

ERISA TARGETED HEALTH INSURANCE REFORM ACT OF  
1996

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MARCH 25, 1996.—Ordered to be printed  
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Mr. GOODLING, from the Committee on Economic and Educational  
Opportunities, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany H.R. 995]

[Including cost estimate of the Congressional Budget Office]

The Committee on Economic and Educational Opportunities, to whom was referred the bill (H.R. 995) to amend the Employee Retirement Income Security Act of 1974 to provide new portability, participation, solvency, claims, and other consumer protections and freedoms for workers in a mobile workforce; to increase purchasing power for employers and employees by removing barriers to the voluntary formation of multiple employer health plans and fully-insured multiple employer arrangements; to increase health plan competition providing more affordable choice of coverage by removing restrictive State laws relating to provider health networks, employer health coalitions, and insured plans and the offering of medisave plans; to expand access to fully-insured coverage for employees of small employers through fair rating standards and open markets, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "ERISA Targeted Health Insurance Reform Act of 1996".

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## TITLE I—INCREASED AVAILABILITY AND CONTINUITY OF GROUP HEALTH PLAN COVERAGE FOR EMPLOYEES AND THEIR FAMILIES

### SEC. 101. DEFINITION OF GROUP HEALTH PLAN.

(a) IN GENERAL.—Section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

“(42) Except as otherwise provided in this title, the term ‘group health plan’ means an employee welfare benefit plan to the extent that the plan provides medical care (within the meaning of section 607(1)) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.”.

(b) INCLUSION OF CERTAIN PARTNERS AND SELF-EMPLOYED SPONSORS IN DEFINITION OF PARTICIPANT.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended—

(1) by inserting “(A)” after “(7)”; and

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

“(B) In the case of a group health plan, such term includes—

“(i) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

“(ii) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual, if such individual is or may become eligible to receive a benefit under the plan or such individual’s beneficiaries may be eligible to receive any such benefit.”.

**SEC. 102. ACCESS TO, AND CONTINUITY OF, GROUP HEALTH PLAN COVERAGE.**

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

**“PART 8—ACCESS TO, AND CONTINUITY OF, GROUP HEALTH PLAN COVERAGE**

**“SEC. 800. DEFINITIONS AND SPECIAL RULES.**

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

“(1) EMPLOYER.—The term ‘employer’ shall have the meaning applicable under section 3(5), except that such term includes the partnership in relation to any partner.

“(2) FULLY INSURED.—The term ‘fully insured’ shall have the meaning applicable under section 701(1).

“(3) HEALTH INSURANCE COVERAGE.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘health insurance coverage’ means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer or a health maintenance organization, to the extent of the benefits under such policy, certificate, or contract consisting of medical care, provided directly, through insurance or reimbursement, or otherwise.

“(B) EXCEPTION.—Such term does not include coverage under any separate policy, certificate, or contract only for one or more of any of the following:

“(i) Coverage for accident, dental, vision, disability income, on-site medical clinics, employee assistance programs, or long-term care insurance, or any combination thereof.

“(ii) Medicare supplemental health insurance (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) and similar supplemental coverage provided under a group health plan.

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

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

“(v) Worker’s compensation or similar insurance.

“(vi) Automobile medical-payment insurance.

“(vii) Coverage consisting of benefit payments made on a periodic basis for a specified disease or illness or period of hospitalization, without regard to the costs incurred or services rendered during the period to which the payments relate.

“(viii) Such other purpose as the Secretary may prescribe by regulation.

“(4) HEALTH MAINTENANCE ORGANIZATION.—The term ‘health maintenance organization’ means a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

“(5) INSURER.—The term ‘insurer’ means an insurance company, insurance service, or insurance organization licensed to engage in the business of insurance in a State.

“(6) MEDICAL CARE.—The term ‘medical care’ means medical care within the meaning of section 607(1).

“(7) NETWORK PLAN.—The term ‘network plan’ means an arrangement of an insurer or a health maintenance organization under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the insurer or health maintenance organization.

“(b) COVERAGE.—This part shall apply in the case of a group health plan for any plan year only if such group health plan has two or more participants as current employees on the first day of such plan year.

“(c) SPECIAL RULES PROVIDING FOR TREATMENT AS GROUP HEALTH PLAN.—

“(1) An employee welfare benefit plan shall be treated as a group health plan under this part only with respect to medical care (within the meaning of section 607(1)) which is provided under the plan and which does not consist of coverage excluded from the definition of health insurance coverage under subsection (a)(3)(B).

“(2) Any plan, fund, or program which would not be (but for this paragraph) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (within the meaning of section 607(1)) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (1)) as an employee welfare benefit plan which is a group health plan.

### **“Subpart A—Preexisting Condition Limitations, Portability, and Renewability**

“SEC. 801. LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS.

“(a) TIME CONSTRAINTS ON LIMITATIONS OR EXCLUSIONS BASED ON PREEXISTING CONDITIONS.—

“(1) IN GENERAL.—A group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, may provide a limitation on, or exclusion of, the benefits of a participant or beneficiary otherwise available under the terms of the plan based on a preexisting condition only if the limitation or exclusion does not extend beyond—

“(A) in the case of a participant or beneficiary whose initial coverage commences at the time such participant or beneficiary first becomes eligible for coverage under the plan, 12 months after the effective date of such coverage, or

“(B) in the case of a participant or beneficiary whose initial coverage commences pursuant to an election made after the period in which the election may first be made, 18 months after the effective date of such coverage.

“(2) PREEXISTING CONDITION.—For purposes of paragraph (1), the term ‘preexisting condition’ means a medical condition which was diagnosed, or which was treated—

“(A) in the case of a participant or beneficiary described in paragraph (1)(A), within the 6-month period preceding the effective date of the coverage of such participant or beneficiary (as determined by disregarding any applicable waiting period), or

“(B) in the case of a participant or beneficiary described in paragraph (1)(B), within the 12-month period preceding the effective date of the coverage of such participant or beneficiary (as determined by disregarding any applicable waiting period).”.

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

“(d) APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization that offers health insurance coverage shall not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwithstanding that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provisions of this subpart, so long as such exclusion is applied in a manner and to an extent consistent with the provisions of this subpart.

“(e) ELIGIBILITY PERIOD IMPOSED BY HEALTH MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXISTING CONDITION LIMITATION.—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not use the preexisting condition limitations allowed under this section and section 802 with respect to any particular coverage option may impose an eligibility period for such coverage option, but only if such period does not exceed—

“(1) 90 days, in the case of a participant or beneficiary whose initial coverage commences at the time such participant or beneficiary first becomes eligible for coverage under the plan, or

“(2) 180 days, in the case of a participant or beneficiary whose initial coverage commences after the date on which such participant or beneficiary first becomes eligible for coverage.

For purposes of this subsection, the term ‘eligibility period’ means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. Any such eligibility period shall be treated for purposes of this subpart as a waiting period under the plan and shall run concurrently with any other applicable waiting period under the plan.

**“SEC. 802. PORTABILITY.**

“(a) IN GENERAL.—Each group health plan, and each insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, shall provide that if a participant or beneficiary is in a period of continuous coverage (as defined in subsection (e)) as of a date upon which coverage takes effect under the plan, any period of limitation on, or exclusion of, covered benefits in connection with a preexisting condition (as permitted under section 801) shall be reduced by 1 month for each month in the period of continuous coverage.

“(b) CONSTRUCTION.—Nothing in this section shall be construed to prohibit a limitation on, or exclusion of, any benefit of a participant or beneficiary otherwise available under the terms of the plan based on a preexisting condition, subject to the limits in section 801(a), if such benefit was not previously provided under the group health plan or health insurance coverage (or coverage consisting of medical care under title XIX of the Social Security Act) under which the individual was covered at the end of the period of continuous coverage referred to in subsection (a).

“(c) DOCUMENTATION.—A participant or beneficiary may be treated by a group health plan, or by an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, as not being in a period of continuous coverage if, upon the request of the plan or of the insurer or health maintenance organization (as the case may be), the participant or beneficiary does not present satisfactory documentation of such period of continuous coverage. The Secretary may prescribe regulations defining standards for satisfactory documentation for purposes of this subsection.

“(d) NO PREEXISTING CONDITION FOR NEWBORNS AND ADOPTED CHILDREN.—For purposes of this subpart—

“(1) NEWBORNS.—A child who, within the 30-day period beginning with the date of birth, becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or coverage consisting of medical care under title XIX of the Social Security Act) and remains thereafter in a period of continuous coverage shall not be considered, beginning at the time of birth, to have any preexisting condition.

“(2) ADOPTED CHILDREN.—An adopted child or a child placed for adoption (within the meaning of section 609(c)(3)(B)) who, within the 30-day period beginning on the date of adoption or placement, becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or coverage providing medical care under title XIX of the Social Security Act) and remains thereafter in a period of continuous coverage shall not be considered, beginning at the time of adoption or placement, to have any preexisting condition.

“(e) PERIOD OF CONTINUOUS COVERAGE.—For purposes of this subpart, the term ‘period of continuous coverage’ means the period—

“(1) beginning on the date an individual becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or coverage consisting of medical care under title XIX of the Social Security Act), and

“(2) ending on the date the individual does not have such coverage for a continuous period of more than 60 days.

**“SEC. 803. REQUIREMENTS FOR RENEWABILITY OF COVERAGE.**

“(a) MULTIPLE EMPLOYER PLANS, MULTIPLE EMPLOYER HEALTH PLANS, AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—A group health plan which is a multiemployer plan or a multiple employer health plan (as defined in section 701(4)), and a multiple employer welfare arrangement (to the extent to which benefits under the arrangement consist of medical care and are fully insured), may not deny an employer whose employees are covered under such a plan or arrangement continued

access to the same or different coverage under the terms of such a plan or arrangement, other than—

“(1) for nonpayment of contributions,

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

“(3) for noncompliance with material plan or arrangement provisions,

“(4) because the plan or arrangement is ceasing to offer any coverage in a geographic area,

“(5) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement,

“(6) in the case of a plan or arrangement to which subparagraph (C), (D), or (E) of section 3(40) applies, to the extent necessary to meet the requirements of such subparagraph, or

“(7) in the case of a multiple employer health plan (as defined in section 701(4)), for failure to meet the requirements under part 7 for exemption under section 514(b)(6)(B).

Nothing in this subsection shall be construed to preclude any such plan or arrangement from establishing employer contribution requirements or group participation requirements not otherwise prohibited by this Act.

“(b) INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS.—

“(1) IN GENERAL.—In any case in which an insurer or a health maintenance organization is providing health insurance coverage in connection with a group health plan, the insurer or health maintenance organization may not deny an employer whose employees are covered under such plan continued access to health insurance coverage provided by such insurer or health maintenance organization, other than—

“(A) for nonpayment of premiums or contributions in accordance with the terms of the health insurance coverage,

“(B) for any act or practice constituting fraud or other intentional misrepresentation under the terms of the health insurance coverage,

“(C) for noncompliance with material plan provisions relating to participation or employer contributions, or

“(D) subject to paragraph (3), because the insurer or health maintenance organization is ceasing to offer any such coverage in a State, or, in the case of a network plan (as defined in section 800(a)(7)), in a geographic area.

“(2) DISCONTINUANCE OF OFFERED HEALTH INSURANCE COVERAGE.—In any case in which a policy, certificate, or contract referred to in section 800(a)(3) is no longer being offered in connection with group health plans by an insurer or health maintenance organization, health insurance coverage as defined by such policy, certificate, or contract may be discontinued by the insurer or health maintenance organization in connection with any group health plan upon the offer to the plan sponsor of an option to purchase any other health insurance coverage currently being offered in connection with group health plans, if the offer of such option is made uniformly in connection with group health plans.

“(3) NOTICE REQUIREMENT FOR MARKET EXIT.—Paragraph (1)(D) shall not apply to an insurer or health maintenance organization ceasing to offer coverage unless the insurer provides notice of such termination to employers and individuals covered at least 180 days before the date of termination of coverage.

“(4) EXCEPTION TO REQUIREMENT FOR RENEWABILITY OF COVERAGE BY REASON OF FAILURE BY PLAN TO MEET CERTAIN MINIMUM PARTICIPATION RULES.—

“(A) IN GENERAL.—Paragraph (1) shall not apply in the case of any group health plan with respect to which participation rules of an insurer or health maintenance organization which are described in subparagraph (B) are not met.

“(B) PARTICIPATION RULES.—For purposes of subparagraph (A), participation rules (if any) of an insurer or health maintenance organization shall be treated as met with respect to a group health plan only if such rules are uniformly applicable and in accordance with applicable State law and the number or percentage of eligible individuals who, under the plan, are participants or beneficiaries equals or exceeds a level which is determined in accordance with such rules.

“SEC. 804. GROUP HEALTH PLAN ENROLLMENT REQUIREMENTS.

“(a) ENROLLMENT PERIODS.—

“(1) ANNUAL PERIOD.—A group health plan shall provide for at least one annual open enrollment period (of not less than 30 days) each year during which—

“(A) employees who are eligible for coverage under the terms of the plan who are not otherwise covered may elect to be covered under at least one benefit option, and

“(B) if family coverage is available, employees who are covered but who do not have family coverage may elect family coverage.

“(2) ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO LOSE OTHER COVERAGE.—A group health plan shall permit an uncovered employee who is otherwise eligible for coverage under the terms of the plan (or an uncovered dependent, as defined under the terms of the plan, of such an employee, if family coverage is available) to enroll for coverage under the plan under at least one benefit option if—

“(A) the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual,

“(B) the employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment,

“(C) the employee or dependent lost coverage under a group health plan or health insurance coverage (as a result of loss of eligibility for the coverage, termination of employment, or reduction in the number of hours of employment), and

“(D) the employee requests such enrollment within 30 days after termination of such coverage.

“(b) DEPENDENTS.—

“(1) IN GENERAL.—If a group health plan makes family coverage available, the plan may not require, as a condition of coverage of a beneficiary of a participant in the plan, a waiting period applicable to the coverage of a beneficiary who is a newborn or an adopted child or child placed for adoption (within the meaning of section 609(c)(3)(B)), at the time of adoption or placement, or a spouse, at the time of marriage, if the participant has met any waiting period applicable to that participant.

“(2) TIMELY ENROLLMENT.—

“(A) IN GENERAL.—Enrollment of a participant’s beneficiary described in paragraph (1) shall be considered to be timely if a request for enrollment is made either—

“(i) within 30 days of the date of the marriage with such a beneficiary who is the spouse of the participant, or within 30 days of the date of the birth, adoption, or placement for adoption of such a beneficiary who is a child of the participant, if family coverage is available as of such date, or

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

“(B) COVERAGE.—If available coverage includes family coverage and enrollment is made under such coverage on a timely basis under subparagraph (A)(i), the coverage shall become effective not later than the first day of the first month beginning 15 days after the date the completed request for enrollment is received.

“(c) DENIAL OF ENROLLMENT BASED ON PREEXISTING CONDITION PROHIBITED.—A group health plan, and an insurer or health maintenance organization providing health insurance coverage in connection with a group health plan, may not exclude an employee or his or her beneficiary from enrollment under the plan on the basis of a preexisting condition (as defined in section 801(a)(2), but regardless of the period within which the condition was diagnosed or treated).”

(b) TREATMENT OF GOVERNMENTAL PLANS.—

(1) COVERAGE.—Section 4(b)(1) of such Act (29 U.S.C. 1003(b)(1)) is amended by inserting “except with respect to sections 801 and 802,” after “(1)”.

(2) VOLUNTARY ELECTION WITH RESPECT TO GOVERNMENTAL PLANS.—Section 4 of such Act is amended further by adding at the end the following new subsection:

“(c) If the plan sponsor of a governmental plan which is a group health plan to which sections 801 and 802 apply makes an election under this paragraph for any specified period (in such form and manner as the Secretary may by regulations prescribe), then the provisions of sections 801 and 802 shall not apply to such governmental plans for such period as if the exception in subsection (b)(1) relating to sections 801 and 802 did not apply with respect to such plan for such period.”

(3) INAPPLICABILITY OF PORTABILITY TO PARTICIPANTS OF NON-ELECTING PLANS.—Section 802 of such Act (as added by subsection (a) of this section) is amended by adding at the end the following new subsection:

“(f) INAPPLICABILITY OF PORTABILITY TO PARTICIPANTS OF NON-ELECTING PLANS.—A group health plan shall not be treated as failing to meet the requirements of this section solely because, in determining whether there is a period of continuous coverage, the plan disregards coverage under any other group health plan that is a governmental plan or church plan which is not subject to this section or section 801.”.

(c) ENFORCEMENT WITH RESPECT TO INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking “subsection (c)(2) or (i) or (l)” and inserting “paragraph (2) or (5) of subsection (c) or subsection (i) or (l)”; and

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

“(5) The Secretary shall enforce under this part the requirements of section 801, 802, or 803 with respect to any entity which is an insurer or health maintenance organization and which is subject to regulation by any State permitted under section 514 only if the Secretary determines—

“(A)(i) with respect to section 801 or 802, that such State has not provided for effective enforcement of State laws which govern the same matters as are governed by such section 801 or 802, respectively (as described in section 514(c)) and which are not superceded by reason of section 514(c), or

“(ii) with respect to section 803, that such State has not provided for effective enforcement of State laws which govern the same matters as are governed by such section 803, and which require compliance by such entity with at least the same requirements as those provided under such section 803, and

“(B) that such entity has failed to comply with the requirements of such section which are applicable to such entity.”.

(d) PREEMPTION OF DIFFERING STATE LAWS.—Section 514 of such Act (29 U.S.C. 1144) is amended—

(1) in subsection (b)(2)(A), by inserting “and subsection (c)” after “subparagraph (B)”; and

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(3) by inserting after subsection (b) the following new subsection:

“(c)(1) The provisions of sections 801 and 802 shall supersede any and all State laws in relation to any group health plan to which such sections apply insofar as the requirements of such laws may now or hereafter—

“(A) relate to insurers or health maintenance organizations offering health insurance coverage in connection with group health plans,

“(B) govern the same matters as are governed by such sections 801 and 802, and

“(C) provide requirements which differ from the requirements of such sections 801 and 802.

“(2) Nothing in this subsection shall be construed to supercede any law of any State to the extent that such law provides for the enforcement of laws which are not superceded under paragraph (1).

“(3) For purposes of this subsection, terms used in this subsection which are defined in section 800 shall have the meanings provided in such section.”.

(e) GOOD FAITH COMPLIANCE WITH REQUIREMENT.—A group health plan (within the meaning of section 3(42) of the Employee Retirement Income Security Act of 1974), an insurer (within the meaning of section 800(a)(5) of such Act), or a health maintenance organization (within the meaning of section 800(a)(4) of such Act) that complies in good faith with an applicable requirement of subpart A of part 8 of title I of such Act before the date a regulation has been published and becomes effective to carry out such requirement shall be considered to be in compliance with such regulation.

(f) CONFORMING AMENDMENT.—Section 607(1) of such Act (29 U.S.C. 1167(1)) is amended—

(1) by striking “The term” and inserting the following:

“(A) IN GENERAL.—The term”;

(2) by striking “(as defined” and all that follows through “1986)”; and

(3) by adding at the end of the following new subparagraph:

“(B) MEDICAL CARE.—For purposes of this paragraph, the term ‘medical care’ means—

“(i) amounts paid for, or items or services in the form of, the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for, or items or services provided for, the purpose of affecting any structure or function of the body,

“(ii) amounts paid for, or services in the form of, transportation primarily for and essential to medical care referred to in clause (i), and

“(iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii).”

(g) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 609 the following new items:

“PART 8—ACCESS TO, AND CONTINUITY OF, GROUP HEALTH PLAN COVERAGE

“Sec. 800. Definitions and special rules.

“SUBPART A—PREEXISTING CONDITION LIMITATIONS, PORTABILITY, AND RENEWABILITY

“Sec. 801. Limitations on preexisting condition exclusions.

“Sec. 802. Portability.

“Sec. 803. Requirements for renewability of coverage.

“Sec. 804. Group health plan enrollment requirements.”.

SEC. 103. EFFECTIVE DATE.

The amendments made by this title shall apply with respect to plan years beginning after 18 months after the month in which this Act is enacted.

## **TITLE II—REQUIREMENTS FOR INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS OFFERING HEALTH INSURANCE COVERAGE TO GROUP HEALTH PLANS OF SMALL EMPLOYERS**

### **SEC. 201. ERISA REQUIREMENTS FOR INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS OFFERING HEALTH INSURANCE COVERAGE TO GROUP HEALTH PLANS OF SMALL EMPLOYERS.**

(a) IN GENERAL.—Part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by the preceding provisions of this title) is amended by adding at the end the following:

#### **“Subpart B—Requirements for Insurers and Health Maintenance Organizations Offering Health Insurance Coverage to Group Health Plans of Small Employers**

##### **“SEC. 811. DEFINITIONS.**

“Except as otherwise specifically provided, for purposes of this subpart:

“(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible individual’ means, with respect to an insurer or health maintenance organization that offers general coverage to any small employer in connection with a group health plan, such an individual in relation to the employer as shall be determined—

“(A) in accordance with the terms of such plan,

“(B) as provided by the insurer or health maintenance organization under rules of the insurer or health maintenance organization which are uniformly applicable, and

“(C) in accordance with all applicable State laws governing such insurer or health maintenance organization.

“(2) GENERAL COVERAGE.—The term ‘general coverage’ means health insurance coverage that—

“(A) is offered at a particular time in the small group market, and

“(B) is not made available solely in connection with any trade, industry, or professional association.

“(3) SMALL EMPLOYER.—The term ‘small employer’ means, in connection with a group health plan with respect to a calendar year, an employer who employs at least 2 but fewer than 51 employees on a typical business day in the year. For purposes of this paragraph, two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group (within the meaning of section 3(40)(B)(ii)).

“(4) SMALL GROUP MARKET.—The term ‘small group market’ means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer.

“(5) STATE.—The term ‘State’ means any of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

**“SEC. 812. REQUIREMENTS FOR INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS IN THE SMALL GROUP MARKET WHO OFFER GENERAL COVERAGE.**

“(a) ISSUANCE OF COVERAGE.—Subject to the succeeding subsections of this section, each insurer or health maintenance organization that offers general coverage in connection with a group health plan in the small group market in a State—

“(1) must accept every small employer in the State that applies for such coverage; and

“(2) must accept for enrollment under such coverage every eligible individual (as defined in section 811(1)) who applies for enrollment on a timely basis (consistent with section 804) and may not place any restriction which is inconsistent with section 804 on the eligibility of an individual to enroll so long as such individual is an eligible individual.

“(b) TREATMENT OF CERTAIN PREVIOUSLY SELF-INSURED EMPLOYERS.—

“(1) IN GENERAL.—An insurer or health maintenance organization may elect not to make general coverage available to group health plans of previously self-insured small employers (described in paragraph (2)), but only if such election is made in a uniform manner for all such employers. The exclusion, pursuant to such an election, of such a group health plan from availability of general coverage shall not apply after the end of the 1-year period (or such uniform, shorter period as the insurer or organization may specify) beginning on the last date no such coverage was provided by such employer.

“(2) PREVIOUS SELF-INSURED EMPLOYER DESCRIBED.—A previously self-insured small employer described in this paragraph is a small employer that has provided medical care (referred to in section 800(a)(6)) to employees other than through health insurance coverage to which this subpart applies.

“(c) CONSTRUCTION WITH RESPECT TO COVERAGE OFFERED IN CONNECTION WITH ASSOCIATIONS.—Nothing in subsection (a) shall be construed as requiring that the general coverage made available by an insurer or health maintenance organization in the small group market in a State in connection with any trade, industry, or professional association be the same as the general coverage offered in the State in the small group market not in connection with such an association.

“(d) SPECIAL RULES FOR NETWORK PLANS AND HEALTH MAINTENANCE ORGANIZATIONS.—

“(1) IN GENERAL.—In the case of an insurer that offers health insurance coverage in connection with a group health plan in the small group market through a network plan (as defined in section 800(a)(7)) and in the case of a health maintenance organization that offers health insurance coverage in connection with such a plan, the insurer or organization may—

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

“(B) limit the individuals who may be enrolled under such coverage to those who reside in the service area for such plan or organization; and

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

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

“(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience or duration of coverage of those employers and their employees or the health status of their employees.

“(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or health maintenance organization, upon denying health insurance coverage in connection with group health plans in any service area in accordance with paragraph (1)(C) may not offer coverage in connection with group health plans in the small group market within such service area for a period of 180 days after such coverage is denied.

“(e) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—

“(1) IN GENERAL.—An insurer or health maintenance organization may deny health insurance coverage in connection with a group health plan in the small group market if the insurer or organization demonstrates to the appropriate enforcing authority (subject to section 502(c)(5)) that—

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

“(B) it is applying this paragraph uniformly to all employers without regard to the claims experience or duration of coverage of those employers and their employees or the health status of their employees.

“(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or health maintenance organization, upon denying health insurance coverage in connection with group health plans in any service area in accordance with paragraph (1) may not offer coverage in connection with group health plans in the small group market within such service area for a period of 180 days after such coverage is denied.

“(f) EXCEPTION TO REQUIREMENT FOR ISSUANCE OF COVERAGE BY REASON OF FAILURE BY PLAN TO MEET CERTAIN MINIMUM PARTICIPATION RULES.—

“(1) IN GENERAL.—Subsection (a) shall not apply in the case of any group health plan with respect to which participation rules of an insurer or health maintenance organization which are described in paragraph (2) are not met.

“(2) PARTICIPATION RULES.—For purposes of paragraph (1), participation rules (if any) of an insurer or health maintenance organization shall be treated as met with respect to a group health plan only if such rules are uniformly applicable and in accordance with applicable State law and the number or percentage of eligible individuals who, under the plan, are participants or beneficiaries equals or exceeds a level which is determined in accordance with such rules.

“(3) SPECIAL RULE FOR COVERAGE IN CONNECTION WITH CERTAIN ASSOCIATIONS.—In the case of health insurance coverage in connection with any trade, industry, or professional association, the insurer or health maintenance organization may not provide for a minimum participation requirement with respect to eligible individuals who are employees of an employer.”

(b) ENFORCEMENT WITH RESPECT TO INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS.—Section 502(c)(5) of such Act (as added by section 102(c)) is amended—

(1) by striking “or 803” and inserting “803, or 812”; and

(2) in subparagraph (A)(ii), by striking “section 803” each place it appears and inserting “section 803 or 812, respectively”.

(c) GOOD FAITH COMPLIANCE WITH REQUIREMENT.—An insurer (within the meaning of section 800(a)(5) of the Employee Retirement Income Security Act of 1974) or a health maintenance organization (within the meaning of section 800(a)(6) of such Act) that complies in good faith with an applicable requirement of subpart B of part 8 of title I of such Act before the date a regulation has been published and becomes effective to carry out such requirement shall be considered to be in compliance with such regulation.

(d) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the items relating to part 8 (added by section 1001(b)) the following new items:

“SUBPART B—REQUIREMENTS FOR INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS OFFERING HEALTH INSURANCE COVERAGE TO GROUP HEALTH PLANS OF SMALL EMPLOYERS

“Sec. 811. Definitions.

“Sec. 812. Requirements for insurers and health maintenance organizations in the small group market who offer general coverage.”.

#### SEC. 202. EFFECTIVE DATE.

The requirements of section 812 of the Employee Retirement Income Security Act of 1974 (added by this title) shall apply with respect to insurers and health maintenance organizations as of 18 months after the month in which this Act is enacted.

## TITLE III—ENCOURAGEMENT OF MULTIPLE EMPLOYER HEALTH PLANS, VOLUNTARY HEALTH INSURANCE ASSOCIATIONS, AND OTHER FULLY INSURED ARRANGEMENTS; PREEMPTION

#### SEC. 301. SCOPE OF STATE REGULATION; CLARIFICATION OF PREEMPTION RULES RELATING TO VOLUNTARY HEALTH INSURANCE ASSOCIATIONS AND OTHER FULLY INSURED ARRANGEMENTS.

(a) SCOPE OF STATE REGULATION.—Section 514(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) (as added by section 102(d)) is amended—

(1) by redesignating paragraph (3) as paragraph (4);

(2) by inserting after paragraph (2) the following new paragraphs:

“(3)(A) The provisions of this title shall supersede any and all State laws insofar as they may now or hereafter require—

“(i) health insurance coverage in connection with a group health plan to include specific items or services consisting of medical care, or

“(ii) an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan to include in such health insurance coverage specific items or services consisting of medical care;

except to the extent that such State laws prohibit an exclusion for a specific disease in such health insurance coverage.

“(B) Notwithstanding subparagraph (A), a State may require an insurer or health maintenance organization offering health insurance coverage in the small group market (as defined in section 811(4)) in connection with a group health plan to offer under such coverage specific items or services consisting of medical care, but only with respect to not more than 2 different policies or contracts of health insurance coverage.”.

(b) PREEMPTION OF STATE FICTITIOUS GROUP LAWS.—Section 514(c) of such Act (as amended by subsection (a)) is further amended by redesignating paragraph (4) as paragraph (5) and inserting after paragraph (3) the following new paragraph:

“(4) The provisions of this title shall supercede any and all State laws insofar as they may now or hereafter prohibit—

“(A) two or more employers from obtaining or offering coverage under a multiple employer welfare arrangement under which all benefits consist of medical care and are fully insured, or

“(B) an insurer or health maintenance organization from offering coverage described in subparagraph (A).”.

(c) CLARIFICATION OF PREEMPTION RULES RELATING TO VOLUNTARY HEALTH INSURANCE ASSOCIATIONS.—Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraphs:

“(E)(i) The provisions of this title shall supercede any and all State laws which regulate insurance insofar as they may now or hereafter preclude an insurer or health maintenance organization offering health insurance coverage in connection with employee welfare benefit plans which are voluntary health insurance associations from setting premium rates based on the claims experience of each voluntary health insurance association, if such claims experience is defined as the claims experience of all employers of each association taken as a whole (without varying the premium rates of any particular employer on the basis of the claims experience of such employer).

“(ii) Subsection (c)(3)(B) shall not apply in the case of an employee welfare benefit plan which is a voluntary health insurance association.

“(iii) For purposes of this subparagraph, the term ‘voluntary health insurance association’ means a multiple employer welfare arrangement—

“(I) under which benefits include medical care (within the meaning of section 607(1)),

“(II) under which all benefits consisting of such medical care are fully insured, and

“(III) which is maintained by a qualified association.

“(iv) For purposes of clause (iii)(III), the term ‘qualified association’ means an association which consists of employers who together employ at least 200 employees who are eligible individuals, but only if the sponsor of the association—

“(I) is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1)), and

“(II) is established as a permanent entity which receives the active support of its members.

“(F) For purposes of this paragraph, the terms ‘fully insured’, ‘health insurance coverage’, ‘health maintenance organization’, and ‘insurer’ have the meanings given such terms in section 800(a).”.

**SEC. 302. CLARIFICATION OF DUTY OF THE SECRETARY OF LABOR TO IMPLEMENT PROVISIONS OF CURRENT LAW PROVIDING FOR EXEMPTIONS FROM STATE REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS.**

(a) RULES GOVERNING STATE REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS.—Subtitle B of title I of the Employee Retirement Income Security Act of

1974 (as amended by the preceding provisions of this title) is amended by inserting after part 6 the following new part:

**“PART 7—RULES GOVERNING STATE REGULATION OF  
MULTIPLE EMPLOYER HEALTH PLANS**

**“SEC. 701. DEFINITIONS.**

“For purposes of this part—

“(1) FULLY INSURED.—A particular benefit under a group health plan or a multiple employer welfare arrangement is ‘fully insured’ if such benefit (irrespective of any recourse available against other parties) is provided in a manner so that such benefit constitutes insurance regulated by the law of any State (within the meaning of section 514(b)(2)).

“(2) INSURER.—The term ‘insurer’ means an insurance company, insurance service, or insurance organization, licensed to engage in the business of insurance by a State.

“(3) MEDICAL CARE.—The term ‘medical care’ means medical care within the meaning of section 607(1).

“(4) MULTIPLE EMPLOYER HEALTH PLAN.—The term ‘multiple employer health plan’ means a multiple employer welfare arrangement which provides medical care and which has been granted an exemption under section 514(b)(6)(B).

“(5) PARTICIPATING EMPLOYER.—The term ‘participating employer’ means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the individuals who are dependents (as defined under the terms of the arrangement) of its employees, are or were covered under such arrangement in connection with the employment of the employees.

“(6) SPONSOR.—The term ‘sponsor’ means, in connection with a multiple employer welfare arrangement, the association or other entity which establishes or maintains the arrangement.

“(7) STATE INSURANCE COMMISSIONER.—The term ‘State insurance commissioner’ means the insurance commissioner (or similar official) of a State.

**“SEC. 702. MULTIPLE EMPLOYER HEALTH PLANS ELIGIBLE FOR RELIEF FROM CERTAIN RESTRICTIONS ON PREEMPTION OF STATE LAW.**

**“(a) TREATMENT AS EMPLOYEE WELFARE BENEFIT PLAN WHICH IS A GROUP HEALTH PLAN.—**

“(1) IN GENERAL.—A multiple employer welfare arrangement—

“(A) under which the benefits consist solely of medical care (disregarding such incidental benefits as the Secretary shall specify by regulation), and

“(B) under which some or all benefits are not fully insured,

shall be treated for purposes of subtitle A and the other parts of this subtitle as an employee welfare benefit plan which is a group health plan if an exception is granted to the arrangement under section 514(b)(6)(B) in accordance with this part.

“(2) EXCEPTION.—In the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii), paragraph (1) shall apply with respect to such arrangement, but only with respect to benefits provided thereunder which constitute medical care.

**“(b) TREATMENT UNDER PREEMPTION RULES.—**

“(1) IN GENERAL.—The Secretary shall prescribe regulations described in section 514(b)(6)(B)(i), applicable to multiple employer welfare arrangements described in subparagraphs (A) and (B) of subsection (a)(1), providing a procedure for granting exemptions from section 514(b)(6)(A)(ii) with respect to such arrangements. Under such regulations, any such arrangement treated under subsection (a) as an employee welfare benefit plan shall be deemed to be an arrangement described in section 514(b)(6)(B)(ii).

“(2) STANDARDS.—Under the procedure prescribed pursuant to paragraph (1), the Secretary shall grant an arrangement described in subsection (a) an exemption described in subsection (a) only if the Secretary finds that—

“(A) such exemption—

“(i) is administratively feasible,

“(ii) is not adverse to the interests of the individuals covered under the arrangement,

“(iii) is protective of the rights and benefits of the individuals covered under the arrangement, and

“(B) under such arrangement—

“(i) the requirements of section 703(a) are met,  
 “(ii) reserves are maintained in an amount of not less than \$100,000  
 which consist of at least a reserve sufficient—

“(I) for unearned contributions,

“(II) for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred (to the extent that the arrangement does not maintain such security, guarantee, hold-harmless arrangement, or other financial arrangement as the Secretary determines to be adequate), and

“(III) for expected administrative costs with respect to such benefit liabilities,

“(iii) the arrangement will provide such timely notice of material changes as the Secretary shall specify in the regulations referred to in paragraph (1), the arrangement will meet such other financial, actuarial, and other reporting requirements as shall be specified in such regulations, the arrangement is maintained by persons who are not disqualified persons as defined in such regulations, and the arrangement will terminate upon failure to meet requirements which shall be specified in such regulations.

“(3) FILING FEE.—Under the procedure prescribed pursuant to paragraph (1), a multiple employer welfare arrangement shall pay to the Secretary at the time of filing an application for an exemption referred to in subsection (a) a filing fee in the amount of \$5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the exemption procedures applicable with respect to such arrangement.

“(4) CLASS EXEMPTION TREATMENT FOR EXISTING LARGE ARRANGEMENTS.—Under the procedure prescribed pursuant to paragraph (1), if—

“(A) at the time of application for an exemption under section 514(b)(6)(B) with respect to an arrangement which has been in existence as of the date of the enactment of the ERISA Targeted Health Insurance Reform Act of 1996 for at least 3 years, either (A) the arrangement covers at least 1,000 participants and beneficiaries, or (B) with respect to the arrangement there are at least 2,000 employees of eligible participating employers,

“(B) a complete application for the exemption with respect to the arrangement has been filed and is pending, and

“(C) the application meets such requirements (if any) as the Secretary may provide with respect to class exemptions under this subsection, the exemption shall be treated as having been granted with respect to the arrangement unless and until the Secretary provides appropriate notice that the exemption has been denied.

“(c) FILING NOTICE OF EXEMPTION WITH STATES.—An exemption granted under section 514(b)(6)(B) to a multiple employer welfare arrangement shall not be effective unless written notice of such exemption is filed with the State insurance commissioner of each State in which at least 5 percent of the individuals covered under the arrangement are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed. The Secretary may by regulation provide in specified cases for the application of the preceding sentence with lesser percentages in lieu of such 5 percent amount.”.

**“SEC. 703. REQUIREMENTS RELATING TO SPONSORS, BOARDS OF TRUSTEES, AND PLAN OPERATIONS.**

“(a) IN GENERAL.—A complete application for an exemption under section 514(b)(6)(B) shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

“(1) SPONSOR.—The sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care (referred to in section 3(42)), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members.

“(2) BOARD OF TRUSTEES.—The arrangement is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

“(3) COVERED PERSONS.—The instruments governing the arrangement include a written instrument which provides that, effective upon the granting of the exemption to the arrangement—

“(A) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer,

“(B) all individuals thereafter commencing coverage under the arrangement must be—

“(i) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

“(ii) the beneficiaries of individuals described in clause (i), and

“(C) no participating employer may provide health insurance coverage in the individual market for any employee not covered under the arrangement which is similar to the coverage contemporaneously provided to employees of the employer under the arrangement, if such exclusion of the employee from coverage under the arrangement is based in whole or in part on the health status of the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the arrangement.

“(4) INCLUSION OF ELIGIBLE EMPLOYERS AND EMPLOYEES.—No employer described in paragraph (3) is excluded as a participating employer, no employee of a participating employer is ineligible for coverage offered under the plan in a geographic area with respect to the employee, and no individual who would otherwise be eligible for coverage under the arrangement in connection with such an employer is excluded as a plan participant, based on—

“(A) enrollment criteria more restrictive than those required under section 804 with respect to group health plans, or

“(B) a minimum participation requirement of the type referred to in section 812(f)(3).

“(5) RESTRICTION ON VARIATIONS OF PREMIUM RATES.—Premium rates under the arrangement with respect any particular employer do not vary on the basis of the claims experience of such employer.

“(b) TREATMENT OF FRANCHISE NETWORKS.—In the case of a multiple employer welfare arrangement which is established and maintained by a franchisor for a franchise network consisting of its franchisees, the requirements of subsection (a)(1) shall be treated as met with respect to such network in any case in which such requirements would be met if the franchisor were deemed to be the sponsor referred to in subsection (a)(1), such network were deemed to be an association described in subsection (a)(1), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in subsection (a)(1).

“(c) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In the case of a multiple employer welfare arrangement in existence on February 1, 1995, which would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii) or (to the extent provided in regulations of the Secretary) solely for the failure to meet the requirements of subparagraph (D) or (F) of section 3(40)—

“(1) subsection (a)(1) shall not apply, and

“(2) the joint board of trustees shall be considered the board of trustees required under subsection (a)(2).

“(d) CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

“(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple employer welfare arrangement are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer—

“(A) subsection (a)(1) shall be treated as satisfied if the sponsor of the arrangement is the person who would be the plan sponsor if the related employers were disregarded in determining whether the requirements of section 3(40)(B) are met, and

“(B) subsection (a)(2) shall be treated as satisfied if the board of trustees is the named fiduciary in connection with the arrangement.

“(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are ‘related’ if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.”.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6)(A)(i) of such Act (29 U.S.C. 1144(b)(6)(A)(i)) is amended by striking “is fully insured” and inserting “under which all benefits are fully insured”, and by inserting “and which is not described in section 702(a)(1)” after “subparagraph (B)”.

(2) Section 514(b)(6)(B) of such Act (29 U.S.C. 1144(b)(6)(B)) is amended—

(A) by inserting “(i)” after “(B)”;

(B) by striking “which are not fully insured” and inserting “under which any benefit is not fully insured”; and

(C) by striking “Any such exemption” and inserting:

“(ii) Subject to part 7, any exemption under clause (i)”.

(c) CONFORMING AMENDMENT TO DEFINITION OF PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 1002(16)(B)) is amended by adding at the end the following new sentence: “Such term also includes the sponsor (as defined in section 701(6)) of a multiple employer welfare arrangement which is or has been a multiple employer health plan (as defined in section 701(4)).”.

(d) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (as amended by section 102(g)) is amended by inserting after the item relating to section 609 the following new items:

“PART 7—RULES GOVERNING STATE REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS

“Sec. 701. Definitions.

“Sec. 702. Multiple employer health plans eligible for relief from certain restrictions on preemption of State law

“Sec. 703. Requirements relating to sponsors, boards of trustees, and plan operations.”.

**SEC. 303. CLARIFICATION OF SCOPE OF PREEMPTION RULES.**

(a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting “, but only, in the case of an arrangement which does not provide medical care (within the meaning of section 607(1)),” before “to the extent not inconsistent with the preceding sections of this title”.

(b) CROSS-REFERENCE.—Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) (as amended by section 301) is amended by adding at the end the following new subparagraph:

“(G) For additional rules relating to exemption from subparagraph (A)(ii) of multiple employer health plans, see part 7.”.

**SEC. 304. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.**

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting “for any plan year of any such plan, or any fiscal year of any such other arrangement,” after “single employer”, and by inserting “during such year or at any time during the preceding 1-year period” after “control group”;

(2) in clause (iii)—

(A) by striking “common control shall not be based on an interest of less than 25 percent” and inserting “an interest of greater than 25 percent may not be required as the minimum interest necessary for common control”; and

(B) by striking “similar to” and inserting “consistent and coextensive with”;

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively;

and

(4) by inserting after clause (iii) the following new clause:

“(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement.”.

**SEC. 305. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.**

(a) **IN GENERAL.**—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

“(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),”.

(b) **LIMITATIONS.**—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

“(C) A plan or other arrangement is established or maintained in accordance with this subparagraph only if the following requirements are met:

“(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

“(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement, or

“(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement,

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

“(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

“(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual’s employment in such a bargaining unit), nor

“(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment),

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the ERISA Targeted Health Insurance Reform Act of 1996 and, as of the end of the preceding plan year, the number of such

covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

“(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

“(D) A plan or arrangement is established or maintained in accordance with this subparagraph only if—

“(i) all of the benefits provided under the plan or arrangement are fully insured (as defined in section 701(2)), or

“(ii)(I) the plan or arrangement is a multiemployer plan, and

“(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

“(E) A plan or arrangement is established or maintained in accordance with this subparagraph only if—

“(i) the plan or arrangement is in effect as of the date of the enactment of the ERISA Targeted Health Insurance Reform Act of 1996, or

“(ii) the employee organization or other entity sponsoring the plan or arrangement—

“(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

“(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.”.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: “Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).”.

#### SEC. 306. TREATMENT OF CHURCH PLANS.

(a) SPECIAL RULES FOR CHURCH PLANS.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of such Act (as added and amended by the preceding provisions of this Act) is amended by adding at the end the following new section:

##### “SEC. 704. SPECIAL RULES FOR CHURCH PLANS.

“(a) ELECTION FOR CHURCH PLANS.—

“(1) IN GENERAL.—Notwithstanding section 4(b)(2), if the church or convention or association of churches which maintains a church plan covered under this section makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulations prescribe), then, subject to this section, the provisions of this part (and other provisions of this title to the extent that they apply to group health plans which are multiple employer welfare arrangements) shall apply to such church plan, with respect to benefits provided under such plan consisting of medical care, as if—

“(A) section 4(b)(2) did not contain an exclusion for church plans, and

“(B) such plan were an arrangement eligible to apply for an exemption under this part.

“(2) ELECTION IRREVOCABLE.—An election under this subsection with respect to any church plan shall be binding with respect to such plan, and, once made, shall be irrevocable.

“(b) COVERED CHURCH PLANS.—A church plan is covered under this section if such plan provides benefits which include medical care and some or all of such benefits are not fully insured.

“(c) SPONSOR AND BOARD OF TRUSTEES.—For purposes of this part, in the case of a church plan to which this part applies pursuant to an election under subsection (a), in treating such plan as if it were a multiple employer welfare arrangement under this part—

“(1) the church, convention or association of churches, or other organization described in section 3(33)(C)(i) which is the entity maintaining the plan shall be treated as the sponsor referred to in section 703(a)(1), and the requirements of section 703(a)(1) shall be deemed satisfied with respect to the sponsor, and

“(2) the board of trustees, board of directors, or other similar governing body of such sponsor shall be treated as the board of trustees referred to in section 703(a)(2), and the requirements of section 703(a)(2) shall be deemed satisfied with respect to the board of trustees.

“(d) DEEMED SATISFACTION OF TRUST REQUIREMENTS.—The requirements of section 403 shall not be treated as not satisfied with respect to a church plan to which

this part applies pursuant to an election under subsection (a) solely because assets of the plan are held by an organization described in section 3(33)(C)(i), if—

“(1) such organization is incorporated separately from the church or convention or association of churches involved, and

“(2) such assets with respect to medical care are separately accounted for.

“(e) **DEEMED SATISFACTION OF EXCLUSIVE BENEFIT REQUIREMENTS.**—The requirements of section 404 shall not be treated as not satisfied with respect to a church plan to which this part applies pursuant to an election under subsection (a) solely because assets of the plan which are in excess of reserves required for exemption under section 514(b)(6)(B) are held in a fund in which such assets are pooled with assets of other church plans, if the assets held by such fund may not, under the terms of the plan and the terms governing such fund, be used for, or diverted to, any purpose other than for the exclusive benefit of the participants and beneficiaries of the church plans whose assets are pooled in such fund.

“(f) **INAPPLICABILITY OF CERTAIN PROVISIONS.**—

“(1) **PROHIBITED TRANSACTIONS.**—Section 406 shall not apply to a church plan by reason of an election under subsection (a).

“(2) **CONTINUATION COVERAGE.**—Section 601 shall not apply to a church plan by reason of an election under subsection (a).”.

(b) **CONFORMING AMENDMENTS.**—

(1) Section 4(b)(2) of such Act (29 U.S.C. 1003(b)(2)) is amended by inserting before the semicolon the following: “, except with respect to provisions made applicable under any election made under section 704(a) of this Act”.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (a), by inserting “(including a church plan which is not exempt under section 4(b)(2) by reason of an election under section 704)” before the period in the first sentence; and

(B) in subsection (b)(2)(B), by inserting “and including a church plan which is not exempt under section 4(b)(2) by reason of an election under section 704” after “death benefits”.

(c) **CLERICAL AMENDMENT.**—The table of contents in section 1 of such Act (as amended by the preceding provisions of this title) is further amended by inserting after the item relating to section 703 the following new item:

“Sec. 704. Special rules for church plans.”.

**SEC. 307. ENFORCEMENT PROVISIONS RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.**

(a) **ENFORCEMENT OF FILING REQUIREMENTS.**—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by sections 102(c)) is further amended—

(1) in subsection (a)(6), by striking “paragraph (2) or (5)” and inserting “paragraph (2), (5), or (6)”; and

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

“(6) The Secretary may assess a civil penalty against any person of up to \$1,000 a day from the date of such person’s failure or refusal to file the information required to be filed with the Secretary under section 101(g).”.

(b) **ACTIONS BY STATES IN FEDERAL COURT.**—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(1) in paragraph (8), by striking “or” at the end;

(2) in paragraph (9), by striking the period and inserting “, or”; and

(3) by adding at the end the following:

“(10) by a State official having authority under the law of such State to enforce the laws of such State regulating insurance, to enjoin any act or practice which violates any requirement under part 7 for an exemption under section 514(b)(6)(B) which such State has the power to enforce pursuant to section 506(c)(1).”.

(c) **CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.**—Section 501 of such Act (29 U.S.C. 1131) is amended—

(1) by inserting “(a)” after “SEC. 501.”; and

(2) by adding at the end the following new subsection:

“(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee’s beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

“(1) being a multiple employer welfare arrangement to which an exemption has been granted under section 514(b)(6)(B),

“(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bar-

gaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, or

“(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met, shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.”.

(d) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

“(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of a multiple employer welfare arrangement providing benefits consisting of medical care (within the meaning of section 607(1)) that—

“(A) is not licensed, registered, or otherwise approved under the insurance laws of the States in which the arrangement offers or provides benefits, and

“(B) if there is in effect with respect to such arrangement an exemption under section 514(b)(6)(B), is not operating in accordance with the requirements under part 7 for such an exemption,

a district court of the United States shall enter an order requiring that the arrangement cease activities.

“(2) Paragraph (1) shall not apply in the case of a multiple employer welfare arrangement if the arrangement shows that—

“(A) all benefits under it referred to in paragraph (1) are fully insured, within the meaning of section 701(1), and

“(B) with respect to each State in which the arrangement offers or provides benefits, the arrangement is operating in accordance with applicable State insurance laws that are not superseded under section 514.

“(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the arrangement.”.

(e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by adding at the end (after and below paragraph (2)) the following new sentence: “The terms of each multiple employer health plan (within the meaning of section 701(4)) shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.”.

#### SEC. 308. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

“(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

“(1) STATE ENFORCEMENT.—

“(A) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary’s authority under sections 502 and 504 to enforce the requirements under part 7 for an exemption under section 514(b)(6)(B). The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

“(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

“(C) CONCURRENT AUTHORITY OF THE SECRETARY.—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

“(D) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular multiple employer welfare arrangement, as the primary domicile State to which authority has been delegated pursuant to such agreements.

“(2) ASSISTANCE TO STATES.—The Secretary shall—

“(A) provide enforcement assistance to the States with respect to multiple employer welfare arrangements, including, but not limited to, coordinating Federal and State efforts through the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

“(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act,

“(C) make readily available to the States timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

“(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.”.

**SEC. 309. FILING AND DISCLOSURE REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS OFFERING HEALTH BENEFITS.**

Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended—

(1) by redesignating subsection (g) as subsection (i); and

(2) by inserting after subsection (f) the following new subsections:

“(g) REGISTRATION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1997) and no later than February 15 of each year (in the case of an arrangement in operation since the beginning of such year), unless, as of the date by which such filing otherwise must be made, such arrangement provides no benefits consisting of medical care (within the meaning of section 607(1)).

“(2) Each registration statement—

“(A) shall be filed in such form, and contain such information concerning the multiple employer welfare arrangement and any persons involved in its operation (including whether coverage under the arrangement is fully insured), as shall be provided in regulations which shall be prescribed by the Secretary, and

“(B) if any benefits under the arrangement consisting of medical care (within the meaning of section 607(1)) are not fully insured, shall contain a certification that copies of such registration statement have been transmitted by certified mail to—

“(i) in the case of an arrangement which is a multiple employer health plan (as defined in section 701(4)), the State insurance commissioner of the domicile State of such arrangement, or

“(ii) in the case of an arrangement which is not a multiple employer health plan, the State insurance commissioner of each State in which the arrangement is located.

“(3) The person or persons responsible for filing the annual registration statement are—

“(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or

“(B) in the case of a multiple employer welfare arrangement for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually responsible for the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.

“(4) Any agreement entered into under section 506(c) with a State as the primary domicile State with respect to any multiple employer welfare arrangement shall provide for simultaneous filings of reports required under this subsection with the Secretary and with the State insurance commissioner of such State.

“(5) For purposes of this subsection, the term ‘domicile State’ means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for an exemption under this 514(b)(6)(B), most individuals to be covered under the arrangement are located, except that, in any case in which information contained in the latest annual report of the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different State.

“(6) The Secretary may exempt from the requirements of this subsection such class of multiple employer welfare arrangements as the Secretary deems appropriate.

“(h) FILING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

“(1) IN GENERAL.—A multiple employer welfare arrangement which provides benefits consisting of medical care (within the meaning of section 607(1)) shall issue to each participating employer—

“(A) a document equivalent to the summary plan description required of plans under this part,

“(B) information describing the contribution rates applicable to participating employers, and

“(C) a statement indicating—

“(i) that the arrangement is not a licensed insurer under the laws of any State,

“(ii) the extent to which any benefits under the arrangement are fully insured,

“(iii) if any benefits under the arrangement are not fully insured, whether the arrangement has been granted an exemption under section 514(b)(6)(B) (or whether such an exemption has ceased to be effective).

“(2) TIME FOR DISCLOSURE.—Such information shall be issued to employers within such reasonable period of time before becoming participating employers as may be prescribed in regulations of the Secretary.”.

**SEC. 310. SINGLE ANNUAL FILING FOR ALL PARTICIPATING EMPLOYERS.**

(a) IN GENERAL.—Section 110 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1030) is amended by adding at the end the following new subsection:

“(c) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are participating employers under a multiple employer welfare arrangement under which all coverage consists of medical care (within the meaning of section 607(1)) and is fully insured (as defined in section 701(1)).”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. The Secretary of Labor shall prescribe the alternative method referred to in section 110(c) of the Employee Retirement Income Security Act of 1974, as added by such amendment, within 90 days after the date of the enactment of this Act.

**SEC. 311. EFFECTIVE DATE; TRANSITIONAL RULE.**

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect on the earlier of—

(1) the date on which the Secretary of Labor issues all regulations necessary to carry out the amendments made by this title, or

(2) July 1, 1997.

The Secretary shall issue all regulations necessary to carry out the amendments made by this title before July 1, 1997.

(b) TRANSITIONAL RULE.—If the sponsor of a multiple employer welfare arrangement which, as of the effective date specified in subsection (a), provides benefits consisting of medical care (within the meaning of section 607(1) of the Employee Retirement Income Security Act of 1974) files with the Secretary of Labor an application for an exemption under section 514(b)(6)(B) of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement during the period following such date and ending on the earlier of—

(1) the date on which the Secretary denies the application under the amendments made by this title or determines, in the Secretary's sole discretion, that such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such arrangement would be detrimental to the interests of individuals covered under such arrangement, or

(2) 18 months after such effective date.

**SEC. 312. RULE OF CONSTRUCTION.**

Nothing in this Act or any amendment made thereby may be construed to require the coverage of any specific procedure, treatment, or service as part of a group health plan or health insurance coverage under this Act or through regulation.

Amend the title so as to read:

A bill to amend the Employee Retirement Income Security Act of 1974 to provide new portability, enrollment, and other consumer protections and freedoms for workers in a mobile work force, to increase purchasing power for employers and employees by removing barriers to the voluntary formation of multiple employer health plans and fully-insured multiple employer arrangements, and to expand access to fully-insured coverage for employees of small employers through open markets, and for other purposes.

## THE ERISA TARGETED HEALTH INSURANCE REFORM ACT OF 1996

### PURPOSE

H.R. 995 delivers availability, affordability, and accountability in health care. It makes two key health insurance reforms which will expand coverage: (1) it improves group to group portability, limiting preexisting condition exclusions, through carefully targeted insurance reforms; and (2) it clarifies ERISA to allow small employers to voluntarily form groups for the purpose of self-insuring or fully-insuring. The bill thus expands coverage by lowering costs.

### COMMITTEE ACTION

The Subcommittee on Employer-Employee Relations held an oversight hearing, "Health Insurance Reform—The ERISA Title I Framework: A 20-Year Success Story," on February 14, 1995. Testimony was received from: Representative Pat Williams; Former Representative John Erlenborn; Frank Cummings, LeBoeuf, Lamb, Greene & MacRae; Randall Johnson, Director of Benefits Planning, Motorola, Inc.; Ralph Brennan, President, Mr. B.'s, Inc.; William Goodrich, President, United Agribusiness League; and Brian Atchinson, Vice President, National Association of Insurance Commissioners, Superintendent, Bureau of Insurance, State of Maine.

H.R. 995, The ERISA Targeted Health Insurance Reform Act, was introduced by Representative Harris Fawell on February 21, 1995. The bipartisan legislation has 50 cosponsors. H.R. 996, the Targeted Individual Health Insurance Reform Act, was introduced by Representative Fawell on the same date.

The Subcommittee on Employer-Employee Relations held a legislative hearing to discuss H.R. 995 and H.R. 996 on March 10, 1995. During this hearing insurance reform issues concerning group-to-group portability, limits on preexisting condition exclusions, and small employer pooling were addressed. Testimony was received from: Jack Faris, President, National Federation of Independent Business; Jerry Jasinowski, President, National Association of Manufacturers; Sean Sullivan, President and CEO, National Business Coalition on Health; Timothy Flaherty, American Medical Association; Charles Masten, Inspector General, U.S. Department of Labor; Gerard McGeehan, Graphic Arts Benefits Corp.; Kala Ladenheim, Intergovernmental Health Policy Project, George Washington University; and Judith Waxman, Director of Government Affairs of Families, USA.

The subcommittee held a third hearing on March 28, 1995. During this hearing, the subcommittee continued its discussion on H.R. 995, H.R. 996, and targeted health insurance reform. Testimony was received from: Richard Leshner, President, U.S. Chamber of Commerce; Keith Richman, President, Medco Associates, Inc.; Jon

Reiker, Vice President, Benefits, General Mills Restaurants, Inc.; Frank Cummings, LeBoeuf, Lamb, Greene & MacRae; and Lee Douglass, Insurance Commissioner of Arkansas, President, National Association of Insurance Commissioners.

On March 6, 1996, the Committee on Economic and Educational Opportunities discharged H.R. 995 from the Subcommittee on Employer-Employee Relations, approved H.R. 995, as amended, on a voice vote, and, by a vote of 24-18, ordered the bill favorably reported.

#### BACKGROUND AND NEED FOR LEGISLATION

The important health insurance reform issues addressed in the Committee bill, the ERISA Targeted Health Insurance Reform Act, H.R. 995, are not new to this Committee and have been addressed in a bipartisan fashion in various legislation introduced in the past. The Committee has studied the need for such health insurance reform measures extensively over the past several years. During the 103rd Congress, the Full Committee and its subcommittees held 33 days of health care hearings throughout the United States. Several of these hearings focused on bipartisan legislation similar in scope to H.R. 995. In addition, the Subcommittee on Labor-Management Relations held 11 days of markup and the Full Committee held 8 days of markup on H.R. 3600.<sup>1</sup>

In the 102nd Congress, hearings were held on bipartisan legislation which included provisions that would promote multiple employer pooling among small employers. H.R. 995 follows in the tradition of this bipartisan effort to promote pooling for small employers in the 102nd Congress. Today's efforts by the Committee build on what originated as a bipartisan concern over the number of uninsured and an endeavor to expand health insurance coverage to such employees and their families by reducing the cost of employer-sponsored health coverage.<sup>2</sup>

Expanding health insurance coverage through multiple employer pooling arrangements is not a new concept. In 1991 Rep. Petri introduced the first bill to accomplish the twin goals of providing solvency standards for legitimate self-insured association health plans and giving the states more clear authority to end abusive schemes run by "bogus unions" and other illegitimate operators. This basic

<sup>1</sup>During the 103rd Congress, the full Committee held seven days of oversight hearings on the President's health care reform proposal, health care reform alternatives, regional health alliances, and the Cooper (H.R. 3222) and Michel (H.R. 3080) bills. The Subcommittee on Labor-Management Relations held 21 days of hearings on the following topics: oversight on the Administration's health care reform proposal; oversight on the effect of health care reform on workers and retirees, providers, the underserved, urban, and low-income populations, and children's mental health; and oversight on the effect of ERISA preemption on state health care reform efforts. In addition, the Subcommittee on Labor Standards, Occupational Health and Safety held two oversight hearings on the Health Security Act (H.R. 3600), the Subcommittee on Human Resources held an oversight hearing on health care reform and the existing long-term care network, and the Subcommittee on Select Education and Civil Rights held three oversight hearing on health care reform and its impact on schools and individuals with disabilities.

<sup>2</sup>During the 102nd Congress, the full Committee held an oversight hearing on national health reform and the Subcommittee on Labor-Management Relations held six days of hearings on the following topics: Legislation relating to ERISA's preemption of certain State laws (H.R. 1602 and H.R. 2782, Mr. Berman), oversight on health care access issues, oversight on access to affordable and adequate health care, oversight on small business health insurance problems, oversight on ERISA and cutbacks in health benefits, and the Multiple Employer Health Benefits Protection Act of 1991 (H.R. 2773, Mr. Petri), the Multiple Employer Self-Insurance Enforcement Act of 1992 (H.R. 4919, Mr. Hughes), and the Multiple Employer Welfare Arrangements Enforcement Improvements Act of 1992 (H.R. 5386, Mr. Petri).

concept received bipartisan support (H.R. 2773 was cosponsored by Reps. Goodling, Gunderson, Armev, Fawell, Ballenger, Molinari, Barrett, Boehner, Klug, Grandy, Sensenbrenner, Roukema, Oxley, Henry, Martinez, Gillmor, Ireland, Quillen, Barnard, Kleczka, Morella, Edwards, Schaefer, Lewis, Barton, and Cox). Similar provisions were included in both the Republican Leader's bill (H.R. 3080, Rep. Michel) and the Bipartisan Health Care Reform Act of 1994 (H.R. 5228, Reps. Rowland, Cooper, Bilirakis, Grandy, McCurdy, Goss, Parker, Hastert, Stenholm, Thomas, Tanner, Boehlert, Deal, Castle, Lloyd, Houghton, Hefner, Klug, Long, Collins, Andrews, and Everett) introduced as alternatives to the Clinton Health Plan in the 103rd Congress.

This Committee has spent years establishing the need for the key elements of H.R. 995, available and affordable health insurance. It is well documented that the most important incremental reforms that can be delivered to the American people are to improve group to group portability, by limiting preexisting condition exclusions, and facilitating through ERISA voluntary pooling by small employers on either a self-insured or fully-insured basis. Expanded coverage will become a reality if the cost of coverage can be made more affordable. Today 85% of the 40 million uninsured are in families with at least one employed worker, the vast majority of whom are employed by small businesses. Small business experts testified last year that 20 million Americans who now lack coverage might gain it under H.R. 995—all through responsible changes that will expand choice in the marketplace. This is the kind of reform that Americans have demanded and deserve.

*The importance of portability and limits on preexisting condition exclusions*

The bill contains important new protections and freedoms for workers who must compete in a more mobile workforce. It enhances insurance portability by removing restrictions on preexisting conditions for individuals who are continuously covered. No longer would covered workers face job-lock because they feared the lack of access to health insurance or denial of coverage because of a preexisting health condition. If an employee once chooses insurance coverage he or she does not have to again satisfy a preexisting condition, as long as some form of coverage is continued.

Today, many health plans deny coverage for the very conditions people most need insured. Preexisting condition limitations are routinely imposed in many health plans, and millions of Americans have such existing medical conditions would not be covered by plans to which they become newly eligible. More than half of all workers are enrolled in employment-based plans that impose some form of preexisting condition exclusion. Such limitations are argued to be justified as an attempt to keep people from waiting to buy insurance until they become sick. When an employer changes its insurance carrier or if a worker changes or loses his or her job, however, even a person who faithfully paid insurance premiums for years can be subjected to such exclusions. An estimated 23 million people lose insurance coverage annually and another 18 million change insurance policies each year as a result of someone in their family changing jobs. This traps millions of Americans in so-called

“job lock”: they fear taking a new job or starting their own business because of the risk of losing their health coverage. A recent Washington Post/CBS News poll found that one-quarter of all American workers stay in jobs they would otherwise leave because they fear losing their health coverage.

The bill will help prevent job-lock with provisions for portability and limits on preexisting conditions. Preexisting condition limitations are limited to a maximum of 12 months for conditions arising 6 months prior to coverage, and the preexisting condition period is reduced by 1 month for each month of prior coverage for the condition.

*Guaranteed renewal of coverage*

The bill also requires insurers and health plans to guarantee the renewal of insurance coverage to all covered employees. Today an employer that has a sudden jump in the cost of health care incurred by its workers risks having its group policy canceled. Under the bill, however, as long as the company has paid its premiums and not acted in violation of the policy rules, the insurer cannot cancel its policy. The only way an insurer could cancel the coverage of a company whose claims had skyrocketed would be to stop selling any group coverage in an entire region.

*The need to preempt state benefit mandates to restore national uniformity*

The issue of federal preemption in employee benefits is not new to this Committee. Throughout past deliberations on employee benefits, both employers and employee representatives stressed the enormous problems that had been created by separate, varying, or conflicting state regulation of these benefits. Congressional concern over national uniformity produced the Employee Retirement Income Security Act (ERISA) in 1974. Employee health coverage under ERISA has flourished and the foundation for this expansive coverage is ERISA’s preemption of costly and conflicting state regulation. Without this preemption, employers would be subject to a patchwork of differing state rules and regulations, including mandates on specific types and levels of benefit coverage.

Unfortunately, the proven benefits of preemption were eroded for many employers—particularly smaller employers—by the Supreme Court’s ruling in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). In that decision, the court held that if an employer’s health plan purchases a fully-insured product offered by an insurer regulated by the states, then such insurance regulation may include imposing requirements that specific benefits be included in the products sold to the plan. For those small employers who can afford health insurance for their employees, a fully insured plan is often their only available option. The net effect of the *Metropolitan Life* decision has been to subject these smaller employers to the burdens of costly state mandates, thereby making health insurance for their employees even less affordable than it is for larger employers who have increased purchasing power. The story—and success—of ERISA in expanding coverage proves beyond any doubt that the cornerstone of preemption has been critical to the growth and expansion of employer-provided health insur-

ance. It also proves, the Supreme Court's ruling in *Metropolitan Life Insurance Co. v. Massachusetts* notwithstanding, that the preemption cornerstone needs to be extended to a larger class of employers, namely small businesses. In reporting H.R. 995, the Committee has acted to build on the proven success of ERISA in this regard.

*Why current ERISA law needs changes to clarify the status of multiple employer health plans under Federal and State law*

Multiple employer plans are the most efficient means to deliver affordable health coverage to employees, particularly for smaller employers and employees who work in industries with high job mobility or above-average insurance risk. However, current law has not achieved the twin goals of preserving the self-insured multiple employer plans of legitimate business and industry associations and of keeping "bogus unions" and fraudulent insurance schemes from attempting to use the ERISA preemption clause as a shield to the promotion of their abusive health insurance practices.

As described in a later section, H.R. 995 meets these twin goals by enabling legitimate self-insured associations (including church plans, franchise networks, and certain large employer and collectively-bargained plans) to maintain or establish multiple employer plans by voluntarily seeking licensure in the few states permitting this or to seek federal certification pursuant to the "exemption" provision (sec. 514(b)(6)(B)) under the current ERISA statute (new reserve, eligibility, and other standards must also be met; such requirements may be enforced by states if they desire, or otherwise by the Department of Labor). Entities that do not have either a state or federal certification are fully subject to state law (states, as they choose, may force them to meet any insurance or multiple employer plan licensing requirements or to terminate them). All such entities must register with the Department of Labor (DOL) and the states and are subject to the criminal penalties under ERISA for failure to do so. Illegitimate entities will become criminal enterprises—the enforcement tool lacking today and hindering both federal and state enforcement efforts. In addition, the DOL is given "cease and desist" authority to curtail the activities of any such illegitimate entities.

The DOL Inspector General testified that the above described changes in H.R. 995 are necessary and important changes to ERISA and key to stopping health insurance fraud.

The above described changes are necessary to clarify the extent of ERISA preemption of state law and the role of the states and the federal government in relation to multiple employer health entities (under current law these entities are termed "multiple employer welfare arrangements" or MEWAs). These entities may be either "self-insured" or "fully-insured." Under H.R. 995 fully-insured multiple employer plans are encouraged by permitting such plans to base premiums on their group experience and by preempting certain state benefit mandates and so-called state "fictitious group" laws—thus allowing them to compete on the same basis as self-insured plans with respect to these important elements.

Under ERISA a MEWA is defined as a plan or other "non-plan" arrangement established to provide benefits (e.g., health benefits)

to the employees of two or more employers. Under current law, the breadth of this definition sweeps in the following types of entities: (1) all collectively-bargained multiple employer plans (including Taft-Hartley jointly-trusted multiple employer plans) unless the DOL “finds” them to be collectively-bargained (the Department has not made any such finding)—under the bill, a new statutory exemption is provided and the exemption safe-harbor is provided for certain plans failing the statutory rule; (2) large employer plans that include employees of entities outside the “control group” of the employer—many large employer plans and plans with franchisee participants are MEWAs—under the bill, a new statutory exemption is provided and an exemption safe-harbor is provided certain plans failing the statutory rule; (3) “church plans” currently exempt from ERISA may voluntarily seek certification under ERISA; (4) multiple employer entities, such as those maintained by legitimate trade, industry and professional associations, which meet the definition under ERISA of an “employee benefit plan”—for which exemptions may be granted under the bill; and (5) other multiple employer welfare arrangements which do not meet the definition under ERISA of an “employee benefit plan”—under the bill such entities are not eligible for an exemption and are fully subject to state law.

In general, ERISA preempts state insurance and other laws “relating to an employee benefit plan”. As originally enacted, this broad preemption included multiple employer arrangements as long as they met the definition of an “employee benefit plan”. Any multiple employer entity that was not a plan did not have the benefit of ERISA preemption.

Because illegitimate schemes (which did not rise to the level of ERISA “employee benefit plans”) promoted by “bogus unions” and others were delaying and thwarting legitimate state enforcement efforts by claiming ERISA preemption (even though ineligible), ERISA was amended in 1983 in an attempt to clarify the ability of states to regulate the non-ERISA-plan entities as well as legitimate self-insured ERISA multiple employer plans (but the regulation by the states of the later was conditional, i.e., regulation is permitted only “to the extent not inconsistent with the provisions \* \* \*.” of ERISA Title I). This later clause was intended to encourage responsible regulation of legitimate ERISA plans, under specific state laws relating to these entities, but not to enable states to terminate legitimate ERISA plan entities solely because they were not “insurance companies”—the later concept is incorporated in ERISA section 514 as the so-called “deemer clause” prohibiting states from deeming ERISA plans to be in the business of insurance.

Unfortunately the 1983 amendment has not achieved its intended purpose. While a few states have enacted specific statutes regulating legitimate self-insured multiple employer plans, others have intervened in the operations of legitimate arrangements meeting the ERISA plan definition and forced the involuntary termination of such arrangements. These state actions have been selective in nature and do not follow any consistent basis either within a state or among states (actions may vary depending on the entity involved—the size of the employer, the industry, the presence of

collective-bargaining, etc.). As reported by the Committee, H.R. 995 provides a consistent basis for regulating the continued operations of legitimate ERISA multiple employer plans and provides that such plans may instead continue to choose to operate under the state laws specifically regulating such entities.

Neither did the 1983 amendment achieve the objective of stemming the number of illegitimate enterprises that continue to bilk the public under arrangements that do not meet the ERISA definition of an "employee benefit plan". Therefore, H.R. 995 makes it clear that entities that have not received either an exemption under ERISA or a state license or certification are fully subject to state law and to improved federal civil and criminal enforcement. As requested by the National Association of Insurance Commissioners (NAIC), the qualification of their authority over non-certified self-insured multiple employer entities is removed (i.e., the clause requiring state authority to be "consistent with" ERISA Title I is repealed).

These clarifications of ERISA preemption relating to multiple employer arrangements will free substantial additional resources that have been spent to stop health insurance fraud and abuse. Moreover, the considerable state resources involved in stopping insurance fraud will be released for more productive purposes. Additional resources of the federal government can also be redirected more productively in administering the new law and helping expand more affordable health coverage.

For example, the DOL Pension and Welfare Benefit Administration's (PBWA) Office of Civil Enforcement expends about 25% of all group health plan civil enforcement resources on problem entities and expends about 68% of all group health plan criminal enforcement resources on illegitimate MEWAs. The Office of the Solicitor of Labor expends about two-thirds of all group health plan enforcement on illegitimate MEWAs. In addition, the Office of the Inspector General has expended between 5-15% of all investigative resources (not just related to group health plans) on illegitimate MEWAs. For 1993, 1994, and 1995 combined, the PWBA has allocated about 43 employees and 33,400 hours on Clinton Health Insurance Reform efforts. With the passage of targeted health insurance reform, a large portion of these resources can be allocated to the administration of H.R. 995.

#### COMMITTEE VIEWS

##### THE AMERICAN PEOPLE HAVE WAITED TOO LONG FOR COMMON-SENSE TARGETED HEALTH INSURANCE REFORM

For nearly three decades the American people have looked to Congress to improve health insurance accessibility, affordability, and accountability. Unfortunately, until this point in time, legislative overreaching has deprived our people of the added security that would result from the common-sense and bipartisan targeted health insurance reforms proposed earlier by various Members of the Economic and Educational Opportunities Committee and others.

The government-run health care plan proposed by President Clinton in 1993 failed because it threatened the health coverage

and health care of the vast majority of Americans who have health insurance with which they are satisfied. The American people were not fooled about the elements of the plan that proved too costly, that were too bureaucratic, and that would lead to health care rationing. At that time, Committee Democrats rejected the alternative targeted health insurance reforms offered by Republicans. However, in the wake of the demise of the Clinton plan the peoples' voice is being listened to more closely. As a result the Committee is encouraged about the prospects for targeted health insurance reform and has taken President Clinton at his word in this regard (i.e., in his State of the Union address last year the President said, "let's do it step by step; let's do whatever we have to do to get something done.").

That is why the ERISA Targeted Health Insurance Reform Act (H.R. 995), which was introduced February 21, 1995, is deliberately more modest in scope. Rather than trying to create a new health care system, the legislation instead seeks to build on those elements of the nation's employment-based system that work well—namely the fully-insured and self-insured group health plans under ERISA—while at the same time making the important changes to the current system which are needed.

*The Bill Includes New Protections for Workers in a Mobile Workforce*

The changes called for by witnesses at the hearings held on H.R. 995 include helping end job-lock by limiting preexisting condition restrictions and eliminating such restrictions for those who maintain continuous health insurance coverage. The bill as reported by the Committee does that and more. No longer would any insurer or group health plan be able to exclude an employee from enrolling in the plan because of a preexisting medical condition. Uncovered employees would have to be permitted to enroll at least once a year and be able to choose at least one benefit option. If family coverage is offered, spouses who lose other coverage and newborns would have to be allowed to be enrolled under group health plans.

Smaller businesses in particular expressed concern that insurers not be able to drop their coverage because of the health status of their employees. The legislation addresses this concern by prohibiting insurers and multiple employer plans from failing to renew health insurance coverage because of adverse claims experience or other reasons. Smaller employers would also have an expanded choice of health insurance coverage made available to them as a result of the provision in H.R. 995 requiring that such employers be able to choose their health insurance from among all of the products offered by insurers and HMOs participating in the small group market.

As important as these increased consumer protections are, the witnesses at the hearing stressed that making health insurance more affordable was the key to making it more available to the American worker and his or her family. Therefore, the legislation contains provisions that will help achieve the goal of expanding coverage to the nearly 34 million individuals in working families who now do not have health insurance coverage. It does this by clarifying the ERISA law to allow employers, especially smaller em-

ployers, to form multiple employer plans through the associations that represent the nation's trades and businesses and by allowing employers and employees to choose and negotiate for the type of coverage they need and can afford.

Under H.R. 995, these multiple employer plans could self-insure or fully-insure, gaining all of the advantages this entails including economies-of-scale and lower costs. Small employers who now do not have access to coverage or cannot afford it would be automatically eligible for more affordable health coverage through their business and trade associations as well as through the offerings presented by their insurance agents who serve the small group market (which is made more accessible under the legislation).

THE TARGETED HEALTH INSURANCE REFORMS ARE BUILT UPON THE  
BEDROCK OF PRIVATE HEALTH COVERAGE

The ERISA Targeted Health Insurance Reform Act of 1996 presents this Congress with perhaps its best opportunity since the passage of ERISA to expand access to affordable health insurance for the many American families who are currently uninsured.

In 1974, Congress enacted the Employee Retirement Income Security Act or, as it came to be known, ERISA. In doing so, Congress shaped and put into place the cornerstone of our country's employee benefits law. More importantly, it laid the foundation upon which employers and negotiated multiemployer plans have been able to successfully provide benefits to workers and their families, including pensions, health and other benefits. H.R. 995 builds upon that success and seeks to expand health coverage to an even greater universe of employers and employees.

By utilizing the time-tested features contained in ERISA, the legislation builds upon the successes produced by private sector innovation and market competition. It is a well-targeted and workable framework within which incremental health insurance reform can be enacted this year.

As Representative John Erlenborn, an author of the original ERISA law and former member of the Committee, stated during the hearings on the bill, "it is my belief that Title I of ERISA has, over the past twenty years, proven to be a success and \* \* \* the judgments that led to ERISA's enactment, continuing to rely on a voluntary system devised by employers and employees with the addition of protections for participants, are as valid today as when we [then] made them." Mr. Frank Cummings, a drafter of an early version of ERISA, stated "this bill is the right step, at the right time, in the right direction." They made clear that the legislation addresses many problems faced by workers who are currently uninsured. Many other witnesses also testified on the benefits of using ERISA as the basis for expanding health insurance coverage.

For example, Mr. Jack Faris, President of the National Federation of Independent Business, stated that "NFIB supports H.R. 995, to increase access to health insurance to allow Multiple Employer Health Plans under an ERISA framework." The most important construct of H.R. 995 is giving small business a chance to purchase health insurance on the same terms as big business. According to Mr. Faris, "H.R. 995 successfully takes on the most vexing challenge when it comes to insurance reforms in the small group mar-

ket: providing for portability, accessibility, renewability, and rate stability without causing a rate hike for those who already have coverage. Providing access on the one hand and holding prices down on the other is a difficult balance to find. We believe H.R. 995 addresses this matter in a responsible way.”

Also, Mr. Jerry J. Jasinowski, President of the National Association of Manufacturers, said that he “is pleased H.R. 995 relies on competition, rather than government.” Supportive of the principles on which H.R. 995 was designed, Mr. Jasinowski said the bill “does what needs to be done \* \* \* It enables competition and market forces—by facilitating purchasing groups within the ERISA framework—to allow smaller employers to band together and improve access to affordable coverage.”

Mr. Sean Sullivan, President and CEO of the National Business Coalition on Health, applauded the sponsors “for seeking through H.R. 995 to allow the market to work for small employers the way we are making it work for larger businesses.” Mr. Sullivan stated that if H.R. 995 were to become law, roughly half of the uninsured, 20 million people, could possibly be covered.

Dr. Timothy Flaherty, testifying on behalf of the American Medical Association’s Board of trustees, “commended H.R. 995 for its vision.” Under H.R. 995, Dr. Flaherty said “the world would begin to change for the better. Insurers would be encouraged to provide insurance. Businesses would be encouraged to focus more of their attention on business. And physicians would be freed up to focus more on providing quality medical services to their patients.” The AMA believes H.R. 995 would “make health care markets more competitive and increase access without resorting to global budgets, price controls, government subsidies or creating a Canadian-style single payer system.”

Mr. Gerald McGeehan, Jr., President of the Graphic Arts Benefits Corporation, testified in support of H.R. 995 because it would “address the issue of multi-jurisdictional reporting and accountability for employer group plans.” The Graphics Arts Benefits Corporation, and similar small employer benefit programs sponsored through local Printing Industry Associations, was established to address a critical need—availability of quality, cost-effective medical benefit programs. “Association-based multiple employer health plans have demonstrated an innovative approach to providing secure, comprehensive levels of medical care benefits,” Mr. McGeehan said.

The Honorable Charles C. Masten, Inspector General of the U.S. Department of Labor, commented on the enforcement aspects of H.R. 995. Mr. Masten said that H.R. 995 “offers the promise of decreasing the level of fraud in health care benefit plans.” “I believe that H.R. 995 will make it easier for the OIG and other enforcement agencies to detect and investigate fraudulent activities, by identifying and defining entities which have created problems under the current law, such as employee leasing arrangements, ‘associate’ union memberships, and non-existent unions,” he said. The Committee agrees with the Inspector General that the strong enforcement aspects of H.R. 995 are necessary and important elements which are needed to stop insurance fraud and to bring increased accountability to the health care system.

Committee testimony also included findings from a report entitled "Small Group Market Reforms: A Snapshot of States' Experience." These findings of the Intergovernmental Health Policy Project of The George Washington University, were based on a survey of officials in 12 states that were among the earliest to enact small group market reforms. The main conclusion was that these small group reforms are unlikely to improve significantly either the affordability or availability of insurance for those working for small firms. The Committee believes that this evidence, substantiated with additional survey information provided the Committee from state insurance commissioners, suggests that the market and competition based reforms under the bill are necessary to empower small businesses to offer their employees more affordable coverage using the same techniques available to larger employers under ERISA.

As important as it is to note what the ERISA Targeted Health Insurance Act does, the Committee wishes to draw Members attention to what H.R. 995 does not do. For instance, by using the ERISA foundation the reported bill will not force Americans to give up their current health insurance coverage, but will serve to increase their choice of coverage. It will not impose government mandates. It will not require any new federal spending or taxes. Importantly, the bill will not create a new government-run health care bureaucracy that imposes price controls, mandates, and other impediments to high quality health care.

EXPANSION OF COVERAGE THROUGH MULTIPLE EMPLOYER HEALTH  
PLANS UNDER TITLE III OF H.R. 995

American workers and their families want availability, affordability and accountability in the systems delivering their health coverage.

The bipartisan Targeted Health Insurance Reform measure reported by the Committee is unique in that it offers the opportunities to dramatically reduce the cost of health insurance available to small businesses by allowing them to voluntarily form large multiple employer groups. This will provide them with all the advantages larger employers now enjoy—the key to significantly reducing the number of uninsured American workers.

Government regulation and micro-management of employee health plans is not the solution Americans want or need, as was aptly demonstrated in the last Congress. Under Title III the bill builds on what works: the 1974 Employee Retirement Income Security Act (ERISA), the successful and time tested free market-oriented cornerstone of employee benefits.

The ERISA law has played an important role in driving down costs for medium and large employers and allowing virtual universal coverage for their employees by allowing employers and unions the option not only to insure but also to self-insure, giving them the low cost, quality, and choice advantages of uniform health benefit plans for all of their employees.

Pooling smaller employers could save them as much as 40 percent in overhead costs, thus enabling employers to cover more employees and provide more benefits. ERISA plans are the foundation of private health care coverage in America. According to the Self-

Insurance Institute of America, ERISA plans cover more than 50 million people, including 60 percent of all workers and their dependents.

Former Delaware Governor Pete du Pont said it best: "ERISA has worked—more people are insured than would be the case had it not been passed" (Washington Times, May 10, 1995).

Unfortunately, the smallest employers and the self-employed have not shared in the advantages of ERISA. A study by Foster and Higgins reported that over the past several years, larger employers saw health costs decline. This was no doubt due to the benefits of economies-of-scale larger employers enjoy, to structure plans to include managed care alternatives, and to negotiate with providers for high quality health plans at lower costs. Conversely, the smallest employers experienced cost increase during this same period of time, up 6.5 percent in 1994. There is obviously a need to put equity into the system.

The Employee Benefit Research Institute (EBRI) has reported that about 85 percent of the nearly 40 million uninsured Americans are employed by a small employer (or are the dependents of such workers), or are self-employed. Clearly, the problem of the uninsured is predominantly a problem of small businesses lacking access to affordable insurance. Sadly, the choice is too often between paying for a Cadillac health insurance package or having no health insurance whatsoever. Too many Americans are paying for benefits they do not need, and too many others cannot get even the most basic coverage.

The enactment of the Title III provisions of the ERISA Targeted Health Insurance Reform Act of 1996 would put the nation well on its way to closing the gap.

It would give associations, such as the Chamber of Commerce or National Federation of Independent Business (NFIB) the ability to form large regional or national groups that could self-insure or fully-insure, gaining all of the advantages that entails: economies-of-scale, bargaining power with providers, uniformity of plans, freedom from costly state-mandated benefit packages, and significantly lower overhead costs. As Mr. Jack Faris, President of the National Federation of Independent Business, explained during hearings on the bill, "Small business owners often pay approximately 30% more than larger companies for similar benefits because of higher administrative costs. In addition, they often pay another 30% in premiums because of costly state mandates for specific types of insurance coverage \* \* \*"

"H.R. 995 would expand this good deal [that larger employers have through ERISA] to the small employer marketplace by giving small firms almost every advantage they lack in purchasing health insurance today," Mr. Faris concluded. Retailers, wholesalers, printers, agricultural employees, churches, franchise networks, and others could form multiple employer groups, thus covering more Americans—but at lower cost.

Some mistakenly claim that expanding ERISA would empower the federal government over the states. Those who understand ERISA know better. Again, former Governor du Pont: "The real issue is regulation, not federalism. By maintaining ERISA intact, or even better, expanding it so smaller employers, by voluntarily

banding together, can utilize ERISA, the federal government would ensure that employers have the freedom they need to establish affordable health insurance policies, and that more and more employees have health insurance.”

This is one issue on which employers and unions agree. For example, Mr. Robert Georgine, Chairman of the National Coordinating Committee for Multiemployer Plans, stated in testimony submitted to the Committee: “Given this reality [that there will be no employer mandate] the next best approach is a policy that encourages an expansion of voluntary, employment-based coverage without imposing additional costs on existing health plans. \* \* \* H.R. 995 takes this approach. We are pleased that the bill uses ERISA as its vehicle.”

*Fully-insured multiple employer and single-employer plans*

As reported, the bill will help expand coverage by making health insurance more affordable and available in the insured marketplace. This goal is advanced in several ways. First, the bill encourages the pooling of employers, particularly smaller employers, to purchase health insurance under fully-insured arrangements. Secondly, the bill removes the impediment under current law which may prevent more affordable coverage being offered in the insured market.

Specifically, the bill will enhance the ability of insurers and HMOs to compete in the small business market, while taking a major step toward cost reduction for smaller employers who fully insure. By preempting expensive and counter-productive “one size fits all” state mandated benefits for single-employer and fully-insured multiple employer plans, the bill will better allow insurers to compete with self-insurance. It will enable them to offer nationally uniform benefit plans, ending the expense and complexity of complying with 50 conflicting state rules. States could still require the offering of two policies of insurance with specific mandates, but the bill would allow consumers a broader choice of coverage and no longer prevent employers and employees from negotiating the benefit packages they want and can afford.

Title III of H.R. 995 also empowers small employers to form fully-insured multiple employer health plans—voluntary health insurance associations (VHIAs)—to achieve economies of scale and reach the 85% of the uninsured who are in working families. A level-playing-field for insurers (vis-a-vis self-insurance) is achieved by allowing fully-insured multiple employer plans (1) to set their own benefit packages (costly state mandated benefits are preempted as explained above), (2) to form along the lines of association and community based pools (state fictitious group laws are preempted to allow community based employer pooling to occur in every state, such as the so-called COSE plan in Cleveland, Ohio), and (3) to set premiums based on the experience of each particular voluntary health insurance association, as is the case for self-insured plans.

A voluntary health insurance association (VHIA) is defined as a multiple employer arrangement maintained by a qualified association under which all medical benefits are fully-insured. The term qualified association means an association which consists of em-

ployers who together employ a minimum number of employees, but only if the sponsor of the association is, and has been for a continuous period of not less than 3 years, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care, and is established as a permanent entity which receives the active support of its members. The criteria used to define fully-insured association arrangements are also required to be met by employer associations that wish to be eligible to establish self-insured multiple employer health plans (as described below).

*Expansion of coverage through self-insured multiple employer health plans*

As reported, the bill also builds on the ERISA cornerstone to empower employers, particularly smaller employers, to offer affordable coverage under multiple employer health plans that are self-insured. Expanding coverage to the uninsured truly is a winning proposition for all—employees (who would have coverage, perhaps for the first time), employers (who could afford to offer coverage), insurers (who would experience less cost shifting from the uninsured), and state governments (who would have fewer uninsured within their borders and reduced uncompensated care costs).

Testifying on this approach, Mr. Sean Sullivan, President and CEO of the National Business Coalition on Health, an organization of employer coalitions whose members collectively provide health benefits to more than 35 million Americans, states: “Under the umbrella of ERISA, real health care reform already is taking place, driven by employers seeking better value from providers in the competitive marketplace. Your legislation [H.R. 995] would empower thousands of small businesses to join this movement that is reinventing the health care system for the 21st century.”

H.R. 995 builds on what works, rather than on what does not. What works is the 1974 Employee Retirement Income Security Act (ERISA), the successful and time-tested, free-market oriented cornerstone of employee benefits. What works is using and improving the incentives and momentum of the market, seeking to expand real coverage to areas that the market is capable of reaching. What does not work is government micro-management of employee health plans.

ERISA has played an important role in driving down costs for medium and large employers, and allowing virtual “universal coverage for the employees of medium and large U.S. employers. ERISA allows an employer to self-insure, permitting companies to offer uniform health benefit plans to all of their employees, no matter where they work or reside. Under ERISA, employers and employees are free to voluntarily work out benefit packages that fit the needs of workers and their pocketbooks.

Unfortunately, the smallest employers and the self-employed have not shared in the advantages of ERISA. H.R. 995 builds on ERISA to give smaller employers the same economies of scale and freedom to offer affordable coverage that larger employers enjoy.

The bill clears the way for market forces to bring small employer costs down, while also carefully addressing the problems of insurance fraud and abuse.

Under current law hundreds of legitimate association self-insured multiple employer plans exist (e.g., nationwide plans for corner hardware and grocery stores, rural electric and telephone coops, etc.). However, federal standards do not exist to assure their solvency and only about a dozen states have enacted specific statutes to regulate them for solvency.

To remedy this situation, the bill provides that legitimate associations, franchise networks, church plans, certain collectively-bargained plans and company affiliates may choose to either remain subject to the few state multiple plan laws or to apply for an "exemption pursuant to a provision under current ERISA law which has not been implemented by the Department of Labor.

As described in more detail below, this process will require self-insured multiple employer plans to meet solvency, fiduciary, and other necessary standards. This provision has been included in bipartisan legislation for over 5 years, including the BIPARTISAN HEALTH CARE REFORM bill developed as an alternative to the Clinton health plan (H.R. 5228, 103rd Congress).

As the National Center for Policy Analysis and the Heritage Foundation have found in their analyses of Title III of H.R. 995, ERISA-based employer pooling is free-market and pro-competition.

While some critics might express concern that the existence of self-insured multiple employer health plans could reduce the pool of small employers subject to state insurance laws, this is not the inevitable consequence of the pooling provisions under Title III.

Without any change in the law the number of self-insured employers exempt from state law under ERISA will increase, as past experience shows, even among the very smallest single employer plans. However, under the bill the health insurance industry is put in a more competitive position than today in comparison with self-insured plans. Insured plans can now compete on the same basis regarding nationally uniform benefits, pooling, and premium structure as described earlier. With the expansion of health coverage the number of workers covered under fully-insured plans will increase, thus reversing the trend under current law. In addition, the small multiple employer plans will look very much like their large-employer cousins (i.e., offering managed care, PPOs, and other cost effective insured options) which means that the insurance products offered under even self-insured plans would still be subject to state insurance regulation as the Supreme Court ruled in *Metropolitan v. Massachusetts*.

The legislation would also draw bright lines regarding state and federal authority regarding self-insured multiple employer plans which does not currently exist. Today the law is confusing regarding the responsibility of the states and the Department of Labor under ERISA. Only a handful of states have specific statutes applicable to legitimate multiple employer plans—and even in these states there are other multiple employer plans operating without the benefit of solvency regulation. The several hundreds of existing self-insured multiple plans, therefore, are not being subjected to state or federal solvency regulation (a condition the bill corrects).

Unfortunately, the illegitimate schemes which are perpetrated by bogus-unions and other fraudulent operators continue to proliferate despite the efforts of the Committee to correct the situation in 1983 (P.L. 97-473). Clearly the limited extent of state regulatory authority under current law has not been adequate to stem the problems that led to the 1983 change to ERISA. The fact is that the problems presented by illegitimate non-ERISA-plans are inter-state in nature and the National Association of Insurance Commissioners (NAIC) testified that changes to federal law are needed. In prepared testimony, the President of the NAIC stated that “states often engage in lengthy jurisdictional battles with [collectively bargained and staff arrangements] even before states can assert their regulatory authority. Consequently, under the current structure, many years can and often do pass before the courts ultimately determine that States can regulate a fraudulent MEWA.”

To address this problem, the bill gives states and the federal government more authority to put an end to health insurance fraud. Under the bill, states are given clear and unrestricted authority to put a stop to illegitimate entities—if an entity does not clearly show that they are either licensed by the state or have received an exemption under section 514 of ERISA, the state can shut it down. To the extent the entity flees a state’s border, the Department of Labor is directed to assist the state to shut the entity down through new “cease and desist authority under the bill. Under the bill, illegal entities become subject to criminal penalties if they try to hide their operations. This is why the Inspector General of the Department of Labor testified that the Department supports these provisions as “necessary and important changes to ERISA. These provisions make the private health insurance system more truly accountable.

The fact is that, under the bill, legitimate association self-insured arrangements will be subject to greater solvency regulation than union-sponsored multiemployer plans and the self-insured single-employer plans of even the smallest employers.

The Committee has taken a different, and we believe a more responsible, approach to the regulation of association plans than that taken by the Committee in the past. In the one “health insurance related bill passed by the committee in this decade and enacted into law (P.L. 102-89, signed on August 14, 1991), the multiple employer health plan of the National Rural Telephone Cooperative was exempted from all state solvency regulation, but without imposing any federal solvency standards for such arrangement.

*Clarification of duty of the Secretary of Labor to implement provisions of current law providing for exemptions and solvency standards for self-insured multiple employer health plans*

In general, section 302 of Title III of the bill clarifies the conditions (solvency, etc) under which non-fully-insured multiple employer arrangements providing medical care (which are defined as multiple employer health plans or MEHPs) may apply for an exemption from certain state laws (states may enforce such conditions). The exemption process is contained under the current ERISA law. Also, the current ERISA law contains restrictions on the ability of states to fully regulate such entities.

Specifically, current law section 514(b)(6)(A)(ii) of ERISA provides that in the case of such a partly insured or fully self-insured arrangement, any law of any State which regulates insurance may apply only “to the extent not inconsistent with other parts of ERISA”. However, under section 514(b)(6)(B) the Department of Labor may issue an exemption from state law with respect to such self-insured arrangements (but has yet to issue a procedure or regulations to implement the exemption process as intended under amendments to ERISA enacted in 1983). The “to the extent not inconsistent” language was intended to encourage states to enact specific statutes regulating such entities without forcing them to become “insurance companies” which is a key concept under the so-called “deemer clause” in ERISA section 514 (i.e., that ERISA “employee benefit plans” shall not be deemed to be in the business of insurance).

Under a new part 7 of ERISA Title I, the bill clarifies that only certain legitimate association health plans and other arrangements (described below) which are not fully insured are eligible for an exemption and thereby treated as ERISA employee welfare benefit plans. (Under section 514(a) of ERISA, States are preempted from regulating employee welfare benefit plans—but an exception is made under this provision to allow states to enforce the conditions of an exemption granted a MEHP). This is accomplished by clarifying the duty of the Secretary of Labor to implement the provisions of current law section 514(b)(6)(B) to provide such exemptions for MEHPs.

Part 7 sets forth criteria which a self-insured arrangement must meet to qualify for an exemption and thus become a MEHP. The Secretary shall grant an exemption to an arrangement only if: (1) a complete application has been filed; (2) the application demonstrates compliance with eligibility requirements described below; (3) the Secretary finds that the exemption is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of the individuals covered under the arrangement; (4) certain reserve requirements (as described below) are met, and (5) all other terms of the exemption are met (e.g. including financial, actuarial, reporting, participation, and other requirements which may be specified as a condition of the exemption).

Under the eligibility requirements for MEHPs, an applicant must demonstrate that the arrangement’s sponsor has been in existence for a continuous period of at least 3 years and organized and maintained in good faith, with a constitution and bylaws, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group) for purposes other than that of obtaining or providing medical care. Also, the applicant must demonstrate that the sponsor is established as a permanent entity and has the active support of its members.

In addition to the associations described above, certain other entities are eligible to seek an exemption as MEHPs. These include (1) franchise networks, (2) certain existing collectively bargained arrangements which fail to meet the statutory exemption criteria, (3) certain arrangements not meeting the statutory exemption cri-

teria for single employer plans, and (4) certain church plans electing to seek an exemption.

The bill also requires that the arrangement be operated, pursuant to a trust agreement, by a "board of trustees" which has complete fiscal control and which is responsible for all operations of the arrangement. The board of trustees must develop rules of operation and financial control based on a three-year plan of operation which is adequate to carry out the terms of the arrangement and to meet all applicable requirements of the exemption and Title I of ERISA. The Board of Trustees must be the "named fiduciary" under ERISA, thus being liable for any breach of fiduciary duty under Part 4 of the law.

The Committee expects that the following requirements will have to be met by any entity provided an exemption under the bill. In general, each multiple employer welfare arrangement which is or has been a multiple employer health plan and under which some or all benefits are not fully insured shall be required to establish and maintain reserves for each plan year, consisting of—(1) a reserve sufficient for unearned contributions, (2) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities, and (3) a reserve, in an amount recommended by the qualified actuary, appointed on behalf of all plan participants, for any other obligations of the arrangement.

The Committee expects that, in general, the total of the reserves described in clause (2) above shall not be less than an amount equal to the greater of 25 percent of the amount of benefit liabilities expected to be incurred for the plan year and for which risk of loss has not been effectively transferred and 25 percent of the amount of expected administrative costs with respect to such benefit liabilities for the plan year, or \$100,000.

The Committee expects that in determining the amounts of reserves required in connection with any multiple employer health plan, the qualified actuary shall include a margin for error and other fluctuations taking into account the specific circumstances of such plan.

The Committee also intends that the Secretary may provide such additional requirements relating to reserves and excess/stop loss coverage as the Secretary considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any arrangement or any class of arrangements. It is anticipated that the Secretary may provide for adjustments to the levels of reserves otherwise required with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such plans.

The Committee also intends that the Secretary shall by regulation permit a multiple employer health plan to substitute, for all or part of the reserves required, such security, guarantee, hold-harmless arrangements, insolvency insurance, or other financial arrangement as the Secretary determines to be adequate to enable the plan to fully satisfy all benefit liabilities on a timely basis.

The Committee also intends that the Secretary will provide by regulation or otherwise procedures for the quarterly reporting of fi-

nancial and actuarial information by the board of trustees and the qualified actuary, in cases of any failure to meet the standards, in order to assure the financial responsibility of the plan. It is expected that notice requirements for voluntary termination and additional rules for mandatory termination, in cases in which this may be necessary, will also be promulgated.

In addition to the above reserve and other consumer protections, H.R. 995 has strict rules to prevent so-called “anti-selection.”

For example, small employers who choose to self-insure either as a single employer or by joining a MEHP do not have an unfettered right to revert to the fully-insured market if their self-insured costs go up—the bill allows insurers to deny previously self-insured small employers coverage in the fully-insured market for one year. This rule allows insurers to stop adverse selection.

Also under the bill, for the first time, self-insured plans must meet enrollment and contribution rules which are at least as strict, if not more strict, than the rules applicable to health insurers. Under the bill, MEHPs cannot deny enrollment to employees because of a preexisting medical condition; MEHPs must offer coverage to all employer members of the association without regard to claims experience, health status of workers, or other conditions; and MEHPs cannot set their premiums in a manner so as to force a high cost employer to pay higher premiums than other employers in the plan so as to force such an employer out of the plan and into the fully-insured market.

In addition, the organizations eligible to sponsor self-insured MEHPs cannot be structured to select only “good risks” because sponsors cannot be organized for the purpose of offering health insurance, but must be in existence for at least 3 years before starting a MEHP; and sponsors can only be legitimate business organizations, church plans, collectively-bargained arrangements, and franchise networks not otherwise in the health insurance business.

Anti-selection against the individual insurance market is also precluded under the bill by prohibiting employers who participate in MEHPs from excluding sick employees and purchasing coverage for such individuals in the individual market.

Selection in favor of self-insured MEHPs is also neutralized by allowing the same associations eligible to establish MEHPs to alternatively establish “voluntary health insurance associations” (VHIAs) to purchase fully-insured products and offer the same benefit packages as self-insured plans (due to the preemption of state benefit mandates) and set premiums for participating employers on the basis of the group’s experience as is the case for MEHPs. Thus fully-insured plans will again become a real choice for affordable coverage for small employers.

It should be noted that these new rules applicable to MEHPs are more strict than those that apply to existing collectively-bargained multiemployer plans covering many small employers.

Since most states have not required fully-insured association plans to meet so-called small group rating reforms, the more strict anti-selection rules applicable to self-insured MEHPs will reduce any anti-selection that may be occurring under current law among self-insured plans, if such anti-selection actually exists—something not clearly shown in any study of which the Committee is aware.

No evidence of such anti-selection has been produced by those who have alleged that such practices exist.

To the contrary, today self-insured multiple employer plans serve as a backstop to practices in the insurance industry which have denied higher-than-average risk industries the access to health insurance they have sought. For example, in testimony a California growers cooperative produced evidence of dozens of insurers who refused to underwrite health insurance coverage for the farm workers in their industry. Also, studies demonstrate that the self-insured population is not composed of "lower health insurance risks" than the population of employees covered under employer sponsored fully-insured health insurance policies.

The bill empowers employers, particularly small employers, to use the same time-tested "self-insured" concept that numerous states, counties, and cities use to secure health insurance coverage for their own employees. Approximately seven million employees are covered under public employee self-insured plans.

The experience under ERISA of expanded coverage and improved cost containment for larger employers in comparison to the unfavorable experience of small employers should convince all but the uninformed observer that small employers should be empowered to band together to offer more affordable health coverage through ERISA self-insured Multiple Employer Health Plans (MEHPs).

#### CONCLUSION

Virtually everyone agrees that something must be done to put an end to the job-lock that occurs when workers fear losing their health insurance because they, or someone in their family, has a pre-existing health condition. The ERISA Targeted Health Insurance Act helps eliminate this fear and enhances insurance portability by removing insurance company and plan restrictions on pre-existing conditions for individuals who are continuously covered. It also establishes enrollment standards and guarantees health insurance renewability.

But, as described above, the ERISA Targeted Health Insurance Act does more than simply create new consumer protections within our nation's private health insurance markets. Equally important, it opens those markets to the millions of American workers and their families who today do not have access to or cannot afford private health insurance. It does so by removing the structural barriers that prevent some employers from voluntarily providing health insurance to their employees, either on their own or as part of a multiple employer health plan.

The bill employs ERISA Title I to provide a twenty-first-Century model of freedom for employees and employers to negotiate benefits, and provide a competitive environment to let market forces help reduce health care costs, thus making health insurance coverage more available and affordable for the American worker.

The bill creates a competitive health care marketplace, removes barriers and conflicting regulations, provides important new protections and freedoms for workers in a more mobile society, and allows cost-saving innovations to be introduced into the marketplace.

It is long overdue that cost-conscious small employers be given the same opportunity to achieve the economies-of-scale and free-

dom from excessive government regulation that large employers already have. The problems of uninsured workers and their families can be strongly attacked by removing barriers and allowing small employers to pool together to voluntarily form ERISA multiple employer health plans.

H.R. 995 builds on what is already working and by letting the market roar, the increased health plan competition that results will mean improved access to more affordable coverage for millions of employees, particularly those working for small businesses who do not have health insurance.

An article in *Group Practice Journal* sums up the basic thrust of the legislation: "The authors of [H.R. 995] presume that if competitive forces are released in the small group market, and if the problems of job-lock, denials based upon pre-existing conditions, and unfair rating practices are removed \* \* \* the opportunities for better quality, competitively priced coverage of individuals and employees of self-insuring small employers will expand. It is no consolation that these goals may be achieved, under a voluntary system, without employer mandates, state regulation, or taxes on providers or insured individuals to subsidize coverage of the uninsured."

In conclusion, the only way major strides in expanding access to health coverage for the uninsured can be achieved in a voluntary market is to make reforms that bring down the cost of providing health coverage to employers, particularly small employers. Health care reform that is effective in expanding access and based on free market principles is possible. It is in the grasp of this Congress in the form of H.R. 995. The way to expand coverage is the free market approach that is already working for over 50 million Americans now covered by an ERISA plan. We urge our colleagues to keep it working for those who already have coverage and expand the advantages of ERISA to those who do not by passing the provisions of the Targeted Health Insurance Reform Act this year.

#### SUMMARY

##### PORTABILITY

The bill will help prevent job-lock with provisions for portability and limits on preexisting conditions. Preexisting condition limitations are limited to a maximum of 12 months for conditions arising 6 months prior to coverage, and the preexisting condition period is reduced by 1 month for each month of prior coverage for the condition. The bill also guarantees to employers the renewal of their health coverage by their insurer or health plan.

##### EXPANDING COVERAGE THROUGH SMALL BUSINESS POOLING

H.R. 995 expands coverage to small businesses by clarifying current law to allow small employers to band together voluntarily in associations (such as Chambers of Commerce) to form multiple employer groups. Under the bill, these groups could self-insure or fully insure, gaining all of the advantages this entails including greater economies of scale and lower costs. The bill recognizes that the problem of the uninsured is one of small businesses unable to afford coverage for their workers: 85% of the 40 million uninsured

are in families with at least one employed worker, the vast majority of whom are employed by small businesses.

#### STOPPING HEALTH INSURANCE FRAUD

The legislation stops health insurance fraud perpetrated by “bogus unions and other illegitimate operators by making legitimate plans accountable and criminalizing fraudulent schemes.

#### SECTION-BY-SECTION ANALYSIS

##### *Sec. 1. Short title*

Section 1 includes the short title and table of contents

TITLE I—INCREASED AVAILABILITY AND CONTINUITY OF GROUP HEALTH PLAN COVERAGE FOR EMPLOYEES AND THEIR FAMILIES

##### *Sec. 101. Definition of group health plan*

Section 101 includes the definition of group health plan under section 3(42) of ERISA.

##### *Sec. 102. Access to, and continuity of, group health plan coverage*

Subsection (a). In General.—Adds a new part 8 (Access to, and Continuity of, Group Health Plan Coverage) to subtitle B of title I of ERISA as follows:

##### *Sec. 800. Definitions and special rules*

This section provides definitions of the following terms: employer; health insurance coverage; fully insured; insurer; health maintenance organization (HMO); medical care; and network plan. Since the definition of medical care is intended to parallel that of the Internal Revenue Code, the term in this bill is intended to be broad enough to encompass the services of Christian Science practitioners.

##### *Sec. 801. Limitations on preexisting condition exclusions*

This section prohibits a group health plan, HMO or insurer from denying or limiting benefits otherwise available under a plan based on a preexisting condition. Such limitations or exclusions are permitted only if they do not extend beyond 12 months (or 18 months for late entrants). A preexisting condition exists if it is diagnosed or treated within 6 months (or 12 months for late entrants) of the date of coverage, disregarding any waiting period. The section permits HMOs qualified under section 1301 of the Public Health Service Act to impose preexisting condition exclusions or alternatively, to impose an eligibility period, during which coverage would not be effective, of 90 days after initial eligibility or 180 days for late entrants.

##### *Sec. 802. Portability*

This section requires that the period of a preexisting condition exclusion be reduced by 1 month for each month during which an individual is in a period of continuous

coverage, defined as beginning on the date the individual becomes covered for such a preexisting condition under a group health plan, individual health insurance coverage, or a public plan and ending when the individual is not so covered for 60 days. The section prohibits use of a preexisting condition exclusion for newborns and adopted children with continuous coverage, if such coverage begins within one month of birth or adoption.

*Sec. 803. Requirements for renewability of coverage*

This section requires a multiemployer plan, multiple employer health plan, or fully insured multiple employer welfare arrangement (MEWA) to guarantee renewal to an employer except for the following reasons: nonpayment, fraud, or noncompliance with plan provisions; if the plan is no longer offering coverage in the area; for failure to meet the terms of a collective bargaining agreement; to meet requirements for exemption from MEWA status under new paragraphs (C) through (E) of section 3(40)(C); or, in the case of a multiple employer health plan, failure to meet the requirements for exemption under section 514(b)(6)(B) (explained below). The section requires an insurer to renew coverage for an employer except in cases of nonpayment, fraud, or noncompliance, or unless the insurer is ceasing to offer that type of group coverage in a State (or, for an HMO or network plan, the geographic area).

*Sec. 804. Group health plan enrollment requirements*

This section requires group health plans to have an annual enrollment period for eligible individuals not previously covered under which at least one benefit option (including family coverage if available) may be elected. A 30-day enrollment period is required to allow enrollment under special circumstances involving the loss of other health coverage, marriage, or birth (if family coverage is offered under the plan). A group health plan, insurer or HMO providing health insurance coverage in connection with a group health plan may not exclude an employee or his or her beneficiary from enrollment under the plan on the basis of a preexisting condition.

*Sec. 102, Subsection (b). Treatment of governmental plans*

In general, governmental plans are subject to the preexisting condition and portability provisions under sections 801 and 802, unless an election is made not to be covered. Former employees of non-covered plans would not have to be provided portability protection under other group health plans subject to the rule.

*Sec. 102, Subsection (c). Enforcement with respect to insurers and HMOs*

Permits the Secretary of Labor to enforce the provisions of new Part 8 only if a State is determined to not be providing effective enforcement. Otherwise, States may enforce such standards in con-

nection with the health insurance policies and contracts offered by insurers and HMOs.

*Sec. 102, Subsection (d). Preemption of differing state laws*

State standards inconsistent with the portability and preexisting condition limitation provisions of sections 801 and 802 are preempted, so as to establish nationally uniform standards applicable to group health plans. (State provisions related to renewal and enrollment requirements, sections 803 and 804, are not preempted.)

*Sec. 102, Subsection (e). Good faith compliance with requirement*

This section provides that prior to the issuance of regulations, a group health plan, insurer or HMO that complies in good faith with the provisions of Part 8 will be considered in compliance with such regulations.

*Sec. 102, Subsections (f) and (g). Conforming amendment and clerical amendments.*

These subsections contain conforming and clerical amendments.

*Sec. 103. Effective date*

Title I of the bill applies to plan years beginning 18 months after the date of enactment.

TITLE II—REQUIREMENTS FOR INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS OFFERING HEALTH INSURANCE COVERAGE TO GROUP HEALTH PLANS OF SMALL EMPLOYERS

*Sec. 201. ERISA requirements for insurers and health maintenance organizations offering health insurance coverage to group health plans of small employers*

Subsection (a). In General—adds a Subpart B (Requirements for Insurers and Health Maintenance Organizations Offering Health Insurance Coverage to Group Health Plans of Small Employers) to new part 8 of subtitle B of part I of ERISA as follows:

*Sec. 811. Definitions.*

This section defines eligible individuals to mean such persons as provided under uniformly applicable rules of the insurer and in accordance with applicable state laws. The term general coverage means health insurance coverage offered by an insurer or HMO at a particular time and not available solely in connection with an association. The term small employer is defined as one with more than 1 but less than 51 eligible employees on a typical business day. Also provided are definitions of small group market and State.

*Sec. 812. Requirements for insurers and health maintenance organizations in the small group market who offer general coverage*

This section requires an insurer or HMO that offers small group coverage in a State to make such general coverage available to small employers. It requires an insurer

or HMO to accept any small group and any eligible individual within the group who applies on a timely basis, subject to plan provisions and the enrollment provisions under section 804 and to any insurer participation standards which are applied uniformly and which are consistent with applicable state laws. It allows an insurer to deny coverage for 1 year to previously self-insured small employers. It also permits coverage offered to associations to be different from that offered to other small groups. The section also allows an HMO or network plan to limit coverage to individuals in their service areas and to refuse coverage of new groups if they have reached their capacity in a service area. It allows an insurer or HMO to deny coverage to new groups if it has insufficient financial reserves.

*Sec. 201, Subsection (b). Enforcement with respect to insurers and HMOs*

This section provides minimum standards and allows states to impose and enforce provisions relating to the subject matter of section 812 on small group insurers and HMOs.

*Sec. 201, Subsection (c). Good faith compliance with requirement*

This section provides that prior to the issuance of regulations an insurer or HMO that complies in good faith with the provisions of Subpart B of Part 8 will be considered in compliance with such regulations.

*Sec. 201, Subsection (d). Clerical amendment*

This section contains a clerical amendment.

*Section 202. Effective Date*

Sections 811 and 812 apply to insurers and HMOs 18 months after the date of enactment.

TITLE III—ENCOURAGEMENT OF MULTIPLE EMPLOYER HEALTH PLANS, VOLUNTARY HEALTH INSURANCE ASSOCIATIONS, AND OTHER FULLY INSURED ARRANGEMENTS; PREEMPTION

*Sec. 301. Scope of State regulation; clarification of preemption rules relating to voluntary health insurance associations and other fully insured arrangements*

**Sec. 301, Subsection (a). Scope of State Regulation.**—Subsection (a) preempts State or local laws that require that health insurance coverage in connection with group health plans cover specific items or services consisting of medical care, but does not preempt laws prohibiting the exclusion of specific diseases. A state may still specify the contents (with respect to covering specific items or services consisting of medical care) of up to two policies of insurance in the small group market.

**Sec. 301, Subsection (b). Preemption of State Fictitious Group Laws.**—Subsection (b) clarifies that ERISA preempts State or local laws that prohibit two or more employers from obtaining, or an insurer or HMO from offering, fully insured health insurance coverage under any fully-insured multiple employer welfare arrange-

ment (MEWA). By eliminating these so-called state “fictitious group laws” employees and employers will be empowered to form groups to more effectively and cost-efficiently purchase fully-insured health insurance coverage.

Sec. 301, Subsection (c). Clarification of Preemption Rules Relating to Voluntary Health Insurance Associations.—Subsection (c) adds a new subparagraph (E) to section 514(b)(6) of ERISA to clarify and refine the preemption rules applicable to voluntary health insurance associations (VHIAs). A voluntary health insurance association is defined as a multiple employer welfare arrangement maintained by a qualified association under which all medical benefits are fully-insured. The term qualified association means an association which consists of employers who together employ at least 200 employees who are eligible individuals, but only if the sponsor of the association is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years, organized and maintained in good faith, with a constitution and by-laws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1)), and is established as a permanent entity which receives the active support of its members. This definition is the same as the definition of the employer associations eligible to establish self-insured multiple employer health plans (in section 302).

This provision would preempt any state law which might otherwise preclude an insurer or HMO from setting premium rates based on the claims experience of a VHIA (without varying the premium rates of a particular employer on the basis of the employer's own experience). Under the provisions of section 301, a qualified association could form a VHIA and offer health insurance coverage and establish and distribute plan costs in a manner similar to that permitted under current law for self-insured plans.

*Sec. 302. Clarification of duty of the Secretary of Labor to implement provisions of current law providing for exemptions from State regulation of multiple employer health plans*

Sec. 302, Subsection (a). Rules Governing State Regulation of Multiple Employer Health Plans.—This subsection adds a new Part 7 (Rules Governing State Regulation of Multiple Employer Health Plans) to Title I of ERISA, as follows:

*Sec. 701. Definitions*

This section defines the following terms: insurer, fully-insured, medical care (as under current law), multiple employer health plan, participating employer, sponsor, and state insurance commissioner.

*Sec. 702. Multiple employer health plans eligible for relief from certain restrictions on preemption of State law*

This section clarifies the conditions under which multiple employer health plans (MEHPs), non-fully-insured multiple employer arrangements providing medical care,

may apply for an exemption from certain state laws. The exemption process is contained in current ERISA law, which also contains restrictions on the ability of states to fully regulate such entities. Specifically, existing section 514(b)(6)(A)(ii) of ERISA provides that in the case of such a partly insured or fully self-insured arrangement, any law of any State which regulates insurance may apply only “to the extent not inconsistent with other parts of ERISA.” However, under section 514(b)(6)(B), the Department of Labor (DOL) may issue an exemption from state law with respect to such self-insured arrangements.

Section 702 clarifies that only certain legitimate association health plans and other arrangements (described below) which are not fully insured are eligible for an exemption and thereby treated as ERISA employee welfare benefit plans. This is accomplished by clarifying the duty of the Secretary of Labor to implement the provisions of current law section 514(b)(6)(B) to provide such exemptions for MEHPs. Under section 514(a) of ERISA, States are preempted from regulating employee welfare benefit plans, but an exception is made under this provision to allow states to enforce the conditions of an exemption granted a MEHP.

Section 702 further sets forth criteria which a self-insured arrangement must meet to qualify for an exemption and thus become a MEHP. The Secretary shall grant an exemption to an arrangement only if: (1) a complete application has been filed, accompanied by the filing fee of \$5,000; (2) the application demonstrates compliance with requirements established in section 703 below; (3) the Secretary finds that the exemption is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of the individuals covered under the arrangement; (4) certain reserve requirements (of not less than \$100,000) are met, and (5) all other terms of the exemption are met (including financial, actuarial, reporting, participation, and such other requirements as may be specified as a condition of the exemption).

Section 702 also provides for a class exemption from section 514(b)(6)(A)(ii) of ERISA for large MEHPs that have been in operation for at least three years on the date of enactment. An arrangement qualifies for this class exemption if: (1) at the time of application for exemption, the arrangement covers at least 1,000 participants and beneficiaries, or has at least 2,000 employees of eligible participating employers; (2) a complete application has been filed and is pending; and (3) the application meets any requirements established by the Secretary with respect to class exemptions. Class exemptions would be treated as having been granted with respect to the arrangement unless the Secretary provides appropriate notice that the exemption has been denied.

*Sec. 703. Requirements relating to sponsors, boards of trustees, and plan operations*

This section establishes eligibility requirements for MEHPs. Applications must comply with requirements established by the Secretary. Applications must demonstrate that the arrangement’s sponsor has been in existence for a continuous period of at least 3

years and is organized and maintained in good faith, with a constitution and bylaws, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group) for purposes other than that of obtaining or providing medical care. Also, the applicant must demonstrate that the sponsor is established as a permanent entity and has the active support of its members.

Section 703 also requires that the arrangement be operated, pursuant to a trust agreement, by a “board of trustees” which has complete fiscal control and which is responsible for all operations of the arrangement. The board of trustees must develop rules of operation and financial control based on a three-year plan of operation which is adequate to carry out the terms of the arrangement and to meet all applicable requirements of the exemption and Title I of ERISA. The rules also require that the employees of all employers who are association members be eligible for participation under the terms of the plan (which cannot require that a minimum number of employees of a particular employer must participate before coverage is effective). The rules also stipulate that premium rates established under the plan with respect to any particular participating employer cannot be based on the claims experience of the particular employer (i.e., premiums would be set so as to reflect the experience of the plan as a whole).

In addition to the associations described above, certain other entities are eligible to seek an exemption as MEHPs under section 514(b)(6)(B). These include (1) franchise networks (section 703(b)), (2) certain existing collectively bargained arrangements which fail to meet the statutory exemption criteria (section 703(c)), and (3) certain arrangements not meeting the statutory exemption criteria for single employer plans (section 703(d)). (Section 704 of ERISA, added by Section 306 of the bill, also makes eligible certain church plans electing to seek an exemption.)

*Section 302, Subsections (b), (c), and (d). Conforming and clerical amendments*

Subsections (b) and (c) contain conforming amendments relating to preemption rules and the definition of plan sponsor, and subsection (d) contains a clerical amendment.

*Sec. 303. Clarification of scope of preemption rules*

This section clarifies the scope of ERISA preemption to make clear the authority of states to fully regulate non-fully-insured MEWAs which are not provided an exemption under new Part 7 of ERISA.

*Sec. 304. Clarification of treatment of single employer arrangements*

This section modifies the treatment of certain single employer arrangements under the section of ERISA that defines a MEWA (section 3(40)). The treatment of a single employer plan as being excluded from the definition of MEWA (and thus from state law) is clarified by defining the minimum interest required for two or more entities to be in “common control” as a percentage which cannot be required to be greater than 25%. Also a plan would be considered

a single employer plan if less than 15% of the covered employees are employed by other participating employers.

*Sec. 305. Clarification of treatment of certain collectively bargained arrangements*

This section clarifies the conditions under which multiemployer and other collectively-bargained arrangements are exempted from the MEWA definition, and thus exempt from state law. This is intended to address the problem of “bogus unions and other illegitimate health insurance operators. The provision amends the definition of MEWA to exclude a plan or arrangement which is established or maintained under or pursuant to a collective bargaining arrangement (as described in the National Labor Relations Act, the Railway Labor Act, and similar laws). (Current law requires the Secretary to “find” that a collective bargaining agreement exists, but no such finding has ever been issued). It then specifies additional conditions which must be met for such a plan to be a statutorily excluded collectively bargained arrangement and thus not a MEWA. These include:

(1) The plan cannot utilize the services of any licensed insurance agent or broker to solicit or enroll employers or pay a commission or other form of compensation to a person that is related to the volume or number of employers or individuals solicited or enrolled in the plan.

(2) A maximum 15 percent rule applies to the number of covered individuals in the plan who are not employees (or their beneficiaries) within a bargaining unit covered by any of the collective bargaining agreements with a participating employer or who are not present or former employees (or their beneficiaries) of sponsoring employee organizations or employers who are or were a party to any of the collective bargaining agreements.

(3) The employee organization or other entity sponsoring the plan or arrangement must certify annually to the Secretary the plan has met the previous requirements.

(4) If the plan or arrangement is not fully insured, it must be a multiemployer plan meeting specific requirements of the Labor Management Relations Act (i.e., the requirement for joint labor-management trusteeship under section 302(c)(5)(B)).

(5) If the plan or arrangement is not in effect as of the date of enactment, the employee organization or other entity sponsoring the plan or arrangement must have existed for at least 3 years or have been affiliated with another employee organization in existence for at least 3 years, or demonstrate to the Secretary that certain of the above requirements have been met.

*Sec. 306. Treatment of church plans*

This section adds a new section 704 to ERISA permitting church plans to voluntarily elect to apply to the Department of Labor for an exemption under section 514(b)(6)(B) and in accordance with new ERISA Part 7. An exempted church plan would, with certain exceptions, have to comply with the provisions of ERISA Title I in order to receive an exception from state law. The

election to be covered by ERISA would be irrevocable. A church plan is covered under this section if the plan provides benefits which include medical care and some or all of the benefits are not fully insured.

*Sec. 307. Enforcement provisions relating to multiple employer welfare arrangements*

This section amends specific provisions of ERISA to establish enforcement provisions relating to the elements of this bill: (1) a civil penalty applies for failure of MEWAs to file registration statements under section 309 of the bill; (2) the section provides for State enforcement through Federal courts with respect to violations by multiple employer health plans, subject to the existence of enforcement agreements described in section 308 below; (3) willful misrepresentation that an entity is an exempted MEWA or collectively-bargained arrangement may result in criminal penalties; (4) the section provides for cease activity orders for arrangements found to be neither licensed, registered, or otherwise approved under State insurance law, or operating in accordance with the terms of an exemption granted by the Secretary under new part 7; and (5) the section provides for the responsibility of the fiduciary or board of trustees of a MEHP to comply with the required claims procedure under ERISA.

*Sec. 308. Cooperation between Federal and State authorities*

This section amends section 506 of ERISA (relating to coordination and responsibility of agencies enforcing ERISA and related laws) to specify State responsibility with respect to self-insured MEWAs. A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority to enforce provisions of ERISA applicable to exempted MEWAs (established under this bill). The Secretary is required to enter into the agreement if the Secretary determines that delegation to the State would not result in a lower level or quality of enforcement. However, if the Secretary delegates authority to a State, the Secretary can continue to exercise such authority concurrently with the State. The Secretary is required to provide enforcement assistance to the States with respect to MEWAs.

*Sec. 309. Filing requirements for multiple employer welfare arrangements offering health benefits*

This section amends the reporting and disclosure requirements of ERISA to require MEWAs offering health benefits to file with the Secretary a registration statement within 60 days before beginning operations (for those starting on or after January 1, 1997) and no later than February 15 of each year. The section also requires MEWAs providing medical care to issue to participating employers certain information including summary plan descriptions, contribution rates, and the status of the arrangement (whether fully-insured or an exempted self-insured plan).

*Sec. 310. Single annual filing for all participating employers*

This section amends ERISA's section 110 (relating to alternative methods of compliance with reporting and disclosure re-

quirements) to provide for a single annual filing for all participating employers of fully insured MEWAs.

*Sec. 311. Effective date; transitional rule*

This section provides that, in general, the amendments made by this title are effective July 1, 1997, except that the Secretary of Labor may issue regulations before that time. In addition, the Secretary is required to issue all regulations needed to carry out the amendments before July 1, 1997. The section provides for transition rules for self-insured MEWAs in operation as of the effective date so that those applying to the Secretary for an exemption from State regulation are deemed to be excluded for a period not to exceed 18 months unless the Secretary denies the exemption or finds the MEWAs application deficient. The Secretary can revoke the exemption at any time if it would be detrimental to the interests of individuals covered under the Act.

*Sec. 312. Rule of construction*

This provision states that nothing in this Act may be construed to require the coverage of any specific procedure, treatment, or service as part of a group health plan or health insurance coverage.

EXPLANATION OF AMENDMENTS

The provisions of the substitute are explained in this report.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF  
THE COMMITTEE

In compliance with clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the body of this report.

INFLATIONARY IMPACT STATEMENT

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee estimates that the enactment into law of H.R. 995 will have no significant inflationary impact on prices and costs in the operation of the national economy. It is the judgment of the Committee that the inflationary impact of this legislation as a component of the federal budget is negligible.

GOVERNMENT REFORM AND OVERSIGHT

With respect to the requirement of clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, the Committee has received no report of oversight findings and recommendations from the Committee on Government Reform and Oversight on the subject of H.R. 995.

COMMITTEE ESTIMATE

Clause 7 of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison by the Committee of the costs which would be incurred in carrying out H.R. 995. However,

clause 7(d) of that rule provides that this requirement does not apply when the Committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Congressional Budget Office under section 403 of the Congressional Budget Act of 1974.

#### APPLICATION OF LAW TO LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104-1 requires a description of the application of this bill to the legislative branch. The bill improves group to group portability, limiting preexisting condition exclusions, through carefully targeted insurance reforms and it clarifies ERISA to allow small employers to voluntarily form groups for the purpose of self-insuring or fully-insuring. This bill does not prohibit legislative branch employees from receiving the benefits of this legislation.

#### UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget & Impoundment Control Act requires a statement of whether the provisions of the reported bill include unfunded mandates. Pursuant to said section, the Committee has not been made aware of any unfunded mandates contained within this bill.

#### BUDGET AUTHORITY AND CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

With respect to the requirement of clause 2(l)(3)(B) of rule XI of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause 2(l)(3)(C) of rule XI of the House of Representatives and section 403 of the Congressional Budget Act of 1974, the Committee has received the following cost estimate for H.R. 995 from the Director of the Congressional Budget Office:

U.S. CONGRESS,  
CONGRESSIONAL BUDGET OFFICE,  
*Washington, DC, March 22, 1996.*

Hon. WILLIAM F. GOODLING,  
*Chairman, Committee on Economic and Educational Opportunities,  
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has prepared the enclosed federal cost estimate for H.R. 995, the ERISA Targeted Health Insurance Reform Act of 1996, as ordered reported by the House Committee on Economic and Educational Opportunities on March 6, 1996. Pay-as-you-go procedures would apply because the bill could affect direct spending and receipts. CBO estimates that the change in direct spending and receipts, however, would not be significant.

CBO is also required to estimate the costs of any mandates that H.R. 995 would impose on state and local governments and the private sector using the definitions and methods prescribed by the Unfunded Mandates Act of 1995. The state and local estimate is enclosed. The private sector estimate will be sent to the Committee separately.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL, *Director*.

Enclosures.

#### CONGRESSIONAL BUDGET OFFICE

1. Bill number: H.R. 995.
2. Bill title: ERISA Targeted Health Insurance Reform Act of 1996.
3. Bill status: As ordered reported by the House Committee on Economic and Educational Opportunities on March 6, 1996.
4. Bill purpose: Title I would make it easier for people who change jobs to maintain adequate coverage by limiting exclusions for preexisting conditions and increasing portability of coverage. Title II would make it easier for small firms to obtain health insurance for their employees by prohibiting insurers and health maintenance organizations (HMOs) from denying coverage to small employers. Insurers and HMOs would be allowed to deny coverage in certain cases. Title III would encourage the use of multiple employer welfare arrangements (MEWAs). MEWAs are arrangements, typically sponsored by an association, that provide benefits to the employees of multiple employers. Specifically, the bill would:
  - Preempt state and local laws that require insurers and HMOs to provide specific types or levels of medical benefits in the group market.
  - Exempt a subset of fully insured MEWAs from state laws that prohibit insurers and HMOs from setting premium rates based on the claims experience of the MEWA, and
  - Require the Secretary of Labor to carry provisions in current law that would allow certain MEWAs that are not fully insured to apply to the Department of Labor for an exemption from state laws relating to health benefit plans.
5. Estimated cost to the Federal Government: Not significant.
6. Basis of the estimate: H.R. 995 addresses health insurance purchased in large and small groups—usually by employers and employees—and MEWAs. The bill does not regulate insurance purchased by individuals and would allow state and local government employers to opt out of the bill's requirements.

*Health Insurance Portability.*—The bill would create uniform national standards to govern the portability of private group health insurance policies. For example, these standards would allow workers with employment-based policies to continue their coverage more easily when changing or leaving jobs. Because private insurance plans often require a waiting period before new employees become eligible for coverage, especially for preexisting medical conditions, workers with chronic conditions or other potential health risks may face gaps in their coverage when they change jobs. Alternatively, such workers may be hesitant to change jobs precisely because they fear the temporary loss of coverage, a situation known as job-lock.

H.R. 995 would reduce the effective length of exclusions for preexisting conditions by crediting enrollees for continuous coverage

by a previous insurer. Plans would be prohibited from denying coverage based on an employee's preexisting condition, and insurers would be required to renew coverage in most cases. This bill would require that group plans hold at least one open enrollment period each year and would allow workers to change their enrollment status under certain conditions without being subject to penalties for late enrollment. To the extent that states have not already implemented similar rules, these changes would clarify the insurance situation for many people.<sup>1</sup>

Because the bill would not regulate the premiums that plans could charge, the net number of people covered by health insurance and the premiums that they pay would continue to be influenced primarily by market forces. Although this provision would make insurance more portable for some people, it would not dramatically increase the availability of insurance in general.

*Health Insurance Regulations.*—The bill would limit the authority of the states to regulate group health insurance in several ways. It would effectively preempt state laws that require group plans to cover certain benefits (although states could require insurers or HMOs in the small group market to offer specific benefits in no more than 2 plans). It would also preempt all state laws with stricter provisions than those in the bill concerning preexisting condition exclusions and portability for group health insurance. State laws prohibiting insurers from experience-rating certain fully-insured MEWAs would also be preempted. In addition, the bill would enable not-fully-insured multiple employer health plans, that met certain criteria, to be exempted from all state laws.

*Impact on Federal Revenues and Outlays.*—H.R. 995 could affect the federal budget in two significant ways. First, if the bill changed the amount of employer-paid health premiums, total federal tax revenues could change. For example, if the total amount employers paid for premiums fell, cash wages would rise, thereby increasing income and payroll tax revenues. Second, if the bill caused people insured by government health programs to obtain private coverage, then federal outlays for those programs could change.

*Impact on Federal Revenues.*—According to the General Accounting Office (GAO), 38 states have enacted legislation to improve the portability and renewability of health plans among small employers.<sup>2</sup> State laws do not apply to employees of firms with self-funded insurance plans, although large employer plans—those most likely to self-insure—generally have fewer exclusions for preexisting conditions than smaller firms. Health maintenance organizations and other health plans that use organized networks of health providers use few exclusions for preexisting conditions within their networks. Most group insurance is now provided through these managed care networks. The new standards for insurance portability created by H.R. 995 would increase the price of health insurance for group plans, with a corresponding reduction in coverage. Because many insurance reforms have already been implemented by the states,

<sup>1</sup>For additional discussion, see GAO, "Health Insurance Regulation: National Portability Standards Would Facilitate Changing Health Plans," testimony before the Senate Committee on Labor and Human Resources, July 18, 1995.

<sup>2</sup>*Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms* (GAO/HEHS-95-161FS, June 12, 1995).

however, and because most health plans tend not to use exclusions for preexisting conditions, these changes would be relatively small.

The clarifications of regulations concerning health insurance and MEWAs would likewise cause only minor changes in overall insurance coverage and premiums. In general, regulations affecting private group health insurance would be relaxed, lowering premiums—perhaps significantly—and increasing coverage. But the bill could also supersede elements of state insurance reforms, with uncertain results on the overall market.

Although the bill could have major effects on the small-group insurance markets in some states, the direction of any change in total premiums is highly uncertain, and CBO does not expect total contributions for health insurance made by employers to change significantly. As a result, federal revenues are unlikely to be changed.<sup>3</sup>

*Impact on Federal Outlays.*—CBO assumes that federal outlays for Medicaid would not change, because any persons eligible for free coverage from Medicaid under current law would also seek Medicaid coverage if H.R. 995 was enacted. CBO also estimates that the bill would cause no appreciable changes to federal outlays for Medicare, Federal Employees Health Benefits, or other government programs.

7. Estimate comparison: CBO has previously estimated the federal budgetary impact of S. 1028, as reported by the Senate Committee on Labor and Human Resources. Unlike H.R. 995, S. 1028 would extend insurance reforms to state and local government employers and the individual insurance market. S. 1028 does not include provisions relating to MEWAs.

8. Previous estimate: None.

9. Estimate prepared by: Jeff Lemieux.

10. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE—ESTIMATED COST OF  
INTERGOVERNMENTAL MANDATES

1. Bill number: H.R. 995.

2. Bill title: ERISA Targeted Health Insurance Reform Act of 1996.

3. Bill status: As ordered reported by the House Committee on Economic and Educational Opportunities on March 6, 1996.

4. Bill purpose: Title I would make it easier for people who change jobs to maintain adequate coverage by limiting exclusions for preexisting conditions and increasing portability of coverage.

Title II would make it easier for small firms to obtain health insurance for their employees by prohibiting insurers and health maintenance organizations (HMOs) from denying coverage to small employers. Insurers and HMOs would be allowed to deny coverage in certain cases.

Title III would encourage the use of multiple employer welfare arrangements (MEWAs), both insured and not fully insured.

<sup>3</sup>CBO cooperates with the Joint Committee on Taxation to produce estimates of revenue changes under proposals that would affect the market for private health insurance. Following CBO's estimate that H.R. 995 would not significantly change spending for employer-paid insurance premiums, the Joint Committee estimates that federal revenues would not change.

(MEWAs are arrangements, typically sponsored by an association, that provide benefits to the employees of multiple employers.) Specifically, the bill would:

- preempt state and local laws that require insurers and HMOs to provide specific types or levels of medical benefits in the group health market,

- exempt a subset of fully-insured MEWAs, which would be defined as voluntary health insurance associations (VHIAs), from state laws that prohibit insurers and HMOs from setting premium rates based on the claims experience of the MEWA,

- require the Secretary of Labor to carry out provisions in current law that would allow certain MEWAs that are not fully insured to apply to the Department of Labor (DOL) for an exemption from state laws relating to health benefit plans—these MEWAs would be defined as multiple employer health plans (MEHPs),

- make other amendments to the Employee Retirement Income Security Act (ERISA).

5. Intergovernmental mandates contained in bill: H.R. 995 would preempt numerous state laws, including those relating to MEHPs, mandated benefits, and premiums paid by VHIAs. These preemptions would constitute intergovernmental mandates because they prohibit states from taking certain actions and could lead to a loss of tax revenues.

6. Estimated direct costs to State, local, and tribal governments: The preemptions of certain State insurance laws that are contained in H.R. 995 would have both positive and negative impacts on the revenues from premium taxes and other assessments collected by States from insurance companies and HMOs. CBO is unable to determine which of these forces would be the stronger, and we therefore cannot estimate whether states would ultimately gain or lose revenues if H.R. 995 is enacted.

On the one hand, if incentives encouraging the shift from insurance companies and HMOs (which are subject to state taxation of premiums) to MEHPs (which are exempt from such taxation) are strong enough, states could lose significant tax and assessment revenue that could exceed the \$50 million threshold established in Public Law 104-4. (CBO estimates that states collect about \$2.5 billion in premium taxes from the group health insurance market; the number of individuals who receive their health benefits through group health plans that are insured would have to drop by only 2 percent in order for this threshold to be exceeded.) On the other hand, if incentives encouraging a shift from self-funded plans (which are exempt from taxation) to insured plans (which are subject to taxation) proves stronger, states could realize an increase in premium tax revenues and other assessments that would offset other revenue losses.

7. Basis of estimate: *Background*.—The health insurance market is extremely complex, and it is difficult to summarize the potential impacts that H.R. 995 would have on state regulation and taxation. There are many types of health benefit plans (indemnity, HMO, preferred provider organization, and point of service). Plans can be insured or self-funded. In addition, plans are provided by employers through different types of arrangements (single employer, mul-

tiple employers, and collectively bargained under multiple employers). These three factors (types of plans, whether they are insured or self-funded, and the types of employer arrangements) combine to produce a vast array of health benefit arrangements that are regulated and taxed differently by states.

For example, a single employer could have an arrangement that is not-fully-insured by offering multiple plans—a self-funded indemnity plan and several HMO options. Under current law, the self-funded plan would not be subject to premium taxes while the premiums paid to the HMOs could be taxed. States are preempted by federal law from taxing self-funded plans provided by a single employer but have the option of taxing insured plans. The situation is made even more complicated because states impose different taxes on commercial insurers. Blue Cross/Blue Shield plans, and often HMOs. H.R. 995 would create even more options and incentives for various arrangements to shift around and the ultimate impact on state revenues is highly uncertain.

*Incentives that could decrease state premium tax collections.*—H.R. 995 would increase the competitive advantage of MEHPs (MEWAs that are not-fully-insured and receive an exemption from state law) over traditional insurance companies in a number of ways. First, even though MEHPs would have to meet the federal requirements contained in the bill, such as reserve requirements, some officials in state insurance departments believe that these requirements would not be as rigorous as current requirements in some states. In addition, H.R. 995 does not provide additional resources for DOL to regulate MEHPs. The bill's sponsors assume that by clarifying that all MEWAs that are not fully insured (except those that are classified as a MEHP) are subject to state regulation, H.R. 995 would reduce the need for federal oversight of these entities and allow DOL to transfer federal resources to the regulation of MEHPs.

Second, MEHPs would not have to pay state premium taxes or other assessments. It is unclear how much of an incentive this creates since few MEWAs, if any, pay premium taxes under current law. Nevertheless, H.R. 995 would clarify the exemptions and eliminate the possibility that states would tax these entities. Many people argue that states have the authority under ERISA to assess premium taxes on MEWAs that are not fully insured, while others argue that ERISA currently preempts this type of taxation on these entities. In any event, CBO estimates that states currently collect only \$1 million or \$2 million from insurance taxes and assessments on MEMAs that are not fully insured.

Finally, the bill would make it much easier for large national associations to provide health insurance to its members without having to meet different insurance laws in each state. Traditional insurance companies would not have this advantage. Therefore, many businesses may decide to obtain their health coverage through their trade association rather than a traditional insurance company.

*Incentives that could increase in state premium taxes.*—The preemption of state laws that require insurers and HMOs to provide specific types or levels of medical benefits could increase premium tax collections. Under current law, self-funded health plans offered

by a single employer are exempt from state laws relating to health benefit plans. Many companies have dropped their fully-insured coverage and have self-funded their health plans in order to avoid state laws that mandate benefits. H.R. 995 would eliminate this incentive to provide self-funded health plans. As a result, employers may decide to switch back to insured plans rather than self-funding. In addition, the preemption of state laws that prohibit insurers and HMOs from basing the premiums they charge on the MEWAs' claims history, would further encourage the use of fully-insured MEWAs. Under H.R. 995, they would not have to abide by two types of state laws. Just like other insured plans, VHIAAs would be subject to premium taxes and other assessments.

8. Appropriation or other Federal financial assistance provided in bill to cover mandate costs: None.

9. Other impacts on State, local, and tribal governments: H.R. 995 would require state and local governments as providers of health coverage to their employees to comply with the preexisting condition and portability requirements unless they specifically opt out in a form and manner determined by the Secretary of Labor. If state and local governments decide to comply with these requirements, they would face an increase in health care costs of less than \$50 million, a 0.1 percent increase. CBO estimates that state and local governments spend about \$40 billion annually on health insurance for their employees. CBO assumes that state and local governments would pass these costs onto their employees in the form of adjustments to pay or other benefits.

Economists generally believe, and CBO's cost estimates have long assumed, that workers as a group bear most of the costs of employers' health insurance premiums. The primary reason for this conclusion is that the supply of labor is relatively insensitive to changes in take-home wages. Because most workers continue to work even if their take-home pay declines, employers have little trouble over time shifting most of the cost of additional health insurance to workers' wages or other fringe benefits.

If states choose to enforce the provisions contained in H.R. 995, state regulatory costs could be affected, although it is difficult to predict whether costs would increase or decrease. On the one hand, the bill would allow states to enforce the exclusion of preexisting conditions, portability requirements, and other insurance reforms. On the other hand, states would no longer have to enforce mandated benefit laws. Finally, if the MEHP market becomes substantial, state regulation could be affected significantly. State laws relating to health benefit plans would not apply to these entities, but states could enter into an agreement with DOL to enforce the federal requirements. In 1995, according to the National Association of Insurance Commissioners, states spent \$650 million regulating all forms of insurance (health and others).

10. Previous CBO estimate: On March 22, 1996, CBO transmitted a mandate cost estimate of S. 1028, the Health Insurance Reform Act of 1995, as reported by the Senate Committee on Labor and Human Resources on October 12, 1995. The preexisting condition and portability provisions of H.R. 995 and S. 1028 are very similar. However, S. 1028 would require state and local govern-

ments to comply with these requirements, and such requirements would constitute an intergovernmental mandate. In contrast, H.R. 995 would allow state and local governments to opt out in a form and manner determined by the Secretary of Labor.

11. Estimate prepared by: John Patterson.

12. Estimate approved by: Paul Van de Water, Assistant Director for Budget Analysis.

#### ROLLCALL VOTES

Rollcall No. 1 (Amendment by Mr. Green): The amendment would have (1) eliminated the national uniformity of the bill's portability and preexisting condition provisions, by striking the preemption of more restrictive state laws; (2) deleted the provision preempting the costly state mandated benefits; (3) deleted the bill's solvency standards for self-insured MEWAs; (4) deleted the provision permitting church plans to elect to become multiple employer health plans (MEHPs); (5) deleted the provision giving the DOL authority to shut down illegitimate health arrangements; and (6) deleted the provision giving the DOL authority over MEHPs. Defeated by a vote of 18–23.

Vote by Members: Chairman Goodling—No; Mr. Petri—No; Mrs. Roukema—No; Mr. Gunderson—No; Mr. Fawell—No; Mr. Ballenger—No; Mr. Barrett—No; Mr. Cunningham—No; Mr. Hoekstra—No; Mr. McKeon—No; Mr. Castle—No; Mrs. Meyers—No; Mr. Johnson—No; Mr. Talent—No; Mr. Greenwood—No; Mr. Hutchinson—No; Mr. Knollenberg—No; Mr. Riggs—No; Mr. Graham—No; Mr. Weldon—No; Mr. Funderburk—No; Mr. Souder—No; Mr. Norwood—No; Mr. Clay—Aye; Mr. Miller—Aye; Mr. Kildee—Aye; Mr. Williams—Aye; Mr. Martinez—Aye; Mr. Owens—Aye; Mr. Sawyer—Aye; Mr. Payne—Aye; Mrs. Mink—Aye; Mr. Andrews—Aye; Mr. Reed—Aye; Mr. Roemer—Aye; Mr. Engel—Aye; Mr. Becerra—Aye; Mr. Scott—Aye; Mr. Green—Aye; Ms. Woolsey—Aye; Mr. Fattah—Aye.

Rollcall No. 2 (Motion by Mr. Petri): To favorably report the bill with an amendment in the nature of a substitute to the House with the recommendation that the bill as amended do pass. Passed by a vote of 24–18.

Vote by Members: Chairman Goodling—Aye; Mr. Petri—Aye; Mrs. Roukema—Aye; Mr. Gunderson—Aye; Mr. Fawell—Aye; Mr. Ballenger—Aye; Mr. Barrett—Aye; Mr. Cunningham—Aye; Mr. Hoekstra—Aye; Mr. McKeon—Aye; Mr. Castle—Aye; Mrs. Meyers—Aye; Mr. Johnson—Aye; Mr. Talent—Aye; Mr. Greenwood—Aye; Mr. Hutchinson—Aye; Mr. Knollenberg—Aye; Mr. Riggs—Aye; Mr. Graham—Aye; Mr. Weldon—Aye; Mr. Funderburk—Aye; Mr. Souder—Aye; Mr. McIntosh—Aye; Mr. Norwood—Aye; Mr. Clay—No; Mr. Miller—No; Mr. Kildee—No; Mr. Williams—No; Mr. Martinez—No; Mr. Owens—No; Mr. Sawyer—No; Mr. Payne—No; Mrs. Mink—No; Mr. Andrews—No; Mr. Reed—No; Mr. Roemer—No; Mr. Engel—No; Mr. Becerra—No; Mr. Scott—No; Mr. Green—No; Ms. Woolsey—No; Mr. Fattah—No.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

**EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974**

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Employee Retirement Income Security Act of 1974".

TABLE OF CONTENTS

Sec. 1. Short title and table of contents.

\* \* \* \* \*

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

\* \* \* \* \*

Subtitle B—Regulatory Provisions

\* \* \* \* \*

*PART 7—RULES GOVERNING STATE REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS*

- Sec. 701. Definitions.*
- Sec. 702. Multiple employer health plans eligible for relief from certain restrictions on preemption of State law*
- Sec. 703. Requirements relating to sponsors, boards of trustees, and plan operations.*
- Sec. 704. Special rules for church plans.*

*PART 8—ACCESS TO, AND CONTINUITY OF, GROUP HEALTH PLAN COVERAGE*

- Sec. 800. Definitions and special rules.*
- SUBPART A—PREEXISTING CONDITION LIMITATIONS, PORTABILITY, AND RENEWABILITY*
- Sec. 801. Limitations on preexisting condition exclusions.*
  - Sec. 802. Portability.*
  - Sec. 803. Requirements for renewability of coverage.*
  - Sec. 804. Group health plan enrollment requirements.*

*SUBPART B—REQUIREMENTS FOR INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS OFFERING HEALTH INSURANCE COVERAGE TO GROUP HEALTH PLANS OF SMALL EMPLOYERS*

- Sec. 811. Definitions.*
- Sec. 812. Requirements for insurers and health maintenance organizations in the small group market who offer general coverage.*

\* \* \* \* \*

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE A—GENERAL PROVISIONS

DEFINITIONS

SEC. 3. For purposes of this title:

(1) \* \* \*

\* \* \* \* \*

(7)(A) The term “participant” means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(B) *In the case of a group health plan, such term includes—*

*(i) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or*

*(ii) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,*

*if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.*

\* \* \* \* \*

(16)(A) The term “administrator” means—

(i) \* \* \*

\* \* \* \* \*

(B) The term “plan sponsor” means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. *Such term also includes the sponsor (as defined in section 701(6)) of a multiple employer welfare arrangement which is or has been a multiple employer health plan (as defined in section 701(4)).*

\* \* \* \* \*

(40)(A) The term “multiple employer welfare arrangement” means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

**[(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,]**

*(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),*

\* \* \* \* \*

## (B) For purposes of this paragraph—

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer *for any plan year of any such plan, or any fiscal year of any such other arrangement*, if such trades or businesses are within the same control group *during such year or at any time during the preceding 1-year period*,

(ii) the term “control group” means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under “common control” with another trade or business shall be determined under regulations of the Secretary applying principles **【similar to】** *consistent and coextensive with* the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, **【common control shall not be based on an interest of less than 25 percent】** *an interest of greater than 25 percent may not be required as the minimum interest necessary for common control*,

(iv) *in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement*,

**【(iv)】** (v) the term “rural electric cooperative” means—

(I) any organization which is exempt from tax under section 501(a) of the Internal Revenue Code of 1986 and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under section 501(a) of such Code and at least 80 percent of the members of which are organizations described in subclause (I), and

**【(v)】** (vi) the term “rural telephone cooperative association” means an organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under section 501(a) of such Code and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

(C) *A plan or other arrangement is established or maintained in accordance with this subparagraph only if the following requirements are met:*

(i) *The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—*

(I) *utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals*

*as participating employers or covered individuals under the plan or other arrangement, or*

*(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement,*

*except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.*

*(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—*

*(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit), nor*

*(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment),*

*does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the ERISA Targeted Health Insurance Reform Act of 1996 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.*

*(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).*

*(D) A plan or arrangement is established or maintained in accordance with this subparagraph only if—*

*(i) all of the benefits provided under the plan or arrangement are fully insured (as defined in section 701(2)), or*

*(ii)(I) the plan or arrangement is a multiemployer plan, and  
(II) the requirements of clause (B) of the proviso to clause (5)  
of section 302(c) of the Labor Management Relations Act, 1947  
(29 U.S.C. 186(c)) are met with respect to such plan or other ar-  
rangement.*

*(E) A plan or arrangement is established or maintained in ac-  
cordance with this subparagraph only if—*

*(i) the plan or arrangement is in effect as of the date of the  
enactment of the ERISA Targeted Health Insurance Reform Act  
of 1996, or*

*(ii) the employee organization or other entity sponsoring the  
plan or arrangement—*

*(I) has been in existence for at least 3 years or is affili-  
ated with another employee organization which has been in  
existence for at least 3 years, or*

*(II) demonstrates to the satisfaction of the Secretary that  
the requirements of subparagraphs (C) and (D) are met  
with respect to the plan or other arrangement.*

\* \* \* \* \*

*(42) Except as otherwise provided in this title, the term “group  
health plan” means an employee welfare benefit plan to the extent  
that the plan provides medical care (within the meaning of section  
607(1)) to employees or their dependents (as defined under the terms  
of the plan) directly or through insurance, reimbursement, or other-  
wise.*

COVERAGE

SEC. 4. (a) \* \* \*

*(b) The provisions of this title shall not apply to any employee  
benefit plan if—*

*(1) except with respect to sections 801 and 802, such plan is  
a governmental plan (as defined in section 3(32));*

*(2) such plan is a church plan (as defined in section 3(33))  
with respect to which no election has been made under section  
410(d) of the Internal Revenue Code of 1986, except with re-  
spect to provisions made applicable under any election made  
under section 704(a) of this Act;*

\* \* \* \* \*

*(c) If the plan sponsor of a governmental plan which is a group  
health plan to which sections 801 and 802 apply makes an election  
under this paragraph for any specified period (in such form and  
manner as the Secretary may by regulations prescribe), then the  
provisions of sections 801 and 802 shall not apply to such govern-  
mental plans for such period as if the exception in subsection (b)(1)  
relating to sections 801 and 802 did not apply with respect to such  
plan for such period.*

## SUBTITLE B—REGULATORY PROVISIONS

## PART 1—REPORTING AND DISCLOSURE

## DUTY OF DISCLOSURE AND REPORTING

## SEC. 101. (a) \* \* \*

\* \* \* \* \*

*(g) REGISTRATION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1997) and no later than February 15 of each year (in the case of an arrangement in operation since the beginning of such year), unless, as of the date by which such filing otherwise must be made, such arrangement provides no benefits consisting of medical care (within the meaning of section 607(1)).*

*(2) Each registration statement—*

*(A) shall be filed in such form, and contain such information concerning the multiple employer welfare arrangement and any persons involved in its operation (including whether coverage under the arrangement is fully insured), as shall be provided in regulations which shall be prescribed by the Secretary, and*

*(B) if any benefits under the arrangement consisting of medical care (within the meaning of section 607(1)) are not fully insured, shall contain a certification that copies of such registration statement have been transmitted by certified mail to—*

*(i) in the case of an arrangement which is a multiple employer health plan (as defined in section 701(4)), the State insurance commissioner of the domicile State of such arrangement, or*

*(ii) in the case of an arrangement which is not a multiple employer health plan, the State insurance commissioner of each State in which the arrangement is located.*

*(3) The person or persons responsible for filing the annual registration statement are—*

*(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or*

*(B) in the case of a multiple employer welfare arrangement for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually responsible for the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.*

*(4) Any agreement entered into under section 506(c) with a State as the primary domicile State with respect to any multiple employer welfare arrangement shall provide for simultaneous filings of reports required under this subsection with the Secretary and with the State insurance commissioner of such State.*

(5) For purposes of this subsection, the term "domicile State" means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for an exemption under this 514(b)(6)(B), most individuals to be covered under the arrangement are located, except that, in any case in which information contained in the latest annual report of the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different State.

(6) The Secretary may exempt from the requirements of this subsection such class of multiple employer welfare arrangements as the Secretary deems appropriate.

(h) FILING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

(1) IN GENERAL.—A multiple employer welfare arrangement which provides benefits consisting of medical care (within the meaning of section 607(1)) shall issue to each participating employer—

(A) a document equivalent to the summary plan description required of plans under this part,

(B) information describing the contribution rates applicable to participating employers, and

(C) a statement indicating—

(i) that the arrangement is not a licensed insurer under the laws of any State,

(ii) the extent to which any benefits under the arrangement are fully insured,

(iii) if any benefits under the arrangement are not fully insured, whether the arrangement has been granted an exemption under section 514(b)(6)(B) (or whether such an exemption has ceased to be effective).

(2) TIME FOR DISCLOSURE.—Such information shall be issued to employers within such reasonable period of time before becoming participating employers as may be prescribed in regulations of the Secretary.

[(g)] (i) CROSS REFERENCE.—

For regulations relating to coordination of reports to the Secretaries of Labor and the Treasury, see section 3004.

\* \* \* \* \*

ALTERNATIVE METHODS OF COMPLIANCE

SEC. 110. (a) \* \* \*

\* \* \* \* \*

(c) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are participating employers under a multiple employer welfare arrangement under which all coverage consists of medical care (within the meaning of section 607(1)) and is fully insured (as defined in section 701(1)).

\* \* \* \* \*

## PART 5—ADMINISTRATION AND ENFORCEMENT

## CRIMINAL PENALTIES

SEC. 501. (a) Any person who willfully violates any provision of part 1 of this subtitle, or any regulation or order issued under any such provision, shall upon conviction be fined not more than \$5,000 or imprisoned not more than one year, or both; except that in the case of such violation by a person not an individual, the fine imposed upon such person shall be a fine not exceeding \$100,000.

(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

(1) being a multiple employer welfare arrangement to which an exemption has been granted under section 514(b)(6)(B),

(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, or

(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met,

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.

## CIVIL ENFORCEMENT

SEC. 502. (a) A civil action may be brought—

(1) \* \* \*

\* \* \* \* \*

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under [subsection (c)(2) or (i) or (l)] paragraph (2), (5), or (6) of subsection (c) or subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A));

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1), (A) to enjoin any act or practice which violates subsection (f) of section 101, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; [or]

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension

benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts[.]; or

(10) by a State official having authority under the law of such State to enforce the laws of such State regulating insurance, to enjoin any act or practice which violates any requirement under part 7 for an exemption under section 514(b)(6)(B) which such State has the power to enforce pursuant to section 506(c)(1).

(c)(1) \* \* \* \* \*

(5) The Secretary shall enforce under this part the requirements of section 801, 802, 803, or 812 with respect to any entity which is an insurer or health maintenance organization and which is subject to regulation by any State permitted under section 514 only if the Secretary determines—

(A)(i) with respect to section 801 or 802, that such State has not provided for effective enforcement of State laws which govern the same matters as are governed by such section 801 or 802 (as described in section 514(c)) and which are not superceded by reason of section 514(c), or

(ii) with respect to section 803 or 812, that such State has not provided for effective enforcement of State laws which govern the same matters as are governed by such section 803 or 812, respectively, and which require compliance by such entity with at least the same requirements as those provided under such section 803 or 812, respectively, and

(B) that such entity has failed to comply with the requirements of such section which are applicable to such entity.

(6) The Secretary may assess a civil penalty against any person of up to \$1,000 a day from the date of such person's failure or refusal to file the information required to be filed with the Secretary under section 101(g).

(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of a multiple employer welfare arrangement providing benefits consisting of medical care (within the meaning of section 607(1)) that—

(A) is not licensed, registered, or otherwise approved under the insurance laws of the States in which the arrangement offers or provides benefits, and

(B) if there is in effect with respect to such arrangement an exemption under section 514(b)(6)(B), is not operating in accordance with the requirements under part 7 for such an exemption,

a district court of the United States shall enter an order requiring that the arrangement cease activities.

(2) Paragraph (1) shall not apply in the case of a multiple employer welfare arrangement if the arrangement shows that—

(A) all benefits under it referred to in paragraph (1) are fully insured, within the meaning of section 701(1), and

(B) with respect to each State in which the arrangement offers or provides benefits, the arrangement is operating in accordance with applicable State insurance laws that are not superseded under section 514.

(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the arrangement.

CLAIMS PROCEDURE

SEC. 503. In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

*The terms of each multiple employer health plan (within the meaning of section 701(4)) shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.*

\* \* \* \* \*

COORDINATION AND RESPONSIBILITY OF AGENCIES ENFORCING EMPLOYEE RETIREMENT INCOME SECURITY ACT AND RELATED FEDERAL LAWS

SEC. 506. (a) \* \* \*

\* \* \* \* \*

(c) *RESPONSIBILITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.*—

(1) *STATE ENFORCEMENT.*—

(A) *AGREEMENTS WITH STATES.*—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the requirements under part 7 for an exemption under section 514(b)(6)(B). The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

(B) *DELEGATIONS.*—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph

may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

(C) *CONCURRENT AUTHORITY OF THE SECRETARY.*—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

(D) *RECOGNITION OF PRIMARY DOMICILE STATE.*—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular multiple employer welfare arrangement, as the primary domicile State to which authority has been delegated pursuant to such agreements.

(2) *ASSISTANCE TO STATES.*—The Secretary shall—

(A) provide enforcement assistance to the States with respect to multiple employer welfare arrangements, including, but not limited to, coordinating Federal and State efforts through the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act,

(C) make readily available to the States timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.

\* \* \* \* \*

#### EFFECT ON OTHER LAWS

SEC. 514. (a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b) (including a church plan which is not exempt under section 4(b)(2) by reason of an election under section 704). This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B) and subsection (c), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan estab-

lished primarily for the purpose of providing death benefits *and including a church plan which is not exempt under section 4(b)(2) by reason of an election under section 704*, nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

\* \* \* \* \*

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and **[is fully insured]** *under which all benefits are fully insured* (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B) *and which is not described in section 702(a)(1)*), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply, *but only, in the case of an arrangement which does not provide medical care (within the meaning of section 607(1))*, to the extent not inconsistent with the preceding sections of this title.

(B)(i) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements **[which are not fully insured. Any such exemption]** *under which any benefit is not fully insured.*

(ii) *Subject to part 7, any exemption under clause (i) may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 necessary to be considered an employee welfare benefit plan to which this title applies.*

\* \* \* \* \*

(E)(i) *The provisions of this title shall supercede any and all State laws which regulate insurance insofar as they may now or hereafter preclude an insurer or health maintenance organization offering health insurance coverage in connection with employee welfare benefit plans which are voluntary health insurance associations from setting premium rates based on the claims experience of each voluntary health insurance association, if such claims experience is defined as the claims experience of all employers of each association taken as a whole (without varying the premium rates of any par-*

particular employer on the basis of the claims experience of such employer).

(ii) Subsection (c)(3)(B) shall not apply in the case of an employee welfare benefit plan which is a voluntary health insurance association.

(iii) For purposes of this subparagraph, the term "voluntary health insurance association" means a multiple employer welfare arrangement—

(I) under which benefits include medical care (within the meaning of section 607(1)),

(II) under which all benefits consisting of such medical care are fully insured, and

(III) which is maintained by a qualified association.

(iv) For purposes of clause (iii)(III), the term "qualified association" means an association which consists of employers who together employ at least 200 employees who are eligible individuals, but only if the sponsor of the association—

(I) is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years, organized and maintained in good faith, with a constitution and by-laws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1)), and

(II) is established as a permanent entity which receives the active support of its members.

(F) For purposes of this paragraph, the terms "fully insured", "health insurance coverage", "health maintenance organization", and "insurer" have the meanings given such terms in section 800(a).

(G) For additional rules relating to exemption from subparagraph (A)(ii) of multiple employer health plans, see part 7.

(c)(1) The provisions of sections 801 and 802 shall supersede any and all State laws in relation to any group health plan to which such sections apply insofar as the requirements of such laws may now or hereafter—

(A) relate to insurers or health maintenance organizations offering health insurance coverage in connection with group health plans,

(B) govern the same matters as are governed by such sections 801 and 802, and

(C) provide requirements which differ from the requirements of such sections 801 and 802.

(2) Nothing in this subsection shall be construed to supercede any law of any State to the extent that such law provides for the enforcement of laws which are not superceded under paragraph (1).

(3)(A) The provisions of this title shall supersede any and all State laws insofar as they may now or hereafter require—

(i) health insurance coverage in connection with a group health plan to include specific items or services consisting of medical care, or

(ii) an insurer or health maintenance organization offering health insurance coverage in connection with a group health

*plan to include in such health insurance coverage specific items or services consisting of medical care.*

*Nothing in this paragraph shall be construed to supercede any State law that prohibits the exclusion, from the benefits otherwise provided under a group health plan, of health insurance coverage for a specific disease.*

*(B) Notwithstanding subparagraph (A), a State may require an insurer or health maintenance organization offering health insurance coverage in the small group market (as defined in section 811(4)) in connection with a group health plan to offer under such coverage specific items or services consisting of medical care, but only with respect to not more than 2 different policies or contracts of health insurance coverage.*

*(4) The provisions of this title shall supercede any and all State laws insofar as they may now or hereafter prohibit—*

*(A) two or more employers from obtaining or offering coverage under a multiple employer welfare arrangement under which all benefits consist of medical care and are fully insured, or*

*(B) an insurer or health maintenance organization from offering coverage described in subparagraph (A).*

*(5) For purposes of this subsection, terms used in this subsection which are defined in section 800 shall have the meanings provided in such section.*

**[(c)]** *(d) For purposes of this section:*

*(1) The term “State law” includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.*

*(2) The term “State” includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.*

**[(d)]** *(e) Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b)) or any rule or regulation issued under any such law.*

\* \* \* \* \*

**PART 6—GROUP HEALTH PLANS**

\* \* \* \* \*

**SEC. 607. DEFINITIONS AND SPECIAL RULES.**

For purposes of this part—

**(1) GROUP HEALTH PLAN.—[The term]**

*(A) IN GENERAL.—The term “group health plan” means an employee welfare benefit plan providing medical care [(as defined in section 213(d) of the Internal Revenue Code of 1986)] to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.*

*(B) MEDICAL CARE.—For purposes of this paragraph, the term “medical care” means—*

*(i) amounts paid for, or items or services in the form of, the diagnosis, cure, mitigation, treatment, or pre-*

vention of disease, or amounts paid for, or items or services provided for, the purpose of affecting any structure or function of the body,

(ii) amounts paid for, or services in the form of, transportation primarily for and essential to medical care referred to in clause (i), and

(iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii).

\* \* \* \* \*

## **PART 7—RULES GOVERNING STATE REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS**

### **SEC. 701. DEFINITIONS.**

For purposes of this part—

(1) *FULLY INSURED.*—A particular benefit under a group health plan or a multiple employer welfare arrangement is “fully insured” if such benefit (irrespective of any recourse available against other parties) is provided in a manner so that such benefit constitutes insurance regulated by the law of any State (within the meaning of section 514(b)(2)).

(2) *INSURER.*—The term “insurer” means an insurance company, insurance service, or insurance organization, licensed to engage in the business of insurance by a State.

(3) *MEDICAL CARE.*—The term “medical care” means medical care within the meaning of section 607(1).

(4) *MULTIPLE EMPLOYER HEALTH PLAN.*—The term “multiple employer health plan” means a multiple employer welfare arrangement which provides medical care and which has been granted an exemption under section 514(b)(6)(B).

(5) *PARTICIPATING EMPLOYER.*—The term “participating employer” means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the individuals who are dependents (as defined under the terms of the arrangement) of its employees, are or were covered under such arrangement in connection with the employment of the employees.

(6) *SPONSOR.*—The term “sponsor” means, in connection with a multiple employer welfare arrangement, the association or other entity which establishes or maintains the arrangement.

(7) *STATE INSURANCE COMMISSIONER.*—The term “State insurance commissioner” means the insurance commissioner (or similar official) of a State.

### **SEC. 702. MULTIPLE EMPLOYER HEALTH PLANS ELIGIBLE FOR RELIEF FROM CERTAIN RESTRICTIONS ON PREEMPTION OF STATE LAW.**

(a) *TREATMENT AS EMPLOYEE WELFARE BENEFIT PLAN WHICH IS A GROUP HEALTH PLAN.*—

(1) *IN GENERAL.*—A multiple employer welfare arrangement—  
(A) under which the benefits consist solely of medical care (disregarding such incidental benefits as the Secretary shall specify by regulation), and

(B) under which some or all benefits are not fully insured, shall be treated for purposes of subtitle A and the other parts of this subtitle as an employee welfare benefit plan which is a group health plan if an exception is granted to the arrangement under section 514(b)(6)(B) in accordance with this part.

(2) *EXCEPTION.*—In the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii), paragraph (1) shall apply with respect to such arrangement, but only with respect to benefits provided thereunder which constitute medical care.

(b) *TREATMENT UNDER PREEMPTION RULES.*—

(1) *IN GENERAL.*—The Secretary shall prescribe regulations described in section 514(b)(6)(B)(i), applicable to multiple employer welfare arrangements described in subparagraphs (A) and (B) of subsection (a)(1), providing a procedure for granting exemptions from section 514(b)(6)(A)(ii) with respect to such arrangements. Under such regulations, any such arrangement treated under subsection (a) as an employee welfare benefit plan shall be deemed to be an arrangement described in section 514(b)(6)(B)(ii).

(2) *STANDARDS.*—Under the procedure prescribed pursuant to paragraph (1), the Secretary shall grant an arrangement described in subsection (a) an exemption described in subsection (a) only if the Secretary finds that—

(A) such exemption—

- (i) is administratively feasible,
- (ii) is not adverse to the interests of the individuals covered under the arrangement,
- (iii) is protective of the rights and benefits of the individuals covered under the arrangement, and

(B) under such arrangement—

- (i) the requirements of section 703(a) are met,
- (ii) reserves are maintained in an amount of not less than \$100,000 which consist of at least a reserve sufficient—

(I) for unearned contributions,

(II) for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred (to the extent that the arrangement does not maintain such security, guarantee, hold-harmless arrangement, or other financial arrangement as the Secretary determines to be adequate), and

(III) for expected administrative costs with respect to such benefit liabilities,

(iii) the arrangement will provide such timely notice of material changes as the Secretary shall specify in the regulations referred to in paragraph (1), the arrangement will meet such other financial, actuarial, and other reporting requirements as shall be specified in such regulations, the arrangement is maintained by persons who are not disqualified persons as defined in

such regulations, and the arrangement will terminate upon failure to meet requirements which shall be specified in such regulations.

(3) *FILING FEE.*—Under the procedure prescribed pursuant to paragraph (1), a multiple employer welfare arrangement shall pay to the Secretary at the time of filing an application for an exemption referred to in subsection (a) a filing fee in the amount of \$5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the exemption procedures applicable with respect to such arrangement.

(4) *CLASS EXEMPTION TREATMENT FOR EXISTING LARGE ARRANGEMENTS.*—Under the procedure prescribed pursuant to paragraph (1), if—

(A) at the time of application for an exemption under section 514(b)(6)(B) with respect to an arrangement which has been in existence as of the date of the enactment of the ERISA Targeted Health Insurance Reform Act of 1996 for at least 3 years, either (A) the arrangement covers at least 1,000 participants and beneficiaries, or (B) with respect to the arrangement there are at least 2,000 employees of eligible participating employers,

(B) a complete application for the exemption with respect to the arrangement has been filed and is pending, and

(C) the application meets such requirements (if any) as the Secretary may provide with respect to class exemptions under this subsection,

the exemption shall be treated as having been granted with respect to the arrangement unless and until the Secretary provides appropriate notice that the exemption has been denied.

(c) *FILING NOTICE OF EXEMPTION WITH STATES.*—An exemption granted under section 514(b)(6)(B) to a multiple employer welfare arrangement shall not be effective unless written notice of such exemption is filed with the State insurance commissioner of each State in which at least 5 percent of the individuals covered under the arrangement are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed. The Secretary may by regulation provide in specified cases for the application of the preceding sentence with lesser percentages in lieu of such 5 percent amount.

**SEC. 703. REQUIREMENTS RELATING TO SPONSORS, BOARDS OF TRUSTEES, AND PLAN OPERATIONS.**

(a) *IN GENERAL.*—A complete application for an exemption under section 514(b)(6)(B) shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

(1) *SPONSOR.*—The sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of com-

*merce (or similar business group, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care (referred to in section 3(42)), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members.*

*(2) BOARD OF TRUSTEES.—The arrangement is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.*

*(3) COVERED PERSONS.—The instruments governing the arrangement include a written instrument which provides that, effective upon the granting of the exemption to the arrangement—*

*(A) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer,*

*(B) all individuals thereafter commencing coverage under the arrangement must be—*

*(i) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or*

*(ii) the beneficiaries of individuals described in clause (i), and*

*(C) no participating employer may provide health insurance coverage in the individual market for any employee not covered under the arrangement which is similar to the*

coverage contemporaneously provided to employees of the employer under the arrangement, if such exclusion of the employee from coverage under the arrangement is based in whole or in part on the health status of the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the arrangement.

(4) *INCLUSION OF ELIGIBLE EMPLOYERS AND EMPLOYEES.*—No employer described in paragraph (3) is excluded as a participating employer, no employee of a participating employer is ineligible for coverage offered under the plan in a geographic area with respect to the employee, and no individual who would otherwise be eligible for coverage under the arrangement in connection with such an employer is excluded as a plan participant, based on—

(A) enrollment criteria more restrictive than those required under section 804 with respect to group health plans, or

(B) a minimum participation requirement of the type referred to in section 812(f)(3).

(5) *RESTRICTION ON VARIATIONS OF PREMIUM RATES.*—Premium rates under the arrangement with respect any particular employer do not vary on the basis of the claims experience of such employer.

(b) *TREATMENT OF FRANCHISE NETWORKS.*—In the case of a multiple employer welfare arrangement which is established and maintained by a franchisor for a franchise network consisting of its franchisees, the requirements of subsection (a)(1) shall be treated as met with respect to such network in any case in which such requirements would be met if the franchisor were deemed to be the sponsor referred to in subsection (a)(1), such network were deemed to be an association described in subsection (a)(1), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in subsection (a)(1).

(c) *CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.*—In the case of a multiple employer welfare arrangement in existence on February 1, 1995, which would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii) or (to the extent provided in regulations of the Secretary) solely for the failure to meet the requirements of subparagraph (D) or (F) of section 3(40)—

(1) subsection (a)(1) shall not apply, and

(2) the joint board of trustees shall be considered the board of trustees required under subsection (a)(2).

(d) *CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.*—

(1) *IN GENERAL.*—In any case in which the majority of the employees covered under a multiple employer welfare arrangement are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer—

(A) subsection (a)(1) shall be treated as satisfied if the sponsor of the arrangement is the person who would be the plan sponsor if the related employers were disregarded in

determining whether the requirements of section 3(40)(B) are met, and

(B) subsection (a)(2) shall be treated as satisfied if the board of trustees is the named fiduciary in connection with the arrangement.

(2) *RELATED EMPLOYERS.*—For purposes of paragraph (1), employers are “related” if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

**SEC. 704. SPECIAL RULES FOR CHURCH PLANS.**

(a) *ELECTION FOR CHURCH PLANS.*—

(1) *IN GENERAL.*—Notwithstanding section 4(b)(2), if the church or convention or association of churches which maintains a church plan covered under this section makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulations prescribe), then, subject to this section, the provisions of this part (and other provisions of this title to the extent that they apply to group health plans which are multiple employer welfare arrangements) shall apply to such church plan, with respect to benefits provided under such plan consisting of medical care, as if—

(A) section 4(b)(2) did not contain an exclusion for church plans, and

(B) such plan were an arrangement eligible to apply for an exemption under this part.

(2) *ELECTION IRREVOCABLE.*—An election under this subsection with respect to any church plan shall be binding with respect to such plan, and, once made, shall be irrevocable.

(b) *COVERED CHURCH PLANS.*—A church plan is covered under this section if such plan provides benefits which include medical care and some or all of such benefits are not fully insured.

(c) *SPONSOR AND BOARD OF TRUSTEES.*—For purposes of this part, in the case of a church plan to which this part applies pursuant to an election under subsection (a), in treating such plan as if it were a multiple employer welfare arrangement under this part—

(1) the church, convention or association of churches, or other organization described in section 3(33)(C)(i) which is the entity maintaining the plan shall be treated as the sponsor referred to in section 703(a)(1), and the requirements of section 703(a)(1) shall be deemed satisfied with respect to the sponsor, and

(2) the board of trustees, board of directors, or other similar governing body of such sponsor shall be treated as the board of trustees referred to in section 703(a)(2), and the requirements of section 703(a)(2) shall be deemed satisfied with respect to the board of trustees.

(d) *DEEMED SATISFACTION OF TRUST REQUIREMENTS.*—The requirements of section 403 shall not be treated as not satisfied with respect to a church plan to which this part applies pursuant to an election under subsection (a) solely because assets of the plan are held by an organization described in section 3(33)(C)(i), if—

(1) such organization is incorporated separately from the church or convention or association of churches involved, and

(2) such assets with respect to medical care are separately accounted for.

(e) **DEEMED SATISFACTION OF EXCLUSIVE BENEFIT REQUIREMENTS.**—The requirements of section 404 shall not be treated as not satisfied with respect to a church plan to which this part applies pursuant to an election under subsection (a) solely because assets of the plan which are in excess of reserves required for exemption under section 514(b)(6)(B) are held in a fund in which such assets are pooled with assets of other church plans, if the assets held by such fund may not, under the terms of the plan and the terms governing such fund, be used for, or diverted to, any purpose other than for the exclusive benefit of the participants and beneficiaries of the church plans whose assets are pooled in such fund.

(f) **INAPPLICABILITY OF CERTAIN PROVISIONS.**—

(1) **PROHIBITED TRANSACTIONS.**—Section 406 shall not apply to a church plan by reason of an election under subsection (a).

(2) **CONTINUATION COVERAGE.**—Section 601 shall not apply to a church plan by reason of an election under subsection (a).

## **PART 8—ACCESS TO, AND CONTINUITY OF, GROUP HEALTH PLAN COVERAGE**

### **SEC. 800. DEFINITIONS AND SPECIAL RULES.**

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

(1) **EMPLOYER.**—The term “employer” shall have the meaning applicable under section 3(5), except that such term includes the partnership in relation to any partner.

(2) **FULLY INSURED.**—The term “fully insured” shall have the meaning applicable under section 701(1).

(3) **HEALTH INSURANCE COVERAGE.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), the term “health insurance coverage” means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer or a health maintenance organization, to the extent of the benefits under such policy, certificate, or contract consisting of medical care, provided directly, through insurance or reimbursement, or otherwise.

(B) **EXCEPTION.**—Such term does not include coverage under any separate policy, certificate, or contract only for one or more of any of the following:

(i) Coverage for accident, dental, vision, disability income, on-site medical clinics, employee assistance programs, or long-term care insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) and similar supplemental coverage provided under a group health plan.

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

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

(v) *Worker's compensation or similar insurance.*

(vi) *Automobile medical-payment insurance.*

(vii) *Coverage consisting of benefit payments made on a periodic basis for a specified disease or illness or period of hospitalization, without regard to the costs incurred or services rendered during the period to which the payments relate.*

(4) *HEALTH MAINTENANCE ORGANIZATION.*—The term “health maintenance organization” means a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(5) *INSURER.*—The term “insurer” means an insurance company, insurance service, or insurance organization licensed to engage in the business of insurance in a State.

(6) *MEDICAL CARE.*—The term “medical care” means medical care within the meaning of section 607(1).

(7) *NETWORK PLAN.*—The term “network plan” means an arrangement of an insurer or a health maintenance organization under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the insurer or health maintenance organization.

(b) *COVERAGE.*—This part shall apply in the case of a group health plan for any plan year only if such group health plan has two or more participants as current employees on the first day of such plan year.

(c) *SPECIAL RULES PROVIDING FOR TREATMENT AS GROUP HEALTH PLAN.*—

(1) *An employee welfare benefit plan shall be treated as a group health plan under this part only with respect to medical care (within the meaning of section 607(1)) which is provided under the plan and which does not consist of coverage excluded from the definition of health insurance coverage under subsection (a)(3)(B).*

(2) *Any plan, fund, or program which would not be (but for this paragraph) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (within the meaning of section 607(1)) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (1)) as an employee welfare benefit plan which is a group health plan.*

**Subpart A—Preexisting Condition Limitations,  
Portability, and Renewability**

**SEC. 801. LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS.**

(a) *TIME CONSTRAINTS ON LIMITATIONS OR EXCLUSIONS BASED ON PREEXISTING CONDITIONS.*—

(1) *IN GENERAL.*—A group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, may provide a limitation on, or exclusion of, the benefits of a participant or beneficiary otherwise available under the terms of the plan based on a preexisting condition only if the limitation or exclusion does not extend beyond—

(A) in the case of a participant or beneficiary whose initial coverage commences at the time such participant or beneficiary first becomes eligible for coverage under the plan, 12 months after the effective date of such coverage, or

(B) in the case of a participant or beneficiary whose initial coverage commences pursuant to an election made after the period in which the election may first be made, 18 months after the effective date of such coverage.

(2) *PREEXISTING CONDITION.*—For purposes of paragraph (1), the term “preexisting condition” means a medical condition which was diagnosed, or which was treated—

(A) in the case of a participant or beneficiary described in paragraph (1)(A), within the 6-month period preceding the effective date of the coverage of such participant or beneficiary (as determined by disregarding any applicable waiting period), or

(B) in the case of a participant or beneficiary described in paragraph (1)(B), within the 12-month period preceding the effective date of the coverage of such participant or beneficiary (as determined by disregarding any applicable waiting period).

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

(d) *APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.*—A health maintenance organization that offers health insurance coverage shall not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwithstanding that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provisions of this subpart, so long as such exclusion is applied in a manner and to an extent consistent with the provisions of this subpart.

(e) *ELIGIBILITY PERIOD IMPOSED BY HEALTH MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXISTING CONDITION LIMITATION.*—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not use the preexisting condition limitations allowed under this section and section 802 with respect to any particular coverage op-

tion may impose an eligibility period for such coverage option, but only if such period does not exceed—

(1) 90 days, in the case of a participant or beneficiary whose initial coverage commences at the time such participant or beneficiary first becomes eligible for coverage under the plan, or

(2) 180 days, in the case of a participant or beneficiary whose initial coverage commences after the date on which such participant or beneficiary first becomes eligible for coverage.

For purposes of this subsection, the term “eligibility period” means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. Any such eligibility period shall be treated for purposes of this subpart as a waiting period under the plan and shall run concurrently with any other applicable waiting period under the plan.

**SEC. 802. PORTABILITY.**

(a) *IN GENERAL.*—Each group health plan, and each insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, shall provide that if a participant or beneficiary is in a period of continuous coverage (as defined in subsection (e)) as of a date upon which coverage takes effect under the plan, any period of limitation on, or exclusion of, covered benefits in connection with a preexisting condition (as permitted under section 801) shall be reduced by 1 month for each month in the period of continuous coverage.

(b) *CONSTRUCTION.*—Nothing in this section shall be construed to prohibit a limitation on, or exclusion of, any benefit of a participant or beneficiary otherwise available under the terms of the plan based on a preexisting condition, subject to the limits in section 801(a), if such benefit was not previously provided under the group health plan or health insurance coverage (or coverage consisting of medical care under title XIX of the Social Security Act) under which the individual was covered at the end of the period of continuous coverage referred to in subsection (a).

(c) *DOCUMENTATION.*—A participant or beneficiary may be treated by a group health plan, or by an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, as not being in a period of continuous coverage if, upon the request of the plan or of the insurer or health maintenance organization (as the case may be), the participant or beneficiary does not present satisfactory documentation of such period of continuous coverage. The Secretary may prescribe regulations defining standards for satisfactory documentation for purposes of this subsection.

(d) *NO PREEXISTING CONDITION FOR NEWBORNS AND ADOPTED CHILDREN.*—For purposes of this subpart—

(1) *NEWBORNS.*—A child who, within the 30-day period beginning with the date of birth, becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or coverage consisting of medical care under title XIX of the Social Security Act) and remains thereafter in a period of continuous coverage shall not be considered, beginning at the time of birth, to have any preexisting condition.

(2) *ADOPTED CHILDREN.*—An adopted child or a child placed for adoption (within the meaning of section 609(c)(3)(B)) who, within the 30-day period beginning on the date of adoption or placement, becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or coverage providing medical care under title XIX of the Social Security Act) and remains thereafter in a period of continuous coverage shall not be considered, beginning at the time of adoption or placement, to have any preexisting condition.

(e) *PERIOD OF CONTINUOUS COVERAGE.*—For purposes of this subpart, the term “period of continuous coverage” means the period—

(1) beginning on the date an individual becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or coverage consisting of medical care under title XIX of the Social Security Act), and

(2) ending on the date the individual does not have such coverage for a continuous period of more than 60 days.

(f) *INAPPLICABILITY OF PORTABILITY TO PARTICIPANTS OF NON-ELECTING PLANS.*—A group health plan shall not be treated as failing to meet the requirements of this section solely because, in determining whether there is a period of continuous coverage, the plan disregards coverage under any other group health plan that is a governmental plan or church plan which is not subject to this section or section 801.

**SEC. 803. REQUIREMENTS FOR RENEWABILITY OF COVERAGE.**

(a) *MULTIEMPLOYER PLANS, MULTIPLE EMPLOYER HEALTH PLANS, AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.*—A group health plan which is a multiemployer plan or a multiple employer health plan (as defined in section 701(4)), and a multiple employer welfare arrangement (to the extent to which benefits under the arrangement consist of medical care and are fully insured), may not deny an employer whose employees are covered under such a plan or arrangement continued access to the same or different coverage under the terms of such a plan or arrangement, other than—

(1) for nonpayment of contributions,

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

(3) for noncompliance with material plan or arrangement provisions,

(4) because the plan or arrangement is ceasing to offer any coverage in a geographic area,

(5) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement,

(6) in the case of a plan or arrangement to which subparagraph (C), (D), or (E) of section 3(40) applies, to the extent necessary to meet the requirements of such subparagraph, or

(7) in the case of a multiple employer health plan (as defined in section 701(4)), for failure to meet the requirements under part 7 for an exemption under section 514(b)(6)(B).

Nothing in this subsection shall be construed to preclude any such plan or arrangement from establishing employer contribution re-

quirements or group participation requirements not otherwise prohibited by this Act.

(b) *INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS.*—

(1) *IN GENERAL.*—In any case in which an insurer or a health maintenance organization is providing health insurance coverage in connection with a group health plan, the insurer or health maintenance organization may not deny an employer whose employees are covered under such plan continued access to health insurance coverage provided by such insurer or health maintenance organization, other than—

(A) for nonpayment of premiums or contributions in accordance with the terms of the health insurance coverage,

(B) for any act or practice constituting fraud or other intentional misrepresentation under the terms of the health insurance coverage,

(C) for noncompliance with material plan provisions relating to participation or employer contributions, or

(D) subject to paragraph (3), because the insurer or health maintenance organization is ceasing to offer any such coverage in a State, or, in the case of a network plan (as defined in section 800(a)(7)), in a geographic area.

(2) *DISCONTINUANCE OF OFFERED HEALTH INSURANCE COVERAGE.*—In any case in which a policy, certificate, or contract referred to in section 800(a)(3) is no longer being offered in connection with group health plans by an insurer or health maintenance organization, health insurance coverage as defined by such policy, certificate, or contract may be discontinued by the insurer or health maintenance organization in connection with any group health plan upon the offer to the plan sponsor of an option to purchase any other health insurance coverage currently being offered in connection with group health plans, if the offer of such option is made uniformly in connection with group health plans.

(3) *NOTICE REQUIREMENT FOR MARKET EXIT.*—Paragraph (1)(D) shall not apply to an insurer or health maintenance organization ceasing to offer coverage unless the insurer provides notice of such termination to employers and individuals covered at least 180 days before the date of termination of coverage.

(4) *EXCEPTION TO REQUIREMENT FOR RENEWABILITY OF COVERAGE BY REASON OF FAILURE BY PLAN TO MEET CERTAIN MINIMUM PARTICIPATION RULES.*—

(A) *IN GENERAL.*—Paragraph (1) shall not apply in the case of any group health plan with respect to which participation rules of an insurer or health maintenance organization which are described in subparagraph (B) are not met.

(B) *PARTICIPATION RULES.*—For purposes of subparagraph (A), participation rules (if any) of an insurer or health maintenance organization shall be treated as met with respect to a group health plan only if such rules are uniformly applicable and in accordance with applicable State law and the number or percentage of eligible individuals who, under the plan, are participants or beneficiaries equals or exceeds a level which is determined in accordance with such rules.

**SEC. 804. GROUP HEALTH PLAN ENROLLMENT REQUIREMENTS.****(a) ENROLLMENT PERIODS.—**

**(1) ANNUAL PERIOD.—**A group health plan shall provide for at least one annual open enrollment period (of not less than 30 days) each year during which—

(A) employees who are eligible for coverage under the terms of the plan who are not otherwise covered may elect to be covered under at least one benefit option, and

(B) if family coverage is available, employees who are covered but who do not have family coverage may elect family coverage.

**(2) ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO LOSE OTHER COVERAGE.—**A group health plan shall permit an uncovered employee who is otherwise eligible for coverage under the terms of the plan (or an uncovered dependent, as defined under the terms of the plan, of such an employee, if family coverage is available) to enroll for coverage under the plan under at least one benefit option if—

(A) the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual,

(B) the employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment,

(C) the employee or dependent lost coverage under a group health plan or health insurance coverage (as a result of loss of eligibility for the coverage, termination of employment, or reduction in the number of hours of employment), and

(D) the employee requests such enrollment within 30 days after termination of such coverage.

**(b) DEPENDENTS.—**

**(1) IN GENERAL.—**If a group health plan makes family coverage available, the plan may not require, as a condition of coverage of a beneficiary of a participant in the plan, a waiting period applicable to the coverage of a beneficiary who is a newborn or an adopted child or child placed for adoption (within the meaning of section 609(c)(3)(B)), at the time of adoption or placement, or a spouse, at the time of marriage, if the participant has met any waiting period applicable to that participant.

**(2) TIMELY ENROLLMENT.—**

**(A) IN GENERAL.—**Enrollment of a participant's beneficiary described in paragraph (1) shall be considered to be timely if a request for enrollment is made either—

(i) within 30 days of the date of the marriage with such a beneficiary who is the spouse of the participant, or within 30 days of the date of the birth, adoption, or placement for adoption of such a beneficiary who is a child of the participant, if family coverage is available as of such date, or

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

(B) *COVERAGE.*—If available coverage includes family coverage and enrollment is made under such coverage on a timely basis under subparagraph (A)(i), the coverage shall become effective not later than the first day of the first month beginning 15 days after the date the completed request for enrollment is received.

(c) *DENIAL OF ENROLLMENT BASED ON PREEXISTING CONDITION PROHIBITED.*—A group health plan, and an insurer or health maintenance organization providing health insurance coverage in connection with a group health plan, may not exclude an employee or his or her beneficiary from enrollment under the plan on the basis of a preexisting condition (as defined in section 801(a)(2), but regardless of the period within which the condition was diagnosed or treated).

### **Subpart B—Requirements for Insurers and Health Maintenance Organizations Offering Health Insurance Coverage to Group Health Plans of Small Employers**

#### **SEC. 811. DEFINITIONS.**

Except as otherwise specifically provided, for purposes of this subpart:

(1) *ELIGIBLE INDIVIDUAL.*—The term “eligible individual” means, with respect to an insurer or health maintenance organization that offers general coverage to any small employer in connection with a group health plan, such an individual in relation to the employer as shall be determined—

(A) in accordance with the terms of such plan,

(B) as provided by the insurer or health maintenance organization under rules of the insurer or health maintenance organization which are uniformly applicable, and

(C) in accordance with all applicable State laws governing such insurer or health maintenance organization.

(2) *GENERAL COVERAGE.*—The term “general coverage” means health insurance coverage that—

(A) is offered at a particular time in the small group market, and

(B) is not made available solely in connection with any trade, industry, or professional association.

(3) *SMALL EMPLOYER.*—The term “small employer” means, in connection with a group health plan with respect to a calendar year, an employer who employs at least 2 but fewer than 51 employees on a typical business day in the year. For purposes of this paragraph, two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group (within the meaning of section 3(40)(B)(ii)).

(4) *SMALL GROUP MARKET.*—The term “small group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on

*the basis of employment or other relationship with respect to a small employer.*

*(5) STATE.—The term “State” means any of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.*

**SEC. 812. REQUIREMENTS FOR INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS IN THE SMALL GROUP MARKET WHO OFFER GENERAL COVERAGE.**

*(a) ISSUANCE OF COVERAGE.—Subject to the succeeding subsections of this section, each insurer or health maintenance organization that offers general coverage in connection with a group health plan in the small group market in a State—*

*(1) must accept every small employer in the State that applies for such coverage; and*

*(2) must accept for enrollment under such coverage every eligible individual (as defined in section 811(1)) who applies for enrollment on a timely basis (consistent with section 804) and may not place any restriction which is inconsistent with section 804 on the eligibility of an individual to enroll so long as such individual is an eligible individual.*

*(b) TREATMENT OF CERTAIN PREVIOUSLY SELF-INSURED EMPLOYERS.—*

*(1) IN GENERAL.—An insurer or health maintenance organization may elect not to make general coverage available to group health plans of previously self-insured small employers (described in paragraph (2)), but only if such election is made in a uniform manner for all such employers. The exclusion, pursuant to such an election, of such a group health plan from availability of general coverage shall not apply after the end of the 1-year period (or such uniform, shorter period as the insurer or organization may specify) beginning on the last date no such coverage was provided by such employer.*

*(2) PREVIOUS SELF-INSURED EMPLOYER DESCRIBED.—A previously self-insured small employer described in this paragraph is a small employer that has provided medical care (referred to in section 800(a)(6)) to employees other than through health insurance coverage to which this subpart applies.*

*(c) CONSTRUCTION WITH RESPECT TO COVERAGE OFFERED IN CONNECTION WITH ASSOCIATIONS.—Nothing in subsection (a) shall be construed as requiring that the general coverage made available by an insurer or health maintenance organization in the small group market in a State in connection with any trade, industry, or professional association be the same as the general coverage offered in the State in the small group market not in connection with such an association.*

*(d) SPECIAL RULES FOR NETWORK PLANS AND HEALTH MAINTENANCE ORGANIZATIONS.—*

*(1) IN GENERAL.—In the case of an insurer that offers health insurance coverage in connection with a group health plan in the small group market through a network plan (as defined in section 800(a)(7)) and in the case of a health maintenance organization that offers health insurance coverage in connection with such a plan, the insurer or organization may—*

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

(B) limit the individuals who may be enrolled under such coverage to those who reside in the service area for such plan or organization; and

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

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

(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience or duration of coverage of those employers and their employees or the health status of their employees.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or health maintenance organization, upon denying health insurance coverage in connection with group health plans in any service area in accordance with paragraph (1)(C) may not offer coverage in connection with group health plans in the small group market within such service area for a period of 180 days after such coverage is denied.

(e) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—

(1) IN GENERAL.—An insurer or health maintenance organization may deny health insurance coverage in connection with a group health plan in the small group market if the insurer or organization demonstrates to the appropriate enforcing authority (subject to section 502(c)(5)) that—

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

(B) it is applying this paragraph uniformly to all employers without regard to the claims experience or duration of coverage of those employers and their employees or the health status of their employees.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or health maintenance organization, upon denying health insurance coverage in connection with group health plans in any service area in accordance with paragraph (1) may not offer coverage in connection with group health plans in the small group market within such service area for a period of 180 days after such coverage is denied.

(f) EXCEPTION TO REQUIREMENT FOR ISSUANCE OF COVERAGE BY REASON OF FAILURE BY PLAN TO MEET CERTAIN MINIMUM PARTICIPATION RULES.—

(1) IN GENERAL.—Subsection (a) shall not apply in the case of any group health plan with respect to which participation rules of an insurer or health maintenance organization which are described in paragraph (2) are not met.

(2) PARTICIPATION RULES.—For purposes of paragraph (1), participation rules (if any) of an insurer or health maintenance organization shall be treated as met with respect to a group health plan only if such rules are uniformly applicable and in

*accordance with applicable State law and the number or percentage of eligible individuals who, under the plan, are participants or beneficiaries equals or exceeds a level which is determined in accordance with such rules.*

*(3) SPECIAL RULE FOR COVERAGE IN CONNECTION WITH CERTAIN ASSOCIATIONS.—In the case of health insurance coverage in connection with any trade, industry, or professional association, the insurer or health maintenance organization may not provide for a minimum participation requirement with respect to eligible individuals who are employees of an employer.*

\* \* \* \* \*

## MINORITY VIEWS ON H.R. 995

Committee Republicans passed up a golden opportunity to advance realistic, bipartisan health reform legislation when it marked up H.R. 995, the ERISA Targeted Health Insurance Reform Act of 1996, instead of H.R. 2893, the House version of the Kassebaum-Kennedy health reform bill. H.R. 2893 was introduced by our colleague, Rep. Marge Roukema (R-NJ).

To reiterate a point frequently and forcefully made by Democrats at the markup, the Committee should have considered and approved the Roukema bill that morning. What the Majority did report out was a bill weighted down with complex provisions that not only would have disastrous consequences for consumers, but also are extremely controversial with the Nation's governors, State insurance commissioners, and State legislators.

For many Democratic Members, the reforms contained in the Roukema bill are extremely modest; clearly, they will not solve every problem in the current system. And there are, no doubt, other more ambitious proposals that many Democrats would have rather supported.

We live in the here and now, however, and the exigencies of the moment require Democrats and Republicans to unite behind the Roukema bill if there is to be any realistic possibility of health reform during the 104th Congress.

### CONGRESS SHOULD UNITE BEHIND ROUKEMA BILL

While House Republicans busy themselves loading up health reform legislation with divisive proposals, the Nation cries out for the reasonable, constructive approach of the Roukema bill. Twenty-five million Americans would benefit from the protections contained in the bill. It will help end job lock; it will end the worst abuses in the current system. It will go along way toward alleviating the anxiety and suffering of many.

The Kassebaum-Kennedy bill has broad bipartisan support in the Senate. S. 1028 passed the Senate Labor and Human Resources Committee by a unanimous 16-to-0 vote and is assured of a vote on the Senate floor by May 3rd. It boasts broad bipartisan support, with 50 cosponsors, including 27 Democrats and 23 Republicans. In the House, over 170 Democratic Members are cosponsors of the Roukema bill.

In addition, the Roukema bill is supported by a wide range of diverse business, labor, and advocacy organizations. They include the National Association of Manufacturers, the National Governors' Association, the AFL-CIO, the American Medical Association, the Business Roundtable, the American Association of Retired Persons, the American Hospital Association, the Healthcare Leadership Council, and the American Association of Health Plans (formerly known as the Group Health Association of America).

Before a national television audience, President Clinton challenged Congress during last January's State of the Union address to pass the Kassebaum-Kennedy bill and send it to him for his signature. If there was ever any doubt that S. 1028 and H.R. 2893 were viable legislative proposals, that doubt was eliminated the very moment when the President declared his pledge to sign the bill and Speaker Gingrich jumped out of his seat (in unison with hundreds of members) in apparent support of the President's pledge.

Sadly, the moment of bipartisan unity—at least in the House—was all too brief. Within weeks, the same special interests that helped defeat health care reform legislation in the 103rd Congress regained ground and convinced the House Republican Leadership to scrap the sensible, bipartisan approach of the Roukema bill and write a new bill! According to news accounts, the Republican leadership bill contain a number of controversial provisions (including, reportedly, H.R. 995's proposal to expand the Federal ERISA<sup>1</sup> preemption to Federally-certified multi-employer health plans) that the New York Times generously described as "likely to generate bitter, prolonged dispute in Congress."<sup>2</sup>

The House Republican leadership, working through the four committees of jurisdiction, are on the verge of dashing the hopes of millions of people and the modest legislative objectives of a large, bipartisan group of Members in the House and Senate. For lack of a better explanation, the Republican strategy appears to be "an effort to look like you're for health care, but load it up so you can make sure you kill it," as Rep. George Miller (D-CA) charged in the markup.

#### DEMOCRATS PRESSED FOR VOTE ON H.R. 2983

During the markup, Rep. William L. Clay, Ranking Democratic Member, offered the Roukema bill as a substitute for the bill under consideration. The Clay substitute followed a lengthy discussion in which a number of Democrats expressed strong support for the Roukema bill and urged the Majority to consider H.R. 2893 instead of H.R. 995. Democratic Members left no doubt that they were eager to take up the Roukema bill, vote for it, and send it on its way—hopefully—all the way to the President's desk.

Republicans immediately objected to the Clay substitute on narrow procedural grounds. Thus, Committee Republicans would not even give Members a chance to vote on the Roukema bill—even the parts that are in the Committee's jurisdiction.

The Roukema bill is a better, more realistic proposal than H.R. 995 for these reasons:

The Roukema bill provides important protection to individuals who have been laid off or have retired and are trying to purchase

<sup>1</sup> ERISA is the Employee Retirement Income Security Act.

<sup>2</sup> Robert Pear, "G.O.P. Seeks to Expand Access to Health Care, with a Catch," The New York Times, 5 March 1996, p. A13. According to this and other newspaper accounts, Rep. Dennis Hastert, chairman of the House Republican health care task force, has stated that the new bill would include Medical Savings Accounts, limits on medical malpractice lawsuits, antitrust exemptions for certain providers, expanded deductibility for self-employed individuals, and some insurance reforms.

health insurance for themselves. H.R. 995 does not.<sup>3</sup> Under the Roukema bill, insurers and HMOs must issue coverage to individuals who have maintained employment coverage for at least 18 months and who have exhausted, or are not eligible for, COBRA continuation coverage.

Whereas the Roukema bill requires insurers and HMOs to make coverage available to all employers, H.R. 995's guaranteed availability rules benefit small employers only and appear not to apply at all to fully insured trade association plans. These association plans would be allowed to pick and choose the firms to which they will offer health insurance coverage.

The Roukema bill contains a significantly broader nondiscrimination provision than H.R. 995. The Roukema bill would prohibit group health plans, whether insured or self-insured, from establishing rules relating to eligibility, continuation of eligibility, enrollment, and contribution on the basis of an employee's health status, medical condition, claims experience, treatment, medical history, or disability. H.R. 995's narrower provision limits setting eligibility rules on the basis of preexisting conditions only.

The Roukema bill promotes the formation of private, voluntary health purchasing cooperatives without upsetting the current balance between Federal and State regulation of health insurance or undermining the viability of State insurance reform. H.R. 995's expansion of the ERISA preemption to self-funded, multi-employer plans will cause healthy groups to exit the insured market, thus undermining the viability of State insurance reform. [See discussion below.]

Unlike H.R. 995, the Roukema bill improves COBRA coverage for disabled individuals and newborns.

Finally, the Roukema bill has broad bipartisan, public, and editorial support. H.R. 995's ERISA expansion and State preemption provisions are very controversial with the Nation's governors, State insurance commissioners, and State legislators.

#### H.R. 995 IS A FLAWED BILL

In committee markup, Democratic Members expressed disappointment that they were not given the opportunity to consider and vote for a realistic, truly bipartisan health reform proposal like the Roukema bill. In the end, Democratic Members could not support H.R. 995 because, as explained above, the bill's insurance reforms do not go far enough to protect health insurance consumers. More important, the bill's multi-employer and State preemption provisions not only go in the wrong direction, but also are very controversial.

H.R. 995's expansion of the Federal ERISA preemption to self-funded multi-employer plans and its other State preemption provisions would undermine State efforts to enact meaningful health reform. They would leave many individuals now protected by stricter State insurance rules and aggressive State regulators much worse off. For Democrats, that is unacceptable.

<sup>3</sup>The provisions in H.R. 995 and H.R. 2893 providing portability for individuals moving from one group health plan to another group plan and limiting preexisting condition exclusions are comparable.

## A. H.R. 995 WOULD MAKE CONSUMERS WORSE OFF

H.R. 995 establishes one national rule for the treatment of pre-existing condition exclusions and portability, and preempts States from enacting insurance rules that better protect consumers. States would be prevented from enacting new laws or carrying out existing laws that prohibit, for example, insurance companies from limiting coverage for more than 6 months for a preexisting condition.<sup>4</sup>

With respect to portability provisions, a number of States have adopted laws that better protect consumers. Under H.R. 995, for example, if a person switches from a plan that does not include coverage for mental health services to one that does, the second plan would not be required to waive the preexisting condition exclusion for mental health claims. According to the General Accounting Office (GAO), at least 15 States would appear to have laws that better protect consumers because the preexisting condition is waived without regard to whether the previous group plan covered a particular service.<sup>5</sup>

H.R. 995 largely preempts State mandated benefit laws. Millions of consumers use services that State mandated benefit laws require insurance policies to cover; as a result of H.R. 995, they could find themselves worse off. For example, forty-five States require insurers to either cover or offer mammography screening. Other examples of mandated benefits include coverage for pap smears (19 States), well child care (18 States), maternity care (13 States), prostate cancer screening (5 States), and bone marrow transplants (4 States).<sup>6</sup> Under H.R. 995, individuals who now use these services could discover that the carrier (or MEWA) their employer uses no longer covers them.

## B. H.R. 995 WILL CRIPPLE STATE REFORM INITIATIVES

In the last five years there has been a flurry of legislative activity at the State level with respect to regulation and reform of the small employer health insurance market. According to the GAO, between 1990 and 1994, at least 45 States passed legislation that regulated the health insurance markets for small employers. With the failure of the Federal government to enact comprehensive health reform in the 103rd Congress, States have continued to explore legislative solutions to the problems in their local health insurance markets.

H.R. 995 would eviscerate the ability of States to react to insurance market problems that arise in their local markets. As noted above, H.R. 995's preemption of State insurance reform rules would hamper the ability of States to improve access in their insurance markets. In the opinion of one State, H.R. 995's provision that preempts State regulation of association plans with respect to benefits

<sup>4</sup>The following States have laws that provide for limitations on preexisting condition exclusions that better protect consumers (at least in the small group market) than H.R. 995: Maryland, Massachusetts, California, Colorado, Kentucky, New Hampshire, New Jersey and New Mexico. Most have adopted a 6/6 rule for preexisting conditions, and Maryland law prohibits them altogether (GAO, "Variation in Recent State Small Employer Health Insurance Reforms," June 1995).

<sup>5</sup>States with laws that do not specify that services covered previously must have been comparable to current coverage include: Arizona, California, Florida, Kentucky, Louisiana, Maine, Minnesota, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia and West Virginia (GAO, "Variation in Recent State Small Employer Health Insurance Reforms.").

<sup>6</sup>GAO, "Employer-Based Health Plans: Issues, Trends and Challenges posed by ERISA," July 1995.

and rates “is a direct conflict with the fundamental tenets of California’s small group reform that the health insurance markets should not be segmented by risk or benefit design.”<sup>7</sup>

According to the National Association of Insurance Commissioners (NAIC) and the National Conference of State Legislatures (NCSL), H.R. 995 would deter “States from continuing to serve as ‘laboratories of democracy’ in the area of health insurance reform” and “force many States to go backward, rather than forward, with their reforms of the group insurance market.”<sup>8</sup>

### C. PROPOSAL TO FEDERALIZE MEWA’S IS SERIOUSLY FLAWED

The bill makes significant, complex changes in ERISA’s treatment of multiple employer plans that are called multiple employer welfare arrangements, or MEWAs. This proposal is seriously flawed and is more likely to make conditions in the current health insurance market much worse.

#### 1. Background

ERISA defines MEWAs simply as employee welfare benefit plans, including health plans, established or maintained for the purpose of offering or providing benefits to employees of two or more employers.<sup>9</sup> Unlike single employer self-funded plans, which ERISA exempts from most State regulation, MEWAs are largely regulated by State insurance regulators under State law. States typically regulate MEWAs with respect to reserve requirements, licensing, and consumer complaints procedures, among other things. While 17 States have MEWA-specific regulatory laws, other States treat and regulate them as insurance companies. The principal reason Congress more clearly delegated this responsibility to regulate MEWAs to the States in 1983 was that MEWAs had become havens for notoriously unscrupulous, scam operators.<sup>10</sup>

H.R. 995 would largely override current ERISA treatment of MEWAs and expand the ERISA preemption of State law to self-funded MEWAs. In other words, these new Federal MEWAs would no longer be subject to any State regulation. Instead, the Labor Department would regulate them, in the same way the Department now (loosely) regulates single employer health plans like IBM’s or General Motors’ health benefit plans.

While the bill generally requires MEWAs to comply with loosely-defined standards and to apply to the Labor Department for a Federal certificate, the bill grandfatheres existing MEWAs, even unscrupulous or inadequately financed ones, so they can immediately operate as Federally-chartered MEWAs and begin enrolling the public. The Labor Department could try to rescind a certificate if it later determined that the MEWA failed to comply with statutory and regulatory standards.

<sup>7</sup> California Department of Health Services, memorandum dated March 5, 1996.

<sup>8</sup> National Association of Insurance Commissioners and National Conference of State Legislatures, March 5, 1996, joint letter to Chairman William Goodling.

<sup>9</sup> The term MEWA does not include such arrangements when they are established under collective bargaining agreements or by rural electric cooperatives.

<sup>10</sup> MEWAs operate in many respects more like insurance companies than traditional single employer ERISA plans. Historically, States have regulated insurance and possess the regulatory tools to regulate MEWAs. See also Testimony of National Association of Insurance Commissioners, before the Subcommittee on Labor-Management Relations, U.S. House of Representatives, presented by James E. Long, North Carolina Insurance Commissioner, June 16, 1992, p. 12.

2. *Federal MEWAs: The S&L scandal of the next century*

The large, national health benefit plans envisioned by the bill's author, good intentions notwithstanding, would be financial disasters waiting to happen. The reason Congress, in 1983, expressly delegated responsibility for regulating MEWAs to the States still exists today. While, again, many legitimate, successful MEWAs exist and provide valuable coverage to their customers, the MEWA business continues to attract unscrupulous operators and to experience an inordinate number of failures.

According to a recent survey by the General Accounting Office, between January 1988 and June 1991, MEWA failures left almost 400,000 participants with over \$123 million in unpaid claims. In 1994, the State of North Carolina alone reported \$4.4 million in unpaid claims as a result of MEWA frauds and failures. In 1988, one California MEWA doing business in Florida was responsible for \$3.2 million in unpaid claims.<sup>11</sup>

As noted above, States have begun aggressive regulation of MEWAs and, as the National Governors' Association stated in their March 5th letter to Chairman Goodling, they "have made great strides in assuring the efficacy and legality of these arrangements."

Democratic Members and the organizations representing the Nation's governors, State insurance commissioners, and State legislatures are gravely concerned that H.R. 995 would *replace* the existing *strict State regulation* of MEWAs with *illusory, ill-defined Federal regulation* that "does not include sufficient safeguards for employers purchasing, or employees receiving, health care coverage through newly created, federally chartered [MEWAs]."<sup>12</sup>

For example, solvency standards, including reserve requirements, are the principal tool used by State insurance regulators to monitor the financial viability of MEWAs. Accordingly, solvency standards are the principal means to protect the public.

*The solvency standards set forth in H.R. 995 are grossly inadequate to the task assigned to the Labor Department to regulate hundreds, perhaps thousands, of multi-state, multi-employer health plans enrolling up to as many as 20 million people.*<sup>13</sup>

The NAIC and NCSL stated in their March 5th letter to Chairman Goodling:

The proposal contains some financial standards but *no specifics on how, or if, the financial condition of such entities will be subject to regulatory oversight*, or whether the Department of Labor regularly would examine the market conduct of such entities. The bill likely *would lead to further fraud in this area because it contains no mandated time frames for federal review of a MEWA's application*, and specifies no resources to be allocated to this new federal role. \* \* \*

\* \* \* the bill's standards *need further clarification and should better account for the different financial needs of smaller and larger employer groups*. The bill's standards

<sup>11</sup> GAO, "Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements," March 1992.

<sup>12</sup> NAIC and NCSL, March 5, 1996, correspondence to Chairman Goodling.

<sup>13</sup> "Back-Door Clinton Care?", *Wall Street Journal*, 20 February 1996, p. A18 (Statement by Rep. Harris Fawell).

do not provide sufficient assurances for beneficiaries covered under such plans.

These gaps in the [bill] appear to *overlook and underestimate the important role for solvency protection in the provision of health care coverage.* [Emphasis added.]

Conceivably, then, consumers could find very little standing behind a Federal MEWA if it should get into financial trouble. No longer subject to tough State solvency standards and without the corporate assets that an IBM or Xerox can draw on to pay health benefits, the proposed Federal MEWAs would be inherently risky. Federal MEWA insolvencies could leave consumers with billions of dollars in unpaid medical bills—and without consumers having any recourse to State guaranty funds.

In addition to the bill's ill-defined solvency standards, which are reason enough to oppose H.R. 995, the bill creates a swiss cheese-like regulatory structure that will prevent the Labor Department from protecting the public from the scam artists that have been operating in the MEWA "underworld" for years.

Considering the fraud and abuse that has long been associated with certain MEWA operations, Democratic members are incredulous that H.R. 995 includes provisions that would *grandfather existing MEWAs*. Upon the effective date of the bill, many existing MEWAs—the good, the bad, and the ugly—would be exempt from all State solvency and insurance laws and could begin operating and enrolling the public as federally-chartered MEWAs. Having obtained this instant "Good Housekeeping Seal of Approval" under federal law, unscrupulous and inadequately financed operators—the bad and the ugly—would begin preying on the public, one step ahead of the Department which might still be reviewing their application for a Federal certificate.<sup>14</sup>

The final insult is that H.R. 995, in an ironic example of legislative forum shopping, *greatly expands Federal authority over the private sector*. The Federal government (specifically, the Labor Department) for the first time would be in the business of chartering and regulating the solvency of privately-run, national health benefit plans.

Perhaps nothing the Republicans have passed during the 103th Congress would increase Federal financial exposure more than H.R. 995's MEWA provision. It would now be Federal, not State, regulations governing MEWAs and protecting the public from inadequately financed MEWAs. Considering the bill's ill-defined solvency standards and grandfather provisions, it would only be a matter of time before a large, multi-state MEWA would go under, leaving its customers on the hook for millions of dollars in unpaid medical bills.

And to whom will these angry, aggrieved consumers turn when this happens? Their State insurance regulator? No, State solvency standards would no longer apply to these Federally chartered MEWAs. Rather, consumers will turn to the Labor Department and Members of Congress for relief, and as with the savings and loans

<sup>14</sup>In their joint letter of March 5, 1996, the NAIC and the NCSL stated that the bill: "allows for certain class of such entities to operate without receiving full federal approval, as long as they have met requirements for a completed application. The bill thus opens up an opportunity for scam operators to operate in a 'nether world' of loose federal standards with little or no meaningful oversight."

insolvencies of the 1980s, the urge and political pressure to bail out these MEWAs and protect constituents will be overwhelming.

There is another reason why Democratic Members believe that State governors, insurance regulators, and legislators should continue to be able to protect their citizens from unscrupulous and inadequately financed MEWA operators. Republicans have stacked the deck against the Labor Department and any prospect that the Department will be able to adequately and aggressively regulate these proposed Federal MEWAs. In the bill itself, the enumerated regulatory standards are ill-defined. And the grandfather provisions let most of the bad horses out of the barn, forcing the Department into a posture of having to chase down unscrupulous and inadequately financed operators and fight them to rescind their Federal charter.

The Labor Department will also be severely handicapped by the deep anti-regulatory sentiment that exists in the House and the deep funding cuts proposed by Republicans in the Department's budget. Considering the hostility, not to mention the appropriations riders, that has met Labor Department regulatory activity during this Congress, we see no reason to believe that vigorous regulation of MEWAs would be treated any differently. In addition, the House-passed labor appropriations bill for FY 1996 would have cut the budget of the Labor Department's Pension and Welfare Benefits Administration (PWBA) by 7.5 percent; this is the very same agency that now regulates \$3.5 trillion in pension assets and health plans which now enroll 114 million individuals. Under the bill PWBA would regulate Federal MEWAs enrolling as many as 20 million individuals. The design of H.R. 995, combined with the attacks of Republican appropriators and anti-government ideologues, would ensure that the agency that regulates these multi-state, multi-employer health plans will be a *weak regulator!*<sup>15</sup>

### *3. MEWAs will further fragment the insurance market.*

The United States has an extremely fragmented health insurance market. The proliferation of self-funded plans as well as insurance and risk management practices have contributed to risk segmentation. The expansion of self-funded plans envisioned by H.R. 995 will greatly exacerbate the market fragmentation that already exists.

This bill's expansion of the ERISA preemption to self-funded multi-employer plans, and the cost savings associated with not having to comply with State solvency and insurance rules, will make being a Federal MEWA an extremely attractive option for existing multi-employer plans and trade association plans that currently offer fully insured products to their members. Many of these plans would seek to become Federally chartered self-funded MEWAs. And, many employers that now offer an insured product to their employees (through Blue Cross-Blue Shield, for example) will transfer their coverage to these Federal MEWAs.

<sup>15</sup>In a letter to Chairman Goodling dated September 12, 1995, Labor Secretary Robert Reich wrote that "The Department simply does not have the resources to carry out the substantial new responsibilities envisioned by this legislation."

These Federally-regulated, self-funded MEWAs will siphon healthier, younger groups from traditional insurance markets and, as a consequence, will undermine those markets as well as State health reform initiatives. As healthier groups exist the insurance market, premiums will rise, forcing some individuals to drop coverage (and undermining State efforts to increase access and affordability in the insurance markets). In addition, shrinkage in the size of insurance markets means a shrinkage in both a State' insurance premium tax base and high risk pool assessment base; H.R. 995 would cost States millions and millions of dollars in lost revenues—*revenue which States use to finance high risk pools for the uninsured*. H.R. 995 will make it more difficult for States to maintain and expand their efforts to expand coverage to the uninsured. This would be a travesty.

#### CONCLUSION

The Democratic Members believe very strongly that the Committee should have considered and approved the Roukema (Kassebaum-Kennedy) bill at the March 6th markup. The Majority's bill is weighted down with complex provisions that not only will be disastrous for consumers, but also are extremely controversial with the Nation's governors, State insurance commissioners, and State legislators.

House Republicans are on the verge of torpedoing any chance to enact health reform legislation in 1996. They should do the right thing and join with Democrats in passing the Roukema bill this week. Instead, Republicans appear to have decided to offer a less effective, more controversial bill—once again, creating division where division ought not exist and perhaps blocking the last chance this Congress has to enact meaningful health care reform.

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