HEALTH SECURITY ACT

SECTION-BY-SECTION ANALYSIS

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SUBTITLE A - UNIVERSAL COVERAGE AND INDIVIDUAL RESPONSIBILITY
(H.R. 3600 and S. 1757 p. 14)

Subtitle A describes the health care coverage to which all eligible individuals are entitled and the date on which coverage becomes effective. It also sets forth eligibility criteria and describes how individuals and families obtain their coverage by enrolling in health plans offered through health alliances.

PART 1 - UNIVERSAL COVERAGE

Section 1001. Health Benefits. (a) Every eligible individual is eligible to receive the comprehensive benefit package described in subtitle B. This guarantee is secured through enrollment in a health plan in accordance with the provisions of title I.

(b) Every eligible individual is entitled to a Health Security card which is issued by the individual's health alliance or the entity that offers the health plan in which the individual enrolls.

(c) An eligible individual is any person who resides in the United States and who is:

(1) A citizen or a national of the United States;

(2) An alien lawfully admitted for permanent residence in the U.S.; or

(3) A long-term nonimmigrant.

Aliens lawfully admitted for permanent residence in the U.S. are defined under section 1902 as the following persons:

(A) An alien who is admitted as a refugee under the Immigration and Nationality Act (INA).

(B) An alien who is granted asylum under the INA.

(C) An alien whose deportation is withheld under the INA.

(D) An alien who is admitted for residence under the amnesty programs (sections 210, 210A or 245A) of the INA.

(E) An alien who has been parolled indefinitely into the United States or who has been granted an extended voluntary departure.

(F) An alien who: (1) is the spouse or unmarried child under age 21 of a citizen or the parent of a citizen over age 21; and (2) has applied for permanent residence.

(G) Other classes of permanent resident aliens as the National Health Board recognizes.

Long-term nonimmigrants (defined under section 1902) include:

(A) Aliens entering under a treaty of commerce or trade and their families.
(B) Certain temporary workers and trainees (for example, registered nurses).

(d) Medicare-eligible individuals are entitled to benefits through the Medicare program rather than through the Health Security Act unless, in accordance with Section 1012, they are qualified employees or spouses of qualified employees.

(e) Prisoners (who are imprisoned by Federal, state or local authorities following conviction as an adult) are not entitled to coverage under the Act during the term of imprisonment.

Section 1002. Individual Responsibilities. (a) Each eligible individual must enroll in an applicable health plan and must pay required premiums.

(b) No individual may be disenrolled until the individual is either enrolled in another health plan or becomes a Medicare-eligible individual.

Section 1003. Protection of Consumer Choice. Nothing in this Act prohibits any person from purchasing health services or supplemental health insurance (consistent with the Act) to cover health services not included in the comprehensive benefit package. Individuals who are not eligible persons under the Act may purchase health insurance other than through a regional alliance. Employers may provide coverage in addition to that offered through the comprehensive benefit package (subject to certain limitations set forth in subtitle E, part 2, relating to provision of supplemental health insurance).

Section 1004. Applicable Health Plan Providing Coverage. (a) In general, a family's applicable health plan is the plan selected by the family that is offered through the regional health alliance in which the family resides. In the case of families eligible to enroll in a plan through a corporate alliance (defined in section 1311), the family's health plan is the corporate alliance health plan except as provided for multiple employment families in section 10130.

(b) Certain groups have certain additional types of health plans available to them. Military personnel and their families may elect to enroll in a health plan offered by the Department of Defense, as described in section 8001(a). Veterans may elect to enroll in a plan offered through the Department of Veterans Affairs and their families may do so if authorized by the Secretary of Veterans Affairs under section 8101(a). Indians, as defined in section 8302, may elect to enroll in a health program offered through the Indian Health Service.

Section 1005. Treatment of Other Nonimmigrants. (a) Undocumented aliens are ineligible for benefits under the Act.

(b) Diplomats and other foreign officials may enroll in accordance with conditions

established by the Secretary of State. Other nonimmigrants are subject to reciprocal agreements established between the United States and other foreign governments.

Section 1006. Effective Date of Coverage. (a) In general, individuals become eligible for benefits when their states become participating states, as defined in section 1200. In cases in which a state becomes a participating state before the general effective date (January 1, 1998), individuals enrolled in an employee benefit plan offered by an employer that intends to sponsor a corporate health alliance remain with the plan if the employer so notifies the regional alliance of the state in which it is located. In order for employees to remain exempt from the regional alliance, the employer must offer a benefit plan that provides the comprehensive benefit package and must pay at least 80 percent of the premium.

(b) In the case of persons eligible to enroll through corporate alliances, January 1, 1998, is the effective date of coverage under the Act.

PART 2 - TREATMENT OF FAMILIES AND SPECIAL RULES

Section 1011. General Rule of Enrollment of Family In Same Health Plan. (a) In general, all family members enroll in the same health plan.

(b) The term "family" means an eligible individual, the individual's spouse (if eligible) and the individual's (and the spouse's, if any) eligible children.

(c) The following each represents a separate class of family enrollment:

(A) Individual coverage is referred to as the "individual class".

(B) Coverage of a married couple without children is termed a "couple only" class of enrollment.

(C) Coverage of an unmarried individual and one or more children is termed a "single parent" class of enrollment.

(D) Coverage of a married couple and one or more children is termed a "dual parent" class of enrollment.

The term "family" enrollment refers to classes (B), (C), and (D). The term "couple" enrollment refers to classes (B) and (D).

(d) The term "married" means marriage as defined by the law of the applicable state in which the couple resides. The term "couple" refers to an individual and an individual's married spouse.

(e) The term "child" means an eligible individual who is under 18 years of age (or under age 24 in the case of a full-time student) and is a dependent of an eligible individual. State law is used to determine if a person is a child, but the National Board may prescribe uniform rules for determining who is a child. Under such rules, a child shall include a step

or foster child, a disabled adult child, the child of a parent who is herself a child and living with an eligible individual, and a child placed for adoption. Emancipated minors and married individuals shall not be treated as children.

(f) The Board is required to prescribe rules for families in which members do not reside in the same area, individuals who are under 19 and who are not dependents of eligible individuals, children of parents who are separated or divorced, and enrollment rules for families whose composition changes during a year.

Section 1012. Treatment of Certain Families. (a) A Medicare-eligible individual who is a qualifying employee for two consecutive months in a year (and is anticipated to be one in the next following month), or who is the spouse or family member of a qualifying employee, shall be treated as alliance eligible for the remainder of the year and not as a Medicare-eligible individual.

(b) In families that include AFDC or SSI recipients, such recipients are considered their own families, and remaining family members are considered separate families. Also considered separate families for purposes of this Act are electing veterans, electing Indians, and active duty military personnel, unless all family members join in the election. Prisoners are treated as a separate family.

Individuals eligible for multiple coverage options may elect the plan or program of their choice.

(c) Qualifying students (persons who are children and are full-time students in a school located in an alliance area different from their parents' alliance area) may elect to enroll in the alliance in which the school is located. In such a case, the parents' alliance health plan shall pay the plan in which the student enrolls.

(d) The National Health Board is required to promulgate regulations governing married couples who live in different alliance areas.

Section 1013. Multiple Employment Situations. (a) Single adult wage earners and married wage earners whose spouses are not qualified employees and who work for both a corporate alliance employer and a regional alliance employer may elect as their applicable health plan either a regional or corporate alliance plan.

(b) Where members of married couples work for both a regional and a corporate alliance, the couple may elect either a regional or a corporate alliance health plan. In cases in which spouses work for two corporate alliances, a health plan in either alliance may be selected.

Section 1014. Treatment of Residents of States with Statewide Single Payer Systems. Special rules, set forth at section 1222 govern coverage in single payer states. These special rules supersede rules in section 1002.

SUBTITLE B - BENEFITS
(H.R. 3600 and S. 1757 p. 32)

Subtitle B sets forth for all alliance health plans requirements regarding the comprehensive benefit package, benefit limitations and exclusions, and patient cost sharing.

Part 1 lists each covered benefit. Part 2 describes each benefit in detail. Patient cost sharing and benefit limitations and exclusions are described in parts 3 and 4. The National Health Board's duties with respect to defining or modifying the benefit package are set forth in part 5.

PART 1 - COMPREHENSIVE BENEFIT PACKAGE

Section 1101. Provision of Comprehensive Benefit by Plans. This section describes each item and service contained in the benefit package. Health plans must provide the following benefits to all alliance eligible persons:

(1) hospital services;
(2) services of health professionals;
(3) emergency and ambulatory medical and surgical services;
(4) clinical preventive services;
(5) mental illness and substance abuse services;
(6) family planning services and services for pregnant women;
(7) hospice care;
(8) home health care;
(9) extended care services;
(10) ambulance services;
(11) outpatient laboratory, radiology and diagnostic services;
(12) outpatient prescription drugs and biologicals;
(13) outpatient rehabilitative services;
(14) durable medical equipment and prosthetic and orthotic devices;
(15) vision care; and
(16) dental care.

No scope or duration limitations or cost sharing is permitted except as prescribed in the Act.

PART 2 - DESCRIPTION OF ITEMS AND SERVICES COVERED

Section 1111. Hospital Services. Hospital services include (1) inpatient hospital services, (2) hospital services and (3) 24-hour-a-day emergency hospital services. Hospital services as used in this section do not include services provided for treatment of a mental or

substance abuse disorder (which are separately described at section 1115) except for medical detoxification as required to manage conditions associated with alcohol or drug withdrawal.

As used in this section, the term "hospital" has the same meaning as in Section 1861 (e) of the Social Security Act (Medicare) and the term "inpatient hospital services" means the items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act.

Section 1112. Services of Health Professionals. The services of health professionals are inpatient and outpatient professional services, including consultations, that are provided in a home, office, or other ambulatory care setting or in an institutional setting.

The term "health professional services" means professional services (1) that are provided lawfully by a physician or (2) that would be lawfully provided by a physician but that are provided by another person (such as a nurse or physician assistant) who is legally authorized to provide the services in a particular state.

Section 1113. Emergency and Ambulatory Medical and Surgical Services. Emergency ambulatory medical and surgical services are (1) 24-hour-a-day emergency services; and (2) ambulatory medical and surgical services, when furnished by a health facility that is not a hospital (including birthing centers) and that is legally authorized to provide the services in a particular state.

Section 1114. Clinical Preventive Services. Clinical preventive services consist of the following items and services:

(1) items and services for high risk populations (as defined by the National Health Board) when furnished in a manner consistent with any periodicity schedule for such items and services promulgated by the Board;

(2) age-appropriate immunizations, tests and clinician visits furnished in accordance with a specific periodicity schedule set forth on Table 1; and

(3) other immunizations, tests and clinician visits furnished in accordance with standards established by the Board under section 1153.

The immunization or test and any administration fee is covered if the test or immunization is administered to an individual consistent with a periodicity schedule but not during a clinician visit.

For purposes of this section, "clinician visit" consists of the following services provided by a health professional: a complete medical history; an appropriate physical examination; risk assessment; health advice and counseling (including nutrition counseling); and administration of age-appropriate immunizations and tests.

TABLE 1: CLINICAL PREVENTIVE SERVICES

AGE GROUP	IMMUNIZATIONS	TESTS	CLINICIAN VISITS
Under 3 yrs	Age-appropriate immunizations for: • Diphtheria • Tetanus • Pertussis • Polio • Haemophilus influenzae type B • Measles • Mumps • Rubella • Hepatitis B	• One hematocrit • Two blood tests to screen for blood lead levels for children at risk for lead exposure	Eight age-appropriate visits, including a newborn visit
3 to 6 yrs	Age-appropriate immunizations for: • Diphtheria • Tetanus • Pertussis • Polio • Measles • Mumps • Rubella	• One urinalysis	Three clinician visits
6 to 12 yrs			Three clinician visits
13 to 19 yrs	Age-appropriate immunizations for: • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams for females who have reached childbearing age and are at risk for cervical cancer every 3 years, but annually until 3 negative smears have been obtained, if medically necessary, and annually for females who are at risk for fertility-related infectious disease • Annual screening for chlamydia and gonorrhea for females who have reached childbearing age and are at risk for fertility-related infectious illnesses	Three clinician visits

AGE GROUP	IMMUNIZATIONS	TESTS	CLINICIAN VISITS
20 to 39 yrs	Booster immunizations every 10 years against: • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams every 3 years, but annually, following an abnormal smear, until 3 negative smears have been obtained, and annually for females at risk of fertility-related infectious disease • Annual screening for chlamydia and gonorrhea for females who are at risk for fertility-related infectious illnesses • Cholesterol every 5 years	One every three years
40 to 49 yrs	Booster immunizations every 10 years against: • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams for females every 2 years, but annually, following an abnormal smear, until 3 negative smears have been obtained, and annually for females at risk of fertility-related infectious disease • Annual screening for chlamydia and gonorrhea for females who are at risk for fertility-related infectious illnesses • Cholesterol every 5 years	One every two years
50 to 64 yrs	Booster immunizations every 10 years against: • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams for females every 2 years • Mammograms for females every 2 years • Cholesterol every 5 years	One every two years
65 or older	• Booster immunizations every 10 years against tetanus and diptheria • Age-appropriate immunizations against invasive influenza and pneumococcal disease	• Papanicolaou smears and pelvic exams every 2 years for females who are at risk for cervical cancer • Mammograms for females every 2 years • Cholesterol every 5 years	One each year

Section 1115. Mental illness and Substance Abuse Services. (a) Mental illness and substance abuse services consist of the following services:

(1) Inpatient and residential mental illness and substance abuse treatment, consistent with applicable limitations;

(2) Intensive nonresidential mental illness and substance abuse treatment, consistent with applicable limitations;

(3) Outpatient mental illness and substance abuse treatment including case management, screening and assessment, crisis services; and

(4) Collateral services consistent with applicable limitations.

(b)(1) An individual is eligible for inpatient, residential, intensive non-residential, and outpatient mental illness and substance abuse treatment if the individual:

(A) has, or has had, during the one-year period prior to the date of treatment, a diagnosable mental disorder or a diagnosable substance abuse disorder, and

(B) is either experiencing or is at risk of experiencing, or if untreated would experience, impaired functioning in family, work, school or community activities.

(2) An individual is eligible for case management services if a health professional designated by the plan determines that the individual should receive case management, and the individual is eligible for and is receiving outpatient mental illness or substance abuse treatment for a diagnosable mental or substance abuse disorder.

(3) All alliance eligible individuals are eligible for outpatient screening and assessment and crisis services.

(4) Family members (as defined under the Act) who are related to persons eligible for inpatient and residential mental illness and substance abuse treatment are eligible for collateral services.

(c) Inpatient and residential mental illness and substance abuse treatment means the following items and services when provided to a person with a diagnosable mental disorder or substance abuse disorder:

(1) Inpatient hospital services as defined in paragraphs (1) through (3) of section 1861 of the Social Security Act, when provided for a diagnosable mental disorder or substance abuse disorder to an inpatient of a hospital, psychiatric hospital, or a residential treatment or detoxification center, crisis residential program or mental illness residential treatment program, or to a resident of a family or group treatment home or community residential treatment and recovery center for substance abuse.

The National Health Board is required to specify in regulations those health professional services that are to be treated as inpatient treatment services.

(2) The following limitations apply to coverage for inpatient and residential care:

(A) Residential mental illness treatment when provided to a person with a diagnosable mental disorder is covered only when provided in a setting that is not a hospital or a psychiatric hospital and is covered only to avert the need for, or as an alternative to, treatment in a hospital or psychiatric hospital, as determined by a health professional designated by the enrollee's plan.

(B) Residential substance abuse treatment is covered only if a health professional designated by the health plan determines that the individual should receive the treatment.

(C) Inpatient treatment is covered only when provided to an individual in the least restrictive inpatient or residential setting, and when less intensive nonresidential or outpatient treatment would be ineffective or inappropriate.

(D) Before January 1, 2001, 30 days each year of inpatient treatment is covered. A maximum of 30 additional days is covered if a health professional designated by the health plan determines that:

(i) the individual poses a threat to his own life or the life of another; or

(ii) the medical condition of the individual requires inpatient treatment to initiate or adjust pharmacological or somatic therapy.

(E) Inpatient hospital treatment for substance abuse is covered only for medical detoxification required for the management of psychiatric conditions associated with withdrawal from drugs or alcohol.

(d)(1) Intensive nonresidential treatment means diagnosis and therapeutic items and services provided to an individual with a diagnosable mental disorder or substance abuse disorder who is either (A) participating in a partial hospitalization program, day treatment program, psychiatric rehabilitation program, or ambulatory detoxification program or (B) receiving home-based mental illness services or behavioral aide mental illness services.

The National Board is required to specify in regulations which health professional services described in section 1112 must be covered as intensive nonresidential mental illness and substance abuse treatment.

(2) The following limitations apply to coverage for intensive nonresidential treatment:

(A) Treatment is covered if a health professional designated by the

health plan determines that the individual should receive the treatment.

(B) Treatment is covered only if necessary to:

(i) avert the need for residential or inpatient treatment,
(ii) facilitate an individual's earlier discharge from an inpatient or residential setting,
(iii) restore the functioning of an individual with a diagnosable mental disorder or substance abuse disorder, or
(iv) to assist the individual to develop skills necessary for, and to gain access to the support services that the individual needs to achieve the maximum level of functioning in the community.

(C) Before January 1, 2001, for every two days of intensive nonresidential treatment furnished, inpatient coverage for the year is limited by one day, until the number of available inpatient and residential days is reduced to zero.

An additional 60 days of intensive nonresidential substance abuse and mental illness treatment may be furnished in a year if a health professional designated by the health plan determines that the individual should receive the treatment. Cost sharing for the additional 60 days is 25 percent in lower cost sharing plans and 50 percent in higher cost sharing plans.

(D) Before January 1, 2001, deductibles, copayments and coinsurance applicable to intensive nonresidential treatment may not be applied toward any annual, out-of-pocket limit on cost sharing if the treatment is provided for a diagnosable substance abuse disorder or if the deductible, copayment or coinsurance is paid for the additional 60 days of treatment.

(e)(1) Outpatient mental illness and substance abuse treatment means the following services provided on an outpatient basis, for a diagnosable mental disorder or substance abuse disorder:
(A) screening and assessment,
(B) diagnosis,
(C) medical management,
(D) substance abuse counseling and relapse prevention,
(E) crisis services,
(F) somatic treatment services,
(G) psychotherapy,
(H) case management,
(I) collateral services.

(2) The following limitations apply to coverage of outpatient treatment:
(A) Treatment must constitute health professional services as defined

under section 1112.

(B) Treatment for substance abuse counseling and relapse prevention is covered if a health professional designated by the health plan determines that the individual should receive the treatment.

(C) Before January 1, 2001, coverage for both psychotherapy and collateral services is limited to 30 visits per individual per year. Additional visits may be covered to prevent hospitalization or facilitate earlier hospital release. The number of inpatient and residential days is reduced one day for every four of the additional visits. The number of inpatient and residential days available in a year is also reduced by one day for every four days of substance abuse counseling and relapse prevention. Thirty days of group therapy for substance abuse are available without substitution if the individual has received inpatient, residential or intensive nonresidential treatment for the substance abuse disorder within 12 months (regardless of the length of stay for these treatments).

(D) Detoxification in an outpatient setting is covered only if it is provided in the context of a treatment program.

(E) Before January 1, 2001, deductibles, copayments and coinsurance applicable to outpatient treatment may not be applied toward any annual out-of-pocket limit on cost-sharing.

(F) For purposes of this subtitle:

(i) "Case management" means services that assist individuals to gain access to needed medical, social, educational and other services.

(ii) "Diagnosable mental disorder or substance abuse disorder" means a disorder listed in Diagnostic and Statistical Manual of Mental Disorders, Third Edition, or a revised version of such manual, the equivalent of a disorder listed in that text as it is listed in the International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition or revised version of such text, or is listed in any authoritative text that specifies diagnostic criteria for mental disorders or substance abuse disorders that is identified by the National Health Board.

(iii) "Psychiatric hospital" has the same meaning given to such hospitals under section 1861(f) of the Social Security Act, Indian Health Service, Department of Defense, and Department of Veterans Affairs hospitals may all qualify as inpatient psychiatric hospitals for persons electing enrollment in such plans under Section 1004.

Section 1116. Family Planning and Services for Pregnant Women. Family

planning services and services for pregnant women consist of the following items and services:

(1) Voluntary family planning services;

(2) Contraceptive devices that may be dispensed only by prescription and that are subject to approval under the Federal Food, Drug and Cosmetic Act; and

(3) Services for pregnant women.

Section 1117. Hospice Care. Hospice care consists of the items and services described in section 1861(dd)(1) of the Social Security Act as defined in paragraphs (2),(3) and (4)(A) of that section (with the exception of paragraph (2)(A)(iii).

Section 1118. Home Health Care. (a) Home health care consists of the following items and services:

(1) Items and services described in section 1861(m) of the Social Security Act;

(2) Home intravenous drug therapy services described in section 1861(ll) of the Social Security Act (as added by section 2006 of the Health Security Act).

(b) Limitations on home health care are as follows:

(1) Home health care provided after an illness or injury is covered as an alternative to inpatient care in a hospital,skilled nursing facility or rehabilitation facility.

(2) Care may be continued after a mandatory reevaluation at the end of each 60-day period if the care is an alternative to inpatient care in a hospital, skilled nursing facility, or rehabilitation facility.

Section 1119. Extended Care Services. (a) Extended care services consist of items and services described in section 1861(h) of the Social Security Act, if provided to an inpatient in a skilled nursing facility or a rehabilitation facility.

(b) Coverage is limited to 100 days per year and is limited to cases in which care is furnished as an alternative to hospitalization following an illness or an injury.

(c) The term "rehabilitation facility" means an institution (or separate part of an institution) devoted to providing services for rehabilitation from illness or injury. The term "skilled nursing facility" means an institution (or separate part) that primarily provides skilled nursing care or services for rehabilitation from illness or injury.

Section 1120. Ambulance Services. Ambulance services consist of ground transportation by ambulance, or air or water transportation by aircraft or vessels that are equipped for transporting ill or injured persons. Air and water transportation services are covered only if a patient's condition indicates that there is no alternative to such transportation or the alternative is contra-indicated.

Section 1121. Outpatient Laboratory, Radiology, and Diagnostic Services. These services consist of laboratory, radiology and diagnostic services that are prescribed for individuals who are not inpatients in a hospital, hospice, skilled nursing facility or rehabilitation facility.

Section 1122. Outpatient Prescription Drugs and Biologicals. Covered outpatient drugs are drugs that are covered under section 1861(t) of the Social Security Act (as amended by the Health Security Act). A drug is covered as an outpatient drug if used as approved by the FDA or for another use if the drug is FDA-approved and an alternative use is supported by certain recognized drug compendia or alternative use is supported in peer reviewed literature. The National Board may revise the list of specified compendia in the statute. Blood clotting factors are also covered if provided on an outpatient basis.

Section 1123. Outpatient Rehabilitation Services. (a) Covered rehabilitative services are outpatient occupational and physical therapy, and outpatient speech pathology services provided for the purpose of attaining or restoring speech.

(b)(1) Coverage is limited to services or items that are needed to restore an individual's functional capacity or to minimize limitations on an individual's physical and cognitive functions that are the result of an illness or injury.

(2) Outpatient rehabilitation services may be continued only if the need for coverage is reviewed at the end of each 60-day period, and if such a review indicates that an individual's functioning is improving.

Section 1124. Durable Medical Equipment and Prosthetic and Orthotic Devices. (a) Coverage. Items and services covered under this section are:

(1) durable medical equipment (as defined in section 1861(n) of the Social Security Act), including accessories and supplies necessary for the repair, function and maintenance of such equipment;

(2) prosthetic devices (except for dental devices) that replace all or part of the function of an internal body organ (including colostomy bags and supplies directly related to colostomy care), and replacements of such devices;

(3) accessories and supplies used directly with a prosthetic device to achieve its therapeutic benefit or assure its proper functioning;

(4) leg, arm, back, and neck braces;

(5) artificial legs, arms,and eyes, including replacements required because of a change in an individual's physical condition; and

(6) fitting and training for use of such items.

(b) Coverage is limited to items or services that improve an individual's functional capacity or prevent further deterioration in function.

Section 1125. Vision Care. Routine eye examinations and diagnosis and treatment for defects in vision are covered, except that eyeglasses and contact lenses are covered only for individuals under 18 years of age. The National Health Board must develop a periodicity schedule for eye exams.

Section 1126. Dental Care. (a) Coverage and limitations. Dental care covered under this section is:

(1) Emergency dental treatment, including simple extractions, treatment for acute infections, bleeding and injuries to natural teeth and oral structures, requiring immediate care to prevent risks to life or significant medical complications, as specified by the National Health Board.

(2) Prevention and diagnosis of dental disease, including oral dental examinations, radiographs, dental sealants, fluoride application, and dental prophylaxis. Until January 1, 2001, this care is covered only for individuals under age 18. After that date, all services except sealants are covered for all individuals.

(3) Treatment of dental disease, including routine fillings, prosthetics for genetic defects, periodontal maintenance, and endodontic services. Until January 1, 2001, these items and services are covered only for individuals under age 18; on and after that date, these services are covered for all eligible individuals enrolled in a health plan, except that endodontic services continue to be covered only for individuals under age 18.

(4) Space maintenance procedures, to prevent orthodontic complications are covered only for individuals at least 3, but less than 13 years of age. Coverage is also limited to procedures on posterior teeth that involve maintenance of a space or spaces for permanent posterior teeth that, if the space were not maintained, would be prevented from normal eruption. Coverage excludes a space maintainer placed within 6 months of the expected eruption of the permanent, posterior tooth.

(5) Interceptive orthodontic treatment to prevent severe malocclusion is covered only on or after January 1, 2001 and then only for individuals at least 6 years of age but under age 12.

Section 1127. Health Education Classes. Health education and training classes in smoking cessation, nutrition counseling, stress management, support groups, physical training, or classes that are otherwise intended to encourage reduction of behavioral risk factors and promote healthy activities are covered, if a health plan chooses to offer such classes. Classes covered under this section neither include nor limit education or training provided as part of professional health services, as defined in section 1112.

Section 1128. Investigational Treatments. Investigational treatments may be covered by health plans at their discretion if the treatment is furnished for a life threatening disease, disorder or other health condition defined by the National Health Board. Items and services that are routine care and otherwise included in the benefit package are covered when furnished as part of an investigational treatment. Treatment is investigational if its effectiveness has not yet been determined and the treatment is under clinical investigation as

part of an approved research trial.

PART 3 - COST SHARING

Section 1131. Cost Sharing. (a) All health plans must comply with general cost sharing principles as a condition of participation in health alliances. In general, health plans must offer all enrollees the following cost sharing schedule:

(1) lower cost sharing,
(2) higher cost sharing, or
(3) combination cost sharing.

(b) Regional alliances must apply special cost sharing rules for low-income families, as specified in section 1371.

(c)(1)Deductibles and out-of-pocket limits on cost sharing are based on expenses incurred for items and services furnished during a year.

(2) Individual general deductibles represent the countable expenses that an individual can be required to incur in a year before the plan incurs liability. At the point at which a family deductible has been reached for a year, no individual member of the family may be required to incur additional deductibles before plan coverage begins. A countable expense, for purposes of determining if a deductible has been satisfied, is any expense for an item or service covered in the benefit package and for which (but for any applicable deductible or coinsurance) the health plan would be liable for payment.

(3) Coinsurance requirements apply after individual and family deductible requirements have been satisfied.

(4) Individual out-of-pocket limits on cost sharing represent the amount of expenses an individual may be required to incur during a year because of general deductibles and cost sharing for items and services furnished in the benefit package. In the case of families, no family member may be required to incur additional out-of-pocket costs once the out-of-pocket limit is satisfied for the family. Special rules apply in the case of mental health services (see section 1115).

Section 1132. Lower Cost Sharing. (a) A health plan's lower cost sharing schedule may not impose deductibles and must contain individual out-of-pocket limits of $1500 and family out-of-pocket limits of $3000. No copayment for "in-network" items or services is allowed except as consistent with Table 2. Plans must impose coinsurance for "out-of-network" items and services at a level to be specified by the National Health Board. The "out-of-network" coinsurance must be not less than 20 percent and, for those items for which the coinsurance under the higher cost sharing option is greater than 20 percent, the Board

may specify a higher percentage.

Section 1133. Higher Cost Sharing. A health plan's higher cost sharing schedule must have deductibles of $200 for an individual and $400 for a family for all items and services in the comprehensive benefit package. In addition, the following deductibles apply:

(1) a separate individual deductible for inpatient residential and intensive non-residential mental illness and substance abuse treatment equal to the cost of one day of such treatment;

(2) an individual outpatient prescribed drug deductible of $250 annually; and

(3) a separate $50 annual individual dental deductible.

Deductibles for clinical preventive services and prenatal care visits (including one post partum visit) are prohibited.

Coinsurance in accordance with Table 2 is permitted. Annual maximum out-of-pocket limits must be set at $1500 for individuals and $3000 for families.

Section 1134. Combination Cost Sharing.(a) Combination cost sharing plans are required to use the same out-of-pocket limits for individuals and families and must use different cost sharing requirements for out-of-network, as opposed to in-network, items and services.

(b) With respect to in-network items and services, plans may not impose deductibles and must follow the same cost sharing schedule required of lower cost sharing plans.

(c) With respect to out-of-network items and services (as the term is defined in section 1402(f) of the Act relating to health plans), deductibles and coinsurance not exceeding amounts described in section 1133 will be applied to individuals and families.

An item or service is "in-network" under section 1402 if furnished by a provider that has entered into an agreement with the plan that obligates the provider to furnish benefits to enrollees. The term "out-of-network" applies to items and services furnished by providers that are not members of the plan network.

Section 1135. Table of Copayments and Coinsurance. Section 1135 sets for the following table of copayments and coinsurance applicable to low cost sharing, higher cost sharing and combination cost sharing plans. The applicable payment rate referred to in Table 2 refers to the fee-for-service fee schedule to be established for all health alliances under section 1322.

TABLE 2
Copayments and Coinsurance for Items and Services
(Sec. 1135)

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Inpatient hospital services	1111	No copayment	20 percent of applicable payment rate
Outpatient hospital services	1111	$10 per visit	20 percent of applicable payment rate
Hospital emergency room services	1111	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Services of health professionals	1112	$10 per visit	20 percent of applicable payment rate
Emergency services other than hospital emergency room services	1113	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Ambulatory medical and surgical services	1113	$10 per visit	20 percent of applicable payment rate
Clinical preventive services	1114	No copayment	No coinsurance
Inpatient and residential mental health and substance abuse treatment	1115	$25 per visit	50 percent of applicable payment rate
Intensive nonresidential mental health and substance abuse treatment	1115 1115(d)(2)(c)(ii)	No copayment $25 per visit	20 percent of applicable payment rate 50 percent of applicable payment rate
Outpatient mental health and substance abuse treatment (except psychotherapy, collateral services, and case management)	1115	$10 per visit	20 percent of applicable payment rate

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Outpatient psychotherapy and collateral services	1115	$25 per visit until January 1,2001, and $10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter
Case management	1115	No copayment	No coinsurance
Family planning and services for pregnant women (except clinician visits and associated services related to prenatal care and 1 postpartum visit)	1116	$10 per visit	20 percent of applicable payment rate
Clinician visits and associated services related to prenatal care and 1 post-partum visit	1116	No copayment	No coinsurance
Hospice care	1117	No copayment	20 percent of applicable payment rate
Home health care	1118	No copayment	20 percent of applicable payment rate
Extended care services	1119	No copayment	20 percent of applicable payment rate
Ambulance services	1120	No copayment	20 percent of applicable payment rate
Outpatient laboratory, radiology, and diagnostic services	1121	No copayment	20 percent of applicable payment rate
Outpatient prescription drugs and biologicals	1122	$5 per prescription	20 percent of applicable payment rate
Outpatient rehabilitation services	1123	$10 per visit	20 percent of applicable payment rate
Durable medical equipment and prosthetic and orthotic devices	1124	No copayment	20 percent of applicable payment rate
Vision care	1125	$10 per visit (no additional charge for 1 set of necessary eyeglasses for an individual less than 18 years of age)	20 percent of applicable payment rate

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Dental care (except space maintenance procedures and interceptive orthodontic treatment)	1126	$10 per visit	20 percent of applicable payment rate
Space maintenance procedures and interceptive orthodontic treatment	1126	$20 per visit	40 percent of applicable payment rate
Health education classes	1127	All cost sharing rules determined by plans	All cost sharing rules determined by plans
Investigational treatment for life-threatening condition	1128	All cost sharing rules determined by plans	All cost sharing rules determined by plans

Section 1136. Indexing Dollar Amounts Relating to Cost Sharing. (a) Deductibles, coinsurance, copayments and out-of-pocket limits imposed in any year after 1994 must be indexed in accordance with a percentage equal to the product of the cumulative health care inflation factor after 1994. Increases in cost sharing amounts owed must be rounded to the nearest multiple of $1 in the case of amounts of $200 or less, $5 in the case of amounts between $200 and $500 and multiples of $10 in the case of amounts of $500 or more.

PART 4 - EXCLUSIONS

Section 1141. Exclusions. (a) The comprehensive benefit package does not contain items or services that are not medically necessary or appropriate or that the National Health Board by regulation determines are not medically necessary or appropriate.

(b) In addition, the package does not cover the following items or services:

(1) custodial care (except in the case of hospice care);
(2) cosmetic surgery (other than to correct congenital anomalies or following an accident or disease);
(3) hearing aids;
(4) eyeglasses and contact lenses for individuals 18 years of age and older;
(5) in vitro fertilization services;
(6) sex change and related services;
(7) private duty nursing;
(8) personal comfort items (except in the case of hospice care);
(9) orthodontal and other dental procedures other than as described in section 1126.

PART 5 - ROLE OF THE NATIONAL HEALTH BOARD

Section 1151. Definition of Benefits. (a) The National Health Board is authorized to promulgate regulations and guidelines to assure uniformity in benefits across all health plans.

(b) The National Board must permit health plans to use appropriate providers and methods to deliver covered services.

Section 1152. Acceleration of Expanded Benefits. Prior to January 1, 2001, the National Health Board may add benefits not otherwise scheduled for coverage prior to that year or revise the coinsurance provisions in accordance with rules to take effect in the year 2001, if it determines that such additions or revisions will not cause any regional alliance to exceed its per capita expenditures.

Section 1153. Authority With Respect to Clinical Preventive Services. (a) The Board is required to define clinical preventive items and services and a periodicity schedule for high risk populations. The Board is also required to update the periodicity schedule for immunizations, tests and clinician visits and to establish rules for the provision of immunizations, tests and clinician visits provided at periods other than the periodic age ranges. Finally, the Board may modify the clinical preventives service package but may not modify the cost sharing requirements.

Section 1154. Establishment of Standards Regarding Medical Necessity. The National Health Board is authorized to establish regulations regarding the exclusion by the Board of items and services that are not medically necessary or appropriate.

PART 6 - ADDITIONAL PROVISIONS RELATING TO HEALTH CARE PROVIDERS

Section 1161. Override of Restrictive State Practice Laws. No state may through licensure or otherwise restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals.

Section 1162. Provision of Items of Services Contrary to Religious Belief or Moral Conviction. A health professional or facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to that item or service on the basis of religious belief or moral conviction.

SUBTITLE C - STATE RESPONSIBILITIES
(H.R. 3600 and S. 1757 p. 95)

This subtitle sets forth general requirements for participating states and provides special rules for states administering single payer programs.

Section 1200. Participating State. (a) A state is a participating state if it meets the requirements of this subtitle.

(b) States that elect to participate must have an approved system in place by January 1, 1998. In states that do not elect to participate, the provisions of subpart B of part 2 of subtitle F (relating to federal operation) take effect. A state becomes a participating state if it submits its system for approval by the National Health Board and the Board approves the state's health care system.

Participating states must submit annual updates to the Board by February 15 of each year after the first year a state has been approved. Annual updates must consist of such information as the Board requires to determine whether a state health care system meets subtitle C requirements in the year for which the update is submitted, and whether a state system was operated as approved by the Board during the preceding year.

PART 1 - GENERAL STATE RESPONSIBILITIES

Section 1201. General State Responsibilities. Participating states must do the following:

(1) Establish one or more regional alliances, in accordance with section 1202;
(2) Certify health plans, in accordance with section 1203;
(3) Assure financial solvency of health plans, in accordance with section 1204;
(4) Designate an agency or official responsible for coordinating the state responsibilities under Federal law;
(5) Conform state laws to meet the requirements of title X for medical benefits under workers compensation and automobile insurance;
(6) Carry out other responsibilities of participating states under the Act.

Section 1202. State Responsibilities With Respect To Alliances. (a) A participating state must establish and maintain one or more regional alliances and assure that the alliance(s) comply with the requirements of the Act. A state may not be a participating state in any year unless it has established its alliance(s) by March 1 of the preceding year.

(b) A state must designate the geographic area (known as the alliance area) that is assigned to each alliance. The area must have a large enough population to ensure that the

alliance has adequate market share to negotiate effectively with health plans; no area may be assigned to more than one regional alliance; all areas of a state must be assigned to a regional alliance; and the entire portion of a metropolitan statistical area located in a state shall be included in the same alliance. An area that includes a Consolidated Metropolitan Statistical Area is presumed to meet the establishment requirements. In establishing the areas, a state may not discriminate on the basis of or otherwise take into account race, age, language, religion, national origin, socio-economic status, disability, or perceived health status.

(c) One or more states may permit or require two or more regional alliances to coordinate their operations (whether or not the alliances are located in separate states or the same state) by adopting joint operating rules, health plan contracts, enforcement activities and the establishment of unified fee schedules.

(d) A participating state must assure that amounts owed to alliances in the state are collected and paid.

(e) A state must assure that determination of families' eligibility for cost sharing assistance, premium discounts, and cost sharing reductions by regional alliances are made on the basis of the best information available to alliances and the state. A state shall use information available to it under section 6103(l)(7)(D)(x) of the Internal Revenue Code of 1986 to assist alliances in verifying financial eligibility.

(f) A state operating a single payer system must assure that the regional alliance in which the system operates meets the requirements of section 1224(b).

(g) A participating state is responsible in accordance with section 9201 for administrative errors by alliances. (These are errors relating to eligibility determinations which occur at a rate that exceeds an established error rate, as well as regional alliance expenditures attributable to mal- or misfeasance by the alliance or the state.)

Section 1203. State Responsibilities Relating to Health Plans. (a) A participating state must establish and publish health plan certification criteria with respect to quality, financial stability, capacity of a plan to deliver the comprehensive package of services in a designated area, other requirements for health plans in parts 1, 3 and 4 of subtitle E (health plan requirements) and state requirements that are consistent with the Act.

(b) A state must certify as a regional alliance health plan any health plan meeting the criteria applicable for regional alliance health plans.

(c) A state must monitor certified health plans for their continued compliance with the criteria.

(d) A state may not discriminate against a health plan on the basis of the location of

the entity offering the plan. A state may not regulate premiums except as such regulation relates to the state's cost containment responsibilities under Title VI or assurance of financial solvency.

(e)(1) A state must assure that each regional alliance eligible family has within the area in which the family resides adequate access to a choice of regional alliance health plans in which to enroll. This includes, to the maximum extent practicable, adequate access to a health plan with a premium at or below the weighted average for plans offered. The state also must assure that families eligible for a premium discount under section 6104(b) are provided with such a discount. To ensure access, a state may require one or more regional alliance health plans to cover all or part of a regional alliance area, as a condition of entering into a contract under section 1321 with the regional alliance.

(2) A state may also require, as a condition of contracting with a regional alliance, that one or more certified health plans provide their enrollees with access to centers of excellence as designated by the state under rules promulgated by the Secretary of Health and Human Services.

(3) The section also permits a participating state to adjust the risk-adjustment methodology (under section 1542(c)) and otherwise provide financial incentives to plans for enrolling individuals in disadvantaged populations. It permits a state to provide for outreach, transportation, interpretation and other extra services to ensure access for groups facing access barriers because of their location and other specified factors.

(f) A state must also comply with requirements under title X of the Act regarding workers compensation and automobile insurance.

(g) A state must establish a reinsurance program for health plans consistent with regulations established by the Board if a mandatory system is developed under section 1546.

(h) A state may not certify as a regional alliance plan any health plan that offers either a supplemental health benefit policy or cost sharing policy that fails to meet Act requirements under part 2 of subtitle E, or if the entity affiliated with the plan offers such a supplemental health benefit policy.

Section 1204. Financial Solvency; Fiscal Oversight; Guaranty Fund. (a) A participating state must establish capital standards for health plans that meet Federal requirements established by the National Health Board (under section 1505(1)).

(b) A state must establish requirements for health plans' financial reporting, auditing, and fund reserves. These requirements must be adequate for monitoring the financial status of plans.

(c) A state must provide a guaranty fund for health care providers and others in the

event of a health plan's failure. For purposes of this section, plan failure means current or imminent inability of a plan to pay claims. The state may require each regional alliance plan to pay an assessment to the state of up to 2 percent of annual premiums paid by regional alliance members for as long as is necessary to guaranty claims in the case of a failed plan.

The section also requires states to take the following steps to ensure continuity of coverage for individuals enrolled in a failed regional alliance health plan:

(1) designation of a state agency to assume control of a failed plan;

(2) payments by the fund in the following order of precedence: (1) to health care providers for care covered by the plan; and (2) operational, administrative and other costs and debts of the plan. Payments by the fund are the exclusive remedy for providers, who may not bring action against enrollees for amounts owed.

Section 1205. Restriction on Funding of Additional Benefits. A state may not use funds provided under this Act to pay for benefits in addition to those provided through the guaranteed benefit package.

PART 2 -- REQUIREMENTS FOR STATE SINGLE PAYER SYSTEMS

Section 1221. Single Payer System Described. The National Board is required to approve a state's application to administer a single payer system if the state's application either meets the requirement for a statewide single payer system or for an alliance-specific single payer system.

Section 1222. General Requirements for Single Payer Systems. Each state single payer system must meet the following requirements:

(1) The system is established under state law and the state law provides mechanisms to enforce its plan requirements.

(2) The system is operated by a state agency.

(3) The state system provides for enrollment of all persons who are regional alliance eligible individuals, including enrollment of all Medicare eligible individuals if the state has received approval from the Secretary of HHS for Medicare integration and enrollment of all corporate alliance eligible persons if the state has elected to do so. Single payer states may not require enrollment of electing veterans, electing Indians or active duty military personnel.

(4) The state makes direct payments to providers and assumes all financial risk (although payments per capita with the assumption of financial risk by providers is permitted).

(5) The state provides the comprehensive benefit package to all persons and maintains cost sharing requirements no greater on any subgroup of individuals than those permitted under the Act.

(6) The state maintains per capita expenditures within the target established by the Board and has mandatory enforcement mechanisms to reduce payments to health

care providers to assure that per capita expenditures do not exceed applicable targets.

(7) The state meets all requirements applicable to health plans under section 1400 but does not limit enrollment based on capacity, as permitted under section 1402. Requirements for plans relating to marketing and plan solvency do not apply.

Section 1223. Special Rules for States Operating Statewide Single Payer Systems.

(a) States operating statewide single payer systems are required to operate through a single statewide alliance and must meet the basic requirements for participating states. A single payer state must assume the functions otherwise carried out by regional alliances.

(b) Other requirements pertaining to regional alliances and health plans are waived, but coordination of health coverage with workers compensation and automobile insurance continues as a requirement.

(c) Rules for health alliances pertaining to enrollment and issuance of Health Security cards continue to apply. Similarly, rules applicable to regional alliances pertaining to low income assistance, non-discrimination, and data collection and quality assurance.

(d) A state using a single payer system must at least in part use a payroll-based financing system that requires employers to pay at least as much as they would be required to pay under normal rules of operation in non-single payer states.

Section 1224. Special Rules for Alliance-Specific Single Payer Systems. (a) A state operating an alliance-specific single payer system must comply with the rules applicable to participating states.

(b) Each regional alliance must meet requirements generally applicable to regional alliances, except that such alliance does not have to comply with the plan choice or consumer complaint resolution process under sections 1322 and 1326 and does not have the authority to use financial incentives to stimulate service by plans in areas of the alliance with inadequate services.

SUBTITLE D - HEALTH ALLIANCES
(H.R. 3600 and S. 1757 p. 118)

This subtitle sets forth the requirements for regional and corporate health alliances. Part 1 describes general rules for regional and corporate alliances. Part 2 identifies the duties and responsibilities of regional alliances. Part 3 describes the financing and income determination requirements of regional alliances. Part 4 describes the duties of corporate alliances.

Section 1300. Health Alliance Defined. A health alliance means a regional or corporate alliance (as defined in sections 1301 and 1311).

PART 1. ESTABLISHMENT OF REGIONAL AND CORPORATE ALLIANCES

SUBPART A - REGIONAL ALLIANCES

Section 1301. Regional Alliance Defined. A regional alliance is a non-profit organization, independent state agency or an agency of the state which meets the requirements of this subpart and carries out the duties of alliances.

Section 1302. Board of Directors. (a) A regional alliance must be governed by a Board of Directors. The Board of Directors has all of the powers vested in a regional alliance under the Act.

(b) Board members must include in equal proportion representatives of employers (including self-employed persons) and individuals (including employees).

(c) Board members are prohibited from maintaining a financial interest in health care, either directly or through a family member.

Section 1303. Provider Advisory Boards for Regional Alliances. Each regional alliance must have a provider advisory board.

SUBPART B - CORPORATE ALLIANCES

Section 1311. Corporate Alliance Defined; Individuals Eligible for Coverage through Corporate Alliances; Additional Definitions. (a) A corporate alliance means an eligible sponsor that has elected (in a form and manner prescribed by the Secretary of Labor) to be treated as a corporate alliance and that has filed documents with the Secretary.

(b) Eligible sponsors include large employers. Excluded employers include employers whose business is employee leasing, the federal government (other than the United States

Postal Service), and state and local government agencies, including special purpose units of government.

Eligible employers also include plan sponsors, under section 3(16)(B)(iii) of the Employee Retirement Income Security Act (ERISA), of multiemployer group health plans under section (e)(4) of ERISA, but only if the health benefit plan was offered as of September 1, 1993, and has more than 5000 active participants in the United States or 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 and covering more than 5000 employees.

Rural electric cooperative associations may also sponsor a corporate health alliance, but only if the cooperative offered benefits on September 1, 1993, and only if the plan covered more than 5000 full-time employees.

(c) The following employees are eligible to enroll in a corporate alliance health plan:

(1) full-time employees;

(2) participants and beneficiaries of multi-employer alliances, as the terms are defined under section 3 of ERISA; and

(3) full-time employees of rural cooperatives.

Persons eligible to enroll in corporate alliances are ineligible to enroll in regional alliances unless they meet the multiple-employment family requirements of section 1013.

(d) The following individuals are ineligible to enroll in corporate alliances:

(1) AFDC recipients.

(2) SSI recipients.

(3) electing veterans, Indians and active duty military personnel under section 1004 of the Act.

(4) temporary and seasonal workers unless treated as corporate alliance eligible individuals pursuant to a collective bargaining agreement.

(e) Definitions are provided for the following terms:

(1) a "group health plan" means an employee welfare benefit plan as defined in section 3(1) of ERISA providing medical care to participants and beneficiaries as defined in section 3 of ERISA.

(2) the term "large employer" means an employer with more than 5000 full time employees.

(3) the term "multi-employer plan" has the same meaning given the term in section 3(37) of ERISA.

(4) the term "rural electric cooperative" has the meaning given the term in section 3(40)(A)(iv) of ERISA.

(5) the term "rural electric cooperative association" has the meaning given the term in section 3(40) of ERISA.

Section 1312. Timing of Elections. (a) Large employers must notify the Secretary of Labor that they intend to sponsor a corporate alliance by January 1, 1996. In the case of new large employers that are not eligible sponsors as of the general effective date, such employers can become corporate sponsors by filing with the Secretary of Labor by March 1 following the year in which the employer becomes an eligible sponsor.

(b) Multi-employer plans and rural cooperatives must file their election with the Secretary no later than March 1, 1996.

(c) Elections made by large employers or multi-employer and rural cooperative plans shall be effective for coverage under health plans on or after January 1 of the year following the year in which the election is made.

Section 1313. Termination of Alliance Elections. (a) A corporate alliance election shall terminate if the number of full-time employees or active participants falls below 4800.

(b) Termination shall occur if the Secretary of Labor determines that the alliance is in substantial non-compliance or if the corporate alliance's premium expenditures increase excessively, as defined under section 6022.

(c) A corporate alliance may elect to terminate.

(d) Termination under this section takes effect as of the date of the next open enrollment in regional alliance health plans.

PART 2 - GENERAL RESPONSIBILITIES AND AUTHORITIES OF REGIONAL ALLIANCES

Section 1321. Contracts with Health Plans. (a) A regional alliance must negotiate with any willing state-certified health plan to enroll eligible individuals. An alliance may not contract with a plan that is not state certified. Regional alliances must contract with plans offered by the Department of Veterans Affairs and the Department of Defense if requested to do so by an appropriate official.

(b) A regional alliance may deny a contract to a plan only if the plan's bid exceeds 120 percent of the alliance per capita premium target (as determined under section 6003) or if the plan failed to comply with prior contracts, including failing to offer coverage for all services in the plan's entire service area.

Section 1322. Offering Choice of Health Plans for Enrollment; Establishment of Fee-For-Service Schedule. (a) Each alliance must offer residents a choice of health plans among those that have contracts with the alliance.

(b) Each alliance must offer at least one fee-for-service plan. A fee-for-service plan is a plan that offers all of the items and services offered in the comprehensive package and pays providers without regard to whether there is a contractual arrangement between the plan and the provider. Reasonable restrictions that may be imposed on payments under a fee-for-service plan include utilization review, prior approval of specified services, and exclusion of providers on the basis of poor quality of care. Prior approval authority may not be used to impose gatekeeper requirements on the use of specialty services.

(c) Each regional alliance must establish a fee schedule for fee-for-service plans or the fee-for-service component of any other health plan. The fee schedule shall be established only after negotiations with providers, and providers may collectively negotiate. The schedule applies to both regional alliance health plans and to corporate alliance plans furnishing services subject to the schedules in the regional alliance area. A state may elect to establish a statewide fee schedule for all regional alliances. Fee schedules shall be updated annually.

The establishment of a fee schedule shall be considered state action, and negotiations by providers over the schedule (including collective negotiations) shall be considered efforts to influence governmental action. Nothing shall be construed to permit providers to threaten or engage in a boycott.

(d) A regional alliance may use prospective budgeting in creating its fee schedule. Such a fee schedule shall be based on a budget negotiated with providers that contains spending targets for each sector of health plan spending. If the regional alliance determines that plan spending will cause the alliance to exceed its budget, it must reduce expenditures through a withhold or delay in payments. If a regional alliance or the state uses a prospective budget for fee-for-service plans, then payment for all services under fee-for-service plans shall be in accordance with the prospective schedule.

Section 1323. Enrollment Rules and Procedures. (a) A regional alliance must assure that each eligible person (residing in its area) is enrolled in a regional alliance health plan. Procedures developed by the alliance must assure enrollment at the time individuals first become eligible, including at the time of birth or when they move into the alliance area and at the time that they reach the age of individual eligibility as an adult. Alliances must have procedures for assuring that families select a single health plan in which to enroll.

(b)(1) Alliances must maintain a point of service enrollment mechanism enrolling eligible individuals who are not already enrolled in a plan when they seek health services.

(2) Under the point of service mechanism the following procedures apply:

(A) the treating provider must notify the alliance of the individual's identity and may request payment from the alliance.

(B) The alliance must then determine the individual's eligibility and whether the individual already is enrolled in a plan.

(C) If the individual is already enrolled in a regional alliance plan, the alliance shall send the treating provider's claim to the plan, and the plan shall pay in accordance with the alliance fee schedule. If the individual is required to be enrolled in a specific plan as a family member, the alliance shall record the enrollment, notify the individual, submit the treating provider's claim to the plan, and the plan shall make payment.

(D) If the individual is enrolled in a health plan offered by another alliance, the alliance shall forward the claim and the plan shall pay it in accordance with the alliance fee schedule.

(E) If the alliance determines that the individual is eligible for enrollment through another health alliance, it must notify the alliance and forward the claim.

(F) The Board is required to promulgate rules for treatment of other individuals.

(3) The following procedures shall be used in the case of individuals eligible for point-of-service enrollment:

(A) The individual must be provided with information about alliance health plans.

(B) If the individual does not enroll within 30 days, he or she is randomly assigned to a health plan.

(C) The plan in which the individual becomes enrolled must pay the initial treating provider.

(c) Alliances must have procedures for enrolling new residents. Individuals who intend to reside in the alliance area for more than 6 months must register with the alliance and enroll in a plan. Short term residents (those in the alliance areas for more than 3 months but less than 6 months), may either enroll in an alliance plan, continue coverage with their plan, or change enrollment in the previous alliance to a plan that provides coverage on a fee-for-service basis for all items and services furnished outside the area of that alliance.

(d) Each regional alliance must maintain an annual open enrollment period and must have procedures permitting disenrollment for good cause at any time during the year.

(e) An alliance must assure that all family members are enrolled in the same plan.

(f) Each alliance must establish enrollment priorities in the case of oversubscribed plans that do not have sufficient capacity. Current enrollees are required to have priority.

(g) Alliances must have termination procedures that permit enrollees to terminate enrollment in one plan and reenroll in another plan without any interruption in coverage for benefits. Such procedures also must cover enrollment situations involving the failure of a corporate alliance.

(h) An alliance may not knowingly offer enrollment to an individual who is not

eligible. However, any health plan may offer coverage and enrollment without financial payment by the regional alliance.

(i) In the case of an individual who fails to enroll, the alliance must enroll the individual and require payment of twice the amount of the family share of the premiums that otherwise would have been payable under subtitle B of Title VI unless the individual can demonstrate good cause for non-payment.

Section 1324. Issuance of Health Security Cards. A regional alliance must issue a health security card to all regional alliance eligible individuals.

Section 1325. Consumer Information and Marketing. (a) Before each open enrollment, regional alliances must provide enrollees with easily understood and useful information that permits enrollees and other alliance eligible individuals to make valid comparisons among alliance health plans. Brochures must include information about cost, the characteristics and availability of the health professionals and institutions that participate in the plan, any restrictions on access to plan providers,and a summary of the annual quality performance report published under section 5005 of the Act.

(b) Each regional alliance must review and approve all materials used to market health plans.

Section 1326. Ombudsman. (a) Each alliance must establish and maintain an ombudsman to deal with problems arising within the alliance and health plans.

(b) At state option the ombudsman may be financed through a voluntary dollar checkoff arrangement at the time that individuals enroll in plans.

Section 1327. Data Collection; Quality. Each regional alliance must comply with quality requirements under title V and shall take steps to assure that plans comply with requirements.

Section 1328. Additional Duties. (a) In carrying out its activities under this part, a regional alliance may not discriminate against health plans on the basis of race, sex, national origin, religion, mix of health professionals, location of the plan's headquarters or (except as specified) organizational management.

(b) Each alliance must coordinate enrollment and disenrollment activities with other alliances to ensure continuous and non-duplicative coverage for eligible individuals.

Section 1329. Additional Authorities of Regional Alliances to Address Needs in Areas with Inadequate Health Services; Prohibition of Insurance Role. (a) In order to ensure that plans are available in all areas of the alliance, an alliance may adjust payments to plans or use other financial incentives to encourage health plan expansion.

(b) In order to help establish a new health plan in an area with inadequate services, an alliance may help organize health providers and provide technical assistance.

(c) A regional alliance may not bear insurance risk.

Section 1330. Prohibitions Against Self Dealing and Conflict of Interest. (a) The Board shall promulgate conflict of interest standards for any officer, fiduciary or employee of a regional alliance that shall identify improper ownership and investment interests, the circumstances that constitute impermissible conflicts of interest or self dealing. The Board is authorized to seek civil money penalties for violation of these rules in a manner consistent with section 1128 A of the Social Security Act.

PART 3 - AUTHORITIES AND RESPONSIBILITIES OF REGIONAL ALLIANCES RELATING TO FINANCING AND INCOME DETERMINATIONS

SUBPART A - COLLECTION OF FUNDS

Section 1341. Information and Negotiation and Acceptance of Bids.

(a)(1) Each health alliance must provide to interested plans, by April 1 of each year, information that the National Health Board specifies as necessary for plans to be able to estimate the amounts that would be payable to a plan if its premium bid for the year were accepted.

(2) At a minimum, necessary information includes the following:

(A) the demographic characteristics of regional alliance eligible individuals;

(B) the uniform per capita conversion factor for the alliance which converts an accepted bid into a premium for the individual class of enrollment;

(C) premium class factors established by the Board under section 1531;

(D) the regional alliance inflation factor;

(E) the risk adjustment factors and the reinsurance methodology and payment amounts to be used by the regional alliance to compute blended plan per capita rates under section 6201;

(F) the plan bid proportion, the AFDC proportion, the SSI proportion, the AFDC per capita premium amount, and the SSI per capita premium amount for the year, as computed under subtitle D of Title VI;

(G) the alliance administrative allowance percentage computed under section 1352.

(b) A regional alliance shall specify its uniform per capita conversion factor by April 1 of each year (beginning the year before the first year). SSI and AFDC recipients are not included in this calculation.

(c) Regional alliances shall compute and publish the risk adjustment factors and

reinsurance payment amounts to be used in computing blended plan per capita rates.

(d) Regional alliances shall solicit and negotiate with alliance health plans a per capita payment rate for the comprehensive benefit package for alliance eligible persons in the alliance area.

Section 1342. Calculation and Publication of General Family Share and General Employer Premium Amounts. (a)(1) Regional alliances shall compute the following components of the family share of premiums:

(A) a premium, by class of family enrollment, for each health plan offered in the alliance (including the amount imposed to offset the alliance's family collection shortfall);

(B) the alliance credit for each class of enrollment under section 6103;

(C) any excess premium credit provided under section 6105;

(D) the amount of any applicable corporate alliance opt-in credit under section 6106.

(2) Regional alliances shall compute employer premium payments as follows:

(A) the base employer monthly premium for each class of family enrollment under section 6122; and

(B) the employer collection shortfall add-on under section 6125.

(b)(1) Before open enrollment each year, regional alliances shall publish the general family share of the premium, without regard to any premium discounts for which certain families may be eligible and without regard to the special credit for AFDC and SSI families under section 6101(b)(2)(c)(v).

(2) Each December, regional alliances must publish the general employer premium payment for each class of family enrollment without regard to credits or add-ons in sections 6124, 6125 or 6126.

Section 1343. Determination of Family Share for Families. (a) Regional alliances charge the family share in the case of families enrolling in regional alliance health plans.

(b) The family share is based on the general family share, any income-related discounts, and whether the family receives AFDC or SSI.

(c) The alliance credit repayment amount for each family in the alliance takes into account the following factors:

(1) the number of months of enrollment, the class of enrollment, in regional alliance health plans;

(2) reductions in liability based on premium payments reflecting net earnings from self employment under section 6111;

(3) reductions in liability based on months of family employment;

(4) limitations on liability resulting from adjusted family income under section 6113;

(5) the elimination of liability in the case of certain retirees and qualified spouses and children under section 6114;

(6) the elimination of liability in the case of certain working Medicare beneficiaries under section 6115.

(d) The alliances shall have access to the information necessary to make the enrollment determinations, including:

(1) information needed for income-related determinations;

(2) information on SSI and AFDC recipients;

(3) information submitted on a monthly and annual basis by employers under section 1602;

(4) information submitted by self employed persons under section 1602;

(5) applications for premium reductions under section 6114;

(6) information concerning Medicare eligible individuals;

(7) income related discounts provided to families under section 6104;

(8) whether or not the family is an AFDC or SSI family.

(e) Participating states and the Secretary of Health and Human Services (hereafter "the Secretary") must make available information needed to determine and verify the AFDC or SSI status of alliance enrollees.

(f) The Secretary must make available information to alliances regarding the Medicare status of area residents, information on whether they are qualified employees and therefore subject to special treatment under section 6115, and information on amounts owed to the alliance. Alliances must notify the Secretary regarding those individuals that would be Medicare eligible but for the provisions of section 1012(a) (relating to Medicare individuals who are qualified employees).

(g) Regional alliances shall establish an accounting system that meets standards established by the Secretary which shall collect timely information for each enrolled individual regarding the applicable premium, families members covered under the enrollment, premiums paid, employer premiums paid, and government contributions. At the end of the year the system shall report on total premiums imposed and total amounts collected.

Section 1344. Notice of Family Payments Due. (a)(1) Alliances shall notify families who have paid the family share and are not liable for an additional payment under section 6111, that they are not required to make additional payments or file additional information.

(2) Alliances must also notify families of amounts owed and not paid. Such notices shall contain detailed information on amounts owed and the basis for the computation and the date on which payment is due. Notices must include information regarding discounts and reductions available to reduce or eliminate liability and a worksheet that families can use to calculate eligibility. Notices also must contain income reconciliation statements for families receiving a premium discount under

section 6103 and a deadline for making payment. Families that did not receive a discount but qualify for one can submit information and receive a rebate. Notices must be mailed at least 45 days before the deadline for payment.

(b) The Secretary must specify payment deadlines that take into account the date on which income reconciliation information becomes available during the year. Amounts not paid by the deadline are subject to fines and a penalty.

(c) For families changing regional alliances during a year, the Secretary shall establish rules which provide that the regional alliance through which the family most recently obtained coverage is responsible for recovering amounts due and paying other alliances as appropriate.

(d) Nonpayment shall not result in the loss of coverage under the Act.

(e) Regional alliances must maintain dispute resolution systems for resolving disputes over amounts owed.

Section 1345. Collections. (a) Regional alliances are responsible for collection of all amounts owed (whether by individuals or employers or whether on the basis of premiums owed, incorrect amounts of discounts or cost sharing or other reductions made). The Federal government does not pay any amount attributed to the failure to collect. Regional alliances shall use credit and collection procedures including late fees and imposition of interest for failure to make payment and shall be assisted by states.

(b)(1) In the case of the family share owed by qualifying employees, the Secretary of Labor shall promulgate rules for employer withholding of amounts owed. Families with multiple employers shall select the employer to make the deduction. Amounts withheld shall be paid to the alliance and the employee's obligations shall be deemed to be met to the extent that amounts are withheld.

(2) The Secretary of HHS may issue rules governing payment by families that do not include qualifying employees. Payments may not be made less than monthly.

(c) Employer premiums must be paid not less frequently than monthly. Regional alliances may require employers to pay by electronic transfer if they have the capacity to do so.

(d)(1) The Secretary of Labor shall assist regional alliances in order to promote the efficient collection of amounts owed by employers. The Secretary of Labor may also assess civil money penalties on employers that fail to pay.

(2) The Secretary of HHS may assist alliances in developing efficient collection systems for families and may also impose civil money penalties on families that fail to pay.

(e) Additional funds paid to alliances are those paid by states under subtitle A of title IX and the federal government under subtitle B of Title IX.

Section 1346. Coordination Among Regional Alliances. (a) The regional alliance in which a family is enrolled in December is responsible for collection of amounts owed without regard to whether the family resided in the alliance for the full year.

(b) Each alliance must provide to the final alliance information required to determine liability and reductions attributed to alliance credits (through the National Information System under section 5101, or otherwise).

(c) The final alliance shall distribute amounts collected equitably among the alliances that provided coverage during the year.

(d) The Secretary may publish rules to expedite alliance coordination.

(e) For full-time students, the alliance in which the parent is enrolled (if different from the one in which the student is enrolled) shall pay the student's alliance an appropriate portion of the premium.

(f) In the case of couples enrolled in a corporate alliance and in which one member is a qualified employee of a regional alliance employer, the regional alliance shall pay the corporate alliance the amounts received on behalf of the employee from the regional alliance employer without regard to discounts under section 6123.

SUBPART B - PAYMENTS

Section 1351. Payments to Regional Alliance Health Plans. (a) Regional alliances must compute, under section 6201(a) a blended plan per capita payment amount for each regional alliance plan for enrollment for a year.

(b)(1) The amount of payment equals the net blended rate adjusted to take into account the relative actuarial risk associated with such coverage.

(2) The net blended rate is the blended per capita payment amount under section 6201, reduced by the administrative allowance percentage and 1.5 percentage points and any plan payment reduction for the year under section 6011 (relating to payment reductions to keep alliance expenditures within target).

(c) Regional alliances shall use risk adjustment methodologies developed by the National Health Board to make payments to plans.

(d) The 1.5 percent of the premium is paid to the federal government for the support of academic health centers and graduate medical education.

(e) In the case of veterans health plans and uniformed services health plans, Title VI, subtitle A does not apply, except for the requirement to submit a per capita bid, which is not subject to negotiation or reduction under section 0011 and shall be considered the plan's final bid. The proportion of enrolled AFDC and SSI beneficiaries is deemed to be zero. In the case of Indian health programs, families enrolled are not taken into account in computing the blended rate. Regional alliances shall collect employer premiums owed for qualifying employees enrolled in a program of the Indian Health Service. The family share is deemed to be zero. Family residence and enrollment class rules shall be developed by the Secretary.

Section 1352. Alliance Administrative Allowance Percentage. Before obtaining bids, the alliance shall establish an administrative allowance percentage for the operation of the regional alliance. The percentage is equal to the total administrative allowance divided by the total of the amounts payable to regional alliance health plans. In no event may the allowance exceed 2.5 percent of the total amounts payable to regional alliance health plans.

Section 1353. Payments to the Federal Government for Academic Health Centers and Graduate Medical Education. Regional alliances must make payment to the Secretary annually of an amount equal to 1.5 percent of premium amounts collected.

SUBPART C - FINANCIAL MANAGEMENT

Section 1361. Management of Finances and Records. (a) Regional alliances must comply with National Board administrative and financial management requirements.

(b) Specific requirements include:

(1) Annual, published financial audits, with actions to correct deficiencies found. Error rate allowances for premium discounts, liability reductions, and cost sharing reductions consistent with maximum rates set by the Secretary of HHS for families and by the Secretary of Labor for employers and alliance error rates shall be included in the audit.

(2) Procedures for safeguarding funds in accordance with fiduciary standards and in compliance with rules of the Secretary of HHS in consultation with the Secretaries of Labor and Treasury, regarding standards for the holding of funds.

(3) Contingency funds to hold surpluses resulting from estimation discrepancies.

(4) Audits of regional alliance employers to assure proper payment. Regional alliance audits shall be coordinated in the case of employers with employees living in more than one alliance area, according to a process established by the Secretary of Labor, in consultation with the Secretary of HHS. Employers aggrieved by the results of an audit may appeal to the Secretary of Labor.

SUBPART D - REDUCTIONS IN COST SHARING; INCOME DETERMINATIONS

Section 1371. Reduction in Cost Sharing for Low Income Families. (a) AFDC and SSI families and families with adjusted incomes below 150 percent of the applicable poverty level are entitled to a cost sharing reduction. Reductions in cost sharing apply only to items and services furnished after application for the reduction. In the case of AFDC and SSI families, reductions apply only during the periods that they receive AFDC or SSI. Alliances shall furnish providers and plans with information necessary in order to provide cost sharing reductions. A cost sharing reduction is only available if there are not sufficient low-cost or combination cost plans (as defined in section 6104(b)(3)).

(b) Cost sharing reductions shall reduce cost sharing to the level of a lower cost or combination plan.

(c) In the case of AFDC or SSI families enrolled in lower or combination cost sharing plans, health plans shall provide additional cost sharing reductions equal to 20 percent of the amount that otherwise would be owed under the lower cost sharing plan, adjusted for inflation as required in section 1136. The additional reduction does not apply to non-emergency care obtained in emergency rooms.

(d) The regional alliance shall pay health plans the amount represented by the family's cost sharing reduction, except that no payment shall be made for the additional cost sharing reduction to which AFDC and SSI beneficiaries are entitled. Payments shall be made to plans based on prospective estimates of amounts owed by the alliance and reconciled on a quarterly basis.

(e) In the case of Indians, Veterans and active duty military members enrolled in Indian, Veterans and Department of Defense plans, no cost sharing reduction is available since no cost sharing is required.

Section 1372. Application Process for Cost Sharing Reductions. (a) Families may apply to their alliance for a cost sharing reduction. Applications shall include information prescribed by the Secretary of HHS and shall include information on at least family employment and income.

(b) The family's application may be filed at times specified by the Secretary, including open enrollment periods, at the time of a move, or after a change in life circumstances affecting a class of enrollment or amount of family share or repayment amount. Alliances must approve or disapprove a family's share and provide notification of the determination.

(c) Applications shall be approved if the family's adjusted income for the month is (or is expected to be) less than 150 percent of the applicable poverty level. The alliance shall use income from the previous 3-month period as well as current wages, consistent with rules of the Secretary of HHS.