SUBTITLE G - TAX TREATMENT OF LONG-TERM CARE INSURANCE AND SERVICES
(H.R. 3600 and S. 1757 p. 1171)

Section 7701. Qualified Long-Term Care Services Treated as Medical Care. Internal Revenue Code section 213 currently provides a deduction for medical care expenses subject to a floor of 7.5 percent of adjusted gross income. Expenses for medical care include expenses for "the diagnosis, cure, mitigation, treatment, or prevention of disease...[and] those paid for the purpose of affecting any structure or function of the body or for transportation primarily for and essential to medical care." Under regulations, medical care expenses are "confined strictly to expenses incurred for the prevention or alleviation of a physical or mental defect or illness," and do not include expenditures that are "merely beneficial to the general health of an individual." The authorities generally indicate that the cost of personal services, including custodial care, is a medical expense if there is a direct connection between the service and a recognized, specific medical condition. Old age is not a sufficiently specific medical condition for this purpose.

The authorities also indicate that services must be performed directly for the individual. By contrast, services such as housekeeping, cooking, gardening, etc. which are not performed directly for an individual are not considered directly related to a specific medical condition. Where services qualifying as medical care are provided in addition to services not qualifying as medical care, an allocation is generally required.

Regulations provide that the entire amount of an expense may be treated as medical expense if the expense is incurred primarily to provide medical care. Under this rule, the entire cost of services provided in a nursing home or similar institution may be a medical expense if the principal purpose for the individual's presence is the availability of medical care at the institution.

The Health Security Act would provide necessary guidance in establishing the deductibility of long-term care expenses incurred by an incapacitated individual. The definition of medical care under Internal Revenue Code section 213 would be expanded to include qualified long-term care services. Services performed for an incapacitated individual would be treated as deductible medical expenses subject to the 7.5-percent floor. An incapacitated individual is a person who is unable to perform without substantial assistance at least two activities of daily living or suffers from severe cognitive impairment. No inference should be drawn as to whether this amendment represents a change from current law.

Medical care service expenses incurred by an individual who is not incapacitated under this definition would be deductible, as provided under current law.

The provision would apply to taxable years beginning after December 31, 1995.

Section 7702. Treatment of Long-Term Care Insurance. Generally, the treatment under current law of benefits provided under a long-term care insurance policy is unclear. To the extent that long-term care is not treated as medical care, employer-provided long-term care coverage would not be excludable accident or health coverage under Internal Revenue Code section 106, and the value of the coverage would be taxable to the employee. Generally, benefits paid under a long-term care plan or policy would not be treated as amounts received through accident and health insurance on an excludable basis under Internal Revenue Code section 104 or 105, unless the amounts received for long-term care represent reimbursement for medical care.

Favorable tax treatment would be provided by the Health Security Act to encourage the purchase of qualified private long-term care insurance to assist with the financial protection of an aging population. Following the design of the health reform plan, which provides for a comprehensive benefit package, the Health Security Act would establish favorable tax treatment for a qualified long-term care insurance policy. Supplemental long-term care insurance policies could be purchased but would not receive the same tax benefits as a qualified policy.

Under the Act, premiums paid for a qualified long-term care policy would be deductible as a trade or business expense or as an itemized deduction subject to the 7.5-percent-of-adjusted-gross-income floor; the value of employer-provided coverage under the policy would not be taxable to an employee; and benefits under the policy would not be taxable to the recipient. However, funding the purchase of the policy on a tax-favored basis through a cafeteria plan would not be permitted.

A qualified long-term care insurance policy would be required to:

(a) satisfy certain regulatory standards set forth in the Health Security Act;

(b) condition eligibility for benefits on being unable to perform at least two activities of daily living or on suffering severe cognitive impairment;

(c) not allow immediate prefunding or cash values; and

(d) limit benefits to $150 per day (indexed for medical inflation) without regard to actual incurred long-term care expenses.

Any long-term care coverage provided by rider on a life insurance contract would be treated as a separate contract. The addition of a long-term care insurance rider would not be treated as a modification or material change of the contract for purposes of Internal Revenue Code sections 7702 and 7702A.

The provision would apply to policies issued after December 31, 1995. A transition rule would permit existing long-term care insurance policies to be exchanged for qualified

long-term care insurance policies without recognition of gain or loss.

Sections 7703 and 7704. Tax Treatment of Accelerated Death Benefits
(a) Accelerated Death Benefits Under Life Insurance Contracts

Payments made under a life insurance contract other than by reason of an insured's death are generally taxable under current law. However, the tax treatment of payments made under certain circumstances is not entirely clear.

Recognizing the benefits to society of life insurance protection, the tax system encourages the purchase of life insurance by allowing tax-free "inside buildup" and the payment of tax-free benefits upon the insured's death. Other tax provisions limit the extent to which the tax-favored nature of the insurance contract can be abused as a tax-favored investment vehicle.

Terminally ill individuals face varied needs in their last months of life. Gaining access during these months to a portion of the death benefit under their life insurance contract can ease some of the financial burden of the terminal illness. However, there is also a need to balance the financial protection of the beneficiaries under the life insurance contracts (which is the primary purpose of life insurance) against the needs of the terminally ill.

While the tax system supports the purchase of life insurance as a means of providing financial protection for the insured's beneficiaries, the tax system should also support the purchase of an accelerated death benefit rider on a life insurance contract as a means of providing financial protection for the insured who becomes terminally ill. However, the system should not permit abuse of the tax-favored nature of life insurance by allowing unlimited access to death benefits prior to death. The insurance feature would be undermined if the insurance contract were to become a generous tax-favored investment vehicle. Recognizing this potential for abuse, the accelerated payment of death benefits should be permitted on a tax-free basis only if the death of the insured is imminent. The insurance element of the contract would thus not be undermined.

The Health Security Act would provide insurers with standards needed to design and market insurance contracts that provide for payment of benefits prior to an insured's death without subjecting policyholders to taxation on the additions to cash value within the life insurance contract. In recognition of the needs of individuals who become terminally ill, the proposal would allow an accelerated death benefit received by an individual on the life of an insured who is expected, due to terminal illness, to die within 12 months to be excluded from taxable income as a payment by reason of death. No inference should be drawn as to whether this amendment represents a change from current law.

The provision would apply to taxable years beginning after December 31, 1993.

(b) Companies Issuing Qualified Accelerated Death Benefit Riders

Under current law, insurance contracts have been developed that provide for payment of death benefits under a life insurance policy, as a result of terminal illness, prior to an insured's death. Generally, the accelerated death benefit is equal to all or a portion of the death benefit, discounted for the remaining life expectancy (generally 12 months or less) of a terminally ill individual. Internal Revenue Code section 7702 defines a life insurance contract as any contract that is a life insurance contract under applicable law, but only if the contract either (1) meets the cash value accumulation test of section 7702(b), or (2) meets the guideline premium requirements of 7702(c) and falls within the cash value corridor of section 7702(d). For purposes of section 7702, the accelerated death benefit could be viewed as an amount paid upon surrender of a contract and accordingly would be included in the cash surrender value of the contract. The impact of this characterization would be to disqualify as life insurance under section 7702 contracts providing accelerated death benefits.

As discussed above, it is desirable that the tax system support the purchase of an accelerated death benefit rider on a life insurance contract as a means of providing financial protection for the insured who becomes terminally ill. Accordingly, the proposal allows an accelerated death benefit rider to be sold in conjunction with a life insurance contract without causing disqualification of the contract as a life insurance contract. This protects the policyholder from taxation on the inside buildup in the life insurance contract.

The Health Security Act would expand the definition of a life insurance contract to include a qualified accelerated death benefit rider on the contract and would treat the rider as a qualified additional benefit under section 7702(f)(5)(A). Also, the addition of an accelerated death benefit rider to a life insurance contract would not be treated as a modification or material change of the contract for purposes of sections 7702 and 7702A. No inference should be drawn as to whether this amendment represents a change from current law.

The provision would apply to contracts issued after December 31, 1993.

SUBTITLE H - TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS (H.R. 3600 and S. 1757 p. 1192)

Sections 7801 and 7802. Tax Incentives for Health Services Providers. Since the early 1970s, the problems of shortages of health care professionals in certain geographic areas have been the target of the National Health Service Corps (NHSC) program. Pursuant to that program, participating health care professionals who agree to practice in "health professional shortage areas" (HPSAs) may receive scholarships or amounts that are used for the repayment of educational loans.

There continue to be significant shortages of health care professionals in a number of urban and rural areas. Tax incentives would encourage health care professionals to locate in underserved areas and thereby help alleviate these shortages. The current NHSC program has not been sufficient to eliminate these shortages.

The Health Security Act would provide two tax incentives: (i) a nonrefundable credit for certain primary health services providers (section 7801), and (ii) increased expensing under section 179 for certain medical equipment (section 7802).

(a) Non-refundable Credit for Certain Primary Health Services Providers

This proposal would provide a $1,000 per month tax credit for physicians (and a $500 per month credit for physician assistants, nurse practitioners, and certified nurse-midwives) who provide primary health services on a full-time basis in HPSAs. To be eligible for the credit, the individual must first apply for certification, and be certified, by the Department of Health and Human Services in a manner similar to that currently in effect under the existing NHSC program. An individual would be eligible for the credit for up to a maximum of 60 months. Previously claimed credits would be subject to complete or partial recapture if the individual works in the HPSA for less than 60 months. The credit would not be available to health care professionals who begin work in the HPSA before 1995. In an effort to coordinate this tax incentive with NHSC programs, individuals who have previously participated in NHSC programs would not be eligible for the credit.

(b) Increased Expensing of Medical Equipment

Under this proposal, an additional $10,000 of expensing under Internal Revenue Code section 179 would be available for certain medical equipment owned and used by a physician in a HPSA in the active conduct of the physician's full-time trade or business of providing primary health services in the HPSA. As the Omnibus Budget Reconciliation Act of 1993 increased the general section 179 annual limit from $10,000 to $17,500, the combined limit would be increased to $27,500. This expanded level of expensing would apply to equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment.

The credit would generally be effective for taxable years beginning after December 31, 1994. The increased expensing would be effective for medical equipment placed in service after December 31, 1994.

SUBTITLE I - MISCELLANEOUS PROVISIONS
(H.R. 3600 and S. 1757 p. 1199)

Section 7901. Credit for Cost of Personal Assistance Services Required by Employed Individuals. The Internal Revenue Code currently provides tax credits to assist certain categories of workers and disabled taxpayers. For example, the earned income tax credit is available to low-income workers. The dependent care credit is available to taxpayers who incur household and dependent care expenses in order to be able to work. The elderly and those who are totally and permanently disabled are entitled to a credit regardless of whether they are employed.

Individuals with disabilities who are capable of working face a number of special challenges in the daily activities that are associated with gainful employment. The incentives provided to these individuals will assist them in their efforts to become, and remain, part of the work force.

A nonrefundable tax credit would be made available to individuals who work and who, by reason of a medically determinable physical impairment that has lasted (or can be expected to last) for at least 12 months, would be unable to engage in substantial gainful activity without personal assistance services. The amount of the credit would be based on (i) the level of specified personal assistance expenses, (ii) the individual's earned income, and (iii) the individual's (and his or her spouse's) adjusted gross income. For taxpayers with adjusted gross income of less than $50,000, the credit would be equal to 50 percent of up to $15,000 in personal assistance expenses (or 50 percent of earned income, if the individual's personal assistance expenses exceed his or her earned income) -- for a maximum credit of $7,500. The rate of the credit, and accordingly the maximum possible credit, would be phased down for taxpayers with adjusted gross income between $50,000 and $70,000 (with no credit available for taxpayers with adjusted gross income over $70,000).

The credit would be effective for taxable years beginning after December 31, 1995.

Section 7902. Denial of Tax-Exempt Status for Borrowings of Health Care-Related Entities. State and local governments generally may issue tax-exempt bonds to finance their activities. Except in the case of certain qualified bonds, however, under current law, the interest on private activity bonds is not tax-exempt. Private activity bonds include bonds issued as part of an issue if: (1) more than 10 percent of the proceeds are to be used for any private business use (the "private business use test"), and (2) the principal of, or interest on, more than 10 percent of the issue is either secured by property used in a private business use (or payments in respect of such property) or to be derived from payments in respect of property used for a private business use (the "private security or payment test"). The Internal Revenue Code defines qualified bonds to include certain bonds for section 501(c)(3) organizations ("qualified 501(c)(3) bonds").

Generally, the Federal tax laws are designed to limit the ability of State and local governments to issue tax-exempt bonds to be used for other than traditional governmental purposes. Health care alliances and State guaranty funds described in section 1204 of the Health Security Act would perform functions that have traditionally been performed by the private sector. Regardless of who the operator is, each alliance would be organized for the benefit of, and would be financially supported by, the individual members of that alliance. Similarly, State guaranty funds would be operated for the benefit of those covered by the fund. It is inappropriate to provide the indirect Federal subsidy implicit in tax-exempt bonds to the individuals who benefit from the alliances and guaranty funds.

Where appropriate, the Health Security Act would provide more efficient, direct subsidies to individuals in need of Federal assistance in obtaining health insurance, and would prevent State and local governments from substituting tax-exempt debt for taxable debt in these situations. If alliances and guaranty funds were allowed to benefit from tax-exempt financing, there would be a significant revenue loss to the Federal government and an increase in the interest rates that State and local governments are required to pay to finance their activities.

The Act would provide that the use of bond proceeds by a health care alliance or State guaranty fund would be private business use. Therefore, issues of bonds more than 10 percent of the proceeds of which are used to finance the activities of health care alliances or State guaranty funds would be private activity bonds the interest on which would not be tax-exempt (unless the issue failed to meet the private security or payment test).

The amendment would apply to obligations issued after the date of enactment.

Section 7903. Disclosure of Return Information for Administration of Certain Programs Under the Health Security Act. The Internal Revenue Code currently prohibits disclosure of tax returns and return information, except to the extent specifically authorized by Code section 6103. Unauthorized disclosure is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both (Code section 7213). An action for civil damages also may be brought for unauthorized disclosure (Code section 7431). In general, no tax information may be furnished by the Internal Revenue Service to another agency unless the other agency establishes procedures satisfactory to the Internal Revenue Service for safeguarding the tax information it receives (Code section 6103(p)).

The Health Security Act provides for several assistance programs, such as premium discounts for low-income individuals, that would be income-based. The States would verify income information provided by individuals to ensure that they qualify to receive the assistance. Federal tax returns provide the only comprehensive source of information for such verification.

The Act would permit disclosure to Federal and State agencies of certain return

information with respect to assistance provided under the Act. The Act would extend the current-law restrictions on unauthorized disclosure to Federal and State agencies and their employees. Those employees would not be permitted to redisclose tax information to any third party.

The amendment would be effective on the date of enactment.

TITLE VIII - HEALTH AND HEALTH-RELATED PROGRAMS OF THE FEDERAL GOVERNMENT

SUBTITLE A - MILITARY HEALTH CARE REFORM (H.R. 3600 and S. 1757 p. 1207)

Section 8001. Uniformed Services Health Plans.

(a) Chapter 55 of title 10, United States Code, is amended by inserting section 1073a after section 1073. Section 1073a provides:

(a) The Secretary of Defense may establish one or more Uniformed Services Health Plans. The Secretary of Defense must issue regulations to carry out this section. Uniformed Services Health Plans must conform, to the maximum extent practicable, to other requirements for health plans under the Health Security Act.

(b) A Uniformed Services Health Plan may rely upon the use of facilities of the uniformed services for the provision of health care services, supplemented by the use of civilian health care providers or health plans under agreements entered into by the Secretary of Defense. An agreement with a civilian health care provider or a health plan may be entered into without regard to provisions of law requiring the use of competitive procedures. An agreement with a health plan may provide for the sharing of resources with the health plan that is a party to the agreement.

(c) A Uniformed Services Health Plan must provide the items and services in the comprehensive benefit package to persons enrolled in the plan. In addition, a Uniformed Services Health Plan must guarantee to those members of the uniformed services on active duty for a period of more than 30 days as of December 31, 1994 or any person who is a covered beneficiary as of that date who enroll in a Uniformed Services Health Plan those health care services that the person would be entitled to receive under chapter 55 in the absence of this section.

(d) In carrying out its responsibilities under the Health Security Act, a state (or state-established entity) may not impose any standard or requirement or deny certification to a Uniformed Services Health Plan because of a conflict with this section or any regulation prescribed pursuant to this section or other Federal law regarding the operation of this section.

(e) Except as authorized by an administering Secretary, each member of a uniformed service on active duty for a period of more than 30 days must enroll in a Uniformed Services Health Plan available to the member. After enrolling active duty members, Uniformed Services Health Plans may enroll first spouses and children of members of the uniformed services who are on active duty for a period of more than 30 days, and then individuals described in subsection 1086 of title 10. For all enrollees, participation in a Uniformed Services Health Plan is the exclusive source of

health care services available to the member or person under chapter 55.

(f) If person is eligible to enroll in a Uniformed Services Health Plan but does not enroll, the person is not entitled or eligible for health care services in facilities of the uniformed services or pursuant to a contract entered into under chapter 55. However, the person may receive a premium payment from the Secretary of Defense as described in paragraph (h).

A person who is eligible to enroll in a Uniformed Services Health Plan but enrolls in another health plan may receive the items and services in the comprehensive benefit package in a facility of the uniformed services only if:

(1) the Secretary of Defense authorizes the provision of a particular item or service in the package to the person;

(2) the Secretary determines that the provision of the item or service will not interfere with the provision of health care services to members of the uniformed services or persons enrolled in a Uniformed Health Services Plan; and

(3) the health plan in which the person is enrolled agrees to pay the actual and full cost of the items and services provided. An individual who is eligible to enroll in Uniformed Services Health Plans but is not offered the opportunity to enroll in a Uniformed Services Health Plan and is not enrolled in an alliance health plan may enroll in a Uniformed Services Health Plan.

(g) If a person enrolled in the supplementary medical insurance program under Medicare part B enrolls in a Uniformed Services Health Plan, Medicare is responsible for making a premium payment on behalf of the person. Medicare must pay the Uniformed Services Health Plan on the same basis as it pays other eligible organizations with a risk-sharing contract under section 1876 of the Social Security Act. This premium payment is the person's exclusive benefit under Medicare.

(h) If an individual eligible to enroll in a Uniformed Services Health Plan enrolls in another alliance health plan, the Secretary may make a premium payment. In determining the amount of a payment, the Secretary considers the amount of any retiree discount payable under the Health Security Act on behalf of the person and the amount of any premium credits attributable to employer payments with respect to the person. The Secretary will not make a premium payment for any person enrolled in a health plan of the Department of Veterans Affairs or a health program of the Indian Health Service.

(i) An active duty member enrolled in a Uniformed Services Health Plan pays no premiums or cost sharing other than subsistence charges authorized by section 1075 of Title 10.

Spouses and children of active duty members and retirees may be required to pay the family share of premiums and cost sharing as established by regulation by the Secretary of Defense. These payments may not be higher than those charged by other

health plans. In addition, these payments in 1995 must not be higher than the lesser of the out-of-pocket costs owed by this group of individuals on December 31, 1994 and the amount charged by other health plans. The limitation on out-of-pocket costs may be adjusted for years after 1995 by an appropriate economic index, as determined by the Secretary of Defense.

(j) A financial account is established in the Department of Defense for all premium payments and other receipts from other payers and beneficiaries made in connection with any person enrolled in a Uniformed Services Health Plan. The account will be administered by the Secretary of Defense, and funds in the account may be used by the Secretary for any purpose directly related to the delivery and financing of health care services under chapter 55, including operations, maintenance, personnel, procurement, contributions toward construction projects, and related costs. Funds in the account remain available until expended.

(b) The term "Uniformed Services Health Plan" means a plan established by the Secretary of Defense to provide health care services to members of the uniformed services on active duty and other covered beneficiaries under chapter 55.

(c) If the Secretary of Defense chooses to establish any Uniformed Services Health Plans, the Secretary must submit to Congress a report describing the Plans. The report must be submitted not later than 30 days before the date on which the Secretary first issues proposed rules to establish any Plan.

SUBTITLE B - DEPARTMENT OF VETERANS AFFAIRS
(H.R. 3600 and S. 1757 p. 1218)

Section 8101. Benefits and Eligibility Through Department of Veterans Affairs Medical System (DVA).

(a) DVA as a Participant in Health Care Reform. This section amends Title 38, United States Code by inserting "Chapter 18 - Eligibility and Benefits Under Health Security Act" after chapter 17.

Definitions. Adds section 1801 that defines the following terms for the purposes of this chapter:

(1) A 'health plan' is an entity that has been certified under the Health Security Act as a health plan.

(2) A 'VA health plan' is a health plan operated by the Secretary of Veterans Affairs.

(3) A 'VA enrollee' is an individual enrolled in a VA health plan.

Subchapter II - Enrollment

Enrollment: Veterans. Adds section 1811 which states that each veteran who is eligible under the Health Security Act may enroll with a VA health plan. A veteran who selects a VA health plan must enroll.

Enrollment: CHAMPVA Eligibles. Adds section 1812 which states that an individual who is eligible for CHAMPVA and who is eligible under the Health Security Act may enroll in a VA health plan.

Enrollment: Family Members. Adds section 1813 which states that the Secretary may authorize a VA health plan to enroll members of the family of a veteran or CHAMPVA eligible enrollee and may charge premiums and cost sharing as required under the Health Security Act. An enrollee's family is the enrollee's spouse and children (and, if applicable, the spouse's children) if they are eligible individuals under the Health Security Act.

Subchapter III - Benefits

Benefits for VA Enrollees. Adds section 1821 which states that each VA health plan must provide the comprehensive benefit package to each enrollee.

Chapter 17 Benefits Described. Adds section 1822 which states that in addition to the comprehensive benefit package, the Secretary must provide the care and services authorized to be provided under chapter 17 according to current eligibility rules for those benefits.

Supplemental Benefits Packages and Policies. Adds section 1823 which states that a VA health plan may offer supplemental benefits policies for health care services not provided under chapter 17 and cost sharing policies consistent with the requirement of part 2 of Subtitle E of title I of the Health Security Act.

Limitation Regarding Veterans Enrolled With Health Plans Outside the Department. Adds section 1824 which states that a VA health plan may provide items and services in the comprehensive benefit package to veterans enrolled in non-VA health plans if the VA health plan is reimbursed for the actual and full costs of the care provided.

Subchapter IV - Financial Matters

Premiums, Copayments, etc. Adds section 1831 which provides that the Secretary may not impose premiums or cost sharing for the comprehensive benefit package on the following veterans who enroll in VA health plans:

(1) any veteran with a service-connected disability;

(2) any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty;

(3) any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in such section;

(4) any veteran who is a former prisoner of war;

(5) any veteran of the Mexican border period or World War I; and

(6) any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

The Secretary must charge premiums and cost sharing to other VA enrollees. Rates for cost sharing are established by the VA health plan based on rules of the health alliance.

Medicare Coverage and Reimbursement. Adds section 1832 in which VA health plans and Departmental facilities are deemed Medicare providers or eligible organizations under section 1876 of the Social Security Act.

The Secretary of Health and Human Services must reimburse a VA health plan or Department facility providing services as a Medicare provider or eligible organization under section 1876 on the same basis as other Medicare providers or eligible organizations for care provided to veterans other than veterans described in section 1831(b). The Secretary of Veterans Affairs must require that veterans other than veterans described in section 1831(b) pay any deductible or cost sharing that is not covered by Medicare.

Recovery of Cost of Certain Care and Services. Adds section 1833 in which the Secretary of Veterans Affairs has the right to recover or collect charges for care or services

provided to an individual covered under a supplemental insurance policy or a Medicare supplemental health insurance plan (but not including care or services for a service-connected disability) if the individual would be eligible to receive payment for such care or services if the care or services were not being provided by a department or agency of the United States. The provisions of subsections (b) through (f) of section 1729 of this title apply to claims under this section.

Revolving Fund. Adds section 1834 in which the Secretary of Veterans Affairs must establish a revolving fund. Any amount paid to the Department for the provision of health care by a VA health plan or the enrollment of an individual in a VA health plan must be credited to the revolving fund. The Department may not retain amounts received for care furnished to a VA enrollee in a case in which the costs of the care are covered by appropriations. Amounts in the revolving fund are available to the health plan for delivering the comprehensive benefit package and any supplemental benefits policy.

(b)Preservation of Existing Benefits for Facilities Not Operating as Health Plans. This section amends chapter 17 of title 38 by inserting section 1705 after section 1704.

Facilities Not Operating Within Health Plans; Veterans Not Eligible to Enroll in Health Plans. Inserts section 1705 in which the provisions of this chapter apply to: (1) any facility of the Department that is not operating as or within a health plan certified as a health plan within the Health Security Act; and (2) any facility providing care to any veteran who is living abroad and is therefore not an eligible individual under the Health Security Act.

Section 8102. Organization of Department of Veterans Affairs Facilities as Health Plans.

(a) In General. This section amends chapter 73 of title 38 by redesignating subchapter IV as subchapter V and by inserting after subchapter III the following new subchapter:

Subchapter IV - Participation as Part of National Health Care Reform

Organization of Department of Veterans Affairs Facilities as Health Plans. Adds section 7341 which states that the Secretary of Veterans Affairs must organize health plans and operate Department facilities as or within health plans. The Secretary must establish standards for the operation of Department health care facilities as or within health plans that conform, to the maximum extent practicable, to the requirements for health plans.

Health care facilities of the Department within a geographic region may be organized to operate as a single health plan encompassing all facilities or as several health plans.

In carrying out its responsibilities under the Health Security Act, a state (or state-

established entity) may not impose any standard or requirement or deny certification to a VA health plan because of a conflict with this section or any regulation prescribed pursuant to this section or other Federal law regarding the operation of this section.

Contract Authority for Facilities Operating as or Within Health Plans. Adds section 7342 in which the Secretary of Veterans Affairs may enter into a contract (without regard to laws requiring the use of competitive procedures) for the provision of services by a VA health plan if the Secretary determines that contracting is more cost effective than providing care directly through Department facilities or when contracting is necessary because of geographic inaccessibility.

Resource Sharing Authority: Facilities Operating as or Within Health Plans. Adds section 7343 which states that the Secretary of Veterans Affairs may enter into agreements for the sharing of resources of the Department through facilities of the Department operating as or within health plans.

Administrative and Personnel Flexibility. Adds section 7344 in which the Secretary of Veterans Affairs is given authority to carry out administrative reorganizations of the Department, enter into contracts for the performance of services previously performed by employees of the Department, and establish alternative personnel systems or procedures for personnel at facilities operating as or within health plans, except that the Secretary must comply with applicable veterans preference laws. The Secretary may also carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department operating as or within health plans. The Secretary must use only nonappropriated funds.

Veterans Health Care Investment Fund. Inserts section 7345 which states that: if amounts appropriated for each of the fiscal years 1995 through 1997 provide new budget authority for the Department of Veterans Affairs Medical Care account of no less than the amount requested by the President, the Secretary of the Treasury must credit to a special fund of the Treasury an amount equal to $1,000,000,000 for fiscal year 1995, $600,000,000 for fiscal year 1996, and $1,700,000,000 for fiscal year 1997. The amounts in the fund may be used only for the VA health plans authorized under this chapter.

By March 1, 1997, the Secretary must provide to Congress a report concerning the operation of the Department of Veterans Affairs health care system in preparing for, and operating under, health care reform during fiscal years 1995 and 1996. The report must include a discussion of the adequacy of amounts in the investment fund for the plans, the quality of care provided by the plans, the ability of the plans to attract new patients, and the need for additional funds for the investment fund in fiscal years after fiscal year 1997.

Funding Provisions: Grants and Other Sources of Assistance. Adds section 7346 in which the Secretary may apply for and accept, if awarded, any grant or other source of funding intended to meet the needs of special populations that but for this section is

unavailable to facilities of the Department or health plans operated by the Government if these funds will be used by a facility of the Department operating as or within a health plan.

(b) Clerical Amendment. The table of sections is amended at the beginning of chapter 73 to insert a table of contents for subchapter IV.

SUBTITLE C - FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (H.R. 3600 and S. 1757 p. 1233)

Section 8201. Definitions. This section defines the following terms for this subtitle:

(1) The term "abroad" means outside the United States.

(2) The terms "annuitant", "employee", and "Government", have the same respective meanings as are given such terms by section 8901 of title 5.

(3) The term "Employees Health Benefits Fund" means the fund under section 8909 of title 5.

(4) The term "FEHBP" means the health insurance program under chapter 89 of title 5.

(5) The term "FEHBP plan" has the same meaning as is given the term "health benefits plan" by section 8901(6) of title 5.

(6) The term "FEHBP termination date" means the date (specified in section 8202) after which FEHBP ceases to be in effect.

(7) The term "Retired Employees Health Benefits Fund" means the fund under section 8 of the Retired Federal Employees Health Benefits Act.

(8) The term "RFEHBP" means the health insurance program under the Retired Federal Employees Health Benefits Act.

Section 8202. FEHBP Termination. Chapter 89 of title 5 is repealed effective as of December 31, 1997, and all contracts under such chapter will terminate not later than that date.

Section 8203. Treatment of Federal Employees, Annuitants, and Other Individuals (Who Would Otherwise Have Been Eligible for FEHBP) Under Health Plans. This section sets forth rules applicable after the FEHBP termination date for eligible individuals who would have been eligible to enroll in a FEHBP plan before termination.

Federal employees will be treated as other employees (as defined in section 1901) under the Health Security Act, including for purposes of any requirements relating to enrollment and premium payments. Any employer premium payment required on behalf of a Federal employee must be paid from the appropriation or fund from which any Government contribution on behalf of such employee would have been payable under FEHBP.

The Federal Government shall offer to Federal employees one or more FEHBP supplemental plans.

The Office of Personnel Management (or other applicable Government entity) may, on the request of an annuitant enrolled in a health plan, withhold from the annuity of the annuitant any premiums required for enrollment. The Office (or other entity) must forward any amounts withheld to the appropriate fund or as otherwise indicated in the request.

In the case of an annuitant whose liability to the regional alliance is not reduced by employer premium payments, a Government contribution must be made to reduce the employee's liability to zero.

The Office of Personnel Management will develop one or more FEHBP supplemental plans that meet the requirements of supplemental health benefit policies or cost sharing policies under the Health Security Act and that reflect (taking into consideration the benefits in the comprehensive benefit package) the overall level of benefits last generally afforded under FEHBP. The Office of Personnel Management will also develop one or more Medicare supplemental plans that offer benefits which include the core group of basic benefits identified under section 1882(p)(2) of the Social Security Act and reflect (taking into consideration the benefits provided under the Medicare program) the overall level of benefits last generally afforded under FEHBP.

Each annuitant who was an annuitant or family member of an annuitant on December 31, 1997 is eligible to enroll in a FEHBP supplemental plan and is eligible for a Government contribution to premiums for a supplemental plan in an amount that reasonably reflects the portion of the Government contribution (last provided under FEHBP) attributable to the portion of FEHBP benefits which the plan is designed to replace.

The Federal Government shall offer future annuitants one or more FEHBP supplemental plans.

The Federal Government may, but is not required to, offer one or more FEHBP supplemental plans to any individual who would have been eligible to enroll in a FEHBP plan before termination, but would not have been eligible for a Government contribution. The Federal Government will not pay a Government contribution for these individuals.

Each Medicare-eligible annuitant who was Medicare-eligible on December 31, 1997 is eligible to enroll in a Medicare supplemental plan and, if that individual would have been eligible for a Government contribution under FEHBP, is eligible for a Government contribution to premiums for a Medicare supplemental plan and for a contribution that reasonably reflects the portion of the government contributions (last provided under FEHBP) attributable to the portion of FEHBP benefits which the plan is designed to replace.

The Federal Government may, but is not required to, offer one or more Medicare supplemental plans to any individual who was Medicare-eligible on December 31, 1997 and to make a Government contribution to the premium for the plan.

A Medicare-eligible individual may elect to have the amount of the Government contribution applied toward premiums for enrollment with an eligible organization under a risk-sharing contract under section 1876 of the Social Security Act. The amount of the Government contribution will be determined without taking into account this election.

The Government contributions authorized by this section on behalf of an annuitant (including payments to Medicare-eligible annuitants) must be paid from annual appropriations authorized to be made for that purpose and which may be made available until expended.

All contributions relating to any FEHBP supplemental plan, FEHBP Medicare supplemental plan or health insurance program covering FEHBP eligible individuals residing abroad must be paid into a fund established in the United States Treasury. The fund will be administered by the Office of Personnel Management and monies in the fund must be used for these plans and programs.

Section 8204. Treatment of Individuals Residing Abroad. After the FEHBP termination date, individuals residing abroad who would have been eligible for FEHBP continue to be eligible for health insurance under a program that the Office of Personnel Management will establish by regulation. Coverage and benefits under this program will, to the extent practicable, reflect the level of benefits available to individuals in the United States. Any Government contribution payable to a Federal employee under this program must be made from the appropriation or fund from which any Government contribution would have been payable under FEHBP.

Section 8205. Transition and Savings Provisions. The Employees Health Benefits Fund will be maintained, and amounts in the fund will remain available, after the FEHBP termination date, for a period of time that the Office of Personnel Management considers necessary to satisfy any outstanding claims.

After the end of this period, any amounts remaining in the Fund will be disbursed (between the Government and former participants in FEHBP) in accordance with a plan prepared by the Office of Personnel Management, consistent with the cost sharing ratio between the Government and plan enrollees during the final contract term. The details of the plan must be submitted to the President and the Congress at least one year before the date of its proposed implementation.

Chapter 89 of title V will be considered to remain in effect after the FEHBP termination date for the purposes of any liability incurred or violation which occurred before termination.

The Retired Federal Employees Health Benefits Act is repealed effective as of the FEHBP termination date. After the FEHBP termination date, the Retired Employees Health Benefits Fund will remain available temporarily and will then be disbursed in the same manner as the Employees Health Benefits Fund. Retired employees who would have been eligible for coverage under the Retired Federal Employees Health Benefits Act will be treated as if they were annuitants (subject to any differences in the level of coverage and benefits provided under FEHBP and RFEHBP).

Regulations concerning the disbursement of monies in any fund must make necessary

provisions for individuals residing abroad.

Section 8206. Regulations. The Office of Personnel Management must prescribe regulations to carry out this subtitle.

Section 8207. Technical and Conforming Amendments. The following technical and conforming amendments take effect on the day after the FEHBP termination date:

(1) The section of title 5 requiring the Office of Personnel Management to prepare an annual report on FEHBP is repealed.

(2) Any reference to a health insurance program under chapter 89 of title 5 will be considered a reference to the health insurance program under the Health Security Act, subject to clarifications and except as provided in regulations.

(3) Effective as of the date of the enactment of this Act, section 11101(b)(3) of the Omnibus Budget Reconciliation Act of 1993 is amended to substitute December 31, 1997 for September 30, 1998.

SUBTITLE D - INDIAN HEALTH SERVICE
(H.R. 3600 and S. 1757 p. 1249)

Section 8301. Definitions. This section defines the following terms for the purpose of this subtitle:

(1) The term "health program of the Indian Health Service" means a program which provides health services under this Act through a facility of the Indian Health Service, a tribal organization under the authority of the Indian Self-Determination Act or a self-governance compact, or an urban Indian program.

(2) The term "reservation" means the reservation of any federally recognized Indian tribe, former Indian reservations in Oklahoma, and lands held by incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act.

(3) The term "urban Indian program" means any program operated pursuant to title V of the Indian Health Care Improvement Act.

(4) The terms "Indian", "Indian tribe", "tribal organization", and "service unit" have the same meaning as when used in the Indian Health Care Improvement Act.

Section 8302. Eligibility and Health Service Coverage of Indians. An eligible individual is eligible to enroll in a health program of the Indian Health Service, and may elect a health program of the Indian Health Service instead of a health plan, if the individual is: (1) an Indian, or a descendent of a member of an Indian tribe who belongs to and is regarded as an Indian by the Indian community in which the individual lives, who resides on or near an Indian reservation or in a geographical area designated by statute as meeting the requirements of being on or near a reservation notwithstanding the lack of an Indian reservation; (2) an urban Indian; or (3) a Indian living in certain counties in California as described in section 809(b) of the Indian Health Care Improvement Act.

An individual described above who elects a health program of the Indian Health Service must enroll in the program. The individual is not required to pay any health insurance premiums or other cost sharing. If an individual chooses not to enroll in a health program of the Indian Health Service and instead enrolls in an alliance health plan, the Indian Health Service does not pay the premiums and cost sharing required by the health plan.

Section 8303. Supplemental Indian Health Care Benefits. All individuals described in section 8302 remain eligible for supplemental benefits offered by the Indian Health Service at no charge. $180,000,000 for fiscal year 1995 and $200,000,000 for each of the fiscal years 1996 through 1999 are appropriated for supplemental benefits.

Section 8304. Health Plan and Health Alliance Requirements. Beginning on January 1, 1999, all health programs of the Indian Health Service must provide the comprehensive benefit package. The Secretary of Health and Human Services will determine which other health plan requirements will apply to health programs of the Indian Health Service. Beginning on January 1, 1999, all health programs of the Indian Health Service must meet the health plan requirements that the Secretary determines apply to Indian health programs. Before January 1, 1999, all health programs must, to the extent practicable, meet these requirements. The Secretary must also determine which requirements relating to health alliances apply to the Indian Health Service.

Section 8305. Exemption of Tribal Governments and Tribal Organizations from Employer Payments. Tribal governments and tribal organizations under the Indian Self-Determination and Educational Assistance Act or a self-governance compact are not required to make employer premium payments.

Section 8306. Provision of Health Services to Non-Enrollees and Non-Indians. A health program or facility of the Indian Health Service may contract with a health plan to provide services to individuals enrolled in that health plan if the program or facility determines that the contract will not result in a denial or diminution of health services to Indians enrolled in a health program of the Indian Health Service. The health program or facility is reimbursed as an essential community provider based on an alliance fee schedule or Medicare payment methodology and rates, as determined by the Secretary.

A health program of the Indian Health Service may open enrollment to family members of individuals described in section 8302. If the health program opens enrollment to family members, family members who choose to join a health program of the Indian Health Service must enroll. Family members must pay premiums and other cost sharing. The Secretary of Health and Human Services must establish and collect premiums for family members enrolled in health programs of the Indian Health Service.

The Secretary must provide for a process for premium reduction which is the same as the process used by regional alliances for the areas in which family members reside, but in computing the family share of the premiums the Secretary must use the lower of the premium quoted or the reduced weighted average accepted bid for the reference regional alliance. The Secretary must pay to each health program the amounts that would have been paid to a regional alliance if the individual had enrolled in a regional alliance health plan (with a final accepted bid equal to the reduced weighted average accepted bid premium for the regional alliance).

If a health program or facility of the Indian Health Service elects to be an essential community provider, an individual described in section 8302 or a family member of the individual may receive health services from that essential community provider.

Section 8307. Payment By Other Payers. Indian Health Service programs will continue to receive payments from other Federal programs and third party payers. The Indian Health Service continues to be the payer of last resort for Indians eligible for contract health services under a health program of the Indian Health Service.

Section 8308. Contracting Authority. The Indian Health Care Improvement Act is amended to permit contracting for personal services for the provision of direct health care services.

Section 8309. Consultation. The Secretary must consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities.

Section 8310. Infrastructure. The Secretary may expend funds appropriated under section 8313 for the construction and renovation of hospitals, health centers, health stations and other facilities for the purpose of improving and expanding these facilities to deliver the comprehensive benefit package. In order to enable health care facilities to deliver the package, the Secretary will establish a revolving loan program to provide guaranteed loans under terms and conditions determined by the Secretary to providers within the Indian Health Service.

Section 8311. Financing. Each health program of the Indian Health Service must establish a comprehensive benefit package fund. All employer premium payments, family premium payments and premium discount payments, appropriations for the purpose of delivering the comprehensive benefit package to enrollees in a health program of the Indian Health Service and any other amount received for the provision of the comprehensive benefit package must be deposited into the fund. Each fund is managed by the health program. Expenditures may be made from the fund for the delivery of the comprehensive benefit package. Amounts in the fund remain available without further appropriation and remain available until expended for payments for the delivery of the comprehensive benefit package.

Section 8312. Rule of Construction. Unless otherwise provided, no part of this act rescinds or modifies any obligations, findings or purposes contained in the Indian Health Care Improvement Act and in the Indian Self-Determination and Education Assistance Act.

Section 8313. Authorizations of Appropriations. For the purposes of carrying out this subtitle, there are authorized to be appropriated $40,000,000 for fiscal year 1995, $180,000,000 for fiscal year 1996, and $200,000,000 for each of the fiscal years 1997 through 2000. These appropriations are in addition to any other authorizations of appropriations that are available for carrying out this subtitle.

Section 8314. Payment of Premium Discount Equivalent Amounts for Unemployed Indians. The Secretary determines for each fiscal year beginning in fiscal year 1998 an amount equivalent to the total amount of premium discounts that would have been

paid to an individual described in section 8302 who is unemployed. The Secretary certifies this amount to the Secretary of the Treasury who pays the amount to the Indian Health Service.

SUBTITLE E - AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) (H.R. 3600 and S. 1757 p. 1262)

Section 8401. Group Health Plans. Amends Section 3 of ERISA to add the term "group health plan" to the statute. A group health plan is defined as an employee welfare benefit plan which provides medical care to beneficiaries either directly or through insurance.

Section 8402. Limitation on Coverage of Group Health Plans Under Title I of ERISA. (a) Amends Section 4 (29 USC section 1003) to exempt group health plans from ERISA except as provided in a new subsection that defines the relationship of ERISA to the Health Security Act. A group health plan that is maintained by a corporate alliance or that is maintained by a member of a corporate alliance is subject to the requirements of Parts 1 and 4 of subtitle B of title I. Other group health plans permitted under the Health Security Act are also governed by parts 1 and 4.

However, parts 1 and 4 apply only to group health plans that are self funded plans sponsored by corporate alliances. ERISA requirements do not apply to health plans that are state certified plans offered to enrollees of a corporate alliance or the members of a corporate alliance.

The Secretary of Labor is required to prescribe regulations for the treatment of group health plans.

In the case of group health plans to which parts 1 and 4 apply, section 502 of ERISA applies with respect to civil actions brought by either participants, beneficiaries or fiduciaries under the group health plan or by the Secretary. Section 502 does not apply, however, to any cause of action to which sections 5202, 5203, 5204 and 5205 apply (grievances against health plans including external review and administrative and judicial appeals procedures).

Sections 3 and 501 through 511 apply to a group health plan to the extent necessary to carry out and enforce the requirements of ERISA. Section 514 (relating to preemption) apply to any group health plan to which parts 1 and 4 apply (self-insured plans).

(b) Amends part 1 of subtitle B of ERISA to impose new reporting and disclosure requirements on group health plans to which parts 1 and 4 apply. Rules developed by the Secretary of Labor must be consistent with the purposes of ERISA and the Health Security Act and may provide for more frequent reporting and other changes to assure expeditious reporting and disclosure of plan terms and changes. Rules on reporting and disclosure should be similar to and consistent with rules developed for state certified health plans offered in regional alliances and with applicable regulations of the Secretary of Health and Human Services.

(c) Plans maintained by regional alliances are exempt from treatment as multiple employer welfare arrangements under section 3(40)(A) of ERISA (29 USC section 11102(40)(A)).

Section 8403. Amendments Relating to Continuation of Coverage. (a) Amends section 602(2)(D) of ERISA to specify continuation coverage under a group health plan until health security act eligibility is established. Qualified individuals under section 602 shall not include any individuals eligible for coverage under the Health Security Act, and continuation coverage provisions are repealed as of the earlier of January 1, 1998, or the first day of the first calendar year in which individuals are eligible for coverage under a comprehensive benefit package.

Section 8404. Additional Amendments Relating to Group Health Plans. (a) Amends section 601(c) of ERISA to specify that regulations by the Board supersede ERISA rules with respect to adoption cases.

(b) The pediatric vaccine program under section 601(d) of ERISA shall not apply to any group health plan that becomes a corporate alliance plan under section 1311 of the Health Security Act.

Section 8405. Plan Claims Procedures. Section 503 of ERISA is amended by requiring group health plans to comply with the Health Security Act plan claims procedures under section 5201 of the Health Security Act.

Section 8406. Effective Dates. Except as otherwise provided, the effective date is January 1, 1998 or the date prescribed by the National Health Board in connection with plans whose participants reside in a state that becomes a participating state before the general effective date.

SUBTITLE F - SPECIAL FUND FOR WIC PROGRAM
(H.R. 3600 and S. 1757 p. 1274)

Section 8501. Additional Funding for Special Supplemental Food Program for Women, Infants and Children (WIC). This section establishes a special fund, in addition to regular appropriations otherwise available for WIC, to help ensure that the WIC program reaches full funding status at the end of FY 1996 and then remains at full funding levels. The President's budget submitted earlier this year set forth a path to full funding that included an appropriations level of $3.564 billion in FY 1995. This section provides that if in years after FY 1995, discretionary appropriations are provided equal to the $3.564 billion level adjusted for inflation, additional amounts from the special fund will be made available to provide the remaining amounts estimated to be needed for full funding.

This section appropriates for the WIC program the amounts necessary for the Secretary of the Treasury to credit to a special fund of the Treasury the following amounts: $254,000,000 for fiscal year 1996, $407,000,000 for fiscal year 1997, $384,000,000 for fiscal year 1998, $398,000,000 for fiscal year 1999 and $411,000,000 for fiscal year 2000. These funds, which are to be financed from "pay as you go" savings, are available only for the WIC program, exclusive of activities authorized under Section 17(m) of the Child Nutrition Act of 1966, and must be paid to the Secretary of Agriculture for that purpose. For each fiscal year, the amount credited to the fund is available only if discretionary appropriations for that year (that is, funds appropriated exclusive of amounts provided for the special fund) provide new budget authority for WIC of no less than $3,660,000,000 for fiscal year 1996, $3,759,000,000 for fiscal year 1997, $3,861,000,000 for fiscal year 1998, $3,996,000,000 for fiscal year 1999, and $4,136,000,000 for fiscal year 2000. The sum of these discretionary spending levels and the amounts from the special fund equals the amounts estimated to be needed for full funding of WIC.

In short, the Secretary of the Treasury is required to place specified amounts in a special fund each year and to pay these amounts to the Secretary of Agriculture for use in WIC, and Congress is authorized to provide the necessary appropriations for the Secretary of the Treasury to fulfill this requirement. These funds are available for use in WIC in a fiscal year only if regular discretionary appropriations for WIC in that year at least equal the levels specified in this section.

TITLE IX - AGGREGATE GOVERNMENT PAYMENTS

SUBTITLE A - AGGREGATE STATE PAYMENTS
(H.R. 3600 and S. 1757 p. 1277)

Subtitle A describes state maintenance of effort payments associated with Medicaid recipients not receiving cash assistance and state premium payments to regional alliances associated with persons receiving cash assistance.

PART 1 - STATE MAINTENANCE OF EFFORT PAYMENT

Part 1 describes state maintenance of effort payments associated with Medicaid recipients not receiving cash assistance.

Section 9001. State Maintenance Of Effort Payment Relating To Non-Cash Assistance Recipients. Participating states are required to make maintenance of effort payments based on current Medicaid expenditures for the comprehensive benefits package associated with recipients who are not receiving cash assistance.

For the first year of participation by a state, a state's payment is calculated as the sum of:

(A) The state's non-cash, non-disproportionate share (DSH) baseline amount (as determined under section 9002(a)(1)), updated under 9003(a)(1); and

(B) The state's non-cash, DSH baseline amount (as determined under section 9002(a)(2)), updated under section 9003(a)(2).

For a succeeding year, the state's payment is equal to the payment for the first year, updated under section 9003(b).

If a state has more than one regional alliance, the state's payments are divided among the state's regional alliances.

Section 9002. Non-Cash Baseline Amounts. The baseline amount is calculated in two parts: a non-cash, non-DSH amount and a non-cash, DSH amount.

The non-cash, non-DSH amount is the sum of:

(A) state Medicaid expenditures in fiscal year 1993 for the comprehensive benefits package for non-cash assistance children.

(B) state Medicaid expenditures in fiscal year 1993 for the comprehensive benefits package for non-cash assistance adults.

(C) state Medicaid expenditures in fiscal year 1993 for items and services that are not in the comprehensive benefits package and are not long-term care services for qualified children (under 1934(b)(1) of Title XIX, section 4222) who are AFDC or SSI recipients.

The non-cash, DSH amount is equal to the state share of disproportionate share expenditures in fiscal year 1993 (under section 1923 of the Social Security Act), multiplied by the proportion of state Medicaid expenditures for hospital services associated with recipients not receiving cash assistance.

Section 9003. Updating Of Baseline Amounts. Baseline amounts are updated separately to the first year of participation by a state, and then to subsequent years.

Updates from fiscal 1993 to the first year are as follows:

(1) The non-cash, non-DSH baseline amount is updated by the following percentages depending on the first year of participation by a state:

(A) 56.6 percent if the first year is 1996.

(B) 78.1 percent if the first year is 1997.

(C) 102.2 percent if the first year is 1998.

(2) The non-cash, DSH baseline amount is updated by the following percentages depending on the first year of participation by a state:

(A) 45.9 percent if the first year is 1996.

(B) 61.8 percent if the first year is 1997.

(C) 79.0 percent if the first year is 1998.

These percentages represent the projected increases nationwide in the relevant category of expenditures from fiscal year 1993 through the first year of participation.

For subsequent years, the non-cash baseline amount is updated by the general health care inflation factor (described in section 6001(a)(3)) plus projected U.S. population growth for the under-65 population.

Section 9004. Non-Cash Assistance Child And Adult Defined. Section 9004 defines child and adult Medicaid recipients who are not receiving cash assistance.

A non-cash assistance child means a child described in section 1934(b)(1) of the

Social Security Act (as inserted by section 4222(a)) who is not Medicare-eligible.

A non-cash assistance adult means an individual who is:

(1) Over 21 years,

(2) A citizen or national of the United States or an alien who is lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, and

(3) Not an AFDC or SSI recipient or a Medicare-eligible individual.

PART 2 - STATE PREMIUM PAYMENTS

Part 2 describes state premium payments to regional alliances associated with persons receiving cash assistance.

Section 9011. State Premium Payments Relating To Cash Assistance Recipients. For each year, each participating state makes a premium payment for cash assistance recipients equal to 95% of the state medical assistance percentage times the sum of the following:

(1) The AFDC per capita premium amount for the regional alliance for the year (determined under section 9012(a)) times the number of AFDC recipients residing in the alliance area in the year (as determined under section 9014(b)(1)).

(2) The SSI per capita premium amount for the regional alliance for the year (determined under section 9013) times the number of SSI recipients residing in the alliance area in the year (as determined under section 9014(b)(1)).

A participating state's payment under this section is increased by the state medical assistance percentage times amounts attributable to AFDC and SSI recipients for cost sharing subsidies (under section 137(c)(1) and for increased premium discounts where an at-or-below-average cost plan is unavailable (under section 6104(b)(2)).

Section 9012. Determination Of AFDC Per Capita Premium Amount For Regional Alliances. The AFDC per capita premium amount for a regional alliance for a given year is equal to:

(1) Per capita state Medicaid expenditures for the year for the state in which the alliance is located, multiplied by

(2) An adjustment factor (determined under section 9015) for the year for the regional

alliance that is related to health care expenses in that alliance relative to the state as a whole.

Per capita state Medicaid expenditures for a state for a given year are equal to the state share of fiscal year 1993 Medicaid expenditures for the comprehensive benefits package associated with AFDC recipients, updated to the year as below.

Updates from fiscal year 1993 to the year before the first year of participation by a state is as follows:

(1) 32.2 percent if the first year is 1996.

(2) 46.6 percent if the first year is 1997.

(3) 62.1 percent if the first year is 1998.

These percentages are projected increases in per capita expenditures for AFDC recipients for services in the comprehensive benefits package from fiscal year 1993 to the calendar year before the first year of participation.

The Secretary of HHS shall estimate the rate of increase in per capita state Medicaid expenditures between fiscal year 1993 and the year before the first year for a state, adjusting the estimate to eliminate any change in expenditures that results from a reduction in the scope of services, arbitrary reduction in payment rates, or a reduction in access to high quality services. If the estimated rate of increase is less than the percentage amounts specified above, then the Secretary shall update the fiscal year 1993 per capita expenditures by the estimated increase for the state rather than the percentages specified above

Updates from the year before the first year of participation by a state to a subsequent year are equal to the general health care inflation factor for the year (as defined in section 6001(a)(3)).

Section 9013. Determination Of SSI Per Capita Premium Amount For Regional Alliances. The SSI per capita premium amount for a regional alliance for a given year is determined in the same way as the AFDC per capita premium amount, except with respect to SSI recipients instead of AFDC recipients and with different update percentages.

Updates from fiscal year 1993 to the year before the first year of participation by a state with respect to the SSI per capita premium amount are as follows:

(1) 29.4 percent if the first year is 1996.

(2) 43.7 percent if the first year is 1997.

(3) 58.8 percent if the first year is 1998.

Section 9014. Determination Of Number Of AFDC And SSI Recipients. For the purposes of determining the AFDC and SSI per capita premium amounts (under sections 9012 and 9013), the number of AFDC and SSI recipients in a state for fiscal year 1993 is determined based on reports submitted to the Secretary of HHS.

For the purposes of state payments to regional alliances associated with AFDC and SSI recipients (under section 9011(b)), the number of AFDC and SSI recipients is determined on a monthly basis based on actual enrollment.

For the purposes of calculating adjustment factors for regional alliances (under section 9015) and blended plan payment rates (under section 6202), the number of AFDC and SSI recipients is projected by the state prior to the beginning of the year based on the best available information.

Section 9015. Regional Alliance Adjustment Factors. If a state has multiple regional alliances, a regional alliance adjustment factor is calculated for each regional alliance for the purposes of calculating alliance-specific AFDC and SSI per capita premium amounts.

If a state has only one regional alliance, the alliance's adjustment factor is equal to 1.

Regional alliance adjustment factors are calculated to reflect the variation in regional alliance per capita premium targets (determined under section 6003) and the variation in baseline per capita Medicaid expenditures across regional alliances.

The weighted average of regional alliance adjustment factors across all alliances in a state must equal 1.

Regional alliance adjustment factors are calculated separately for AFDC recipients and for SSI recipients.

PART 3 - GENERAL AND MISCELLANEOUS PROVISIONS

Section 9021. Timing And Manner Of Payments. State payments for maintenance of effort or for per capita premiums for AFDC and SSI recipients must be made on a periodic basis, reflecting the cash flow requirements of regional alliances. Each regional alliance must provide the state with information necessary to make these payments.

Section 9022. Review Of Payment Level. The National Health Board must review state payment levels for maintenance of effort and for premiums for AFDC and SSI recipients. The Board may make recommendations to Congress regarding adjustments to

state payment levels, taking into account the revenue base in each state.

Section 9023. Special Rules For Puerto Rico And Other Territories. Subject to guidelines described in this section, the Secretary may waive or modify financial requirements for participating states with respect to Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands to accommodate their unique geographic and social conditions and features of their health care systems.