1 menting bill shall be considered by Congress as de-
2 scribed in section 1108.
3 (2) BENEFITS PACKAGES DESCRIBED.—
4 (A) IN GENERAL.—The legislative proposal
5 developed by the Commission shall establish the
6 following benefits packages:
7 (i) STANDARD BENEFITS PACKAGE.—
8 A standard benefits package which—
9 (I) covers health care interven-
10 tions (as defined in section 1101)
11 specified by the Commission under
12 paragraph (3) in each of the cat-
13 egories of covered benefits (as defined
14 in section 1101) when medically nec-
15 essary or appropriate; and
16 (II) complies with the cost-shar-
17 ing schedules specified by the Com-
18 mission under paragraph (4) for such
19 a package.
20 (ii) CATASTROPHIC BENEFITS PACK-
21 AGE.—A catastrophic benefits package
22 which—
23 (I) covers health care interven-
24 tions specified by the Commission
25 under paragraph (3) in each of the

1 categories of covered benefits when
2 medically necessary or appropriate;
3 and
4 (II) complies with the appro-
5 priate cost-sharing schedules specified
6 by the Commission under paragraph
7 (4) for such a package.
8 (iii) BASIC BENEFITS PACKAGE.—A
9 basic benefits package which—
10 (I) covers health care interven-
11 tions specified by the Commission
12 under paragraph (3) in the categories
13 of covered benefits that are deter-
14 mined appropriate by the Commission
15 when medically necessary or appro-
16 priate; and
17 (II) complies with the appro-
18 priate cost-sharing schedules estab-
19 lished by the Commission under para-
20 graph (4) for such a package.
21 (B) REQUIREMENTS WITH RESPECT TO AC-
22 TUARIAL VALUE.—
23 (i) IN GENERAL.—The standardized
24 benefits packages established by the Com-
25 mission under this subsection shall comply

1 with the following requirements with re-
2 spect to actuarial value:
3 (I) STANDARD BENEFITS PACK-
4 AGE.—The standard benefits package
5 shall have an actuarial value that is
6 no greater than the actuarial value of
7 the benefits package provided by the
8 Blue Cross/Blue Shield Standard Op-
9 tion under the Federal Employees
10 Health Benefits Program during
11 1994, adjusted for cost differences
12 after 1994.
13 (II) CATASTROPHIC BENEFITS
14 PACKAGE.—The catastrophic benefits
15 package shall have an actuarial value
16 that is less than the actuarial value of
17 the benefits package provided by the
18 Blue Cross/Blue Shield Standard Op-
19 tion under the Federal Employees
20 Health Benefits Program during
21 1994, adjusted for cost differences
22 after 1994.
23 (III) BASIC BENEFITS PACK-
24 AGE.—The basic benefits package
25 shall have an actuarial value that is

1 not less than the catastrophic benefits
2 package and not more than the stand-
3 ard benefits package.
4 (ii) DETERMINING ACTUARIAL
5 VALUE.—In determining whether a stand-
6 ardized benefits package meets the require-
7 ments of clause (i), the Commission shall
8 use utilization and unit cost measures
9 based on nationwide experience and shall
10 make appropriate adjustments to reflect
11 differences in the cost effectiveness of the
12 delivery system used by a health plan pro-
13 viding the package.
14 (C) REQUIREMENT WITH RESPECT TO AD-
15 VERSE RISK SELECTION.—The standardized
16 benefits packages established by the Commis-
17 sion under this subsection shall minimize or
18 prevent adverse risk selection.
19 (3) SPECIFICATION OF HEALTH CARE INTER-
20 VENTIONS.—
21 (A) IN GENERAL.—The legislative proposal
22 developed by the Commission shall set forth
23 limitations on health care interventions covered
24 under each of the standardized benefits pack-
25 ages established by the Commission under this

1 subsection. Such limitations shall not have the
2 effect of specifying health care providers or par-
3 ticular procedures or treatments required to be
4 limited.
5 (B) CHILDREN AND VULNERABLE POPU-
6 LATIONS.—In setting forth limitations on
7 health care interventions, the Commission shall
8 consider the needs of children and vulnerable
9 populations (including rural and underserved
10 individuals) and the need to improve the health
11 of individuals through preventive treatments.
12 (4) COST-SHARING SCHEDULES.—
13 (A) IN GENERAL.—The legislative proposal
14 developed by the Commission shall set forth
15 cost-sharing schedules which permit a variety of
16 delivery system options for certified health
17 plans providing the standardized benefits pack-
18 ages established by the Commission under this
19 subsection.
20 (B) CLINICAL PREVENTIVE SERVICES.—No
21 cost-sharing schedule established under the pro-
22 posal may include cost-sharing for clinical pre-
23 ventive services and prenatal care unless such
24 cost-sharing involves exercising a point of serv-
25 ice option

1 (C) COST-SHARING RULES.—Cost-sharing
2 schedules established under the proposal may
3 include copayments, coinsurance, and
4 deductibles, and shall include out-of-pocket lim-
5 its. The copayments, coinsurance, deductibles
6 and out-of-pocket limits on cost-sharing for a
7 year under the schedules shall be applied based
8 upon expenses incurred for covered health care
9 interventions furnished in the year.
10 (D) LIFETIME LIMITS.—No cost-sharing
11 schedule established under the proposal may in-
12 clude lifetime limits.
13 (b) OTHER PROPOSALS.—
14 (1) IN GENERAL.—After the initial legislative
15 proposal developed under subsection (a) is enacted,
16 the Commission may develop subsequent legislative
17 proposals that—
18 (A) modify and update the standardized
19 benefits packages established under such pro-
20 posal; or
21 (B) make modifications to the categories of
22 covered benefits.
23 (2) IMPLEMENTING BILL.—Legislative propos-
24 als described in paragraph (1) shall be submitted to
25 Congress in the form of an implementing bill which

1 contains the statutory provisions necessary or appro-
2 priate to implement the proposal. Such an imple-
3 menting bill shall be considered by Congress as de-
4 scribed in section 1108.

5 **SEC. 1103. ADDITIONAL DUTIES OF THE COMMISSION WITH**
6 **RESPECT TO MENTAL ILLNESS AND SUB-**
7 **STANCE ABUSE SERVICES.**

8 (a) IN GENERAL.—The Commission shall, by regula-
9 tion, clarify mental illness and substance abuse services
10 included under the categories of covered benefits.

11 (b) PARITY.—

12 (1) IN GENERAL.—The Commission shall de-
13 sign mental illness and substance abuse services so
14 as to achieve parity with services for other medical
15 conditions. Except as provided in paragraph (3), day
16 or visit limits or cost-sharing requirements, includ-
17 ing out-of-pocket limits, may not be applied to men-
18 tal illness and substance abuse services that are not
19 applied to services for other medical conditions.

20 (2) PARITY DEFINED.—For purposes of this
21 subsection, the term "parity" means comprehensive,
22 coverage for all medically necessary or appropriate
23 mental illness and substance abuse services in inpa-
24 tient, outpatient, residential, and intensive non-resi-
25 dential settings.

1 (3) SPECIAL RULE.—

2 (A) EFFECT ON OTHER BENEFITS.—If the
3 Commission determines that parity of mental
4 illness and substance abuse services with serv-
5 ices for other medical conditions cannot be
6 achieved without imposing unduly burdensome
7 cost-sharing requirements on other services, the
8 Commission may design mental illness and sub-
9 stance abuse services such that they include the
10 limit described in subparagraph (B). If, after
11 limiting mental illness and substance abuse
12 services as described in subparagraph (B), the
13 Commission determines that such parity cannot
14 be achieved without imposing unduly burden-
15 some cost-sharing requirements on other serv-
16 ices, the Commission may also limit such serv-
17 ices as described in subparagraph (C).

18 (B) LIMIT ON INPATIENT HOSPITAL
19 CARE.—The Commission may limit inpatient
20 hospital care, but in the case of mental illness
21 the limit may not be set at a level below 30
22 days per year, and in the case of substance
23 abuse services the limit may not be set at a
24 level below the level sufficient to provide detoxi-
25 fication services.

1 (C) COINSURANCE FOR OUTPATIENT
2 ADULT PSYCHOTHERAPY.—The Commission
3 may set the coinsurance for outpatient adult
4 psychotherapy at a level higher than the coin-
5 surance for other services, but no higher than
6 a 50 percent coinsurance level, after the first 5
7 visits for such services.
8 (D) REQUIREMENT TO ACHIEVE PARITY
9 BY DATE CERTAIN.—The Commission shall en-
10 sure that parity for mental illness and sub-
11 stance abuse services with services for other
12 medical conditions is established no later than
13 January 1, 2001. If the Commission finds that
14 establishing parity for mental illness and sub-
15 stance abuse services with services for other
16 medical conditions cannot be achieved by Janu-
17 ary 1, 2001, without imposing unduly burden-
18 some cost-sharing on all services, the Commis-
19 sion shall develop a legislative proposal for an
20 extension of such date. Not later than January
21 1, 2000, the Commission shall submit to the
22 Congress an implementing bill which contains
23 such statutory provisions as are necessary or
24 appropriate to implement the legislative pro-
25 posal developed under the preceding sentence.

1 (c) MANAGEMENT OF SERVICES.—
2 (1) IN GENERAL.—The Commission shall de-
3 velop standards for the appropriate management of
4 mental illness and substance abuse services. Such
5 standards shall include quality managed care tech-
6 niques.
7 (2) QUALITY MANAGED CARE.—For purposes of
8 paragraph (1), the term "quality managed care" re-
9 fers to the administration of benefits through meth-
10 ods of central intake, preauthorization, and utiliza-
11 tion review under circumstances that protect individ-
12 uals from unwarranted denial of services.
13 (d) SETTINGS.—The Commission shall give priority
14 to ensuring that mental illness and substance abuse serv-
15 ices are provided in the least restrictive setting that is
16 clinically appropriate and encouraging the use of out-
17 patient and intensive nonresidential treatments to the
18 greatest extent possible.
19 **SEC. 1104. RECOMMENDATIONS FOR PRACTICE GUIDE-**
20 **LINES AND COVERAGE.**
21 (a) RECOMMENDATIONS TO AGENCY FOR HEALTH
22 CARE POLICY AND RESEARCH.—
23 (1) IN GENERAL.—The Commission may rec-
24 ommend that the Agency for Health Care Policy and
25 Research (referred to in this subsection as the

1 "Agency") undertake the development of a practice
2 guideline if the Commission determines that health
3 plans need guidance for determination of coverage
4 decisions for a health care intervention.
5 (2) PETITION FOR GUIDELINE.—Health plans,
6 providers, or citizens may petition the Agency to re-
7 quest the development of a guideline.
8 (3) GUIDELINE PRIORITIES.—The Agency must
9 consider all petitions under paragraph (2) as well as
10 recommendations of the Commission in determining
11 its priorities.
12 (b) COVERAGE RECOMMENDATIONS.—
13 (1) IN GENERAL.—The Commission may apply
14 the criteria set forth in section 1106(b) to issue cov-
15 erage recommendations for plans if the Commission
16 determines that a health care intervention—
17 (A) raises exceptionally significant issues
18 of safety and effectiveness;
19 (B) on the basis of information received
20 from health plans is, or is likely to be, the sub-
21 ject of conflicting determinations by health
22 plans with respect to findings of medical neces-
23 sity or appropriateness; and
24 (C) is used or is contemplated for use for
25 a significant number of enrollees.

1 (2) REQUIREMENTS ON RECOMMENDATIONS.—
2 Coverage recommendations shall be published for no-
3 tice and comment pursuant to the Administrative
4 Procedure Act, shall be based on application of the
5 criteria set forth in section 1106(b) and may include
6 interim guidelines, including recommendations that
7 plans include or exclude a health care intervention,
8 pending the issuance of a practice guideline by the
9 Agency for Health Care Policy and Research.
10 (3) TIME LIMITED.—The guidelines described
11 in paragraph (2) shall expire within 2 years after
12 the issuance of such guidelines.

13 **SEC. 1105. REPORTS ON ACTUARIAL VALUE.**

14 The Commission shall submit to Congress an annual
15 report on the fiscal impact of the actuarial value require-
16 ments imposed on the standardized benefits packages and
17 make recommendations with respect to necessary modi-
18 fications to such requirements based on data on quality
19 and cost.

20 **SEC. 1106. MEDICAL NECESSITY OR APPROPRIATENESS.**

21 (a) IN GENERAL.—Health care interventions in the
22 categories of covered benefits shall be covered by a cer-
23 tified health plan when medically necessary or appropriate.
24 A health plan may, but is not required to, exclude health

1 care interventions that are not medically necessary or ap-
2 propriate.
3 (b) DEFINITION.—A health care intervention shall be
4 considered to be medically necessary or appropriate if:
5 (1) MEDICAL CONDITION.—
6 (A) IN GENERAL.—The health care inter-
7 vention is for a medical condition.
8 (B) MEDICAL CONDITION DEFINED.—The
9 term "medical condition" means a disease, ill-
10 ness, injury, congenital defect, or biological or
11 psychological condition or status for which
12 health care intervention is indicated to improve,
13 maintain, restore, or stabilize a health outcome
14 (as defined in section 1101) or which, in the
15 absence of such intervention, could lead to an
16 adverse change in a health outcome or a dete-
17 rioration.
18 (C) ADVERSE CHANGE IN HEALTH OUT-
19 COME DEFINED.—In subparagraph (B), an ad-
20 verse change in a health outcome occurs if there
21 is a biological, psychological, or functional
22 decremental change in a health status.
23 (2) SAFETY AND EFFECTIVENESS.—
24 (A) IN GENERAL.—The health care inter-
25 vention is safe and effective.

1 (B) WHEN SAFE AND EFFECTIVE.—A
2 health care intervention is safe and effective if
3 there is sufficient basis to support conclusions
4 that such health care intervention can reason-
5 ably be expected to produce the intended health
6 outcome and if the expected benefit for the en-
7 rollee of the health care intervention outweighs
8 any expected harm.
9 (3) INDICATED FOR SPECIFIC ENROLLEE.—
10 (A) IN GENERAL.—The health care inter-
11 vention is indicated for the specific enrollee.
12 (B) WHEN INDICATED.—A health care
13 intervention is indicated for a specific enrollee
14 if, with respect to that enrollee's medical condi-
15 tion (and age), and in consideration with other
16 available options, the health care intervention is
17 appropriate and can reasonably be expected to
18 provide a clinically meaningful benefit for the
19 enrollee.
20 (c) BASIS FOR DETERMINATIONS.—
21 (1) IN GENERAL.—Determinations pursuant to
22 subsection (b) shall be supportable by evidence that
23 includes one or more of the following—
24 (A) published peer-reviewed medical lit-
25 erature;

1 (B) opinions of medical speciality groups;
2 (C) general acceptance in the medical com-
3 munity; or
4 (D) recommendations of the Commission
5 pursuant to this section.
6 (2) PRESUMPTIONS.—The following presump-
7 tions shall apply with respect to determinations
8 under subsection (b):
9 (A) FDA-APPROVED DRUGS AND BIO-
10 LOGICS.—A drug or biologic which is approved
11 for marketing by the Food and Drug Adminis-
12 tration is deemed to be safe and effective if
13 such drug or biologic is furnished for treatment
14 of a medically accepted indication (as defined in
15 section 1927(k)(6) of the Social Security Act).
16 (B) FDA-APPROVED DEVICES.—A medical
17 device that has been cleared for marketing by
18 the Food and Drug Administration is deemed
19 safe and effective when used for the conditions,
20 purposes, or uses prescribed, recommended, or
21 suggested in the labeling of the device.
22 (C) PRACTICE GUIDELINES.—A health
23 care intervention furnished to an enrollee con-
24 sistent with a practice guideline developed or
25 certified by the Agency for Health Care Policy

1 and Research under section 912 of the Public
2 Health Service Act is deemed to be safe and ef-
3 fective, but the omission of an item or proce-
4 dure from a practice guideline does not give rise
5 to a presumption that an item or procedure is
6 not safe and effective.
7 (d) PRACTICE GUIDELINES AND UTILIZATION PROTO-
8 COLS.—A certified health plan at its discretion may, but
9 is not required to, use treatment guidelines or utilization
10 protocols, provided the plan follows the following proce-
11 dures:
12 (1) GENERAL REQUIREMENTS.—If a certified
13 health plan has established a practice guideline or
14 utilization protocol—
15 (A) the guideline or protocol shall be sup-
16 ported by evidence required for the determina-
17 tion of medical necessity or appropriateness set
18 forth in this section;
19 (B) the plan shall provide, upon request, a
20 written statement of the basis for such guide-
21 line or protocol to the certifying authority and
22 to each affected provider with which the plan
23 has an arrangement;

1 (C) the guideline or protocol shall be pro-
2 vided, upon request, within 30 days to plan en-
3 rollees and any interest party; and
4 (D) the plan shall revise such guideline or
5 protocol periodically, or if new scientific evi-
6 dence becomes available, as soon as possible
7 after such evidence is available.
8 (2) ADDITIONAL REQUIREMENTS.—Certified
9 health plans shall provide a process for providers to
10 comment on such guidelines and protocols and any
11 revisions to such guidelines and protocols.

12 **SEC. 1107. FLEXIBLE SERVICE OPTION.**

13 (a) EXTRA CONTRACTUAL SERVICES.—A certified
14 health plan may provide coverage to individuals enrolled
15 under the plan for extra contractual items and services
16 (as defined in section 1101) determined appropriate by the
17 plan and the individual (or in appropriate circumstances
18 the parent or legal guardian of the individual).
19 (b) DISPUTED CLAIMS.—A decision by a health plan
20 to permit or deny the provision of extra contractual serv-
21 ices shall not be subject to subtitle D of title V.

22 **SEC. 1108. CONGRESSIONAL CONSIDERATION OF COMMIS-**
23 **SION PROPOSALS.**

24 (a) IN GENERAL.—Any implementing bill described
25 in this subtitle or in section 4102 shall be considered by

1 Congress under the procedures for consideration described
2 in subsection (b).
3 (b) CONGRESSIONAL CONSIDERATION.—
4 (1) RULES OF HOUSE OF REPRESENTATIVES
5 AND SENATE.—This subsection is enacted by
6 Congress—
7 (A) as an exercise of the rulemaking power
8 of the House of Representatives and the Sen-
9 ate, respectively, and as such is deemed a part
10 of the rules of each House, respectively, but ap-
11 plicable only with respect to the procedure to be
12 followed in that House in the case of an imple-
13 menting bill described in subsection (a), and su-
14 persedes other rules only to the extent that
15 such rules are inconsistent therewith; and
16 (B) with full recognition of the constitu-
17 tional right of either House to change the rules
18 (so far as relating to the procedure of that
19 House) at any time, in the same manner, and
20 to the same extent as in the case of any other
21 rule of that House.
22 (2) INTRODUCTION AND REFERRAL.—On the
23 day on which the implementing bill described in sub-
24 section (a) is transmitted to the House of Represent-
25 atives and the Senate, such bill shall be introduced

1 (by request) in the House of Representatives by the
2 Majority Leader of the House, for himself or herself
3 and the Minority Leader of the House, or by Mem-
4 bers of the House designated by the Majority Leader
5 and Minority Leader of the House and shall be in-
6 troduced (by request) in the Senate by the Majority
7 Leader of the Senate, for himself or herself and the
8 Minority Leader of the Senate, or by Members of
9 the Senate designated by the Majority Leader and
10 Minority Leader of the Senate. If either House is
11 not in session on the day on which the implementing
12 bill is transmitted, the bill shall be introduced in the
13 House, as provided in the preceding sentence, on the
14 first day thereafter on which the House is in session.
15 The implementing bill introduced in the House of
16 Representatives and the Senate shall be referred to
17 the appropriate committees of each House.
18 (3) AMENDMENTS PROHIBITED.—No amend-
19 ment to an implementing bill shall be in order in ei-
20 ther the House of Representatives or the Senate and
21 no motion to suspend the application of this sub-
22 section shall be in order in either House, nor shall
23 it be in order in either House for the Presiding Offi-
24 cer to entertain a request to suspend the application
25 of this subsection by unanimous consent.

1 (4) PERIOD FOR COMMITTEE AND FLOOR CON-
2 SIDERATION.—
3 (A) IN GENERAL.—Except as provided in
4 subparagraph (B), if the committee or commit-
5 tees of either House to which an implementing
6 bill has been referred have not reported it at
7 the close of the 45th day after its introduction,
8 such committee or committees shall be auto-
9 matically discharged from further consideration
10 of the implementing bill and it shall be placed
11 on the appropriate calendar. A vote on final
12 passage of the implementing bill shall be taken
13 in each House on or before the close of the
14 45th day after the implementing bill is reported
15 by the committees or committee of that House
16 to which it was referred, or after such commit-
17 tee or committees have been discharged from
18 further consideration of the implementing bill.
19 If prior to the passage by one House of an im-
20 plementing bill of that House, that House re-
21 ceives the same implementing bill from the
22 other House then—
23 (i) the procedure in that House shall
24 be the same as if no implementing bill had
25 been received from the other House; but

1 "(ii) the vote on final passage shall be
2 on the implementing bill of the other
3 House.
4 (B) COMPUTATION OF DAYS.—For pur-
5 poses of subparagraph (A), in computing a
6 number of days in either House, there shall be
7 excluded—
8 (i) the days on which either House is
9 not in session because of an adjournment
10 of more than 3 days to a day certain, or
11 an adjournment of the Congress sine die,
12 and
13 (ii) any Saturday and Sunday not ex-
14 cluded under clause (i) when either House
15 is not in session.
16 (5) FLOOR CONSIDERATION IN THE HOUSE OF
17 REPRESENTATIVES.—
18 (A) MOTION TO PROCEED.—A motion in
19 the House of Representatives to proceed to the
20 consideration of an implementing bill shall be
21 highly privileged and not debatable. An amend-
22 ment to the motion shall not be in order, nor
23 shall it be in order to move to reconsider the
24 vote by which the motion is agreed to or dis-
25 agreed to.

1 (B) DEBATE.—Debate in the House of
2 Representatives on an implementing bill shall
3 be limited to not more than 20 hours, which
4 shall be divided equally between those favoring
5 and those opposing the bill. A motion further to
6 limit debate shall not be debatable. It shall not
7 be in order to move to recommit an implement-
8 ing bill or to move to reconsider the vote by
9 which an implementing bill is agreed to or dis-
10 agreed to.
11 (C) MOTION TO POSTPONE.—Motions to
12 postpone, made in the House of Representatives
13 with respect to the consideration of an imple-
14 menting bill, and motions to proceed to the con-
15 sideration of other business, shall be decided
16 without debate.
17 (D) APPEALS.—All appeals from the deci-
18 sions of the Chair relating to the application of
19 the Rules of the House of Representatives to
20 the procedure relating to an implementing bill
21 shall be decided without debate.
22 (E) GENERAL RULES APPLY.—Except to
23 the extent specifically provided in the preceding
24 provisions of this paragraph, consideration of
25 an implementing bill shall be governed by the

1 Rules of the House of Representatives applica-
2 ble to other bills and resolutions in similar cir-
3 cumstances.
4 (6) FLOOR CONSIDERATION IN THE SENATE.—
5 (A) MOTION TO PROCEED.—A motion in
6 the Senate to proceed to the consideration of an
7 implementing bill shall be privileged and not de-
8 batable. An amendment to the motion shall not
9 be in order, nor shall it be in order to move to
10 reconsider the vote by which the motion is
11 agreed to or disagreed to.
12 (B) GENERAL DEBATE.—Debate in the
13 Senate on an implementing bill, and all debat-
14 able motions and appeals in connection there-
15 with, shall be limited to not more than 20
16 hours. The time shall be equally divided be-
17 tween, and controlled by, the Majority Leader
18 and the Minority Leader or their designees.
19 (C) DEBATE OF MOTIONS AND APPEALS.—
20 Debate in the Senate on any debatable motion
21 or appeal in connection with an implementing
22 bill shall be limited to not more than one hour,
23 to be equally divided between, and controlled
24 by, the mover and the manager of the imple-
25 menting bill, except that in the event the man-

1 ager of the implementing bill is in favor of any
2 such motion or appeal, the time in opposition
3 thereto, shall be controlled by the Minority
4 Leader or his designee. Such leaders, or either
5 of them, may, from time under their control on
6 the passage of an implementing bill, allot addi-
7 tional time to any Senator during the consider-
8 ation of any debatable motion or appeal.
9 (D) OTHER MOTIONS.—A motion in the
10 Senate to further limit debate is not debatable.
11 A motion to recommit an implementing bill is
12 not in order.

13 **SEC. 1109. REVIEW OF BENEFIT DETERMINATION.**

14 Except as provided in section 1107, benefit deter-
15 minations under this Act that are in dispute shall be re-
16 solved in accordance with subtitle D of title V.

1 # Subtitle C—Expanded Access to
2 # Health Plans

3 ## PART 1—ACCESS THROUGH EMPLOYERS

4 ### SEC. 1201. EMPLOYER ACCESS AND ENROLLMENT RE-
5 ### QUIREMENTS.

6 (a) IN GENERAL.—Each employer shall—
7 (1) make available to each employee of the em-
8 ployer the opportunity to enroll through the em-
9 ployer in one of at least three certified health plans
10 including, if available, either a fee-for-service plan or
11 a health plan with a point-of-service option, and
12 (2) to provide, upon request, payroll withhold-
13 ing of the employee's premiums.
14 (b) SPECIAL RULES.—
15 (1) PURCHASING COOPERATIVE.—A small em-
16 ployer may meet the requirements of subsection
17 (a)(1) through a purchasing cooperative.
18 (2) LARGE EMPLOYER.—
19 (A) IN GENERAL.—Except as provided in
20 section 3(a)(3)(F)(ii)(II), a large employer shall
21 meet the requirements of subsection (a)(1) only
22 through offering experience-rated health plans.
23 (B) SINGLE INSURER.—Nothing in this
24 section shall be construed as preventing or re-
25 quiring a large employer from complying with

1 subsection (a)(1) through the offering of plans
2 by a single insurer.

3 **SEC. 1202. SMALL EMPLOYER REQUIREMENTS.**

4 (a) FORWARDING INFORMATION.—
5 (1) INFORMATION REGARDING PLANS.—A small
6 employer must provide, either directly or through a
7 purchasing cooperative, each employee of such em-
8 ployer (including any part-time or seasonal em-
9 ployee) with information described in section 1306
10 regarding all certified health plans offered in the
11 community rating area in which the employer is lo-
12 cated, and if the employee resides in another com-
13 munity rating area, information regarding how to
14 obtain information on certified health plans offered
15 to residents of such other community rating area.
16 (2) INFORMATION REGARDING EMPLOYEES.—A
17 small employer must forward the name and address
18 (and any other necessary identifying information
19 specified by the Secretary) of each employee enroll-
20 ing through the employer—
21 (A) to the certified health plan in which
22 such employee is enrolled, or
23 (B) to the purchasing cooperative (if any)
24 through which such employee is enrolling.

1 (b) PAYROLL DEDUCTION.—Upon authorization
2 from an employee, a small employer shall deduct from the
3 employee's wages the employee's share of any premium
4 due to a certified health plan or purchasing cooperative.
5 This subsection shall only apply to plans made available,
6 either directly or through a purchasing cooperative, by the
7 employer.
8 (c) NO REQUIREMENT TO ENROLL IN EMPLOYER-
9 PROVIDED PLAN.—A community-rated individual who is
10 an employee of a small employer may elect not to enroll
11 in a certified health plan offered by such employer under
12 this section. Such an employee may enroll in any certified
13 health plan offered in the community rating area in which
14 the employee works or in which the employee resides (in-
15 cluding certified health plans offered through purchasing
16 cooperatives serving such area).
17 **SEC. 1203. LARGE EMPLOYER REQUIREMENTS.**
18 (a) ANNUAL INFORMATION.—A large employer shall
19 provide to the Secretary of Labor each year such informa-
20 tion (in such form and manner) as the Secretary may re-
21 quire in order to monitor the compliance of such employer
22 with the requirements of this part.
23 (b) ANNUAL NOTICE OF EMPLOYEES OR PARTICI-
24 PANTS.—Each large employer shall submit to the Sec-
25 retary of Labor information on the number of employees

1 or participants obtaining coverage through the employer
2 as of January 1 of that year.

3 PART 2—ACCESS THROUGH PURCHASING 4 COOPERATIVES

5 SEC. 1211. ESTABLISHMENT OF PURCHASING COOPERA- 6 TIVES.

7 (a) IN GENERAL.—Purchasing cooperatives may be
8 established in accordance with this part. Each purchasing
9 cooperative shall be certified under State law. An insurer,
10 agent, broker or any other individual or entity engaged
11 in the sale of insurance may not form or underwrite a
12 purchasing cooperative or hold or control any right to vote
13 with respect to a purchasing cooperative.

14 (b) STATE CERTIFICATION.—An organization seek-
15 ing to form a purchasing cooperative under this section
16 shall submit an application to the State for certification.
17 The State shall determine whether to issue such a certifi-
18 cation and otherwise ensure compliance with the require-
19 ments of this Act.

20 (c) BOARD OF DIRECTORS.—Each purchasing coop-
21 erative established under this section shall be governed by
22 a board of directors or have active input from an advisory
23 board consisting of individuals and businesses participat-
24 ing in the cooperative.

1 (d) DOMICILIARY STATE.—For purposes of this sec-
2 tion, a purchasing cooperative operating in more than one
3 State shall be certified by the State in which the coopera-
4 tive is domiciled.
5 (e) MEMBERSHIP.—
6 (1) IN GENERAL.—A purchasing cooperative
7 shall accept all small employers and community-
8 rated individuals residing within the area served by
9 the cooperative as members if such employers or in-
10 dividuals request such membership.
11 (2) VOTING.—Members of a purchasing cooper-
12 ative shall have voting rights consistent with the
13 rules established by the State.
14 (f) DUTIES OF PURCHASING COOPERATIVES.—Each
15 purchasing cooperative shall—
16 (1) enter into agreements with at least three
17 certified health plans offering the standard benefits
18 package, at least one of which shall be a point-of-
19 service or fee-for-service plan (where available);
20 (2) enter into agreements with small employers
21 under section 1212;
22 (3) enroll only community-rated individuals in
23 certified health plans, in accordance with section
24 1213;
25 (4) provide enrollee information to the State;

1 (5) provide for coordination with other purchas-
2 ing cooperatives, in accordance with section 1305;
3 (6) meet the marketing requirements under sec-
4 tion 1215; and
5 (7) carry out other functions provided for under
6 this Act.
7 (g) LIMITATION ON ACTIVITIES.—A purchasing coop-
8 erative shall not—
9 (1) perform any activity involving approval or
10 enforcement of payment rates for providers;
11 (2) perform any activity (other than the report-
12 ing of noncompliance) relating to compliance of cer-
13 tified health plans with the requirements of this Act;
14 (3) assume financial risk in relation to any such
15 health plan; or
16 (4) perform other activities identified by the
17 State as being inconsistent with the performance of
18 its duties under this Act.
19 (h) RULES OF CONSTRUCTION.—
20 (1) ESTABLISHMENT NOT REQUIRED.—Nothing
21 in this section shall be construed as requiring—
22 (A) that a State organize, operate or oth-
23 erwise establish a purchasing cooperative, or
24 otherwise require the establishment of coopera-
25 tives; and

1 (B) that there be only one purchasing co-
2 operative established with respect to a commu-
3 nity rating area.
4 (2) SINGLE ORGANIZATION SERVING MULTIPLE
5 AREAS AND STATES.—Nothing in this section shall
6 be construed as preventing a single entity from
7 being a purchasing cooperative in more than one
8 community rating area or in more than one State.
9 (3) VOLUNTARY PARTICIPATION.—Nothing in
10 this section shall be construed as requiring any indi-
11 vidual or small employer to purchase a certified
12 health plan exclusively through a purchasing cooper-
13 ative.

14 **SEC. 1212. AGREEMENTS WITH SMALL EMPLOYERS.**

15 (a) IN GENERAL.—A purchasing cooperative shall
16 offer to enter into an agreement under this section with
17 each small employer that employs individuals in the area
18 served by the cooperative.
19 (b) PAYROLL DEDUCTION.—
20 (1) IN GENERAL.—Under an agreement under
21 this section between a small employer and a pur-
22 chasing cooperative, the employer shall deduct pre-
23 miums from an employee's wages as provided in sec-
24 tion 1202(b).

1 (2) ADDITIONAL PREMIUMS.—If the amount
2 withheld under paragraph (1) is not sufficient to
3 cover the entire cost of the premiums, the employee
4 shall be responsible for paying directly to the pur-
5 chasing cooperative the difference between the
6 amount of such premiums and the amount withheld.

7 **SEC. 1213. ENROLLING COMMUNITY-RATED INDIVIDUALS**
8 **IN HEALTH PLANS THROUGH A PURCHASING**
9 **COOPERATIVE.**

10 (a) IN GENERAL.—Each purchasing cooperative shall
11 offer community-rated individuals the opportunity to en-
12 roll in any certified health plan which has an agreement
13 with the purchasing cooperative for the community rating
14 area in which the individual resides.

15 (b) COORDINATING ENROLLMENT IN MULTIPLE
16 PLANS.—Each purchasing cooperative shall establish a
17 procedure for the coordination of standard, basic, or cata-
18 strophic benefits which provides for the orderly payment
19 of claims where community-rated individuals (and depend-
20 ents) may be enrolled in more than one certified health
21 plan for the coverage of standard, basic, or catastrophic
22 benefits.

1 **SEC. 1214. RECEIPT OF PREMIUMS.**

2 (a) ENROLLMENT CHARGE.—The amount charged by
3 a purchasing cooperative for coverage under a certified
4 health plan shall be equal to the sum of—
5 (1) the premium rate offered by such health
6 plan,
7 (2) the administrative charge for such health
8 plan, and
9 (3) the purchasing cooperative administrative
10 charge for enrollment of individuals through the co-
11 operative.
12 (b) DISCLOSURE OF PREMIUM RATES AND ADMINIS-
13 TRATIVE CHARGES.—Each purchasing cooperative shall,
14 prior to the time of enrollment, disclose to enrollees and
15 other interested parties the premium rate for a certified
16 health plan, the administrative charge for such plan, and
17 the administrative charge of the cooperative, separately.

18 **SEC. 1215. COOPERATIVE MARKETING ACTIVITIES.**

19 Each purchasing cooperative shall market certified
20 health plans to members through the entire community
21 rating area served by the purchasing cooperative. A pur-
22 chasing cooperative shall provide to each of its members
23 information described in section 1306.

1 **SEC. 1216. SPECIAL RULE FOR CERTAIN STATE AND LOCAL**
2 **EMPLOYEE PURCHASING COOPERATIVES.**

3 (a) IN GENERAL.—An applicable entity which makes
4 an irrevocable election to have this section apply shall be
5 treated as a purchasing cooperative and except as other-
6 wise provided by this section, shall meet all requirements
7 under this Act applicable to purchasing cooperatives.

8 (b) TREATMENT OF EMPLOYERS AND EMPLOYEES.—
9 For purposes of this Act, each individual covered by a
10 health plan offered through a purchasing cooperative de-
11 scribed in subsection (a), and any State or local govern-
12 ment (or instrumentality thereof) employing such individ-
13 ual shall be treated as an experience-rated individual and
14 a large employer, respectively.

15 (c) SPECIAL RULES.—A purchasing cooperative to
16 which this section applies shall—

17 (1) only offer experience-rated insured plans to
18 active or retired employees of State or local govern-
19 ments (or instrumentalities thereof), and

20 (2) meet the risk adjustment requirements of
21 section 1018.

22 (d) APPLICABLE ENTITY.—For purposes of this sec-
23 tion, the term "applicable entity" means an entity which
24 is maintained to provide health benefits to State and local
25 employees and which, on August 1, 1994—

1 (1) had been in existence for at least 5 years,
2 and
3 (2) covered at least 100,000 lives.

4 **SEC. 1217. DEVELOPMENT OF PURCHASING GROUPS FOR**
5 **LARGE EMPLOYERS.**

6 (a) IN GENERAL.—Nothing in this Act shall be con-
7 strued as prohibiting 2 or more large employers from
8 forming a purchasing group with respect to the employees
9 of such employers. Each employer shall comply with the
10 requirements applicable to large employers under this title
11 with respect to its employees, including, in the case of a
12 self-insured plan, meeting any solvency, reserve, or stop-
13 loss requirement separately with respect to its employees.
14 (b) RULES BY SECRETARY.—The Secretary of Labor
15 may provide additional rules for purchasing groups, in-
16 cluding rules regarding fiduciary responsibilities and fi-
17 nancial management.
18 (c) NO USE OF PURCHASING COOPERATIVES.—Ex-
19 cept as provided in section 3(a)(3)(F)(ii)(II), a large em-
20 ployer shall be ineligible to purchase health insurance
21 through a purchasing cooperative.

1 PART 3—ACCESS THROUGH ASSOCIATION PLANS

2 Subpart A—Certified Association Plans

3 SEC. 1221. TREATMENT OF CERTIFIED ASSOCIATION
4 PLANS.

5 (a) TREATMENT AS EXPERIENCE-RATED PLAN.—
6 For purposes of this Act, in the case of a certified associa-
7 tion plan—

8 (1) except as otherwise provided in this sub-
9 part, the plan shall be required to meet all applicable
10 requirements of this Act for certified health plans
11 providing the standard benefit package under sub-
12 title B which are offered by large employers,

13 (2) if such plan is certified as meeting such re-
14 quirements, such plan shall be treated as a health
15 plan established and maintained by a large employer
16 and individuals enrolled in such plan shall be treated
17 as experience-rated individuals,

18 (3) any individual who is a member of the asso-
19 ciation not enrolling in the plan shall not be treated
20 as an experience-rated individual solely by reason of
21 membership in such association, and

22 (4) such plan shall cover at least 500 lives on
23 and after the date of enactment of this Act.

24 (b) ASSOCIATIONS OPERATING MORE THAN ONE
25 PLAN.—In the case of a qualified association which main-
26 tains more than one health plan—

1 (1) subsection (a) shall apply only to one health
2 plan elected by the qualified association, and
3 (2) all other health plans maintained by the
4 qualified association shall be required to meet all ap-
5 plicable requirements of this Act for certified health
6 plans providing the standard, basic, or catastrophic
7 benefit package under subtitle B which are offered
8 by small employers, except that the qualified associa-
9 tion may only enroll individuals who are members of
10 the qualified association, employees of such mem-
11 bers, or spouses or dependents of either.

12 **SEC. 1222. MODIFICATIONS OF STANDARDS APPLICABLE TO**
13 **CERTIFIED ASSOCIATION PLANS.**

14 (a) CERTIFYING AUTHORITY.—
15 (1) MULTISTATE CERTIFIED ASSOCIATION
16 SELF-INSURED PLANS.—For purposes of this Act,
17 the Secretary of Labor shall be the appropriate cer-
18 tifying authority with respect to a certified associa-
19 tion plan which is a multistate self-insured health
20 plan.
21 (2) SINGLE STATE CERTIFIED ASSOCIATION
22 SELF-INSURED PLANS.—For purposes of this Act,
23 the State shall be the appropriate certifying author-
24 ity with respect to a certified association plan which
25 is a single State self-insured health plan.

1 (b) CAPITAL REQUIREMENTS.—
2 (1) IN GENERAL.—The solvency requirements
3 established under paragraph (2) shall, on and after
4 the effective date of such regulations, apply to a
5 plan described in section 1221(a)(1) in lieu of the
6 requirements under section 1019.
7 (2) SOLVENCY REQUIREMENTS.—
8 (A) IN GENERAL.—Except as provided in
9 subparagraph (B), the requirements under this
10 paragraph shall be any of the following stand-
11 ards developed by the NAIC within 9 months of
12 the date of the enactment of this Act:
13 (i) Solvency standards for certified as-
14 sociation plans which ensure that benefits
15 under such plans will be provided in full
16 when due.
17 (ii) Rules for monitoring and enforc-
18 ing compliance with such standards.
19 (B) FAILURE TO ADOPT ADEQUATE
20 STANDARDS.—If—
21 (i) the NAIC does not adopt stand-
22 ards described in subparagraph (A) within
23 the required time period, or
24 (ii) the Secretary of Labor deter-
25 mines, within 30 days of adoption by the

1 NAIC, that the NAIC's standards are not
2 adequate,
3 the Secretary of Labor shall establish such
4 standards not later than 15 months after the
5 date of the enactment of this Act and such
6 standards shall constitute the requirements
7 under this paragraph.
8 (c) AVAILABILITY.—A certified association plan may
9 only include in coverage any business or individual who
10 is a member of the association establishing or maintaining
11 the plan, an employee of such member, or a spouse or de-
12 pendent of either.

13 **SEC. 1223. CERTIFIED ASSOCIATION PLAN DEFINED.**

14 (a) IN GENERAL.—The term "certified association
15 plan" means a health plan which—
16 (1) is (or is a continuation of) an existing plan,
17 and
18 (2) is established or maintained by a qualified
19 association.
20 (b) EXISTING PLAN.—For purposes of this section—
21 (1) IN GENERAL.—A health plan is an existing
22 plan if—
23 (A) on August 1, 1994, the plan was a
24 self-insured health plan which—

1 (i) had been in existence and operat-
2 ing at all times during the 18-month pe-
3 riod ending on such date as a multiple em-
4 ployer welfare arrangement,
5 (ii) had an application pending with,
6 or approved by, the State insurance com-
7 missioner for a certificate of operation as
8 a health plan, and
9 (iii) covered at least 500 lives, or
10 (B) on and after the date of enactment of
11 this Act, the plan was an experience-rated in-
12 sured health plan covering at least 500 lives.
13 (2) DISQUALIFICATION OF CERTAIN ARRANGE-
14 MENTS.—A health plan shall not be treated as meet-
15 ing the requirements of paragraph (1)(A) if a State
16 demonstrates that—
17 (A) fraudulent or material misrepresenta-
18 tions have been made by the sponsor in the ap-
19 plication,
20 (B) the arrangement that is the subject of
21 the application, on its face, fails to meet the re-
22 quirements for a complete application, or
23 (C) a financial impairment exists with re-
24 spect to the applicant that is sufficient to dem-

1 onstrate the applicant's inability to continue its
2 operations.
3 (c) QUALIFIED ASSOCIATION.—For purposes of this
4 section, the term "qualified association" means any orga-
5 nization (or wholly-owned subsidiary thereof) which—
6 (1) is organized and maintained in good faith
7 by a trade association, an industry association, a
8 professional association, a local chamber of com-
9 merce, or public entity association,
10 (2) is organized and maintained for substantial
11 purposes other than to provide a health plan and
12 whose revenues do not come from the sale of health
13 plans,
14 (3) has a constitution, bylaws, or other similar
15 governing document which specifically states its pur-
16 pose,
17 (4) receives the active support of its members,
18 (5) does not have membership policies or prac-
19 tices which screen members or prospective members
20 (or their dependents), and does not otherwise limit
21 access to any health plan maintained by it, on the
22 basis of health status or evidence (or lack of evi-
23 dence) of insurability of an individual, and
24 (6) has been in operation continuously during
25 the 3-year period ending August 1, 1994.

1 (d) COORDINATION WITH SUBPART B.—The term
2 "certified association plan" shall not include a plan to
3 which subpart B applies.
4 (e) DEFINITIONS.—For purposes of this part, the
5 term "multiple employer welfare arrangement" has the
6 meaning given such term by section 3(40) of the Employee
7 Retirement Income Security Act of 1974 (as in effect be-
8 fore the date of the enactment of the Health Reform Act).

9 **SEC. 1224. REPEAL OF ERISA PROVISIONS.**

10 (a) DEFINITION.—Paragraph (40) of section 3 of the
11 Employee Retirement Income Security Act of 1974 (29
12 U.S.C. 1002(40)) is repealed.
13 (b) PREEMPTION.—Paragraph (6) of section 514(b)
14 of such Act (29 U.S.C. 1144(b)(6)) is repealed.

15 **Subpart B—Special Rule for Church and**
16 **Multiemployer Plans**

17 **SEC. 1225. SPECIAL RULE FOR CHURCH AND MULTIEM-**
18 **PLOYER PLANS.**

19 (a) GENERAL RULE.—For purposes of this Act, in
20 the case of a health plan to which this section applies—
21 (1) except as otherwise provided in this part,
22 the plan shall be required to meet all applicable re-
23 quirements of this Act for certified health plans pro-
24 viding the standard benefit package under subtitle B
25 which are offered by large employers,

1 (2) if such plan is certified as meeting such re-
2 quirements, such plan shall be treated as a health
3 plan established and maintained by a large employer
4 and individuals enrolled in such plan shall be treated
5 as experience-rated individuals, and
6 (3) any individual eligible to enroll in the plan
7 who does not enroll in the plan shall not be treated
8 as an experience-rated individual solely by reason of
9 being eligible to enroll in the plan.
10 (b) MODIFIED STANDARDS.—
11 (1) CERTIFYING AUTHORITY.—For purposes of
12 this Act, the Secretary of Labor shall be the appro-
13 priate certifying authority with respect to a plan to
14 which this section applies.
15 (2) SOLVENCY AND AVAILABILITY.—Rules simi-
16 lar to the rules of subsections (b) and (c) of section
17 1222 shall apply to a plan to which this section ap-
18 plies.
19 (3) ACCESS.—An employer which, pursuant to
20 a collective bargaining agreement, offers an em-
21 ployee the opportunity to enroll in a plan described
22 in subsection (c)(2) shall not be required to make
23 any other plan available to the employee.
24 (c) PLANS TO WHICH SECTION APPLIES.—This sec-
25 tion shall apply to a health plan which—

1 (1) is a church plan (as defined in section
2 414(e) of the Internal Revenue Code of 1986) which
3 covers 100 or more lives in the United States, or
4 (2) is a multiemployer plan (as defined in sec-
5 tion 3(37) of the Employee Retirement Income Se-
6 curity Act of 1974) which is maintained by a health
7 plan sponsor described in section 3(16)(B)(iii) of
8 such Act but only if such plan (or a predecessor
9 plan)—
10 (A) offered health benefits as of August 1,
11 1994, and
12 (B) as of August 1, 1994—
13 (i) covered at least 500 lives in the
14 United States, or
15 (ii) was maintained by one or more af-
16 filiates of the same labor organization, or
17 one or more affiliates of labor organiza-
18 tions representing employees in the same
19 industry, covering at least 500 employees
20 in the United States.

1 # Subtitle D—State Role in Reform

2 ## PART 1—STATE MARKET REFORM

3 **SEC. 1301. ESTABLISHMENT OF STATE MARKET REFORM**
4 **PROGRAMS.**

5 (a) IN GENERAL.—Each State shall establish a State
6 market reform program that meets the requirements of
7 this title.

8 (b) SUMMARY OF PROGRAM RESPONSIBILITIES.—
9 The requirements for a market reform program under
10 subsection (a) include—

11 (1) certification of insured health plans as cer-
12 tified health plans under section 1302;

13 (2) establishment of community rating areas
14 under section 1303;

15 (4) establishment of procedures for establish-
16 ment and operation of purchasing cooperatives
17 under section 1304;

18 (5) preparation of information concerning plans
19 and purchasing cooperatives under section 1306;

20 (6) providing for a risk adjustment program for
21 community-rated health plans under section 1307;

22 (7) specification of an annual general enroll-
23 ment period and an initial enrollment period under
24 section 1308;

1 (8) designation of public access sites under sec-
2 tion 1309; and
3 (9) granting of special operating rules for net-
4 work plans under section 1310.
5 (c) DEADLINE.—Each State shall establish and have
6 in operation a State market reform program by not later
7 than January 1, 1997, to carry out this title. Such pro-
8 gram shall provide for the enrollment of individuals in cer-
9 tified health plans by not later than such date.
10 (d) PERIODIC SECRETARIAL REVIEW OF STATE PRO-
11 GRAMS.—
12 (1) IN GENERAL.—The Secretary may periodi-
13 cally review State programs established under sub-
14 section (a) to determine if such programs meet the
15 requirements of subsection (b).
16 (2) REPORTING REQUIREMENTS OF STATES.—
17 For purposes of paragraph (1), each State shall sub-
18 mit to the Secretary, at intervals established by the
19 Secretary, a report on the compliance of the State
20 with the requirements of subsection (b).
21 **SEC. 1302. CERTIFICATION OF INSURED HEALTH PLANS.**
22 (a) IN GENERAL.—Each State market reform pro-
23 gram shall provide for the certification of insured health
24 plans as certified health plans if the appropriate certifying

1 authority finds that the plan meets the applicable require-
2 ments for certification under this title.
3 (b) NETWORK PLANS.—A State market reform pro-
4 gram may grant a network plan a certification to operate
5 in a service area which is a geographic area within or con-
6 tiguous with the borders of a community rating area if
7 the network plan has demonstrated to the satisfaction of
8 the State that the plan has met the requirements of sec-
9 tion 1011(a)(4).

10 **SEC. 1303. ESTABLISHMENT OF COMMUNITY RATING**
11 **AREAS.**

12 (a) ESTABLISHMENT.—Each State program shall
13 provide, by not later than January 1, 1996, for the divi-
14 sion of the State into 1 or more community rating areas.
15 The program may revise the boundaries of such areas
16 from time to time consistent with this section.
17 (b) MULTIPLE AREAS.—With respect to a community
18 rating area—
19 (1) no metropolitan statistical area in a State
20 may be incorporated into more than 1 community
21 rating area in such State;
22 (2) the number of individuals residing within a
23 community rating area may not be less than
24 250,000 (and shall respect the existing referral pat-
25 terns within market areas); and

1 (3) no area incorporated in a community rating
2 area may be incorporated into another community
3 rating area.
4 (c) INTERSTATE AREAS.—Two or more contiguous
5 States are encouraged to provide for the establishment of
6 a common community rating area that includes adjoining
7 portions of the States if the market area extends across
8 State lines, so long as all portions of any metropolitan sta-
9 tistical area within such States are within the same com-
10 munity rating area.
11 (d) SPECIAL OR UNDERSERVED POPULATIONS.—In
12 establishing community rating areas, the State shall take
13 into consideration the needs of special or underserved pop-
14 ulations and network plans established to serve those pop-
15 ulations and other appropriate factors that would enhance
16 competition and be in the public interest.
17 (e) DISCRIMINATION.—A State may not establish
18 boundaries for community rating areas in a manner that
19 has the effect of discriminating on the basis of race, reli-
20 gion, national origin, gender socio-economic status, lan-
21 guage, age, disability, or perceived health status.

1 **SEC. 1304. PROCEDURES FOR CERTIFICATION OF PUR-**
2 **CHASING COOPERATIVES.**

3 Each State market reform program shall establish a
4 process for the certification of purchasing cooperatives
5 consistent with part 2 of subtitle C.

6 **SEC. 1305. COORDINATION AMONG PURCHASING COOPERA-**
7 **TIVES.**

8 Each State shall establish rules consistent with part
9 2 of subtitle C for the coordination among purchasing co-
10 operatives with respect to enrollment, payment of pre-
11 miums, and provision of out-of-area benefits and services.

12 **SEC. 1306. PREPARATION OF INFORMATION CONCERNING**
13 **PLANS AND PURCHASING COOPERATIVES.**

14 Each State market reform program shall prepare and
15 make available to purchasing cooperatives, employers and
16 to individuals located in the State information, in stand-
17 ardized comparative form as required under the program,
18 concerning the health plans certified by such State and
19 purchasing cooperatives operating in the State. Such in-
20 formation shall include a description of the following:

21 (1) The community rating areas in the State
22 and the certified health plans available with respect
23 to each community rating area.

24 (2) The benefit packages, rates, prices, out-
25 comes, enrollee satisfaction, and other information
26 pertaining to the quality of certified health plans.

1 (3) The existence of purchasing cooperatives
2 within each such community rating area.
3 (4) The administrative charges of the purchas-
4 ing cooperatives itemized separately from the rates
5 and prices of the plans offered through such co-
6 operatives.
7 (5) An identification of State enrollment loca-
8 tions.
9 (6) Any other information determined appro-
10 priate by the State.

11 **SEC. 1307. RISK ADJUSTMENT PROGRAM.**

12 Each State market reform program shall provide for
13 a risk adjustment program for community-rated health
14 plans that meets the standards developed by the Secretary
15 under section 1018.

16 **SEC. 1308. SPECIFICATION OF ANNUAL GENERAL AND INI-**
17 **TIAL ENROLLMENT PERIODS.**

18 (a) ANNUAL GENERAL ENROLLMENT PERIOD.—
19 Each State market reform program shall specify an an-
20 nual period, of not less than 30 days, during which an
21 eligible individual in the State may enroll in a certified
22 health plan or change the certified health plan in which
23 the individual is enrolled.
24 (b) INITIAL ENROLLMENT PERIOD.—Each State
25 market reform program shall specify an initial enrollment

1 period in 1996 of not less than 45 days, during which indi-
2 viduals in the State may enroll in certified health plans
3 for coverage beginning as of January 1, 1997.

4 **SEC. 1309. PUBLIC ACCESS SITES.**

5 The State market reform program shall—
6 (1) make available at publicly accessible loca-
7 tions within each community rating area consumer
8 information described in section 1306 concerning
9 community-rated health plans offered and purchas-
10 ing cooperatives operating in such areas; and
11 (2) provide for direct enrollment in such plans
12 at such locations.
13 Such locations shall be provided in a manner that ensures
14 ready access by community-rated individuals throughout
15 each community rating area.

16 **SEC. 1310. SPECIAL RULES REGARDING NETWORK PLANS.**

17 (a) IN GENERAL.—A participating State may grant
18 a network plan a certification to operate in a service area
19 which is a geographic area within or contiguous with the
20 borders of a community rating area if—
21 (1) the plan has not established its service area
22 in a manner that has the effect of discriminating on
23 a basis described in section 1303(e);
24 (2) the service area is not smaller than a coun-
25 ty or a 3-digit zip code area; and

1 (3) the network plan participates in a risk ad-
2 justment program established for such area.
3 (b) CERTAIN AREAS DEEMED TO MEET CONDI-
4 TIONS.—A health plan service area which has been ap-
5 proved pursuant to title XIII of the Public Health Service
6 Act shall be deemed to meet the conditions of subsection
7 (a)(2).
8 (c) DEFINITIONS RELATING TO NETWORK PLANS.—
9 For purposes of this Act—
10 (1) NETWORK PLAN DEFINED.—The term "net-
11 work plan" means a certified health plan that uti-
12 lizes a provider network.
13 (2) PROVIDER NETWORK DEFINED.—The term
14 "provider network" means, with respect to a cer-
15 tified health plan, health care providers that have
16 entered into an agreement with the plan under
17 which such providers are obligated to provide net-
18 work services to individuals enrolled in the plan, or
19 have an agreement to provide network services on a
20 fee-for-service basis.
21 (3) NETWORK SERVICES.—The term "network
22 services" means services provided to an individual
23 enrolled under a certified health plan with a stand-
24 ard, basic, or catastrophic benefits package estab-

1 lished under subtitle B by a health care provider
2 who is a member of a provider network of the plan.

3 **PART 2—STATE FLEXIBILITY**

4 **SEC. 1311. WAIVERS AND DEMONSTRATION PROJECTS.**

5 (a) WAIVER AUTHORITY.—If a State submits an ap-
6 plication to the Secretary and demonstrates to the satis-
7 faction of the Secretary that, in the case of a frontier area
8 or because of unique geographic and related features, the
9 application of one or more of the requirements of this title
10 with respect to community-rated health plans in the State
11 (or a portion thereof) would impact the provision of cov-
12 ered benefits, the Secretary may waive such requirements
13 of this title as may be necessary to fulfill the purposes
14 of this title.

15 (b) AFFECT OF DEMONSTRATION PROJECTS.—In the
16 case of any experimental or demonstration project in a
17 State that is, in the judgment of the Secretary, likely to
18 assist in promoting the purposes and objectives of this
19 title, the Secretary may waive all or a portion of the fol-
20 lowing requirements with respect to community-rated
21 health plans:

22 (1) Part 1 (relating to requirements for State
23 market reform programs).

24 (2) Subtitle A (relating to requirements for cer-
25 tified health plans).

1 **SEC. 1312. CONTINUANCE OF EXISTING FEDERAL LAW**
2 **WAIVERS.**
3 Nothing in this Act shall preempt any feature of a
4 State health care system operating under a waiver granted
5 before the date of the enactment of this Act under titles
6 XVIII or XIX of the Social Security Act (42 U.S.C. 1395
7 et seq. or 1396 et seq.) or the Employee Retirement In-
8 come Security Act of 1974 (29 U.S.C. 1001 et seq.).
9 **SEC. 1313. HAWAII PREPAID HEALTH CARE ACT.**
10 (a) ERISA WAIVER.—
11 (1) IN GENERAL.—Section 514(b)(5) of the
12 Employee Retirement Income Security Act of 1974
13 (29 U.S.C. 1144(b)(5)) is amended to read as fol-
14 lows:
15 "(5)(A) Except as provided in subparagraphs
16 (B) and (C), subsection (a) shall not apply to the
17 Hawaii Prepaid Health Care Act (Haw. Rev. Stat.
18 §§ 393-1 through 393-51).
19 "(B) Nothing in subparagraph (A) shall be con-
20 strued to exempt from subsection (a) any State tax
21 law relating to employee benefits plans.
22 "(C) If the Secretary of Labor notifies the Gov-
23 ernor of the State of Hawaii that as the result of
24 an amendment to the Hawaii Prepaid Health Care
25 Act enacted after the date of the enactment of this
26 paragraph—

1 "(i) the proportion of the population with
2 health care coverage under such Act is less than
3 such proportion on such date, or
4 "(ii) the level of benefit coverage provided
5 under such Act is less than the actuarial equiv-
6 alent of such level of coverage on such date,
7 subparagraph (A) shall not apply with respect to the
8 application of such amendment to such Act after the
9 date of such notification.".
10 (2) EFFECTIVE DATE.—The amendment made
11 by paragraph (1) shall take effect on the date of the
12 enactment of this Act.
13 (b) HRA WAIVER.—
14 (1) IN GENERAL.—The Secretary shall, at the
15 request of the Governor of the State of Hawaii and
16 in accordance with this section, grant a waiver to
17 the State from the requirements of this Act (other
18 than the requirements specified in paragraph (3)).
19 (2) SCOPE OF WAIVER.—The waiver granted
20 under paragraph (1) shall exempt—
21 (A) the State of Hawaii;
22 (B) health plans offered within the State;
23 and

1 (C) health plan participants, including em-
2 ployers, employees, residents, and health plan
3 sponsors within the State,
4 from requirements otherwise applicable to the State
5 and such plans and participants.
6 (3) REQUIRED COMPLIANCE OF OTHER RE-
7 QUIREMENTS.—The waiver shall initially be granted
8 under paragraph (1) if the State of Hawaii dem-
9 onstrates to the Secretary that the State
10 maintains—
11 (A) a standard benefits package (including
12 cost sharing) that is comparable with the re-
13 quirements of subtitle B of this title;
14 (B) a percentage of State population with
15 health care coverage that is not less than the
16 national average;
17 (C) a quality control mechanism and data
18 system that are comparable to the applicable re-
19 quirements of title V; and
20 (D) health care cost containment consist-
21 ent with the provisions of this Act.
22 (4) WAIVER PERIOD.—The waiver initially
23 granted under paragraph (1) shall extend for the pe-
24 riod during which the State of Hawaii continues to
25 comply with the requirements specified in paragraph

1 (3). The Secretary may require the State, every 5
2 years, to demonstrate to the Secretary the State's
3 continued compliance with such requirements.
4 (5) PROCEDURE IN THE EVENT OF NON-COM-
5 PLIANCE.—
6 (A) NOTICE.—If, at any time after grant-
7 ing a waiver under paragraph (1), the Secretary
8 finds that the State of Hawaii is not meeting
9 the requirements specified in paragraph (3), the
10 Secretary shall notify the State of the Sec-
11 retary's findings.
12 (B) OPPORTUNITY TO CONTEST.—The
13 State may contest the Secretary's findings
14 under procedures provided by the Secretary.
15 (C) OPPORTUNITY FOR CORRECTION.—
16 (i) FINDINGS NOT CONTESTED.—If
17 the State does not contest the Secretary's
18 findings within the 30-day period begin-
19 ning on the date of receipt of a notice of
20 such findings, the State shall have—
21 (I) a 90-day period beginning on
22 such date to show a good faith effort
23 to remedy the non-compliance, and
24 (II) an additional 12-month pe-
25 riod to take such actions as may be

1 required to bring the State into com-
2 pliance with the requirements speci-
3 fied in paragraph (3).
4 (ii) CONTESTED FINDINGS.—If the
5 State contests the Secretary's findings
6 within such 30-day period but such find-
7 ings are upheld, the State shall have—
8 (I) a 90-day period beginning on
9 the date of final adjudication to show
10 a good faith effort to remedy the non-
11 compliance, and
12 (II) an additional 12-month pe-
13 riod to take such actions as may be
14 required to bring the State into com-
15 pliance with the requirements speci-
16 fied in paragraph (3).
17 (D) TERMINATION.—If the State fails
18 to demonstrate a good faith effort under
19 subparagraph (C)(i)(I) or (C)(ii)(I) or to
20 take actions under subparagraph (C)(i)(II)
21 or (C)(ii)(II) within the time period speci-
22 fied, the Secretary may revoke the waiver
23 granted in paragraph (1).
24 (6) COOPERATIVE AGREEMENT WITH THE SEC-
25 RETARY.—The Secretary shall enter into cooperative

1 agreements with appropriate officials of the State of
2 Hawaii—
3 (A) to develop standards and reporting re-
4 quirements necessary for the issuance and
5 maintenance of the State's waiver under para-
6 graph (1); and
7 (B) otherwise to effectuate the provisions
8 of this subsection.
9 (7) ELIGIBILITY FOR FEDERAL FUNDS PRO-
10 VIDED TO PARTICIPATING STATES.—Nothing in this
11 subsection shall preclude the eligibility of the State
12 of Hawaii to participate in any public health initia-
13 tive, grant, or financial aid program under this Act
14 (including the medicaid program under title XIX of
15 the Social Security Act), or the sharing of revenue
16 resulting from the amendments made by title VI, de-
17 signed to implement the purpose of this Act. The
18 Secretary shall work with appropriate officials of the
19 State of Hawaii to develop comparable, alternative
20 standards to govern the State's entitlement under
21 subtitle A of title I.

22 **SEC. 1314. ALTERNATIVE STATE PROVIDER PAYMENT SYS-**
23 **TEMS.**

24 Notwithstanding any other provision of law, if a hos-
25 pital reimbursement system operated by a State meets the

1 requirements of section 1814(b) of the Social Security Act
2 (42 U.S.C. 1395f(b)) and has been approved by the Sec-
3 retary and in continuous operation since July 1, 1977, the
4 payment rates and methodologies required under the sys-
5 tem for services provided in the State shall apply to all
6 purchasers and payers, including those under employee
7 welfare benefit plans authorized under the Employee Re-
8 tirement Income Security Act of 1974 (29 U.S.C. 1001
9 et seq.), workers' compensation programs under State law,
10 the Federal Employees' Compensation Act under chapter
11 81 of title 5, United States Code, and Federal employee
12 health benefit plans under chapter 89 of title 5, United
13 States Code.

14 **SEC. 1315. ALTERNATIVE STATE UNCOMPENSATED CARE**
15 **POOL.**

16 (a) IN GENERAL.—No State shall be prevented by
17 any provision of the Employee Retirement Income Secu-
18 rity Act of 1974 (29 U.S.C. 1001 et seq.) from enforcing
19 a State system in operation during the period beginning
20 January 1, 1992, and ending March 31, 1994, which
21 funded uncompensated and under-compensated hospital
22 care through an assessment or tax on hospitals or hospital
23 charges.

24 (b) APPLICABILITY.—Subsection (a) shall not apply
25 with respect to any final judgment or order by a Federal

1 district court entered before August 1994 or any appeal
2 of such judgment or order.

3 PART 3—REQUIREMENTS FOR STATE SINGLE-
4 PAYER SYSTEMS

5 SEC. 1321. SINGLE-PAYER SYSTEM DESCRIBED.

6 The Secretary may approve an application of a State
7 to operate a single-payer system if the Secretary finds that
8 the system meets the requirements of section 1322 and
9 1323.

10 SEC. 1322. GENERAL REQUIREMENTS FOR SINGLE-PAYER
11 SYSTEMS.

12 Each single-payer system shall meet the following re-
13 quirements:

14 (1) ESTABLISHMENT BY STATE.—The system is
15 established under State law, and State law provides
16 for mechanisms to enforce the requirements of the
17 system.

18 (2) OPERATION BY STATE.—The system is op-
19 erated by the State or a designated agency of the
20 State.

21 (3) ENROLLMENT OF INDIVIDUALS.—

22 (A) MANDATORY ENROLLMENT OF ALL
23 COMMUNITY-RATED INDIVIDUALS.—The system
24 shall provide for the enrollment of all commu-

1 nity-rated individuals residing in the State who
2 are not medicare-eligible individuals.
3 (B) OPTIONAL ENROLLMENT OF EXPERI-
4 ENCE-RATED INDIVIDUALS.—
5 (i) IN GENERAL.—Except as provided
6 in clause (ii), at the option of the State, a
7 single-payer system may provide for the
8 enrollment of experience-rated individuals
9 residing in the State.
10 (ii) PARTICIPATION BY CERTAIN
11 MULTISTATE PLANS.—The system shall
12 not require participation by any experi-
13 ence-rated individual who is enrolled in a
14 certified self-insured health plan which is a
15 multiemployer plan (as defined in section
16 3(37) of Employee Retirement Income Se-
17 curity Act of 1974), or which is sponsored
18 by an large employer sponsor with at least
19 1,000 full-time employees.
20 (C) OPTIONS INCLUDED IN STATE PRO-
21 GRAM REPORT.—A State may not exercise any
22 of the options described in subparagraphs (B)
23 or (C) for a year unless the State included a de-
24 scription of the option in the submission of its

1 program report to the Secretary for the year
2 under section 1301(d)(2).
3 (D) EXCLUSION OF CERTAIN INDIVID-
4 UALS.—A single-payer system may not require
5 the enrollment of veterans, active duty military
6 personnel, and American Indians.
7 (4) DIRECT PAYMENT TO PROVIDERS.—
8 (A) IN GENERAL.—With respect to provid-
9 ers who furnish items and services included in
10 the standard benefits package established under
11 subtitle B to individuals enrolled in the system,
12 the State shall make payments directly, or
13 through fiscal intermediaries, to such providers
14 and assume (subject to subparagraph (B)) all
15 financial risk associated with making such pay-
16 ments.
17 (B) CAPITATED PAYMENTS PERMITTED.—
18 Nothing in subparagraph (A) shall be construed
19 to prohibit providers furnishing items and serv-
20 ices under the system from receiving payments
21 on a capitated, at-risk basis based on prospec-
22 tively determined rates.
23 (5) PROVISION OF STANDARD BENEFITS PACK-
24 AGE.—

1 (A) IN GENERAL.—The system shall pro-
2 vide for coverage of the standard benefits pack-
3 age established under subtitle B, including the
4 cost-sharing provided under the package (sub-
5 ject to subparagraph (B)), to all individuals en-
6 rolled in the system.
7 (B) IMPOSITION OF REDUCED COST-SHAR-
8 ING.—The system may decrease the cost-shar-
9 ing otherwise provided in the standard benefits
10 package established under subtitle B with re-
11 spect to any individuals enrolled in the system
12 or any class of services included in the package,
13 so long as the system does not increase the
14 cost-sharing otherwise imposed with respect to
15 any other individuals or services.
16 (6) COST CONTAINMENT.—The system shall
17 provide for mechanisms to ensure, in a manner sat-
18 isfactory to the Secretary, that—
19 (A) the rate of growth in health care
20 spending will not be higher than the National
21 rate of growth;
22 (B) the expenditures described in subpara-
23 graph (A) are computed and effectively mon-
24 itored; and

1 (C) Federal payments to a single payer
2 State shall be limited to the payments that
3 would have been made in the absence of the im-
4 plementation of the single payer system.
5 (7) FEDERAL PAYMENTS.—The system shall
6 provide for mechanisms to ensure, in a manner sat-
7 isfactory to the Secretary, that Federal payments to
8 a single-payer State shall be limited to the payments
9 that would have been made in the absence of the im-
10 plementation of the single-payer system.
11 (8) REQUIREMENTS GENERALLY APPLICABLE
12 TO STANDARD HEALTH PLANS.—The system shall
13 meet the requirements applicable to a standard
14 health plan, except that—
15 (A) the system does not have the authority
16 provided to standard health plans under section
17 1011(a)(3) (relating to permissible limitations
18 on the enrollment of community-rated eligible
19 individuals on the basis of limits on the plan's
20 capacity); and
21 (B) the system is not required to meet the
22 requirements of sections 1013 (relating to rat-
23 ing limitations for community-rated market)
24 and 1019 (relating to plan solvency).

1 **SEC. 1323. ADDITIONAL RULES FOR SINGLE-PAYER SYSTEM.**

2 (a) IN GENERAL.—In the case of a State operating
3 a single-payer system—
4 (1) the State shall operate the system through-
5 out the State;
6 (2) except as provided in subsection (b), the
7 State shall meet the requirements for participating
8 States under part 1; and
9 (3) the State shall not use any funds collected
10 pursuant to section 1321 and 1322 or any earning
11 for any reason other than to pay health care claims
12 or provide health care benefits.
13 (b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR
14 PARTICIPATING STATES.—In the case of a State operating
15 a single-payer system, the State is not required to meet
16 the following requirements otherwise applicable to partici-
17 pating States under part 1:
18 (1) ESTABLISHMENT OF COMMUNITY RATING
19 AREAS.—The requirement of sections 1303 (relating
20 to the establishment of community rating areas).
21 (2) OTHER REFERENCES INAPPLICABLE.—Any
22 requirement which the Secretary determines is not
23 appropriate to apply to a State single-payer system.
24 (c) SINGLE-PAYER STATE DEFINED.—In this title,
25 the term "single-payer State" means a State with a single-

1 payer system in effect that has been approved by the Sec-

2 retary in accordance with this part.

1 # Subtitle E—Federal Role in Reform

2 **PART 1—ESTABLISHMENT OF FEDERAL STAND-**
3 **ARDS FOR CERTIFIED INSURED HEALTH**
4 **PLANS**

5 **SEC. 1400. ESTABLISHMENT.**

6 The Secretary, in consultation with the NAIC and
7 other qualified experts, shall develop and publish the
8 standards specified in part 2 of subtitle B by not later
9 than January 1, 1996.

10 **PART 2—CERTIFICATION OF SELF-INSURED**
11 **HEALTH PLANS**

12 **SEC. 1401. ESTABLISHMENT AND CERTIFICATION OF**
13 **STANDARDS APPLICABLE TO SELF-INSURED**
14 **CERTIFIED HEALTH PLANS.**

15 (a) ESTABLISHMENT OF STANDARDS BY SECRETARY
16 OF LABOR.—The Secretary of Labor, in consultation with
17 the Secretary, shall develop and publish standards applica-
18 ble to certified self-insured health plans relating to the re-
19 quirements specified in part 3 of subtitle A. The Secretary
20 shall develop and publish such standards by not later than
21 January 1, 1996. Such standards shall be the health plan
22 standards applicable under this Act and shall apply to all
23 certified self-insured health plans.

24 (b) CERTIFICATION OF HEALTH PLANS.—In the case
25 of self-insured health plans, the Secretary of Labor shall

1 provide for the certification of self-insured health plans as
2 certified health plans.
3 (c) FINANCIAL STANDARDS.—The Secretary of
4 Labor shall develop, by not later than January 1, 1996,
5 standards for the solvency, reserve, and stop-loss require-
6 ments for certified self-insured health plans under sections
7 1019 and 1404 and for certified association plans under
8 section 1222.

9 **SEC. 1402. CORRECTIVE ACTIONS FOR SELF-INSURED**
10 **HEALTH PLANS.**

11 (a) IN GENERAL.—The plan sponsor of each self-in-
12 sured health plan shall determine annually whether the re-
13 quirements of this Act are met. In any case in which the
14 plan sponsor determines that there is reason to believe
15 there is or will be a failure to meet such requirements,
16 or the Secretary of Labor makes such a determination and
17 so notifies the plan sponsor, the plan sponsor shall, within
18 90 days after making such determination or receiving such
19 notification, notify such Secretary (in such form and man-
20 ner as such Secretary may prescribe by regulation) of a
21 description of the corrective actions (if any) that the plan
22 sponsor has taken or plans to take in response to such
23 recommendations. The plan sponsor shall thereafter report
24 to such Secretary, in such form and frequency as such
25 Secretary may specify to the plan sponsor, regarding cor-

1 rective action taken by the plan sponsor until such require-
2 ments are met. Such Secretary may make a determination
3 that a self-insured health plan has ceased to be a certified
4 self-insured health plan only if such Secretary is satisfied
5 that the necessary corrective action cannot reasonably be
6 expected to occur on a timely basis necessary to avoid fail-
7 ure to provide benefits for which the plan is obligated.
8 (b) DISQUALIFIED OR TERMINATION OF PLAN.—
9 (1) IN GENERAL.—In any case in which the
10 plan sponsor of a self-insured health plan determines
11 that there is reason to believe that the plan will
12 cease to be a certified self-insured health plan or will
13 terminate, the plan sponsor shall so inform the Sec-
14 retary of Labor, shall develop a plan for winding up
15 the affairs of the plan in connection with such dis-
16 qualification or termination in a manner which will
17 result in timely payment of all benefits for which the
18 plan is obligated, and shall submit such plan in writ-
19 ing to such Secretary. Actions required under this
20 subparagraph shall be taken in such form and man-
21 ner as may be prescribed in regulations jointly pre-
22 scribed by such Secretary.
23 (2) ACTIONS REQUIRED IN CONNECTION WITH
24 DISQUALIFICATION OR TERMINATION.—
25 (A) IN GENERAL.—In any case in which—

1 (i) the Secretary of Labor has been
2 notified under paragraph (1) of a failure of
3 a self-insured health plan to meet the re-
4 quirements of this Act and has not been
5 notified by the plan sponsor that corrective
6 action has restored compliance with such
7 requirements, and
8 (ii) such Secretary determines that
9 the continuing failure to meet such re-
10 quirements can be reasonably expected to
11 result in a continuing failure to pay bene-
12 fits for which the plan is obligated,
13 the plan sponsor and the large employer shall
14 comply with the requirements of subparagraph
15 (B) or (C), as applicable.
16 (B) ACTIONS BY PLAN SPONSOR.—Upon a
17 determination by the Secretary of Labor under
18 subparagraph (A)(ii), the plan sponsor shall, at
19 the direction of such Secretary, terminate the
20 plan and, in the course of the termination, take
21 such actions as such Secretary may require as
22 necessary to ensure that the affairs of the plan
23 will be, to the maximum extent possible, wound
24 up in a manner which will result in timely pay-

1 ment of all benefits for which the plan is obli-
2 gated.
3 (C) ACTIONS BY LARGE EMPLOYER.—
4 Upon a determination by the Secretary of
5 Labor under subparagraph (A)(ii), the large
6 employer shall provide for such contingency cov-
7 erage for all employees of the employer in ac-
8 cordance with regulations which shall be pre-
9 scribed in joint regulations of such Secretary.
10 Such regulations may provide for temporary
11 coverage of such employees under a plan pro-
12 vided by a purchasing cooperative in the appro-
13 priate area, a plan provided under chapter 89
14 of title 5, United States Code, or other appro-
15 priate means established in such regulations.

16 **SEC. 1403. ERISA APPLICABILITY TO SELF-INSURED**
17 **HEALTH PLANS.**

18 (a) REPORTING AND DISCLOSURE REQUIREMENTS
19 APPLICABLE TO SELF-INSURED GROUP HEALTH
20 PLANS.—
21 (1) IN GENERAL.—Part 1 of subtitle B of title
22 I of the Employee Retirement Income Security Act
23 of 1974 is amended—
24 (A) in the heading for section 110, by add-
25 ing "BY PENSION PLANS" at the end;

1 (B) by redesignating section 111 as section
2 112; and
3 (C) by inserting after section 110 the fol-
4 lowing new section:
5 "SPECIAL RULES FOR GROUP HEALTH PLANS
6 "SEC. 111. (a) IN GENERAL.—The Secretary may by
7 regulation provide special rules for the application of this
8 part to group health plans which are consistent with the
9 purposes of this title and the Health Reform Act and
10 which take into account the special needs of participants,
11 beneficiaries, and health care providers under such plans.
12 "(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—
13 Such special rules may include rules providing for—
14 "(1) reductions in the periods of time referred
15 to in this part,
16 "(2) increases in the frequency of reports and
17 disclosures required under this part, and
18 "(3) such other changes in the provisions of
19 this part as may result in more expeditious reporting
20 and disclosure of plan terms and changes in such
21 terms to the Secretary and to plan participants and
22 beneficiaries,
23 to the extent that the Secretary determines that the rules
24 described in this subsection are necessary to ensure timely
25 reporting and disclosure of information consistent with the

1 purposes of this part and the Health Reform Act as they
2 relate to group health plans.
3 "(c) ADDITIONAL REQUIREMENTS.—Such special
4 rules may include rules providing for reporting and disclo-
5 sure to the Secretary and to participants and beneficiaries
6 of additional information or at additional times with re-
7 spect to group health plans to which this part applies
8 under section 4(c)(2), if such reporting and disclosure
9 would be comparable to and consistent with similar re-
10 quirements applicable under the Health Reform Act with
11 respect to community-rated health plans and applicable
12 regulations of the Secretary of Health and Human Serv-
13 ices prescribed thereunder.".
14 (2) CLERICAL AMENDMENT.—The table of con-
15 tents in section 1 of such Act is amended by striking
16 the items relating to sections 110 and 111 and in-
17 serting the following new items:

"Sec. 110. Alternative methods of compliance by pension plans.
"Sec. 111. Special rules for group health plans.
"Sec. 112. Repeal and effective date.".

18 (b) APPLICABILITY OF ERISA ENFORCEMENT
19 MECHANISMS FOR ENFORCEMENT OF CERTAIN REQUIRE-
20 MENTS.—The provisions of sections 502 (relating to civil
21 enforcement) and 504 (relating to investigative authority)
22 of the Employee Retirement Income Security Act of 1974
23 shall apply to enforcement by the Secretary of Labor of

1 this part in the same manner and to same extent as such
2 provisions apply to enforcement of title I of such Act.
3 (c) APPLICABILITY OF CERTAIN ERISA PROTEC-
4 TIONS TO ENROLLED INDIVIDUALS.—The provisions of
5 sections 510 (relating to interference with rights protected
6 under Act) and 511 (relating to coercive interference) of
7 the Employee Retirement Income Security Act of 1974
8 shall apply, in relation to the provisions of this Act, with
9 respect to individuals enrolled under self-insured health
10 plans in the same manner and to the same extent as such
11 provisions apply, in relation to the provisions of the Em-
12 ployee Retirement Income Security Act of 1974, with re-
13 spect to participants and beneficiaries under employee wel-
14 fare benefit plans covered by title I of such Act.

15 **SEC. 1404. DISCLOSURE AND RESERVE REQUIREMENTS**
16 **FOR SELF-INSURED HEALTH PLANS.**

17 (a) IN GENERAL.—The Secretary of Labor shall en-
18 sure that each self-insured health plan maintains plan as-
19 sets in trust as provided in section 403 of the Employee
20 Retirement Income Security Act of 1974—
21 (1) without any exemption under section
22 403(b)(4) of such Act, and
23 (2) in amounts which the Secretary determines
24 are sufficient to provide at any time for payment to

1 health care providers of all outstanding balances
2 owed by the plan at such time.
3 The requirements of the preceding sentence may be met
4 through letters of credit, bonds, or other appropriate secu-
5 rity to the extent provided in regulations of the Secretary.
6 (b) DISCLOSURE.—Each self-insured health plan
7 shall notify the Secretary at such time as the financial
8 reserve requirements of this section are not being met.
9 The Secretary may assess a civil money penalty of not
10 more than $10,000 against any health plan sponsor for
11 any failure to provide such notification in such form and
12 manner and within such time periods as the Secretary may
13 prescribe by regulation.

14 **SEC. 1405. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
15 **VENT SELF-INSURED HEALTH PLANS.**

16 (a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
17 INSOLVENT PLANS.—Whenever the Secretary of Labor
18 determines that a self-insured health plan will be unable
19 to provide benefits when due or is otherwise in a finan-
20 cially hazardous condition as defined in regulations of the
21 Secretary, the Secretary shall, upon notice to the plan,
22 apply to the appropriate United States district court for
23 appointment of the Secretary as trustee to administer the
24 plan for the duration of the insolvency. The plan may ap-
25 pear as a party and other interested persons may inter-

1 vene in the proceedings at the discretion of the court. The
2 court shall appoint the Secretary trustee if the court deter-
3 mines that the trusteeship is necessary to protect the in-
4 terests of the enrolled individuals or health care providers
5 or to avoid any unreasonable deterioration of the financial
6 condition of the plan. The trusteeship of the Secretary
7 shall continue until the conditions described in the first
8 sentence of this subsection are remedied or the plan is ter-
9 minated.

10 (b) DUTIES OF TRUSTEE.—The trustee may do any
11 act authorized by the plan, this Act, or other applicable
12 provisions of law to be done by the plan administrator or
13 any trustee of the plan.

14 (c) NOTICE OF APPOINTMENT.—As soon as prac-
15 ticable after the Secretary's appointment as trustee, the
16 Secretary shall give notice of such appointment to—

17 (1) the plan administrator,

18 (2) each enrolled individual,

19 (3) each employer who may be liable for con-
20 tributions to the plan, and

21 (4) each employee organization which, for pur-
22 poses of collective bargaining, represents enrolled in-
23 dividuals.

24 (d) ADDITIONAL DUTIES.—Except to the extent in-
25 consistent with the provisions of this Act or part 4 of sub-

1 title B of title I of the Employee Retirement Income Secu-
2 rity Act of 1974, or as may be otherwise ordered by the
3 court, the Secretary of Labor, upon appointment as trust-
4 ee under this section, shall be subject to the same duties
5 as those of a trustee under section 704 of title 11, United
6 States Code, and shall have the duties of a fiduciary for
7 purposes of such part 4.

8 **PART 3—NATIONAL HEALTH BENEFITS AND**
9 **COVERAGE COMMISSION**

10 **SEC. 1411. CREATION OF NATIONAL HEALTH BENEFITS AND**
11 **COVERAGE COMMISSION; MEMBERSHIP.**

12 (a) IN GENERAL.—There is hereby established in the
13 Department of Health and Human Services a National
14 Health Benefits and Coverage Commission (referred to in
15 this part as the "Commission").

16 (b) COMPOSITION.—The Commission is composed of
17 7 members appointed by the President, by and with the
18 advice and consent of the Senate. No more than 4 mem-
19 bers of the Commission may be affiliated with the same
20 political party. Members shall be appointed not later than
21 90 days after the date of the enactment of this title.

22 (c) CHAIR.—The President shall designate one of the
23 members of the Commission as chair.

24 (d) TERMS.—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (2), the term of each member of the Commis-
3 sion is 6 years and begins when the term of the
4 predecessor of that member ends.
5 (2) INITIAL TERMS.—The initial terms of the
6 members of the Commission first taking office after
7 the date of the enactment of this title, shall expire
8 as designated by the President, two at the end of
9 two years, two at the end of four years, and three
10 at the end of six years.
11 (3) CONTINUATION IN OFFICE.—Upon the expi-
12 ration of a term of office, a member shall continue
13 to serve until a successor is appointed and qualified.
14 (e) VACANCIES.—
15 (1) IN GENERAL.—If a vacancy occurs, other
16 than by expiration of term, a successor shall be ap-
17 pointed by the President, by and with the consent of
18 the Senate, to fill such vacancy. The appointment
19 shall be for the remainder of the term of the prede-
20 cessor.
21 (2) NO IMPAIRMENT OF FUNCTION.—A vacancy
22 in the membership of the Commission does not im-
23 pair the authority of the remaining members to exer-
24 cise all of the powers of the Commission.

1 (3) ACTING CHAIR.—The Commission may des-
2 ignate a member to act as chair during any period
3 in which there is no chair designated by the Presi-
4 dent.
5 (f) MEETINGS; QUORUM.—
6 (1) MEETINGS.—The chair shall preside at
7 meetings of the Commission, and in the absence of
8 the chair, the Commission shall elect a member to
9 act as chair pro tempore.
10 (2) FREQUENCY.—The Commission shall meet
11 not less frequently than 4 times each year.
12 (3) QUORUM.—Four members of the Commis-
13 sion shall constitute a quorum thereof.
14 **SEC. 1412. QUALIFICATIONS OF COMMISSION MEMBERS.**
15 (a) CITIZENSHIP.—Each member of the Commission
16 shall be a citizen of the United States.
17 (b) BASIS OF SELECTION.—Commission members
18 shall be selected on the basis of their experience and exper-
19 tise in relevant subjects, including the practice of medi-
20 cine, nursing, or other clinical practices, health care fi-
21 nancing and delivery, health insurance, State health sys-
22 tems, consumer protection, business, law, and delivery of
23 care to vulnerable populations.
24 (c) PAY AND TRAVEL EXPENSES.—
25 (1) PAY.—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (2), the term of each member of the Commis-
3 sion is 6 years and begins when the term of the
4 predecessor of that member ends.
5 (2) INITIAL TERMS.—The initial terms of the
6 members of the Commission first taking office after
7 the date of the enactment of this title, shall expire
8 as designated by the President, two at the end of
9 two years, two at the end of four years, and three
10 at the end of six years.
11 (3) CONTINUATION IN OFFICE.—Upon the expi-
12 ration of a term of office, a member shall continue
13 to serve until a successor is appointed and qualified.
14 (e) VACANCIES.—
15 (1) IN GENERAL.—If a vacancy occurs, other
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20 cessor.
21 (2) NO IMPAIRMENT OF FUNCTION.—A vacancy
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21 nancing and delivery, health insurance, State health sys-
22 tems, consumer protection, business, law, and delivery of
23 care to vulnerable populations.
24 (c) PAY AND TRAVEL EXPENSES.—
25 (1) PAY.—

1 (A) CHAIR.—The chair of the Commission
2 shall be paid at a rate equal to the daily equiva-
3 lent of the minimum annual rate of basic pay
4 payable for level II of the Executive Schedule
5 under section 5315 of title 5, United States
6 Code, for each day (including travel time) dur-
7 ing which the chair is engaged in the actual
8 performance of duties vested in the Commis-
9 sion.
10 (B) MEMBERS.—Each member of the
11 Commission shall be paid at a rate equal to the
12 daily equivalent of the minimum annual rate of
13 basic pay payable for level III of the Executive
14 Schedule under section 5315 of title 5, United
15 States Code, for each day (including travel
16 time) during which the member is engaged in
17 the actual performance of duties vested in the
18 Commission.
19 (2) TRAVEL EXPENSES.—Members of the Com-
20 mission shall receive travel expenses, including per
21 diem in lieu of subsistence, in accordance with sec-
22 tions 5702 and 5703 of title 5, United States Code.
23 **SEC. 1413. POWERS.**
24 (a) EXECUTIVE DIRECTOR; STAFF.—
25 (1) EXECUTIVE DIRECTOR.—

1 (A) IN GENERAL.—The Commission shall,
2 without regard to section 5311(b) of title 5,
3 United States Code, appoint an Executive Di-
4 rector.
5 (B) PAY.—The Executive Director shall be
6 paid at a rate equivalent to a rate for the Sen-
7 ior Executive Service.
8 (2) STAFF.—
9 (A) IN GENERAL.—Subject to subpara-
10 graphs (B) and (C), the Executive Director,
11 with the approval of the Commission, may ap-
12 point and fix the pay of additional personnel.
13 (B) PAY.—The Executive Director may
14 make such appointments without regard to the
15 provisions of title 5, United States Code, gov-
16 erning appointments in the competitive service,
17 and any personnel so appointed may be paid
18 without regard to the provisions of chapter 51
19 and subchapter III of chapter 53 of such title,
20 relating to classification and General Schedule
21 pay rates, except that an individual so ap-
22 pointed may not receive pay in excess of 120
23 percent of the annual rate of basic pay payable
24 for GS–15 of the General Schedule.

1 (C) DETAILED PERSONNEL.—Upon re-
2 quest of the Executive Director, the head of any
3 Federal department or agency may detail any
4 of the personnel of that department or agency
5 to the Commission to assist the Commission in
6 carrying out its duties under this Act.
7 (b) CONTRACT AUTHORITY.—To the extent provided
8 in advance in appropriations Acts, the Commission may
9 contract with any person (including an agency of the Fed-
10 eral Government) for studies and analysis as required to
11 execute its functions. Any employee of the Executive
12 Branch may be detailed to the Commission to assist the
13 Commission in carrying out its duties.
14 (c) CONSULTATIONS WITH EXPERTS.—The Commis-
15 sion may consult with any outside expert individuals or
16 groups that the Commission determines appropriate in
17 performing its duties under subtitle B of this title or sub-
18 title C of title II. The Commission may establish advisory
19 committees.
20 (d) ACCESS TO INFORMATION.—The Commission
21 may secure directly from any department or agency of the
22 United States information necessary to enable it to carry
23 out its functions, to the extent such information is other-
24 wise available to a department or agency of the United
25 States. Upon request of the chair, the head of that depart-

1 ment or agency shall furnish that information to the Com-
2 mission.
3 (e) DELEGATION OF AUTHORITY.—Except as other-
4 wise provided, the Commission may delegate any function
5 to such officers and employees as the Commission may
6 designate and may authorize such successive redelegations
7 of such functions with the Commission as the Commission
8 deems to be necessary or appropriate. No delegation of
9 functions by the Commission shall relieve the Commission
10 of responsibility for the administration of such functions.
11 (f) RULEMAKING.—The Commission is authorized to
12 establish such rules as may be necessary to carry out this
13 subtitle.
14 **SEC. 1414. FUNDING.**
15 (a) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to the Commission
17 $5,000,000 for each year and such additional sums as may
18 be necessary to carry out the purposes of this part.
19 (b) SUBMISSION OF BUDGET.—Under the procedures
20 of chapter 11 of title 31, United States Code, the budget
21 for the Commission for a fiscal year shall be reviewed by
22 the Director of the Office of Management and Budget and
23 submitted to the Congress as part of the President's sub-
24 mission of the Budget of the United States for the fiscal
25 year.

PART 4—OTHER RESPONSIBILITIES

SEC. 1421. FEDERAL ROLE IN THE CASE OF A DEFAULT BY A STATE.

If a State fails to establish a State program under subtitle D or, having established such a program, the program fails to continue to meet the requirements of such subtitle, the Secretary shall, after notice and opportunity for correction, terminate such program, impose intermediate sanctions, order corrective actions, and shall carry out activities under subtitle D in the same manner as a State program would carry out activities under such subtitle.

SEC. 1422. ESTABLISHMENT OF RESIDENCY RULES.

The Secretary shall establish rules relating to identifying the State (and the community rating area) in which individuals reside. Such rules shall be based on the principal residence of such an individual.

SEC. 1423. RULES DETERMINING SEPARATE EMPLOYER STATUS.

Under rules of the Secretary, employers that are related (as defined under such rules) shall be treated under this Act as a single employer if a reason for their separation relates to the health risk characteristics of eligible employees of such employers.

SEC. 1424. WORKPLACE WELLNESS PROGRAM.

(a) IN GENERAL.—The Secretary shall develop certification criteria for workplace wellness programs.

1 (b) APPLICATION OF SECTION.—Any health plan may
2 offer a uniform premium discount, not to exceed 10 per-
3 cent, to employers maintaining certified workplace
4 wellness programs.

TITLE II—INCENTIVES TO PROMOTE AFFORDABLE UNIVERSAL COVERAGE

Subtitle A—Tax Incentives To Encourage Health Insurance Coverage

SEC. 2000. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 2001. DEDUCTION FOR INDIVIDUALS AND SELF-EMPLOYED INDIVIDUALS PROVIDING OWN STANDARD HEALTH INSURANCE.

(a) GENERAL RULE.—Section 213 (relating to medical, dental, etc. expenses) is amended by adding at the end the following new subsection:

"(f) CERTIFIED HEALTH INSURANCE COSTS OF INDIVIDUALS.—

"(1) IN GENERAL.—The adjusted gross income limitation under subsection (a) shall not apply to certified health insurance costs paid by an individual during the taxable year (and such costs shall not be

1 taken into account in determining whether such limi-
2 tation applies to other amounts).
3 "(2) CERTIFIED HEALTH INSURANCE COSTS.—
4 For purposes of this subsection—
5 "(A) IN GENERAL.—The term 'certified
6 health insurance costs' means amounts paid for
7 insurance described in subsection (d)(1)(D)(i)
8 for coverage of the taxpayer, the taxpayer's
9 spouse, or any dependent (as defined in section
10 152) of the taxpayer under a certified health
11 plan.
12 "(B) EXCESS PREMIUMS DISREGARDED.—
13 "(i) IN GENERAL.—Certified health
14 insurance costs shall not include any ex-
15 cess premiums.
16 "(ii) EXCESS PREMIUMS.—For pur-
17 poses of clause (i), the term 'excess pre-
18 miums' means, with respect to any month
19 during the taxable year, the excess (if any)
20 of—
21 "(I) the certified health insur-
22 ance costs of the taxpayer for such
23 month (determined without regard to
24 this subparagraph), over

1 "(II) one-twelfth of the applicable
2 percentage of the reference premium
3 for such month (for the community
4 rating area in which the taxpayer en-
5 rolls) for the same class of enrollment
6 of the taxpayer.
7 "(iii) APPLICABLE PERCENTAGE.—
8 For purposes of clause (ii)(II), the term
9 'applicable percentage' means the percent-
10 age which the taxpayer's portion of the
11 premium for coverage under a certified
12 health plan is of the total premium for
13 such coverage.
14 "(iv) REFERENCE PREMIUM.—For
15 purposes of this subparagraph, the term
16 'reference premium' has the meaning given
17 such term by section 294(b).
18 "(C) OTHER LIMITATIONS.—For purposes
19 of subparagraph (A)—
20 "(i) NO DEDUCTION FOR EMPLOYER-
21 SUBSIDIZED HEALTH COSTS.—Certified
22 health insurance costs shall not include
23 any amount paid for insurance coverage of
24 an individual for any month if the individ-
25 ual is eligible to participate for such month

1 in an employer-subsidized health plan
2 maintained by any employer of the tax-
3 payer, the taxpayer's spouse, or any de-
4 pendent.
5 "(ii) CERTAIN PREPAYMENTS.—If any
6 amount paid during a taxable year is allo-
7 cable to coverage to be provided more than
8 12 months after the month of the pay-
9 ment, such amount shall be treated as paid
10 ratably over the period of the coverage.
11 "(iii) PHASE-IN.—In the case of tax-
12 able years beginning after 1995 and before
13 2000, only the following percentages of the
14 qualified health insurance costs shall be
15 taken into account:

"If the taxable year begins in:	**The applicable percentage is:**
1996 or 1997	50 percent
1998 or 1999	75 percent.

16 "(3) DEDUCTION NOT ALLOWED FOR SELF-EM-
17 PLOYMENT TAX PURPOSES.—The deduction allow-
18 able by reason of this subsection shall not be taken
19 into account in determining an individual's net earn-
20 ings from self-employment (within the meaning of
21 section 1402(a)) for purposes of chapter 2.
22 "(4) CERTIFIED HEALTH PLAN.—For purposes
23 of this subsection, the term 'certified health plan'

1 has the meaning given such term by section 3 of the
2 Health Reform Act."
3 (b) DEDUCTION ALLOWED AGAINST GROSS IN-
4 COME.—Section 62(a) (defining adjusted gross income) is
5 amended by inserting after paragraph (15) the following
6 new paragraph:
7 "(16) DEDUCTION FOR HEALTH INSURANCE
8 PREMIUMS.—The deduction allowed under section
9 213(a) for amounts described in section 213(f)."
10 (c) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to taxable years beginning after
12 December 31, 1995.

13 **SEC. 2002. 2-YEAR EXTENSION OF DEDUCTION FOR HEALTH**
14 **INSURANCE COSTS OF SELF-EMPLOYED INDI-**
15 **VIDUALS.**

16 (a) IN GENERAL.—Paragraph (6) of section 162(l)
17 (relating to special rules for health insurance costs of self-
18 employed individuals) is amended by striking "1993" and
19 inserting "1995".
20 (b) EFFECTIVE DATE.—The amendment made by
21 paragraph (1) shall apply to taxable years beginning after
22 December 31, 1993.

Subtitle B—Individual Premium and Cost-Sharing Assistance

SEC. 2101. REQUIREMENT TO OPERATE STATE PROGRAM.

(a) IN GENERAL.—A participating State shall have in effect a program for furnishing premium assistance and cost-sharing assistance in accordance with this subtitle for calendar years beginning after 1996.

(b) DESIGNATION OF STATE AGENCY.—A State may designate any appropriate State agency to administer the program under this subtitle.

SEC. 2102. ASSISTANCE WITH CERTIFIED STANDARD HEALTH PLAN PREMIUMS.

(a) ELIGIBILITY.—

(1) IN GENERAL.—An eligible individual (as defined in section 2109(4)) who has been determined by a State under section 2104 to be a premium subsidy eligible individual (as defined in paragraph (2)) shall be eligible for premium assistance in the amount determined under subsection (b).

(2) PREMIUM SUBSIDY ELIGIBLE INDIVIDUAL.—For purposes of this subtitle, the term "premium subsidy eligible individual" means any of the following individuals:

(A) INDIVIDUALS WITH INCOMES BELOW CERTAIN INCOME THRESHOLDS.—

1 (i) IN GENERAL.—An eligible individ-
2 ual who has a family income determined
3 under section 2109(3) which does not ex-
4 ceed the eligibility percentage specified
5 under clause (ii) of the poverty line (as de-
6 fined in section 2109(5)).
7 (ii) ELIGIBILITY PERCENTAGE.—The
8 eligibility percentage specified under this
9 clause shall be determined under the fol-
10 lowing table:

Calendar year:	Applicable eligibility percentage:
1997	90
1998	110
1999	125
2000	140
2001	155
2002	170
2003	185
2004	200

11 (B) CHILDREN AND PREGNANT WOMEN.—
12 (i) IN GENERAL.—An eligible individ-
13 ual who is a child (as defined in section
14 2109(2)) or a pregnant woman (as defined
15 in section 2109(6)) and has a family in-
16 come determined under section 2109(3)
17 which does not exceed the eligibility per-
18 centage specified under clause (ii) of the
19 poverty line.
20 (ii) ELIGIBILITY PERCENTAGE.—The
21 eligibility percentage specified under this

1 clause shall be determined under the fol-
2 lowing table:

Calendar year:	Applicable eligibility percentage:
1997	185
1998	215
1999	240

3 (b) AMOUNT OF ASSISTANCE.—
4 (1) IN GENERAL.—
5 (A) DETERMINATION OF AMOUNT.—The
6 amount of premium assistance for a month for
7 a premium subsidy eligible individual is the
8 lesser of—
9 (i) the premium assistance amount
10 determined under paragraph (2); or
11 (ii) the amount of the premium for
12 coverage under the certified standard
13 health plan in which the individual is en-
14 rolled that is not paid (or offered to be
15 paid) on behalf of such individual by an
16 employer.
17 (B) SPECIAL RULES FOR DETERMINING
18 AMOUNT OF EMPLOYER PAYMENTS.—
19 (i) FAMILY CONTRIBUTIONS.—If an
20 employer makes a payment toward the pre-
21 mium for coverage under a certified stand-
22 ard health plan on behalf of a family (rath-
23 er than any particular individual), such

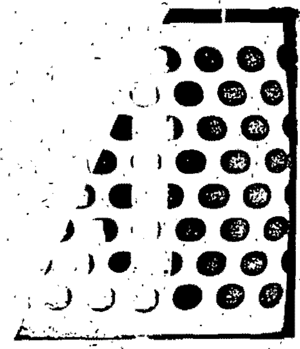
1 contribution shall be allocated ratably
2 among the individuals in the family.
3 (ii) GREATEST EMPLOYER CONTRIBU-
4 TION AVAILABLE.—The employer contribu-
5 tion with respect to any individual is the
6 largest employer contribution offered to be
7 made on behalf of the individual by the in-
8 dividual's employer or any employer of any
9 member of the individual's family.
10 (2) PREMIUM ASSISTANCE AMOUNT DETER-
11 MINED.—
12 (A) IN GENERAL.—The premium assist-
13 ance amount determined under this paragraph
14 is an amount equal to the lesser of—
15 (i) the subsidy percentage specified in
16 paragraph (3) multiplied by 1/12th of the
17 annual premium paid for coverage under a
18 certified standard health plan in which the
19 individual is enrolled, or
20 (ii) the subsidy percentage specified in
21 paragraph (3) multiplied by 1/12th of the
22 weighted average annual premium rate (as
23 defined in subparagraph (B)) for all com-
24 munity-rated certified standard health

1 plans offered in the community rating area
2 in which the individual resides.
3 (B) WEIGHTED AVERAGE ANNUAL PRE-
4 MIUM RATE.—For purposes of this paragraph,
5 the term "weighted average annual premium
6 rate" means the average premium for the com-
7 munity-rated certified standard health plans of-
8 fered in the community rating area in which the
9 individual resides, weighted to reflect the total
10 enrollment of community-rated eligible individ-
11 uals among such plans.
12 (3) SUBSIDY PERCENTAGE.—For purposes of
13 paragraph (2)(A), the term "subsidy percentage"
14 means the following:
15 (A) INDIVIDUALS WITH INCOMES BELOW
16 CERTAIN INCOME THRESHOLDS.—For a pre-
17 mium subsidy eligible individual described in
18 subsection (a)(2)(A), 100 percent reduced (but
19 not below zero) by the number of percentage
20 points (rounded to the nearest whole number)
21 by which such individual's family income (ex-
22 pressed as a percent) exceeds 100 percent of
23 the poverty line.
24 (B) CHILDREN AND PREGNANT WOMEN.—
25 For a premium subsidy eligible individual de-

1 ble individuals with incomes that exceed 100
2 percent of the poverty line.
3 (C) Third, to pay any other cost-sharing
4 requirements imposed on cost-sharing eligible
5 individuals.
6 (c) PAYMENTS.—The amount of the cost-sharing as-
7 sistance available to a cost-sharing eligible individual
8 under subsection (b) shall be paid by the State in which
9 the individual resides directly to the certified standard
10 health plan in which the individual is enrolled. Payments
11 under the preceding sentence shall commence in the first
12 month during which the individual is enrolled in a certified
standard health plan and determined under section 2104
to b[illegible]ost-sharing eligible individual.

[illegible]C. 2104. ELIGIBILITY DETERMINATIONS.

(a) IN GENERAL.—The Secretary shall promulgate
[illegible]tions specifying requirements for State programs
[illegible]his subtitle with respect to determining eligibility
[illegible]um and cost-sharing assistance.
[illegible]ECIFICATIONS FOR REGULATIONS.—The regu-
[illegible]lgated by the Secretary under subsection (a)
[illegible]e following requirements:
[illegible]PPLICATIONS.—A State program shall
[illegible]an in[illegible]idual may file an application for



1 SEC. 2103. ASSISTANCE WITH COST-SHARING FOR CER-
2 TIFIED STANDARD HEALTH PLANS.

3 (a) ELIGIBILITY.—
4 (1) IN GENERAL.—An eligible individual who
5 has been determined by a State under section 2104
6 to be a cost-sharing eligible individual (as defined in
7 paragraph (2)) shall be eligible for cost-sharing as-
8 sistance as provided under subsection (b).
9 (2) COST-SHARING ELIGIBLE INDIVIDUAL.—For
10 purposes of this subtitle, the term "cost-sharing eli-
11 gible individual" means an individual who is eligible
12 for premium assistance under section 2102.
13 (b) AMOUNT OF ASSISTANCE.—
14 (1) IN GENERAL.—The cost-sharing assistance
15 provided under this subsection is the assistance de-
16 termined appropriate by the State in accordance
17 with the priorities established under paragraph (2).
18 (2) PRIORITIES.—Cost-sharing assistance under
19 this subtitle shall be provided in accordance with the
20 following priorities:
21 (A) First, to pay any deductibles for out-
22 patient services furnished to cost-sharing eligi-
23 ble individuals with incomes at or below 100
24 percent of the poverty line.
25 (B) Second, to pay any deductibles for out-
26 patient services furnished to cost-sharing eligi-

1 (1) IN GENERAL.—The Secretary shall establish
2 standards for States operating programs under this
3 subtitle which ensure that such programs are oper-
4 ated in a uniform manner with respect to application
5 procedures, data processing systems, and such other
6 administrative activities as the Secretary determines
7 to be necessary.
8 (2) APPLICATION FORMS.—The Secretary shall
9 develop an application form for assistance which
10 shall—
11 (A) be simple in form and understandable
12 to the average individual;
13 (B) require the provision of information
14 necessary to make a determination as to wheth-
15 er an individual is eligible for assistance, includ-
16 ing a declaration of estimated income by the in-
17 dividual based, at the election of the
18 individual—
19 (i) on multiplying by a factor of 4 the
20 individual's family income for the 3-month
21 period immediately preceding the month in
22 which the application is made, or
23 (ii) on estimated income for the entire
24 year for which the application is submitted;
25 and

1 (C) require attachment of such documenta-
2 tion as deemed necessary by the Secretary in
3 order to ensure eligibility for assistance.
4 (d) EFFECTIVENESS OF ELIGIBILITY.—A determina-
5 tion by a State that an individual is a premium subsidy
6 eligible individual or an individual eligible for cost-sharing
7 assistance shall be effective for the calendar year for which
8 such determination is made unless a revised application
9 submitted under subsection (b)(4) indicates that an indi-
10 vidual is no longer eligible for assistance.
11 **SEC. 2105. END-OF-YEAR RECONCILIATION FOR ASSIST-**
12 **ANCE.**
13 (a) IN GENERAL.—
14 (1) REQUIREMENT TO FILE STATEMENT.—An
15 individual who received assistance under this subtitle
16 from a State for any month in a calendar year shall
17 file with the State an income reconciliation state-
18 ment to verify the individual's family income for the
19 year. Such a statement shall be filed at such time,
20 and contain such information, as the State may
21 specify in accordance with regulations promulgated
22 by the Secretary.
23 (2) NOTICE OF REQUIREMENT.—A State shall
24 provide a written notice of the requirement under
25 paragraph (1) at the end of the year to an individual

1 who received assistance under this subtitle from
2 such State in any month during the year.
3 (b) RECONCILIATION OF ASSISTANCE BASED ON AC-
4 TUAL INCOME.—
5 (1) IN GENERAL.—Based on and using the in-
6 come reported in the reconciliation statement filed
7 under subsection (a) with respect to an individual,
8 the State shall compute the amount of assistance
9 that should have been provided under this subtitle
10 with respect to the individual for the year involved.
11 (2) OVERPAYMENT OF ASSISTANCE.—If the
12 total amount of the assistance provided was greater
13 than the amount computed under paragraph (1), the
14 individual is liable to the State to pay an amount
15 equal to the amount of the excess payment. Any
16 amount collected by a State under this paragraph
17 shall be submitted to the Secretary in a timely man-
18 ner.
19 (3) UNDERPAYMENT OF ASSISTANCE.—If the
20 total amount of the assistance provided was less
21 than the amount computed under paragraph (1), the
22 State shall pay to the individual an amount equal to
23 the amount of the deficit.
24 (4) STATE OPTION.—A State may, in accord-
25 ance with regulations promulgated by the Secretary,

1 establish a procedure under which any overpayments
2 or underpayments of assistance determined under
3 paragraphs (2) and (3) with respect to an individual
4 for a year may be collected or paid, as appropriate,
5 through adjustments to the assistance furnished to
6 such individual in the succeeding year.
7 (c) VERIFICATION.—Each State may use such infor-
8 mation as it has available to verify income of individuals
9 with applications filed under this subtitle, including return
10 information disclosed to the State for such purpose under
11 section 6103(l)(15) of the Internal Revenue Code of 1986.
12 (d) PENALTIES FOR FAILURE TO FILE.—In the case
13 of an individual who is required to file a statement under
14 this section in a year who fails to file such a statement,
15 the entire amount of the assistance provided in such year
16 shall be considered an excess amount under subsection
17 (b)(2) and such individual shall not be eligible for assist-
18 ance under this subtitle until such statement is filed. A
19 State, using rules established by the Secretary, shall waive
20 the application of this subsection if the individual estab-
21 lishes, to the satisfaction of the State under such rules,
22 good cause for the failure to file the statement on a timely
23 basis.

1 **SEC. 2106. PENALTIES FOR MATERIAL MISREPRESENTA-**
2 **TIONS.**
3 (a) IN GENERAL.—Any individual who knowingly
4 makes a material misrepresentation of information in an
5 application for assistance under this subtitle or in an in-
6 come reconciliation statement under section 2105, shall be
7 liable to the Federal Government for the amount any as-
8 sistance received by individual on the basis of a misrepre-
9 sentation and interest on such amount at a rate specified
10 by the Secretary, and, shall, in addition, be liable to the
11 Federal Government for $2,000 or, if greater, 3 times the
12 amount any assistance received by individual on the basis
13 of a misrepresentation.
14 (b) COLLECTION OF PENALTY AMOUNTS.—A State
15 which receives an application for assistance or an income
16 reconciliation statement with respect to which a material
17 misrepresentation has been made shall collect the penalty
18 amount required under subsection (a) and submit such
19 amount to the Secretary in a timely manner.
20 **SEC. 2107. ENROLLMENT OUTREACH.**
21 (a) IN GENERAL.—The Secretary shall promulgate
22 regulations under which each State operating a program
23 for premium assistance under this subtitle shall have in
24 effect an enrollment outreach system under which individ-
25 uals may be determined eligible for such assistance by

1 health care providers who furnish services to such individ-
2 uals.
3 (b) SPECIFICATIONS FOR REGULATIONS.—The regu-
4 lations promulgated by the Secretary under subsection (a)
5 shall include the following requirements:
6 (1) HEALTH CARE PROVIDERS.—Each State
7 shall permit only the classes or categories of health
8 care providers determined appropriate by the Sec-
9 retary (referred to in this subsection as "eligible
10 health care providers") to participate in an enroll-
11 ment outreach system established by the State.
12 (2) APPLICATION FOR ASSISTANCE.—Each
13 State shall develop and make available to eligible
14 health care providers in the State an enrollment
15 package for distribution to potentially eligible indi-
16 viduals which includes a simple form for individuals
17 who receive services from such providers to apply for
18 premium assistance. Such form shall—
19 (A) permit an individual completing the
20 form to make a declaration that the individual
21 is eligible for a full premium subsidy under sec-
22 tion 2102; and
23 (B) permit an individual to enroll in a
24 community-rated certified standard health plan

1 offered in the community rating area in which
2 the individual resides.
3 (3) SUBMISSION OF COMPLETED APPLICA-
4 TION.—An individual who receives an enrollment ap-
5 plication form from an eligible health care provider
6 may complete the form and submit it to the individ-
7 ual's provider or the State agency operating the pro-
8 gram for premium assistance under this subtitle. If
9 a health care provider receives an application under
10 this section the provider shall submit the application
11 to the State agency administering the premium as-
12 sistance program under this subtitle within a period
13 of time determined appropriate by the Secretary in
14 regulations.
15 (4) SELECTION OF HEALTH PLAN.—An individ-
16 ual may select a community-rated certified standard
17 health plan with which to enroll on the date the indi-
18 vidual submits an application form under this sec-
19 tion or the individual may make such selection at a
20 later date determined appropriate by the Secretary
21 in regulations. If an individual fails to select a
22 health plan with which to enroll by the date deter-
23 mined appropriate by the Secretary, the State agen-
24 cy shall select such a plan for the individual.

1 (5) EFFECTIVE DATE OF ENROLLMENT.—An
2 individual who is enrolled in a community-rated cer-
3 tified standard health plan in accordance with the
4 enrollment eligibility system established under this
5 section shall be an enrollee of the plan as of the date
6 the individual submits an application to the State
7 agency or a health care provider.
8 (6) PERIOD OF ELIGIBILITY.—An individual
9 who submits an application to a health care provider
10 under an enrollment outreach system under this sec-
11 tion shall be eligible for premium assistance under
12 this subtitle for the period beginning on the date
13 such application is submitted and ending 60 days
14 after such date.
15 (7) NO RECONCILIATION REQUIRED.—The rec-
16 onciliation provisions of section 2105 shall not apply
17 to any assistance paid on behalf of an individual
18 during a period of eligibility for such assistance
19 under this section.
20 (8) REQUIREMENT ON STATES.—During a pe-
21 riod of eligibility for premium assistance under this
22 section, an individual shall be given an opportunity
23 by a State to apply for continuing eligibility for pre-
24 mium assistance under this subtitle.

1 **SEC. 2108. PAYMENTS TO STATES.**

2 (a) IN GENERAL.—

3 (1) PAYMENTS FOR PREMIUM ASSISTANCE—A
4 State operating a program for furnishing premium
5 assistance under this subtitle shall be entitled to re-
6 ceive payments from the Secretary in an amount
7 equal to the premium assistance paid on behalf of
8 individuals eligible for such assistance under this
9 subtitle. Such payments shall be made at such time
10 and in such form as provided in regulations promul-
11 gated by the Secretary.

12 (2) PAYMENTS FOR COST-SHARING ASSIST-
13 ANCE.—

14 (A) IN GENERAL.—A State operating a
15 program for furnishing cost-sharing assistance
16 under this subtitle shall be entitled to receive
17 payments from the Secretary in an amount
18 equal to the cost-sharing assistance paid on be-
19 half of individuals eligible for such assistance
20 under this subtitle. Such payments shall be
21 made at such time and in such form as pro-
22 vided in regulations promulgated by the Sec-
23 retary.

24 (B) LIMITATION ON FEDERAL PAY-
25 MENTS.—

1 (i) IN GENERAL.—The total amount
2 paid to a State under subparagraph (A)
3 for a fiscal year shall not exceed the
4 amount determined under clause (ii).
5 (ii) AMOUNT DETERMINED.—The
6 amount determined under this clause for a
7 State for a fiscal year is the product of—
8 (I) $4,000,000,000; multiplied by
9 (II) the ratio of the number of
10 individuals who are eligible for pre-
11 mium assistance under this subtitle in
12 the State during the fiscal year as es-
13 timated by the Secretary to the num-
14 ber of such individuals in all States.
15 (2) MATCHING PAYMENTS FOR ADMINISTRA-
16 TIVE EXPENSES.—The Secretary shall pay to each
17 State operating a program for furnishing premium
18 and cost-sharing assistance under this subtitle, for
19 each quarter beginning with the quarter commencing
20 January 1, 1996, an amount equal to 50 percent of
21 the total amount expended by the State during the
22 quarter as found necessary by the Secretary for the
23 proper and efficient administration of the program.
24 (3) STATE ENTITLEMENT.—This subsection
25 constitutes budget authority in advance of appro-

1 priations Acts, and represents the obligation of the
2 Federal Government to provide payments to States
3 operating programs under this subtitle in accordance
4 with this subsection.
5 (b) AUDITS.—The Secretary may conduct regular au-
6 dits of the activities under the State programs conducted
7 under this subtitle.

8 **SEC. 2109. DEFINITIONS AND DETERMINATIONS OF IN-**
9 **COME.**

10 For purposes of this subtitle:
11 (1) CERTIFIED STANDARD HEALTH PLAN.—The
12 term "certified standard health plan" means a cer-
13 tified health plan (as defined in section 3(a)(2)) pro-
14 viding the standard benefits package (as defined in
15 section 1101(1)(A)).
16 (2) CHILD.—The term "child" means an indi-
17 vidual who is under 19 years of age.
18 (3) DETERMINATIONS OF INCOME.—
19 (A) FAMILY INCOME.—The term "family
20 income" means, with respect to an individual
21 who—
22 "(i) is not a dependent (as defined in
23 subparagraph (B)) of another individual,
24 the sum of the modified adjusted gross in-
25 comes (as defined in subparagraph (D))

1 for the individual, the individual's spouse,
2 and children who are dependents of the in-
3 dividual; or
4 (ii) is a dependent of another individ-
5 ual, the sum of the modified adjusted gross
6 incomes for the other individual, the other
7 individual's spouse, and children who are
8 dependents of the other individual.
9 (B) DEPENDENT.—The term "dependent"
10 shall have the meaning given such term under
11 section 152 of the Internal Revenue Code of
12 1986.
13 (C) SPECIAL RULE FOR FOSTER CHIL-
14 DREN.—For purposes of subparagraph (A), a
15 child who is placed in foster care by a State
16 agency shall not be considered a dependent of
17 another individual.
18 (D) MODIFIED ADJUSTED GROSS IN-
19 COME.—The term "modified adjusted gross in-
20 come" means adjusted gross income (as defined
21 in section 62(a) of the Internal Revenue Code
22 of 1986)—
23 (i) determined without regard to sec-
24 tions 135, 162(l), 911, 931, and 933 of
25 such Code, and

1 (ii) increased by—
2 (I) the amount of interest re-
3 ceived or accrued by the individual
4 during the taxable year which is ex-
5 empt from tax, and
6 (II) the amount of the social se-
7 curity benefits (as defined in section
8 86(d) of such Code) received during
9 the taxable year to the extent not in-
10 cluded in gross income under section
11 86 of such Code.
12 The determination under the preceding sen-
13 tence shall be made without regard to any car-
14 ryover or carryback.
15 (E) RULES RELATING TO DISREGARD OF
16 CERTAIN INCOME.—The Secretary may promul-
17 gate rules under which spousal income may be
18 disregarded in instances where a spouse is not
19 part of a family unit.
20 (4) ELIGIBLE INDIVIDUAL.—
21 (A) IN GENERAL.—The term "eligible indi-
22 vidual" means an individual who is residing in
23 the United States and who is—
24 (i) a citizen or national of the United
25 States; or

1 (ii) an alien permanently residing in
2 the United States under color of law (as
3 defined in subparagraph (C)).
4 (B) EXCLUSION.—The term "eligible indi-
5 vidual" shall not include an individual who is
6 an inmate of a public institution (except as a
7 patient of a medical institution).
8 (C) ALIEN PERMANENTLY RESIDING IN
9 THE UNITED STATES UNDER COLOR OF LAW.—
10 The term "alien permanently residing in the
11 United States under color of law" means an
12 alien lawfully admitted for permanent residence
13 (within the meaning of section 101(a)(20) of
14 the Immigration and Nationality Act), and in-
15 cludes any of the following:
16 (i) An alien who is admitted as a refu-
17 gee under section 207 of the Immigration
18 and Nationality Act.
19 (ii) An alien who is granted asylum
20 under section 208 of such Act.
21 (iii) An alien whose deportation is
22 withheld under section 243(h) of such Act.
23 (iv) An alien who is admitted for tem-
24 porary residence under section 210, 210A,
25 or 245A of such Act.

1 (v) An alien who has been paroled
2 into the United States under section
3 212(d)(5) of such Act for an indefinite pe-
4 riod or who has been granted extended vol-
5 untary departure as a member of a nation-
6 ality group.
7 (vi) An alien who is the spouse or un-
8 married child under 21 years of age of a
9 citizen of the United States, or the parent
10 of such a citizen if the citizen is over 21
11 years of age, and with respect to whom an
12 application for adjustment to lawful per-
13 manent residence is pending.
14 (5) POVERTY LINE.—The term "poverty line"
15 means the income official poverty line (as defined by
16 the Office of Management and Budget, and revised
17 annually in accordance with section 673(2) of the
18 Omnibus Budget Reconciliation Act of 1981) that—
19 (A) in the case of a family of less than five
20 individuals, is applicable to a family of the size
21 involved; and
22 (B) in the case of a family of more than
23 four individuals, is applicable to a family of
24 four persons.
25 (6) PREGNANT WOMAN.—

1 (A) IN GENERAL.—The term "pregnant
2 woman" includes a woman deemed to be a
3 pregnant woman under subparagraph (B).
4 (B) PERIOD AFTER TERMINATION OF
5 PREGNANCY.—For purposes of this subtitle, a
6 woman shall be deemed to be a pregnant
7 woman during the period beginning on the date
8 of the termination of the pregnancy and ending
9 on the first day of the first month that begins
10 more than 90 days after such date.

1 # Subtitle C—Coverage

2 **SEC. 2201. NATIONAL HEALTH BENEFITS AND COVERAGE**
3 **COMMISSION ROLE.**

4 (a) IN GENERAL.—The National Health Benefits and
5 Coverage Commission (referred to in this subtitle as the
6 "Commission") shall monitor and respond to—
7 (1) trends in health insurance coverage; and
8 (2) changes in per-capita premiums and other
9 indicators of health care inflation.
10 The Commission may be advised by individuals with exper-
11 tise concerning the economic, demographic, and insurance
12 market factors that affect the cost and availability of
13 health insurance.
14 (b) BIENNIAL REPORTS.—
15 (1) IN GENERAL.—The Commission shall report
16 to Congress biennially on January 1 (beginning in
17 1996) on the status of health insurance coverage in
18 the nation and the national goal of universal cov-
19 erage.
20 (2) HEALTH INSURANCE COVERAGE.—For pur-
21 poses of this title, the term "health insurance cov-
22 erage" means coverage under—
23 (A) a certified health plan;
24 (B) an equivalent health care program; or

1 (C) any governmental health care program
2 for institutionalized individuals.
3 (3) CONTENTS OF REPORT.—Each biennial re-
4 port shall include the structure and performance
5 measures of every community rating area, including
6 the following:
7 (A) Demographics of the uninsured indi-
8 viduals, and findings on why such individuals
9 are uninsured.
10 (B) Structure of delivery systems.
11 (C) Number and organizational form of
12 certified health plans described in paragraph
13 (2)(A).
14 (D) Level of enrollment in such certified
15 health plans.
16 (E) State implementation of responsibil-
17 ities, including establishment of community rat-
18 ing areas, under title I.
19 (F) Status of insurance reforms.
20 (G) Development of purchasing coopera-
21 tives and other buyer reforms.
22 (H) Success of market and other mecha-
23 nisms of controlling health expenditures and
24 premium costs in the community rating areas
25 and nationally.

1 (I) Status of medicaid-eligible individuals
2 under the medicaid program under title XIX of
3 the Social Security Act, the integration of such
4 individuals into coverage by certified health
5 plans providing standard benefits packages, and
6 the transition of such program toward managed
7 care.
8 (J) Adequacy of subsidies for individuals
9 under subtitle B of this title.
10 (K) Status of medicare-eligible individuals
11 under the medicare program under title XVIII
12 of the Social Security Act, the integration of
13 such individuals into coverage by certified
14 health plans providing standard benefits pack-
15 ages, and the transition of such program into
16 medicare risk contracts.
17 (L) Coverage progress among individuals
18 who are employed, including status and level of
19 voluntary employer contributions and participa-
20 tion rates in purchasing cooperatives and
21 among large employers.
22 (M) Percentage of individuals who are en-
23 rolled in certified health plans described in
24 paragraph (2)(A), separated into categories of
25 medicare-eligible individuals, medicaid-eligible

1 individuals, employed individuals, and individ-
2 uals eligible for subsidies.
3 (N) Recommendations, specific to each
4 community rating area, on how the area might
5 increase coverage among the residents and fur-
6 ther moderate growth in premiums.
7 (4) PROHIBITED ACTIVITY.—In carrying out its
8 duties, including the preparation of any biennial re-
9 port, the Commission may not address issues related
10 to defining an employee for tax purposes, including
11 discussing such issues with the Internal Revenue
12 Service or the Department of the Treasury.
13 (c) COVERAGE TRIGGER.—
14 (1) IN GENERAL.—In the event the Commission
15 determines that health insurance coverage of at least
16 95 percent of the resident population in the United
17 States will not be attained by 2002, the Commission
18 shall submit recommendations in its biennial report
19 to Congress on January 1, 2002.
20 (2) RECOMMENDATION REQUIREMENTS.—
21 (A) IN GENERAL.—The recommendations
22 of the Commission shall include methods to
23 reach 95 percent health insurance coverage in
24 community rating areas that have failed to
25 meet that target. Such recommendations shall

20

1 address all relevant parties, including States,
2 employers, employees, unemployed and low-in-
3 come individuals, and public program partici-
4 pants.
5 (B) REQUIRED SEPARATE RECOMMENDA-
6 TIONS.—In addition to any other recommenda-
7 tions the Commission submits, the Commission
8 shall make separate recommendations on the
9 following:
10 (i) A schedule of assessments or con-
11 tributions to encourage employers who are
12 not doing so to purchase coverage for their
13 employees.
14 (ii) A method of encouraging full cov-
15 erage which does not require any assess-
16 ments on or contributions from employers.
17 (iii) Possible adjustments to the actu-
18 arial value of any of the benefits packages
19 described in subsection (b)(2)(A).
20 (iv) Possible adjustments to subsidies
21 under subtitle B of this title.
22 (v) Possible adjustments to the tax
23 treatment of health benefits.
24 (3) IMPLEMENTING BILL.—The Commission
25 shall submit to the Congress an implementing bill

1 which contains such statutory provisions as the
2 Commission determines are necessary or appropriate
3 to implement the recommendations developed under
4 this subsection.
5 (d) DEFINITIONS.—For purposes of this subtitle—
6 (1) COMMUNITY RATING AREA.—The term
7 "community rating area" means an area established
8 under section 1303.
9 (2) RESIDENT POPULATION.—The term "resi-
10 dent population" includes any individual who is re-
11 siding in the United States and who is—
12 (A) a citizen or national of the United
13 States; or
14 (B) an alien permanently residing in the
15 United States under color of law (as defined in
16 section 2109(4)(C)).
17 (3) UNITED STATES.—The term "United
18 States" means the various States (as defined in sec-
19 tion 3(b)(15)).
20 **SEC. 2202. CONGRESSIONAL CONSIDERATION OF COMMIS-**
21 **SION RECOMMENDATIONS.**
22 (a) IN GENERAL.—An implementing bill described in
23 section 2101(c)(3) shall be considered by Congress under
24 the procedures for consideration described in subsection
25 (b).

1 (b) CONGRESSIONAL CONSIDERATION.—

2 (1) RULES OF HOUSE OF REPRESENTATIVES
3 AND SENATE.—This subsection is enacted by
4 Congress—

5 (A) as an exercise of the rulemaking power
6 of the House of Representatives and the Sen-
7 ate, respectively, and as such is deemed a part
8 of the rules of each House, respectively, but ap-
9 plicable only with respect to the procedure to be
10 followed in that House in the case of an imple-
11 menting bill described in subsection (a), and su-
12 persedes other rules only to the extent that
13 such rules are inconsistent therewith; and

14 (B) with full recognition of the constitu-
15 tional right of either House to change the rules
16 (so far as relating to the procedure of that
17 House) at any time, in the same manner and
18 to the same extent as in the case of any other
19 rule of that House.

20 (2) INTRODUCTION AND REFERRAL.—On the
21 day on which the implementing bill described in sub-
22 section (a) is transmitted to the House of Represent-
23 atives and the Senate, such bill shall be introduced
24 (by request) in the House of Representatives by the
25 Majority Leader of the House, for himself or herself

1 and the Minority Leader of the House, or by Mem-
2 bers of the House designated by the Majority Leader
3 and Minority Leader of the House and shall be in-
4 troduced (by request) in the Senate by the Majority
5 Leader of the Senate, for himself or herself and the
6 Minority Leader of the Senate, or by Members of
7 the Senate designated by the Majority Leader and
8 Minority Leader of the Senate. If either House is
9 not in session on the day on which the implementing
10 bill is transmitted, the bill shall be introduced in
11 that House, as provided in the preceding sentence,
12 on the first day thereafter on which that House is
13 in session. If the implementing bill is not introduced
14 within 5 days of its transmission, any Member of the
15 House and of the Senate may introduce such bill.
16 The implementing bill introduced in the House of
17 Representatives and the Senate shall be referred to
18 the appropriate committees of each House.
19 (3) PERIOD FOR COMMITTEE CONSIDER-
20 ATION.—If the committee or committees of either
21 House to which an implementing bill has been re-
22 ferred have not reported the bill at the close of July
23 1, 2002 (or if such House is not in session, the next
24 day such House is in session), such committee or
25 committees shall be automatically discharged from

1 further consideration of the implementing bill and it
2 shall be placed on the appropriate calendar.
3 (4) FLOOR CONSIDERATION IN THE SENATE.—
4 (A) IN GENERAL.—Within 5 days after the
5 implementing bill is placed on the calendar, the
6 Majority Leader, at a time to be determined by
7 the Majority Leader in consultation with the
8 Minority Leader, shall proceed to the consider-
9 ation of the bill. If on the sixth day after the
10 bill is placed on the calendar, the Senate has
11 not proceeded to consideration of the bill, then
12 the presiding officer shall automatically place
13 the bill before the Senate for consideration. A
14 motion in the Senate to proceed to the consider-
15 ation of an implementing bill shall be privileged
16 and not debatable. An amendment to the mo-
17 tion shall not be in order, nor shall it be in
18 order to move to reconsider the vote by which
19 the motion is agreed to or disagreed to.
20 (B) TIME LIMITATION ON CONSIDERATION
21 OF BILL.—
22 (i) IN GENERAL.—Debate in the Sen-
23 ate on an implementing bill, and all
24 amendments and debatable motions and
25 appeals in connection therewith, shall be

1 limited to not more than 30 hours. The
2 time shall be equally divided between, and
3 controlled by, the Majority Leader and the
4 Minority Leader or their designees.
5 (ii) DEBATE OF AMENDMENTS, MO-
6 TIONS, POINTS OF ORDER, AND AP-
7 PEALS.—In the Senate, no amendment
8 which is not relevant to the bill shall be in
9 order. Debate in the Senate on any amend-
10 ment, debatable motion or appeal, or point
11 of order in connection with an implement-
12 ing bill shall be limited to—
13 (I) not more than 2 hours for
14 each first degree relevant amendment,
15 (II) one hour for each second de-
16 gree relevant amendment, and
17 (III) 30 minutes for each debat-
18 able motion or appeal, or point of
19 order submitted to the Senate,
20 to be equally divided between, and con-
21 trolled by, the mover and the manager of
22 the implementing bill, except that in the
23 event the manager of the implementing bill
24 is in favor of any such amendment, mo-
25 tion, appeal, or point of order, the time in

1 opposition thereto, shall be controlled by
2 the Minority Leader or designee of the Mi-
3 nority Leader. The Majority Leader and
4 Minority Leader, or either of them, may,
5 from time under their control on the pas-
6 sage of an implementing bill, allot addi-
7 tional time to any Senator during the con-
8 sideration of any amendment, debatable
9 motion or appeal, or point of order.
10 (C) OTHER MOTIONS.—A motion to recom-
11 mit an implementing bill is not in order.
12 (D) FINAL PASSAGE.—Upon the expiration
13 of the 30 hours available for consideration of
14 the implementing bill, it shall not be in order to
15 offer or vote on any amendment to, or motion
16 with respect to, such bill. Immediately following
17 the conclusion of debate in the Senate on an
18 implementing bill that was introduced in the
19 Senate, such bill shall be deemed to have been
20 read a third time and the vote on final passage
21 of such bill shall occur without any intervening
22 action or debate.
23 (E) DEBATE ON DIFFERENCES BETWEEN
24 THE HOUSES.—Debate in the Senate on mo-
25 tions and amendments appropriate to resolve

1 the differences between the Houses, at any par-
2 ticular stage of the proceedings, shall be limited
3 to not more than 5 hours.
4 (F) DEBATE ON CONFERENCE REPORT.—
5 Debate in the Senate on the conference report
6 shall be limited to not more than 10 hours.
7 (5) FLOOR CONSIDERATION IN THE HOUSE OF
8 REPRESENTATIVES.—
9 (A) PROCEED TO CONSIDERATION.—On
10 the sixth day after the implementing bill is
11 placed on the calendar, it shall be privileged for
12 any Member to move without debate that the
13 House resolve itself into the Committee of the
14 Whole House on the State of the Union, for the
15 consideration of the bill, and the first reading
16 of the bill shall be dispensed with.
17 (B) GENERAL DEBATE.—After general de-
18 bate, which shall be confined to the implement-
19 ing bill and which shall not exceed 4 hours, to
20 be equally divided and controlled by the Chair-
21 man and Ranking Minority Member of the
22 Committee or Committees to which the bill had
23 been referred, the bill shall be considered for
24 amendment by title under the 5-minute rule
25 and each title shall be considered as having