

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

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Targeted Individual
5 Health Insurance Reform Act of 1995”.

1 **TITLE I—DEFINITIONS AND**
2 **SPECIAL RULES**

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Sec. 1001. General definitions.

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

3 **SEC. 1001. GENERAL DEFINITIONS.**

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

5 (1) DEPENDENT.—The term “dependent”
6 means, with respect to any individual, any person
7 who is—

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

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

12 (i) under 19 years of age, or

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

15 (2) EMPLOYER.—The term “employer” shall
16 have the meaning applicable under section 3(5) of
17 the Employee Retirement Income Security Act of
18 1974, except that such term includes the partnership
19 in relation to any partner.

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

1 ERISA Targeted Health Insurance Reform Act of
2 1995)), but does not include any type of coverage
3 excluded from the definition of health insurance cov-
4 erage under paragraph (6)(B).

5 (B) The term “plan” means a group health
6 plan (including any such plan which is a multiem-
7 ployer plan (as defined in section 3(37) of the Em-
8 ployee Retirement Income Security Act of 1974))
9 and an exempted multiple employer health plan
10 (within the meaning of part 7 of the Employee Re-
11 tirement Income Security Act of 1974 (as added by
12 the ERISA Targeted Health Insurance Reform Act
13 of 1995)).

14 (4) HEALTH INSURANCE COVERAGE.—

15 (A) IN GENERAL.—Except as provided in
16 subparagraph (B), the term “health insurance
17 coverage” means any hospital or medical service
18 policy or certificate, hospital or medical service
19 plan contract, or health maintenance organiza-
20 tion group contract offered by an insurer.

21 (B) EXCEPTION.—Such term does not in-
22 clude any of the following:

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

1 (ii) Medicare supplemental health in-
2 surance.

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

5 (iv) Liability insurance, including gen-
6 eral liability insurance and automobile li-
7 ability insurance.

8 (v) Worker's compensation or similar
9 insurance.

10 (vi) Automobile medical-payment in-
11 surance.

12 (vii) Coverage for a specified disease
13 or illness.

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

16 (5) INDIVIDUAL MARKET.—The term “individ-
17 ual market” means the health insurance market
18 under which individuals obtain health insurance cov-
19 erage on behalf of themselves (and their dependents)
20 and not on the basis of employment.

21 (6) INSURER.—(A) The term “insurer”
22 means—

23 (i) an insurance company, insurance serv-
24 ice, or insurance organization licensed to en-
25 gage in the business of insurance in a State, or

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

4 (B) HEALTH MAINTENANCE ORGANIZATION.—
5 The term ‘health maintenance organization’ means a
6 Federally qualified health maintenance organization
7 (as defined in section 1301(a) of the Public Health
8 Service Act), an organization recognized under State
9 law as a health maintenance organization, or a simi-
10 lar organization regulated under State law for sol-
11 vency in the same manner and to the same extent
12 as such a health maintenance organization.

13 (7) NAIC.—The term “NAIC” means the Na-
14 tional Association of Insurance Commissioners.

15 (8) NETWORK PLAN.—The term “network
16 plan” includes, as defined in standards established
17 under section 2101, an arrangement of an insurer
18 under which health services are offered to be pro-
19 vided primarily through a defined set of providers
20 who have contracts with the insurer.

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

1 (10) STATE COMMISSIONER OF INSURANCE.—
2 The term “State commissioner of insurance” in-
3 cludes a State superintendent of insurance.

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

9 (c) SECRETARY.—For purposes of this Act, except
10 with respect to references specifically to the Secretary of
11 Labor, the term “Secretary” means the Secretary of
12 Health and Human Services.

13 **SEC. 1002. GENERAL, CATASTROPHIC, AND MEDISAVE COV-**
14 **ERAGE DEFINED.**

15 (a) GENERAL COVERAGE.—In this Act, the term
16 “general coverage” means health insurance coverage that
17 meets the applicable standards provided for under section
18 2021 and that is not catastrophic coverage or medisave
19 coverage (as defined in this section).

20 (b) CATASTROPHIC COVERAGE.—In this Act, the
21 term “catastrophic coverage” means health insurance cov-
22 erage that meets the applicable standards provided for
23 under section 2101 and under which benefits are available
24 for a year only to the extent that expenses for covered
25 services in a year exceed a catastrophic deductible amount.

1 (c) MEDISAVE COVERAGE.—

2 (1) IN GENERAL.—In this Act, the term
3 “medisave coverage” means coverage that meets the
4 applicable standards provided for under section 2021
5 and—

6 (A) consists of—

7 (i) health insurance coverage under
8 which benefits are available for a year only
9 to the extent that expenses for covered
10 services in a year exceed a catastrophic de-
11 ductible amount; and

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

14 (B) meets such standards as may be pre-
15 scribed under section 2101.

16 (2) MEDISAVE CASH BENEFIT COVERAGE.—

17 (A) IN GENERAL.—Medisave cash benefit
18 coverage is considered to be consistent with this
19 paragraph to the extent that, in addition to and
20 separate from the benefits from the health in-
21 surance coverage described in paragraph
22 (1)(A)—

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

1 catastrophic deductible amount for the cata-
2 strophic coverage described in paragraph
3 (1)(A);

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

10 (iii) any such amount of benefits not
11 so used shall be accumulated, shall remain
12 available to be applied against future
13 deductibles, cost-sharing, and other ex-
14 penses, and may be withdrawn for any
15 purpose, or used to pay for coverage de-
16 scribed in paragraph (1)(A)(i), to the ex-
17 tent that the dollar amount exceeds 150
18 percent of the catastrophic deductible
19 amount for the catastrophic coverage de-
20 scribed in paragraph (1)(A), shall be non-
21 forfeitable, and, upon the death of all bene-
22 ficiaries with respect to such benefits, shall
23 be payable in cash to the estate of the ben-
24 eficiary who dies last; and

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

3 (B) PORTABILITY RULES.—In the case of
4 an individual who has medisave cash benefit
5 coverage with respect to which the requirements
6 of clauses (i), (ii), and (iii) of subparagraph (A)
7 are met in a year, who has accumulated an
8 amount of benefits under such coverage, and
9 who terminates such coverage (or terminates
10 enrollment under health insurance coverage
11 that contains medisave cash benefit coverage),
12 the coverage meets the portability rules of this
13 subparagraph if, under the terms of such cov-
14 erage, the individual is permitted (as elected by
15 the individual)—

16 (i) to have an amount equal to all or
17 some of the amount of benefits accumu-
18 lated under such coverage paid towards the
19 payment of premiums under any group
20 health plan or health insurance coverage
21 providing coverage for the individual, and

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

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

5 (d) CATASTROPHIC DEDUCTIBLE AMOUNT DE-
6 FINED.—

7 (1) IN GENERAL.—For purposes of this section,
8 subject to paragraph (2), the term “catastrophic de-
9 ductible amount” means a deductible amount that is
10 at least \$1,800 (or \$3,600 if the coverage includes
11 family members).

12 (2) ADJUSTMENTS.—In the case of any cal-
13 endar year after the first year to which this title II
14 applies, each dollar amount in paragraph (1) shall
15 be increased by the percentage by which (A) the av-
16 erage of the monthly consumer price indexes for all
17 urban consumers for the previous year, exceeds (B)
18 the average of the monthly consumer price indexes
19 for all urban consumers for such first year. If any
20 increase under the preceding sentence does not re-
21 sult in an amount that is a multiple of \$50, such in-
22 crease shall be rounded so that the amount is deter-
23 mined to the nearest multiple of \$50.

1 **TITLE II—ACCESS TO AND FAIR**
 2 **RATING OF HEALTH INSUR-**
 3 **ANCE COVERAGE FOR INDI-**
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1 **Subtitle A—Increased Availability**
2 **and Continuity of Health Insur-**
3 **ance Coverage for Individuals**

4 **PART 1—NONDISCRIMINATION, PORTABILITY,**
5 **AND RENEWABILITY STANDARDS**

6 **SEC. 2001. NONDISCRIMINATION AND LIMITATIONS ON**
7 **PREEXISTING CONDITION EXCLUSIONS.**

8 (a) IN GENERAL.—Except as provided in subsection
9 (b), an insurer offering health insurance coverage in the
10 individual market may deny, or impose a limitation or ex-
11 clusion of, covered benefits relating to treatment of a con-
12 dition based on health status, based on claims experience
13 of an individual, based on receipt of health care by an indi-
14 vidual, based on the medical history of an individual, or
15 based on the fact that the condition preexisted the effec-
16 tive date of coverage of the individual, only if—

17 (1) the condition relates to a condition that was
18 diagnosed or treated within a period of not to exceed
19 6 months before the date of such coverage; and

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

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

1 having had such coverage as of the beginning of the wait-
2 ing period.

3 (b) SPECIAL RULE FOR HEALTH INSURANCE COV-
4 ERAGE OFFERED IN THE INDIVIDUAL MARKET.—Not-
5 withstanding subsection (a), an insurer may offer an indi-
6 vidual health insurance coverage in the individual market
7 which imposes a limitation or exclusion based on a pre-
8 existing condition but only if—

9 (1) the condition relates to a condition that was
10 not diagnosed or treated within a period (that ex-
11 ceeds 6 months but does not exceed 12 months) be-
12 fore the date of such coverage; and

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

16 (c) NO COVERAGE OF SPECIFIC TREATMENT, PRO-
17 CEDURES, OR CLASSES REQUIRED.—Nothing in this sec-
18 tion may be construed to require the coverage of any spe-
19 cific procedure, treatment, or service as part of health in-
20 surance coverage under this Act or through regulation.

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

1 standing that it provides for an exclusion of the coverage
2 based on a preexisting condition consistent with the provi-
3 sions of this part so long as such exclusion is applied con-
4 sistent with the provisions of this part.

5 (e) APPLICABILITY TO LATE ENROLLMENT UNDER
6 ASSOCIATION COVERAGE.—In the case of association cov-
7 erage (as defined in section 2021(b)(4)(B)), this section
8 applies in the case of any individual with respect to whom
9 coverage is elected upon initially becoming eligible for cov-
10 erage or in connection with any subsequent enrollment pe-
11 riods.

12 (f) AFFILIATION PERIOD ALTERNATIVE TO PRE-
13 EXISTING CONDITION LIMITATION.—An insurer offering
14 health insurance coverage in the individual market which
15 does not use the preexisting limitations allowed under this
16 section and section 2002 may impose an affiliation period.
17 For purposes of this subsection, the term “affiliation pe-
18 riod” means a period—

19 (1) not to exceed 90 days in the case of an indi-
20 vidual first becoming eligible under such coverage,
21 and

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

1 during which no contributions or premiums are required
2 or collected and which must expire before the coverage be-
3 comes effective.

4 **SEC. 2002. PORTABILITY.**

5 (a) IN GENERAL.—Each insurer offering health in-
6 surance coverage in the individual market shall provide
7 that if a covered individual is in a period of continuous
8 coverage (as defined in subsection (c)) as of a date upon
9 which coverage takes effect, any period of exclusion of cov-
10 erage from covered benefits with respect to a preexisting
11 condition (as permitted to be excluded under section 2001)
12 shall be reduced by at least 1 month for each month in
13 the period of continuous coverage. A covered individual
14 may be treated by an insurer as not being in a period
15 of continuous coverage if, upon the request of the insurer,
16 the covered individual does not present satisfactory docu-
17 mentation of such period of continuous coverage. The Sec-
18 retary may prescribe regulations defining standards for
19 satisfactory documentation for purposes of this subsection.

20 (b) NO PREEXISTING CONDITION FOR NEWBORNS
21 AND ADOPTED CHILDREN.—For purposes of this sub-
22 title—

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

1 have any preexisting condition beginning at the time
2 of birth.

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

8 (c) PERIOD OF CONTINUOUS COVERAGE.—

9 (1) IN GENERAL.—In this part, the term “pe-
10 riod of continuous coverage” means the period—

11 (A) beginning on the date an individual be-
12 comes covered under a group health plan or
13 health insurance coverage (or coverage under a
14 public plan providing medical benefits), and

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

18 if such period is documented in such form and man-
19 ner as may be prescribed in regulations of the Sec-
20 retary.

21 (2) SPECIAL RULE.—For purposes of para-
22 graph (1), if the immediately preceding coverage for
23 an individual was obtained in the individual mar-
24 ket—

1 (A) the insurer may require that previous
2 coverage have provided for a period of at least
3 one year for such previous coverage to con-
4 stitute a period of continuous coverage; and

5 (B) an insurer may provide that the subse-
6 quent coverage under this section has a deduct-
7 ible which is not less than the deductible that
8 applied with respect to the immediately preced-
9 ing coverage.

10 **SEC. 2003. REQUIREMENTS RELATING TO RENEWABILITY**

11 **GENERALLY.**

12 (a) IN GENERAL.—An insurer may not cancel (or
13 deny renewal of) health insurance coverage in the individ-
14 ual market other than—

15 (1) for nonpayment of premiums,

16 (2) for fraud or other intentional misrepresen-
17 tation by the insured,

18 (3) for noncompliance with material plan provi-
19 sions, or

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

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

7 (c) LIMITATION ON REENTRY IN INDIVIDUAL MAR-
8 KET.—If an insurer ceases to offer health insurance cov-
9 erage or a type of coverage in an area with respect to the
10 individual market, the insurer may not offer such coverage
11 (or type of coverage) in the area in such market until 5
12 years after the date of the termination.

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

17 **PART 2—ENCOURAGEMENT OF STANDARDS-SET-**
18 **TING ORGANIZATIONS FOR PROVIDER NET-**
19 **WORKS AND UTILIZATION REVIEW**

20 **SEC. 2011. ENCOURAGEMENT OF STANDARDS-SETTING OR-**
21 **GANIZATIONS FOR PROVIDER NETWORKS.**

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

1 (b) STANDARDS.—

2 (1) IN GENERAL.—If the Secretary of Health
3 and Human Services determines that a private en-
4 tity has established standards for provider networks
5 providing items and services covered under health
6 insurance coverage offered by insurers in the individ-
7 ual market, in consultation with appropriate parties
8 (including representatives of health care providers,
9 specialists, insurers, plan administrators, and other
10 experts), and provides for a process for the periodic
11 review and update of such standards, such standards
12 shall be the standards applied under this section.

13 (2) CONTINGENCY.—If the Secretary of Health
14 and Human Services makes a determination con-
15 trary to the determination described in paragraph
16 (1), such Secretary shall submit such determination
17 in writing to each House of the Congress.

18 (c) REQUIREMENTS FOR STANDARDS.—The stand-
19 ards established under subsection (a) shall consist only of
20 standards relating to—

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

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

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

6 (A) without regard to whether or not the
7 provider furnishing such services has a contrac-
8 tual (or other) arrangement with the entity to
9 provide items or services to covered individuals,
10 and

11 (B) in the case of services furnished for
12 the treatment of an emergency medical condi-
13 tion, without regard to prior authorization, and
14 (3) the extent to which—

15 (A) standards (including criteria for qual-
16 ity, efficiency, credentialing, and services) are
17 established by the provider network for entering
18 into contracts (other than a contract providing
19 for employment of an employee) with health
20 care providers with respect to the provider net-
21 work,

22 (B) such standards are established pursu-
23 ant to a mechanism which provides for receipt
24 and consideration of recommendations of the

1 providers who are members of the provider net-
2 work,

3 (C) written notification to the provider is
4 required to terminate or to refuse to renew the
5 agreement and, unless otherwise provided in the
6 agreement and if requested by the provider,
7 written notification to the provider of the rea-
8 sons for such termination or refusal is also re-
9 quired, and

10 (D) unless otherwise provided in the agree-
11 ment and if requested by the provider, internal
12 review of any such decision to terminate or to
13 refuse renewal is provided for under the pro-
14 vider network.

15 (d) PROVIDER NETWORK.—For purposes of this sec-
16 tion, the term “provider network” means, with respect to
17 health insurance coverage provided by an insurer in the
18 individual market, providers who have entered into an
19 agreement under which such providers are obligated to
20 provide covered items and services to covered individuals.

21 **SEC. 2012. ENCOURAGEMENT OF PRIVATE STANDARDS-SET-**
22 **TING ORGANIZATIONS FOR UTILIZATION RE-**
23 **VIEW.**

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

1 ual market may not deny coverage of or payment for items
2 and services on the basis of a utilization review program
3 unless the program meets such standards as may be recog-
4 nized or established under this section.

5 (b) STANDARDS.—

6 (1) IN GENERAL.—If the Secretary of Health
7 and Human Services determines that a private en-
8 tity has established standards for utilization review
9 programs described in subsection (c), in consultation
10 with appropriate parties (including representatives
11 of health care providers, specialists, insurers, plan
12 administrators, and other experts), and provides for
13 a process for the periodic review and update of such
14 standards, such standards shall be the standards ap-
15 plied under this section.

16 (2) CONTINGENCY.—If the Secretary of Health
17 and Human Services makes a determination con-
18 trary to the determination described in paragraph
19 (1), such Secretary shall submit such determination
20 in writing to each House of the Congress.

21 (c) REQUIREMENTS FOR STANDARDS.—The stand-
22 ards established under subsection (a) shall consist only of
23 standards relating to—

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

4 (2) the process under which a covered individ-
5 ual or provider may obtain timely review of a denial
6 of coverage, including the extent to which a review
7 must be conducted by a medical director of the in-
8 surer or a physician designated by the insurer;

9 (3) the extent to which utilization review is to
10 be conducted in accordance with uniformly applied
11 standards that are based on currently available med-
12 ical evidence; and

13 (4) the extent to which providers are to partici-
14 pate in the development of the utilization review pro-
15 gram.

16 **PART 3—REQUIREMENTS FOR INSURERS PRO-**
17 **VIDING HEALTH INSURANCE COVERAGE IN**
18 **THE INDIVIDUAL MARKET**

19 **SEC. 2021. REQUIREMENT FOR INSURERS TO OFFER GEN-**
20 **ERAL, CATASTROPHIC, AND OPTIONAL**
21 **MEDISAVE COVERAGE IN THE INDIVIDUAL**
22 **MARKET.**

23 (a) REQUIREMENT.—

1 (1) IN GENERAL.—Each insurer that makes
2 available any health insurance coverage to individ-
3 uals in the individual market in a State—

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

11 (B) shall make available, to each eligible
12 individual in the individual market in the State,
13 catastrophic coverage (as defined in section
14 1002(b)), and

15 (C) may make available, to each eligible in-
16 dividual in the individual market in the State,
17 medisave coverage (as defined in section
18 1002(c)).

19 (2) SPECIAL RULE FOR HEALTH MAINTENANCE
20 ORGANIZATIONS.—The requirements of paragraph
21 (1)(A) (with regard to requiring a fee-for-service op-
22 tion) and paragraph (1)(B) shall not apply with re-
23 spect to health insurance coverage that is offered
24 by—

25 (A) a health maintenance organization, or

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

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

5 (A) FEE-FOR-SERVICE OPTION.—General
6 coverage is considered to provide a “fee-for-
7 service option” if benefits with respect to the
8 covered items and services in the coverage are
9 made available for such items and services pro-
10 vided through any lawful provider of such cov-
11 ered items and services.

12 (B) MANAGED CARE OPTION.—General
13 coverage is considered to provide a “managed
14 care option” if benefits with respect to the cov-
15 ered items and services in the coverage are
16 made available exclusively through a managed
17 care arrangement, except in the case of emer-
18 gency and urgent services and as otherwise re-
19 quired under law.

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

1 ered individual to obtain such benefits for items
2 and services provided through any lawful pro-
3 vider of such covered items and services. The
4 coverage may provide for different cost sharing
5 schedules based on whether the items and serv-
6 ices are provided through such an arrangement
7 or outside such an arrangement.

8 (4) CONSTRUCTION WITH RESPECT TO ASSOCIA-
9 TION COVERAGE.—Nothing in paragraph (1) or sub-
10 section (b)(1) shall be construed as requiring the
11 general, catastrophic, or medisave coverage made
12 available by an insurer in the individual market in
13 a State as association coverage (as defined in sub-
14 section (b)(4)(B)) to be the same as the general,
15 catastrophic, or medisave coverage offered in the
16 State in the individual market not as such associa-
17 tion coverage.

18 (b) ISSUANCE OF COVERAGE.—

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

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

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

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

8 (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,

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

10 (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.

1 (3) SPECIAL RULE FOR FINANCIAL CAPACITY
2 LIMITS.—An insurer may deny health insurance cov-
3 erage to individuals if the insurer demonstrates
4 that—

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

7 (B) it is applying this paragraph uniformly
8 to all individuals without regard to the health
9 status, claims experience, or duration of cov-
10 erage, and

11 (C) it shall not offer coverage to such indi-
12 viduals within such service area for a period of
13 at least 180 days after such coverage is denied.

14 (4) SPECIAL RULE FOR ASSOCIATION COV-
15 ERAGE.—

16 (A) IN GENERAL.—In the case of associa-
17 tion coverage (as defined in subparagraph (B))
18 in the individual market, an insurer may re-
19 strict the coverage to individuals who are bona
20 fide members in the association and who apply
21 for enrollment on a timely basis (consistent
22 with subparagraphs (B) through (F)).

23 (B) ASSOCIATION COVERAGE DEFINED.—
24 In this paragraph, the term “association cov-
25 erage” means coverage provided through an as-

1 society (such as a trade association, industry
2 association, or professional association) to its
3 members, but only if such association—

4 (i) has been (together with its imme-
5 diate predecessor, if any) organized and
6 maintained for a continuous period of not
7 less than 3 years before the date of the ini-
8 tiation of such coverage, and

9 (ii) is organized and maintained in
10 good faith, with a constitution and bylaws
11 specifically stating its purpose, for sub-
12 stantial purposes other than providing
13 such coverage.

14 (C) GENERAL INITIAL ENROLLMENT RE-
15 QUIREMENT.—Except as provided in subpara-
16 graphs (D) through (F), enrollment of an indi-
17 vidual for general, catastrophic, or medisave
18 coverage may be considered not to be timely if
19 the individual fails to enroll under such cov-
20 erage during an initial enrollment period, if
21 such period is at least 30 days long.

22 (D) ENROLLMENT DUE TO LOSS OF PRE-
23 VIOUS COVERAGE.—Enrollment under general,
24 catastrophic, or medisave coverage is considered
25 to be timely in the case of an individual who—

1 (i) was covered under a group health
2 plan or had other health insurance cov-
3 erage at the time of the individual's initial
4 enrollment period,

5 (ii) stated at the time of the initial en-
6 rollment period that coverage under a
7 group health plan or other health insur-
8 ance coverage was the reason for declining
9 enrollment,

10 (iii) lost coverage under a group
11 health plan or other health insurance cov-
12 erage (as a result of the termination of the
13 coverage, termination of employment, re-
14 duction or hours of employment, or other
15 reason other than a reason described in
16 paragraph (1) or (2) of section 2003(a)),
17 and

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

20 (E) REQUIREMENT APPLIES DURING OPEN
21 ENROLLMENT PERIODS.—Each insurer provid-
22 ing association coverage in the individual mar-
23 ket shall provide for at least one period (of not
24 less than 30 days) each year during which en-
25 rollment under such coverage shall be consid-

1 ered to be timely. A late enrollment penalty
2 may apply with respect to any subsequent pe-
3 riod (not to extend beyond the effective date of
4 the next such enrollment period).

5 (F) ENROLLMENT OF DEPENDENTS.—

6 (i) IN GENERAL.—If association cov-
7 erage includes coverage of dependents, en-
8 rollment of an individual who is a spouse
9 or child of a covered individual shall be
10 considered to be timely if a request for en-
11 rollment is made either—

12 (I) within 30 days of the date of
13 the marriage or of the date of the
14 birth or adoption of such child, if fam-
15 ily coverage is available as of such
16 date, or

17 (II) within 30 days of the date
18 family coverage is first made avail-
19 able.

20 (ii) COVERAGE.—If available associa-
21 tion coverage includes family coverage and
22 enrollment is made under such coverage on
23 a timely basis under clause (i)(I), the cov-
24 erage shall become effective not later than
25 the first day of the first month beginning

1 after the date the completed request for
2 enrollment is received.

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

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

13 (B) INSURANCE MECHANISMS.—The Sec-
14 retary shall request the NAIC to develop (in
15 consultation with the American Academy of Ac-
16 tuaries), within 12 months after the date of the
17 enactment of this Act, a definition of individ-
18 uals who would be expected to incur dispropor-
19 tionately high health care costs and mechanisms
20 relating to risk adjustment mechanisms, high-
21 risk pools, or other mechanisms to provide addi-
22 tional access to health insurance coverage for
23 such individuals. If the NAIC develops such a
24 definition and mechanisms within such period,
25 the Secretary shall review the definition and

1 mechanisms. Such review shall be completed
2 within 120 days after the date the definition
3 and mechanisms are developed. Unless the Sec-
4 retary determines within such period that such
5 definition and mechanisms do not meet the re-
6 quirements of this paragraph, such definition
7 and mechanisms shall serve as the definition
8 and mechanisms applicable under subparagraph
9 (A), with such amendments as the Secretary
10 deems necessary.

11 (c) DEFINITIONS.—In this section—

12 (1) the term “eligible individual”, at the elec-
13 tion of the insurer, may exclude an individual eligi-
14 ble for coverage under a group health plan; and

15 (2) the term “group health plan” has the mean-
16 ing given such term under section 3(42) of the Em-
17 ployee Retirement Income Security Act of 1974.

18 **SEC. 2022. USE OF FAIR RATING, UNIFORM MARKETING MA-**
19 **TERIALS, AND MISCELLANEOUS CONSUMER**
20 **PROTECTIONS.**

21 (a) USE OF FAIR RATING.—

22 (1) IN GENERAL.—As a standard under section
23 2101(a), subject to the succeeding paragraphs of
24 this subsection, the premium rates established by an
25 insurer for general, catastrophic, or medisave cov-

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

3 (A) AGE.—By age.

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

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

12 (D) BENEFIT DESIGN.—By benefit design
13 of coverage, including by type of coverage, such
14 as general, catastrophic, and medisave coverage
15 and by type of coverage option (described in
16 section 2021(a)(3)) with respect to general cov-
17 erage.

18 (E) 12-MONTH SURCHARGE FOR LESS RE-
19 STRICTIVE PRE-EXISTING CONDITION EXCLU-
20 SION.—By whether coverage is being provided
21 pursuant to section 2001(a) (relating to a less
22 restrictive pre-existing condition exclusion), and
23 which is not described in section 2001(b), but
24 only during the first 12 months in which such
25 coverage is provided.

1 (F) ADMINISTRATIVE CATEGORIES.—By
2 permitted expense category, based on dif-
3 ferences in expenses among such categories,
4 consistent with subsection (b).

5 (2) TREATMENT OF ASSOCIATIONS AS SEPA-
6 RATE POOLS.—

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

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

15 (3) TREATMENT OF PERMANENT HEALTH IN-
16 SURANCE POLICIES.—Paragraph (1) shall not apply
17 in connection with a permanent policy of health in-
18 surance existing on the effective date specified in
19 section 2104, if each individual covered under the
20 policy is given the option to convert the policy to a
21 policy of health insurance that is subject to this sub-
22 title and that meets the requirements of this section.

23 (4) ADDITIONAL VARIATIONS IN RENEWAL PRE-
24 MIUMS PERMITTED FOR CLAIMS EXPERIENCE WITH-
25 IN CLASS OF BUSINESS.—

1 (A) IN GENERAL.—Subject to the succeed-
2 ing provisions of this paragraph and unless an
3 alternative method is provided under standards
4 established under section 2021 with respect to
5 permissible variations for renewal premiums,
6 for a class of business of an insurer in the indi-
7 vidual market, with respect to individuals with
8 similar demographic and other similar objective
9 characteristics (not relating to claims experi-
10 ence, health status, occupation, or duration of
11 coverage since issue) for the same or similar
12 coverage, the insurer offering health insurance
13 coverage in the individual market may vary the
14 renewal premiums charged during a rating pe-
15 riod based on claims experience so long as the
16 highest rates which could be charged to such in-
17 dividuals under the rating system for that class
18 of business does not exceed the following per-
19 centage of the base premium rate for the class
20 of business for the rating period:

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

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

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

4 (B) LIMIT ON TRANSFER OF INDIVIDUALS
5 AMONG CLASSES OF BUSINESS.—In carrying
6 out subparagraph (A), an insurer offering
7 health insurance coverage in the individual mar-
8 ket may not involuntarily transfer an individual
9 into or out of a class of business. An insurer
10 providing such coverage may not offer to trans-
11 fer an individual into or out of a class of busi-
12 ness unless such offer is made to transfer all in-
13 dividuals in the class of business without regard
14 to demographic characteristics, claim experi-
15 ence, health status, occupation, or duration
16 since issue.

17 (C) DEFINITIONS.—In this paragraph:

18 (i) BASE PREMIUM RATE.—The term
19 “base premium rate” means, for each class
20 of business for each rating period, the low-
21 est premium rate charged or which could
22 have been charged under a rating system
23 for that class of business by the insurer to
24 individuals in the individual market with
25 similar demographic characteristics and

1 other similar objective characteristics (not
2 relating to claims experience, health status,
3 occupation, or duration of coverage since
4 issue) for the same or similar health insur-
5 ance coverage.

6 (ii) CLASS OF BUSINESS.—The term
7 “class of business” means, with respect to
8 an insurer, all (or a distinct group of) indi-
9 viduals in the individual market as shown
10 on the records of the insurer.

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

14 (I) an insurer offering health in-
15 surance coverage in the individual
16 market may establish, subject to
17 subclause (II), a distinct group of in-
18 dividuals on the basis that the appli-
19 cable health insurance coverage either
20 is marketed and sold through individ-
21 uals and organizations which are not
22 participating in the marketing or sale
23 of other distinct groups of individuals
24 for the insurer or has been acquired

1 from another insurer as a distinct
2 group; and

3 (II) such an insurer may not es-
4 tablish more than 2 groupings under
5 each class of business based on the in-
6 surer's use of managed-care tech-
7 niques if the techniques are expected
8 to produce substantial variation in
9 health care costs.

10 (iv) DEMOGRAPHIC CHARACTERIS-
11 TICS.—The term “demographic character-
12 istics” means age (based upon classes es-
13 tablished under paragraph (1)(A)), gender,
14 geographic area (based upon areas identi-
15 fied under paragraph (1)(B)), and family
16 composition (based upon family classes es-
17 tablished under paragraph (1)(C)).

18 (5) ADDITIONAL VARIATIONS IN INITIAL PRE-
19 MIUMS PERMITTED FOR UNDERWRITING CHARAC-
20 TERISTICS.—

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

1 tion, or duration of coverage since issue), for
2 the same or similar coverage, the insurer offer-
3 ing health insurance coverage in such market
4 may vary the initial premiums charged on the
5 basis of prior claims experience, health status,
6 occupation, and other underwriting characteris-
7 tics so long as the highest rates which could be
8 charged to such individuals under the rating
9 system for that class of business does not ex-
10 ceed the following percentage of the base pre-
11 mium rate for the class of business for the rat-
12 ing period:

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

16 (ii) For a rating (or portion thereof)
17 that occurs in a succeeding year, a per-
18 centage specified in any regulation of the
19 Secretary that may be prescribed under
20 paragraph (6).

21 (B) DEFINITIONS.—In this paragraph:

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

1 under a rating system for that class of
2 business by the insurer to individuals in
3 the individual market with similar demo-
4 graphic characteristics and other similar
5 objective characteristics (not relating to
6 claims experience, health status, occupa-
7 tion, or duration of coverage since issue)
8 for the same or similar health insurance
9 coverage.

10 (ii) OTHER DEFINITIONS.—Clause (ii)
11 (relating to class of business), clause (iii)
12 (relating to rules for establishing classes of
13 business), and clause (iv) (relating to de-
14 mographic characteristics) of paragraph
15 (4)(C) shall also apply with respect to this
16 paragraph.

17 (6) GRADUATED REDUCTION IN ALLOWABLE
18 PERCENTAGES OF BASE PREMIUM RATE.—The Sec-
19 retary shall request the NAIC to determine (in con-
20 sultation with the American Academy of Actuaries),
21 within 12 months after the date of the enactment of
22 this Act, whether model regulations that provide for
23 a schedule of graduated reductions in the percent-
24 ages of the base premium rates allowable under each
25 of paragraphs (4)(A)(ii) and (5)(A)(ii) can be devel-

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

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

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

1 ual, rating practices for health insurance coverage applica-
2 ble to that individual, including rating practices for dif-
3 ferent benefit designs offered to the individual.

4 (d) ACTUARIAL CERTIFICATION.—Each insurer that
5 offers health insurance coverage in the individual market
6 in a State shall file annually with the State commissioner
7 of insurance, to the extent required by such commissioner,
8 a written statement by a member of the American Acad-
9 emy of Actuaries (or other individual acceptable to the
10 commissioner) that, based upon an examination by the in-
11 dividual which includes a review of the appropriate records
12 and of the actuarial assumptions of the insurer and meth-
13 ods used by the insurer in establishing premium rates for
14 applicable health insurance coverage—

15 (1) the insurer is in compliance with the appli-
16 cable provisions of this section, and

17 (2) the rating methods are actuarially sound.

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

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

1 (f) **MARKETING MATERIAL.**—Each insurer that of-
2 fers any health insurance coverage in the individual mar-
3 ket in a State shall file with the State those marketing
4 materials relating to the offer and sale of health insurance
5 coverage to be used for distribution before the materials
6 are used. Such materials shall be in a uniform format,
7 as may be provided under standards established under sec-
8 tion 2101.

9 **Subtitle B—Establishment of**
10 **Standards; Enforcement; Effec-**
11 **tive Dates**

12 **SEC. 2101. ESTABLISHMENT OF STANDARDS.**

13 (a) **ROLE OF NAIC.**—

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

19 (2) **REVIEW BY SECRETARY.**—If the NAIC de-
20 velops recommended regulations specifying the
21 standards with respect to the requirements of sub-
22 title A within the 12-month period referred to in
23 paragraph (1), the Secretary shall review the stand-
24 ards. Such review shall be completed within 120
25 days after the date the regulations are developed.

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

5 (A) the standards do not effectively provide
6 for the application of requirements of sections
7 2001, 2002, and 2003 to insurers in a manner
8 and to an extent equivalent in substance to the
9 manner and extent to which the requirements
10 apply to group health plans under section 821
11 of the Employee Retirement Income Security
12 Act of 1974 (as added by the ERISA Targeted
13 Health Insurance Reform Act of 1995), or

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

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

19 (4) REQUIREMENTS RELATING TO MANAGED
20 CARE AND UTILIZATION REVIEW.—If the Secretary
21 determines under section 2011(b)(1) that a private
22 entity has established standards for provider net-
23 works consistent with section 2011(c), the standards
24 established under this section with respect to the re-
25 quirements of section 2011 shall consist of the

1 standards recognized or established under section
2 2011. If the Secretary determines under section
3 2012(b)(1) that a private entity has established
4 standards for utilization review programs that are
5 consistent with section 2012(c), the standards estab-
6 lished under this section with respect to the require-
7 ments of section 2012 shall consist of the standards
8 recognized or established under section 2012.

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

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

19 (c) DEFINITIONS.—In this title, the term “section
20 2101 standards” means the standards established under
21 this section.

22 **SEC. 2102. ENFORCEMENT.**

23 (a) VOLUNTARY ENFORCEMENT BY STATES.—

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

1 insurers shall submit to the Secretary of Health and
2 Human Services, by the deadline specified in para-
3 graph (2), a report on the program the State has es-
4 tablished by such deadline and consistent with sec-
5 tion 2104 to implement and enforce such standards.

6 (2) DEADLINE.—

7 (A) 1 YEAR AFTER FINAL MODEL REGULA-
8 TIONS.—Subject to subparagraph (B), the
9 deadline under this paragraph is 1 year after
10 the date model regulations are established
11 under section 2101.

12 (B) EXCEPTION FOR LEGISLATION.—In
13 the case of a State which the Secretary of
14 Health and Human Services identifies, in con-
15 sultation with the NAIC, as—

16 (i) requiring State legislation (other
17 than legislation appropriating funds) in
18 order for insurers to meet the section 2101
19 standards provided under such model regu-
20 lations, but

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

1 the date specified in this paragraph is the first
2 day of the first calendar quarter beginning after
3 the close of the first legislative session of the
4 State legislature that begins on or after Janu-
5 ary 1, 1997. For purposes of the previous sen-
6 tence, in the case of a State that has a 2-year
7 legislative session, each year of such session
8 shall be deemed to be a separate regular session
9 of the State legislature.

10 (3) NO FEDERAL MANDATE ON STATES.—Noth-
11 ing in this subsection shall be construed as imposing
12 a requirement on a State. The establishment by a
13 State of an enforcement program under this sub-
14 section is voluntary.

15 (b) FEDERAL ROLE.—

16 (1) STATE ENFORCEMENT EXCLUSIVE OF FED-
17 ERAL ENFORCEMENT.—If the Secretary determines
18 that a State has submitted a report by the deadline
19 specified under subsection (a)(2) and finds that the
20 State has provided for implementation and enforce-
21 ment of the section 2101 standards, such implemen-
22 tation and enforcement shall be carried out exclu-
23 sively under State law.

24 (2) REVIEW OF STATE ENFORCEMENT PRO-
25 GRAMS.—If the Secretary determines that a State

1 has submitted a report by the deadline specified
2 under subsection (a)(2) but finds that the State pro-
3 gram does not provide for implementation and en-
4 forcement of the section 2101 standards, the Sec-
5 retary shall notify the State and provide the State
6 a period of 60 days in which to provide for changes
7 that assure such implementation and enforcement of
8 such standards.

9 (3) CONTINGENCY.—If the Secretary deter-
10 mines that a State has not submitted a report by
11 the deadline specified under subsection (a)(2) or, in
12 the case of a State described in paragraph (1), the
13 State has not provided for an implementation and
14 enforcement program after the period of 60 days
15 specified in such paragraph, the Secretary shall pro-
16 vide for such mechanism for the implementation and
17 enforcement of the section 2101 standards in the
18 State (including the application of civil money pen-
19 alties under paragraph (3)) as the Secretary deter-
20 mines to be appropriate. Any such implementation
21 and enforcement shall cease to be effective on the
22 date the Secretary finds that a State has established
23 an implementation and enforcement program de-
24 scribed in subsection (a)(1).

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

3 (A) IN GENERAL.—If the Secretary is pro-
4 viding for implementation and enforcement of
5 section 2101 standards under paragraph (2)
6 and determines that an insurer has failed to
7 comply with such standards applicable to the
8 insurer, the Secretary may impose on the in-
9 surer a civil money penalty of not to exceed
10 \$25,000 for each such failure. Under regula-
11 tions of the Secretary, provisions consistent and
12 coextensive with section 1128A of the Social Se-
13 curity Act (other than the first sentence of sub-
14 section (a) of such section and other than sub-
15 section (b) of such section) shall apply to a civil
16 money penalty under this paragraph in the
17 same manner as such section applies to a pen-
18 alty or proceeding under section 1128A(a) of
19 such Act.

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

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

1 (ii) such failure is corrected within the
2 30-day period beginning on the earliest
3 date the insurer knew, or exercising rea-
4 sonable diligence would have known, that
5 such failure existed.

6 (c) GOOD FAITH COMPLIANCE WITH REQUIRE-
7 MENT.—An insurer that complies in good faith with an
8 applicable requirement of subtitle A shall not be subject
9 to a penalty under this section for failure to meet such
10 requirement on the basis of its failure to meet section
11 2101 standards (or regulations to carry out such stand-
12 ards) for any failure that occurs before the date such
13 standards (or regulations) have been published and be-
14 come effective.

15 (d) TREATMENT OF POLICY APPROVAL BY DOMICILE
16 STATE.—If a particular policy or contract of health insur-
17 ance coverage offered by an insurer is approved in a State
18 that has adopted and is enforcing section 2101 standards
19 and that is the domicile State with respect to the insurer,
20 the policy or contract shall be deemed to meet such stand-
21 ards with respect to any other State but only if a copy
22 of the approval by the domicile State is filed by the insurer
23 with the applicable regulatory authority of such other
24 State at least 60 days before the date the policy or con-
25 tract is offered, sold, or issued in that other State.

1 **SEC. 2103. PREEMPTION.**

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

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

15 (c) PROHIBITION OF STATE BENEFIT MANDATES.—

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

18 (A) health insurance coverage in the indi-
19 vidual market to provide coverage of one or
20 more specific benefits, services, or categories of
21 health care, or services of any class or type of
22 provider of health care; or

23 (B) an insurer (in relation to health insur-
24 ance coverage offered in the individual market)
25 to provide coverage of one or more specific ben-
26 efits, services, or categories of health care, or

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

3 (2) EXCEPTION.—

4 (A) STATE ENFORCEMENT PROGRAMS.—
5 Paragraph (1) shall not apply a State enforce-
6 ment program under section 2102.

7 (B) CERTAIN POLICIES.—Notwithstanding
8 subsection (a), a State may require an insurer
9 (in relation to health insurance coverage offered
10 in the individual market) to provide coverage of
11 one or more specific benefits, services, or cat-
12 egories of health care, or services of any class
13 or type of provider of health care, but only with
14 respect to—

15 (i) not more than 2 policies or con-
16 tracts of health insurance coverage, one of
17 which provides less comprehensive coverage
18 than the other, and

19 (ii) policies for which the State pro-
20 vides subsidies to individuals to purchase
21 such coverage.

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

24 (1) PREEMPTION OF STATE LAW PROVISIONS.—

25 Subject to paragraph (2)(C), the following provisions

1 of State law are preempted and may not be en-
2 forced:

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

6 (i) restricts the ability of an insurer
7 offering health insurance coverage in the
8 individual market to negotiate reimburse-
9 ment rates or forms of payments with pro-
10 viders,

11 (ii) restricts the ability of such an in-
12 surer to limit the number of participating
13 providers, or

14 (iii) requires standards inconsistent
15 with any standards established under sec-
16 tion 2011(b).

17 (B) RESTRICTIONS ON UTILIZATION RE-
18 VIEW METHODS.—Any State law that, in rela-
19 tion to a health insurance coverage offered in
20 the individual market—

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

1 preauthorization of ambulatory procedures,
2 and retrospective review),

3 (ii) requires that such review be made
4 (I) by a resident of the State in which the
5 treatment is to be offered or by an individ-
6 ual licensed in such State, or (II) by a
7 physician in any particular specialty or
8 with any board certified specialty of the
9 same medical specialty as the provider
10 whose services are being reviewed,

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

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

18 (v) imposes liability for delays in per-
19 forming such review, or

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

1 **SEC. 2104. EFFECTIVE DATE.**

2 The requirements of subtitle A and the preemption
3 provisions of section 2103, shall apply with respect to in-
4 surers on January 1, 1998.

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