MAINSTREAM

103D CONGRESS
2D SESSION

S. _____

IN THE SENATE OF THE UNITED STATES

_____ introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To provide for health care reform, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health Reform Act".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. FINDINGS AND PURPOSES.

[To be supplied]

SEC. 3. DEFINITIONS AND SPECIAL RULES.

(a) DEFINITIONS AND SPECIAL RULES RELATING TO HEALTH PLANS.—For purposes of this Act—

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term "health plan" means any plan or arrangement which provides, or pays the cost of, health benefits. Such term does not include the following, or any combination thereof:

(i) Coverage only for accidental death or dismemberment.

(ii) Coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury.

(iii) A medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act).

(iv) Coverage issued as a supplement to liability insurance.

(v) General liability insurance.

(vi) Worker's compensation or similar insurance.

(vii) Automobile or automobile medical-payment insurance.

(viii) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such

a policy provides sufficiently comprehensive coverage of a benefit so that it should be treated as a health plan).

(ix) A specified disease or illness insurance policy.

(x) A hospital or fixed indemnity income-protection policy.

(xi) A disability income policy.

(xii) Insurance with respect to accidents.

(xiii) An equivalent health care program.

(xiv) Such other plan or arrangement as the Secretary determines is not a health plan.

(B) INSURED HEALTH PLAN.—

(i) IN GENERAL.—The term "insured health plan" means any health plan which is a hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization or preferred provider organization group contract offered by an insurer.

(ii) INSURER.—The term "insurer" means—

(I) a licensed insurance company,

(II) a prepaid hospital or medical service plan,

(III) a preferred provider organization,

(IV) a health maintenance organization, or

(V) any similar entity (other than an entity described in subparagraph (C)),

which is engaged in the business of providing a plan of health insurance or health benefits.

(C) SELF-INSURED HEALTH PLAN.—

(i) IN GENERAL.—The term "self-insured health plan" means a health plan which is a group health plan—

(I) which is established and maintained by a large employer, and

(II) under which the large employer retains a substantial risk for the providing of health benefits under the plan.

(ii) GROUP HEALTH PLAN.—The term "group health plan" means an employee

welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries (as defined in section 3 of the Employee Retirement Income Security Act of 1974) directly or through reimbursement.

(2) CERTIFIED HEALTH PLAN.—The term "certified health plan" means a health plan which is certified by the appropriate certifying authority as meeting the applicable requirements of this Act, including the offering of the standard benefits package, and, at the plan's option, the basic benefits package or the catastrophic benefits package. A health plan shall not fail to be treated as a certified health plan if such plan offers a medicare-eligible benefits package to medicare beneficiaries under—

(A) a contract entered into with the Secretary under section 1876 of the Social Security Act, or

(B) a plan of an organization providing benefits pursuant to an agreement under section 1833(a)(1)(A) of such Act.

(3) TERMS AND RULES RELATING TO COMMUNITY AND EXPERIENCE RATING.—

(A) COMMUNITY-RATED HEALTH PLAN.—The term "community-rated health plan" means a health plan which meets the requirements of section 1013.

(B) COMMUNITY-RATED INDIVIDUAL.—The term "community-rated individual" means an individual—

(i) who is not an experience-rated individual, or

(ii) who is an experience-rated individual (determined without regard to this subparagraph) who is not a full-time employee of a large employer and who does not enroll in a certified health plan offered by the employer.

(C) SMALL EMPLOYER.—The term "small employer" means, with respect to any calendar year, any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed less than 100 full-time employees for some portion of the day.

(D) EXPERIENCE-RATED HEALTH PLAN.—The term "experience-rated health plan" means an insured or self-insured health plan covering only experience-rated individuals.

(E) EXPERIENCE-RATED INDIVIDUAL.—The term "experience-rated individual" means an individual who is an employee (or the dependent of an employee) of a large employer, or a member (or the dependent of a member) of a qualified association (as defined in section 1223).

(F) LARGE EMPLOYER.—

(i) IN GENERAL.—The term "large employer" means, with respect to any calendar year, any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed 100 or more full-time employees for some portion of the day.

(ii) AGGREGATION RULES FOR EMPLOYERS.—For purposes of title I—

(I) IN GENERAL.—Except as provided in subclause (II)—

(aa) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

(bb) under regulations of the Secretary of the Treasury, all employees of organizations which are under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer.

The regulations prescribed under item (bb) shall be based on principles similar to the principles which apply to taxable organizations under item (aa).

(II) ELECTION NOT TO AGGREGATE.—Any employer may elect not to aggregate its employees across community rating areas. Upon such election, the employer shall be treated

as a small employer in any community rating area in which it employs less than 100 full-time employees and as a large employer in any community rating area in which it employs 100 or more full-time employees. Such election shall remain in effect for a period of not less than 5 years. An employer may revoke such election after such period by notifying the Secretary of Labor under rules prescribed by the Secretary.

(iii) SPECIAL RULE FOR LEASING BUSINESSES.—In the case of an employer the primary trade or business of which is employee leasing—

(I) all of the employees which such employer leases to other employers shall be treated as community-rated individuals unless treated as employees of a large employer other than the leasing trade or business, and

(II) this Act shall be applied separately with respect to its other employees.

(G) FULL-TIME EMPLOYEE.—The term "full-time employee" means, with respect to any month, an employee who normally performs at least 30 hours of service per week for an employer in the month (not including the month which includes the hiring date of such employee).

(H) SPECIAL RULE FOR SPOUSES AND DEPENDENTS.—If any individual is offered coverage under a health plan as the spouse or a dependent of a primary enrollee of such plan, such individual shall have the status of such enrollee unless such individual is eligible to elect other coverage and so elects.

(b) GENERAL DEFINITIONS AND RULES.—Except as otherwise specifically provided, in this Act the following definitions and rules apply:

(1) APPROPRIATE CERTIFYING AUTHORITY.—The term "appropriate certifying authority" means—

(A) except as provided in subparagraph (B), in the case of an insured health plan, any authority designated by the State; or

(B) in the case of a self-insured health plan, the Secretary of Labor.

(2) DELIVERY SYSTEM.—The term "delivery system" with respect to a health plan includes a fee-for-service, use of preferred providers, staff or group model health maintenance organizations, and such other arrangements as the Secretary may recognize.

(3) DEPENDENT.—The term "dependent" means, with respect to any individual, any person—

(A) who is a child (within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986) of the individual; and

(B) who is—

(i) under 25 years of age and unmarried, or

(ii) permanently and totally disabled (within the meaning of section 151(c)(5)(C) of such Code).

(4) EMPLOYER, EMPLOYEE, AND EMPLOYMENT DEFINED.—

(A) IN GENERAL.—Except as otherwise provided in this Act—

(i) the term "employment" has the meaning given such term under section 3121 of the Internal Revenue Code of 1986,

(ii) the term "employee" has the meaning given such term under section 3121 of such Code, subject to the provisions of chapter 25 of such Code, and

(iii) the term "employer" has the same meaning as the term ""employer"" as used in such section 3121.

(B) EXCEPTIONS.—For purposes of subparagraph (A)—

(i) EMPLOYMENT.—

(I) EMPLOYMENT INCLUDED.—Paragraphs (1), (2), (5), (7) (other than clauses (i) through (iv) of subparagraph (C) and clauses (i) through (v) of subparagraph (F)), (8), (9), (10), (11), (13), (15), (18), and (19) of section 3121(b) of the Internal Revenue Code of 1986 shall not apply.

(II) EXCLUSION OF INMATES AS EMPLOYEES.—Employment shall not include services performed in a penal

institution by an inmate thereof or in a hospital or other health care institution by a patient thereof.

(III) EXCLUSION OF PART-TIME DOMESTIC SERVICE.—Employment shall not include domestic service in a private home of the employer (within the meaning section 3121(a)(7)(B), determined without dollar limitation) by an individual who is not a full-time employee.

(IV) EXCLUSION OF SEASONAL OR TEMPORARY.—Employment shall not include seasonal or temporary services performed for an employer for less than 6 months in a calendar year.

(VI) CONSIDERATION OF INDUSTRY PRACTICE.—As provided under regulation by the Secretary of Labor, an employee shall be considered to be employed on a full-time basis by an employer (and to be a full-time employee of an employer) for a month (or for all months in a 12-month period) if the employee is employed by

that employer on a continuing basis that, taking into account the structure or nature of employment in the industry, represents full-time employment in that industry.

(ii) EXCLUSION OF CERTAIN FOREIGN EMPLOYMENT.—The term "employee" does not include an individual with respect to service, if the individual is not a citizen or resident of the United States and the service is performed outside the United States.

(5) EQUIVALENT HEALTH CARE PROGRAM.—The term "equivalent health care program" means—

(A) part A or part B of the medicare program under title XVIII of the Social Security Act,

(B) the medicaid program under title XIX of the Social Security Act,

(C) the health care program for active military personnel under title 10, United States Code,

(D) the veterans health care program under chapter 17 of title 38, United States Code,

(E) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code,

(F) the Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), and

(G) a State single-payer system approved by the Secretary under section 1321.

(6) FAMILY.—The term "family" includes an individual, the individual's spouse, and the individual's dependents (if any), as defined in paragraph (3).

(7) HEALTH PLAN SPONSOR.—The term "health plan sponsor" means, with respect to—

(A) an insured health plan, the insurer, and

(B) a self-insured health plan, the large employer sponsor.

(8) HEALTH PROFESSIONAL.—The term "health professional" means an individual who is legally authorized to provide services in the State in which such services are provided.

(9) LEGALLY AUTHORIZED.—The term "legally authorized" means, with respect to a provider, au-

thorization under licensing or certification laws of a State.

(10) NAIC.—The term "NAIC" means the National Association of Insurance Commissioners.

(11) PARTICIPATING STATE.—The term "participating State" means a State establishing a State program under this title.

(12) PROVIDER.—The term "provider" includes a health professional.

(13) PURCHASING COOPERATIVE.—The term "purchasing cooperative" means a health insurance purchasing cooperative established under section 1211.

(14) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services or the Secretary"s delegate.

(15) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

TITLE I—BASIC INSURANCE REFORMS TO EXPAND ACCESS TO HEALTH INSURANCE

Subtitle A—Standards for Reform

PART 1—ESTABLISHMENT AND APPLICATION OF STANDARDS

SEC. 1001. CERTIFIED HEALTH PLANS.

A certified health plan shall meet the applicable reform standards established under part 2 for insured health plans and part 3 for self-insured health plans.

SEC. 1002. GENERAL RULES.

(a) CONSTRUCTION.—Whenever in this subtitle a requirement or standard is imposed on a health plan, the requirement or standard is deemed to have been imposed on the insurer or sponsor of the plan in relation to that plan.

(b) USE OF INTERIM, FINAL REGULATIONS.—In order to permit the timely implementation of the provisions of this title, the Secretary and the Secretary of Labor are each authorized to issue regulations under this title on an interim basis that become final on the date of publication, subject to change based on subsequent public comment.

(c) REFERENCE TO REFORM STANDARDS.—For purposes of this title, the term "reform standards" means the standards established and applied under this subtitle.

PART 2—STANDARDS APPLICABLE TO CERTIFIED INSURED HEALTH PLANS

SEC. 1011. GUARANTEED ISSUE AND RENEWAL.

(a) ISSUE.—

(1) IN GENERAL.—Except as otherwise provided in this section, a certified health plan sponsor—

(A) offering—

(i) a community-rated certified health plan, shall offer such plan to any community-rated individual applying for coverage, and

(ii) an experience-rated certified health plan, shall offer such plan to any experience-rated individual eligible for coverage under the plan through the individual's employer; and

(B) shall offer such plan for each class of enrollment described in section 1113(b)(2)(B)(ii).

(2) AVAILABILITY.—

(A) IN GENERAL.—Except as provided in paragraph (4), a community-rated certified health plan shall be made available throughout the entire community rating area in which such plan is offered, including through any purchasing cooperative choosing to offer such plan.

(B) GEOGRAPHIC LIMITATIONS.—

(i) IN GENERAL.—Except as provided in clause (ii), a community-rated certified health plan may deny coverage under the plan to a community-rated individual who resides outside the community rating area (or service area in the case of a network plan) in which such plan is offered, but only if such denial is applied uniformly, without regard to health status or insurability of individuals.

(ii) NO FEE-FOR-SERVICE PLAN IN AREA.—If a fee-for-service community-rated certified health plan is not available to a community-rated individual in a community rating area, a fee-for-service community-rated certified health plan operating in a contiguous community rating area

may not deny coverage under the plan to such individual.

(3) APPLICATION OF CAPACITY LIMITS.—

(A) IN GENERAL.—Subject to subparagraph (B), a certified health plan may cease enrolling individuals under the plan if—

(i) the plan ceases to enroll any new individuals; and

(ii) the plan can demonstrate to the applicable certifying authority, if required, that its financial or provider capacity to serve previously covered groups or individuals (and additional individuals who will be expected to enroll because of affiliation with such previously covered groups or individuals) will be impaired if it is required to enroll other individuals.

(B) FIRST-COME-FIRST-SERVED.—A certified health plan is only eligible to exercise the limitations provided for in subparagraph (A) if such plan provides for enrollment of individuals on a first-come-first-served basis (except in the case of additional individuals described in subparagraph (A)(ii)). Individuals shall be provided with a fair opportunity to enroll regardless of

the method of enrollment or the date of the open enrollment period in accordance with rules established by the Secretary.

(4) NETWORK PLANS.—A network plan may be made available only in a service area within or contiguous with the borders of a community rating area if the State determines, under section 1302(b), that the following conditions are met—

(A)(i) the plan has not established its service area in a manner that has the effect of discriminating against an individual or groups of individuals on the basis of race, national origin, gender, language, socio-economic status, age, disability, or health status;

(ii) the service area is not smaller than a county, or 3-digit zip code area; and

(iii) the network plan shall participate in any risk adjustment program established for the community rating area involved; or

(B) the service area has been approved pursuant to title XIII of the Public Health Service Act.

(b) RENEWAL.—

(1) IN GENERAL.—Except as provided in paragraph (2), a certified health plan that is issued to

an individual shall be renewed at the option of the individual.

(2) GROUNDS FOR REFUSAL TO RENEW.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a certified health plan sponsor may under no circumstances refuse to renew, or for any reason terminate, a certified health plan with respect to any individual, family, or employer under this title.

(B) EXCEPTION.—Subparagraph (A) shall not apply in the case of—

(i) nonpayment of premiums;

(ii) fraud on the part of the individual involved;

(iii) misrepresentation of material facts on the part of the individual relating to an application for coverage or claim for benefits; or

(iv) exit of the insurer from the market as provided for in subparagraph (C).

(C) EXIT FROM MARKET.—

(i) IN GENERAL.—An insurer shall renew a certified insured health plan through a particular type of delivery sys-

tem with respect to a community-rated individual, unless such insurer—

(I) elects not to renew all of its insured health plans using such delivery system issued to all such individuals in a State; and

(II) provides notice to the appropriate certifying authority and to each such individual covered under the plan of such termination at least 180 days before the date of expiration of the plan.

(ii) PROHIBITION ON MARKET REENTRY.—In the case of such a termination, such insurer may not provide for the issuance of any certified insured health plan using such a delivery system to a community-rated individual in such State during the 5-year period beginning on the date of the termination of the last plan not so renewed.

(c) FEHBP PLANS.—Any certified health plan sponsor participating in the Federal Employees Health Benefits Program, and operating a certified health plan within a community rating area, shall offer a community-rated

certified health plan in such area, except that this requirement shall not apply to nationwide plans under paragraphs (1), (2), and (3) of section 8903 of title 5, United States Code.

(d) CERTAIN EXCLUDED PLANS.—The provisions of this section (other than subsection (b)) and section 1051 (other than subsections (b)(1)(B), (b)(2), and (b)(4)), shall not apply to any religious fraternal benefit society in existence as of September 1993, which bears the risk of providing insurance to its members, and which is an organization described in section 501(c)(8) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code.

SEC. 1012. ENROLLMENT.

(a) ENROLLMENT PROCESS.—

(1) IN GENERAL.—A certified health plan shall establish an enrollment process consistent with this subsection.

(2) INITIAL ENROLLMENT PERIOD.—Each individual shall have an initial enrollment period in which to enroll in a certified health plan as specified by the appropriate certifying authority under section 1308(a).

(3) GENERAL ENROLLMENT PERIOD.—Each certified health plan shall permit eligible individuals

to enroll (or change enrollment) in the plan during each general annual enrollment period specified by the appropriate certifying authority under section 1308(b).

(4) SPECIAL ENROLLMENT PERIODS.—In the case of an individual who—

(A) through marriage, separation, divorce, birth or adoption of a child, death, experiences a change in family composition;

(B) experiences a change in employment status (including a significant change in the terms and conditions of employment) or in continuation coverage;

(C) changes residence to another community rating area;

(D) disenrolls for cause from a certified health plan; or

(E) is subject to the decertification of a certified health plan under section 1302,

each certified health plan shall provide for a special enrollment period in which the employee or individual is permitted to change the individual or family basis of coverage or the plan in which the employee or individual is enrolled.

(b) COMMENCEMENT OF COVERAGE.—

(1) IN GENERAL.—In the case of an individual who enrolls with a certified health plan during an enrollment period, coverage under the plan shall begin not later than the first day of the first month that begins 15 days after the date of enrollment.

(2) NEWBORNS.—In the event of the birth or adoption of a child of an enrollee, coverage of such child under such enrollee's certified health plan (regardless of the class of enrollment) shall begin on the date of such birth or adoption and shall continue, in the absence of any enrollment of such child during a special enrollment period provided under subsection (a)(4), for at least 45 days.

SEC. 1013. RATING LIMITATIONS FOR COMMUNITY-RATED MARKET.

(a) STANDARD PREMIUMS WITH RESPECT TO COMMUNITY-RATED ELIGIBLE INDIVIDUALS.—Each certified health plan which covers community-rated individuals shall establish within each community rating area in which the plan is to be offered, a standard premium for individual enrollment for—

(1) the standard benefits package,

(2) the basic benefits package, and

(3) the catastrophic benefits package,

established under subtitle B.

(b) UNIFORM PREMIUMS WITHIN COMMUNITY RATING AREAS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), the standard premium for each package described in subsection (a) shall be the same, but shall not include the costs of premium processing and enrollment that would vary depending on whether the method of enrollment is through a purchasing cooperative, public access site, or directly through a health plan, an employer, or a broker.

(2) APPLICATION TO ENROLLEES.—

(A) IN GENERAL.—The premium charged for coverage in a certified health plan which covers community-rated individuals shall be the product of—

(i) the standard premium (established under paragraph (1));

(ii) in the case of enrollment other than individual enrollment, the family adjustment factor specified under subparagraph (B); and

(iii) the age adjustment factor (specified under subparagraph (C)).

(B) FAMILY ADJUSTMENT FACTOR.—

(i) IN GENERAL.—The reform standards shall specify family adjustment factors that reflect the relative actuarial costs of benefit packages based on family classes of enrollment (as compared with such costs for individual enrollment).

(ii) CLASSES OF ENROLLMENT.—For purposes of this Act, there are 6 classes of enrollment:

(I) Coverage only of an individual (other than an individual described in subclause (II)) (referred to in this Act as the "individual" enrollment or class of enrollment).

(II) Coverage only of an individual who has not attained age 19 (referred to in this Act as the "single child" enrollment or class of enrollment).

(III) Coverage only of two or more children (referred to in this Act as the "multiple children" enrollment or class of enrollment).

(IV) Coverage of a married couple without children (referred to in

this Act as the "couple-only" enrollment or class of enrollment).

(V) Coverage of an individual and one or more children (referred to in this Act as the "single parent" enrollment or class of enrollment).

(VI) Coverage of a married couple and one or more children (referred to in this Act as the "dual parent" enrollment or class of enrollment).

(iii) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this title:

(I) FAMILY.—The terms "family enrollment" and "family class of enrollment" refer to enrollment in a class of enrollment described in any subclause of clause (ii) (other than subclause (I)).

(II) COUPLE.—The term "couple class of enrollment" refers to enrollment in a class of enrollment described in subclause (IV) or (VI) of clause (ii).

(iv) SPOUSE; MARRIED; COUPLE.—

(I) IN GENERAL.—In this title, the terms "spouse" and "married" mean, with respect to an individual, another individual who is the spouse of, or is married to, the individual, as determined under applicable State law.

(II) COUPLE.—The term "couple" means an individual and the individual's spouse.

(C) AGE ADJUSTMENT FACTOR.—The Secretary, in consultation with the NAIC, shall specify uniform age categories and rating increments for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. For individuals who have attained age 18 but not age 65, the highest age adjustment factor may not exceed twice the lowest age adjustment factor.

(3) ADMINISTRATIVE CHARGES.—

(A) IN GENERAL.—In accordance with the reform standards, a certified health plan which covers community-rated individuals may add a separately-stated administrative charge which is based on identifiable differences in legitimate

administrative costs which vary by size of the enrolling group and method of enrollment, including enrollment through a public access site or directly through a health plan, an employer, or a broker (as defined in such standards).

(B) ENROLLMENT THROUGH PURCHASING COOPERATIVE.—Except as provided in subparagraph (C), in the case of an administrative charge under subparagraph (A) for enrollment through a purchasing cooperative, such charge may not exceed the lowest charge of such plan for enrollment other than through a purchasing cooperative in such area.

(C) EXCEPTION.—In the case of a charge for enrollment through a public access site in a community rating area, such charge may not exceed the lowest charge of such plan for enrollment through a purchasing cooperative or if such plan is not offered through a purchasing cooperative, the lowest administrative charge for the plan in such area.

(c) TREATMENT OF NEGOTIATED RATE AS COMMUNITY RATE.—Notwithstanding any other provision of this section, a certified health plan which negotiates a premium rate (exclusive of any administrative charge described in

subsection (b)(3)) with a purchasing cooperative in a community rating area shall charge the same premium rate to all community-rated individuals.

SEC. 1014. RATING PRACTICES AND PAYMENT OF PREMIUMS.

(a) FULL DISCLOSURE OF RATING PRACTICES.—

(1) IN GENERAL.—A certified health plan sponsor shall fully disclose rating practices for such plan to the appropriate certifying authority.

(2) NOTICE ON EXPIRATION.—A certified health plan sponsor shall provide for notice, at least 60 days before the date of expiration of the plan, of the terms for renewal of the plan.

(3) ACTUARIAL CERTIFICATION.—Each certified health plan sponsor shall file annually with the appropriate certifying authority a written statement by a member of the American Academy of Actuaries (or other individual acceptable to such authority) who is not an employee of the plan certifying that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of such sponsor and methods used by such sponsor in establishing premium rates for certified insured health plans—

(A) such sponsor is in compliance with the applicable provisions of this section; and

(B) the rating methods are actuarially sound.

Each sponsor shall retain a copy of such statement at its principal place of business for examination by any individual.

(b) PAYMENT OF PREMIUMS.—

(1) IN GENERAL.—With respect to a new enrollee in a certified health plan, the plan may require advanced payment of an amount equal to the monthly applicable premium for the plan at the time such individual is enrolled.

(2) NOTIFICATION OF FAILURE TO RECEIVE PREMIUM.—If a certified health plan fails to receive payment on a premium due with respect to an individual covered under the plan, the plan shall provide notice of such failure to the individual within the 20-day period after the date on which such premium payment was due. A plan may not terminate the enrollment of an individual unless such individual has been notified of any overdue premiums.

SEC. 1015. NONDISCRIMINATION BASED ON HEALTH STATUS.

(a) IN GENERAL.—Except as otherwise provided in this Act, a certified health plan may not deny, limit, or condition the coverage under (or benefits of) the plan for any reason, including but not limited to, health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health care expenses, disability, or lack of evidence of insurability, of an individual.

(b) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

(1) IN GENERAL.—Subject to paragraph (4), a certified health plan may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual only if—

(A) the condition was diagnosed or treated during the 3-month period ending on the day before the date of enrollment under the plan;

(B) the limitation or exclusion extends for a period not more than 6 months after the date of enrollment under the plan;

(C) the limitation or exclusion does not apply to an individual who, as of the date of birth, was covered under the plan; or

(D) the limitation or exclusion does not apply to pregnancy.

(2) CREDITING OF PREVIOUS COVERAGE.—A certified health plan shall provide that if an individual under such plan is in a period of continuous coverage as of the date of enrollment under such plan, any period of exclusion of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in the period of continuous coverage.

(3) DEFINITIONS.—As used in this subsection:

(A) PERIOD OF CONTINUOUS COVERAGE.—The term "period of continuous coverage" means the period beginning on the date an individual is enrolled under a health plan or health care program which provides benefits equivalent to those provided by the certified health plan in which the individual is seeking to enroll with respect to coverage of a preexisting condition and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(B) PREEXISTING CONDITION.—The term "preexisting condition" means, with respect to coverage under a certified health plan, a condition which was diagnosed, or which was treated, within the 3-month period ending on the day before the date of enrollment (without regard to any waiting period).

(4) PROHIBITION ON PREEXISTING CONDITION EXCLUSION DURING AMNESTY PERIOD.—This subsection shall not apply during an initial enrollment period described in section 1012(a)(2).

SEC. 1016. BENEFITS OFFERED.

A certified health plan shall offer to all enrollees in the plan the standard benefits package, and, in addition, may offer to such enrollees the basic benefits package or the catastrophic benefits package established under subtitle B.

SEC. 1017. REQUIREMENTS OF SUPPLEMENTALS.

A certified health plan sponsor may only offer benefits that are not covered benefits, or a reduction in cost sharing below the cost sharing specified under section 1102 for the applicable benefits package, if—

(1) such additional coverage is offered and priced separately from the standard, basic, or catastrophic benefits package offered in such plan;

(2) the purchase of the certified health plan is not conditioned upon the purchase of such additional coverage;

(3) coverage of such additional benefits is also offered to individuals who are not enrolled in the certified health plan; and

(4) the cost sharing reduction is offered only to individuals enrolled in the certified health plan for a price which includes any expected increase in utilization resulting from the purchase of such cost sharing reduction.

SEC. 1018. RISK ADJUSTMENT.

(a) IN GENERAL.—Each community-rated certified health plan shall participate in a risk adjustment program of the State in accordance with subsection (b).

(b) ESTABLISHMENT OF STANDARDS FOR RISK ADJUSTMENT PROGRAMS.—

(1) IN GENERAL.—The Secretary shall develop standards under paragraph (2) for participating States to provide risk adjustment programs under section 1307 for participation by certified health plans.

(2) RISK ADJUSTMENT PROGRAM.—

(A) IN GENERAL.—The standards developed by the Secretary under this paragraph

shall include a risk adjustment program which—

(i) assures that payments to community-rated certified health plans reflect the expected relative utilization and expenditures for health care services by each plan's enrollees compared to the average utilization and expenditures for community-rated individuals; and

(ii) protects plans that enroll a disproportionate share of such individuals with respect to whom expected utilization of health care services and expected health care expenditures for such services are greater than the average utilization and expenditures for such eligible individuals.

(B) FACTORS TO BE CONSIDERED.—In developing the standards for a risk adjustment program, the Secretary may take into account the following factors with respect to enrollees:

(i) Demographic characteristics.

(ii) Health status.

(iii) Other factors, including socio-economic status, as determined appropriate by the Secretary.

(C) ZERO SUM.—The standards for the risk adjustment program methodology shall assure that the total payments to all community-rated certified health plans after application of the methodology are the same as the amount of payments that would have been made without application of the methodology.

SEC. 1019. FINANCIAL REQUIREMENTS.

(a) SOLVENCY PROTECTION.—Each sponsor offering a community-rated certified health plan shall meet financial solvency requirements to assure protection of enrollees with respect to potential insolvency.

(b) PROTECTION AGAINST PROVIDER CLAIMS.—In the case of a failure of a certified health plan to make payments with respect to covered items and services, an individual who is enrolled under the plan is not liable to any health care provider or practitioner with respect to the provision of such items and services for payments in excess of the amount for which the enrollee would have been liable if the plan were to have made payments in a timely manner.

SEC. 1020. COLLECTION AND PROVISION OF STANDARDIZED INFORMATION.

(a) HEALTH PLANS REQUIRED TO SUBMIT INFORMATION.—Each certified health plan that provides cov-

erage for individuals residing in a State shall submit to the State and, upon request, to community-rated individuals, information regarding—

(1) certification status of the plan;

(2) benefits offered under the plan;

(3) premiums, cost-sharing, and administrative charges under the plan;

(4) risk and referral arrangements under the plan;

(5) the number, distribution, and variety of health care providers used under the plan and the availability of such providers;

(6) the enrollee complaint and appeals process used under the plan; and

(7) other appropriate information as determined by the Secretary.

(b) ADDITIONAL REQUIREMENTS.—Each certified health plan shall meet the requirements specified under subtitles B and C of title V with respect to such plans.

SEC. 1021. QUALITY IMPROVEMENT AND ASSURANCE.

(a) IN GENERAL.—Each certified health plan shall comply with subtitle A of title V. Each certified health plan shall establish procedures, including ongoing quality improvement procedures, to ensure that the health care services provided to enrollees under the plan will be pro-

vided under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice and the quality standards established under such subtitle.

(b) INTERNAL QUALITY ASSURANCE PROGRAM.—Each certified health plan shall establish, and communicate to its enrollees and its providers, an ongoing internal program, including periodic reporting, to monitor and evaluate the quality and cost effectiveness of its health care services, pursuant to standards established by the National Quality Council.

(c) UTILIZATION MANAGEMENT PROTOCOLS.—The utilization review and management activities of each certified health plan, provided either directly or through contract, shall meet the following standards as defined by the Secretary:

(1) PERSONNEL.—All review determinations shall be made by licensed, certified, or otherwise credentialed health professionals who are qualified to review utilization of the treatment being sought.

(2) REVIEW PROCESS.—Each certified health plan shall base utilization management on current scientific knowledge, stress the efficient delivery of health care and outcomes, rely primarily on evaluating and comparing practice patterns rather than

routine case-by-case review, be consistent and timely in application, and have a process for making review determinations for urgent and emergency care 24 hours a day.

(3) NO FINANCIAL INCENTIVES.—Utilization management by each certified health plan may not create financial incentives for reviewers to reduce or limit medically necessary or appropriate services.

(4) CONSUMER DISCLOSURE.—Each certified health plan shall disclose, upon request, to enrollees (and prospective enrollees) and to participating providers (and prospective providers) the utilization review protocols and the type of financial arrangements, if any, used by the plan for controlling utilization and costs, while protecting proprietary business information to the extent specified by the Secretary.

(d) PHYSICIAN INCENTIVE PLANS.—A certified health plan may not operate a physician incentive plan unless such incentive plan meets the requirements of section 1876(i)(8)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(8)(A)).

(e) CREDENTIALING.—Each certified health plan shall—

(1) verify the credentials of participating physicians and practitioners; and

(2) ensure that participating providers and facilities are appropriately accredited, certified, and licensed.

(f) CONTINUITY OF CARE.—Each certified health plan that is a network plan shall develop and implement mechanisms for coordinating the delivery of care among different providers.

(g) MEDICAL RECORDKEEPING.—Each certified health plan shall assure that clinical and other information is readily available to appropriate professionals.

SEC. 1022. PATIENT PROTECTIONS AND PROVIDER SELECTION.

(a) PATIENT INFORMATION.—Each certified health plan shall provide to enrollees clear descriptive information about the rights and responsibilities of enrollees.

(b) INFORMATION REGARDING A PATIENT'S RIGHT TO SELF-DETERMINATION IN HEALTH CARE SERVICES.—Each certified health plan shall be considered to be an eligible organization under title XVIII of the Social Security Act for purposes of applying the rules under section 1866(f) of such Act (42 U.S.C. 1395cc(f)).

(c) GATEKEEPER.—Each certified health plan that uses a gatekeeper or similar process shall ensure that an

undue burden for enrollees with complex or chronic health conditions is not created and shall ensure access to relevant specialists for continued care when medically indicated. In cases of a patient with a severe, complex or chronic health condition, such plan shall determine whether it is medically indicated to use a specialists or an interdisciplinary team.

(d) CONFIDENTIALITY OF PATIENT RECORDS.—Each certified health plan shall have explicit procedures to protect the confidentiality of individual patient information consistent with the rules established under subtitle C of title V.

(e) MARKETING.—A sponsor of a certified health plan may not engage in selective marketing that would have the effect of avoiding high-risk subscribers within a community rating area. Marketing materials may not contain false or materially misleading information.

(f) NO PATIENT LIABILITY FOR UNPAID PLAN OBLIGATIONS.—An individual enrolled in a certified health plan shall not be liable to any health care providers or practitioner with respect to the provision of health services covered by the plan in excess of the amount for which the individual would have been liable had the health plan made payments to providers in a timely manner.

(g) REMEDIES AND ENFORCEMENT.—

(1) IN GENERAL.—Each certified health plan shall comply with the remedies and enforcement requirements described in subtitle F of title V.

(2) GRIEVANCE PROCESS.—Each certified health plan shall establish a grievance process for enrollees dissatisfied with matters other than the denial of payment or provision of benefits by the plan.

(h) ETHICAL BUSINESS CONDUCT.—Each certified health plan shall develop and implement a code of ethical business conduct for its activities, including those of its components, and assure proficient management and planning functions.

(i) ENROLLMENT.—A certified health plan may not knowingly accept the enrollment of an individual who is enrolled in another certified health plan.

(j) PROVIDER SELECTION.—

(1) IN GENERAL.—In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a certified health plan may not engage in any practice that discriminates against a provider based on the actual or anticipated health status of the patients of the provider.

(2) ADDITIONAL ANTIDISCRIMINATION REQUIREMENTS.—No State, certified health plan, or

certified health plan sponsor may discriminate in participation, reimbursement, or indemnification against a health care provider who is acting within the scope of the provider's license or certification under applicable State or Federal law solely on the basis of such license or certification of such provider.

(3) NUMBER AND TYPE.—Nothing in this subsection shall—

(A) prevent a certified health plan sponsor from matching the number and type of health care providers to the needs of the plan members; or

(B) establish any other measure designed to maintain quality or to control costs.

(k) PHYSICIAN PARTICIPATION.—Each certified health plan shall establish mechanisms through which physicians have input into matters affecting patient care and through which patients have the ability to choose any primary care physician from among participating providers.

SEC. 1023. DUE PROCESS FOR HEALTH CARE PROVIDERS.

(a) PUBLICLY AVAILABLE STANDARDS AND PROCESS.—Each certified health plan shall establish and utilize—

(1) publicly available standards for contracting with health care providers; and

(2) a publicly available process for dismissing such providers or failing to renew contracts with such providers.

(b) NOTICE REQUIREMENT.—

(1) IN GENERAL.—The process established by a certified health plan under subsection (a) shall include notification to a health care provider of a decision to dismiss such provider or not to renew a contract with such provider not later than 45 days before such decision takes effect.

(2) EXCEPTION.—The notice required under paragraph (1) shall not apply if failure to dismiss a provider or renewing a provider's contract would adversely affect the health or safety of a patient.

(3) CONTENTS OF NOTICE.—Each notice to a health care provider under paragraph (1) shall contain the reasons for the dismissal or failure to renew. Such reasons shall be consistent with the standards established under subsection (a).

(c) REVIEW.—The process established by a certified health plan under subsection (a) shall include an opportunity for review of such plan's action by a health care provider who is dismissed by a certified health plan or with respect to whom such plan fails to renew a contract. Such review shall be conducted by—

(1) the provider's peers who have contracts with, or are employed by, the certified health plan; and

(2) if there is mutual consent of the provider and the certified health plan, one or more enrollees in the health plan.

A health care provider may have an attorney present in connection with any review under this subsection if the provider notifies the plan that an attorney will be present in advance of the review proceeding.

(d) EFFECT OF REVIEW.—The findings and conclusions under subsection (c) shall be advisory and non-binding.

(e) EFFECT ON OTHER LAWS.—The provisions of this section shall not supersede any other provision of Federal or State law.

SEC. 1024. ALTERNATIVE DISPUTE RESOLUTION PROCEDURES RELATING TO MALPRACTICE CLAIMS.

Each certified health plan shall establish and maintain an alternative dispute resolution procedures program that complies with the standards developed under subtitle E of title V.

SEC. 1025. ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.

(a) IN GENERAL.—For the transition period specified in subsection (f), each certified health plan—

(1) shall offer to enter into a written provider participation agreement with a reasonable number (as determined by the Secretary taking into account the needs of the community) of the category I essential community providers with a service area included in the community rating area of the plan; and

(2) shall—

(A) meet the access and availability standards established by the Secretary under subsection (d), or

(B) offer to enter into a written provider participation agreement with a sufficient number (as determined by the Secretary) of category II essential community providers to meet such standards.

(b) CATEGORIES OF ESSENTIAL COMMUNITY PROVIDERS.—

(1) CATEGORY I.—A provider is a "category I essential community provider" if such provider is—

(A) a federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4))), or

(B) a rural health clinic (as defined in section 1861(aa)(2) of such Act (42 U.S.C. 1395x(aa)(4))) that is—

(i) a nonprofit rural health clinic, or

(ii) a rural health clinic that is not described in clause (i) and has been designated as a rural health clinic under title XVIII of such Act as of the date of the enactment of this Act or had applied for such designation as of August 1, 1994, and since received such designation.

(2) CATEGORY II.—A provider is a "category II essential community provider" if such provider applies for designation as a category II essential community provider (in such manner and form and at such time as the Secretary may prescribe) and the Secretary certifies that such provider meets the requirements of subsection (c).

(c) REQUIREMENTS FOR CATEGORY II ECPS.—A provider meets the requirements of this subsection if such provider—

(1) furnishes services in a medically underserved area;

(2) is a public or private, nonprofit organization;

(3) provides the full range of primary health services (as defined in section 330(b)(1) of the Public Health Service Act (42 U.S.C. 254c(b)(1))) that are included in the standard benefits package established under subtitle B;

(4) derives at least 30 percent of its operating revenues (for a period specified by the Secretary) from State and local government sources (excluding any revenues attributable to a State plan approved under title XIX of the Social Security Act); and

(5) meets requirements (as established by the Secretary) that are comparable to those described in the following provisions of section 330(e)(3) of the Public Health Service Act (42 U.S.C. 254c(e)(3)):

(A) subparagraph (B) (relating to organizational arrangements for quality assurance and patient confidentiality),

(B) subparagraph (C) (relating to financial responsibility),

(C) subparagraph (E) (relating to reimbursement collection efforts),

(D) subparagraph (F) (relating to sliding-scale fee schedule),

(E) subparagraph (H) (relating to overall plan and compilation of statistical information),

(F) subparagraph (I) (relating to periodic review of service area), and

(G) subparagraph (J) (relating to arrangements for individuals with English-speaking ability).

(d) ACCESS AND AVAILABILITY STANDARDS.—Not later than January 1, 1996, the Secretary shall promulgate regulations that establish standards for assuring that primary health services (as defined in section 330(b)(1) of the Public Health Service Act (42 U.S.C. 254c(b)(1))) are accessible and available to individuals residing in a medically underserved area included in the community rating area of a certified health plan.

(e) WRITTEN PARTICIPATION AGREEMENTS.—

(1) CATEGORY I ECPS.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the written participation agreement referred to in subsection (a)(1) shall include terms and conditions that are no more restrictive than the terms and conditions that a certified health plan includes in

its agreements with other participating providers with respect to—

(i) the scope of services for which payment is made to the provider;

(ii) the assignment of enrollees by the plan to the provider;

(iii) the limitation on financial risk or availability of financial incentives to the provider;

(iv) accessibility of care,

(v) professional credentialing and recredentialing,

(vi) licensure,

(vii) quality and utilization management,

(viii) confidentiality of patient records,

(ix) grievance procedures,

(x) indemnification arrangements between the plans and providers, and

(xi) other terms and conditions that are required of certified health plans under this Act.

(B) PAYMENT.—The written participation agreement referred to in subsection (a)(1) shall, at the election of the provider, provide for pay-

ment to the provider on the basis of the payment methodology used to determine the amount of payment for services furnished by such provider under section 1833(a) or 1876(h) of the Social Security Act, or on a capitated or other basis that is acceptable to the provider and the plan. Payments to providers under this subparagraph shall include payment for services described in paragraphs (1) and (3) of section 1861A(a) of the Social Security Act.

(2) CATEGORY II ECPS.—

(A) COVERED SERVICES.—Services for which payment may be made under a written participation agreement referred to in subsection (a)(2)(B) are limited to primary health services (as defined in section 330(b)(1) of the Public Health Service Act (42 U.S.C. 254c(b)(1))) that are—

(i) included in the standard benefits package established under subtitle B, and

(ii) furnished on an outpatient basis.

(B) TERMS AND CONDITIONS.—Except as provided in subparagraphs (C) and (D), a written participation referred to in subsection (a)(2)(B) shall include terms and conditions

that are no more restrictive than the terms and conditions that a certified health plan includes in its agreements with other participating providers with respect to—

(i) the scope of services for which payment is made to the provider;

(ii) the assignment of enrollees by the plan to the provider;

(iii) the limitation on financial risk or availability of financial incentives to the provider;

(iv) accessibility of care,

(v) professional credentialing and recredentialing,

(vi) licensure,

(vii) quality and utilization management,

(viii) confidentiality of patient records,

(ix) grievance procedures,

(x) indemnification arrangements between the plans and providers, and

(xi) other terms and conditions that are required of certified health plans under this Act.

(C) PAYMENT.—The written participation agreement referred to in subsection (a)(2)(B) shall provide for payment to the provider on a basis that is comparable to the basis on which other providers are paid.

(f) TRANSITION PERIOD.—The transition period specified in this subsection is the 5-year period beginning in the first year that the State has in effect a State market reform program.

SEC. 1026. ACCESS TO SPECIALIZED SERVICES.

(a) IN GENERAL.—Each certified health plan shall have within the plan's network, or have such other arrangements with, a sufficient number, distribution, and variety of providers of specialized services and to assure that such services are available and accessible to adults, infants, children, and persons with disabilities.

(b) CENTERS OF SPECIALIZED CARE.—

(1) IN GENERAL.—A certified health plan may satisfy the standard under subsection (a) by contracting with centers of specialized care designated by the Secretary. With respect to children such specialized care shall be in pediatrics.

(2) REQUIREMENTS FOR CENTERS.—The Secretary shall designate centers of specialized care in the field of institutional care that meet evaluation

criteria established by the Secretary for the delivery of care for complex cases requiring specialized treatment and also meet 2 or more of the following requirements:

"(A) Provide specialized education and training through approved graduate medical education programs with multi-specialty, multidisciplinary teaching and services in both inpatient and outpatient settings, with medical staff with faculty appointments at an affiliated medical school.

"(B) Attract patients from outside the center's local geographic region.

"(C) Either sponsor or participate in, or have medical staff who participate in, peer-reviewed research.

(c) EVALUATION CRITERIA FOR SPECIALIZED SERVICES STANDARDS.—A certified health plan may choose to provide specialized services within a provider network.

SEC. 1027. COMMUNITY RATING AREA CAPACITY.

On and after January 1, 1997, each certified health plan shall have the capacity within the plan's network, or through arrangements with a sufficient number, distribution, and variety of providers, to deliver the standard benefits package established under subtitle B throughout the

community rating area (designated under section 1303) in which such plan is offered. Services shall be provided with reasonable promptness and accessibility, in a manner which assures continuity, and in a manner which appropriately serves the diverse needs of the population.

SEC. 1028. OUT-OF-AREA COVERAGE.

Each certified health plan shall provide for urgent and emergency out-of-area coverage for enrollees of the plan.

PART 3—STANDARDS APPLICABLE TO CERTIFIED SELF-INSURED HEALTH PLANS

SEC. 1031. STANDARDS APPLICABLE TO CERTIFIED SELF-INSURED HEALTH PLANS.

(a) IN GENERAL.—Subject to subsection (b), the requirements applicable to certified self-insured health plans are the requirements specified in the following provisions:

(1) Subsection (a) of section 1011 (relating to guaranteed issue), subject to subsection (d) of such section, except that such subsection (a) shall be applied (for purposes of this subsection) only with respect to employees of the employer sponsor.

(2) Section 1012 (relating to enrollment) or establish such comparable enrollment procedures as the Secretary of Labor specifies, including an annual 30-day open enrollment period.

(3) Section 1013 (relating to premium rating limitations) with respect to experience-rated individuals.

(4) Section 1014(b) (relating to payment of premiums).

(5) Section 1015 (relating to nondiscrimination based on health status).

(6) Section 1016 (relating to benefits).

(7) Section 1019 (relating to financial requirements), except that such requirements shall be consistent with the applicable rules under section 414 of the Employee Retirement Income Security Act of 1974.

(8) Section 1020 (relating to collection and provision of standardized information).

(9) Section 1021 (relating to quality assurance).

(10) Section 1022 (relating to patient protections and provider selection).

(11) Section 1023 (relating to due process for health care providers).

(12) Section 1024 (relating to alternative dispute resolution for medical malpractice).

(13) Section 1026 (relating to centers of specialized care).

(b) COLLECTIVE BARGAINING EXCEPTION.—Paragraphs (1) and (7) of subsection (a) shall not apply to a certified self-insured health plan sponsor that is providing benefits pursuant to a collective bargaining agreement.

(c) FINANCIAL SOLVENCY.—Each certified self-insured health plan shall meet the solvency, reserve, and stop-loss requirements established by the Secretary of Labor under section 1401.

(d) MANAGEMENT OF FUNDS.—

(1) MANAGEMENT OF FUNDS.—A certified self-insured health plan sponsor shall, in the management of the plan's funds, be subject to the applicable fiduciary requirements of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, together with the applicable enforcement provisions of part 5 of subtitle B of title I of such Act.

(2) MANAGEMENT OF FINANCES AND RECORDS; ACCOUNTING SYSTEM.—A certified self-insured health plan sponsor shall comply with standards relating to the management of finances and records and accounting systems as the Secretary of Labor shall specify.

(e) ADDITIONAL STANDARDS.—In addition to the requirements applicable to certified self-insured health plans

under subsection (a), the Secretary of Labor shall establish standards to ensure that such health plans—

(1) do not vary premiums for any reason described in section 1015(a);

(2) do not discriminate on a basis described in section 1303(e) (relating to geographic discrimination); and

(3) provide information to employees of the employer sponsor of the plans offered.

PART 4—PREEMPTION OF CERTAIN STATE LAWS

SEC. 1041. PREEMPTION FROM STATE BENEFIT MANDATES.

Effective as of January 1, 1995, no State shall establish or enforce any law or regulation that—

(1) requires the offering, as part of a certified health plan, of any services, category of care, or services of any class or type of provider that is different from the benefit categories specified under this Act;

(2) specifies the individuals to be covered under such a plan or the duration of such coverage; or

(3) requires a right of conversion from a group health plan that is a certified health plan to an individual certified health plan.

SEC. 1042. PREEMPTION OF STATE LAW RESTRICTIONS ON CERTIFIED HEALTH PLANS.

Effective as of January 1, 1995—

(1) a State may not prohibit or limit a certified health plan from including incentives for enrollees to use the services of participating providers;

(2) a State may not prohibit or limit such plans from limiting coverage of services to those provided by a participating provider;

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers under such plans;

(4) a State may not prohibit or limit such plans from limiting the number of participating providers;

(5) a State may not prohibit or limit such plans from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers;

(6) a State may not prohibit or limit the corporate practice of medicine;

(7) a State may not regulate utilization management and review programs of any health plan to the extent not provided by this title;

(8) a State may not prohibit or limit a health plan from using single source suppliers for pharmacy

services, medical equipment, and other supplies and services; and

(9) a State may not prohibit a certified health plan, including a Federally qualified health maintenance organization, from offering a point of service option.

PART 5—INTERIM STANDARDS

SEC. 1051. APPLICATION OF INTERIM STANDARDS.

(a) IN GENERAL.—During the interim standards application period, a health plan sponsor may only offer a health plan in a State if such plan meets the standards specified in subsection (b).

(b) SPECIFIED STANDARDS.—

(1) ISSUE.—The standards specified in—

(A) section 1011(a), and

(B) sections 1015(a) and 1031(d)(1),

with respect to self-insured health plans.

(2) RENEWAL.—The standards specified in section 1011(b).

(3) COVERAGE.—A self-insured health plan may not reduce or limit coverage of any condition or course of treatment that is expected to cost not less than $5,000 during any 12-month period.

(c) INTERIM STANDARDS APPLICATION PERIODS.—The interim standards application period is—

(1) in the case of the standard specified in subsection (b)(1), on or after January 1, 1995, and before January 1, 1997;

(2) in the case of the standards specified in subsections (b)(2) and (b)(4), on or after June 28, 1994, and before January 1, 1997; and

(3) in the case of the standard specified in subsection (b)(3), on or after the date of the enactment of this Act, and before January 1, 1997.

(d) PREEMPTION.—The requirements of this section do not preempt any State law unless State law directly conflicts with such requirements. The provision of additional protections under State law shall not be considered to directly conflict with such requirements. The Secretary may issue letter determinations with respect to whether this section preempts a provision of State law.

(e) CONSTRUCTION.—The provisions of this section shall be construed in a manner that assures, to the greatest extent practicable, continuity of health benefits under health plans in effect on the effective date of this Act.

(f) SPECIAL RULES FOR ACQUISITIONS AND TRANSFERS.—The Secretary may issue regulations regarding the application of this section in the case of health plans (or groups of such plans) which are transferred from one

health plan sponsor to another sponsor through assumption, acquisition, or otherwise.

Subtitle B—Benefits

SEC. 1101. DEFINITIONS.

For purposes of this subtitle:

(1) BENEFITS PACKAGES.—

(A) STANDARD BENEFITS PACKAGE.—The term "standard benefits package" means a benefits package described in section 1102(a)(2)(A)(i).

(B) CATASTROPHIC BENEFITS PACKAGE.—The term "catastrophic benefits package" means a benefits package described in section 1102(a)(2)(A)(ii).

(C) BASIC BENEFITS PACKAGE.—The term "basic benefits package" means a benefits package described in section 1102(a)(2)(A)(iii).

(2) CATEGORIES OF COVERED BENEFITS.—

(A) IN GENERAL.—The term "categories of covered benefits" means the following categories of benefits:

(i) Inpatient and outpatient care, including hospital and health professional services (as defined in paragraph (6)).

(ii) 24-hour emergency services, including appropriate transport services.

(iii) Clinical preventive services, including services for high risk populations, immunizations, tests, and clinician visits.

(iv) Mental illness and substance abuse services.

(v) Family planning services and services for pregnant women.

(vi) Prescription drugs and biologicals.

(vii) Hospice care services.

(viii) Home health and extended care services.

(ix) Outpatient laboratory, radiology, and diagnostic services and medical equipment, including orthotics and prosthetics.

(x) Outpatient rehabilitation services.

(xi) For individuals under 22 years of age, vision care, dental care, and hearing aids

(xii) Patient care costs pursuant to a qualified investigational treatments (as defined in paragraph (7)).

(B) ADDITIONAL BENEFITS.—The categories of covered benefits defined in this paragraph shall also include the following:

(i) Treatment provided by a Christian Science practitioner and care provided at an individual's home by a Christian Science nurse.

(ii) Care provided in a Christian Science sanatorium (as defined in section 1861(e) of the Social Security Act), including treatment provided by a Christian Science practitioner.

(3) EXTRA CONTRACTUAL ITEMS AND SERVICES.—The term "extra contractual items and services" means, with respect to a health plan, case management services, medical foods, and other appropriate alternatives (either alternative items or services or alternative care settings) to traditional covered items or services that are determined by the health plan to be the most cost effective way to provide appropriate treatment to the enrolled individual.

(4) HEALTH CARE INTERVENTION.—The term "health care intervention" means any health-related item or service provided, with respect to a specific indication, to diagnose, improve, maintain, restore, or stabilize a health outcome or to prevent or mitigate an adverse change in a health outcome.

(5) HEALTH OUTCOME.—The term "health outcome" means an outcome that affects the length or quality of an enrollee's life. Quality of life includes ability to perform activities of daily living, ability to work, relief from discomfort or pain, alleviation of fatigue, and cognitive, social, or emotional functioning and wellbeing, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

(6) HEALTH PROFESSIONAL SERVICES.—The term "health professional services" means professional services that are lawfully provided by a physician or another health professional who is legally authorized to provide such services in the State in which the services are provided.

(7) QUALIFIED INVESTIGATIONAL TREATMENT.—The term "qualified investigational treatment" means an investigational treatment that is part of a peer-reviewed and approved research program (as defined by the Secretary) or research trials approved by the Secretary. A research trial is deemed to be approved for purposes of this paragraph if such trial is approved by one or more of the following: the National Institutes of Health, the

Food and Drug Administration (through an investigational new drug exemption pursuant to section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or an investigational device exemption pursuant to section 520(g) of such Act (21 U.S.C. 360j(g))), the Department of Veterans Affairs, the Department of Defense, or by a qualified nongovernmental research entity as defined in guidelines issued by one or more of the National Institutes of Health, including guidelines for cancer center support grants designated by the National Cancer Institute.

SEC. 1102. LEGISLATIVE PROPOSALS ESTABLISHING STANDARDIZED BENEFITS PACKAGES.

(a) INITIAL PROPOSAL.—

(1) IN GENERAL.—The National Health Benefits and Coverage Commission established under section 1411 (referred to in this subtitle as the "Commission") shall develop a legislative proposal establishing standardized benefits package in accordance with this subsection. Such legislative proposal shall be submitted to Congress no later than January 1, 1996, in the form of an implementing bill which contains the statutory provisions necessary or appropriate to implement the proposal. Such an imple-