

103^D CONGRESS
1ST SESSION

H. R. 2089

To promote the use of State-coordinated health insurance buying programs and assist States in establishing Health Insurance Purchasing Cooperatives, through which small employers may purchase health insurance, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 12, 1993

Mr. BROWN of California introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, and the Judiciary

A BILL

To promote the use of State-coordinated health insurance buying programs and assist States in establishing Health Insurance Purchasing Cooperatives, through which small employers may purchase health insurance, 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 “Health Insurance
5 Purchasing Cooperatives Act”.

1 **SEC. 2. HEALTH INSURANCE PURCHASING COOPERATIVES**
2 **GRANT PROGRAM.**

3 (a) IN GENERAL.—The Secretary shall award grants
4 to States, which submit applications and otherwise meet
5 the requirements of this Act, to assist such States in es-
6 tablishing coordinated buying programs through which
7 small employers may purchase health insurance for their
8 employees.

9 (b) APPLICATION REQUIREMENTS.—To be eligible to
10 receive a grant under this section, a State shall prepare
11 and submit to the Secretary an application in such form,
12 at such time, and containing such information, certifi-
13 cations, and assurances as the Secretary shall reasonably
14 require, including a certification that—

15 (1) the State has, through State law, executive
16 order, or regulation, initiated the steps necessary to
17 establish a coordinated buying program that meets
18 the requirements of subsection (d), through which
19 each small employer in the State desiring to pur-
20 chase health insurance for its employees shall pur-
21 chase such insurance; or

22 (2) in the case of a State which the Secretary
23 identifies, in consultation with the National Associa-
24 tion of Insurance Commissioners, as—

25 (A) requiring State legislation (other than
26 legislation appropriating funds) to establish a

1 coordinated buying program that meets the re-
2 quirements of subsection (d); and

3 (B) having a legislature that does not meet
4 during the first year after the date of enact-
5 ment of this Act in a legislative session in
6 which such legislation may be considered;

7 the State has established a plan, to be fully imple-
8 mented not later than 2 years after the date on
9 which the grant is awarded to such State by the
10 Secretary, for the establishment of a coordinated
11 buying program that meets the requirements of sub-
12 section (d).

13 (c) USE OF FUNDS.—Amounts awarded under this
14 section may be used to finance the administrative costs
15 associated with planning, developing, and implementing a
16 coordinated buying program, comprised of one or more
17 Health Insurance Purchasing Cooperatives, for small em-
18 ployers. Such administrative costs may include the costs
19 associated with—

20 (1) engaging in education and outreach efforts
21 to inform small employers, carriers, and the public
22 about the coordinated buying program;

23 (2) soliciting bids and negotiating with carriers
24 to make available health benefit plans, consistent
25 with section 3, through the coordinated buying pro-

1 gram and one or more Health Insurance Purchasing
2 Cooperatives; and

3 (3) preparing and disseminating the docu-
4 mentation required by Federal agencies to certify
5 participation in the coordinated buying program and
6 one or more Health Insurance Purchasing Coopera-
7 tives.

8 (d) COORDINATED BUYING PROGRAM.—To receive
9 funding under this section, a State coordinated buying
10 program shall—

11 (1) be authorized and enforced under State law,
12 executive order, or regulation as the sole mechanism
13 through which health insurance for employees of
14 small employers shall be purchased in such State;

15 (2) provide each small employer in the State
16 with access to health insurance for its employees and
17 their dependents, through one or more Health Insur-
18 ance Purchasing Cooperatives qualified under sub-
19 section (e);

20 (3) require that each Health Insurance Pur-
21 chasing Cooperative participating in the State co-
22 ordinated buying program meet the requirements of
23 section 5 with respect to reporting data to a Re-
24 gional Data Collection Center and participating in
25 the National Health Insurance Data System; and

1 (4) meet such other criteria as reasonably re-
2 quired by the Secretary, the National Health Board,
3 or mandated under this Act.

4 (e) HEALTH INSURANCE PURCHASING COOPERA-
5 TIVE.—

6 (1) REQUIREMENTS.—To be a qualified Health
7 Insurance Purchasing Cooperative an entity shall—

8 (A) be a nonprofit entity established and
9 regulated in accordance with State law in a
10 manner that will ensure an economy of scale
11 based on the State’s geographic and demo-
12 graphic characteristics;

13 (B) be designated by the State as the ex-
14 clusive agent for purchasing, coordinating, and
15 administering services among carriers on behalf
16 of small employers and their employees within
17 a defined geographic area (hereafter referred to
18 in this section as a “district”);

19 (C) except as provided under paragraph
20 (3), certify that it will not contract with any
21 carriers that deny, limit, or condition coverage
22 under (or benefits of) the plan based on the
23 health status, claims experience, receipt of
24 health care, medical history or lack of evidence
25 of insurability, of an individual;

1 (D) after the date that is 2 years after the
2 date of enactment of this Act, certify that it
3 will not contract with any carriers that do not
4 meet the minimum benefits requirements estab-
5 lished by the National Health Board under sec-
6 tion 4;

7 (E) not less than annually, hold an open
8 enrollment period for all employees covered by
9 the Health Insurance Purchasing Cooperative
10 health benefit plans;

11 (F) use adjusted community ratings (under
12 which the only factors that may be applied are
13 age, gender, and geography within a district) to
14 determine the cost for each covered employee or
15 dependent; and

16 (G) meet such other criteria as reasonably
17 required by the State or the Secretary, or man-
18 dated under this Act.

19 (2) ACTIVITIES.—Within its district, each
20 Health Insurance Purchasing Cooperative shall—

21 (A) provide for the comprehensive purchas-
22 ing of health insurance and services for all
23 small employers;

24 (B) act as an agent for the small employ-
25 ers and, based on the recommendations of the

1 National Health Board, assist the small em-
2 ployers, employees, and dependents in determin-
3 ing appropriate health benefit plans;

4 (C) solicit bids from and contract with car-
5 riers for specific health benefit plans, which
6 shall include those benefits determined by the
7 National Health Board under section 4, and,
8 notwithstanding any other provision of Federal
9 or State law—

10 (i) hold confidential proprietary infor-
11 mation upon which estimates on bids are
12 derived; and

13 (ii) issue contracts only to those car-
14 riers providing both cost effective and
15 quality health benefits, plans, and services;

16 (D) administer all aspects of health insur-
17 ance coverage for all small employers, their em-
18 ployees and dependents, including routine
19 health benefits, COBRA benefits, relevant Fed-
20 eral health insurance earned income tax credits,
21 and the collection of premiums paid under sec-
22 tion 1906 of the Social Security Act;

23 (E) inform employees and dependents
24 about their benefits, rights, and responsibilities
25 and enable employees and dependents to select

1 benefits based on standardized plans that com-
2 pete in cost and quality; and

3 (F) in a timely fashion, report, as required
4 by section 5, all relevant data, including health
5 outcomes data, to the appropriate Regional
6 Health Insurance Data Collection Center.

7 (3) EXCLUSION OF COVERAGE.—Notwithstand-
8 ing paragraph (1)(C), a Health Insurance Purchas-
9 ing Cooperative may, in accordance with this sub-
10 section, contract with a carrier for a health benefit
11 plan that limits exclusion of coverage, with respect
12 to services related to treatment of a preexisting con-
13 dition, to a period not exceeding 6 months. The ex-
14 clusion of coverage shall not apply to services fur-
15 nished to newborns.

16 (f) RELATION TO OTHER LAWS.—

17 (1) ANTITRUST LAWS.—Notwithstanding any
18 provision of the antitrust laws, it shall not be consid-
19 ered a violation of the antitrust laws for a State, in
20 accordance with this section, to develop a State co-
21 ordinated buying program comprised of Health In-
22 surance Purchasing Cooperatives, or for any carrier,
23 in accordance with this section, to participate in
24 such a program or Cooperative.

1 (2) DEFINITION.—For purposes of this section,
2 the term “antitrust laws” means—

3 (A) the Act entitled “An Act to protect
4 trade and commerce against unlawful restraints
5 and monopolies”, approved July 2, 1890, com-
6 monly known as the “Sherman Act” (26 Stat.
7 209; chapter 647; 15 U.S.C. 1 et seq.);

8 (B) the Federal Trade Commission Act,
9 approved September 26, 1914 (38 Stat. 717;
10 chapter 311; 15 U.S.C. 41 et seq.);

11 (C) the Act entitled “An Act to supple-
12 ment existing laws against unlawful restraints
13 and monopolies, and for other purposes”, ap-
14 proved October 15, 1914, commonly known as
15 the “Clayton Act” (38 Stat. 730; chapter 323;
16 15 U.S.C. 12 et seq.; 18 U.S.C. 402, 660,
17 3285, 3691; 29 U.S.C. 52, 53); and

18 (D) any State antitrust laws that would
19 prohibit the activities described in paragraph
20 (1).

21 (g) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section,
23 \$25,000,000 for fiscal year 1994, and \$30,000,000 for
24 each of the fiscal years 1995 through 1998.

1 **SEC. 3. NATIONAL HEALTH BOARD.**

2 (a) IN GENERAL.—There is hereby established a Na-
3 tional Health Board (hereafter referred to in this section
4 as the “Board”) which shall be composed of 11 members
5 to be appointed by the President by and with the advice
6 and consent of the Senate not later than 6 months after
7 the date of enactment of this Act.

8 (b) MEMBERSHIP.—

9 (1) REPRESENTATION.—The membership of the
10 Board shall include individuals with national rec-
11 ognition for their expertise in health insurance,
12 health economics, health care provider reimburse-
13 ment, and related fields. In appointing individuals
14 under subsection (a), the President shall assure rep-
15 resentation of consumers of health services, large
16 and small employers, State and local governments,
17 labor organizations, and health care providers and
18 carriers.

19 (2) CHAIRPERSON.—The members of the Board
20 shall elect a Chairperson.

21 (3) TERMS.—Members of the Board shall be
22 appointed to serve for terms of 6 years, except that
23 the terms of the members first appointed shall be
24 staggered so that the terms of no more than 4 mem-
25 bers expire in any year. The term of the Chairperson
26 shall be coincident with the term of the President.

1 Individuals appointed to fill a vacancy created in the
2 Board shall be appointed for the remainder of the
3 term.

4 (c) DUTIES.—

5 (1) PRECEPTS.—The Board shall establish Co-
6 ordinated Buying Program Precepts, that shall set
7 forth criteria for—

8 (A) establishing a uniform data system
9 that will assist in designating qualified Health
10 Insurance Purchasing Cooperatives and car-
11 riers;

12 (B) determining and implementing a sys-
13 tem for the collection of relevant health out-
14 comes data, including quality monitors, func-
15 tional status, expense reporting methods
16 (including the costs associated with providing
17 services within State coordinated buying pro-
18 gram), demographic and behavioral measures,
19 and changes in clinical conditions as a result of
20 therapeutic interventions expressed in Quality
21 Life Years in a manner that assumes confiden-
22 tiality of patient information; and

23 (C) determining and revising, if necessary,
24 appropriate minimum benefit requirements of a
25 qualified health benefit plan, consistent with

1 section 4 and developing additional benefit
2 plans as necessary to provide more extensive
3 benefits.

4 (2) SCIENTIFIC BASIS.—To the extent prac-
5 ticable, the precepts of the Board shall be derived
6 from an evaluation of the extant scientific literature
7 and outcome data collected under this Act.

8 (3) ASSISTANCE TO SECRETARY.—The Board
9 shall make written recommendations on at least an
10 annual basis to the Secretary and the States in the
11 planning, development, and implementation of all
12 components of the National Health Insurance Data
13 System established under section 5, including the
14 determination of health outcomes data to be col-
15 lected through the standardized universal electronic
16 card, and shall provide such other assistance as the
17 Secretary or the States may request.

18 (d) MISCELLANEOUS.—

19 (1) AUTHORITY.—The Board may—

20 (A) employ and fix the compensation of an
21 Executive Director and solicit other personnel
22 (not to exceed 15) as may be necessary to carry
23 out its duties (without regard to the provisions
24 of title 5, United States Code, governing ap-
25 pointments in the competitive service);

1 (B) seek such assistance and support as
2 may be required in the performance of its du-
3 ties from appropriate Federal departments and
4 agencies;

5 (C) enter into contracts or make other ar-
6 rangements, as may be necessary for the con-
7 duct of the work of the Board (without regard
8 to section 3709 of the Revised Statutes (41
9 U.S.C. 5)); and

10 (D) make advance, progress, and other
11 payments which relate to the work of the
12 Board.

13 (2) COMPENSATION.—While serving on the
14 business of the Board (including traveltime), a mem-
15 ber of the Board shall be entitled to compensation
16 at the per diem equivalent of the rate provided for
17 level IV of the Executive Schedule under section
18 5315 of title 5, United States Code, and while so
19 serving away from the member’s home and regular
20 place of business, a member may be allowed travel
21 expenses, as authorized by the Chairperson of the
22 Board.

23 (3) ACCESS TO INFORMATION, ETC.—The
24 Board shall have access to such relevant information
25 and data as may be available from appropriate Fed-

1 eral agencies and shall assure that its activities, es-
2 pecially the conduct of original research and medical
3 studies, are coordinated with the activities of Fed-
4 eral agencies. The Board shall be subject to periodic
5 audit by the General Accounting Office.

6 (4) AUTHORIZATION OF APPROPRIATIONS.—

7 There are authorized to be appropriated, \$500,000
8 for each of the fiscal years 1994 through 1998.

9 **SEC. 4. HEALTH BENEFITS.**

10 (a) ESTABLISHMENT OF REQUIREMENTS.—Not later
11 than 18 months after the date of enactment of this Act,
12 the National Health Board shall establish minimum bene-
13 fit requirements for health benefit plans offered through
14 Health Insurance Purchasing Cooperatives. Such mini-
15 mum benefits shall include—

16 (1) inpatient and outpatient hospital care, ex-
17 cept that treatment for a mental disorder is subject
18 to the special limitations described in paragraph
19 (6)(A);

20 (2) inpatient and outpatient physician services,
21 except that psychotherapy or counseling for a mental
22 disorder is subject to the special limitations de-
23 scribed in paragraph (6)(B);

24 (3) diagnostic tests;

1 (4) prenatal care and well-baby care provided to
2 children who are 1 year of age or younger;

3 (5) preventive and early intervention services,
4 including—

5 (A) well child care;

6 (B) pap smears; and

7 (C) mammograms; and

8 (6)(A) inpatient hospital care for a mental dis-
9 order for not less than 45 days per year, except that
10 days of partial hospitalization, residential care, or
11 outpatient treatment may be substituted for days of
12 inpatient care according to a ratio established by the
13 Board; and

14 (B) outpatient psychotherapy and counseling
15 for a mental disorder for not less than 20 visits per
16 year provided by a provider who is acting within the
17 scope of State law and who—

18 (i) is a physician; or

19 (ii) meets the standards of subsection
20 (e)(2)(B) and is a duly licensed or certified clin-
21 ical psychologist or a duly licensed or certified
22 clinical social worker, a duly licensed or cer-
23 tified equivalent mental health professional, or
24 a clinic or center providing duly licensed or cer-
25 tified mental health services.

1 (b) EXCEPTIONS.—Subsection (a) shall not be con-
2 strued as requiring the Board to specify that a plan in-
3 clude payment for—

4 (1) items and services that are not medically
5 necessary; or

6 (2) experimental services and procedures, ex-
7 cept that the Board may include coverage of routine
8 medical costs associated with peer-reviewed and ap-
9 proved protocols conducted in connection with peer-
10 reviewed and approved research programs, pursuant
11 to standards established by the Board.

12 (c) AMOUNT, SCOPE, AND DURATION OF CERTAIN
13 BENEFITS.—Except as provided in subsection (b), a
14 health benefit plan shall place no limits on the amount,
15 scope, or duration of benefits described in paragraphs (1)
16 through (3) of subsection (a).

17 (d) LIMITATIONS.—

18 (1) PANELS AND MANAGED CARE SYSTEMS.—
19 Nothing in this section or this Act shall prohibit a
20 health benefit plan from providing benefits for the
21 items and services described in this section through
22 a managed care system, and from selecting particu-
23 lar health care providers or types, classes, or cat-
24 egories of health care providers to participate in
25 such managed care system. Such managed care sys-

1 tem shall provide reasonable access, as defined by
2 the Board, to care by plan enrollees.

3 (2) DIFFERENT LEVELS OF PAYMENTS.—Noth-
4 ing in this section or this Act shall prohibit a health
5 benefit plan from establishing a different level of
6 payments for reimbursement for different health
7 care providers furnishing the benefits for the items
8 and services described in this section.

9 (3) DENIAL OF PAYMENT TO EXCLUDED PRO-
10 VIDERS.—Nothing in this section or this Act shall
11 require a health benefit plan to make payment to
12 any health care provider that is excluded from par-
13 ticipation in any Federal health care program.

14 (e) MENTAL HEALTH CARE.—

15 (1) INPATIENT CARE.—Subject to the provi-
16 sions of subsection (d), inpatient hospital care de-
17 scribed in subsection (a)(6)(A) shall include reim-
18 bursement for professional care provided to the indi-
19 vidual while the individual is receiving such inpatient
20 care, by a physician or duly licensed or certified clin-
21 ical psychologist operating within the scope of prac-
22 tice of the physician or psychologist, as determined
23 appropriate under State law. Nothing in this sub-
24 section shall be construed to modify hospital prac-

1 tices with regard to scope of practice, admitting
2 privileges, or billing arrangements.

3 (2) OUTPATIENT CARE.—

4 (A) USE OF PROVIDERS.—Subject to the
5 provisions of subsection (d), a health benefit
6 plan that provided benefits with respect to out-
7 patient psychotherapy described in subsection
8 (a)(6)(B) prior to January 1, 1994, shall not be
9 required under such subsection to provide bene-
10 fits for outpatient psychotherapy provided by
11 any health care provider (or type, class, or cat-
12 egory of health care provider) described in sub-
13 section (a)(6)(B)(ii), other than duly licensed or
14 certified clinical psychologists and health care
15 providers being used by the plan on January 1,
16 1994.

17 (B) STANDARDS FOR CERTAIN PROVID-
18 ERS.—The Board shall establish standards that
19 providers referred to in subsection (a)(6)(B)(ii)
20 must meet to be eligible for payment under a
21 health benefit plan and such standards shall re-
22 quire that such providers have training and
23 education equivalent to a licensed clinical social
24 worker (as defined in title XVIII of the Social
25 Security Act).

1 (f) ADDED BENEFIT PLANS.—Not later than 24
2 months after the date of enactment of this Act, the Board
3 shall establish minimum benefit requirements for two ad-
4 ditional health benefit plans that—

5 (1) shall provide benefits more extensive or
6 more innovative than those provided by the plan de-
7 veloped under subsection (a); and

8 (2) may be compared on the basis of cost and
9 quality outcome measures.

10 (g) STUDIES.—

11 (1) INITIAL REPORT.—Not later than 3 years
12 after the date of enactment of this Act, the Board
13 shall—

14 (A) review the appropriateness of the mini-
15 mum benefits and services required to be cov-
16 ered under subsection (a); and

17 (B) prepare and submit to the Secretary
18 and the appropriate committees of Congress a
19 report concerning the cost-effectiveness and de-
20 sirability of such benefits and services and mak-
21 ing recommendations for changes in the list of
22 such benefits and services.

23 (2) BIENNIAL REPORT.—Not later than 2 years
24 after the date on which the report is submitted
25 under paragraph (1), and every 2 years thereafter,

1 the Board shall prepare and submit to the Secretary
2 and the appropriate committees of Congress a report
3 updating the preceding report and reviewing, con-
4 sistent with paragraph (1), the additional benefits
5 and services included in the plans developed under
6 subsection (f).

7 (h) EXEMPTION FROM HMO REQUIREMENTS.—Sec-
8 tion 1301 of the Public Health Service Act (42 U.S.C.
9 300e) is amended by adding at the end thereof the follow-
10 ing new subsection:

11 “(d) The provisions of this title relating to health
12 services offered by a health maintenance organization shall
13 not apply with respect to those health maintenance organi-
14 zations that provide services that meet the requirements
15 for health insurance plans offered through Health Insur-
16 ance Purchasing Cooperatives under section 4 of the
17 Health Insurance Purchasing Cooperatives Act.”.

18 **SEC. 5. NATIONAL HEALTH INSURANCE DATA SYSTEM.**

19 (a) IN GENERAL.—Using advanced technologies to
20 the maximum extent practicable, the Secretary shall estab-
21 lish and maintain a National Health Insurance Data Sys-
22 tem, which shall be comprised of—

23 (1) a centralized National Data Base for
24 Health Insurance and Health Outcomes Informa-
25 tion;

1 (2) a network of no more than five Regional
2 Health Insurance Data Collection Centers; and

3 (3) a standardized, universal mechanism for
4 electronically processing health insurance and health
5 outcomes data.

6 (b) NATIONAL DATA BASE FOR HEALTH INSURANCE
7 INFORMATION.—The National Data Base for Health In-
8 surance Information shall—

9 (1) be centrally located;

10 (2) rely on advanced technologies to the maxi-
11 mum extent practicable; and

12 (3) be readily accessible by each State coordi-
13 nated buying program for data input and retrieval.

14 (c) REGIONAL HEALTH INSURANCE DATA COLLEC-
15 TION CENTERS.—The Secretary shall designate not more
16 than five regional centers, to be located throughout the
17 United States, for the initial collection and analysis of
18 data on each State coordinated buying program, as de-
19 scribed in section 3(c)(1)(B), and such other information
20 as determined useful to the Secretary or the National
21 Health Board. The regional centers shall transmit relevant
22 data, as determined appropriate by the Secretary and the
23 National Health Board, to the National Data Base for
24 Health Insurance and Health Outcomes Information.

1 (d) ELECTRONIC DATA COLLECTION CARD.—The
2 Secretary, upon the recommendation of the National
3 Health Board, shall—

4 (1) establish uniform billing and claims forms
5 and mandatory reporting requirements, including in-
6 formation on member eligibility, benefits, use, out-
7 comes, and efficacy, which shall be adopted for use
8 by each State and State coordinated buying program
9 receiving funding under section 2; and

10 (2) ensure that no State receives funding under
11 this Act if carriers in such State do not agree to
12 issue to each participant in the State coordinated
13 buying program an electronic data processing card
14 approved by the Secretary that shall—

15 (A) contain information on billing, eligi-
16 bility, and other financial, administrative, and
17 health outcomes matters, as determined nec-
18 essary by the Secretary and the National
19 Health Board, which can be conveyed electroni-
20 cally to a regional data processing center; and

21 (B) enable health care providers to enter
22 information into a participant's file concerning
23 administrative matters, treatment, such as di-
24 agnosis based on standard codes, and outcome,
25 except that participating health care providers

1 must agree to provide data in standard format,
2 which shall be established by the Secretary and
3 the National Health Board.

4 (e) RELIGIOUS OBJECTIONS.—Nothing in this Act
5 shall be construed to require any State coordinated buying
6 program or Health Insurance Purchasing Cooperative to
7 compel any person to undergo any medical screening, ex-
8 amination, diagnosis, or treatment or to accept any other
9 health care or services provided under a health benefit
10 plan for any purpose (other than for the purpose of discov-
11 ering and preventing the spread of infection or contagious
12 disease or for the purpose of protecting environmental
13 health), if such person objects (or, in case such person
14 is a child, his parent or guardian objects) thereto on
15 religious grounds.

16 (f) CONFIDENTIALITY.—The Secretary, upon the rec-
17 ommendation of the National Health Board, shall ensure
18 that all patient information collected under this section is
19 managed so that confidentiality is protected.

20 (g) AUTHORIZATION OF APPROPRIATIONS.—There
21 shall be authorized to be appropriated, annually,
22 \$1,000,000 for fiscal years 1994 through 1998.

23 **SEC. 6. DEFINITIONS.**

24 As used in this Act:

1 (1) CARRIER.—The term “carrier” means any
2 person or entity that offers a health benefit plan,
3 whether through insurance or otherwise, including a
4 licensed insurance company, a prepaid hospital or
5 medical service plan, or a health maintenance
6 organization.

7 (2) ELIGIBLE EMPLOYEE.—The term “eligible
8 employee” means, with respect to an employer, an
9 employee who normally performs on a monthly basis
10 at least 30 hours of service per week for that
11 employer.

12 (3) HEALTH BENEFIT PLAN.—The term
13 “health benefit plan” means any hospital or medical
14 service policy or certificate, hospital or medical serv-
15 ice plan contract, or health maintenance organiza-
16 tion group contract, but does not include any of the
17 following offered by a carrier—

18 (A) accident only, dental only, disability
19 only insurance, or long-term care only
20 insurance;

21 (B) coverage issued as a supplement to li-
22 ability insurance;

23 (C) workmen’s compensation or similar in-
24 surance; or

1 (D) automobile medical-payment
2 insurance.

3 (4) HEALTH MAINTENANCE ORGANIZATION.—
4 The term “health maintenance organization” has the
5 meaning given the term “eligible organization” in
6 section 1876(b) of the Social Security Act.

7 (5) NAIC.—The term “NAIC” means the Na-
8 tional Association of Insurance Commissioners.

9 (6) PREEXISTING CONDITION.—The term “pre-
10 existing condition” means, with respect to coverage
11 under a health benefit plan issued to a small em-
12 ployer, employee or dependent by a carrier, a condi-
13 tion which has been diagnosed or treated during the
14 3-month period ending on the day before the first
15 date of such coverage (without regard to any waiting
16 period).

17 (7) SECRETARY.—The term “Secretary” means
18 the Secretary of Health and Human Services.

19 (8) SMALL EMPLOYER.—The term “small em-
20 ployer” means, with respect to a calendar year, an
21 employer that normally employs at least 1 but less
22 than 51 eligible employees on a typical business day.
23 For the purposes of this paragraph, the term “em-
24 ployer” includes a self-employed individual.

1 **SEC. 7. INCREASE IN DEDUCTIBLE HEALTH INSURANCE**
2 **COSTS FOR SELF-EMPLOYED INDIVIDUALS**
3 **FOR INSURANCE PURCHASED THROUGH A**
4 **HEALTH INSURANCE PURCHASING**
5 **COOPERATIVE.**

6 (a) IN GENERAL.—Paragraph (1) of section 162(l)
7 of the Internal Revenue Code of 1986 (relating to special
8 rules for health insurance costs of self-employed individ-
9 uals) is amended by striking “equal to” and all that fol-
10 lows and inserting the following: “equal to—

11 “(A) 100 percent of the amount paid dur-
12 ing the taxable year for insurance which is pur-
13 chased through a Health Insurance Purchasing
14 Cooperative under the Health Insurance Pur-
15 chasing Cooperatives Act and which constitutes
16 medical care for the taxpayer, his spouse, and
17 dependents, and

18 “(B) 25 percent of the amount paid during
19 the taxable year for insurance not described in
20 subparagraph (A) which constitutes medical
21 care for the taxpayer, his spouse, and depend-
22 ents.”.

23 (b) PERMANENT DEDUCTION.—Section 162(l) of
24 such Code is amended by striking paragraph (6).

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1993.

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