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104TH CONGRESS
1ST SESSION

H. R. 996

To improve portability, access, and fair rating for health insurance coverage for individuals.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 21, 1995

Mr. FAWELL (for himself, Mr. GOODLING, Mr. PETRI, Mr. ROUKEMA, Mr. BALLENGER, Mr. HOEKSTRA, Mr. MCKEON, Mrs. MEYERS of Kansas, Mr. TALENT, Mr. GREENWOOD, Mr. HUTCHINSON, Mr. KNOLLENBERG, Mr. GRAHAM, Mr. WELDON of Florida, and Mr. MCINTOSH) introduced the following bill; which was referred to the Committee on Commerce and, in addition, to the Committee on Economic and Educational Opportunity, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve portability, access, and fair rating for health insurance coverage for individuals.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Targeted Individual Health Insurance Reform Act of 1995''.

TITLE I—DEFINITIONS AND SPECIAL RULES

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Sec. 1001. General definitions.
Sec. 1002. General, catastrophic, and medisave coverage defined.

SEC. 1001. GENERAL DEFINITIONS.

(a) IN GENERAL.—For purposes of this Act:

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

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

(B) a child (including an adopted child) of such individual and—

(i) under 19 years of age, or

(ii) under 25 years of age and a full-time student.

(2) EMPLOYER.—The term ''employer'' shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term includes the partnership in relation to any partner.

(3) GROUP HEALTH PLAN; PLAN.—(A) The term ''group health plan'' means a group health plan (as defined in section 3(42) of the Employee Retirement Income Security Act of 1974 (as added by

ERISA Targeted Health Insurance Reform Act of 1995)), but does not include any type of coverage excluded from the definition of health insurance coverage under paragraph (6)(B).

(B) The term ''plan'' means a group health plan (including any such plan which is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974)) and an exempted multiple employer health plan (within the meaning of part 7 of the Employee Retirement Income Security Act of 1974 (as added by the ERISA Targeted Health Insurance Reform Act of 1995)).

(4) HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance coverage'' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

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

(i) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

(ii) Medicare supplemental health insurance.

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

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Worker's compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital fixed indemnity policy or other fixed indemnity policy.

(5) INDIVIDUAL MARKET.—The term ''individual market'' means the health insurance market under which individuals obtain health insurance coverage on behalf of themselves (and their dependents) and not on the basis of employment.

(6) INSURER.—(A) The term ''insurer'' means—

(i) an insurance company, insurance service, or insurance organization licensed to engage in the business of insurance in a State, or

(ii) a health maintenance organization (as defined in subparagraph (B)) licensed to do business in a State.

(B) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' means a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

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

(8) NETWORK PLAN.—The term ''network plan'' includes, as defined in standards established under section 2101, an arrangement of an insurer under which health services are offered to be provided primarily through a defined set of providers who have contracts with the insurer.

(9) STATE.—The term ''State'' means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(10) STATE COMMISSIONER OF INSURANCE.—The term ''State commissioner of insurance'' includes a State superintendent of insurance.

(b) APPLICATION OF ERISA DEFINITIONS.—Except as otherwise provided in this Act, terms used in this Act shall have the meanings applicable to such terms under section 3 of the Employee Retirement Income Security Act of 1974.

(c) SECRETARY.—For purposes of this Act, except with respect to references specifically to the Secretary of Labor, the term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 1002. GENERAL, CATASTROPHIC, AND MEDISAVE COVERAGE DEFINED.

(a) GENERAL COVERAGE.—In this Act, the term ''general coverage'' means health insurance coverage that meets the applicable standards provided for under section 2021 and that is not catastrophic coverage or medisave coverage (as defined in this section).

(b) CATASTROPHIC COVERAGE.—In this Act, the term ''catastrophic coverage'' means health insurance coverage that meets the applicable standards provided for under section 2101 and under which benefits are available for a year only to the extent that expenses for covered services in a year exceed a catastrophic deductible amount.

(c) MEDISAVE COVERAGE.—

(1) IN GENERAL.—In this Act, the term ''medisave coverage'' means coverage that meets the applicable standards provided for under section 2021 and—

(A) consists of—

(i) health insurance coverage under which benefits are available for a year only to the extent that expenses for covered services in a year exceed a catastrophic deductible amount; and

(ii) medisave cash benefit coverage consistent with paragraph (2); and

(B) meets such standards as may be prescribed under section 2101.

(2) MEDISAVE CASH BENEFIT COVERAGE.—

(A) IN GENERAL.—Medisave cash benefit coverage is considered to be consistent with this paragraph to the extent that, in addition to and separate from the benefits from the health insurance coverage described in paragraph (1)(A)—

(i) under the terms of such coverage there is a fixed dollar amount of additional benefits that does not exceed the cata-

strophic deductible amount for the catastrophic coverage described in paragraph (1)(A);

(ii) subject to clause (iii), the dollar amount may be used for deductibles, cost-sharing, and other expenses, for items and services specified under such catastrophic coverage and medisave cash benefit coverage;

(iii) any such amount of benefits not so used shall be accumulated, shall remain available to be applied against future deductibles, cost-sharing, and other expenses, and may be withdrawn for any purpose, or used to pay for coverage described in paragraph (1)(A)(i), to the extent that the dollar amount exceeds 150 percent of the catastrophic deductible amount for the catastrophic coverage described in paragraph (1)(A), shall be nonforfeitable, and, upon the death of all beneficiaries with respect to such benefits, shall be payable in cash to the estate of the beneficiary who dies last; and

(iv) the coverage meets the portability rules established under subparagraph (B).

(B) PORTABILITY RULES.—In the case of an individual who has medisave cash benefit coverage with respect to which the requirements of clauses (i), (ii), and (iii) of subparagraph (A) are met in a year, who has accumulated an amount of benefits under such coverage, and who terminates such coverage (or terminates enrollment under health insurance coverage that contains medisave cash benefit coverage), the coverage meets the portability rules of this subparagraph if, under the terms of such coverage, the individual is permitted (as elected by the individual)—

(i) to have an amount equal to all or some of the amount of benefits accumulated under such coverage paid towards the payment of premiums under any group health plan or health insurance coverage providing coverage for the individual, and

(ii) to have an amount equal to all or some of the remaining balance transferred to a plan which will provide medisave cash benefit coverage for that individual in ac-

cordance with the requirements of this paragraph (and such plan shall credit such amount transferred towards Medisave cash benefit coverage provided by such plan).

(d) CATASTROPHIC DEDUCTIBLE AMOUNT DEFINED.—

(1) IN GENERAL.—For purposes of this section, subject to paragraph (2), the term ''catastrophic deductible amount'' means a deductible amount that is at least $1,800 (or $3,600 if the coverage includes family members).

(2) ADJUSTMENTS.—In the case of any calendar year after the first year to which this title II applies, each dollar amount in paragraph (1) shall be increased by the percentage by which (A) the average of the monthly consumer price indexes for all urban consumers for the previous year, exceeds (B) the average of the monthly consumer price indexes for all urban consumers for such first year. If any increase under the preceding sentence does not result in an amount that is a multiple of $50, such increase shall be rounded so that the amount is determined to the nearest multiple of $50.

TITLE II—ACCESS TO AND FAIR RATING OF HEALTH INSURANCE COVERAGE FOR INDIVIDUALS

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Subtitle A—Increased Availability and Continuity of Health Insurance Coverage for Individuals

PART 1—NONDISCRIMINATION, PORTABILITY, AND RENEWABILITY STANDARDS

SEC. 2001. NONDISCRIMINATION AND LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—Except as provided in subsection (b), an insurer offering health insurance coverage in the individual market may deny, or impose a limitation or exclusion of, covered benefits relating to treatment of a condition based on health status, based on claims experience of an individual, based on receipt of health care by an individual, based on the medical history of an individual, or based on the fact that the condition preexisted the effective date of coverage of the individual, only if—

(1) the condition relates to a condition that was diagnosed or treated within a period of not to exceed 6 months before the date of such coverage; and

(2) the limitation or exclusion extends over a period of not to exceed 12 months after the date of such coverage.

In the case of an individual who is eligible for coverage but for a waiting period imposed by an insurer, in applying paragraphs (1) and (2), the individual shall be treated as

having had such coverage as of the beginning of the waiting period.

(b) SPECIAL RULE FOR HEALTH INSURANCE COVERAGE OFFERED IN THE INDIVIDUAL MARKET.—Notwithstanding subsection (a), an insurer may offer an individual health insurance coverage in the individual market which imposes a limitation or exclusion based on a preexisting condition but only if—

(1) the condition relates to a condition that was not diagnosed or treated within a period (that exceeds 6 months but does not exceed 12 months) before the date of such coverage; and

(2) the limitation or exclusion extends over a period that does not exceed 12 months after the date of such coverage.

(c) NO COVERAGE OF SPECIFIC TREATMENT, PROCEDURES, OR CLASSES REQUIRED.—Nothing in this section may be construed to require the coverage of any specific procedure, treatment, or service as part of health insurance coverage under this Act or through regulation.

(d) APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization that offers health insurance coverage shall not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwith-

standing that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provisions of this part so long as such exclusion is applied consistent with the provisions of this part.

(e) APPLICABILITY TO LATE ENROLLMENT UNDER ASSOCIATION COVERAGE.—In the case of association coverage (as defined in section 2021(b)(4)(B)), this section applies in the case of any individual with respect to whom coverage is elected upon initially becoming eligible for coverage or in connection with any subsequent enrollment periods.

(f) AFFILIATION PERIOD ALTERNATIVE TO PREEXISTING CONDITION LIMITATION.—An insurer offering health insurance coverage in the individual market which does not use the preexisting limitations allowed under this section and section 2002 may impose an affiliation period. For purposes of this subsection, the term ''affiliation period'' means a period—

(1) not to exceed 90 days in the case of an individual first becoming eligible under such coverage, and

(2) not to exceed 180 days in the case of a later election of coverage,

during which no contributions or premiums are required or collected and which must expire before the coverage becomes effective.

SEC. 2002. PORTABILITY.

(a) IN GENERAL.—Each insurer offering health insurance coverage in the individual market shall provide that if a covered individual is in a period of continuous coverage (as defined in subsection (c)) as of a date upon which coverage takes effect, any period of exclusion of coverage from covered benefits with respect to a preexisting condition (as permitted to be excluded under section 2001) shall be reduced by at least 1 month for each month in the period of continuous coverage. A covered individual may be treated by an insurer as not being in a period of continuous coverage if, upon the request of the insurer, the covered individual does not present satisfactory documentation of such period of continuous coverage. The Secretary may prescribe regulations defining standards for satisfactory documentation for purposes of this subsection.

(b) NO PREEXISTING CONDITION FOR NEWBORNS AND ADOPTED CHILDREN.—For purposes of this subtitle—

(1) NEWBORNS.—A child who is covered at the time of birth and remains in a period of continuous coverage after such time shall not be considered to

have any preexisting condition beginning at the time of birth.

(2) ADOPTED CHILDREN.—An adopted child who is covered at the time of adoption and remains in a period of continuous coverage shall not be considered, beginning on the date of adoption, to have any preexisting condition.

(c) PERIOD OF CONTINUOUS COVERAGE.—

(1) IN GENERAL.—In this part, the term ''period of continuous coverage'' means the period—

(A) beginning on the date an individual becomes covered under a group health plan or health insurance coverage (or coverage under a public plan providing medical benefits), and

(B) ending on the date the individual does not have such coverage for a continuous period of more than 3 months,

if such period is documented in such form and manner as may be prescribed in regulations of the Secretary.

(2) SPECIAL RULE.—For purposes of paragraph (1), if the immediately preceding coverage for an individual was obtained in the individual market—

(A) the insurer may require that previous coverage have provided for a period of at least one year for such previous coverage to constitute a period of continuous coverage; and

(B) an insurer may provide that the subsequent coverage under this section has a deductible which is not less than the deductible that applied with respect to the immediately preceding coverage.

SEC. 2003. REQUIREMENTS RELATING TO RENEWABILITY GENERALLY.

(a) IN GENERAL.—An insurer may not cancel (or deny renewal of) health insurance coverage in the individual market other than—

(1) for nonpayment of premiums,

(2) for fraud or other intentional misrepresentation by the insured,

(3) for noncompliance with material plan provisions, or

(4) subject to subsection (b), because the insurer is ceasing to provide any such coverage (or the same type of coverage in the individual market) in a State, or, in the case of an insurer that is a health maintenance organization or that provides coverage through a network plan in a geographic area.

(b) NOTICE REQUIREMENT FOR MARKET EXIT.—Subsection (a)(4) shall not apply to an insurer ceasing to provide coverage in the individual market unless the insurer provides notice of such termination to individuals covered at least 180 days before the date of termination of coverage.

(c) LIMITATION ON REENTRY IN INDIVIDUAL MARKET.—If an insurer ceases to offer health insurance coverage or a type of coverage in an area with respect to the individual market, the insurer may not offer such coverage (or type of coverage) in the area in such market until 5 years after the date of the termination.

(d) TYPE OF COVERAGE DEFINED.—In this section, general coverage, catastrophic coverage, and medisave coverage (as defined in section 1002) shall each be considered to be separate types of health insurance coverage.

PART 2—ENCOURAGEMENT OF STANDARDS-SETTING ORGANIZATIONS FOR PROVIDER NETWORKS AND UTILIZATION REVIEW

SEC. 2011. ENCOURAGEMENT OF STANDARDS-SETTING ORGANIZATIONS FOR PROVIDER NETWORKS.

(a) REQUIREMENT TO MEET STANDARDS.—Each insurer offering health insurance coverage in the individual market shall meet such standards as may be recognized or established under this section.

(b) STANDARDS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services determines that a private entity has established standards for provider networks providing items and services covered under health insurance coverage offered by insurers in the individual market, in consultation with appropriate parties (including representatives of health care providers, specialists, insurers, plan administrators, and other experts), and provides for a process for the periodic review and update of such standards, such standards shall be the standards applied under this section.

(2) CONTINGENCY.—If the Secretary of Health and Human Services makes a determination contrary to the determination described in paragraph (1), such Secretary shall submit such determination in writing to each House of the Congress.

(c) REQUIREMENTS FOR STANDARDS.—The standards established under subsection (a) shall consist only of standards relating to—

(1) the extent to which individuals covered under the plan are assured to have reasonably prompt access, through the provider network, to all items and services contained in any package of benefits that may be provided under the provider net-

work, in a manner that assures the continuity of the provision of such items and services,

(2) the extent to which emergency services are provided to covered individuals (including trauma services)—

(A) without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the entity to provide items or services to covered individuals, and

(B) in the case of services furnished for the treatment of an emergency medical condition, without regard to prior authorization, and

(3) the extent to which—

(A) standards (including criteria for quality, efficiency, credentialing, and services) are established by the provider network for entering into contracts (other than a contract providing for employment of an employee) with health care providers with respect to the provider network,

(B) such standards are established pursuant to a mechanism which provides for receipt and consideration of recommendations of the

providers who are members of the provider network,

(C) written notification to the provider is required to terminate or to refuse to renew the agreement and, unless otherwise provided in the agreement and if requested by the provider, written notification to the provider of the reasons for such termination or refusal is also required, and

(D) unless otherwise provided in the agreement and if requested by the provider, internal review of any such decision to terminate or to refuse renewal is provided for under the provider network.

(d) PROVIDER NETWORK.—For purposes of this section, the term ''provider network'' means, with respect to health insurance coverage provided by an insurer in the individual market, providers who have entered into an agreement under which such providers are obligated to provide covered items and services to covered individuals.

SEC. 2012. ENCOURAGEMENT OF PRIVATE STANDARDS-SETTING ORGANIZATIONS FOR UTILIZATION REVIEW.

(a) REQUIRING REVIEW TO MEET STANDARDS.—An insurer offering health insurance coverage in the individ-

ual market may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets such standards as may be recognized or established under this section.

(b) STANDARDS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services determines that a private entity has established standards for utilization review programs described in subsection (c), in consultation with appropriate parties (including representatives of health care providers, specialists, insurers, plan administrators, and other experts), and provides for a process for the periodic review and update of such standards, such standards shall be the standards applied under this section.

(2) CONTINGENCY.—If the Secretary of Health and Human Services makes a determination contrary to the determination described in paragraph (1), such Secretary shall submit such determination in writing to each House of the Congress.

(c) REQUIREMENTS FOR STANDARDS.—The standards established under subsection (a) shall consist only of standards relating to—

(1) the extent to which individuals performing utilization review may receive financial compensation based upon the number of denials of coverage;

(2) the process under which a covered individual or provider may obtain timely review of a denial of coverage, including the extent to which a review must be conducted by a medical director of the insurer or a physician designated by the insurer;

(3) the extent to which utilization review is to be conducted in accordance with uniformly applied standards that are based on currently available medical evidence; and

(4) the extent to which providers are to participate in the development of the utilization review program.

PART 3—REQUIREMENTS FOR INSURERS PROVIDING HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL MARKET

SEC. 2021. REQUIREMENT FOR INSURERS TO OFFER GENERAL, CATASTROPHIC, AND OPTIONAL MEDISAVE COVERAGE IN THE INDIVIDUAL MARKET.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each insurer that makes available any health insurance coverage to individuals in the individual market in a State—

(A) shall make available, to each eligible individual in such market in the State, general coverage (as defined in section 1002(a)), with a fee-for-service option and, if the insurer makes the option available in the State outside the individual market, a point-of-service option and a managed care option,

(B) shall make available, to each eligible individual in the individual market in the State, catastrophic coverage (as defined in section 1002(b)), and

(C) may make available, to each eligible individual in the individual market in the State, medisave coverage (as defined in section 1002(c)).

(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—The requirements of paragraph (1)(A) (with regard to requiring a fee-for-service option) and paragraph (1)(B) shall not apply with respect to health insurance coverage that is offered by—

(A) a health maintenance organization, or

(B) any other entity if such other entity does not provide for a fee-for-service option.

(3) COVERAGE OPTIONS.—For purposes of this subsection—

(A) FEE-FOR-SERVICE OPTION.—General coverage is considered to provide a ''fee-for-service option'' if benefits with respect to the covered items and services in the coverage are made available for such items and services provided through any lawful provider of such covered items and services.

(B) MANAGED CARE OPTION.—General coverage is considered to provide a ''managed care option'' if benefits with respect to the covered items and services in the coverage are made available exclusively through a managed care arrangement, except in the case of emergency and urgent services and as otherwise required under law.

(C) POINT-OF-SERVICE OPTION.—General coverage is considered to provide a ''point-of-service option'' if the benefits with respect to covered items and services in the coverage are made available principally through a managed care arrangement, with the choice of the cov-

ered individual to obtain such benefits for items and services provided through any lawful provider of such covered items and services. The coverage may provide for different cost sharing schedules based on whether the items and services are provided through such an arrangement or outside such an arrangement.

(4) CONSTRUCTION WITH RESPECT TO ASSOCIATION COVERAGE.—Nothing in paragraph (1) or subsection (b)(1) shall be construed as requiring the general, catastrophic, or medisave coverage made available by an insurer in the individual market in a State as association coverage (as defined in subsection (b)(4)(B)) to be the same as the general, catastrophic, or medisave coverage offered in the State in the individual market not as such association coverage.

(b) ISSUANCE OF COVERAGE.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection and subsection (a)(4), each insurer that offers general, catastrophic, or medisave coverage to an eligible individual in the individual market in a State must accept every such individual in the State, to the extent so eligible, that applies for such coverage.

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of an insurer that is an health maintenance organization or that provides coverage through a network plan in the individual market, the insurer may—

(A) limit the individuals that may apply for such coverage to those with individuals residing in the service area of such organization or plan; and

(B) within the service area of such organization or plan, deny such coverage to such individuals if the insurer demonstrates that—

(i) it will not have the capacity to deliver services adequately to additional individuals because of its obligations to existing group contract holders and enrollees,

(ii) it is applying this subparagraph uniformly to all individuals without regard to the health status, claims experience, or duration of coverage, and

(iii) it will not offer coverage to such individuals within such service area for a period of at least 180 days after such coverage is denied.

(3) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—An insurer may deny health insurance coverage to individuals if the insurer demonstrates that—

(A) it does not have the financial reserves necessary to underwrite additional coverage,

(B) it is applying this paragraph uniformly to all individuals without regard to the health status, claims experience, or duration of coverage, and

(C) it shall not offer coverage to such individuals within such service area for a period of at least 180 days after such coverage is denied.

(4) SPECIAL RULE FOR ASSOCIATION COVERAGE.—

(A) IN GENERAL.—In the case of association coverage (as defined in subparagraph (B)) in the individual market, an insurer may restrict the coverage to individuals who are bona fide members in the association and who apply for enrollment on a timely basis (consistent with subparagraphs (B) through (F)).

(B) ASSOCIATION COVERAGE DEFINED.—In this paragraph, the term ''association coverage'' means coverage provided through an as-

sociation (such as a trade association, industry association, or professional association) to its members, but only if such association—

(i) has been (together with its immediate predecessor, if any) organized and maintained for a continuous period of not less than 3 years before the date of the initiation of such coverage, and

(ii) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, for substantial purposes other than providing such coverage.

(C) GENERAL INITIAL ENROLLMENT REQUIREMENT.—Except as provided in subparagraphs (D) through (F), enrollment of an individual for general, catastrophic, or medisave coverage may be considered not to be timely if the individual fails to enroll under such coverage during an initial enrollment period, if such period is at least 30 days long.

(D) ENROLLMENT DUE TO LOSS OF PREVIOUS COVERAGE.—Enrollment under general, catastrophic, or medisave coverage is considered to be timely in the case of an individual who—

(i) was covered under a group health plan or had other health insurance coverage at the time of the individual's initial enrollment period,

(ii) stated at the time of the initial enrollment period that coverage under a group health plan or other health insurance coverage was the reason for declining enrollment,

(iii) lost coverage under a group health plan or other health insurance coverage (as a result of the termination of the coverage, termination of employment, reduction or hours of employment, or other reason other than a reason described in paragraph (1) or (2) of section 2003(a)), and

(iv) requests enrollment within 30 days after termination of the coverage.

(E) REQUIREMENT APPLIES DURING OPEN ENROLLMENT PERIODS.—Each insurer providing association coverage in the individual market shall provide for at least one period (of not less than 30 days) each year during which enrollment under such coverage shall be consid-

ered to be timely. A late enrollment penalty may apply with respect to any subsequent period (not to extend beyond the effective date of the next such enrollment period).

(F) ENROLLMENT OF DEPENDENTS.—

(i) IN GENERAL.—If association coverage includes coverage of dependents, enrollment of an individual who is a spouse or child of a covered individual shall be considered to be timely if a request for enrollment is made either—

(I) within 30 days of the date of the marriage or of the date of the birth or adoption of such child, if family coverage is available as of such date, or

(II) within 30 days of the date family coverage is first made available.

(ii) COVERAGE.—If available association coverage includes family coverage and enrollment is made under such coverage on a timely basis under clause (i)(I), the coverage shall become effective not later than the first day of the first month beginning

after the date the completed request for enrollment is received.

(5) CONDITIONS OF COVERAGE APPLICABLE TO CERTAIN INDIVIDUALS.—

(A) IN GENERAL.—An insurer may offer or deny coverage under paragraph (1) with respect to an individual who would be expected to incur disproportionately high health care costs and who is a resident of a State under terms and conditions that may involve risk adjustment mechanisms, high-risk pools, or other mechanisms described in subparagraph (B).

(B) INSURANCE MECHANISMS.—The Secretary shall request the NAIC to develop (in consultation with the American Academy of Actuaries), within 12 months after the date of the enactment of this Act, a definition of individuals who would be expected to incur disproportionately high health care costs and mechanisms relating to risk adjustment mechanisms, high-risk pools, or other mechanisms to provide additional access to health insurance coverage for such individuals. If the NAIC develops such a definition and mechanisms within such period, the Secretary shall review the definition and

mechanisms. Such review shall be completed within 120 days after the date the definition and mechanisms are developed. Unless the Secretary determines within such period that such definition and mechanisms do not meet the requirements of this paragraph, such definition and mechanisms shall serve as the definition and mechanisms applicable under subparagraph (A), with such amendments as the Secretary deems necessary.

(c) DEFINITIONS.—In this section—

(1) the term ''eligible individual'', at the election of the insurer, may exclude an individual eligible for coverage under a group health plan; and

(2) the term ''group health plan'' has the meaning given such term under section 3(42) of the Employee Retirement Income Security Act of 1974.

SEC. 2022. USE OF FAIR RATING, UNIFORM MARKETING MATERIALS, AND MISCELLANEOUS CONSUMER PROTECTIONS.

(a) USE OF FAIR RATING.—

(1) IN GENERAL.—As a standard under section 2101(a), subject to the succeeding paragraphs of this subsection, the premium rates established by an insurer for general, catastrophic, or medisave cov-

erage in the individual market may not vary except by the following:

(A) AGE.—By age.

(B) GEOGRAPHIC AREA.—By geographic area, based on 3-digit zip code or counties, as identified by the Secretary in consultation with the NAIC and the States involved.

(C) FAMILY CLASS.—By family class, based on classes of family coverage established by the Secretary, in consultation with the NAIC and the States.

(D) BENEFIT DESIGN.—By benefit design of coverage, including by type of coverage, such as general, catastrophic, and medisave coverage and by type of coverage option (described in section 2021(a)(3)) with respect to general coverage.

(E) 12-MONTH SURCHARGE FOR LESS RESTRICTIVE PRE-EXISTING CONDITION EXCLUSION.—By whether coverage is being provided pursuant to section 2001(a) (relating to a less restrictive pre-existing condition exclusion), and which is not described in section 2001(b), but only during the first 12 months in which such coverage is provided.

(F) ADMINISTRATIVE CATEGORIES.—By permitted expense category, based on differences in expenses among such categories, consistent with subsection (b).

(2) TREATMENT OF ASSOCIATIONS AS SEPARATE POOLS.—

(A) IN GENERAL.—At the election of an insurer, the provisions of this section may be applied separately with respect to all individuals who are provided association coverage (as defined in section 2021(b)(4)(B)).

(B) 5-YEAR RULE.—An election under subparagraph (A) may not be made (or revoked) more frequently than once every 5 years.

(3) TREATMENT OF PERMANENT HEALTH INSURANCE POLICIES.—Paragraph (1) shall not apply in connection with a permanent policy of health insurance existing on the effective date specified in section 2104, if each individual covered under the policy is given the option to convert the policy to a policy of health insurance that is subject to this subtitle and that meets the requirements of this section.

(4) ADDITIONAL VARIATIONS IN RENEWAL PREMIUMS PERMITTED FOR CLAIMS EXPERIENCE WITHIN CLASS OF BUSINESS.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and unless an alternative method is provided under standards established under section 2021 with respect to permissible variations for renewal premiums, for a class of business of an insurer in the individual market, with respect to individuals with similar demographic and other similar objective characteristics (not relating to claims experience, health status, occupation, or duration of coverage since issue) for the same or similar coverage, the insurer offering health insurance coverage in the individual market may vary the renewal premiums charged during a rating period based on claims experience so long as the highest rates which could be charged to such individuals under the rating system for that class of business does not exceed the following percentage of the base premium rate for the class of business for the rating period:

(i) For a rating (or portion thereof) that occurs in the first 2 years in which this section is in effect, 200 percent.

(ii) For a rating (or portion thereof) that occurs in a succeeding year, a per-

centage specified in any regulation of the Secretary that may be prescribed under paragraph (6).

(B) LIMIT ON TRANSFER OF INDIVIDUALS AMONG CLASSES OF BUSINESS.—In carrying out subparagraph (A), an insurer offering health insurance coverage in the individual market may not involuntarily transfer an individual into or out of a class of business. An insurer providing such coverage may not offer to transfer an individual into or out of a class of business unless such offer is made to transfer all individuals in the class of business without regard to demographic characteristics, claim experience, health status, occupation, or duration since issue.

(C) DEFINITIONS.—In this paragraph:

(i) BASE PREMIUM RATE.—The term ''base premium rate'' means, for each class of business for each rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business by the insurer to individuals in the individual market with similar demographic characteristics and

other similar objective characteristics (not relating to claims experience, health status, occupation, or duration of coverage since issue) for the same or similar health insurance coverage.

(ii) CLASS OF BUSINESS.—The term ''class of business'' means, with respect to an insurer, all (or a distinct group of) individuals in the individual market as shown on the records of the insurer.

(iii) RULES FOR ESTABLISHING CLASSES OF BUSINESS.—For purposes of clause (ii)—

(I) an insurer offering health insurance coverage in the individual market may establish, subject to subclause (II), a distinct group of individuals on the basis that the applicable health insurance coverage either is marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groups of individuals for the insurer or has been acquired

from another insurer as a distinct group; and

(II) such an insurer may not establish more than 2 groupings under each class of business based on the insurer's use of managed-care techniques if the techniques are expected to produce substantial variation in health care costs.

(iv) DEMOGRAPHIC CHARACTERISTICS.—The term ''demographic characteristics'' means age (based upon classes established under paragraph (1)(A)), gender, geographic area (based upon areas identified under paragraph (1)(B)), and family composition (based upon family classes established under paragraph (1)(C)).

(5) ADDITIONAL VARIATIONS IN INITIAL PREMIUMS PERMITTED FOR UNDERWRITING CHARACTERISTICS.—

(A) IN GENERAL.—For a class of business of an insurer, with respect to individuals in the individual market with similar demographic and other similar objective characteristics (not relating to claims experience, health status, occupa-

tion, or duration of coverage since issue), for the same or similar coverage, the insurer offering health insurance coverage in such market may vary the initial premiums charged on the basis of prior claims experience, health status, occupation, and other underwriting characteristics so long as the highest rates which could be charged to such individuals under the rating system for that class of business does not exceed the following percentage of the base premium rate for the class of business for the rating period:

(i) For a rating (or portion thereof) that occurs in the first 2 years in which this section is in effect, 200 percent.

(ii) For a rating (or portion thereof) that occurs in a succeeding year, a percentage specified in any regulation of the Secretary that may be prescribed under paragraph (6).

(B) DEFINITIONS.—In this paragraph:

(i) BASE PREMIUM RATE.—The term ''base premium rate'' means, for each class of business, the lowest premium rate charged or which could have been charged

under a rating system for that class of business by the insurer to individuals in the individual market with similar demographic characteristics and other similar objective characteristics (not relating to claims experience, health status, occupation, or duration of coverage since issue) for the same or similar health insurance coverage.

(ii) OTHER DEFINITIONS.—Clause (ii) (relating to class of business), clause (iii) (relating to rules for establishing classes of business), and clause (iv) (relating to demographic characteristics) of paragraph (4)(C) shall also apply with respect to this paragraph.

(6) GRADUATED REDUCTION IN ALLOWABLE PERCENTAGES OF BASE PREMIUM RATE.—The Secretary shall request the NAIC to determine (in consultation with the American Academy of Actuaries), within 12 months after the date of the enactment of this Act, whether model regulations that provide for a schedule of graduated reductions in the percentages of the base premium rates allowable under each of paragraphs (4)(A)(ii) and (5)(A)(ii) can be devel-

oped without adversely affecting coverage rates and affordability of coverage. If the NAIC makes such a determination and develops such model regulations providing for such schedules, the Secretary shall review the schedules provided in such model regulations. Such review shall be completed within 120 days after the date the regulations are developed. Unless the Secretary determines within such period that any schedule provided in such model regulations for paragraph (4)(A)(ii) or (5)(A)(ii) does not meet the requirements of this subsection, such schedule shall serve as the schedule applicable under such paragraph, with such amendments as the Secretary deems necessary. The Secretary shall provide for public comment in connection with the regulations during such 120-day period and in advance of any determination by the Secretary.

(b) ADMINISTRATIVE VARIATIONS.—Expense categories shall be established under subsection (a)(1)(F) by an insurer in a manner that only reflects differences based on marketing, commissions, and similar expenses.

(c) FULL DISCLOSURE OF APPLICABLE RATING PRACTICES.—At the time an insurer offers health insurance coverage in the individual market, the insurer shall fully disclose to the individual, at the request of an individ-

ual, rating practices for health insurance coverage applicable to that individual, including rating practices for different benefit designs offered to the individual.

(d) ACTUARIAL CERTIFICATION.—Each insurer that offers health insurance coverage in the individual market in a State shall file annually with the State commissioner of insurance, to the extent required by such commissioner, a written statement by a member of the American Academy of Actuaries (or other individual acceptable to the commissioner) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for applicable health insurance coverage—

(1) the insurer is in compliance with the applicable provisions of this section, and

(2) the rating methods are actuarially sound.

Each such insurer shall retain a copy of such statement for examination at its principal place of business.

(e) REGISTRATION AND REPORTING.—Each insurer that offers any health insurance coverage in the individual market in a State shall be registered or licensed with the State commissioner of insurance and shall comply with any reporting requirements of the commissioner relating to such coverage.

(f) MARKETING MATERIAL.—Each insurer that offers any health insurance coverage in the individual market in a State shall file with the State those marketing materials relating to the offer and sale of health insurance coverage to be used for distribution before the materials are used. Such materials shall be in a uniform format, as may be provided under standards established under section 2101.

Subtitle B—Establishment of Standards; Enforcement; Effective Dates

SEC. 2101. ESTABLISHMENT OF STANDARDS.

(a) ROLE OF NAIC.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall request the NAIC to develop, within 12 months after the date of the enactment of this Act, model regulations that specify standards with respect to the requirements of subtitle A.

(2) REVIEW BY SECRETARY.—If the NAIC develops recommended regulations specifying the standards with respect to the requirements of subtitle A within the 12-month period referred to in paragraph (1), the Secretary shall review the standards. Such review shall be completed within 120 days after the date the regulations are developed.

(3) REQUIREMENTS.—Except with respect to the requirements of section 2011 and 2012, unless the Secretary determines within such 120-day period that—

(A) the standards do not effectively provide for the application of requirements of sections 2001, 2002, and 2003 to insurers in a manner and to an extent equivalent in substance to the manner and extent to which the requirements apply to group health plans under section 821 of the Employee Retirement Income Security Act of 1974 (as added by the ERISA Targeted Health Insurance Reform Act of 1995), or

(B) the standards do not otherwise meet the requirements of subtitle A,

such standards shall serve as the standards under this section, with such amendments as the Secretary deems necessary.

(4) REQUIREMENTS RELATING TO MANAGED CARE AND UTILIZATION REVIEW.—If the Secretary determines under section 2011(b)(1) that a private entity has established standards for provider networks consistent with section 2011(c), the standards established under this section with respect to the requirements of section 2011 shall consist of the

standards recognized or established under section 2011. If the Secretary determines under section 2012(b)(1) that a private entity has established standards for utilization review programs that are consistent with section 2012(c), the standards established under this section with respect to the requirements of section 2012 shall consist of the standards recognized or established under section 2012.

(5) PUBLIC COMMENT.—The Secretary shall provide for public comment in connection with the standards during such 120-day period and in advance of any determination by the Secretary.

(b) CONTINGENCY.—If the NAIC does not develop such model regulations within such period or the Secretary makes the determination described in subsection (a), the Secretary shall specify, within 24 months after the date of the enactment of this Act, standards to carry out those requirements.

(c) DEFINITIONS.—In this title, the term ''section 2101 standards'' means the standards established under this section.

SEC. 2102. ENFORCEMENT.

(a) VOLUNTARY ENFORCEMENT BY STATES.—

(1) IN GENERAL.—Each State that desires to enforce the section 2101 standards with respect to

insurers shall submit to the Secretary of Health and Human Services, by the deadline specified in paragraph (2), a report on the program the State has established by such deadline and consistent with section 2104 to implement and enforce such standards.

(2) DEADLINE.—

(A) 1 YEAR AFTER FINAL MODEL REGULATIONS.—Subject to subparagraph (B), the deadline under this paragraph is 1 year after the date model regulations are established under section 2101.

(B) EXCEPTION FOR LEGISLATION.—In the case of a State which the Secretary of Health and Human Services identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for insurers to meet the section 2101 standards provided under such model regulations, but

(ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1997. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(3) NO FEDERAL MANDATE ON STATES.—Nothing in this subsection shall be construed as imposing a requirement on a State. The establishment by a State of an enforcement program under this subsection is voluntary.

(b) FEDERAL ROLE.—

(1) STATE ENFORCEMENT EXCLUSIVE OF FEDERAL ENFORCEMENT.—If the Secretary determines that a State has submitted a report by the deadline specified under subsection (a)(2) and finds that the State has provided for implementation and enforcement of the section 2101 standards, such implementation and enforcement shall be carried out exclusively under State law.

(2) REVIEW OF STATE ENFORCEMENT PROGRAMS.—If the Secretary determines that a State

has submitted a report by the deadline specified under subsection (a)(2) but finds that the State program does not provide for implementation and enforcement of the section 2101 standards, the Secretary shall notify the State and provide the State a period of 60 days in which to provide for changes that assure such implementation and enforcement of such standards.

(3) CONTINGENCY.—If the Secretary determines that a State has not submitted a report by the deadline specified under subsection (a)(2) or, in the case of a State described in paragraph (1), the State has not provided for an implementation and enforcement program after the period of 60 days specified in such paragraph, the Secretary shall provide for such mechanism for the implementation and enforcement of the section 2101 standards in the State (including the application of civil money penalties under paragraph (3)) as the Secretary determines to be appropriate. Any such implementation and enforcement shall cease to be effective on the date the Secretary finds that a State has established an implementation and enforcement program described in subsection (a)(1).

(3) APPLICATION OF CIVIL MONEY PENALTY UNDER SECRETARIAL MECHANISM.—

(A) IN GENERAL.—If the Secretary is providing for implementation and enforcement of section 2101 standards under paragraph (2) and determines that an insurer has failed to comply with such standards applicable to the insurer, the Secretary may impose on the insurer a civil money penalty of not to exceed $25,000 for each such failure. Under regulations of the Secretary, provisions consistent and coextensive with section 1128A of the Social Security Act (other than the first sentence of subsection (a) of such section and other than subsection (b) of such section) shall apply to a civil money penalty under this paragraph in the same manner as such section applies to a penalty or proceeding under section 1128A(a) of such Act.

(B) CORRECTIONS WITHIN 30 DAYS.—The Secretary shall not impose a civil money penalty under this paragraph by reason of any failure if—

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

(ii) such failure is corrected within the 30-day period beginning on the earliest date the insurer knew, or exercising reasonable diligence would have known, that such failure existed.

(c) GOOD FAITH COMPLIANCE WITH REQUIREMENT.—An insurer that complies in good faith with an applicable requirement of subtitle A shall not be subject to a penalty under this section for failure to meet such requirement on the basis of its failure to meet section 2101 standards (or regulations to carry out such standards) for any failure that occurs before the date such standards (or regulations) have been published and become effective.

(d) TREATMENT OF POLICY APPROVAL BY DOMICILE STATE.—If a particular policy or contract of health insurance coverage offered by an insurer is approved in a State that has adopted and is enforcing section 2101 standards and that is the domicile State with respect to the insurer, the policy or contract shall be deemed to meet such standards with respect to any other State but only if a copy of the approval by the domicile State is filed by the insurer with the applicable regulatory authority of such other State at least 60 days before the date the policy or contract is offered, sold, or issued in that other State.

SEC. 2103. PREEMPTION.

(a) IN GENERAL.—Except as provided in this section, a State may not establish or enforce standards for insurers or health insurance coverage offered in the individual market with respect to the subject matter of this title that are different from the standards established under this title.

(b) TRANSITION FOR MORE RESTRICTIVE STATE STANDARDS.—Subsection (a) shall not apply to a State establishing and enforcing more restrictive standards relating to the matters under this title during the 3-year period beginning on January 1, 1998, if such standards have been established and are enforced by the State as of February 1, 1995.

(c) PROHIBITION OF STATE BENEFIT MANDATES.—

(1) IN GENERAL.—No provision of State or local law shall apply that requires—

(A) health insurance coverage in the individual market to provide coverage of one or more specific benefits, services, or categories of health care, or services of any class or type of provider of health care; or

(B) an insurer (in relation to health insurance coverage offered in the individual market) to provide coverage of one or more specific benefits, services, or categories of health care, or

services of any class or type of provider of health care.

(2) EXCEPTION.—

(A) STATE ENFORCEMENT PROGRAMS.—Paragraph (1) shall not apply a State enforcement program under section 2102.

(B) CERTAIN POLICIES.—Notwithstanding subsection (a), a State may require an insurer (in relation to health insurance coverage offered in the individual market) to provide coverage of one or more specific benefits, services, or categories of health care, or services of any class or type of provider of health care, but only with respect to—

(i) not more than 2 policies or contracts of health insurance coverage, one of which provides less comprehensive coverage than the other, and

(ii) policies for which the State provides subsidies to individuals to purchase such coverage.

(d) PREEMPTION OF STATE ANTI-MANAGED CARE LAWS.—

(1) PREEMPTION OF STATE LAW PROVISIONS.—Subject to paragraph (2)(C), the following provisions

of State law are preempted and may not be enforced:

(A) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any State law that—

(i) restricts the ability of an insurer offering health insurance coverage in the individual market to negotiate reimbursement rates or forms of payments with providers,

(ii) restricts the ability of such an insurer to limit the number of participating providers, or

(iii) requires standards inconsistent with any standards established under section 2011(b).

(B) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—Any State law that, in relation to a health insurance coverage offered in the individual market—

(i) prohibits utilization review of any or all treatments and conditions (including preadmission certification, application of practice guidelines, continued stay review,

preauthorization of ambulatory procedures, and retrospective review),

(ii) requires that such review be made (I) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (II) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being reviewed,

(iii) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews,

(iv) requires payments to providers for the expenses of responding to utilization review requests,

(v) imposes liability for delays in performing such review, or

(vi) requires standards in addition to or inconsistent with standards established under section 2012(b).

SEC. 2104. EFFECTIVE DATE.

The requirements of subtitle A and the preemption provisions of section 2103, shall apply with respect to insurers on January 1, 1998.

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