SUBTITLE B - AGGREGATE FEDERAL ALLIANCE PAYMENTS (H.R. 3600 and S. 1757 p. 1296)

Subtitle B describes payments by the Federal Government to alliances for the federal share of premiums for AFDC and SSI recipients and for business and family discounts.

Section 9101. Federal Premium Payments For Cash Assistance Recipients. The Secretary of HHS must make payments each year to each regional alliance for the Federal share of premium payments and certain discounts for AFDC and SSI recipients. The payment is calculated in the same manner as a state's payment (described in section 9011), except that the Federal medical assistance percentage (defined in section 1905(b) of the Social Security Act) is used instead of the state medical assistance percentage.

Federal payments must be made on a periodic basis, reflecting the cash flow requirements of regional alliances. Each regional alliance must provide the Secretary with information necessary to make these payments.

Federal payments are reconciled based on information provided by states, subject to audit by the Secretary.

Section 9102. Capped Federal Alliance Payments.

(a) CAPPED ENTITLEMENT: Beginning January 1, 1996, the Secretary must provide to each regional alliance payments for family and employer discounts ("capped Federal alliance payment amount," as defined in this section). The total amount of these payments is a capped entitlement.

(b) CAPPED FEDERAL ALLIANCE PAYMENT AMOUNT: The capped Federal alliance payment amount is determined on a quarterly basis, and is equal to the payment obligations of the alliance minus amounts receivable by the alliance subject to the cap as set forth in subsection (e). Payment obligations include payments to plans, payments for cost sharing reductions, and alliance administrative expenses. Amounts receivable by the alliance include premiums owed by families and employers (not taking into account amounts that are owed but not paid) and amounts payable by Federal and state Governments for maintenance of effort and for per capita premium amounts for AFDC and SSI recipients.

The Federal Government is not responsible for amounts owed to an alliance but not collected, for administrative errors in providing discounts that exceed maximum permissible error rates (specified in section 1361(b)(1)(C)), or for misappropriations or other regional alliance expenditures that the Secretary finds are attributable to malfeasance or misfeasance by the regional alliance or the state.

For a single-payer state, the Secretary must pay an amount equal to what regional alliances in the state would have received under this section if the state were not a single-

payer state.

(c) DETERMINATION OF CAPPED FEDERAL ALLIANCE PAYMENT AMOUNTS: Before the beginning of each year, the Secretary must estimate the capped Federal alliance payment amount for each regional alliance. The Secretary must report to Congress an estimate of the total capped Federal alliance payment amounts owed for all alliances.

(d) PAYMENTS TO REGIONAL ALLIANCES: The capped Federal alliance payment amount must be made on a periodic basis, reflecting the cash flow requirements of regional alliances. Each regional alliance must provide the Secretary with information necessary to make these payments.

(e) CAP ON PAYMENTS: The total amount of the capped Federal alliance payments for a fiscal year may not exceed the caps specified in this section.

For fiscal years 1996 through 2000, the caps are as follows:

(1) $10.3 billion for fiscal year 1996.

(2) $28.3 billion for fiscal year 1997.

(3) $75.6 billion for fiscal year 1998.

(4) $78.9 billion for fiscal year 1999.

(5) $81.0 billion for fiscal year 2000.

If the CPI is projected to be significantly different from what was projected by the Council of Economic Advisors to the President as of October 1993, the Secretary may adjust the caps so as to reflect the different inflation assumption.

For subsequent fiscal years, the cap from the previous year is updated by a formula that is based on increases in the CPI, U.S. population, and real per capita Gross Domestic Product.

If total capped Federal alliance payment amounts are less than the cap for a fiscal year, the surplus is accumulated and made available for future years.

If the Secretary anticipates that the amount of the cap, plus any amount carried forward from a previous year, will not be sufficient for a fiscal year, the Secretary must notify the President, the Congress, and each regional alliance of the anticipated shortfall and when the shortfall will first occur.

Within 30 days of receiving notice from the Secretary, the President must submit to Congress a report containing specific legislative recommendations for actions which would eliminate the shortfall.

The President's report is considered under an expedited process. If a joint resolution is introduced that contains the President's recommendations, that resolution is considered in a manner described in the Defense Base Closure and Realignment Act of 1990.

SUBTITLE C - BORROWING AUTHORITY TO COVER CASH-FLOW SHORTFALLS
(H.R. 3600 and S. 1757 p. 1308)

Section 9201. Borrowing Authority To Cover Cash-Flow Shortfalls. (a) Authorizes the Secretary to make loans available to regional alliances in order to cover temporary cash-flow shortfalls attributable to:

(1) estimation discrepancies,
(2) administrative errors,
(3) the relative timing during the year in which amounts are received and payments are required to be made.

(b) Requires that loans made to regional alliances under this section be under terms and conditions specified by the Secretary, in consultation with the Secretary of the Treasury, that take into account Treasury cash management rules. Loans under this section are repayable over a period of no more than 2 years. Alliances pay interest on the loans at a rate of interest determined by the Secretary of the Treasury. The Secretary takes into consideration the current average rate on outstanding marketable obligations of the United states in determining the interest rate.

As a condition of receiving a loan under this section, a regional alliance must agree to make appropriate adjustments (as described in subsection (f)) to future premiums or collections to assure the repayment of the amount so borrowed.

(c) Sets forth the manner for repayment of loans under this section. Loans to regional alliances for shortfalls that result from estimation discrepancies of timing or receipts are repaid through a reduction in the payment amounts made to regional alliances under section 9102. Loans for shortfalls that result from administrative error are repaid through a temporary increase in the amount of the state maintenance-of-effort payment required under section 9001.

(d) Requires the Secretary to make annual reports to Congress on the loans made (and loan amounts repaid) under this section.

(e) More precisely describes the purposes for which loans are available under this section.

The estimation discrepancies referred to in this section are discrepancies in estimating the following:

(1) the average premium payments per family under section 6122(b).
(2) the AFDC and SSI proportions under section 6202.
(3) the distribution of enrolled families in different risk categories for purposes of under section 1343(b)(2).

(4) the distribution of enrollment in excess premium plans.
(5) the collection shortfalls (used in computing the family collection shortfall add-on under section 6107).

The administrative errors referred to in this section include the following:

(1) an eligibility error rate for premium discounts and liability reductions that exceeds the maximum permissible error rate established for the alliance.
(2) misappropriations or other regional alliance expenditures that are determined to be attributable to malfeasance or misfeasance by the regional alliance or the state.

(f) Describes the estimation adjustment provisions that an alliance must agree to follow as a condition of receiving a loan under this section:

(1) adjustments for average premium payments per family under section 6122(b)(4).
(2) adjustments in the AFDC and SSI proportions under section 6202(d).
(3) adjustments pursuant to methodology described in section 1541(b)(8).
(4) adjustments in excess premium credit pursuant to section 6105(b)(2).
(5) adjustment in the collection shortfall add-on under section 6017(b)(2)(C)).

(g) Authorizes the Secretary of the Treasury to advance to the Secretary amounts sufficient to cover the loans made under this section. The amount of advances outstanding at any time may not exceed $3,500,000,000.

TITLE X - COORDINATION OF MEDICAL PORTION OF WORKERS COMPENSATION AND AUTOMOBILE INSURANCE

SUBTITLE A - WORKERS COMPENSATION INSURANCE (H.R. 3600 and S. 1757 p. 1314)

Section 10000. Definitions.

The term ''injured worker'' is defined to mean an individual enrolled under a health plan who has a work-related injury or illness for which workers compensation medical benefits are available under state law.

The term ''specialized workers compensation provider'' is defined to mean a health care provider that specializes in the provision of treatment relating to work-related injuries or illness (including specialists in industrial medicine, specialists in occupational therapy and centers of excellence in industrial medicine and occupational therapy).

The term ''workers compensation medical benefits'' is defined to mean the comprehensive medical benefits for work-related injuries and illnesses provided for under the workers compensation laws of a state to an injured worker.

The term ''workers compensation carrier'' is defined to mean an insurance company that underwrites workers compensation medical benefits, including an employer or fund that is financially at risk for the provision of workers compensation medical benefits.

The term ''workers compensation services'' is defined to mean items and services included in workers compensation medical benefits and includes items and services (including rehabilitation services and long-term care services) commonly used for treatment of work-related injuries and illnesses.

PART 1 - HEALTH PLAN REQUIREMENTS RELATING TO WORKERS COMPENSATION

Section 10001. Provision Of Workers Compensation Services. (a) Requires each health plan that provides services to enrollees through participating providers to enter into contracts and arrangements to provide or arrange for the provision of workers compensation services to such enrollees. Payments for workers compensation services are made by workers compensation carriers under section 10002.

Services may be provided or arranged by the health plan through:

(1) A participating provider in the plan;

(2) Another provider with whom the plan has entered into an agreement for the provision of such services, or

(3) A specialized workers compensation provider (designated by the state under 10011).

Individuals who are entitled to workers compensation medical benefits generally must receive workers compensation services through the health plan in which they are enrolled. This requirement applies without regard to whether the health plan uses participating providers to provide health benefits to its enrollees. This requirement does not apply in the case of an injured worker who needs emergency services or to certain electing veterans, active duty military personnel, and Indians as described in section 1004(b).

(b) Permits an injured worker and a workers compensation carrier to agree to the provision of workers compensation services in a manner other than by or through the health plan in which the worker is enrolled.

(c) Requires each health plan to employ or contract one or more individuals with experience in the treatment of occupational illness and injury to provide case management services to injured workers enrolled in the plan. The case manager is responsible for ensuring that:

(1) there is a plan of treatment (when appropriate) for each enrollee who is an injured worker designed to assure appropriate treatment and facilitate return to work;
(2) the plan of treatment is coordinated with the workers compensation carrier and the employer;
(3) the health plan (and its providers) comply with legal duties and requirements under state law; and
(4) the injured worker is referred to appropriate providers (when necessary).

Section 10002. Payment By Workers Compensation Carrier. (a) Provides that payment for workers compensation services by workers compensation carriers generally will be made in accordance with the applicable regional alliance fee schedule established under section 1322(c) or the state fee schedule established under section 10013.

(b) Permits an alliance or state to establish an alternative payment methodology (such as payment on a negotiated fee for each case) for payment for workers compensation services. Workers compensation carriers and health plans also are permitted to negotiate alternative payment arrangements.

(c) Provides that this subpart may not be construed to require an injured worker to make any payment (including payment of any cost sharing or any amount in excess of the applicable fee schedule) to any health plan or health care provider for the receipt of workers compensation services.

PART 2 - REQUIREMENTS OF PARTICIPATING STATES

Section 10011. Coordination Of Specialized Workers Compensation Providers. (a) Requires each participating state to coordinate access to specialized workers compensation providers on behalf of health plans providing coverage to individuals residing in the state.

(b) Authorizes states to designate specialized workers compensation providers to provide workers compensation services with respect to one or more types of injuries or illnesses for a geographic area that are:

(1) not included in the comprehensive benefit package; or
(2) specialized services that are typically provided (as determined by the state) by specialists in occupational or rehabilitative medicine.

Injured workers and health plans are authorized to use providers designated under this subsection.

Section 10012. Preemption Of State Laws Restricting Delivery of Workers Compensation Medical Benefits. (a) Provides that no state law will have any effect that restricts the choice, or payment, of providers that may provide workers compensation services for individuals enrolled in a health plan.

(b) Preserves the authority of state law to provide for a method for resolving disputes among parties related to:

(1) an individual's entitlement to workers compensation medical benefits under state law;
(2) the necessity and appropriateness of workers compensation services provided to an injured worker; and
(3) the reasonableness of charges or fees charged for workers compensation services (subject to the requirements of this subpart related to the use of alliance and state fee schedules).

Section 10013. Development Of Supplemental Schedule.
Each participating state is required to develop a fee schedule for workers compensation services for which a fee is not included in the applicable regional alliance fee schedule.

Section 10014. Construction. (a) Provides that this subtitle should not be construed as altering:

(1) the effect of a state workers compensation law as the exclusive remedy for work-related injuries or illnesses;

(2) the determination of whether or not a person is an injured worker and entitled to workers compensation medical benefits under state law;
(3) the scope of items and services available to injured workers entitled to workers compensation medical benefits under state law; or
(4) the eligibility of any individual or class of individuals for workers compensation medical benefits under state law.

(b) Provides that this subtitle does not prevent a state from integrating or otherwise coordinating the payment for workers compensation medical benefits with payment for benefits under health insurance or health benefit plans before the date the Commission submits its report on integration of health benefits under section 10201(e).

PART 3 - APPLICATION OF INFORMATION REQUIREMENTS; REPORT ON PREMIUM REDUCTIONS

Section 10021. Application Of Information Requirements. (a) Provides that the provisions of the Act relating to the use of standard forms and participation in the quality management program apply to the provision of workers compensation services.

(b) Requires the Secretary of Labor to promulgate rules to clarify the responsibilities of health plans and workers compensation carriers in carrying out the provisions referred to in subsection (a).

Section 10022. Report On Reduction In Workers Compensation Premiums.
(a) Provides for the Secretary of Labor to conduct a study of the impact of the provisions of this subtitle on the premium rates charged to employers for workers compensation insurance. The report must be submitted to the Congress not later than 2 years after the date that this subtitle applies in all states.

(b) Requires each workers compensation carrier (other than a self-funded employer) to make a filing with each state in which it provides coverage describing how the carrier has modified (or intends to modify) its premium rates for workers compensation insurance to reflect the changes brought about by the provisions in this subtitle. The report must be made within six months after the date the provisions of this subtitle are in effect in a state and must include such actuarial projections and assumptions as necessary to support the modifications of such rates.

Each participating state is required to provide to the Secretary of Labor such information on filings made under this subsection.

PART 4 - DEMONSTRATION PROJECTS

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Section 10031. Authorization.

This section authorizes the Secretary of Health and Human Services and the Secretary of Labor to conduct demonstration projects under this part in one or more states with respect to treatment of work-related injuries and illnesses.

Section 10032. Development Of Work-Related Protocols. (a) Authorizes the Secretary of Health and Human Services and the Secretary of Labor, in consultation with states and others, to develop protocols for the appropriate treatment of work-related conditions.

(b) authorizes the Secretaries to enter into contracts with one or more health alliances to test the validity of the protocol.

Section 10033. Development Of Capitation Payment Models.

This section authorizes the Secretary of Health and Human Services and the Secretary of Labor to develop (using protocols developed under the previous section) methods of providing for payment by workers compensation carriers to health plans on a per case, per capita payment for the treatment of specified work-related injuries and illnesses.

SUBTITLE B - AUTOMOBILE INSURANCE
(H.R. 3600 and S. 1757 p. 1326)

Section 10100. Definitions.

The term ''injured worker'' is defined to mean an individual enrolled under a health plan who has an injury or illness sustained in an automobile accident for which automobile insurance medical benefits are available.

The term automobile insurance medical benefits is defined to mean the comprehensive medical benefits for injuries or illnesses sustained in automobile accidents.

The term ''automobile insurance carrier'' means an insurance company that underwrites automobile insurance medical benefits and includes an employer or fund that is financially at risk for the provision of automobile insurance medical benefits.

The term "automobile insurance medical services'' means items and services included in automobile insurance medical benefits and includes items and services (such as rehabilitation services and long-term care services) commonly used for treatment of injuries and illnesses sustained in automobile accidents.

PART 1 - HEALTH PLAN REQUIREMENTS RELATING TO AUTOMOBILE INSURANCE

Section 10101. Provision Of Automobile Insurance Medical Benefits Through Health Plans. (a) Provides that an individual entitled to automobile insurance medical benefits and enrolled in a health plan will receive automobile insurance medical services through the provision (or arrangement for the provision) of such services by the health plan.

(b) Requires health plans to make necessary referrals for automobile insurance medical services as may be necessary to assure appropriate treatment of injured individuals.

(c) Provides that the requirements of this section do not apply to certain electing veterans, active duty military personnel, and indians as described in section 1004(b).

(d) Permits an injured individual and an automobile insurance carrier to agree to the provision of automobile insurance medical services in a manner other than by or through the health plan in which the worker is enrolled.

Section 10102. Payment By Automobile Insurance Carrier. (a) Provides that payment for automobile insurance medical services by automobile insurance carriers generally will be made in accordance with the applicable regional alliance fee schedule

established under section 1322(c) or the state fee schedule established under section 10111.

(b) Permits an alliance or state to establish an alternative payment methodology (such as payment on a negotiated fee for each case) for payment for automobile insurance medical services. Automobile insurance carriers and health plans also are permitted to negotiate alternative payment arrangements.

(c) Provides that this subpart may not be construed to require an injured individual to make any payment (including payment of any cost sharing or any amount in excess of the applicable fee schedule) to any health plan or health care provider for the receipt of automobile insurance medical services.

PART 2 - REQUIREMENT OF PARTICIPATING STATES

Section 10111. Development Of Supplemental Schedule.
Each participating state is required to develop a fee schedule for automobile medical services for which a fee is not included in the applicable regional alliance fee schedule.

Section 10112. Construction. (a) Provides that the subtitle should not be construed as altering:

(1) the determination of whether or not a person is an injured individual and entitled to automobile insurance medical benefits under state law, or
(2) the scope of items and services available to injured individuals entitled to automobile insurance medical benefits under state law.

PART 3 - APPLICATION OF INFORMATION REQUIREMENTS.

Section 10121. Application Of Information Requirements. (a) Provides that provisions of the Act relating to use of standard forms and to the provision of data on quality of care will apply to the provision of automobile insurance medical services in the same manner as such provisions apply with respect to the provision of services included in the comprehensive benefit package.

(b) Requires the Secretary of Labor to promulgate rules to clarify the responsibilities of health plans and automobile insurance carriers in carrying out the provisions referred to in subsection (a).

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SUBTITLE C - COMMISSION ON INTEGRATION OF HEALTH BENEFITS (H.R. 3600 and S. 1757 p. 1331)

Section 10201. Commission.
This section establishes the Commission on Integration of Health Benefits.

The Commission will consist of 15 members appointed jointly by the Secretaries of Health and Human Services and the Secretary of Labor. Members of the Commission will serve without compensation. The Secretaries provide that each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

The Commission is directed to study the feasibility and appropriateness of transferring financial responsibility for all medical benefits (including those currently covered under workers compensation and automobile insurance) to health plans. Staff support for the Commission is provided by the Secretaries.

The Commission must submit a report to the President by not later than July 1, 1995. If the Commission recommends the integration of financial responsibility for all medical benefits in health plans, the report must contain a detailed plan as to how (and when) such an integration should be effected under this Act.

The Commission shall terminate 90 days after the date of submission of its report. Appropriation of the amounts necessary to carry out this section are authorized under the section.

SUBTITLE D - FEDERAL EMPLOYEES' COMPENSATION ACT (H.R. 3600 and S. 1757 p. 1333)

Section 10301. Application Of Policy.
This section makes technical changes to the Federal Employees' Compensation Act (Chapter 81 of title 5, United States Code) to conform it to the changes made to state workers compensation systems under subtitle A.

SUBTITLE E - DAVIS-BACON ACT AND SERVICE CONTRACT ACT (H.R. 3600 and S. 1757 p. 1333)

Section 10401. Coverage Of Benefits Under Health Security Act.
This section make technical changes to the Section 1(b)(2) of the Davis Bacon Act (40

U.S.C. 276a(b)(2)) and to the second sentence of section 2(a)(2) of the Service Contract Act of 1965 (41 U.S.C. 351(a)(2)). The amendments insert after ''local law'' the following: ''(other than benefits provided pursuant to the Health Security Act)''.

SUBTITLE F - EFFECTIVE DATES
(H.R. 3600 and S. 1757 p. 1334)

Section 10501. Regional Alliances.

The section provides that the provisions of subtitles A and B of this title will apply to regional alliances and regional alliance health plans in a state 2 years after the state's first year (as defined in section 1902(17)).

Section 10502. Corporate Alliances.

The section provides that the provisions of subtitles A and B of this title will apply to corporate alliances and corporate alliance health plans on January 1, 1998.

Section 10503. Federal Requirements.

The section provides that the provisions of subtitle D of this title will take effect on January 1, 1998.

TITLE XI - TRANSITIONAL INSURANCE REFORM
(H.R. 3600 and S. 1757 p. 1335)

Section 11001. Imposition Of Requirements. (a) Provides that the purpose of the title is to assure, to the extent possible, the maintenance of current health care coverage and benefits during the period between the enactment of the Health Security Act and the dates its provisions are implemented in the various states.

(b) Provides that the Secretary of Health and Human Services will enforce the requirements of the title with respect to health insurance plans and that the Secretary of Labor will enforce the requirements with respect to self-funded health plans. Each Secretary is required to promulgate regulations to carry out the requirements under this title. Regulations for carrying out section 11004 must be promulgated within 90 days after the date of the enactment of the Act.

The Secretaries are authorized to enter into arrangements with a state to enforce the requirements of this title with respect to health insurance plans and self-insured plans providing coverage in the state.

(c) Provides that the requirements of the title do not preempt any state law unless state law directly conflicts with such requirements. State laws that provide additional protection to consumers will not be considered to directly conflict with the requirements of the title. Each Secretary may issue letter determinations with respect to whether this Act preempts a provision of state law.

(d) Provides that regulations issued to carry out this title may be issued as interim final regulations. The Secretary is authorized to consult with states and the National Association of Insurance Commissioners in issuing regulations and guidelines under this title.

(e) Provides that this title will be construed, to the greatest extent practicable, to assure the continuity of health benefits provided under health benefit plans in effect on the effective date of this Act.

(f) Authorizes the Secretary to issue regulations relating to the application of this title when health insurance plans are transferred from one insurer to another insurer through assumption, acquisition, or otherwise.

Section 11002. Enforcement. (a) Provides that a health insurer or health benefit plan sponsor that violates a requirement of this title is subject to civil money penalties of not more than $25,000 for each such violation.

(b) Authorizes the appropriate Secretary to bring a civil action to enjoin any act or practice which violates any provision of this title or to obtain other appropriate equitable

relief to redress violations or enforce any provision of this title.

Section 11003. Requirements Relating To Preserving Current Coverage.

(a) Generally prohibits health insurers from terminating (or failing to renew) coverage under a group or individual health insurance plan except in the cases of:

(1) nonpayment of required premiums;
(2) fraud; or
(C) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

The provisions of this subsection take effect on the date of enactment and apply to coverage on or after such date.

(b) Requires health insurers that provide group health insurance plans to provide coverage to new full-time employees (and their eligible dependents) of any employer covered under the plan. Premium rates for new employees must be consistent with the provisions of section 11004(b) and any exclusions imposed for preexisting conditions must meet the requirements of section 11005.

Section 11004. Restrictions On Premium Increases During Transition.

This section establishes requirements relating to premium increases by health insurers during the transition period.

(a) Requires health insurers to divide their health insurance business into three sectors for the purpose of calculating rate increases: a large group sector (which applies to groups with 100 or more covered lives); a small group sector (which applies to groups with fewer than 100 covered lives) and an individual sector.

(b) Establishes requirements for changes in premiums relating to changes in individual or group characteristics. The subsection applies to changes in premiums for:

(1) changes in the number of individuals covered under a plan;
(2) changes in the demographic or group characteristics (including age, gender, family composition or geographic area but not including health status, claims experience or duration of coverage under the plan) of individuals covered under a plan;
(3) changes in the level of benefits under the plan; and
(4) changes in any material terms and conditions of the health insurance plan (not related to health status).

Health insurers that increase premiums are required to calculate a reference rate for each such sector. The reference rate for a sector is calculated so that when applied to the rate factors (specified in the subsection) it would approximate the average premium rates charged

individuals and groups in the sector as of the effective date of this title.

Health insurers that increase premiums are also required to develop a single set of rate factors for each sector. The rate factors are used to calculate changes in premium that relate to changes in group or individual characteristics, changes in benefits or material changes in the terms of the plan.

Rate factors developed by insurers must relate to reasonable and objective differences in demographic characteristics, in the design and in levels of coverage, and in other terms and conditions of a contract and may not relate to expected health status, claims experience, or duration of coverage of the one or more groups or individuals.

Changes in premiums are calculated using the rate factors developed pursuant this section.

For changes in premium rates that relate to a change in the number of people covered under a health insurance plan, the premium change is calculated by applying the reference rate (for the sector) to the rate factors applicable to the people who joined or left the plan.

For changes in premium rates that relate to changes in group or individual characteristics, changes in benefits or material changes in the terms of the plan, the premium changes are calculated by applying the rate factors developed pursuant to this subsection applied to the current premium charged for the health insurance plan.

In applying rate factors under this subsection, resulting changes in premium may not reflect any change in the health status, claims experience or duration of coverage with respect to any employer or individual covered under the plan.

The provisions of this subsection apply only:

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

(2) for groups and individuals covered after the date of enactment, to changes in premiums after the date coverage begins.

This subsection does not require the application of rate factors related to individual or group characteristics with respect to community-rated plans.

(c) Establishes limitations on changes in premiums related to increases in health care costs and utilization.

In general, health insurers that increase premiums because of increases in costs or utilization must apply the same percentage increase to all plans in all sectors. Health insurers may vary the percentage increase among plans in the large group sector, based on

the credible claims experience of particular employers, as long as the weighted average of increases for all such plans in the sector is equal to the percentage increase in other sectors.

Premium increases under this subsection may be applied on a national level or may vary based on geographic area. Area variations may be applied only if the areas are sufficiently large to provide credible data on which to calculate the variation and the variation is due to reasonable factors related to the objective differences among the areas in costs and utilization of health services.

The Secretary is authorized to grant exceptions to the limitations on rate increases contained in this subsection to accommodate state insurance reform efforts if necessary to permit a state to narrow the variations in premiums among health insurance plans offered by health insurers to similarly situated groups or individuals within a sector.

The limitations on rate increases contained in this subsection do not apply to premium rates that are subject to prior approval by a state insurance commissioner (or similar official) and are in fact approved by such official.

The Secretary is authorized to specify other exceptions through regulations that the Secretary determines are required to enhance stability of the health insurance market and continued availability of coverage.

Premium increases must be applied in a consistent, even manner so that any variations in the rate of increase applied in consecutive months are even and continuous during the year.

A health insurer may petition for an exception from the application of the provisions of this subsection. The Secretary may approve grant an exception if the health insurer demonstrates that the application of this subsection would threaten the financial viability of the insurer and the health insurer offers an alternative method for increasing premiums that is not substantially discriminatory to any sector or to any group or individual covered by a health insurance plan offered by the insurer.

(d) Requires health insurers to obtain prior approval for proposed premium increases for the individual and small group sector if the proposed premium increase exceeds a percentage specified by the Secretary.

In specifying a percentage under this subsection, the Secretary must consider the rate of increase in health care costs and utilization, previous trends in health insurance premiums, and the conditions in the health insurance market. The Secretary must specify a percentage within 30 days after the date of the enactment of the Act.

(e) Requires that premiums for each health plan be conformed in a manner that complies with the provisions of this section within one year after the date of enactment of the

Act.

Health insurers are required to document the methodology used in applying limitations to premium increases under subsections (b) and (c). The documentation must be sufficient to permit the auditing of the application of the methodology used to determine consistency with the requirements of the section.

Health insurers must file a certification with the Secretary every six months certifying compliance with the requirements of the section.

(f) Requires the Secretary to establish regulations to carry out this section. The regulations may specify the permissible variation that results from the use of demographic or other characteristics in the development of rate factors. The guidelines may be based on the guidelines currently used by states in applying rate limitations under state insurance regulations.

(g) Provides that the section will apply to premium increases occurring during the period beginning on the date of the enactment of the Act and ending on the date a state implements universal coverage through alliances under the provisions of the Act.

Section 11005. Requirements Relating To Portability. (a) Limits the period of exclusion that a group health benefit plan may apply with respect to services related to treatment of a preexisting condition to a period of not more than 6 months. An exclusion of coverage for treatment of a preexisting condition may not apply to services furnished to newborns or in the case of a plan that did not apply such exclusions as of the effective date of this title.

A group health benefit plan must reduce any period of exclusion applied with respect to treatment of a preexisting condition for individuals that were previously covered by health insurance. The amount of reduction is one month for each month of previous coverage. The previous coverage must have been continuous (with no more than three consecutive months without coverage).

(b) Provides that self-insured plans and employers sponsoring group health insurance plans may not discriminate among employees in the establishment of waiting periods for health insurance on the basis of health status or related factors.

Section 11006. Requirements Limiting Reduction Of Benefits.

The section prohibits a sponsor of a self-insured benefit plan from modifying benefits under the plan in a manner that reduces or limits coverage with respect to any medical condition or course of treatment for which the anticipated cost is likely to exceed $5,000 in any 12-month period.

A modification of benefits includes the termination of a plan if the sponsor establishes

a substitute plan that reflects such a reduction or limitation.

A modification made in violation of this section is not effective and the self-insured sponsor must continue to provide benefits as though the modification (described in subsection (b)) had not occurred.

Section 11007. National Transitional Health Insurance Risk Pool.

(a) Authorizes the Secretary to establish a National Transitional Health Insurance Risk Pool ("national risk pool") during the transition.

(b) Authorizes the Secretary to administer the national risk pool through contracts with state health insurance risk pools, private health insurers, or other contractors as the Secretary deems appropriate.

The Secretary is authorized to enter into such arrangements with existing state health insurance risk pools to coordinate the coverage under such pools with the coverage under the national risk pool.

(c) Provides that coverage under the national risk pool may be provided to individuals who are unable to secure health insurance coverage from private health insurers because of their health status or condition (as determined in accordance with rules and procedures specified by the Secretary).

(d) Provides that the benefits and terms of coverage provided through the national risk pool will include items and services, conditions of coverage, and cost sharing (subject to out-of-pocket limits on cost sharing) comparable to the benefits and terms of coverage available in state health insurance risk pools.

Payments to providers by the national risk pool for covered items and services will be made at rates specified by the Secretary based on payment rates for comparable items and services under the Medicare program. Providers who accept payment from the national risk pool must accept the payment as payment in full.

(e) Provides for premiums for coverage in the national risk pool to be set in a manner specified by the Secretary. Premiums vary based upon age, place of residence, and other traditional underwriting factors other than on the basis of health status or claims experience. Premiums charged individuals must be set at a level that is no less than 150 percent of the premiums that the Secretary estimates would be charged to a population of average risk for the covered benefits.

(f) Requires the Secretary to estimate each year the extent to which the total premiums collected by the national risk pool are insufficient to cover the expenses of the national risk pool with respect to the year. The Secretary of the Treasury is authorized to

advance to the Secretary amounts sufficient to cover the amount estimated.

The Secretary must repay such amounts, with interest at a rate specified by the Secretary of the Treasury, from the assessments made on health benefit plan sponsors. Assessments on health benefit plans in a year may not exceed 1/2 of 1 percent of the total amount of premiums (and premium equivalents in the case of self-insured plans) for health benefits under the plan for the previous year.

Section 11008. Definitions.

The term "applicable Secretary" means the Secretary of Health and Human Services with respect to health insurance plans and insurers and the Secretary of Labor with respect to self-insured plans and self-insured plan sponsors.

The term "covered employee" means an employee (or dependent of such an employee) covered under a group health benefits plan.

The term "covered individual" means an individual insured, enrolled, eligible for benefits, or otherwise covered under a health benefit plan.

The term "group health benefits plan" means a group health insurance plan and a self-insured plan.

The term "group health insurance plan" means a health insurance plan offered primarily to employers for the purpose of providing health insurance to the employees (and dependents) of the employer. The term includes arrangements offered through associations and trusts, and includes a multi-employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974), whether funded through insurance or otherwise.

The term "health benefits plan" means health insurance plan and a self-insured health benefit plan.

The term "health benefit plan sponsor" means the insurer offering a health insurance plan or the self-insured sponsor for a self-insured plan.

The term "health insurance plan" means any contract of health insurance, including any hospital or medical service policy or certificate, any major medical policy or certificate, any hospital or medical service plan contract, or health maintenance organization subscriber contract offered by an insurer. The term does not include any of the following:

(1) coverage only for accident, dental, vision, disability income, or long-term care insurance;

(2) Medicare supplemental health insurance;

(3) coverage issued as a supplement to liability insurance;

(4) worker's compensation or similar insurance; or
(5) automobile medical-payment insurance.

The term also does not include any aggregate or specific stop-loss insurance or similar coverage applicable to a self-insured plan. The Secretary is authorized to develop rules determining the applicability of this subparagraph with respect to minimum premium plans or other partially insured plans.

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

The term "individual health insurance plan" means any health insurance plan directly purchased by an individual or offered primarily to individuals (including families) for the purpose of permitting individuals (without regard to an employer contribution) to purchase health insurance coverage. The includes any arrangement in which coverage for health benefits is offered to individuals through an association, trust, list-billing arrangement, or other arrangement in which the individual purchaser is primarily responsible for the payment of any premium associated with the contract.

The term "self-insured plan" means an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides benefits with respect to some or all of the items and services included in the comprehensive benefit package (as in effect as of January 1, 1995) that is funded in a manner other than through the purchase of one or more health insurance plans. such term shall not include a group health insurance plan (as defined in paragraph (5)(B)(ii)).

The term "self-insured sponsor" includes any entity which establishes or maintains a self-insured plan.

The term "state commissioner of insurance" includes a state superintendent of insurance.

Section 11009. Termination. (a) Provides that this title will not apply to a health insurance plan provided in a state on and after the time a state implements universal coverage pursuant to the provisions of this Act.

(b) Provides that, for self-insured plans sponsored by corporate alliance eligible sponsors, the provisions of this title will not apply as of the effective date of the sponsor's election to be a corporate alliance. For self-insured plans sponsored by a sponsor that is not such an eligible corporate alliance sponsor, the provisions of this title will not apply in a state on and after the time a state implements universal coverage pursuant to the provisions of this Act.

PHOTOCOPY
PRESERVATION