

103^D CONGRESS
2^D SESSION

H. R. 5302

To promote portability of health insurance by limiting discrimination in health coverage based on health status or past claims experience.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 29, 1994

Mr. HAYES introduced the following bill; which was referred jointly to the Committees on Energy and Commerce and Education and Labor

A BILL

To promote portability of health insurance by limiting discrimination in health coverage based on health status or past claims experience.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Insurance Eq-
5 uity Act of 1994”.

6 **SEC. 2. HEALTH INSURANCE STANDARDS.**

7 The Social Security Act is amended by adding at the
8 end the following new title:

3 **“SEC. 2101. PROHIBITION OF DISCRIMINATION BASED ON**
4 **HEALTH STATUS FOR COVERAGE, BENEFITS,**
5 **AND PREMIUMS.**

6 “(a) IN GENERAL.—Except as provided under sub-
7 section (b), an insurer or group health plan providing
8 health coverage may not deny, limit, or condition the
9 health coverage or benefits with respect to health services,
10 or vary the premiums charged for such coverage, based
11 on the health status, claims experience, receipt of health
12 care, medical history, or lack of evidence of insurability,
13 of an individual.

14 “(b) EXCEPTION FOR CERTAIN PREEXISTING CONDI-
15 TIONS.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, an insurer or group health plan providing health coverage may exclude coverage of services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns who are covered at the time of birth or to treatment of conditions relating to pregnancy.

25 “(2) CREDITING OF PREVIOUS COVERAGE.—

1 “(A) IN GENERAL.—An insurer or group
2 health plan providing health coverage shall pro-
3 vide that if a covered individual is in a period
4 of continuous coverage (as defined in subpara-
5 graph (B)(i)) with respect to particular services
6 as of the date of application for coverage (de-
7 termined without regard to any waiting period
8 for coverage), any period of exclusion of cov-
9 erage with respect to a preexisting condition for
10 such services or type of services shall be re-
11 duced by 1 month for each month in the period
12 of continuous coverage.

13 “(B) DEFINITIONS.—As used in this sub-
14 section:

15 “(i) PERIOD OF CONTINUOUS COV-
16 ERAGE.—The term ‘period of continuous
17 coverage’ means, with respect to particular
18 services, the period beginning on the date
19 an individual has health coverage (includ-
20 ing coverage under title XVIII or XIX)
21 which provides substantially the same or
22 similar benefits with respect to such serv-
23 ices and ends on the date the individual
24 does not have such coverage for a continu-
25 ous period of more than 3 months.

1 “(ii) PREEXISTING CONDITION.—The
2 term ‘preexisting condition’ means a condi-
3 tion which has been diagnosed or treated
4 during the 6-month period ending on the
5 day before the first date of such coverage.

6 “(3) EXCEPTION.—

7 “(A) IN GENERAL.—Subsection (a) shall
8 not affect a variation of premiums based only
9 on the age, sex, or geographic area of residence
10 of an individual.

11 “(B) WAITING PERIOD.—An insurer or
12 group health plan providing health coverage
13 may offer to an individual to waive an exclusion
14 of coverage with respect to a preexisting condi-
15 tion for which an exclusion could otherwise be
16 applied under this subsection in exchange for
17 an increase in the premium during the period
18 in which the exclusion could otherwise be ap-
19 plied. If the individual rejects this offer, the
20 limitations on premiums and exclusions that
21 would apply in the absence of such offer shall
22 continue to apply.

23 “(c) APPLICATION OF RULES BY CERTAIN HEALTH
24 MAINTENANCE ORGANIZATIONS.—A health maintenance
25 organization that provides health insurance coverage shall

1 not be considered as failing to meet the requirements of
2 section 1301 of the Public Health Service Act notwith-
3 standing that it provides for an exclusion of the coverage
4 based on a preexisting condition consistent with the provi-
5 sions of this section so long as such exclusion is applied
6 consistent with the provisions of this section. Nothing in
7 this section shall be construed as requiring such an organi-
8 zation to impose such an exclusion.

9 **“SEC. 2102. ENROLLMENT AND RENEWAL PRACTICES FOR**
10 **HEALTH INSURANCE COVERAGE.**

11 **“(a) CONSTRUCTION INVOLVING APPLICATION OF**
12 **CAPACITY LIMITS FOR HEALTH INSURANCE COV-**
13 **ERAGE.—**

14 **“(1) IN GENERAL.—**Subject to paragraph (2)
15 and subsection (b), nothing in this title shall be con-
16 strued as preventing an insurer providing health in-
17 surance coverage to individuals or small employers
18 in an area from ceasing to enroll individuals or small
19 employers under such coverage if—

20 **“(A)** the insurer ceases to enroll any new
21 individuals or small employers; and

22 **“(B)** the insurer can demonstrate to the
23 State insurance commissioner that the insurer’s
24 financial or provider capacity to serve pre-
25 viously covered individuals or small employers

1 (and additional individuals who will be expected
2 to enroll because of affiliation with such pre-
3 viously covered individuals or small employers)
4 will be impaired if it is required to enroll addi-
5 tional individuals or small employers.

6 “(2) FIRST-COME-FIRST-SERVED.—An insurer
7 is only eligible to exercise the limitations provided
8 for in paragraph (1) if such insurer provides for en-
9 rollment of individuals or small employers on a first-
10 come-first-served basis (except in the case of addi-
11 tional individuals or small employers described in
12 paragraph (1)(B)).

13 “(b) REQUIREMENTS RELATING TO RENEWAL OF
14 HEALTH INSURANCE COVERAGE.—

15 “(1) IN GENERAL.—Except as provided in para-
16 graphs (2) and (3), an insurer that provides health
17 insurance coverage to an individual or small em-
18 ployer shall not deny, cancel, or refuse to renew such
19 coverage of the individual or small employer.

20 “(2) GROUNDS FOR REFUSAL TO RENEW.—An
21 insurer may deny, cancel, refuse to renew, or termi-
22 nate health insurance coverage within a type of cov-
23 erage option described in paragraph (4) in an area
24 described in paragraph (6) only—

25 “(A) for nonpayment of premiums;

1 “(B) for fraud on the part of the individ-
2 ual or small employer;

3 “(C) with respect to an individual, for mis-
4 representation of material facts on the part of
5 the individual relating to an application for cov-
6 erage or claim for benefits;

7 “(D) in the case of coverage provided
8 through a geographically limited managed care
9 arrangement, the individual or employer leaves
10 the geographic service area in which the cov-
11 erage is provided; or

12 “(E) subject to paragraph (3), because the
13 insurer elects not to renew any health insurance
14 coverage for individuals or small employers in
15 the area within such type of coverage option
16 and provides notice of such election to the State
17 insurance commissioner and to each such em-
18 ployer and individual covered in the area at
19 least 180 days before the effective date of such
20 nonrenewal.

21 “(3) PROHIBITION ON MARKET REENTRY.—In
22 the case of an election described in paragraph (2)(E)
23 by an insurer for an area for a type of coverage op-
24 tion, the insurer may not provide for any health in-
25 surance coverage to an individual or small employer

1 in the area within the type of coverage option during
2 the 5-year period beginning on the effective date of
3 the nonrenewal for the area and for the type of cov-
4 erage option.

5 “(4) OPTIONS.—For purposes of this sub-
6 section, each of the following is a ‘type of coverage
7 option’:

8 “(A) FEE-FOR-SERVICE OPTION.—Health
9 insurance coverage is considered to provide a
10 ‘fee-for-service option’ if, regardless of whether
11 covered individuals may receive benefits through
12 a provider network, benefits with respect to the
13 covered items and services in the coverage are
14 made available for such items and services pro-
15 vided through any lawful provider of such cov-
16 ered items and services and payment is made to
17 such a provider whether or not there is a con-
18 tractual arrangement between the provider and
19 the carrier or plan.

20 “(B) MANAGED CARE OPTION.—Health in-
21 surance coverage is considered to provide a
22 ‘managed care option’ if benefits with respect to
23 the covered items and services in the coverage
24 are made available exclusively through a pro-

1 vider network, except in the case of emergency
2 services and as otherwise required under law.

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

16 “(5) MANAGED CARE ARRANGEMENTS.—In this
17 subsection:

18 “(A) MANAGED CARE ARRANGEMENT.—
19 The term ‘managed care arrangement’ means,
20 with respect to health insurance coverage, an
21 arrangement under such coverage under which
22 providers agree to provide items and services
23 covered under the arrangement to individuals
24 who have such coverage.

1 “(B) PROVIDER NETWORK.—The term
2 ‘provider network’ means, with respect to health
3 insurance coverage, providers who have entered
4 into an agreement described in subparagraph
5 (A).

6 “(6) LIMITATIONS ON AREA.—An area de-
7 scribed in this paragraph is an area in which there
8 is no division of any of the following:

9 “(A) A 3-digit zip code.

10 “(B) Any county, parish, or borough.

11 “(C) All portions of a metropolitan statis-
12 tical area.

13 **“SEC. 2103. ENFORCEMENT.**

14 “(a) HEALTH INSURANCE COVERAGE.—

15 “(1) ENFORCEMENT THROUGH STATE INSUR-
16 ANCE COMMISSIONER.—

17 “(A) ESTABLISHMENT OF ENFORCEMENT
18 PROGRAMS.—Each State, through its State in-
19 surance commissioner, is responsible for estab-
20 lishing a program to enforce requirements of
21 this title with respect to insurers (and health
22 coverage offered by insurers) in the State. The
23 State shall provide the Secretary of Health and
24 Human Services annually (for years beginning
25 with 1996) with such description of the pro-

1 gram established to enforce adequately such re-
2 quirements as the Secretary specifies.

3 “(B) MORE STRINGENT STATE STANDARDS
4 PERMITTED.—A State may implement stand-
5 ards that are more stringent than the standards
6 established under this title.

7 “(C) AUTHORIZATION OF APPROPRIATIONS
8 FOR STATE ENFORCEMENT PROGRAMS.—There
9 are authorized to be appropriated to the Sec-
10 retary of Health and Human Services (for each
11 fiscal year beginning with fiscal year 1996)
12 such sums as may be necessary to provide for
13 grants to States to provide for enforcement pro-
14 grams described in subparagraph (A). Such
15 grants shall be made available in such amounts
16 and subject to such reasonable terms and condi-
17 tions as the Secretary shall provide.

18 “(2) FEDERAL FALLBACK ENFORCEMENT.—

19 “(A) REVIEW AND CONTINGENCY.—The
20 Secretary annually shall review State enforce-
21 ment programs under paragraph (1)(A) to de-
22 termine if they provide for adequate enforce-
23 ment of the requirements of this title. If the
24 Secretary initially determines that such a pro-
25 gram does not provide for such enforcement,

1 the Secretary shall notify the State and provide
2 the State an opportunity to adopt such a plan
3 of correction that would provide for adequate
4 enforcement. If the Secretary makes a final de-
5 termination that the State program fails to pro-
6 vide for an adequate enforcement program after
7 such an opportunity, the succeeding provisions
8 of this paragraph shall apply with respect to in-
9 surers and health insurance coverage in the
10 State until the Secretary has been provided a
11 description of an adequate enforcement pro-
12 gram.

13 “(B) CIVIL MONEY PENALTIES.—

14 “(i) IN GENERAL.—If this paragraph
15 applies in a State in a year, subject to
16 clause (ii), an insurer in that State that
17 fails to comply with a requirement applica-
18 ble to the insurer or health insurance cov-
19 erage under this title is subject to a civil
20 money penalty of \$150 for each day during
21 which such failure persists for each indi-
22 vidual to which such failure relates.

23 “(ii) LIMITATION.—The amount of
24 the penalty imposed by this subparagraph
25 for an insurer with respect to health insur-

1 ance coverage shall not exceed 25 percent
2 of the amounts received under the plan for
3 coverage during the period such failure
4 persists.

5 “(C) EXCEPTIONS.—

6 “(i) CORRECTIONS WITHIN 30 DAYS.—
7 No civil money penalty shall be imposed
8 under this paragraph by reason of any fail-
9 ure if—

10 “(I) such failure was due to rea-
11 sonable cause and not to willful ne-
12 glect, and

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

18 “(ii) WAIVER BY SECRETARY.—In the
19 case of a failure which is due to reasonable
20 cause and not to willful neglect, the Sec-
21 retary may waive part or all of the penalty
22 imposed by this paragraph to the extent
23 that payment of such penalty would be ex-
24 cessive relative to the failure involved.

1 “(D) PROCEDURES.—The Secretary by
2 regulation shall provide for procedures for the
3 imposition of civil money penalties under this
4 paragraph. Such procedures shall assure writ-
5 ten notice and opportunity for a determination
6 to be made on the record after a hearing at
7 which the insurer is entitled to be represented
8 by counsel, to present witnesses, and to cross-
9 examine witnesses against the insurer. The pro-
10 visions of subsections (e), (f), (j), and (k) of
11 section 1128A shall apply to determinations
12 and civil money penalties under this paragraph
13 in the same manner as they apply to determina-
14 tions and civil money penalties under such sec-
15 tion.

16 “(b) ENFORCEMENT BY DEPARTMENT OF LABOR
17 FOR GROUP HEALTH PLANS.—

18 “(1) IN GENERAL.—For purposes of part 5 of
19 subtitle B of title I of the Employee Retirement In-
20 come Security Act of 1974, the provisions of sections
21 2101 and 2102 shall be deemed to be provisions of
22 title I of such Act irrespective of exclusions under
23 section 4(b) of such Act.

24 “(2) REGULATORY AUTHORITY.—With respect
25 to the regulatory authority of the Secretary of Labor

1 under this title pursuant to paragraph (1), section
2 505 of the Employee Retirement Income Security
3 Act of 1974 (29 U.S.C. 1135) shall apply.

4 **“SEC. 2104. DEFINITIONS.**

5 “For purposes of this title:

6 “(1) GROUP HEALTH PLAN.—The term ‘group
7 health plan’ means an employee welfare benefit plan
8 providing medical care (as defined in section 213(d)
9 of the Internal Revenue Code of 1986) to partici-
10 pants or beneficiaries directly or through insurance,
11 reimbursement, or otherwise, but does not include
12 any type of coverage excluded from the definition of
13 an health insurance coverage under paragraph
14 (3)(B).

15 “(2) HEALTH COVERAGE.—The term ‘health
16 coverage’ means health insurance coverage provided
17 by an insurer or medical care provided under a
18 group health plan.

19 “(3) HEALTH INSURANCE COVERAGE.—

20 “(A) IN GENERAL.—Except as provided in
21 subparagraph (B), the term ‘health insurance
22 coverage’ means any hospital or medical service
23 policy or certificate, hospital or medical service
24 plan contract, or health maintenance organiza-
25 tion group contract offered by an insurer.

1 “(B) EXCEPTION.—Such term does not in-
2 clude any of the following (or any combination
3 of the following):

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

7 “(ii) Medicare supplemental health in-
8 surance.

9 “(iii) Coverage issued as a supplement
10 to liability insurance.

11 “(iv) Liability insurance, including
12 general liability insurance and automobile
13 liability insurance.

14 “(v) Workers’ compensation or similar
15 insurance.

16 “(vi) Automobile medical-payment in-
17 surance.

18 “(vii) Coverage for a specified disease
19 or illness.

20 “(viii) A hospital or fixed indemnity
21 policy.

22 “(4) INSURER.—The term ‘insurer’ means a li-
23 censed insurance company, an entity offering pre-
24 paid hospital or medical services, and a health main-

1 tenance organization, and includes a similar organi-
2 zation regulated under State law for solvency.

3 “(5) SMALL EMPLOYER.—The term ‘small em-
4 ployer’ means, with respect to a calendar year, an
5 employer (as defined in section 3(5) of the Employee
6 Retirement Income Security Act of 1974) that nor-
7 mally employs on a typical business day more than
8 1 but less than 50 employees who normally perform
9 on a monthly basis at least 30 hours of service per
10 week for that employer. For the purposes of this
11 paragraph, the term ‘employee’ includes a self-em-
12 ployed individual. For purposes of determining if an
13 employer is a small employer, rules similar to the
14 rules of subsections (b) and (c) of section 414 of the
15 Internal Revenue Code of 1986 shall apply.

16 “(6) STATE INSURANCE COMMISSIONER.—The
17 term ‘State insurance commissioner’ includes a State
18 superintendent of insurance or other State authority
19 responsible for regulation of health insurance.”.

20 **SEC. 3. EFFECTIVE DATE.**

21 The requirements of title XXI of the Social Security
22 Act, as added by section 2, shall apply with respect to—

23 (1) group health plans for plan years beginning
24 after December 31, 1995, and

1 (2) insurers as of January 1, 1996, for health
2 insurance coverage issued or renewed on or after
3 such date.

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