"(ii) in the case of services described in section 1861(ff)(2)(C), for up to 180 days during any calendar year, except that such services may be furnished to the individual for a number of additional days during the year equal to the difference between the total number of days of intensive residential services which the individual may receive during the year under part A (as determined under section 1812(a)(6)) and the number of days of such services which the individual has received during the year, or

"(iii) in the case of any other such services, for up to 90 days during any calendar year, except that such services may be furnished to the individual for the number of additional days during the year described in clause (ii).".

(B) REDUCTION IN NUMBER OF DAYS OF INTENSIVE RESIDENTIAL SERVICES.—Section 1812(a)(6) (42 U.S.C. 1395d(a)(6)), as added by subsection (b)(1), is amended—

(i) by inserting "(A)" before "such services"; and

(ii) by striking the period at the end and inserting the following: ", and (B) reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of intensive community-based services furnished to the individual under section 1832(a)(2)(J) during the year after such services have been furnished to the individual for 90 days (or, in the case of services described in section 1832(a)(2)(J)(ii), for 180 days) during the year (rounded to the nearest day).".

(2) SERVICES DESCRIBED.—Section 1861(ff)(2) (42 U.S.C. 1395x(ff)(2)) is amended—

(A) in the matter preceding subparagraph (A), by striking "are—" and inserting "are as follows:";

(B) in subparagraph (C)—

(i) by inserting "behavioral aide services," after "nurses", and

(ii) by adding at the end the following: "(to the extent authorized under State law)";

(C) by adding "and" at the end of subparagraph (G);

(D) in subparagraph (H), by striking ", and" and inserting a period;

(E) by redesignating subparagraphs (A) through (H) as clauses (i) through (viii) and moving such subparagraphs 2 ems to the right;

(F) by inserting before clause (i) (as so redesignated) the following:

"(A) Partial hospitalization services consisting of—";

(G) by inserting after clause (viii) (as so redesignated) the following new subparagraphs:

"(B) Psychiatric rehabilitation services.

"(C) Day treatment services for individuals under 19 years of age.

"(D) In-home services.

"(E) Case management services, including collateral services designated as such case management services by the Secretary.

"(F) Ambulatory detoxification services.".

(3) PERMITTING NON-PHYSICIAN PROVIDERS TO SUPERVISE INDIVIDUAL PROGRAM OF TREATMENT.—Section 1861(ff)(1) (42 U.S.C. 1395x(ff)(1)) is amended by inserting after "supervision of a physician" the following: "(or, to the extent permitted under the law of the State in which the services are furnished, a non-physician mental health professional)".

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(4) REQUIRING SERVICES TO MEET MANAGEMENT STANDARDS.—Section 1861(ff)(1) (42 U.S.C. 1395x(ff)(1)) is amended by striking the period at the end and inserting the following: ", but does not include any item or service that is not furnished in accordance with standards established by the Secretary for the management of such services.".

(5) PROGRAMS ELIGIBLE TO PROVIDE SERVICES.—Section 1861(ff)(3) (42 U.S.C. 1395x(ff)(3)) is amended to read as follows:

"(3) A program described in this paragraph is a program (whether facility-based or freestanding) which is furnished by an entity—

"(A) legally authorized to furnish such a program under State law (or the State regulatory mechanism provided by State law) or certified to furnish such a program by an appropriate accreditation entity approved by the State in consultation with the Secretary; and

"(B) meeting such other requirements as the Secretary may impose to assure the quality of the intensive community-based services provided.".

(6) WAIVER OF COPAYMENT FOR CASE MANAGEMENT SERVICES FURNISHED TO CERTAIN INDIVIDUALS.—Section 1832(a)(3) (42 U.S.C. 1395k(a)(2)) is amended—

(A) in subparagraph (B), by striking "or (E)" and inserting "(E), or (F)";

(B) by striking "and" at the end of subparagraph (D);

(C) by adding "and" at the end of subparagraph (E); and

(D) by adding at the end the following new subparagraph:

"(F) with respect to services described in section 1832(a)(2)(J)(i), the amount determined under subparagraph (B), except that '100 percent' shall be substituted for any reference in such subparagraph to '80 percent';".

(7) CONFORMING AMENDMENTS.—(A) Section 1835(a)(2)(F) (42 U.S.C. 1395n(a)(2)(F)) is amended—

(i) by striking "partial hospitalization" and inserting "intensive community-based"; and

(ii) in clause (ii), by striking "physician" and inserting "physician (or, to the extent permitted under the law of the State in which the services are furnished, a non-physician mental health professional)".

(B) Section 1861(s)(2)(B) (42 U.S.C. 1395x(s)(2)(B)) is amended by striking "partial hospitalization" and inserting "intensive community-based".

(C) Section 1861(ff) (42 U.S.C. 1395x(ff)) is amended—

(i) in the heading, by striking "Partial Hospitalization" and inserting "Intensive Community-Based"; and

(ii) in paragraph (1), by striking "partial hospitalization" and inserting "intensive community-based".

(D) Section 1866(e)(2) (42 U.S.C. 1395cc(e)(2)) is amended by striking "partial hospitalization" and inserting "intensive community-based".

(e) REQUIREMENT FOR PROVISION OF SERVICES THROUGH ORGANIZED SYSTEMS OF CARE FOR AT-RISK CHILDREN.—

(1) REQUIRING COORDINATION OF MENTAL HEALTH SERVICES THROUGH ORGANIZED SYSTEMS OF CARE.—

(A) PSYCHIATRIC HOSPITAL SERVICES.—Section 1812(a)(5) (42 U.S.C. 1395d(a)(5)), as added by subsection (a)(1), is amended by striking the period at the end and inserting the following: ", but only if (with respect to services furnished to an at-risk child described in section 1861(rr)) such services are furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1861(rr).".

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(B) OTHER PART B ITEMS AND SERVICES.—Section 1862(a)(18), as added by subsection (c)(2), is amended by striking the period at the end and inserting the following: ", and, in the case of services furnished to an at-risk child described in section 1861(rr) who is not an inpatient of a hospital, if the services are not furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1861(rr).".

(C) INTENSIVE RESIDENTIAL SERVICES.—Section 1861(qq) (42 U.S.C. 1395x(qq)) as added by subsection (b)(2), is amended—

(i) in paragraph (1), by striking "paragraph (2)" and inserting "paragraphs (2) and (3)"; and

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

"(3) In the case of services furnished to an at-risk child described in section 1861(rr), no service may be treated as an intensive residential service under this subsection unless the service is furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1861(rr).".

(D) INTENSIVE COMMUNITY-BASED SERVICES.—Section 1861(ff)(1) (42 U.S.C. 1395x(ff)(1)) is amended by inserting after "by a physician" the following: "(or, in the case of services furnished to an at-risk child described in section 1861(rr), by an organized system of care for mental health and substance abuse services in accordance with such section)".

(2) ORGANIZED SYSTEMS OF CARE DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Organized System of Care for Mental Health and Substance Abuse Services

"(rr)(1) The term 'organized system of care for mental health and substance abuse services' means, with respect to mental health services provided to an at-risk child, a community-based service delivery network consisting of public or private providers that a State determines meets the following requirements (in accordance with guidelines of the Secretary):

"(A) The system has established linkages with existing mental illness and substance abuse service delivery programs in the area in which the child resides (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

"(B) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile or criminal justice, health care, mental health, and substance abuse treatment.

"(C) The system provides for the involvement of the families of children to whom mental illness and substance abuse services are provided in the planning of treatment and the delivery of services.

"(D) The system provides for the development and implementation by multidisciplinary and multi-agency teams of individualized treatment plans that are recognized and followed by the requisite providers in the area.

"(E) The system ensures the delivery and coordination of the range of mental illness and substance abuse services required for at-risk children.

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"(F) The system provides for the management of the individualized treatment plans and for a flexible response to treatment changes over time.

"(G) In the case of individuals receiving substance abuse treatment services, the system places such individuals in treatment programs in accordance with uniform patient placement criteria established by the Secretary in consultation with the States.

"(H) The system provides for assessment of clinical outcomes of individuals receiving services through the system.

"(2) In this subsection—

"(A) the term 'at-risk child' means an individual under 19 years of age who has a serious emotional disorder or substance abuse disorder (in accordance with criteria established by the Secretary for purposes of this subsection) and is currently involved or at imminent risk of being involved with one or more public agencies providing services to children, including agencies relating to child welfare, special education, and juvenile or criminal justice; and

"(B) the term 'mental health services' has the meaning given such term in section 1893(c).".

(3) ESTABLISHMENT OF CRITERIA FOR SEVERITY OF ILLNESS BY SECRETARY.—Not later 1 year after the date of the enactment of this Act, the Secretary shall develop criteria for determining whether an individual has a serious emotional disorder or substance abuse disorder for purposes of section 1861(rr)(2).

(f) SPECIAL RULE FOR BENEFICIARIES IN STATES WITH MANAGED PROGRAMS.—Title XVIII is amended by inserting after section 1892 the following new section:

"COVERAGE OF MENTAL HEALTH SERVICES FOR INDIVIDUALS IN STATES WITH MANAGED MENTAL HEALTH PROGRAMS

"SEC. 1893. (a) APPLICATION OF STATE COVERAGE RULES.—Notwithstanding any other provision of this title, in the case of an individual entitled to benefits under part A or enrolled under part B who is a resident of a State or a member of a tribe or tribal organization operating a comprehensive managed mental health program under section 1981 of the Public Health Service Act and who is enrolled in the program during a month—

"(1) the individual is considered to have waived the right to benefits for mental health services under this title in consideration of receipt of benefits for mental health services through such program;

"(2) the Secretary shall make a per capita payment to the State or the tribe or tribal organization, in the amount specified in subsection (b)(1), on behalf of the individual; and

"(3) no other payment may be made under this title with respect to mental health services furnished to the individual during the month.

Payments under paragraph (2) shall be made on a monthly basis.

"(b) AMOUNT OF CAPITATION PAYMENT.—

"(1) IN GENERAL.—In the case of a State or tribe or tribal organization operating a program described in subsection (a) for a month, the amount specified in this subsection is the Secretary's estimate of the sum of the following products:

"(A) The product of—

"(i) the part A per enrollee mental health payment described in paragraph (2) for the month; and

"(ii) the number of individuals who are entitled to benefits under part A during the month and (as estimated prior to the month based on information provided by the State or the tribe or tribal organization) who are enrolled in the program described in subsection (a).

"(B) The product of—

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"(i) the part B per enrollee mental health payment described in paragraph (2) for the month; and

"(ii) the number of individuals who are enrolled under part B during the month and (as estimated prior to the month based on information provided by the State or the tribe or tribal organization) who are enrolled in the program described in subsection (a).

"(2) PER ENROLLEE PAYMENTS.—In paragraph (1)—

"(A) the 'part A per enrollee payment' for a month is an amount equal to the Secretary's estimate of the average actuarial value of the mental health services for which payment would be made under part A for the month on behalf of individuals enrolled in the State program described in subsection (a) during the month if the individuals were not enrolled in the State program during the month; and

"(B) the 'part B per enrollee payment' for a month is an amount equal to the Secretary's estimate of the average actuarial value of the mental health services for which payment would be made under part B for the month on behalf of individuals enrolled in the State program described in subsection (a) during the month if the individuals were not enrolled in the State program during the month.

"(3) ADJUSTMENTS.—The Secretary shall adjust the amount of payment otherwise made to a State or a tribe or tribal organization under this subsection for a month—

"(A) to reduce such payment to take into account any amounts paid to the State or tribe or tribal organization under other programs towards the costs of providing mental health services to individuals enrolled in the program; and

"(B) to take into account overpayments or underpayments made under this subsection in previous months.

"(c) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES DESCRIBED.—In this section, the term 'mental health and substance abuse services' means the following items and services:

"(1) Inpatient psychiatric services (as described in section 1812(a)(5).

"(2) Any items or services furnished under part B for the treatment of mental illness or substance abuse for an individual who is not an inpatient of a hospital.

"(3) Intensive community-based mental health services (as described in section 1861(ff)).

"(4) Intensive residential services (as described in section 1861(qq).".

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SEC. 3117. EXPANDED COVERAGE OF CERTAIN CHIROPRACTIC SERVICES.

Section 1861(r)(5) (42 U.S.C. 1395x(r)(5)) is amended by striking "sections 1861(s)(1) and 1861(s)(2)(A)" and inserting "paragraphs (1), (2)(A), (3), and (4) of subsection (s)".

SEC. 3118. MANAGED CARE OPTIONS.

Section 1876(g) (42 U.S.C. 1395mm(g)) is amended by adding at the end the following new paragraph:

"(7) An eligible organization with a risk-sharing contract under this section may provide services under part A and B to individuals enrolled with the organization through an unlimited-choice-of-provider plan described in section 5504(15) of the Guaranteed Health Insurance Act of 1994, except that in no case could the cost sharing requirements imposed under such option with respect to services furnished through providers who are not members of the organization's provider network (as defined in section 5504(10) of such Act) exceed the cost-sharing requirements that would otherwise be imposed with respect to the services if the services were furnished under this title other than through the eligible organization.".

SEC. 3119. EFFECTIVE DATE.

The amendments made by this part shall apply to items and services furnished on or after January 1, 1998.

TITLE IV—STATE PROGRAMS

Subtitle A—State Single-Payer Systems

SEC. 4001. STANDARDS FOR STATE SINGLE-PAYER SYSTEMS.

(a) ESTABLISHMENT OF SYSTEMS.—

(1) IN GENERAL.—As an alternative to the method otherwise provided in this Act to achieving universal health insurance coverage for residents of a State, a State may operate a State single-payer system approved by the Secretary of Health and Human Services and the Secretary of Labor (in this title jointly referred to as the "Secretaries") under this subtitle.

(2) REQUIREMENTS.—For purposes of this section, a State single-payer system is a system established by a State under which meets the following requirements:

(A) DIRECT PAYMENT TO PROVIDERS.—

(i) IN GENERAL.—Under the system, the State makes payments directly to providers who furnish items and services included in the guaranteed national benefit package to individuals covered under the system and assume (subject to clause (ii)) all financial risk associated with making such payments.

(ii) CAPITATED PAYMENTS PERMITTED.—Nothing in clause (i) shall be construed to prohibit providers furnishing items and services under the system from receiving payments from the State on a capitated, at risk-basis based on prospectively determined amounts.

(B) GUARANTEED NATIONAL BENEFIT PACKAGE.—The system guarantees coverage for at least the guaranteed national benefit package, including pediatric services for children, for all eligible individuals who are residents of the State, subject to section 4002.

(C) BUDGETARY COMPLIANCE.—The system controls aggregate health care expenditures in the State subject to the same tests as a State operating a State provider reimbursement system under subtitle C, without regard to the adjustment described in section 4203(a)(2)(A).

(b) CONDITIONS FOR APPROVAL.—The Secretaries may not approve a single-payer system under this subtitle unless—

(1) the State submits to the Secretaries an application in such form and manner as the Secretaries may require [under the coordinated process established under section 4301], and

(2) the Secretaries determine to their satisfaction that the State and the system meet the applicable requirements of section 4002.

(c) TERMINATION OF APPROVAL.—Either Secretary shall terminate approval of a system in accordance with section 4006 if that Secretary determines that the State or the system no longer meet the applicable requirements of section 4002.

SEC. 4002. GENERAL REQUIREMENTS FOR APPROVAL.

(a) UNIVERSAL COVERAGE.—

(1) IN GENERAL.—Except as provided in this subsection and section 4003, the single-payer system shall cover all eligible individuals who are residents of the State.

(2) EXCEPTION FOR INDIANS.—

(A) IN GENERAL.—A State may not require an individual described in subparagraph (B) to be covered under the system, but shall allow such an individual the option of coverage under such system.

(B) INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is an individual who is—

(i) eligible to receive services pursuant to sections 36.1—36.14 of title 42, Code of Federal Regulations (1986);

(ii) an urban Indian (as defined in section ____ of the Indian Health Care Improvement Act); or

(iii) an Indian described in section 809(b) of the Indian Health Care Improvement Act.

(3) EXCEPTION FOR QUALIFIED RELIGIOUS EXEMPTION, VETERANS, AND ACTIVE DUTY MILITARY.—A State may not require any of the following individuals to be covered under the single-payer system:

(A) An individual who is described in section 1004(b)(1).

(B) An eligible person (within the meaning of section 1710(a)(1) of title 38, United States Code).

(C) An individual on active duty as a member of the uniformed services (as defined in section 101 of title 10, United States Code).

(4) INCLUSION OF CHAMPUS AND FEHBP.—For provisions authorizing inclusion of—

(A) certain CHAMPUS-eligible individuals in State single-payer systems, see section ____ of title 10, United States Code; or

(B) Federal employees and annuitants in State single-payer systems, see section ____ of title 5, United States Code.

(5) DETERMINATION OF RESIDENCE IN STATE.—

(A) IN GENERAL.—For the purposes of determining eligibility for coverage under a State single-payer system, an individual shall be considered a "resident" of the State if the individual lives in the State with the intention of remaining there permanently or indefinitely.

(B) CERTAIN INDIVIDUALS EXCLUDED.—The State may not deny coverage under the State single-payer system to an individual described in subparagraph (A) because the individual has not resided in the State for a specified period, or because the individual is temporarily absent from the State. However, a State may deny eligibility for benefits under the system to an individual if the State determines that the individual is residing in the State substantially for the purpose of receiving medical treatment in that State.

(b) ENSURING ACCESS TO BENEFITS.—

(1) IN GENERAL.—The system shall provide for coverage of not less than the guaranteed national benefit package, including the cost sharing provided under the package (subject to paragraph (2)), to all individuals required to be covered under the system.

(2) IMPOSITION OF REDUCED COST SHARING.—The system may decrease the cost sharing otherwise provided in the package with respect to any class of individuals enrolled in the system or any class of items or services included in the package, so long as the system does not increase the cost sharing otherwise imposed with respect to any other class of individuals, items, or services.

(3) ACCESS TO SERVICES.—Services covered under the guaranteed national benefit package shall be reasonably accessible to individuals required to be covered under subsection (a).

[*New (8/9):*] (4) ACCESS TO CHOICE OF PROVIDERS.—The system shall provide individuals with unlimited choice of providers for receiving services under the system, except that nothing in this paragraph shall be construed to prohibit the State from imposing cost-sharing requirements that result in variations in out-of-pocket expenses based on the provider chosen, so long as such variations do not impose a significant financial impairment on the individual's choice.

(c) PUBLIC OPERATION AND ACCOUNTABILITY.—

(1) IN GENERAL.—The system shall be established under State law and State law shall provide for mechanisms to enforce the requirements of the system.

(2) OPERATION BY STATE.—The State single-payer system shall be operated by the State, a designated agency of the State, or a non-profit entity established through State law in a manner that provides for public accountability with respect to the operation of the system.

(3) USE OF CONTRACTS.—During the 5-year period beginning the date of the approval of the application under this subtitle, nothing in this subsection shall be construed to prohibit a State from contracting with private organizations to assist in the administration of the system, but only if, under any contract entered into with such a private organization pursuant to this paragraph, such private organization is required to limit administrative expenses under the system to a rate of not more than 3 percent of program expenses. Any arrangement under the system under which items or services are provided by carriers shall meet such standards under title V as the Secretaries shall determine appropriate by regulation.

(d) NONDISCRIMINATORY FINANCING.—Any taxes, fees, or other assessments imposed with respect to the financing of the State single-payer system may not be imposed in a manner that discriminates, with respect to employment or employers, on the basis of the type of sponsor, or the size, self-insured nature, or other characteristics of an employer.

[*New (8/9)*] (e) APPLICATION OF CERTAIN INSURANCE REFORM STANDARDS.—The State single-payer system shall meet the following additional requirements:

(1) The system shall meet such standards applicable to insured health benefit plans under subtitle A of title V as the Secretary determines to be appropriate for a single-payer system.

(2) The system shall provide coverage for emergency and urgent care services furnished to individuals enrolled in the system by out-of-State providers.

(3) The system provides coverage and coordination of payment for services provided to individuals enrolled in the system by out-of-State providers.

(4) The system has in effect procedures to coordinate the delivery and payment of benefits for individuals enrolled in health benefit plans outside of the State who receive services from providers in the State, individuals who are employees of employers in the State but are not residents of the State, and other individuals for whom coordination of enrollment and delivery and payment of benefits is necessary.

(f) ONGOING REPORTS.—A State operating an approved State single-payer system shall submit annual reports to the Secretaries on the operation of the system, together with such other reports as either of the Secretaries may require.

SEC. 4003. TREATMENT OF MEDICARE BENEFICIARIES.

(a) PERMITTING STATES TO COVER MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—A State single-payer system may cover an individual who is a medicare part A beneficiary and who resides in the State, but only if the State demonstrates to the satisfaction of the Secretary [of Health and Human Services], in its application under this subtitle, that—

(A) all services for which such beneficiaries would otherwise be eligible under the medicare program shall be provided under the system without additional cost to such beneficiaries and shall be reasonably accessible to all such beneficiaries residing in the State; and

(B) such beneficiaries shall be eligible for the same benefits and provided the same opportunities with respect to choice of providers as other residents of the State under the system.

For purposes of subparagraph (A), coverage determinations under the system shall be made under rules that are no more restrictive than are otherwise applicable under the medicare program.

(2) TIMING OF COVERAGE.—The coverage of medicare part A beneficiaries shall begin no earlier than the beginning of the fourth year that occurs after the Secretaries have approved the system pursuant to this subtitle and only if the State provides evidence, satisfactory to the Secretary, that all of the requirements for the system will be met, and that all benefits guaranteed to such beneficiaries will be provided.

(3) CONTROL OF MEDICARE EXPENDITURES.—If medicare part A beneficiaries are included in a system under this section, the State shall guarantee that total expenditures under the medicare program in the State during the year will not exceed the expenditures that would otherwise have been made with respect to such beneficiaries residing in the State during the year if the system were not approved under this section.

[*New (8/9):*] (4) EFFECT ON FINANCING.—Nothing in this section shall be construed to prohibit a State from subjecting medicare beneficiaries to any generally applicable taxes used to finance the State system.

(b) REFERENCE TO MEDICARE PAYMENT RULES.—In the case of a State single-payer system that covers medicare part A beneficiaries, such beneficiaries shall receive benefits under the State system, and the Secretary shall make payments to the State, in accordance with section 1894 of the Social Security Act (as added by section 8361).

(c) REINSTATEMENT OF MEDICARE IN EVENT OF FAILURE TO MEET SYSTEM REQUIREMENTS.—In the case of a State system which covers medicare part A beneficiaries or medicare part C beneficiaries and fails substantially to meet requirements of this section or of the medicare program or medicare part C, the Secretary shall terminate coverage of such beneficiaries under the State system and make payment for any services covered under the medicare program or medicare part C that were provided to such beneficiaries but were not reimbursed under the State system.

(d) MEDICARE PART C BENEFICIARY DEFINED.—In this section, the term "medicare part C beneficiary" means an individual who would be eligible for benefits under medicare part C but for approval of a State single-payer system under this subtitle.

SEC. 4004. OPTIONS RELATING TO PAYMENT FOR PREMIUM SUBSIDIES AND WRAP-AROUND BENEFITS.

(a) PREMIUM SUBSIDIES.—

(1) PREMIUM CERTIFICATE ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—Under a State single-payer system, payment shall be made directly to the State under section 2124(c)(1)(C)(i) of the Social Security Act in an amount described in subparagraph (B).

(B) DETERMINATION OF AMOUNT OF PERIODIC PAYMENTS.—The amount described in this subparagraph is, subject to subparagraph (C), with respect to periods occurring during a year, the Secretary's estimate of the aggregate amount of the payments that would have been made for premium certificates under part A of title XXII of the Social Security Act to individuals covered under the State single-payer system during the most recent preceding year if payment had been made as provided in such subpart, increased by the Secretary's estimate of the rate of increase in the total amount of such payments with respect to such individuals during the year.

(C) SPECIAL RULE FOR PAYMENT TO STATES FOR YEARS BEFORE 2000.—In the case of periods occurring during a year before 2000, the State shall submit to the Secretary such information as the Secretary may require to appropriately estimate the amounts described in subparagraph

(B) based on a system established by the State to determine the eligibility of State residents for the premium certificates described in part A of title XXII of the Social Security Act (using the same eligibility criteria applicable under such part).

(2) TREATMENT OF PART C ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—The Secretary shall make payments to the State under section 2124(c)(1)(C)(iii) of the Social Security Act in the amount described in subparagraph (B).

(B) AMOUNT.—The amount described in this subparagraph is the Secretary's estimate of the aggregate amount of the reduction in the tax imposed under section 59B of the Internal Revenue Code of 1986 that would have resulted from the application of subsection (b) of such section with respect to individuals enrolled in the system during the applicable period if the State did not have an approved system under this subtitle.

(C) USE OF DATA.—In computing amounts under subparagraph (B), the Secretary may use information made available under section 6103(l)(16) of the Internal Revenue Code of 1986.

(3) RECONCILIATION FOR PREVIOUS ERRORS IN ESTIMATION.—The Secretary shall adjust the amount of payment made to the State pursuant to this subsection for periods occurring in a year to take into account any errors in the estimations made in previous payments, based on information furnished by the Secretary of the Treasury and such other information as the Secretary deems necessary.

(b) WRAP-AROUND BENEFITS.—

(1) IN GENERAL.—Under a State single-payer system, payment shall be made under section 2124(c)(1)(C)(ii) of the Social Security Act directly to the State in an amount described in paragraph (B).

(2) DETERMINATION OF AMOUNT.—The amount described in this paragraph is, subject to paragraph (3), the Secretary's estimate of the aggregate amount of the payments that would been made under part B of title XXII of the Social Security Act if payment had been made as provided in such part.

(3) SPECIAL RULE FOR PAYMENT TO STATES FOR YEARS PRIOR TO 2000.—In the case of periods occurring during a year prior to 2000, the State shall submit to the Secretary such information as the Secretary may require to appropriately estimate the amounts described in paragraph (2), based on a system established by the State to determine the individuals enrolled in the single-payer system who would be wrap-around eligible individuals but for the election under the State single-payer system (applying the same criteria and a similar process used by the Secretary to determine whether individuals are wrap-around eligible individuals under part B of title XXII of the Social Security Act).

(4) RECONCILIATION FOR PREVIOUS ERRORS IN ESTIMATION.—The Secretary shall adjust the amount of payment made to the State under this subsection for periods occurring in a year to take into account any errors in the estimations made under this subsection.

(5) DEFINITIONS.—In this subsection:

(A) The term "State wrap-around benefits" means a package of benefits consisting of items and services not covered under the guaranteed national benefit package that the Secretary finds is comparable to the wrap-around benefits provided under part B of title XXII of the Social Security Act.

(B) The term "wrap-around benefits" means the benefits described in section 2212 of the Social Security Act (as added by section 8102(a)).

(C) The term "wrap-around eligible individual" has the meaning given such term in section 2211(b) of the Social Security Act (as added by section 8102(a)).

SEC. 4005. OFFSET TO DIRECT PAYMENTS FOR OUTSTANDING MAINTENANCE OF EFFORT PAYMENTS.

The Secretary shall reduce the amount of any payment made directly to the State under section 4003(b) or subsection (a) or (b)]of section 4004 for a period by the amount of any payments owed by the State under part 2 of subtitle B of title VIII for such period.

SEC. 4006. TERMINATION OF APPROVAL.

(a) ANNUAL DETERMINATION OF BUDGETARY COMPLIANCE BY SECRETARIES.—The Secretaries shall annually determine whether a State system has met the tests described in section 4001(a)(2)(C) for the most recent 3-year period, determined based on all classes of services covered under the system.

(b) PROCESS FOR TERMINATION.—If either Secretary finds under subsection (a) that the single-payer system approved under this subtitle fails the tests described in section 4001(a)(2)(C), or no longer meets any of the other applicable requirements of section 4001(a)(2) or section 4002, such Secretary shall terminate approval of the system, in accordance with the process described in section 4204(b) (relating to termination of a State provider reimbursement system under subtitle C).

Subtitle B—State Managed Competition Programs

SEC. 4101. STANDARDS FOR STATE MANAGED COMPETITION PROGRAMS.

(a) ESTABLISHMENT OF STATE PROGRAMS.—As an alternative to the method otherwise provided in this Act to achieving universal health insurance coverage for residents of a State, a State may operate a managed competition program approved by the Secretary of Health and Human Services and the Secretary of Labor (in this subtitle jointly referred to as the "Secretaries") under this subtitle under which the State, subject to subsection (b), requires eligible individuals to obtain coverage through a consumer purchasing cooperative established under subtitle E of title V. In this subtitle, the term "State managed competition program" means a managed competition program approved by the Secretaries under this subtitle.

(b) CONDITIONS FOR APPROVAL.—The Secretaries may not approve a managed competition program under this subtitle unless—

(1) the State submits to the Secretaries an application in such form and manner as the Secretaries may require, and

(2) the Secretaries determine to their satisfaction that the State and the program meets the applicable requirements of sections 4102.

(c) TERMINATION OF APPROVAL.—Either Secretary shall terminate approval of a managed competition program in accordance with section 4106 if that Secretary determines that the State or the program no longer meet the applicable requirements of sections 4102.

SEC. 4102. GENERAL REQUIREMENTS FOR STATE MANAGED COMPETITION PROGRAMS.

(a) PROVISION OF COVERAGE THROUGH QUALIFIED INSURED HEALTH BENEFIT PLANS OFFERED BY CONSUMER PURCHASING COOPERATIVES.—

(1) REQUIREMENT.—

(A) IN GENERAL.—Except as provided in this paragraph, under the managed competition program eligible individuals residing in the State are required to obtain health coverage through enrollment in a qualified insured

health benefit plan offered through a consumer purchasing cooperative.

(B) APPLICATION OF COMMUNITY-RATING TO ALL PLANS AND ENROLLEES.—All such plans shall meet the requirements of section 5008 (relating to community-rating of premiums) with respect to all individuals and employers covered under the program.

(2) EXCEPTION FOR INDIANS, QUALIFIED RELIGIOUS EXEMPTION, VETERANS, ACTIVE DUTY MILITARY, CHAMPUS ELIGIBLE INDIVIDUALS, FEHBP ENROLLEES, MEDICARE PART A BENEFICIARIES.—Paragraph (1) shall not apply to—

(A) individuals described in paragraph (2) or (3) of section 4002(a);

(B) individuals who are entitled to benefits under the Civilian Health and Medical Program of the Uniformed Services (as defined in section 1072(4) of title 10, United States Code);

(C) individuals who are enrolled in a health plan under chapter 89 of title 5, United States Code;

(D) medicare part A beneficiaries.

(3) EXCEPTION FOR FULL-TIME EMPLOYEES IN LARGE FIRMS OR IN MULTIEMPLOYER PLANS.—

(A) FULL-TIME EMPLOYEES OF LARGE EMPLOYERS.—A managed competition program may not require an individual who is a full-time employee of an employer that has more than 1,000 full-time employees in the United States to participate in the program.

(B) BENEFICIARIES AND PARTICIPANTS IN MULTIEMPLOYER PLANS.—

(i) IN GENERAL.—A managed competition program may not require an individual who is a participant or beneficiary (as defined in clause (ii)) under a multiemployer plan described in clause (iii) to participate in the program.

(ii) PARTICIPANT AND BENEFICIARY DEFINED.—In clause (i), subject to clause (iv), the terms "participant" and "beneficiary" have the meaning given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

(iii) PLAN DESCRIBED.—A plan described in this clause is a multiemployer plan that—

(I) covers more than 1,000 active participants in the United States whose coverage under such plan is on terms at least as favorable as those provided under this Act with respect to a full-time employee, or

(II) is maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering more than 1,000 such active participants.

(iv) ELIGIBILITY STANDARDS.—A multiemployer plan may establish eligibility standards for those individuals who will be treated as participants and beneficiaries for purposes of this section. Such standards shall not discriminate on the basis of race, national origin, sex, religion, language, socioeconomic status, age, disability, sexual orientation, health status, or anticipated need for health services, but may take into account the level and rate at which employer contributions are paid on behalf of employees. Nothing in this clause shall be construed as affecting the ability of a multiemployer plan to provide health or other benefits to participants and beneficiaries who are not treated as participants and beneficiaries with respect to the plan.

(C) RURAL ELECTRIC AND TELEPHONE COOPERATIVES.—

(i) IN GENERAL.—A managed competition program may not require an individual who is a full-time employee of a member of a rural cooperative described in clause (ii), or a family member of such an employee, to participate in the program.

(ii) RURAL COOPERATIVE DESCRIBED.—A rural cooperative described in this clause is a rural electric cooperative or rural telephone cooperative association if the cooperative or association (or members of the cooperative or association) maintain a health plan under which at least 1,000 full-time employees in the United States are entitled to health benefits.

(D) OPTION.—A managed competition program may permit individuals otherwise exempt under this paragraph to participate in the program.

(b) ENSURING ACCESS OF LOW-INCOME INDIVIDUALS TO PLANS.—The managed competition program shall provide such financial assistance toward the premiums of low-income individuals described in section 2211(b)(1)(A)as will assure that such individuals may obtain coverage under a certified health plan upon the presentation of premium certificate issued under part A of title XXII of the Social Security Act.

(c) COMPLIANCE WITH PLAN REQUIREMENTS.—

(1) IN GENERAL.—The plans offered under the managed competition program shall comply with the requirements of subtitle A (and, if applicable, subtitle C) title V, except that the Secretaries may waive such provisions of such title as may be necessary to permit the operation of such a program under this subtitle.

(2) EXCLUSIVE OFFER THROUGH COOPERATIVES.—The managed competition program shall require carriers to offer certified health plans (other than to individuals exempt from participation under subsection (a)(3)) through consumer purchasing cooperatives.

(d) BUDGETARY COMPLIANCE.—The managed competition program shall control aggregate health care expenditures in the State subject to the same tests as a State operating a State provider reimbursement system under subtitle C, without regard to the adjustment described in section 4203(a)(2)(A).

(e) APPLICATION OF CERTAIN RULES.—

(1) DETERMINATION OF RESIDENCE AND ONGOING REPORTS.—Subsections (a)(5) and (e) of section 4002 apply to a managed competition program under this section in the same manner as they apply to a single-payer system under such section.

(2) NONDISCRIMINATORY FINANCING.—

(A) IN GENERAL.—Section (d) of section 4002 applies to a managed competition program under this section in the same manner as it applies to a single-payer system under such section, except that no tax, fee, or other assessment may be imposed with respect to coverage of individuals who do not participate in the program pursuant to subsection (b)(3).

(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as permitting apply with respect to only apply with respect to In carrying out subparagraph (A),

SEC. 4103. TERMINATION OF APPROVAL.

(a) ANNUAL DETERMINATION OF BUDGETARY COMPLIANCE BY SECRETARY.—The Secretary shall annually determine whether a managed competition program has met the tests described in subsection 4101(a)(2) for the most recent 3-year period, determined based on all classes of services covered under the program.

(b) PROCESS FOR TERMINATION.—If the Secretary finds under subsection (a) that the managed competition program fails the tests described in section 4101(a)(2), or no longer meets any of the appli-

cable requirements of section 4102, the Secretary shall terminate approval of the program, in accordance with the process described in section 4204(b) (relating to termination of a State provider reimbursement system under subtitle C).

(c) REINSTATEMENT OF MEDICARE PART C IN EVENT OF FAILURE TO MEET PROGRAM REQUIREMENTS.—In the case of a managed competition program which covers individuals who would (but for approval of the program) be medicare part C eligible individuals and fails substantially to meet requirements of this section with respect to such individuals, the Secretary shall terminate the approval of the program with respect to medicare part C eligible individuals.

Subtitle C—State Provider Reimbursement Systems

SEC. 4201. STANDARDS FOR STATE PROVIDER REIMBURSEMENT SYSTEMS.

(a) IN GENERAL.—During the period in which a State provider reimbursement system (in this subtitle referred to as a "State payment system") is approved under this section—

(1) the payment rates provided under such system shall apply to services covered under the system and furnished in the State;

(2) maximum payment rates shall not apply to such services under subtitle D of title VI, in accordance with section 6201(b)(2)(A); and

(3) the requirements relating to the determination of payment amounts under the medicare program, medicare part C, and medicaid programs are waived insofar as such waiver is necessary to implement such system.

State preemption requirements under the Employee Retirement Income Security Act of 1974 are waived under section 514(b)(11) of such Act (as added by section 12____) in order to carry out such a system.

(b) APPLICATION.—

(1) IN GENERAL.—Subject to subsection (e), the Secretaries may not approve a state payment system under this subtitle unless—

(A) the State submits to the Secretaries an application in such form and manner and containing such information and assurances (consistent with this subtitle) as the Secretaries may require, and

(B) the Secretaries determine to their satisfaction that the State and the system meet the applicable requirements of sections 4202 and 4203 are met.

(2) LIMITATION ON DISAPPROVAL.—The Secretaries cannot deny the application of a State for a state payment system on the ground that the methodology used under the system to control payments for inpatient hospital services is based on a payment methodology other than on the basis of a diagnosis-related group.

(c) TERMINATION OF APPROVAL.—

(1) IN GENERAL.—Either Secretary may terminate approval of a state payment system in accordance with section 4204 if that Secretary—

(A) determines that the State or the system no longer meets the requirements of section 4202(b)(1) (relating to all payers), section 4202(b)(3)(B) (relating to limitation on differentials for medicaid services), or section 4202(e) (relating to certain requirements for hospitals); or

(B) has reason to believe that the assurances described in any of the following sections are not being (or will not be) met:

(i) Section 4202(b)(2) (relating to equitable treatment of all payers).

(ii) Section 4202(f) (relating to special requirements for hospital admissions and exclusions).

(iii) Section 4203 (relating to limiting aggregate expenditures).

(2) ADDITIONAL AUTHORITY.—Either of the Secretaries may terminate such approval if such Secretary determines that the system no longer continues to meet another condition for approval described in section 4202 or 4203.

(e) DEEMED APPROVAL OF CERTAIN SYSTEMS.—

(1) IN GENERAL.—In the case of a hospital reimbursement control system approved under section 1886(c)(4) of the Social Security Act or described in section 1814(b)(3) of such Act and used for payment of hospital services in the State under the medicare program, the system is deemed to be a state payment system approved under this section with respect to payment for hospital services.

(2) TERMINATION.—Insofar as paragraph (1) applies to a state payment system, the continuation of the approval of the system is conditioned only upon the system's compliance with the requirements described in such paragraph.

SEC. 4202. GENERAL CONDITIONS FOR STATE PROVIDER REQUIREMENTS FOR STATE SYSTEMS.

(a) APPLICATION TO SERVICES.—

(1) IN GENERAL.—Subject to paragraph (2), the state payment system applies to services described in any (or all) of the following subparagraphs:

(A) Inpatient hospital services (including services of exempt hospitals (as defined in section 6311(a)(4)) statewide.

(B) Outpatient hospital services (including services of exempt hospitals (as so defined)) statewide.

(C) Physicians services statewide.

For purposes of this part, services described in each of subparagraphs (A), (B), and (C) shall be treated as a separate class of services.

(2) ADDITIONAL SERVICES ONLY BY CLASS OF SERVICE.—The system may apply to services in addition to services described in paragraph (1) only if the system applies to all services within the class (established under section 6002) in which the services are classified.

(b) APPLICATION TO ALL PAYERS; EQUITABLE TREATMENT.—

(1) APPLICATION TO ALL PAYERS.—

(A) IN GENERAL.—The system applies to substantially all payers (including the medicaid program in the State) for services to which the system applies.

(B) EXCLUSION OF MEDICARE PROGRAM.—A State may elect not to include the medicare program under the system.

(2) EQUITABLE TREATMENT OF PAYERS.—Assurances satisfactory to both Secretaries have been provided as to the equitable and nondiscriminatory treatment of all payers (including the medicare program, medicare part C, and medicaid programs and other Federal and State programs) under the system.

(3) PAYMENT RATE DIFFERENTIALS PERMITTED.—

(A) IN GENERAL.—Subject to subparagraph (B), a State may provide for payment rates for services furnished under the medicaid program that are different from the payment rates for services for which payment is made by other payers.

(B) LIMITATION ON DIFFERENTIALS FOR SERVICES UNDER MEDICAID.—The ratio of the average rate of payment for services under the medicaid program to such average rate of payment for the same services by health benefit plans (other than the medicare program, medicare part C, and medicaid programs) may not be less than the ratio

of the average of the rates of payment within the class of services for which payment is provided under the medicaid program to such average rate of payment under other health benefit plans (other than the medicare program, medicare part C, and medicaid programs) during the most recent year before the implementation of the state payment system, as determined jointly by the Secretaries.

(4) SEPARATE RATE NEGOTIATIONS PERMITTED FOR HEALTH MAINTENANCE ORGANIZATIONS.—

(A) IN GENERAL.—A State may provide that a health maintenance organization (as defined in subparagraph (B)) may negotiate directly with a provider of services covered under the system with respect to the organization's rate of payment for such services.

(B) DEFINITION.—In subparagraph (A), the term "health maintenance organization" means an eligible organization with a contract under section 1876 of the Social Security Act or a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act).

(5) MINIMUM PAYMENT RATES.—Under the state payment system, the State may provide that the amount of payment for any service within a class of services under the system may not be less than a minimum payment rate established by the State for the services.

(6) LIMITING USE OF ADDITION PAYMENT AMOUNTS TO BAD DEBT AND CHARITY.—Under the State payment system, amounts required to be paid (for items or services) that are in excess of the reasonable cost or charges or other reasonable measure (as may be designated by the Secretaries) of cost for such items and services shall be accounted for separately and applied solely for the purpose of covering bad debts or charity care (as defined by the Secretary).

(c) OPERATION.—The system is operated directly by the State or by a State agency or other public authority. The previous sentence shall be construed to prohibit a State from contracting with private organizations to carry out the requirements of the state payment system.

(d) REPORTS REQUIRED.—Providers of services covered under the system must make such reports as the Secretaries may jointly require in order to monitor assurances provided under section 4203 and make determinations under section 4204.

(e) CONTINUED ACCESS.—The State must demonstrate to the satisfaction of the Secretaries that operation of the system will not result in any change in hospital admission practices or the provision of other services which result in—

(1) a significant reduction in the proportion of patients (receiving services covered under the system) who have no third-party coverage and who are unable to pay for such services,

(2) a significant reduction in the proportion of individuals provided services for which payment is (or is likely to be) less than the anticipated charges or costs of such services, or

(3) the refusal to provide services to individuals who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available from the provider.

(f) SPECIAL REQUIREMENTS FOR HOSPITAL ADMISSIONS AND EXCLUSIONS.—If the system applies to payment for hospital services, the system requires hospitals to which the system applies to meet the requirement of section 1866(a)(1)(G) of the Social Security Act with respect to the medicare program and the system provides for the exclusion of certain costs in accordance with section 1862(a)(14) of such Act (except for such waivers thereof as the Secretaries jointly provide by regulation).

SEC. 4203. CONTROL OF AGGREGATE EXPENDITURES REQUIREMENT FOR STATE SYSTEMS.

(a) ASSURANCES REQUIRED.—

(1) IN GENERAL.—A state payment system may not be approved until the Secretaries have been provided assurances satisfactory to the Secretaries that under the system, during a 3-year period (the first such period beginning with the first month in which this section applies to that system in the State) the following 2 tests are met:

(A) AGGREGATE EXPENDITURE TEST.—The sum of—

(i) aggregate private sector expenditures (as defined in paragraph (4)), and

(ii) the aggregate medicare expenditures (as defined in paragraph (5)) for such class (or classes) under the system,

will not exceed the applicable total limit specified in paragraph (2).

(B) MEDICARE EXPENDITURE TEST.—The aggregate medicare expenditures for such class (or classes) under the system will not exceed the applicable medicare limit specified in paragraph (3).

(2) APPLICABLE TOTAL LIMIT.—The applicable total limit specified in this paragraph is the total of the maximum amount of payments that would be payable in the State for the covered class (or classes) of services if the state payment system were not in effect. With respect to payments for individuals who are not enrolled under the medicare program or medicare part C, such amount shall be based on the State private per capita expenditure estimate (established under subtitle B of title VI) for the State, adjusted—

(A) to remove the effect of the adjustment described in section 6101(b)(3), and

(B) to take into account only the proportion of such estimate that is attributable to the covered class (or classes).

(3) APPLICABLE MEDICARE LIMIT.—The applicable medicare limit specified in this paragraph is the sum of—

(A) the maximum amount of payments that would be payable in the State for the covered class (or classes) of services under the medicare program if the state payment system were not in effect, and

(B) the maximum amount of payments that would be payable in the State for the covered class (or classes) of services under medicare part C if the state payment system were not in effect.

(4) AGGREGATE PRIVATE SECTOR EXPENDITURES DEFINED.—In this subtitle, the term "aggregate private sector expenditures" means the product of—

(A) the State private per capita expenditure estimate (referred to in paragraph (2), subject to the adjustment described in such paragraph) for the class (or classes) of services covered under the system, and

(B) the average number of residents of the State enrolled in certified health plans.

(5) AGGREGATE MEDICARE EXPENDITURES DEFINED.—In this subtitle, the term "aggregate medicare expenditures" means expenditures under the medicare program and medicare part C for items and services included in the class (or classes) of services covered under the system.

(6) WAIVER OF AGGREGATE EXPENDITURE TEST FOR YEARS PRIOR TO 1997.—The aggregate expenditure test described in paragraph (1) shall not apply with respect to a state payment system for any year prior to 1997.

(b) ANNUAL DETERMINATION BY SECRETARIES.—The Secretaries shall jointly determine annually whether a state payment system has met the tests described in subsection (a)(1) for the most recent 3-year period, determined based on all classes of services covered under the system.

(c) USE OF MEDICARE SAVINGS.—

(1) IN GENERAL.—If the Secretaries jointly determine that a state payment system under this subtitle has resulted in medicare savings over a period of 3 consecutive years, in the 4th year there shall be paid to the State an amount equal to the medicare savings in the first year of such 3-year period. Such payments shall be made from the Federal Hospital Insurance Trust Fund, the Federal Supplementary Medical Insurance Trust Fund, Medicare Part C Trust Fund in such amounts as reflects the medicare savings attributable to the respective Trust Fund in such first year.

(2) DEFINITIONS.—In this subsection:

(A) The term "medicare spending" means, with respect to a State in a year, aggregate medicare expenditures incurred under the medicare program and medicare part C in the State in the year.

(B) The term "baseline medicare spending" means, with respect to a State in a year, the amount of aggregate medicare expenditures that the Secretaries jointly estimate would have been incurred under the medicare program and medicare part C in the State in the year if this subtitle did not apply in the State.

(C) The term "medicare savings" means, with respect to a State in a year, the amount by which the baseline medicare spending for the State in the year exceeds the medicare spending for the State in the year.

SEC. 4204. TERMINATION OF APPROVAL OF STATE SYSTEM.

(a) IN GENERAL.—Either of the Secretaries shall terminate approval of a state payment system in accordance with this section if such Secretary determines under section 4203(b) that the State has not met the tests referred to in such section.

(b) PROCESS.—

(1) NOTICE.—Either of the Secretaries may terminate the approval of a state payment system under this subtitle only after the expiration of a 90-day period beginning on the date such Secretary informs the State of such Secretary's intention to terminate such approval, unless, during such 90-day period, the State requests a hearing with such Secretary.

(2) HEARING.—If the State requests a hearing during the 90-day period described in paragraph (1), such Secretary shall conduct a hearing during which the State may present evidence showing that such Secretary should not terminate the approval of its system. If such Secretary decides to reject such evidence, such Secretary shall terminate the approval of the State's system beginning with the first day of the first month that begins after the date of such Secretary's decision.

(3) JUDICIAL REVIEW PROHIBITED.—There shall be no administrative or judicial review of a decision by either of the Secretaries with respect to the approval (or termination of approval) of a state payment system under this subsection.

(c) ADJUSTMENTS TO RECAPTURE EXCESS SPENDING.—

(1) ADJUSTMENT OF MAXIMUM PAYMENT RATES.—If either of the Secretaries terminates the approval of a state payment system under this section due to—

(A) a failure to meet the test described in section 4203(a)(1)(A) (relating to aggregate private sector and medicare expenditures), the maximum payment rates otherwise established for services within the class (or classes) of services under subtitle D of title VI shall be adjusted in accordance with paragraph (2)(A), but only for that State; or

(B) a failure to meet the test described in section 4203(a)(1)(B) (relating to aggregate medicare expenditures), the payment rates otherwise established for items and services within the class (or classes) of services under

subtitle C of title VIII shall be adjusted in accordance with paragraph (2)(B), but only for that State.

(2) ADJUSTMENTS.—

(A) IN MAXIMUM PAYMENT RATES FOR PRIVATE SECTOR EXPENDITURES.—The adjustment described in this subparagraph is such a reduction in the maximum payment rates for the class (or classes) of services covered under the system as such Secretary determines necessary to decrease—

(i) the amount of aggregate private sector expenditures that would otherwise be made for services provided in the State, by

(ii) the amount by which aggregate private sector expenditures for such class (or classes) of services for the 3-year period involved exceeded the applicable private sector limit specified in section 4203(a)(4) for such period.

(B) IN MEDICARE PAYMENT RATES.—The adjustment described in this subparagraph for a State is such a reduction in the applicable medicare payment rate for the class (or classes) of services covered under the system as the Secretary determines necessary to decrease—

(i) the amount of aggregate medicare expenditures that would otherwise be made for services provided in the State, by

(ii) the amount by which aggregate medicare expenditures for such class (or classes) of services for the 3-year period involved exceeded the applicable medicare limit specified in section 4203(a)(3) for such period.

(C) PERIOD OF ADJUSTMENT.—The adjustments under subparagraphs (A) and (B) shall be made—

(i) during the year following the termination of the system, or

(ii) during each year in the 3-year period following the termination, if such Secretary determines that a reduction over such 3-year period is appropriate in the case of a State.

Subtitle D—General Rules, Coordination, and Transition

SEC. 4301. PROCEDURES.

The Secretaries shall prescribe by regulation a process for coordinating the procedures of each such Secretary governing submission, consideration, and determination of applications for approval, ongoing reports, and termination procedures under this title. Under such process, no approval of any system or program under this title may apply to the portions of a metropolitan statistical area which are located in the counties of Monroe, Wayne, Ontario, and Livingston.

SEC. 4302. AVAILABILITY OF PRIVATE RIGHT OF ACTION FOR AGGRIEVED INDIVIDUALS.

(a) IN GENERAL.—Any person aggrieved by an act or omission of a State under this title which constitutes a failure to comply with an applicable requirement of this title may obtain from the State in any court of competent jurisdiction appropriate relief, including actual and compensatory damages and equitable relief.

(b) EXCEPTION FOR CERTAIN VIOLATIONS.—Subsection (a) does not apply in the case of an act or omission upon which a complaint may be filed in a complaint review office pursuant to section 9304 or for which a remedy may be sought under section 9331.

(c) ATTORNEY'S FEES AND COSTS.—In any action under this section in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevail-

ing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(d) EXHAUSTION OF REMEDIES.—In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

SEC. 4303. REFERENCES TO WAIVERS UNDER THE MEDICARE PROGRAMS.

For waiver of certain provisions of the medicare program, see section 1894 of the Social Security Act, as added by section 8361 of this Act.

SEC. 4304. EXEMPTIONS FROM ERISA PREEMPTION.

For exemptions from preemption of State law, under the Employee Retirement Income Security Act of 1974, see paragraphs (9), (10), and (11) of section 514(b) of such Act, as added by section 12004 of this Act.

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Subtitle A—Standards for Carriers and Insured Health Benefit Plans

SEC. 5001. REQUIREMENTS FOR CERTIFICATION OF CARRIERS AND PLANS.

(a) CERTIFICATION REQUIRED FOR CARRIERS PROVIDING INSURED HEALTH BENEFIT PLANS.—

(1) IN GENERAL.—No carrier may sell, issue, or renew a contract under an insured health benefit plan (as defined in section 5504) in a State, or sell, issue, or renew a contract under a supplemental health benefit policy (as defined in section 5504(11)) in a State, unless the carrier, in relation to the plan, and the plan have been certified as meeting the applicable standards established under section 5501 consistent with this subtitle—

(A) by a State regulatory program of the State (approved under section 5502), or

(B) in the case of a State without such an approved program, by the Secretary (in accordance with such procedures as the Secretary establishes).

(2) PLAN DISAPPROVED.—If the applicable regulatory authority determines that a carrier with respect to an insured health benefit plan or a supplemental health benefit policy does not meet the applicable standards of this subtitle on or after the effective date described in subsection (b), the carrier may not provide coverage under the plan to individuals not enrolled as of the date of the determination and may not continue to provide the plan for plan years beginning after the date of such determination until the authority determines that such carrier and plan are in compliance with such standards.

(3) SPECIAL RULE FOR CARRIERS OFFERING PLANS IN MULTI-STATE METROPOLITAN STATISTICAL AREAS.—In the case of a carrier offering an insured health benefit plan in a portion of a State that is located in a metropolitan statistical area, the carrier may not sell, issue, or renew a contract under the plan with respect to an individual or employer in such metropolitan statistical area unless the carrier, in relation to the plan, and

the plan have been certified as meeting the applicable standards established under section 5501 by the State regulatory program of each State in which the metropolitan statistical area is located. The Secretary may waive the application of this paragraph to a carrier with respect to a State with an approved single-payer system under subtitle A of title IV, or under unusual circumstances.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subsection (a) shall apply to contracts under insured health benefit plans sold, issued, or renewed on or after January 1, 1997.

(2) EXCEPTION FOR PLANS OFFERED IN STATES REQUIRING LEGISLATION.—In the case of an insured health benefit plan sold, issued, or renewed in a State which the Secretary identifies, in consultation with the NAIC, as—

(A) requiring State legislation (other than legislation appropriating funds) in order for carriers and plans to meet the requirements of this subtitle, but

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

the date specified in this subsection is January 1, 1998, or, if earlier, the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1997. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 5002. NONDISCRIMINATION.

(a) NO DISCRIMINATION BASED ON HEALTH STATUS.—A carrier may not deny, limit, or condition the coverage under (or benefits of) an insured health benefit plan based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

(b) OTHER DISCRIMINATION PROHIBITED.—A carrier may not engage in any activity in relation to an insured health benefit plan offered in a market sector that directly or through contractual arrangements would have the effect of discriminating against an individual on the basis of race, national origin, religion, gender, sexual orientation, language, socioeconomic status, age, status of an eligible individual as a citizen of the United States, health status, or anticipated need for health services.

SEC. 5003. OPEN ENROLLMENT.

(a) ENROLLMENT REQUIREMENTS.—Subject to the succeeding provisions of this section, a carrier that offers an insured health benefit plan in a market sector to individuals residing (or to employers located) in a community-rating area (described in section 5008(c)) must offer the same plan to any other resident of (or employer located in) such area who is eligible to seek coverage through such a sector.

(b) ENROLLMENT PERIODS.—

(1) IN GENERAL.—Except as provided under paragraph (2), the requirement described in subsection (a) shall apply on a continuous, year-round basis.

(2) ENROLLMENT FOR INDIVIDUALS IN COMMUNITY-RATED MARKET SECTOR.—With respect to eligible individuals seeking enrollment in an insured health benefit plan offered in the community-rated market sector who are seeking coverage on behalf of themselves (and their dependents) and not seeking coverage on the basis of employment or through a consumer purchasing cooperative, the following rules apply:

(A) ANNUAL OPEN ENROLLMENT PERIOD.—The State shall establish an annual open enrollment period of at least 45 days during which a carrier may not refuse to enroll such individuals. Before and during each such open

enrollment period, the carrier shall make public information on the availability of coverage in the community-rated market sector (in accordance with section 5010).

(B) CONTINUOUS OPEN ENROLLMENT FOR NEW MARKET ENTRANTS.—A carrier may not refuse to enroll such an individual who is not enrolled in an insured health benefit plan offered in the community-rated market sector.

(C) PERMITTING CHANGE IN PLAN.—

(i) GROUNDS FOR CHANGE.—An individual may change the plan under which the individual is provided coverage under an insured health benefit plan—

(I) during the individual's first year of coverage; or

(II) for good cause during any year of the individual's coverage (under procedures developed by the Secretary).

(ii) TIMING OF CHANGE.—A change in plan described in clause (i) shall be effective on the first day of the first month beginning at least 45 days after the date the individual provides notice to the carrier offering the plan in which the individual seeks coverage.

(D) PERMITTING CONTINUOUS OPEN ENROLLMENT.—Nothing in this subparagraph may be construed to prohibit a carrier from permitting enrollment of any individual at any other time, so long as the carrier permits enrollment of any individual eligible to enroll and does not discriminate among such individuals in violation of section 5002.

(3) EXCEPTION FOR YEARS BEFORE 1999.—

(A) INDIVIDUALS.—Notwithstanding any other provision of this title, during any year prior to 1999, a carrier offering an insured health benefit plan offered in the community-rated market sector may refuse to enroll an individual who seeks coverage under the plan on behalf of the individual (and the individual's dependents) and not seeking coverage on the basis of employment or membership in a qualifying association, or through a consumer purchasing cooperative, except during an annual 30-day open enrollment period established by the Secretary for States during which the plan would be required to provide for enrollment of any such eligible individual. Before and during such open enrollment period, the carrier shall make public information on the availability of coverage under such plans (in accordance with section 5010).

(B) SMALL EMPLOYERS.—Notwithstanding any other provision of this title, during any year prior to 1999, a carrier may refuse to provide coverage with respect to a small employer through the community-rated market sector if the employer does not meet standards of the carrier relating to the minimum participation of employees of the employer in insured health benefit plans offered through such sector (in accordance with standards established by the Secretary), except during the annual 30-day open enrollment period described in subparagraph (A) during which the plan would be required to provide for coverage with respect to any small employer. Prior to and during such open enrollment period, the carrier shall make public information on the availability of coverage under such plans (in accordance with section 5010).

(4) EXCEPTION FOR TERMINATED PLANS.—A carrier may refuse to enroll an individual in an insured health benefit plan offered in a market sector if the carrier is terminating enrollment in the plan pursuant to section 5006(c).

(c) SPECIAL RULES FOR PLANS OFFERED THROUGH QUALIFYING ASSOCIATIONS.—

(1) OFFERING OF PLANS PERMITTED.—Subject to paragraph (2), a carrier may offer an insured health benefit plan through

an association that is a qualifying association defined in subsection (e)(4).

(2) SPECIAL RULES FOR ASSOCIATION PLANS.—With respect to an insured health benefit plan offered by a carrier through a qualifying association—

(A) the carrier shall offer the same plan to all individuals and employers eligible to seek coverage through the community-rated sector; and

(B) the carrier may not offer the plan to a large employer seeking coverage through the association on behalf of its employees.

(3) CARRIERS THAT ARE QUALIFYING ASSOCIATIONS.—In the case of a qualifying association that—

(A) is a religious fraternal organization, and

(B) is a carrier (and was a carrier as of December 31, 1993),

the association may limit enrollment in health plans it offers as a carrier to members of the association.

(d) CAPACITY LIMITATION.—

(1) IN GENERAL.—A carrier offering an insured health benefit plan may apply to the applicable regulatory authority to cease enrolling new employers or individuals in part or all of the service area of the plan if it can demonstrate that its financial or administrative capacity (or, in the case of a staff model or dedicated group model health maintenance organization, its service capacity) to serve previously enrolled employers and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled employers) will be impaired if it is required to enroll new employers or individuals.

(2) PRIORITIES IN CASE OF OVERSUBSCRIPTION.—

(A) IN GENERAL.—The applicable regulatory authority in a State shall establish a method for establishing enrollment priorities in the case of an insured health benefit plan offered by a carrier that is permitted to limit enrollment under this subsection. Except as provided in subparagraph (B), such priorities shall not take into account personal characteristics of potential enrollees, such as health status, socioeconomic status, anticipated need for health care, age, occupation, sexual orientation, race, sex, national origin, or affiliation with any person or entity.

(B) PRIORITIES.—Such method shall provide that in the case of such an oversubscribed plan—

(i) individuals already enrolled in the plan are given priority in continuing enrollment in the plan, and

(ii) to the extent that other individuals may be enrolled, such enrollment shall be in accordance with a method that provides equal opportunity for all individuals who seek enrollment during the same enrollment period, regardless of when during the period the enrollment has been sought.

(e) MARKET SECTORS DESCRIBED.—For purposes of this title, each of the following is a separate market sector:

(1) COMMUNITY-RATED MARKET SECTOR.—The community-rated market sector, consisting of (subject to subsection (f))—

(A) individuals seeking coverage on behalf of themselves (and their dependents) and not seeking coverage on the basis of employment or membership in a qualifying association, or through a consumer purchasing cooperative; and

(B) small employers seeking coverage on behalf of their employees (and dependents) and on behalf of other individuals on the basis of their employment (or similar business relationship) with the employer and not seeking

coverage on the basis of membership in a qualifying association or through a consumer purchasing cooperative.

(2) LARGE GROUP MARKET SECTOR.—The large group market sector, consisting of eligible large group sponsors seeking coverage on behalf of individuals eligible to seek coverage through such sponsors.

(3) ELIGIBLE LARGE GROUP SPONSOR DEFINED.—In this section, the term "eligible large group sponsor" means an eligible sponsor described in section 5102(b).

(4) OTHER DEFINITIONS.—

(A) CONSUMER PURCHASING COOPERATIVE.—The term "consumer purchasing cooperative" means a cooperative described in section subtitle E, without regard to whether or not a grant is made under such subtitle for the area in which the cooperative is established.

(B) EMPLOYEE INCLUDING SELF-EMPLOYED.—The term "employee" includes, with respect to an employer that is a self-employed individual, the self-employed individual.

(C) LARGE EMPLOYER.—The term "large employer" has the meaning given such term in section 1106(b)(1)(A).

(D) QUALIFYING ASSOCIATION.—The term "qualifying association" means an association, religious fraternal organization, or other organization (which may be a trade, industry, or professional association, a chamber of commerce, or a public entity association) that the Secretary finds—

(i) has been formed for purposes other than the sale of health insurance and does not restrict membership based on any characteristic described in section 5002(a),

(ii) does not exist solely or principally for the purpose of selling insurance,

(iii) has at least 1,000 individual members or 200 employer members,

(iv) offered a health benefit plan as of December 31, 1993,

(v) any health benefit plan it offers to its members is made available consistent with the requirements of section 5002(a), and

(vi) any health benefit plan it offers to its members is not made available to any eligible large group sponsor described in paragraph (3).

Such term includes a subsidiary or corporation that is wholly owned by one or more qualifying organizations.

(E) SMALL EMPLOYER.—The term "small employer" means an employer that is not a large employer and employs at least 2 employees.

(f) CERTAIN INDIVIDUALS NOT INCLUDED IN COMMUNITY-RATED MARKET SECTOR.—The following individuals are not included in the community-rated market sector under subsection (e)(1):

(1) MEDICARE ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—Subject to subparagraph (B), an individual who is entitled to benefits or enrolled under part A of title XVIII of the Social Security Act.

(B) EXCEPTION WHERE MEDICARE SECONDARY PAYER.—Subparagraph (A) shall not apply to an individual if the certified health plan in which the individual enrolls (or will be enrolled) under this subtitle is (or would be) a primary plan (as defined in section 1862(b)(2)(A) of the Social Security Act) with respect to the individual.

(2) ENROLLED AS A DEPENDENT.—An individual who is enrolled under another health plan as a dependent of an individual.

(3) SPECIAL REQUIREMENT FOR MEDICAID-ELIGIBLE INDIVIDUALS.—An individual who is entitled to benefits with respect to the guaranteed national benefit package under a State medicaid plan under title XIX of the Social Security Act.

(4) FULL-TIME EMPLOYEE OF SMALL EMPLOYERS ENROLLED IN MEDICARE PART C.—An individual who is a medicare part C covered employee and who is a full-time employee of an employer who is not a large employer.

SEC. 5004. PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—A carrier may not exclude or limit coverage under an insured health benefit plan with respect to services covered under the plan related to treatment of a preexisting condition.

(b) TRANSITION FOR YEARS PRIOR TO 1999.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier providing an insured 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 and such exclusion shall not apply with respect to services furnished to newborns, pregnancy-related services, or to a plan for which such exclusion did not apply as of the effective date of subtitle F.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A carrier providing an insured health benefit plan shall provide that if an individual covered under such a 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 health benefit plan, the medicare program, a State medicaid plan, or other health benefit arrangement which provides benefits with respect to the same or substantially similar services (as determined in accordance with criteria established by the Secretary) and ends on the date the individual is not so enrolled for a continuous period of more than 3 months (or for a longer period with respect to individuals who lose employment and meet such other conditions as the Secretary may specify).

(ii) PREEXISTING CONDITION.—The term "preexisting condition" means, with respect to coverage under a health benefit 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).

SEC. 5005. PROHIBITION AGAINST WAITING PERIODS.

(a) IN GENERAL.—Except as otherwise provided in this section, a carrier shall provide coverage of an individual under an insured health benefit plan as of the first day of the month following the month of enrollment. A carrier may not impose any waiting period on an enrollee before providing coverage under an insured health benefit plan.

(b) COVERAGE AFTER ENROLLMENT DURING ANNUAL OPEN ENROLLMENT PERIOD.—In the case of an individual who enrolls in an insured health benefit plan during an open enrollment period described in section 5003(b)(3)(A), the carrier shall provide coverage of the individual under the plan effective as of such date as the Secretary may establish with respect to enrollments made during such period.

SEC. 5006. CONTINUATION OF COVERAGE REQUIREMENTS.

(a) IN GENERAL.—A carrier may not refuse to enroll, refuse to renew the enrollment of, or terminate the enrollment of, an individual or employer in an insured health benefit plan except for—

(1) nonpayment of premiums, or

(2) fraud or misrepresentation of material fact.

(b) TRANSITION FOR NONCONFORMING POLICIES.—Notwithstanding State law or the provision of any agreement to the contrary, effective January 1, 1999, a carrier may cancel or refuse to renew a health insurance policy issued in a State prior to the application of this part to health benefit plans sold or issued in the State if the policy does not provide for coverage of the guaranteed national benefit package, but only if the carrier offers the policyholder affected the opportunity to obtain coverage under an insured health benefit plan meeting the standards established under this part.

(c) EXCEPTION FOR PLANS EXITING MARKET.—

(1) IN GENERAL.—A carrier may refuse to renew the enrollment of, or terminate the enrollment of, an individual or employer in an insured health benefit plan offered in a market sector if—

(A) the carrier is terminating the enrollment of all individuals in such plan with the approval of the applicable regulatory authority, or

(B) the carrier is terminating the plan pursuant to a joint marketing agreement entered into prior to January 1, 1994.

(2) LIMITATION ON OFFERING OF OTHER PLANS IN MARKET SECTOR.—If a carrier terminates the enrollment of individuals in a plan offered in a market sector pursuant to paragraph (1) in a State, the carrier may not offer a plan (that is the same type as the type of plan terminated) in the market sector to individuals or employers in the State until the expiration of the 5-year period that begins on the date that no individual is enrolled in the plan in the State.

SEC. 5007. BENEFIT REQUIREMENTS.

(a) REQUIRING OFFER OF PLAN CONSISTING OF GUARANTEED NATIONAL BENEFIT PACKAGE.—

(1) IN GENERAL.—Each carrier that offers an insured health benefit plan shall offer such a plan that only includes coverage for the benefits contained in the guaranteed national benefit package. A carrier may offer a plan within each type of plan within each market sector.

(2) LIMITATION ON OFFERING OF HIGH DEDUCTIBLE PLANS.—A carrier may not offer an insured health benefit plan that is a high deductible plan other than to an employer who demonstrates that the employer is making contributions to medical savings accounts in accordance with section 3466(d)(2)(C)(i) of the Internal Revenue Code of 1986.

(b) PREEMPTION OF STATE LAWS REQUIRING PLANS TO COVER ADDITIONAL BENEFITS.—Subsection (a)(1) shall preempt any State law requiring a carrier to include in an insured health benefit plan coverage for any benefit not contained in the guaranteed national benefit package.

(c) SPECIAL RULE FOR ENROLLEES COVERED UNDER MANAGED MENTAL HEALTH PROGRAMS.—

(1) PAYMENT TO STATE OF CAPITATED PAYMENT.—In the case of an individual enrolled in an insured health benefit plan who is enrolled in a managed mental health program of a State or an Indian tribe or tribal organization approved under section 1981 of the Public Health Service Act for a month—

(A) the individual is considered to have waived the right to benefits for mental health services through the plan in consideration of receipt of benefits for mental health services through such program;

(B) the carrier providing the plan shall make a per capita payment to the State or Indian tribe or tribal organization, in the amount specified in paragraph (2), on behalf of the individual; and

(C) the carrier is not obligated to make any other payment under the plan with respect to mental health services furnished to the individual during the month.

Payments under subparagraph (B) shall be made on a monthly basis.

(2) CAPITATED PAYMENT AMOUNTS.—The amount of the per capita payment required under paragraph (1) shall be an amount determined in accordance with a methodology established by the Secretary (similar to the methodology used under section 1893(b) to determine capitated payments to States and Indian tribes or tribal organizations on behalf of medicare beneficiaries enrolled in such programs) that reflects the portion of the premium associated with the coverage of mental health services under the guaranteed national benefit package that would be provided to the individual under the plan if the individual were not enrolled in the managed mental health program.

(3) MENTAL HEALTH SERVICES DESCRIBED.—In this subsection, the term 'mental health services' has the meaning given such term in section 1893(c) of the Social Security Act.

(d) SPECIAL REQUIREMENTS RELATING TO PRESCRIPTION DRUGS.—With respect to outpatient prescription drugs covered under an insured health benefit plan, the plan may subject the coverage of the drug to prospective review, prior authorization, or drug use review, but only if such review or authorization is conducted in the same manner and under the same terms as provided under section 1834(d)(6) of the Social Security Act.

SEC. 5008. REQUIREMENTS RELATING TO COMMUNITY RATING OF PREMIUMS.

(a) RATING REQUIREMENT.—Subject to subsections (b) and (e), the premium rate charged by a carrier for a type of insured health benefit plan in a community-rating area (as specified under subsection (c)) within the community-rated market sector shall not vary except by class of enrollment in accordance with subsection (d).

(b) TRANSITION.—

(1) GENERAL TRANSITION.—Except in the case of a State described in paragraph (2):

(A) FIRST YEAR.—In the first year for which this part applies to a carrier in a State, the premium rate charged by the carrier for an insured health benefit plan providing the guaranteed national benefit package in a community-rating area may vary within a class of enrollment so long as the premium range percentage (as defined in paragraph (3)) does not exceed ⅔ of the premium range percentage of premium rates charged by the carrier for insured health benefit plans providing similar benefits in the community-rating area in the previous year.

(B) SECOND YEAR.—In the second year for which this part applies to a carrier in a State, the premium rate charged by the carrier for an insured health benefit plan providing the guaranteed national benefit package in a community-rating area may vary within a class of enrollment so long as the premium range percentage does not exceed ½ of the maximum premium range percentage permitted under paragraph (1) for the previous year.

(2) SPECIAL TRANSITION FOR STATES SUBJECT TO DELAYED IMPLEMENTATION.—In the case of a State described in section 5001(b)(2), in the first year for which this part applies to a carrier in the State, the premium rate charged by the carrier for an insured health benefit plan providing the guaranteed national benefit package in a community-rating area may vary within a class of enrollment so long as the premium range percentage (as defined in paragraph (3)) does not exceed ½ of the premium range percentage of premium rates charged by the

carrier for insured health benefit plans providing similar benefits in the community-rating area in the previous year.

(3) PREMIUM RANGE PERCENTAGE DEFINED.—In this subsection, the term "premium range percentage" means—

(A) the highest premium rate minus the lowest premium rate, divided by

(B) the lowest premium rate,

expressed as a percentage.

(4) PERMISSIBLE VARIATION.—Section 5002(a) and 5002(b) (insofar as such sections relate to age, health status, or anticipated need for health services) shall not apply to variations in premiums permitted under this subsection.

(5) NO TRANSITION PERMITTED AFTER 1998.—In no event may any variation in premiums be permitted pursuant to this subsection after December 31, 1998.

(c) SPECIFICATION OF COMMUNITY-RATING AREA.—

(1) IN GENERAL.—For purposes of this section, a community-rating area shall be determined consistent with this subsection.

(2) NO SPLITTING OF MSA.—The entire part of a metropolitan statistical area shall be in the same community-rating area.

(3) TREATMENT OF NON-MSA.—

(A) IN GENERAL.—Except as provided in subparagraph (B), all portions of a State that are outside a metropolitan statistical area shall be in a single community-rating area.

(B) STATE MAY DIVIDE.—A State may divide the portions of a State that are outside a metropolitan statistical area into more than one community-rating area.

(4) NO OVERLAPPING AREAS PERMITTED.—No portion of a State may be in more than one community-rating area.

(5) SPECIAL RULE.—Notwithstanding paragraph (2), the State of New York shall define a community-rating area to be the same area as an area defined (as of August 1, 1994) pursuant to section 4317 of the Insurance Law of the State of New York.

(d) CHARGING RATES BY CLASS OF ENROLLMENT.—

(1) IN GENERAL.—Each carrier shall establish separate premium rates for each of the three classes of enrollment described in section 3(b) for each market sector (including the large employer market sector).

(2) VARIATIONS ONLY BY ACTUARIAL VALUE.—The differences among such rates for an insured health benefit plan shall reflect only differences in the actuarial value of the guaranteed national benefit package among the classes of enrollment, consistent with standards established by the Secretary.

(e) RISK ADJUSTMENT.—

(1) DEVELOPMENT OF MODELS BY SECRETARY.—

(A) IN GENERAL.—The Secretary shall develop one or more model risk adjustment systems under which premiums applicable to insured health plans offered by carriers in the community-rated market sector would be adjusted to take into account such factors as the Secretary considers appropriate to predict the future need and use of services by individuals enrolled in such plans, which may include—

(i) the age, gender, geographic residence, health status, socioeconomic status, or other demographic characteristics of individuals enrolled in such plans; and

(ii) the proportion of individuals enrolled in such plans who are AFDC recipients (as defined in section 2(1)) or SSI recipients (as defined in section 2(11)).

(B) UPDATING MODELS.—The Secretary may periodically modify the model risk adjustment systems developed

under subparagraph (A) as the Secretary considers appropriate.

(C) ADJUSTMENT FOR PEDIATRIC RISK FACTORS.—In addition to the risk adjustment methodology developed under subparagraph (A), the Secretary shall develop such a model methodology for pediatric risk factors, based on factors that predict solely the future need and use of health services by children enrolled in health benefit plans.

(2) APPLICATION OF METHODOLOGY TO PLANS.—The State shall require carriers providing insured health plans in the State in the community-rated market sector to meet the requirements of one of the model risk adjustment systems developed by the Secretary under paragraph (1)(A), or the requirements of an alternative system adopted by the State and approved by the Secretary.

(f) EXTENSION OF COMMUNITY RATES TO LARGE GROUP MARKET SECTOR.—Nothing in this section shall be construed to prohibit a carrier from offering a plan in the large group market sector at the rate applicable to the plan in the community-rated market sector.

SEC. 5009. SPECIAL REQUIREMENTS FOR MANAGED CARE AND POINT-OF-SERVICE PLANS.

(a) IN GENERAL.—The additional requirements of this section shall apply—

(1) in the case of a managed care plan; and

(2) with respect to the furnishing of items and services through a provider network of a point-of-service plan.

(b) ARRANGEMENTS WITH PROVIDERS.—

(1) IN GENERAL.—The carrier shall enter into such agreements with health care providers (including primary and specialty providers for children), or have such other arrangements as may be necessary to assure that individuals enrolled with the plan have reasonably prompt access to all items and services contained in the guaranteed national benefit package (including access to services on a 24-hour basis where medically necessary), in a manner that assures the continuity of the provision of such items and services.

(2) PROVISION OF PHYSICIANS' SERVICES.—In the case of a managed care plan, the plan provides for coverage of physicians' services primarily—

(A) directly through physicians who are either employees or partners of the carrier offering the plan; or

(B) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(3) ACCESS TO CENTERS OF EXCELLENCE.—

(A) IN GENERAL.—The carrier shall demonstrate that individuals enrolled in a plan (including individuals with acute life-threatening and chronic diseases) have access through the plan's provider network to specialized treatment expertise of designated centers of excellence. The carrier shall demonstrate such access according to standards developed by the Secretary, including requirements relating to plan arrangements with such centers and plan referral of patients to such centers.

(B) DESIGNATION PROCESS FOR CENTERS OF EXCELLENCE.—The Secretary shall establish a process for the designation of facilities as centers of excellence for purposes of this paragraph. Such process may include the use of treatment outcomes data.

(C) REQUIREMENTS FOR DESIGNATION.—A facility may not be designated pursuant to subparagraph (B) unless the facility is determined—

(i) to provide specialty care,

(ii) to deliver care for complex cases requiring specialized treatment and for individuals with acute life-threatening or chronic diseases, and

(iii) to meet any other requirements that shall be established by the Secretary relating to specialized education and training of health professionals, participation in peer-reviewed research or clinical trials, or treatment of patients from outside the geographic area of the facility.

(4) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—A carrier may not require an individual to obtain a referral in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

(5) PROTECTIONS FOR INDIVIDUALS WITH DISABILITIES.—A carrier take such measures as may be necessary to ensure the provision of covered items and services for individuals with disabilities, including such measures as may be necessary to ensure access to centers of excellence and essential community providers.

(c) PROVISION OF EMERGENCY AND URGENT CARE SERVICES.—

(1) IN GENERAL.—The plan must cover medically necessary emergency and urgent care services provided to enrollees (including trauma services provided by designated trauma centers), without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the plan to provide items or services to enrollees of the plan and, in the case of services furnished for the treatment of an emergency medical condition (as defined in section 1867(e)(1) of the Social Security Act), without regard to prior authorization.

(2) DESIGNATED TRAUMA CENTERS DEFINED.—In paragraph (1), the term "designated trauma center"—

(A) has the meaning given such term in section 1231 of the Public Health Service Act, and

(B) includes (for years prior to 2001) a trauma center that—

(i) is located in a State that has not designated trauma centers under section 1213 of such Act, and

(ii) the Secretary finds meets the standards under such section to be a designated trauma center.

(d) STANDARDS RELATING TO PROVIDER NETWORKS.—

(1) LIMITATIONS ON ABILITY TO EXCLUDE PROVIDERS FROM NETWORK.—

(A) IN GENERAL.—Except as provided in subparagraph (C), a carrier offering an insured health plan may not exclude from the provider network of the plan any provider of covered items or services (including a nonphysician provider) who is willing to accept the terms for participation in the network, including terms relating to the schedule of fees, covered expenses, and quality standards.

(B) CONSTRUCTION.—Nothing in this section may be construed to prohibit a carrier from carrying out any of the following activities with respect to providers who are members of a plan's provider network:

(i) Instituting criteria for the credentialing of providers.

(ii) Requiring providers to accept discounts in fees.

(iii) Matching the availability of providers with the needs of individuals enrolled in the plan.

(iv) Establishing measures to maintain quality and control costs.

(C) EXCEPTION FOR DEDICATED GROUP AND STAFF MODEL HEALTH MAINTENANCE ORGANIZATIONS.—Subparagraph (A) shall not apply with respect to a managed care plan that is a health maintenance organization if the organization—

(i) is treated as described in section 501(c)(3) of the Internal Revenue Code of 1986 pursuant to section 501(n)(2) of such Code, or

(ii) is not so treated but substantially all of its primary care health services are provided by the organization to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization.

(2) DUE PROCESS PROTECTIONS FOR PROVIDERS.—

(A) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—

(i) ESTABLISHMENT.—The carrier shall establish standards to be used by the carrier for contracting with health care providers with respect the plan's provider network. Such standards shall be established in consultation with providers who are members of the network.

(ii) DISTRIBUTION OF INFORMATION.—Descriptive information regarding these standards shall be made available to enrollees, providers who are members of the network, and prospective enrollees and prospective participating providers.

(B) NOTICE REQUIREMENT.—

(i) IN GENERAL.—The carrier may not terminate or refuse to renew an agreement with a provider to participate in the plan's provider network unless the carrier provides written notification to the provider of the carrier's decision to terminate or refuse to renew the agreement. The notification shall include a statement of the reasons for the carrier's decision, consistent with the standards established under subparagraph (A).

(ii) TIMING OF NOTIFICATION.—The carrier shall provide the notification required under clause (i) at least 60 days prior to prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of an individual enrolled with the plan.

(C) REVIEW PROCESS.—

(i) IN GENERAL.—The carrier shall provide a process under which the provider may request a review of the carrier's decision to terminate or refuse to renew the provider's participation agreement. Such review shall be conducted by a group of individuals the majority of whom are health care providers who are members of the plan's provider network or employees of the carrier, and who are members of the same profession as the provider who requests the review.

(ii) COUNSEL.—If the provider requests in advance, the carrier shall permit an attorney representing the provider to be present at the provider's review.

(iii) REVIEW ADVISORY.—The findings and conclusions of a review under this subparagraph shall be advisory and nonbinding.

(D) CONSTRUCTION.—Nothing in this paragraph shall be construed to affect any other provision of law that provides an appeals process or other form of relief to a provider of health care services.

(3) DEVELOPMENT OF MEDICAL POLICIES.—The carrier shall consult with physicians who are members of the plan's network in the development of the plan's medical policy, quality and credentialing criteria, and medical management procedures.

SEC. 5010. STANDARDS FOR MARKETING OF HEALTH BENEFIT PLANS.

(a) MARKETING RESTRICTIONS ON CARRIERS.—

(1) IN GENERAL.—Each carrier—

(A) shall file any marketing materials for insured health benefit plans it provides for approval by the applicable regulatory authority prior to distributing them within the plan's service area;

(B) may not distribute any such materials that have not been previously approved by such authority, and

(C) shall comply with such other requirements as the Secretary may impose, including requirements to assure that marketing materials do not include false or materially misleading information and other requirements designed to inappropriate marketing practices, including abusive enrollment procedures.

(2) RESTRICTION ON USE OF MARKETING MATERIALS.—All such approved marketing materials—

(A) shall be made available uniformly to all individuals eligible to enroll in plans of the carrier pursuant to section 5003, and

(B) may not be used to attract or limit enrollment of certain individuals or groups on the basis of personal characteristics or anticipated need for health services.

(3) PROHIBITION OF TIE-INS.—A carrier may not seek to influence an individual's choice to enroll in a health benefit plan in conjunction with the offering or sale of any other product. The Secretary may establish rules to carry out this paragraph.

(b) NONDISCRIMINATION IN AGENT COMPENSATION.—A carrier—

(1) may not vary or condition the compensation provided to an agent or broker related to the sale or renewal of an insured health benefit plan because of the health status or claims experience of any individuals enrolled with the carrier through the agent or broker; and

(2) may not terminate, fail to renew, or limit its contract or agreement of representation with an agent or broker for any reason related to the health status or claims experience of any individuals enrolled with the carrier through the agent or broker.

(c) CONSTRUCTION.—Nothing in this subtitle (other than subsection (b)) may be construed to permit a State (including the enrollment assistance program established in the State under section 5011(b)) or a consumer purchasing cooperative to restrict the ability of a carrier to contract with an agent or broker for the sale of an insured health plan offered by the carrier.

SEC. 5011. COLLECTION AND DISSEMINATION OF PLAN INFORMATION.

(a) PROVISION OF INFORMATION BY CARRIERS.—A carrier providing an insured health benefit plan in a State shall provide to the applicable regulatory authority information requested by the State to disseminate under this section.

(b) ENROLLMENT ASSISTANCE PROGRAM.—Each applicable regulatory mechanism in a State shall establish and operate an enrollment assistance program which—

(1) provides for enrollment assistance with respect to all insured health benefit plans offered in the community-rated market sector in the State;

(1) provides for sites that are readily available to individuals and employers eligible to seek coverage through plans in such areas and that are not controlled by any carrier (or group or association of carriers), and

(3) must be coordinated with the preparation and provision of annual information on insured health benefit plans under subsection (c).

(c) PROVIDING ANNUAL INFORMATION ON INSURED HEALTH BENEFIT PLANS.—

(1) IN GENERAL.—Each applicable regulatory authority in a State shall annually prepare and make available to consumers, in a uniform format, information on insured health benefit plans sold in the State.

(2) INFORMATION DESCRIBED.—Such information shall include summary information—

(A) for each plan, on—

(i) the premium for the plan and the 3-year rate of increase in such premium,

(ii) identity, location, qualifications and availability of providers in any provider networks of the plan, including the ratio of primary care providers to enrollees during the previous year,

(iii) the number of individuals enrolling and disenrolling from the plan in the previous year,

(iv) procedures used by the plan to control utilization of services and expenditures,

(v) procedures used by the plan to assure quality of care,

(vi) the plan's loss ratio, and

(vii) rights and responsibilities of enrollees, including rights described in title IX;

(B) in addition, for each managed care plan, on—

(i) restrictions on payment for services provided outside the plan's provider network,

(ii) the process by which services may be obtained through the plan's provider network,

(iii) coverage for out-of-area services, and

(iv) any exclusions in the types of providers participating in the plan's provider network;

(C) the means by which individuals may contact the Consumer Health Advocacy Office available for consumers in the State (as established under part O of title III of the Public Health Service Act, as added by title VII); and

(D) such other information as the Secretary may require.

(3) DISSEMINATION OF INFORMATION.—Carriers, agents, and brokers shall provide the information described in this subsection to individuals and employers seeking to purchase health coverage.

(d) DISCLOSURE OF UTILIZATION REVIEW AND QUALITY STANDARDS.—Upon the request of any individual with respect to an insured health plan offered in the State, the State shall make available information on—

(1) procedures used by the plan to control utilization of services and expenditures; and

(2) procedures used by the plan to assure quality of care.

SEC. 5012. REQUIREMENTS FOR ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.

(a) IN GENERAL.—

(1) AGREEMENTS REQUIRED.—Each carrier providing an insured health benefit plan shall, with respect to each essential community provider (as defined in subsection (c)) located within the plan's service area (except as provided in paragraph (2)), offer to enter into a written provider participation agreement (described in subsection (b)) with any such provider who is willing to accept the generally applicable terms for participation, including terms relating to the schedule of fees, covered expenses, and quality standards.

(2) EXCEPTION FOR AGREEMENTS BETWEEN CERTAIN HEALTH MAINTENANCE ORGANIZATIONS AND HOSPITALS.—Paragraph (1) shall not apply with respect to any essential community provider that is a hospital in the case of an insured health benefit plan described as follows:

(A) The plan is a managed care plan that is a dedicated group or staff model health maintenance organization (as described in section 5009(d)(1)(C)) and is treated as described in section 501(c)(3) of the Internal Revenue Code of 1986 pursuant to section 501(n)(2) of such Code.

(B) The hospitals through which the plan provides services to its enrollees are owned and operated by the plan, or owned and operated by an organization that shares common ownership and control with the plan.

(b) PARTICIPATION AGREEMENT.—A participation agreement between a carrier and an essential community provider under this subsection shall provide that the plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers with a participation agreement with the plan with respect to each of the following:

(1) The scope of items and services for which payment is made by the plan to the provider.

(2) The rate of payment for covered care and services.

(3) The applicability of financial incentives to participating providers.

(4) Limitations on financial risk provided to other participating providers.

(5) Assignment of enrollees to participating providers.

(c) ESSENTIAL COMMUNITY PROVIDERS DESCRIBED.—In this section, an "essential community provider" means any of the following:

(1) CERTAIN MEDICARE DISPROPORTIONATE SHARE HOSPITALS.—A hospital—

(A) described in section 1886(d)(5)(F)(i)(II) of the Social Security Act;

(B) described in section 1886(d)(5)(F)(iv)(I) of such Act with a disproportionate patient percentage (as defined in section 1886(d)(5)(F)(vi) of such Act) greater than 20.2; or

(C) that would be described in subparagraph (A) or (B) if—

(i) the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act), or

(ii) in the case of a hospital whose inpatients are predominantly individuals under 18 years of age, if the hospital were a subsection (d) hospital with more than 100 beds.

(2) DESIGNATED CANCER HOSPITALS.—A hospital that the Secretary has classified as a hospital involved extensively in treatment for or research on cancer, as described in section 1886(d)(1)(B)(v) of such Act.

(3) SOLE COMMUNITY HOSPITALS.—A sole community hospital (as described in section 1886(d)(5)(D)(iii) of such Act).

(4) MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—A medicare-dependent, small rural hospital (as described in section 1886(d)(5)(G)(iii) of such Act), or a hospital that would be a medicare-dependent, small rural hospital if the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act).

(5) FEDERALLY QUALIFIED HEALTH CENTERS.—A Federally qualified health center (as defined in section 1905(l)(2)(B) of such Act) or an entity that would be such a center but for its failure to meet the requirement described in section 329(f)(2)(G)(i) of the Public Health Service Act or the requirement described in section 330(e)(3)(G)(i) of such Act (relating to the composition of the entity's governing board).

(6) RURAL HEALTH CLINICS.—A rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act).

(7) FAMILY PLANNING CLINICS.—A family planning project receiving funds under title X of the Public Health Service Act (or receiving funds from a State pursuant to such title) or receiving funds under title V or XX of the Social Security Act (or receiving funds from a State pursuant to such a title).

(8) CERTAIN DIAGNOSTIC AND TREATMENT CENTERS.—A nonprofit center or clinic that is licensed under a State law in effect as of January 1, 1994, as a diagnostic and treatment center which provides primary care services (including obstetric and gynecology services) in an area—

(A) designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act, or

(B) with a significant number of individuals who are members of a medically underserved population designated by the Secretary under section 330 of such Act.

(9) LOCAL HEALTH DEPARTMENTS.—A health department of a unit of State or local government which provides health services directly to individuals.

(10) PROVIDERS SERVING UNDERSERVED AREAS.—

(A) IN GENERAL.—Any provider of health care services who meets the requirement of subparagraph (B) (if applicable) and is described as follows (in accordance with certification standards of the Secretary):

(i) The provider furnishes services not less than 20 hours per week—

(I) in an area designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act, or

(II) in an area with a significant number of individuals who are members of a medically underserved population designated by the Secretary under section 330 of such Act.

(ii) The provider—

(I) serves for at least 20 hours per week at the principal site in a neighborhood or community in which persons reside who are at risk of being medically underserved (in accordance with criteria established by the Secretary), and

(II) is available to patients evenings and weekends at the principal site.

(B) REQUIREMENT FOR PHYSICIANS.—In the case of an individual provider who is a physician, the provider must be board certified, hold hospital staff privileges, or be affiliated with one or more physicians holding hospital staff privileges.

(11) INDIAN HEALTH FACILITIES.—A health program of the Indian Health Service electing treatment as an essential community provider under section 903(c) of the Indian Health Care Improvement Act.

(12) CERTAIN PROVIDERS OF SERVICES FOR HIV.—Any public or private nonprofit entity receiving funds from a State or unit of local government pursuant to title XXVI of the Public Health Service Act that the Secretary determines provides primary care services, or any entity receiving a grant under subpart 2 of part C of such title.

(13) PROVIDER OF SCHOOL HEALTH SERVICES.—A provider of school health services that is eligible to receive funds under subtitle D of title VII, without regard to whether the provider receives such funds, but only with respect to services for which the provider may receive funding under such subtitle.

(14) NATIVE HAWAIIAN HEALTH CENTERS.—A Native Hawaiian Health Center (as defined in section 8(4) of the Native Hawaiian Health Care Act of 1988).

(15) RURAL PRIMARY CARE HOSPITAL.—A rural primary care hospital (as designated by the Secretary under section 1820(i)(2)).

(16) RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT WOMEN.—A program receiving a grant under section 508 of the Public Health Service Act.

(17) MEDICAL ASSISTANCE FACILITIES.—A facility participating in a demonstration project described in section 4008(i) of the Omnibus Budget Reconciliation Act of 1990.

(18) HEMOPHILIA TREATMENT CENTERS.—A comprehensive hemophilia diagnostic and treatment center receiving a grant under section 501(a)(2) of the Social Security Act.

(19) CERTAIN COMMUNITY CLINICS.—A community clinic organized as a nonprofit, public benefit corporation under California Health and Safety Code § 1204(a) that does not charge patients directly for services rendered.

(d) SPECIAL RULE FOR PAYMENTS TO CERTAIN ESSENTIAL COMMUNITY PROVIDERS.—In the case of services in the guaranteed national benefit package that are furnished to an enrollee of an insured health benefit plan by any Federally qualified health center (described in subsection (c)(5)) or rural health clinic (described in subsection (c)(6)), the amount of payment made to the center or clinic for such services shall be determined in accordance with the payment methodology used to determine the amount of payment to such a center for services furnished under part B of title XVIII, unless the center or clinic elects to receive payment under an alternative methodology.

(e) REQUIRING ESSENTIAL COMMUNITY PROVIDERS TO PROVIDE SERVICES TO CERTAIN INDIVIDUALS.—An individual or entity may not be treated as an essential community provider under this section unless the individual or entity—

(1) provides services to individuals without regard to their ability to pay for such services (in accordance with standards established by the Secretary); and

(2) effective January 1, 1999, is a participating provider under medicare part C.

SEC. 5013. REQUIREMENTS RELATING TO PLAN SOLVENCY.

(a) IN GENERAL.—A carrier shall comply with the following procedures and requirements in order to assure solvency of insured health benefit plans provided by the carrier:

(1) The carrier shall meet the capital requirements established by the applicable regulatory authority.

(2) The carrier shall arrange for an annual audit by an independent accountant of financial statements reporting its financial position and its financial activities with regard to its health plan business.

(3) The carrier shall arrange for an annual opinion by its appointed actuary on the reasonableness of assets held by the carrier.

(4) The carrier shall maintain separate records of finances, financial transactions, assets, and liabilities related to all business undertaken with respect to its health plan or plans.

(5) The carrier shall participate in the health plan guaranty fund established by the applicable regulatory authority.

(6) The carrier shall comply with such corrective actions, and shall cease such practices which, if not corrected, would jeopardize the financial solvency of the carrier, as the applicable regulatory authority may require.

(7) The carrier shall comply with all other solvency standards and requirements established by the Secretary.

(b) AUTHORITY OF APPLICABLE REGULATORY AUTHORITIES IN RELATION TO FINANCIAL SOLVENCY.—Each applicable regulatory authority, with respect to carriers and insured health benefit plans over which it exercises authority—

(1) may examine the financial and operating records of the carriers (and each plan of such carriers) and plans,

(2) may order a carrier to take corrective actions and to cease practices which, if not corrected, would jeopardize the financial solvency of the carrier, and

(3) shall take any actions necessary to assure the payment of claims on behalf of individuals enrolled in insured health benefit plans provided by carriers declared to be financially impaired, in a financially hazardous condition, or insolvent.

(c) RESPONSE TO CARRIER FINANCIAL INSTABILITY.—

(1) NOTIFICATION.—Upon determining that a carrier may be financially impaired, in a financially hazardous condition, or insolvent, the applicable regulatory authority of a State in which a carrier is licensed to operate shall—

(A) notify the Secretary of such determination in a timely manner; and

(B) notify the applicable regulatory authority of the State in which the carrier is domiciled (if the carrier is domiciled in a State other than the State providing the notification).

(2) PROCEEDINGS TO REHABILITATE OR LIQUIDATE INSOLVENT CARRIERS.—Upon receiving a notification under paragraph (1)(B) (if applicable), the applicable regulatory authority of the State in which the carrier is domiciled shall take the carrier into conservatorship and begin proceedings to rehabilitate or liquidate the carrier in accordance with State law.

(3) PROTECTIONS FOR ENROLLEES.—In the case of an insured health benefit plan in a State for which the applicable regulatory authority in the State has made a determination that the carrier offering the plan may be financially impaired, in a financially hazardous condition, or insolvent—

(A) a provider of items and services covered under the plan may not charge or collect payment for such an item or service furnished to an individual enrolled in the plan (other than any cost-sharing otherwise applicable with respect to the item or service); and

(B) a provider of items and services covered under the plan shall continue to provide such items and services to individuals enrolled in the plan until such individuals are no longer enrolled in the plan.

(d) STATE HEALTH PLAN GUARANTY FUND.—Each State shall assure that there is a health plan guaranty fund in operation in the State that meets requirements established by the Secretary in order to provide for the payment of outstanding provider claims and obligations of an insured health benefit plan offered by a carrier determined to be financially impaired, in a financially hazardous condition, or insolvent by the applicable regulatory authority in the State.

SEC. 5014. UTILIZATION REVIEW.

(a) REQUIRING REVIEW TO MEET STANDARDS.—A carrier offering an insured health benefit plan may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets the standards established by the Secretary under this section.

(b) ESTABLISHMENT OF STANDARDS BY SECRETARY.—The Secretary shall establish standards for utilization review programs of insured health benefit plans, consistent with subsection (c), and shall periodically review and update such standards to reflect changes in the delivery of health care services. The Secretary shall establish such standards in consultation with appropriate parties.

(c) REQUIREMENTS FOR STANDARDS.—Under the standards established under subsection (b)—

(1) individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage;

(2) negative determinations of the medical necessity or appropriateness of services or the site at which services are furnished may be made only by clinically qualified personnel;

(3) the utilization review program shall provide for a process under which an enrollee or provider may obtain timely review of a denial of coverage;

(4) utilization review shall be conducted in accordance with uniformly applied standards that are based on the most currently available medical evidence;

(5) providers shall participate in the development of the utilization review program;

(6) the timing of the utilization review and the information required to be reviewed shall be commensurate with the medical need of the individual for whom the service is to be furnished; and