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104TH CONGRESS
2D SESSION

H. R. 3013

To increase the availability and continuity of health coverage for individuals, small employers, and other groups, to reduce paperwork and simplify administration of health care claims, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 5, 1996

Mr. NEY introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Economic and Educational Opportunities and Ways and Means, 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 increase the availability and continuity of health coverage for individuals, small employers, and other groups, to reduce paperwork and simplify administration of health care claims, 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 ''Insurance and Health Care Reform Act of 1995''.

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

TITLE I—HEALTH INSURANCE REFORMS

Subtitle A—Improving Access to and Continuity of Coverage

SEC. 101. LIMITATION ON PRE-EXISTING CONDITIONS PROVISIONS IN THE SMALL EMPLOYER MARKET.

(a) IN GENERAL.—An insurer may impose a pre-existing conditions provision (as defined in subsection (b)) with respect to an individual under a health benefit plan covering small employers only if—

(1) the limitation or exclusion does not extend for a period beyond 12 months following the individual's effective date of coverage under the plan and only relates to conditions during the six months immediately preceding the effective date of coverage; and

(2) the limitation or exclusion does not apply to an individual who, as of the date of birth, was covered under the plan.

(b) PRE-EXISTING CONDITIONS PROVISION DEFINED.—In this title, the term ''pre-existing conditions provision'' means a policy provision that excludes or limits coverage for charges or expenses incurred during a speci-

fied period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care or treatment was recommended or received, or a pregnancy existing on the effective date of coverage.

SEC. 102. ASSURANCE OF CONTINUITY OF COVERAGE THROUGH PREVIOUS SATISFACTION OF PRE-EXISTING CONDITION REQUIREMENT.

(a) IN GENERAL.—In determining whether a pre-existing conditions provision applies to an eligible employee or dependent covered under any health benefit plan, the plan shall credit the time the person was covered under a previous health benefit plan if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under the plan.

(b) TREATMENT OF WAITING PERIODS.—In applying subsection (a), any waiting period, which may not exceed 90 days, imposed by an employer before an employee is eligible to be covered under a plan shall be treated as a period in which the employee was covered under a health benefit plan.

SEC. 103. REQUIREMENTS RELATING TO RENEWABILITY GENERALLY.

(a) MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—A multiple employer welfare arrangement may not cancel coverage or deny renewal of coverage under such a plan with respect to an employer other than—

(1) for nonpayment of contributions;

(2) for fraud or other misrepresentation by the employer;

(3) for noncompliance with plan provisions; and

(4) because the plan is ceasing to provide any coverage in a geographic area.

(b) INSURERS.—An insurer may not cancel a health benefit plan or deny renewal of coverage under such a plan other than—

(1) for nonpayment of premiums;

(2) for fraud or other misrepresentation by the insured;

(3) for noncompliance with plan provisions;

(4) in the case of a plan issued to a small employer, for failure to maintain minimum participation rates (consistent with subsection (d)); or

(5) because the insurer is ceasing to provide any health benefit plan in a State, or, in the case of an HMO, in a geographic area.

(c) LIMITATION ON MARKET RE-ENTRY.—If an insurer ceases to offer health benefit plans to employers in a geographic area, the insurer may not offer such a health benefit plan to any employer in the geographic area until 5 years after the date of the termination.

(d) MINIMUM PARTICIPATION RATES.—An insurer may require, with respect to a health benefit plan issued to a small employer, that a minimum percentage of eligible employees who do not otherwise have health insurance are enrolled in such plan if such percentage is applied uniformly to all plans offered to employers of comparable size.

(e) UNDERWRITING AND SELECTIVE EXCLUSION.—

(1) IN GENERAL.—Except as provided in this subsection, an insurer may underwrite and rate small employer groups using accepted underwriting and actuarial practices.

(2) PROHIBITION OF HEALTH STATUS UNDERWRITING.—Subject to paragraph (3), an insurer shall not exclude any eligible employee or dependent, who would otherwise be covered under a health benefit plan offered by the insurer, on the basis of any actual or expected health condition of the employee or dependent.

(3) EXCLUSION OF LATE ENROLLEES.—With respect to an individual who is a late enrollee (as defined in paragraph (4)), an insurer—

(A) may exclude the individual for a period of up to 24 months or may, in the discretion of the insurer, extend coverage to the individual at any time during that period, and

(B) may medically underwrite the individual.

(4) LATE ENROLLEE.—In this title, the term ''late enrollee'' means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period provided under the terms of the first plan for which the employee or dependent was eligible through the small employer, unless any of the following apply:

(A) The individual—

(i) was covered under another employer-provided health benefit plan at the time the individual was eligible to enroll;

(ii) states, at the time of the initial eligibility, that coverage under another employer health benefit plan was the reason for declining enrollment;

(iii) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and

(iv) requests enrollment within 30 days after the termination of coverage under another employer health benefit plan.

(B) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period.

(C) A court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and a request for enrollment is made within 30 days after issuance of the court order.

SEC. 104. LIMITS ON PREMIUMS AND OTHER RATING PRACTICES IN THE SMALL EMPLOYER MARKET.

(a) LIMITS ON PREMIUMS.—

(1) LIMIT ON VARIATION OF RATES.—

(A) NEW ISSUANCE.—With respect to a health benefit plan offered to small employers by an insurer and issued on or after the date

of the enactment of this Act, the premium rates charged or offered for a rating period for the same or similar coverage under the plan covering any small employer with similar case characteristics may not vary from the applicable midpoint rate by more than 35 percent of the midpoint rate.

(B) CURRENT ISSUANCE.—

(i) IN GENERAL.—If the premium rate charged or offered for the same or similar coverage under the plan covering any small employer with similar case characteristics exceeds the applicable midpoint rate by more than 35 percent, any increase in premium for a new rating period shall not exceed the sum of the following:

(I) BASE PREMIUM INCREASE.—Subject to clause (ii), any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period.

(II) ADJUSTMENT FOR CASE CHARACTERISTICS.—Any adjustment due to change in case characteristics

or plan design of the small employer, as determined by the insurer.

(ii) LIMITATION.—Any increase in premium rates for a new rating period shall not exceed any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period plus 15 percent, adjusted on a pro rata basis for rating periods greater or less than one year and adjustments due to a change in case characteristics or plan design of the small employer.

(iii) RATING PERIOD.—For purposes of this subsection, an insurer shall treat all health benefit plans covering small employers issued or renewed in the same calendar month as having the same rating period.

(C) LIMITATION ON VARIATION DUE TO USE OF INDUSTRY AS CASE CHARACTERISTIC.—If an insurer uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary by more than 15 percent

from the arithmetic average of the rate factors associated with all industry classifications.

(2) LIMIT ON VARIATION OF PREMIUM RATES WITHIN A CLASS A BUSINESS.—For a class of business (as defined in subsection (e)(3)) of an insurer, the highest premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the highest rates which could be charged to such employers under the rating system for that class of business, shall not exceed an amount that is 1.5 times the base premium rate for the class of business for a rating period (or portion thereof) that occurs in the first 3 years in which this section is in effect, and 1.35 times the base premium rate thereafter.

(3) LIMIT ON TRANSFER OF EMPLOYERS AMONG CLASSES OF BUSINESS.—An insurer may not involuntarily transfer a small employer into or out of a class of business. An insurer may not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to claim experience, health status, or duration of coverage since issue.

(b) FULL DISCLOSURE OF RATING PRACTICES.—At the time an insurer offers a health benefit plan to a small employer, the insurer shall fully disclose to the employer rating practices applicable to such plan.

(c) ACTUARIAL CERTIFICATION.—Each insurer that offers a health benefit plan to a small employer in a State shall file annually with the State commissioner of insurance 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 the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for applicable health benefit plans—

(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.

(d) REGISTRATION AND REPORTING.—Each insurer that issues any health benefit plan to a small employer 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 a plan.

(e) DEFINITIONS.—In this section:

(1) BASE PREMIUM RATE.—The term ''base premium rate'' means, as to any health benefit plan that is issued by an insurer and that covers more than 1 but less than 51 employees of a small employer, the lowest premium rate for a new or existing business for same or similar coverage covering any small employer with small case characteristics.

(2) CASE CHARACTERISTICS.—The term ''case characteristics'' means, with respect to a small employer, any of the following:

(A) The geographic area in which the employees reside.

(B) The age and sex of the individual employees and their dependents.

(C) The appropriate industry classification as determined by the insurer.

(D) The number of employees and dependents.

(E) Such other objective criteria as may be established by the insurer, but not including claims experience, health status, or duration of coverage from the date of issue.

(3) CLASS OF BUSINESS.—The term ''class of business'' means, with respect to an insurer, all (or

a distinct group of) small employers as shown on the records of the insurer.

(4) MIDPOINT RATE ''midpoint rate'' means, for small employers with similar case characteristics and plan designs and as determined by the applicable insurer for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

SEC. 105. SMALL EMPLOYER PURCHASING GROUPS.

(a) SMALL EMPLOYER PURCHASING GROUPS DESCRIBED.—

(1) IN GENERAL.—As used in this section, the term ''small employer purchasing group'' means an organization that—

(A) has a membership consisting solely of small employers;

(B) is administered solely under the authority and control of its member employers;

(C) with respect to each State in which its members are located, consists of not fewer than the number of small employers established by the State as appropriate for such a group;

(D) offers a program to assist such small employer members to obtain coverage for their

employees under one or more health benefit plans; and

(E) is not directly or indirectly controlled, through voting membership, representation on its governing board or otherwise, by an insurer, agent, broker, or any other individual or entity engaged in the sale of insurance, provider, or by persons who are officers, trustees, or directors of such enterprises.

(2) SPECIAL RULE.—An employer member of a small employer purchasing group that meets the requirements of paragraph (1) may retain its membership in the group if the number of employees of the employer increases such that the employer is no longer a small employer.

(b) AUTHORITY.—A small employer purchasing group established under this section may do any of the following:

(1) OFFERING HEALTH BENEFIT PLANS.—Negotiate and enter into agreements with one or more insurers for the insurers to offer and provide one or more health benefit plans to small employers for their employees and retirees, and the dependents and members of the families of such employees and retirees, which coverage may be made available to

enrolled small employers without regard to industrial, rating, or other classifications, and for the purchasing group to perform, or contract with others for the performance of, functions for or with respect to such purchasing group.

(2) CONTRACTS WITH OTHER GROUPS.—Contract with another small employer purchasing group for the inclusion of the small employer members of one in the program of the other.

(3) INFORMATION DISSEMINATION.—Provide or cause to be provided to small employers information concerning the availability coverage, benefits, premiums, and other information regarding purchasing groups.

(4) ADMINISTRATION.—Provide, or contract with others to provide, enrollment, recordkeeping, information, premium billing, collection and transmittal, and other services for a purchasing group.

(5) AUDITS.—Receive reports and information from the insurer and negotiate and enter into agreements with respect to inspection and audit of the books and records of the insurer.

(c) LIMITATION ON ACTIVITIES.—A small employer purchasing group may not—

(1) perform any activity involving approval or enforcement of payment rates for providers;

(2) assume financial risk in relation to any health benefit plan; or

(3) perform other activities identified by the State as being inconsistent with the performance of its duties under this section.

(d) RULES OF CONSTRUCTION.—

(1) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

(A) that a State organize, operate, or otherwise establish a small employer purchasing group, or otherwise require the establishment of purchasing groups; and

(B) that there be only one small employer purchasing group established with respect to a community rating area.

(2) ELIGIBILITY REQUIREMENTS.—Nothing in this section shall be construed as inhibiting or preventing a small employer purchasing group from adopting, imposing, and enforcing rules, conditions, limitations, or restrictions that are based on factors other than the health status of employees or their dependents for the purpose of determining whether

a small employer is eligible to become a member of a purchasing group.

(e) RECEIPT OF PREMIUMS.—

(1) ENROLLMENT CHARGE.—The amount charged by a small employer purchasing group for coverage under a health benefit plan shall be equal to the sum of—

(A) the premium rate offered by such health plan;

(B) the administrative charge for such health plan; and

(C) the purchasing group administrative charge for enrollment of eligible employees, eligible individuals and certain uninsured individuals through the group.

(2) DISCLOSURE OF PREMIUM RATES AND ADMINISTRATIVE CHARGES.—Each small employer purchasing group shall, prior to the time of enrollment, disclose to enrollees and other interested parties the premium rate for a health benefit plan, administrative charge for such plan, and administrative charge of the group, separately.

(f) SPECIAL RULES.—No health benefit plan offered or provided by an insurer to a small employer in a small

employer purchasing group is subject to any law that does any of the following:

(1) SELECTIVE CONTRACTING.—Inhibits the insurer from selectively contracting with providers or groups of providers with respect to health care service or benefits.

(2) PAYMENT NEGOTIATION.—Imposes any restrictions on the ability of the insurer to negotiate with providers regarding the level or method of reimbursing for care or services.

(3) BENEFIT OR PROVIDER MANDATES.—Requires the reimbursement, utilization, or consideration of a specific category of health care services or benefits.

(4) BENEFICIARY INCENTIVES.—Limits the financial incentives that a health benefit plan may require a beneficiary to pay when a nonplan provider is used on a nonemergency basis.

(5) UTILIZATION REVIEW.—(A) Prohibits utilization review of any or all treatments and conditions, (B) 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, (C) requires payments to providers for the expenses of responding to utilization review requests,

or (D) imposes liability for delays in performing such review.

Subtitle B—Open Enrollment and Related Practices

SEC. 111. ENROLLMENT GUIDELINES.

(a) REQUIREMENT OF OPEN ENROLLMENT.—

(1) IN GENERAL.—Beginning in January of each year, each insurer shall accept applicants for open enrollment coverage described in paragraph (2) or (3) in the order in which they apply for coverage, subject to subsection (f).

(2) SMALL EMPLOYERS.—In the case of an applicant that is a small employer, the applicant must accept the employer if coverage is not otherwise available and if coverage had not been terminated by the employer (or by an insurer with respect to the employer) during the preceding 12-month period.

(3) INDIVIDUALS.—In the case of an applicant that is an individual, the applicant—

(A) is not applying for coverage as an employee of an employer, as a member of an association, or as a member of any other group; and

(B) is not covered, and is not eligible for coverage, under any other private or public health benefits arrangement, including the Med-

icare program under title XVIII of the Social Security Act or any other Act of Congress or law of any State that provides benefits comparable to the benefits provided under this section or any conversion or continuation of coverage policy under State or Federal law.

(b) MINIMUM COVERAGE.—An insurer shall provide to any individual or small employer group accepted under this section a health benefit plan that provides, at a minimum, coverage of the following health care services, when such services are provided within the scope of authorized practice by the applicable licensed providers:

(1) Major medical.

(2) Hospital services.

(3) Basic medical-surgical services, both inpatient and outpatient medical and surgical services, diagnostic services, anesthesia services, and consultation services.

(4) Prescription drugs, insulin, syringes, diagnostic x-rays and laboratory tests.

(5) Screening by low-dose mammography for the presence of breast cancer and cytologic screening for the presence of cervical cancer in accordance with standards of the National Cancer Institute.

(6) Maternity services.

(c) PREEXISTING CONDITIONS PROVISIONS.—Health benefit plans issued under this section may establish preexisting conditions provisions (as defined in section 101(b)) that exclude or limit coverage for a period of up to 12 months (or 24 months in the case of a late enrollee, as defined in section 101(e)(4) and at the option of the insurer) following the individual's effective date of coverage and that may relate only to conditions during the 6 months immediately preceding the effective date of coverage.

(d) PREMIUMS.—

(1) SMALL EMPLOYERS.—Premiums charged to small employers under this section may not exceed an amount that is 1½ times the highest rate charged any other small employer with similar case characteristics for same or similar coverage.

(2) INDIVIDUALS.—Premiums charged to individuals under this section may not exceed an amount that is 1½ times the highest rate charged to any other individual of the same age and gender for same or similar coverage. If the insurer does not have established individual rates in a State, the premium charged to individuals may not exceed an amount that is 1½ times the rate charged a small employer with case characteristics similar to the in-

dividual seeking coverage for same or similar coverage.

(e) USE OF NETWORKS.—In offering health benefit plans under this section, an insurer may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers.

(f) LIMITATION ON NUMBER OF NEW INSUREDS REQUIRED TO ACCEPT.—

(1) IN GENERAL.—An insurer is not required to accept annually under this section either individuals or small employers that, in the aggregate, would cause the insurer to have a total number of new insureds under this section that is more than ½ percent per year of its total number of insured individuals or small group certificate holders, calculated as of the immediately preceding 31st day of December and excluding Medicare supplemental policies and conversion or continuation of coverage policies under State or Federal law.

(2) CERTIFICATION.—An officer of the insurer shall certify to the State commissioner of insurance of its domiciliary State when it has met the enrollment limit under paragraph (1). Upon providing such certification, the insurer shall be relieved of its

open enrollment requirement under this section for the remainder of the calendar year.

(g) LIMITATION ON ACCEPTANCE OF CERTAIN CONFINED INDIVIDUALS.—An insurer shall not be required to accept under this section applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the insurer if the applicants were accepted, or to make the effective date of benefits for individuals or groups accepted under this section earlier than 90 days after the date of acceptance.

(h) NO APPLICATION TO INSOLVENT INSURERS.—The requirements of this section do not apply to any insurer that is in a state of supervision, insolvency, or liquidation. If the insurer demonstrates to the satisfaction of the State commissioner of insurance of the insurer's domiciliary State that the application of the requirements of this section would place the insurer in a State of supervision, insolvency, or liquidation, the commissioner may waive or modify the requirements of subsection (a) and (f). The actions of the commissioner under this subsection shall be effective for a period of not more than 1 year. At the expiration of such time, a new showing of need for a waiver or modification by the insurer shall be made before a new waiver or modification is issued or imposed.

(i) LIMITATION ON AGENT COMPENSATION.—No insurer shall pay or allow, or cause to be paid or allowed, and no agent shall accept, or agree to receive or accept, any commission, consideration, money, or other thing of value in excess of 5 percent of the premium charged for initial placement or for otherwise securing the issuance of, or in excess of 4 percent of the premium charged for the renewal of, a policy or contract issued to an individual or small employer group under this section. The Secretary may adopt such rules as are necessary to enforce this subsection.

(j) EXCLUSION OF CERTAIN POLICIES.—This section does not apply to any policy that provides coverage for specified diseases or accidents only or to any hospital indemnity, Medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than 6 months, or other policy that offers only supplemental benefits.

Subtitle C—Preemption of State Mandated Benefits, Anti-managed Care Laws, and State Insurance Standards

SEC. 121. PREEMPTION FROM STATE MANDATED BENEFITS.

Effective as of January 1, 1996, no State shall establish or enforce any law or regulation that—

(1) requires the offering, as part of health insurance coverage, of any services, category of care, or services of any class or type of provider; or

(2) specifies the individuals to be provided health insurance coverage or the duration of such coverage.

SEC. 122. PREEMPTION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.

Effective as of January 1, 1996—

(1) a State may not prohibit or limit an insurer or health benefit plan providing health coverage from including incentives for enrollees to use the services of participating providers;

(2) a State may not prohibit or limit such insurer or plan from limiting coverage of services to those provided by a participating provider;

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers by such insurer or plan with respect to health coverage;

(4) a State may not prohibit or limit such insurer or plan from limiting the number of participating providers; and

(5) a State may not prohibit or limit such insurer or plan from requiring that services be pro-

vided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers or from requiring enrollees to obtain referral in order to have coverage for treatment by a specialist or health institution.

SEC. 123. PREEMPTION OF STATE INSURANCE STANDARDS.

A State may not establish or enforce standards for health insurance coverage made available in the individual and small group markets that are different from the standards established under this title, unless the State has already established or has been enforcing such standards for health insurance coverage prior to the effective date of this title.

Subtitle D—Administrative Simplification

SEC. 131. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall adopt standards relating to each of the following:

(1) DATA ELEMENTS.—Data elements for use in paper and electronic claims processing under health benefit plans, as well as for use in utilization

review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

(2) UNIFORM CLAIMS FORMS.—Uniform claims forms (including uniform procedure and billing codes for use with such forms and including information or other health benefit plans that may be liable for benefits).

(3) UNIFORM ELECTRONIC TRANSMISSION.—Uniform electronic transmission of the date elements (for purposes of billing and utilization review).

The standards under paragraph (3) (relating to electronic transmission of data elements) for claims for services) shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) (relating to the submission of paper claims) for such services. The standards under paragraph (3) shall include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(b) USE OF TASK FORCES.—In adopting standards under this section, the Secretary shall—

(1) take into account the recommendations of current task forces;

(2) consult with the National Association of Insurance Commissioners (and, with respect to standards under subsection (a)(3), the American National Standards Institute); and

(3) to the maximum extent practicable, seek to make the standards consistent with any uniform clinical data sets which have been adopted and are widely recognized.

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

(1) subsection (a)(1) relating to claims processing data, by not later than 12 months after the date of the enactment of this Act;

(2) subsection (a)(2) (relating to uniform claims forms) by not later than 12 months after the date of the enactment of this Act; and

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of the enactment of this Act; and

(B) subsection (a)(3) relating to transmission of information on other services by such later date as the Secretary may determine it to be feasible.

SEC. 132. APPLICATION OF STANDARDS.

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 131 with respect to classes of services, that a significant number of claims for benefits for such services under health benefit plans are not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of such services must submit claims to health benefit plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection (a) for a class of services only if the Secretary finds that there would be a significant, measurable, additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

(1) IN GENERAL.—If the Secretary imposes the requirement under subsection (a)—

(A) in the case of a requirement that imposes the standards relating to electronic trans-

mission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health benefit plan shall transmit electronically and directly to the plan on behalf of the beneficiary involved a claim for such services in accordance with such standards;

(B) any health benefit plan may reject any claim subject to the standards adopted under section 131 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health benefit plan—

(i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards; or

(ii) to require, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 131; and

(D) the Secretary may impose a civil money penalty on any provider that knowingly

and repeatedly submits claims in violation of such standards or on any health benefit plan (other than a health benefit plan described in paragraph (2)) that knowingly, and repeatedly rejects claims in violation of subparagraph (B), in an amount not to exceed $100 for each such claim.

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraph (D) in the same manner as such provisions apply to penalty or proceeding under section 1128 of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan—

(A) that is subject to regulation by a State; and

(B) with respect to which the Secretary finds that—

(i) the State provides for application of the standards established under section 131; and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c), the plan shall permit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic manner that meets the requirements for acceptance of the claim under such subsection.

SEC. 133. PERIODIC REVIEW AND REVISION OF STANDARDS.

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 131;

(2) establish a schedule for the periodic review of such standards; and

(3) based upon such comments, suggestions, and review, revise such standards and promulgate such revisions.

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in section 131, then, in the case of any claim for benefits submitted under a health benefit plan more than

the minimum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a), such standards shall apply under section 132 instead of the standards previously promulgated.

Subtitle E—Restriction on Genetic Screening and Testing

SEC. 141. GENETIC SCREENING AND TESTING RESTRICTIONS IN HEALTH INSURANCE.

(a) IN GENERAL.—No insurer, in processing an application for coverage under a health benefit plan or in determining insurability under such plan, shall do any of the following:

(1) Require an individual seeking coverage to submit to genetic screening or testing (as defined in subsection (g)).

(2) Take into consideration, other than in accordance with subsection (f), the results of genetic screening or testing.

(3) Make any inquiry to determine the results of genetic screening or testing.

(4) Make a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.

(b) NO QUESTIONS.—In developing and asking questions regarding medical histories of applicants for an individual or group health benefit plan, no insurer shall ask for the results of genetic screening or testing or ask questions designed to ascertain the results of genetic screening or testing.

(c) NO CANCELLATION.—No insurer shall cancel or refuse to issue or renew coverage under a health benefit plan based on the results of genetic screening or testing.

(d) NO BENEFIT LIMITATION.—No insurer shall deliver, issue for delivery, or renew an individual or group health benefit plan that limits benefits based on the results of genetic screening or testing.

(e) USE OF VOLUNTARY TESTING.—Notwithstanding the previous provisions of this section, an insurer may consider the results of genetic screening or testing if the results are voluntarily submitted by an applicant for coverage or renewal of coverage and the results are favorable to the applicant.

(f) GENETIC SCREENING OR TESTING DEFINED.—As used in this section, the term ''genetic screening or testing'' means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a suscepti-

bility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

Subtitle F—Administrative Expenses

SEC. 151. LIMITATION ON ADMINISTRATIVE EXPENSES.

(a) IN GENERAL.—The following apply to every insurer with respect to administrative expenses for sickness and accident insurance business of the insurer offered in each State:

(1) For calendar year 1996, each insurer shall have aggregate administrative expenses for such business of no more than 40 percent of the premium income of the insurer for such business, based on the premiums received in that year on the sickness and accident insurance business of the insurer.

(2) For calendar year 1997, each insurer shall have aggregate administrative expenses of no more than 30 percent of the premium income of the insurer, based on the premiums received in that year on the sickness and accident insurance business of the insurer.

(3) For calendar year 1998, each insurer shall have aggregate administrative expenses of no more

than 25 percent of the premium income of the insurer, based on the premiums received in that year on the sickness and accident insurance business of the insurer.

(4) For calendar year 1999 and each calendar year thereafter, each insurer shall have aggregate administrative expenses of no more than 20 percent of the premium income of the insurer, based on the premiums received in that year on the sickness and accident insurance business of the insurer.

(b) ANNUAL STATEMENT.—Each insurer, during the first 2 months of each year (beginning with 1997), shall annually prepare, under oath, and deposit in the office of the commissioner of insurance of the insurer's State of domicile, a statement of the aggregate administrative expenses of the insurer, based on the premiums received in the immediately preceding calendar year on the sickness and accident insurance business of the insurer.

(c) DEFINITIONS.—As used in this section:

(1) ADMINISTRATIVE EXPENSE.—

(A) IN GENERAL.—The term ''Administrative expense'' means the amount of premiums received by the insurer for sickness and accident insurance business, minus the sum of the following:

(i) The amount of claims for losses paid.

(ii) The amount of losses incurred but not reported.

(iii) The amount paid for State fees, Federal and State taxes, and reinsurance.

(iv) The amount paid for commissions.

(B) EXCLUSION OF ERISA ITEMS.—Such term does not include any amounts collected, or administrative expenses incurred, by an insurer for the administration of an employee health benefit plan subject to regulation by the Employee Retirement Income Security Act of 1974. In the previous sentence, the term ''amount collected or administrative expenses incurred'' means the total amount paid to an administrator for the administration and payment of claims minus the sum of the amount of claims for losses paid and the amount of losses incurred but not reported.

(2) SICKNESS AND ACCIDENT INSURANCE BUSINESS.—The term ''sickness and accident insurance business'' does not include—

(A) coverage provided by an insurer for specific diseases or accidents only;

(B) any hospital indemnity, Medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than 6 months, or other policy that offers only supplemental benefits; or

(C) coverage provided to individuals who are not residents of the State involved.

Subtitle G—Limitations on Balance Billing

SEC. 161. MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1848(g)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(g)(2)(B)) is amended by striking ''115 percent'' and inserting ''105 percent''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to charges for items and services furnished on or after the first January 1 that occurs after the date of the enactment of this Act.

SEC. 162. OTHER PROGRAMS.

(a) IN GENERAL.—No provider shall balance bill any individual or dependent of an individual or any eligible employee or dependent of an employee for any health care supplies or services provided to the individual or dependent or the eligible employee or dependent, who is insured

under a health benefit plan. The provider shall accept payments made to it by the insurer under the terms of the plan insuring or covering such individual as payment in full for such health care supplies or services.

(b) BALANCED BILL DEFINED.—As used in this section, the term ''balance bill'' means charging or collecting an amount in excess of the amount reimbursable or payable under a health benefit plan for such health care supply or service. Such term does not include charging for or collecting copayments or deductibles required by the plan.

Subtitle H—Enforcement; General Definitions

SEC. 171. GENERAL ENFORCEMENT.

(a) INSURERS.—If a commissioner of insurance for an insurer's State of domicile determines that an insurer has failed to comply with a requirement of subtitle A, B, E, or F of this title applicable to the insurer, the commissioner is responsible for suspending the insurer's license to do the business of sickness and accident insurance in the State until the commissioner is satisfied that the insurer is in compliance with such requirements. If the insurer continues to do the business of sickness and accident insurance in the State while under the suspension order, the commissioner may impose a civil money penalty (speci-

fied by the commissioner) for each day of the violation. Any funds collected by the commissioner under the previous sentence shall be deposited into the State treasury to the credit of the operating fund for the commissioner.

(b) OTHER HEALTH BENEFIT PLANS.—Insofar as a requirement under subtitle A, B, or F of this title applies to a health benefit plan that is not offered by an insurer, the Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall take such actions as may be appropriate to ensure enforcement with such requirement. Such actions may include—

(1) an action in an appropriate court to enjoin violations of such requirements, and

(2) a civil money penalty (of not to exceed $50,000) for each violation of such a requirement.

SEC. 172. GENERAL DEFINITIONS.

As used in this title:

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

(2) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means an employee who works a normal work week of 25 or more hours. Such term does not include a temporary or substitute or seasonal employee who works only part of the calendar year.

(3) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means any contract or arrangement under which an entity bears all or part of the cost of providing health care items and services. Such term includes a hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer, but does not include any of the following:

(A) Coverage only for accident, dental, vision, disability, or long term care, Medicare supplemental health insurance, or any combination thereof.

(B) Coverage issued as supplemental to liability insurance.

(C) Workers' compensation or similar insurance.

(D) Automobile medical-payment insurance.

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

(F) Coverage for a specified disease or illness.

(4) HMO.—The term ''HMO'' means an organization that is recognized under State law as an

HMO or managed care organization or a similar organization regulated under State law for solvency and that offers health care services on a prepaid, at-risk basis primarily through a defined set of providers.

(5) INSURER.—The term ''Insurer'' means—

(A) a licensed insurance company;

(B) an entity offering prepaid hospital or medical services;

(C) an HMO; or

(D) a multiple small employer welfare arrangement or other combination of small employers associated for the purpose of providing health insurance plan coverage for their employers.

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

(7) SMALL EMPLOYER.—The term ''small employer'' means, with respect to a calendar year, an employer whose total employed work force consisted of, on at least 50 percent of its working days during the preceding year, more than 1 but less than 51 eli-

gible employees. For purposes of determining if an employer is a small employer, rules similar to the rules of subsections (B) of (C) of Section 414 of the Internal Revenue Code of 1986 shall apply.

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

TITLE II—EXTENSION OF PREVENTIVE PUBLIC HEALTH

SEC. 201. IMMUNIZATIONS AGAINST VACCINE-PREVENTABLE DISEASES.

Section 317(j)(1) of the Public Health Service Act (42 U.S.C. 247b(j)(1)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 202. PREVENTION, CONTROL, AND ELIMINATION OF TUBERCULOSIS.

Section 317E(g)(1)(A) of the Public Health Service Act (42 U.S.C. 247b–6(g)(1)(A)) is amended by striking ''through 1998'' and inserting ''through 1999''.

SEC. 203. LEAD POISONING PREVENTION.

Section 317A(l)(1) of the Public Health Service Act (42 U.S.C. 247b–1(l)(1)) is amended by striking ''through 1998'' and inserting ''through 1999''.

TITLE III—TAX PROVISIONS

SEC. 301. INCREASED DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) PHASE-IN OF INCREASED DEDUCTION.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

''(1) IN GENERAL.—

''(A) DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage for any taxable year beginning in a calendar year is the percentage determined in accordance with the following table:

Calendar year:	Applicable percentage:
1996	30 percent
1997	55 percent

1998	75 percent
1999 or any subsequent year	100 percent.''

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

SEC. 302. SAFE HARBOR FOR HEALTH CARE PROVIDERS OTHERWISE EXEMPT UNDER 501(c) (3) OR (4) WHICH AFFILIATE WITH CERTAIN HEALTH ENTITIES.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and inserting after subsection (m) the following new subsection:

''(n) SAFE HARBOR FOR HEALTH CARE PROVIDERS OTHERWISE EXEMPT UNDER SUBSECTION (c) (3) OR (4) WHICH AFFILIATE WITH CERTAIN HEALTH ENTITIES.—

''(1) IN GENERAL.—For purposes of this title, a health care provider shall not be treated as failing to be described in paragraph (3) or (4) of subsection (c) for any taxable year solely for the reason that such health care provider is affiliated with or controlled by a qualified health entity (through a management services agreement, joint venture, membership, or other arrangement) if such health care pro-

vider meets the requirements of paragraph (3) for such year.

"(2) BONDS ISSUED BY HEALTH CARE PROVIDERS OTHERWISE EXEMPT UNDER SUBSECTION (c)(3) WHICH AFFILIATE WITH CERTAIN HEALTH ENTITIES.—

"(A) IN GENERAL.—For purposes of this title, obligations issued by a health care provider shall not be treated as failing to be described in section 145(a) for any taxable year solely for the reason that such health care provider is affiliated with or controlled by a qualified health entity (through a management services agreement, joint venture, membership, or other arrangement) if such health care provider meets the requirements of paragraph (3) for such year.

"(B) SPECIAL RULES FOR MERGERS, CONSOLIDATIONS, AND PARTNERSHIPS.—For purposes of applying section 150 to an obligation described in subparagraph (A), if the affiliation or control referred to in subparagraph (A) is a merger or consolidation, or the creation of a partnership—

''(i) property owned by the entity resulting from such merger or consolidation (or by such partnership) shall be treated as owned by a 501(c)(3) organization to the extent that such property was owned, on the day preceding the affiliation date, by the 501(c)(3) organization issuing such obligation, and

''(ii) each trade or business of such resulting entity (or such partnership) shall be treated as a trade or business of a 501(c)(3) organization to the extent that such trade or business was conducted, on the day preceding the affiliation date, by the 501(c)(3) organization issuing such obligation.

''(C) AFFILIATION DATE.—For purposes of subparagraph (B), the term 'affiliation date' means—

''(i) with respect to a merger or consolidation, the date of such merger or consolidation, and

''(ii) with respect to a partnership, the date on which the property referred to in

section 150(b) is contributed to such partnership.

''(D) OBLIGATIONS ISSUED TO REFUND.—An obligation issued to refund an obligation described in subparagraph (A) shall be treated as described in subparagraph (A) if such refunding obligation meets the requirements of subclauses (I), (II), and (III) of section 144(a)(12)(A)(ii).

''(3) REQUIREMENTS.—A health care provider meets the requirements of this paragraph if, for the taxable year, such health care provider—

''(A)(i) assesses the health care needs of the community in which the health care provider is located,

''(ii) develops a written plan which states the manner in which the health care provider plans to meet such needs, consistent with the purpose of the health care provider, and

''(iii) makes the plan available in the same manner as a return filed under section 6033 is required to be made available under section 6104(e)(1),

''(B) maintains a board of directors or trustees, at least 50 percent of whom are representatives of the community in which the

health care provider is located, and at least 80 percent of whom receive no compensation (directly or indirectly) from the health care provider for the taxable year for medical services performed in connection with the health care provider or as an officer of the health care provider,

''(C) does not discriminate in the provision of health care services on the basis of whether an individual is insured by Medicare, Medicaid, or a health care provider who contracts with a State to provide health care services under a government-sponsored health plan, and

''(D) does not discriminate in the provision of emergency health care services on the basis of the patient's ability to pay.

''(4) DEFINITIONS.—For purposes of this subsection:

''(A) HEALTH CARE PROVIDER.—The term 'health care provider' means any person whose predominant activity is the provision of health care services.

''(B) HEALTH CARE SERVICES.—The term 'health care services' means any activity described in section 213(d)(1)(A).

"(C) QUALIFIED HEALTH ENTITY.—The term 'qualified health entity' means any organization—

"(i) the predominant activity of which is the provision of health care services, or

"(ii) a primary activity of which is the provision of insurance relating to such services,

either directly or through arrangements with health care providers, to individuals enrolled with the organization."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995, except that the requirements of section 501(n)(3)(B) of such Code (as added by this Act) shall apply to taxable years beginning after December 31, 1996.

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