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103D CONGRESS
1ST 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.

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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Universal Health Benefits Empowerment and Partnership Act of 1993''.

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

SEC. 2. FINDINGS AND DECLARATION OF POLICY.

(a) FINDINGS.—The Congress finds that—

(1) the health care delivery system of the United States provides most Americans with a level of access and quality of care that is unsurpassed;

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

(3) these individuals represent a diversity of situations for which there is no single solution;

(4) assuring access to basic health care coverage and quality care for these individuals is a com-

pelling national priority that will require commitments from both the private and public sectors;

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

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

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

(C) recognize that both the complexity of the problem and the existence of fiscal constraints means that responsibility must be shared among employers, employees, insurers, providers, and patients, as well as Federal, State, and local governments;

(6) Federal efforts need to be closely coordinated with others who share in the responsibility for improving access to basic health care services;

(7) Federal efforts need to reflect not only the diversity of interested parties but also the diversity of areas where action is appropriate, including public health, basic group health coverage, State initiatives, medical malpractice laws, Medicaid, and tax incentives; and

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

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

(B) the inability of many individuals to protect themselves against catastrophic health care expenses because preexisting conditions make them ''uninsurable''.

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

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

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

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

(1) provide universal access to basic group health coverage for all Americans under plans offered by employers or, in the case in which such coverage is unavailable to employees and other individuals from private sources or existing public programs, under accessible health benefits systems;

(2) make such basic health coverage more affordable—

(A) by removing barriers and encouraging ''group'' plans and arrangements to spread risk and lower expenses;

(B) by preempting State health benefit mandates, thereby encouraging group health coverage providers to offer lower cost basic coverage to the uninsured;

(C) by preempting State barriers to the providing of managed care, thereby encouraging competition, innovation of cost-control approaches, and quality review;

(D) by encouraging the development of treatment practice guidelines and outcomes research to aid in reducing unnecessary services, increasing quality care, and reducing malpractice costs;

(E) by eliminating tax inequities and barriers—

(i) to the full deductibility of contributions to health plans covering the self-employed, and

(ii) to the establishment of soundly financed multiple employer basic group health plans;

(3) improve and make more efficient the provision of medical and health insurance information; and

(4) improve enforcement of requirements relating to multiple employer welfare arrangements.

TITLE I—UNIVERSAL ACCESS TO HEALTH COVERAGE

SEC. 101. UNIVERSAL ACCESS TO COVERAGE UNDER GROUP HEALTH PLANS AND ACCESSIBLE HEALTH BENEFITS SYSTEMS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by striking the heading for part 6 and inserting the following:

''**Subpart E—Continuation Coverage Requirements**'';

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

(3) by inserting after part 5 the following:

''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.**

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

''(1) GROUP HEALTH PLAN.—The term 'group health plan' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.

''(2) BASIC GROUP HEALTH PLAN.—

''(A) IN GENERAL.—The term 'basic group health plan' means a group health plan, or any combination of two or more group health plans, which includes at least a basic health benefits provision.

''(B) TREATMENT OF UNINSURABLE RISKS.—A plan which excludes from coverage under a basic health benefits provision any individual (who would otherwise be eligible for coverage) solely because the individual is an uninsurable risk shall not be treated as a basic group health plan, unless the requirements of subparagraph (D) are met for purposes of this subparagraph with respect to such individual.

''(C) TREATMENT OF MATERIAL PRE-EXISTING CONDITIONS.—A plan which provides coverage to any individual under a basic health benefits provision subject to a substantial restriction based on a material pre-existing condition shall not be treated as a basic group health plan, unless the requirements of subparagraph (D) are met for purposes of this subparagraph with respect to such individual.

''(D) EXEMPTION WHERE ADEQUATE ACCESSIBLE HEALTH BENEFITS SYSTEM OR SUBSTITUTE SYSTEM IS AVAILABLE.—The requirements of this subparagraph are met with respect to any individual—

''(i) for purposes of subparagraph (B), if such individual is eligible for coverage under an accessible health benefits system established and maintained in accordance with subpart C (and subpart D as applicable) (or under any substitute basic health benefits system with respect to which the Secretary of Health and Human Services has made a determination pursuant to section 102(b) of the Universal Health Benefits Empowerment and Partnership Act of 1993 relating to the element of coverage described in section 102(b)(2)(B)(i) of such Act (relating to treatment of individuals as uninsurable risks)), or

''(ii) for purposes of subparagraph (C), if such individual is eligible for coverage for the material pre-existing condition referred to in subparagraph (C) under

an accessible health benefits system established and maintained in accordance with subpart C (and subpart D as applicable) (or under any substitute basic health benefits system with respect to which the Secretary of Health and Human Services has made a determination pursuant to section 102(b) of the Universal Health Benefits Empowerment and Partnership Act of 1993 relating to the element of coverage described in section 102(b)(2)(B)(ii) of such Act (relating to treatment of material preexisting conditions)).

''(3) BASIC HEALTH BENEFITS PROVISION.—The term 'basic health benefits provision' means, with respect to any plan, combination of plans, or health benefit system, an arrangement which—

''(A) provides to individuals provided coverage under such plan, combination of plans, or system, directly or through insurance, reimbursement, or otherwise, medical care (as defined in section 213(d) of the Internal Revenue Code of 1986)—

''(i) which consists of services determined by the Secretary of Health and

Human Services, under regulations prescribed by such Secretary, to consist of basic health care services (including physician's, inpatient hospital, and outpatient hospital services which are prevalent under group health plans and other services which may be necessary for basic health care), and

''(ii) which consists of coverage at a percentage of cost determined by such Secretary under such regulations (by means of deductibles, coinsurance, and other limits on covered services) to be not less than a percentage which is, taking into account the population covered and the extent of cost currently covered under group health plans, adequate to meet basic health care needs, and

''(B) in the case of any individual described in paragraph (2)(B) or (C) in relation to a basic group health plan maintained by the employer of such individual (or of the person of whom such individual is a dependent), requires contributions by the employer of not less than the amount provided under the plan with re-

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

In issuing regulations referred to in this paragraph (including any revisions thereof), the Secretary of Health and Human Services shall take into account recommendations submitted to such Secretary by the Federal Advisory Council on Health Care Coverage and Costs pursuant to section 107(d)(2) of the Universal Health Benefits Empowerment and Partnership Act of 1993.

''(4) DEPENDENT.—The term 'dependent' means, with respect to any individual, any person who—

''(A) is the spouse or surviving spouse of the individual, or

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

''(i) is under 18 years of age,

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

''(iii) is otherwise dependent on such individual.

''(5) EMPLOYER.—The term 'employer' shall have the meaning applicable under section 3(5), except that such term shall include any State (or political subdivision thereof), or any agency or instrumentality of one or more of the foregoing.

''(6) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any employee or dependent thereof, unless such employee or dependent—

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

''(B) is excluded from coverage under such a plan as an uninsurable risk but is eligible for uninsurable risk coverage under an accessible health benefits system in accordance with subpart C (and subpart D as applicable) (or any substitute basic health benefits system with respect to which the Secretary of Health and Human Services has made a determination pursuant to section 102 of the Universal Health Benefits Empowerment and Partnership Act of

1993 relating to the element of coverage described in section 102(b)(2)(B)(i) of such Act (relating to treatment of individuals as uninsurable risks)).

''(7) UNINSURABLE RISK.—An individual shall be deemed to have been excluded from coverage under a basic health benefits provision as an 'uninsurable risk' if such denial of coverage is provided—

''(A) in such terms, or

''(B) in such other terms or under such circumstances as are, subject to such regulations as the Secretary of Health and Human Services may prescribe, reasonably equivalent to such a denial.

''(8) MATERIAL PRE-EXISTING CONDITION.—An individual shall be deemed to have been provided coverage by a basic health benefits provision subject to a restriction based on a 'material pre-existing condition' if, subject to such regulations as the Secretary of Health and Human Services may prescribe, under such provision—

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

''(B) the costs for coverage of the individual with a material pre-existing condition, to either an employer or to the individual, are at a rate materially greater than costs for coverage of similarly situated individuals without such a material pre-existing condition, to the extent such costs are payable to a third party.

''(b) CROSS-REFERENCES.—

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

''(2) SECRETARY.—Except with respect to references specifically to the Secretary of Health and Human Services, for the definition of 'Secretary', see section 3(13).

''(3) REGULATIONS.—Except with respect to provisions for which regulatory authority is specifically provided to the Secretary of Health and Human Services, for provisions governing regulatory authority under this part, see section 505.

''**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.**

''(a) REQUIREMENT THAT EMPLOYERS OFFER COVERAGE FOR ELIGIBLE INDIVIDUALS UNDER BASIC GROUP HEALTH PLANS OR GROUP HEALTH PAYROLL DEDUCTION PLANS.—Each employer shall maintain with respect to each eligible individual—

''(1) a basic group health plan under which coverage of such individual may be elected, or

''(2) a group health payroll deduction plan (as defined in section 612).

''(b) SPECIAL RULES.—

''(1) EXCLUSION OF CERTAIN EMPLOYERS.—

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

''(i) such employer (including any predecessor thereof) has been an employer for less than 2 years,

''(ii) such employer has no more than 2 individuals in such employer's employ, or

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

''(B) EXCLUSION OF FAMILY MEMBERS.—Under such procedures as the Secretary may prescribe, any relative of an employer may be, at the election of the employer, excluded from consideration as an employee for purposes of this paragraph. In the case of an employer that is not an individual, an employee who is a relative of a key employee (as defined in section 416(i)(1) of the Internal Revenue Code of 1986) of the employer may, at the election of the key employee, be considered a relative excludible under this subparagraph.

''(2) EXCLUSION OF CERTAIN TEMPORARY EMPLOYEES.—A plan shall not be treated as failing to meet the requirements of this section solely because a period of service by an employee of not more than 60 days is required under the plan for coverage of such employee or any dependent thereof under the plan.

"SEC. 612. GROUP HEALTH PAYROLL DEDUCTION PLANS.

''(a) GENERAL RULE.—For purposes of this subpart, the term 'group health payroll deduction plan' means a

basic group health plan under which amounts are deducted by the employer from the employee's wages pursuant to an election by the employee and paid as a contribution to such plan in accordance with such regulations as the Secretary may prescribe relating to withholding procedures and timely payment of premiums.

''(b) ELECTIONS.—

''(1) IN GENERAL.—Any election by an employee under a group health payroll deduction plan shall specify the amount which is to be deducted in relation to the benefits provided under the plan. Any such election may be revoked or changed by the employee under the terms of the plan.

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

"SEC. 613. AVAILABILITY OF COVERAGE UNDER ACCESSIBLE HEALTH BENEFITS SYSTEMS.

''In any case in which there is in effect, as of the beginning of a plan year of any group health payroll deduction plan, an entity determined by the Secretary of Health and Human Services to be an accessible health

benefits system established and maintained in accordance with subpart C (and subpart D as applicable) with respect to the employee, such plan shall not be treated as failing to meet the requirements of section 612(a) for such plan solely because the amounts deducted are, under such plan, paid for such plan year or the succeeding plan year as a contribution to such a system accepting coverage of such employee rather than to such plan, if a provider of group health plan coverage with respect to the plan rejects an individual otherwise eligible for coverage under such plan because of a requirement that a certain number or percentage of individuals otherwise eligible for coverage under the plan are not covered.

"Subpart C—Accessible Health Benefits Systems

"SEC. 621. GENERAL REQUIREMENTS.

''For purposes of this part, an accessible health benefits system established and maintained in accordance with this subpart is any system which, with respect to any group of individuals residing in a defined geographic area—

''(1) meets the reporting requirements of section 622,

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

''(3) meets the benefit requirements of section 624,

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

''(5) provides coverage in accordance with subpart D (relating to uninsurable risks and material pre-existing conditions) as applicable.

"SEC. 622. REPORTING REQUIREMENTS.

''(a) IN GENERAL.—A health benefits system meets the reporting requirements of this section if the system maintains a program under which the system provides, upon the request of group health payroll deduction plans under which amounts are paid from such plans to the system, such information held by the system as the plans require to meet the requirements of part 1 of subtitle B of title I.

''(b) FORM OF REQUESTS.—Each system shall be required to process requests made under this section only if such requests are made in such form and manner as may be prescribed in regulations of the Secretary.

"SEC. 623. PARTICIPATION REQUIREMENTS.

''A health benefits system meets the participation requirements of this section if the system provides that an individual within the group referred to in section 621 is provided coverage under the system if such individual—

''(1) is an eligible individual (as defined in section 601(a)(6)),

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

''(3) is an individual described in section 632, or

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

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

"**SEC. 624. BENEFITS REQUIREMENTS.**

''(a) IN GENERAL.—Except as otherwise provided in this section, a health benefits system meets the benefits requirements of this section if the system provides medical care (as defined in section 213(d) of the Internal Revenue Code of 1986), directly or through insurance, reimbursement, or otherwise, in the form of at least the following options, available at the election of the individual provided coverage:

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

''(2) CATASTROPHIC ONLY COVERAGE.—Catastrophic coverage with respect to basic health care services.

''(3) SUPPLEMENTAL BENEFITS.—Coverage consisting of coverage described in paragraph (1) and such supplemental coverage as the Secretary of Health and Human Services may by regulation prescribe.

''(b) COST CONTAINMENT AND QUALITY OF CARE.—A health benefits system does not meet the requirements of this section unless such system, to the maximum extent determined practicable under regulations of the Secretary of Health and Human Services, taking into account quality of care, provides for a hospital precertification utilization review program, constraint of costs to the extent practicable through the use of appropriately managed care, and such other cost containment procedures as may from time to time be proven effective.

''(c) TREATMENT OF UNINSURABLE RISKS AND MATERIAL PRE-EXISTING CONDITIONS.—In any case in which the requirements of section 633 are met with respect to any individual with respect to whom the system meets the requirements of section 631, the requirements

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

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

''(e) COVERAGE UNDER ACCESSIBLE HEALTH BENEFITS SYSTEM SECONDARY TO COVERAGE UNDER EMPLOYEE BENEFIT PLANS.—A health benefits system does not meet the requirements of this section unless, under the terms of such system, coverage under such system with respect to any claim is secondary to coverage provided under any employee benefit plan with respect to such claim.

"SEC. 625. CONTRIBUTION REQUIREMENTS.

''(a) IN GENERAL.—Except as otherwise provided in this section, a health benefits system meets the contribution requirements of this section if the system does not require, for coverage of individuals described in paragraphs (1) and (2) of section 623(a), contributions in excess of levels determined—

''(1) on the basis of its own experience with respect to covered individuals described in such paragraphs (1) and (2), and

''(2) without regard to any coverage provided under the system to individuals who are not described in such paragraphs (1) and (2).

''(b) VARIANCES IN RATE LEVEL.—

''(1) SEPARATE SCHEDULE REQUIRED FOR CHILDREN-ONLY COVERAGE.—A health benefits system does not meet the contribution requirements of this section unless the system provides for a separate schedule of contributions with respect to children-only coverage.

''(2) OTHER VARIANCES PERMITTED.—A health benefits system shall not be treated as failing to meet the requirements of this section solely because the system otherwise provides for differing rates of contributions to reflect the age, family composition, or income of the covered individual and the location at which the covered individual is expected to normally receive medical care.

''(c) CERTAIN STATE AND OTHER CONTRIBUTIONS PERMITTED.—A health benefits system shall not be treated as failing to meet the requirements of this section solely because the system provides for—

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

''(2) varying the amount of such payment based on the individual's income or any other basis, or

''(3) payment by any State or any other entity of all or part of monthly premiums for purposes of enrollment under section 1818 or 1818A of the Social Security Act, or of premiums under section 1916(c) of such Act.

''(d) MAXIMIZED PARTICIPATION.—A health benefits system does not meet the requirements of this section if the Secretary of Health and Human Services determines, under regulations prescribed by such Secretary and on the basis of past experience, that, under such system, contributions are not established and maintained in such form and manner as to be promotive of participation in the system.

"SEC. 626. RECIPROCITY AND RELIANCE BY ACCESSIBLE HEALTH BENEFITS SYSTEMS ON OTHER SUCH SYSTEMS.

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

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

''SEC. 627. REGULATORY AUTHORITY OF SECRETARY OF HEALTH AND HUMAN SERVICES.

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

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

''SEC. 631. COVERAGE FOR UNINSURABLE RISKS AND PRE-EXISTING CONDITIONS.

''A health benefits system provides coverage in accordance with this subpart if such system, such system in combination with one or more other health benefits systems, or such system under voluntary participation in a program established by or under State law—

''(1) meets the participation requirements of section 632,

''(2) meets the benefits requirements of section 633, and

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

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

"SEC. 632. PARTICIPATION REQUIREMENTS FOR UNINSURABLE RISKS AND MATERIAL PRE-EXISTING CONDITIONS.

''A health benefits system meets the participation requirements of this section if the system meets the following requirements:

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

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

''(B) such individual is not an employee (or dependent) described in subparagraph (A), and—

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

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

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

''(2) COVERAGE FOR MATERIAL PRE-EXISTING CONDITIONS.—The system provides that an individual is provided coverage under the system for any material pre-existing condition if—

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

''(B) such individual is not an employee (or dependent) described in subparagraph (A), and—

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

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

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

''SEC. 633. BENEFITS REQUIREMENTS FOR UNINSURABLE RISKS AND MATERIAL PRE-EXISTING CONDITIONS.

''A health benefits system meets the benefits requirements of this section if the system provides, directly or through insurance, reinsurance, or otherwise—

''(1) in the case of individuals described in section 632(1), benefits described in section 624(a), and

''(2) in the case of individuals described in section 632(2), coverage of the material pre-existing condition which is not otherwise covered to the ex-

tent necessary to constitute basic health care services described in section 601(a)(3)(A) with respect to such condition, in accordance with such regulations as the Secretary of Health and Human Services may prescribe.

"SEC. 634. REGULATORY AUTHORITY OF SECRETARY OF HEALTH AND HUMAN SERVICES.

''The Secretary of Health and Human Services shall prescribe such regulations as such Secretary considers necessary to carry out the provisions of this subpart.''.

(b) REGULATIONS FOR DEFINING BASIC HEALTH CARE PROVISIONS.—

(1) INITIAL REGULATIONS.—Not later than July 1, 1994, the Secretary of Health and Human Services shall publish in the Federal Register proposed regulations referred to in section 601(a)(3) of the Employee Retirement Income Security Act of 1974 (as amended by subsection (a)). In prescribing such proposed regulations, the Secretary shall take into account recommendations submitted to the Secretary by the Federal Advisory Council on Health Care Coverage and Costs pursuant to section 107(d)(1) of this Act.

(2) INTERIM REVIEW PERIOD BEFORE ISSUANCE OF FINAL REGULATIONS.—The Secretary of

Health and Human Services shall not issue the regulations referred to in section 601(a)(3) of the Employee Retirement Income Security Act of 1974 in final form before July 1, 1995.

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

''With respect to provisions of subparts C and D of part 6 (other than section 622), the references to 'Secretary' in paragraph (5), and in other provisions of this part relating to actions brought under such paragraph, shall be deemed a reference to the Secretary of Health and Human Services.''.

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

SEC. 102. ESTABLISHMENT OF STATE-BASED SYSTEM IN ABSENCE OF STATE-WIDE ACCESS TO COVERAGE; SUBSTITUTE SYSTEMS.

(a) STATE-BASED SYSTEMS.—

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

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

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

(i) a basic group health plan (as defined in section 601(a)(2) of such Act (as amended by this Act)),

(ii) an accessible health benefits system meeting the requirements of subpart C (and subpart D as applicable) of part 6 of subtitle B of title I of such Act, and

(iii) a substitute health benefits system (as defined in subsection (b)(2)(A)),

then such State may establish and maintain a health benefits system covering such residents to the extent that such system is an accessible health benefits system established and maintained in accordance with this subsection and such subpart C (and such subpart D as applicable).

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

(A) is administered by a nonprofit corporation which is established by and regulated under the laws of such State,

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

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

(C) such corporation is subject under State law to the supervision of an agency of the State which is responsible for the regulation of providers of group health plan coverage.

(3) EXCLUSIONS.—The system shall not be treated as meeting the requirements of this subsection unless the system excludes from coverage—

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

(B) inmates of public institutions.

(b) SUBSTITUTE BASIC HEALTH BENEFITS SYSTEMS.—

(1) IN GENERAL.—If, at any time before the effective date for the amendments made by section 101, the Secretary of Health and Human Services determines, under regulations prescribed by the Secretary—

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

(B) that, with respect to such group of individuals, such system meets requirements (provided in such regulations) for a specified element of coverage which are substantially equivalent to the requirements of the specified ERISA provision which is applicable to such specified element of coverage,

then the requirements of such specified ERISA provision shall be treated as met with respect to such individuals until such Secretary nullifies such determination under such regulations.

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

(A) SUBSTITUTE BASIC HEALTH BENEFITS SYSTEM.—The term ''substitute basic health benefits system'' means, with respect to any group of individuals, any arrangement (other than an accessible health benefits system established and maintained in accordance with subpart C (and subpart D as applicable) of part 6 of subtitle B of title I of ERISA) which—

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

(ii) meets, with respect to such individuals, the reporting requirements of section 622 of ERISA, the participation requirements of section 623 of ERISA, the benefits requirements of section 624 of ERISA, and the contribution requirements of section 625 of ERISA.

(B) SPECIFIED ELEMENT OF COVERAGE.—The term ''specified element of coverage'' means any of the following:

(i) TREATMENT OF UNINSURABLE RISKS.—Exclusion from coverage of an individual as an uninsurable risk under a basic health benefits provision included in a plan, within the meaning of section 601(a)(7) of ERISA.

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

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

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

(C) SPECIFIED ERISA PROVISIONS.—

(i) TREATMENT OF UNINSURABLE RISKS.—The ''specified ERISA provision'' applicable to the specified element of coverage described in subparagraph (B)(i) is section 601(a)(2)(D)(i) of ERISA.

(ii) TREATMENT OF MATERIAL PRE-EXISTING CONDITIONS.—The ''specified ERISA provision'' applicable to the specified element of coverage described in subparagraph (B)(ii) is section 601(a)(2)(D)(ii) of ERISA.

(iii) PROVISION OF CONTINUATION COVERAGE.—The ''specified ERISA provisions'' applicable to the specified element of coverage described in subparagraph (B)(iii) are section 641(b) of ERISA, sec-

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

(D) STATE.—The term ''State'' has the meaning provided in section 3(10) of ERISA.

(E) ERISA.—The term ''ERISA'' means the Employee Retirement Income Security Act of 1974, as amended by this Act.

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

(1) GRANT PROGRAM.—The Secretary of Health and Human Services shall establish by regulation a program of monetary assistance in the form of grants to accessible health benefits systems established and maintained in accordance with subpart C (and subpart D as applicable) of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 pursuant to the amendments made by this Act. Grants to any system shall be in such amount as such Secretary considers appropriate to facilitate the effectuation of the policies of this Act.

(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for the Department of Health and Human Services, for the

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

SEC. 103. CONTINUATION COVERAGE AND ACCESSIBLE HEALTH BENEFITS SYSTEMS OR SUBSTITUTE SYSTEMS.

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

''(b) SUBSTITUTION OF ACCESSIBLE HEALTH BENEFITS SYSTEM OR SUBSTITUTE SYSTEM.—The requirements of this subpart may be met by providing, as an option to qualified beneficiaries or otherwise, for coverage of them under an accessible health benefits system established and maintained in accordance with subpart C (and subpart D as applicable), or under a substitute health benefits system providing continuation coverage in accordance with section 102 of the Universal Health Benefits Empowerment and Partnership Act of 1993, in lieu of coverage as otherwise required under this subpart.''.

(b) CONFORMING AMENDMENT TO INTERNAL REVENUE CODE.—Section 4980B of the Internal Revenue Code of 1986 (relating to excise tax for failure to satisfy continuation coverage requirements of group health plans) is amended—

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

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

''(8) SUBSTITUTION OF ACCESSIBLE HEALTH BENEFITS SYSTEM OR SUBSTITUTE SYSTEM.—The requirements of this subsection may be met by providing, as an option to qualified beneficiaries or otherwise, for coverage of them under an accessible health benefits system established and maintained in accordance with subpart C (and subpart D as applicable) of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or under a substitute health benefits system providing continuation coverage in accordance with section 102 of the Universal Health Benefits Empowerment and Partnership Act of 1993, in lieu of coverage as otherwise required under this subsection.''.

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

''(b) SUBSTITUTION OF ACCESSIBLE HEALTH BENEFITS SYSTEM OR SUBSTITUTE SYSTEM.—The require-

ments of this title may be met by providing, as an option to qualified beneficiaries or otherwise, for coverage of them under an accessible health benefits system established and maintained in accordance with subpart C (and subpart D as applicable) of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or under a substitute health benefits system providing continuation coverage in accordance with section 102 of the Universal Health Benefits Empowerment and Partnership Act of 1993, in lieu of coverage as otherwise required under this title.''.

SEC. 104. PREEMPTION OF STATE LAW TO PROVIDE FOR MORE AFFORDABLE HEALTH CARE COVERAGE.

(a) IN GENERAL.—Section 514(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(2)(B)) is amended—

(1) by inserting ''(i)'' after ''(B)''; and

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

''(ii) A provision of State law which provides that one or more specific benefits must be provided or made available by a contract or policy of health insurance issued to an employee benefit plan, or which provides that services rendered by one or more particular classes of health care

providers must be covered under such a contract or policy, is a law which relates to an employee benefit plan within the meaning of subsection (a) and is not a law which regulates insurance within the meaning of subparagraph (A).''.

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

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

SEC. 105. ENCOURAGEMENT OF MULTIPLE EMPLOYER ARRANGEMENTS PROVIDING BASIC HEALTH BENEFITS.

Paragraph (9) of section 501(c) of the Internal Revenue Code of 1986 (relating to exempt organizations) is amended—

(1) by inserting ''(A)'' after ''(9)''; and

(2) by adding at the end the following:

''(B) Any determination of whether a multiple employer welfare arrangement (as defined in section 3(25) of the Employee Retirement Income Security Act of 1974) is a voluntary employees' beneficiary association meeting the requirements of this paragraph shall be made without regard to any determination of commonality of interest or geographic location if—

''(i) such arrangement provides at least basic health care services described in section 601(a)(3)(A) of the Employee Retirement Income Security Act of 1974, and

''(I) such arrangement is fully insured, or

''(II) meets the requirements enforcible under section 514(b)(6)(B)(i) of such Act, and

''(ii) meets reporting requirements which shall be prescribed by the Secretary and are similar to the requirements of section 622 of such Act.''.

SEC. 106. TREATMENT PRACTICE GUIDELINES AND OUTCOMES RESEARCH FOR ALL AMERICANS.

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

''PART A—ESTABLISHMENT AND GENERAL DUTIES

''SEC. 901. ESTABLISHMENT.

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

''(b) PURPOSE.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of health care services for all Americans, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services.

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

search. The Administrator shall be appointed by the Secretary. The Secretary, acting through the Administrator, shall carry out the authorities and duties established in this title.

"SEC. 902. GENERAL AUTHORITIES AND DUTIES.

''(a) IN GENERAL.—In carrying out section 901(b), the Administrator shall conduct and support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information, on health care services and on systems for the delivery of such services to all Americans, including activities with respect to—

''(1) the effectiveness, efficiency, and quality of health care services;

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

''(3) clinical practice, including primary care and practice-oriented research;

''(4) health care technologies, facilities, and equipment;

''(5) health care costs, productivity, and market forces;

''(6) health promotion and disease prevention;

''(7) health statistics and epidemiology; and

''(8) medical liability.

''(b) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND UNDERSERVED POPULATIONS.—In carrying out subsection (a), the Administrator shall undertake and support research, demonstration projects, and evaluations with respect to—

''(1) the delivery of health care services in rural areas (including frontier areas) to Americans of all ages; and

''(2) the health of low-income groups, minority groups, and the elderly.''.

(b) FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE.—So much of part B of title IX of the Public Health Service Act as precedes section 912(c) is amended to read as follows:

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

''SEC. 911. ESTABLISHMENT OF OFFICE.

''There is established within the Agency an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. The office shall be headed by a director, who shall be appointed by the Administrator.

''SEC. 912. DUTIES.

''(a) ESTABLISHMENT OF FORUM PROGRAM.—The Administrator, acting through the Director, shall establish a program to be known as the Forum for Quality and Ef-

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

''(1) clinically relevant guidelines that may be used by physicians, educators, and health care practitioners to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and

''(2) standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

''(b) CERTAIN REQUIREMENTS.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

''(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures;

''(2) be presented—

''(A) in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations,

''(B) in formats appropriate for use by group health plans (as defined in section 601(a)(1) of the Employee Retirement Income Security Act of 1974), health benefits systems established and maintained by States in accordance with subpart C of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and substitute basic health benefits systems with respect to which the Secretary has made a determination pursuant to section 4 of the Universal Health Benefits Empowerment and Partnership Act of 1990 relating to an element of coverage described in section 4(a)(2)(B) of such Act, and

''(C) in formats appropriate for use by consumers of health care; and

''(3) include treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for

use in reviewing quality and appropriateness of medical care.''.

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

''(c) DISSEMINATION.—

''(1) IN GENERAL.—The Director shall promote and support the dissemination of the guidelines, standards, performance measures, and review criteria described in section 912(a).

''(2) ORGANIZATIONS UTILIZED.—Such dissemination shall be carried out through—

''(1) organizations representing health care providers;

''(2) group health plans (as defined in section 601(a)(1) of the Employee Retirement Income Security Act of 1974);

''(3) accessible health benefits systems established and maintained in accordance with subpart C (and subpart D as applicable) of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974;

''(4) organizations representing health care consumers;

''(5) peer review organizations;

''(6) accrediting bodies; and

''(7) other appropriate entities.''.

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

(e) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS.—Section 926(a) of the Public Health Service Act is amended by adding at the end the following: ''In addition to amounts otherwise authorized by this subsection, for the purpose of carrying out the amendments made by section 8 of the Universal Health Benefits Empowerment and Partnership Act of 1993, there are authorized to be appropriated $10,000,000 for fiscal year 1994, $15,000,000 for fiscal year 1995, and $20,000,000 for fiscal year 1996.''.

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

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

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

(b) MEMBERSHIP.—The Council shall consist of a Chairman and 12 other persons, appointed by the Secretary of Health and Human Services with the concurrence of the Secretary of Labor and without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall, to the extent possible, represent organizations of small and large employers, employee organizations, health care providers, providers of group health plan coverage, State and local governments, the field of actuarial counseling, and the general public.

(c) EXPENSES.—

(1) SERVICES AND ASSISTANCE.—The Council is authorized to engage such technical assistance, including actuarial services, as may be required to carry out its functions, and the Secretary of Health and Human Services and the Secretary of Labor shall, in addition, make available to the Council such secretarial, clerical, and other assistance as it may require to carry out such functions. The Secretary of Health and Human Services and the Secretary of

Labor shall, in addition, make available to the Council such actuarial and other pertinent data prepared by the Department of Health and Human Services, the Department of Labor, or other agencies of the Government as it may require to carry out such functions.

(2) TRAVEL AND PER DIEM.—Appointed members of the Council, while serving on the business of the Council (inclusive of travel time), while so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

(d) FUNCTIONS.—The Council shall—

(1) make timely recommendations to the Secretary of Health and Human Services for purposes of the issuance of initial regulations under section 101(b)(1),

(2) make recommendations to the Secretary of Health and Human Services relating to appropriate mechanisms for and the frequency of revisions of regulations under section 601(a)(3) of the Employee Retirement Income Security Act of 1974 (as amended by this Act),

(3) otherwise advise the Secretary of Health and Human Services and the Secretary of Labor with respect to the implementation of the amendments made by this Act,

(4) offer States and other entities advice regarding health benefits systems and implementation of the amendments made by this Act,

(5) serve as a forum for exchange of advice, recommendations, and information regarding the amendments made by this Act, their implementation, and health benefits systems established and maintained by States, and otherwise foster cooperation between States and other entities in implementing such amendments,

(6) make from time to time such recommendations as it considers appropriate relating to possible improvements relating to the financing and affordability of health care coverage for individuals eligible for coverage under health benefits systems established and maintained by States and other entities, and

(7) make from time to time such recommendations to the Secretary of Health and Human Services and to the Congress as it considers appropriate

relating to changes in the costs of health care coverage and delivery.

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

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

SEC. 108. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS FROM 25 PERCENT TO 100 PERCENT.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking ''25 percent'' and inserting ''the applicable percentage''.

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

''(6) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

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

SEC. 109. EFFECTIVE DATES.

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

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

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

(d) SECTION 105.—The amendments made by section 105 shall apply with respect to determinations made on or after January 1, 1994.

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

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

(g) SECTION 108.—The amendments made by section 108 shall apply with respect to taxable years beginning on or after January 1, 1992.

TITLE II—MEDICAL AND HEALTH INSURANCE INFORMATION REFORM

SEC. 201. SHORT TITLE.

This title may be cited as the ''Medical and Health Insurance Information Reform Act of 1993''.

SEC. 202. MEDICAL AND HEALTH INSURANCE INFORMATION REFORM.

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

''TITLE XXII—MEDICAL AND HEALTH INSURANCE INFORMATION REFORM

''PART A—COMPARATIVE VALUE INFORMATION

''COMPARATIVE VALUE INFORMATION PROGRAMS FOR HEALTH CARE PURCHASING

''SEC. 2200. (a) PURPOSE.—In order to assure the availability of comparative value information to purchasers of health care in each State, the Secretary shall determine whether each State is developing and implementing a health care value information program that meets the criteria and the schedule see out in subsection (b).

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

''(1) the State begins promptly after enactment of this section to develop (directly or through contractual or other arrangements with coalitions of health care purchasers, one or more States, other entities, or any combination of such arrangements) information systems regarding comparative health care values;

''(2) the information contained in such systems covers at least the average prices of common health care services (as defined in subsection (c)) and information related to the value of each health insurance plan available in the State, including premium costs and the value of benefits, and, where available, measures of the variability of those prices within the State or other market areas;

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

''(4) not later than four years following the enactment of this section, the State has developed information systems that provide comparative quality and outcomes data with respect to health insurance plans and hospitals and made the information broadly available within the relevant market areas.

''(c) DEFINITION.—For purposes of this section, 'common health care services' includes such procedures as the Secretary may specify and any additional health care services which a State may wish to include in its comparative value information program.

''(d) FEDERAL IMPLEMENTATION.—If the Secretary finds, at any time, that a State has not developed a health care value information program, or has failed to implement it (on a continuing basis) in accordance with the criteria and schedule set out in subsection (b), he shall take the actions necessary, directly or through grant or contract, to implement a comparable program in such State. Fees may be charged by the Secretary for the informational materials provided pursuant to such program. Any amounts so collected shall be deposited in the appropriation account from which the Secretary's costs of developing and providing such materials were met, and shall remain available for such purposes until expended.

''(e) COMPARATIVE VALUE INFORMATION CONCERNING FEDERAL PROGRAMS.—The head of each Federal agency with responsibility for the provision of health insurance, or of health care services, to individuals shall promptly develop health care value information relating to each program that he administers, and covering types of data comparative to the types of data that a State program meeting the criteria of this part would provide. Such information shall be made generally available to States and to providers and consumers of health care services.

''(f) INFORMATION FOR RESEARCH FROM INSURERS.—

''(1) The Secretary, after consulting with insurers, providers, and others, shall promulgate (and may modify from time to time) requirements for the periodic submission by insurers to the Secretary on a sample basis of health care data relevant to research concerning health care services, and shall promulgate an effective date for those requirements, to be at least one year after their promulgation.

''(2) Each insurer shall comply with the requirements specified by the Secretary under paragraph (1) by the effective date specified by the Secretary.

''(3) For provisions imposing an excise tax with respect to noncompliance with Federal requirements under this subsection, see section 5000A of the Internal Revenue Code of 1986.

''(g) RELEASE OF MEDICARE INFORMATION.—

''(1) The Department of Health and Human Services shall make available, under section 552 of title 5, United States Code, all records of claims filed under the programs established by title XVIII of the Social Security Act, without regard to the consent of the physician or other individual who furnished the item or service in question.

''(2)(A) Paragraph (1) shall not affect any prohibition against disclosure under section 552a of title 5, United States Code, with respect to any individual to whom an item or service was furnished.

''(B) The requirement of paragraph (1) does not apply to information received by the Department of Health and Human Services, or by any of its contractors, before the date of enactment of the Medical and Health Insurance Information Reform Act of 1994.

''(h) DEVELOPMENT OF MODEL SYSTEMS.—

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

gathering of health care cost, quality, and outcomes data and analyzing such data in a manner that will permit the valid comparison of such data cost, quality, and outcomes among providers and among health plans. The Secretary shall support experimentation with different approaches to achieve the objectives of the preceding sentence in the most cost effective manner (relative to the accuracy and timeliness of the data secured) and shall evaluate the various methods to determine their relative success. When he considers it appropriate, the Secretary may establish standards for the collection and reporting of health care cost, quality, and outcomes data in order to facilitate analysis and comparisons among States and nationally.

''(2) There are authorized to be appropriated such sums as are necessary for each fiscal year beginning with fiscal year 1994, to enable the Secretary to conduct the activities required by paragraph (1), including evaluation of the different approaches tested under such paragraph and their relative cost effectiveness.

''GRANTS FOR THE DEVELOPMENT OF STATE PROGRAMS

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

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

''(b) OFFSET AUTHORITY.—If, at any time within the three year period following the receipt by a State of a grant pursuant to subsection (a), the Secretary is required by section 2200(d) to implement a health care information program in such State, he may recover the amount of the grant under subsection (a) by offset against any other amount payable to such State under this Act. The amount of the offset shall be made available (from the appropriation account with respect to which the offset was taken) to the Secretary to carry out section 2200(d) in such State.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section, to remain available until expended.

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

''PREEMPTION OF STATE QUILL PEN LAWS

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

''PROMULGATION OF REQUIREMENTS BY SECRETARY

''SEC. 2211. (a) HEALTH INSURANCE INFORMATION PRIVACY AND CONFIDENTIALITY PROTECTION.—

''(1) The Secretary, after taking into consideration the Insurance Information and Privacy Protection Model Act of the NAIC, shall promulgate by January 1, 1994, (and may modify from time to time) requirements concerning health insurance information privacy and confidentiality protection for individuals. There shall be included a requirement that information that identifies individuals shall not be redisclosed (with such limited exceptions as the Secretary may provide) except to the extent necessary to carry out the purpose for which the information was collected.

''(2) The Secretary, in promulgating requirements under paragraph (1), shall take into consider-

ation the following principles concerning information that identifies individuals:

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

''(B) Such information collected for one purpose should not be used for another purpose without the individual's informed consent.

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

''(D) Methods to ensure the accuracy, reliability, relevance, completeness, and timeliness of such information should be instituted.

''(E) Individuals should be notified (in advance of the collection of such information) as to whether the furnishing of such information is mandatory or voluntary, as to what the record keeping practices are concerning such information, and as to what uses will be made of such information.

''(F) Individuals should be permitted to inspect and correct such information concerning themselves.

''(b) STANDARDS AND REQUIREMENTS FOR THE ELECTRONIC RECEIPT AND TRANSMISSION OF HEALTH INSURANCE INFORMATION.—

''(1) By January 1, 1995, the Secretary shall determine whether problems relating to standards for the electronic receipt and transmission of health insurance information cause significant administrative costs. If the Secretary determines that such problems do cause significant administrative costs, the Secretary, after consulting with the Accredited Standards Committee X–12 of the American National Standards Institute, insurers, providers, and others, shall promulgate (and may modify from time to time) standards concerning the electronic receipt and transmission of claims, payment, eligibility, and enrollment information (including requirements, consistent with those promulgated under subsection (a), to protect privacy and confidentiality), and shall promulgate an effective date for those standards, to be at least one year after the promulgation of the standards.

''(2) By January 1, 1995, the Secretary shall determine whether problems relating to the receipt and transmission of health insurance eligibility verification cause significant administrative costs. If the

Secretary determines that such problems do cause significant administrative costs, the Secretary, after consulting with the Accredited Standards Committee X–12 of the American National Standards Institute, insurers, providers, and others, shall promulgate (and may modify from time to time) requirements concerning the receipt and transmission of health insurance eligibility verification, and shall promulgate an effective date for those requirements, to be at least one year after the promulgation of the requirement.

''(3) By January 1, 1995, the Secretary shall determine whether the proportion of health insurance claims and payment information received and transmitted by paper will continue to cause significant administrative costs. If the Secretary determines that the proportion will continue to cause significant administrative costs, the Secretary, after consulting with the Accredited Standards Committee X–12 of the American National Standards Institute, insurers, providers, and others, shall promulgate (and may modify from time to time) a requirement that insurers receive and transmit a specified proportion of (or all) health insurance claims and payment information electronically (with such excep-

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

''(c) HEALTH INSURANCE CLAIM FORMS.—

''(1) By January 1, 1995, the Secretary, after consulting with insurers, providers, and others, shall promulgate (and may modify from time to time) requirements for the format and content of basic claim forms under health insurance plans.

''(2) The Secretary shall determine whether the variety of information requested by insurers (in addition to the information requested in basic claim forms) causes administrative costs that are disproportionate to the benefits derived from that information. If the Secretary determines that the variety of information requested does cause such costs, the Secretary, after consulting with insurers, providers, and others, shall publish (and may modify from time to time) recommendations concerning what additional information should be allowed to be requested and in what format.

''(d) PRIORITY AMONG INSURERS.—By January 1, 1995, but after June 30, 1994, the Secretary, after consulting with the NAIC, shall promulgate (and may modify

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

''(e) FURNISHING OF INFORMATION AMONG INSURERS.—By January 1, 1996, but after June 30, 1995, the Secretary shall determine whether problems relating to the availability of information among insurers when benefits are payable under two or more health insurance plans cause significant mistaken benefit payments or administrative costs. If the Secretary determines that such problems do cause significant mistaken benefit payments or administrative costs, the Secretary shall promulgate (and may modify from time to time) requirements concerning the transfer among insurers (and annual updating) of appropriate information (which may include requirements for the use of unique identifiers, and for the listing of all individuals covered under a health insurance plan), and shall promulgate an effective date for those requirements (to be not earlier than one year after the promulgation of the requirements).

''STATE PROGRAMS

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

''(1) the State has in effect standards, requirements, and rules (for insurers other than administrators of self-insured employee plans) substantially

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

''(2) the State maintains an effective enforcement mechanism for those State requirements.

''APPLICATION OF FEDERAL REQUIREMENTS

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

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

''(1) with respect to a section, the Secretary determines that the State does not meet the requirements of section 2212, or

''(2) with respect to a section, the State fails to provide such information from time to time as requested by the Secretary to enable the Secretary to make a determination under section 2212.

''HEALTH INSURANCE INFORMATION PRIVACY AND CONFIDENTIALITY PROTECTION

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

''IDENTIFICATION NUMBERS

''SEC. 2215. As of January 1, 1995, each insurer shall—

''(1) for each of its beneficiaries that has a social security number, use that number, and

''(2) for each provider that has a unique identifier for purposes of title XVIII and that furnishes health care items or services to a beneficiary under a health insurance plan of that insurer, use that identifier.

''STANDARDS AND REQUIREMENTS FOR THE RECEIPT AND TRANSMISSION OF HEALTH INSURANCE INFORMATION

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

''HEALTH INSURANCE CLAIM FORMS

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

''PRIORITY AMONG INSURERS

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

''FURNISHING OF INFORMATION AMONG INSURERS

''SEC. 2219. If the Secretary promulgates requirements under section 2211(e), each insurer, by the effective date specified by the Secretary for those requirements, shall comply with them.

''NONCOMPLIANCE WITH FEDERAL REQUIREMENTS

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

''NO EFFECT ON SCOPE OF BENEFITS COVERED

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

''PART C—MEDICAL DATA REQUIREMENTS

''PROMULGATION OF REQUIREMENTS BY SECRETARY

''SEC. 2230. (a) PROMULGATION OF REQUIREMENTS FOR HOSPITALS.—

''(1) By January 1, 1996, but after June 30, 1995, the Secretary shall promulgate requirements for hospitals concerning electronic medical data. In developing the requirements, the Secretary shall consult with the American National Standards Institute, insurers, hospitals, and other interested parties (and shall take into consideration, in developing requirements under paragraph (2)(A), the data set

used by the utilization and quality control peer review program under part B of title XI).

''(2) The requirements promulgated under paragraph (1) shall include—

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

''(B) the definition of a set of data elements for use by intermediaries and carriers under the programs established by title XVIII (that shall include the standard set of data elements defined under subparagraph (A)),

''(C) standards for an electronic patient care information system with data obtained at the point of care (including requirements, consistent with those promulgated under section 2211(a), to protect privacy and confidentiality),

''(D) the specification of, and manner of presentation of, the individual data elements of the sets and system under the preceding subparagraph, and

''(E) standards concerning the transmission of electronic medical data.

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

ards Institute, insurers, hospitals, and other interested parties) modify the requirements promulgated under the preceding paragraphs.

''(b) PROMULGATION OF REQUIREMENTS FOR OTHER HEALTH CARE PROVIDERS.—

''(1) The Secretary may promulgate requirements concerning electronic medical data for providers that are not hospitals. In developing the requirements, the Secretary shall consult with the American National Standards Institute, insurers, providers other than hospitals, and other interested parties.

''(2) The requirements promulgated under paragraph (1) may include—

''(A) the definition of a set of data elements for use by intermediaries and carriers under the programs established by title XVIII,

''(B) the specification of, and manner of presentation of, the individual data elements of the set under subparagraph (A), and

''(C) standards concerning the transmission of electronic medical data.

''(3) The Secretary may from time to time modify the requirements promulgated under paragraph (1).

''MEDICARE REQUIREMENTS FOR HOSPITALS

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

''(1) maintain an electronic patient care information system that meets the requirements of subparagraphs (C) and (D) of section 2230(a)(2);

''(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI), transmit electronically the data set specified under subparagraphs (A) and (D) of section 2230(a)(2) with respect to a specified discharge;

''(3) upon request of the Secretary, or of a fiscal intermediary or carrier (as defined in both cases in title XVIII), transmit electronically any data (with respect to a claim) from the data set specified under subparagraphs (B) and (D) of section 2230(a)(2); and

''(4) transmit the data specified under paragraphs (2) and (3) in accordance with the requirements of section 2230(a)(2)(E).

''(b) WAIVERS.—

''(1) The Secretary may waive the requirements of subsection (a) until January 1, 1999, for a hospital that—

''(A) is in the process of developing a system specified under section 2230(a)(2)(C) and that executes agreements with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 1999), or

''(B) is a small rural hospital (as defined by the Secretary).

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

''(A) agrees to obtain from its records the data elements that are needed to meet the requirements of paragraphs (2) and (3) of subsection (a), and

''(B) agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

''ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES

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

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

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

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

''PART D—GENERAL PROVISIONS

''DEFINITIONS

''SEC. 2240. For purposes of this title—

''(1) The term 'administrator' has the meaning given that term in section 3(16)(A) of the Employee Retirement Income Security Act of 1974.

''(2) The term 'employee welfare benefit plan' has the meaning given that term in section 3(1) of the Employee Retirement Income Security Act of 1974.

''(3) The term 'health insurance plan' means any contract or arrangement under which an entity bears all or part of the cost of providing health care items and services, including a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract (including any self-insured

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

''(A) coverage only for accident, dental, vision, disability, or long-term care, medicare supplemental health insurance, or any combination thereof,

''(B) coverage issued as a supplement to liability insurance,

''(C) workers' compensation or similar insurance, or

''(D) automobile medical-payment insurance.

''(4) The term 'insurer' means any entity that offers a health insurance plan under which that entity is at risk for all or part of the cost of benefits under the plan, and includes any agent of that entity.

''(5) The term 'NAIC' means the National Association of Insurance Commissioners.

''(6) The term 'provider' means a physician, hospital, pharmacy, laboratory, or other person licensed or otherwise authorized under applicable State laws to furnish health care items or services.

''(7) The term 'administrator of a self-insured employee plan' means an insurer that is an administrator of an employee welfare benefit plan.

''(8) The term 'utilization review' means review of the medical necessity, appropriateness, and quality of health care items and services.''.

SEC. 203. CONFORMING AMENDMENT.

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

(1) by striking ''and'' at the end of subparagraph (P),

(2) by striking the period at the end of subparagraph (Q) and inserting a comma and ''and'', and

(3) by adding at the end the following:

''(R) in the case of hospitals, to comply with the requirements of section 2231.''.

SEC. 204. FAILURE TO SATISFY CERTAIN HEALTH INSURANCE REQUIREMENTS.

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

''SEC. 5000B. FAILURE TO SATISFY CERTAIN HEALTH INSURANCE REQUIREMENTS.

''(a) GENERAL RULE.—

''(1) ADMINISTRATORS OF SELF-INSURED EMPLOYEE PLANS.—There is hereby imposed, on any administrator of a self-insured employee plan, a tax on any failure to comply with a requirement under section 2214, 2215, 2216, 2217, 2218, or 2219 of that Act. The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall determine whether any administrator of a self-insured employee plan meets the requirements of those sections.

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

''(3) RESEARCH DATA REQUIREMENTS.—There is hereby imposed on any insurer a tax on any failure to comply with a requirement under paragraph (2) of section 2200(f) of the Social Security Act. The Secretary of Health and Human Services shall

determine whether any insurer meets the requirements of that paragraph.

''(b) AMOUNT OF TAX.—The amount of tax imposed by subsection (a) for a taxable year in which an insurer fails to comply with a requirement described in that subsection shall be equal to $100 for each such failure.

''(c) CONTROLLED GROUPS.—

''(1) EMPLOYERS.—In the case of an insurer that is an employer, for purposes of this section all persons that are treated as part of the same employer (within the meaning of section 414) as the insurer shall be treated as the same person.

''(2) OTHER INSURERS.—In the case of an insurer that is not an employer, for purposes of this section—

''(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as one person. For purposes of the preceding sentence, the term 'controlled group of corporations' has the meaning given to such term by section 1563(a), except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in section 1563(a)(1), and

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

''(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary, all trades or businesses (whether or not incorporated) which are under common control shall be treated as one person. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

''(d) LIMITATIONS ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person liable for tax did not know, and by exercising reasonable diligence would not have known, that the failure existed.

''(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN THIRTY DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) the failure was due to reasonable cause and not to willful neglect, and

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

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

''(e) DEFINITIONS.—For purposes of this section—

''(1) the terms 'insurer' and 'administrator of a self-insured employee plan' have the meanings given to those terms by section 2230 of the Social Security Act, and

''(2) the term 'State' has the meaning given to that term by section 1101(1) of the Social Security Act.''.

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

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

''Sec. 5000B. Failure to satisfy certain health insurance requirements.''

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

TITLE III—MEWA ENFORCEMENT IMPROVEMENTS

SEC. 301. SHORT TITLE.

This title may be cited as the ''Multiple Employer Welfare Arrangements Enforcement Improvements Act of 1993''.

SEC. 302. AMENDMENT TO DEFINITION OF EMPLOYEE WELFARE BENEFIT PLAN.

Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)) is amended—

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

(2) by inserting ''(A)'' after ''(1)''; and

(3) by adding at the end the following new subparagraphs:

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

ployees of the employer (or members or former members of the employee organization) which established or maintains the plan, or their beneficiaries, if at no time during the plan year the number of such individuals exceeds five percent of the aggregate number of individuals covered under the plan.

''(C) A plan, fund, or program shall not fail to be an 'employee welfare benefit plan' solely because the plan, fund, or program is established or maintained by a franchise network (as defined in paragraph (40)(B)(vi)).

''(D) A plan, fund, or program shall not fail to be an 'employee welfare benefit plan' solely because the plan, fund, or program is established or maintained by two or more trades or businesses, whether or not incorporated, that are within the same control group or were within the same control group at any time during the period commencing with the preceding one-year period. For purposes of this subparagraph, the term 'control group' shall have the meaning provided in clauses (ii) and (iii) of paragraph (40)(B).''.

SEC. 303. AMENDMENT TO DEFINITION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENT.

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

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

''(i) pursuant to one or more collective bargaining agreements, if, under such arrangements, coverage under such arrangements is limited to—

''(I) employees covered by a collective bargaining agreement,

''(II) employees of the plan,

''(III) employees of an employee organization which is a party to such collective bargaining agreement, and

''(IV) beneficiaries of participants described in subclauses (I), (II), and (III), or'';

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

''(iv) by a franchise network, or

''(v) by an insurer (as defined in section 401(b)(2)(A)) or by a health maintenance organization, if such insurer or organization is licensed to do business in a State.'';

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

plan, or any fiscal year of any other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding one-year period.''; and

(4) in subparagraph (B), by redesignating clauses (iv) and (v) as clauses (viii) and (ix), respectively, and by inserting after clause (iii) the following new clauses:

''(iv) the term 'employee' includes any former employee who is receiving benefits under the plan or under part 6 of subtitle B,

''(v) the term 'collective bargaining agreement' means a written agreement between an employer or a group of employers and one or more employee organizations which has been negotiated through a process of arm's length, good faith bargaining, pursuant to the National Labor Relations Act or other applicable law, where a broad range of matters pertaining to the employment relationship such as wages, rates of pay, hours of employment, grievances, and conditions of employment, in addition to employee benefits, have been negotiated,

''(vi) the term 'franchise network' means a group or association of franchisees (which may include the franchisor), if each of such franchisees is

a party to a franchise with the same franchisor, except that, for purposes of this clause—

''(I) the terms 'franchise', 'franchisor', and 'franchisee' shall have the meanings provided such terms in the regulations of the Federal Trade Commission, as in effect on January 1, 1991, under paragraphs (1) and (2) of section 436.2(a) of title 16 of the Code of Federal Regulations, without regard to paragraph (5) of such section 436.2(a), if the franchise has as its primary economic basis a business activity in fact apart from the provision of health care benefits to employees of the franchisees,

''(II) a franchise that is exempted from the provisions of part 436 of title 16 of the Code of Federal Regulations pursuant to section 436.2(a)(3) of such title 16, or is an arrangement that is excluded under section 436.2(a)(4) of such title 16, is not a franchise for purposes of this part, and

''(III) the Secretary may by regulation amend the definition of 'franchise network' for purposes of maintaining consistency with any changes in the definition of 'franchise' adopted

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

''(vii) an employee welfare benefit plan which is maintained by a single employer shall not be deemed to be a multiple employer welfare arrangement for any plan year solely because the plan covers individuals who are not employees or former employees of the employer, or their beneficiaries, if, at no time during the plan year, the number of such individuals exceeds five percent of the aggregate number of individuals covered under the plan,''.

SEC. 304. COVERAGE.

Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended by adding at the end the following new subsection:

''(c) Except as provided in subsection (b), this title shall apply to any multiple employer welfare arrangement engaged in commerce or in any industry or activity affecting commerce.''.

SEC. 305. REGISTRATION REQUIREMENT.

Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended—

(1) by redesignating subsection (f) as subsection (g); and

(2) by inserting after subsection (e) the following new subsections:

''(f) REGISTRATION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

''(1) EXISTING ARRANGEMENTS.—The person or persons responsible under paragraph (4), with respect to each multiple employer welfare arrangement which provides benefits of medical care (within the meaning of section 213(d) of the Internal Revenue Code of 1986) and which have commenced operations as of 180 days after the date of the enactment of the Multiple Employer Welfare Arrangements Enforcement Improvements Act of 1993, shall file with the Secretary—

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

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

''(2) NEW ARRANGEMENTS.—The person or persons responsible under paragraph (4), with respect to each multiple employer welfare arrangement

which provides benefits of medical care (within the meaning of section 213(d) of the Internal Revenue Code of 1986) and which have not commenced operations as of 180 days after the date of the enactment of the Multiple Employer Welfare Arrangements Enforcement Improvements Act of 1993, shall file with the Secretary a registration statement described in paragraph (3)—

''(A) at least 60 days before the date on which the multiple employer welfare arrangement commences operations, and

''(B) within 30 days after the end of each fiscal year.

''(3) REGISTRATION STATEMENTS.—A registration statement filed under this subsection shall—

''(A) be filed in such form, and contain such information concerning the multiple employer welfare arrangement, as shall be provided in regulations promulgated by the Secretary, including information disclosing the names and addresses of any person involved in its operation, the address of the arrangement, the fiscal year of the arrangement, and a list of States in which the arrangement conducts busi-

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

''(B) contain a certification that copies of such registration statement have been filed with the Insurance Commissioner (or other similar official) of each State in which the multiple employer welfare arrangement currently offers or provides benefits, or intends to offer or provide benefits during the following 12-month period, and

''(C) indicate whether the multiple employer welfare arrangement has obtained, applied for, or intends to apply for an exemption from State regulation under section 514(b)(6)(B).

''(4) PERSONS RESPONSIBLE FOR FILING.—The person or persons responsible for filing the annual registration statement with respect to a multiple employer welfare arrangement are—

''(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or

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

trustees cannot be identified, the person or persons actually responsible for the acquisition, disposition, control, or management of the cash or property of the multiple employer welfare arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.''.

SEC. 306. ENFORCEMENT AND CIVIL PENALTIES.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by inserting ''or (c)(4)'' after ''(c)(2)''; and

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

''(4) The Secretary may assess, against the person or persons responsible for filing with the Secretary an annual registration statement with respect to a multiple employer welfare arrangement as required under section 101(f), a civil penalty of up to $1,000 a day from the date of such person's or persons' failure or refusal to timely file such statement. For purposes of this paragraph, an annual registration statement which the Secretary deter-

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

(b) COURT ORDERS.—Section 502 of such Act is further amended by adding at the end the following new subsection:

''(m)(1) Upon application by the Secretary showing the operation, promotion, or marketing of a multiple employer welfare arrangement that—

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

''(B) is neither—

''(i) licensed, registered, or otherwise approved under the insurance laws of all States in which the arrangement offers or provides benefits, nor

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

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

''(2) Paragraph (1) shall not apply if it is shown that the arrangement—

''(A) is fully insured, within the meaning of section 514(b)(6)(D),

''(B) meets the requirements of paragraph (2)(A), except to the extent that all or some of the States in which the arrangement offers or provides benefits do not require licensing, registration, or approval of fully-insured multiple employer welfare arrangements, and

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

The court may grant such additional equitable or remedial relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the arrangement.''.

SEC. 307. EXEMPTION PROCEDURE.

(a) IN GENERAL.—Section 514(b)(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)) is amended—

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

(2) by subparagraph (A)(ii), by striking ''the preceding sections of'';

(3) in subparagraph (B), by striking ''(B) The Secretary'' and all that follows through the end of the first sentence and inserting the following: ''(B)(i) The Secretary may exempt from subparagraph (A), for a period not to exceed three years, individually or by class, multiple employer welfare arrangements which are not fully insured and which provide benefits of medical care (within the meaning of section 213(d) of the Internal Revenue Code of 1986). This exemption may be renewed by the Secretary upon application.''; and

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

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

''(I) administratively feasible,

''(II) not adverse to the interests of the participants and beneficiaries of the employee welfare benefit plan which is a multiple employer welfare arrangement, and

''(III) protective of the rights and benefits of such participants and beneficiaries.

''(iii) Before granting an exemption under this subparagraph, the Secretary shall—

''(I) publish notice in the Federal Register of the pendency of the exemption,

''(II) require that adequate notice be given to interested persons, including the insurance commissioner (or similar official having jurisdiction over the offering or sale of insurance) of each State in which the multiple employer welfare arrangement offers or provides, or intends to offer or provide, benefits, and

''(III) afford interested persons opportunity to present views.

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

''(iv) Any determination made by the Secretary under this subparagraph shall be in the Secretary's sole discretion.''.

(b) TRANSITIONAL RULE.—During the 540-day period commencing with the date of the enactment of this Act, section 514(b)(6)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)) shall not apply to any multiple employer welfare arrangement which, as of such date, is an employee welfare benefit plan which provides benefits for medical care (within

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

(1) an application for an exemption with respect to such arrangement is filed pursuant to section 514(b)(6)(B)(i) of the Employee Retirement Income Security Act of 1974 (as amended by this Act) during the 180-day period following the date of the enactment of this Act, and

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

If the Secretary determines, at any time after the date of the enactment of this Act, that such exemption from such section 514(b)(6)(A) would be detrimental to the interests of participants or beneficiaries of a multiple employer welfare arrangement, such exclusion shall cease as of the date of the determination. Any determination made by the Secretary under this subsection shall be in the Secretary's sole discretion.

SEC. 308. CLARIFICATION OF STATES' ABILITY TO OBTAIN INFORMATION.

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

''(9) Notwithstanding any other provision of this section, in the case of an employee welfare benefit plan, any law of any State which regulates insurance may apply to such plan to the extent that such law, in connection with an investigation to determine whether or not a person has violated or is about to violate a provision of such law, gives the State the ability to require disclosure of information necessary to determine whether such plan—

''(A) is a multiple employer welfare arrangement,

''(B) is in compliance with an exemption granted by the Secretary under paragraph (6)(B)(i), or

''(C) is in compliance with paragraph (6)(B)(ii).''.

SEC. 309. EFFECTIVE DATE.

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

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