2 justment procedures which are similar to the proce-  
3 dures used to adjust benefit amounts under section  
4 215(i)(2)(A) of the Social Security Act.

5 “(2) SPECIAL RULE IF NO EMPLOYEE DE-  
6 SCRIBED IN PARAGRAPH (1).—If no employee is  
7 treated as a highly compensated employee under  
8 paragraph (1), the highest paid officer for the year  
9 shall be treated as a highly compensated employee.

10 “(3) 5-PERCENT OWNER.—An employee shall be  
11 treated as a 5-percent owner for any year if at any  
12 time during such year such employee was a 5-per-  
13 cent owner (as defined under regulations consistent  
14 and coextensive with section 416(i)(1) of the Inter-  
15 nal Revenue Code of 1986, as in effect on January  
16 1, 1995) of the employer.

17 “(4) COMPENSATION.—For purposes of this  
18 subsection—

19 “(A) IN GENERAL.—The term ‘compensa-  
20 tion’ means compensation as defined in regula-  
21 tions consistent and coextensive with the defini-  
22 tion in section 415(c)(3) of the Internal Reve-  
23 nue Code of 1986, as in effect on January 1,  
24 1995.

1           “(B) CERTAIN PROVISIONS NOT TAKEN  
2 INTO ACCOUNT.—The determination under sub-  
3 paragraph (A) shall be made in accordance with  
4 regulations that are consistent and coextensive  
5 with section 414(q)(7) of the Internal Revenue  
6 Code of 1986, as in effect on January 1, 1995.

7           “(5) FORMER EMPLOYEES.—A former employee  
8 and an employee who is a nonresident alien and who  
9 receives no earned income from sources within the  
10 United States shall be treated as a highly com-  
11 pensated employee under regulations that are con-  
12 sistent and coextensive with paragraphs (9) and (11)  
13 of section 414(a) of the Internal Revenue Code of  
14 1986, as in effect on January 1, 1995.

15           “(c) APPLICATION OF ERISA DEFINITIONS.—Ex-  
16 cept as otherwise provided in this part, terms used in this  
17 part shall have the meanings applicable to such terms  
18 under section 3.

19           **“Subpart A—Nondiscrimination, Portability,  
20 Renewability, and Plan Participation Standards**

21           **“SEC. 801. NONDISCRIMINATION AND LIMITATIONS ON PRE-  
22 EXISTING CONDITION EXCLUSIONS.**

23           “(a) IN GENERAL.—Except as provided in sub-  
24 sections (b) and (c), a group health plan and an insurer  
25 offering health insurance coverage in connection with a

1 group health plan may deny, or impose a limitation or ex-  
2 clusion of, covered benefits relating to treatment of a con-  
3 dition based on health status of an individual, based on  
4 claims experience of an individual, based on receipt of  
5 health care by an individual, based on the medical history  
6 of an individual, or based on the fact that the condition  
7 preexisted the effective date of coverage of the individual,  
8 only if—

9           “(1) the condition relates to a condition that  
10       was diagnosed or treated within a period of not to  
11       exceed 3 months before the date of such coverage;  
12       and

13           “(2) the limitation or exclusion extends over a  
14       period of not to exceed 6 months after the date of  
15       such coverage.

16 In the case of an individual who is eligible for coverage  
17 but for a waiting period imposed by a group health plan  
18 or an insurer, in applying paragraphs (1) and (2), the in-  
19 dividual shall be treated as having had such coverage as  
20 of the beginning of the waiting period.

21           “(b) SPECIAL RULE FOR GROUP HEALTH PLANS OF  
22 SMALL EMPLOYERS AND HEALTH INSURANCE COVERAGE  
23 OFFERED IN THE SMALL GROUP MARKET.—Notwith-  
24 standing subsection (a), health insurance coverage offered  
25 by an insurer in connection with a group health plan to

1 a small employer in the small group market (as defined  
2 in section 803(b)(4)(B)), and a group health plan with  
3 respect to such an employer, may consist of health insur-  
4 ance coverage which imposes a limitation or exclusion  
5 based on a preexisting condition but only if—

6 “(1) the condition relates to a condition that  
7 was not diagnosed or treated within a period (that  
8 exceeds 3 months but does not exceed 6 months) be-  
9 fore the date of such coverage; and

10 “(2) the limitation or exclusion extends over a  
11 period (that exceeds 6 months but does not exceed  
12 12 months) after the date of such coverage.

13 “(c) NO COVERAGE OF SPECIFIC TREATMENT, PRO-  
14 CEDURES, OR CLASSES REQUIRED.—Nothing in this sec-  
15 tion may be construed to require the coverage of any spe-  
16 cific procedure, treatment, or service as part of a group  
17 health plan or health insurance coverage under this Act  
18 or through regulation.

19 “(d) APPLICATION OF RULES BY CERTAIN HEALTH  
20 MAINTENANCE ORGANIZATIONS.—A health maintenance  
21 organization that offers health insurance coverage shall  
22 not be considered as failing to meet the requirements of  
23 section 1301 of the Public Health Service Act notwith-  
24 standing that it provides for an exclusion of the coverage  
25 based on a preexisting condition consistent with the provi-

1 sions of this subpart so long as such exclusion is applied  
2 consistent with the provisions of this subpart.

3 “(e) APPLICABILITY TO LATE ENROLLMENT.—This  
4 section applies in the case of any individual with respect  
5 to whom coverage is elected upon initially becoming eligi-  
6 ble for coverage or in connection with any subsequent en-  
7 rollment periods under the plan.

8 “(f) AFFILIATION PERIOD ALTERNATIVE TO PRE-  
9 EXISTING CONDITION LIMITATION.—A group health plan  
10 or an insurer offering health insurance coverage in connec-  
11 tion with a group health plan which does not use the pre-  
12 existing limitations allowed under this section and section  
13 802 may impose an affiliation period. For purposes of this  
14 subsection, the term ‘affiliation period’ means a period—

15 “(1) not to exceed 90 days in the case of an in-  
16 dividual first becoming eligible under such plan or  
17 coverage, and

18 “(2) not to exceed 180 days in the case of a  
19 later election of coverage,

20 during which no contributions or premiums are required  
21 or collected and which must expire before the coverage  
22 under the plan or the health insurance coverage offered  
23 in connection with the plan becomes effective.

1 **“SEC. 802. PORTABILITY.**

2       “(a) IN GENERAL.—Each group health plan and each  
3 insurer offering health insurance coverage in connection  
4 with a group health plan shall provide that if a covered  
5 individual is in a period of continuous coverage (as defined  
6 in subsection (c)) as of a date upon which coverage takes  
7 effect, any period of exclusion of coverage from covered  
8 benefits with respect to a preexisting condition (as per-  
9 mitted to be excluded under section 801) shall be reduced  
10 by at least 1 month for each month in the period of contin-  
11 uous coverage. A covered individual may be treated by a  
12 group health plan, or by an insurer offering health insur-  
13 ance coverage in connection with a group health plan, as  
14 not being in a period of continuous coverage if, upon the  
15 request of the plan or insurer (as the case may be), the  
16 covered individual does not present satisfactory docu-  
17 mentation of such period of continuous coverage. The Sec-  
18 retary may prescribe regulations defining standards for  
19 satisfactory documentation for purposes of this subsection.

20       “(b) NO PREEXISTING CONDITION FOR NEWBORNS  
21 AND ADOPTED CHILDREN.—For purposes of this part—

22               “(1) NEWBORNS.—A child who is covered at  
23 the time of birth and remains in a period of continu-  
24 ous coverage after such time shall not be considered  
25 to have any preexisting condition beginning at the  
26 time of birth.



1 of medical care (referred to in section 3(42)) and such  
2 coverage is fully insured) may not deny an employer who  
3 is covered under such a plan or arrangement continued  
4 access to coverage under the terms of such a plan or ar-  
5 rangement other than—

6 “(1) for nonpayment of contributions,

7 “(2) for fraud or other intentional misrepresen-  
8 tation by the employer,

9 “(3) for noncompliance with material plan or  
10 arrangement provisions,

11 “(4) because the plan or arrangement is ceasing  
12 to offer any coverage in a geographic area,

13 “(5) for failure to meet the terms of an applica-  
14 ble collective bargaining agreement,

15 “(6) in the case of a plan or arrangement to  
16 which section 3(40)(C) applies, to the extent nec-  
17 essary to meet the requirements of section 3(40)(C),  
18 or

19 “(7) in the case of a multiple employer health  
20 plan, for failure to meet the requirements of part 7.

21 “(b) INSURERS.—

22 “(1) IN GENERAL.—An insurer offering health  
23 insurance coverage in connection with a group health  
24 plan may not cancel (or deny renewal of) such cov-  
25 erage, other than—

1           “(A) for nonpayment of premiums,

2           “(B) for fraud or other intentional mis-  
3 representation by the employer or insured,

4           “(C) for noncompliance with material plan  
5 provisions, or

6           “(D) subject to paragraph (2), because the  
7 insurer is ceasing to offer any such coverage (or  
8 the same type of coverage in the small employer  
9 market) in a State, or, in the case of an insurer  
10 that is a health maintenance organization or  
11 that offers coverage through a network plan (as  
12 defined in section 800(a)(13)), in a geographic  
13 area.

14           “(2) NOTICE REQUIREMENT FOR MARKET  
15 EXIT.—Paragraph (1)(D) shall not apply to an in-  
16 surer ceasing to offer coverage unless the insurer  
17 provides notice of such termination to employers and  
18 individuals covered at least 180 days before the date  
19 of termination of coverage.

20           “(3) LIMITATION ON REENTRY IN EMPLOYER  
21 MARKETS.—If an insurer offering health insurance  
22 coverage in connection with a group health plan  
23 ceases to offer such coverage (or a type of such cov-  
24 erage) in an area with respect to the small group  
25 market (as defined in paragraph (4)(B)), the insurer

1 may not offer such coverage (or type of coverage) in  
2 the area in such market until 5 years after the date  
3 of the termination.

4 “(4) TYPE OF COVERAGE AND INSURANCE MAR-  
5 KET DEFINED.—In this subsection—

6 “(A) general coverage, catastrophic cov-  
7 erage, and medisave coverage (as defined in sec-  
8 tion 800(a)(1)) shall each be considered to be  
9 separate types of health insurance coverage;  
10 and

11 “(B) the term ‘small group market’ means  
12 the health insurance market under which indi-  
13 viduals obtain health insurance coverage (di-  
14 rectly or through any arrangement) on behalf of  
15 themselves (and their dependents) on the basis  
16 of employment or other relationship with re-  
17 spect to a small employer (as defined in section  
18 831(4)).

19 **“SEC. 804. GROUP HEALTH PLAN PARTICIPATION STAND-**  
20 **ARDS.**

21 “(a) EMPLOYEES.—No group health plan may re-  
22 quire, as a condition of participation of an employee in  
23 the plan, that the employee—

24 “(1) complete a waiting period consisting of  
25 service with the employer or employers maintaining

1 the plan (or contributing to the plan in the case of  
2 a multiemployer plan or a multiple employer health  
3 plan) if the period extends beyond a period of 90  
4 days;

5 “(2) have attained any specified age;

6 “(3) be a highly compensated employee (as de-  
7 fined in section 800(b)); or

8 “(4) be employed (or expected to be employed)  
9 for a minimum period by the employer or employers  
10 if (except as provided in paragraph (1)) the em-  
11 ployee normally performs during a plan year a year  
12 of service (within the meaning of section 202(a)(3))  
13 under the plan.

14 Nothing in this section shall be construed to require em-  
15 ployer contributions to a group health plan.

16 “(b) DEPENDENTS.—

17 “(1) IN GENERAL.—If a group health plan  
18 makes family coverage available, the plan may not  
19 require, as a condition of participation of a depend-  
20 ent of an employee in the plan, a waiting period ap-  
21 plicable to the coverage of a dependent who is a  
22 newborn or an adopted child (at the time of adop-  
23 tion) or a spouse (at the time of marriage) if the  
24 employee has met any waiting period applicable to  
25 that employee.

1 “(2) TIMELY ENROLLMENT.—

2 “(A) IN GENERAL.—Enrollment of an eli-  
3 gible individual who is an eligible employee’s de-  
4 pendent described in paragraph (1) shall be  
5 considered to be timely if a request for enroll-  
6 ment is made either—

7 “(i) within 30 days of the date of the  
8 marriage with such a dependent who is the  
9 spouse of the eligible employee, or within  
10 30 days of the date of the birth or adop-  
11 tion of such a dependent who is a child of  
12 the eligible employee, if family coverage is  
13 available as of such date, or

14 “(ii) within 30 days of the date family  
15 coverage is first made available.

16 “(B) COVERAGE.—If available coverage in-  
17 cludes family coverage and enrollment is made  
18 under such coverage on a timely basis under  
19 subparagraph (A)(i), the coverage shall become  
20 effective not later than the first day of the first  
21 month beginning after the date the completed  
22 request for enrollment is received.

23 “(c) ENROLLMENT PERIODS.—

24 “(1) ANNUAL PERIOD.—A group health plan  
25 shall provide for at least one annual open enrollment

1 period (of not less than 30 days) each year during  
2 which—

3 “(A) employees who are eligible for cov-  
4 erage under the terms of the plan who are not  
5 otherwise covered may elect to be covered, and

6 “(B) if family coverage is available, em-  
7 ployees who are covered but who do not have  
8 family coverage may elect family coverage.

9 “(2) ENROLLMENT OF ELIGIBLE INDIVIDUALS  
10 WHO LOSE OTHER COVERAGE.—A group health plan  
11 shall permit an uncovered employee who is otherwise  
12 eligible for coverage under the terms of the plan (or  
13 an uncovered dependent of such an employee, if fam-  
14 ily coverage is available) to enroll for coverage under  
15 the plan if—

16 “(A) the employee or dependent was cov-  
17 ered under a group health plan or had health  
18 insurance coverage at the time coverage was  
19 previously offered to the employee or individual,

20 “(B) the employee stated at such time that  
21 coverage under a group health plan or health  
22 insurance coverage was the reason for declining  
23 enrollment,

24 “(C) the employee or dependent lost cov-  
25 erage under a group health plan or health in-

1           surance coverage (as a result of the termination  
2           of the coverage, termination of employment, re-  
3           duction in the number of hours of employment,  
4           or other reason not involving a condition de-  
5           scribed in section 803(a)(1), 803(a)(2),  
6           803(b)(1)(A), or 803(b)(1)(B)), and

7           “(D) the employee requests such enroll-  
8           ment within 30 days after termination of such  
9           coverage.

10 **“Subpart B—Encouragement of Private Standards-**  
11 **Setting Organizations for Provider Networks**  
12 **and Utilization Review under Group Health**  
13 **Plans**

14 **“SEC. 811. ENCOURAGEMENT OF PRIVATE STANDARDS-SET-**  
15 **TING ORGANIZATIONS FOR PROVIDER NET-**  
16 **WORKS UNDER GROUP HEALTH PLANS.**

17           “(a) REQUIREMENT TO MEET STANDARDS.—Each  
18 group health plan, and each insurer offering health insur-  
19 ance coverage in connection with a group health plan, shall  
20 meet such standards as may be recognized or established  
21 under this section.

22           “(b) STANDARDS.—

23           “(1) IN GENERAL.—If the Secretary of Health  
24 and Human Services determines that a private en-  
25 tity has established standards for provider networks

1 providing items and services covered under group  
2 health plans or under health insurance coverage of-  
3 fered by insurers in connection with group health  
4 plans, in consultation with appropriate parties (in-  
5 cluding representatives of health care providers, spe-  
6 cialists, insurers, plan administrators, and other ex-  
7 perts), and provides for a process for the periodic re-  
8 view and update of such standards, such standards  
9 shall be the standards applied under this section.

10 “(2) CONTINGENCY.—If the Secretary of  
11 Health and Human Services makes a determination  
12 contrary to the determination described in para-  
13 graph (1), such Secretary shall submit such deter-  
14 mination in writing to each House of the Congress.

15 “(c) REQUIREMENTS FOR STANDARDS.—The stand-  
16 ards established under subsection (a) shall consist only of  
17 standards relating to—

18 “(1) the extent to which individuals covered  
19 under the plan are assured to have reasonably  
20 prompt access, through the provider network, to all  
21 items and services contained in any package of bene-  
22 fits that may be provided under the provider net-  
23 work, in a manner that assures the continuity of the  
24 provision of such items and services,

1           “(2) the extent to which emergency services are  
2 provided to covered individuals (including trauma  
3 services)—

4           “(A) without regard to whether or not the  
5 provider furnishing such services has a contrac-  
6 tual (or other) arrangement with the entity to  
7 provide items or services to covered individuals,  
8 and

9           “(B) in the case of services furnished for  
10 the treatment of an emergency medical condi-  
11 tion, without regard to prior authorization, and

12           “(3) the extent to which—

13           “(A) standards (including criteria for qual-  
14 ity, efficiency, credentialing, and services) are  
15 established by the provider network for entering  
16 into contracts (other than a contract providing  
17 for employment of an employee) with health  
18 care providers with respect to the provider net-  
19 work,

20           “(B) such standards are established pursu-  
21 ant to a mechanism which provides for receipt  
22 and consideration of recommendations of the  
23 providers who are members of the provider net-  
24 work,



1 coverage in connection with a group health plan may not  
2 deny coverage of or payment for items and services on the  
3 basis of a utilization review program unless the program  
4 meets such standards as may be recognized or established  
5 under this section.

6 “(b) STANDARDS.—

7 “(1) IN GENERAL.—If the Secretary of Health  
8 and Human Services determines that a private en-  
9 tity has established standards for utilization review  
10 programs described in subsection (c), in consultation  
11 with appropriate parties (including representatives  
12 of health care providers, specialists, insurers, plan  
13 administrators, and other experts), and provides for  
14 a process for the periodic review and update of such  
15 standards, such standards shall be the standards ap-  
16 plied under this section.

17 “(2) CONTINGENCY.—If the Secretary of  
18 Health and Human Services makes a determination  
19 contrary to the determination described in para-  
20 graph (1), such Secretary shall submit such deter-  
21 mination in writing to each House of the Congress.

22 “(c) REQUIREMENTS FOR STANDARDS.—The stand-  
23 ards established under subsection (a) shall consist only of  
24 standards relating to—

1           “(1) the extent to which individuals performing  
2 utilization review may receive financial compensation  
3 based upon the number of denials of coverage;

4           “(2) the process under which a covered individ-  
5 ual or provider may obtain timely review of a denial  
6 of coverage, including the extent to which a review  
7 must be conducted by a medical director of the in-  
8 surer or plan (as applicable) or a physician des-  
9 ignated by the insurer or plan;

10           “(3) the extent to which utilization review is to  
11 be conducted in accordance with uniformly applied  
12 criteria that are based on currently available medical  
13 evidence; and

14           “(4) the extent to which providers are to par-  
15 ticipate in the development of the utilization review  
16 program.

17           **“Subpart C—Establishment of Standards;**

18                           **Enforcement**

19           **“SEC. 821. ESTABLISHMENT OF STANDARDS APPLICABLE**  
20                           **TO INSURERS OFFERING HEALTH INSUR-**  
21                           **ANCE COVERAGE TO GROUP HEALTH PLANS.**

22           “(a) ROLE OF NAIC.—The Secretary shall request  
23 the NAIC to develop, within 12 months after the date of  
24 the enactment of the ERISA Targeted Health Insurance  
25 Reform Act of 1995, model regulations that specify stand-

1 ards with respect to the requirements of subpart A (other  
2 than section 804) and subpart B of this part to the extent  
3 that such requirements are applicable to insurers offering  
4 health insurance coverage in connection with group health  
5 plans and not applicable to group health plans. If the Sec-  
6 retary of Health and Human Services determines under  
7 section 811(b)(1) that a private entity has established  
8 standards for provider networks consistent with section  
9 811(c), the standards established under this section with  
10 respect to the requirements of section 811 shall consist  
11 of the standards recognized or established under section  
12 811. If the Secretary of Health and Human Services de-  
13 termines under section 812(b)(1) that a private entity has  
14 established standards for utilization review programs that  
15 are consistent with section 812(c), the standards estab-  
16 lished under this section with respect to the requirements  
17 of section 812 shall consist of the standards recognized  
18 or established under section 812. If the NAIC develops  
19 recommended regulations under this section specifying  
20 standards within such period, the Secretary shall review  
21 the standards. Such review shall be completed within 120  
22 days after the date the regulations are developed. Unless  
23 the Secretary determines within such period that the  
24 standards do not effectively provide for the application of  
25 requirements to insurers in a manner and to an extent

1 equivalent in substance to the manner and extent to which  
2 the requirements apply to group health plans, such stand-  
3 ards shall serve as the standards under this section, with  
4 such amendments as the Secretary deems necessary. The  
5 Secretary shall provide for public comment in connection  
6 with the regulations during such 120-day period and in  
7 advance of any determination by the Secretary.

8 “(b) CONTINGENCY.—If the NAIC does not develop  
9 such model regulations within such period or the Secretary  
10 makes the determination described in subsection (a), the  
11 Secretary shall specify, within 24 months after the date  
12 of the enactment of the ERISA Targeted Health Insur-  
13 ance Reform Act of 1995, standards to carry out those  
14 requirements.

15 “(c) DEFINITIONS.—In this subpart, the term ‘sec-  
16 tion 821 standards’ means the standards established  
17 under this section.

18 **“SEC. 822. ENFORCEMENT WITH RESPECT TO INSURERS**  
19 **OFFERING HEALTH INSURANCE COVERAGE**  
20 **TO GROUP HEALTH PLANS.**

21 “(a) VOLUNTARY ENFORCEMENT BY STATES.—

22 “(1) IN GENERAL.—Each State that desires to  
23 enforce the section 821 standards (to the extent that  
24 the requirements to which such standards apply are  
25 applicable to insurers offering health insurance cov-

1 erage in connection with group health plans and not  
2 applicable to group health plans) shall submit to the  
3 Secretary, by the deadline specified in paragraph  
4 (2), a report on the program the State has estab-  
5 lished by such deadline and consistent with section  
6 823 to implement and enforce such standards.

7 “(2) DEADLINE.—

8 “(A) 1 YEAR AFTER FINAL MODEL REGU-  
9 LATIONS.—Subject to subparagraph (B), the  
10 deadline under this paragraph is 1 year after  
11 the date model regulations are established  
12 under section 821.

13 “(B) EXCEPTION FOR LEGISLATION.—In  
14 the case of a State which the Secretary identi-  
15 fies, in consultation with the NAIC, as—

16 “(i) requiring State legislation (other  
17 than legislation appropriating funds) in  
18 order for insurers offering health insurance  
19 coverage to group health plans to meet the  
20 section 821 standards provided under such  
21 model regulations, but

22 “(ii) having a legislature which is not  
23 scheduled to meet in 1996 in a legislative  
24 session in which such legislation may be  
25 considered,

1 the date specified in this paragraph is the first  
2 day of the first calendar quarter beginning after  
3 the close of the first legislative session of the  
4 State legislature that begins on or after Janu-  
5 ary 1, 1997. For purposes of the previous sen-  
6 tence, in the case of a State that has a 2-year  
7 legislative session, each year of such session  
8 shall be deemed to be a separate regular session  
9 of the State legislature.

10 “(3) NO FEDERAL MANDATE ON STATES.—

11 Nothing in this subsection shall be construed as im-  
12 posing a requirement on a State. The establishment  
13 by a State of an enforcement program under this  
14 subsection is voluntary.

15 “(b) FEDERAL ROLE.—

16 “(1) STATE ENFORCEMENT EXCLUSIVE OF  
17 FEDERAL ENFORCEMENT.—If the Secretary deter-  
18 mines that a State has submitted a report by the  
19 deadline specified under subsection (a)(2) and finds  
20 that the State has provided for implementation and  
21 enforcement of the section 821 standards (to the ex-  
22 tent that the requirements to which such standards  
23 apply are applicable to insurers offering health in-  
24 surance coverage in connection with group health  
25 plans and not applicable to group health plans),

1 such implementation and enforcement shall be car-  
2 ried out exclusively under State law.

3 “(2) REVIEW OF STATE ENFORCEMENT PRO-  
4 GRAMS.—If the Secretary determines that a State  
5 has submitted a report by the deadline specified  
6 under subsection (a)(2) but finds that the State pro-  
7 gram does not provide for implementation and en-  
8 forcement of the section 821 standards that are ap-  
9 plicable to insurers and not applicable to group  
10 health plans, the Secretary shall notify the State and  
11 provide the State a period of 60 days in which to  
12 provide for changes that assure such implementation  
13 and enforcement of such standards.

14 “(3) CONTINGENCY.—If the Secretary deter-  
15 mines that a State has not submitted a report by  
16 the deadline specified under subsection (a)(2) or, in  
17 the case of a State described in paragraph (2), the  
18 State has not provided for an implementation and  
19 enforcement program after the period of 60 days  
20 specified in such paragraph, the Secretary shall pro-  
21 vide for such mechanism for the implementation and  
22 enforcement in the State of the section 821 stand-  
23 ards (to the extent that the requirements to which  
24 such standards apply are applicable to insurers of-  
25 fering health insurance coverage in connection with

1 group health plans and not applicable to group  
2 health plans) (including the application of civil  
3 money penalties under paragraph (4)) as the Sec-  
4 retary determines to be appropriate. Any such imple-  
5 mentation and enforcement shall cease to be effec-  
6 tive on the date the Secretary finds that a State has  
7 established an implementation and enforcement pro-  
8 gram described in subsection (a)(1).

9 “(4) APPLICATION OF CIVIL MONEY PENALTY  
10 UNDER SECRETARIAL MECHANISM.—

11 “(A) IN GENERAL.—If the Secretary is  
12 providing for implementation and enforcement  
13 of section 821 standards under paragraph (3)  
14 and determines that an insurer offering health  
15 insurance coverage in connection with a group  
16 health plan has failed to comply with such  
17 standards applicable to the insurer, the Sec-  
18 retary may impose on the insurer a civil money  
19 penalty of not to exceed \$25,000 for each such  
20 failure. Provisions consistent and coextensive  
21 with section 1128A of the Social Security Act  
22 (other than the first sentence of subsection (a)  
23 of such section and other than subsection (b) of  
24 such subsection) shall apply to a civil money  
25 penalty under this paragraph in the same man-

1           ner as such section applies to a penalty or pro-  
2           ceeding under section 1128A(a) of such Act.  
3           Any action authorized under this subparagraph  
4           shall be in addition to actions authorized under  
5           section 502.

6           “(B) CORRECTIONS WITHIN 30 DAYS.—The  
7           Secretary shall not impose a civil money penalty  
8           under this paragraph by reason of any failure  
9           if—

10                   “(i) such failure was due to reason-  
11                   able cause and not to willful neglect, and

12                   “(ii) such failure is corrected within  
13                   the 30-day period beginning on the earliest  
14                   date the insurer knew, or exercising rea-  
15                   sonable diligence would have known, that  
16                   such failure existed.

17           “(c) GOOD FAITH COMPLIANCE WITH REQUIRE-  
18           MENT.—An insurer that complies in good faith with an  
19           applicable requirement of subpart A of this part shall not  
20           be subject to a penalty under this section for failure to  
21           meet such requirement on the basis of its failure to meet  
22           section 821 standards (or regulations to carry out such  
23           standards) for any failure that occurs before the date such  
24           standards (or regulations) have been published and be-  
25           come effective.

1       “(d) TREATMENT OF POLICY APPROVAL BY DOMI-  
2 CILE STATE.—If a particular policy or contract of health  
3 insurance coverage offered by an insurer is approved in  
4 a State that has adopted and is enforcing section 821  
5 standards and that is the domicile State with respect to  
6 the insurer, the policy or contract shall be deemed to meet  
7 such standards with respect to any other State but only  
8 if a copy of the approval by the domicile State is filed  
9 by the insurer with the applicable regulatory authority of  
10 such other State at least 60 days before the date the policy  
11 or contract is offered, sold, or issued in that other State.

12 **“SEC. 823. PREEMPTION.**

13       “(a) IN GENERAL.—Subject to subsection (b), a  
14 State may not establish or enforce standards applicable  
15 to insurers offering health insurance coverage in connec-  
16 tion with group health plans and not applicable to group  
17 health plans, if the standards are different from the sec-  
18 tion 821 standards (to the extent that the requirements  
19 to which such standards apply are applicable to such in-  
20 surers and not applicable to group health plans).

21       “(b) EXCEPTION FOR GOVERNMENTAL HEALTH  
22 PLANS.—Subsection (a) shall not prevent a State from es-  
23 tablishing and enforcing different standards with respect  
24 to group health plans that are established or maintained  
25 by the State or political subdivision thereof, or by any

1 agency or instrumentality of the State or political subdivi-  
 2 sion thereof. This part shall not be construed as imposing  
 3 any requirements on States or local governments. A group  
 4 health plan shall not be treated as failing to meet the re-  
 5 quirements of section 802 solely because the plan dis-  
 6 regards coverage under any other plan established or  
 7 maintained by a State or a political subdivision thereof  
 8 for which different standards not meeting the minimum  
 9 requirements of subpart A are established or enforced by  
 10 the State or political subdivision.”.

11 (b) TREATMENT OF GOVERNMENTAL PLANS.—Sec-  
 12 tion 4(b)(1) of such Act (29 U.S.C. 1003(b)(1)) is amend-  
 13 ed by inserting “except with respect to part 8 of subtitle  
 14 B,” after “(1)”.

15 (c) CLERICAL AMENDMENT.—The table of contents  
 16 in section 1 of the Employee Retirement Income Security  
 17 Act of 1974 is amended by inserting after the item relat-  
 18 ing to section 608 the following new items:

“PART 8—ACCESS TO, AND CONTINUITY OF, GROUP HEALTH  
 PLAN COVERAGE

“Sec. 800. Definitions and special rules.

“SUBPART A—NONDISCRIMINATION, PORTABILITY, RENEWABILITY, AND  
 PLAN PARTICIPATION STANDARDS

“Sec. 801. Nondiscrimination and limitations on preexisting condition exclu-  
 sions.

“Sec. 802. Portability.

“Sec. 803. Requirements for renewability of coverage.

“Sec. 804. Group health plan participation standards.

“SUBPART B—ENCOURAGEMENT OF PRIVATE STANDARDS-SETTING ORGANIZATIONS FOR PROVIDER NETWORKS AND UTILIZATION REVIEW UNDER GROUP HEALTH PLANS

“Sec. 811. Encouragement of private standards-setting organizations for provider networks under group health plans.

“Sec. 812. Encouragement of private standards-setting organizations for utilization review under group health plans.

“SUBPART C—ESTABLISHMENT OF STANDARDS; ENFORCEMENT

“Sec. 821. Establishment of standards applicable to insurers offering health insurance coverage to group health plans.

“Sec. 822. Enforcement with respect to insurers offering health insurance coverage to group health plans.

“Sec. 823. Preemption.”.

1 (d) GOOD FAITH COMPLIANCE WITH REQUIRE-  
2 MENT.—A group health plan (within the meaning of sec-  
3 tion 3(42) of the Employee Retirement Income Security  
4 Act of 1974) that complies in good faith with an applicable  
5 requirement of subpart A of part 8 of title I of such Act  
6 before the date a regulation has been published and be-  
7 comes effective to carry out such requirement shall be con-  
8 sidered to be in compliance with such regulation.

9 **SEC. 1002. EFFECTIVE DATE.**

10 The requirements of subparts A and B of part 8 of  
11 subtitle B of title I of the Employee Retirement Income  
12 Security Act of 1974 (added by this subtitle), and the pre-  
13 emption provisions of section 823 of such Act (added by  
14 this subtitle), shall apply with respect to plan years begin-  
15 ning after December 31, 1997.

1 **Subtitle B—Requirements for Insurers Offering Health Insurance Coverage to Group Health Plans of Small Employers**

2  
3  
4  
5 **SEC. 1101. ERISA REQUIREMENTS FOR INSURERS OFFERING HEALTH INSURANCE COVERAGE TO GROUP HEALTH PLANS OF SMALL EMPLOYERS**

6  
7  
8  
9 (a) IN GENERAL.—Part 8 of subtitle B of title I of  
10 the Employee Retirement Income Security Act of 1974 (as  
11 added by the preceding provisions of this title) is amended  
12 by adding at the end the following:

13 **“Subpart D—Requirements for Insurers Offering Health Insurance Coverage to Group Health Plans of Small Employers**

14  
15  
16 **“SEC. 831. DEFINITIONS.**

17 “Except as otherwise specifically provided, for purposes of this subpart:

18  
19 “(1) CATASTROPHIC DEDUCTIBLE AMOUNT.—

20 (A) Subject to subparagraph (B), the term ‘catastrophic deductible amount’ means a deductible  
21 amount that is at least \$1,800 (or \$3,600 if the coverage includes family members).  
22  
23

24 “(B) In the case of any calendar year after the  
25 first year to which this subpart applies, each dollar

1 amount in subparagraph (A) shall be increased by  
2 the percentage by which (i) the average of the  
3 monthly consumer price indexes for all urban con-  
4 sumers for the previous year, exceeds (ii) the aver-  
5 age of the monthly consumer price indexes for all  
6 urban consumers for such first year. If any increase  
7 under the preceding sentence does not result in an  
8 amount that is a multiple of \$50, such increase shall  
9 be rounded so that the amount is determined to the  
10 nearest multiple of \$50.

11 “(2) DEPENDENT CHILD.—The term ‘depend-  
12 ent child’ means a child (including an adopted child)  
13 who is under 19 years of age or who is a full-time  
14 student and under 25 years of age.

15 “(3) SECRETARY.—Notwithstanding section  
16 3(13), the term ‘Secretary’ means the Secretary of  
17 Health and Human Services.

18 “(4) SMALL EMPLOYER.—The term ‘small em-  
19 ployer’ means, with respect to a calendar year, an  
20 employer with more than 1 but less than 51 eligible  
21 employees on a typical business day. For purposes of  
22 this paragraph, the term ‘eligible employee’ includes  
23 a self-employed individual.

1           “(5) SMALL GROUP MARKET.—The term ‘small  
2           group market’ has the meaning provided in section  
3           803(b)(4)(B).

4           “(6) STATE.—The term ‘State’ means the 50  
5           States, the District of Columbia, Puerto Rico, the  
6           Virgin Islands, Guam, and American Samoa.

7           “(7) STATE COMMISSIONER OF INSURANCE.—  
8           The term ‘State commissioner of insurance’ includes  
9           a State superintendent of insurance.

10 **“SEC. 832. REQUIREMENT FOR INSURERS TO OFFER GEN-**  
11 **ERAL, CATASTROPHIC, AND OPTIONAL**  
12 **MEDISAVE COVERAGE TO SMALL EMPLOY-**  
13 **ERS.**

14           “(a) REQUIREMENT.—

15           “(1) IN GENERAL.—Each insurer that makes  
16           available any health insurance coverage in connec-  
17           tion with a group health plan in the small group  
18           market in the State—

19           “(A) shall make available to each small  
20           employer in the State general coverage (as de-  
21           fined in section 833(a)), with a fee-for-service  
22           option and, if the insurer makes the option  
23           available in the State outside the small group  
24           market, a point-of-service option and a man-

1 aged care option (as such terms are defined in  
2 section 800(a)(14)),

3 “(B) shall make available to each small  
4 employer in the State catastrophic coverage (as  
5 defined in section 833(b)), and

6 “(C) may make available to each small em-  
7 ployer in the State medisave coverage (as de-  
8 fined in section 833(c)).

9 “(2) TREATMENT OF CERTAIN PREVIOUSLY  
10 SELF-INSURED EMPLOYERS.—

11 “(A) IN GENERAL.—An insurer may elect  
12 not to make general, catastrophic, and medisave  
13 coverage available to group health plans of pre-  
14 viously self-insured small employers (described  
15 in subparagraph (B)), but only if such election  
16 is made in a uniform manner for all such em-  
17 ployers. Such an election shall not apply after  
18 the end of the 1-year period (or such uniform,  
19 shorter period as the insurer may specify) be-  
20 ginning on the last date no such coverage was  
21 provided by an employer.

22 “(B) PREVIOUS SELF-INSURED EMPLOYER  
23 DESCRIBED.—A previously self-insured small  
24 employer described in this subparagraph is a  
25 small employer that has provided medical care

1 (referred to in section 3(42)) to employees  
2 other than through health insurance coverage to  
3 which this subpart applies.

4 “(3) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—The requirements of para-  
5 graph (1)(A) (with regard to requiring a fee-for-  
6 service option) and paragraph (1)(B) shall not apply  
7 with respect to a health insurance coverage that is  
8 offered by—  
9

10 “(A) a health maintenance organization, or

11 “(B) any other entity if such other entity  
12 does not provide for a fee-for-service option.

13 “(4) CONSTRUCTION WITH RESPECT TO COV-  
14 ERAGE OFFERED IN CONNECTION WITH ASSOCIA-  
15 TIONS.—Nothing in paragraph (1) or subsection  
16 (b)(1) shall be construed as requiring the general,  
17 catastrophic, or medisave coverage made available by  
18 an insurer in the small group market in a State in  
19 connection with an association referred to in section  
20 834(a)(4) to be the same as the general, cata-  
21 strophic, or medisave coverage offered in the State  
22 in the small group market not in connection with  
23 such an association.

24 “(b) ISSUANCE OF COVERAGE.—

1           “(1) IN GENERAL.—Subject to the succeeding  
2 paragraphs of this subsection and subsection (a)(4),  
3 each insurer that offers general, catastrophic, or  
4 medisave coverage in connection with a group health  
5 plan in the small group market in a State—

6                   “(A) must accept every small employer in  
7 the State that applies for such coverage; and

8                   “(B) must accept for enrollment under  
9 such coverage every eligible individual (as de-  
10 fined in section 800(a)(4)) who applies for en-  
11 rollment on a timely basis (consistent with  
12 paragraph (4)) and may not place any restric-  
13 tion on the eligibility of an individual to enroll  
14 so long as such individual is an eligible individ-  
15 ual consistent with subpart D.

16           “(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of an insurer  
17 that offers health insurance coverage in connection  
18 with a group health plan in the small group market  
19 and that is a health maintenance organization or of-  
20 fers coverage through a network plan (as defined in  
21 section 800(a)(13)), the insurer may—

22                   “(A) limit the employers that may apply  
23 for such coverage to those with eligible individ-  
24

1 uals residing in the service area for such orga-  
2 nization or plan;

3 “(B) limit the individuals who may be en-  
4 rolled under such coverage to those who reside  
5 in the service area for such organization or  
6 plan; and

7 “(C) within the service area of such orga-  
8 nization or plan, deny such coverage to such  
9 employers if the insurer demonstrates that—

10 “(i) it will not have the capacity to de-  
11 liver services adequately to enrollees of any  
12 additional groups because of its obligations  
13 to existing group contract holders and en-  
14 rollees,

15 “(ii) it is applying this subparagraph  
16 uniformly to all employers without regard  
17 to the health status, claims experience, or  
18 duration of coverage of those employers  
19 and their employees, and

20 “(iii) it will not offer coverage to such  
21 employers within such service area for a  
22 period of at least 180 days after such cov-  
23 erage is denied.

24 “(3) SPECIAL RULE FOR FINANCIAL CAPACITY  
25 LIMITS.—An insurer may deny health insurance cov-

1 erage in connection with a group health plan in the  
2 small group market if the insurer demonstrates  
3 that—

4 “(A) it does not have the financial reserves  
5 necessary to underwrite additional coverage,

6 “(B) it is applying this paragraph uni-  
7 formly to all employers without regard to the  
8 health status, claims experience, or duration of  
9 coverage of the small employers and their em-  
10 ployees, and

11 “(C) it shall not offer coverage to such em-  
12 ployers within such service area for a period of  
13 at least 180 days after such coverage is denied.

14 “(4) CLARIFICATION OF TIMELY ENROLL-  
15 MENT.—

16 “(A) GENERAL INITIAL ENROLLMENT RE-  
17 QUIREMENT.—Except as provided in this para-  
18 graph, enrollment of an eligible individual for  
19 general, catastrophic, or medisave coverage may  
20 be considered not to be timely if the eligible em-  
21 ployee or dependent fails to enroll under such  
22 coverage during an initial enrollment period, if  
23 such period is at least 30 days long.

24 “(B) ENROLLMENT DUE TO LOSS OF PRE-  
25 VIOUS COVERAGE.—Enrollment under general,

1 catastrophic, or medisave coverage is considered  
2 to be timely in the case of an eligible individual  
3 who—

4 “(i) was covered under a group health  
5 plan or had health insurance coverage at  
6 the time of the individual’s initial enroll-  
7 ment period,

8 “(ii) stated at the time of the initial  
9 enrollment period that coverage under a  
10 group health plan or health insurance cov-  
11 erage was the reason for declining enroll-  
12 ment,

13 “(iii) lost coverage under a group  
14 health plan or health insurance coverage  
15 (as a result of the termination of the cov-  
16 erage, termination of employment, reduc-  
17 tion of numbers of hours of employment,  
18 or other reason other than a reason de-  
19 scribed in subparagraph (A) or (B) of sec-  
20 tion 803(b)), and

21 “(iv) requests enrollment within 30  
22 days after termination of the coverage.

23 “(C) REQUIREMENT APPLIES DURING  
24 OPEN ENROLLMENT PERIODS.—Each insurer  
25 offering general, catastrophic, or medisave cov-

1           erage in connection with a group health plan in  
2           the small group market shall provide for at  
3           least one period (of not less than 30 days) each  
4           year during which enrollment under such cov-  
5           erage shall be considered to be timely. A late  
6           enrollment penalty may apply with respect to  
7           any subsequent period (not to extend beyond  
8           the effective date of the next such enrollment  
9           period).

10           “(D) ENROLLMENT OF DEPENDENTS.—

11           “(i) IN GENERAL.—Enrollment of an  
12           eligible individual who is a spouse or child  
13           of an eligible employee shall be considered  
14           to be timely if a request for enrollment is  
15           made either—

16           “(I) within 30 days of the date of  
17           the marriage or of the date of the  
18           birth or adoption of such child, if fam-  
19           ily coverage is available as of such  
20           date, or

21           “(II) within 30 days of the date  
22           family coverage is first made avail-  
23           able.

24           “(ii) COVERAGE.—If available cov-  
25           erage includes family coverage and enroll-

1           ment is made under such coverage on a  
2           timely basis under clause (i)(I), the cov-  
3           erage shall become effective not later than  
4           the first day of the first month beginning  
5           after the date the completed request for  
6           enrollment is received.

7           “(5) MINIMUM EMPLOYEE PARTICIPATION RE-  
8           QUIREMENT AND WAITING PERIOD PERMITTED.—

9           “(A) IN GENERAL.—Subject to subpara-  
10          graphs (B) and (C), an insurer offering general,  
11          catastrophic, or medisave coverage in connec-  
12          tion with a group health plan in the small  
13          group market may—

14               “(i) provide for a minimum participa-  
15               tion requirement with respect to eligible  
16               employees of an employer if such require-  
17               ment does not exceed 25 percent of the eli-  
18               gible employees of the employer who do not  
19               otherwise have coverage under a group  
20               health plan or health insurance coverage  
21               (or coverage under a public plan providing  
22               medical benefits); and

23               “(ii) require a waiting period with re-  
24               spect to coverage of an eligible employee of

1 an employer if such period is consistent  
2 with section 804(a)(1).

3 “(B) SPECIAL RULE FOR COVERAGE IN  
4 CONNECTION WITH CERTAIN ASSOCIATIONS.—  
5 In the case of health insurance coverage in con-  
6 nection with an association referred to in sec-  
7 tion 834(a)(4), the insurer may not provide for  
8 a minimum participation requirement with re-  
9 spect to eligible employees of an employer.

10 “(C) TREATMENT OF COVERAGE ELECTED  
11 SOLELY FOR DEPENDENTS.—In determining  
12 whether the minimum participation require-  
13 ments of subparagraph (A)(i) are met with re-  
14 spect to a plan, coverage provided under the  
15 plan for dependents of an eligible employee,  
16 pursuant to an election of coverage by the eligi-  
17 ble employee for dependents only, shall be treat-  
18 ed as participation by the eligible employee  
19 under the plan.

20 **“SEC. 833. GENERAL, CATASTROPHIC, AND MEDISAVE COV-  
21 ERAGE DEFINED.**

22 “(a) GENERAL COVERAGE.—In this part, the term  
23 ‘general coverage’ means health insurance coverage that  
24 meets the applicable standards provided for under section

1 835 and that is not catastrophic coverage or medisave cov-  
2 erage (as defined in this section).

3 “(b) CATASTROPHIC COVERAGE.—In this part, the  
4 term ‘catastrophic coverage’ means health insurance cov-  
5 erage that meets the applicable standards provided for  
6 under section 835 and under which benefits are available  
7 for a year only to the extent that expenses for covered  
8 services in a year exceed a catastrophic deductible amount  
9 (as defined in section 831(1)).

10 “(c) MEDISAVE COVERAGE.—

11 “(1) IN GENERAL.—In this part, the term  
12 ‘medisave coverage’ means coverage that meets the  
13 applicable standards provided for under section 832  
14 and—

15 “(A) consists of—

16 “(i) health insurance coverage under  
17 which benefits are available for a year only  
18 to the extent that expenses for covered  
19 services in a year exceed a catastrophic de-  
20 ductible amount (as defined in section  
21 831(1)); and

22 “(ii) medisave cash benefit coverage  
23 consistent with paragraph (2); and

24 “(B) meets such standards as may be pre-  
25 scribed under section 835.

1 “(2) MEDISAVE CASH BENEFIT COVERAGE.—

2 “(A) IN GENERAL.—Medisave cash benefit  
3 coverage is considered to be consistent with this  
4 paragraph to the extent that, in addition to and  
5 separate from the benefits from the health in-  
6 surance coverage described in paragraph  
7 (1)(A)—

8 “(i) under the terms of such coverage  
9 there is a fixed dollar amount of additional  
10 benefits that does not exceed the cata-  
11 strophic deductible amount (as defined in  
12 section 831(1)) for the catastrophic cov-  
13 erage described in paragraph (1)(A);

14 “(ii) subject to clause (iii), the dollar  
15 amount may be used for deductibles, cost-  
16 sharing, and other expenses, for items and  
17 services specified under such catastrophic  
18 coverage and medisave cash benefit cov-  
19 erage;

20 “(iii) any such amount of benefits not  
21 so used shall be accumulated, shall remain  
22 available to be applied against future  
23 deductibles, cost-sharing, and other ex-  
24 penses, and may be withdrawn for any  
25 purpose, or used to pay for coverage de-

1           scribed in paragraph (1)(A)(i), to the ex-  
2           tent that the dollar amount exceeds 150  
3           percent of the catastrophic deductible  
4           amount (as defined in section 831(1)) for  
5           the catastrophic coverage described in  
6           paragraph (1)(A), shall be nonforfeitable,  
7           and, upon the death of all beneficiaries  
8           with respect to such benefits, shall be pay-  
9           able in cash to the estate of the beneficiary  
10          who dies last; and

11                 “(iv) the coverage meets the port-  
12                 ability rules established under subpara-  
13                 graph (B).

14                 “(B) PORTABILITY RULES.—In the case of  
15                 an individual who has medisave cash benefit  
16                 coverage with respect to which the requirements  
17                 of clauses (i), (ii), and (iii) of subparagraph (A)  
18                 are met in a year, who has accumulated an  
19                 amount of benefits under such coverage, and  
20                 who terminates such coverage (or terminates  
21                 enrollment under health insurance coverage  
22                 that contains medisave cash benefit coverage),  
23                 the coverage meets the portability rules of this  
24                 subparagraph if, under the terms of such cov-

1 erage, the individual is permitted (as elected by  
2 the individual)—

3 “(i) to have an amount equal to all or  
4 some of the amount of benefits accumu-  
5 lated under such coverage paid towards the  
6 payment of premiums under any group  
7 health plan or health insurance coverage  
8 providing coverage for the individual, and

9 “(ii) to have an amount equal to all or  
10 some of the remaining balance transferred  
11 to a plan which will provide medisave cash  
12 benefit coverage for that individual in ac-  
13 cordance with the requirements of this  
14 paragraph (and such plan shall credit such  
15 amount transferred towards Medisave cash  
16 benefit coverage provided by such plan).

17 **“SEC. 834. USE OF FAIR RATING, UNIFORM MARKETING MA-**  
18 **TERIALS, AND MISCELLANEOUS CONSUMER**  
19 **PROTECTIONS.**

20 “(a) USE OF FAIR RATING.—

21 “(1) IN GENERAL.—As a standard under sec-  
22 tion 835(a), subject to the succeeding paragraphs of  
23 this subsection, the premium rates established by an  
24 insurer for general, catastrophic, or medisave cov-  
25 erage offered in connection with a group health plan

1 in the small group market may not vary except by  
2 the following:

3 “(A) AGE.—

4 “(i) IN GENERAL.—Subject to clause  
5 (ii), by age classes of individuals under 65  
6 years of age which do not result in the  
7 ratio of the highest age rate to the lowest  
8 age rate exceeding 4-to-1.

9 “(ii) SCHEDULE OF PHASED-IN RE-  
10 Ductions IN RATIO.—The Secretary shall  
11 request the NAIC to determine, within 12  
12 months after the date of the enactment of  
13 the ERISA Targeted Health Insurance Re-  
14 form Act of 1995, whether the ratio re-  
15 ferred to in clause (i) can be adjusted for  
16 years after 1998, without adversely affect-  
17 ing coverage rates and affordability of cov-  
18 erage, so that the ratio of the highest age  
19 rate to the lowest age rate in effect for any  
20 year is reduced and phased in to a ratio of  
21 not less than 3-to-1. If the NAIC submits  
22 to the Secretary a determination that such  
23 a reduction can so be made, under a sched-  
24 ule of reductions in such ratio effective for  
25 calendar years after 1998, and specifies

1 the schedule of reductions for such years,  
2 the Secretary shall review the schedule of  
3 reductions. Such review shall be completed  
4 within 120 days after the date the deter-  
5 mination of the NAIC is submitted to the  
6 Secretary. Unless the Secretary determines  
7 within such period that such schedule of  
8 reduced ratios will adversely affect cov-  
9 erage rates and affordability of coverage,  
10 the ratio in effect under this subparagraph  
11 for any year under such schedule shall be  
12 the ratio in effect for such year under this  
13 subparagraph.

14 “(B) GEOGRAPHIC AREA.—By geographic  
15 area, based on 3-digit zip code or counties, as  
16 identified by the Secretary in consultation with  
17 the NAIC and the States involved.

18 “(C) FAMILY CLASS.—By family class,  
19 based on classes of family coverage established  
20 by the Secretary, in consultation with the NAIC  
21 and the States.

22 “(D) BENEFIT DESIGN.—By benefit design  
23 of coverage, including by type of coverage, such  
24 as general, catastrophic, and medisave coverage  
25 and by type of coverage option (described in

1 section 800(a)(14)) with respect to general cov-  
2 erage.

3 “(E) 12-MONTH SURCHARGE FOR LESS RE-  
4 STRICTIVE PRE-EXISTING CONDITION EXCLU-  
5 SION.—By whether coverage is being offered  
6 pursuant to section 801(a) (relating to a less  
7 restrictive pre-existing condition exclusion), and  
8 which is not described in section 801(b), but  
9 only during the first 12 months in which such  
10 coverage is offered.

11 “(F) ADMINISTRATIVE CATEGORIES.—By  
12 permitted expense category, based on dif-  
13 ferences in expenses among such categories,  
14 consistent with subsection (b).

15 “(2) DISCOUNT FOR EMPLOYER WELLNESS  
16 PROGRAM.—An insurer offering health insurance  
17 coverage in connection with a group health plan in  
18 the small group market may provide for a group dis-  
19 count with respect to the employer that provides for  
20 a wellness program for employees.

21 “(3) ADDITIONAL VARIATIONS IN RENEWAL  
22 PREMIUMS PERMITTED FOR CLAIMS EXPERIENCE  
23 WITHIN CLASS OF BUSINESS.—

24 “(A) IN GENERAL.—Subject to the suc-  
25 ceeding provisions of this paragraph, for a class

1 of business of an insurer, with respect to small  
2 employers with similar demographic and other  
3 similar objective characteristics (and not relat-  
4 ing to claims experience, health status, indus-  
5 try, occupation, or duration of coverage since  
6 issue) for the same or similar coverage, the in-  
7 surer offering health insurance coverage in con-  
8 nection with a group health plan in the small  
9 group market may vary the renewal premiums  
10 charged during a rating period based on claims  
11 experience so long as the highest rates which  
12 could be charged to such employers under the  
13 rating system for that class of business does  
14 not exceed the following percentage of the base  
15 premium rate for the class of business for the  
16 rating period:

17 “(i) For a rating (or portion thereof)  
18 that occurs in the first 2 years in which  
19 this section is in effect, 150 percent.

20 “(ii) For a rating (or portion thereof)  
21 that occurs in a succeeding year, a per-  
22 centage specified in any regulation of the  
23 Secretary that may be prescribed under  
24 paragraph (6).

1           “(B) LIMIT ON TRANSFER OF EMPLOYERS  
2           AMONG CLASSES OF BUSINESS.—In carrying  
3           out subparagraph (A), an insurer offering  
4           health insurance coverage in connection with a  
5           group health plan in the small group market  
6           may not involuntarily transfer a small employer  
7           into or out of a class of business. An insurer of-  
8           fering such coverage may not offer to transfer  
9           a small employer into or out of a class of busi-  
10          ness unless such offer is made to transfer all  
11          small employers in the class of business without  
12          regard to demographic characteristics, claim ex-  
13          perience, health status, industry, occupation, or  
14          duration since issue.

15           “(C) DEFINITIONS.—In this paragraph:

16           “(i) BASE PREMIUM RATE.—The term  
17           ‘base premium rate’ means, for each class  
18           of business for each rating period, the low-  
19           est premium rate charged or which could  
20           have been charged under a rating system  
21           for that class of business by the insurer to  
22           small employers with similar demographic  
23           characteristics and other similar objective  
24           characteristics (not relating to claims expe-  
25           rience, health status, industry, occupation,

1 or duration of coverage since issue) for the  
2 same or similar health insurance coverage.

3 “(ii) CLASS OF BUSINESS.—The term  
4 ‘class of business’ means, with respect to  
5 an insurer, all (or a distinct group of)  
6 small employers as shown on the records of  
7 the insurer.

8 “(iii) RULES FOR ESTABLISHING  
9 CLASSES OF BUSINESS.—For purposes of  
10 clause (ii)—

11 “(I) an insurer offering health  
12 insurance coverage in connection with  
13 a group health plan in the small  
14 group market may establish, subject  
15 to subclause (II), a distinct group of  
16 small employers on the basis that the  
17 applicable health insurance coverage  
18 either is marketed and sold through  
19 individuals and organizations which  
20 are not participating in the marketing  
21 or sale of other distinct groups of  
22 small employers for the insurer or has  
23 been acquired from another insurer as  
24 a distinct group; and

1                   “(II) such an insurer may not es-  
2                   tablish more than 2 groupings under  
3                   each class of business based on the in-  
4                   surer’s use of managed-care tech-  
5                   niques if the techniques are expected  
6                   to produce substantial variation in  
7                   health care costs.

8                   “(iv) DEMOGRAPHIC CHARACTERIS-  
9                   TICS.—The term ‘demographic characteris-  
10                  tics’ means age (based upon classes estab-  
11                  lished under paragraph (1)(A)), geographic  
12                  area (based upon areas identified under  
13                  paragraph (1)(B)), and family composition  
14                  (based upon family classes established  
15                  under paragraph (1)(C)).

16                  “(4) TREATMENT OF ASSOCIATIONS AS SEPA-  
17                  RATE POOLS.—

18                         “(A) IN GENERAL.—At the election of an  
19                         insurer, the provisions of this section may be  
20                         applied separately with respect to either of the  
21                         following:

22                                 “(i) POOLED EXPERIENCE FOR EACH  
23                                 ASSOCIATION.—Small employers which are  
24                                 members of each separate qualified asso-  
25                                 ciation.

1           “(ii) POOLED EXPERIENCE FOR ALL  
2           ASSOCIATIONS.—Small employers which  
3           are members of any qualified association.

4           “(B) 5-YEAR RULE.—An election under  
5           subparagraph (A) may not be made (or re-  
6           voked) more frequently than once every 5 years.

7           “(C) QUALIFIED ASSOCIATION DEFINED.—  
8           In this paragraph, the term ‘qualified associa-  
9           tion’ means an association which meets the fol-  
10          lowing requirements:

11           “(i) The association consists of em-  
12           ployers who together employ at least 200  
13           eligible employees.

14           “(ii) At least 25 percent of the eligible  
15           employees of employer members of the as-  
16           sociation are eligible employees of small  
17           employer members.

18           “(iii) The sponsor of the association—

19           “(I) is, and has been (together  
20           with its immediate predecessor, if  
21           any) for a continuous period of not  
22           less than 3 years, organized and  
23           maintained in good faith, with a con-  
24           stitution and bylaws specifically stat-  
25           ing its purpose, as a trade association,

1 an industry association, a professional  
2 association, or a chamber of com-  
3 merce (or similar business group), for  
4 substantial purposes other than that  
5 of obtaining or providing medical care,  
6 and

7 “(II) is established as a perma-  
8 nent entity which receives the active  
9 support of its members.

10 “(D) VARIATION WITHIN ASSOCIATION  
11 BASED ON EXPERIENCE NOT PERMITTED.—In  
12 the case of a small employer that is a member  
13 of an association that an insurer elects to treat  
14 separately under subparagraph (A), the insurer  
15 may not vary premiums pursuant to paragraph  
16 (3).

17 “(5) ADDITIONAL VARIATIONS IN INITIAL PRE-  
18 MIUMS PERMITTED FOR UNDERWRITING CHARAC-  
19 TERISTICS.—

20 “(A) IN GENERAL.—Subject to the suc-  
21 ceeding provisions of this paragraph, for a class  
22 of business of an insurer, with respect to small  
23 employers with similar demographic and other  
24 similar objective characteristics (not relating to  
25 claims experience, health status, industry, occu-

1           pation, or duration of coverage since issue), for  
2           the same or similar coverage, the insurer offer-  
3           ing health insurance coverage in connection  
4           with a group health plan in the small group  
5           market may vary the initial premiums charged  
6           on the basis of prior claims experience, health  
7           status, industry, occupation, and other under-  
8           writing characteristics so long as the highest  
9           rates which could be charged to such employers  
10          under the rating system for that class of busi-  
11          ness does not exceed the following percentage of  
12          the base premium rate for the class of business  
13          for the rating period:

14               “(i) For a rating (or portion thereof)  
15               that occurs in the first 2 years in which  
16               this section is in effect, 150 percent.

17               “(ii) For a rating (or portion thereof)  
18               that occurs in a succeeding year, a per-  
19               centage specified in any regulation of the  
20               Secretary that may be prescribed under  
21               paragraph (6).

22               “(B) DEFINITIONS.—In this paragraph:

23                   “(i) BASE PREMIUM RATE.—The term  
24                   ‘base premium rate’ means, for each class  
25                   of business, the lowest premium rate

1 charged or which could have been charged  
2 under a rating system for that class of  
3 business by the insurer to small employers  
4 with similar demographic characteristics  
5 and other similar objective characteristics  
6 (not relating to past claims experience,  
7 health status, industry, occupation, and  
8 other underwriting characteristics) for the  
9 same or similar health insurance coverage.

10 “(ii) OTHER DEFINITIONS.—Clause  
11 (ii) (relating to class of business), clause  
12 (iii) (relating to rules for establishing  
13 classes of business), and clause (iv) (relat-  
14 ing to demographic characteristics) of  
15 paragraph (3)(C) shall also apply with re-  
16 spect to this paragraph.

17 “(6) GRADUATED REDUCTION IN ALLOWABLE  
18 PERCENTAGES OF BASE PREMIUM RATE.—The Sec-  
19 retary shall request the NAIC to determine (in con-  
20 sultation with the American Academy of Actuaries),  
21 within 12 months after the date of the enactment of  
22 the ERISA Targeted Health Insurance Reform Act  
23 of 1995, whether model regulations that provide for  
24 a schedule of graduated reductions in the percent-  
25 ages of the base premium rates allowable under each

1 of paragraphs (3)(A)(ii) and (5)(A)(ii) can be devel-  
2 oped without adversely affecting coverage rates and  
3 affordability of coverage. If the NAIC makes such a  
4 determination and develops such model regulations  
5 providing for such schedules, the Secretary shall re-  
6 view the schedules provided in such model regula-  
7 tions. Such review shall be completed within 120  
8 days after the date the regulations are developed.  
9 Unless the Secretary determines within such period  
10 that any schedule provided in such model regulations  
11 for paragraph (3)(A)(ii) or (5)(A)(ii) does not meet  
12 the requirements of this subsection, such schedule  
13 shall serve as the schedule applicable under such  
14 paragraph, with such amendments as the Secretary  
15 deems necessary. The Secretary shall provide for  
16 public comment in connection with the regulations  
17 during such 120-day period and in advance of any  
18 determination by the Secretary.

19 “(b) ADMINISTRATIVE VARIATIONS.—

20 “(1) EXPENSE CATEGORIES.—Expense cat-  
21 egories shall be established under subsection  
22 (a)(1)(F) by an insurer offering health insurance  
23 coverage in connection with a group health plan in  
24 the small group market in a manner that only re-

1       fleets differences based on marketing, commissions,  
2       and similar expenses.

3               “(2) LIMITATION ON VARIATIONS.—The vari-  
4       ation provided among expense categories under sub-  
5       section (a)(1)(F) may not result in a premium for  
6       the highest expense category exceeding 115 percent  
7       of the premium for the lowest expense category.

8               “(c) FULL DISCLOSURE OF APPLICABLE RATING  
9       PRACTICES.—At the time an insurer offers health insur-  
10      ance coverage in connection with a group health plan in  
11      the small group market, the insurer shall fully disclose to  
12      the plan sponsor, at the request of the plan sponsor, rating  
13      practices for health insurance coverage applicable to that  
14      plan, including rating practices for different benefit de-  
15      signs offered to the plan sponsor.

16              “(d) ACTUARIAL CERTIFICATION.—Each insurer that  
17      offers health insurance coverage in connection with a  
18      group health plan in the small group market in a State  
19      shall file annually with the State commissioner of insur-  
20      ance, to the extent required by such commissioner, a writ-  
21      ten statement by a member of the American Academy of  
22      Actuaries (or other individual acceptable to the commis-  
23      sioner) that, based upon an examination by the individual  
24      which includes a review of the appropriate records and of  
25      the actuarial assumptions of the insurer and methods used

1 by the insurer in establishing premium rates for applicable  
2 health insurance coverage—

3 “(1) the insurer is in compliance with the appli-  
4 cable provisions of this section, and

5 “(2) the rating methods are actuarially sound.

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

8 “(e) REGISTRATION AND REPORTING.—Each insurer  
9 that issues any health insurance coverage in connection  
10 with a group health plan in the small group market in  
11 a State shall be registered or licensed with the State com-  
12 missioner of insurance and shall comply with any report-  
13 ing requirements of the commissioner relating to such cov-  
14 erage.

15 “(f) MARKETING MATERIAL.—Each insurer that is-  
16 sues any health insurance coverage in connection with a  
17 group health plan in the small group market in a State  
18 shall file with the State those marketing materials relating  
19 to the offer and sale of health insurance coverage to be  
20 used for distribution before the materials are used. Such  
21 materials shall be in a uniform format, as may be provided  
22 under standards established under section 835.

23 **“SEC. 835. ESTABLISHMENT OF STANDARDS.**

24 “(a) ROLE OF NAIC.—The Secretary of Labor shall  
25 request the NAIC to develop, within 12 months after the

1 date of the enactment of the ERISA Targeted Health In-  
2 surance Reform Act of 1995, model regulations that speci-  
3 fy standards with respect to the requirements of this sub-  
4 part to the extent that such requirements are applicable  
5 to insurers offering health insurance coverage in connec-  
6 tion with group health plans in the small group market  
7 and not applicable to group health plans. If the NAIC de-  
8 velops recommended regulations specifying such standards  
9 within such period, the Secretary of Labor shall review  
10 the standards. Such review shall be completed within 120  
11 days after the date the regulations are developed. Unless  
12 the Secretary of Labor determines within such period that  
13 the standards do not effectively provide for the application  
14 of the requirements to such insurers, such standards shall  
15 serve as the standards under this section, with such  
16 amendments as the Secretary of Labor deems necessary.  
17 Such Secretary shall provide for public comment in con-  
18 nection with the standards during such 120-day period  
19 and in advance of any determination by the Secretary.

20 “(b) CONTINGENCY.—If the NAIC does not develop  
21 such model regulations within such period or the Secretary  
22 of Labor makes the determination described in subsection  
23 (a), the Secretary of Labor shall specify, within 24 months  
24 after the date of the enactment of ERISA Targeted

1 Health Insurance Reform Act of 1995, standards to carry  
2 out those requirements.

3 “(c) DEFINITIONS.—In this part, the term ‘section  
4 835 standards’ means the standards established under  
5 this section.

6 **“SEC. 836. ENFORCEMENT.**

7 “(a) VOLUNTARY ENFORCEMENT BY STATES.—

8 “(1) IN GENERAL.—Each State that desires to  
9 enforce the section 835 standards (to the extent that  
10 the requirements to which such standards apply are  
11 applicable to insurers offering health insurance cov-  
12 erage in connection with group health plans in the  
13 small group market and not applicable to group  
14 health plans) shall submit to the Secretary of Labor,  
15 by the deadline specified in paragraph (2), a report  
16 on the program the State has established by such  
17 deadline and consistent with section 837 to imple-  
18 ment and enforce such standards.

19 “(2) DEADLINE.—

20 “(A) 1 YEAR AFTER FINAL MODEL REGU-  
21 LATIONS.—Subject to subparagraph (B), the  
22 deadline under this paragraph is 1 year after  
23 the date model regulations are established  
24 under section 835.

1           “(B) EXCEPTION FOR LEGISLATION.—In  
2           the case of a State which the Secretary of  
3           Labor identifies, in consultation with the NAIC,  
4           as—

5                   “(i) requiring State legislation (other  
6                   than legislation appropriating funds) in  
7                   order for insurers to meet the section 835  
8                   standards provided under such model regu-  
9                   lations, but

10                   “(ii) having a legislature which is not  
11                   scheduled to meet in 1996 in a legislative  
12                   session in which such legislation may be  
13                   considered,

14           the date specified in this paragraph is the first  
15           day of the first calendar quarter beginning after  
16           the close of the first legislative session of the  
17           State legislature that begins on or after Janu-  
18           ary 1, 1997. For purposes of the previous sen-  
19           tence, in the case of a State that has a 2-year  
20           legislative session, each year of such session  
21           shall be deemed to be a separate regular session  
22           of the State legislature.

23           “(3) NO FEDERAL MANDATE ON STATES.—  
24           Nothing in this subsection shall be construed as im-  
25           posing a requirement on a State. The establishment

1 by a State of an enforcement program under this  
2 subsection is voluntary.

3 “(b) FEDERAL ROLE.—

4 “(1) STATE ENFORCEMENT EXCLUSIVE OF  
5 FEDERAL ENFORCEMENT.—If the Secretary of  
6 Labor determines that a State has submitted a re-  
7 port by the deadline specified under subsection  
8 (a)(2) and finds that the State has provided for im-  
9 plementation and enforcement of the section 835  
10 standards (to the extent that the requirements to  
11 which such standards apply are applicable to insur-  
12 ers offering health insurance coverage in connection  
13 with group health plans in the small group market  
14 and not applicable to group health plans), such im-  
15 plementation and enforcement shall be carried out  
16 exclusively under State law.

17 “(2) REVIEW OF STATE ENFORCEMENT PRO-  
18 GRAMS.—If the Secretary of Labor determines that  
19 a State has submitted a report by the deadline speci-  
20 fied under subsection (a)(2) but finds that the State  
21 program does not provide for implementation and  
22 enforcement of the section 835 standards (to the ex-  
23 tent that the requirements to which such standards  
24 apply are applicable to insurers offering health in-  
25 surance coverage in connection with group health

1 plans in the small group market and not applicable  
2 to group health plans), the Secretary of Labor shall  
3 notify the State and provide the State a period of  
4 60 days in which to provide for changes that assure  
5 such implementation and enforcement of such stand-  
6 ards.

7 “(3) CONTINGENCY.—If the Secretary of Labor  
8 determines that a State has not submitted a report  
9 by the deadline specified under subsection (a)(2) or,  
10 in the case of a State described in paragraph (1),  
11 the State has not provided for an implementation  
12 and enforcement program after the period of 60  
13 days specified in such paragraph, the Secretary of  
14 Labor shall provide for such mechanism for the im-  
15 plementation and enforcement in the State of the  
16 section 835 standards (to the extent that the re-  
17 quirements to which such standards apply are appli-  
18 cable to insurers offering health insurance coverage  
19 in connection with group health plans and not appli-  
20 cable to group health plans) (including the applica-  
21 tion of civil money penalties under paragraph (3))  
22 as the Secretary of Labor determines to be appro-  
23 priate. Any such implementation and enforcement  
24 shall cease to be effective on the date the Secretary  
25 of Labor finds that a State has established an imple-

1       mentation and enforcement program described in  
2       subsection (a)(1).

3               “(4) APPLICATION OF CIVIL MONEY PENALTY  
4       UNDER SECRETARIAL MECHANISM.—

5               “(A) IN GENERAL.—If the Secretary of  
6       Labor is providing for implementation and en-  
7       forcement of section 835 standards under para-  
8       graph (2) and determines that an insurer has  
9       failed to comply with such standards applicable  
10      to the insurer, the Secretary of Labor may im-  
11      pose on the insurer a civil money penalty of not  
12      to exceed \$25,000 for each such failure. Under  
13      regulations of the Secretary of Labor, provi-  
14      sions consistent and coextensive with section  
15      1128A of the Social Security Act (other than  
16      the first sentence of subsection (a) of such sec-  
17      tion and other than subsection (b) of such sec-  
18      tion) shall apply to a civil money penalty under  
19      this paragraph in the same manner as such sec-  
20      tion applies to a penalty or proceeding under  
21      section 1128A(a) of such Act. Any action au-  
22      thorized under this subparagraph shall be in  
23      addition to actions authorized under section  
24      502.

1           “(B) CORRECTIONS WITHIN 30 DAYS.—The  
2           Secretary of Labor shall not impose a civil  
3           money penalty under this paragraph by reason  
4           of any failure if—

5                   “(i) such failure was due to reason-  
6                   able cause and not to willful neglect, and

7                   “(ii) such failure is corrected within  
8                   the 30-day period beginning on the earliest  
9                   date the insurer knew, or exercising rea-  
10                  sonable diligence would have known, that  
11                  such failure existed.

12          “(c) GOOD FAITH COMPLIANCE WITH REQUIRE-  
13          MENT.—An insurer that complies in good faith with an  
14          applicable requirement of this subpart shall not be subject  
15          to a penalty under this section for failure to meet such  
16          requirement on the basis of its failure to meet section 835  
17          standards (or regulations to carry out such standards) for  
18          any failure that occurs before the date such standards (or  
19          regulations) have been published and become effective.

20          “(d) TREATMENT OF POLICY APPROVAL BY DOMI-  
21          CILE STATE.—If a particular policy or contract of health  
22          insurance coverage offered by an insurer is approved in  
23          a State that has adopted and is enforcing section 835  
24          standards and that is the domicile State with respect to  
25          the insurer, the policy or contract shall be deemed to meet

1 such standards with respect to any other State but only  
2 if a copy of the approval by the domicile State is filed  
3 by the insurer with the applicable regulatory authority of  
4 such other State at least 60 days before the date the policy  
5 or contract is offered, sold, or issued in that other State.

6 **“SEC. 837. PREEMPTION.**

7       “(a) IN GENERAL.—Subject to subsection (b), a  
8 State may not establish or enforce standards applicable  
9 to insurers offering health insurance coverage in connec-  
10 tion with group health plans in the small group market  
11 and not applicable to group health plans, if the standards  
12 are different from the section 835 standards (to the extent  
13 that the requirements to which such standards apply are  
14 applicable to such insurers and not applicable to group  
15 health plans).

16       “(b) TRANSITION FOR MORE RESTRICTIVE STATE  
17 STANDARDS.—Subsection (a) shall not apply to a State  
18 establishing and enforcing more restrictive standards re-  
19 lating to the matters under this subpart during the 3-year  
20 period beginning on January 1, 1998, if such standards  
21 have been established and are enforced by the State as  
22 of February 1, 1995.

23       “(c) REFERENCE TO ADDITIONAL PROVISIONS.—For  
24 additional preemption provisions relating to State benefit  
25 mandates, see section 841.”.

1 (b) CONFORMING AMENDMENT.—Section 505 of  
2 such Act (29 U.S.C. 1135) is amended by striking “and  
3 section 109” and inserting “, subpart D of part 8, and  
4 section 109”.

5 (c) CLERICAL AMENDMENT.—The table of contents  
6 in section 1 of the Employee Retirement Income Security  
7 Act of 1974 is amended by inserting after the items relat-  
8 ing to part 8 (added by section 1001(b)) the following new  
9 items:

“SUBPART D—REQUIREMENTS FOR INSURERS OFFERING HEALTH  
INSURANCE COVERAGE TO GROUP HEALTH PLANS OF SMALL EMPLOYERS

“Sec. 831. Definitions.

“Sec. 832. Requirement for insurers to offer general, catastrophic, and optional  
medisave coverage to small employers.

“Sec. 833. General, catastrophic, and medisave coverage defined.

“Sec. 834. Use of fair rating, uniform marketing materials, and miscellaneous  
consumer protections.

“Sec. 835. Establishment of standards.

“Sec. 836. Enforcement.

“Sec. 837. Preemption.”.

10 (d) AVAILABILITY OF MEDISAVE COVERAGE TO EM-  
11 PLOYERS OF ALL SIZES.—In addition to the provisions  
12 of section 832(a)(1)(C) of the Employee Retirement In-  
13 come Security Act of 1974, an insurer that makes avail-  
14 able any health insurance coverage in connection with a  
15 group health plan may make available to employers that  
16 are not small employers medisave coverage (as defined in  
17 section 833(c) of such Act).

1 **SEC. 1102. EFFECTIVE DATE.**

2 The requirements of sections 832, 833, and 834 of  
3 the Employee Retirement Income Security Act of 1974  
4 (added by this subtitle) and the provisions of section 837  
5 of such Act (added by this subtitle) shall apply with re-  
6 spect to insurers as of January 1, 1998.

7 **Subtitle C—Encouragement of Mul-**  
8 **iple Employer Health Plans**  
9 **and Preemption**

10 **SEC. 1201. SCOPE OF STATE REGULATION.**

11 (a) IN GENERAL.—Part 8 of subtitle B of title I of  
12 the Employee Retirement Income Security Act of 1974  
13 (added by subtitle A of this title) is amended by adding  
14 at the end the following new subpart:

15 **“Subpart E—Scope of State Regulation**

16 **“SEC. 841. PROHIBITION OF STATE BENEFIT MANDATES**  
17 **FOR GROUP HEALTH PLANS.**

18 “(a) IN GENERAL.—No provision of State or local  
19 law shall apply that requires—

20 “(1) health insurance coverage in connection  
21 with a group health plan to include coverage of one  
22 or more specific benefits, services, or categories of  
23 health care, or services of any class or type of pro-  
24 vider of health care; or

25 “(2) an insurer offering health insurance cov-  
26 erage in connection with a group health plan to pro-

1       vide coverage of one or more specific benefits, serv-  
2       ices, or categories of health care, or services of any  
3       class or type of provider of health care.

4       “(b) EXCEPTION.—

5               “(1) STATE ENFORCEMENT PROGRAMS.—Sub-  
6       section (a) shall not apply with respect to a State  
7       enforcement program under section 822 or 835.

8               “(2) CERTAIN POLICIES.—Notwithstanding  
9       subsection (a), a State may require an insurer offer-  
10      ing health insurance coverage in connection with a  
11      group health plan to offer coverage of one or more  
12      specific benefits, services, or categories of health  
13      care, or services of any class or type of provider of  
14      health care, but only with respect to not more than  
15      2 policies or contracts of health insurance coverage,  
16      one of which provides less comprehensive coverage  
17      than the other.

18   **“SEC. 842. PROHIBITION OF PROVISIONS PROHIBITING EM-**  
19                   **PLOYER GROUPS FROM PURCHASING**  
20                   **HEALTH INSURANCE.**

21       “No provision of State or local law shall apply that  
22      prohibits—

23               “(1) 2 or more employers from obtaining cov-  
24      erage under a multiple employer welfare arrange-  
25      ment under which all coverage consists of medical

1 care referred to in section 3(42) and is fully insured  
2 (within the meaning of section 701(8)), or

3 “(2) an insurer from offering coverage de-  
4 scribed in paragraph (1).

5 **“SEC. 843. PREEMPTION OF STATE ANTI-MANAGED CARE**  
6 **LAWS.**

7 “(a) PREEMPTION OF STATE LAW PROVISIONS.—  
8 Subject to subsection (b)(3), the following provisions of  
9 State law are preempted and may not be enforced:

10 “(1) RESTRICTIONS ON REIMBURSEMENT  
11 RATES OR SELECTIVE CONTRACTING.—Any State  
12 law that—

13 “(A) restricts the ability of an insurer of-  
14 fering health insurance coverage in connection  
15 with a group health plan to negotiate reim-  
16 bursement rates or forms of payments with pro-  
17 viders,

18 “(B) restricts the ability of such an insurer  
19 to limit the number of participating providers,  
20 or

21 “(C) requires standards inconsistent with  
22 any standards established under section 811(b).

23 “(2) RESTRICTIONS ON UTILIZATION REVIEW  
24 METHODS.—Any State law that, in relation to health

1 insurance coverage offered by an insurer in connec-  
2 tion with a group health plan—

3 “(A) prohibits utilization review of any or  
4 all treatments and conditions (including  
5 preadmission certification, application of prac-  
6 tice guidelines, continued stay review,  
7 preauthorization of ambulatory procedures, and  
8 retrospective review),

9 “(B) requires that such review be made (i)  
10 by a resident of the State in which the treat-  
11 ment is to be offered or by an individual li-  
12 censed in such State, or (ii) by a physician in  
13 any particular specialty or with any board cer-  
14 tified specialty of the same medical specialty as  
15 the provider whose services are being reviewed,

16 “(C) requires the use of specified stand-  
17 ards of health care practice in such reviews or  
18 requires the disclosure of the specific criteria  
19 used in such reviews,

20 “(D) requires payments to providers for  
21 the expenses of responding to utilization review  
22 requests,

23 “(E) imposes liability for delays in per-  
24 forming such review, or

1           “(F) requires standards in addition to or  
2           inconsistent with standards established under  
3           section 812(b).”.

4           (b) CLERICAL AMENDMENT.—The table of contents  
5           in section 1 of the Employee Retirement Income Security  
6           Act of 1974 is amended by inserting after the items relat-  
7           ing to part 8 (added by sections 1001(b) and 1101(c))  
8           the following new items:

                                  “SUBPART E—SCOPE OF STATE REGULATION

                                  “Sec. 841. Prohibition of State benefit mandates for group health plans.

                                  “Sec. 842. Prohibition of provisions prohibiting employer groups from purchas-  
                                  ing health insurance.

                                  “Sec. 843. Preemption of State anti-managed care laws.”.

9           **SEC. 1202. PREEMPTION OF STATE LAW FOR MULTIPLE EM-**  
10                               **PLOYER HEALTH PLANS MEETING FEDERAL**  
11                               **STANDARDS.**

12           (a) IN GENERAL.—Subtitle B of title I of the Em-  
13           ployee Retirement Income Security Act of 1974 (as  
14           amended by the preceding provisions of this title) is  
15           amended by inserting after part 6 the following new part:

16                               **“Part 7—Multiple Employer Health Plans**

17           **“SEC. 701. DEFINITIONS.**

18           “For purposes of this part—

19                               “(1) INSURER.—The term ‘insurer’ means an  
20           insurance company, insurance service, or insurance  
21           organization, licensed to engage in the business of  
22           insurance by a State.

1           “(2) PARTICIPATING EMPLOYER.—The term  
2           ‘participating employer’ means, in connection with a  
3           multiple employer welfare arrangement, any em-  
4           ployer if any of its employees, or any of the depend-  
5           ents of its employees, are or were covered under  
6           such arrangement in connection with the employ-  
7           ment of the employees.

8           “(3) EXCESS/STOP LOSS COVERAGE.—The term  
9           ‘excess/stop loss coverage’ means, in connection with  
10          a multiple employer welfare arrangement or group  
11          health plan, a contract under which an insurer pro-  
12          vides for payment with respect to claims under the  
13          arrangement, relating to participants or beneficiaries  
14          individually or otherwise, in excess of an amount or  
15          amounts specified in such contract.

16          “(4) QUALIFIED ACTUARY.—The term ‘quali-  
17          fied actuary’ means an individual who is a member  
18          of the American Academy of Actuaries or meets  
19          such reasonable standards and qualifications as the  
20          Secretary may provide by regulation.

21          “(5) SPONSOR.—The term ‘sponsor’ means, in  
22          connection with a multiple employer welfare arrange-  
23          ment, the association or other entity which estab-  
24          lishes or maintains the arrangement.

1           “(6) STATE INSURANCE COMMISSIONER.—The  
2 term ‘State insurance commissioner’ means the in-  
3 surance commissioner (or similar official) of a State.

4           “(7) DOMICILE STATE.—The term ‘domicile  
5 State’ means, in connection with a multiple employer  
6 welfare arrangement, the State in which, according  
7 to the application for an exemption under this part,  
8 most individuals to be covered under the arrange-  
9 ment are located, except that, in any case in which  
10 information contained in the latest annual report of  
11 the arrangement filed under this part indicates that  
12 most individuals covered under the arrangement are  
13 located in a different State, such term means such  
14 different State.

15           “(8) FULLY INSURED.—Coverage under a plan  
16 or other arrangement is ‘fully insured’ if one or  
17 more insurers or health maintenance organizations  
18 (as defined in section 800(a)(10)(B)), or any com-  
19 bination thereof, are liable under one or more insur-  
20 ance policies or contracts for all benefits under the  
21 arrangement (irrespective of any recourse they may  
22 have against other parties).

23           “(9) EXEMPTED MULTIPLE EMPLOYER HEALTH  
24 PLAN.—The term ‘exempted multiple employer  
25 health plan’ means a multiple employer welfare ar-

1 rangement treated as an employee welfare benefit  
2 plan by reason of an exemption under this part.

3 “(10) PROVIDER HEALTH NETWORK.—The  
4 term ‘provider health network’ means an arrange-  
5 ment—

6 “(A) under which one or more providers of  
7 medical care (referred to in section 3(42)) (in-  
8 cluding medical practitioners), or one or more  
9 such providers and one or more community  
10 groups, and such other organizations as may be  
11 designated by the arrangement, enter into one  
12 or more agreements with one or more group  
13 health plans, sponsors of group health plans, or  
14 both,

15 “(B) under which such agreements provide  
16 that such providers make available to such  
17 group health plan or plans the items and serv-  
18 ices which constitute the medical care provided  
19 as benefits thereunder to participants and bene-  
20 ficiaries thereunder, and

21 “(C) which receives payment for such  
22 items and services on a prospective capitated  
23 basis or through a fee withhold arrangement, a  
24 bonus arrangement, a per diem arrangement, a  
25 fee-for-service arrangement, or any combination

1 of the foregoing (irrespective of the extent to  
2 which any of the foregoing may involve accept-  
3 ance of risk).

4 **“SEC. 702. EXEMPTED MULTIPLE EMPLOYER HEALTH**  
5 **PLANS RELIEVED OF CERTAIN RESTRIC-**  
6 **TIONS ON PREEMPTION OF STATE LAW AND**  
7 **TREATED AS EMPLOYEE WELFARE BENEFIT**  
8 **PLANS.**

9 “(a) IN GENERAL.—Subject to subsection (b), a mul-  
10 tiple employer welfare arrangement under which coverage  
11 is not fully insured and with respect to which there is in  
12 effect an exemption granted by the Secretary under this  
13 part (or with respect to which there is pending a complete  
14 application for such an exemption and the Secretary deter-  
15 mines that provisional protection under this part is appro-  
16 priate)—

17 “(1) shall be treated for purposes of subtitle A  
18 and the other parts of this subtitle as an employee  
19 welfare benefit plan, irrespective of whether such ar-  
20 rangement is an employee welfare benefit plan, and

21 “(2) shall be exempt from section  
22 514(b)(6)(A)(ii).

23 “(b) BENEFITS MUST CONSIST OF MEDICAL  
24 CARE.—Subsection (a) shall apply to a multiple employer  
25 welfare arrangement only if the benefits provided there-

1 under consist solely of medical care referred to in section  
2 3(42) (disregarding such incidental benefits as the Sec-  
3 retary shall specify by regulation).

4 “(c) RESTRICTION ON COMMENCEMENT OF NEW AR-  
5 RANGEMENTS.—A multiple employer welfare arrangement  
6 providing benefits which consist of medical care referred  
7 to in section 3(42) which has not commenced operations  
8 as of January 1, 1998, may commence operations only if  
9 an exemption granted to the arrangement under this part  
10 is in effect (or there is pending with respect to the ar-  
11 rangement a complete application for such an exemption  
12 and the Secretary determines that provisional protection  
13 under this part is appropriate).

14 “(d) CLASS EXEMPTION TREATMENT.—In the case  
15 of a multiple employer welfare arrangement, if—

16 “(1) at the time of application for an exemption  
17 under this part with respect to the arrangement, ei-  
18 ther (A) the arrangement covers at least 1,000 par-  
19 ticipants and beneficiaries, or (B) with respect to  
20 the arrangement there are at least 2,000 employees  
21 of eligible participating employers,

22 “(2) a complete application for an exemption  
23 under this part with respect to the arrangement has  
24 been filed and is pending, and

1           “(3) the application meets such requirements  
2           (if any) as the Secretary may provide with respect  
3           to class exemptions under this subsection,  
4           an exemption under this part shall be treated as having  
5           been granted with respect to the arrangement unless and  
6           until the Secretary provides appropriate notice that the  
7           exemption has been denied.

8           **“SEC. 703. EXEMPTION PROCEDURE.**

9           “(a) IN GENERAL.—The Secretary shall grant an ex-  
10          emption described in section 702(a) to a multiple employer  
11          welfare arrangement if—

12                 “(1) an application for such exemption with re-  
13                 spect to such arrangement, identified individually or  
14                 by class, has been duly filed in complete form with  
15                 the Secretary in accordance with this part,

16                 “(2) such application demonstrates compliance  
17                 with the requirements of section 704 with respect to  
18                 such arrangement, and

19                 “(3) the Secretary finds that such exemption  
20                 is—

21                         “(A) administratively feasible,

22                         “(B) not adverse to the interests of the in-  
23                         dividuals covered under the arrangement, and

1           “(C) protective of the rights and benefits  
2           of the individuals covered under the arrange-  
3           ment.

4           “(b) NOTICE AND HEARING.—Before granting an ex-  
5           emption under this section, the Secretary shall publish no-  
6           tice in the Federal Register of the pendency of the exemp-  
7           tion, shall require that adequate notice be given to inter-  
8           ested persons, including the State insurance commissioner  
9           of each State in which covered individuals under the ar-  
10          rangement are, or are expected to be, located, and shall  
11          afford interested persons opportunity to present views.  
12          The Secretary may not grant an exemption under this sec-  
13          tion unless the Secretary affords an opportunity for a  
14          hearing and makes a determination on the record with re-  
15          spect to the findings required under subsection (a)(3). The  
16          Secretary shall, to the maximum extent practicable, make  
17          a final determination with respect to any application filed  
18          under this section in the case of a newly established ar-  
19          rangement within 90 days after the date which the Sec-  
20          retary determines is the date on which such application  
21          is filed in complete form.

22          **“SEC. 704. ELIGIBILITY REQUIREMENTS.**

23                 “(a) APPLICATION FOR EXEMPTION.—

24                         “(1) IN GENERAL.—An exemption may be  
25                         granted by the Secretary under this part only on the

1 basis of an application filed with the Secretary in  
2 such form and manner as shall be prescribed in reg-  
3 ulations of the Secretary. Any such application shall  
4 be signed by the operating committee and the spon-  
5 sor of the arrangement.

6 “(2) FILING FEE.—The arrangement shall pay  
7 to the Secretary at the time of filing an application  
8 under this section a filing fee in the amount of  
9 \$5,000, which shall be available, to the extent pro-  
10 vided in appropriation Acts, to the Secretary for the  
11 sole purpose of administering the exemption proce-  
12 dures under this part.

13 “(3) INFORMATION INCLUDED.—An application  
14 filed under this section shall include, in a manner  
15 and form prescribed in regulations of the Secretary,  
16 at least the following information:

17 “(A) IDENTIFYING INFORMATION.—The  
18 names and addresses of—

19 “(i) the sponsor, and

20 “(ii) the members of the operating  
21 committee of the arrangement.

22 “(B) STATES IN WHICH ARRANGEMENT IN-  
23 TENDS TO DO BUSINESS.—The States in which  
24 individuals covered under the arrangement are

1 to be located and the number of such individ-  
2 uals expected to be located in each such State.

3 “(C) BONDING REQUIREMENTS.—Evidence  
4 provided by the operating committee that the  
5 bonding requirements of section 412 will be met  
6 as of the date of the application.

7 “(D) PLAN DOCUMENTS.—A copy of the  
8 documents governing the arrangement (includ-  
9 ing any bylaws and trust agreements), the sum-  
10 mary plan description, and other material de-  
11 scribing the benefits and coverage that will be  
12 provided to individuals covered under the ar-  
13 rangement.

14 “(E) AGREEMENTS WITH SERVICE PROVID-  
15 ERS.—A copy of any agreements between the  
16 arrangement and contract administrators and  
17 other service providers.

18 “(F) FUNDING REPORT.—A report setting  
19 forth information determined as of a date with-  
20 in the 120-day period ending with the date of  
21 the application, including the following:

22 “(i) RESERVES.—A statement, cer-  
23 tified by the operating committee of the ar-  
24 rangement, and a statement of actuarial  
25 opinion, signed by a qualified actuary, that

1 all applicable requirements of section 707  
2 are or will be met in accordance with regu-  
3 lations which the Secretary shall prescribe.

4 “(ii) ADEQUACY OF CONTRIBUTION  
5 RATES.—A statement of actuarial opinion,  
6 signed by a qualified actuary, which sets  
7 forth a description of the extent to which  
8 contribution rates are adequate to provide  
9 for the payment of all obligations and the  
10 maintenance of required reserves under the  
11 arrangement for the 12-month period be-  
12 ginning with such date within such 120-  
13 day period, taking into account the ex-  
14 pected coverage and experience of the ar-  
15 rangement. If the contribution rates are  
16 not fully adequate, the statement of actu-  
17 arial opinion shall indicate the extent to  
18 which the rates are inadequate and the  
19 changes needed to ensure adequacy.

20 “(iii) CURRENT AND PROJECTED  
21 VALUE OF ASSETS AND LIABILITIES.—A  
22 statement of actuarial opinion signed by a  
23 qualified actuary, which sets forth the cur-  
24 rent value of the assets and liabilities accu-  
25 mulated under the arrangement and a pro-

1           jection of the assets, liabilities, income,  
2           and expenses of the arrangement for the  
3           12-month period referred to in clause (ii).  
4           The income statement shall identify sepa-  
5           rately the arrangement’s administrative ex-  
6           penses and claims.

7           “(iv) COSTS OF COVERAGE TO BE  
8           CHARGED AND OTHER EXPENSES.—A  
9           statement of the costs of coverage to be  
10          charged, including an itemization of  
11          amounts for administration, reserves, and  
12          other expenses associated with the oper-  
13          ation of the arrangement.

14          “(v) OTHER INFORMATION.—Any  
15          other information which may be prescribed  
16          in regulations of the Secretary as nec-  
17          essary to carry out the purposes of this  
18          part.

19          “(b) OTHER REQUIREMENTS.—A complete applica-  
20          tion for an exemption under this part shall include infor-  
21          mation which the Secretary determines to be complete and  
22          accurate and sufficient to demonstrate that the following  
23          requirements are met with respect to the arrangement:

24                 “(1) SPONSOR.—

1           “(A) IN GENERAL.—Except in a case to  
2           which subparagraph (B) or (C) applies, the  
3           sponsor is, and has been (together with its im-  
4           mediate predecessor, if any) for a continuous  
5           period of not less than 3 years before the date  
6           of the application, organized and maintained in  
7           good faith, with a constitution and bylaws spe-  
8           cifically stating its purpose, as a trade associa-  
9           tion, an industry association, a professional as-  
10          sociation, or a chamber of commerce (or similar  
11          business group, including a corporation or simi-  
12          lar organization that operates on a cooperative  
13          basis (within the meaning of section 1381 of  
14          the Internal Revenue Code of 1986)), for sub-  
15          stantial purposes other than that of obtaining  
16          or providing medical care (referred to in section  
17          3(42)), and the applicant demonstrates to the  
18          satisfaction of the Secretary that the sponsor is  
19          established as a permanent entity which re-  
20          ceives the active support of its members.

21          “(B) SPECIAL RULE FOR PROVIDER  
22          HEALTH NETWORKS.—In the case of an ar-  
23          rangement that is a provider health network (as  
24          defined in section 701(10)), the sponsor is the  
25          operating committee of the network.

1           “(C) SPECIAL RULE FOR EMPLOYERS IN  
2 THE SAME TRADE OR BUSINESS.—In the case  
3 of an arrangement under which all participating  
4 employers are engaged in a common type of  
5 trade or business, the sponsor is the operating  
6 committee of the arrangement.

7           “(2) OPERATING COMMITTEE.—

8           “(A) IN GENERAL.—Except as provided in  
9 subparagraph (B), the arrangement is operated,  
10 pursuant to a trust agreement, by an operating  
11 committee which has complete fiscal control  
12 over the arrangement and which is responsible  
13 for all operations of the arrangement, and the  
14 operating committee has in effect rules of oper-  
15 ation and financial controls, based on a 3-year  
16 plan of operation, adequate to carry out the  
17 terms of the arrangement and to meet all re-  
18 quirements of this title applicable to the ar-  
19 rangement. The members of the committee are  
20 individuals selected from individuals who are  
21 the owners, officers, directors, or employees of  
22 the participating employers or who are partners  
23 in the participating employers and actively par-  
24 ticipate in the business. No such member is an  
25 owner, officer, director, or employee of, or part-

1           ner in, a contract administrator or other service  
2           provider to the arrangement, except that offi-  
3           cers or employees of a sponsor which is a serv-  
4           ice provider (other than a contract adminis-  
5           trator) to the arrangement may be members of  
6           the committee if they constitute not more than  
7           25 percent of the membership of the committee  
8           and they do not provide services to the arrange-  
9           ment other than on behalf of the sponsor. The  
10          committee has sole authority to approve appli-  
11          cations for participation in the arrangement  
12          and to contract with a service provider to ad-  
13          minister the day-to-day affairs of the arrange-  
14          ment.

15               “(B) SPECIAL RULE FOR PROVIDER  
16          HEALTH NETWORKS.—In the case of an ar-  
17          rangement that is a provider health network (as  
18          defined in section 701(10)), the operating com-  
19          mittee is the board of the entity that is the net-  
20          work.

21               “(3) CONTENTS OF GOVERNING INSTRU-  
22          MENTS.—The instruments governing the arrange-  
23          ment include a written instrument, meeting the re-  
24          quirements of an instrument required under section  
25          402(a)(1), which—

1           “(A) provides that the committee serves as  
2 the named fiduciary required for plans under  
3 section 402(a)(1) and serves in the capacity of  
4 a plan administrator (referred to in section  
5 3(16)(A)),

6           “(B) provides that the sponsor is to serve  
7 as plan sponsor (referred to in section  
8 3(16)(B)),

9           “(C) incorporates the requirements of sec-  
10 tion 707, and

11           “(D) provides that, effective upon the  
12 granting of an exemption under this part to the  
13 arrangement (except in the case of a provider  
14 health network)—

15           “(i) all participating employers must  
16 be members or affiliated members of the  
17 sponsor, except that, in the case of a spon-  
18 sor which is a professional association or  
19 other individual-based association, if at  
20 least one of the officers, directors, or em-  
21 ployees of an employer, or at least one of  
22 the individuals who are partners in an em-  
23 ployer and who actively participates in the  
24 business, is a member or affiliated member

1 of the sponsor, participating employers  
2 may also include such employer, and

3 “(ii) all individuals thereafter com-  
4 mencing coverage under the arrangement  
5 must be—

6 “(I) active or retired owners (in-  
7 cluding self-employed individuals), of-  
8 ficers, directors, or employees of, or  
9 partners in, participating employers,  
10 or

11 “(II) the beneficiaries of individ-  
12 uals described in subclause (I).

13 “(4) CONTRIBUTION RATES.—The contribution  
14 rates referred to in subsection (a)(3)(F)(ii) are ade-  
15 quate.

16 “(5) VARIATION IN CONTRIBUTIONS.—The con-  
17 tribution rates established under the arrangement do  
18 not vary except by age, geographic area, family  
19 class, and benefit design in a manner provided under  
20 such regulations as the Secretary may prescribe con-  
21 sistent with subparagraphs (A), (B), (C), and (D) of  
22 section 834(a)(1).

23 “(6) REGULATORY REQUIREMENTS.—Such  
24 other requirements as the Secretary may prescribe

1 by regulation as necessary to carry out the purposes  
2 of this part.

3 “(c) TREATMENT OF PARTY SEEKING EXEMPTION  
4 WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

5 “(1) IN GENERAL.—In the case of any applica-  
6 tion for an exemption under this part with respect  
7 to a multiple employer welfare arrangement, if the  
8 Secretary determines that the sponsor of the ar-  
9 rangement or any other person associated with the  
10 arrangement is subject to disqualification under  
11 paragraph (2), the Secretary may deny the exemp-  
12 tion with respect to such arrangement.

13 “(2) DISQUALIFICATION.—A person is subject  
14 to disqualification under this paragraph if such per-  
15 son—

16 “(A) has intentionally made a material  
17 misstatement in the application for exemption;

18 “(B) has obtained or attempted to obtain  
19 an exemption under this part through misrepre-  
20 sentation or fraud;

21 “(C) has misappropriated or converted to  
22 such person’s own use, or improperly withheld,  
23 money held under a plan or any multiple em-  
24 ployer welfare arrangement;

1           “(D) is prohibited (or would be prohibited  
2           if the arrangement were a plan) from serving in  
3           any capacity in connection with the arrange-  
4           ment under section 411,

5           “(E) has failed to appear without reason-  
6           able cause or excuse in response to a subpoena,  
7           examination, warrant, or any other order law-  
8           fully issued by the Secretary compelling such  
9           response,

10          “(F) has previously been subject to a de-  
11          termination under this part resulting in the de-  
12          nial, suspension, or revocation of an exemption  
13          under this part on similar grounds, or

14          “(G) has otherwise violated any provision  
15          of this title with respect to a matter which the  
16          Secretary determines of sufficient consequence  
17          to merit disqualification for purposes of this  
18          part.

19          “(d) FRANCHISE NETWORKS.—In the case of a mul-  
20          tiple employer welfare arrangement established and main-  
21          tained by a franchisor for a franchise network consisting  
22          of its franchisees, such franchisor shall be treated as the  
23          sponsor referred to in the preceding provisions of this sec-  
24          tion, such network shall be treated as an association re-  
25          ferred to in such provisions, and each franchisee shall be

1 treated as a member (of the association and the sponsor)  
2 referred to in such provisions, if all participating employ-  
3 ers are such franchisees and the requirements of sub-  
4 section (b)(1) with respect to a sponsor are met with re-  
5 spect to the network.

6 “(e) CERTAIN COLLECTIVELY BARGAINED ARRANGE-  
7 MENTS.—In applying the preceding provisions of this sec-  
8 tion in the case of a multiple employer welfare arrange-  
9 ment in existence on February 1, 1995, which would be  
10 described in section 3(40)(A)(i) but solely for the failure  
11 to meet the requirements of section 3(40)(C)(ii)—

12 “(1) paragraphs (1) and (2) of subsection (b)  
13 and subparagraphs (A), (B), and (D) of paragraph  
14 (3) of subsection (b) shall be disregarded, and

15 “(2) the joint board of trustees shall be consid-  
16 ered the operating committee of the arrangement.

17 “(f) CERTAIN ARRANGEMENTS NOT MEETING SIN-  
18 GLE EMPLOYER REQUIREMENT.—

19 “(1) IN GENERAL.—In any case in which the  
20 majority of the employees covered under a multiple  
21 employer welfare arrangement are employees of a  
22 single employer (within the meaning of clauses (i)  
23 and (ii) of section 3(40)(B)), if all other employees  
24 covered under the arrangement are employed by em-

1       employers who are related to such single employer, sub-  
2       section (b)(3)(D) shall be disregarded.

3               “(2) RELATED EMPLOYERS.—For purposes of  
4       paragraph (1), employers are ‘related’ if there is  
5       among all such employers a common ownership in-  
6       terest or a substantial commonality of business oper-  
7       ations based on common suppliers or customers.

8       **“SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO**  
9                       **EXEMPTED MULTIPLE EMPLOYER HEALTH**  
10                      **PLANS.**

11       “(a) NOTICE OF MATERIAL CHANGES.—In the case  
12       of any exempted multiple employer health plan, descrip-  
13       tions of material changes in any information which was  
14       required to be submitted with the application for the ex-  
15       emption granted under this part shall be filed in such form  
16       and manner as shall be prescribed in regulations of the  
17       Secretary. The Secretary may require by regulation prior  
18       notice of material changes with respect to specified mat-  
19       ters which might serve as the basis for suspension or rev-  
20       ocation of the exemption.

21       “(b) REPORTING REQUIREMENTS.—Under regula-  
22       tions of the Secretary, the requirements of sections 102,  
23       103, and 104 shall apply with respect to any multiple em-  
24       ployer welfare arrangement which is or has been an ex-  
25       empted multiple employer health plan in the same manner

1 and to the same extent as such requirements apply to em-  
2 ployee welfare benefit plans, irrespective of whether such  
3 exemption continues in effect. The annual report required  
4 under section 103 for any plan year in the case of any  
5 such multiple employer welfare arrangement shall also in-  
6 clude information described in section 704(a)(3)(F) with  
7 respect to the plan year and, notwithstanding section  
8 104(a)(1)(A), shall be filed not later than 90 days after  
9 the close of the plan year.

10 “(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The  
11 operating committee of each multiple employer welfare ar-  
12 rangement which is or has been an exempted multiple em-  
13 ployer health plan shall engage, on behalf of all covered  
14 individuals, a qualified actuary who shall be responsible  
15 for the preparation of the materials comprising informa-  
16 tion necessary to be submitted by a qualified actuary  
17 under this part. The qualified actuary shall utilize such  
18 assumptions and techniques as are necessary to enable  
19 such actuary to form an opinion as to whether the con-  
20 tents of the matters reported under this part—

21 “(1) are in the aggregate reasonably related to  
22 the experience of the arrangement and to reasonable  
23 expectations, and

24 “(2) represent such actuary’s best estimate of  
25 anticipated experience under the arrangement.

1 The opinion by the qualified actuary shall be made with  
2 respect to, and shall be made a part of, the annual report.

3 “(d) FILING NOTICE OF EXEMPTION WITH  
4 STATES.—An exemption granted to a multiple employer  
5 welfare arrangement under this part shall not be effective  
6 unless written notice of such exemption is filed with the  
7 State insurance commissioner of each State in which at  
8 least 5 percent of the individuals covered under the ar-  
9 rangement are located. For purposes of this paragraph,  
10 an individual shall be considered to be located in the State  
11 in which a known address of such individual is located or  
12 in which such individual is employed. The Secretary may  
13 by regulation provide in specified cases for the application  
14 of the preceding sentence with lesser percentages in lieu  
15 of such 5 percent amount.

16 **“SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY**  
17 **ARRANGEMENTS PROVIDING MEDICAL CARE.**

18 “(a) IN GENERAL.—A multiple employer welfare ar-  
19 rangement providing benefits consisting of medical care  
20 (referred to in section 3(42)) shall issue to each participat-  
21 ing employer—

22 “(1) a document equivalent to the summary  
23 plan description required of plans under part 1,

24 “(2) information describing the contribution  
25 rates applicable to participating employers, and

1 “(3) a statement indicating—

2 “(A) that the arrangement is not a li-  
3 censed insurer under the laws of any State,

4 “(B) whether coverage under the arrange-  
5 ment is fully insured,

6 “(C) if coverage under the arrangement is  
7 not fully insured, (i) whether the arrangement  
8 is (or has ceased to be) an exempted multiple  
9 employer health plan, and (ii) if such an ar-  
10 rangement is an exempted multiple employer  
11 health plan, that such arrangement is treated  
12 as an employee welfare benefit plan under this  
13 title.

14 “(b) TIME FOR DISCLOSURE.—Such information  
15 shall be issued to employers within such reasonable period  
16 of time before becoming participating employers as may  
17 be prescribed in regulations of the Secretary.

18 **“SEC. 707. MAINTENANCE OF RESERVES.**

19 “(a) IN GENERAL.—Each multiple employer welfare  
20 arrangement which is or has been an exempted multiple  
21 employer health plan and under which coverage is not fully  
22 insured shall establish and maintain reserves, consisting  
23 of—

24 “(1) a reserve sufficient for unearned contribu-  
25 tions,

1           “(2) a reserve sufficient for payment of claims  
2           reported and not yet paid and claims incurred but  
3           not yet reported, and for expected administrative  
4           costs with respect to such claims, and

5           “(3) a reserve, in an amount recommended by  
6           the qualified actuary, for any other obligations of  
7           the arrangement.

8           “(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—  
9           The total of the reserves described in subsection (a)(2)  
10          shall not be less than an amount equal to the greater of  
11          (1) 25 percent of expected incurred claims and expenses  
12          for the plan year, or (2) \$100,000.

13          “(c) REQUIRED MARGIN.—In determining the  
14          amounts of reserves required under this section in connec-  
15          tion with any multiple employer welfare arrangement, the  
16          qualified actuary shall include a margin for error and  
17          other fluctuations taking into account the specific cir-  
18          cumstances of such arrangement.

19          “(d) ADDITIONAL REQUIREMENTS.—The Secretary  
20          may provide such additional requirements relating to re-  
21          serves and excess/stop loss coverage as the Secretary con-  
22          siders appropriate. Such requirements may be provided,  
23          by regulation or otherwise, with respect to any arrange-  
24          ment or any class of arrangements.





1 files the committee, the committee shall immediately notify  
2 the qualified actuary engaged by the arrangement, and  
3 such actuary shall, not later than the end of the next fol-  
4 lowing month, make such recommendations to the commit-  
5 tee for corrective action as the actuary determines nec-  
6 essary to ensure compliance with section 707. Not later  
7 than 10 days after receiving from the actuary rec-  
8 ommendations for corrective actions, the committee shall  
9 notify the Secretary (in such form and manner as the Sec-  
10 retary may prescribe by regulation) of such recommenda-  
11 tions of the actuary for corrective action, together with  
12 a description of the actions (if any) that the committee  
13 has taken or plans to take in response to such rec-  
14 ommendations. The committee shall thereafter report to  
15 the Secretary, in such form and frequency as the Sec-  
16 retary may specify to the committee, regarding corrective  
17 action taken by the committee until the requirements of  
18 section 707 are met.

19       “(b) MANDATORY TERMINATION.—In any case in  
20 which—

21               “(1) the Secretary has been notified under sub-  
22               section (a) of a failure of a multiple employer wel-  
23               fare arrangement which is or has been an exempted  
24               multiple employer health plan to meet the require-  
25               ments of section 707 and has not been notified by

1 the operating committee of the arrangement that  
2 corrective action has restored compliance with such  
3 requirements, and

4 “(2) the Secretary determines that the continu-  
5 ing failure to meet the requirements of section 707  
6 can be reasonably expected to result in a continuing  
7 failure to pay benefits for which the arrangement is  
8 obligated,

9 the operating committee of the arrangement shall, at the  
10 direction of the Secretary, terminate the arrangement and,  
11 in the course of the termination, take such actions as the  
12 Secretary may require as necessary to ensure that the af-  
13 fairs of the arrangement will be, to the maximum extent  
14 possible, wound up in a manner which will result in timely  
15 payment of all benefits for which the arrangement is obli-  
16 gated.

17 **“SEC. 710. EXPIRATION, SUSPENSION, OR REVOCATION OF**  
18 **EXEMPTION.**

19 “(a) EXPIRATION AND RENEWAL OF EXEMPTION.—  
20 An exemption granted to a multiple employer welfare ar-  
21 rangement under this part shall expire 3 years after the  
22 date on which the exemption is granted. An exemption  
23 which has expired may be renewed by means of application  
24 for an exemption in accordance with section 704.

1       “(b) SUSPENSION OR REVOCATION OF EXEMPTION  
2 BY SECRETARY.—The Secretary may suspend or revoke  
3 an exemption granted to a multiple employer welfare ar-  
4 rangement under this part—

5               “(1) for any cause that may serve as the basis  
6 for the denial of an initial application for such an  
7 exemption under section 704, or

8               “(2) if the Secretary finds that—

9                       “(A) the arrangement, or the sponsor  
10 thereof, in the transaction of business while  
11 under the exemption, has used fraudulent, coer-  
12 cive, or dishonest practices, or has dem-  
13 onstrated incompetence, untrustworthiness, or  
14 financial irresponsibility,

15                       “(B) the arrangement, or the sponsor  
16 thereof, is using such methods or practices in  
17 the conduct of its operations, so as to render its  
18 further transaction of operations hazardous or  
19 injurious to participating employers, or covered  
20 individuals,

21                       “(C) the arrangement, or the sponsor  
22 thereof, has refused to be examined in accord-  
23 ance with this part or to produce its accounts,  
24 records, and files for examination in accordance  
25 with this part, or

1           “(D) any of the officers of the arrange-  
2           ment, or the sponsor thereof, has refused to  
3           give information with respect to the affairs of  
4           the arrangement or the sponsor or to perform  
5           any other legal obligation relating to such an  
6           examination when required by the Secretary in  
7           accordance with this part.

8 Any such suspension or revocation under this subsection  
9 shall be effective only upon a final decision of the Sec-  
10 retary made after notice and opportunity for a hearing  
11 is provided in accordance with section 710.

12           “(c) SUSPENSION OR REVOCATION OF EXEMPTION  
13 UNDER COURT PROCEEDINGS.—An exemption granted to  
14 a multiple employer welfare arrangement under this part  
15 may be suspended or revoked by a court of competent ju-  
16 risdiction in an action by the Secretary brought under  
17 paragraph (2), (5), or (6) of section 502(a), except that  
18 the suspension or revocation under this subsection shall  
19 be effective only upon notification of the Secretary of such  
20 suspension or revocation.

21           “(d) NOTIFICATION OF PARTICIPATING EMPLOY-  
22 ERS.—All participating employers in a multiple employer  
23 welfare arrangement shall be notified of the expiration,  
24 suspension, or revocation of an exemption granted to such  
25 arrangement under this part, by such persons and in such

1 form and manner as shall be prescribed in regulations of  
2 the Secretary, not later than 20 days after such expiration  
3 or after receipt of notice of a final decision requiring such  
4 suspension or revocation.

5 “(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS,  
6 AND REVOCATIONS.—The Secretary shall publish all expi-  
7 rations of, and all final decisions to suspend or revoke,  
8 exemptions granted under this part.

9 **“SEC. 711. REVIEW OF ACTIONS OF THE SECRETARY.**

10 “(a) IN GENERAL.—Any decision by the Secretary  
11 which involves the denial of an application by a multiple  
12 employer welfare arrangement for an exemption under this  
13 part or the suspension or revocation of such an exemption  
14 shall contain a statement of the specific reason or reasons  
15 supporting the Secretary’s action, including reference to  
16 the specific terms of the exemption and the statutory pro-  
17 vision or provisions relevant to the determination.

18 “(b) DENIALS OF APPLICATIONS.—In the case of the  
19 denial of an application for an exemption under this part,  
20 the Secretary shall send a copy of the decision to the appli-  
21 cant by certified or registered mail at the address specified  
22 in the records of the Secretary. Such decision shall con-  
23 stitute the final decision of the Secretary unless the ar-  
24 rangement, or any party that would be prejudiced by the  
25 decision, files a written appeal of the denial within 30 days

1 after the mailing of such decision. The Secretary may af-  
2 firm, modify, or reverse the initial decision. The decision  
3 on appeal shall become final upon the mailing of a copy  
4 by certified or registered mail to the arrangement or party  
5 that filed the appeal.

6 “(c) SUSPENSIONS OR REVOCATIONS OF EXEMP-  
7 TION.—In the case of the suspension or revocation of an  
8 exemption granted under this part, the Secretary shall  
9 send a copy of the decision to the arrangement by certified  
10 or registered mail at its address, as specified in the  
11 records of the Secretary. Upon the request of the arrange-  
12 ment, or any party that would be prejudiced by the sus-  
13 pension or revocation, filed within 15 days of the mailing  
14 of the Secretary’s decision, the Secretary shall schedule  
15 a hearing on such decision by written notice, sent by cer-  
16 tified or registered mail to the arrangement or party re-  
17 questing such hearing. Such notice shall set forth—

18 “(1) a specific date and time for the hearing,  
19 which shall be within the 10-day period commencing  
20 20 days after the date of the mailing of the notice,  
21 and

22 “(2) a specific place for the hearing, which shall  
23 be in the District of Columbia or in the State and  
24 county thereof (or parish or other similar political

1 subdivision thereof) in which is located the arrange-  
2 ment's principal place of business.

3 The decision as affirmed or modified in such hearing shall  
4 constitute the final decision of the Secretary, unless such  
5 decision is reversed in such hearing.”.

6 (b) CONFORMING AMENDMENT TO DEFINITION OF  
7 PLAN SPONSOR.—Section 3(16)(B) of such Act (29  
8 U.S.C. 1002(16)(B)) is amended by adding at the end the  
9 following new sentence: “Such term also includes the spon-  
10 sor (as defined in section 701(5)) of a multiple employer  
11 welfare arrangement which is or has been an exempted  
12 multiple employer health plan (as defined in section  
13 701(9)).”.

14 (c) ALTERNATIVE MEANS OF DISTRIBUTION OF  
15 SUMMARY PLAN DESCRIPTIONS.—Section 110 of such  
16 Act (29 U.S.C. 1030) is amended by adding at the end  
17 the following new subsection:

18 “(c) The Secretary shall prescribe, as an alternative  
19 method for distributing summary plan descriptions in  
20 order to meet the requirements of section 104(b)(1) in the  
21 case of multiple employer welfare arrangements providing  
22 benefits consisting of medical care referred to in section  
23 3(42), a means of distribution of such descriptions by par-  
24 ticipating employers.”.

1 (d) CLERICAL AMENDMENT.—The table of contents  
 2 in section 1 of the Employee Retirement Income Security  
 3 Act of 1974 is amended by inserting after the item relat-  
 4 ing to section 608 the following new items:

“PART 7—MULTIPLE EMPLOYER HEALTH PLANS

“Sec. 701. Definitions.

“Sec. 702. Exempted multiple employer health plans relieved of certain restric-  
 tions on preemption of State law and treated as employee wel-  
 fare benefit plans.

“Sec. 703. Exemption procedure.

“Sec. 704. Eligibility requirements.

“Sec. 705. Additional requirements applicable to exempted multiple employer  
 health plans.

“Sec. 706. Disclosure to participating employers by arrangements providing  
 medical care.

“Sec. 707. Maintenance of reserves.

“Sec. 708. Notice requirements for voluntary termination.

“Sec. 709. Corrective actions and mandatory termination.

“Sec. 710. Expiration, suspension, or revocation of exemption.

“Sec. 711. Review of actions of the Secretary.”

5 **SEC. 1203. CLARIFICATION OF SCOPE OF PREEMPTION**  
 6 **RULES.**

7 (a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the  
 8 Employee Retirement Income Security Act of 1974 (29  
 9 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting “, but  
 10 only, in the case of an arrangement which provides medi-  
 11 cal care referred to in section 3(42) and with respect to  
 12 which an exemption under part 7 is not in effect,” before  
 13 “to the extent not inconsistent with the preceding sections  
 14 of this title”.

15 (b) CROSS-REFERENCE.—Section 514(b)(6) of such  
 16 Act (29 U.S.C. 1144(b)(6)) is amended by adding at the  
 17 end the following new subparagraph:

1 “(E) For additional rules relating to exemption from  
2 subparagraph (A)(ii) of multiple employer welfare ar-  
3 rangements providing medical care, see part 7.”.

4 (c) CONFORMING AMENDMENT.—Section 514 of such  
5 Act is amended by adding at the end the following new  
6 subsection:

7 “(e) For additional provisions relating to preemption  
8 of State law with respect to group health plans, see sec-  
9 tions 702, 823, 837, 841, 842, and 843.”.

10 **SEC. 1204. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
11 **PLOYER ARRANGEMENTS.**

12 Section 3(40)(B) of the Employee Retirement Income  
13 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-  
14 ed—

15 (1) in clause (i), by inserting “for any plan year  
16 of any such plan, or any fiscal year of any such  
17 other arrangement,” after “single employer”, and by  
18 inserting “during such year or at any time during  
19 the preceding 1-year period” after “common con-  
20 trol”;

21 (2) in clause (iii)—

22 (A) by striking “common control shall not  
23 be based on an interest of less than 25 percent”  
24 and inserting “an interest of greater than 25

1           percent may not be required as the minimum  
2           interest necessary for common control”;

3                   (B) by striking “similar to” and inserting  
4           “consistent and coextensive with”; and

5                   (C) by striking “and” at the end;

6           (3) by redesignating clause (iv) as clause (v);

7           and

8                   (4) by inserting after clause (iii) the following  
9           new clause:

10           “(iv) in determining, after the application of  
11           clause (i), whether benefits are provided to employ-  
12           ees of two or more employers, the arrangement shall  
13           be treated as having only 1 participating employer  
14           if, after the application of clause (i), the number of  
15           individuals who are employees and former employees  
16           of any one participating employer and who are cov-  
17           ered under the arrangement is greater than 85 per-  
18           cent of the aggregate number of all individuals who  
19           are employees or former employees of participating  
20           employers and who are covered under the arrange-  
21           ment.”.

1 **SEC. 1205. CLARIFICATION OF TREATMENT OF CERTAIN**  
2 **COLLECTIVELY BARGAINED ARRANGE-**  
3 **MENTS.**

4 (a) **IN GENERAL.**—Section 3(40)(A)(i) of the Em-  
5 ployee Retirement Income Security Act of 1974 (29  
6 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

7 “(i) under or pursuant to one or more collective  
8 bargaining agreements,”.

9 (b) **LIMITATIONS.**—Section 3(40) of such Act (29  
10 U.S.C. 1002(40)) is amended by adding at the end the  
11 following new subparagraphs:

12 “(C) Clause (i) of subparagraph (A) shall  
13 apply in the case of any plan or other arrange-  
14 ment only if—

15 “(i) the plan or other arrangement,  
16 and the employee organization or any other  
17 entity sponsoring the plan or other ar-  
18 rangement, do not—

19 “(I) utilize the services of any li-  
20 censed insurance agent or broker for  
21 soliciting or enrolling employers or in-  
22 dividuals as participating employers or  
23 covered individuals under the plan or  
24 other arrangement, or

25 “(II) pay a commission or any  
26 other type of compensation to a per-

1 son that is related either to the vol-  
2 ume or number of employers or indi-  
3 viduals solicited or enrolled as partici-  
4 pating employers or covered individ-  
5 uals under the plan or other arrange-  
6 ment, or to the dollar amount or size  
7 of the contributions made by partici-  
8 pating employers or covered individ-  
9 uals to the plan or other arrangement,

10 “(ii) covered individuals under the  
11 plan or other arrangement who are nei-  
12 ther—

13 “(I) employed within a bargain-  
14 ing unit covered by any of the collec-  
15 tive bargaining agreements with a  
16 participating employer (nor covered  
17 on the basis of an individual’s employ-  
18 ment in such a bargaining unit), nor

19 “(II) present or former employ-  
20 ees of the sponsoring employee organi-  
21 zation, of an employer who is or was  
22 a party to any of the collective bar-  
23 gaining agreements, or of the plan or  
24 other arrangement or a related plan  
25 or arrangement (nor covered on the

1           basis of such present or former em-  
2           ployment),  
3           comprise not more than the lesser of 15  
4           percent of the total number of present and  
5           former employees enrolled under the plan  
6           or other arrangement, or the total number  
7           of such covered individuals under the plan  
8           or other arrangement as of the date of the  
9           enactment of the ERISA Targeted Health  
10          Insurance Reform Act of 1995,

11           “(iii) the plan or other arrangement  
12          does not provide benefits to individuals  
13          (other than individuals described in clause  
14          (ii)(II)) who work outside the standard  
15          metropolitan statistical area in which the  
16          sponsoring employee organization rep-  
17          resents employees (or to individuals (other  
18          than individuals described in clause  
19          (ii)(II)) on the basis of such work by oth-  
20          ers), except that in the case of a sponsor-  
21          ing employee organization that represents  
22          employees who work outside of any stand-  
23          ard metropolitan statistical area, this  
24          clause shall be applied by reference to the

1 State in which the sponsoring organization  
2 represents employees,

3 “(iv) the employee organization or  
4 other entity sponsoring the plan or other  
5 arrangement certifies to the Secretary each  
6 year, in a form and manner which shall be  
7 prescribed in regulations of the Sec-  
8 retary—

9 “(I) that the plan or other ar-  
10 rangement meets the requirements of  
11 clauses (i), (ii), and (iii), and

12 “(II) if, for any year, 10 percent  
13 or more of the covered individuals  
14 under the plan are individuals not de-  
15 scribed in subclause (I) or (II) of  
16 clause (ii), the total number of cov-  
17 ered individuals and the total number  
18 of covered individuals not so de-  
19 scribed,

20 “(v) in the case of a plan or other ar-  
21 rangement which is not fully insured (as  
22 defined in section 701(8))—

23 “(I) the plan or arrangement is a  
24 multiemployer plan, and

1                   “(II) the requirements of clause  
2                   (B) of the proviso to clause (5) of sec-  
3                   tion 305(c) of the National Labor Re-  
4                   lations Act (29 U.S.C. 186(c)) are  
5                   met with respect to such plan or other  
6                   arrangement, and

7                   “(vi) in the case of a plan or other ar-  
8                   rangement not in effect as of the date of  
9                   the enactment of the ERISA Targeted  
10                  Health Insurance Reform Act of 1995, the  
11                  employee organization or other entity spon-  
12                  soring the plan or arrangement—

13                  “(I) has been in existence for at  
14                  least 3 years or is affiliated with an-  
15                  other employee organization which has  
16                  been in existence for at least 3 years,  
17                  or

18                  “(II) demonstrates to the satis-  
19                  faction of the Secretary that the re-  
20                  quirements of clauses (i) through (v)  
21                  are met with respect to the plan or  
22                  other arrangement.

23                  “(D)(i) Clause (i) of subparagraph (A)  
24                  shall not apply to a plan or other arrangement  
25                  that is established or maintained pursuant to

1 one or more collective bargaining agreements  
2 which the National Labor Relations Boards de-  
3 termines to have been negotiated or otherwise  
4 agreed to in a manner or through conduct  
5 which violates section 8(a)(2) of the National  
6 Labor Relations Act (29 U.S.C. 158(a)(2)).

7 “(ii)(I) Whenever a State insurance com-  
8 missioner has reason to believe that this sub-  
9 paragraph is applicable to part or all of a plan  
10 or other arrangement, the State insurance com-  
11 missioner may file a petition with the National  
12 Labor Relations Board for a determination  
13 under clause (i), along with sworn written testi-  
14 mony supporting the petition.

15 “(II) The Board shall give any such peti-  
16 tion priority over all other petitions and cases,  
17 other than other petitions under subclause (I)  
18 or cases given priority under section 10 of the  
19 National Labor Relations Act (29 U.S.C. 160).

20 “(III) The Board shall determine, upon  
21 the petition and any response, whether, on the  
22 facts before it, the plan or other arrangement  
23 was negotiated, created, or otherwise agreed to  
24 in a manner or through conduct which violates  
25 section 8(a)(2) of the National Labor Relations

1 Act (29 U.S.C. 158(a)(2)). Such determination  
2 shall constitute a final determination for pur-  
3 poses of this subparagraph and shall be binding  
4 in all Federal or State actions with respect to  
5 the status of the plan or other arrangement  
6 under this subparagraph.

7 “(IV) A person aggrieved by the deter-  
8 mination of the Board under subclause (III)  
9 may obtain review of the determination in any  
10 United States court of appeals in the circuit in  
11 which the collective bargaining at issue oc-  
12 curred. Commencement of proceedings under  
13 this subclause shall not, unless specifically or-  
14 dered by the court, operate as a stay of any  
15 State administrative or judicial action or pro-  
16 ceeding related to the status of the plan or  
17 other arrangement, except that in no case may  
18 the court stay, before the completion of the re-  
19 view, an order which prohibits the enrollment of  
20 new individuals into coverage under a plan or  
21 arrangement.”.

22 (c) CONFORMING AMENDMENTS TO DEFINITIONS OF  
23 PARTICIPANT AND BENEFICIARY.—Section 3(7) of such  
24 Act (29 U.S.C. 1002(7)) is amended by adding at the end  
25 the following new sentence: “Such term includes an indi-

1 vidual who is a covered individual described in paragraph  
2 (40)(C)(ii).”.

3 **SEC. 1206. EMPLOYEE LEASING HEALTHCARE ARRANGE-**  
4 **MENTS.**

5 (a) EMPLOYEE LEASING HEALTHCARE ARRANGE-  
6 MENT DEFINED.—Section 3 of the Employee Retirement  
7 Income Security Act of 1974 (29 U.S.C. 1002) is amended  
8 by adding at the end the following new paragraph:

9 “(43) EMPLOYEE LEASING HEALTHCARE ARRANGE-  
10 MENT.—

11 “(A) IN GENERAL.—Subject to subparagraph  
12 (B), the term ‘employee leasing healthcare arrange-  
13 ment’ means any labor leasing arrangement, staff  
14 leasing arrangement, extended employee staffing or  
15 supply arrangement, or other arrangement under  
16 which—

17 “(i) one business or other entity (herein-  
18 after in this paragraph referred to as the ‘les-  
19 see’), under a lease or other arrangement en-  
20 tered into with any other business or other en-  
21 tity (hereinafter in this paragraph referred to  
22 as the ‘lessor’), receives from the lessor the  
23 services of individuals to be performed under  
24 such lease or other arrangement, and

1           “(ii) benefits consisting of medical care re-  
2           ferred to in section 3(42) are provided to such  
3           individuals or such individuals and their de-  
4           pendents as participants and beneficiaries.

5           “(B) EXCEPTION.—Such term does not include  
6           an arrangement described in subparagraph (A) if,  
7           under such arrangement, the lessor retains, both le-  
8           gally and in fact, a complete right of direction and  
9           control within the scope of employment over the in-  
10          dividuals whose services are supplied under such  
11          lease or other arrangement, and such individuals  
12          perform a specified function for the lessee which is  
13          separate and divisible from the primary business or  
14          operations of the lessee.”.

15          (b) TREATMENT OF EMPLOYEE LEASING  
16          HEALTHCARE ARRANGEMENTS AS MULTIPLE EMPLOYER  
17          WELFARE ARRANGEMENTS.—Section 3(40) of such Act  
18          (29 U.S.C. 1002(40)) (as amended by the preceding provi-  
19          sions of this title) is further amended by adding at the  
20          end the following new subparagraph:

21           “(E)(i) Except as provided in clause (ii), the term  
22          ‘multiple employer welfare arrangement’ includes any em-  
23          ployee leasing healthcare arrangement.

24           “(ii) An arrangement which would not, by reason of  
25          subparagraph (B), be treated as a multiple employer wel-

1 fare arrangement but for this subparagraph shall not be  
2 treated as a multiple employer welfare arrangement for  
3 any plan year solely because such arrangement is an em-  
4 ployee leasing healthcare arrangement if, as of the com-  
5 mencement of such plan year—

6 “(I) there are at least 1,000 individuals covered  
7 under the arrangement, and

8 “(II) under the lease or other arrangement re-  
9 ferred to in paragraph (43)(A)(i), the number of in-  
10 dividuals covered under the arrangement whose serv-  
11 ices are received by the lessee from the lessor con-  
12 stitute less than 15 percent of the total number of  
13 individuals covered under the arrangement.”.

14 (c) SPECIAL RULES FOR EMPLOYEE LEASING  
15 HEALTHCARE ARRANGEMENTS.—

16 (1) IN GENERAL.—Part 7 of subtitle B of title  
17 I of such Act (as added by the preceding provisions  
18 of this Act) is amended by adding at the end the fol-  
19 lowing new section:

20 **“SEC. 712. SPECIAL RULES FOR EMPLOYEE LEASING**  
21 **HEALTHCARE ARRANGEMENTS.**

22 “(a) IN GENERAL.—The requirements of paragraphs  
23 (1), (2), and (3) of section 704(b) shall be treated as satis-  
24 fied in the case of a multiple employer welfare arrange-  
25 ment that is an employee leasing healthcare arrangement

1 if the application for exemption includes information  
2 which the Secretary determines to be complete and accu-  
3 rate and sufficient to demonstrate that the following re-  
4 quirements are met with respect to the arrangement:

5           “(1) 3-YEAR TENURE.—The lessor has been in  
6 operation for not less than 3 years.

7           “(2) SOLICITATION RESTRICTIONS.—Employee  
8 leasing services provided under the arrangement are  
9 not solicited, advertised, or marketed through li-  
10 censed insurance agents or brokers acting in such  
11 capacity.

12           “(3) CREATION OF EMPLOYMENT RELATION-  
13 SHIP.—

14           “(A) DISCLOSURE STATEMENT.—Written  
15 notice is provided to each applicant for employ-  
16 ment subject to coverage under the arrange-  
17 ment, at the time of application for employment  
18 and before commencing coverage under the ar-  
19 rangement, stating that the employer is the les-  
20 sor under the arrangement.

21           “(B) INFORMED CONSENT.—Each such  
22 applicant signs a written statement consenting  
23 to the employment relationship with the lessor.

24           “(C) INFORMED RECRUITMENT OF LES-  
25 SEE’S EMPLOYEES.—In any case in which the

1 lessor offers employment to an employee of a  
2 lessee under the arrangement, the lessor in-  
3 forms each employee in writing that his or her  
4 acceptance of employment with the lessor is vol-  
5 untary and that refusal of such offer will not be  
6 deemed to be resignation from or abandonment  
7 of current employment.

8 “(4) REQUISITE EMPLOYER-EMPLOYEE RELA-  
9 TIONSHIP UNDER ARRANGEMENT.—Under the em-  
10 ployer-employee relationship with the employees of  
11 the lessor—

12 “(A) the lessor retains the ultimate author-  
13 ity to hire, terminate, and reassign such em-  
14 ployees,

15 “(B) the lessor is responsible for the pay-  
16 ment of wages, payroll-related taxes, and em-  
17 ployee benefits, without regard to payment by  
18 the lessee to the lessor for its services,

19 “(C) the lessor maintains the right of di-  
20 rection and control over its employees, except to  
21 the extent that the lessee is responsible for su-  
22 pervision of the work performed consistent with  
23 the lessee’s responsibility for its product or  
24 service, and

1           “(D) in accordance with section 301(a) of  
2           the Labor Management Relations Act, 1947 (29  
3           U.S.C. 185(a)), the lessor retains in the ab-  
4           sence of an applicable collective bargaining  
5           agreement, the right to enter into arbitration  
6           and to decide employee grievances, and

7           “(E) no owner, officer, or director of, or  
8           partner in, a lessee is an employee of the lessor,  
9           and not more than 10 percent of the individuals  
10          covered under the arrangement consist of own-  
11          ers, officers, or directors of, or partners in,  
12          such a lessee (or any combination thereof).

13          “(b) DEFINITIONS.—For purposes of this section—

14                 “(1) LESSOR.—The term ‘lessor’ means the  
15                 business or other entity from which services of indi-  
16                 viduals are obtained under an employee leasing  
17                 healthcare arrangement.

18                 “(2) LESSEE.—The term ‘lessee’ means a busi-  
19                 ness or other entity which receives the services of in-  
20                 dividuals provided under an employee leasing  
21                 healthcare arrangement.”.

22                 (2) CLERICAL AMENDMENT.—The table of con-  
23                 tents in section 1 of such Act (as amended by the  
24                 preceding provisions of this title) is further amended

1 by inserting after the item relating to section 711  
2 the following new item:

“Sec. 712. Employee leasing healthcare arrangements.”.

3 **SEC. 1207. ENFORCEMENT PROVISIONS RELATING TO MUL-**  
4 **TIPLE EMPLOYER WELFARE ARRANGEMENTS**  
5 **AND EMPLOYEE LEASING HEALTHCARE AR-**  
6 **RANGEMENTS.**

7 (a) ENFORCEMENT OF FILING REQUIREMENTS.—  
8 Section 502 of the Employee Retirement Income Security  
9 Act of 1974 (29 U.S.C. 1132) is amended—

10 (1) in subsection (a)(6), by striking “subsection  
11 (c)(2) or (i) or (l)” and inserting “paragraph (2) or  
12 (4) of subsection (c) or subsection (i) or (l)”; and

13 (2) by adding at the end of subsection (c) the  
14 following new paragraph:

15 “(4) The Secretary may assess a civil penalty against  
16 any person of up to \$1,000 a day from the date of such  
17 person’s failure or refusal to file the information required  
18 to be filed with the Secretary under section 101(e).”.

19 (b) ACTIONS BY STATES IN FEDERAL COURT.—Sec-  
20 tion 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

21 (1) in paragraph (5), by striking “or” at the  
22 end;

23 (2) in paragraph (6), by striking the period and  
24 inserting “, or”; and

25 (3) by adding at the end the following:

1           “(7) by a State official having authority under  
2           the law of such State to enforce the laws of such  
3           State regulating insurance, to enjoin any act or  
4           practice which violates any provision of part 7 which  
5           such State has the power to enforce under part 7.”.

6           (c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
7 MISREPRESENTATIONS.—Section 501 of such Act (29  
8 U.S.C. 1131) is amended—

9           (1) by inserting “(a)” after “SEC. 501.”; and

10           (2) by adding at the end the following new sub-  
11           section:

12           “(b) Any person who, either willfully or with willful  
13 blindness, falsely represents, to any employee, any employ-  
14 ee’s beneficiary, any employer, the Secretary, or any State,  
15 an arrangement established or maintained for the purpose  
16 of offering or providing any benefit described in section  
17 3(1) to employees or their beneficiaries as—

18           “(1) being an exempted multiple employer wel-  
19 fare arrangement (as defined in section 701(10)),

20           “(2) being an employee leasing healthcare ar-  
21 rangement under an exemption granted under part  
22 7,

23           “(3) having been established or maintained  
24 under or pursuant to a collective bargaining agree-  
25 ment, or

1           “(4) being a plan or arrangement with respect  
2           to which the requirements of section 3(40)(C) are  
3           met,  
4 shall, upon conviction, be imprisoned not more than five  
5 years, be fined under title 18, United States Code, or  
6 both.”.

7           (d) CEASE ACTIVITIES ORDERS.—Section 502 of  
8 such Act (29 U.S.C. 1132) is amended by adding at the  
9 end the following new subsection:

10          “(m)(1) Subject to paragraph (2), upon application  
11 by the Secretary showing the operation, promotion, or  
12 marketing of a multiple employer welfare arrangement  
13 providing benefits consisting of medical care referred to  
14 in section 3(42) that—

15           “(A) is not licensed, registered, or otherwise ap-  
16           proved under the insurance laws of the States in  
17           which the arrangement offers or provides benefits, or

18           “(B) is not operating in accordance with the  
19           terms of an exemption granted by the Secretary  
20           under part 7,

21 a district court of the United States shall enter an order  
22 requiring that the arrangement cease activities.

23          “(2) Paragraph (1) shall not apply in the case of a  
24 multiple employer welfare arrangement if the arrangement  
25 shows that—



1           (1) by redesignating subsection (e) as sub-  
2           section (f); and

3           (2) by inserting after subsection (d) the follow-  
4           ing new subsection:

5           “(e)(1) Each multiple employer welfare arrangement  
6 shall file with the Secretary a registration statement de-  
7 scribed in paragraph (2) within 60 days before commenc-  
8 ing operations (in the case of an arrangement commencing  
9 operations on or after January 1, 1998) and no later than  
10 February 15 of each year (in the case of an arrangement  
11 in operation since the beginning of such year), unless, as  
12 of the date by which such filing otherwise must be made,  
13 such arrangement provides no benefits consisting of medi-  
14 cal care referred to in section 3(42).

15          “(2) Each registration statement—

16           “(A) shall be filed in such form, and contain  
17           such information concerning the multiple employer  
18           welfare arrangement and any persons involved in its  
19           operation (including whether coverage under the ar-  
20           rangement is fully insured), as shall be provided in  
21           regulations which shall be prescribed by the Sec-  
22           retary, and

23           “(B) if coverage under the arrangement is not  
24           fully insured, shall contain a certification that copies

1 of such registration statement have been transmitted  
2 by certified mail to—

3 “(i) in the case of an arrangement which  
4 is an exempted multiple employer health plan  
5 (as defined in section 701(10)), the State insur-  
6 ance commissioner of the domicile State of such  
7 arrangement, or

8 “(ii) in the case of an arrangement which  
9 is not an exempted multiple employer health  
10 plan, the State insurance commissioner of each  
11 State in which the arrangement is located.

12 “(3) The person or persons responsible for filing the  
13 annual registration statement are—

14 “(A) the trustee or trustees so designated by  
15 the terms of the instrument under which the mul-  
16 tiple employer welfare arrangement is established or  
17 maintained, or

18 “(B) in the case of a multiple employer welfare  
19 arrangement for which the trustee or trustees can-  
20 not be identified, or upon the failure of the trustee  
21 or trustees of an arrangement to file, the person or  
22 persons actually responsible for the acquisition, dis-  
23 position, control, or management of the cash or  
24 property of the arrangement, irrespective of whether  
25 such acquisition, disposition, control, or management

1 is exercised directly by such person or persons or  
2 through an agent designated by such person or per-  
3 sons.

4 “(4) Any agreement entered into under section  
5 506(c) with a State as the primary domicile State with  
6 respect to any multiple employer welfare arrangement  
7 shall provide for simultaneous filings of reports required  
8 under this subsection with the Secretary and with the  
9 State insurance commissioner of such State.”.

10 **SEC. 1209. COOPERATION BETWEEN FEDERAL AND STATE**  
11 **AUTHORITIES.**

12 Section 506 of the Employee Retirement Income Se-  
13 curity Act of 1974 (29 U.S.C. 1136) is amended by adding  
14 at the end the following new subsection:

15 “(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE  
16 EMPLOYER WELFARE ARRANGEMENTS.—

17 “(1) STATE ENFORCEMENT.—

18 “(A) AGREEMENTS WITH STATES.—A  
19 State may enter into an agreement with the  
20 Secretary for delegation to the State of some or  
21 all of the Secretary’s authority under sections  
22 502 and 504 to enforce the provisions of part  
23 7 applicable to multiple employer welfare ar-  
24 rangements which are or have been exempted  
25 multiple employer health plans (as defined in

1 section 701(10)). The Secretary shall enter into  
2 the agreement if the Secretary determines that  
3 the delegation provided for therein would not  
4 result in a lower level or quality of enforcement  
5 of the provisions of this title.

6 “(B) DELEGATIONS.—Any department,  
7 agency, or instrumentality of a State to which  
8 authority is delegated pursuant to an agree-  
9 ment entered into under this paragraph may, if  
10 authorized under State law and to the extent  
11 consistent with such agreement, exercise the  
12 powers of the Secretary under this title which  
13 relate to such authority.

14 “(C) CONCURRENT AUTHORITY OF THE  
15 SECRETARY.—If the Secretary delegates author-  
16 ity to a State in an agreement entered into  
17 under subparagraph (A), the Secretary may  
18 continue to exercise such authority concurrently  
19 with the State.

20 “(D) RECOGNITION OF PRIMARY DOMICILE  
21 STATE.—In entering into any agreement with a  
22 State under subparagraph (A), the Secretary  
23 shall ensure that, as a result of such agreement  
24 and all other agreements entered into under  
25 subparagraph (A), only one State will be recog-

1 nized, with respect to any particular multiple  
2 employer welfare arrangement, as the primary  
3 domicile State to which authority has been dele-  
4 gated pursuant to such agreements.

5 “(2) ASSISTANCE TO STATES.—The Secretary  
6 shall—

7 “(A) provide enforcement assistance to the  
8 States with respect to multiple employer welfare  
9 arrangements, including, but not limited to, co-  
10 ordinating Federal and State efforts through  
11 the establishment of cooperative agreements  
12 with appropriate State agencies under which  
13 the Pension and Welfare Benefits Administra-  
14 tion keeps the States informed of the status of  
15 its cases and makes available to the States in-  
16 formation obtained by it,

17 “(B) provide continuing technical assist-  
18 ance to the States with respect to issues involv-  
19 ing multiple employer welfare arrangements  
20 and this Act,

21 “(C) assist the States in obtaining from  
22 the Office of Regulations and Interpretations  
23 timely and complete responses to requests for  
24 advisory opinions on issues described in sub-  
25 paragraph (B), and

1           “(D) distribute copies of all advisory opin-  
2           ions described in subparagraph (C) to the State  
3           insurance commissioner of each State.”.

4 **SEC. 1210. CLARIFICATION OF TREATMENT OF EMPLOYER**  
5           **HEALTH COALITIONS AND HEALTH MAINTENANCE ORGANIZATIONS.**  
6

7           (a) IN GENERAL.—Section 3(40) of the Employee  
8 Retirement Income Security Act of 1974 (29 U.S.C.  
9 1002(40)) is amended—

10           (1) in subparagraph (A), by striking “or” at  
11           the end of clause (ii), by striking the period at the  
12           end of clause (iii) and inserting a comma, and by  
13           adding at the end the following new clauses:

14           “(iv) by an employer health coalition that—

15           “(I) is not an arrangement excluded under  
16           clause (i), and

17           “(II) otherwise would not be, but for the  
18           agreements described in subparagraph (B)(vi),  
19           a multiple employer welfare arrangement (as  
20           defined in the preceding provisions of this sub-  
21           paragraph), or

22           “(v) as a health maintenance organization (as  
23           defined in section 800(a)(10)(B)).”;

24           and



1 as amended by section 1202(c) of this subtitle, is amended  
2 by adding at the end the following new subsection:

3 “(d) The Secretary shall prescribe by regulation or  
4 otherwise an alternative method providing for the filing  
5 of a single annual report (as referred to in section  
6 104(a)(1)(A)) with respect to all employers who are par-  
7 ticipating employers under a multiple employer welfare ar-  
8 rangement under which all coverage consists of medical  
9 care (referred to in section 3(42)) and is fully insured (as  
10 defined in section 701(8)).”.

11 (b) EFFECTIVE DATE.—The amendment made by  
12 subsection (a) shall take effect on the date of the enact-  
13 ment of this Act. The Secretary of Labor shall prescribe  
14 the alternative method referred to in section 110(d) of the  
15 Employee Retirement Income Security Act of 1974, as  
16 added by such amendment, within 90 days after the date  
17 of the enactment of this Act.

18 **SEC. 1212. EFFECTIVE DATE; TRANSITIONAL RULES.**

19 (a) EFFECTIVE DATE.—The amendments made by  
20 this subtitle (other than sections 1210 and 1211) shall  
21 take effect January 1, 1998, except that the Secretary of  
22 Labor may issue regulations before such date under such  
23 amendments. The Secretary shall issue all regulations nec-  
24 essary to carry out the amendments made by this subtitle  
25 before the effective date thereof.

1 (b) TRANSITIONAL RULES.—If the sponsor of a mul-  
2 tiple employer welfare arrangement which, as of January  
3 1, 1998, provides benefits consisting of medical care re-  
4 ferred to in section 3(42) of the Employee Retirement In-  
5 come Security Act of 1974 (added by section 1301(b) of  
6 this Act) files with the Secretary of Labor an application  
7 for an exemption under part 7 of subtitle B of title I of  
8 such Act within 180 days after such date and the Sec-  
9 retary has not, as of 90 days after receipt of such applica-  
10 tion, found such application to be materially deficient, sec-  
11 tion 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A))  
12 shall not apply with respect to such arrangement during  
13 the 18-month period following such date. If the Secretary  
14 determines, at any time after the date of the enactment  
15 of this Act, that any such exclusion from coverage under  
16 the provisions of such section 514(b)(6)(A) of such Act  
17 of a multiple employer welfare arrangement would be det-  
18 rimental to the interests of individuals covered under such  
19 arrangement, such exclusion shall cease as of the date of  
20 the determination. Any determination made by the Sec-  
21 retary under this subsection shall be in the Secretary's  
22 sole discretion.

1 **Subtitle D—Remedies and Enforce-**  
2 **ment With Respect to Group**  
3 **Health Plans**

4 **SEC. 1301. CLAIMS PROCEDURE FOR GROUP HEALTH**  
5 **PLANS.**

6 (a) IN GENERAL.—Section 503 of the Employee Re-  
7 tirement Income Security Act of 1974 (29 U.S.C. 1133)  
8 is amended—

9 (1) by inserting “(a) IN GENERAL.—” after  
10 “SEC. 503.”; and

11 (2) by adding at the end the following new sub-  
12 section:

13 “(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

14 “(1) IN GENERAL.—In addition to meeting the  
15 requirements of subsection (a), every group health  
16 plan shall afford a reasonable opportunity to any  
17 participant or beneficiary, whose request for a  
18 preauthorization, an emergency preauthorization, a  
19 utilization review determination, or an emergency  
20 utilization review determination has been denied, for  
21 a full and fair review by the appropriate fiduciary of  
22 the decision denying the request.

23 “(2) TIME LIMITS FOR DECIDING CLAIMS.—

24 “(A) INITIAL DECISIONS.—A group health  
25 plan shall issue an initial approval or denial of

1 any claim for benefits under the terms of the  
2 plan not later than 45 days after its filing com-  
3 pletion date. Failure to approve or deny such a  
4 claim within such 45-day period shall be treated  
5 as a denial of the claim.

6 “(B) REVIEWS OF INITIAL DECISIONS.—  
7 Every review by a fiduciary required under  
8 paragraph (1) of an initial denial under sub-  
9 paragraph (A) shall be completed not later than  
10 45 days after the review filing date. Failure to  
11 issue a decision affirming, reversing, or modify-  
12 ing the initial denial shall be treated as a final  
13 decision denying the claim.

14 “(3) TIME LIMIT FOR DECIDING REQUESTS FOR  
15 PREAUTHORIZATION.—

16 “(A) GENERAL RULE.—Except as provided  
17 in subparagraph (B)—

18 “(i) INITIAL DECISIONS.—If a request  
19 for preauthorization is required under the  
20 terms of a group health plan, the plan  
21 shall approve or deny any such request not  
22 later than 45 days after its filing comple-  
23 tion date. Failure to approve or deny such  
24 a request within such 45-day period shall  
25 be treated as a denial of the request.

1           “(ii) REVIEWS OF INITIAL DECI-  
2           SIONS.—Every review by a fiduciary re-  
3           quired under paragraph (1) of an initial  
4           denial under clause (i) shall be completed  
5           not later than 45 days after the review fil-  
6           ing date. Failure to issue a decision affirm-  
7           ing, reversing, or modifying the initial de-  
8           nial within such 45-day period shall be  
9           treated as a final decision denying the re-  
10          quest.

11          “(B) REQUESTS FOR EMERGENCY  
12          PREAUTHORIZATION.—

13                 “(i) INITIAL DECISIONS.—In any case  
14                 in which a request for preauthorization re-  
15                 quired under the terms of a group health  
16                 plan is a request for emergency  
17                 preauthorization, the plan shall approve or  
18                 deny any such request not later than 10  
19                 days after its filing completion date (48  
20                 hours after such date in cases involving  
21                 emergency medical care). Failure to ap-  
22                 prove or deny such a request within such  
23                 10-day period (or 48-hour period) shall be  
24                 treated as a denial of the request.

1           “(ii) **REVIEWS OF INITIAL DECI-**  
2           **SIONS.**—Every review by a fiduciary re-  
3           quired under paragraph (1) of an initial  
4           denial under clause (i) shall be completed  
5           not later than 10 days after the review fil-  
6           ing date (48 hours after such date in cases  
7           involving emergency medical care). Failure  
8           to issue a decision affirming, reversing, or  
9           modifying the initial denial within such 10-  
10          day period (or 48-hour period) shall be  
11          treated as a final decision denying the re-  
12          quest.

13           “(4) **TIME LIMIT FOR DECIDING REQUESTS FOR**  
14          **UTILIZATION REVIEW DETERMINATIONS.**—

15           “(A) **GENERAL RULE.**—Except as provided  
16          in subparagraph (B)—

17           “(i) **INITIAL DECISIONS.**—If a request  
18          for a utilization review determination is re-  
19          quired under the terms of a group health  
20          plan, the plan shall approve or deny any  
21          such request not later than 45 days after  
22          its filing completion date. Failure to ap-  
23          prove or deny such a request within such  
24          45-day period shall be treated as a denial  
25          of the request.

1           “(ii) **REVIEWS OF INITIAL DECISIONS.**—Every review by a fiduciary re-  
2           quired under paragraph (1) of an initial  
3           denial under clause (i) shall be completed  
4           not later than 45 days after the review fil-  
5           ing date. Failure to issue a decision affirm-  
6           ing, reversing, or modifying the initial de-  
7           nial within such 45-day period shall be  
8           treated as a final decision denying the re-  
9           quest.  
10          

11          “(B) **REQUESTS FOR EMERGENCY UTILIZA-**  
12          **TION REVIEW DETERMINATIONS.**—

13                 “(i) **INITIAL DECISIONS.**—In any case  
14                 in which a request for a utilization review  
15                 determination required under the terms of  
16                 a group health plan is a request for an  
17                 emergency utilization review determination,  
18                 the plan shall approve or deny any such re-  
19                 quest not later than 10 days after its filing  
20                 completion date (48 hours after such date  
21                 in cases involving emergency medical care).  
22                 Failure to approve or deny such a request  
23                 within such 10-day period (or 48-hour pe-  
24                 riod) shall be treated as a denial of the re-  
25                 quest.

1           “(ii) REVIEWS OF INITIAL DECI-  
2           SIONS.—Every review by a fiduciary re-  
3           quired under paragraph (1) of an initial  
4           denial under clause (i) shall be completed  
5           not later than 10 days after the review fil-  
6           ing date (48 hours after such date in cases  
7           involving emergency medical care). Failure  
8           to issue a decision affirming, reversing, or  
9           modifying the initial denial within such 10-  
10          day period (or 48-hour period) shall be  
11          treated as a final decision denying the re-  
12          quest.

13           “(5) DEFINITIONS.—For purposes of this sub-  
14          section—

15           “(A) CLAIM FOR BENEFITS.—The term  
16          ‘claim for benefits’ means a request for pay-  
17          ment by a group health plan of benefits made  
18          by or on behalf of a participant or beneficiary  
19          after the expense for such benefits has been in-  
20          curred.

21           “(B) UTILIZATION REVIEW DETERMINA-  
22          TION.—The term ‘utilization review determina-  
23          tion’ means a determination under a group  
24          health plan solely that proposed medical care  
25          meets the plan’s requirements for medical ap-

1           appropriateness or necessity. Unless otherwise ex-  
2           pressly provided under the terms of the plan,  
3           any such determination shall not by itself con-  
4           stitute a guarantee that benefits under the plan  
5           will be provided.

6           “(C)    PREAUTHORIZATION.—The    term  
7           ‘preauthorization’ means a determination under  
8           a group health plan that proposed medical care  
9           meets, under the facts and circumstances at the  
10          time of the determination, the plan’s terms and  
11          conditions of coverage. Such a determination  
12          shall, except in the case of a claim involving  
13          fraud or misrepresentation, constitute a guar-  
14          antee that benefits under the plan will be pro-  
15          vided.

16          “(D)    REQUEST    FOR    PREAUTHOR-  
17          IZATION.—The    term    ‘request    for  
18          preauthorization’ means a request for  
19          preauthorization by a group health plan of med-  
20          ical care made by or on behalf of a participant  
21          or beneficiary before the expense for such medi-  
22          cal care has been incurred.

23          “(E)    REQUEST    FOR    EMERGENCY  
24          PREAUTHORIZATION.—The term ‘request for  
25          emergency preauthorization’ means a request

1 for preauthorization by a group health plan in  
2 any case in which the medical care for which  
3 the expense is to be incurred constitutes urgent  
4 medical care or emergency medical care.

5 “(F) REQUEST FOR UTILIZATION REVIEW  
6 DETERMINATION.—The term ‘request for a uti-  
7 lization review determination’ means a request  
8 by or on behalf of a participant or beneficiary,  
9 made before an expense for medical care has  
10 been incurred, for a utilization review deter-  
11 mination by a plan.

12 “(G) REQUEST FOR EMERGENCY UTILIZA-  
13 TION REVIEW DETERMINATION.—The term ‘re-  
14 quest for an emergency utilization review deter-  
15 mination’ means a request for a utilization re-  
16 view determination in any case in which the  
17 medical care to be incurred constitutes urgent  
18 medical care or emergency medical care.

19 “(H) URGENT MEDICAL CARE.—The term  
20 ‘urgent medical care’ means medical care in any  
21 case in which a physician with appropriate ex-  
22 pertise has certified in writing that failure to  
23 provide the participant or beneficiary with such  
24 medical care within 45 days will result in ei-  
25 ther—

1           “(i) the death of the participant or  
2           beneficiary within 120 days, or

3           “(ii) the immediate, serious, and irre-  
4           versible deterioration of the health of the  
5           participant or beneficiary within 120 days  
6           which will significantly increase the reason-  
7           able likelihood of death of the participant  
8           or beneficiary.

9           “(I) EMERGENCY MEDICAL CARE.—The  
10          term ‘emergency medical care’ means medical  
11          care in any case in which a physician with ap-  
12          propriate expertise has certified in writing—

13               “(i) that failure to immediately pro-  
14               vide the care to the participant or bene-  
15               ficiary could reasonably be expected to re-  
16               sult in—

17                       “(I) placing the health of such  
18                       participant or beneficiary (or, with re-  
19                       spect to such a participant or bene-  
20                       ficiary who is a pregnant woman, the  
21                       health of the woman or her unborn  
22                       child) in serious jeopardy,

23                       “(II) serious impairment to bod-  
24                       ily functions, or

1                   “(III) serious dysfunction of any  
2                   bodily organ or part,

3                   or

4                   “(ii) that immediate provision of the  
5                   care is necessary because the participant  
6                   or beneficiary has made or is at serious  
7                   risk of making an attempt to harm himself  
8                   or herself or another individual.

9                   “(J) FILING COMPLETION DATE.—The  
10                  term ‘filing completion date’ means, in connec-  
11                  tion with a group health plan, the date as of  
12                  which the plan is in receipt of all information  
13                  reasonably required to make an initial decision  
14                  to approve or deny a claim for benefits, a re-  
15                  quest for preauthorization, a request for emer-  
16                  gency preauthorization, a request for a utiliza-  
17                  tion review determination, or a request for an  
18                  emergency utilization review determination.

19                  “(K) REVIEW FILING DATE.—The term  
20                  ‘review filing date’ means, in connection with a  
21                  group health plan, the date as of which the ap-  
22                  propriate fiduciary is in receipt of all informa-  
23                  tion reasonably required to make a decision  
24                  upon a full and fair review of the denial, in  
25                  whole or in part, of a claim for benefits, a re-

1           quest for preauthorization, a request for emer-  
2           gency preauthorization, a request for a utiliza-  
3           tion review determination or a request for an  
4           emergency utilization review determination.

5           “(L) APPROPRIATE FIDUCIARY.—The term  
6           ‘appropriate fiduciary’ means, with respect to  
7           any determination under a group health plan,  
8           the fiduciary designated under section 404(e) to  
9           make such determination.

10           “(M) MEDICAL CARE.—The term ‘medical  
11           care’ means medical care referred to in section  
12           3(42)(A).”.

13           (b) DEFINITION OF GROUP HEALTH PLAN.—

14           (1) IN GENERAL.—Section 3 of such Act (29  
15           U.S.C. 1002) is amended by adding at the end the  
16           following new paragraph:

17           “(42)(A) The term ‘group health plan’ means an em-  
18           ployee welfare benefit plan providing medical care (as de-  
19           fined under regulations that are consistent and coextensive  
20           with section 213(d) of the Internal Revenue Code of 1986,  
21           as of January 1, 1995) to participants or beneficiaries di-  
22           rectly or through insurance, reimbursement, or otherwise.

23           “(B) Any plan, fund, or program which would be a  
24           group health plan (as defined in subparagraph (A)), if the  
25           term ‘employer’ in paragraph (1) included a partnership

1 and the term ‘participant’ in paragraph (1) included a  
2 partner in connection with such partnership—

3 “(i) shall be treated as a group health plan, and

4 “(ii) shall be treated as an employee welfare  
5 benefit plan.”.

6 (2) INCLUSION OF ELIGIBLE EMPLOYEE IN  
7 DEFINITION OF PARTICIPANT.—Section 3(7) of such  
8 Act (29 U.S.C. 1002(7)) is amended—

9 (A) by inserting “(A)” after “(7)”; and

10 (B) by adding at the end the following new  
11 paragraph:

12 “(B) In the case of a group health plan, such term  
13 includes an eligible employee (as defined in section  
14 800(a)(3))”.

15 (3) CONFORMING AMENDMENT.—Section 607  
16 of such Act (29 U.S.C. 1167) is amended by striking  
17 paragraph (1).

18 (c) DESIGNATION OF APPROPRIATE FIDUCIARIES.—  
19 Section 404 of such Act (29 U.S.C. 1104) is amended by  
20 adding at the end the following new subsection:

21 “(e) One or more fiduciaries shall be designated  
22 under each group health plan, in accordance with proce-  
23 dures specified under the plan, for making determinations  
24 under the plan to which section 503(b) applies.”.

1 (d) STANDARD OF REVIEW UNAFFECTED.—Nothing  
2 in this subtitle (or the amendments made thereby) shall  
3 be construed to affect the standard of review applicable  
4 under the provisions amended by this subtitle.

5 **SEC. 1302. AVAILABLE COURT REMEDIES.**

6 (a) IN GENERAL.—Section 502(c) of the Employee  
7 Retirement Income Security Act of 1974 (29 U.S.C. 1132)  
8 is amended by adding at the end the following new para-  
9 graphs:

10 “(5) In any action commenced under subsection (a)  
11 by a participant or beneficiary with respect to a group  
12 health plan in which the plaintiff alleges that a person,  
13 in the capacity of a fiduciary and in violation of the terms  
14 of the plan or this title, has taken an action resulting in  
15 a denial of a claim for benefits in violation of the terms  
16 of the plan, or has failed to take an action for which such  
17 person is responsible under the plan and which is nec-  
18 essary under the plan for approval of a claim for benefits  
19 required under the terms of the plan, upon finding in favor  
20 of the plaintiff, the court shall cause to be served on the  
21 defendant an order requiring the defendant—

22 “(A) to cease and desist from the alleged action  
23 or failure to act,

24 “(B) to remedy any such violation of the terms  
25 of the plan by such person (including any such fail-

1 ure by such person to take action necessary for ap-  
2 proval of a claim for benefits as required under the  
3 terms of the plan), and to otherwise comply with the  
4 terms of the plan and the applicable requirements of  
5 this title,

6 “(C) to pay to the plaintiff prejudgment inter-  
7 est on the claims for benefits at issue in the com-  
8 plaint which were unpaid in violation of the terms of  
9 the plan, and

10 “(D) to pay to the plaintiff a reasonable attor-  
11 ney’s fee and other reasonable costs relating to the  
12 prosecution of the action on the charges on which  
13 the plaintiff prevails.

14 The remedies provided under this paragraph shall be in  
15 addition to remedies otherwise provided under this section  
16 and shall apply only after exhaustion of the remedies avail-  
17 able under section 503.

18 “(6)(A) The Secretary may assess a civil penalty  
19 against the plan administrator of, or the appropriate fidu-  
20 ciary (as defined in section 503(b)(5)(L)) of, one or more  
21 group health plans for any pattern or practice thereof of  
22 repeated failures to provide benefits under the terms of  
23 the plan or plans without any reasonable basis or repeated  
24 violations thereby of the requirements of section 503 with  
25 respect to such plan or plans. Such penalty shall be pay-

1 able only upon proof by clear and convincing evidence of  
2 such pattern or practice.

3 “(B) Such penalty shall be in an amount not to ex-  
4 ceed the lesser of—

5 “(i) 5 percent of the aggregate value of claims  
6 shown by the Secretary to have been denied, or un-  
7 lawfully delayed in violation of section 503, under  
8 such pattern or practice, or

9 “(ii) \$100,000.

10 “(C) The plan administrator or the appropriate fidu-  
11 ciary of any group health plan or plans who has engaged  
12 in any such pattern or practice with respect to such plans,  
13 upon the petition of the Secretary, may be removed by  
14 the court from that position, and from any other involve-  
15 ment, with respect to such plan or plans, for a period of  
16 not less than 7 years.

17 “(D) For purposes of this paragraph, the phrase  
18 ‘without any reasonable basis’ means, in connection with  
19 any denial of claims for benefits under a group health  
20 plan, that such denial does not have any reasonable basis,  
21 support, or justification under—

22 “(i) the facts regarding such claim of which the  
23 plan administrator or the appropriate fiduciary was  
24 in receipt at the time the claim was denied, and

25 “(ii) the terms of the plan.”.

1 (b) CONFORMING AMENDMENT.—Section 502(a)(6)  
2 of such Act (29 U.S.C. 1132(a)(6)) is amended by insert-  
3 ing “or (c)(6)” after “(c)(2)”.

4 **SEC. 1303. EFFECTIVE DATE.**

5 The amendments made by this subtitle shall take ef-  
6 fect January 1, 1998, except that the Secretary of Labor  
7 may issue regulations before such date under such amend-  
8 ments. The Secretary shall issue all regulations necessary  
9 to carry out the amendments made by this subtitle before  
10 the effective date thereof.

11 **Subtitle E—Funding and Plan Ter-**  
12 **mination Requirements for Self-**  
13 **Insured Group Health Plans**

14 **SEC. 1401. SPECIAL RULES FOR SELF-INSURED GROUP**  
15 **HEALTH PLANS.**

16 Part 6 of subtitle B of title I of the Employee Retire-  
17 ment Income Security Act of 1974 (29 U.S.C. 1161 et  
18 seq.) is amended by adding at the end the following new  
19 sections:

20 **“SEC. 610. SPECIAL FUNDING RULES FOR SELF-INSURED**  
21 **GROUP HEALTH PLANS.**

22 “(a) SELF-INSURED GROUP HEALTH PLANS.—For  
23 purposes of this section, the term ‘self-insured group  
24 health plan’ means a group health plan under which some  
25 or all coverage is not fully insured (within the meaning

1 of section 701(8)), other than a multiple employer health  
2 plan (to which the funding requirements of section 707  
3 apply).

4 “(b) FUNDING REQUIREMENTS FOR SELF-INSURED  
5 GROUP HEALTH PLANS OF SMALL EMPLOYERS.—

6 “(1) IN GENERAL.—The Secretary shall pre-  
7 scribe by regulation provisions described in para-  
8 graph (2) applicable to self-insured group health  
9 plans which are not multiemployer plans and which  
10 offer coverage only with respect to employees of  
11 small employers (as defined in section 831(9)), for  
12 the purpose of promoting adequate funding of such  
13 plans.

14 “(2) REQUIREMENTS.—

15 “(A) GENERAL RULE.—Except as provided  
16 in subparagraph (B), the provisions described  
17 in paragraph (1) shall require the group health  
18 plan to establish and maintain reserves in an  
19 amount at least equal to the greater of—

20 “(i) a reserve sufficient for payment  
21 of claims reported and not yet paid and  
22 claims incurred but not yet reported, and  
23 for expected administrative costs with re-  
24 spect to such claims, or

1           “(ii) 25 percent of the amount of ex-  
2           pected incurred claims and expenses for  
3           the plan year.

4           “(B) EXCEPTION.—The Secretary may in  
5           such regulations permit a group health plan to  
6           substitute, for all or part of the reserves re-  
7           quired under subparagraph (A), such security,  
8           guarantee, or other financial arrangement as  
9           the Secretary determines to be adequate to en-  
10          able the plan to fully meet all its financial obli-  
11          gations on a timely basis.

12          “(3) CRITERIA FOR COMPLIANCE.—The criteria  
13          that the Secretary shall take into account in deter-  
14          mining compliance with the requirements described  
15          in paragraph (2) shall include:

16               “(A) the size of the employer involved;

17               “(B) the benefit package provided under  
18               the plan;

19               “(C) whether the coverage provided under  
20               the plan is in the form of a fee-for-service ar-  
21               rangement, a health maintenance organization,  
22               or any other type of coverage;

23               “(D) the extent to which excess/stop loss  
24               coverage (within the meaning of section 701(3))  
25               is maintained for the plan and the extent to

1           which such coverage is maintained for the plan  
2           sponsor; and

3                   “(E) the nature of any security, guarantee,  
4           or other financial arrangement described in  
5           paragraph (2)(B) obtained for the plan.

6           “(c) FUNDING REQUIREMENTS FOR PLANS SPON-  
7           SORED BY LARGE EMPLOYERS WHEN PLAN SPONSORS  
8           ARE IN DISTRESS.—

9                   “(1) NOTIFICATION OF PLAN DISTRESS.—Ex-  
10           cept as provided in paragraph (5), in the case of any  
11           self-insured group health plan (other than a multi-  
12           employer plan) which offers coverage with respect to  
13           employees of any employer who is not a small em-  
14           ployer (as defined in section 831(4)), if—

15                           “(A) a named fiduciary of such plan deter-  
16                           mines that there is reason to believe that the  
17                           plan is in distress, or

18                                   “(B) the Secretary makes such a deter-  
19                                   mination and the Secretary notifies the named  
20                                   fiduciary of such determination,

21           the named fiduciary shall immediately notify a quali-  
22           fied actuary, who shall be engaged by the plan on  
23           behalf of plan participants and beneficiaries, of such  
24           determination and such actuary shall, not later than  
25           the end of the next following month, provide to each

1 named fiduciary under the plan all information nec-  
2 essary to enable the fiduciary or fiduciaries to de-  
3 velop and implement a strategy for plan mainte-  
4 nance in accordance with paragraph (3). Not later  
5 than 10 days after the named fiduciary receives such  
6 information from the actuary, the named fiduciary  
7 shall notify the participants and beneficiaries and  
8 the Secretary (in such form and manner as the Sec-  
9 retary may prescribe by regulation) of the deter-  
10 mination that the plan had entered into distress and  
11 the reasons for such determination (including the in-  
12 formation provided by the actuary pursuant to this  
13 paragraph), and shall include in such notification a  
14 description of the strategy for plan maintenance for  
15 the plan that the plan administrator or any named  
16 fiduciary has implemented or plans to implement.

17 “(2) DISTRESS.—

18 “(A) IN GENERAL.—For purposes of this  
19 subsection, a plan is in ‘distress’ if each person  
20 who is a plan sponsor of the plan or a substan-  
21 tial member of the controlled group of the plan  
22 sponsor of the plan satisfies the distress criteria  
23 of clause (i), (ii), or (iii) of subparagraph (B).

24 “(B) SATISFACTION OF DISTRESS CRI-  
25 TERIA.—

1           “(i) INABILITY TO PAY DEBTS.—A  
2 person satisfies the distress criteria of this  
3 clause if such person breaches a material  
4 payment covenant, under any debt instru-  
5 ment, that is not cured within any grace  
6 period applicable under such covenant.

7           “(ii) LIQUIDATION IN BANKRUPTCY  
8 OR INSOLVENCY PROCEEDINGS.—A person  
9 satisfies the distress criteria of this clause  
10 if—

11                   “(I) such person has filed, or has  
12 had filed against such person, a peti-  
13 tion seeking liquidation in a case  
14 under title 11, United States Code, or  
15 under any similar law of a State or  
16 political subdivision of a State (or a  
17 case described in subparagraph (A)  
18 filed by or against such person has  
19 been converted to a case in which liq-  
20 uidation is sought), and

21                   “(II) such case has not been dis-  
22 missed.

23           “(iii) REORGANIZATION IN BANK-  
24 RUPTCY OR INSOLVENCY PROCEEDINGS.—

1           A person satisfies the distress criteria of  
2           this clause if—

3                   “(I) such person has filed, or has  
4                   had filed against such person, a peti-  
5                   tion seeking reorganization in a case  
6                   under title 11, United States Code, or  
7                   under any similar law of a State or  
8                   political subdivision of a State (or a  
9                   case described in subparagraph (B)  
10                  filed by or against such person has  
11                  been converted to such a case in  
12                  which reorganization is sought), and

13                   “(II) such case has not been dis-  
14                  missed.

15                  “(3) STRATEGY FOR PLAN MAINTENANCE.—  
16                  Any strategy for plan maintenance referred to in  
17                  paragraph (1) shall include such measures as are  
18                  necessary (as determined in accordance with such  
19                  regulations as the Secretary may prescribe) to en-  
20                  sure that, as of the end of a reasonable period of  
21                  time (determined in accordance with such regula-  
22                  tions as the Secretary may prescribe)—

23                   “(A) there is no unreasonable risk of fail-  
24                  ure by the plan to timely provide benefits under  
25                  the terms of the plan, and

1           “(B) if the plan were to then terminate,  
2           the affairs of the plan could be wound up in a  
3           manner which would result in timely provision  
4           of all benefits for which the plan is then obli-  
5           gated.

6           “(4) QUALIFIED ACTUARY.—The requirements  
7           of subsection (c) of section 705 shall apply with re-  
8           spect to self-insured group health plans for purposes  
9           of this subsection in the same manner and to the  
10          same extent as such subsection applies to multiple  
11          employer health plans under section 705.

12          “(5) ELECTION OF RESERVE REQUIREMENTS IN  
13          LIEU OF DISTRESS RULES.—In any case in which  
14          the plan sponsor of a self-insured group health plan  
15          referred to in paragraph (1) makes an election (in  
16          such form and manner as shall be prescribed in reg-  
17          ulations of the Secretary) to have subsection (b)  
18          apply with respect to the plan—

19                  “(A) the preceding paragraphs of this sub-  
20                  section shall not apply with respect to such plan  
21                  in connection with any distress, and

22                  “(B) subsection (b) shall apply with re-  
23                  spect to such plan for the period of such elec-  
24                  tion in the same manner and to the same extent

1 as subsection (b) applies to plans described in  
2 subsection (b)(1).

3 Any such election may be made before, on, or after  
4 the date on which the plan enters into such distress  
5 and shall apply for a reasonable period of time  
6 (specified in accordance with such regulations of the  
7 Secretary) in relation to such date.

8 “(d) FUNDING REQUIREMENTS FOR OVERBURDENED  
9 MULTIEMPLOYER PLANS.—

10 “(1) IN GENERAL.—If a self-insured group  
11 health plan which is a multiemployer plan is over-  
12 burdened for a plan year, then the plan sponsor  
13 shall, within a reasonable period of time after the  
14 beginning of such plan year, amend the plan, in ac-  
15 cordance with such regulations as the Secretary may  
16 prescribe, to increase required employer contribu-  
17 tions, decrease benefits, or both, to the extent nec-  
18 essary to ensure that the plan is not overburdened  
19 for the subsequent plan year.

20 “(2) DEFINITIONS.—

21 “(A) OVERBURDENED PLAN.—For pur-  
22 poses of this section, a self-insured group health  
23 plan which is a multiemployer plan is ‘overbur-  
24 dened’ for a plan year if the overburden ratio

1 for the plan for the plan year exceeds 10 per-  
2 cent.

3 “(B) OVERBURDEN RATIO.—For purposes  
4 of subparagraph (A), the term ‘overburden  
5 ratio’ for a plan for a plan year is a fraction—

6 “(i) the numerator of which is the ex-  
7 cess of—

8 “(I) the sum of expected claims  
9 reported and not yet paid as of the  
10 end of the preceding plan year, ex-  
11 pected claims incurred but not yet re-  
12 ported as of the end of the preceding  
13 plan year, expected administrative  
14 costs with respect to such claims, and  
15 the amount of expected incurred  
16 claims for the plan year, over

17 “(II) the sum of the value of  
18 plan assets of the plan as of the end  
19 of the preceding plan year, expected  
20 earnings on plan assets for the plan  
21 year (if any), and the amount of ex-  
22 pected contributions to the plan for  
23 the plan year, and

1                   “(ii) the denominator of which is the  
2                   amount of expected contributions to the  
3                   plan for the plan year.

4           “(e) CORRECTIVE ACTIONS TO AVOID DEPLETION  
5 OF RESERVES FOR SINGLE-EMPLOYER PLANS.—

6                   “(1) ANNUAL REVIEW.—In any case in which  
7                   the requirements of subsection (b) are applicable to  
8                   a self-insured group health plan, each named fidu-  
9                   ciary of such plan shall conduct an annual review of  
10                  the plan for the purpose of determining whether the  
11                  requirements of subsection (b) are met with respect  
12                  to such plan.

13                  “(2) NOTIFICATION OF FAILURE TO MEET RE-  
14                  SERVES AND REQUIRED RECOMMENDATIONS.—In  
15                  any case in which a named fiduciary of such self-in-  
16                  sured group health plan determines that there is  
17                  reason to believe that there is or will be a failure to  
18                  meet the applicable requirements referred to in para-  
19                  graph (1) with respect to such plan, or the Secretary  
20                  makes such a determination and so notifies the  
21                  named fiduciary, the named fiduciary shall imme-  
22                  diately notify a qualified actuary who shall be en-  
23                  gaged by the plan on behalf of plan participants and  
24                  beneficiaries, and such actuary shall, not later than  
25                  the end of the next following month, provide to each

1 named fiduciary under the plan all information nec-  
2 essary to enable the fiduciary or fiduciaries to take  
3 such corrective action as may be necessary to ensure  
4 compliance with such requirements.

5 “(3) CORRECTIVE ACTION.—Not later than 10  
6 days after the named fiduciary receives information  
7 from the actuary pursuant to paragraph (2), the  
8 named fiduciary shall notify the participants and  
9 beneficiaries and the Secretary (in such form and  
10 manner as the Secretary may prescribe by regula-  
11 tion) of the nature and extent of the failure referred  
12 to in paragraph (2) and the information provided by  
13 the actuary pursuant to paragraph (2), and shall in-  
14 clude in such notification a description of the actions  
15 (if any) that the plan administrator or any named  
16 fiduciary has taken or plans to take to ensure com-  
17 pliance with the applicable requirements referred to  
18 in paragraph (1). The named fiduciary shall there-  
19 after report to the Secretary, in such form and fre-  
20 quency as the Secretary may specify, regarding cor-  
21 rective action taken by the administrator or named  
22 fiduciary until the applicable requirements referred  
23 to in paragraph (1) are met.

24 “(4) QUALIFIED ACTUARY.—The requirements  
25 of subsection (c) of section 705 shall apply with re-

1 spect to self-insured group health plans for purposes  
2 of this subsection in the same manner and to the  
3 same extent as such subsection applies to multiple  
4 employer health plans under section 705.

5 “(f) CORRECTIVE ACTIONS TO AVOID DEPLETION OF  
6 RESERVES FOR MULTIEMPLOYER PLANS.—

7 “(1) ANNUAL REVIEW.—Not later than 3  
8 months after the beginning of each plan year, the  
9 plan sponsor of each self-insured group health plan  
10 which is a multiemployer plan shall conduct a review  
11 of the plan for the purpose of determining whether  
12 the plan will be overburdened for such plan year.

13 “(2) NOTIFICATION THAT PLAN WILL BE OVER-  
14 BURDENED AND REQUIRED RECOMMENDATIONS.—  
15 In any case in which the plan sponsor of such multi-  
16 employer plan determines that there is reason to be-  
17 lieve that the plan will be overburdened for a plan  
18 year, or the Secretary makes such a determination  
19 and so notifies the plan sponsor, the plan sponsor  
20 shall immediately notify a qualified actuary who  
21 shall be engaged by the plan on behalf of plan par-  
22 ticipants and beneficiaries, and such actuary shall,  
23 not later than the end of the next following month,  
24 provide to the plan sponsor all information necessary  
25 to enable the plan sponsor to take such corrective

1 action as may be necessary to ensure that the plan  
2 will not be overburdened for such plan year.

3 “(3) CORRECTIVE ACTION.—Not later than 10  
4 days after the plan sponsor receives information  
5 from the actuary pursuant to paragraph (2), the  
6 plan sponsor shall notify the participants and bene-  
7 ficiaries and the Secretary (in such form and man-  
8 ner as the Secretary may prescribe by regulation)  
9 that there is reason to believe that the plan will be  
10 overburdened for the plan year and of the extent to  
11 which the plan will be overburdened for the plan  
12 year and the information provided by the actuary  
13 pursuant to paragraph (2), and shall include in such  
14 notification a description of the actions (if any) that  
15 the plan sponsor has taken or plans to take in re-  
16 sponse to ensure that the plan will not be overbur-  
17 dened for such plan year. The plan sponsor shall  
18 thereafter report to the Secretary, in such form and  
19 frequency as the Secretary may specify, regarding  
20 corrective action taken by the plan sponsor.

21 “(4) QUALIFIED ACTUARY.—The requirements  
22 of subsection (c) of section 705 shall apply with re-  
23 spect to self-insured group health plans which are  
24 multiemployer plans for purposes of this subsection  
25 in the same manner and to the same extent as such

1 subsection applies to multiple employer health plans  
2 under section 705.

3 **“SEC. 611. TERMINATION OF SELF-INSURED GROUP**  
4 **HEALTH PLANS.**

5 “In the case of any self-insured group health plan  
6 (as defined in section 610(a))—

7 “(1) NOTICE REQUIREMENTS FOR VOLUNTARY  
8 TERMINATION.—Except as provided in paragraph  
9 (2), the plan may terminate only if, not less than 60  
10 days before the proposed termination date, the plan  
11 administrator provides to the participants and bene-  
12 ficiaries a written notice of intent to terminate stat-  
13 ing that such termination is intended and the pro-  
14 posed termination date.

15 “(2) MANDATORY TERMINATION.—In any case  
16 in which—

17 “(A) the Secretary has been notified under  
18 section 610(e)(3) of a failure of the plan to  
19 meet the applicable requirements referred to in  
20 section 610(e)(1) or has been notified under  
21 section 610(f)(3) that the plan will be overbur-  
22 dened and has not been notified by the adminis-  
23 trator or the plan within the time prescribed by  
24 the Secretary that corrective action has restored  
25 compliance with such requirements or prevented

1 the plan from being overburdened for the plan  
2 year, and

3 “(B) the Secretary directs the plan admin-  
4 istrator of the plan to terminate the plan,  
5 the administrator of the plan shall terminate the  
6 plan. In the course of the termination, the adminis-  
7 trator shall take such actions as the Secretary may  
8 require as necessary to ensure that the affairs of the  
9 plan will be, to the maximum extent possible, wound  
10 up in a manner which will result in timely provision  
11 of all benefits for which the plan is obligated.”.

12 (b) CLERICAL AMENDMENT.—The table of contents  
13 in section 1 of such Act is amended by inserting after the  
14 item relating to section 609 the following new items:

“Sec. 610. Special rules for self-insured group health plans.  
“Sec. 611. Termination of self-insured group health plans.”.

15 **SEC. 1402. EFFECTIVE DATE.**

16 Subsections (b), (c), (d), and (e) of section 610 of  
17 the Employee Retirement Income Security Act of 1974  
18 (added by section 1401) shall apply with respect to plan  
19 years beginning on or after January 1, 1998. Section 611  
20 of such Act shall apply with respect to plan terminations  
21 occurring on or after such date.

1       **Subtitle F—General Provisions**

2       **SEC. 1501. RULE OF CONSTRUCTION.**

3           Nothing in this Act or any amendment made thereby  
4 may be construed to require the coverage of any specific  
5 procedure, treatment, or service as part of a group health  
6 plan or health insurance coverage under this Act or  
7 through regulation.



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HR 995 SC—6

HR 995 SC—7

HR 995 SC—8

HR 995 SC—9

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