purposes of determining the amount of an employer contribution under subparagraph (A), the following rules shall apply:

(i) FAMILY CONTRIBUTIONS.—If an employer makes a contribution on behalf of a family (rather than any particular individual) such contribution shall be allocated ratably among the individuals in the family.

(ii) GREATEST EMPLOYER CONTRIBUTION AVAILABLE.—The employer contribution with respect to any individual is the largest employer contribution offered to be made on behalf of the individual by the individual's employer or any employer of any member of the individual's family.

(2) SUBSIDY PERCENTAGE.—For purposes of paragraph (1)(A), the term 'subsidy percentage' means the following:

(A) INDIVIDUALS WITH INCOMES BELOW CERTAIN INCOME THRESHOLD.—

(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), for a premium subsidy eligible individual described in subsection (a)(2)(A), 100 percent reduced

(but not below zero) by .80 percentage points for each 1 percentage point (or portion thereof) by which such individual's family income exceeds 75 percent of the poverty line.

(ii) AFDC RECIPIENTS.—For a premium subsidy eligible individual described in subsection (a)(2)(A) who—

(I) is a member of a family receiving aid to families with dependent children under part A or E of title IV of the Social Security Act, the subsidy percentage shall be 100 percent; or

[(II) is a member of a family that became ineligible for such aid due to earned income attributable to the family, the subsidy percentage shall be 100 percent for the 2-year period beginning on the date the family became ineligible for such aid.]

(iii) NON-CASH MEDICAID ELIGIBLES.—

(I) IN GENERAL.—For a premium subsidy eligible individual described in subsection (a)(2)(A) who is

a non-cash medicaid eligible described in subclause (II), the subsidy percentage shall be 100 percent during the 6-month period beginning on January 1, 1997.

(II) NON-CASH MEDICAID ELIGIBLE.—The non-cash medicaid eligibles described in this subclause are individuals receiving medical assistance under the State plan under title XIX of the Social Security Act as of December 31, 1996, who are not individuals—

(aa) who are members of a family receiving aid to families with dependent children under part A or E of title IV of the Social Security Act;

(bb) with respect to whom supplemental security income benefits are being paid under title XVI of such Act; or

(cc) eligible for benefits under part A of title XVIII of such Act.

(B) CHILDREN AND PREGNANT WOMEN.—For a premium subsidy eligible individual described in subparagraph (B) or (C) of subsection (a)(2), 100 percent reduced (but not below zero) by 1.82 percentage points for each 1 percentage point (or portion thereof) by which such individuals family income exceeds 185 percent of the poverty line.

(c) PAYMENTS.—

(1) IN GENERAL.—The amount of the premium assistance available to a premium subsidy eligible individual under subsection (b) shall be paid by the State in which the individual resides directly to the standard health plan in which the individual is enrolled. Payments under the preceding sentence shall commence in the first month during which the individual is enrolled in a certified standard health plan and determined under section 6003 to be a premium subsidy eligible individual.

(2) SPECIAL RULE WITH RESPECT TO FAMILIES WITH MULTIPLE CHILDREN.—If a family includes more than 1 child described in subsection (a)(2)(B), no premium assistance may be paid to a plan under paragraph (1) on behalf of any such child unless such assistance is paid on behalf of all such children.

(3) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium assistance paid based on an eligibility determination error to the extent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

**SEC. 6003. ELIGIBILITY DETERMINATIONS.**

(a) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State programs under this subtitle with respect to determining eligibility for premium assistance.

(b) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under subsection (a) shall include the following requirements:

(1) FREQUENCY OF APPLICATIONS.—A State program shall provide that an individual may file an application for assistance with an agency designated by the State at any time, in person or by mail.

(2) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under subsection (c).

(3) DISTRIBUTION OF APPLICATIONS.—A State program shall make applications accessible at locations where individuals are most likely to obtain the applications.

(4) REQUIREMENT TO SUBMIT REVISED APPLICATION.—A State program shall require individuals to submit revised applications to reflect changes in estimated family incomes, including changes in employment status of family members, during the year. The State shall revise the amount of any premium assistance based on such a revised application.

(5) VERIFICATION.—A State program shall provide for verification of the information supplied in applications under this subtitle. Such verification may include examining return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

(c) ADMINISTRATION OF STATE PROGRAMS.—

(1) IN GENERAL.—The Secretary shall establish standards for States operating programs under this subtitle which ensure that such programs are operated in a uniform manner with respect to application procedures, data processing systems, and such other administrative activities as the Secretary determines to be necessary.

(2) APPLICATION FORMS.—The Secretary shall develop an application form for assistance which shall—

(A) be simple in form and understandable to the average individual;

(B) require the provision of information necessary to make a determination as to whether an individual is a premium subsidy eligible individual including a declaration of estimated income by the individual based, at the election of the individual—

(i) on multiplying by a factor of 4 the individual's family income for the 3-month period immediately preceding the month in which the application is made, or

(ii) on estimated income for the entire year for which the application is submitted; and

(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

(3) OUTREACH ACTIVITIES.—A State operating a program under this subtitle shall conduct such outreach activities as the Secretary determines appropriate in order to provide maximum opportunities for individuals to apply for and receive premium assistance under this subtitle.

(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM SUBSIDIES.—A determination by a State that an individual is a premium subsidy eligible individual shall be effective for the calendar year for which such determination is made unless a revised application submitted under subsection (b)(4) indicates that an individual is no longer eligible for premium assistance.

(e) PENALTIES FOR MATERIAL MISREPRESENTATIONS.—

(1) IN GENERAL.—Any individual who knowingly makes a material misrepresentation of information in an application for assistance under this subtitle shall be liable to the Federal Government for the amount any premium assistance received by individual on the basis of a misrepresentation and interest on such amount at a rate specified by the Secretary, and, shall, in addition, be liable to the Federal Government for $2,000 or, if greater, 3 times the amount any premium assistance received by individual on the basis of a misrepresentation.

(2) COLLECTION OF PENALTY AMOUNTS.—A State which receives an application for assistance with respect to which a material misrepresentation has been made shall collect the penalty amount re-

quired under paragraph (1) and submit such amount to the Secretary in a timely manner.

**SEC. 6004. END-OF-YEAR RECONCILIATION FOR PREMIUM ASSISTANCE.**

(a) IN GENERAL.—

(1) REQUIREMENT TO FILE STATEMENT.—An individual who received premium assistance under this subtitle from a State for any month in a calendar year shall file with the State an income reconciliation statement to verify the individual's family income for the year. Such a statement shall be filed at such time, and contain such information, as the State may specify in accordance with regulations promulgated by the Secretary.

(2) NOTICE OF REQUIREMENT.—A State shall provide a written notice of the requirement under paragraph (1) at the end of the year to an individual who received premium assistance under this subtitle from such State in any month during the year.

(b) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—

(1) IN GENERAL.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to an individual, the State shall compute the amount of premium as-

sistance that should have been provided under this subtitle with respect to the individual for the year involved.

(2) OVERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was greater than the amount computed under paragraph (1), the individual is liable to the State to pay an amount equal to the amount of the excess payment. Any amount collected by a State under this paragraph shall be submitted to the Secretary in a timely manner.

(3) UNDERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was less than the amount computed under paragraph (1), the State shall pay to the individual an amount equal to the amount of the deficit.

(4) STATE OPTION.—A State may, in accordance with regulations promulgated by the Secretary, establish a procedure under which any overpayments or underpayments of premium assistance determined under paragraphs (2) and (3) with respect to an individual for a year may be collected or paid, as appropriate, through adjustments to the premium assistance furnished to such individual in the succeeding year.

(c) VERIFICATION.—Each State may use such information as it has available to verify income of individuals with applications filed under this subtitle, including return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

(d) PENALTIES FOR FAILURE TO FILE.—In the case of an individual who is required to file a statement under this section in a year who fails to file such a statement, the entire amount of the premium assistance provided in such year shall be considered an excess amount under subsection (b)(2) and such individual shall not be eligible for premium assistance under this subtitle until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the individual establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

(e) PENALTIES FOR FALSE INFORMATION.—Any individual who provides false information in a statement filed under subsection (a) is subject to the same penalties as are provided under section 6003(e) for a misrepresentation of material fact described in such section.

**SEC. 6005. STATE PROGRAM FOR PRESUMPTIVE ELIGIBILITY.**

(a) IN GENERAL.—The Secretary shall promulgate regulations under which each State operating a program for premium assistance under this subtitle shall have in effect a system under which individuals may be determined presumptively eligible for such assistance by health care providers who furnish services to such individuals.

(b) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under subsection (a) shall include the following requirements:

(1) APPLICATION FOR ASSISTANCE.—Each State shall develop and make available to health care providers in the State a simple form for individuals who receive services from such providers to apply for premium assistance. Such form shall provide for a simple declaration of eligibility for premium assistance under this subtitle and shall permit an individual to enroll in a community-rated standard health plan offered in the community rating area in which the individual resides.

(2) SUBMISSION OF COMPLETED APPLICATION.—If a health care provider receives an application for presumptive eligibility under this section the provider shall submit the application to the State agency administering the premium assistance pro-

gram under this subtitle in a timely manner. If the State agency receives an application for presumptive eligibility and the individual who completed such application has failed to select a community-rated standard health plan offered in the community rating area in which the individual resides, the State agency shall select such a plan for the individual.

(3) EFFECTIVE DATE OF ENROLLMENT.—An individual who enrolls in a community-rated standard health plan in accordance with the presumptive eligibility system established under this section shall be an enrollee of the plan as of the date the individual submits an application to a health care provider.

(4) PERIOD OF PRESUMPTIVE ELIGIBILITY.—An individual who submits an application to a health care provider under a presumptive eligibility system under this section shall be presumptively eligible for premium assistance under this subtitle for the period beginning on the date such application is submitted and ending 60 days after such date.

(5) NO RECONCILIATION REQUIRED.—The reconciliation provisions of section 6004 shall not apply to any premium assistance paid on behalf of an individual during a period of presumptive eligibility.

(6) REQUIREMENT ON STATES.—During a period of presumptive eligibility, an individual shall be given an opportunity by a State to apply for continuing eligibility for premium assistance under this subtitle.

**SEC. 6006. PAYMENTS TO STATES.**

(a) IN GENERAL.—A State operating a program for furnishing premium assistance under this subtitle shall be entitled to receive payments in an amount equal to the amount expended by the State to operate the program, including the amount of premium assistance paid on behalf of premium subsidy eligible individuals. Such payments shall be made at such time and in such form as provided in regulations promulgated by the Secretary.

(b) STATE ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide payments to States operating programs under this subtitle in accordance with this section.

(c) AUDITS.—The Secretary shall conduct regular audits of the activities under the State programs conducted under this subtitle.

**SEC. 6007. DEFINITIONS AND DETERMINATIONS OF INCOME.**

For purposes of this subtitle:

[(1) STANDARD HEALTH PLAN.—The term "standard health plan" means a health plan (as defined in section ____) providing the standard benefits package as described in section ____.]

(2) CHILD.—The term "child" means an individual who is under 19 years of age.

(3) DETERMINATIONS OF INCOME.—

(A) FAMILY INCOME.—The term "family income" means, with respect to an individual who—

"(i) is not a dependent (as defined in subparagraph (B)) of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (D)) for the individual, the individual's spouse, and children who are dependents of the individual; or

(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes for the other individual, the other individual's spouse, and children who are dependents of the other individual.

(B) DEPENDENT.—The term "dependent" shall have the meaning given such term under

section 152 of the Internal Revenue Code of 1986.

(C) SPECIAL RULE FOR FOSTER CHILDREN.—For purposes of subparagraph (A), a child who is placed in foster care by a State agency under part E of title IV of the Social Security Act shall not be considered a dependent of another individual.

(D) MODIFIED ADJUSTED GROSS INCOME.—The term "modified adjusted gross income" means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

(i) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code, and

(ii) increased by—

(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax,

(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during the taxable year to the extent not in-

cluded in gross income under section 86 of such Code, and

(III) the amount of aid to families with dependent children received during the taxable year under part A of title IV of the Social Security Act to the extent not included in gross income under such Code.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

[(E) SPECIAL RULE FOR INDIVIDUALS TEMPORARILY UNEMPLOYED.—

(i) IN GENERAL.—Notwithstanding subparagraph (A), for purposes of determining eligibility for premium assistance under this subtitle in the case of any individual whose enrollment in a health plan terminates because the individual becomes unemployed or because a member of the individual's family becomes unemployed, the family income of such individual shall—

(I) for each month before and after the period of unemployment, be

reduced by an amount equal to 75 percent of the poverty line (determined on a monthly basis); and

(II) for each month after the date the individual becomes unemployed, by an amount equal to any unemployment compensation under an unemployment compensation law of a State or of the United States received by or on behalf of the unemployed individual.

(ii) LIMITATION.—Clause (i) shall no longer apply to an individual on the earlier of—

(I) the date on which the individual is able to enroll in health plan due to the individual's employment or the employment of a member of the individual's family; or

(II) the end of the 6-month period beginning on the first day of the first month during which the individual receives premium assistance under this subtitle that would not be avail-

able to such individual if the provisions of clause (i) did not apply.]

(4) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term "eligible individual" means an individual who is residing in the United States and who is—

(i) a citizen or national of the United States; or

(ii) an alien permanently residing in the United States under color of law (as defined in subparagraph (C)).

(B) EXCLUSION.—The term "eligible individual" shall not include an individual who is an inmate of a public institution (except as a patient of a medical institution).

(C) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term "alien permanently residing in the United States under color of law" means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

(i) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(ii) An alien who is granted asylum under section 208 of such Act.

(iii) An alien whose deportation is withheld under section 243(h) of such Act.

(iv) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(v) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

(vi) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(5) POVERTY LINE.—The term "poverty line" means, for a family for a year, the official poverty

line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(6) PREGNANT WOMAN.—

(A) IN GENERAL.—The term "pregnant woman" includes a woman deemed to be a pregnant woman under subparagraph (B).

(B) PERIOD AFTER TERMINATION OF PREGNANCY.—For purposes of this subtitle, a woman shall be deemed to be a pregnant woman during the period beginning on the date of the termination of the pregnancy and ending on the first day of the first month that begins more than 90 days after such date.

## Subtitle B—Individual Cost-Sharing Assistance

**[Need specifications.]**

## Subtitle C—Employer Subsidies

**SEC. 6201. PURPOSE.**

It is the purpose of this subtitle to provide subsidies to eligible employers to assist such employers in providing, or expanding the provision of, health care coverage for the employees of such employers.

**SEC. 6202. ELIGIBLE EMPLOYERS.**

(a) IN GENERAL.—To be eligible for a subsidy under this subtitle an employer shall—

(1) comply with the requirements of part 1 of subtitle D of title I;

(2) contribute to the cost of health care coverage for all employees of the same class (limited to full- or part-time) employed by the employer;

(3) contribute not less than 50 percent of the cost of health care coverage for each class of family enrollment for each employee so covered;

(4) prepare and submit to the Secretary of Labor an application, at such time, in such manner and containing such information as the Secretary may require.

[(b) APPLICATION OF REQUIREMENTS.—

(1) IN GENERAL.—The requirements of paragraphs (2) and (3) of subsection (a) shall only apply with respect to the employees described in paragraph (2).

(2) COVERAGE OF EMPLOYEES.—The employees described in this paragraph are those employees—

(A) for which the employer is contributing to the costs of health care coverage; and

(B) for which the employer did not make such a contribution prior to the date of enactment of this Act.]

(c) SOLE PROPRIETORSHIPS.—A sole proprietorship with not less than 3 full-time employees (including the sole proprietor) shall be eligible for a subsidy under this subtitle if such proprietorship reports the payment of wages (as defined in the Internal Revenue Code of 1986), in the year prior to the year for which the subsidy is applied for, in an amount required under regulations promulgated by the Secretary of Labor.

(d) INELIGIBILITY.—

(1) SELF-EMPLOYED.—A self-employed individual (as such term is defined in section 1011(c)) shall not be eligible for a subsidy under this subtitle.

(2) EMPLOYEE LEASING FIRMS.—An employer that is an employee leasing firm shall not be eligible for a subsidy under this subtitle. The Secretary of Labor shall promulgate regulations defining the term "employee leasing firm".

(3) STATE OF LOCAL GOVERNMENTS.—An employer that is a State or local government shall not be eligible for a subsidy under this section.

**SEC. 6203. EMPLOYER CERTIFICATION.**

(a) REQUIREMENT.—An employer that submits an application under section 6202(a)(4) shall certify that such employer, prior to the date of enactment of this Act, did not contribute to the costs of health care coverage for the employees for which the employer is applying for the subsidy.

(b) CONTRIBUTION LIMIT.—For purposes of subsection (a), an employer shall be treated as having contributed to the health care coverage of an employee if the amount of such contribution is $500 or more (as annualized).

(c) UNION SICKNESS FUNDS.—For purposes of this subtitle, employers that contribute to union sickness funds on behalf of their employees shall be deemed to have contributed to the costs of health care coverage for the employees of such employer.

(d) REGULATIONS.—For purposes of this section, the Secretary of Labor shall promulgate regulations to enable an employer to determine whether and to what extent an employer contributed to the costs of an employee's health care coverage prior to the date of enactment of this Act. An employer shall utilize such regulations in submitting a certification under this section.

**SEC. 6204. AMOUNT OF SUBSIDY.**

(a) IN GENERAL.—An employer for which an application has been approved by the Secretary of Labor under this subtitle shall receive a subsidy (to be paid over a 5-year period) in an amount that equals—

(1) with respect to the first 3 years after the date of enactment of this Act—

(A) 50 percent of the lesser of—

(i)(I) the reference premium (as defined in section 6002(b)(1)(C)) with respect to the employees for which the subsidy is applied for (for the year involved); or

(II) the weighted average premium rate (as defined in section 6002(b)(1)(C)) for the purchasing cooperative through which the employer has contributed to the employee's health care coverage (for the year involved); or

(ii) in the case of an experience-rated employer, the premium of the experience-rated plan (for the year involved); less

(B) 8 percent of the wages of the employees for which the employer is applying for the subsidy (for the year involved);

(2) with respect to the fourth year after the date of enactment of this Act—

(A) 37.5 percent of the lesser of the amounts referred to in subparagraph (A) of paragraph (1) (for the year involved); less

(B) 8 percent of the wages of the employees for which the employer is applying for the subsidy (for the year involved); and

(3) with respect to the fifth year after the date of enactment of this Act—

(A) 25 percent of the lesser of the amounts referred to in subparagraph (A) of paragraph (1) (for the year involved); less

(B) 8 percent of the wages of the employees for which the employer is applying for the subsidy (for the year involved).

(b) LIMITATIONS.—

(1) AMOUNT OF CONTRIBUTION.—If, in applying the formula under subsection (a), the Secretary of Labor determines that an employer's contributions to the health care coverage costs of its employees exceeds 50 percent of the weighted average premium rate for the purchasing cooperative through which the employer has so contributed (for the year involved), the Secretary shall notify such employer

that such employer is not eligible for a subsidy under this subtitle.

(2) PART-TIME EMPLOYEES.—With respect to subsidies for health care coverage for part-time employee, the Secretary of Labor shall develop a formula for the pro-rata reduction in such subsidies based on the formula described in subsection (a) and the hours of work performed by the employee.

(3) SINGLE SUBSIDY.—An employer shall not be eligible to receive more than one subsidy under this section. The Secretary of Labor shall promulgate regulations to ensure that no employer will receive a second or subsequent subsidy under this subtitle regardless of whether such employer had previously received the previous subsidy as an employer in a capacity different from that of the employer's present capacity.

**SEC. 6205. DEFINITION.**

For purposes of this Act, an employee who is employed by an employer—

(1) for at least 120 hours in a month shall be deemed to be employed on a full-time basis with respect to that month, or

(2) for at least 40 hours, but less than 120 hours, in a month shall be deemed to be employed on a part-time basis.

**SEC. ___. HIGH COST HEALTH PLAN ASSESSMENT.**

(a) IN GENERAL.—Subchapter A of chapter 37 (relating to assessments on insured and self-insured health benefits), as added by section ____, is amended by adding at the end the following new part:

## "PART II—HIGH COST HEALTH PLANS



## "Subpart A—Community-Rated Plans



**"SEC. 4511. COMMUNITY-RATED PLANS.**

"(a) IMPOSITION OF TAX.—

"(1) IN GENERAL.—If a community-rated standard health plan is a high cost plan for any coverage period beginning after December 31, 1996, there is hereby imposed a tax equal to 35 percent of the excess premiums of the plan for the period.

"(2) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the issuer of the high cost plan.

"(b) HIGH COST PLAN.—For purposes of this section—

"(1) IN GENERAL.—A plan is a high cost plan for any coverage period if—

"(A) it is operating within a noncompetitive community rating area, and

"(B) it has excess premiums for the period.

"(2) NONCOMPETITIVE COMMUNITY RATING AREA.—A community rating area is a noncompetitive community rating area for any coverage period if, for the preceding coverage period—

"(A) the average premium per primary insured for all standard health plans in the area, exceeded

"(B) the weighted average reference premium for all classes of enrollment.

"(c) EXCESS PREMIUMS.—For purposes of this section—

"(1) IN GENERAL.—The term 'excess premiums' means the excess (if any) of—

"(A) the premiums received under the plan during the coverage period, over

"(B) the sum of the amounts determined under paragraph (2) with respect to each class of enrollment.

"(2) EXCESS PREMIUM BASELINE.—

"(A) IN GENERAL.—The amount determined under this paragraph for any class of en-

rollment for any coverage period is an amount equal to the product of the reference premium for such class and the number of primary insureds in such class for the period.

"(B) PROPORTIONATE REDUCTION OF REFERENCE PREMIUM.—The reference premium applicable under subparagraph (A) to an individual who was a primary insured for only a portion of the coverage period shall be proportionately reduced to reflect the period the individual was not a primary insured.

"(3) DISREGARD OF AGE ADJUSTMENT.—The amount determined under paragraph (1)(A) shall be adjusted to reflect the premiums which would have been received if no age adjustment were permitted under section 1116 of the Health Security Act.

"(d) COVERAGE PERIOD.—For purposes of this subpart, the term 'coverage period' means, with respect to any community-rating area, the period for which an individual is covered under a standard health plan if the individual enrolls in the plan during the annual open enrollment period for the area under section 1503 of the Health Security Act.

"(e) PLANS COVERING MORE THAN ONE AREA.—For purposes of this subpart, if a community-rated plan

covers individuals residing in more than 1 community-rating area, the individuals in each such area shall be treated as covered by a separate plan.

**"SEC. 4512. REFERENCE PREMIUMS.**

"(a) ESTABLISHMENT OF REFERENCE PREMIUMS.—For purposes of this subpart—

"(1) IN GENERAL.—The Secretary shall, in consultation with the Secretary of Health and Human Services, establish for each coverage period a reference premium for each class of enrollment for community-rated plans within a community rating area. The Secretary shall publish such reference premiums within a reasonable period of time before the annual open enrollment period for the coverage period.

"(2) METHOD OF DETERMINING REFERENCE PREMIUM.—Each reference premium for a class of enrollment for any coverage period shall be the reference premium in effect for such class for the preceding coverage period—

"(A) increased by the target growth rate for the coverage period as provided under subsection (b)(1), and

"(B) adjusted to reflect—

"(i) material changes in the characteristics of community-rated individuals as provided under subsection (b)(2), and

"(ii) changes in the actuarial value of the standard benefits package as provided under subsection (b)(3).

"(b) ANNUAL ADJUSTMENTS TO REFERENCE PREMIUMS.—For purposes of subsection (a)(2)—

"(1) TARGET GROWTH RATE.—The target growth rate for any coverage period is the percentage increase in the Consumer Price Index (as defined in section 1(f)(4)) which the Secretary estimates will occur during the coverage period—

"(A) increased by 2 percentage points (3 and 2.5 percentage points in the case of periods beginning in 1997 and 1998, respectively), and

"(B) increased or decreased by the amount the estimate under this paragraph was incorrect for the preceding coverage period.

"(2) MATERIAL CHANGES.—

"(A) IN GENERAL.—The Secretary shall, pursuant to such method as the Secretary may prescribe, adjust the reference premium to reflect changes in the demographic characteristics (including at least age, gender, and socio-

economic status) and health status of community-rated individuals in the community rating area which are materially different when compared to the average changes in such characteristics and status in the United States.

[“(B) EFFECT ON WEIGHTED AVERAGE.—Any adjustments under subparagraph (A) for any coverage period shall not result in a change in the weighted average of such factors which is taken into account in computing the reference premium.]

“(3) CHANGES IN BENEFIT PACKAGE.—If the actuarial value of the standard benefits package is changed pursuant to subtitle C of title I of the Health Security Act, the Secretary shall adjust the reference premiums to appropriately reflect such change.

“(c) COMPUTATION OF REFERENCE PREMIUM FOR 1996.—

“(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, shall compute the reference premium for each class of enrollment for 1996. Each such reference premium shall be the reference premium which is adjusted under subsection (a)(2) in determining the

reference premium for coverage periods beginning in 1997.

"(2) METHOD OF DETERMINING REFERENCE PREMIUMS.—Each reference premium under paragraph (1) shall be equal to the national average per capita current coverage health expenditures for 1994 (determined under subsection (d))—

"(A) increased as provided in paragraph (3),

"(B) adjusted to reflect the differences in the community rating area as provided in paragraph (4), and

"(C) modified to reflect the class of enrollment for which it is being determined.

"(3) UPDATING FOR 1995 AND 1996.—The Secretary shall update the national average per capita current coverage health expenditures for 1994 to reflect the annual percentage increases for calendar years 1995 and 1996 in private sector health care spending for items and services included in the standard benefits package. Such increase shall not exceed the current projected increase in such spending for such years contained in _____ _____.

"(4) AREA ADJUSTMENTS.—

"(A) IN GENERAL.—The Secretary shall, using information of the type described in subparagraph (B), establish an adjustment for each community rating area which takes into account the differences among community rating areas, including variations in health care expenditures, in rates of uninsurance and underinsurance, and in the proportion of expenditures for services provided by academic health centers.

"(B) TYPE OF INFORMATION.—The type of information described in this subparagraph is—

"(i) information on variations in premiums across States and across community rating areas within a State (based on surveys and other data);

"(ii) information on variations in per capita health spending by State, as measured by the Secretary;

"(iii) information on variations across States in per capita spending under the medicare program and in such spending among community rating areas within a State under such program; and

"(iv) area rating factors commonly used by actuaries.

"(C) CONSULTATION PROCESS.—The Secretary shall consult with representatives of States and community rating areas before establishing the adjustment under this subsection.

"(D) TREATMENT OF CERTAIN STATES.—

"(i) NONPARTICIPATING STATES.—In the case of a State that is not a participating State or otherwise has not established community rating areas, the entire State shall be treated as a single community rating area.

"(ii) CHANGES IN BOUNDARIES.—In the case of a State that changes the boundaries of its community rating areas, the Secretary shall provide a method for computing reference premiums for each area affected by such change in a manner that—

"(I) reflects the factors taken into account in establishing the adjustment factors under subparagraph (A), and

"(II) results in the weighted average of the newly computed reference premiums for the areas affected by the change being equal to the weighted average of the reference premiums for the areas as previously established.

"(d) DETERMINATION OF NATIONAL AVERAGE PER CAPITA CURRENT COVERAGE HEALTH EXPENDITURES.—

"(1) IN GENERAL.—The national average per capita current coverage health expenditures are equal to—

"(A) total amount of covered current health care expenditures described in paragraph (2), divided by

"(B) the estimated population in the United States of community-rated individuals as of 1994 (as determined under paragraph (4)) for whom such expenditures were determined.

The population under subparagraph (B) shall not include SSI recipients or AFDC recipients.

"(2) COVERED CURRENT HEALTH CARE EXPENDITURES.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'covered current health care expenditures' means the amount of total pay-

ments made in the United States during 1994 (determined without regard to cost sharing) for items and services included in the standard benefits package.

"(B) REMOVAL OF CERTAIN EXPENDITURES NOT TO BE COVERED.—The amount determined under subparagraph (A) shall be decreased by the proportion of such amount that is attributable to any of the following:

"(i) Medicare beneficiaries.

"(ii) AFDC recipients or SSI recipients.

"(iii) Expenditures which are paid for through workers' compensation or automobile or other liability insurance.

"(iv) Expenditures by parties (including the Federal Government) that the Secretary determines will not be payable by community-rated plans for coverage of the standard benefits package.

"(C) ADDITION OF PROJECTED EXPENDITURES FOR UNINSURED AND UNDERINSURED INDIVIDUALS.—The amount determined under subparagraph (A) (as adjusted under subparagraph (B)) shall be increased to take into ac-

count increased utilization of, and expenditures for, items and services covered under the standard benefits package likely to occur, as a result of coverage under a community-rated plan of individuals who, as of 1994, were uninsured or underinsured with respect to the standard benefits package. In making such determination, such expenditures shall be based on the estimated average cost for such services in 1994 (and not on private payment rates established for such services). In making such determination, the estimated amount of uncompensated care in 1994 shall be removed and will not include adjustments to offset payments below costs by public programs.

"(D) ADDITION OF HEALTH PLAN AND ALLIANCE COSTS OF ADMINISTRATION.—The amount determined under subparagraph (A) (as adjusted under the preceding subparagraphs) shall be increased by an estimated percentage (determined by the Secretary, but no more than 15 percent) that reflects the proportion of premiums that are required for administration [(including for administration of income-related premium discounts and cost-sharing reduc-

tions)] and for State premium taxes (which taxes shall be limited to such amounts in 1994 as are attributable to the health benefits to be included in the standard benefits package).

"(E) DECREASE FOR COST SHARING.—The amount determined under subparagraph (A) (as adjusted under the preceding subparagraphs) shall be decreased by a percentage that reflects (i) the estimated average percentage of total amounts payable for items and services covered under the standard benefits package that will be payments in the form of cost sharing under a high deductible plan, and (ii) the percentage reduction in utilization estimated to result from the application of such cost sharing.

"(3) SPECIAL RULES.—

"(A) BENEFITS USED.—The determinations under this subsection shall be based on the standard benefits package as in effect in 1996.

"(B) ASSUMING NO CHANGE IN EXPENDITURE PATTERN.—The determination under paragraph (2) shall be made without regard to any change in the pattern of expenditures that may result from the enrollment of AFDC recipi-

ents and SSI recipients in community-rated plans.

"(4) ELIGIBLE INDIVIDUALS.—The determination of individuals who are community-rated individuals under this subsection shall be made as though the Health Security Act was fully in effect in each State as of 1994.

**"Subpart B—Experience-Rated Plans**

"Sec. 4515. Experience-rated plans.

**"SEC. 4515. EXPERIENCE-RATED PLANS.**

"(a) IMPOSITION OF TAX.—

"(1) IN GENERAL.—In the case of any calendar year beginning after December 31, 1999, there is hereby imposed a tax equal to 25 percent of the excess premium equivalents of an experience-rated standard health plan.

"(2) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the plan sponsor.

"(b) EXCESS PREMIUM EQUIVALENTS.—For purposes of this section—

"(1) IN GENERAL.—The term 'excess premium equivalents' means the excess (if any) of—

"(A) the premium equivalents of the plan for the calendar year, over

"(B) the product of the reference premium and the number of primary insureds covered by the plan during the calendar year.

"(2) PROPORTIONATE REDUCTION IN REFERENCE PREMIUM.—The reference premium applicable under paragraph (1)(B) to a primary insured covered under the plan for only a portion of the calendar year shall be proportionately reduced to reflect the period the individual was not a primary insured.

"(c) REFERENCE PREMIUM.—For purposes of this section—

"(1) IN GENERAL.—The reference premium for any plan for any calendar year shall be the reference premium in effect for the preceding calendar year—

"(A) increased by the target growth rate for the calendar year as provided under paragraph (2), and

"(B) adjusted to reflect—

"(i) material changes in the characteristics of individuals covered by the plan as provided under paragraph (3), and

"(ii) changes in the actuarial value of the standard benefits package as provided under paragraph (4).

"(2) TARGET GROWTH RATE.—The target growth rate for any calendar year is the percentage increase in the Consumer Price Index (as defined in section 1(f)(4)) which the Secretary estimates will occur during the calendar year—

"(A) increased by 2 percentage points, and

"(B) increased or decreased by the amount the estimate under this paragraph was incorrect for the preceding calendar year.

"(3) MATERIAL CHANGES.—The Secretary shall establish such method as the Secretary determines appropriate for adjusting the reference premium for any plan to reflect changes in the demographic characteristics (including at least age, gender, and socioeconomic status) and health status of individuals in the plan which are materially different when compared to the average changes in such characteristics and status in the United States.

"(4) CHANGES IN BENEFIT PACKAGE.—If the actuarial value of the standard benefits package is changed pursuant to subtitle C of title I of the Health Security Act, the Secretary shall adjust the reference premiums to appropriately reflect such change.

"(d) REFERENCE PREMIUM FOR 1999.—

"(1) IN GENERAL.—The reference premium for calendar year 1999 shall be equal to the average of the per capita premium equivalents for calendar years 1997, 1998, and 1999. Such reference premium shall be the reference premium which is adjusted under subsection (c) for determining the reference premium for calendar year 2000.

"(2) PER CAPITA PREMIUM EQUIVALENTS.—

"(A) IN GENERAL.—The per capita premium equivalent for any calendar year shall be equal to the premium equivalent for providing the standard benefits package to each primary insured.

"(B) GROWTH FACTORS.—The amount determined under subparagraph (A)—

"(i) for calendar year 1997 shall be increased by the target growth rates for calendar years 1998 and 1999, and

"(ii) for calendar year 1998 shall be increased by the target growth rate for calendar year 1999.

For purposes of this subparagraph, the target growth rate for calendar year 1998 shall be determined by substituting '2.5' for '2' in subsection (c)(2)(A).

"(e) PREMIUM EQUIVALENTS.—For purposes of this section—

"(1) IN GENERAL.—The term 'premium equivalents' means, with respect to any calendar year, the sum of—

"(A) expenditures described in subsections (d) and (e) of section 4502 with respect to coverage under the plan, and

"(B) in the case of any coverage provided through an insurance policy, premiums paid for such coverage.

"(2) EXCLUSION OF NONSTANDARD COVERAGE.—The premium equivalents for any calendar year shall not include amounts with respect to—

"(A) any coverage other than coverage for the standard benefits package, or

"(B) any cost-sharing coverage.

"(3) RISK ADJUSTMENT PAYMENTS.—The premium equivalents for any calendar year shall include payments under any risk adjustment program established under title I of the Health Security Act.

"(f) SPECIAL RULES.—For purposes of this section—

"(1) AGGREGATION RULES.—

"(A) PLANS.—All plans maintained by the same plan sponsor shall be treated as 1 plan.

"(B) SPONSORS.—All plan sponsors which are treated as a single employer under subsection (b) or (c) of section 414 shall be treated as 1 plan sponsor.

"(2) STARTUP PLANS.—If a plan sponsor first begins operation of an experience-rated plan after 1997, the reference premium for the first calendar year for which the plan is in operation and to which this section applies shall, under regulations prescribed by the Secretary, be determined as if the reference premium for the preceding calendar year were equal to the average of the average reference premium for all experience-rated plans in the areas in which the plan is operating for each of the 3 preceding calendar years.

"(3) ACQUISITIONS AND DISPOSITIONS.—The Secretary shall prescribe regulations for the determination of a reference premium after an acquisition or disposition described in section 41(f)(3) involving the plan sponsor of an experience-rated plan.

"(4) INFORMATION.—The Secretary may require a plan sponsor of an experience-rated plan to adopt such conventions as are necessary in its ac-

counting practices and financial records to assure that only costs related to the standard benefits package are taken into account.

**"Subpart C—Definitions and Special Rules**

**"SEC. 4518. DEFINITIONS AND SPECIAL RULES.**

"(a) HEALTH PLANS.—For purposes of this part—

"(1) STANDARD HEALTH PLAN.—The term 'standard health plan' has the meaning given such term by section ____ of the Health Security Act, except that such term does not include a plan offering the alternative standard benefit package described in ____ of such Act.

"(2) STANDARD BENEFITS PACKAGE.—The term 'standard benefits package' has the meaning given such term by section ____ of such Act.

"(b) COMMUNITY RATING AREAS AND PLANS.—For purposes of this part—

"(1) COMMUNITY RATING AREA.—The term 'community rating area' means an area established under section 1502 of the Health Security Act.

"(2) COMMUNITY-RATED PLAN.—The term 'community-rated plan' means a plan which is community-rated under section 1116 of such Act.

"(3) EXPERIENCE-RATED PLAN.—The term 'experience-rated plan' means any plan which is not a community-rated plan.

"(c) PREMIUMS.—For purposes of this part—

"(1) IN GENERAL.—The term 'premium' has the meaning given such term by section 4503(a)(3).

"(2) ADMINISTRATIVE COSTS.—Amounts received for health-related administrative services (as defined in section 4501(d)) provided in connection with any standard health plan taken into account under section 4511(c)(3) shall be treated as premiums.

"(d) INSURANCE POLICY AND PLAN SPONSOR.—For purposes of this part—

"(1) INSURANCE POLICY.—The term 'insurance policy' has the meaning given such term by section 4503(a)(2).

"(2) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term by section 4502(b)(2), except that in the case of a plan not described in such section, such term means the person or persons who establish or maintain the plan.

"(e) SPECIAL RULES.—For purposes of this part—

"(1) DEPOSITS.—The Secretary may require deposits of any taxes imposed by subpart A or B at such times as the Secretary determines appropriate.

"(2) GOVERNMENTAL ENTITIES SUBJECT TO TAX.—The rules of section 4503(b) shall apply for purposes of this part.

"(3) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this part shall be covered over to any possession of the United States.

"(f) REGULATIONS.—The Secretary shall issue such regulations as are necessary to carry out the provisions of this part, including regulations—

"(1) requiring the maintenance of such records, and the reporting of such information as the Secretary determines necessary, and

"(2) which provide that 2 or more plans of a person or any related persons must be aggregated, or a plan must be treated as 2 or more separate plans."

(b) CONFORMING AMENDMENTS.—

(1) Subchapter A of chapter 37, as added by section ____, is amended by inserting after the subchapter heading the following:

"Part I. Premium and related assessments.
"Part II. High cost health plans.

**"PART I—PREMIUM AND RELATED ASSESSMENTS".**

(2) Section 4503, as so added, is amended by striking "subchapter" each place it appears and inserting "part".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

2151

6603