TITLE XI - TRANSITIONAL INSURANCE REFORM

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Section 11001 IMPOSITION OF REQUIREMENTS.

(a) In General. - The Secretary and the Secretary of Labor shall apply the provisions of this title to assure, to the extent possible, the maintenance of current health care coverage and benefits during the period between the enactment of this Act and the dates its provisions are implemented in the various States.

(b) Enforcement. -

(1) Health insurance plans. - The Secretary shall enforce the requirements of this title with respect to health insurance plans. The Secretary shall promulgate regulations to carry out the requirements under this title with respect to health insurance plans. The Secretary shall promulgate regulations with respect to section 11004 within 90 days after the date of the enactment of this Act.

(2) Self-insured plans. - The Secretary of Labor shall enforce the requirements of this title with respect to self-insured plans. Such Secretary shall promulgate regulations to carry out the requirements under this title as they relate to

self-funded plans.

(3) Arrangements with states. - The Secretary and the Secretary of Labor may enter into arrangements with a State to enforce the requirements of this title with respect to health insurance plans and self-insured plans issued or sold, or established and maintained, in the State.

(c) Preemption. - The requirements of this title do not preempt any State law unless State law directly conflicts with such requirements. The provision of additional protections under State law shall not be considered to directly conflict with such requirements. The Secretary (or, in the case of a self-insured plan, the Secretary of Labor) may issue letter determinations with respect to whether this Act preempts a provision of State law.

(d) Interim Final Regulations. - Section 1911 shall apply to regulations issued to carry out this title. The Secretary may consult with States and the National Association of Insurance Commissioners in issuing regulations and guidelines under this title.

(e) Construction. - The provisions of this title shall be construed in a manner that assures, to the greatest extent practicable, continuity of health benefits under health benefit plans in effect on the effective date of this Act.

(f) Special Rules for Acquisitions and Transfers. - The Secretary may issue regulations regarding the application of this title in the case of health insurance plans (or groups of such plans) which are transferred from one insurer to another insurer through assumption, acquisition, or otherwise.

Section 11002 ENFORCEMENT.

(a) In General. - Any health insurer or health benefit plan sponsor that violates a requirement of this title shall be subject to a civil money penalty of not more than $25,000 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

(b) Equitable Remedies. -

(1) In general. - A civil action may be brought by the applicable 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 violations, or (ii) to enforce any provision of this title, including, in the case of a wrongful termination of (or refusal to renew) coverage, reinstating coverage effective as of the date of the violation.

Section 11003 REQUIREMENTS RELATING TO PRESERVING CURRENT COVERAGE.

(a) Prohibition of Termination. -

(1) Group health insurance plans. - Each health insurer that provides a group health insurance plan may not terminate (or fail to renew) coverage for any covered employee if the employer of the employee continues the plan, except in the case of -

(A) nonpayment of required premiums,

(B) fraud, or

(C) misrepresentation of a material fact relating to for coverage or claim for benefits.

(2) Individual health insurance plans. - Each health individual health insurance plan may not terminate (or fail to renew) coverage for such individual (or a covered dependent), except in the case of -

(A) nonpayment of required premiums,

(B) fraud, or

(C) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(2) Effective date of title. -

(A) In general. - This subsection shall take effect on the effective date of this title and shall apply to coverage on or after such date.

(B) Definition. - Except as otherwise provided, in this title the term `effective date of this title` means the date of the enactment of this Act.

(b) Acceptance of New Members in a Group Health Insurance Plan. -

(1) In general. - In the case of a health insurer that provides a group health insurance plan that is in effect on the effective date of this title, the insurer is required -

(A) to accept all individuals, and their eligible dependents, who become full-time employees (as defined in section 1901(b)(2)(C)) of an employer covered after such effective date;

(B) to establish and apply premium rates that are consistent with section 11004(b); and

(C) to limit the application of pre-existing condition restrictions in accordance with section 11005.

(2) Consistent application of rules relating to dependents and waiting periods. - In this subsection, the term `eligible dependent`, with respect to a group health insurance plan, has the meaning provided under the plan as of October 27, 1993, or, in the case of a plan not established as of such date, as of the date of establishment of the plan.

Section 11004. RESTRICTIONS ON PREMIUM INCREASES DURING TRANSITION.

(a) Division of Health Insurance Plans by Sector. - For purposes of this section, each health insurer shall divide its health insurance business into the following 3 sectors:

(1) Health insurance for groups with at least 100 covered lives (in this section referred to as the `large group sector`)

(2) Health insurance for groups with fewer than 100 covered lives (in this section referred as the `small group sector`).

(3) Health insurance for individuals, and not for groups (in this section referred to as the `individual sector`).

(b) Premium Changes to Reflect Changes in Group or Individual Characteristics or Terms of Coverage. -

(1) Application. - The provisions of this subsection shall apply to changes in premiums that reflect -

(A) changes in the number of individuals covered under a plan;

(B) changes in the group or individual characteristics (including age, gender, family composition or geographic area but not including health status, claims experience or duration of coverage under the plan) of individuals covered under a plan;

(C) changes in the level of benefits (including changes in cost-sharing) under the plan; and

(D) changes in any material terms and conditions of the health insurance plan (other than factors related to health status, claims experience, and duration of coverage under the plan).

(2) Specification of reference rate for each sector. - Each health insurer shall calculate a reference rate for each such sector. The reference rate for a sector shall be calculated so that, if it were applied using the rate factors specified under paragraph (3), the average premium rate for individuals and groups in that sector would approximate the average premium rate charged individuals and groups in the sector as of the effective date of this title.

(3) Single set of rate factors within each sector. -

(A) In general. - Each health insurer shall develop for each sector a single set of rate factors which will be used to calculate any changes in premium that relate to the reasons described in subparagraphs (B) through (D) of paragraph (1).

(B) Standards. - Such rate factors -

(i) shall relate to reasonable and objective differences in demographic characteristics, in the design and in levels of coverage, and in other terms and conditions of a contract,

(ii) shall not relate to expected health status, claims experience, or duration of coverage of the one or more groups or individuals, and

(iii) shall comply with regulations established under subsection (f).

(4) Computation of Premium Changes. -

(A) In general. - Changes in premium rates that relate to the reasons described in paragraph (1) shall be calculated using the rate factors developed pursuant to paragraph (3).

(B) Application to changes in number of covered individuals. - In the case of a change in premium rates related to the reason described in paragraph (1)(A), the change in premium rates shall be calculated to reflect, with respect to the enrollees who enroll or disenroll in a health insurance plan, the sum of the products, for such individuals, of the reference rate (determined under paragraph (2)) and the rate factors (specified under paragraph (3)) applicable to such enrollees.

(C) Application of other factors. -

(i) In general. - In the case of a change in premium rates related to a reason described in subparagraph (B), (C), or (D) of paragraph (1), the change in premium rates with respect to each health insurance plan in each sector shall reflect the rate factors specified under paragraph (3) applicable to the reason as applied to the current premium charged for the health insurance plan. Such rate factors shall be applied in a manner so that the resulting adjustment, to the extent possible, reflects the premium that would have been charged under the plan if the reason for the change in premium had existed at the time that the current premium rate was calculated.

(ii) No reflection of change in health status. - In applying the rate factors under this subparagraph, the adjustment shall not reflect any change in the health status, claims experience or duration of coverage with respect to any employer or individual covered under the plan.

(5) Limitation on application. - This subsection shall only apply -

(A) to changes in premiums occurring on or after the date of the enactment of this Act to groups and individuals covered as of such date, and

(B) with respect to groups and individuals subsequently covered, to changes in premiums subsequent to such coverage.

(6) Application to community-rated plans. - Nothing in this subsection shall require the application of rate factors related to individual or group characteristics with respect to community-rated plans.

(c) Limitations on Changes in Premiums Related to Increases in Health Care Costs and Utilization. -

(1) Application. - The provisions of this subsection shall apply to changes in premiums that reflect increases in health

care costs and utilization.

(2) Equal increase for all plans in all sectors. -

(A) In general. - Subject to subparagraph (B), the annual percentage increase in premiums by a health insurer for health insurance plans in the individual sector, small group sector, and large group sector, to the extent such increase reflect increases in health care costs and utilization, shall be the same for all such plans in those sectors.

(B) Special rule for large group sector. - The annual percentage increase in premiums by a health insurer for health insurance plans in the large group sector may vary among such plans based on the claims experience of an employer (to the extent the experience is credible), so long as the weighted average of such increases for all such plans in the sector complies with the requirement of subparagraph (A).

(C) Geographic application. - Subparagraphs (A) and (B)

(i) may be applied on a national level, or

(ii) may vary based on geographic area, but only if

(I) such areas are sufficiently large to provide credible data on which to calculate the variation and

(II) the variation is due to reasonable factors related to the objective differences among such areas in costs and utilization of health services.

(D) Exceptions to accommodate state rate reform efforts. - Subparagraphs (A) and (B) shall not apply, in accordance with guidelines of the Secretary, to the extent necessary to permit a State to narrow the variations in premiums among health insurance plans offered by health insurers to similarly situated groups or individuals within a sector.

(E) Exception for rates subject to prior approval. - Subparagraphs (A) and (B) shall not apply to premiums that are subject to prior approval by a State insurance commissioner (or similar official) and are approved by such official.

(F) Other reasons specified by the secretary. - The Secretary may specify through regulations such other exceptions to the provisions of this subsection as the Secretary determines are required to enhance stability of the health insurance market and continued availability of coverage.

(3) Even application throughout a year. - In applying the provisions of this subsection to health insurance plans that are renewed in different months of a year, the annual percentage increase shall be applied in a consistent, even manner so that any variations in the rate of increase applied in consecutive months are even and continuous during the year.

(4) Petition for exception. - A health insurer may petition the Secretary (or a State acting under a contract with the Secretary under section 11001(b)(3)) for an exception from the application of the provisions of this subsection. The Secretary may approve such an exception if -

(A) the health insurer demonstrates that the application of this subsection would threaten the financial viability of the insurer, and

(B) the health insurer offers an alternative method for increasing premiums that is not substantially discriminatory to any sector or to any group or individual covered by a health insurance plan offered by the insurer.

(d) Prior Approval for Certain Rate Increases. -

(1) In general. - If the percentage increase in the premium rate for the individual and small group sector exceeds a percentage specified by the Secretary under paragraph (2), annualized over any 12-month period, the increase shall not take effect unless the Secretary (or a State acting under a contract with the Secretary under section 11001(b)(3)) has approved the increase.

(2) Percentage. - The Secretary shall specify, for each 12-month period beginning after the date of the enactment of this Act, a percentage that will apply under paragraph (1). Such percentage shall be determined taking into consideration the rate of increase in health care costs and utilization, previous trends in health insurance premiums, and the conditions in the health insurance market. Within 30 days after the date of the enactment of this Act, the Secretary shall first specify a percentage under this paragraph.

(e) Documentation of Compliance. -

(1) Period for conformance. - Effective 1 year after the date of the enactment of this Act, the premium for each health insurance plan shall be conformed in a manner that complies with the provisions of this section.

(2) Methodology. - Each health insurer shall document the methodology used in applying subsections (b) and (c) with respect to each sector (and each applicable health plan). Such documentation shall be sufficient to permit the auditing of the application of such methodology to determine if such application was consistent with such subsections.

(3) Certification. - For each 6-month period in which this section is effective, each health insurer shall file a certification with the Secretary (or with a State with which the Secretary has entered into an arrangement under section 11001(b)(3)) that the insurer is in compliance with such requirements.

(f) Regulations. - The Secretary shall establish regulations to carry out this section. Such regulations may include guidelines relating to the permissible variation that results from the use of demographic or other characteristics in the development of rate factors. Such guidelines may be based on the guidelines currently used by States in applying rate limitations under State insurance regulations.

(g) Effective Period. - This section shall apply to premium increases occurring during the period beginning on the date of the enactment of this Act and ending, for a health insurance plan provided in a State, on the first day of the State`s first year.

Section 11005 REQUIREMENTS RELATING TO PORTABILITY.

(a) Treatment of Preexisting Condition Exclusions. -

(1) In general. - Subject to the succeeding provisions of this subsection, a group health benefit plan may exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns or in the case of a plan that did not apply such exclusions as of the effective date of this title.

(2) Crediting of previous coverage. -

(A) In general. - A group health benefit plan shall provide that if an individual covered under such plan is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type

of services shall be reduced by 1 month for each month in the period of continuous coverage.

(B) Definitions. - As used in this paragraph:

(i) Period of continuous coverage. - The term `period of continuous coverage` means, with respect to particular services, the period beginning on the date an individual is enrolled under a group or individual health benefit plan, self-insured plan, the medicare program, a State medicaid plan, or other health benefit arrangement which provides benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(ii) Preexisting condition. - The term `preexisting condition` means, with respect to coverage under a health benefits plan, a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(b) Waiting Periods. - A self-insured plan, and an employer with respect to a group health insurance plan, may not discriminate among employees in the establishment of a waiting period before making health insurance coverage available based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of the employee or the employee`s dependents.

Section 11006. REQUIREMENTS LIMITING REDUCTION OF BENEFITS.

(a) In General. - A self-insured sponsor may not make a modification of benefits described in subsection (b).

(b) Modification of Benefits Described. -

(1) In general. - A modification of benefits described in this subsection is any reduction or limitation in coverage, effected on or after the effective date of this title, with respect to any medical condition or course of treatment for which the anticipated cost is likely to exceed $5,000 in any 12-month period.

(2) Treatment of termination. - A modification of benefits includes the termination of a plan if the sponsor, within a period (specified by the Secretary of Labor) establishes a substitute plan that reflects the reduction or limitation described in paragraph (1).

(c) Remedy. - Any modification made in violation of this section shall not be effective and the self-insured sponsor shall continue to provide benefits as though the modification (described in subsection (b)) had not occurred.

Section 11007. NATIONAL TRANSITIONAL HEALTH INSURANCE RISK POOL.

(a) Establishment. - In order to assure access to health insurance during the transition, the Secretary is authorized to establish a National Transitional Health Insurance Risk Pool (in this section referred to as the `national risk pool`) in accordance with this section.

(b) Administration. -

(1) In general. - The Secretary may administer the national risk pool through contracts with -

(A) one or more existing State health insurance risk pools,

(B) one or more private health insurers, or

(C) such other contracts as the Secretary deems appropriate.

(2) Coordination with state risk pools. - The Secretary may enter into such arrangements with existing State health insurance risk pools to coordinate the coverage under such pools with the coverage under the national risk pool. Such coordination may address eligibility and funding of coverage for individuals currently covered under State risk pools.

(c) Eligibility for Coverage. - The national risk pool shall provide health insurance coverage to individuals who are unable to secure health insurance coverage from private health insurers because of their health status or condition (as determined in accordance with rules and procedures specified by the Secretary).

(d) Benefits. -

(1) In general. - Benefits and terms of coverage provided through the national risk pool shall include items and services, conditions of coverage, and cost sharing (subject to out-of-pocket limits on cost sharing) comparable to the benefits and terms of coverage available in State health insurance risk pools.

(2) Payment rates. - Payments under the national risk pool

for covered items and services shall be made at rates (specified by the Secretary) based on payment rates for comparable items and services under the medicare program. Providers who accept payment from the national risk pool shall accept such payment as payment in full for the service, other than for cost sharing provided under the national risk pool.

(e) Premiums. -

(1) In general. - Premiums for coverage in the national risk pool shall be set in a manner specified by the Secretary.

(2) Variation. - Such premiums shall vary based upon age, place of residence, and other traditional underwriting factors other than on the basis of health status or claims experience.

(3) Limitation. - The premiums charged individuals shall be set at a level that is no less than 150 percent of the premiums that the Secretary estimates would be charged to a population of average risk for the covered benefits.

(f) Treatment of Shortfalls. -

(1) Estimates. - The Secretary shall estimate each year the extent to which the total premiums collected under subsection (e) in the year are insufficient to cover the expenses of the national risk pool with respect to the year.

(2) Temporary borrowing authority. - The Secretary of the Treasury is authorized to advance to the Secretary amounts sufficient to cover the amount estimated under paragraph (1) during the year before assessments are collected under paragraph (3), except that the total balance of such Treasury advances at any time shall not exceed $1,500,000,000. The Secretary shall repay such amounts, with interest at a rate specified by the Secretary of the Treasury, from the assessments under paragraph (3).

(3) Assessments. -

(A) In general. - Each health benefit plan sponsor shall be liable for an assessment in the amount specified in subparagraph (C).

(B) Amount. - For each year for which amounts are advanced under paragraph (2), the Secretary shall -

(i) estimate the total amount of premiums (and premium equivalents) for health benefits under health benefit

plans for the succeeding year, and

(ii) calculate a percentage equal to (I) the total amounts repayable by the Secretary to the Secretary of the Treasury under paragraph (2) for the year, divided by the amount determined under clause (i).

(C) Assessment amount. - The amount of an assessment for a sponsor of a health benefit plan for a year shall be equal to the percentage calculated under subparagraph (B)(ii) (or, if less, 1/2 of 1 percent) of the total amount of premiums (and premium equivalents) for health benefits under the plan for the previous year.

(D) Self-insured plans. - The amount of premiums (and premium equivalents) under this paragraph shall be estimated -

(i) by the Secretary for health insurance plans, and

(ii) by the Secretary of Labor for self-insured plans.

Such estimates may be based on a methodology that requires plans liable for assessment to file information with the applicable Secretary.

Section 11008. DEFINITIONS.

In this title:

(1) Applicable secretary. - The term `applicable Secretary` means -

(A) the Secretary with respect to health insurance plans
and insurers, or

(B) the Secretary of Labor with respect to self-insured plans and self-insured plan sponsors.

(2) Covered employee. - The term `covered employee` means an employee (or dependent of such an employee) covered under a group health benefits plan.

(3) Covered individual. - The `covered individual` means, with respect to a health benefit plan, an individual insured, enrolled, eligible for benefits, or otherwise covered under the plan.

(4) Group health benefits plan. - The term `group health benefits plan` means a group health insurance plan and a self-insured plan.

(5) Group health insurance plan. -

(A) In general. - The term `group health insurance plan` means a health insurance plan offered primarily to employers for the purpose of providing health insurance to the employees (and dependents) of the employer.

(B) Inclusion of association plans and mewas. - Such term includes -

(i) any arrangement in which coverage for health benefits is offered to employers through an association, trust, or other arrangement, and

(ii) a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974), whether funded through insurance or otherwise.

(6) Health benefits plan. - The term `health benefits plan` means health insurance plan and a self-insured health benefit plan.

(7) Health benefit plan sponsor. - The term `health benefit plan sponsor` means, with respect to a health insurance plan or self-insured plan, the insurer offering the plan or the self-insured sponsor for the plan, respectively.

(8) Health insurance plan. -

(A) In general. - Except as provided in subparagraph (B), the term `health insurance plan` means any contract of health insurance, including any hospital or medical service policy or certificate, any major medical policy or certificate, any hospital or medical service plan contract, or health maintenance organization subscriber contract offered by an insurer.

(B) Exception. - Such term does not include any of the following -

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

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker`s compensation or similar insurance, or

(v) automobile medical payment insurance,
or any combination thereof.

(C) Stop loss insurance not covered. - Such term does not include any aggregate or specific stop-loss insurance or similar coverage applicable to a self-insured plan. The Secretary may develop rules determining the applicability of this subparagraph with respect to minimum premium plans or other partially insured plans.

(9) Health insurer. - The term `health insurer` means a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or other entity providing a plan of health insurance or health benefits with respect to which the State insurance laws are not preempted under section 514 of the Employee Retirement Income Security Act of 1974.

(10) Individual health insurance plan. -

(A) In general. - The term `individual health insurance plan` means any health insurance plan directly purchased by an or offered primarily to individuals (including families) for the purpose of permitting individuals (without regard to an employer contribution) to purchase health insurance coverage.

(B) Inclusion of association plans. - Such term includes any arrangement in which coverage for health benefits is offered to individuals through an association, trust, list-billing arrangement, or other arrangement in which the individual purchaser is primarily responsible for the payment of any premium associated with the contract.

(C) Treatment of certain association plans. - In the case of a health insurance plan sponsored by an association, trust, or other arrangement that provides health insurance coverage both to employers and to individuals, the plan shall be treated as -

(i) a group health insurance plan with respect to such employers, and

(ii) an individual health insurance plan with respect to such individuals.

(11) Self-insured plan. - The term `self-insured plan` means an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides benefits with respect to some or all of the items and services included in the comprehensive benefit package (as in effect as of January 1, 1996) that is funded in a manner other than through the purchase of one or more health insurance plans. Such term shall not include a group health insurance plan described in paragraph (5)(B)(ii).

(12) Self-insured sponsor. - The term `self-insured sponsor` includes, with respect to a self-insured plan, any entity which establishes or maintains the plan.

(13) State commissioner of insurance. - The term `State commissioner of insurance` includes a State superintendent of insurance.

Section 11009. TERMINATION.

(a) Health Insurance Plans. - The provisions of this title shall not apply to a health insurance plan provided in a State on and after the first day of the first year for the State.

(b) Self-Insured Plans. - The provisions of this title shall not apply to a self-insured plan that -

(1) is sponsored by a sponsor that is an eligible sponsor of a corporate alliance (described in section 1311(b)(1)), as of the effective date of the election under section 1312(c); and

(2) is sponsored by a sponsor that is not such an eligible sponsor, with respect to individuals or groups in a State on and after the first day of the first year for the State.