

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Reform Act”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings and purposes.
- Sec. 3. Definitions and special rules.

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.

Sec. 1002. General rules.

PART 2—STANDARDS APPLICABLE TO CERTIFIED INSURED HEALTH PLANS

Sec. 1011. Guaranteed issue and renewal.

Sec. 1012. Enrollment.

Sec. 1013. Rating limitations for community-rated market.

Sec. 1014. Rating practices and payment of premiums.

Sec. 1015. Nondiscrimination based on health status.

Sec. 1016. Benefits offered.

Sec. 1017. Requirements of supplementals.

Sec. 1018. Risk adjustment.

Sec. 1019. Financial requirements.

Sec. 1020. Collection and provision of standardized information.

Sec. 1021. Quality improvement and assurance.

Sec. 1022. Patient protections and provider selection.

Sec. 1023. Due process for health care providers.

Sec. 1024. Alternative dispute resolution procedures relating to malpractice claims.

Sec. 1025. Arrangements with essential community providers.

Sec. 1026. Access to specialized services.

Sec. 1027. Community rating area capacity.

Sec. 1028. Out-of-area coverage.

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

Sec. 1031. Standards applicable to certified self-insured health plans.

PART 4—PREEMPTION OF CERTAIN STATE LAWS

Sec. 1041. Preemption from State benefit mandates.

Sec. 1042. Preemption of State law restrictions on certified health plans.

PART 5—INTERIM STANDARDS

Sec. 1051. Application of interim standards.

Subtitle B—Benefits

Sec. 1101. Definitions.

Sec. 1102. Legislative proposals establishing standardized benefits packages.

Sec. 1103. Additional duties of the Commission with respect to mental illness and substance abuse services.

Sec. 1104. Recommendations for practice guidelines and coverage.

Sec. 1105. Reports on actuarial value.

Sec. 1106. Medical necessity or appropriateness.

Sec. 1107. Flexible service option.

Sec. 1108. Congressional consideration of Commission proposals.

Sec. 1109. Review of benefit determination.

Subtitle C—Expanded Access to Health Plans

PART 1—ACCESS THROUGH EMPLOYERS

Sec. 1201. Employer access and enrollment requirements.

Sec. 1202. Small employer requirements.

Sec. 1203. Large employer requirements.

PART 2—ACCESS THROUGH PURCHASING COOPERATIVES

Sec. 1211. Establishment of purchasing cooperatives.

Sec. 1212. Agreements with small employers.

Sec. 1213. Enrolling community-rated individuals in health plans through a purchasing cooperative.

Sec. 1214. Receipt of premiums.

Sec. 1215. Cooperative marketing activities.

Sec. 1216. Special rule for certain State and local employee purchasing cooperatives.

Sec. 1217. Development of purchasing groups for large employers.

PART 3—ACCESS THROUGH ASSOCIATION PLANS

SUBPART A—CERTIFIED ASSOCIATION PLANS

Sec. 1221. Treatment of certified association plans.

Sec. 1222. Modifications of standards applicable to certified association plans.

Sec. 1223. Certified association plan defined.

Sec. 1224. Repeal of ERISA provisions.

SUBPART B—SPECIAL RULE FOR CHURCH AND MULTIEMPLOYER PLANS

Sec. 1225. Special rule for church and multiemployer plans.

Subtitle D—State Role in Reform

PART 1—STATE MARKET REFORM

Sec. 1301. Establishment of State market reform programs.

Sec. 1302. Certification of insured health plans.

Sec. 1303. Establishment of community rating areas.

Sec. 1304. Procedures for certification of purchasing cooperatives.

Sec. 1305. Coordination among purchasing cooperatives.

Sec. 1306. Preparation of information concerning plans and purchasing cooperatives.

Sec. 1307. Risk adjustment program.

Sec. 1308. Specification of annual general and initial enrollment periods.

Sec. 1309. Public access sites.

Sec. 1310. Special rules regarding network plans.

PART 2—STATE FLEXIBILITY

Sec. 1311. Waivers and demonstration projects.

Sec. 1312. Continuance of existing Federal law waivers.

Sec. 1313. Hawaii Prepaid Health Care Act.

Sec. 1314. Alternative State provider payment systems.

Sec. 1315. Alternative State uncompensated care pool.

PART 3—REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

Sec. 1321. Single-payer system described.

Sec. 1322. General requirements for single-payer systems.

Sec. 1323. Additional rules for single-payer system.

Subtitle E—Federal Role

PART 1—ESTABLISHMENT OF FEDERAL STANDARDS FOR CERTIFIED
HEALTH PLANS

Sec. 1400. General requirements.

PART 2—CERTIFICATION OF SELF-INSURED HEALTH PLANS

Sec. 1401. Establishment and certification of standards applicable to certified self-insured health plans.

Sec. 1402. Corrective actions for self-insured health plans.

Sec. 1403. ERISA applicability to self-insured health plans.

Sec. 1404. Disclosure and reserve requirements for self-insured health plans.

Sec. 1405. Trusteeship by the secretary of insolvent self-insured health plans.

PART 3—NATIONAL HEALTH BENEFITS AND COVERAGE COMMISSION

Sec. 1411. Creation of National Health Benefits and Coverage Commission; membership.

Sec. 1412. Qualifications of Commission members.

Sec. 1413. Powers.

Sec. 1414. Funding.

PART 4—OTHER RESPONSIBILITIES

Sec. 1421. Federal role in the case of a default by a State.

Sec. 1422. Establishment of residency rules.

Sec. 1423. Rules determining separate employer status.

Sec. 1424. Workplace wellness program.

TITLE II—INCENTIVES TO PROMOTE AFFORDABLE UNIVERSAL
COVERAGE

Subtitle A—Tax Incentives To Encourage Health Insurance Coverage

Sec. 2000. Amendment of 1986 code.

Sec. 2001. Deduction for individuals and self-employed individuals providing own standard health insurance.

Sec. 2002. 2-year extension of deduction for health insurance costs of self-employed individuals.

Subtitle B—Individual Premium and Cost-Sharing Assistance

Sec. 2101. Requirement to operate State program.

Sec. 2102. Assistance with certified standard health plan premiums.

Sec. 2103. Assistance with cost-sharing for certified standard health plans.

Sec. 2104. Eligibility determinations.

Sec. 2105. End-of-year reconciliation for assistance.

Sec. 2106. Penalties for material misrepresentations.

Sec. 2107. Enrollment outreach.

Sec. 2108. Payments to States.

Sec. 2109. Definitions and determinations of income.

Subtitle C—Coverage

Sec. 2201. National health benefits and coverage commission role.

Sec. 2202. Congressional consideration of commission recommendations.

TITLE III—ENTITLEMENT REFORMS

Sec. 3000. References in title.

Subtitle A—Medicaid

PART 1—REFORMS

SUBPART A—COORDINATION OF THE MEDICAID PROGRAM WITH REFORMED
HEALTH CARE SYSTEM

- Sec. 3001. State plan requirement regarding eligibility for medical assistance.
 Sec. 3002. Integration of certain medicaid eligibles into reformed health care system through State premium and cost-sharing assistance program.
 Sec. 3003. State programs for providing supplemental benefits.
 Sec. 3004. Demonstration projects permitting coverage under certified health plans of SSI-eligible individuals.

SUBPART B—STATE ELIGIBILITY TO CONTRACT FOR COORDINATED CARE SERVICES

- Sec. 3011. Modification of Federal requirements to allow States more flexibility in contracting for coordinated care services under medicaid.

PART 2—FINANCING PROVISIONS

- Sec. 3101. Replacement of DSH payment provisions with provisions relating to payments to hospitals serving vulnerable populations.

Subtitle B—Medicare

PART 1—REFORMS

- Sec. 3201. Improvements to risk contracts.
 Sec. 3202. Additional improvements to risk contracts and incorporation of insurance reforms.
 Sec. 3203. Enrollment of medicare beneficiaries in certified standard health plans.

PART 2—FINANCING PROVISIONS

SUBPART A—PROVISIONS RELATING TO PART A

- Sec. 3211. Inpatient hospital services update for PPS hospitals.
 Sec. 3212. Reduction in payments for capital-related costs for inpatient hospital services.
 Sec. 3213. Reductions in disproportionate share payments.
 Sec. 3214. Prospective payment methodology and reductions in inflation updates for skilled nursing facilities.
 Sec. 3215. Revised payment methodology for rehabilitation and long-term care hospitals.

SUBPART B—PROVISIONS RELATING TO PART B

- Sec. 3221. Substitution of real GDP to adjust for volume and intensity; repeal of restriction on maximum reduction permitted in default update.
 Sec. 3222. Correction of MVP's upward bias.
 Sec. 3223. Reduction in conversion factor for physician fee schedule for 1995.

- Sec. 3224. Elimination of formula-driven overpayments for certain outpatient hospital services.
- Sec. 3225. General part B premium.

SUBPART C—PROVISIONS RELATING TO PARTS A AND B

- Sec. 3231. Reduction in routine cost limits for home health services.
- Sec. 3232. Medicare as secondary payer.
- Sec. 3233. Increase in medicare secondary payer coverage for end stage renal disease services to 24 months.

Subtitle C—Home and Community-Based Services

- Sec. 3301. State programs for home and community-based services for eligible individuals with disabilities.
- Sec. 3302. State plans.
- Sec. 3303. Individuals with disabilities defined.
- Sec. 3304. Home and community-based services covered under State plan.
- Sec. 3305. Cost sharing.
- Sec. 3306. Quality assurance and safeguards.
- Sec. 3307. Advisory groups.
- Sec. 3308. Payments to States.
- Sec. 3309. Total Federal budget; allotments to States.
- Sec. 3310. Federal evaluations.

TITLE IV—INFRASTRUCTURE REFORM

Subtitle A—Programs to Improve Access To Underserved Areas

PART 1—GRANTS FOR THE DEVELOPMENT AND OPERATION OF COMMUNITY HEALTH GROUPS AND FOR CAPITAL ASSISTANCE

- Sec. 4001. Designation of rural and urban underserved areas.
- Sec. 4002. Community health group; certified community health plan; community health network; eligible entities; isolated rural facilities.

SUBPART A—GRANTS FOR THE DEVELOPMENT AND OPERATION OF COMMUNITY HEALTH GROUPS

- Sec. 4011. Grants and contracts for development of plans and networks.
- Sec. 4012. Grants and contracts for operation of plans and networks.

SUBPART B—CAPITAL ASSISTANCE

- Sec. 4013. Loans, loan guarantees, and grants for capital investment.

PART 2—DEVELOPMENT OF TELEMEDICINE IN RURAL UNDERSERVED AREAS

- Sec. 4021. Grants for development of rural telemedicine.
- Sec. 4022. Report and evaluation of telemedicine.
- Sec. 4023. Regulations on reimbursement of telemedicine.
- Sec. 4024. Authorization of appropriations.

PART 3—ESSENTIAL PUBLIC HEALTH ACTIVITIES

- Sec. 4031. Grants to States for essential public health activities.
- Sec. 4032. Submission of information.
- Sec. 4033. Reports.
- Sec. 4034. Application for grant.

- Sec. 4035. Allocations for certain activities.
- Sec. 4036. Definitions.
- Sec. 4037. Authorization of appropriations.
- Sec. 4038. Single application and uniform reporting systems for essential public health activities of public health and public health categorical grant programs administered by the Centers for Disease Control and Prevention.

PART 4—RURAL HEALTH PLAN DEMONSTRATION PROJECTS

- Sec. 4041. Rural health plan demonstration projects.

PART 5—MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEM INTEGRATION

- Sec. 4051. Integration of mental health and substance abuse systems.

PART 6—SCHOOL-RELATED HEALTH SERVICES

- Sec. 4061. Authorization of appropriations.
- Sec. 4062. Eligibility for grants.
- Sec. 4063. Preferences.
- Sec. 4064. Planning and development grants.
- Sec. 4065. Grants for operation of school health services.

PART 7—ADDITIONAL PROVISIONS REGARDING PUBLIC HEALTH

- Sec. 4071. Community scholarship program.
- Sec. 4072. Women's and pediatric health services research.
- Sec. 4073. Parity for Federal facilities supporting research.

PART 8—NATIONAL HEALTH SERVICE CORPS

- Sec. 4081. National Health Service Corps.

Subtitle B—Graduate Medical Education

PART 1—WORKFORCE PRIORITIES FOR DIRECT GRADUATE MEDICAL EDUCATION

- Sec. 4101. National Commission on Graduate Medical Education.
- Sec. 4102. Fast track procedure for consideration of legislative proposal on national health care workforce.

PART 2—PAYMENTS FOR OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS

SUBPART A—PAYMENTS FOR OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS

- Sec. 4111. Federal formula payments for the direct costs of the operation of approved physician training programs.
- Sec. 4112. Application for payments.
- Sec. 4113. Availability of funds for payments, annual amount of payments.
- Sec. 4114. Termination of medical education payments.

SUBPART B—INTERIM GRADUATE MEDICAL EDUCATION CONSORTIUM PROGRAM

- Sec. 4115. Graduate medical education consortium program.

PART 3—INDIRECT GRADUATE MEDICAL EDUCATION

Sec. 4121. Funding under medicare for training in nonhospital-owned facilities.

PART 4—STUDY ON HEALTH PROFESSIONS SCHOOLS PAYMENTS

Sec. 4131. Study on health professions schools payments.

PART 5—MISCELLANEOUS PROVISION

Sec. 4141. Waiver of foreign country residence requirement with respect to international medical graduates.

TITLE V—QUALITY AND CONSUMER PROTECTION

Subtitle A—Quality Management and Improvement

- Sec. 5001. National Quality Council.
- Sec. 5002. National quality goals.
- Sec. 5003. Standards and performance measures of quality for health plans.
- Sec. 5004. Plan data analysis and consumer surveys.
- Sec. 5005. Evaluation and reporting of quality performance.
- Sec. 5006. Quality improvement foundations.
- Sec. 5007. Authorization of appropriations.
- Sec. 5008. Role of health plans in quality management.
- Sec. 5009. Conforming amendments to Public Health Service Act.

Subtitle B—Administrative Simplification

PART 1—PURPOSE AND DEFINITIONS

- Sec. 5101. Purpose.
- Sec. 5102. Definitions.

PART 2—STANDARDS FOR DATA ELEMENTS AND INFORMATION
TRANSACTIONS

- Sec. 5111. General requirements on Secretary.
- Sec. 5112. Standards for data elements of health information.
- Sec. 5113. Information transaction standards.
- Sec. 5114. Standards relating to written explanations of benefits.
- Sec. 5115. Timetables for adoption of standards.

PART 3—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND
INFORMATION

- Sec. 5121. Requirements with respect to certain transactions and information.
- Sec. 5122. Timetables for compliance with requirements.

PART 4—ACCESSING HEALTH INFORMATION

- Sec. 5131. Accessing health information for authorized purposes.
- Sec. 5132. Responding to access requests.
- Sec. 5133. Length of time information should be accessible.
- Sec. 5134. Timetables for adoption of standards and compliance.

PART 5—STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION
NETWORK

- Sec. 5141. Standards and certification for health information network services.

Sec. 5142. Ensuring availability of information.

PART 6—PENALTIES

Sec. 5151. General penalty for failure to comply with requirements and standards.

PART 7—MISCELLANEOUS PROVISIONS

Sec. 5161. Imposition of additional requirements.

Sec. 5162. Effect on State law.

Sec. 5164. Health information continuity.

Sec. 5165. Protection of commercial information.

Sec. 5166. Payment for health care services or health plan premiums.

Sec. 5167. Health security cards.

Sec. 5168. Misuse of health security card or personal health identifier.

Sec. 5169. Direct billing for clinical laboratory services.

Sec. 5170. Authorization of appropriations.

PART 8—ASSISTANCE TO THE SECRETARY

Sec. 5171. General requirement on Secretary.

Sec. 5172. Health Information Advisory Committee.

Sec. 5181. Grants for demonstration projects.

PART 9—MEDICARE AND MEDICAID COVERAGE DATA BANK

Sec. 5191. Medicare and Medicaid Coverage Data Bank and related identification processes.

Subtitle C—Privacy of Health Information

PART 1—FINDINGS AND DEFINITIONS

Sec. 5201. Findings and purposes.

Sec. 5202. Definitions.

PART 2—AUTHORIZED DISCLOSURES

SUBPART A—GENERAL PROVISIONS

Sec. 5206. General rules regarding disclosure.

Sec. 5207. Authorizations for disclosure of protected health information.

Sec. 5208. Certified health information network services.

SUBPART B—SPECIFIC DISCLOSURES RELATING TO PATIENT

Sec. 5211. Disclosures for treatment and financial and administrative transactions.

Sec. 5212. Next of kin and directory information.

Sec. 5213. Emergency circumstances.

SUBPART C—DISCLOSURE FOR OVERSIGHT, PUBLIC HEALTH, AND RESEARCH PURPOSES

Sec. 5216. Oversight.

Sec. 5217. Public health.

Sec. 5218. Health research.

10

SUBPART D—DISCLOSURE FOR JUDICIAL, ADMINISTRATIVE, AND LAW
ENFORCEMENT PURPOSES

- Sec. 5221. Judicial and administrative purposes.
- Sec. 5222. Law enforcement.

SUBPART E—DISCLOSURE PURSUANT TO GOVERNMENT SUBPOENA OR
WARRANT

- Sec. 5226. Government subpoenas and warrants.
- Sec. 5227. Access procedures for law enforcement subpoenas and warrants.
- Sec. 5228. Challenge procedures for law enforcement warrants and subpoenas.

SUBPART F—DISCLOSURE PURSUANT TO PRIVATE PARTY SUBPOENA

- Sec. 5231. Private party subpoenas.
- Sec. 5232. Access procedures for private party subpoenas.
- Sec. 5233. Challenge procedures for private party subpoenas.

PART 3—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH
INFORMATION

SUBPART A—ESTABLISHMENT OF SAFEGUARDS

- Sec. 5236. Establishment of safeguards.
- Sec. 5237. Accounting for disclosures.

SUBPART B—REVIEW OF PROTECTED HEALTH INFORMATION BY SUBJECTS OF
THE INFORMATION

- Sec. 5241. Inspection of protected health information.
- Sec. 5242. Amendment of protected health information.
- Sec. 5243. Notice of information practices.

SUBPART C—STANDARDS FOR ELECTRONIC DISCLOSURES

- Sec. 5246. Standards for electronic disclosures.

PART 4—SANCTIONS

SUBPART A—NO SANCTIONS FOR PERMISSIBLE ACTIONS

- Sec. 5251. No liability for permissible disclosures.
- Sec. 5252. No liability for institutional review board determinations.
- Sec. 5253. Reliance on certified entity.

SUBPART B—CIVIL SANCTIONS

- Sec. 5256. Civil penalty.
- Sec. 5257. Civil action.

SUBPART C—CRIMINAL SANCTIONS

- Sec. 5261. Wrongful disclosure of protected health information.

PART 5—ADMINISTRATIVE PROVISIONS

- Sec. 5266. Relationship to other laws.
- Sec. 5267. Rights of incompetents.
- Sec. 5268. Exercise of rights.

Subtitle D—Review of Benefit Determinations for Enrolled Individuals

- Sec. 5301. Definitions.
- Sec. 5302. Claims procedures for health plans.
- Sec. 5303. Review in area claims dispute offices of grievances based on acts or practices by health plans.
- Sec. 5304. Proceedings before hearing officers in claims dispute offices.
- Sec. 5305. Small claims disputes.
- Sec. 5306. Alternative binding arbitration.
- Sec. 5307. Civil money penalties.
- Sec. 5308. Technical amendments.
- Sec. 5309. Reasonable care in conducting preauthorization and utilization review.
- Sec. 5310. Exclusive remedies.

Subtitle E—Enhanced Penalties for Health Care Fraud

PART 1—ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM

- Sec. 5401. All-payer fraud and abuse control program.
- Sec. 5402. Application of Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health plan.
- Sec. 5403. Health care fraud and abuse guidance.
- Sec. 5404. Reporting of fraudulent actions under medicare.

PART 2—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

- Sec. 5411. Mandatory exclusion from participation in medicare and State health care programs.
- Sec. 5412. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.
- Sec. 5413. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.
- Sec. 5414. Actions subject to criminal penalties.
- Sec. 5415. Sanctions against practitioners and persons for failure to comply with statutory obligations.
- Sec. 5416. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 5417. Effective date.

PART 3—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

- Sec. 5421. Establishment of the health care fraud and abuse data collection program.

PART 4—CIVIL MONETARY PENALTIES

- Sec. 5431. Civil monetary penalties.

PART 5—AMENDMENTS TO CRIMINAL LAW

- Sec. 5441. Health care fraud.
- Sec. 5442. Forfeitures for Federal health care offenses.
- Sec. 5443. Injunctive relief relating to Federal health care offenses.

PART 6—PAYMENTS FOR STATE HEALTH CARE FRAUD CONTROL UNITS

- Sec. 5451. Establishment of State fraud units.
- Sec. 5452. Requirements for State-fraud units.

- Sec. 5453. Scope and purpose.
- Sec. 5454. Payments to States.

Subtitle F—Health Care Malpractice Reform

- Sec. 5501. Findings and purpose.
- Sec. 5502. Applicability.
- Sec. 5503. Definitions.

PART 1—ALTERNATIVE DISPUTE RESOLUTION

- Sec. 5511. Alternative dispute resolution.
- Sec. 5512. Court actions.

PART 2—LIABILITY REFORM

- Sec. 5521. Preemption of State law.
- Sec. 5522. Limitation on amount of attorney's contingency fees.
- Sec. 5523. Reform of damages.

Subtitle G—Patient's Right to Self-Determination Regarding Health Care

- Sec. 5601. Treatment of advance directives.
- Sec. 5602. Amendments to rules under medicare and medicaid.
- Sec. 5603. Study of issues related to end of life care.

TITLE VI—REVENUE PROVISIONS

- Sec. 6000. Amendment of 1986 Code.

Subtitle A—Financing Provisions

PART 1—INCREASE IN TAX ON TOBACCO PRODUCTS

- Sec. 6101. Increase in excise taxes on tobacco products.
- Sec. 6102. Modifications of certain tobacco tax provisions.
- Sec. 6103. Imposition of excise tax on manufacture or importation of roll-your-own tobacco.

PART 2—HEALTH RELATED ASSESSMENTS

- Sec. 6111. Assessments on insured and self-insured health plans.

PART 3—PROVISIONS RELATING TO MEDICARE

- Sec. 6121. Recapture of certain health care subsidies received by high-income individuals.

PART 4—OTHER PROVISIONS

- Sec. 6131. Extending medicare coverage of, and application of hospital insurance tax to, all State and local government employees.

Subtitle B—Tax Treatment of Employer-Provided Health Care

PART 1—EXCLUSION FROM EMPLOYEES' INCOME

- Sec. 6201. Limitation on exclusion for employer-provided health benefits.

PART 2—LIMITATIONS ON DEDUCTIBILITY OF EMPLOYER-PROVIDED HEALTH BENEFITS

- Sec. 6211. Limitations on deductibility of employer-provided health benefits.
- Sec. 6212. Application to tax-exempt organizations and governments.
- Sec. 6213. Denial of deduction for certain contingent employer health contributions.

PART 3—OTHER PROVISIONS.

- Sec. 6221. Limitation on prepayment of medical insurance premiums.

Subtitle C—Exempt Health Care Organizations

- Sec. 6301. Treatment of health insurance purchasing cooperatives.
- Sec. 6302. Tax exemption for high-risk insurance pools.
- Sec. 6303. Special rule for deferred compensation plans offered by certain section 501(c)(3) organizations.
- Sec. 6304. Tax treatment of 501(c)(3) bonds similar to governmental bonds.

Subtitle D—Tax Treatment of Long-Term Care Insurance and Services

PART 1—GENERAL PROVISIONS

- Sec. 6401. Qualified long-term care services treated as medical care.
- Sec. 6402. Treatment of long-term care insurance.

PART 2—CONSUMER PROTECTION PROVISIONS

- Sec. 6411. Policy requirements.
- Sec. 6412. Additional requirements for issuers of long-term care insurance policies.
- Sec. 6413. Uniform language and definitions.
- Sec. 6414. Effective dates.

PART 3—ACCELERATED DEATH BENEFITS

- Sec. 6421. Tax treatment of accelerated death benefits under life insurance contracts.
- Sec. 6422. Tax treatment of companies issuing qualified accelerated death benefit riders.

Subtitle E—Other Revenue Provisions

PART 1—TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS.

- Sec. 6501. Nonrefundable credit for certain primary health services providers.
- Sec. 6502. Expensing of medical equipment.

PART 2—MISCELLANEOUS PROVISIONS

- Sec. 6511. Credit for cost of personal assistance services required by employed individuals.
- Sec. 6512. Increase in services reporting penalties.
- Sec. 6513. Disclosure of return information for administration of certain programs under the Health Reform Act.
- Sec. 6514. Disclosure of return information for administration of certain programs under the Health Reform Act.

Subtitle F—Graduate Medical Education Trust Fund

Sec. 6601. Establishment of graduate medical education trust fund.

Subtitle G—Automobile Insurance Coordination

Sec. 6701. Definitions.

PART 1—REQUIREMENTS RELATING TO AUTOMOBILE INSURANCE MEDICAL SERVICES

Sec. 6711. Provision of automobile insurance medical services through health plans.

Sec. 6712. Payment for automobile insurance medical services.

PART 2—ADMINISTRATION

Sec. 6721. Payment facilitation.

TITLE VII—ENSURING HEALTH CARE REFORM FINANCING

Sec. 7001. Ensuring health care reform financing.

TITLE VIII—MISCELLANEOUS AND TECHNICAL MEDICARE AND MEDICAID AMENDMENTS

Sec. 8000. References in title.

Subtitle A—Medicare

PART 1—PROVISIONS RELATING TO PART A

Sec. 8101. Limited service hospital program.

Sec. 8102. Medicare-dependent, small rural hospitals.

Sec. 8103. Provisions relating to rural health transition grant program.

Sec. 8104. Subacute care study.

Sec. 8105. Psychology services in hospitals.

Sec. 8106. Medicare-dependent rural secondary specialty center demonstration project.

Sec. 8107. Provider status for blood centers.

PART 2—PROVISIONS RELATING TO PART B

Sec. 8201. Development and implementation of resource-based methodology for practice expenses.

Sec. 8202. Demonstration projects for medicare State-based performance standard rate of increase.

Sec. 8203. Expanded coverage for physician assistants and nurse practitioners.

Sec. 8204. Direct payment for services of registered nurses who are certified as assistants at surgery.

Sec. 8205. Payment for anesthesia services.

Sec. 8206. Eye or eye and ear hospitals.

PART 3—PROVISIONS RELATING TO PARTS A AND B

Sec. 8301. Extension of social health maintenance organization demonstrations.

Sec. 8302. Study on medicare spending.

Sec. 8303. Streamlined processing systems.

Sec. 8304. Payment for certain medical devices.

- Sec. 8305. Necessary stabilizing treatment for emergency medical conditions and labor.
- Sec. 8306. Medicare select.
- Sec. 8307. Medigap.
- Sec. 8308. Funding under direct graduate medical education for training in non-hospital owned facilities.
- Sec. 8309. Clarification of secondary payer for beneficiaries covered under group health plans.

PART 4—OTHER PROVISIONS

- Sec. 8401. Cooperative care research.

Subtitle B—Medicaid Program

PART 1—LONG-TERM CARE PROVISIONS

- Sec. 8501. Elimination of rule regarding availability of beds in certain institutions.
- Sec. 8502. Certain demonstration projects permitted under the medicaid program.
- Sec. 8503. Elimination of requirement of prior institutionalization with respect to habilitation services furnished under a waiver for home or community-based services.
- Sec. 8504. Relief from third party liability requirements when cost-effective.
- Sec. 8505. State expenditures for medical assistance with respect to home and community-based services provided under a waiver.
- Sec. 8506. Extension and consolidation of frail elderly demonstration project waivers.
- Sec. 8507. Certain improvements in medicaid case management services and home and community-based waivers.
- Sec. 8508. Demonstration projects on acute and long-term care integration; chronic care commission.
- Sec. 8509. Preadmission screening for mentally retarded individuals.

PART 2—OTHER PROVISIONS

- Sec. 8601. Revision of Federal medical assistance percentage for certain States.
- Sec. 8602. Criteria for determining the amount of disallowances.
- Sec. 8603. Technical corrections relating to section 4752 of OBRA-1990 (physicians' services).
- Sec. 8604. Technical correction relating to section 4712 of OBRA-1990 (community supported living arrangements services).
- Sec. 8605. Extension of minnesota prepaid medicaid demonstration project.
- Sec. 8606. Extension of moratorium on treatment of certain facilities as institutions for mental diseases.

1 SEC. 2. FINDINGS AND PURPOSES.

2 **[To be supplied]**

3 SEC. 3. DEFINITIONS AND SPECIAL RULES.

4 (a) DEFINITIONS AND SPECIAL RULES RELATING TO

5 HEALTH PLANS.—For purposes of this Act—

1 (1) HEALTH PLAN.—

2 (A) IN GENERAL.—The term “health plan”
3 means any plan or arrangement which provides,
4 or pays the cost of, health benefits. Such term
5 does not include the following, or any combina-
6 tion thereof:

7 (i) Coverage only for accidental death
8 or dismemberment.

9 (ii) Coverage providing wages or pay-
10 ments in lieu of wages for any period dur-
11 ing which the employee is absent from
12 work on account of sickness or injury.

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

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

18 (v) General liability insurance.

19 (vi) Worker’s compensation or similar
20 insurance.

21 (vii) Automobile or automobile medi-
22 cal-payment insurance.

23 (viii) A long-term care policy, includ-
24 ing a nursing home fixed indemnity policy
25 (unless the Secretary determines that such

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

4 (ix) A specified disease or illness in-
5 surance policy.

6 (x) A hospital or fixed indemnity in-
7 come-protection policy.

8 (xi) A disability income policy.

9 (xii) Insurance with respect to acci-
10 dents.

11 (xiii) An equivalent health care pro-
12 gram.

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

16 (B) INSURED HEALTH PLAN.—

17 (i) IN GENERAL.—The term “insured
18 health plan” means any health plan which
19 is a hospital or medical service policy or
20 certificate, hospital or medical service plan
21 contract, or health maintenance organiza-
22 tion or preferred provider organization
23 group contract offered by an insurer.

24 (ii) INSURER.—The term “insurer”
25 means—

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- 1 (I) a licensed insurance company,
2 (II) a prepaid hospital or medical
3 service plan,
4 (III) a preferred provider organi-
5 zation,
6 (IV) a health maintenance orga-
7 nization, or
8 (V) any similar entity (other than
9 an entity described in subparagraph
10 (C)),

11 which is engaged in the business of provid-
12 ing a plan of health insurance or health
13 benefits.

14 (C) SELF-INSURED HEALTH PLAN.—

15 (i) IN GENERAL.—The term “self-in-
16 sured health plan” means a health plan
17 which is a group health plan—

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

20 (II) under which the large em-
21 ployer retains a substantial risk for
22 the providing of health benefits under
23 the plan.

24 (ii) GROUP HEALTH PLAN.—The term
25 “group health plan” means an employee

1 welfare benefit plan (as defined in section
2 3(1) of the Employee Retirement Income
3 Security Act of 1974) providing medical
4 care (as defined in section 213(d) of the
5 Internal Revenue Code of 1986) to partici-
6 pants or beneficiaries (as defined in section
7 3 of the Employee Retirement Income Se-
8 curity Act of 1974) directly or through re-
9 imbursement.

10 (2) CERTIFIED HEALTH PLAN.—The term “cer-
11 tified health plan” means a health plan which is cer-
12 tified by the appropriate certifying authority as
13 meeting the applicable requirements of this Act, in-
14 cluding the offering of the standard benefits pack-
15 age, and, at the plan’s option, the basic benefits
16 package or the catastrophic benefits package. A
17 health plan shall not fail to be treated as a certified
18 health plan if such plan offers a medicare-eligible
19 benefits package to medicare beneficiaries under—

20 (A) a contract entered into with the Sec-
21 retary under section 1876 of the Social Security
22 Act, or

23 (B) a plan of an organization providing
24 benefits pursuant to an agreement under sec-
25 tion 1833(a)(1)(A) of such Act.

1 (3) TERMS AND RULES RELATING TO COMMU-
2 NITY AND EXPERIENCE RATING.—

3 (A) COMMUNITY-RATED HEALTH PLAN.—

4 The term “community-rated health plan”
5 means a health plan which meets the require-
6 ments of section 1013.

7 (B) COMMUNITY-RATED INDIVIDUAL.—The
8 term “community-rated individual” means an
9 individual—

10 (i) who is not an experience-rated in-
11 dividual, or

12 (ii) who is an experience-rated individ-
13 ual (determined without regard to this sub-
14 paragraph) who is not a full-time employee
15 of a large employer and who does not en-
16 roll in a certified health plan offered by the
17 employer.

18 (C) SMALL EMPLOYER.—The term “small
19 employer” means, with respect to any calendar
20 year, any employer if, on each of 20 days dur-
21 ing the preceding calendar year (each day being
22 in a different week), such employer (or any
23 predecessor) employed less than 100 full-time
24 employees for some portion of the day.

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(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)—

1 (aa) all employers treated as
2 a single employer under sub-
3 section (a) or (b) of section 52 of
4 the Internal Revenue Code of
5 1986 shall be treated as a single
6 employer, and

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

17 The regulations prescribed under item
18 (bb) shall be based on principles simi-
19 lar to the principles which apply to
20 taxable organizations under item (aa).

21 (II) ELECTION NOT TO AGGRE-
22 GATE.—Any employer may elect not
23 to aggregate its employees across
24 community rating areas. Upon such
25 election, the employer shall be treated

1 as a small employer in any community
2 rating area in which it employs less
3 than 100 full-time employees and as a
4 large employer in any community rat-
5 ing area in which it employs 100 or
6 more full-time employees. Such elec-
7 tion shall remain in effect for a period
8 of not less than 5 years. An employer
9 may revoke such election after such
10 period by notifying the Secretary of
11 Labor under rules prescribed by the
12 Secretary.

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

17 (I) all of the employees which
18 such employer leases to other employ-
19 ers shall be treated as community-
20 rated individuals unless treated as
21 employees of a large employer other
22 than the leasing trade or business,
23 and

1 (II) this Act shall be applied sep-
2 arately with respect to its other em-
3 ployees.

4 (G) FULL-TIME EMPLOYEE.—The term
5 “full-time employee” means, with respect to any
6 month, an employee who normally performs at
7 least 30 hours of service per week for an em-
8 ployer in the month (not including the month
9 which includes the hiring date of such em-
10 ployee).

11 (H) SPECIAL RULE FOR SPOUSES AND DE-
12 PENDENTS.—If any individual is offered cov-
13 erage under a health plan as the spouse or a
14 dependent of a primary enrollee of such plan,
15 such individual shall have the status of such en-
16 rollee unless such individual is eligible to elect
17 other coverage and so elects.

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

21 (1) APPROPRIATE CERTIFYING AUTHORITY.—

22 The term “appropriate certifying authority”
23 means—

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

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

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

11 (3) DEPENDENT.—The term “dependent”
12 means, with respect to any individual, any person—

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

16 (B) who is—

17 (i) under 25 years of age and unmar-
18 ried, or

19 (ii) permanently and totally disabled
20 (within the meaning of section
21 151(c)(5)(C) of such Code).

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

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

1 (i) the term "employment" has the
2 meaning given such term under section
3 3121 of the Internal Revenue Code of
4 1986,

5 (ii) the term "employee" has the
6 meaning given such term under section
7 3121 of such Code, subject to the provi-
8 sions of chapter 25 of such Code, and

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

12 (B) EXCEPTIONS.—For purposes of sub-
13 paragraph (A)—

14 (i) EMPLOYMENT.—

15 (I) EMPLOYMENT INCLUDED.—

16 Paragraphs (1), (2), (5), (7) (other
17 than clauses (i) through (iv) of sub-
18 paragraph (C) and clauses (i) through
19 (v) of subparagraph (F)), (8), (9),
20 (10), (11), (13), (15), (18), and (19)
21 of section 3121(b) of the Internal
22 Revenue Code of 1986 shall not apply.

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

1 institution by an inmate thereof or in
2 a hospital or other health care institu-
3 tion by a patient thereof.

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

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

17 (VI) CONSIDERATION OF INDUS-
18 TRY PRACTICE.—As provided under
19 regulation by the Secretary of Labor,
20 an employee shall be considered to be
21 employed on a full-time basis by an
22 employer (and to be a full-time em-
23 ployee of an employer) for a month
24 (or for all months in a 12-month pe-
25 riod) if the employee is employed by

1 that employer on a continuing basis
2 that, taking into account the structure
3 or nature of employment in the indus-
4 try, represents full-time employment
5 in that industry.

6 (ii) EXCLUSION OF CERTAIN FOREIGN
7 EMPLOYMENT.—The term “employee” does
8 not include an individual with respect to
9 service, if the individual is not a citizen or
10 resident of the United States and the serv-
11 ice is performed outside the United States.

12 (5) EQUIVALENT HEALTH CARE PROGRAM.—

13 The term “equivalent health care program” means—

14 (A) part A or part B of the medicare pro-
15 gram under title XVIII of the Social Security
16 Act,

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

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

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

1 (E) the Civilian Health and Medical Pro-
2 gram of the Uniformed Services (CHAMPUS),
3 as defined in section 1073(4) of title 10, United
4 States Code,

5 (F) the Indian health service program
6 under the Indian Health Care Improvement Act
7 (25 U.S.C. 1601 et seq.), and

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

10 (6) FAMILY.—The term “family” includes an
11 individual, the individual’s spouse, and the individ-
12 ual’s dependents (if any), as defined in paragraph
13 (3).

14 (7) HEALTH PLAN SPONSOR.—The term
15 “health plan sponsor” means, with respect to—

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

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

20 (8) HEALTH PROFESSIONAL.—The term
21 “health professional” means an individual who is le-
22 gally authorized to provide services in the State in
23 which such services are provided.

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

1 thorization under licensing or certification laws of a
2 State.

3 (10) NAIC.—The term “NAIC” means the Na-
4 tional Association of Insurance Commissioners.

5 (11) PARTICIPATING STATE.—The term “par-
6 ticipating State” means a State establishing a State
7 program under this title.

8 (12) PROVIDER.—The term “provider” includes
9 a health professional.

10 (13) PURCHASING COOPERATIVE.—The term
11 “purchasing cooperative” means a health insurance
12 purchasing cooperative established under section
13 1211.

14 (14) SECRETARY.—The term “Secretary”
15 means the Secretary of Health and Human Services
16 or the Secretary’s delegate.

17 (15) STATE.—The term “State” means each of
18 the several States, the District of Columbia, the
19 Commonwealth of Puerto Rico, the United States
20 Virgin Islands, Guam, American Samoa, and the
21 Commonwealth of the Northern Mariana Islands.

IA-1

1 **TITLE I—BASIC INSURANCE RE-**
2 **FORMS TO EXPAND ACCESS**
3 **TO HEALTH INSURANCE**

4 **Subtitle A—Standards for Reform**

5 **PART 1—ESTABLISHMENT AND APPLICATION OF**
6 **STANDARDS**

7 **SEC. 1001. CERTIFIED HEALTH PLANS.**

8 A certified health plan shall meet the applicable re-
9 form standards established under part 2 for insured health
10 plans and part 3 for self-insured health plans.

11 **SEC. 1002. GENERAL RULES.**

12 (a) **CONSTRUCTION.**—Whenever in this subtitle a re-
13 quirement or standard is imposed on a health plan, the
14 requirement or standard is deemed to have been imposed
15 on the insurer or sponsor of the plan in relation to that
16 plan.

17 (b) **USE OF INTERIM, FINAL REGULATIONS.**—In
18 order to permit the timely implementation of the provi-
19 sions of this title, the Secretary and the Secretary of
20 Labor are each authorized to issue regulations under this
21 title on an interim basis that become final on the date
22 of publication, subject to change based on subsequent pub-
23 lic comment.

IA-2

1 (c) REFERENCE TO REFORM STANDARDS.—For pur-
2 poses of this title, the term “reform standards” means the
3 standards established and applied under this subtitle.

4 **PART 2—STANDARDS APPLICABLE TO CERTIFIED**
5 **INSURED HEALTH PLANS**

6 **SEC. 1011. GUARANTEED ISSUE AND RENEWAL.**

7 (a) ISSUE.—

8 (1) IN GENERAL.—Except as otherwise pro-
9 vided in this section, a certified health plan
10 sponsor—

11 (A) offering—

12 (i) a community-rated certified health
13 plan, shall offer such plan to any commu-
14 nity-rated individual applying for coverage,
15 and

16 (ii) an experience-rated certified
17 health plan, shall offer such plan to any
18 experience-rated individual eligible for cov-
19 erage under the plan through the individ-
20 ual’s employer; and

21 (B) shall offer such plan for each class of
22 enrollment described in section
23 1113(b)(2)(B)(ii).

24 (2) AVAILABILITY.—

LA-3

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

7 (B) GEOGRAPHIC LIMITATIONS.—

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

18 (ii) NO FEE-FOR-SERVICE PLAN IN
19 AREA.—If a fee-for-service community-
20 rated certified health plan is not available
21 to a community-rated individual in a com-
22 munity rating area, a fee-for-service com-
23 munity-rated certified health plan operat-
24 ing in a contiguous community rating area

IA-4

1 may not deny coverage under the plan to
2 such individual.

3 (3) APPLICATION OF CAPACITY LIMITS.—

4 (A) IN GENERAL.—Subject to subpara-
5 graph (B), a certified health plan may cease en-
6 rolling individuals under the plan if—

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

9 (ii) the plan can demonstrate to the
10 applicable certifying authority, if required,
11 that its financial or provider capacity to
12 serve previously covered groups or individ-
13 uals (and additional individuals who will be
14 expected to enroll because of affiliation
15 with such previously covered groups or in-
16 dividuals) will be impaired if it is required
17 to enroll other individuals.

18 (B) FIRST-COME-FIRST-SERVED.—A cer-
19 tified health plan is only eligible to exercise the
20 limitations provided for in subparagraph (A) if
21 such plan provides for enrollment of individuals
22 on a first-come-first-served basis (except in the
23 case of additional individuals described in sub-
24 paragraph (A)(ii)). Individuals shall be provided
25 with a fair opportunity to enroll regardless of

LA-5

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

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

9 (A)(i) the plan has not established its serv-
10 ice area in a manner that has the effect of dis-
11 criminating against an individual or groups of
12 individuals on the basis of race, national origin,
13 gender, language, socio-economic status, age,
14 disability, or health status;

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

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

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

23 (b) RENEWAL.—

24 (1) IN GENERAL.—Except as provided in para-
25 graph (2), a certified health plan that is issued to

LA-6

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

3 (2) GROUNDS FOR REFUSAL TO RENEW.—

4 (A) IN GENERAL.—Except as provided in
5 subparagraph (B), a certified health plan spon-
6 sor may under no circumstances refuse to
7 renew, or for any reason terminate, a certified
8 health plan with respect to any individual, fam-
9 ily, or employer under this title.

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

12 (i) nonpayment of premiums;

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

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

19 (iv) exit of the insurer from the mar-
20 ket as provided for in subparagraph (C).

21 (C) EXIT FROM MARKET.—

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

IA-7

1 tem with respect to a community-rated in-
2 dividual, unless such insurer—

3 (I) elects not to renew all of its
4 insured health plans using such deliv-
5 ery system issued to all such individ-
6 uals in a State; and

7 (II) provides notice to the appro-
8 priate certifying authority and to each
9 such individual covered under the plan
10 of such termination at least 180 days
11 before the date of expiration of the
12 plan.

13 (ii) PROHIBITION ON MARKET RE-
14 ENTRY.—In the case of such a termi-
15 nation, such insurer may not provide for
16 the issuance of any certified insured health
17 plan using such a delivery system to a
18 community-rated individual in such State
19 during the 5-year period beginning on the
20 date of the termination of the last plan not
21 so renewed.

22 (c) FEHBP PLANS.—Any certified health plan spon-
23 sor participating in the Federal Employees Health Bene-
24 fits Program, and operating a certified health plan within
25 a community rating area, shall offer a community-rated

IA-8

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

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

14 SEC. 1012. ENROLLMENT.

15 (a) ENROLLMENT PROCESS.—

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

19 (2) INITIAL ENROLLMENT PERIOD.—Each indi-
20 vidual shall have an initial enrollment period in
21 which to enroll in a certified health plan as specified
22 by the appropriate certifying authority under section
23 1308(a).

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

IA-9

1 to enroll (or change enrollment) in the plan during
2 each general annual enrollment period specified by
3 the appropriate certifying authority under section
4 1308(b).

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

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

10 (B) experiences a change in employment
11 status (including a significant change in the
12 terms and conditions of employment) or in con-
13 tinuation coverage;

14 (C) changes residence to another commu-
15 nity rating area;

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

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

20 each certified health plan shall provide for a special
21 enrollment period in which the employee or individ-
22 ual is permitted to change the individual or family
23 basis of coverage or the plan in which the employee
24 or individual is enrolled.

25 (b) COMMENCEMENT OF COVERAGE.—

IA-10

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

6 (2) NEWBORNS.—In the event of the birth or
7 adoption of a child of an enrollee, coverage of such
8 child under such enrollee's certified health plan (re-
9 gardless of the class of enrollment) shall begin on
10 the date of such birth or adoption and shall con-
11 tinue, in the absence of any enrollment of such child
12 during a special enrollment period provided under
13 subsection (a)(4), for at least 45 days.

14 **SEC. 1013. RATING LIMITATIONS FOR COMMUNITY-RATED**
15 **MARKET.**

16 (a) STANDARD PREMIUMS WITH RESPECT TO COM-
17 MUNITY-RATED ELIGIBLE INDIVIDUALS.—Each certified
18 health plan which covers community-rated individuals
19 shall establish within each community rating area in which
20 the plan is to be offered, a standard premium for individ-
21 ual enrollment for—

- 22 (1) the standard benefits package,
23 (2) the basic benefits package, and
24 (3) the catastrophic benefits package,
25 established under subtitle B.

IA-11

1 (b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-
2 ING AREAS.—

3 (1) IN GENERAL.—Subject to paragraphs (2)
4 and (3), the standard premium for each package de-
5 scribed in subsection (a) shall be the same, but shall
6 not include the costs of premium processing and en-
7 rollment that would vary depending on whether the
8 method of enrollment is through a purchasing coop-
9 erative, public access site, or directly through a
10 health plan, an employer, or a broker.

11 (2) APPLICATION TO ENROLLEES.—

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

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

18 (ii) in the case of enrollment other
19 than individual enrollment, the family ad-
20 justment factor specified under subpara-
21 graph (B); and

22 (iii) the age adjustment factor (speci-
23 fied under subparagraph (C)).

24 (B) FAMILY ADJUSTMENT FACTOR.—

IA-12

1 (i) IN GENERAL.—The reform stand-
2 ards shall specify family adjustment fac-
3 tors that reflect the relative actuarial costs
4 of benefit packages based on family classes
5 of enrollment (as compared with such costs
6 for individual enrollment).

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

10 (I) Coverage only of an individual
11 (other than an individual described in
12 subclause (II)) (referred to in this Act
13 as the “individual” enrollment or class
14 of enrollment).

15 (II) Coverage only of an individ-
16 ual who has not attained age 19 (re-
17 ferred to in this Act as the “single
18 child” enrollment or class of enroll-
19 ment).

20 (III) Coverage only of two or
21 more children (referred to in this Act
22 as the “multiple children” enrollment
23 or class of enrollment).

24 (IV) Coverage of a married cou-
25 ple without children (referred to in

IA-13

1 this Act as the "couple-only" enroll-
2 ment or class of enrollment).

3 (V) Coverage of an individual
4 and one or more children (referred to
5 in this Act as the "single parent" en-
6 rollment or class of enrollment).

7 (VI) Coverage of a married cou-
8 ple and one or more children (referred
9 to in this Act as the "dual parent"
10 enrollment or class of enrollment).

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

14 (I) FAMILY.—The terms "family
15 enrollment" and "family class of en-
16 rollment" refer to enrollment in a
17 class of enrollment described in any
18 subclause of clause (ii) (other than
19 subclause (I)).

20 (II) COUPLE.—The term "couple
21 class of enrollment" refers to enroll-
22 ment in a class of enrollment de-
23 scribed in subclause (IV) or (VI) of
24 clause (ii).

25 (iv) SPOUSE; MARRIED; COUPLE.—

IA-14

1 (I) IN GENERAL.—In this title,
2 the terms “spouse” and “married”
3 mean, with respect to an individual,
4 another individual who is the spouse
5 of, or is married to, the individual, as
6 determined under applicable State
7 law.

8 (II) COUPLE.—The term “cou-
9 ple” means an individual and the indi-
10 vidual’s spouse.

11 (C) AGE ADJUSTMENT FACTOR.—The Sec-
12 retary, in consultation with the NAIC, shall
13 specify uniform age categories and rating incre-
14 ments for age adjustment factors that reflect
15 the relative actuarial costs of benefit packages
16 among enrollees. For individuals who have at-
17 tained age 18 but not age 65, the highest age
18 adjustment factor may not exceed twice the
19 lowest age adjustment factor.

20 (3) ADMINISTRATIVE CHARGES.—

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

IA-15

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

6 (B) ENROLLMENT THROUGH PURCHASING
7 COOPERATIVE.—Except as provided in subpara-
8 graph (C), in the case of an administrative
9 charge under subparagraph (A) for enrollment
10 through a purchasing cooperative, such charge
11 may not exceed the lowest charge of such plan
12 for enrollment other than through a purchasing
13 cooperative in such area.

14 (C) EXCEPTION.—In the case of a charge
15 for enrollment through a public access site in a
16 community rating area, such charge may not
17 exceed the lowest charge of such plan for enroll-
18 ment through a purchasing cooperative or if
19 such plan is not offered through a purchasing
20 cooperative, the lowest administrative charge
21 for the plan in such area.

22 (c) TREATMENT OF NEGOTIATED RATE AS COMMU-
23 NITY RATE.—Notwithstanding any other provision of this
24 section, a certified health plan which negotiates a premium
25 rate (exclusive of any administrative charge described in

IA-16

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

4 **SEC. 1014. RATING PRACTICES AND PAYMENT OF PRE-**
5 **MIUMS.**

6 (a) **FULL DISCLOSURE OF RATING PRACTICES.—**

7 (1) **IN GENERAL.—**A certified health plan spon-
8 sor shall fully disclose rating practices for such plan
9 to the appropriate certifying authority.

10 (2) **NOTICE ON EXPIRATION.—**A certified
11 health plan sponsor shall provide for notice, at least
12 60 days before the date of expiration of the plan, of
13 the terms for renewal of the plan.

14 (3) **ACTUARIAL CERTIFICATION.—**Each certified
15 health plan sponsor shall file annually with the ap-
16 propriate certifying authority a written statement by
17 a member of the American Academy of Actuaries (or
18 other individual acceptable to such authority) who is
19 not an employee of the plan certifying that, based
20 upon an examination by the individual which in-
21 cludes a review of the appropriate records and of the
22 actuarial assumptions of such sponsor and methods
23 used by such sponsor in establishing premium rates
24 for certified insured health plans—

IA-17

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

3 (B) the rating methods are actuarially
4 sound.

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

8 (b) PAYMENT OF PREMIUMS.—

9 (1) IN GENERAL.—With respect to a new en-
10 rollee in a certified health plan, the plan may require
11 advanced payment of an amount equal to the month-
12 ly applicable premium for the plan at the time such
13 individual is enrolled.

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

IA-18

1 SEC. 1015. NONDISCRIMINATION BASED ON HEALTH STA-
2 TUS.

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

11 (b) TREATMENT OF PREEXISTING CONDITION EX-
12 CLUSIONS FOR ALL SERVICES.—

13 (1) IN GENERAL.—Subject to paragraph (4), a
14 certified health plan may impose a limitation or ex-
15 clusion of benefits relating to treatment of a condi-
16 tion based on the fact that the condition preexisted
17 the effective date of the plan with respect to an indi-
18 vidual only if—

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

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

IA-19

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

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

6 (2) CREDITING OF PREVIOUS COVERAGE.—A
7 certified health plan shall provide that if an individ-
8 ual under such plan is in a period of continuous cov-
9 erage as of the date of enrollment under such plan,
10 any period of exclusion of coverage with respect to
11 a preexisting condition shall be reduced by 1 month
12 for each month in the period of continuous coverage.

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

14 (A) PERIOD OF CONTINUOUS COVERAGE.—
15 The term “period of continuous coverage”
16 means the period beginning on the date an indi-
17 vidual is enrolled under a health plan or health
18 care program which provides benefits equivalent
19 to those provided by the certified health plan in
20 which the individual is seeking to enroll with re-
21 spect to coverage of a preexisting condition and
22 ends on the date the individual is not so en-
23 rolled for a continuous period of more than 3
24 months.

IA-20

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

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

12 **SEC. 1016. BENEFITS OFFERED.**

13 A certified health plan shall offer to all enrollees in
14 the plan the standard benefits package, and, in addition,
15 may offer to such enrollees the basic benefits package or
16 the catastrophic benefits package established under sub-
17 title B.

18 **SEC. 1017. REQUIREMENTS OF SUPPLEMENTALS.**

19 A certified health plan sponsor may only offer bene-
20 fits that are not covered benefits, or a reduction in cost
21 sharing below the cost sharing specified under section
22 1102 for the applicable benefits package, if—

23 (1) such additional coverage is offered and
24 priced separately from the standard, basic, or cata-
25 strophic benefits package offered in such plan;

LA-21

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

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

7 (4) the cost sharing reduction is offered only to
8 individuals enrolled in the certified health plan for a
9 price which includes any expected increase in utiliza-
10 tion resulting from the purchase of such cost sharing
11 reduction.

12 **SEC. 1018. RISK ADJUSTMENT.**

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

16 (b) **ESTABLISHMENT OF STANDARDS FOR RISK AD-**
17 **JUSTMENT PROGRAMS.**—

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

23 (2) **RISK ADJUSTMENT PROGRAM.**—

24 (A) **IN GENERAL.**—The standards devel-
25 oped by the Secretary under this paragraph

IA-22

1 shall include a risk adjustment program
2 which—

3 (i) assures that payments to commu-
4 nity-rated certified health plans reflect the
5 expected relative utilization and expendi-
6 tures for health care services by each
7 plan's enrollees compared to the average
8 utilization and expenditures for commu-
9 nity-rated individuals; and

10 (ii) protects plans that enroll a dis-
11 proportionate share of such individuals
12 with respect to whom expected utilization
13 of health care services and expected health
14 care expenditures for such services are
15 greater than the average utilization and
16 expenditures for such eligible individuals.

17 (B) FACTORS TO BE CONSIDERED.—In de-
18 veloping the standards for a risk adjustment
19 program, the Secretary may take into account
20 the following factors with respect to enrollees:

21 (i) Demographic characteristics.

22 (ii) Health status.

23 (iii) Other factors, including socio-eco-
24 nomic status, as determined appropriate by
25 the Secretary.

IA-23

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

8 **SEC. 1019. FINANCIAL REQUIREMENTS.**

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

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

22 **SEC. 1020. COLLECTION AND PROVISION OF STANDARD-**
23 **IZED INFORMATION.**

24 (a) HEALTH PLANS REQUIRED TO SUBMIT INFOR-
25 MATION.—Each certified health plan that provides cov-

IA-24

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

4 (1) certification status of the plan;

5 (2) benefits offered under the plan;

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

8 (4) risk and referral arrangements under the
9 plan;

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

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

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

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

20 **SEC. 1021. QUALITY IMPROVEMENT AND ASSURANCE.**

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

IA-25

1 vided under reasonable standards of quality of care con-
2 sistent with prevailing professionally recognized standards
3 of medical practice and the quality standards established
4 under such subtitle.

5 (b) INTERNAL QUALITY ASSURANCE PROGRAM.—

6 Each certified health plan shall establish, and commu-
7 nicate to its enrollees and its providers, an ongoing inter-
8 nal program, including periodic reporting, to monitor and
9 evaluate the quality and cost effectiveness of its health
10 care services, pursuant to standards established by the
11 National Quality Council.

12 (c) UTILIZATION MANAGEMENT PROTOCOLS.—The
13 utilization review and management activities of each cer-
14 tified health plan, provided either directly or through con-
15 tract, shall meet the following standards as defined by the
16 Secretary:

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

21 (2) REVIEW PROCESS.—Each certified health
22 plan shall base utilization management on current
23 scientific knowledge, stress the efficient delivery of
24 health care and outcomes, rely primarily on evaluat-
25 ing and comparing practice patterns rather than

IA-26

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

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

9 (4) CONSUMER DISCLOSURE.—Each certified
10 health plan shall disclose, upon request, to enrollees
11 (and prospective enrollees) and to participating pro-
12 viders (and prospective providers) the utilization re-
13 view protocols and the type of financial arrange-
14 ments, if any, used by the plan for controlling utili-
15 zation and costs, while protecting proprietary busi-
16 ness information to the extent specified by the Sec-
17 retary.

18 (d) PHYSICIAN INCENTIVE PLANS.—A certified
19 health plan may not operate a physician incentive plan un-
20 less such incentive plan meets the requirements of section
21 1876(i)(8)(A) of the Social Security Act (42 U.S.C.
22 1395mm(i)(8)(A)).

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

IA-27

1 (1) verify the credentials of participating physi-
2 cians and practitioners; and

3 (2) ensure that participating providers and fa-
4 cilities are appropriately accredited, certified, and li-
5 censed.

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

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

13 **SEC. 1022. PATIENT PROTECTIONS AND PROVIDER SELEC-**
14 **TION.**

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

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

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

IA-28

1 undue burden for enrollees with complex or chronic health
2 conditions is not created and shall ensure access to rel-
3 evant specialists for continued care when medically indi-
4 cated. In cases of a patient with a severe, complex or
5 chronic health condition, such plan shall determine wheth-
6 er it is medically indicated to use a specialists or an inter-
7 disciplinary team.

8 (d) CONFIDENTIALITY OF PATIENT RECORDS.—
9 Each certified health plan shall have explicit procedures
10 to protect the confidentiality of individual patient informa-
11 tion consistent with the rules established under subtitle
12 C of title V.

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

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

25 (g) REMEDIES AND ENFORCEMENT.—

IA-29

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

4 (2) GRIEVANCE PROCESS.—Each certified
5 health plan shall establish a grievance process for
6 enrollees dissatisfied with matters other than the de-
7 nial of payment or provision of benefits by the plan.

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

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

16 (j) PROVIDER SELECTION.—

17 (1) IN GENERAL.—In selecting among providers
18 of health services for membership in a provider net-
19 work, or in establishing the terms and conditions of
20 such membership, a certified health plan may not
21 engage in any practice that discriminates against a
22 provider based on the actual or anticipated health
23 status of the patients of the provider.

24 (2) ADDITIONAL ANTIDISCRIMINATION RE-
25 QUIREMENTS.—No State, certified health plan, or

LA-30

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

7 (3) NUMBER AND TYPE.—Nothing in this sub-
8 section shall—

9 (A) prevent a certified health plan sponsor
10 from matching the number and type of health
11 care providers to the needs of the plan mem-
12 bers; or

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

15 (k) PHYSICIAN PARTICIPATION.—Each certified
16 health plan shall establish mechanisms through which phy-
17 sicians have input into matters affecting patient care and
18 through which patients have the ability to choose any pri-
19 mary care physician from among participating providers.

20 **SEC. 1023. DUE PROCESS FOR HEALTH CARE PROVIDERS.**

21 (a) PUBLICLY AVAILABLE STANDARDS AND PROC-
22 ESS.—Each certified health plan shall establish and
23 utilize—

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

IA-31

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

4 (b) NOTICE REQUIREMENT.—

5 (1) IN GENERAL.—The process established by a
6 certified health plan under subsection (a) shall in-
7 clude notification to a health care provider of a deci-
8 sion to dismiss such provider or not to renew a con-
9 tract with such provider not later than 45 days be-
10 fore such decision takes effect.

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

15 (3) CONTENTS OF NOTICE.—Each notice to a
16 health care provider under paragraph (1) shall con-
17 tain the reasons for the dismissal or failure to
18 renew. Such reasons shall be consistent with the
19 standards established under subsection (a).

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

IA-32

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

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

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

11 (d) EFFECT OF REVIEW.—The findings and conclu-
12 sions under subsection (c) shall be advisory and non-bind-
13 ing.

14 (e) EFFECT ON OTHER LAWS.—The provisions of
15 this section shall not supersede any other provision of Fed-
16 eral or State law.

17 **SEC. 1024. ALTERNATIVE DISPUTE RESOLUTION PROCE-**
18 **DURES RELATING TO MALPRACTICE CLAIMS.**

19 Each certified health plan shall establish and main-
20 tain an alternative dispute resolution procedures program
21 that complies with the standards developed under subtitle
22 E of title V.

LA-33

1 SEC. 1025. ARRANGEMENTS WITH ESSENTIAL COMMUNITY
2 PROVIDERS.

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

5 (1) shall offer to enter into a written provider
6 participation agreement with a reasonable number
7 (as determined by the Secretary taking into account
8 the needs of the community) of the category I essen-
9 tial community providers with a service area in-
10 cluded in the community rating area of the plan;
11 and

12 (2) shall—

13 (A) meet the access and availability stand-
14 ards established by the Secretary under sub-
15 section (d), or

16 (B) offer to enter into a written provider
17 participation agreement with a sufficient num-
18 ber (as determined by the Secretary) of cat-
19 egory II essential community providers to meet
20 such standards.

21 (b) CATEGORIES OF ESSENTIAL COMMUNITY PRO-
22 VIDERS.—

23 (1) CATEGORY I.—A provider is a “category I
24 essential community provider” if such provider is—

IA-34

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

4 (B) a rural health clinic (as defined in sec-
5 tion 1861(aa)(2) of such Act (42 U.S.C.
6 1395x(aa)(4))) that is—

7 (i) a nonprofit rural health clinic, or

8 (ii) a rural health clinic that is not de-
9 scribed in clause (i) and has been des-
10 igned as a rural health clinic under title
11 XVIII of such Act as of the date of the en-
12 actment of this Act or had applied for such
13 designation as of August 1, 1994, and
14 since received such designation.

15 (2) CATEGORY II.—A provider is a “category II
16 essential community provider” if such provider ap-
17 plies for designation as a category II essential com-
18 munity provider (in such manner and form and at
19 such time as the Secretary may prescribe) and the
20 Secretary certifies that such provider meets the re-
21 quirements of subsection (c).

22 (c) REQUIREMENTS FOR CATEGORY II ECPs.—A
23 provider meets the requirements of this subsection if such
24 provider—

LA-35

1 (1) furnishes services in a medically undeserved
2 area;

3 (2) is a public or private, nonprofit organiza-
4 tion;

5 (3) provides the full range of primary health
6 services (as defined in section 330(b)(1) of the Pub-
7 lic Health Service Act (42 U.S.C. 254c(b)(1))) that
8 are included in the standard benefits package estab-
9 lished under subtitle B;

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

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

19 (A) subparagraph (B) (relating to organi-
20 zational arrangements for quality assurance
21 and patient confidentiality),

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

24 (C) subparagraph (E) (relating to reim-
25 bursement collection efforts),

IA-36

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

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

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

7 (G) subparagraph (J) (relating to arrange-
8 ments for individuals with English-speaking
9 ability).

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

18 (e) WRITTEN PARTICIPATION AGREEMENTS.—

19 (1) CATEGORY I ECPS.—

20 (A) IN GENERAL.—Except as provided in
21 subparagraphs (B) and (C), the written partici-
22 pation agreement referred to in subsection
23 (a)(1) shall include terms and conditions that
24 are no more restrictive than the terms and con-
25 ditions that a certified health plan includes in

IA-37

1 its agreements with other participating provid-
2 ers with respect to—

3 (i) the scope of services for which pay-
4 ment is made to the provider;

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

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

10 (iv) accessibility of care,

11 (v) professional credentialing and
12 recredentialing,

13 (vi) licensure,

14 (vii) quality and utilization manage-
15 ment,

16 (viii) confidentiality of patient records,

17 (ix) grievance procedures,

18 (x) indemnification arrangements be-
19 tween the plans and providers, and

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

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

IA-38

1 ment to the provider on the basis of the pay-
2 ment methodology used to determine the
3 amount of payment for services furnished by
4 such provider under section 1833(a) or 1876(h)
5 of the Social Security Act, or on a capitated or
6 other basis that is acceptable to the provider
7 and the plan. Payments to providers under this
8 subparagraph shall include payment for services
9 described in paragraphs (1) and (3) of section
10 1861A(a) of the Social Security Act.

11 (2) CATEGORY II ECPS.—

12 (A) COVERED SERVICES.—Services for
13 which payment may be made under a written
14 participation agreement referred to in sub-
15 section (a)(2)(B) are limited to primary health
16 services (as defined in section 330(b)(1) of the
17 Public Health Service Act (42 U.S.C.
18 254c(b)(1))) that are—

- 19 (i) included in the standard benefits
20 package established under subtitle B, and
21 (ii) furnished on an outpatient basis.

22 (B) TERMS AND CONDITIONS.—Except as
23 provided in subparagraphs (C) and (D), a writ-
24 ten participation referred to in subsection
25 (a)(2)(B) shall include terms and conditions

IA-39

1 that are no more restrictive than the terms and
2 conditions that a certified health plan includes
3 in its agreements with other participating pro-
4 viders with respect to—

5 (i) the scope of services for which pay-
6 ment is made to the provider;

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

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

12 (iv) accessibility of care,

13 (v) professional credentialing and
14 recredentialing,

15 (vi) licensure,

16 (vii) quality and utilization manage-
17 ment,

18 (viii) confidentiality of patient records,

19 (ix) grievance procedures,

20 (x) indemnification arrangements be-
21 tween the plans and providers, and

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

LA-40

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

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

10 **SEC. 1026. ACCESS TO SPECIALIZED SERVICES.**

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

17 (b) CENTERS OF SPECIALIZED CARE.—

18 (1) IN GENERAL.—A certified health plan may
19 satisfy the standard under subsection (a) by con-
20 tracting with centers of specialized care designated
21 by the Secretary. With respect to children such spe-
22 cialized care shall be in pediatrics.

23 (2) REQUIREMENTS FOR CENTERS.—The Sec-
24 retary shall designate centers of specialized care in
25 the field of institutional care that meet evaluation

IA-41

1 criteria established by the Secretary for the delivery
2 of care for complex cases requiring specialized treat-
3 ment and also meet 2 or more of the following re-
4 quirements:

5 “(A) Provide specialized education and
6 training through approved graduate medical
7 education programs with multi-specialty, multi-
8 disciplinary teaching and services in both inpa-
9 tient and outpatient settings, with medical staff
10 with faculty appointments at an affiliated medi-
11 cal school.

12 “(B) Attract patients from outside the cen-
13 ter’s local geographic region.

14 “(C) Either sponsor or participate in, or
15 have medical staff who participate in, peer-re-
16 viewed research.

17 (c) EVALUATION CRITERIA FOR SPECIALIZED SERV-
18 ICES STANDARDS.—A certified health plan may choose to
19 provide specialized services within a provider network.

20 **SEC. 1027. COMMUNITY RATING AREA CAPACITY.**

21 On and after January 1, 1997, each certified health
22 plan shall have the capacity within the plan’s network, or
23 through arrangements with a sufficient number, distribu-
24 tion, and variety of providers, to deliver the standard bene-
25 fits package established under subtitle B throughout the

IA-42

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

6 **SEC. 1028. OUT-OF-AREA COVERAGE.**

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

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

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

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

17 (1) Subsection (a) of section 1011 (relating to
 18 guaranteed issue), subject to subsection (d) of such
 19 section, except that such subsection (a) shall be ap-
 20 plied (for purposes of this subsection) only with re-
 21 spect to employees of the employer sponsor.

22 (2) Section 1012 (relating to enrollment) or es-
 23 tablish such comparable enrollment procedures as
 24 the Secretary of Labor specifies, including an annual
 25 30-day open enrollment period.

IA-43

- 1 (3) Section 1013 (relating to premium rating
- 2 limitations) with respect to experience-rated individ-
- 3 uals.
- 4 (4) Section 1014(b) (relating to payment of
- 5 premiums).
- 6 (5) Section 1015 (relating to nondiscrimination
- 7 based on health status).
- 8 (6) Section 1016 (relating to benefits).
- 9 (7) Section 1019 (relating to financial require-
- 10 ments), except that such requirements shall be con-
- 11 sistent with the applicable rules under section 414 of
- 12 the Employee Retirement Income Security Act of
- 13 1974.
- 14 (8) Section 1020 (relating to collection and pro-
- 15 vision of standardized information).
- 16 (9) Section 1021 (relating to quality assur-
- 17 ance).
- 18 (10) Section 1022 (relating to patient protec-
- 19 tions and provider selection).
- 20 (11) Section 1023 (relating to due process for
- 21 health care providers).
- 22 (12) Section 1024 (relating to alternative dis-
- 23 pute resolution for medical malpractice).
- 24 (13) Section 1026 (relating to centers of spe-
- 25 cialized care).

IA-44

1 (b) COLLECTIVE BARGAINING EXCEPTION.—Para-
2 graphs (1) and (7) of subsection (a) shall not apply to
3 a certified self-insured health plan sponsor that is provid-
4 ing benefits pursuant to a collective bargaining agreement.

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

9 (d) MANAGEMENT OF FUNDS.—

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

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

24 (e) ADDITIONAL STANDARDS.—In addition to the re-
25 quirements applicable to certified self-insured health plans

IA-45

1 under subsection (a), the Secretary of Labor shall estab-
2 lish standards to ensure that such health plans—

3 (1) do not vary premiums for any reason de-
4 scribed in section 1015(a);

5 (2) do not discriminate on a basis described in
6 section 1303(e) (relating to geographic discrimina-
7 tion); and

8 (3) provide information to employees of the em-
9 ployer sponsor of the plans offered.

10 **PART 4—PREEMPTION OF CERTAIN STATE LAWS**

11 **SEC. 1041. PREEMPTION FROM STATE BENEFIT MANDATES.**

12 Effective as of January 1, 1995, no State shall estab-
13 lish or enforce any law or regulation that—

14 (1) requires the offering, as part of a certified
15 health plan, of any services, category of care, or
16 services of any class or type of provider that is dif-
17 ferent from the benefit categories specified under
18 this Act;

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

21 (3) requires a right of conversion from a group
22 health plan that is a certified health plan to an indi-
23 vidual certified health plan.

IA-46

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

3 Effective as of January 1, 1995—

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

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

10 (3) a State may not prohibit or limit the nego-
11 tiation of rates and forms of payments for providers
12 under such plans;

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

15 (5) a State may not prohibit or limit such plans
16 from requiring that services be provided (or author-
17 ized) by a practitioner selected by the enrollee from
18 a list of available participating providers;

19 (6) a State may not prohibit or limit the cor-
20 porate practice of medicine;

21 (7) a State may not regulate utilization man-
22 agement and review programs of any health plan to
23 the extent not provided by this title;

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

LA-47

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

3 (9) a State may not prohibit a certified health
4 plan, including a Federally qualified health mainte-
5 nance organization, from offering a point of service
6 option.

7 **PART 5—INTERIM STANDARDS**

8 **SEC. 1051. APPLICATION OF INTERIM STANDARDS.**

9 (a) IN GENERAL.—During the interim standards ap-
10 plication period, a health plan sponsor may only offer a
11 health plan in a State if such plan meets the standards
12 specified in subsection (b).

13 (b) SPECIFIED STANDARDS.—

14 (1) ISSUE.—The standards specified in—

15 (A) section 1011(a), and

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

17 with respect to self-insured health plans.

18 (2) RENEWAL.—The standards specified in sec-
19 tion 1011(b).

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

24 (c) INTERIM STANDARDS APPLICATION PERIODS.—

25 The interim standards application period is—

IA-48

1 (1) in the case of the standard specified in sub-
2 section (b)(1), on or after January 1, 1995, and be-
3 fore January 1, 1997;

4 (2) in the case of the standards specified in
5 subsections (b)(2) and (b)(4), on or after June 28,
6 1994, and before January 1, 1997; and

7 (3) in the case of the standard specified in sub-
8 section (b)(3), on or after the date of the enactment
9 of this Act, and before January 1, 1997.

10 (d) PREEMPTION.—The requirements of this section
11 do not preempt any State law unless State law directly
12 conflicts with such requirements. The provision of addi-
13 tional protections under State law shall not be considered
14 to directly conflict with such requirements. The Secretary
15 may issue letter determinations with respect to whether
16 this section preempts a provision of State law.

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

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

LA-49

- 1 health plan sponsor to another sponsor through assump-
- 2 tion, acquisition, or otherwise.

IB-1

Subtitle B—Benefits

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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.

IB-2

1 (iii) Clinical preventive services, in-
2 cluding services for high risk populations,
3 immunizations, tests, and clinician visits.

4 (iv) Mental illness and substance
5 abuse services.

6 (v) Family planning services and serv-
7 ices for pregnant women.

8 (vi) Prescription drugs and
9 biologicals.

10 (vii) Hospice care services.

11 (viii) Home health and extended care
12 services.

13 (ix) Outpatient laboratory, radiology,
14 and diagnostic services and medical equip-
15 ment, including orthotics and prosthetics.

16 (x) Outpatient rehabilitation services.

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

20 (xii) Patient care costs pursuant to a
21 qualified investigational treatments (as de-
22 fined in paragraph (7)).

23 (B) ADDITIONAL BENEFITS.—The cat-
24 egories of covered benefits defined in this para-
25 graph shall also include the following:

IB-3

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

5 (ii) Care provided in a Christian
6 Science sanatorium (as defined in section
7 1861(e) of the Social Security Act), includ-
8 ing treatment provided by a Christian
9 Science practitioner.

10 (3) EXTRA CONTRACTUAL ITEMS AND SERV-
11 ICES.—The term “extra contractual items and serv-
12 ices” means, with respect to a health plan, case
13 management services, medical foods, and other ap-
14 propriate alternatives (either alternative items or
15 services or alternative care settings) to traditional
16 covered items or services that are determined by the
17 health plan to be the most cost effective way to pro-
18 vide appropriate treatment to the enrolled individual.

19 (4) HEALTH CARE INTERVENTION.—The term
20 “health care intervention” means any health-related
21 item or service provided, with respect to a specific
22 indication, to diagnose, improve, maintain, restore,
23 or stabilize a health outcome or to prevent or miti-
24 gate an adverse change in a health outcome.

IB-4

1 (5) HEALTH OUTCOME.—The term “health out-
2 come” means an outcome that affects the length or
3 quality of an enrollee’s life. Quality of life includes
4 ability to perform activities of daily living, ability to
5 work, relief from discomfort or pain, alleviation of
6 fatigue, and cognitive, social, or emotional function-
7 ing and wellbeing, taking into account both the func-
8 tional capacity of the individual and those functional
9 capacities that are appropriate for individuals of the
10 same age.

11 (6) HEALTH PROFESSIONAL SERVICES.—The
12 term “health professional services” means profes-
13 sional services that are lawfully provided by a physi-
14 cian or another health professional who is legally au-
15 thorized to provide such services in the State in
16 which the services are provided.

17 (7) QUALIFIED INVESTIGATIONAL TREAT-
18 MENT.—The term “qualified investigational treat-
19 ment” means an investigational treatment that is
20 part of a peer-reviewed and approved research pro-
21 gram (as defined by the Secretary) or research trials
22 approved by the Secretary. A research trial is
23 deemed to be approved for purposes of this para-
24 graph if such trial is approved by one or more of the
25 following: the National Institutes of Health, the

IB-5

1 Food and Drug Administration (through an inves-
2 tigational new drug exemption pursuant to section
3 505 of the Federal Food, Drug, and Cosmetic Act
4 (21 U.S.C. 355) or an investigational device exemp-
5 tion pursuant to section 520(g) of such Act (21
6 U.S.C. 360j(g))), the Department of Veterans Af-
7 fairs, the Department of Defense, or by a qualified
8 nongovernmental research entity as defined in guide-
9 lines issued by one or more of the National Insti-
10 tutes of Health, including guidelines for cancer cen-
11 ter support grants designated by the National Can-
12 cer Institute.

13 **SEC. 1102. LEGISLATIVE PROPOSALS ESTABLISHING**
14 **STANDARDIZED BENEFITS PACKAGES.**

15 (a) **INITIAL PROPOSAL.—**

16 (1) **IN GENERAL.—**The National Health Bene-
17 fits and Coverage Commission established under sec-
18 tion 1411 (referred to in this subtitle as the “Com-
19 mission”) shall develop a legislative proposal estab-
20 lishing standardized benefits package in accordance
21 with this subsection. Such legislative proposal shall
22 be submitted to Congress no later than January 1,
23 1996, in the form of an implementing bill which con-
24 tains the statutory provisions necessary or appro-
25 priate to implement the proposal. Such an imple-