PART 3—STATE FLEXIBILITY

Subpart A—Existing State Laws

SEC. 1521. CONTINUANCE OF EXISTING FEDERAL LAW WAIVERS.

Nothing in this Act shall preempt any feature of a State health care system operating under a waiver granted before the date of the enactment of this Act under titles XVIII or XIX of the Social Security Act or the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

SEC. 1522. HAWAII PREPAID HEALTH CARE ACT.

(a) ERISA WAIVER.—

(1) IN GENERAL.—Section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)) is amended to read as follows:

"(5)(A) Except as provided in subparagraphs (B) and (C), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 through 393–51).

"(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any State tax law relating to employee benefits plans.

"(C) If the Secretary of Labor notifies the Governor of the State of Hawaii that as the result of an amendment to the Hawaii Prepaid Health Care

Act enacted after the date of the enactment of this paragraph—

"(i) the proportion of the population with health care coverage under such Act is less than such proportion on such date, or

"(ii) the level of benefit coverage provided under such Act is less than the actuarial equivalent of such level of coverage on such date,

subparagraph (A) shall not apply with respect to the application of such amendment to such Act after the date of such notification.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(b) HSA WAIVER.—

(1) IN GENERAL.—The Board shall, at the request of the Governor of the State of Hawaii and in accordance with this section, grant a waiver to the State from the requirements of this Act (other than the requirements specified in paragraph (3)).

(2) SCOPE OF WAIVER.—The waiver granted under paragraph (1) shall exempt—

(A) the State of Hawaii;

(B) health plans offered within the State; and

(C) health plan participants, including employers, employees, residents, and health plan sponsors within the State,

from requirements otherwise applicable to the State and such plans and participants.

(3) REQUIRED COMPLIANCE OF OTHER REQUIREMENTS.—The waiver shall initially be granted under paragraph (1) if the State of Hawaii demonstrates to the Board that the State maintains—

(A) a requirement that employers make premium contributions comparable to the requirements of this Act;

(B) a comprehensive benefit package (including cost sharing) that is comparable with the requirements of subtitle B of this title;

(C) a percentage of State population with health care coverage that is not less than the national average;

(D) a quality control mechanism and data system that are comparable to the applicable requirements of title V; and

(E) health care cost containment that is comparable to subtitle A of title VI.

(4) WAIVER PERIOD.—The waiver initially granted under paragraph (1) shall extend for the pe-

riod during which the State of Hawaii continues to comply with the requirements specified in paragraph (3). The Board may require the State, every 5 years, to demonstrate to the Board the State's continued compliance with such requirements.

(5) PROCEDURE IN THE EVENT OF NON-COMPLIANCE.—

(A) NOTICE.—If, at any time after granting a waiver under paragraph (1), the Board finds that the State of Hawaii is not meeting the requirements specified in paragraph (3), the Board shall notify the State of the Board's findings.

(B) OPPORTUNITY TO CONTEST.—The State may contest the Board's findings under the procedures provided under section 5231.

(C) OPPORTUNITY FOR CORRECTION.—

(i) FINDINGS NOT CONTESTED.—If the State does not contest the Board's findings within the 30-day period beginning on the date of receipt of a notice of such findings, the State shall have—

(I) a 90-day period beginning on such date to show a good faith effort to remedy the non-compliance, and

(II) an additional 12-month period to take such actions as may be required to bring the State into compliance with the requirements specified in paragraph (3).

(ii) CONTESTED FINDINGS.—If the State contests the Board's findings within such 30-day period but such findings are upheld, the State shall have—

(I) a 90-day period beginning on the date of final adjudication to show a good faith effort to remedy the noncompliance, and

(II) an additional 12-month period to take such actions as may be required to bring the State into compliance with the requirements specified in paragraph (3).

(D) TERMINATION.—If the State fails to demonstrate a good faith effort under subparagraph (C)(i)(I) or (C)(ii)(I) or to take actions under subparagraph (C)(i)(II) or (C)(ii)(II) within the time period specified, the Board may revoke the waiver granted in paragraph (1).

(6) COOPERATIVE AGREEMENT WITH THE NATIONAL HEALTH BOARD.—The Board shall enter into cooperative agreements with appropriate officials of the State of Hawaii—

(A) to develop standards and reporting requirements necessary for the issuance and maintenance of the State's waiver under paragraph (1); and

(B) otherwise to effectuate the provisions of this subsection.

(7) ELIGIBILITY FOR FEDERAL FUNDS PROVIDED TO PARTICIPATING STATES.—Nothing in this subsection shall preclude the eligibility of the State of Hawaii to participate in any public health initiative, grant, or financial aid program under this Act (including the medicaid program under title XIX of the Social Security Act), or the sharing of revenue resulting from the amendments made by title VII, designed to implement the purpose of this Act. The Secretary shall work with appropriate officials of the State of Hawaii to develop comparable, alternative standards to govern the State's entitlement under title XI.

SEC. 1523. ALTERNATIVE STATE PROVIDER PAYMENT SYSTEMS.

Notwithstanding any other provision of law, if a hospital reimbursement system operated by a State meets the requirements of section 1814(b) of the Social Security Act and has been approved by the Secretary and in continuous operation since July 1, 1977, the payment rates and methodologies required under the system for services provided in the State shall apply to all purchasers and payers, including those under employee welfare benefit plans authorized under the Employee Retirement Income Security Act of 1974, workers' compensation programs under State law, the Federal Employees' Compensation Act under chapter 81 of title 5, United States Code, and Federal employee health benefit plans under chapter 89 of title 5, United States Code.

SEC. 1524. ALTERNATIVE STATE HOSPITAL SERVICES PAYMENT SYSTEMS.

(a) IN GENERAL.—No State shall be prevented from enforcing—

(1) a State system described in subsection (b), or

(2) a State system described in subsection (c), by any provision of the Employee Retirement Income Security Act of 1974 (42 U.S.C. 1001 et seq.) or chapter 81 or 89 of title 5, United States Code.

(b) REIMBURSEMENT CONTROL SYSTEM.—A State system is described in this subsection if it is a State reimbursement control system in operation before the date of the enactment of this Act which—

(1) applies to substantially all non-Federal acute care hospitals in the State, and

(2) regulates substantially all rates of payment (including maximum charges) in the State for inpatient hospital services, except payments made under title XVIII of the Social Security Act.

(c) HEALTH INSURANCE REFORM SYSTEM.—A State system is described in this subsection if it is a State health insurance reform system in operation before the date of the enactment of this Act which requires any insurer (including a health maintenance organization) to comply with requirements governing open enrollment and community rating, including premium adjustments or other health care assessments, for the purpose of risk adjustment.

(d) EFFECTIVE DATES.—

(1) SUBSECTION (b).—In the case of a State system described in subsection (b), the provisions of this section shall apply before, on, and after the date of the enactment of this Act.

(2) SUBSECTION (c).—In the case of a State system described in subsection (c), the provisions of

this section shall apply before, on, and after the date of the enactment of this Act, and before the effective date of section 1116 of this Act.

Subpart B—Requirements for State Single-Payer Systems

SEC. 1531. SINGLE-PAYER SYSTEM DESCRIBED.

The Secretary shall approve an application of a State to operate a single-payer system if the Secretary finds that the system—

(1) meets the requirements of section 1532;

(2)(A) in the case of a system offered throughout a State, meets the requirements for a Statewide single-payer system under section 1533; or

(B) in the case of a system offered in a single community rating area of a State, meets the requirements for an area specific single-payer system under section 1534.

SEC. 1532. GENERAL REQUIREMENTS FOR SINGLE-PAYER SYSTEMS.

Each single-payer system shall meet the following requirements:

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

(2) OPERATION BY STATE.—The system is operated by the State or a designated agency of the State.

(3) ENROLLMENT OF INDIVIDUALS.—

(A) MANDATORY ENROLLMENT OF ALL COMMUNITY-RATED INDIVIDUALS.—The system shall provide for the enrollment of all community-rated individuals residing in the State (or, in the case of an area-specific single-payer system, in the community rating area) who are not medicare-eligible individuals.

(B) OPTIONAL ENROLLMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—At the option of the State and if the Secretary has approved an application submitted by the State, the system may provide for the enrollment of medicare-eligible individuals residing in the State (or, in the case of an area-specific single-payer system, in the community rating area) [if the Secretary of Health and Human Services has approved an application submitted by the State under section 1893 of the Social Security Act (as added by section 4001(a)) for the integration of Medicare beneficiaries into plans of the State. Nothing in this subparagraph shall be construed as

requiring that a State have a single-payer system in order to provide for such integration].

(C) OPTIONAL ENROLLMENT OF EXPERIENCE-RATED INDIVIDUALS IN STATEWIDE PLANS.—

(i) IN GENERAL.—Except as provided in clause (ii), at the option of the State, a Statewide single-payer system may provide for the enrollment of experience-rated individuals residing in the State (or, in the case of an area-specific single-payer system, in the community rating area).

(ii) PARTICIPATION BY CERTAIN MULTISTATE PLANS.—The system shall not require (but may permit) participation by any sponsor of a certified multistate self-insured standard health plan (as described in section 1482(b)), or any experience-rated employer sponsor of a certified multistate self-insured standard health plan with at least 5,000 participants.

(D) OPTIONS INCLUDED IN STATE SYSTEM DOCUMENT.—A State may not exercise any of the options described in subparagraphs (B) or (C) for a year unless the State included a de-

scription of the option in the submission of its system document to the Board for the year under section 1501(a).

[(E) EXCLUSION OF CERTAIN INDIVIDUALS.—A single-payer system may not require the enrollment of electing veterans, active duty military personnel, and electing American Indians (as defined in 1012(d)).]

(4) DIRECT PAYMENT TO PROVIDERS.—

(A) IN GENERAL.—With respect to providers who furnish items and services included in the standard benefits package established under subtitle C to individuals enrolled in the system, the State shall make payments directly, or through fiscal intermediaries, to such providers and assume (subject to subparagraph (B)) all financial risk associated with making such payments.

(B) CAPITATED PAYMENTS PERMITTED.—Nothing in subparagraph (A) shall be construed to prohibit providers furnishing items and services under the system from receiving payments on a capitated, at-risk basis based on prospectively determined rates.

(5) PROVISION OF STANDARD BENEFITS PACKAGE.—

(A) IN GENERAL.—The system shall provide for coverage of the standard benefits package established under subtitle C, including the cost-sharing provided under the package (subject to subparagraph (B)), to all individuals enrolled in the system.

(B) IMPOSITION OF REDUCED COST-SHARING.—The system may decrease the cost-sharing otherwise provided in the standard benefits package established under subtitle C with respect to any individuals enrolled in the system or any class of services included in the package, so long as the system does not increase the cost-sharing otherwise imposed with respect to any other individuals or services.

[*Labor* (6) COST CONTAINMENT.—The system shall provide for mechanisms to ensure, in a manner satisfactory to the Board, that—

(A) the rate of growth in health care spending will not be higher than the target established under this Act;

(B) the expenditures described in subparagraph (A) are computed and effectively monitored;

(C) automatic, mandatory, nondiscretionary reductions in payments to health care providers will be imposed to the extent required to assure that such per capita expenditures do not exceed the applicable target referred to in subparagraph (A); and

(D) Federal payments to a single payer State or health care coverage area shall be limited to the payments that would have been made in the absence of the implementation of the single payer system.]

(6) FEDERAL PAYMENTS.—The system shall provide for mechanisms to ensure, in a manner satisfactory to the Secretary, that Federal payments to a single-payer State or community rating area shall be limited to the payments that would have been made in the absence of the implementation of the single-payer system.

[*Finance* (7) INCREASED COVERAGE OR IMPROVED COST CONTAINMENT.—The system, when fully implemented, shall be expected by the State to—

(A) reduce the number of residents of the State (or, in the case of an area-specific single-payer system, the community rating area) who are without health insurance coverage (as defined in section ____) by at least 10 percent, or

(B) decrease the rate of growth of per capita health care spending in the State (or, in the case of an area-specific single-payer system, the community rating area),

compared to baseline projections developed by the State on the basis of the most recent data, including data provided by the National Health Care Commission established under section ____.]

(8) REQUIREMENTS GENERALLY APPLICABLE TO STANDARD HEALTH PLANS. The system shall meet the requirements applicable to a standard health plan, except that—

(A) the system does not have the authority provided to standard health plans under section 1111(b)(3) (relating to permissible limitations on the enrollment of community-rated eligible individuals on the basis of limits on the plan's capacity); and

(B) the system is not required to meet the requirements of sections 1116 (relating to rat-

ing limitations for community-rated market), 1123(a) (relating to plan solvency), and section 1125 (relating to restrictions on the marketing of plan materials).

SEC. 1533. SPECIAL RULES FOR STATES OPERATING STATE-WIDE SINGLE-PAYER SYSTEM.

(a) IN GENERAL.—In the case of a State operating a Statewide single-payer system—

(1) the State shall operate the system throughout the State; and

(2) except as provided in subsection (b), the State shall meet the requirements for participating States under part 1.

(b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR PARTICIPATING STATES.—In the case of a State operating a Statewide single-payer system, the State is not required to meet the following requirements otherwise applicable to participating States under part 1:

(1) ESTABLISHMENT OF COMMUNITY RATING AND SERVICE AREAS.—The requirements of sections 1502 (relating to the establishment of community rating areas) and ____ (relating to the designation of health plan service areas).

(2) OTHER REFERENCES INAPPLICABLE.—Any requirement which the Secretary determines is not appropriate to apply to a State single-payer system.

[(c) FINANCING.—

(1) IN GENERAL.—A State operating a State-wide single-payer system shall provide for the financing of the system using, at least in part, a payroll-based financing system that requires employers to pay at least the amount that the employers would be required to pay if the employers were subject to the requirements of subtitle B of title VI defined as the applicable percentage of the per capita cost of health care.

(2) USE OF FINANCING METHODS.—Such a State may use, consistent with paragraph (1), any other method of financing.]

(d) SINGLE-PAYER STATE DEFINED.—In this title, the term "single-payer State" means a State with a State-wide single-payer system in effect that has been approved by the Secretary in accordance with this part.

SEC. 1534. SPECIAL RULES FOR COMMUNITY RATING AREA-SPECIFIC SINGLE-PAYER SYSTEMS.

(a) IN GENERAL.—In the case of a State operating a community rating area specific single-payer system, ex-

cept as provided in subsection (b), the State shall meet the requirements for participating States under part 1.

(b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR PARTICIPATING STATES.—

(1) ESTABLISHMENT OF SERVICE AREAS.—The requirement of section ____ (relating to the designation of health plan service areas).

(2) OTHER REFERENCES INAPPLICABLE.—Any requirement which the Secretary determines is not appropriate to apply to a community rating area specific single-payer system.

Subpart C—Early Implementation of Comprehensive State Programs

SEC. 1541. EARLY IMPLEMENTATION OF COMPREHENSIVE STATE PROGRAMS

(a) APPLICATION.—

(1) IN GENERAL.—In accordance with this section, each State desiring to implement the reform standards established in this Act before January 1, 1997, may submit an application to the Secretary of Health and Human Services and the Secretary of Labor to request approval of a State comprehensive health care reform program which meets the requirements specified in subsection (b).

(2) ESTABLISHMENT OF CRITERIA.—The Secretaries shall establish criteria for the approval of such applications.

(3) EXPEDITED PROCEDURE.—The Secretaries shall establish an expedited procedure for the consideration and disposition of applications under this subsection. The procedure established by the Secretaries shall provide that such consideration and disposition be completed within 90 days, and that if the application is approved, multistate employers be notified of such approval.

(b) REQUIREMENTS SPECIFIED.—The requirements specified in this subsection are as follows:

(1) The State program is consistent with the reform standards established in this Act and the interim and final (if any) regulations promulgated by the Secretaries.

(2) The State program specifically includes—

(A) a standardized benefits package meeting the requirements established under subtitle C, or in the event such requirements have not been fully promulgated on the date of the application, the requirements for a qualified health maintenance organization (as defined in section

1310(d) of the Public Health Service Act (42 U.S.C. 300e-9(d));

(B) insurance reforms and rating requirements as specified under part 2 of subtitle B;

(C) standards for health plans as specified under part 3 of subtitle B;

(D) the recognition of, and standards for, purchasing cooperatives, as specified in part 2 of subtitle D;

(E) compliance with the data collection and privacy procedures established under subtitles [A and B] of title V;

(F) uniform administrative procedures as specified in section 1126;

(G) the imposition of employer and individual responsibilities as specified in part 1 of subtitle D;

(H) the establishment of the subsidy program described in ____; and

(I) health care cost containment provisions.

(c) QUALIFICATION FOR FEDERAL FUNDS.—For purposes of this Act, A State with an approved State program under this section shall be considered a participating State.

(d) EMPLOYER CERTIFICATION PROCESS.—In the case of any multistate self-insured health plan, certification by the ~~Secretary~~ plan to the Secretary of Labor that such plan is in compliance with the Federal standards described in subsection (b) shall satisfy compliance with any State program approved under this section.

(e) FINANCING SOURCE.—To be supplied and placed in revenue provisions.

219-5526

GEORGE J. MITCHELL
MAINE

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Washington, DC 20510-7010

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Number of Pages, including cover 2 (2)

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(2) PAYMENT AMOUNTS.—In the case of emergency and urgent care provided to an enrollee outside of a standard health plan's community rating area, the payment amounts of the plan shall be based on the applicable fee schedule described in subsection (e).

(e) APPLICATION OF FEE SCHEDULE.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), each standard health plan that provides for payment for services on a fee-for-service basis and has not established an agreement or contractual arrangement with providers specifying a basis for payment shall make such payment to such providers under a fee schedule established by the plan.

(2) RULE OF CONSTRUCTION.—Nothing in the paragraph (1) shall be construed to prevent a standard health plan from providing for a different basis or level of payment than the fee schedule established under such paragraph as part of a contractual agreement with participating providers under the plan.

(3) REDUCTION FOR PROVIDERS VOLUNTARILY REDUCING CHARGES.—If a provider under a standard health plan voluntarily agrees to reduce the amount charged to an individual enrolled under the

plan, the plan shall reduce the amount otherwise determined under the fee schedule applicable under paragraph (1) by the proportion of the reduction in such amount charged.

(f) ALLOWANCE OF BALANCE BILLING; REQUIREMENT OF DIRECT BILLING.—

(1) ALLOWANCE OF BALANCE BILLING.—A provider may—

(A) accept a fee equal to the applicable payment amount under the applicable fee schedule under subsection (e), and in the case of such an assignment, receive reimbursement through electronic means; or

(B) not accept such an assignment, receive 95 percent of such applicable payment amount, and charge or collect from an enrollee a fee in excess of such amount to the extent such fee does not exceed 15 percent of such amount.

(2) DIRECT BILLING.—

(A) IN GENERAL.—A provider may not charge or collect from an enrollee amounts that are payable by the standard health plan (including any cost-sharing reduction assistance payable by the plan) and shall submit charges to such plan in accordance with any applicable re-

quirements of subtitle B of title V (relating to health information systems).

(B) PROHIBITION.—An individual or entity that performs ancillary health services, such as clinical laboratory services or other services as defined by the Secretary, may not present or cause to be presented, a claim, bill, or demand for payment to any person other than the individual receiving such services, or to the standard health plan of the individual, except that the Secretary may by regulation establish appropriate exceptions to the requirement of this subparagraph.

(3) COVERAGE UNDER AGREEMENTS WITH PLANS.—The agreements or other arrangements entered into under section 1124(c)(2) between a standard health plan and the health care providers providing the standard benefits package or the alternative standard benefits package to individuals enrolled with the plan shall prohibit a provider from engaging in balance billing described in paragraph (1).

(4) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to—

(A) require or force an individual to receive health care solely through the individual's standard health plan; or

(B) prohibit any individual from privately contracting with any health care provider and paying for the treatment or service provider by such provider on a cash basis or any other basis as agreed to between the individual and the provider.

(g) PROVIDERS OUTSIDE AREA.—A State may not limit the ability of any plan to contract with a provider of health services located outside of the geographic boundaries of a community rating area or the State, so long as the provider is authorized under State law to provide such services.

SEC. 1130. HEALTH SECURITY CARDS.

Each standard health plan shall issue a health security card to each individual enrolled in such plan in accordance with subtitle B of title V and regulations promulgated by the Board.

SEC. 1131. UTILIZATION MANAGEMENT PROTOCOLS AND PHYSICIAN INCENTIVE PLANS.

(a) REQUIRING CONSUMER DISCLOSURE.—Each standard health plan shall disclose to enrollees (and prospective enrollees) and providers, the protocols and finan-

cial incentives used by the plan, including utilization management protocols and physician incentive plans (as defined in subsection (b)), for controlling utilization and costs.

(b) UTILIZATION MANAGEMENT.—Each standard health plan shall provide that all treatment assessment and placement decisions, or review of such decisions, shall be made by personnel—

(1) licensed, certified or otherwise credentialed by the State in the field for which the assessment or treatment is sought; and

(2) qualified to review utilization of the specific treatment delivered.

(c) PHYSICIAN INCENTIVE PLAN DEFINED.—As used in this section, the term "physician incentive plan" means any compensation arrangement between a standard health plan, a utilization management organization or other organization, and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.

(d) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—A standard health plan, or any provider or group of providers with whom the health plan contracts, may not operate a physician incentive plan (as defined in sub-

section (c)) unless the following requirements are complied with:

(1) The physician incentive plan provides that no specific payment may be made directly or indirectly under the plan to a physician or physician group or utilization management organization as an inducement to reduce or limit medically necessary or appropriate services provided to individuals enrolled with the organization.

(2) If the standard health plan places a physician or physician group at financial risk for services not provided by the physician or physician group, the physician incentive plan shall provide stop-loss protection for the physician or physician group that is adequate and appropriate, based on standards developed by the Board that take into account the number of physicians placed at such financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group.

(3) The standard health plan and any physician or physician group with whom the health plan contracts shall provide the Board with descriptive information regarding the physician incentive plan, sufficient to permit the Board to determine whether the

plan is in compliance with the requirements of this subsection.

PART 4—SUPPLEMENTAL HEALTH BENEFITS PLANS

SEC. 1141. SUPPLEMENTAL HEALTH BENEFITS PLANS.

(a) TREATMENT OF SUPPLEMENTAL HEALTH BENEFITS PLANS.—

(1) IN GENERAL.—Nothing in this Act may be construed as preventing a standard health plan sponsor from offering and pricing (in a manner that is separate from the offering and pricing of the standard health plans offered by such sponsor in the community rating area) supplemental health benefits plans pursuant to the State certification plan, the requirements of this section, and regulations promulgated by the Board.

(2) PLANS DEFINED.—In this Act—

(A) SUPPLEMENTAL HEALTH BENEFITS PLAN.—The term "supplemental health benefits plan" means a supplemental services plan or a cost-sharing plan.

(B) SUPPLEMENTAL SERVICES PLAN.—The term "supplemental services plan" means a health plan which provides—

(i) coverage for services and items not included in the standard benefits package or the alternative standard benefits package established under subtitle C,

(ii) coverage for items and services included in such package but not covered because of a limitation in amount, duration, or scope of benefits, or

(iii) both.

(C) COST-SHARING PLAN.—The term "cost-sharing plan" means a health plan which provides coverage for deductibles and coinsurance imposed as part of the standard benefits package established under subtitle C.

(b) REQUIREMENTS FOR SUPPLEMENTAL SERVICES PLANS.—

(1) APPLICATION OF CERTAIN HEALTH PLAN STANDARDS.—

(A) IN GENERAL.—The standards specified in subparagraph (B) shall apply with respect to each supplemental services plan in the same manner as such standards apply with respect to a certified standard health plan.

(B) SPECIFIED STANDARDS.—The standards specified in this subparagraph are as follows:

(i) Section 1111 (relating to guaranteed issue, availability, and renewability).

(ii) Section 1112 (relating to enrollment).

(iii) Section 1114 (relating to nondiscrimination based on health status).

(iv) Section 1116 (relating to rating limitations for community-rated market).

(2) NO DUPLICATIVE HEALTH BENEFITS.—A standard health plan sponsor or any other entity may not offer any supplemental services plan that—

(A) duplicates the standard benefits package,

(B) is linked in any manner to the plan's standard benefits package; or

(C) duplicates any coverage provided under the medicare program to any medicare-eligible individual.

(3) RESTRICTIONS ON MARKETING ABUSES.—Not later than May 1, 1995, the Secretary shall develop minimum standards that prohibit marketing practices by standard health plan sponsors and other

entities offering supplemental services plans that involve:

(A) Providing monetary incentives for, or tying or otherwise conditioning, the sale of the plan to enrollees in a certified standard health plan of the sponsor or entity.

(B) Using or disclosing to any party information about the health status or claims experience of participants in a certified standard health plan for the purpose of marketing a supplemental services plan.

(c) TREATMENT OF COST-SHARING PLANS.—

(1) RULES FOR OFFERING OF POLICIES.—A cost-sharing plan may be offered to an individual only if—

(A) the plan is offered by the standard health plan in which the individual is enrolled;

(B) the standard health plan offers the plan to all individuals enrolled in the standard health plan; and

(C) the plan is offered only during the annual open enrollment period for standard health plans (described in section 1503).

(2) PROHIBITION OF COVERAGE OF COPAYMENTS.—Each cost-sharing plan may not pro-

vide any benefits relating to any copayments established under subtitle C.

(3) EQUIVALENT COVERAGE FOR ALL SERVICES.—Each cost-sharing plan shall provide coverage for items and services in the standard benefits package to the same extent as the plan provides coverage for all items and services in the package.

(4) REQUIREMENTS FOR PRICING.—

(A) IN GENERAL.—The price of any cost-sharing plan shall—

(i) be the same for each individual to whom the plan is offered;

(ii) take into account any expected increase in utilization resulting from the purchase of the plan by individuals enrolled in the standard health plan; and

(iii) not result in a loss-ratio of less than 90 percent.

(B) LOSS-RATIO DEFINED.—In subparagraph (A)(iii), a "loss-ratio" is the ratio of the premium returned to the consumer in payout relative to the total premium collected.