(d) Family adjusted income means the sum of adjusted incomes (defined as adjusted gross income under the Internal Revenue Code) of all family members. Families may include the income of other individuals who are claimed as dependents for income tax purposes, but such individuals are not counted as family members for purposes of determining the size of the family.

(e) Family eligibility for discounts depends on periodic confirmation by the regional alliance; also, family income must be reverified at each new filing of income reconciliation statements. The Secretary is required to issue rules on confirmation and verification of income. Families must notify alliances of material changes in family income or employment status. If an alliance learns of changes in a family's income or employment status, it shall promptly reconfirm the family's eligibility, whether it learns of the change from the family, an employer, or otherwise.

(f) The alliance shall promptly terminate cost sharing reductions if it determines that a family is no longer eligible.

(g) AFDC and SSI recipients are not required to apply for cost sharing reductions. states and the Secretary shall notify each alliance of the identity of the AFDC and SSI recipients.

Section 1373. Application for Premium Discounts and Reduction in Liabilities to Alliances. (a) Families may apply for a premium discount to regional alliances under 6104 or a reduction in liability under 6113.

(b) Applications for premium reductions and reductions in liability can be filed at the times that cost sharing reduction applications are filed and may also be filed at the end of the year to obtain a rebate for excessive premiums paid.

(c) Alliances shall approve applications for a premium discount if the family's adjusted income for a month is (or is expected to be) less than 150 percent of the applicable poverty level. Alliances may grant a reduction in liability under section 6113 if the family's wage adjusted income is or is expected to be less than 250 percent of the applicable poverty level. (Wage adjusted income is equal to family adjusted income reduced by (a) the amount of wages received from employment, up to a maximum of $5,000 per month; (b) net earnings from self employment; and (c) the amount of unemployment compensation included in income). In making the determination, the alliance shall use family income from the previous 3-month period and current wages from employment, and a statement of estimated income for the year.

(d) Periodic verification and confirmation requirements apply to discounts and liability reductions, as well as to cost sharing assistance.

Section 1374. General Provisions Relating to the Application Process. (a) Regional

alliances must distribute applications under this subpart directly to consumers and through banks, employers and designated public agencies.

(b) Applications may be filed in person or by mail and may be submitted with a health plan enrollment form.

(c) Applications shall contain a declaration of annual income for the year involved.

(d) The Secretary shall prescribe the form and contents of the application for a discount or reduction.

(e) Applications may be filed at any time during the year, including during the reconciliation process under section 1373. Families may also apply to have premium discounts and reductions reduced if their incomes change.

(f) Premium discounts and reductions apply to payments required and expenses incurred after the date of approval. For AFDC and SSI recipients, the date of approval of the application for financial assistance shall be the date of approval under this subpart.

(g) Verification methods shall be prescribed by the Secretary and shall be separate from the reconciliation requirements.

(h) Regional alliances shall assist individuals in completing applications.

(i) Penalties shall be imposed on persons who knowingly misrepresent or understate their income.

Section 1375. End-of-Year Reconciliation for Premium Discount and Repayment Reduction with Actual Income. (a) Families receiving premium discounts and reductions in liability must file annual income reconciliation statements. Statements must contain such information as the Secretary of HHS may specify. Deadlines for income reconciliation shall be coordinated with regional alliance notifications to families of payments due.

(b) Regional alliances shall compute the amount of premium discount that should have been provided on the basis of the family's annual income statement (above). If the amount of discount provided is greater than it should have been, the family is liable for repaying the excess (either directly or through an increase in future payments). If the amount of rebate actually provided is less than should have been provided, the alliance must pay the difference to the family directly or by reducing the family's future premiums or payments.

(c) No reconciliation is required for AFDC and SSI families.

(d) Families that fail to file reconciliation forms are disqualified from receiving premium discounts or liability reductions.

(e) Individuals who file false statements shall be subject to monetary penalties.

(f) Regional alliances shall notify families in writing of their obligation to reconcile their income.

(g) States may use available information to assist alliances to verify family income claimed on family applications and may be provided by the Secretary of Treasury, income information from Federal tax returns consistent with section 6103 of the Internal Revenue Code so long as it is not disclosed directly to alliances.

(h) Nothing in this section shall be construed to permit reconciliation of cost sharing.

PART 4 - RESPONSIBILITIES AND AUTHORITIES OF CORPORATE ALLIANCES

Section 1381. Contracts with Health Plans. (a) A corporate alliance may offer eligible individuals either a self insured plan or a state certified health plan or both.

(b) Corporate alliances and state certified plans may contain additional provisions but may not abrogate the requirements of the corporate alliance to provide health benefits to eligible individuals.

Section 1382. Offering Choice of Health Plans for Enrollment. (a) A corporate alliance must offer enrollees a choice of at least 3 health plans. At least one must be a fee-for-service plan, and at least two of the plans must not be fee-for-service plans.

Section 1383. Enrollment; Issuance of Health Security Card. (a) Each corporate alliance shall assure the enrollment of each alliance eligible individual and shall assure enrollment as soon as individuals become alliance eligible. A corporate alliance is also responsible for issuing Health Security cards.

(b) A corporate alliance that is notified of a person who appears to be alliance eligible at a point of service shall promptly ascertain eligibility and enroll the person if eligible, and also notify the Secretary of Labor of the enrollment. The alliance shall forward the claim for payment to the enrollee's health plan.

(c) Corporate alliances shall follow regional alliance rules under subsections (d) through (f) of section 1323 with respect to annual open enrollment, enrollment of family members, and procedures in the event of over-subscription.

(d)(1) Corporate alliances shall use the same termination procedures for alliance eligible persons that apply to regional alliances under section 1323 (g).

(2) Health plans may terminate contracts with corporate alliances that fail to

pay premiums, in which case the corporate alliance is responsible for promptly enrolling plan members in another health plan.

(e) Corporate alliances must cover individuals as of the first day of the month in which the individual becomes eligible for the corporate alliance and must continue coverage through the end of the month in which the covered individuals loses eligibility.

Section 1384. Community Rated Premiums Within Premium Areas. (a) Premiums charged by corporate alliances shall vary only by the class of family enrollment and by premium area.

(b) Corporate alliances shall designate premium areas to be used to impose premiums and calculate employer payments. Boundaries shall reflect labor market or health service delivery areas and shall be consistent with rules of the Secretary of Labor so that within such areas there are not substantial differences in per capita health spending. The rules of sections 1202(b) (relating to anti-redlining and the use of metropolitan statistical areas) shall apply to corporate alliance premium areas.

(c) Premiums shall be applied based on class of family enrollment and shall vary based on class factors that take into account the considerations the National Health Board uses under section 1531 to establish premium class factors, the cost of regional alliance health plans for different classes, consisten with rules established by the Secretary of Labor.

(d) The Secretary of Labor may exempt multi-employer plans from certain requirements as may be appropriate to reflect the unique historical relationship between employers and employees under such alliances.

Section 1385. Assistance for Low Wage Employees. Corporate alliances shall adhere to rules in section 6131(b)(2) in making additional premium contributions for low wage employees who qualify for a premium discount.

Section 1386. Consumer Information and Marketing; Data Collection and Quality; Additional Duties. Corporate alliances shall follow the data, quality and information collection duties of regional alliances under sections 1325(a), 1327 and 1328.

Section 1387. Plan and Information Requirements. (a) Corporate alliances must provide written information to the Secretary of Labor regarding how they will carry out their duties.

(b) Corporate alliances must annually report on their compliance with the Act's requirements.

(c) Each alliance must notify the Secretary by March 1 each year of the number of full-time employees or participants that obtained coverage through the alliance as of January

1. Large employers that are not corporate alliances also must report to the Secretary of Labor on the number of such employees on January 1.

Section 1388. Management of Funds; Relations with Employees. The management of funds by a corporate alliance is governed by applicable parts 4 and 5 of subtitle B of ERISA (fiduciary and enforcement provisions respectively). The corporate alliance shall comply with rules of the Secretary of Labor on management of finances, records and accounting systems.

Section 1389. Cost Control. Corporate alliances must control covered expenditures in compliance with part 2 of subtitle A of Title VI.

Section 1390. Payment by Corporate Alliance Employers to Corporate Alliances.
(a) Large employer sponsors shall fund benefits in a manner consistent with 6131, through insurance or otherwise, and shall meet certain solvency requirements in sections 1394, 1395 and 1396.

(b) Other corporate sponsors make premium payments in a manner consistent with rules of the Secretary of Labor.

Section 1391. Coordination of Payments. (a) A corporate alliance shall make premium payments to regional alliances in cases in which a married couple has enrolled with a regional alliance plan, and one spouse is an employee of a regional alliance employer, and the other an employee of a corporate alliance employer that has made payments for the employee to the corporate alliance.

(b) Where a couple is employed by two different corporate alliances, the alliance in which the couple is not enrolled shall make payments to the alliance in which the couple is enrolled.

Section 1392. Applicability of ERISA Enforcement Mechanisms for Enforcement of Certain Requirements. Sections 502 (civil remedies) and 504 (investigative enforcement) of ERISA shall apply to enforcement actions by the Secretary of Labor under this part.

Section 1393. Applicability of Certain ERISA Protections to Enrolled Individuals. The provisions of sections 510 (relating to interference with rights protected under the Act) and 511 (relating to coercive interference) shall apply to corporate alliance enrollees as they apply to participants and beneficiaries in employee welfare benefit plans covered under ERISA.

Section 1394. Disclosure and Reserve Requirements. (a) The Secretary of Labor must assure that each self insured corporate alliance health plan reserves in trust sufficient assets to ensure that the plan can at any time pay health care providers the outstanding balance owed by the plan. (The trust arrangement is to be as provided under section 403 of

the Employee Retirement Income Security Act of 1974 (but omitting the section 403(b)(4) exemption of that act.)) The Secretary shall prescribe the type of security that satisfies the requirement of this section.

(b) Self insured plans must notify the Secretary if they do not satisfy the reserve requirements and are subject to a $100,000 penalty for failing to disclose the lack of security.

Section 1395. Trusteeship by the Secretary of Labor of Insolvent Corporate Alliance Health Plans. (a) If the Secretary of Labor determines that a self insured corporate alliance plan will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulation, the Secretary shall apply to the appropriate United States District Court for appointment as trustee. The Court shall appoint the Secretary after a hearing if it determines that a trusteeship is necessary to prevent further financial deterioration or protect the interest of the covered individuals or health care providers. The trusteeship shall continue until the hazardous conditions are remedied.

(b) The Secretary shall have broad powers to manage the health plan, secure information and records, collect funds and premiums owed, terminate and liquidate or preserve the plan, and otherwise protect the interests of plan enrollees.

(c) The Secretary shall notify the plan administrator, enrolled individuals and employers that are liable for contributions of the appointment.

(d) The Secretary shall carry out other duties specified by ERISA for a trustee.

(e) The Secretary may file a trusteeship application notwithstanding other judicial proceedings against the plan.

(f) The court in which the application for trusteeship is filed shall have exclusive jurisdiction of the plan and its property wherever located and may stay any other proceeding against the plan. Venue lies in the judicial district where the plan administrator resides or does business or where plan assets are situated.

(g) The Secretary may appoint personnel needed to carry out trustee duties.

Section 1396. Guaranteed Benefits Under Trusteeship of the Secretary of Labor. (a) The Secretary of Labor shall guarantee all benefits of the self-insured plan.

(b) Any increase in benefits resulting from a plan amendment that was made or became effective within 180 days of the Secretary's appointment shall be disregarded for the purpose of determining the guarantee.

(c) The Secretary shall establish a Corporate Alliance Health Plan Insolvency Fund to pay guaranteed benefits. The fund shall receive assessments and funds borrowed and shall

make payments needed to cover guaranteed benefits, repay loans, and operate the fund. The total balance of outstanding fund obligations at any time may not exceed $500 million.

(d) The fund shall have sufficient borrowing authority, in accordance with terms established by the Secretary of the Treasury, to carry out its duties.

Section 1397. Imposition and Collection of Periodic Assessments on Self Insured Corporate Alliance Plans. (a) The Secretary of Labor may impose assessments on self insured corporate alliances in order to permit the insolvency fund in section 1396, to repay loans and carry out its duties.

(b) Assessments shall be uniform but may vary the amount by category or reserve requirements.

(c) Not more than 2 percent of total premiums paid to plans may be assessed during a year.

(d) Plans shall pay assessments when due, as determined by the Secretary. The Secretary is authorized to impose fines and penalties for late payment. Plans can obtain a waiver of the timely payment requirement on a showing of substantial hardship.

(e) The Secretary may commence a civil action in federal district court against a plan for non-payment.

(f) The Secretary shall continue to guarantee benefits even if assessments are not paid.

(g) The designated payer is the employer or plan administrator in the case of a large employer or the contributing employers and the administrator in the case of a multi-employer plan. Controlled groups who are treated as a single employer (as defined in the Internal Revenue Code) are jointly and severally liable for payment of assessments.

Section 1398. Payments to Federal Government by Multiemployer Corporate Alliance for Academic Health Centers and Graduate Medical Education. A multiemployer corporate alliance must pay the Secretary of HHS an amount equal to the amount that would have been payable under section 1353 if the alliance were a regional alliance. The Secretary shall develop rules estimating amounts owed. Such estimates must be based on the annual per capita expenditure equivalent under section 6021.

SUBTITLE E - HEALTH PLANS
(H.R. 3600 and S. 1757 p. 224)

This subtitle sets forth requirements for plans contracting with alliances as health plans. Part 1 describes plan duties with respect to the comprehensive benefit package. Part 2 sets forth requirements relating to supplemental insurance. Part 3 describes plan duties with respect to essential community providers. Part 4 relates to workers compensation and automobile medical liability coverage.

Section 1400. Health Plan Defined. (a) The term health plan means a plan that provides the comprehensive benefit package and meets the requirements of parts 1, 3 and 4 of this subtitle.

(b) An appropriate self-insured health plan is a self-insured group health plan to which the applicable requirements of Title I of ERISA apply.

(c) A state certified health plan is a health plan certified by a state or by the Board in the case of federal administration.

(d) The applicable regulatory authority is the Secretary of Labor for self-insured plans and the state authority with respect to state-certified plans.

PART 1 - REQUIREMENTS RELATING TO COMPREHENSIVE BENEFIT PACKAGE

Section 1401. Application of Requirements. A plan may not be treated as a health plan under the Act unless it is self-insured or state-certified or if the applicable regulatory authority determines that the plan is not in compliance with applicable requirements.

Section 1402. Requirements Relating to Enrollment and Coverage.

(a)(1) Health plans offered by regional or corporate alliances must accept every eligible person seeking enrollment. Plans may not engage in practices that have the effect of attracting or limiting enrollees on the basis of personal characteristics such as health status, anticipated needs for health care, age, occupation, or affiliation with any person or entity.

(2) Health plans may limit enrollment because of limits in capacity or financial constraints, with the approval of the applicable regulatory authority.

(b) Plans may not:

(1) terminate, restrict, or limit coverage for any reason, including non-payment of premiums;

(2) cancel coverage for any enrollee until the individual is enrolled in another plan;

(3) exclude an individual from coverage because of the individual's medical condition;

(4) impose waiting periods before coverage begins

(5) impose a rider that serves to exclude certain eligible individuals

(c)(1) A health plan may not discriminate or engage (directly or through contractual arrangements) in any activity, including the selection of a service area, that has the effect of discriminating, on the basis of race, national origin, sex, language, socio-economic status, age, disability, health status, or anticipated need for health services.

(2) In selecting network providers or establishing terms and conditions for membership, a health plan may not engage in any practice that has the effect of discriminating against a provider on the basis of race, national origin, sex, language, age, disability of the provider or patients, or on the basis of socio-economic status, disability, health status or anticipated need for health services of a patient of the provider.

(3) A person may take an action that is prohibited by this section if the action is required by business necessity but may never intentionally discriminate.

(4) The Secretary of HHS is required to issue regulations implementing these non-discrimination provisions within a year of the date of enactment.

(d) Plans offering the lower cost sharing schedule (section 1131):

(1) shall apply the schedule to all items and services in the comprehensive benefit package;

(2) shall offer enrollees the opportunity to obtain coverage for out-of-network services and items; and

(3) notwithstanding the community rating requirements of section 1403, may charge an alternative premium to take into account coverage of out-of-network use of services.

(e) Health plans, in providing the comprehensive benefit package,

(1) must include in payments to providers such additional reimbursement as is necessary to reflect cost sharing reductions described in section 1371 and

(2) must maintain claims or encounter records as may be necessary to audit the additional amount of reimbursement paid to providers.

(f)(1) The term "in network" under this subtitle means items or services provided to an enrollee by a provider who is a member of the provider network of the plan.

(2) The term "out of network" means items or services provided to an enrollee by a health provider who is not a member of the plan network.

(3) The term "provider network" means providers who have entered into an agreement with the health plan under which they are obligated to furnish items and services in the benefit package on a fee-for-service or other basis.

(g) Health plans are not required to furnish services to detention facilities for detainees in the facility.

Section 1403. Community Rating. (a) Regional alliance plans may vary premiums only with respect to different types of family coverage under section 6102.

(b) Corporate alliance plans may vary premiums only with respect to different types of family coverage under section 1384.

Section 1404. Marketing of Health Plans; Information.

(a)(1) As a condition of contracting with an alliance, health plans may not include false or misleading information in their marketing materials and shall submit materials for prior approval by alliances before distribution.

(2) Regional alliance health plans must distribute their marketing materials to entire market areas served by the plan.

(3) Plans may not seek to influence an individual's choice of plans in conjunction with the sale of any other insurance.

(b)(1) Regional alliance health plans must provide eligible individuals with information about plan cost, participating providers, utilization control procedures, quality management procedures, rights and responsibilities, and information on plan disenrollment.

(2) No health plan may be state certified if it is determined that the plan provided to consumers contains materially inaccurate information.

(c) Health plans (whether self-insured or state-certified) must provide information on advance directives for use when a patient becomes unable to consent to care, as described in section 1876 of the Social Security Act.

Section 1405. Grievance Procedure. Health plans must establish grievance procedures that meet the requirements of subtitle C of title V. Enrollees may also seek assistance from the alliance ombudsman and seek any additional legal remedies.

Section 1406. Health Plan Arrangements with Providers. (a) Health plans must have arrangements with providers as necessary to assure the provision of all items and services covered by the comprehensive benefit package to enrollees.

(b)(1) Health plans must cover emergency and urgent care services without regard to whether the provider furnishing the service has a contractual agreement to furnish the services, and in the case of emergency care, without prior authorization.

(2) Payments for emergency and urgent care services outside the health plan's service area must be paid in accordance with the alliance fee schedule where services are provided.

(c)(1) Health plans operating on a fee for service basis must use the alliance or statewide fee schedule.

(2) If a provider under a health plan voluntarily agrees to reduce the amount charged to an enrollee, the plan shall reduce payment to the provider under the fee schedule by the proportion of the provider's discount.

(3) Noncomplying plans (whose expenditures exceed alliance targets) must reduce payments under the fee schedule to providers that are not participating providers under section 6012.

(d)(1) Providers may not charge or collect from enrollees amounts in excess of the fee schedule; neither the plan nor enrollees are liable for any such excess charges.

(2) Providers may not directly bill enrollees for amounts that are payable by the health plan (including cost sharing reduction assistance payable by the plan).

(3) Agreements between plans and providers shall provide for a prohibition on balance billing (provider billing exceeding the scheduled fee above).

(e) Agreements, between plans and providers must provide for reductions in payments to providers under section 6012 in the event that the plan is found to be in noncompliance.

Section 1407. Preemption of Certain State Laws Relating to Health Plans. (a) State laws may not be applied against health plans that are not fee-for-service plans (or fee for service components of plans) if they have the effect of prohibiting plans from:

(1) limiting the number and types of participating providers;

(2) requiring enrollees to obtain care from participating providers;

(3) requiring enrollees to obtain referrals for specialty treatment;

(4) establishing different payment rates for network and non-network providers;

(5) creating incentives for the use of participating providers;

(6) using single source suppliers for pharmacy services, medical equipment, and other supplies and services.

(b) State laws related to the corporate practice of medicine shall not apply to health plans that are not fee-for-service plans and their participating providers.

(c) A participating provider is a provider who is a member of a plan's provider network.

Section 1408. Financial Solvency. Health plans must meet or exceed a state's minimum capital requirements for such plans, participate in a state's guaranty fund, and meet other requirements relating to fiscal soundness established by the state.

Section 1409. Requirement for Offering Cost Sharing Policy. Health plans must offer cost sharing policies (as described in section 1421 (b)(2)) to enrolling families that cover the cost of out-of-network items and services as well as deductibles and coinsurance

applicable to network services.

Section 1410. Quality Assurance. Each health plan shall comply with quality assurance requirements under title V.

Section 1411. Provider Verification. Health plans must verify the credentials and licenses of participating providers, oversee their quality and performance of providers, and investigate and resolve complaints against participating providers.

Section 1412. Consumer Disclosures of Utilization Management Protocols. Health plans must disclose protocols used by the plan to control utilization and costs.

Section 1413. Confidentiality, Data Management, and Reporting. Health plans must comply with confidentiality, data management and reporting requirements under Title V and must assure that health information submitted in electronic form is accurate and reliable. Health plans must comply with federal privacy requirements.

Section 1414. Participation in Reinsurance System. Health plans must participate in state reinsurance systems.

PART 2 - REQUIREMENTS RELATING TO SUPPLEMENTAL INSURANCE

Section 1421. Imposition of Requirements on Supplemental Insurance. (a) Health plans may offer supplemental health benefit policies but only if the policies meet requirements under section 1422 and may sell cost-sharing policies but only if they meet requirements under section 1423.

(b)(1) A supplemental health benefit policy means a health insurance policy or health benefit plan which provides coverage for items and services not covered in the benefit package or coverage for items and services that are covered but limited in the amount, duration and scope of coverage. Supplemental health benefit policies do not include cost sharing policies, long-term care insurance policies, disease-specific insurance, hospital or nursing home indemnity insurance, Medicare supplemental policies, and accident insurance.

(2) A cost sharing policy is a health insurance policy or health benefit plan providing coverage for deductibles, coinsurance and copayments imposed as part of the comprehensive benefit package under title II, whether imposed on a higher cost sharing plan or with respect to out-of-network providers.

Section 1422. Standards for Supplemental Health Benefit Policies. (a) No health plan, insurer or any other person may offer supplemental benefit policies that duplicate coverage under either the comprehensive benefit package or the Medicare program.

(b) Health plans offering supplemental policies must accept all applicants for

enrollment, subject to capacity and financial limits. This requirement does not apply in the case of supplemental plans offered only on the basis of an individual's employment or membership in a fraternal, religious, professional, or other organization.

(c) The National Board will develop rules to prohibit marketing abuses by sellers of supplemental plans that involve tie-in arrangements, financial inducements to purchase policies, or the disclosure of information about the health status of health plan participants for the purpose of marketing a policy.

(d) Entities that violate this provision are subject to civil money penalties in accordance with the procedures of section 1128 of the Social Security Act.

Section 1423. Standards for Cost Sharing Policies. (a) A regional allliance health plan may offer cost sharing policies only if offered by the plan in which an individual is enrolled, only if offered to all enrollees in the health plan, only if both standard and maximum coverage policies are offered, and only if offered during the annual open enrollment period.

(b) Health plans may not offer insurance against the copayments required under the schedule under section 1135 (Table 2).

(c) Cost sharing policies must cover items and services to the same extent that the benefit package covers the items and services. The price of a policy must be the same to each individual and must take into account an expected increase in utilization rates resulting for the policy. Policies may not have a loss-ratio (the ratio of premium returned to consumers relative to the total payout collected in premiums) of less than 90 percent.

(d) States may not certify a health plan if the cost sharing policy does not meet the standards of this section.

(e) Supplemental plans offered under the Federal Employee Health Benefits Program (FEHBP) are exempt from the requirements of subsection (a) but only if the supplemental plans are offered to all persons to whom a comprehensive benefit plan must be offered under section 8203, both standards and maximum policies are offered, the supplemental plan is offered only during the open enrollment period, and the price takes into account any expected increased in utilization resulting from the supplemental plan.

PART 3 - REQUIREMENTS RELATING TO ESSENTIAL COMMUNITY PROVIDERS

Section 1431. Health Plan Requirement. (a) Health plans must, with respect to each electing essential community health provider (as defined in subsection (d)) located in the plan's service area, either

(1) enter into a written provider participation agreement with the provider; or

(2) enter into a written agreement under which the plan shall make payment to the provider in accordance with subsection (c).

(b) A participation agreement between a health plan and an essential community provider shall include terms and conditions at least as favorable as those applicable to other participating providers with respect to the following:

(1) the scope of services for which payment is made by the plan to the provider;

(2) the rate of payment for covered care and services;

(3) the availability of financial incentives;

(4) limitations on financial risk provided to other providers;

(5) assignment of enrollees to participating providers;

(6) access by the provider's patients to the plan's specialists.

(c) In the case of providers electing payment without regard to a participation agreement, the provider may elect to be paid either in accordance with the alliance fee schedule or on the basis of the most closely related Medicare payment rate or methodology, as specified by the Secretary of HHS in regulations. Payment may be subject to utilization review, but not to otherwise applicable gate-keeper requirements.

(d) An electing essential community provider is an essential community provider that is certified as an essential community provider under section 1581 and that elects to apply to the health plan. The Secretary of HHS shall specify the form and manner in which election is to occur; election shall include notice to the health plan. An election may be made once annually, unless the plan and provider agree to a more frequent election.

(e) In the case of essential providers that are school health clinics, each health plan shall pay to each school health provider an amount determined by the Secretary.

Section 1432. Sunset Requirement. The provisions of Section 1431 apply to health plans only during the five-year period beginning with the first year that a regional alliance health plan is offered by the alliance.

(b) The Secretary shall conduct studies of essential providers, how the term is defined, examining how payment is made, the effects of the contracting and payment requirements under this part, and other matters.

(c) No later than March, 2001, the Secretary shall report to Congress with recommendations concerning the continuation, modification or termination of the special health plan contracting requirements for essential providers. Congress shall have 60 days from the date the recommendations are presented to act. In the event that the recommendations of the Secretary are not disapproved, they shall be adopted.

PART 4 - REQUIREMENTS RELATING TO WORKERS' COMPENSATION AND AUTOMOBILE MEDICAL LIABILITY COVERAGE

Section 1441. Reference to Requirements Relating to Workers Compensation Coverage. See part 2 of subtitle A of Title VIII.

Section 1442. Reference to Requirements Relating to Automobile Medical Liability Services. See Part 2 of Subtitle B of title VIII.

SUBTITLE F - FEDERAL RESPONSIBILITIES
(H.R. 3600 and S. 1757 p. 256)

PART 1 - NATIONAL HEALTH BOARD

SUBPART A - ESTABLISHMENT OF A NATIONAL HEALTH BOARD

Section 1501. Creation of A National Health Board; Membership. A National Health Board, composed of seven members appointed by the President and subject to Senate confirmation, is created to oversee the implementation of Health Security Act. The Board shall have a chair designated by the President, who serves a term concurrent with that of the president and who shall also act as the chief executive officer of the Board. The Chair may serve a maximum of three terms; other members serve terms of four years. Rules on the staggering of terms and the filling of vacancies are also provided.

Section 1502. Qualifications of Board Members. (a) Each member must be a United States citizen.

(b)Members will be selected on the basis of their experience and expertise in relevant subjects, such as the practice of medicine, nursing, or other clinical practices, health care financing and delivery, state health systems, consumer protection, business, law and delivery of care to vulnerable populations.

(c) Service on the Board shall constitute federal employment and shall be exclusive employment.

(d) Members of the Board may hold no interest in an affected health care industry.

(e) Members are subject to post-employment restrictions applicable to comparable federal employees.

(f) Federal pay schedules for the Board members and the Chair are specified at levels IV and II, respectively, of the Executive Schedule.

Section 1503. General Duties and Responsibilities. (a) The Board shall interpret the comprehensive benefit package, make adjustments in the delivery of preventive health services, and assure national uniformity in coverage standards. The Board also may recommend to the President and Congress changes in the benefit package that are appropriate in light of changes in technology, health care needs, health care costs, and methods of service delivery.

(b) The Board shall oversee the cost containment provisions of Title VI.

(c) The Board shall develop rules for eligibility, plan coverage of certain individuals, and treatment of families.

(d) The Board shall oversee the performance based quality management system described in Title V.

(e) The Board shall oversee the development of the national health information system described in Title V.

(f) The Board shall establish standards for participating states, monitor state compliance and provide technical assistance in a manner that assures access to the comprehensive benefit package.

(g) The Board shall develop premium class factors under subpart D.

(h) The Board shall develop a risk adjustment methodology for premium payments to plans in accordance with part 3 of this subtitle.

(i) The Board shall establish minimum capital requirements and requirements for guaranty funds under subpart G.

(j) The Board shall establish standards for health plan grievance procedures.

Section 1504. Annual Report. (a) The Board shall prepare and send to Congress and the President an annual report addressing overall implementation of the system. The report shall include information on federal and state implementation, quality data, recommendations or changes in the administration, regulation, and laws related to health care coverage, and a full account of Board actions in the preceding year.

Section 1505. Powers. (a) The Board shall have authority, consistent with federal civil service laws, to appoint officers and employees and may enter into contracts for studies and analyses. Executive branch employees may be detailed to assist the Board in carrying out its duties.

(b) The Board may establish advisory committees.

(c) The Board may secure directly (from any federal agency) necessary information to the extent such information is available to a federal department or agency.

(d) The Board may delegate functions to officers and employees but may not be relieved of responsibility for administration of such functions.

(e) The Board may promulgate rules needed to carry out the Act.

Section 1506. Funding. (a) There are authorized such sums as may be necessary for fiscal years 1994 through fiscal years 1998. The Office of Management and Budget shall review the Board's budget annually.

SUBPART B - RESPONSIBILITIES RELATING TO REVIEW AND APPROVAL OF STATE SYSTEMS

Section 1511. Federal Review and Action on State Systems. (a) (1) The Board shall approve a state health care system unless the Board finds that the system does not or will not provide for the state to meet its participation responsibilities under the Act.

(2) The Board shall issue regulations outlining participation requirements by July 1, 1995. The Board must take action on states intending to participate before the date of issuance of regulation.

(3) The Board may not approve a state health care system for any year prior to 1996.

(b)(1) The Board must notify states within 7 days of the receipt of documents as to whether the document is complete and provides the Board with sufficient information to approve or disapprove the state's plan.

(2) In the case of incomplete documents, states have 45 days to submit additional information.

(c) The Board shall act on a state proposal within 90 days after the state has submitted a complete document. The Board's failure to act within the prescribed time period shall be deemed to be approval of the state's document.

(d) If the Board does not approve a state's document, the state has 30 days in which to submit additional information. The Board shall respond to this additional information within 30 days. If the Board does not meet this deadline, the plan is deemed approved.

(e) If the Board terminates its approval of a state's system, it shall approve the system in a succeeding year if the state satisfies the Board that the cause of its failure no longer exists and provides reasonable assurances that the actions that formed the basis of the termination will not recur.

(f) A state may revise its system, but revisions will not take effect until the Board has approved documents revising the state system. The Board shall act on state amendments within 60 days of submission. If the Board fails to act within 60 days, the revision shall be considered approved. A state shall have an opportunity to respond to rejected revisions.

(g) If a state fails to submit documents to become a participating state, the Board shall notify the Secretary of HHS and the Secretary of the Treasury.

Section 1512. Failure of Participating States to Meet Conditions for Compliance.

(a) If the Board determines that a state system fails to meet the requirements of the Act, sanctions shall be imposed in accordance with subsection (b).

(b)(1) If the Board determines that the state's failure does not substantially jeopardize individuals' access to health coverage, it may directly order compliance by a regional alliance to correct the problem and may, if it determines that the problem has not been corrected, notify the Secretary of Health and Human Services who shall reduce payments in accordance with section 1513.

(2) If the Board determines that the state's non-compliance substantially jeopardizes individuals' access to coverage, it shall terminate its approval of the state's plan and notify the Secretary, who shall assume the duties described in section 1522..

(c) A state against which a sanction has been imposed may submit information at any time to demonstrate that the failure has been corrected. Following a determination the Board may then notify the alliance that has been sanctioned or notify the Secretary in the case of other sanctions that have been applied against the state under subsection (b).

(d) The Secretary shall exercise authority only in a manner that assures uninterrupted coverage for individuals in the state.

Section 1513. Reduction in Payments for Health Programs by the Secretary of Health and Human Services. (a) Upon receiving notice from the Board, the Secretary shall reduce certain payments that otherwise would be made to individuals and entities in the state.

(b) Payments subject to reduction are:

(1) Payments to academic health centers under Title III;

(2) Payments for health services research funded under the Public Health Service Act;

(3) Payments to hospitals serving vulnerable populations under Title III.

Section 1514. Review of Federal Determination. A state or alliance that is affected by a decision of the Board may appeal the decision under section 5231 of the Act.

Section 1515. Federal Support for State Implementation. (a) Not later than 90 days after enactment, the Secretary shall make planning grants available to each state to develop the system needed to become a participating state. Funds for this purpose will be distributed according to a formula developed by the Secretary. Appropriations of $50,000,000 in each of fiscal years 1995 and 1996 are authorized.

(b) States that have enacted enabling legislation qualify for grants to assist in the development of regional alliances. Grants shall be allocated in accordance with a formula developed by the Secretary. States must expend amounts equal to the amount made available under this section in order to qualify for federal assistance. Authorized funding levels are

$313,000,000 for fiscal year 1996, $625,000,000 for fiscal year 1997, and $313,000,000 for fiscal year 1998.

SUBPART C - RESPONSIBILITIES IN THE ABSENCE OF STATE SYSTEM

Section 1521. Application of Subpart. (a) This section applies to states beginning January 1, 1998, unless the state submits its documents by July 1, 1997, and the Board determines that the state meets the requirements of the Act.

(b) In the case of states whose systems have been disapproved, this subpart becomes effective as of a date that is appropriate to assure that continuity of coverage for the comprehensive benefit for eligible individuals is not lost.

Section 1522. Federal Assumption of Responsibilities in Non-Participating States. (a) When the Board determines that this subpart applies to a state in a calendar year, it shall notify the Secretary.

(b) Upon receiving notice the Secretary shall establish a regional alliance system in the state and shall take other steps required of participating states.

(c) Regional alliances established by the Secretary must meet all of the requirements of alliances in participating states.

(d) The Secretary shall establish a guaranty fund to provide financial protection for health care providers and individuals in the event of an alliance health plan failure. The Secretary is authorized to impose assessments on health plans for so long as necessary to generate sufficient revenues for the guaranty fund.

Section 1523. Imposition of Surcharge on Premiums Under Federally Operated Systems. (a) In operating a state alliance system under this subpart, the Secretary shall impose premiums equal to the amount the state alliance(s) would have imposed, increased by an additional 15 percent to reimburse the Secretary for expenses incurred in operating the system.

(b) The 15 percent surcharge shall be treated as part of the premium.

Section 1524. Return to State Alliance. (a) A state may apply at any time for approval to assume operation of a federally administered alliance system.

(b) If the Board approves the state's application, the state's takeover shall begin as of January 1, following the date of approval.

SUBPART D - ESTABLISHMENT OF CLASS FACTORS FOR CHARGING PREMIUMS

Section 1531. Premium Class Factors. (a) For each class of family enrollment under section 1011(c), the Board shall establish a premium class factor that reflects the relative actuarial value of the comprehensive benefit package of the class of family enrollment, compared to individual enrollment. The factor for individual enrollment shall be one, and the factor for a couple-only class shall be two.

SUBPART E - RISK ADJUSTMENT AND REINSURANCE METHODOLOGY FOR PAYMENT OF PLANS

Section 1541. Development of a Risk Adjustment and Reinsurance Methodology. (a) By April, 1995, the Board shall develop a risk adjustment and reinsurance methodology. The Board shall make improvements in the methodology as appropriate in order to achieve the purposes of the methodology.

(b)(1) The purposes of the methodology are to assure that payments to plans reflect expected utilization and expenditures for such services by plan enrollees compared to average utilization and expenditure rates and to protect plans that enroll a disproportionate share of individuals whose utilization and expenditures are higher than average.

(2) In developing its methodology, the Board shall consider the following factors:

(A) demographic characteristics;

(B) health status;

(C) geographic area of residence;

(D) socio-economic status;

(E) the proportion of enrollees who are SSI and AFDC recipients unless the Board concludes that other risk adjustment factors are sufficient to adjust premiums to take into account the effects of high AFDC and SSI enrollment;

(F) other material factors identified by the Board.

(3) The methodology shall assure that the total payment to health plans in the alliance would be the same after application of the factors as in the absence of the risk adjusters.

(4) The risk adjustment methodology shall allow for prospective adjustment to plans, to the maximum extent possible.

(5) The Board may eliminate a special AFDC and SSI adjustment if it determines that other adjustments are sufficient.

(6) The Board shall give special consideration to payment adjustments with respect to persons with mental illness.

(7) The Board shall give special consideration to adjustment for Indian, Veterans and Department of Defense health plans.

(8) If total payments by a regional alliance to its health plans either exceed or fall short of the total of such payments estimated by the alliance using the Board's risk adjustment methodology, and if the problem results from a discrepancy between the alliance estimate of the distribution of enrolled families by risk categories and their actual distribution, the Board shall adjust its methodology in a succeeding year by the amount of the excess or deficit to take the discrepancy into account.

(c)(1) The Board's methodology may include a system of mandatory reinsurance, but not voluntary reinsurance.

(2) If the Board determines that a risk adjustment system cannot be developed and readied for implementation by April, 1995, it shall include mandatory reinsurance as a component of the methodology. The Board may eliminate this requirement when it determines that a risk adjustment system has been developed and is ready for implementation.

(3) The Board, in developing a reinsurance methodology, shall provide for health plans to make payments to state reinsurance programs for the purpose of reinsuring some or all classes of items and services in the comprehensive benefit package for specified classes of high risk enrollees, and for high cost diagnoses and treatments. The Board also may specify the structure and operation of the system.

(d) The Board shall assure that reinsurance systems are developed in conformity with confidentiality requirements.

Section 1542. Incentives to Enroll Disadvantaged Groups. The Board shall establish standards to permit states to adjust the risk adjustment methodology to create financial incentives for health plans to enroll disadvantaged groups.

Section 1543. Advisory Committee. The Board shall establish a 15 member technical advisory committee to assist in the development of a risk adjustment methodology, which shall include representatives of health plans, regional alliances, consumers, employers and health providers.

Section 1544. Research and Demonstrations. The Secretary shall conduct research and demonstrations to aid in the development of a risk adjustment methodology.

Section 1545. Technical Assistance to States and Alliances. The Board shall assist states and alliances implement the risk adjustment methodology.

SUBPART F - RESPONSIBILITIES FOR FINANCIAL REQUIREMENTS

Section 1551. Capital Standards for Regional Alliance Health Plans. (a) The Board

shall develop in consultation with the states, minimum capital requirements for regional alliance health plans.

(b) For each regional alliance health plan, there must be at least $500,000 in capital maintained, regardless of whether a sponsor offers more than one plan in the area.

(c) The Board may require additional capital, based on factors likely to affect the financial stability of health plans, including the following factors:

(1) projected plan enrollment and the number of participating providers;
(2) market share and strength of competition;
(3) extent and nature of risk sharing with participating providers and their financial stability;
(4) prior performance of the plan, its risk history, and liquidity of assets.

(d) The National Association of Insurance Commissioners shall develop model standards for additional capital requirements for the Board by July 1, 1995. The Board may accept or modify such standards.

Section 1552. Standards for Guaranty Funds. (a) In consultation with the states, the Board shall develop standards for state guaranty funds.

(b) Standards shall include the following:

(1) A fund must be able to generate sufficient resources to pay providers and others in the event of plan failure, in order to meet obligations with respect to services rendered by providers for the comprehensive benefit package and any supplemental coverage for cost sharing. Fund resources must also be sufficient to meet plan obligations for services rendered prior to and after plan insolvency, before they plan to enroll in other health plans.

(2) The fund must be liable for all claims against the plan by health care providers with respect to items and services furnished under the comprehensive benefit package.

(3) The fund stands as a creditor for payments owed the plan, to the extent of payments made by the fund for plan obligations.

(4) The fund has authority to borrow against future assessments.

PART 2 - RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBPART A - GENERAL RESPONSIBILITIES

Section 1571. General Responsibilities of the Secretary of Health and Human Services. (a) Except as specifically provided, the Secretary shall administer all provisions of

the Act except those delegated to the National Board, any other executive agency or a state.

(b) The Secretary shall develop standards for the financial management of health alliances.

(c) The Secretary shall periodically audit regional alliances in the areas of:
(1) enrollment of all regional alliance eligible individuals;
(2) management of premium and cost sharing discounts and reductions; and
(3) financial management, including collection shortfalls.

Section 1572. Advisory Council on Breakthrough Drugs. (a) The Secretary shall appoint an Advisory Council on Breakthrough Drugs that will examine the reasonableness of new drug pricing in the case of drugs that represent a breakthrough or significant advance over existing therapies.

(b) At the request of the Secretary, the Council shall determine the reasonableness of launch prices of breakthrough drugs. Determinations shall be based on:
(A) the price of other drugs in the same therapeutic class,
(B) cost information supplied by the manufacturer,
(C) the price of the drug in countries specified in section 802(b)(4)(A) of the Federal Food, Drug and Cosmetic Act, and
(D) projected prescription volume, economies of scale, product stability, special manufacturing and research costs,
(E) cost effectiveness relative to the cost of alternative treatments, and
(F) improvements in the quality of life offered by the new product.
The Secretary shall review and publish the determinations of the Council along with minority opinions.

(c) The Council shall include 12 members, including a representative from the pharmaceutical industry, consumer organizations, physician organizations, the hospital industry, and the managed care industry. Other members must be recognized experts in the fields of health care economics, pharmacology, pharmacy and prescription drug reimbursement.

(d) Appointments shall be for three-year terms; but the Secretary may provide initially for shorter terms so that no more than five members' terms expire in any one year.

(e) Members shall be reimbursed for their travel expenses and per diem in lieu of subsistence.

(f) Notwithstanding the Federal Advisory Committee Act, the Council shall continue in existence until otherwise specified by law.

SUBPART B - CERTIFICATION OF ESSENTIAL COMMUNITY PROVIDERS

Section 1581. Certification. (a) The Secretary shall certify as an "essential community provider" any health care provider or organization that:

(1) is within any of the categories specified in section 1582(a) or

(2) meets certification standards under section 1583(a).

(b) The Secretary shall develop a certification process that permits providers to be certified prior to the date of implementation of the Act in a state.

Section 1582. Categories of Providers Automatically Certified. (a) The following providers are automatically certified as essential community providers:

(1) migrant health centers;

(2) community health centers;

(3) homeless program providers funded under section 340A of the Public Health Service Act;

(4) public housing providers funded under section 340A of the Public Health Service Act;

(5) family planning clinics;

(6) service units of the Indian Health Service, a tribal organization, or an urban Indian program, as defined in the Indian Health Care Improvement Act;

(7) AIDS providers funded under the Ryan White Act;

(8) public and private non-profit entities furnishing prenatal, pediatric or ambulatory services to children, including children with special health care needs and that receive funding under Title V of the Social Security Act;

(9) Federally qualified community health centers and rural health clinics;

(10) providers of school health services receiving funding under subtitle G of Title III; and

(11) community practice networks receiving development funding under subtitle E of title III.

(b) Certification applies to both recipients and sub-recipients of grants. A sub-recipient is an entity that receives funding under a contract with the principal recipient and meets the requirements needed to be a recipient.

Section 1583. Standards for Additional Providers. (a) The Secretary shall publish standards for certification of additional categories of health care providers and organizations as essential community providers. Such health providers may be certified only if the Secretary determines that health plans operating in areas served by the applicant would not be able to assure adequate access to the comprehensive benefit package without contracting with the applicant.

(b) Optional categories include:

(1) health professionals (including physicians, nurses, nurse practitioners,

certified nurse midwives, physicians assistants, psychologists, dentists, pharmacists, and other health care professionals recognized by the Secretary) who either are located in a health professions shortage area (as the term is used in section 332 of the Public Health Services Act), or who provide a substantial amount of health services to medically underserved populations (as the term is used in section 330 of the Public Health Service Act).

(2) Institutional providers meeting the same location and service requirements as health professionals.

(3) other public and private non-profit agencies and organizations that meet the location or service requirements for health professionals.

Section 1584. Certification Process; Review; Termination of Certifications.

(a)(1) The Secretary shall decide on public certification procedures within 6 months of enactment of this Act and shall describe the form and manner in which application for certification is to be made.

(2) The Secretary shall act on an application under section 1582 within 15 days and on an application under section 1583 within 60 days of submission of a completed application. Certification of entities under section 1582 shall only involve verifying that the entity falls into one of the automatic certification classes.

(b) The Secretary shall periodically review certified essential community providers to determine that they meet the requirements of this subpart.

(c) If the Secretary finds that an entity does not meet certification requirements or fails to continue to meet such requirements, the Secretary shall notify the entity and permit the entity an opportunity to rebut such findings. If the Secretary continues to find that the entity fails to meet the requirements of this subpart, the Secretary shall notify the entity and regional and corporate alliances of the termination and its effective date.

Section 1585. Notification of Health Alliances and Participation States. (a) The Secretary shall notify participating states and health alliances regarding certified essential providers. The notice shall include sufficient information to permit each health alliance to identify the provider; the notice must also report to health plans the location of the provider, the health services furnished by the provider and other information necessary for health plans to carry out their duties under subtitle E of title I.

PART 3 - SPECIFIC DUTIES OF THE SECRETARY OF LABOR

Section 1591. Responsibilities of the Secretary of Labor. (a) The Secretary is responsible for the following:

(1) enforcement of employer requirements in regional health alliances under subtitle D of Title I and the administration of corporate alliances;

(2) oversight of the election of eligible sponsors to become corporate alliances

and termination of such an election;

(3) temporary assumption of insolvent corporate alliances under section 1395;

(4) establishment of a Corporate Alliance Health Plan Insolvency Fund under section 1396;

(5) carrying out of other responsibilities assigned to the Secretary under the Act; and

(6) administration of Title I of ERISA as it relates to group health plans maintained by corporate alliances.

(b) The Secretary of Labor may enter into agreements with states to enforce responsibilities of employers and corporate alliance health plans and subtitle B of Title I of ERISA.

(c) In carrying out his or her responsibilities, the Secretary shall consult with the Board.

(d)(1) The Secretary of Labor shall assure that employers pay premiums and withhold and make payment for the family share of premiums, submit timely reports, and otherwise comply with the requirements of the Act.

(2) The Secretary of Labor may carry out audits and investigations of employers and health alliances and may exercise the authorities provided in ERISA, arrange for collection activities for amounts owed to alliances, and may impose civil money penalties.

SUBTITLE G - EMPLOYER RESPONSIBILITIES
(H.R. 3600 and S. 1757 p. 303)

Section 1601. Payment Responsibilities. (a) Employers must make payments as required under section 6121 (general payment responsibilities) or section 6123 (payment responsibilities for small employers).

(b) Employer payment responsibilities in single payer states supersedes the foregoing requirements.

(c) Employers participating in multi-employer plans acting as a regional alliance employer satisfy their payment obligations under section 6121 if they pay the plan the required premium amount and the plan assumes the duties of a regional alliance employer.

Section 1602. Requirements for Information Reporting. (a)(1) Employers must provide certain information to persons who were qualifying employees during any month of the previous year.

(2) This information includes the following:

(A) For each regional alliance through which the employee obtained health coverage, the total number of months of the employee's full-time equivalent employment (defined under section 1901(b)(2) as 120 hours per month), the amount of wages attributable to such employment, the amount of covered wages, the total amount deducted and paid in as the family share, and other information required by the Secretary of Labor.

(B) With respect to corporate alliances, employers must report the total number of months of the employee's full-time equivalent employment and other information required by the Secretary of Labor.

(3) The required information shall be provided for each regional alliance to which the employer made premium payments (on behalf of the employee).

(4) "Covered wages" means wages paid during a month in which the employee was a qualifying employee.

(b)(1) Employers must provide certain information to regional alliances on an annual, monthly and one-time basis.

(2) Annual information includes:

(A) For each regional alliance,

(i) the total number of months of full-time equivalent employment for each employee and for each class of enrollment and the total amount deducted from wages and paid toward the family share of the premium for the qualifying employee.

(ii) the total employer premium payment on behalf of all qualifying employees, and in the case of small employers who have a discount under section 6123, the total amount that would have been

owed if there had been no discount.

(iii) The number of full-time equivalent employees for each class of family enrollment

(iv) in the case of large employers electing to enroll in regional alliances under section 6124, additional information required by the Secretary of Labor

(v) amounts to be paid as part of the employer collection shortfall add-on.

(vi) the amount of covered wages for each qualified employee.

(3) Monthly information includes the following:

(A) information on individuals who changed qualifying employee status during the month, the regional alliance in which the individual resides, and the class of family enrollment.

(B) Individuals are considered as having changed qualifying employee status if they either became qualifying employees during the month or ceased qualifying employment during the month.

(4) Initial information, that employers must provide to regional alliances on behalf of qualifying employees, is to be specified by the National Health Board.

(c)(1) Employers liable for premium payments to a regional alliance (including small employers with discounts) must provide the alliance with the reconciliation information needed by the alliance to determine if the employer's payments were correct.

(2) Reconciliation information shall be provided by February following the year subject to reconciliation.

(3) Employers shall adjust premium payments in the month in which they provide reconciliation information. This adjustment must reflect the amount by which payments were greater or less than they should have been. Employers that cease to be employers shall make a final payment to the alliance if owed.

(4) In the case of self-employed individuals, the family share reconciliation system under section 1344, shall be used instead of the system described in this section.

(d) Self-employed persons shall provide information on net earnings needed to compute the amount payable.

(e) Information shall be provided in a form specified by the Secretary, but in a way that, to the extent feasible, simplifies administration for small employers.

(f) The Board shall use regional information centers that are part of the electronic data network under section 5103 to perform information clearinghouse functions. Clearinghouse functions include the receipt of employer information, transmittal of information to regional alliances, and other functions specified by the Board.

(g) Employers must provide annual information to their employees by the deadline in section 6051 of the Internal Revenue Code of 1986. Employers must provide annual information to alliances by the same date as used under section 232 of the Social Security Act.

(h) Employers shall notify individuals on whose behalf they are not obligated to make payments. These individuals are those who perform more than 40 hours per month of services, but who are not employees of the person to whom they supply services. Notices shall commence after January 1, 1998 and shall be furnished within a reasonable time after employment begins. The Secretary shall issue regulations on exceptions to the notice requirement with respect to individuals performing services on an irregular, incidental or casual basis, as well as model notice forms.

Section 1603. Requirements Relating to New Employees. (a) When an individual is hired as a new employee, a regional alliance employer must obtain the following information:

(1) The individual's name;

(2) the individual's alliance area of residence and whether the individual has moved from another alliance area;

(3) the individual's class of family enrollment (single; couple; couple with children; or single parent with children);

(4) the individual's health plan; and

(5) if the individual moved from another area, whether the individual intends to enroll in a regional alliance plan.

(b) Employers must transmit employee information to the alliance in which the employee resides.

(c) In the case of individuals who have recently moved, the employer must provide the employee with information about his or her choice of regional alliance health plans and how to enroll. The employer must also provide an enrollment form. Alliances must provide this material to employers.

Section 1604. Auditing of Records. Regional alliance employers must maintain records, in their principal place of business, that permit alliances to audit them for compliance with the Act.

Section 1605. Prohibition of Certain Employer Discrimination. Employers may not discriminate against employees on the basis of the family status of the employee or the class of family enrollment selected by the employee.

Section 1606. Prohibition of Self-Funding of Cost-Sharing Benefits by Regional Alliance Employers. (a) A regional alliance employer (and a corporate alliance with respect

to employees enrolled in regional alliance) may not self-fund employee cost sharing benefits but must instead purchase insurance for such benefits.

(b) Cost sharing rules in single payer states supersede this part.

Section 1607. Equal Voluntary Contribution Requirement.

(a)(1) An employer must treat all qualifying employees as generously as it treats any full-time employees with respect to voluntary premium payments. The equal voluntary premium payment requirement applies to both regional and corporate alliance employments. With respect to regional alliances, a voluntary premium payment by an employer may vary only by class of enrollment and alliance area. With respect to corporate alliances, a voluntary premium payment by an employer may vary only by class of enrollment and premium area. Part-time employees must receive a pro-rata share of the voluntary full-time employer premium payment.

(2) Employer voluntary premium payments may not exceed the family share of the premium for the most expensive health plan offered in the regional or corporate alliance. The equal contribution rule does not apply in the case of health plans that do not have material enrollment, as defined by the Secretary of Labor. Employers may not discriminate in providing voluntary contributions on the basis of the plan selected by an employee.

(b) Employers must rebate the difference between the amount of premium contributions they voluntarily make and the value of the insurance plan chosen by employees. Rebates shall be treated as wages for Federal tax purposes. Couples who both qualify for rebates may elect to have the full rebate furnished for all employment.

(c) Rebate requirements shall not apply when voluntary contributions are made pursuant to a collective bargaining agreement; however, subsection (a)(2) does apply.

(d) "Voluntary employer premium payment" means payments designed to be used exclusively (or primarily) toward the cost of the family share of premiums.

Section 1608. Employer Retiree Obligation. (a) Employers furnishing threshold payments (as defined in subsection (c) as of October 1, 1993, must pay an amount specified beginning January 1998 but only for so long as the person is a qualifying retired beneficiary.

(b) A qualifying retired beneficiary is an eligible retiree or qualified spouse or child (as the terms are defined in subsections (b) and (c) of section 6114).

(c) The threshold payment equals 20 percent of the amount of the premium for coverage under a health plan.

(d) The amount of the payment is 20 percent of the weighted average premium for the regional alliance in which the beneficiary resides and for the applicable class of family

enrollment.

(e) This requirement is in addition to any other requirement under the Act.

(f) Nothing in this Act or this section shall be construed as affecting collective bargaining rights.

Section 1609. Enforcement. The Secretary of Labor may impose a civil money penalty of up to $10,000, for each violation of this subtitle.

SUBTITLE J - DEFINITIONS; MISCELLANEOUS PROVISIONS
(H.R. 3600 and S. 1757 p. 341)

PART 1 - GENERAL DEFINITIONS

Sections 1901 and 1902 provide general definitions for the following terms: employer, employee, employment, covered child, covered aliens, alliance area, types of health plans and other elements of the Act.

PART 2 - MISCELLANEOUS PROVISIONS

Section 1911. Use of Interim Final Regulations. To assure timely promulgation of rules, the Board, the Secretary of HHS, and the Secretary of Labor are authorized to promulgate rules on an interim final basis that become final on the date of publication and are subject to subsequent public comment.

Section 1912. Social Security Act References. Except as provided, references to the Social Security Act are references to the act as in effect on the date of enactment.