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103D CONGRESS
2D SESSION

H. R. 4410

To provide for universal affordable access to health care and health insurance through tax and savings incentives, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 12, 1994

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

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A BILL

To provide for universal affordable access to health care and health insurance through tax and savings incentives, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Bipartisan Health Security Reform Act of 1994''.

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

TITLE I—AMENDMENTS OF INTERNAL REVENUE CODE OF 1986

Subtitle A—Tax Incentives for Purchase of Health Care Coverage

SEC. 101. REFUNDABLE CREDIT FOR PURCHASE OF HEALTH CARE COVERAGE.

(a) ALLOWANCE OF CREDIT.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

"SEC. 35. PURCHASE OF HEALTH CARE COVERAGE.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to 30 percent of the sum of—

''(1) the amount paid by the taxpayer during the taxable year for health care coverage for the taxpayer, the spouse of the taxpayer, and any dependent (as defined in section 152) of the taxpayer, and

''(2) if the individual is an eligible individual, the amount contributed by the taxpayer for the taxable year to a medical care savings account of such individual.

''(b) LIMITATION ON CONTRIBUTIONS TO MEDICAL CARE SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—The amount taken into account under subsection (a)(2) for any taxable year for contributions to a medical care savings account of an individual shall not exceed the amount of patient cost-sharing required under the high deductible health plan or the health maintenance organization covering the individual. In the case of a husband and wife, the excess described in the preceding sentence shall be divided equally between such spouses.

''(2) PRORATION OF LIMITATION IF PART-YEAR ELIGIBILITY.—In the case of an individual who is an eligible individual only for a portion (but not all) of the calendar year ending with or within the taxable year, the limitation under this subsection for such taxable year shall be an amount which bears the same ratio to such limitation (determined without regard to this paragraph) as such portion bears to the entire calendar year.

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

''(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any individual who is covered under a high deductible health plan or by a health maintenance organization. Such term shall not in-

clude an individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which the individual's taxable year begins.

''(2) HIGH DEDUCTIBLE HEALTH PLAN.—The term 'high deductible health plan' means insurance which constitutes medical care (as defined in section 213(d)), but only if such insurance requires patient cost-sharing of at least $1,000 per year but not more than $5,000 per year.

''(3) HEALTH CARE COVERAGE.—The term 'health care coverage' means—

''(A) coverage under insurance which constitutes medical care (as defined in section 213(d)),

''(B) coverage under an accident or health plan, and

''(C) coverage by a health maintenance organization.

Such term does not include excluded coverage.

''(4) EXCLUDED COVERAGE.—The term 'excluded coverage' means—

''(A) any coverage providing wages or payments in lieu of wages for any period during

which the employee is absent from work on account of sickness or injury,

''(B) any coverage providing for payments referred to in section 105(c),

''(C) any coverage provided to an employee or former employee after such employee has attained age 65, unless such coverage is provided by reason of the current employment of the individual (within the meaning of section 1862(b)(1)(A)(i)(I) of the Social Security Act) with the employer providing the coverage,

''(D) any coverage provided under Federal law to any individual (or spouse or dependent thereof) by reason of such individual being—

''(i) a member of the Armed Forces of the United States, or

''(ii) a veteran, and

''(E) any other coverage to the extent that the Secretary determines that the continuation of an exclusion for such coverage is not inconsistent with the purposes of this section.''

''(d) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Any amount which is taken into ac-

count in determining the credit under this section shall not be taken into account under section 213.

''(2) COORDINATION WITH FLEXIBLE SPENDING ACCOUNTS.—Any amount paid from a flexible spending account shall be treated as not paid by the taxpayer.''

(b) REPEAL OF DEDUCTION OF HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS.—Subsection (l) of section 162 is hereby repealed.

(c) TECHNICAL AMENDMENTS.—

(1) The table of sections for such subpart C is amended by striking the last item and inserting the following new items:

''Sec. 35. Purchase of health care coverage.
''Sec. 36. Overpayments of tax.''

(2) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period ''or from section 35 of such Code''.

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

Subtitle B—Medical Care Savings Accounts

SEC. 111. MEDICAL CARE SAVINGS ACCOUNTS.

(a) IN GENERAL.—Subpart A of part I of subchapter D of chapter 1 of the Internal Revenue Code of 1986 is

amended by inserting after section 408 the following new section:

"SEC. 408A. MEDICAL CARE SAVINGS ACCOUNTS.

''(a) GENERAL RULE.—For purposes of this title, the term 'medical care savings account' (which may also be referred to as a 'Medical IRA') means a trust created or organized in the United States for the exclusive benefit of an individual and the individual's spouse and dependents (as defined in section 152), but only if the written instrument creating the trust meets the following requirements:

''(1) Except in the case of a rollover contribution described in subsection (c)(5), no contribution will be accepted unless it is in cash and contributions will not be accepted during any calendar year in excess of the limitation applicable to the individual under section 35(b)(2).

''(2) The trustee is a bank (as defined in section 408(n)), insurance company (as defined in section 816), or such other person who demonstrates to the satisfaction of the Secretary that the manner in which such other person will administer the trust will be consistent with the requirements of this section.

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

''(4) The interest of an individual in the balance of the account is nonforfeitable.

''(5) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(b) TAX TREATMENT OF ACCOUNTS.—

''(1) ACCOUNT TAXED AS GRANTOR TRUST.—The account beneficiary of a medical care savings account shall be treated for purposes of this title as the owner thereof and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

''(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

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

''(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any ac-

count ceases to be a medical care savings account by reason of subparagraph (A) on the first day of any taxable year, subsection (c) shall be applied as if—

''(i) there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day), and

''(ii) no portion of such distribution were used to pay qualified expenses.

''(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the account beneficiary uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed and not used to pay qualified expenses.

''(c) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—Any amount paid or distributed out of a medical care savings account shall be included in the gross income of the account beneficiary unless such amount is used exclusively to pay the qualified expenses of such beneficiary or of the spouse and dependents (as defined in section 152) of such beneficiary.

''(2) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall

not apply to the distribution of any contribution paid during a taxable year to a medical care savings account to the extent that such contribution exceeds the limitation applicable under section 35(b)(2) if—

''(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (B) shall be included in the gross income of the individual for the taxable year in which it is received.

''(3) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED EXPENSES.—

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

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

''(C) DISABILITY OR DEATH CASES.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

''(4) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—Paragraph (1) does not apply to any amount paid or distributed out of a medical care savings account to the account beneficiary if the entire amount received is paid into a medical care savings account for the benefit of such beneficiary not later than the 60th day after the day on which he receives the payment or distribution.

''(B) LIMITATION.—This paragraph does not apply to any amount described in subparagraph (A) received by an individual from a

medical care savings account if at any time during the one-year period ending on the day of such receipt such individual received any other amount described in subparagraph (A) from a medical care savings account which was not includible in his gross income because of the application of this paragraph.

''(C) DENIAL OF ROLLOVER TREATMENT FOR INHERITED ACCOUNTS, ETC.—

''(i) IN GENERAL.—In the case of an inherited medical care savings account—

''(I) this paragraph shall not apply to any amount received by an individual from such an account (and no amount transferred from such account to another medical care savings account shall be excluded from gross income by reason of such transfer), and

''(II) such inherited account shall not be treated as a medical care savings account for purposes of determining whether any other amount is a rollover contribution.

''(ii) INHERITED MEDICAL CARE SAVINGS ACCOUNT.—A medical care savings account shall be treated as inherited if—

''(I) the account beneficiary acquired such account by reason of the death of another individual, and

''(II) the account beneficiary was not the surviving spouse of such other individual.

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

''(1) QUALIFIED EXPENSES.—The term 'qualified expenses' means any of the following expenses which are incurred for the benefit of the account beneficiary or the spouse or dependents (as defined in section 152) of such beneficiary:

''(A) Expenses for medical care (as defined in section 213(d)).

''(B) Expenses for long-term care services (or premiums for long-term care insurance).

''(C) Expenses for work-related training, education, and child care.

''(2) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual for whose benefit the medical care savings account is established.

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

''(1) the assets of such account are held by a bank (as defined in section 408(n)), insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

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

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

''(f) REPORTS.—The trustee of a medical care savings account shall make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''

(b) EMPLOYER PAYMENTS EXCLUDED FROM EMPLOYMENT TAX BASE.—

(1) SOCIAL SECURITY TAXES.—

(A) Subsection (a) of section 3121 of such Code is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106.''

(B) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting ''; or'', and by inserting after paragraph (19) the following new paragraph:

''(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106 of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

''(10) MEDICAL CARE SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106.''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106.''

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'',

and by inserting after paragraph (20) the following new paragraph:

''(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106.''

(c) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL CARE SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical care savings account (within the meaning of section 408A),'',

(3) by striking ''or'' at the end of paragraph (1) of subsection (a), and

(4) by adding at the end thereof the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO MEDICAL CARE SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical care savings account (within the meaning of section 408A), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the limitation applicable under section 35(b)(2) for such taxable year. For purposes of this subsection, any contribution which is distributed out of the medical care savings account in a distribution to which section 408A(c)(2) applies shall be treated as an amount not contributed.''

(d) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to prohibited transactions) is amended—

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

''(4) SPECIAL RULE FOR MEDICAL CARE SAVINGS ACCOUNTS.—An individual for whose benefit a medical care savings account (within the meaning of section 408A) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical care savings account by reason of the ap-

plication of section 408A(b)(2)(A) to such account.'', and

(2) by inserting ''or a medical care savings account described in section 408A'' in subsection (e)(1) after ''described in section 408(a)''.

(e) FAILURE TO PROVIDE REPORTS ON MEDICAL CARE SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement account or annuities) is amended—

(1) by inserting ''**OR ON MEDICAL CARE SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

(2) by adding at the end of subsection (a) the following: ''The person required by section 408A(f) to file a report regarding a medical care savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.''

(f) CLERICAL AMENDMENTS.—

(1) The table of sections for subpart A of part I of subchapter D of chapter 1 of such Code is amended by inserting after the item relating to section 408 the following:

''Sec. 408A. Medical care savings accounts.''

(2) The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4973 and inserting the following:

''Sec. 4973. Tax on excess contributions to individual retirement accounts, medical care savings accounts, certain 403(b) contracts, and certain individual retirement annuities.''

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

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

SEC. 112. UNUSED AMOUNTS IN FLEXIBLE SPENDING ACCOUNTS TRANSFERABLE TO MEDICAL CARE SAVINGS ACCOUNTS.

(a) IN GENERAL.—Subsection (d) of section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by adding at the end thereof the following new paragraph:

''(3) UNUSED AMOUNTS TRANSFERABLE TO MEDICAL CARE SAVINGS ACCOUNTS.—Subsection (a) shall not fail to apply to a participant in a plan, and a plan shall not fail to be treated as a cafeteria plan, solely because under the plan amounts not paid out as reimbursements under a flexible spending arrangement for medical care (as defined in section

213(d)) for an individual or such individual's spouse and dependents) are contributed on the last day of the plan year of the cafeteria plan to a medical care savings account (as defined in section 408A) of such individual.''

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

Subtitle C—Expansion of COBRA Continuation Coverage

SEC. 121. EXPANSION OF COBRA CONTINUATION COVERAGE.

(a) AMENDMENTS TO INTERNAL REVENUE CODE.—

(1) SMALLER EMPLOYERS SUBJECT TO REQUIREMENTS.—Paragraph (1) of section 4980B(d) of the Internal Revenue Code of 1986 (relating to tax not to apply to certain plans) is amended by striking ''20 employees'' and inserting ''4 employees''.

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

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

''(i) MAXIMUM REQUIRED PERIOD.—

''(I) IN GENERAL.—The date which is 36 months after the date of the qualifying event.

''(II) SPECIAL RULE FOR CERTAIN BANKRUPTCY PROCEEDINGS.—In the case of a qualifying event described in paragraph (3)(F) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in subsection (g)(1)(D)(iii)), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee.

''(III) QUALIFYING EVENT INVOLVING MEDICARE ENTITLEMENT.—In the case of an event described in paragraph (3)(D) (without regard to whether such event is a qualifying event), the period of coverage for qualified beneficiaries other than the covered employee for such event or any subsequent qualifying event shall not terminate before the close of the

36-month period beginning on the date the covered employee becomes entitled to benefits under title XVIII of the Social Security Act.''

(B) TECHNICAL AMENDMENT.—The last sentence of section 4980B(f)(2)(C) of such Code is amended to read as follows: ''In the case of a qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in paragraph (3)(B), any reference in clause (i) to '102 percent' is deemed a reference to '150 percent' for any month after the 36th month of continuation coverage.''

(b) AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) SMALLER EMPLOYERS SUBJECT TO REQUIREMENTS.—Subsection (b) of section 601 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161) (relating to exception for certain plans) is amended by striking ''20 employees'' and inserting ''4 employees''.

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

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

''(A) MAXIMUM REQUIRED PERIOD.—

''(i) IN GENERAL.—The date which is 36 months after the date of the qualifying event.

''(ii) SPECIAL RULE FOR CERTAIN BANKRUPTCY PROCEEDINGS.—In the case of a qualifying event described in section 603(6) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in section 607(3)(C)(iii)), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee.

''(iii) QUALIFYING EVENT INVOLVING MEDICARE ENTITLEMENT.—In the case of an event described in section 603(4) (without regard to whether such event is a qualifying event), the period of coverage for qualified beneficiaries other than the

covered employee for such event or any subsequent qualifying event shall not terminate before the close of the 36-month period beginning on the date the covered employee becomes entitled to benefits under title XVIII of the Social Security Act.''

(B) TECHNICAL AMENDMENT.—The last sentence of section 602(3) of such Act is amended to read as follows: ''In the case of an individual who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 603(2), any reference in subparagraph (A) to '102 percent' is deemed a reference to '150 percent' for any month after the 36th month of continuation coverage.''

(c) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—

(1) SMALLER EMPLOYERS SUBJECT TO REQUIREMENTS.—Paragraph (1) of section 2201(b) of the Public Health Service Act (42 U.S.C. 300bb-1(b)) (relating to exception for certain plans) is amended by striking ''20 employees'' and inserting ''4 employees''.

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

(A) IN GENERAL.—Subparagraph (A) of section 2202(2) of such Act (42 U.S.C. 300bb–2(2)) (relating to period of coverage) is amended to read as follows:

''(A) MAXIMUM REQUIRED PERIOD.—

''(i) IN GENERAL.—The date which is 36 months after the date of the qualifying event.

''(ii) QUALIFYING EVENT INVOLVING MEDICARE ENTITLEMENT.—In the case of an event described in section 2203(4) (without regard to whether such event is a qualifying event), the period of coverage for qualified beneficiaries other than the covered employee for such event or any subsequent qualifying event shall not terminate before the close of the 36-month period beginning on the date the covered employee becomes entitled to benefits under title XVIII of the Social Security Act.''

(B) TECHNICAL AMENDMENT.—The last sentence of section 2202(3) of such Act is

amended to read as follows: ''In the case of an individual who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 2203(2), any reference in subparagraph (A) to '102 percent' is deemed a reference to '150 percent' for any month after the 36th month of continuation coverage.''

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

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

(2) qualifying events occurring on or before such date if the period of continuation coverage required under section 4980B of the Internal Revenue Code of 1986 (determined without regard to the amendments made by this section) has not expired on or before such date.

TITLE II—INSURANCE REFORM

Subtitle A—Employer Insurance Protections

SEC. 201. SMALL GROUP EMPLOYER INSURANCE PROTECTIONS.

(a) REQUIREMENTS FOR INSURERS.—Any health benefit insurer that provides or offers a small group health

benefit plan within a State (in this subtitle referred to as a ''covered insurer'') must meet the requirements specified in this section with respect to such a plan.

(b) SMALL EMPLOYER PROTECTION AGAINST TERMINATION OR NON-RENEWAL OR INDUSTRY BLACKLISTING.—

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

(A) cancel or nonrenew an individual small employer group because of high claims costs or the health of the group, or

(B) refuse to provide coverage to such a group based solely on the nature of the employer's business or industry.

(2) PERMISSIBLE TERMINATION.—A covered insurer may cancel or nonrenew a small group health benefit plan for an individual small employer group for any of the following:

(A) Failure to make premium payments.

(B) Failure to remain eligible for inclusion in the class of business by which its coverage was provided.

(C) Failure to comply with the insurer's minimum participation requirements.

(D) Fraud or misrepresentation by the employer.

(3) CANCELLATION OF CLASS OF BUSINESS.—

(A) IN GENERAL.—A covered insurer may cancel or nonrenew an entire class of business with respect to a small group health benefit plan.

(B) LIMITATION ON MARKET REENTRY.—In the case of such a cancellation or nonrenewal, the insurer may not write new business with the same or similar class of small group employers for a period of 5 years beginning on the date of termination of the last plan so cancelled or not renewed.

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

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

(2) A percentage (not to exceed 15 percent) based on claims experience, health status, or duration of coverage.

(3) Any adjustment due to changes in the coverage provided or changes in the case characteristics of the small employer group.

(d) LIMIT ON VARIATION IN PREMIUMS.—

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

(2) WITHIN A CLASS OF BUSINESS.—For a class of business, the premium rates charged during a rating period to small employer groups with similar case characteristics for the same or similar coverage (or rates that could be charged to such employers under the rating system for that class of business) shall not vary from the index rate for such class by more than 25 percent of the index rate.

(3) USE OF INDUSTRY AS A CASE CHARACTERISTIC.—

(A) IN GENERAL.—Subject to subparagraph (B), a covered insurer may utilize industry as a case characteristic in establishing premium rates.

(B) LIMITATION ON VARIATION.—If a covered insurer that utilizes industry as a case characteristic in establishing premium rates,

the highest rate factor associated with an industry classification may not exceed the lowest rate associated with any industry classification by more than 15 percent.

SEC. 202. GENERAL PORTABILITY REQUIREMENT FOR EMPLOYER-BASED HEALTH INSURANCE.

(a) LIMITATIONS ON USE OF PREEXISTING CONDITIONS.—

(1) IN GENERAL.—A group health benefit plan of an employer shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage due to a preexisting condition.

(2) RESTRICTIONS ON DEFINITION OF PREEXISTING CONDITION.—For purposes of paragraph (1), such a plan shall not define a preexisting condition more restrictively than the following:

(A) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 6 months immediately preceding the effective date of coverage.

(B) A condition for which medical advice, diagnosis, care, or treatment was recommended

or received during the 6 months immediately preceding the effective date of coverage.

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

(b) LIMITATION ON UNDERWRITING.—

(1) IN GENERAL.—In the case of a previously covered individual who becomes an employee of an employer, the group health plan of (or contributed to by) the employer shall accept the individual for coverage upon the date of application for coverage on the basis relating to the individual's health status as of the date the individual applied for employment with the previous employer.

(2) PREVIOUSLY COVERED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term ''previously covered individual'' means, with respect to an employer, an individual who before employment by the employer was an employee of another employer and was provided coverage under a group health plan of (or contributed to by) the previous employer.

(c) RESTRICTIONS FOR SMALL EMPLOYER HEALTH PLANS.—

(1) IN GENERAL.—No insurer offering a health benefit plan to a small employer shall refuse to ac-

cept under the plan any individual who, on the date of the application for such coverage, has been continuously covered (as defined in paragraph (2)) and would be eligible for such coverage except for underwriting considerations relating to the individual's health status.

(2) CONTINUOUS COVERAGE.—

(A) IN GENERAL.—For purposes of this subsection, an individual is deemed to be continuously covered as of a date if the individual is covered under any employee health benefit plan or other health insurance policy at the beginning and end of the 1-year period ending with such date and has not had any lapse in such coverage during such period totalling more than 31 days, not including as such a lapse any applicable employment waiting or probationary period.

(B) SPECIAL RULE.—For purposes of subparagraph (A), there shall not be taken into account coverage provided by or in connection with any State high risk insurance pool.

(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring an insurer or health benefit plan to provide benefits greater than those provided to an indi-

vidual insured as a standard risk had the previous coverage remained in force.

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

(1) COVERED INDIVIDUAL.—The term ''covered individual'' means—

(A) an individual who is (or will be) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986), and

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

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

SEC. 203. EXEMPTION FROM CERTAIN STATE MANDATES.

An covered insurer that complies with the requirements of sections 201 and 202 with respect to a small employer group is exempt from State law requirements concerning the providing of specified health insurance benefits or laws which prohibit the use of managed care networks.

SEC. 204. ENFORCEMENT.

(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 thereof the following new section:

"SEC. 5000A. ENFORCEMENT OF REQUIREMENTS FOR EMPLOYER HEALTH BENEFIT PLANS.

''(a) GENERAL RULE.—There is hereby imposed a tax on the failure of an insurer or group health plan to meet the applicable requirements of section 201 or 202 of the Bipartisan Health Security Reform Act of 1994 with respect to any covered individual.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure with respect to—

''(A) a requirement in such section 201 shall be $100 for each day in the noncompliance period with respect to such failure; or

''(B) a requirement in such section 202 with respect to a covered individual shall be $100 for each day in the noncompliance period with respect to such failure.

''(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'noncompliance period' means, with respect to any failure, the period—

''(A) beginning on the date such failure first occurs, and

''(B) ending on the date such failure is corrected.

''(3) CORRECTION.—A failure of a group health plan to meet the requirements of section 202 of the Bipartisan Health Security Reform Act of 1994 with respect to any covered individual shall be treated as corrected if—

''(A) such failure is retroactively undone to the extent possible, and

''(B) the covered individual is placed in a financial position which is as good as such individual would have been in had such failure not occurred.

For purposes of applying subparagraph (B), the covered individual shall be treated as if the individual had elected the most favorable coverage in light of the expenses incurred since the failure first occurred.

''(c) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is es-

tablished to the satisfaction of the Secretary that none of the persons referred to in subsection (d) knew, or exercising reasonable diligence would have known, that such failure existed.

''(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

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

''(B) such failure is corrected during the 30-day period beginning on the first date any of the persons referred to in subsection (d) knew, or exercising reasonable diligence would have known, that such 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 such tax would be excessive relative to the failure involved.

''(d) LIABILITY FOR TAX.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the following shall be liable for the tax imposed by subsection (a) on a failure:

''(A) In the case of a group health plan other than a self-insured group health plan, the issuer.

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

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

''(C) Each person who is responsible (other than in a capacity as an employee) for administering or providing benefits under the group health plan, health insurance plan, or other health benefit arrangement (including a self-insured plan) and whose act or failure to act caused (in whole or in part) the failure.

''(2) SPECIAL RULES FOR PERSONS DESCRIBED IN PARAGRAPH (1)(C).—A person described in subparagraph (C) (and not in subparagraphs (A) and (B)) of paragraph (1) shall be liable for the tax imposed by subsection (a) on any failure only if such person assumed (under a legally enforceable written agreement) responsibility for the performance of the act to which the failure relates.''.

(b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of section 275(a) of such Code (relating to nondeductibility

of certain taxes) is amended by inserting ''47,'' after ''46,''.

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

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

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

SEC. 205. DEFINITIONS.

In this subtitle:

(1) CASE CHARACTERISTICS.—The term ''case characteristics'' means demographic, geographic, and other relevant characteristics as determined by the insurer that are considered by the insurer in the determination of premium rates for a small employer, but not including—

(A) claims experience,

(B) health status, and

(C) duration of coverage since date of issue.

(2) INSURER.—The term ''insurer'' means an entity that provides health insurance in a State.

(3) SMALL EMPLOYER.—The term ''small employer'' means a business that, during the most re-

cent calendar year, employed at least 3, but not more than 25, employees who are eligible for coverage under a health benefit plan on at least 50 percent of that business' working days.

(4) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means any employee welfare benefit plan (as defined in the Employee Retirement Income Security Act of 1974) that is insured by an insurer that provides medical, surgical, or hospital care or benefits to employees of a small employer and their dependents and to which the employer contributes 50 percent or more of the single coverage cost at the time of purchase. Such term does not include any individual major medical policies and group insurance that are not designed or administered as a health benefit plan to be provided by an employer for its employees.

(5) INDEX RATE.—The term ''index rate'' means, for a class of business as to a small employer's rating period with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(6) CLASS OF BUSINESS.—The term ''class of business'' means each separate class of business es-

tablished by an insurer to reflect substantial differences in expected claims experience or administrative costs related only to one or more of the following:

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

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

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

SEC. 206. EFFECTIVE DATE.

This title shall take effect on January 1, 1996.

Subtitle B—Guaranteeing Portability of Health Insurance for Individuals

SEC. 211. COVERAGE OF INDIVIDUAL HEALTH BENEFIT PLANS.

(a) IN GENERAL.—This subtitle applies only to health benefit plans delivered or issued for delivery to individuals in a State and does not apply to—

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

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

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

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

(C) under another State or Federal program, unless the eligible individual was previously covered as an employee of the State or Federal Government.

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

SEC. 212. PORTABILITY PROTECTIONS.

(a) CONSIDERATION OF APPLICATIONS.—If an eligible individual or eligible family applies for an individual health benefit plan, the insurer offering the plan must either—

(1) offer coverage to all eligible individuals applying on the same application, or

(2) deny coverage to all eligible individuals applying on the application.

(b) PREEXISTING CONDITION PERIOD LIMITATION.—No policy provision of an individual health benefit plan shall exclude or limit coverage for a preexisting condition for a period beyond 12 months following the effective date of the individual's coverage.

(c) PORTABILITY OF COVERAGE.—The preexisting condition limitation period under any individual health benefit plan shall be reduced by one month for each month of continuous coverage the eligible individual had under a prior health benefit plan.

(d) LIMITATION ON RIDERS.—

(1) IN GENERAL.—Except as provided in paragraph (2), an insurer issuing an individual health benefit plan may not modify the plan with respect to an eligible individual.

(2) RELATION TO PREEXISTING CONDITION EXCLUSION PERIOD.—

(A) IN GENERAL.—To the extent that a preexisting condition limitation applies, an insurer may restrict or exclude coverage or benefits for a specific condition for a maximum period of 12 months from the effective date of coverage of an eligible individual by way of rider or endorsement.

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

(C) COMBINATION.—If both a rider and a preexisting condition exclusion period are used,

the combined limitation period may not exceed 12 months.

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

SEC. 213. DEFINITIONS.

In this subtitle:

(1) ELIGIBLE FAMILY.—The term ''eligible family'' means an applicant, an applicant's spouse, and any eligible individual who is a dependent child of the applicant.

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

(3) HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ''health benefit plan'' means any hospital or medical expense insured policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract.

(B) EXCLUSION.—Such term does not include any of the following:

(i) short-term limited duration insurance,

(ii) accident-only, credit-only, dental-only, vision-only insurance,

(iii) medicare supplement insurance,

(iv) hospital indemnity insurance,

(v) long-term care or disability income insurance,

(vi) coverage issued as a supplement to liability insurance,

(vii) workmen's compensation or similar insurance, or

(viii) automobile medical-payment insurance.

(4) PREEXISTING CONDITION.—The term ''preexisting condition'' means any injury or illness—

(A) for which the covered individual received medical advice or treatment within 12 months immediately preceding the applicable effective date the covered individual became insured under the policy, or

(B) which in the opinion of a qualified doctor—

(i) probably began prior to the applicable effective date the covered individual became insured under the policy, and

(ii) manifested symptoms which would cause an ordinarily prudent individual to seek diagnosis or treatment within 12 months immediately preceding the applicable effective date the covered individual because insured under the policy.

(5) PRIOR SIMILAR HEALTH BENEFIT PLAN.—The term ''prior similar health benefit plan'' means a health benefit plan under which an eligible individual was previously covered and which provides benefits who do not materially differ from the new health benefit plan in any of the following respects:

(A) The type of medical benefits provided.

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

(C) The maximum benefits available for specific services.

(D) Cost containment provisions.

SEC. 214. EFFECTIVE DATE.

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

Subtitle C—Assuring Health Insurance Coverage for Uninsurable Individuals

SEC. 221. ESTABLISHMENT OF PROGRAMS BY STATES.

(a) IN GENERAL.—For years beginning with 1997, each State shall establish, administer, and fund a high risk health insurance pool (in this subtitle referred to as a ''State high risk program'') that assures, in accordance with this subtitle, the availability of qualified health insurance coverage to uninsurable individuals.

(b) DEADLINE.—Each State shall comply with subsection (a) by not later than January 1, 1997.

(c) WAIVER.—Subsection (a) shall not apply in the case of a State that has established a comprehensive health insurance program that assures the availability of qualified health insurance coverage to all eligible individuals residing in the State.

(d) RECOMMENDATION FOR COMPLIANCE REQUIREMENT.—Not later than January 1, 1996, the Secretary of Health and Human Services shall submit to Congress a recommendation on appropriate sanctions for States that fail to meet the requirement of subsection (a).

SEC. 222. UNINSURABLE INDIVIDUALS ELIGIBLE FOR COVERAGE.

(a) UNINSURABLE AND ELIGIBLE INDIVIDUAL DEFINED.—In this subtitle:

(1) UNINSURABLE INDIVIDUAL.—The term ''uninsurable individual'' means, with respect to a State, an eligible individual who presents proof of uninsurability by 2 private insurers in accordance with subsection (b).

(2) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means, with respect to a State, a citizen or national of the United States (or an alien lawfully admitted for permanent residence) who is a resident of the State for at least 90 days.

(b) PROOF OF UNINSURABILITY.—

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

(A) a notice of rejection or refusal to issue substantially similar insurance for health reasons, or

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

(C) an offer to insure but only subject to a reduction or an exclusion of coverage for a preexisting condition for a period exceeding 6 months.

(2) EXCEPTION.—A State may waive the requirement of proof described in paragraph (1) in the case of an individual who demonstrates a provable medical or health condition.

SEC. 223. QUALIFIED HEALTH INSURANCE COVERAGE UNDER PROGRAM.

In this subtitle, the term ''qualified health insurance coverage'' means health insurance coverage that—

(1) provides benefits typical of major medical insurance available in the individual health insurance market, and

(2) may include coinsurance (in a percentage not to exceed 20 percent) and a stop loss on out-of-pocket expenses of not to exceed—

(A) for 1997, $5,000, or

(B) for a subsequent year, the dollar amount specified in this paragraph for the previous year increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending with September of the preceding calendar year.

In applying subparagraph (B) for a year, if the dollar amount computed under such subparagraph is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

SEC. 224. FUNDING OF PROGRAM.

(a) LIMITATIONS ON PREMIUMS.—

(1) IN GENERAL.—The applicable premium established under a State high-risk program may not exceed 135 percent of the applicable standard risk rate, except as provided in paragraph (2).

(2) SURCHARGE FOR AVOIDABLE HEALTH RISKS.—A State high-risk program may impose a surcharge on premiums for individuals with avoidable high risks, such as smoking.

(b) FLEXIBILITY IN ADDITIONAL FUNDING.—A State high-risk program shall provide for additional funding through other means specified under State law. Such means may include—

(1) an assessment on all insurers in the State through a nonprofit association consisting of all health benefits insurers doing business in the State on an equitable and pro rata basis,

(2) a designated tax source, or

(3) general revenues of the State.

SEC. 225. ADMINISTRATION.

A State high-risk program shall be administered through a contract with one or more insurers operating in the State.

TITLE III—MEDICAID REFORM

SEC. 301. PROVIDING COVERAGE FOR OUT-OF-POCKET EXPENSES UNDER PRIVATE HEALTH PLANS.

(a) STATE OPTION.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) by striking ''and'' at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting ''; and''; and

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

''(63) at the option of the State, provide that an individual eligible for medical assistance under the State plan has the option to receive medical assistance through enrollment with a health plan under a program described in section 1931.''.

(b) PROGRAM FOR ENROLLMENT DESCRIBED.—Title XIX of such Act (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

''OPTIONAL STATE PROGRAM TO ENROLL INDIVIDUALS IN PRIVATE HEALTH PLANS

''SEC. 1931. (a) IN GENERAL.—For purposes of section 1902(a)(63), a program under this section is a program under which the State makes payments to health plans that provide qualified health insurance coverage under section 223 of the Bipartisan Health Security Reform Act for enrolling individuals for coverage under such plans, including all necessary payments of premiums, copayments, and deductibles applicable under such a plan on behalf of such an individual.

''(b) TREATMENT OF PAYMENTS AS MEDICAL ASSISTANCE.—Subject to paragraph (3), for purposes of determining the amount of Federal financial participation for a State under section 1903 in a quarter, any payments made by a State under the program under this section shall be treated as expenditures for medical assistance under the State plan for such quarter.

''(c) OPTIONAL USE OF CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS OR VOUCHERS TO OBTAIN COVERAGE.—Under a program under this section, a State may provide for the enrollment of individuals in health plans—

''(1) by making contributions to an individual's medical savings account established under section 220 of the Internal Revenue Code of 1986; or

''(2) by providing the individual with a voucher that may be used toward the payment of the costs of enrollment in a health plan (as determined under an agreement between the State and the plan).''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to quarters beginning on or after January 1, 1996.

TITLE IV—MEDICAL CHARGE DISCLOSURE

SEC. 401. REQUIRING PROVIDERS OF MEDICAL SERVICES TO DISCLOSE MAXIMUM CHARGES

(a) REQUIREMENT DESCRIBED.—Each individual or entity providing a medical procedure or diagnostic test shall post (at a place and in a manner that will be visible to the individuals receiving the procedures or tests)—

(1) the maximum charge assessed for the procedure or test; and

(2) the costs to the individual or entity that are associated with the procedure or test.

(b) PROHIBITION AGAINST CHARGING IN EXCESS OF POSTED MAXIMUM CHARGE.—An individual or entity may not charge an amount for a medical procedure or diag-

nostic test in excess of the maximum charge posted for the procedure or test pursuant to paragraph (1).

(c) RECOMMENDATIONS FOR ENFORCEMENT.—Not later than April 1, 1995, the Secretary of Health and Human Services shall submit to Congress specific recommendations for sanctions that should be imposed on individuals and entities that fail to meet the requirements of this section.

(d) EFFECTIVE DATE.—This section shall apply to medical procedures and diagnostic tests provided on or after January 1, 1996.

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