

103<sup>D</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 30

To provide for universal access to basic group health benefits coverage and to remove barriers and provide incentives in order to make such coverage more affordable, to improve and make more efficient the provision of medical and health insurance information, and to improve enforcement of requirements relating to multiple employer welfare arrangements.

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## IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

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

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## A BILL

To provide for universal access to basic group health benefits coverage and to remove barriers and provide incentives in order to make such coverage more affordable, to improve and make more efficient the provision of medical and health insurance information, and to improve enforcement of requirements relating to multiple employer welfare arrangements.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the  
3 “Universal Health Benefits Empowerment and Partner-  
4 ship Act of 1993”.

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

- Sec. 1. Short title and table of contents.
- Sec. 2. Findings and declaration of policy.

TITLE I—UNIVERSAL ACCESS TO HEALTH COVERAGE

Sec. 101. Universal access to coverage under group health plans and accessible health benefits systems.

“PART 6—UNIVERSAL ACCESS TO COVERAGE UNDER GROUP HEALTH PLANS AND ACCESSIBLE HEALTH BENEFITS SYSTEMS

“Subpart A—General Provisions

“Sec. 601. Definitions and special rules.

“Subpart B—Required Coverage Options; Group Health Payroll Deduction Plans

“Sec. 611. Coverage for eligible individuals under basic group health plans or group health payroll deduction plans.

“Sec. 612. Group health payroll deduction plans.

“Sec. 613. Availability of coverage under accessible health benefits systems.

“Subpart C—Accessible Health Benefits Systems

“Sec. 621. General requirements.

“Sec. 622. Reporting requirements.

“Sec. 623. Participation requirements.

“Sec. 624. Benefits requirements.

“Sec. 625. Contribution requirements.

“Sec. 626. Reciprocity and reliance by accessible health benefits systems on other such systems.

“Sec. 627. Regulatory authority of Secretary of Health and Human Services.

“Subpart D—Coverage for Uninsurable Risks and Material Pre-Existing Conditions

“Sec. 631. Coverage for uninsurable risks and pre-existing conditions.

“Sec. 632. Participation requirements for uninsurable risks and material pre-existing conditions.

“Sec. 633. Benefits requirements for uninsurable risks and material pre-existing conditions.

- “Sec. 634. Regulatory authority of Secretary of Health and Human Services.”.
- Sec. 102. Establishment of State-based system in absence of State-wide access to coverage; substitute systems.
- Sec. 103. Continuation coverage and accessible health benefits systems or substitute systems.
- Sec. 104. Preemption of State law to provide for more affordable health care coverage.
- Sec. 105. Encouragement of multiple employer arrangements providing basic health benefits.
- Sec. 106. Treatment practice guidelines and outcomes research for all Americans.

“PART A—ESTABLISHMENT AND GENERAL DUTIES

- “Sec. 901. Establishment.
- “Sec. 902. General authorities and duties.

“PART B—FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE

- “Sec. 911. Establishment of office.
- “Sec. 912. Duties.
- Sec. 107. Federal Advisory Council on Health Care Coverage and Costs.
- Sec. 108. Increase in deduction for health insurance costs of self-employed individuals from 25 percent to 100 percent.
- Sec. 109. Effective dates.

TITLE II—MEDICAL AND HEALTH INSURANCE INFORMATION REFORM

- Sec. 201. Short title.
- Sec. 202. Medical and health insurance information reform.

“TITLE XXII—MEDICAL AND HEALTH INSURANCE INFORMATION REFORM

“PART A—COMPARATIVE VALUE INFORMATION

- “Sec. 2200. Comparative value information programs for health care purchasing.
- “Sec. 2201. Grants for the development of State programs.

“PART B—STORAGE AND TRANSMISSION OF MEDICAL AND HEALTH INSURANCE INFORMATION AND PRIORITY OF PAYMENT

- “Sec. 2210. Preemption of State quill pen laws.
- “Sec. 2211. Promulgation of requirements by Secretary.
- “Sec. 2212. State programs.
- “Sec. 2213. Application of Federal requirements.
- “Sec. 2214. Health insurance information privacy and confidentiality protection.
- “Sec. 2215. Identification numbers.
- “Sec. 2216. Standards and requirements for the receipt and transmission of health insurance information.
- “Sec. 2217. Health insurance claim forms.
- “Sec. 2218. Priority among insurers.
- “Sec. 2219. Furnishing of information among insurers.
- “Sec. 2220. Noncompliance with Federal requirements.

“Sec. 2221. No effect on scope of benefits covered.

“PART C—MEDICAL DATA REQUIREMENTS

“Sec. 2230. Promulgation of requirements by Secretary.

“Sec. 2231. Medicare requirements for hospitals.

“Sec. 2232. Electronic transmission to Federal agencies.

“PART D—GENERAL PROVISIONS

“Sec. 2240. Definitions.”.

Sec. 203. Conforming amendment.

Sec. 204. Failure to satisfy certain health insurance requirements.

TITLE III—MEWA ENFORCEMENT IMPROVEMENTS

Sec. 301. Short title.

Sec. 302. Amendment to definition of employee welfare benefit plan.

Sec. 303. Amendment to definition of multiple employer welfare arrangement.

Sec. 304. Coverage.

Sec. 305. Registration requirement.

Sec. 306. Enforcement and civil penalties.

Sec. 307. Exemption procedure.

Sec. 308. Clarification of States’ ability to obtain information.

Sec. 309. Effective date.

1 **SEC. 2. FINDINGS AND DECLARATION OF POLICY.**

2 (a) FINDINGS.—The Congress finds that—

3 (1) the health care delivery system of the Unit-  
4 ed States provides most Americans with a level of  
5 access and quality of care that is unsurpassed;

6 (2) for a significant minority of Americans, the  
7 system works less well because they cannot obtain or  
8 otherwise do not have basic health care coverage  
9 under either public or private programs;

10 (3) these individuals represent a diversity of sit-  
11 uations for which there is no single solution;

12 (4) assuring access to basic health care cov-  
13 erage and quality care for these individuals is a com-

1 pelling national priority that will require commit-  
2 ments from both the private and public sectors;

3 (5) the most practical and effective solutions for  
4 these access problems are ones that—

5 (A) preserve the pluralistic base of the  
6 health care delivery system of the United  
7 States;

8 (B) emphasize incentives, innovation, and  
9 the removal of current barriers to access; and

10 (C) recognize that both the complexity of  
11 the problem and the existence of fiscal con-  
12 straints means that responsibility must be  
13 shared among employers, employees, insurers,  
14 providers, and patients, as well as Federal,  
15 State, and local governments;

16 (6) Federal efforts need to be closely coordi-  
17 nated with others who share in the responsibility for  
18 improving access to basic health care services;

19 (7) Federal efforts need to reflect not only the  
20 diversity of interested parties but also the diversity  
21 of areas where action is appropriate, including public  
22 health, basic group health coverage, State initiatives,  
23 medical malpractice laws, Medicaid, and tax incen-  
24 tives; and

1           (8) improving access requires dealing with  
2 many of the most difficult problems in the health  
3 system, including—

4           (A) the escalating costs, State mandated  
5 health benefits, and other factors that have  
6 made health care coverage less affordable for  
7 many employers and individuals, especially the  
8 near poor who need more creative workplace  
9 and public options to be able to obtain basic  
10 health care coverage; and

11           (B) the inability of many individuals to  
12 protect themselves against catastrophic health  
13 care expenses because preexisting conditions  
14 make them “uninsurable”.

15       (b) PURPOSES.—Therefore the Congress declares the  
16 purposes of this Act to be to provide a sound, flexible,  
17 and workable Federal framework to simultaneously ad-  
18 dress the issues of access to basic health care coverage  
19 and the affordability of such coverage, with an emphasis  
20 on improving health care quality by—

21           (1) empowering employers, employees, and  
22 other individuals to obtain more affordable basic  
23 health care coverage, and

1           (2) providing incentives for private and public-  
2 private partnership arrangements to be established  
3 for such purposes.

4           (c) DECLARATION OF POLICY.—In carrying out such  
5 purposes, it is the policy of this Act to—

6           (1) provide universal access to basic group  
7 health coverage for all Americans under plans of-  
8 fered by employers or, in the case in which such cov-  
9 erage is unavailable to employees and other individ-  
10 uals from private sources or existing public pro-  
11 grams, under accessible health benefits systems;

12           (2) make such basic health coverage more af-  
13 fordable—

14           (A) by removing barriers and encouraging  
15 “group” plans and arrangements to spread risk  
16 and lower expenses;

17           (B) by preempting State health benefit  
18 mandates, thereby encouraging group health  
19 coverage providers to offer lower cost basic cov-  
20 erage to the uninsured;

21           (C) by preempting State barriers to the  
22 providing of managed care, thereby encouraging  
23 competition, innovation of cost-control ap-  
24 proaches, and quality review;

1           (D) by encouraging the development of  
2           treatment practice guidelines and outcomes re-  
3           search to aid in reducing unnecessary services,  
4           increasing quality care, and reducing mal-  
5           practice costs;

6           (E) by eliminating tax inequities and bar-  
7           riers—

8                   (i) to the full deductibility of contribu-  
9                   tions to health plans covering the self-em-  
10                  ployed, and

11                  (ii) to the establishment of soundly fi-  
12                  nanced multiple employer basic group  
13                  health plans;

14           (3) improve and make more efficient the provi-  
15           sion of medical and health insurance information;  
16           and

17           (4) improve enforcement of requirements relat-  
18           ing to multiple employer welfare arrangements.

1 **TITLE I—UNIVERSAL ACCESS TO**  
2 **HEALTH COVERAGE**

3 **SEC. 101. UNIVERSAL ACCESS TO COVERAGE UNDER**  
4 **GROUP HEALTH PLANS AND ACCESSIBLE**  
5 **HEALTH BENEFITS SYSTEMS.**

6 (a) IN GENERAL.—Subtitle B of title I of the Em-  
7 ployee Retirement Income Security Act of 1974 is amend-  
8 ed—

9 (1) by striking the heading for part 6 and in-  
10 serting the following:

11 **“Subpart E—Continuation Coverage Requirements”;**

12 (2) by redesignating sections 601 through 608  
13 as sections 641 through 648, respectively; and

14 (3) by inserting after part 5 the following:

15 “PART 6—UNIVERSAL ACCESS TO COVERAGE UNDER GROUP  
16 HEALTH PLANS AND ACCESSIBLE HEALTH BENEFITS SYSTEMS

17 **“Subpart A—General Provisions**

18 **“SEC. 601. DEFINITIONS AND SPECIAL RULES.**

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

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

1 “(2) BASIC GROUP HEALTH PLAN.—

2 “(A) IN GENERAL.—The term ‘basic group  
3 health plan’ means a group health plan, or any  
4 combination of two or more group health plans,  
5 which includes at least a basic health benefits  
6 provision.

7 “(B) TREATMENT OF UNINSURABLE  
8 RISKS.—A plan which excludes from coverage  
9 under a basic health benefits provision any indi-  
10 vidual (who would otherwise be eligible for cov-  
11 erage) solely because the individual is an unin-  
12 surable risk shall not be treated as a basic  
13 group health plan, unless the requirements of  
14 subparagraph (D) are met for purposes of this  
15 subparagraph with respect to such individual.

16 “(C) TREATMENT OF MATERIAL PRE-EX-  
17 ISTING CONDITIONS.—A plan which provides  
18 coverage to any individual under a basic health  
19 benefits provision subject to a substantial re-  
20 striction based on a material pre-existing condi-  
21 tion shall not be treated as a basic group health  
22 plan, unless the requirements of subparagraph  
23 (D) are met for purposes of this subparagraph  
24 with respect to such individual.

1           “(D) EXEMPTION WHERE ADEQUATE AC-  
2           CESSIBLE HEALTH BENEFITS SYSTEM OR SUB-  
3           STITUTE SYSTEM IS AVAILABLE.—The require-  
4           ments of this subparagraph are met with re-  
5           spect to any individual—

6                   “(i) for purposes of subparagraph  
7                   (B), if such individual is eligible for cov-  
8                   erage under an accessible health benefits  
9                   system established and maintained in ac-  
10                  cordance with subpart C (and subpart D  
11                  as applicable) (or under any substitute  
12                  basic health benefits system with respect to  
13                  which the Secretary of Health and Human  
14                  Services has made a determination pursu-  
15                  ant to section 102(b) of the Universal  
16                  Health Benefits Empowerment and Part-  
17                  nership Act of 1993 relating to the element  
18                  of coverage described in section  
19                  102(b)(2)(B)(i) of such Act (relating to  
20                  treatment of individuals as uninsurable  
21                  risks)), or

22                   “(ii) for purposes of subparagraph  
23                   (C), if such individual is eligible for cov-  
24                   erage for the material pre-existing condi-  
25                   tion referred to in subparagraph (C) under

1 an accessible health benefits system estab-  
2 lished and maintained in accordance with  
3 subpart C (and subpart D as applicable)  
4 (or under any substitute basic health bene-  
5 fits system with respect to which the Sec-  
6 retary of Health and Human Services has  
7 made a determination pursuant to section  
8 102(b) of the Universal Health Benefits  
9 Empowerment and Partnership Act of  
10 1993 relating to the element of coverage  
11 described in section 102(b)(2)(B)(ii) of  
12 such Act (relating to treatment of material  
13 preexisting conditions)).

14 “(3) BASIC HEALTH BENEFITS PROVISION.—  
15 The term ‘basic health benefits provision’ means,  
16 with respect to any plan, combination of plans, or  
17 health benefit system, an arrangement which—

18 “(A) provides to individuals provided cov-  
19 erage under such plan, combination of plans, or  
20 system, directly or through insurance, reim-  
21 bursement, or otherwise, medical care (as de-  
22 fined in section 213(d) of the Internal Revenue  
23 Code of 1986)—

24 “(i) which consists of services deter-  
25 mined by the Secretary of Health and

1 Human Services, under regulations pre-  
2 scribed by such Secretary, to consist of  
3 basic health care services (including physi-  
4 cian's, inpatient hospital, and outpatient  
5 hospital services which are prevalent under  
6 group health plans and other services  
7 which may be necessary for basic health  
8 care), and

9 “(ii) which consists of coverage at a  
10 percentage of cost determined by such Sec-  
11 retary under such regulations (by means of  
12 deductibles, coinsurance, and other limits  
13 on covered services) to be not less than a  
14 percentage which is, taking into account  
15 the population covered and the extent of  
16 cost currently covered under group health  
17 plans, adequate to meet basic health care  
18 needs, and

19 “(B) in the case of any individual de-  
20 scribed in paragraph (2)(B) or (C) in relation  
21 to a basic group health plan maintained by the  
22 employer of such individual (or of the person of  
23 whom such individual is a dependent), requires  
24 contributions by the employer of not less than  
25 the amount provided under the plan with re-

1           spect to individuals covered under such plan  
2           who are similarly situated, disregarding any  
3           condition under the plan relating to uninsurable  
4           risks (in the case of an individual described in  
5           paragraph (2)(B)) or to material pre-existing  
6           conditions (in the case of an individual de-  
7           scribed in paragraph (2)(C)).

8           In issuing regulations referred to in this paragraph  
9           (including any revisions thereof), the Secretary of  
10          Health and Human Services shall take into account  
11          recommendations submitted to such Secretary by the  
12          Federal Advisory Council on Health Care Coverage  
13          and Costs pursuant to section 107(d)(2) of the Uni-  
14          versal Health Benefits Empowerment and Partner-  
15          ship Act of 1993.

16               “(4) DEPENDENT.—The term ‘dependent’  
17               means, with respect to any individual, any person  
18               who—

19                       “(A) is the spouse or surviving spouse of  
20                       the individual, or

21                       “(B) is, under regulations of the Secretary,  
22                       a child of such individual who—

23                               “(i) is under 18 years of age,

24                               “(ii) is under 23 years of age and a  
25                               full-time student, or

1                   “(iii) is otherwise dependent on such  
2                   individual.

3                   “(5) EMPLOYER.—The term ‘employer’ shall  
4                   have the meaning applicable under section 3(5), ex-  
5                   cept that such term shall include any State (or polit-  
6                   ical subdivision thereof), or any agency or instru-  
7                   mentality of one or more of the foregoing.

8                   “(6) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
9                   individual’ means any employee or dependent there-  
10                  of, unless such employee or dependent—

11                  “(A) was eligible for coverage under a  
12                  basic group health plan which is maintained by  
13                  the employer and to which the employer makes  
14                  contributions but such coverage was declined  
15                  under such plan, or

16                  “(B) is excluded from coverage under such  
17                  a plan as an uninsurable risk but is eligible for  
18                  uninsurable risk coverage under an accessible  
19                  health benefits system in accordance with sub-  
20                  part C (and subpart D as applicable) (or any  
21                  substitute basic health benefits system with re-  
22                  spect to which the Secretary of Health and  
23                  Human Services has made a determination pur-  
24                  suant to section 102 of the Universal Health  
25                  Benefits Empowerment and Partnership Act of

1           1993 relating to the element of coverage de-  
2           scribed in section 102(b)(2)(B)(i) of such Act  
3           (relating to treatment of individuals as uninsur-  
4           able risks)).

5           “(7) UNINSURABLE RISK.—An individual shall  
6           be deemed to have been excluded from coverage  
7           under a basic health benefits provision as an ‘unin-  
8           surable risk’ if such denial of coverage is provided—

9                   “(A) in such terms, or

10                   “(B) in such other terms or under such  
11           circumstances as are, subject to such regula-  
12           tions as the Secretary of Health and Human  
13           Services may prescribe, reasonably equivalent to  
14           such a denial.

15           “(8) MATERIAL PRE-EXISTING CONDITION.—An  
16           individual shall be deemed to have been provided  
17           coverage by a basic health benefits provision subject  
18           to a restriction based on a ‘material pre-existing  
19           condition’ if, subject to such regulations as the Sec-  
20           retary of Health and Human Services may prescribe,  
21           under such provision—

22                   “(A) benefits (which would otherwise be  
23           payable) are not paid solely on the basis of a  
24           material pre-existing condition, or

1           “(B) the costs for coverage of the individ-  
2           ual with a material pre-existing condition, to ei-  
3           ther an employer or to the individual, are at a  
4           rate materially greater than costs for coverage  
5           of similarly situated individuals without such a  
6           material pre-existing condition, to the extent  
7           such costs are payable to a third party.

8           “(b) CROSS-REFERENCES.—

9           “(1) GENERAL RULE.—Except as otherwise  
10          provided in this part, for definitions of terms used  
11          in this part, see section 3.

12          “(2) SECRETARY.—Except with respect to ref-  
13          erences specifically to the Secretary of Health and  
14          Human Services, for the definition of ‘Secretary’,  
15          see section 3(13).

16          “(3) REGULATIONS.—Except with respect to  
17          provisions for which regulatory authority is specifi-  
18          cally provided to the Secretary of Health and  
19          Human Services, for provisions governing regulatory  
20          authority under this part, see section 505.

1     **“Subpart B—Required Coverage Options; Group**  
2                     **Health Payroll Deduction Plans**

3     **“SEC. 611. COVERAGE FOR ELIGIBLE INDIVIDUALS UNDER**  
4                     **BASIC GROUP HEALTH PLANS OR GROUP**  
5                     **HEALTH PAYROLL DEDUCTION PLANS.**

6             “(a) REQUIREMENT THAT EMPLOYERS OFFER COV-  
7 ERAGE FOR ELIGIBLE INDIVIDUALS UNDER BASIC GROUP  
8 HEALTH PLANS OR GROUP HEALTH PAYROLL DEDUC-  
9 TION PLANS.—Each employer shall maintain with respect  
10 to each eligible individual—

11             “(1) a basic group health plan under which cov-  
12 erage of such individual may be elected, or

13             “(2) a group health payroll deduction plan (as  
14 defined in section 612).

15             “(b) SPECIAL RULES.—

16             “(1) EXCLUSION OF CERTAIN EMPLOYERS.—

17             “(A) IN GENERAL.—This section shall not  
18 apply to any employer for any plan year if, as  
19 of the beginning of such plan year—

20             “(i) such employer (including any  
21 predecessor thereof) has been an employer  
22 for less than 2 years,

23             “(ii) such employer has no more than  
24 2 individuals in such employer’s employ, or

1           “(iii) no more than 2 individuals in  
2           such employer’s employ are not covered  
3           under any basic group health plan.

4           “(B) EXCLUSION OF FAMILY MEMBERS.—  
5           Under such procedures as the Secretary may  
6           prescribe, any relative of an employer may be,  
7           at the election of the employer, excluded from  
8           consideration as an employee for purposes of  
9           this paragraph. In the case of an employer that  
10          is not an individual, an employee who is a rel-  
11          ative of a key employee (as defined in section  
12          416(i)(1) of the Internal Revenue Code of  
13          1986) of the employer may, at the election of  
14          the key employee, be considered a relative ex-  
15          cludible under this subparagraph.

16          “(2) EXCLUSION OF CERTAIN TEMPORARY EM-  
17          PLOYEES.—A plan shall not be treated as failing to  
18          meet the requirements of this section solely because  
19          a period of service by an employee of not more than  
20          60 days is required under the plan for coverage of  
21          such employee or any dependent thereof under the  
22          plan.

23       **“SEC. 612. GROUP HEALTH PAYROLL DEDUCTION PLANS.**

24          “(a) GENERAL RULE.—For purposes of this subpart,  
25          the term ‘group health payroll deduction plan’ means a

1 basic group health plan under which amounts are de-  
2 ducted by the employer from the employee's wages pursu-  
3 ant to an election by the employee and paid as a contribu-  
4 tion to such plan in accordance with such regulations as  
5 the Secretary may prescribe relating to withholding proce-  
6 dures and timely payment of premiums.

7 “(b) ELECTIONS.—

8 “(1) IN GENERAL.—Any election by an em-  
9 ployee under a group health payroll deduction plan  
10 shall specify the amount which is to be deducted in  
11 relation to the benefits provided under the plan. Any  
12 such election may be revoked or changed by the em-  
13 ployee under the terms of the plan.

14 “(2) MANNER FOR MAKING OR REVOKING  
15 ELECTIONS.—Any election under a group health  
16 payroll deduction plan (and any revocation or  
17 change of such an election) shall be made in such  
18 form and in such manner as the Secretary may by  
19 regulations prescribe.

20 **“SEC. 613. AVAILABILITY OF COVERAGE UNDER ACCES-**  
21 **SIBLE HEALTH BENEFITS SYSTEMS.**

22 “In any case in which there is in effect, as of the  
23 beginning of a plan year of any group health payroll de-  
24 duction plan, an entity determined by the Secretary of  
25 Health and Human Services to be an accessible health

1 benefits system established and maintained in accordance  
2 with subpart C (and subpart D as applicable) with respect  
3 to the employee, such plan shall not be treated as failing  
4 to meet the requirements of section 612(a) for such plan  
5 solely because the amounts deducted are, under such plan,  
6 paid for such plan year or the succeeding plan year as  
7 a contribution to such a system accepting coverage of such  
8 employee rather than to such plan, if a provider of group  
9 health plan coverage with respect to the plan rejects an  
10 individual otherwise eligible for coverage under such plan  
11 because of a requirement that a certain number or per-  
12 centage of individuals otherwise eligible for coverage under  
13 the plan are not covered.

14 **“Subpart C—Accessible Health Benefits Systems**

15 **“SEC. 621. GENERAL REQUIREMENTS.**

16 “For purposes of this part, an accessible health bene-  
17 fits system established and maintained in accordance with  
18 this subpart is any system which, with respect to any  
19 group of individuals residing in a defined geographic  
20 area—

21 “(1) meets the reporting requirements of sec-  
22 tion 622,

23 “(2) meets the participation requirements of  
24 section 623 with respect to residents of the State,

1           “(3) meets the benefit requirements of section  
2       624,

3           “(4) meets the contribution requirements of  
4       section 625, and

5           “(5) provides coverage in accordance with sub-  
6       part D (relating to uninsurable risks and material  
7       pre-existing conditions) as applicable.

8       **“SEC. 622. REPORTING REQUIREMENTS.**

9           “(a) IN GENERAL.—A health benefits system meets  
10      the reporting requirements of this section if the system  
11      maintains a program under which the system provides,  
12      upon the request of group health payroll deduction plans  
13      under which amounts are paid from such plans to the sys-  
14      tem, such information held by the system as the plans re-  
15      quire to meet the requirements of part 1 of subtitle B of  
16      title I.

17          “(b) FORM OF REQUESTS.—Each system shall be re-  
18      quired to process requests made under this section only  
19      if such requests are made in such form and manner as  
20      may be prescribed in regulations of the Secretary.

21       **“SEC. 623. PARTICIPATION REQUIREMENTS.**

22          “A health benefits system meets the participation re-  
23      quirements of this section if the system provides that an  
24      individual within the group referred to in section 621 is  
25      provided coverage under the system if such individual—

1           “(1) is an eligible individual (as defined in sec-  
2           tion 601(a)(6)),

3           “(2) is an individual required to be provided  
4           coverage under subpart E of this part or under title  
5           XXII of the Public Health Service Act,

6           “(3) is an individual described in section 632,  
7           or

8           “(4) is an individual (other than an individual  
9           described in paragraph (1), (2), or (3)) who is not  
10          covered under any arrangement providing basic  
11          health care services described in section  
12          601(a)(3)(A),

13          and is not otherwise eligible for coverage under a basic  
14          group health plan or under a plan for medical assistance  
15          under title XIX of the Social Security Act.

16          **“SEC. 624. BENEFITS REQUIREMENTS.**

17          “(a) IN GENERAL.—Except as otherwise provided in  
18          this section, a health benefits system meets the benefits  
19          requirements of this section if the system provides medical  
20          care (as defined in section 213(d) of the Internal Revenue  
21          Code of 1986), directly or through insurance, reimburse-  
22          ment, or otherwise, in the form of at least the following  
23          options, available at the election of the individual provided  
24          coverage:

1           “(1) BASIC AND CATASTROPHIC BENEFITS.—  
2 Coverage under a basic health benefits provision.

3           “(2) CATASTROPHIC ONLY COVERAGE.—Cata-  
4 strophic coverage with respect to basic health care  
5 services.

6           “(3) SUPPLEMENTAL BENEFITS.—Coverage  
7 consisting of coverage described in paragraph (1)  
8 and such supplemental coverage as the Secretary of  
9 Health and Human Services may by regulation pre-  
10 scribe.

11          “(b) COST CONTAINMENT AND QUALITY OF CARE.—  
12 A health benefits system does not meet the requirements  
13 of this section unless such system, to the maximum extent  
14 determined practicable under regulations of the Secretary  
15 of Health and Human Services, taking into account qual-  
16 ity of care, provides for a hospital precertification utiliza-  
17 tion review program, constraint of costs to the extent prac-  
18 ticable through the use of appropriately managed care,  
19 and such other cost containment procedures as may from  
20 time to time be proven effective.

21          “(c) TREATMENT OF UNINSURABLE RISKS AND MA-  
22 TERIAL PRE-EXISTING CONDITIONS.—In any case in  
23 which the requirements of section 633 are met with re-  
24 spect to any individual with respect to whom the system  
25 meets the requirements of section 631, the requirements

1 of subsection (a) shall be treated as satisfied with respect  
2 to such individual.

3 “(d) DURATION OF COVERAGE.—A health benefits  
4 system does not meet the requirements of this section if  
5 coverage under such system terminates solely by reason  
6 of the termination of a period of coverage required under  
7 subpart E of this part or title XXII of the Public Health  
8 Service Act.

9 “(e) COVERAGE UNDER ACCESSIBLE HEALTH BENE-  
10 FITS SYSTEM SECONDARY TO COVERAGE UNDER EM-  
11 PLOYEE BENEFIT PLANS.—A health benefits system does  
12 not meet the requirements of this section unless, under  
13 the terms of such system, coverage under such system  
14 with respect to any claim is secondary to coverage pro-  
15 vided under any employee benefit plan with respect to such  
16 claim.

17 **“SEC. 625. CONTRIBUTION REQUIREMENTS.**

18 “(a) IN GENERAL.—Except as otherwise provided in  
19 this section, a health benefits system meets the contribu-  
20 tion requirements of this section if the system does not  
21 require, for coverage of individuals described in para-  
22 graphs (1) and (2) of section 623(a), contributions in ex-  
23 cess of levels determined—

1           “(1) on the basis of its own experience with re-  
2           spect to covered individuals described in such para-  
3           graphs (1) and (2), and

4           “(2) without regard to any coverage provided  
5           under the system to individuals who are not de-  
6           scribed in such paragraphs (1) and (2).

7           “(b) VARIANCES IN RATE LEVEL.—

8           “(1) SEPARATE SCHEDULE REQUIRED FOR  
9           CHILDREN-ONLY COVERAGE.—A health benefits sys-  
10          tem does not meet the contribution requirements of  
11          this section unless the system provides for a sepa-  
12          rate schedule of contributions with respect to chil-  
13          dren-only coverage.

14          “(2) OTHER VARIANCES PERMITTED.—A health  
15          benefits system shall not be treated as failing to  
16          meet the requirements of this section solely because  
17          the system otherwise provides for differing rates of  
18          contributions to reflect the age, family composition,  
19          or income of the covered individual and the location  
20          at which the covered individual is expected to nor-  
21          mally receive medical care.

22          “(c) CERTAIN STATE AND OTHER CONTRIBUTIONS  
23          PERMITTED.—A health benefits system shall not be treat-  
24          ed as failing to meet the requirements of this section solely  
25          because the system provides for—

1           “(1) payment by any State or any other entity  
2 of part or all of the contribution with respect to any  
3 covered individual,

4           “(2) varying the amount of such payment based  
5 on the individual’s income or any other basis, or

6           “(3) payment by any State or any other entity  
7 of all or part of monthly premiums for purposes of  
8 enrollment under section 1818 or 1818A of the So-  
9 cial Security Act, or of premiums under section  
10 1916(c) of such Act.

11          “(d) MAXIMIZED PARTICIPATION.—A health benefits  
12 system does not meet the requirements of this section if  
13 the Secretary of Health and Human Services determines,  
14 under regulations prescribed by such Secretary and on the  
15 basis of past experience, that, under such system, con-  
16 tributions are not established and maintained in such form  
17 and manner as to be promotive of participation in the  
18 system.

19          **“SEC. 626. RECIPROCITY AND RELIANCE BY ACCESSIBLE**  
20                           **HEALTH BENEFITS SYSTEMS ON OTHER**  
21                           **SUCH SYSTEMS.**

22          “The requirements of the preceding provisions of this  
23 subpart may be met with respect to any health benefits  
24 system by means of reciprocity agreements between such

1 system and any other such system with respect to which  
2 such requirements are met.

3 **“SEC. 627. REGULATORY AUTHORITY OF SECRETARY OF**  
4 **HEALTH AND HUMAN SERVICES.**

5 “The Secretary of Health and Human Services shall  
6 prescribe such regulations as such Secretary considers  
7 necessary to carry out the provisions of this subpart (other  
8 than section 622).

9 **“Subpart D—Coverage for Uninsurable Risks and**  
10 **Material Pre-Existing Conditions**

11 **“SEC. 631. COVERAGE FOR UNINSURABLE RISKS AND PRE-**  
12 **EXISTING CONDITIONS.**

13 “A health benefits system provides coverage in ac-  
14 cordance with this subpart if such system, such system  
15 in combination with one or more other health benefits sys-  
16 tems, or such system under voluntary participation in a  
17 program established by or under State law—

18 “(1) meets the participation requirements of  
19 section 632,

20 “(2) meets the benefits requirements of section  
21 633, and

22 “(3) to the extent practicable and actuarially  
23 sound, provides for separate accounting for such  
24 coverage so as to separately account at least for in-

1 individuals described in section 632(1)(A) and for in-  
2 dividuals described in section 632(2)(A).

3 **“SEC. 632. PARTICIPATION REQUIREMENTS FOR UNINSUR-**  
4 **ABLE RISKS AND MATERIAL PRE-EXISTING**  
5 **CONDITIONS.**

6 “A health benefits system meets the participation re-  
7 quirements of this section if the system meets the follow-  
8 ing requirements:

9 “(1) COVERAGE FOR UNINSURABLE RISKS.—  
10 The system provides that an individual is provided  
11 coverage under the system if—

12 “(A) such individual is an employee (or a  
13 dependent thereof) who has been excluded as an  
14 uninsurable risk from coverage under a basic  
15 health benefits provision included in the system  
16 or in a basic group health plan maintained by  
17 the employer, or

18 “(B) such individual is not an employee  
19 (or dependent) described in subparagraph (A),  
20 and—

21 “(i) would, in accordance with section  
22 623 (except section 623(a)(3)), be subject  
23 to exclusion from coverage under a basic  
24 health benefits provision included in the  
25 system, or

1           “(ii) in the case of an individual not  
2 otherwise eligible for coverage under a  
3 basic health benefits provision included in  
4 the system or in a basic group health plan  
5 or coverage under title XIX of the Social  
6 Security Act, is rejected for coverage under  
7 any policy of insurance which provides at  
8 least basic health care services described in  
9 section 601(a)(3)(A),

10 but would be eligible for such coverage but for  
11 the exclusion of such individual from coverage  
12 as an uninsurable risk.

13           “(2) COVERAGE FOR MATERIAL PRE-EXISTING  
14 CONDITIONS.—The system provides that an individ-  
15 ual is provided coverage under the system for any  
16 material pre-existing condition if—

17           “(A) such individual is an employee (or a  
18 dependent thereof) who is provided coverage  
19 under a basic health benefits provision included  
20 in the system or in a basic group health plan,  
21 subject to a substantial restriction based on  
22 such material pre-existing condition, or

23           “(B) such individual is not an employee  
24 (or dependent) described in subparagraph (A),  
25 and—

1           “(i) is provided coverage under a basic  
2 health benefits provision included in the  
3 system under subpart C, or

4           “(ii) in the case of an individual not  
5 otherwise eligible for coverage under a  
6 basic health benefits provision included in  
7 the system or in a basic group health plan  
8 or coverage under title XIX of the Social  
9 Security Act, is provided coverage under a  
10 policy of insurance which provides at least  
11 basic health care services,

12           but such coverage is provided subject to such a  
13 substantial restriction.

14 **“SEC. 633. BENEFITS REQUIREMENTS FOR UNINSURABLE**  
15 **RISKS AND MATERIAL PRE-EXISTING CONDI-**  
16 **TIONS.**

17           “A health benefits system meets the benefits require-  
18 ments of this section if the system provides, directly or  
19 through insurance, reinsurance, or otherwise—

20           “(1) in the case of individuals described in sec-  
21 tion 632(1), benefits described in section 624(a),  
22 and

23           “(2) in the case of individuals described in sec-  
24 tion 632(2), coverage of the material pre-existing  
25 condition which is not otherwise covered to the ex-



1 Health and Human Services shall not issue the reg-  
 2 ulations referred to in section 601(a)(3) of the Em-  
 3 ployee Retirement Income Security Act of 1974 in  
 4 final form before July 1, 1995.

5 (c) ENFORCEMENT OF CERTAIN PROVISIONS BY SEC-  
 6 RETARY OF HEALTH AND HUMAN SERVICES.—Section  
 7 502(a) of the Employee Retirement Income Security Act  
 8 of 1974 (29 U.S.C. 1132(a)) is amended by adding at the  
 9 end, after and below paragraph (6), the following new  
 10 flush sentence:

11 “With respect to provisions of subparts C and D of part  
 12 6 (other than section 622), the references to ‘Secretary’  
 13 in paragraph (5), and in other provisions of this part relat-  
 14 ing to actions brought under such paragraph, shall be  
 15 deemed a reference to the Secretary of Health and Human  
 16 Services.”.

17 (d) CLERICAL AMENDMENT.—The table of contents  
 18 in section 1 of such Act is amended by striking the items  
 19 relating to part 6 of subtitle B of title I and inserting  
 20 the following new items:

“PART 6—UNIVERSAL ACCESS TO COVERAGE UNDER GROUP HEALTH PLANS  
 AND STATE HEALTH BENEFITS SYSTEMS

“Subpart A—General Provisions

“Sec. 601. Definitions and special rules.

“Subpart B—Required Coverage Options; Group Health Payroll Deduction  
 Plans

“Sec. 611. Coverage for eligible individuals under basic group health plans or  
 group health payroll deduction plans.

“Sec. 612. Group health payroll deduction plans.

“Sec. 613. Availability of coverage under accessible health benefits systems.

“Subpart C—Accessible Health Benefits Systems

“Sec. 621. General requirements.

“Sec. 622. Reporting requirements.

“Sec. 623. Participation requirements.

“Sec. 624. Benefits requirements.

“Sec. 625. Contribution requirements.

“Sec. 626. Reciprocity and reliance by accessible health benefits systems on other such systems.

“Sec. 627. Regulatory Authority of Secretary of Health and Human Services.

“Subpart D—Coverage for Uninsurable Risks and Material Pre-Existing Conditions

“Sec. 631. Coverage for uninsurable risks and material pre-existing conditions.

“Sec. 632. Participation requirements for uninsurable risks and material pre-existing conditions.

“Sec. 633. Benefit requirements for uninsurable risks and material pre-existing conditions.

“Sec. 634. Regulatory authority of Secretary of Health and Human Services.

“Subpart E—Continuation Coverage Requirements

“Sec. 641. Plans must provide continuation coverage to certain individuals.

“Sec. 642. Continuation coverage.

“Sec. 643. Qualifying event.

“Sec. 644. Applicable premium.

“Sec. 645. Election.

“Sec. 646. Notice requirements.

“Sec. 647. Definitions.

“Sec. 648. Regulations.”.

1 **SEC. 102. ESTABLISHMENT OF STATE-BASED SYSTEM IN AB-**  
 2 **SENCE OF STATE-WIDE ACCESS TO COV-**  
 3 **ERAGE; SUBSTITUTE SYSTEMS.**

4 (a) STATE-BASED SYSTEMS.—

5 (1) IN GENERAL.—If, as of January 1, 1996,  
 6 one or more residents of any State (as defined in  
 7 section 3(10) of the Employee Retirement Income  
 8 Security Act of 1974 (29 U.S.C. 1002(10))) are—

9 (A) individuals described in section 623(a)  
 10 of such Act (as amended by this Act), and

1 (B) are eligible for coverage under none of  
2 the following:

3 (i) a basic group health plan (as de-  
4 fined in section 601(a)(2) of such Act (as  
5 amended by this Act)),

6 (ii) an accessible health benefits sys-  
7 tem meeting the requirements of subpart C  
8 (and subpart D as applicable) of part 6 of  
9 subtitle B of title I of such Act, and

10 (iii) a substitute health benefits sys-  
11 tem (as defined in subsection (b)(2)(A)),

12 then such State may establish and maintain a health  
13 benefits system covering such residents to the extent  
14 that such system is an accessible health benefits sys-  
15 tem established and maintained in accordance with  
16 this subsection and such subpart C (and such sub-  
17 part D as applicable).

18 (2) GOVERNANCE OF SYSTEM.—The system  
19 shall not be treated as meeting the requirements of  
20 this subsection unless such system—

21 (A) is administered by a nonprofit corpora-  
22 tion which is established by and regulated  
23 under the laws of such State,

24 (B) such corporation is governed by a  
25 Board of Directors whose membership includes

1 representatives of at least employers, employee  
2 organizations, and providers of group health  
3 plan coverage, and

4 (C) such corporation is subject under State  
5 law to the supervision of an agency of the State  
6 which is responsible for the regulation of pro-  
7 viders of group health plan coverage.

8 (3) EXCLUSIONS.—The system shall not be  
9 treated as meeting the requirements of this sub-  
10 section unless the system excludes from coverage—

11 (A) except to the extent permitted under  
12 section 625(c)(3) of the Employee Retirement  
13 Income Security Act of 1974 (as amended by  
14 this Act), individuals entitled to benefits under  
15 title XVIII or XIX of the Social Security Act,  
16 or

17 (B) inmates of public institutions.

18 (b) SUBSTITUTE BASIC HEALTH BENEFITS SYS-  
19 TEMS.—

20 (1) IN GENERAL.—If, at any time before the ef-  
21 fective date for the amendments made by section  
22 101, the Secretary of Health and Human Services  
23 determines, under regulations prescribed by the Sec-  
24 retary—

1 (A) that there is in effect, with respect to  
2 any group of individuals, an arrangement which  
3 is a substitute basic health benefits system, and

4 (B) that, with respect to such group of in-  
5 dividuals, such system meets requirements (pro-  
6 vided in such regulations) for a specified ele-  
7 ment of coverage which are substantially equiv-  
8 alent to the requirements of the specified  
9 ERISA provision which is applicable to such  
10 specified element of coverage,

11 then the requirements of such specified ERISA pro-  
12 vision shall be treated as met with respect to such  
13 individuals until such Secretary nullifies such deter-  
14 mination under such regulations.

15 (2) DEFINITIONS AND SPECIAL RULES.—For  
16 purposes of this subsection—

17 (A) SUBSTITUTE BASIC HEALTH BENEFITS  
18 SYSTEM.—The term “substitute basic health  
19 benefits system” means, with respect to any  
20 group of individuals, any arrangement (other  
21 than an accessible health benefits system estab-  
22 lished and maintained in accordance with sub-  
23 part C (and subpart D as applicable) of part 6  
24 of subtitle B of title I of ERISA) which—

1 (i) includes at least a basic health  
2 benefits provision (as defined in section  
3 601(a)(3) of ERISA), and

4 (ii) meets, with respect to such indi-  
5 viduals, the reporting requirements of sec-  
6 tion 622 of ERISA, the participation re-  
7 quirements of section 623 of ERISA, the  
8 benefits requirements of section 624 of  
9 ERISA, and the contribution requirements  
10 of section 625 of ERISA.

11 (B) SPECIFIED ELEMENT OF COVERAGE.—

12 The term “specified element of coverage”  
13 means any of the following:

14 (i) TREATMENT OF UNINSURABLE  
15 RISKS.—Exclusion from coverage of an in-  
16 dividual as an uninsurable risk under a  
17 basic health benefits provision included in  
18 a plan, within the meaning of section  
19 601(a)(7) of ERISA.

20 (ii) TREATMENT OF MATERIAL PRE-  
21 EXISTING CONDITIONS.—Coverage of an  
22 individual under a basic health benefits  
23 provision included in a plan subject to a  
24 restriction based on a material pre-existing

1 condition, within the meaning of section  
2 601(a)(8) of ERISA.

3 (iii) PROVISION OF CONTINUATION  
4 COVERAGE.—Provision of coverage by a  
5 plan to qualified beneficiaries required  
6 under subpart E of part 6 of subtitle B of  
7 title I of ERISA or under title XXII of the  
8 Public Health Service Act.

9 (C) SPECIFIED ERISA PROVISIONS.—

10 (i) TREATMENT OF UNINSURABLE  
11 RISKS.—The “specified ERISA provision”  
12 applicable to the specified element of cov-  
13 erage described in subparagraph (B)(i) is  
14 section 601(a)(2)(D)(i) of ERISA.

15 (ii) TREATMENT OF MATERIAL PRE-  
16 EXISTING CONDITIONS.—The “specified  
17 ERISA provision” applicable to the speci-  
18 fied element of coverage described in sub-  
19 paragraph (B)(ii) is section  
20 601(a)(2)(D)(ii) of ERISA.

21 (iii) PROVISION OF CONTINUATION  
22 COVERAGE.—The “specified ERISA provi-  
23 sions” applicable to the specified element  
24 of coverage described in subparagraph  
25 (B)(iii) are section 641(b) of ERISA, sec-

1                   tion 4980B(f)(8) of the Internal Revenue  
2                   Code of 1986, and section 2201(b) of the  
3                   Public Health Service Act.

4                   (D) STATE.—The term “State” has the  
5                   meaning provided in section 3(10) of ERISA.

6                   (E) ERISA.—The term “ERISA” means  
7                   the Employee Retirement Income Security Act  
8                   of 1974, as amended by this Act.

9                   (c) FEDERAL ASSISTANCE IN ESTABLISHMENT OF  
10                  UNIVERSAL ACCESS TO COVERAGE.—

11                  (1) GRANT PROGRAM.—The Secretary of  
12                  Health and Human Services shall establish by regu-  
13                  lation a program of monetary assistance in the form  
14                  of grants to accessible health benefits systems estab-  
15                  lished and maintained in accordance with subpart C  
16                  (and subpart D as applicable) of part 6 of subtitle  
17                  B of title I of the Employee Retirement Income Se-  
18                  curity Act of 1974 pursuant to the amendments  
19                  made by this Act. Grants to any system shall be in  
20                  such amount as such Secretary considers appro-  
21                  priate to facilitate the effectuation of the policies of  
22                  this Act.

23                  (2) AUTHORIZATION OF APPROPRIATIONS.—  
24                  There is authorized to be appropriated for the De-  
25                  partment of Health and Human Services, for the

1 purpose of carrying out the provisions of paragraph  
2 (1), \$200,000,000 for each of the fiscal years 1994,  
3 1995, and 1996.

4 **SEC. 103. CONTINUATION COVERAGE AND ACCESSIBLE**  
5 **HEALTH BENEFITS SYSTEMS OR SUBSTITUTE**  
6 **SYSTEMS.**

7 (a) AMENDMENT TO ERISA.—Section 641(b) of the  
8 Employee Retirement Income Security Act of 1974 (as re-  
9 designated by section 102) is amended to read as follows:

10 “(b) SUBSTITUTION OF ACCESSIBLE HEALTH BENE-  
11 FITS SYSTEM OR SUBSTITUTE SYSTEM.—The require-  
12 ments of this subpart may be met by providing, as an op-  
13 tion to qualified beneficiaries or otherwise, for coverage  
14 of them under an accessible health benefits system estab-  
15 lished and maintained in accordance with subpart C (and  
16 subpart D as applicable), or under a substitute health ben-  
17 efits system providing continuation coverage in accordance  
18 with section 102 of the Universal Health Benefits  
19 Empowerment and Partnership Act of 1993, in lieu of cov-  
20 erage as otherwise required under this subpart.”.

21 (b) CONFORMING AMENDMENT TO INTERNAL REVE-  
22 NUE CODE.—Section 4980B of the Internal Revenue Code  
23 of 1986 (relating to excise tax for failure to satisfy con-  
24 tinuation coverage requirements of group health plans) is  
25 amended—

1 (1) in subsection (d), by striking paragraph (1)  
2 and redesignating paragraphs (2) and (3) as para-  
3 graphs (1) and (2), respectively; and

4 (2) by adding at the end of subsection (f) the  
5 following new paragraph:

6 “(8) SUBSTITUTION OF ACCESSIBLE HEALTH  
7 BENEFITS SYSTEM OR SUBSTITUTE SYSTEM.—The  
8 requirements of this subsection may be met by pro-  
9 viding, as an option to qualified beneficiaries or oth-  
10 erwise, for coverage of them under an accessible  
11 health benefits system established and maintained in  
12 accordance with subpart C (and subpart D as appli-  
13 cable) of part 6 of subtitle B of title I of the Em-  
14 ployee Retirement Income Security Act of 1974, or  
15 under a substitute health benefits system providing  
16 continuation coverage in accordance with section 102  
17 of the Universal Health Benefits Empowerment and  
18 Partnership Act of 1993, in lieu of coverage as oth-  
19 erwise required under this subsection.”.

20 (c) CONFORMING AMENDMENT TO PUBLIC HEALTH  
21 SERVICE ACT.—Section 2201 of the Public Health Service  
22 Act is amended by striking subsection (b) and inserting  
23 the following new subsection:

24 “(b) SUBSTITUTION OF ACCESSIBLE HEALTH BENE-  
25 FITS SYSTEM OR SUBSTITUTE SYSTEM.—The require-

1 ments of this title may be met by providing, as an option  
2 to qualified beneficiaries or otherwise, for coverage of  
3 them under an accessible health benefits system estab-  
4 lished and maintained in accordance with subpart C (and  
5 subpart D as applicable) of part 6 of subtitle B of title  
6 I of the Employee Retirement Income Security Act of  
7 1974, or under a substitute health benefits system provid-  
8 ing continuation coverage in accordance with section 102  
9 of the Universal Health Benefits Empowerment and Part-  
10 nership Act of 1993, in lieu of coverage as otherwise re-  
11 quired under this title.”.

12 **SEC. 104. PREEMPTION OF STATE LAW TO PROVIDE FOR**  
13 **MORE AFFORDABLE HEALTH CARE COV-**  
14 **ERAGE.**

15 (a) IN GENERAL.—Section 514(b)(2)(B) of the Em-  
16 ployee Retirement Income Security Act of 1974 (29  
17 U.S.C. 1144(b)(2)(B)) is amended—

18 (1) by inserting “(i)” after “(B)”; and

19 (2) by adding at the end the following new  
20 clause:

21 “(ii) A provision of State law which provides that one  
22 or more specific benefits must be provided or made avail-  
23 able by a contract or policy of health insurance issued to  
24 an employee benefit plan, or which provides that services  
25 rendered by one or more particular classes of health care

1 providers must be covered under such a contract or policy,  
2 is a law which relates to an employee benefit plan within  
3 the meaning of subsection (a) and is not a law which regu-  
4 lates insurance within the meaning of subparagraph (A).”.

5 (b) PREEMPTION OF CERTAIN STATE LAWS RE-  
6 STRICTING MANAGED CARE UNDER EMPLOYEE WELFARE  
7 BENEFIT PLANS.—Section 514(b) of such Act is amended  
8 by adding at the end the following new paragraph:

9 “(9) For purposes of this section, a provision of State  
10 law which in any manner restricts managed care under  
11 an employee welfare benefit plan providing medical care  
12 (as defined in section 213(d) of the Internal Revenue Code  
13 of 1986) to participants or beneficiaries directly or  
14 through insurance, reimbursement, or otherwise, by re-  
15 stricting the ability to negotiate provider reimbursement  
16 rates or to set such rates for any provider, limiting the  
17 number or type of providers, or restricting utilization or  
18 quality review in connection with such plan shall be  
19 deemed a law which relates to an employee benefit plan  
20 within the meaning of subsection (a) and not a law which  
21 regulates insurance within the meaning of paragraph  
22 (2)(A).”.

1 **SEC. 105. ENCOURAGEMENT OF MULTIPLE EMPLOYER AR-**  
2 **RANGEMENTS PROVIDING BASIC HEALTH**  
3 **BENEFITS.**

4 Paragraph (9) of section 501(c) of the Internal Reve-  
5 nue Code of 1986 (relating to exempt organizations) is  
6 amended—

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

8 (2) by adding at the end the following:

9 “(B) Any determination of whether a multiple  
10 employer welfare arrangement (as defined in section  
11 3(25) of the Employee Retirement Income Security  
12 Act of 1974) is a voluntary employees’ beneficiary  
13 association meeting the requirements of this para-  
14 graph shall be made without regard to any deter-  
15 mination of commonality of interest or geographic  
16 location if—

17 “(i) such arrangement provides at least  
18 basic health care services described in section  
19 601(a)(3)(A) of the Employee Retirement In-  
20 come Security Act of 1974, and

21 “(I) such arrangement is fully in-  
22 sured, or

23 “(II) meets the requirements  
24 enforceable under section 514(b)(6)(B)(i) of  
25 such Act, and

1           “(ii) meets reporting requirements which  
2           shall be prescribed by the Secretary and are  
3           similar to the requirements of section 622 of  
4           such Act.”.

5 **SEC. 106. TREATMENT PRACTICE GUIDELINES AND OUT-**  
6 **COMES RESEARCH FOR ALL AMERICANS.**

7           (a) AGENCY FOR HEALTH CARE POLICY AND RE-  
8 SEARCH.—So much of part A of title IX of the Public  
9 Health Service Act as precedes section 902(c) is amended  
10 to read as follows:

11       “PART A—ESTABLISHMENT AND GENERAL DUTIES

12 **“SEC. 901. ESTABLISHMENT.**

13       “(a) IN GENERAL.—There is established within the  
14 Service an agency to be known as the Agency for Health  
15 Care Policy and Research.

16       “(b) PURPOSE.—The purpose of the Agency is to en-  
17 hance the quality, appropriateness, and effectiveness of  
18 health care services for all Americans, and access to such  
19 services, through the establishment of a broad base of sci-  
20 entific research and through the promotion of improve-  
21 ments in clinical practice and in the organization, financ-  
22 ing, and delivery of health care services.

23       “(c) APPOINTMENT OF ADMINISTRATOR.—There  
24 shall be at the head of the Agency an official to be known  
25 as the Administrator for Health Care Policy and Re-

1 search. The Administrator shall be appointed by the Sec-  
2 retary. The Secretary, acting through the Administrator,  
3 shall carry out the authorities and duties established in  
4 this title.

5 **“SEC. 902. GENERAL AUTHORITIES AND DUTIES.**

6 “(a) IN GENERAL.—In carrying out section 901(b),  
7 the Administrator shall conduct and support research,  
8 demonstration projects, evaluations, training, guideline de-  
9 velopment, and the dissemination of information, on  
10 health care services and on systems for the delivery of  
11 such services to all Americans, including activities with re-  
12 spect to—

13 “(1) the effectiveness, efficiency, and quality of  
14 health care services;

15 “(2) subject to subsection (d), the outcomes of  
16 health care services and procedures;

17 “(3) clinical practice, including primary care  
18 and practice-oriented research;

19 “(4) health care technologies, facilities, and  
20 equipment;

21 “(5) health care costs, productivity, and market  
22 forces;

23 “(6) health promotion and disease prevention;

24 “(7) health statistics and epidemiology; and

25 “(8) medical liability.



1   fectiveness in Health Care. For the purpose of promoting  
2   the quality, appropriateness, and effectiveness of health  
3   care, the Director, using the process set forth in section  
4   913, shall arrange for the development and periodic review  
5   and updating of—

6           “(1) clinically relevant guidelines that may be  
7           used by physicians, educators, and health care prac-  
8           titioners to assist in determining how diseases, dis-  
9           orders, and other health conditions can most effec-  
10          tively and appropriately be prevented, diagnosed,  
11          treated, and managed clinically; and

12          “(2) standards of quality, performance meas-  
13          ures, and medical review criteria through which  
14          health care providers and other appropriate entities  
15          may assess or review the provision of health care  
16          and assure the quality of such care.

17          “(b) CERTAIN REQUIREMENTS.—Guidelines, stand-  
18          ards, performance measures, and review criteria under  
19          subsection (a) shall—

20               “(1) be based on the best available research and  
21               professional judgment regarding the effectiveness  
22               and appropriateness of health care services and pro-  
23               cedures;

24               “(2) be presented—

1           “(A) in formats appropriate for use by  
2 physicians, health care practitioners, providers,  
3 medical educators, and medical review organiza-  
4 tions,

5           “(B) in formats appropriate for use by  
6 group health plans (as defined in section  
7 601(a)(1) of the Employee Retirement Income  
8 Security Act of 1974), health benefits systems  
9 established and maintained by States in accord-  
10 ance with subpart C of part 6 of subtitle B of  
11 title I of the Employee Retirement Income Se-  
12 curity Act of 1974, and substitute basic health  
13 benefits systems with respect to which the Sec-  
14 retary has made a determination pursuant to  
15 section 4 of the Universal Health Benefits  
16 Empowerment and Partnership Act of 1990 re-  
17 lating to an element of coverage described in  
18 section 4(a)(2)(B) of such Act, and

19           “(C) in formats appropriate for use by  
20 consumers of health care; and

21           “(3) include treatment-specific or condition-spe-  
22 cific practice guidelines for clinical treatments and  
23 conditions in forms appropriate for use in clinical  
24 practice, for use in educational programs, and for

1 use in reviewing quality and appropriateness of med-  
2 ical care.”.

3 (c) DISSEMINATION OF STANDARDS, CRITERIA,  
4 ETC.—Section 914(c) of the Public Health Service Act is  
5 amended to read as follows:

6 “(c) DISSEMINATION.—

7 “(1) IN GENERAL.—The Director shall promote  
8 and support the dissemination of the guidelines,  
9 standards, performance measures, and review cri-  
10 teria described in section 912(a).

11 “(2) ORGANIZATIONS UTILIZED.—Such dissemi-  
12 nation shall be carried out through—

13 “(1) organizations representing health care  
14 providers;

15 “(2) group health plans (as defined in sec-  
16 tion 601(a)(1) of the Employee Retirement In-  
17 come Security Act of 1974);

18 “(3) accessible health benefits systems es-  
19 tablished and maintained in accordance with  
20 subpart C (and subpart D as applicable) of part  
21 6 of subtitle B of title I of the Employee Re-  
22 tirement Income Security Act of 1974;

23 “(4) organizations representing health care  
24 consumers;

25 “(5) peer review organizations;

1                   “(6) accrediting bodies; and

2                   “(7) other appropriate entities.”.

3           (d) STUDY OF ROLE OF PRACTICE GUIDELINES IN  
4 REDUCING MALPRACTICE COSTS.—As soon as practicable  
5 after the date of the enactment of this Act, the Federal  
6 Advisory Council on Health Care Coverage and Costs shall  
7 undertake a study of the manner in which practice guide-  
8 lines may be used in reducing medical malpractice costs.  
9 The Council shall submit the results of such study to-  
10 gether with any recommendations to the Secretary of  
11 Health and Human Services.

12           (e) AUTHORIZATION OF ADDITIONAL APPROPRIA-  
13 TIONS.—Section 926(a) of the Public Health Service Act  
14 is amended by adding at the end the following: “In addi-  
15 tion to amounts otherwise authorized by this subsection,  
16 for the purpose of carrying out the amendments made by  
17 section 8 of the Universal Health Benefits Empowerment  
18 and Partnership Act of 1993, there are authorized to be  
19 appropriated \$10,000,000 for fiscal year 1994,  
20 \$15,000,000 for fiscal year 1995, and \$20,000,000 for fis-  
21 cal year 1996.”.

22 **SEC. 107. FEDERAL ADVISORY COUNCIL ON HEALTH CARE**  
23 **COVERAGE AND COSTS.**

24           (a) IN GENERAL.—There is hereby established a  
25 Federal Advisory Council on Health Care Coverage and

1 Costs for the purpose of reviewing, overseeing, and making  
2 recommendations relating to the implementation of the  
3 provisions of this Act and studying the causes of changes  
4 in the costs of health care coverage and delivery.

5 (b) MEMBERSHIP.—The Council shall consist of a  
6 Chairman and 12 other persons, appointed by the Sec-  
7 retary of Health and Human Services with the concur-  
8 rence of the Secretary of Labor and without regard to the  
9 provisions of title 5, United States Code, governing ap-  
10 pointments in the competitive service. The appointed  
11 members shall, to the extent possible, represent organiza-  
12 tions of small and large employers, employee organiza-  
13 tions, health care providers, providers of group health plan  
14 coverage, State and local governments, the field of actuar-  
15 ial counseling, and the general public.

16 (c) EXPENSES.—

17 (1) SERVICES AND ASSISTANCE.—The Council  
18 is authorized to engage such technical assistance, in-  
19 cluding actuarial services, as may be required to  
20 carry out its functions, and the Secretary of Health  
21 and Human Services and the Secretary of Labor  
22 shall, in addition, make available to the Council such  
23 secretarial, clerical, and other assistance as it may  
24 require to carry out such functions. The Secretary of  
25 Health and Human Services and the Secretary of

1 Labor shall, in addition, make available to the Coun-  
2 cil such actuarial and other pertinent data prepared  
3 by the Department of Health and Human Services,  
4 the Department of Labor, or other agencies of the  
5 Government as it may require to carry out such  
6 functions.

7 (2) TRAVEL AND PER DIEM.—Appointed mem-  
8 bers of the Council, while serving on the business of  
9 the Council (inclusive of travel time), while so serv-  
10 ing away from their homes or regular places of busi-  
11 ness, may be allowed travel expenses, including per  
12 diem in lieu of subsistence, as authorized by section  
13 5703 of title 5, United States Code, for persons in  
14 the Government employed intermittently.

15 (d) FUNCTIONS.—The Council shall—

16 (1) make timely recommendations to the Sec-  
17 retary of Health and Human Services for purposes  
18 of the issuance of initial regulations under section  
19 101(b)(1),

20 (2) make recommendations to the Secretary of  
21 Health and Human Services relating to appropriate  
22 mechanisms for and the frequency of revisions of  
23 regulations under section 601(a)(3) of the Employee  
24 Retirement Income Security Act of 1974 (as amend-  
25 ed by this Act),

1           (3) otherwise advise the Secretary of Health  
2           and Human Services and the Secretary of Labor  
3           with respect to the implementation of the amend-  
4           ments made by this Act,

5           (4) offer States and other entities advice re-  
6           garding health benefits systems and implementation  
7           of the amendments made by this Act,

8           (5) serve as a forum for exchange of advice,  
9           recommendations, and information regarding the  
10          amendments made by this Act, their implementation,  
11          and health benefits systems established and main-  
12          tained by States, and otherwise foster cooperation  
13          between States and other entities in implementing  
14          such amendments,

15          (6) make from time to time such recommenda-  
16          tions as it considers appropriate relating to possible  
17          improvements relating to the financing and afford-  
18          ability of health care coverage for individuals eligible  
19          for coverage under health benefits systems estab-  
20          lished and maintained by States and other entities,  
21          and

22          (7) make from time to time such recommenda-  
23          tions to the Secretary of Health and Human Serv-  
24          ices and to the Congress as it considers appropriate

1 relating to changes in the costs of health care cov-  
2 erage and delivery.

3 (e) REPORTS.—The Council shall, at least annually,  
4 submit a report to the Secretary of Health and Human  
5 Services and the Secretary of Labor of any findings or  
6 recommendations relating to matters considered by the  
7 Council, and such reports shall thereupon be transmitted  
8 to the Congress.

9 (f) FINAL REPORT AND TERMINATION.—Upon the  
10 request of the Secretary of Health and Human Services,  
11 the Council shall submit a final report to such Secretary  
12 and the Secretary of Labor. The Council shall terminate  
13 upon the submission of such final report.

14 **SEC. 108. INCREASE IN DEDUCTION FOR HEALTH INSUR-**  
15 **ANCE COSTS OF SELF-EMPLOYED INDIVID-**  
16 **UALS FROM 25 PERCENT TO 100 PERCENT.**

17 (a) IN GENERAL.—Paragraph (1) of section 162(l)  
18 of the Internal Revenue Code of 1986 (relating to special  
19 rules for health insurance costs of self-employed individ-  
20 uals) is amended by striking “25 percent” and inserting  
21 “the applicable percentage”.

22 (b) APPLICABLE PERCENTAGE.—Paragraph (6) of  
23 section 162(l) of such Code is amended to read as follows:

24 “(6) APPLICABLE PERCENTAGE.—For purposes  
25 of paragraph (1)—

<b>In the case of taxable years beginning in calendar year:</b>	<b>The applicable percentage is:</b>
1992, 1993, 1994, or 1995 .....	25 percent
1996 or 1997 .....	50 percent
1998 or thereafter .....	100 percent.”

1 **SEC. 109. EFFECTIVE DATES.**

2 (a) SECTIONS 101 AND 103.—The amendments made  
3 by section 101 shall take effect January 1, 1996, and the  
4 amendments made by section 103 shall apply with respect  
5 to plan years beginning on or after such date.

6 (b) SECTION 102.—The provisions of section 102  
7 shall take effect on the date of the enactment of this Act.

8 (c) SECTION 104.—The amendments made by section  
9 104(b) shall take effect January 1, 1994. The amend-  
10 ments made by section 104(a) shall take effect January  
11 1, 1994, except that with respect to plans in effect on the  
12 date of the enactment of this Act, such amendments shall  
13 take effect on the effective date of section 101.

14 (d) SECTION 105.—The amendments made by sec-  
15 tion 105 shall apply with respect to determinations made  
16 on or after January 1, 1994.

17 (e) SECTION 106.—The amendments made by section  
18 106 shall take effect January 1, 1994.

19 (f) SECTION 107.—The provisions of section 107  
20 shall take effect on the date of the enactment of this Act.

1 (g) SECTION 108.—The amendments made by sec-  
 2 tion 108 shall apply with respect to taxable years begin-  
 3 ning on or after January 1, 1992.

4 **TITLE II—MEDICAL AND HEALTH**  
 5 **INSURANCE INFORMATION**  
 6 **REFORM**

7 **SEC. 201. SHORT TITLE.**

8 This title may be cited as the “Medical and Health  
 9 Insurance Information Reform Act of 1993”.

10 **SEC. 202. MEDICAL AND HEALTH INSURANCE INFORMA-**  
 11 **TION REFORM.**

12 The Social Security Act, as amended by section 202,  
 13 is further amended by adding at the end the following new  
 14 title:

15 “TITLE XXII—MEDICAL AND HEALTH  
 16 INSURANCE INFORMATION REFORM

17 “PART A—COMPARATIVE VALUE INFORMATION

18 “COMPARATIVE VALUE INFORMATION PROGRAMS FOR

19 HEALTH CARE PURCHASING

20 “SEC. 2200. (a) PURPOSE.—In order to assure the  
 21 availability of comparative value information to purchasers  
 22 of health care in each State, the Secretary shall determine  
 23 whether each State is developing and implementing a  
 24 health care value information program that meets the cri-  
 25 teria and the schedule set out in subsection (b).

1       “(b) CRITERIA FOR STATE PROGRAMS.—A State’s  
2 health care value information program shall be determined  
3 by the Secretary to meet the criteria and the schedule of  
4 this subsection if—

5           “(1) the State begins promptly after enactment  
6 of this section to develop (directly or through con-  
7 tractual or other arrangements with coalitions of  
8 health care purchasers, one or more States, other  
9 entities, or any combination of such arrangements)  
10 information systems regarding comparative health  
11 care values;

12           “(2) the information contained in such systems  
13 covers at least the average prices of common health  
14 care services (as defined in subsection (c)) and infor-  
15 mation related to the value of each health insurance  
16 plan available in the State, including premium costs  
17 and the value of benefits, and, where available,  
18 measures of the variability of those prices within the  
19 State or other market areas;

20           “(3) the information described in paragraph (2)  
21 is made available within the State beginning not  
22 later than one year after enactment of this section,  
23 and is revised as frequently as reasonably necessary,  
24 but at intervals of no greater than one year; and

1           “(4) not later than four years following the en-  
2           actment of this section, the State has developed in-  
3           formation systems that provide comparative quality  
4           and outcomes data with respect to health insurance  
5           plans and hospitals and made the information broad-  
6           ly available within the relevant market areas.

7           “(c) DEFINITION.—For purposes of this section,  
8           ‘common health care services’ includes such procedures as  
9           the Secretary may specify and any additional health care  
10          services which a State may wish to include in its compara-  
11          tive value information program.

12          “(d) FEDERAL IMPLEMENTATION.—If the Secretary  
13          finds, at any time, that a State has not developed a health  
14          care value information program, or has failed to imple-  
15          ment it (on a continuing basis) in accordance with the cri-  
16          teria and schedule set out in subsection (b), he shall take  
17          the actions necessary, directly or through grant or con-  
18          tract, to implement a comparable program in such State.  
19          Fees may be charged by the Secretary for the informa-  
20          tional materials provided pursuant to such program. Any  
21          amounts so collected shall be deposited in the appropria-  
22          tion account from which the Secretary’s costs of develop-  
23          ing and providing such materials were met, and shall re-  
24          main available for such purposes until expended.

1       “(e) COMPARATIVE VALUE INFORMATION CONCERN-  
2   ING FEDERAL PROGRAMS.—The head of each Federal  
3   agency with responsibility for the provision of health in-  
4   surance, or of health care services, to individuals shall  
5   promptly develop health care value information relating to  
6   each program that he administers, and covering types of  
7   data comparative to the types of data that a State pro-  
8   gram meeting the criteria of this part would provide. Such  
9   information shall be made generally available to States  
10  and to providers and consumers of health care services.

11       “(f) INFORMATION FOR RESEARCH FROM INSUR-  
12  ERS.—

13           “(1) The Secretary, after consulting with insur-  
14   ers, providers, and others, shall promulgate (and  
15   may modify from time to time) requirements for the  
16   periodic submission by insurers to the Secretary on  
17   a sample basis of health care data relevant to re-  
18   search concerning health care services, and shall  
19   promulgate an effective date for those requirements,  
20   to be at least one year after their promulgation.

21           “(2) Each insurer shall comply with the re-  
22   quirements specified by the Secretary under para-  
23   graph (1) by the effective date specified by the Sec-  
24   retary.

1           “(3) For provisions imposing an excise tax with  
2           respect to noncompliance with Federal requirements  
3           under this subsection, see section 5000A of the In-  
4           ternal Revenue Code of 1986.

5           “(g) RELEASE OF MEDICARE INFORMATION.—

6           “(1) The Department of Health and Human  
7           Services shall make available, under section 552 of  
8           title 5, United States Code, all records of claims  
9           filed under the programs established by title XVIII  
10          of the Social Security Act, without regard to the  
11          consent of the physician or other individual who fur-  
12          nished the item or service in question.

13          “(2)(A) Paragraph (1) shall not affect any pro-  
14          hibition against disclosure under section 552a of  
15          title 5, United States Code, with respect to any indi-  
16          vidual to whom an item or service was furnished.

17          “(B) The requirement of paragraph (1) does  
18          not apply to information received by the Department  
19          of Health and Human Services, or by any of its con-  
20          tractors, before the date of enactment of the Medical  
21          and Health Insurance Information Reform Act of  
22          1994.

23          “(h) DEVELOPMENT OF MODEL SYSTEMS.—

24          “(1) The Secretary shall, directly or through  
25          grant or contract, develop model systems to facilitate

1 gathering of health care cost, quality, and outcomes  
2 data and analyzing such data in a manner that will  
3 permit the valid comparison of such data cost, qual-  
4 ity, and outcomes among providers and among  
5 health plans. The Secretary shall support experimen-  
6 tation with different approaches to achieve the objec-  
7 tives of the preceding sentence in the most cost ef-  
8 fective manner (relative to the accuracy and timeli-  
9 ness of the data secured) and shall evaluate the var-  
10 ious methods to determine their relative success.  
11 When he considers it appropriate, the Secretary may  
12 establish standards for the collection and reporting  
13 of health care cost, quality, and outcomes data in  
14 order to facilitate analysis and comparisons among  
15 States and nationally.

16 “(2) There are authorized to be appropriated  
17 such sums as are necessary for each fiscal year be-  
18 ginning with fiscal year 1994, to enable the Sec-  
19 retary to conduct the activities required by para-  
20 graph (1), including evaluation of the different ap-  
21 proaches tested under such paragraph and their rel-  
22 ative cost effectiveness.

23 “GRANTS FOR THE DEVELOPMENT OF STATE PROGRAMS

24 “SEC. 2201. (a) GRANT AUTHORITY.—The Secretary  
25 may make grants to each State to enable such State to  
26 plan the development of its health care value information

1 program described in section 2200, and if necessary, to  
2 initiate the implementation of such program. Each State  
3 seeking such a grant shall submit an application therefor,  
4 containing such information as the Secretary finds nec-  
5 essary to assure that the State is likely to develop and  
6 implement a program in accordance with the criteria and  
7 schedule of section 2200(b).

8       “(b) OFFSET AUTHORITY.—If, at any time within the  
9 three year period following the receipt by a State of a  
10 grant pursuant to subsection (a), the Secretary is required  
11 by section 2200(d) to implement a health care information  
12 program in such State, he may recover the amount of the  
13 grant under subsection (a) by offset against any other  
14 amount payable to such State under this Act. The amount  
15 of the offset shall be made available (from the appropria-  
16 tion account with respect to which the offset was taken)  
17 to the Secretary to carry out section 2200(d) in such  
18 State.

19       “(c) AUTHORIZATION OF APPROPRIATIONS.—There  
20 are authorized to be appropriated such sums as are nec-  
21 essary to carry out this section, to remain available until  
22 expended.

1 “PART B—STORAGE AND TRANSMISSION OF MEDICAL  
2 AND HEALTH INSURANCE INFORMATION AND PRI-  
3 ORITY OF PAYMENT

4 “PREEMPTION OF STATE QUILL PEN LAWS

5 “SEC. 2210. After 1994, no effect shall be given to  
6 any provision of State law that requires medical or health  
7 insurance records (including billing information) to be  
8 maintained in written, rather than electronic, form.

9 “PROMULGATION OF REQUIREMENTS BY SECRETARY

10 “SEC. 2211. (a) HEALTH INSURANCE INFORMATION  
11 PRIVACY AND CONFIDENTIALITY PROTECTION.—

12 “(1) The Secretary, after taking into consider-  
13 ation the Insurance Information and Privacy Protec-  
14 tion Model Act of the NAIC, shall promulgate by  
15 January 1, 1994, (and may modify from time to  
16 time) requirements concerning health insurance in-  
17 formation privacy and confidentiality protection for  
18 individuals. There shall be included a requirement  
19 that information that identifies individuals shall not  
20 be redisclosed (with such limited exceptions as the  
21 Secretary may provide) except to the extent nec-  
22 essary to carry out the purpose for which the infor-  
23 mation was collected.

24 “(2) The Secretary, in promulgating require-  
25 ments under paragraph (1), shall take into consider-

1        ation the following principles concerning information  
2        that identifies individuals:

3                “(A) Such information should be collected  
4                only to the extent necessary to carry out the  
5                purpose for which the information is collected.

6                “(B) Such information collected for one  
7                purpose should not be used for another purpose  
8                without the individual’s informed consent.

9                “(C) Such information should be disposed  
10               of when no longer necessary to carry out the  
11               purpose for which it was collected.

12               “(D) Methods to ensure the accuracy, reli-  
13               ability, relevance, completeness, and timeliness  
14               of such information should be instituted.

15               “(E) Individuals should be notified (in ad-  
16               vance of the collection of such information) as  
17               to whether the furnishing of such information is  
18               mandatory or voluntary, as to what the record  
19               keeping practices are concerning such informa-  
20               tion, and as to what uses will be made of such  
21               information.

22               “(F) Individuals should be permitted to in-  
23               spect and correct such information concerning  
24               themselves.

1       “(b) STANDARDS AND REQUIREMENTS FOR THE  
2 ELECTRONIC RECEIPT AND TRANSMISSION OF HEALTH  
3 INSURANCE INFORMATION.—

4           “(1) By January 1, 1995, the Secretary shall  
5 determine whether problems relating to standards  
6 for the electronic receipt and transmission of health  
7 insurance information cause significant administra-  
8 tive costs. If the Secretary determines that such  
9 problems do cause significant administrative costs,  
10 the Secretary, after consulting with the Accredited  
11 Standards Committee X-12 of the American Na-  
12 tional Standards Institute, insurers, providers, and  
13 others, shall promulgate (and may modify from time  
14 to time) standards concerning the electronic receipt  
15 and transmission of claims, payment, eligibility, and  
16 enrollment information (including requirements, con-  
17 sistent with those promulgated under subsection (a),  
18 to protect privacy and confidentiality), and shall pro-  
19 mulgate an effective date for those standards, to be  
20 at least one year after the promulgation of the  
21 standards.

22           “(2) By January 1, 1995, the Secretary shall  
23 determine whether problems relating to the receipt  
24 and transmission of health insurance eligibility ver-  
25 ification cause significant administrative costs. If the

1 Secretary determines that such problems do cause  
2 significant administrative costs, the Secretary, after  
3 consulting with the Accredited Standards Committee  
4 X-12 of the American National Standards Institute,  
5 insurers, providers, and others, shall promulgate  
6 (and may modify from time to time) requirements  
7 concerning the receipt and transmission of health in-  
8 surance eligibility verification, and shall promulgate  
9 an effective date for those requirements, to be at  
10 least one year after the promulgation of the require-  
11 ment.

12 “(3) By January 1, 1995, the Secretary shall  
13 determine whether the proportion of health insur-  
14 ance claims and payment information received and  
15 transmitted by paper will continue to cause signifi-  
16 cant administrative costs. If the Secretary deter-  
17 mines that the proportion will continue to cause sig-  
18 nificant administrative costs, the Secretary, after  
19 consulting with the Accredited Standards Committee  
20 X-12 of the American National Standards Institute,  
21 insurers, providers, and others, shall promulgate  
22 (and may modify from time to time) a requirement  
23 that insurers receive and transmit a specified pro-  
24 portion of (or all) health insurance claims and pay-  
25 ment information electronically (with such excep-

1 tions as the Secretary may specify from time to  
2 time), and shall promulgate an effective date for  
3 that requirement, to be at least one year after the  
4 promulgation of the requirement.

5 “(c) HEALTH INSURANCE CLAIM FORMS.—

6 “(1) By January 1, 1995, the Secretary, after  
7 consulting with insurers, providers, and others, shall  
8 promulgate (and may modify from time to time) re-  
9 quirements for the format and content of basic claim  
10 forms under health insurance plans.

11 “(2) The Secretary shall determine whether the  
12 variety of information requested by insurers (in ad-  
13 dition to the information requested in basic claim  
14 forms) causes administrative costs that are dis-  
15 proportionate to the benefits derived from that infor-  
16 mation. If the Secretary determines that the variety  
17 of information requested does cause such costs, the  
18 Secretary, after consulting with insurers, providers,  
19 and others, shall publish (and may modify from time  
20 to time) recommendations concerning what addi-  
21 tional information should be allowed to be requested  
22 and in what format.

23 “(d) PRIORITY AMONG INSURERS.—By January 1,  
24 1995, but after June 30, 1994, the Secretary, after con-  
25 sulting with the NAIC, shall promulgate (and may modify

1 from time to time) rules for determining the liability of  
2 insurers when benefits are payable under two or more  
3 health insurance plans.

4 “(e) FURNISHING OF INFORMATION AMONG INSUR-  
5 ERS.—By January 1, 1996, but after June 30, 1995, the  
6 Secretary shall determine whether problems relating to the  
7 availability of information among insurers when benefits  
8 are payable under two or more health insurance plans  
9 cause significant mistaken benefit payments or adminis-  
10 trative costs. If the Secretary determines that such prob-  
11 lems do cause significant mistaken benefit payments or  
12 administrative costs, the Secretary shall promulgate (and  
13 may modify from time to time) requirements concerning  
14 the transfer among insurers (and annual updating) of ap-  
15 propriate information (which may include requirements  
16 for the use of unique identifiers, and for the listing of all  
17 individuals covered under a health insurance plan), and  
18 shall promulgate an effective date for those requirements  
19 (to be not earlier than one year after the promulgation  
20 of the requirements).

21 “STATE PROGRAMS

22 “SEC. 2212. The Secretary shall determine from time  
23 to time, for each State, whether—

24 “(1) the State has in effect standards, require-  
25 ments, and rules (for insurers other than adminis-  
26 trators of self-insured employee plans) substantially

1 the same (or, for section 2214, at least as protective  
2 of privacy and confidentiality) as those described in  
3 sections 2214 through 2219, and

4 “(2) the State maintains an effective enforce-  
5 ment mechanism for those State requirements.

6 “APPLICATION OF FEDERAL REQUIREMENTS

7 “SEC. 2213. (a) ADMINISTRATORS OF SELF-INSURED  
8 EMPLOYEE PLANS.—The provisions in each of sections  
9 2214 through 2219 apply to administrators of self-insured  
10 employee plans.

11 (b) OTHER INSURERS.—The provisions in each of  
12 sections 2214 through 2219 apply to activities (of insurers  
13 other than administrators of self-insured employee plans)  
14 in a State only if—

15 “(1) with respect to a section, the Secretary de-  
16 termines that the State does not meet the require-  
17 ments of section 2212, or

18 “(2) with respect to a section, the State fails to  
19 provide such information from time to time as re-  
20 quested by the Secretary to enable the Secretary to  
21 make a determination under section 2212.

22 “HEALTH INSURANCE INFORMATION PRIVACY AND  
23 CONFIDENTIALITY PROTECTION

24 “SEC. 2214. As of January 1, 1995, each insurer  
25 shall comply with the requirements promulgated by the  
26 Secretary under section 2211(a).

1                   “IDENTIFICATION NUMBERS

2           “SEC. 2215. As of January 1, 1995, each insurer  
3 shall—

4                   “(1) for each of its beneficiaries that has a so-  
5 cial security number, use that number, and

6                   “(2) for each provider that has a unique identi-  
7 fier for purposes of title XVIII and that furnishes  
8 health care items or services to a beneficiary under  
9 a health insurance plan of that insurer, use that  
10 identifier.

11 “STANDARDS AND REQUIREMENTS FOR THE RECEIPT  
12 AND TRANSMISSION OF HEALTH INSURANCE INFOR-  
13 MATION

14           “SEC. 2216. If the Secretary promulgates standards  
15 or requirements under section 2211(b), each insurer, by  
16 the effective date specified by the Secretary for those  
17 standards or requirements, shall comply with them.

18                   “HEALTH INSURANCE CLAIM FORMS

19           “SEC. 2217. As of January 1, 1996, each insurer  
20 shall comply with the requirements promulgated by the  
21 Secretary under section 2211(c)(1).

22                   “PRIORITY AMONG INSURERS

23           “SEC. 2218. As of January 1, 1996, each insurer  
24 shall comply with the rules promulgated by the Secretary  
25 under section 2211(d).

1 “FURNISHING OF INFORMATION AMONG INSURERS

2 “SEC. 2219. If the Secretary promulgates require-  
3 ments under section 2211(e), each insurer, by the effective  
4 date specified by the Secretary for those requirements,  
5 shall comply with them.

6 “NONCOMPLIANCE WITH FEDERAL REQUIREMENTS

7 “SEC. 2220. For provisions imposing an excise tax  
8 with respect to noncompliance with Federal requirements  
9 under this part, see section 5000A of the Internal Revenue  
10 Code of 1986.

11 “NO EFFECT ON SCOPE OF BENEFITS COVERED

12 “SEC. 2221. Nothing in this part shall be construed  
13 to specify what items and services are covered under a  
14 health insurance plan.

15 “PART C—MEDICAL DATA REQUIREMENTS

16 “PROMULGATION OF REQUIREMENTS BY SECRETARY

17 “SEC. 2230. (a) PROMULGATION OF REQUIREMENTS  
18 FOR HOSPITALS.—

19 “(1) By January 1, 1996, but after June 30,  
20 1995, the Secretary shall promulgate requirements  
21 for hospitals concerning electronic medical data. In  
22 developing the requirements, the Secretary shall con-  
23 sult with the American National Standards Insti-  
24 tute, insurers, hospitals, and other interested parties  
25 (and shall take into consideration, in developing re-  
26 quirements under paragraph (2)(A), the data set

1 used by the utilization and quality control peer re-  
2 view program under part B of title XI).

3 “(2) The requirements promulgated under  
4 paragraph (1) shall include—

5 “(A) the definition of a standard set of  
6 data elements for use by utilization and quality  
7 control peer review organizations,

8 “(B) the definition of a set of data ele-  
9 ments for use by intermediaries and carriers  
10 under the programs established by title XVIII  
11 (that shall include the standard set of data ele-  
12 ments defined under subparagraph (A)),

13 “(C) standards for an electronic patient  
14 care information system with data obtained at  
15 the point of care (including requirements, con-  
16 sistent with those promulgated under section  
17 2211(a), to protect privacy and confidentiality),

18 “(D) the specification of, and manner of  
19 presentation of, the individual data elements of  
20 the sets and system under the preceding sub-  
21 paragraph, and

22 “(E) standards concerning the trans-  
23 mission of electronic medical data.

24 “(3) The Secretary may from time to time  
25 (after consulting with the American National Stand-

1 ards Institute, insurers, hospitals, and other inter-  
2 ested parties) modify the requirements promulgated  
3 under the preceding paragraphs.

4 “(b) PROMULGATION OF REQUIREMENTS FOR  
5 OTHER HEALTH CARE PROVIDERS.—

6 “(1) The Secretary may promulgate require-  
7 ments concerning electronic medical data for provid-  
8 ers that are not hospitals. In developing the require-  
9 ments, the Secretary shall consult with the American  
10 National Standards Institute, insurers, providers  
11 other than hospitals, and other interested parties.

12 “(2) The requirements promulgated under  
13 paragraph (1) may include—

14 “(A) the definition of a set of data ele-  
15 ments for use by intermediaries and carriers  
16 under the programs established by title XVIII,

17 “(B) the specification of, and manner of  
18 presentation of, the individual data elements of  
19 the set under subparagraph (A), and

20 “(C) standards concerning the trans-  
21 mission of electronic medical data.

22 “(3) The Secretary may from time to time  
23 modify the requirements promulgated under para-  
24 graph (1).

1           “MEDICARE REQUIREMENTS FOR HOSPITALS

2           “SEC. 2231. (a) GENERAL RULE.—As of January 1,  
3 1997, each hospital that has entered into an agreement  
4 under section 1866 shall (except as otherwise provided by  
5 subsection (b))—

6           “(1) maintain an electronic patient care infor-  
7 mation system that meets the requirements of sub-  
8 paragraphs (C) and (D) of section 2230(a)(2);

9           “(2) upon request of the Secretary or of a utili-  
10 zation and quality control peer review organization  
11 (with which the Secretary has entered into a con-  
12 tract under part B of title XI), transmit electroni-  
13 cally the data set specified under subparagraphs (A)  
14 and (D) of section 2230(a)(2) with respect to a  
15 specified discharge;

16           “(3) upon request of the Secretary, or of a fis-  
17 cal intermediary or carrier (as defined in both cases  
18 in title XVIII), transmit electronically any data  
19 (with respect to a claim) from the data set specified  
20 under subparagraphs (B) and (D) of section  
21 2230(a)(2); and

22           “(4) transmit the data specified under para-  
23 graphs (2) and (3) in accordance with the require-  
24 ments of section 2230(a)(2)(E).

25           “(b) WAIVERS.—

1           “(1) The Secretary may waive the requirements  
2 of subsection (a) until January 1, 1999, for a hos-  
3 pital that—

4           “(A) is in the process of developing a sys-  
5 tem specified under section 2230(a)(2)(C) and  
6 that executes agreements with its fiscal  
7 intermediary and its utilization and quality con-  
8 trol peer review organization that the hospital  
9 will meet the requirements of subsection (a) by  
10 a specified date (not later than January 1,  
11 1999), or

12           “(B) is a small rural hospital (as defined  
13 by the Secretary).

14           “(2) The Secretary may waive the requirements  
15 of subsection (a)(1) for a hospital that—

16           “(A) agrees to obtain from its records the  
17 data elements that are needed to meet the re-  
18 quirements of paragraphs (2) and (3) of sub-  
19 section (a), and

20           “(B) agrees to subject its data transfer  
21 process to a quality assurance program speci-  
22 fied by the Secretary.

23           “ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES

24           “SEC. 2232. As of January 1, 1999, the head of any  
25 Federal agency may require any provider that is required  
26 to transmit a data element (utilized by that agency in car-

1 rying out health care or research programs) specified  
2 under section 2230(a)(2)(D) or 2230(b)(2)(B)—

3 “(1) to transmit the data element electronically  
4 in accordance with the requirements of section  
5 2230(a)(2)(E) or 2230(b)(2)(C), as applicable, and

6 “(2) to present the data element in the manner  
7 prescribed under section 2230(a)(2)(D) or  
8 2230(b)(2)(B), as applicable.

9 “PART D—GENERAL PROVISIONS

10 “DEFINITIONS

11 “SEC. 2240. For purposes of this title—

12 “(1) The term ‘administrator’ has the meaning  
13 given that term in section 3(16)(A) of the Employee  
14 Retirement Income Security Act of 1974.

15 “(2) The term ‘employee welfare benefit plan’  
16 has the meaning given that term in section 3(1) of  
17 the Employee Retirement Income Security Act of  
18 1974.

19 “(3) The term ‘health insurance plan’ means  
20 any contract or arrangement under which an entity  
21 bears all or part of the cost of providing health care  
22 items and services, including a hospital or medical  
23 expense incurred policy or certificate, hospital or  
24 medical service plan contract, or health maintenance  
25 subscriber contract (including any self-insured

1 health insurance plan), but does not include (except  
2 for purposes of sections 2211(d), 2211(e), 2218, and  
3 2219)—

4 “(A) coverage only for accident, dental, vi-  
5 sion, disability, or long-term care, medicare  
6 supplemental health insurance, or any combina-  
7 tion thereof,

8 “(B) coverage issued as a supplement to li-  
9 ability insurance,

10 “(C) workers’ compensation or similar in-  
11 surance, or

12 “(D) automobile medical-payment insur-  
13 ance.

14 “(4) The term ‘insurer’ means any entity that  
15 offers a health insurance plan under which that en-  
16 tity is at risk for all or part of the cost of benefits  
17 under the plan, and includes any agent of that en-  
18 tity.

19 “(5) The term ‘NAIC’ means the National As-  
20 sociation of Insurance Commissioners.

21 “(6) The term ‘provider’ means a physician,  
22 hospital, pharmacy, laboratory, or other person li-  
23 censed or otherwise authorized under applicable  
24 State laws to furnish health care items or services.

1           “(7) The term ‘administrator of a self-insured  
2 employee plan’ means an insurer that is an adminis-  
3 trator of an employee welfare benefit plan.

4           “(8) The term ‘utilization review’ means review  
5 of the medical necessity, appropriateness, and qual-  
6 ity of health care items and services.”.

7 **SEC. 203. CONFORMING AMENDMENT.**

8           The first sentence of section 1866(a)(1) of the Social  
9 Security Act is amended—

10           (1) by striking “and” at the end of subpara-  
11 graph (P),

12           (2) by striking the period at the end of sub-  
13 paragraph (Q) and inserting a comma and “and”,  
14 and

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

16           “(R) in the case of hospitals, to comply with  
17 the requirements of section 2231.”.

18 **SEC. 204. FAILURE TO SATISFY CERTAIN HEALTH INSUR-**  
19 **ANCE REQUIREMENTS.**

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

23 **“SEC. 5000B. FAILURE TO SATISFY CERTAIN HEALTH IN-**  
24 **SURANCE REQUIREMENTS.**

25           “(a) GENERAL RULE.—

1           “(1) ADMINISTRATORS OF SELF-INSURED EM-  
2           PLOYEE PLANS.—There is hereby imposed, on any  
3           administrator of a self-insured employee plan, a tax  
4           on any failure to comply with a requirement under  
5           section 2214, 2215, 2216, 2217, 2218, or 2219 of  
6           that Act. The Secretary of Health and Human Serv-  
7           ices, in consultation with the Secretary of Labor,  
8           shall determine whether any administrator of a self-  
9           insured employee plan meets the requirements of  
10          those sections.

11          “(2) OTHER INSURERS.—There is hereby im-  
12          posed, on any insurer other than an administrator of  
13          a self-insured employee plan, a tax on any failure to  
14          comply with a requirement under section 2214,  
15          2215, 2216, 2217, 2218, or 2219 of that Act with  
16          respect to an activity in a State that is subject to  
17          Federal regulation pursuant to section 2213(b) of  
18          the Social Security Act. The Secretary of Health  
19          and Human Services shall determine whether any in-  
20          surer meets the requirements of those sections.

21          “(3) RESEARCH DATA REQUIREMENTS.—There  
22          is hereby imposed on any insurer a tax on any fail-  
23          ure to comply with a requirement under paragraph  
24          (2) of section 2200(f) of the Social Security Act.  
25          The Secretary of Health and Human Services shall

1 determine whether any insurer meets the require-  
2 ments of that paragraph.

3 “(b) AMOUNT OF TAX.—The amount of tax imposed  
4 by subsection (a) for a taxable year in which an insurer  
5 fails to comply with a requirement described in that sub-  
6 section shall be equal to \$100 for each such failure.

7 “(c) CONTROLLED GROUPS.—

8 “(1) EMPLOYERS.—In the case of an insurer  
9 that is an employer, for purposes of this section all  
10 persons that are treated as part of the same em-  
11 ployer (within the meaning of section 414) as the in-  
12 surer shall be treated as the same person.

13 “(2) OTHER INSURERS.—In the case of an in-  
14 surer that is not an employer, for purposes of this  
15 section—

16 “(A) CONTROLLED GROUP OF CORPORA-  
17 TIONS.—All corporations which are members of  
18 the same controlled group of corporations shall  
19 be treated as one person. For purposes of the  
20 preceding sentence, the term ‘controlled group  
21 of corporations’ has the meaning given to such  
22 term by section 1563(a), except that—

23 “(i) ‘more than 50 percent’ shall be  
24 substituted for ‘at least 80 percent’ each  
25 place it appears in section 1563(a)(1), and

1           “(ii) the determination shall be made  
2           without regard to subsections (a)(4) and  
3           (e)(3)(C) of section 1563.

4           “(B) PARTNERSHIPS, PROPRIETORSHIPS,  
5           ETC., WHICH ARE UNDER COMMON CONTROL.—  
6           Under regulations prescribed by the Secretary,  
7           all trades or businesses (whether or not incor-  
8           porated) which are under common control shall  
9           be treated as one person. The regulations pre-  
10          scribed under this subparagraph shall be based  
11          on principles similar to the principles which  
12          apply in the case of subparagraph (A).

13          “(d) LIMITATIONS ON TAX.—

14                 “(1) TAX NOT TO APPLY WHERE FAILURE NOT  
15                 DISCOVERED EXERCISING REASONABLE DILI-  
16                 GENCE.—No tax shall be imposed by subsection (a)  
17                 with respect to any failure for which it is established  
18                 to the satisfaction of the Secretary that the person  
19                 liable for tax did not know, and by exercising rea-  
20                 sonable diligence would not have known, that the  
21                 failure existed.

22                 “(2) TAX NOT TO APPLY TO FAILURES COR-  
23                 RECTED WITHIN THIRTY DAYS.—No tax shall be im-  
24                 posed by subsection (a) on any failure if—

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

3           “(B) the failure is corrected during the  
4           thirty-day period beginning on the 1st date the  
5           person liable for the tax knew, or by exercising  
6           reasonable diligence would have known, that the  
7           failure existed.

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

14          “(e) DEFINITIONS.—For purposes of this section—

15                 “(1) the terms ‘insurer’ and ‘administrator of a  
16                 self-insured employee plan’ have the meanings given  
17                 to those terms by section 2230 of the Social Security  
18                 Act, and

19                 “(2) the term ‘State’ has the meaning given to  
20                 that term by section 1101(1) of the Social Security  
21                 Act.”.

22          (b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of  
23          section 275(a) of that Code (relating to nondeductibility  
24          of certain taxes) is amended by inserting “47,” after  
25          “46,”.

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

“Sec. 5000B. Failure to satisfy certain health insurance require-  
 ments.”

4 EFFECTIVE DATE.—The amendments made by this  
 5 section shall take effect on January 1, 1995.

6 **TITLE III—MEWA ENFORCEMENT**  
 7 **IMPROVEMENTS**

8 **SEC. 301. SHORT TITLE.**

9 This title may be cited as the “Multiple Employer  
 10 Welfare Arrangements Enforcement Improvements Act of  
 11 1993”.

12 **SEC. 302. AMENDMENT TO DEFINITION OF EMPLOYEE WEL-**  
 13 **FARE BENEFIT PLAN.**

14 Section 3(1) of the Employee Retirement Income Se-  
 15 curity Act of 1974 (29 U.S.C. 1002(1)) is amended—

16 (1) by redesignating clauses (A) and (B) as  
 17 clauses (i) and (ii), respectively;

18 (2) by inserting “(A)” after “(1)”; and

19 (3) by adding at the end the following new sub-  
 20 paragraphs:

21 “(B) Notwithstanding subparagraph (A), a plan,  
 22 fund, or program shall not fail to be an ‘employee welfare  
 23 benefit plan’ solely because the plan, fund, or program  
 24 covers individuals who are not employees or former em-

1 ployees of the employer (or members or former members  
2 of the employee organization) which established or main-  
3 tains the plan, or their beneficiaries, if at no time during  
4 the plan year the number of such individuals exceeds five  
5 percent of the aggregate number of individuals covered  
6 under the plan.

7 “(C) A plan, fund, or program shall not fail to be  
8 an ‘employee welfare benefit plan’ solely because the plan,  
9 fund, or program is established or maintained by a fran-  
10 chise network (as defined in paragraph (40)(B)(vi)).

11 “(D) A plan, fund, or program shall not fail to be  
12 an ‘employee welfare benefit plan’ solely because the plan,  
13 fund, or program is established or maintained by two or  
14 more trades or businesses, whether or not incorporated,  
15 that are within the same control group or were within the  
16 same control group at any time during the period com-  
17 mencing with the preceding one-year period. For purposes  
18 of this subparagraph, the term ‘control group’ shall have  
19 the meaning provided in clauses (ii) and (iii) of paragraph  
20 (40)(B).”.

21 **SEC. 303. AMENDMENT TO DEFINITION OF MULTIPLE EM-**  
22 **PLOYER WELFARE ARRANGEMENT.**

23 Section 3(40) of the Employee Retirement Income  
24 Security Act of 1974 (29 U.S.C. 1002(40)) is amended—

1           (1) in subparagraph (A), by striking clause (i)  
2           and inserting the following:

3           “(i) pursuant to one or more collective bargain-  
4           ing agreements, if, under such arrangements, cov-  
5           erage under such arrangements is limited to—

6                   “(I) employees covered by a collective bar-  
7                   gaining agreement,

8                   “(II) employees of the plan,

9                   “(III) employees of an employee organiza-  
10                  tion which is a party to such collective bargain-  
11                  ing agreement, and

12                  “(IV) beneficiaries of participants de-  
13                  scribed in subclauses (I), (II), and (III), or”;

14           (2) in subparagraph (A), by striking “or” at  
15           the end of clause (ii), by striking the period at the  
16           end of clause (iii) and inserting a comma, and by  
17           adding after clause (iii) the following new clauses:

18                   “(iv) by a franchise network, or

19                   “(v) by an insurer (as defined in section  
20                   401(b)(2)(A)) or by a health maintenance organiza-  
21                   tion, if such insurer or organization is licensed to do  
22                   business in a State.”;

23           (3) in subparagraph (B)(i), by striking “if such  
24           trades or businesses are within the same control  
25           group” and inserting “for any plan year of any such

1 plan, or any fiscal year of any other arrangement,  
2 if such trades or businesses are within the same con-  
3 trol group during such year or at any time during  
4 the preceding one-year period.”; and

5 (4) in subparagraph (B), by redesignating  
6 clauses (iv) and (v) as clauses (viii) and (ix), respec-  
7 tively, and by inserting after clause (iii) the follow-  
8 ing new clauses:

9 “(iv) the term ‘employee’ includes any former  
10 employee who is receiving benefits under the plan or  
11 under part 6 of subtitle B,

12 “(v) the term ‘collective bargaining agreement’  
13 means a written agreement between an employer or  
14 a group of employers and one or more employee or-  
15 ganizations which has been negotiated through a  
16 process of arm’s length, good faith bargaining, pur-  
17 suant to the National Labor Relations Act or other  
18 applicable law, where a broad range of matters per-  
19 taining to the employment relationship such as  
20 wages, rates of pay, hours of employment, griev-  
21 ances, and conditions of employment, in addition to  
22 employee benefits, have been negotiated,

23 “(vi) the term ‘franchise network’ means a  
24 group or association of franchisees (which may in-  
25 clude the franchisor), if each of such franchisees is

1 a party to a franchise with the same franchisor, ex-  
2 cept that, for purposes of this clause—

3 “(I) the terms ‘franchise’, ‘franchisor’, and  
4 ‘franchisee’ shall have the meanings provided  
5 such terms in the regulations of the Federal  
6 Trade Commission, as in effect on January 1,  
7 1991, under paragraphs (1) and (2) of section  
8 436.2(a) of title 16 of the Code of Federal Reg-  
9 ulations, without regard to paragraph (5) of  
10 such section 436.2(a), if the franchise has as its  
11 primary economic basis a business activity in  
12 fact apart from the provision of health care  
13 benefits to employees of the franchisees,

14 “(II) a franchise that is exempted from the  
15 provisions of part 436 of title 16 of the Code  
16 of Federal Regulations pursuant to section  
17 436.2(a)(3) of such title 16, or is an arrange-  
18 ment that is excluded under section 436.2(a)(4)  
19 of such title 16, is not a franchise for purposes  
20 of this part, and

21 “(III) the Secretary may by regulation  
22 amend the definition of ‘franchise network’ for  
23 purposes of maintaining consistency with any  
24 changes in the definition of ‘franchise’ adopted

1 by the Federal Trade Commission under the  
2 Federal Trade Commission Act,

3 “(vii) an employee welfare benefit plan which is  
4 maintained by a single employer shall not be deemed  
5 to be a multiple employer welfare arrangement for  
6 any plan year solely because the plan covers individ-  
7 uals who are not employees or former employees of  
8 the employer, or their beneficiaries, if, at no time  
9 during the plan year, the number of such individuals  
10 exceeds five percent of the aggregate number of indi-  
11 viduals covered under the plan.”.

12 **SEC. 304. COVERAGE.**

13 Section 4 of the Employee Retirement Income Secu-  
14 rity Act of 1974 (29 U.S.C. 1003) is amended by adding  
15 at the end the following new subsection:

16 “(c) Except as provided in subsection (b), this title  
17 shall apply to any multiple employer welfare arrangement  
18 engaged in commerce or in any industry or activity affect-  
19 ing commerce.”.

20 **SEC. 305. REGISTRATION REQUIREMENT.**

21 Section 101 of the Employee Retirement Income Se-  
22 curity Act of 1974 (29 U.S.C. 1021) is amended—

23 (1) by redesignating subsection (f) as sub-  
24 section (g); and

1           (2) by inserting after subsection (e) the follow-  
2           ing new subsections:

3           “(f) REGISTRATION OF MULTIPLE EMPLOYER WEL-  
4 FARE ARRANGEMENTS.—

5           “(1) EXISTING ARRANGEMENTS.—The person  
6           or persons responsible under paragraph (4), with re-  
7           spect to each multiple employer welfare arrangement  
8           which provides benefits of medical care (within the  
9           meaning of section 213(d) of the Internal Revenue  
10          Code of 1986) and which have commenced oper-  
11          ations as of 180 days after the date of the enact-  
12          ment of the Multiple Employer Welfare Arrange-  
13          ments Enforcement Improvements Act of 1993, shall  
14          file with the Secretary—

15                 “(A) a registration statement described in  
16                 paragraph (3) covering the current fiscal year  
17                 or any part thereof, within 30 days after the  
18                 180-day period following the date of enactment  
19                 of such Act, and

20                 “(B) a registration statement described in  
21                 paragraph (3) for each fiscal year thereafter,  
22                 within 30 days after the end of each fiscal year.

23           “(2) NEW ARRANGEMENTS.—The person or  
24           persons responsible under paragraph (4), with re-  
25           spect to each multiple employer welfare arrangement

1 which provides benefits of medical care (within the  
2 meaning of section 213(d) of the Internal Revenue  
3 Code of 1986) and which have not commenced oper-  
4 ations as of 180 days after the date of the enact-  
5 ment of the Multiple Employer Welfare Arrange-  
6 ments Enforcement Improvements Act of 1993, shall  
7 file with the Secretary a registration statement de-  
8 scribed in paragraph (3)—

9 “(A) at least 60 days before the date on  
10 which the multiple employer welfare arrange-  
11 ment commences operations, and

12 “(B) within 30 days after the end of each  
13 fiscal year.

14 “(3) REGISTRATION STATEMENTS.—A registra-  
15 tion statement filed under this subsection shall—

16 “(A) be filed in such form, and contain  
17 such information concerning the multiple em-  
18 ployer welfare arrangement, as shall be pro-  
19 vided in regulations promulgated by the Sec-  
20 retary, including information disclosing the  
21 names and addresses of any person involved in  
22 its operation, the address of the arrangement,  
23 the fiscal year of the arrangement, and a list of  
24 States in which the arrangement conducts busi-

1           ness or intends to conduct business within the  
2           following 12-month period,

3           “(B) contain a certification that copies of  
4           such registration statement have been filed with  
5           the Insurance Commissioner (or other similar  
6           official) of each State in which the multiple em-  
7           ployer welfare arrangement currently offers or  
8           provides benefits, or intends to offer or provide  
9           benefits during the following 12-month period,  
10          and

11          “(C) indicate whether the multiple em-  
12          ployer welfare arrangement has obtained, ap-  
13          plied for, or intends to apply for an exemption  
14          from State regulation under section  
15          514(b)(6)(B).

16          “(4) PERSONS RESPONSIBLE FOR FILING.—The  
17          person or persons responsible for filing the annual  
18          registration statement with respect to a multiple em-  
19          ployer welfare arrangement are—

20                 “(A) the trustee or trustees so designated  
21                 by the terms of the instrument under which the  
22                 multiple employer welfare arrangement is estab-  
23                 lished or maintained, or

24                 “(B) in the case of a multiple employer  
25                 welfare arrangement for which the trustee or

1 trustees cannot be identified, the person or per-  
2 sons actually responsible for the acquisition,  
3 disposition, control, or management of the cash  
4 or property of the multiple employer welfare ar-  
5 rangement, irrespective of whether such acquisi-  
6 tion, disposition, control, or management is ex-  
7 exercised directly by such person or persons or  
8 through an agent designated by such person or  
9 persons.”.

10 **SEC. 306. ENFORCEMENT AND CIVIL PENALTIES.**

11 (a) IN GENERAL.—Section 502 of the Employee Re-  
12 tirement Income Security Act of 1974 (29 U.S.C. 1132)  
13 is amended—

14 (1) in subsection (a)(6), by inserting “or  
15 (c)(4)” after “(c)(2)”; and

16 (2) in subsection (c), by adding at the end the  
17 following new paragraph:

18 “(4) The Secretary may assess, against the person  
19 or persons responsible for filing with the Secretary an an-  
20 nual registration statement with respect to a multiple em-  
21 ployer welfare arrangement as required under section  
22 101(f), a civil penalty of up to \$1,000 a day from the date  
23 of such person’s or persons’ failure or refusal to timely  
24 file such statement. For purposes of this paragraph, an  
25 annual registration statement which the Secretary deter-

1 mines to be materially incomplete, and which is not refiled  
2 in a manner satisfactory to the Secretary within 45 days  
3 after the Secretary makes such determination, shall not  
4 be treated as having been filed with the Secretary.”.

5 (b) COURT ORDERS.—Section 502 of such Act is fur-  
6 ther amended by adding at the end the following new sub-  
7 section:

8 “(m)(1) Upon application by the Secretary showing  
9 the operation, promotion, or marketing of a multiple em-  
10 ployer welfare arrangement that—

11 “(A) offers or provides benefits to participants  
12 covered by an employee welfare benefit plan, and

13 “(B) is neither—

14 “(i) licensed, registered, or otherwise ap-  
15 proved under the insurance laws of all States in  
16 which the arrangement offers or provides bene-  
17 fits, nor

18 “(ii) operating in accordance with the  
19 terms of an exemption granted by the Secretary  
20 pursuant to section 514(b)(6)(B),

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 if it is shown that  
24 the arrangement—

1           “(A) is fully insured, within the meaning of sec-  
2           tion 514(b)(6)(D),

3           “(B) meets the requirements of paragraph  
4           (2)(A), except to the extent that all or some of the  
5           States in which the arrangement offers or provides  
6           benefits do not require licensing, registration, or ap-  
7           proval of fully-insured multiple employer welfare ar-  
8           rangements, and

9           “(C) with respect to such States, is operating in  
10          accordance with applicable State insurance laws that  
11          are not superseded pursuant to section 514.

12       The court may grant such additional equitable or remedial  
13       relief, including any relief available under this title, as it  
14       deems necessary to protect the interests of the public and  
15       of persons having claims for benefits against the arrange-  
16       ment.”.

17       **SEC. 307. EXEMPTION PROCEDURE.**

18       (a) IN GENERAL.—Section 514(b)(6) of the Em-  
19       ployee Retirement Income Security Act of 1974 (29  
20       U.S.C. 1144(b)(6)) is amended—

21           (1) in subparagraph (A)(i), by striking “(or  
22           which is a multiple employer welfare arrangement  
23           subject to an exemption under subparagraph (B))”;

24           (2) by subparagraph (A)(ii), by striking “the  
25           preceding sections of”;

1           (3) in subparagraph (B), by striking “(B) The  
2     Secretary” and all that follows through the end of  
3     the first sentence and inserting the following:  
4     “(B)(i) The Secretary may exempt from subpara-  
5     graph (A), for a period not to exceed three years, in-  
6     dividually or by class, multiple employer welfare ar-  
7     rangements which are not fully insured and which  
8     provide benefits of medical care (within the meaning  
9     of section 213(d) of the Internal Revenue Code of  
10    1986). This exemption may be renewed by the Sec-  
11    retary upon application.”; and

12           (4) by adding at the end of subparagraph (B)  
13    the following new clauses:

14    “(ii) The Secretary may not grant an exemption  
15    under this subparagraph unless the Secretary finds that  
16    such exemption is—

17           “(I) administratively feasible,

18           “(II) not adverse to the interests of the partici-  
19    pants and beneficiaries of the employee welfare ben-  
20    efit plan which is a multiple employer welfare ar-  
21    rangement, and

22           “(III) protective of the rights and benefits of  
23    such participants and beneficiaries.

24    “(iii) Before granting an exemption under this sub-  
25    paragraph, the Secretary shall—

1           “(I) publish notice in the Federal Register of  
2           the pendency of the exemption,

3           “(II) require that adequate notice be given to  
4           interested persons, including the insurance commis-  
5           sioner (or similar official having jurisdiction over the  
6           offering or sale of insurance) of each State in which  
7           the multiple employer welfare arrangement offers or  
8           provides, or intends to offer or provide, benefits, and

9           “(III) afford interested persons opportunity to  
10          present views.

11          The Secretary may not grant an exemption under this  
12          subparagraph unless the Secretary affords an opportunity  
13          for a hearing and makes a determination on the record  
14          with respect to the findings required by clauses (I), (II),  
15          and (III) of clause (ii).

16          “(iv) Any determination made by the Secretary under  
17          this subparagraph shall be in the Secretary’s sole discre-  
18          tion.”.

19          (b) TRANSITIONAL RULE.—During the 540-day pe-  
20          riod commencing with the date of the enactment of this  
21          Act, section 514(b)(6)(A) of the Employee Retirement In-  
22          come Security Act of 1974 (29 U.S.C. 1144(b)(6)(A))  
23          shall not apply to any multiple employer welfare arrange-  
24          ment which, as of such date, is an employee welfare bene-  
25          fit plan which provides benefits for medical care (within

1 the meaning of section 213(d) of the Internal Revenue  
2 Code of 1986) to participants and beneficiaries, if—

3 (1) an application for an exemption with re-  
4 spect to such arrangement is filed pursuant to sec-  
5 tion 514(b)(6)(B)(i) of the Employee Retirement In-  
6 come Security Act of 1974 (as amended by this Act)  
7 during the 180-day period following the date of the  
8 enactment of this Act, and

9 (2) as of 90 days after receipt of the exemption  
10 application, the Secretary of Labor has not found  
11 such application to be materially deficient.

12 If the Secretary determines, at any time after the date  
13 of the enactment of this Act, that such exemption from  
14 such section 514(b)(6)(A) would be detrimental to the in-  
15 terests of participants or beneficiaries of a multiple em-  
16 ployer welfare arrangement, such exclusion shall cease as  
17 of the date of the determination. Any determination made  
18 by the Secretary under this subsection shall be in the Sec-  
19 retary's sole discretion.

20 **SEC. 308. CLARIFICATION OF STATES' ABILITY TO OBTAIN**  
21 **INFORMATION.**

22 Section 514(b) of the Employee Retirement Income  
23 Security Act of 1974 (29 U.S.C. 1144(b)) is amended by  
24 adding at the end the following new paragraph:

1       “(9) Notwithstanding any other provision of this sec-  
 2 tion, in the case of an employee welfare benefit plan, any  
 3 law of any State which regulates insurance may apply to  
 4 such plan to the extent that such law, in connection with  
 5 an investigation to determine whether or not a person has  
 6 violated or is about to violate a provision of such law, gives  
 7 the State the ability to require disclosure of information  
 8 necessary to determine whether such plan—

9           “(A) is a multiple employer welfare arrange-  
 10 ment,

11           “(B) is in compliance with an exemption grant-  
 12 ed by the Secretary under paragraph (6)(B)(i), or

13           “(C) is in compliance with paragraph  
 14 (6)(B)(ii).”.

15 **SEC. 309. EFFECTIVE DATE.**

16       The amendments made by this title shall take effect  
 17 upon the date of enactment of this Act.

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