

MEMORANDUM

TO: Senator Harkin *JS*
FROM: Bobby Silverstein and Andy Imparato *ai*
SUBJECT: Improvements in Chairman Kennedy's Mark of the Health Security Act for Individuals with Disabilities and Chronic Conditions
DATE: June 2, 1994

Set out below are the major improvements included in Chairman Kennedy's mark of the Health Security Act from a disability perspective as of June 2, 1994. The bulk of the positive changes, many of which you proposed, were in the areas of the basic benefits package, subsidies, plan management and governance, but there were some significant changes in the home and community-based long term care program, care coordination provisions, and medical training sections as well.

This memorandum begins with an overview of the major areas of refinement and improvement in the Chairman's mark. It continues with more detailed discussions of changes in the basic benefits package; improvements in organization, management and structure of health plans; amendments affecting the new home and community-based long-term care program; new language regarding coordination with existing programs; and new provisions regarding training of health providers to meet the needs of individuals with disabilities.

All of the changes in the Chairman's mark have been reviewed by the Congressional Research Service. Attached as Appendix A is a memorandum from CRS estimating the costs of the changes contemplated by the Chairman's mark. Overall, the effect of benefit changes in the Chairman's mark has been estimated by the Congressional Research Service to reduce premiums by between 1.2 and 2.6 percent, as compared with the estimated cost of premiums under the Clinton bill.

The methodology and assumptions underlying the CRS estimates have been coordinated with the Budget Analysis Division of the Congressional Budget Office to ensure that they are consistent with estimates we may receive from them later.

I. MAJOR REFINEMENTS/IMPROVEMENTS IN THE CHAIRMAN'S MARK FOR PEOPLE WITH DISABILITIES INCLUDE:

CONCEPT OF ACUTE HEALTH CARE

The concept of "acute" health care in Chairman's mark recognizes the needs of those with congenital or chronic conditions as well as those who need services as a result of an acute illness or injury. Likewise, the Chairman's mark includes coverage for cost effective services that maintain functioning and prevent deterioration in functioning that, if unaddressed,

might lead to the development of secondary disabilities.

BASIC BENEFITS PACKAGE

- * Improves coverage of **outpatient rehabilitation services, home health services, and extended care services** for those with congenital and chronic conditions and disabilities (§§ 1123, 1118, 1119, attached as appendices B, C, and D, respectively).
- * Improves coverage of **outpatient rehabilitation services** by including consultative coverage for maintenance of functioning and prevention of deterioration in functioning; clarifies inclusion of **respiratory therapy and audiology services** for purpose of attaining or restoring speech (§ 1123, appendix B).
- * Expands coverage of **mental health/substance abuse services** by eliminating many numerical limits and strengthening role of managed care in controlling costs; expanding eligibility for children under 6 at risk of a mental disorder; including mental health/substance abuse payments in out-of-pocket limit (§ 1115, attached as appendix E).
- * Adds coverage for **hearing aids for children** (creating parity with the eyeglasses benefit) (§ 1130, attached as appendix F).
- * Clarifies coverage of **durable medical equipment, prosthetics and orthotics** to include external devices; accessories and supplies; replacement, adjustment and repair of devices; and items and services necessary to minimize deterioration in functioning (§ 1124, attached as appendix G).
- * Eliminates 100 day annual limit on **extended care services** if services continue to be a cost-effective alternative to hospital care (§ 1119, appendix D).
- * Clarifies coverage for **disposable medical supplies** like syringes and blood glucose monitoring strips (§ 1122(a)(4), attached as appendix H).
- * Clarifies inclusion of **medical foods** for inborn errors of metabolism (e.g. PKU) under drug/biological coverage (§ 1122(a)(3), appendix H).
- * Adds **extra-contractual services** at plan option with consent of enrollee (§ 1129, attached as appendix I).

ACCESS TO APPROPRIATE SPECIALISTS

The Chairman's mark includes a number of provisions that

make it more likely that people with disabilities will be able to choose a plan that meets their needs, particularly their need to have appropriate access to specialists. These include:

- * language requiring that gatekeepers be specialists when medically necessary or appropriate (§ 1507(c)(2), attached as appendix J);
- * language requiring that people be allowed to maintain a relationship with a specialist without going through a gatekeeper when necessary (§ 1507(c)(3), appendix J);
- * prohibition of physician incentive plans that inappropriately discourage access to specialists (§ 1513(c), attached as appendix K);
- * mandatory disclosure of plan protocols to enrollees (§ 1513(a), appendix K);
- * inclusion of new programs for training specialists who perform a primary care role (e.g. pediatricians, psychiatrists) (§ 3012(g)(3), attached as appendix L); and
- * enhanced access to centers with specialized treatment expertise and essential community providers (§§ 1507(c)(4), 1531 and 1681-85, attached as appendix Z).

ACCOUNTABILITY AND GOVERNANCE

The Chairman's mark includes improvements in the accountability and governance provisions, e.g., quality assurances, grievance procedure, ombudsman, councils, privacy and confidentiality, remedies, and sanctions which ensure that the bill addresses the needs of those with disabilities, not just the average consumer (see, e.g., § 5002(a), attached as appendix M).

LONG-TERM SERVICES/PERSONAL ASSISTANCE SERVICES

The Chairman's mark maintains the Clinton commitment to substantial new federal funding for home and community-based long-term care services, and refines the provisions in the Clinton bill. Improvements in the Chairman's mark include:

- * expanded definition of personal assistance services to include instrumental activities of daily living for persons with primarily mental, cognitive, or sensory impairments (§ 2104(g)(1), attached as appendix N);
- * language requiring new program to have eligibility criteria of comparable severity for people of all ages and all categories of disability (§ 2103(b), attached as appendix O; see also § 2102(a)(2)(D), attached as appendix P);

- * creation of a new program of extended services for children with special health care needs (§§ 2111 through 2117, attached as appendix Q);
- * addition of a State client advocacy agency to protect consumer rights in the new system (§ 2106(c) and (d), attached as appendix R);
- * language regarding affordability when cost sharing becomes exorbitant (§ 2105(c), attached as appendix S);
- * provisions clarifying the employer obligations of persons who use consumer-directed personal assistance services (§ 2104(g)(2), attached as appendix T); and
- * strengthened federal monitoring and oversight of State plans (§ 2106(a) and (b), attached as appendix U).

COORDINATION WITH EXISTING PROGRAMS

The Chairman's mark adds language requiring coordination with existing programs (e.g., MCH, special education, early intervention), particularly for children, in the mental health benefit in Title I (§ 1115(i), appendix E), and in the long-term care provisions in Title II (§ 2114(c)(2), attached as appendix V; § 2102(a)(9)(C), attached as appendix W).

TRAINING OF HEALTH PROFESSIONALS

The Chairman's mark includes provisions requiring that health professionals receive training in meeting the needs of people with mental, physical, and developmental disabilities, including mental retardation (§ 3081, attached as appendix X).

II. DETAILED ANALYSIS OF CHANGES IN BASIC BENEFITS PACKAGE

The Chairman's mark is based upon a premise that "acute" health care covered by the basic benefits package must meet the needs of all people, including people with congenital disabilities. The package in the Chairman's mark clarifies and refines many of the benefits in the Clinton bill from a disability perspective. As the Chairman stated in his opening remarks, the benefits package in his mark is not a "cadillac," but more of a "family van." It does not contain frills and luxury items, but instead represents a solid, fiscally responsible attempt to meet the needs of all Americans.

People with Congenital Disabilities

Although the Clinton Administration intended to eliminate pre-existing condition exclusions as part of health care reform, the Clinton bill inadvertently permitted such exclusions for people with congenital disabilities in three specific areas in the basic benefits package. Under outpatient rehabilitation services (occupational therapy, physical therapy, and speech pathology services), home health services, and extended care services, the Clinton plan provided coverage for services only when they were needed "as a result of an illness or injury." This language had the unintended effect of perpetuating a pre-existing condition exclusion for people with congenital disabilities who were in need of these services.

The Chairman's mark corrects this oversight in the Clinton bill, providing for coverage of such services when they are needed in response to an "illness, injury, disorder, or other health condition." See appendices B, C, and D.

Maintenance of Functioning and Prevention of Deterioration

For many people with significant disabilities, ongoing rehabilitation services are essential to maintain functioning or prevent deterioration in functioning. Without a maintenance program, people with disabilities are often at risk of losing functional abilities that they often have worked hard to achieve. Such deterioration, if it occurs, will often result in increased dependence and increased cost to the medical system. Under the Clinton bill, rehabilitation services were covered to restore functioning or minimize limitations in functioning. The bill also provided that, at the end of each 60 days of treatment, the need for continued therapy was re-evaluated with additional periods of therapy covered only if "function is improving." It was unclear whether the improved functioning language applied only to therapies that were being provided to restore functioning, or also to therapies that were provided to minimize deterioration in functioning.

The Chairman's mark clarifies the ambiguities in the Clinton bill. First, it clarifies that minimization of functional deterioration includes both maintenance of functioning and prevention of deterioration in functioning. The Chairman's mark allows for continuing consultative care by a rehabilitation professional where the rehabilitation services accomplish these purposes. The maintenance or prevention of deterioration benefit includes:

- * the initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional;
- * the designing by a qualified rehabilitation health professional of a maintenance or prevention program that is appropriate considering the capacity and tolerance of the patient and the treatment objectives;
- * the instruction of the patient, family members, or support personnel in carrying out the program; and
- * reevaluations.

The Chairman's mark also clarifies that services may be provided after the initial 60 day period when such services either result in restored functioning or minimized limitations in functioning. See appendix B.

Mental Health/Substance Abuse

The Chairman's mark also includes some significant improvements in the mental health/substance abuse benefit in the basic benefits package. These include:

- * Outpatient treatment with no arbitrary limits, including screening and assessment, psychotherapy, medications management, substance abuse counseling and relapse prevention. Cost sharing is on par with other outpatient medical services.
- * Intensive nonresidential treatment with no arbitrary limits, including day treatment and psychiatric rehabilitation programs. Cost sharing is on par with other rehabilitation services.
- * Residential mental health and substance abuse treatment without arbitrary limits, in non-medical settings that are inexpensive and cost-effective such as therapeutic communities. Cost sharing is on par with hospital services.
- * Organized systems of care for children with emotional disturbances.

- * 60 days per year of residential mental health treatment. Consumers may receive 4 days of residential treatment by substituting them for 1 day of hospital treatment, up to 15 days of the hospital benefit. Cost-sharing is on par with hospital services.
- * 30 days per year of inpatient hospital treatment. Consumers may substitute 15 days of this benefit for 60 days of residential treatment, leaving a base benefit of 15 days.

See appendix E.

Durable Medical Equipment, Prosthetics and Orthotics

The Clinton bill provided for coverage of durable medical equipment, prosthetics and orthotics, but described this benefit in a way that might have resulted in some medically necessary items and services such as external devices being left out. The Chairman's mark clarifies coverage of durable medical equipment, prosthetics and orthotics to include external devices that replace all or part of the function of an internal body organ or external body member; accessories and supplies; replacement, adjustment and repair of devices; and items and services necessary to minimize deterioration in functioning. See appendix G.

Medical Supplies

The Clinton bill was ambiguous with regard to whether disposable medical supplies such as syringes and blood glucose monitoring strips would be covered as part of the comprehensive benefits package.

These types of supplies are typically covered by private insurance when prescription drugs are covered, and the Chairman's mark includes language clarifying that these items would be covered. In Section 1122(a)(4), the section describing coverage for outpatient prescription drugs and biologicals, the mark clarifies that "[a]ccessories and supplies that are used directly with drugs and biologicals to achieve the therapeutic benefit of such drugs or biologicals" will be covered. See appendix H.

Hearing Aids

In the Clinton bill, hearing aids were listed as an excluded benefit. The Chairman's mark provides for coverage for hearing aids for individuals under 18 years of age. See appendix F. The Clinton bill did provide for coverage of eyeglasses for children under the age of 18. Many persons pointed out that hearing aids, like eyeglasses, should at least be covered for children under 18, in part for parity between vision and hearing care, but primarily because the consequences of not providing them are so

detrimental to a child's development.

With regard to this second point, it has been well-demonstrated by medical and educational researchers that early identification of hearing loss in infants and young children can save considerable expense in the long term because it leads to early and appropriate intervention and habilitation for the acquisition of language, whether oral or sign language. This in turn increases a child's reading and achievement levels, academic and social skills, and, ultimately, employment.

Along these lines, it is useful to note that the critical years in which speech and language develop are birth through age 6. By age 5, a child with average hearing understands the meaning of 5,000-25,000 words. For a child who needs hearing aids, and does not have them, this speech and language acquisition window of opportunity is lost.

Medical Foods to Correct Inborn Errors of Metabolism

The Clinton bill included coverage of prescription drugs and biologicals. This left open the question of whether prescribed medical foods to treat inborn errors of metabolism like PKU would be covered. The Chairman's mark clarifies that such prescribed medical foods will be covered under the prescription drugs and biologicals benefit. See appendix H.

Extra-contractual Services

Many private insurance companies pay for "extra-contractual" services i.e., services typically not covered such as retrofitting a home or long-term care services. They do so where it is in the best interest of the consumer and the company believes it will be cost-effective in the long run (e.g., avoid long hospital stays). Language in the Clinton bill would have inadvertently prohibited such practices. The Chairman's mark includes provisions to ensure that such practices continue. See appendix I.

III. ORGANIZATION, MANAGEMENT, AND STRUCTURE OF HEALTH PLANS

The disability community has raised a number of related issues regarding the organization, management, and structure of health plans under the Clinton proposal. A real fear of many people with disabilities is that the health reform will look great on paper but will not work in practice. The Chairman's mark includes a number of provisions to ensure that covered benefits are in fact provided to people who need the benefits.

Many people with disabilities prefer the fee-for-service option, where they can choose the provider that best meets their needs without going through a gatekeeper. Under the Clinton

proposal and in the Chairman's mark, this option must be made available to all people; but it costs more than the managed care option. Because of the cost, it may not be affordable by most people with disabilities, even with a discount (subsidy).

Many people with disabilities have had bad experiences with HMOs (failure to provide necessary services and lack of access to knowledgeable specialists). Problems stem from the use of gatekeepers (generalists) who do not understand their special problems, and financial disincentives to provide necessary services (e.g., providing bonuses for physicians who do not exceed certain utilization levels). Often, physicians in managed care settings experience pressure to increase the volume of patients they treat, making it hard for them to spend extra time with patients who may require this time because of cognitive or mobility impairments. Page 200 of the September outline for the Clinton plan acknowledged that "in many regions of the country, organized delivery systems have little experience providing care to severely disabled persons."

The Chairman's mark includes provisions that address problems with gatekeepers and physician incentive plans. The mark includes language requiring that gatekeepers be specialists when necessary. See appendix J. Also, it includes language requiring that people be allowed to maintain a relationship with a specialist without going through a gatekeeper when necessary. See appendix J. Moreover, the Chairman's mark explicitly prohibits physician incentive plans that inappropriately discourage access to specialists, and requires disclosure of plan utilization protocols to enrollees. See appendix K.

Clinton's proposal contained provisions for risk adjustment and re-insurance mechanisms to provide additional reimbursement for plans that serve more expensive patients. It is important to ensure that persons with disabilities are not discriminated against, and to analyze whether risk adjustment, re-insurance, and other mechanisms included in the Clinton bill and the Chairman's mark will in fact increase the likelihood that plans will provide necessary services to individuals with disabilities.

One way to ensure that the system is working for people with disabilities is to collect outcomes and quality data for this population. The Chairman's mark, like the Clinton bill, includes provisions designed to measure quality under the new system. The mark specifically requires the National Quality Council to develop quality assessment instruments that produce data for the general population and for subpopulations of individuals based on demographic characteristics and health status. See appendix M. These instruments will then be used as report cards to review the performance of health plans. If a health plan gets an "A" for the general population and an "F" with regard to people with

disabilities, the "F" will be apparent to enrollees, potential enrollees, and monitors.

Under the Clinton bill, the only sanction specified for a plan found not to be complying with its obligations was decertification. The Chairman's mark authorizes a range of corrective measures for plans, including fines and corrective action plans. See § 1203(c), attached as Appendix Y. This range will make it easier to address problems when they exist without requiring a plan to go out of business.

IV. LONG-TERM SERVICES/PERSONAL ASSISTANCE SERVICES

The Clinton bill maintained existing federal programs under the Social Security Act that finance long-term care and made some improvements in nursing home coverage from current law. In addition, it created substantial new federal funding for home and community-based long-term care services, including personal assistance services. The federal portion of the funding for this new formula grant program was to be phased in over 7 years, with federal participation at \$38 billion a year at full phase-in.

The Chairman's mark maintains the Clinton commitment to substantial new federal funding for home and community-based long-term care services, and refines the provisions in the Clinton bill. Improvements in the Chairman's mark include:

- * an expanded definition of personal assistance services to include instrumental activities of daily living for persons with primarily mental, cognitive, or sensory impairments (see appendix N);
- * language requiring the new program to have eligibility criteria of comparable severity for individuals of all ages and with all categories of disability (see appendices O and P);
- * creation of a new program of extended services for children with special health care needs (see appendix Q);
- * addition of a State client advocacy agency to protect consumer rights in the new system (see appendix R);
- * provisions to help ensure affordability when cost sharing becomes exorbitant (see appendix S);
- * provisions clarifying the employer obligations of persons who use personal assistance services (see appendix T); and
- * strengthened federal monitoring and oversight of State plans (see appendix U).

The new program of extended services for children with special health care needs, which is funded with up to two percent of the funding for the home and community-based formula grant, is designed to meet the needs of children who do not meet the severity of disability level established for the larger program, but who nonetheless have a need for services beyond those covered in the basic benefits package. This program is intended to work alongside the new poverty level program for children with special needs in Title IV of the Clinton bill to ensure that cost-effective, preventive wraparound services are made available to children at all income levels.

V. COORDINATION WITH EXISTING PROGRAMS

Children who currently receive Medicaid are entitled to a wide range of services under the federally mandated early and periodic screening, diagnostic and treatment (EPSDT) program. EPSDT, which applies to all Medicaid recipients under 21, requires states to screen children on Medicaid and provide any treatment or service that is medically necessary to treat an illness, disease, or condition discovered during the screening examination, including otherwise optional services like speech therapy, occupational therapy, and physical therapy to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening. States cannot exclude maintenance services, e.g., frequent and extended physical therapy services for a chronic disability. Services also include screening, vision, dental, hearing (including hearing aids), transportation, and case management.

In addition, children are entitled to educationally-related services like speech, occupational and physical therapies under Part H and Part B of IDEA. The maternal and child health programs under Title V of the Social Security Act also provide some funding for health services to children with special needs, and there are a large number of state programs designed to meet the needs of children.

The Chairman's mark adds language requiring coordination between health plans, providers, and administrators of new programs under the Health Security Act with existing programs (e.g., MCH, special education, early intervention), particularly for children, in the mental health benefit in Title I (see appendix E), and in the long-term care provisions in Title II (see appendices V and W).

VI. TRAINING OF HEALTH PROFESSIONALS

The President's proposal attempted to shift the balance in the graduate training of physicians from specialties to primary care. Many individuals expressed a need to ensure that physicians receive adequate training in addressing the special

needs of individuals with disabilities.

The September 7 draft proposal attempted to address this issue. The proposal identified priority projects that would get increased support for training providers in certain special areas (page 131 of Sept. 7 draft). One area that the Administration had identified was developmental disabilities. This important first step was not included in the bill presented to Congress.

The Chairman's mark includes provisions requiring that health professionals receive training in meeting the needs of people with mental, physical, and developmental disabilities, including mental retardation. See appendix X. It also includes provisions ensuring adequate graduate medical training to produce specialists such as psychiatrists and OB-GYNs who are able to fulfill a primary care role for some individuals who require their care. See appendix L.

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Appendix A



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May 16, 1994

TO : Senate Labor and Human Resources Committee
Attention: David Nexon and Mary Beth Fiske

FROM : Michael J. O'Grady
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : Varying the Benefits in the Health Security Act, S. 1757--
Premium Effects

In response to our meeting and subsequent phone conversations I have prepared the following memorandum analyzing the effect of various benefit changes on health insurance premiums.

In the first stage of this analysis we used the Health Security Act, S. 1757, as a basis for comparing any changes in the benefit package. In conjunction with our consulting actuaries at Hay/Huggins Co., Inc., we then estimated the actuarial value of the benefits changes specified in Chairman Kennedy's mark dated May 11, 1994.

With the estimates of actuarial value, I have used the Census Bureau's March 1993 Current Population Survey (CPS) to model the distribution of the U.S. population¹ into the four types of coverage groups specified in S. 1757: self only, two adults, single-parent families and two-parent families.

Table 1 details the effect of the benefit changes on the four premium types specified in S.1757. The percentage change estimates are of the total premium and have been calculated for both the high and low cost sharing plans. It is unclear how the premium estimates under the combination plan would be effected, but given the hybrid nature of the combination plan we are comfortable with the assumption that the high and low cost sharing estimates provide a reasonable range of estimates for the combination plan. No assumptions have been made about how people might sort themselves into the different plans. It is assumed that the populations covered by the high and low cost sharing plans are demographically similar to the population overall.

¹Except those people who primarily rely on Medicare for their health insurance.

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Table 2 provides some details of our interpretation of the provisions. We have tried to put ourselves in the position of an insurer determining what benefits are covered, at what cost sharing. If in any of these provisions we have misinterpreted the intent please let us know.

There are a few areas where we are not yet able to make estimates of the effects of Chairman Kennedy's mark. Our work on the premium effects of your changes to the mental health coverage should be completed shortly.

The overall effect of the benefit changes specified in table 1 reduces premiums between 1.2 and 2.6 percent. Keep in mind, that we have only analyzed the changes specified in table 1 and other modifications could alter the overall result considerably.

The methodology and assumptions underlying the estimates have been coordinated with the Budget Analysis Division of the Congressional Budget Office to ensure that they are consistent with estimates you may receive from them later.

If you have any questions or we can be of further assistance, I can be reached at 7-7347.

TABLE 1. Percentage Change in Premiums for Expanded Benefits, Under Four Types of Coverage

Benefit	Individual		Couple		Single-parent family		Two-parent family	
	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing
Clinton baseline	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
A) Clinical preventive services								
1) Tests	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.2%	0.3%
2) Clinician visits under age 20	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.2%	0.3%
B) Hearing aids for children	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%
C) Rehabilitation services extensions	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
D) Home health care and extended care facilities	0.6%	0.7%	0.6%	0.7%	0.6%	0.7%	0.6%	0.7%
E) Enhanced mammograms								
1) Ages 50-64 annually	0.6%	0.6%	0.6%	0.6%	0.3%	0.3%	0.3%	0.4%
2) Ages 40-49 biannually	0.3%	0.4%	0.3%	0.4%	0.2%	0.2%	0.2%	0.2%
F) Enhanced pap smears	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
G) Contraceptive drugs and prescription devices	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%
H) Extended care annual limit	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
I) Medical foods (PKU, etc.)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
J) Outpatient drugs--accessories and supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
K) Outpatient speech pathology and audiology services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
L) Durable medical equipment--replacement	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
M) Vision care limitation to periodicity schedule	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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TABLE 1. Percentage Change in Premiums for Expanded Benefits, Under Four Types of Coverage

Benefit	Individual		Couple		Single-parent family		Two-parent family	
	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing
N) Investigational treatments--discretion of plan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
O) Extracontractual items and services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
P) Hospital deductible of \$250--low cost sharing plan	-1.6%	0.0%	-1.6%	0.0%	-1.5%	0.0%	-1.5%	0.0%
Q) Drug copayment of \$10--low cost sharing plan	-2.0%	0.0%	-2.0%	0.0%	-1.9%	0.0%	-1.9%	0.0%
R) Individual max. out-of-pocket increased from \$1,500 to \$2,500--high cost sharing plan	0.0%	-4.9%	0.0%	-4.9%	0.0%	-4.7%	0.0%	-4.7%
Insurance units--in thousands* (total = 107,076)	51,503		17,220		11,419		26,933	
Population--in thousands* (total = 223,621)	51,503		34,522		31,954		105,641	
Percentage children	0.0%		0.0%		60.6%		46.6%	

*Except those people who primarily rely on Medicare for their health insurance.

Source: Actuarial value of benefit variations calculated uses CRS Health Benefits Model v. 5.3. Demographic adjusters developed from data provided by major insurers, the Office of Personnel Management and the Nation Medical Expenditures Survey. Insurance units and population data developed using the Census Bureau's March 1993 Current Population Survey.

TABLE 2. Modifications to the Health Security Act

Benefit	Proposed Benefit Changes
A. Enhanced Children's Preventive Services 1. Tests 2. Clinician visits under age 20	Modifications to S. 1757 that either increase or decrease the incidence of clinical preventive services.
B. Hearing Aids and Comprehensive Hearing Assessments for Children under 18	Benefit added to S. 1757 for children who have failed a hearing screening as originally covered by S. 1757.
C. Rehabilitation Services Extensions	S. 1757 benefits clarified include coverage for outpatient respiratory therapy, and audiology services for outpatient speech-language pathology services. Established a maintenance or prevention program to include the following services: 1. Rehab health professional to provide initial evaluation & periodic oversight of the patient. 2. Rehab health professional to design a maintenance or prevention program appropriate for the patient. 3. Instruct patient and family members on how program is to be implemented. 4. Periodic reevaluations (in addition to a reevaluation at the end of each 60 day period). The plan will not deny coverage for outpatient occupational therapy, outpatient physical therapy, outpatient respiratory therapy and outpatient speech language pathology services and audiology services as a result of a disorder or other health condition. (S. 1757 only provides coverage if condition is a result of an illness or injury.
D. Home Health Care and Extended Care Facilities Extensions	Extends the coverage clause under S. 1757 to include conditions that did not result from an illness or injury. Also extends the annual number of visits in ECF if the care is found to be a "cost-effective alternative to necessary inpatient hospitalization".
E. Enhanced Mammograms	Augments the benefit under S. 1757 for: • Age 50-64 to cover mammograms annually rather than biannually. • For 40-49 to cover mammograms biannually.
F. Enhanced Pap Smears	Benefit added to S. 1757 to cover pap smears annually unless individual has 3 years of negative pap smears and no risk factors for STDs or cervical cancer.
G. Contraceptive Drugs and Prescription Devices	Extends benefit to include coverage for contraceptives drugs and prescription devices.
H. Extended care annual limit	Provides for an annual limit of 100 days for extended care services, with conditions under which the limit can be waived.

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TABLE 2. Modifications to the Health Security Act

Benefit	Proposed Benefit Changes
I. Medical foods (PKU, etc.)	Medical foods prescribed by a physician are added to the outpatient prescription drugs and biologicals coverage.
J. Outpatient drugs accessories and supplies	Clarifies accessories and supplies typically covered under current health insurance policies. For example, syringes and glucose testing supplies for diabetics.
K. Outpatient speech pathology and audiology services	Under outpatient rehabilitation services, clarifies that outpatient speech language and audiology services are covered for the purpose of attaining or restoring speech.
L. Durable medical equipment—replacement	Clarifying language covering the replacement of durable medical equipment. Conforms with typical current insurance practices.
M. Vision care limitation to periodicity schedule	Allows the Board to establish the periodicity schedule for benefit.
N. Investigational treatments—discretion of plan	Allows the plan to cover an investigational treatment at it's discretion, as long as it's done based upon objective protocols and applied consistently.
O. Extracontractual items and services	Allows the plan discretion to use cost effective alternatives, as long as appropriate treatment is provided.
P. Hospital deductible of \$250 - low cost sharing plan	Increase from \$0 to \$250
Q. Drug copayment of \$10—low cost sharing plan	Increase copayment from \$5 to \$10
R. Individual maximum out-of-pocket increased from \$1,500 to \$2,500—high cost sharing plan	Increase individual maximum out-of-pocket liability from \$1,500 to \$2,500. Leave family liability at \$3,000.



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May 17, 1994

TO : Senate Labor and Human Resources Committee
Attention: Ron Weich

FROM : Michael J. O'Grady
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : Varying the Mental Health Benefits in the Health Security Act,
S. 1757—Premium Effects

In response to our meeting and subsequent phone conversations this memorandum analyzes the effect of various changes in the mental health benefits on health insurance premiums.

In the first stage of this analysis we used the Health Security Act, S. 1757, as a basis for comparing any changes in the mental health benefit package. In conjunction with our consulting actuaries at Hay/Huggins Co., Inc., we then estimated the actuarial value of the benefits changes specified in Chairman Kennedy's mark dated May 11, 1994.

The mental health benefits changes specified in the Chairman's mark would increase premiums by 1.6 percent in the high cost sharing plan for all four types of coverage groups, self only, two adults, single-parent families and two-parent families. In making these estimates we used a \$2,500 maximum out-of-pocket limit for individuals and \$3,000 for families. Further we allowed the maximum out-of-pocket limits to apply to mental health charges for inpatient, residential, intensive nonresidential and outpatient services. The coinsurance used was 20 percent for all four types of service.

A less costly alternative would be to use the cost sharing provisions specified in S. 1757 for outpatient psychotherapy—i.e., require a payment of 50 percent coinsurance. This modification increases premiums by only 0.1 percent in the high cost sharing plan for all four types of coverage groups.

If, in conjunction with the modification in the cost sharing provisions for outpatient psychotherapy, a further modification were made to strengthen the language regarding managed care, there would be no premium increase over S. 1757. Language that would require and specifically define quality managed care, rather than leaving it to the discretion of the plan would be sufficient for this purpose.

CRS-2

It is our understanding that these modifications to the outpatient cost sharing and managed care provisions are consistent with later versions of the Chairman's mark. With the modifications as specified, CRS estimates no premium increase for mental health benefits compared to S. 1757, the Health Security Act.

The methodology and assumptions underlying the estimates have been coordinated with the Budget Analysis Division of the Congressional Budget Office to ensure that they are consistent with estimates you may receive from them later.

If you have any questions or if we can be of further assistance, I can be reached at 7-7347.

(3) Medical foods prescribed by a physician that comply with the requirements of the Federal Food, Drug, and Cosmetic Act and that treat inborn errors of metabolism identified by the Secretary as rendering a person unable to sustain life without significant mental or physical impairment by the ingestion of conventional foods.

(4) Accessories and supplies that are used directly with drugs and biologics to achieve the therapeutic benefit of such drugs or biologics.

(b) REVISION OF COMPENDIA LIST.—The Secretary may revise the list of compendia in subsection (a)(1)(A)(ii) designated as appropriate for identifying medically accepted indications for drugs.

(c) BLOOD CLOTTING FACTORS.—For purposes of this subtitle, the term "blood clotting factors" has the meaning given such term in section 1861(s)(2)(D) of the Social Security Act.

SEC. 1123. OUTPATIENT REHABILITATION SERVICES.

(a) COVERAGE.—The outpatient rehabilitation services described in this section are—

- (1) outpatient occupational therapy;
- (2) outpatient physical therapy;
- (3) outpatient respiratory therapy; and
- (4) outpatient speech-language pathology services and audiology services.

(b) LIMITATIONS.—Coverage for outpatient rehabilitation services is subject to the following limitations:

(1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS.—Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder or other health condition.

(2) MAINTENANCE OF FUNCTION OR PREVENTION OF DETERIORATION.—To the extent that the services described in paragraph (1) are for the purpose of maintaining functioning or preventing deterioration, such services shall be limited to—

(A) the initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional;

(B) the designing by the qualified rehabilitation health professional of a maintenance or prevention program that is appropriate considering the capacity and tolerance of the patient and the treatment objectives;

(C) the instruction of the patient, family members, or support personnel in carrying out the program; and

(D) reevaluations.

(3) REEVALUATION.—

(A) IN GENERAL.—At the end of each 60-day period of outpatient rehabilitation services (other than services described in paragraph (2)), the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied.

(B) QUALIFIED REHABILITATION HEALTH PROFESSIONAL.—Periodically, outpatient rehabilitation services described in paragraph (2) shall be reevaluated by a qualified rehabilitation health professional.

SEC. 1124. DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.

(a) COVERAGE.—The items and services described in this section are—

- (1) durable medical equipment;
- (2) prosthetic devices (other than dental devices) which replace all or part of the function of an internal body organ (including devices that are surgically inserted, devices that are physically attached to the body, such as colostomy bags and

outpatient
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SEC. 1116. FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN.

The services described in this section are the following items and services:

(1) Voluntary comprehensive family planning services, including family planning counseling and education.

(2) Contraceptive drugs and devices, subject to approval by the Secretary under the Federal Food, Drug, and Cosmetic Act.

(3) Services for pregnant women.

SEC. 1117. HOSPICE CARE.

The hospice care described in this section is the items and services described in paragraph (1) of section 1861(dd) of the Social Security Act, as defined in paragraphs (2), (3), and (4)(A) of such section (with the exception of paragraph (2)(A)(iii)), except that all references to the Secretary of Health and Human Services in such paragraphs shall be treated as references to the National Health Board.

SEC. 1118. HOME HEALTH CARE.

(a) **COVERAGE.**—The home health care described in this section is—

(1) the items and services described in section 1861(m) of the Social Security Act; and

(2) home infusion drug therapy services described in section 1861(ll) of the Social Security Act (as inserted by section 2005).

(b) **LIMITATIONS.**—Coverage for home health care is subject to the following limitations:

(1) **INPATIENT TREATMENT ALTERNATIVE.**—Such care is covered only as an alternative to inpatient treatment in a hospital, skilled nursing facility, or rehabilitation facility after an illness, injury, disorder or other health condition.

(2) **REEVALUATION.**—At the end of each 60-day period of home health care, the need for continued care shall be reevaluated by the person who is primarily responsible for providing the home health care. Additional periods of care are covered only if such person determines that the requirement in paragraph (1) is satisfied.

SEC. 1119. EXTENDED CARE SERVICES.

(a) **COVERAGE.**—The extended care services described in this section are the items and services described in section 1861(h) of the Social Security Act when provided to an inpatient of a skilled nursing facility or a rehabilitation facility.

(b) **LIMITATIONS.**—Coverage for extended care services is subject to the following limitations:

(1) **HOSPITAL SERVICES ALTERNATIVE.**—Such services are covered only as an alternative to treatment for inpatient hospital services (as defined under section 1111) after an illness, injury, disorder or other health condition. An entity qualifying as a hospital for purposes of section 1111 may also qualify as a rehabilitation facility for purposes of this section.

(2) **ANNUAL LIMIT.**—Such services are subject to an aggregate annual limit of 100 days, except that such limit may be waived if the need for continued care is reevaluated by the prescribing health care professional and determined to be a cost effective alternative to necessary hospital services.

(c) **DEFINITIONS.**—For purposes of this subtitle:

(1) **REHABILITATION FACILITY.**—The term "rehabilitation facility" means an institution (or a distinct part of an institution) which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to individuals for rehabilitation from illness, injury, disorder or other health condition.

(2) **SKILLED NURSING FACILITY.**—The term "skilled nursing facility" means an institution (or a distinct part of an institution) which is primarily engaged in providing to residents—

HOME HEALTH

1861(m)

SEC. 1116. FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN.

The services described in this section are the following items and services:

(1) Voluntary comprehensive family planning services, including family planning counseling and education.

(2) Contraceptive drugs and devices, subject to approval by the Secretary under the Federal Food, Drug, and Cosmetic Act.

(3) ~~Services for pregnant women.~~

SEC. 1117. HOSPICE CARE.

The hospice care described in this section is the items and services described in paragraph (1) of section 1861(dd) of the Social Security Act, as defined in paragraphs (2), (3), and (4)(A) of such section (with the exception of paragraph (2)(A)(iii)), except that all references to the Secretary of Health and Human Services in such paragraphs shall be treated as references to the National Health Board.

SEC. 1118. HOME HEALTH CARE.

(a) **COVERAGE.**—The home health care described in this section is—

(1) the items and services described in section 1861(m) of the Social Security Act; and

(2) home infusion drug therapy services described in section 1861(l) of the Social Security Act (as inserted by section 2005).

(b) **LIMITATIONS.**—Coverage for home health care is subject to the following limitations:

(1) **INPATIENT TREATMENT ALTERNATIVE.**—Such care is covered only as an alternative to inpatient treatment in a hospital, skilled nursing facility, or rehabilitation facility after an illness, injury, disorder or other health condition.

(2) **REEVALUATION.**—At the end of each 60-day period of home health care, the need for continued care shall be reevaluated by the person who is primarily responsible for providing the home health care. Additional periods of care are covered only if such person determines that the requirement in paragraph (1) is satisfied.

SEC. 1119. EXTENDED CARE SERVICES.

(a) **COVERAGE.**—The extended care services described in this section are the items and services described in section 1861(h) of the Social Security Act when provided to an inpatient of a skilled nursing facility or a rehabilitation facility.

(b) **LIMITATIONS.**—Coverage for extended care services is subject to the following limitations:

(1) **HOSPITAL SERVICES ALTERNATIVE.**—Such services are covered only as an alternative to treatment for inpatient hospital services (as defined under section 1111) after an illness, injury, disorder or other health condition. An entity qualifying as a hospital for purposes of section 1111 may also qualify as a rehabilitation facility for purposes of this section.

(2) **ANNUAL LIMIT.**—Such services are subject to an aggregate annual limit of 100 days, except that such limit may be waived if the need for continued care is re-evaluated by the prescribing health care professional and determined to be a cost effective alternative to necessary hospital services.

(c) **DEFINITIONS.**—For purposes of this subtitle:

(1) **REHABILITATION FACILITY.**—The term "rehabilitation facility" means an institution (or a distinct part of an institution) which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to individuals for rehabilitation from illness, injury, disorder or other health condition.

(2) **SKILLED NURSING FACILITY.**—The term "skilled nursing facility" means an institution (or a distinct part of an institution) which is primarily engaged in providing to residents—

Extended
Care

(A) skilled nursing care and related services for residents who require medical or nursing care; or

(B) rehabilitation services to residents for rehabilitation from illness, injury, disorder or other health condition.

SEC. 1120. AMBULANCE SERVICES

~~(a) COVERAGE.~~ The ambulance services described in this section are the following items and services:

(1) Ground transportation by ambulance;

(2) Air transportation by an aircraft equipped for transporting an injured or sick individual;

(3) Water transportation by a vessel equipped for transporting an injured or sick individual.

(b) LIMITATIONS.—Coverage for ambulance services is subject to the following limitations:

(1) MEDICAL INDICATION.—Ambulance services are covered only in cases in which the use of an ambulance is indicated by the medical condition of the individual concerned.

(2) AIR TRANSPORT.—Air transportation is covered only in cases in which there is no other method of transportation or where the use of another method of transportation is contraindicated by the medical condition of the individual concerned.

(3) WATER TRANSPORT.—Water transportation is covered only in cases in which there is no other method of transportation or where the use of another method of transportation is contraindicated by the medical condition of the individual concerned.

SEC. 1121. OUTPATIENT LABORATORY, RADIOLOGY, AND DIAGNOSTIC SERVICES

The items and services described in this section are laboratory, radiology, and diagnostic services (including genetic testing and counseling) provided upon prescription to individuals who are not inpatients of a hospital, hospice, skilled nursing facility, or rehabilitation facility.

SEC. 1122. OUTPATIENT PRESCRIPTION DRUGS AND BIOLOGICALS

(a) COVERAGE.—The items described in this section are the following:

(1) Covered outpatient drugs described in section 1861(t) of the Social Security Act (as amended by section 2001(b))—

(A) except that, for purposes of this section, a medically accepted indication with respect to the use of a covered outpatient drug includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

(i) the drug has been approved by the Food and Drug Administration; and

(ii) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia; or

(iii) such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this clause by the Secretary; and

(B) notwithstanding any exclusion from coverage that may be made with respect to such a drug under title XVII of such Act pursuant to section 1862(a)(18) of such Act.

(2) Blood clotting factors when provided on an outpatient basis.

(5) The administration of age-appropriate immunizations and tests specified in subsections (b) through (h).

(k) IMMUNIZATIONS AND TESTS NOT ADMINISTERED DURING CLINICIAN VISIT.—Notwithstanding subsection (i)(5), the clinical preventive services described in this section include an immunization or test described in this section that is administered to an individual consistent with any periodicity schedule for the immunization or test during the age range specified for the immunization or test, and any administration fee for such immunization or test, even if the immunization or test is not administered during a clinician visit.

SEC. 1115. MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

(a) COVERAGE.—The mental illness and substance abuse services that are described in this section are the following items and services for eligible individuals, as defined in section 1001(c), including individuals with multiple mental disorders or mental retardation and mental illness, who satisfy the eligibility requirements in subsection (b):

(1) Inpatient mental illness and substance abuse treatment (described in subsection (d)).

(2) Residential mental illness and substance abuse treatment (described in subsection (e)).

(3) Intensive nonresidential mental illness and substance abuse treatment (described in subsection (f)).

(4) Outpatient mental illness and substance abuse treatment (described in subsection (g)), including case management, screening and assessment, crisis services, and collateral services.

(b) ELIGIBILITY.—The eligibility requirements referred to in subsection (a) are as follows:

(1) INPATIENT, RESIDENTIAL, NONRESIDENTIAL, AND OUTPATIENT TREATMENT.—An eligible individual is eligible to receive coverage for inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment (except case management, screening and assessment, crisis services, and collateral services) if the individual—

(A) has, or has had during the 1-year period preceding the date of such treatment, a diagnosable mental disorder or a diagnosable substance abuse disorder or, in the case of a child 5 years of age or less, is at risk of a mental disorder; and

(B) is experiencing, or is at significant risk of experiencing, functional impairment in family, work, school, or community activities.

For purposes of this paragraph, an individual who has a diagnosable mental disorder or a diagnosable substance abuse disorder, is receiving treatment for such disorder, but does not satisfy the functional impairment criterion in subparagraph (B) shall be treated as satisfying such criterion if the individual would satisfy such criterion without such treatment.

(2) CASE MANAGEMENT.—An eligible individual is eligible to receive coverage for case management if the individual is eligible to receive coverage for, and is receiving, mental illness and substance abuse treatment with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder.

(3) SCREENING AND ASSESSMENT AND CRISIS SERVICES.—All eligible individuals enrolled under a health plan are eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of screening and assessment and crisis services.

(4) COLLATERAL SERVICES.—An eligible individual is eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of collateral services if the individual is a family member (described in section 1011(b)) of an

individual who is receiving inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment.

(c) **HEALTH PROFESSIONAL.**

(1) **IN GENERAL.**—The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient, residential, intensive nonresidential, and outpatient mental illness and substance abuse treatment.

(2) **RULE OF CONSTRUCTION.**—Nothing in section 1861(e) of the Social Security Act, including paragraph (4), shall be construed as requiring that individuals receiving items and services under this section be under the care of a physician when such individuals are under the care of a mental health or substance abuse health professional in a State in which such care is permitted by State law.

(d) **INPATIENT TREATMENT.**

(1) **DEFINITION.**—For purposes of this subtitle, the term "inpatient mental illness and substance abuse treatment" means the items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to an inpatient of a hospital or psychiatric hospital.

(2) **LIMITATIONS.**—Coverage for inpatient mental illness and substance abuse treatment is subject to the following limitations:

(A) **LEAST RESTRICTIVE SETTING.**—Such treatment is covered only when—

(i) provided to an individual in the least restrictive inpatient or residential setting that is effective and appropriate for the individual; and

(ii) less restrictive intensive nonresidential or outpatient treatment would be ineffective or inappropriate.

(B) **INPATIENT HOSPITAL TREATMENT FOR SUBSTANCE ABUSE.**—Such treatment, when provided in a hospital or a psychiatric hospital with respect to a diagnosable substance abuse disorder, is covered under this section only for detoxification requiring the management of psychiatric conditions associated with withdrawal from alcohol or drugs. The items and services described in this section do not include medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is covered under section 1111).

(C) **ANNUAL LIMIT.**—Prior to January 1, 2001, such treatment, when furnished to an inpatient of a hospital or psychiatric hospital is subject to an aggregate annual limit of 30 days, 15 of which may not be reduced in substitution for other covered services. On or after such date, such

(e) **RESIDENTIAL TREATMENT.**

(1) **DEFINITION.**—For purposes of this subtitle, the term "residential mental illness and substance abuse treatment" means the items and services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to a resident of a residential treatment center, residential detoxification center, crisis residential program, mental illness residential treatment program, therapeutic family home, therapeutic community, group treatment home, community residential treatment program, or recovery center for substance abuse.

(2) **LEAST RESTRICTIVE SETTING.**—

(A) **IN GENERAL.**—Such treatment is covered only when—

(i) provided to an individual in the least restrictive residential setting that is effective and appropriate for the individual; and

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1861(b)

annual aggregate limit
shall not apply

(ii) less restrictive intensive nonresidential or outpatient treatment would be ineffective or inappropriate.
(B) ANNUAL LIMIT.—

(i) Prior to January 1, 2001, the number of covered days of residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (d)(2)(C), shall be reduced by 1 day for each 4 covered days of residential mental illness and substance abuse treatment that are provided to the individual, until such number is reduced to 15. The Secretary may increase the reduction period under clause (i) if the Secretary determines that such an increase is actuarially equivalent of the 15 days of inpatient treatment being substituted for residential treatment.

(ii) The limit contained in clause (i) shall not apply to substance abuse treatment provided in a therapeutic community, halfway house, recovery center or other comparably inexpensive residential substance abuse treatment facility, as determined by the Secretary.

(f) INTENSIVE NONRESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "intensive nonresidential mental illness and substance abuse treatment" means diagnostic or therapeutic items or services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to an individual—

(A) participating in a partial hospitalization program, a day treatment program, a psychiatric rehabilitation program, or an ambulatory detoxification program; or

(B) receiving home-based mental illness services or behavioral aide mental illness services.

(2) LIMITATIONS.—Coverage for intensive nonresidential mental illness and substance abuse treatment is subject to the following limitations:

(A) TREATMENT PURPOSES.—Such treatment is covered only when provided—

(i) to avert the need for, or as an alternative to, treatment in residential or inpatient settings;

(ii) to facilitate the earlier discharge of an individual receiving inpatient or residential care;

(iii) to restore the functioning of an individual with a diagnosable mental disorder or a diagnosable substance abuse disorder; or

(iv) to assist such an individual to develop the skills and gain access to the support services the individual needs to achieve the maximum level of functioning of the individual within the community.

(B) DETOXIFICATION.—Intensive nonresidential mental illness and substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(g) OUTPATIENT TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "outpatient mental illness and substance abuse treatment" means the following services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder in an outpatient setting:

(A) Screening and assessment.

(B) Diagnosis.

(C) Medications management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

After such number is reduced to 15, no residential treatment may be covered, except as provided in clause (ii). On or after such date, such annual aggregate limit shall not apply to a mental health consumer-run service center,

mental health

(1) Collateral services.

(2) **LIMITATIONS.**—Coverage for outpatient mental illness and substance abuse treatment is subject to the following limitations:

(A) **HEALTH PROFESSIONAL SERVICES.**—Such treatment is covered only when it constitutes health professional services (as defined in section 1112(c)(2)).

(B) **DETOXIFICATION.**—Outpatient substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(h) **MANAGEMENT OF CARE FOR MENTAL ILLNESS AND SUBSTANCE ABUSE.**—

(1) **PROVISION OF TREATMENT.**—Quality managed care techniques may be utilized by plans to ensure that all necessary care is provided in the most appropriate, cost-effective setting, and that unnecessary care is not provided.

(2) **QUALITY MANAGED CARE.**—The term "quality managed care" refers to the administration of benefits through methods, such as central intake, clinician-to-clinician preauthorization, precertification, and utilization review. Plans may utilize specialized behavioral managed care entities to administer benefits if such entities are certified by the State as proficient in the use of quality managed care techniques that facilitate the provision of clinically appropriate, cost-effective, and confidential treatment, providing continuity of care between and among treatment sites.

(3) **TREATMENT DECISIONS.**—Treatment placement decisions shall be based on publicly available criteria, such as medical necessity, with inpatient treatment regarded as the placement of last resort.

(4) **RULE OF CONSTRUCTION.**—Nothing in this section shall be construed as prohibiting health plans from providing mental health and substance abuse treatment through fee-for-service arrangements.

(i) **SPECIAL DELIVERY REQUIREMENTS FOR SERVICES PROVIDED TO CHILDREN.**—

(1) **REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.**—Health plans shall ensure that the mental illness and substance abuse services described in this section and furnished to an eligible person are furnished through organized systems of care, as described in paragraph (2), if the eligible person is a person under 22 years of age who has a serious emotional disturbance or a substance abuse disorder, and who is, or is at imminent risk of being, involved with one or more public child-serving agencies, including child welfare, special education, and juvenile or criminal justice.

(2) **REQUIREMENTS OF SYSTEM OF CARE.**—As used in this subsection, the term "organized system of care" means a community-based service delivery network, which may consist of public and private providers, that meets the following requirements:

(A) The system has established linkages with existing mental illness and substance abuse service delivery programs in the plan service area (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

(B) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile or criminal justice, health care, mental health, and substance abuse prevention and treatment.

(C) The system provides for the involvement of the families of children to whom mental illness and substance

See replacement language on page E-7

Special Delivery Requirement for children

Insert new paragraphs
from page E-7

abuse services are provided in the planning of treatment and the delivery of services.

(D) The system provides for the development and implementation of individualized treatment plans by multidisciplinary and multiagency teams that are recognized and followed by the applicable agencies and providers in the area.

(E) The system ensures the delivery and coordination of the range of mental illness and substance abuse services required by individuals under 22 years of age who have a serious emotional disturbance or a substance abuse disorder.

(F) The system provides for the management of the individualized treatment plans described in subparagraph (D) and for a flexible response to changes in treatment needs over time.

(j) OTHER DEFINITIONS.—For purposes of this subtitle:

(1) CASE MANAGEMENT.—The term "case management" means services that assist individuals in gaining access to needed medical, social, educational, and other services.

(2) DIAGNOSABLE MENTAL DISORDER AND DIAGNOSABLE SUBSTANCE ABUSE DISORDER.—The terms "diagnosable mental disorder" and "diagnosable substance abuse disorder" mean a disorder that—

(A) is listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised or a revised version of such manual (except V Codes for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment);

(B) is the equivalent of a disorder described in subparagraph (A), but is listed in the International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition or a revised version of such text; or

(C) is listed in any authoritative text specifying diagnostic criteria for mental disorders or substance abuse disorders that is identified by the National Health Board.

(3) MEDICATIONS MANAGEMENT.—

(A) IN GENERAL.—The term "medications management" refers to the prescription, use, monitoring, and review of medication for treatment of a mental disorder or pharmacotherapy for the treatment of a substance abuse disorder, including no more than minimal medical psychotherapy or counseling.

(B) VISIT.—For purposes of medications management, the term "visit" in section 1135 means one week of treatment.

(4) PSYCHIATRIC HOSPITAL.—The term "psychiatric hospital" has the meaning given such term in section 1861(f) of the Social Security Act, except that such term shall include—

(A) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(1), a facility of the uniformed services under title 10, United States Code, that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital;

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(2), a facility operated by the Department of Veterans Affairs that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital; and

(C) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(3), a facility operated by the Indian Health Service that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital.

(d) *CONSTRUCTION.*—The National Health Board shall adopt procedures that assure that each person who is eligible for enrollment in an applicable health plan is able to enroll in such a plan.

In section 1114(a)(2), after "clinician visit" insert "(including preventive counseling and health advice)".

In subsections (a)(2), (f)(2), (g)(2), and (h)(2) of section 1114, strike subparagraph (A) and insert the following new subparagraph:

(A) Annual papanicolaou smears and pelvic exams, for females who are at risk for cervical cancer, unless three consecutive annual pap smears have been negative and it has been determined that the female is not at risk for sexually transmitted diseases, in which case pap smears and pelvic exams are covered every 3 years.

In section 1115(d)(2)(A), strike "or residential".

In section 1115(d)(2)(C), add after the period the following: "On or after such date, such annual aggregate limit shall not apply."

In section 1115(e)(2)(B)(i), strike the last sentence and insert "After such number is reduced to 15, no residential treatment may be covered, except as provided in clause (ii). On or after such date, such annual aggregate limit shall not apply."

In section 1115(e)(2)(B)(ii), insert "mental health" after "residential".

In section 1115(e)(2)(B)(ii), strike "Secretary." and insert "National Health Board."

In section 1115(f)(1)(A), insert "a mental health consumer-run service center" after "hospitalization program,".

In section 1115(f)(2)(A), strike ", or as an alternative to,".

In section 1115(f)(2)(B), strike "mental illness and".

In section 1115(g)(2)(B), strike "mental illness and"

Strike subsection (h) of section 1115 and insert the following new subsection:

(h) MANAGEMENT OF CARE FOR MENTAL ILLNESS AND SUBSTANCE ABUSE.—

(1) PROVISION OF TREATMENT.—Quality managed care techniques shall be utilized by health plans to ensure that all necessary care is provided in the most appropriate, cost effective setting, and that unnecessary care is not provided.

(2) QUALITY MANAGED CARE.—The term "quality managed care" refers to the administration of benefits through the methods of central intake, preauthorization, and utilization review. Health plans may contract with specialized behavioral care entities to administer benefits if such entities are certified by the State as proficient in the use of quality managed care techniques that facilitate the provision of clinically appropriate, cost-effective, and confidential treatment, providing continuity of care between and among treatment providers.

(3) TREATMENT DECISIONS.—

(A) Treatment placement decisions shall be based primarily on medical necessity, with inpatient treatment regarded as the placement of last resort. Criteria used for placement shall be based on uniform assessment tools recognized by treatment and other professional organizations in the fields of mental illness and substance abuse or approved for use by the National Health Board and shall be publicly available.

(B) All treatment assessment and placement decisions or review of such decisions shall be made by personnel—

(i) with certification, licensure, or other credentials recognized in the fields of mental health and substance abuse treatment;

(ii) with no financial stake in the outcome of such decisions; and

(iii) in the same mental health or substance abuse provider category as the treating provider.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting health plans from providing mental health and substance abuse treatment through fee-for-service arrangements.

In section 1115(i), add the following new paragraphs:

(3) FULL IMPLEMENTATION OF PLAN.—Subject to paragraph (2)(F), the State shall assure that public or philanthropic resources are available to implement each child's plan, including residential treatment in excess of the limit set forth in subsection (e) if clinically appropriate.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting a child or a child's legal guardian from freely choosing the child's health care provider.

In section 1127, strike "classes" each place such term appears and insert "programs"

In section 1127(a), after "programs" (as added under the previous amendment) insert "including community-based programs"

In section 1127(a), insert after the period the following: "Health care providers may refer plan members to health education pro-

in order for the treatment to be medically necessary or appropriate.

Nothing in this section shall be construed as limiting the authority of the Commissioner of Food and Drugs over clinical investigations of products within the Commissioner's jurisdiction.

SEC. 1129. EXTRA CONTRACTUAL SERVICES.

(a) **IN GENERAL.**—A health plan may provide coverage to individuals enrolled under the plan for extra-contractual items and services determined appropriate by the plan and the individual, or in appropriate circumstances the parent or legal guardian of the individual.

(b) **DEFINITION.**—As used in this section, the term "extra-contractual items and services" means, with respect to a health plan, case management services and those medically appropriate alternatives (either alternative items or services or alternative care settings) to traditional covered items or services that are determined by the health plan to be the most cost effective way to provide appropriate treatment to the enrolled individual.

(c) **DISPUTED CLAIMS.**—A decision by a health plan to permit or deny the provision of extra-contractual services shall not be subject to a benefit determination review or other review unless such review involves a claim of discrimination under this Act.

SEC. 1130. HEARING AIDS FOR CHILDREN.

(a) **IN GENERAL.**—A health plan shall provide coverage to individuals under the age of 18 enrolled under the plan for hearing care items described in subsection (b).

(b) **HEARING CARE.**—The hearing care items described in this subsection are hearing aids for individuals up to age 18 when recommended by a physician or audiologist.

PART 3—COST SHARING

SEC. 1131. COST SHARING.

(a) **IN GENERAL.**—Each health plan shall offer to individuals enrolled under the plan one, but not more than one, of the following cost sharing schedules, which schedule shall be offered to all such enrollees:

- (1) Lower cost sharing (described in section 1132).
- (2) Higher cost sharing (described in section 1133).
- (3) Combination cost sharing (described in section 1134).

(b) **COST SHARING FOR LOW-INCOME FAMILIES.**—For provisions relating to reducing cost sharing for certain low-income families, see section 1281.

(c) **DEDUCTIBLES, COST SHARING, AND OUT-OF-POCKET LIMITS ON COST SHARING.**—

(1) **APPLICATION ON AN ANNUAL BASIS.**—The deductibles and out-of-pocket limits on cost sharing for a year under the schedules referred to in subsection (a) shall be applied based upon expenses incurred for items and services furnished in the year.

(2) **INDIVIDUAL AND FAMILY GENERAL DEDUCTIBLES.**—

(A) **INDIVIDUAL.**—Subject to subparagraph (B), with respect to an individual enrolled under a health plan (regardless of the class of enrollment), any individual general deductible in the cost sharing schedule offered by the plan represents the amount of countable expenses (as defined in subparagraph (C)) that the individual may be required to incur in a year before the plan incurs liability for expenses for such items and services furnished to the individual.

(B) **FAMILY.**—In the case of an individual enrolled under a health plan under a family class of enrollment (as defined in section 1011(c)(2)(A)), the individual general deductible under subparagraph (A) shall not apply to count

grams that best meet their needs based on an assessment of individual risks and learning styles."

In section 1127(b), insert after the period the following: "Health plans shall inform health providers about the availability of such health education programs annually, either at the time of paying the first claim to that provider, or in the case of a network plan, at the time of contracting with the provider."

In section 1130(a) and (b), strike "and services" each place that such term appears.

In section 1130(b), strike "is routine ear examinations and diagnosis for defects in hearing as part of a physician visit and".

In section 1133(7)(A), strike "\$1,500" and insert "\$2,500".

In the table in section 1135, in the 13th item, strike "Clinician" and insert "Family planning services described in 1116(1), and clinician".

Strike section 1163 and insert the following new section:

SEC. 1163. DUTY TO DISCLOSE INCORRECT TEST RESULTS.

(a) **IN GENERAL.**—Any facility, including hospitals, clinics, and clinical laboratories, which provide health care items and services covered under this Act shall promptly notify the patient (or family if patient is incapacitated) and the provider who ordered the test, of the existence of life threatening errors in the results of the tests performed.

(b) **PENALTIES.**—The Secretary shall establish by regulation the penalties for failure to promptly notify the patient or family and provider who ordered the test.

In section 1201(3), strike "and all such fees shall be used exclusively for medical board activities".

In section 1202(c)(1), strike "may not discriminate" and all that follows through the end thereof and insert "comply with the anti-discrimination requirements of section 1915."

In section 1202(c), strike paragraph (2).

In section 1203(a)(1), insert after the period the following: "A State may not limit the ability of any plan to contract with a provider of health services located outside of the geographic boundaries

(3) Medical foods prescribed by a physician that comply with the requirements of the Federal Food, Drug, and Cosmetic Act and that treat inborn errors of metabolism identified by the Secretary as rendering a person unable to sustain life without significant mental or physical impairment by the ingestion of conventional foods.

(4) Accessories and supplies that are used directly with drugs and biologics to achieve the therapeutic benefit of such drugs or biologics.

(b) REVISION OF COMPENDIA LIST.—The Secretary may revise the list of compendia in subsection (a)(1)(A)(ii) designated as appropriate for identifying medically accepted indications for drugs.

(c) BLOOD CLOTTING FACTORS.—For purposes of this subtitle, the term "blood clotting factors" has the meaning given such term in section 1861(s)(2)(T) of the Social Security Act.

SEC. 1123. OUTPATIENT REHABILITATION SERVICES.

(a) COVERAGE.—The outpatient rehabilitation services described in this section are—

- (1) outpatient occupational therapy;
- (2) outpatient physical therapy;
- (3) outpatient respiratory therapy; and
- (4) outpatient speech-language pathology services and audiology services.

(b) LIMITATIONS.—Coverage for outpatient rehabilitation services is subject to the following limitations:

(1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS.—Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder or other health condition.

(2) MAINTENANCE OF FUNCTION OR PREVENTION OF DETERIORATION.—To the extent that the services described in paragraph (1) are for the purpose of maintaining functioning or preventing deterioration, such services shall be limited to—

(A) the initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional;

(B) the designing by the qualified rehabilitation health professional of a maintenance or prevention program that is appropriate considering the capacity and tolerance of the patient and the treatment objectives;

(C) the instruction of the patient, family members, or support personnel in carrying out the program; and

(D) reevaluations.

(3) REEVALUATION.—

(A) IN GENERAL.—At the end of each 60-day period of outpatient rehabilitation services (other than services described in paragraph (2)), the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied.

(B) QUALIFIED REHABILITATION HEALTH PROFESSIONAL.—Periodically, outpatient rehabilitation services described in paragraph (2) shall be reevaluated by a qualified rehabilitation health professional.

SEC. 1124. DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.

(a) COVERAGE.—The items and services described in this section are—

- (1) durable medical equipment;
- (2) prosthetic devices (other than dental devices) which replace all or part of the function of an internal body organ (including devices that are surgically inserted, devices that are physically attached to the body, such as colostomy bags and

supplies directly related to colostomy care, and external devices);

(3) orthotics (leg, arm, back and neck braces) and prosthetics (artificial legs, arms and eyes);

(4)(A) accessories and supplies which are used directly with equipment or devices described in paragraphs (1) through (3) to achieve the therapeutic benefits of such equipment or devices or to assure the proper functioning of such equipment or device;

(B) replacement of such equipment or devices when required in cases of loss, irreparable damage, wear, or because of a change in the patient's condition; and

(C) repair and maintenance of such equipment and devices; and

(5) fitting (including adjustments) and training for use of the items described in paragraphs (1) through (4).

(b) **LIMITATION.**—An item or service described in this section is covered only if it improves functional ability or prevents or minimizes deterioration in function.

(c) **DURABLE MEDICAL EQUIPMENT.**—For purposes of this subtitle, the term "durable medical equipment" has the meaning given such term in section 1861(n) of the Social Security Act.

SEC. 1125. VISION CARE

(a) **COVERAGE.**—The vision care described in this section is routine eye examinations, diagnosis, and treatment for defects in vision.

(b) **LIMITATION.**—Eyeglasses and contact lenses are covered only for individuals less than 18 years of age, according to a periodicity schedule established by the Board.

SEC. 1126. DENTAL CARE

(a) **COVERAGE.**—The dental care described in this section is the following:

(1) Emergency dental treatment, including simple extractions, for acute infections, bleeding, and injuries to natural teeth and oral structures for conditions requiring immediate attention to prevent risks to life or significant medical complications, as specified by the National Health Board.

(2) Prevention and diagnosis of dental disease, including oral dental examinations, radiographs, dental sealants, fluoride application, and dental prophylaxis.

(3) Treatment of dental disease, including routine fillings, prosthetics for genetic defects, periodontal maintenance, and endodontic services.

(4) Space maintenance procedures to prevent orthodontic complications.

(5) Interceptive orthodontic treatment to prevent severe malocclusion.

(b) **LIMITATIONS.**—Coverage for dental care is subject to the following limitations:

(1) **PREVENTION AND DIAGNOSIS.**—Prior to January 1, 2001, the items and services described in subsection (a)(2) are covered only for individuals less than 18 years of age. On or after such date, such items and services are covered for all eligible individuals enrolled under a health plan, except that dental sealants are not covered for individuals 18 years of age or older.

(2) **TREATMENT OF DENTAL DISEASE.**—Prior to January 1, 2001, the items and services described in subsection (a)(3) are covered only for individuals less than 18 years of age. On or after such date, such items and services are covered for all eligible individuals enrolled under a health plan, except that endodontic services are not covered for individuals 18 years of age or older.

(3) **SPACE MAINTENANCE.**—The items and services described in subsection (a)(4) are covered only for individuals at least 3 years of age, but less than 13 years of age and—

(A) are limited to posterior teeth;

- (A) skilled nursing care and related services for residents who require medical or nursing care; or
 (B) rehabilitation services to residents for rehabilitation from illness, injury, disorder or other health condition.

SEC. 1120. AMBULANCE SERVICES.

(a) ~~COVERAGE.~~ The ambulance services described in this section are the following items and services:

- (1) Ground transportation by ambulance.
- (2) Air transportation by an aircraft equipped for transporting an injured or sick individual.
- (3) Water transportation by a vessel equipped for transporting an injured or sick individual.

(b) **LIMITATIONS.**—Coverage for ambulance services is subject to the following limitations:

(1) **MEDICAL INDICATION.**—Ambulance services are covered only in cases in which the use of an ambulance is indicated by the medical condition of the individual concerned.

(2) **AIR TRANSPORT.**—Air transportation is covered only in cases in which there is no other method of transportation or where the use of another method of transportation is contra-indicated by the medical condition of the individual concerned.

(3) **WATER TRANSPORT.**—Water transportation is covered only in cases in which there is no other method of transportation or where the use of another method of transportation is contra-indicated by the medical condition of the individual concerned.

SEC. 1121. OUTPATIENT LABORATORY, RADIOLOGY, AND DIAGNOSTIC SERVICES.

The items and services described in this section are laboratory, radiology, and diagnostic services (including genetic testing and counseling) provided upon prescription to individuals who are not inpatients of a hospital, hospice, skilled nursing facility, or rehabilitation facility.

SEC. 1122. OUTPATIENT PRESCRIPTION DRUGS AND BIOLOGICALS.

(a) **COVERAGE.**—The items described in this section are the following:

(1) Covered outpatient drugs described in section 1861(t) of the Social Security Act (as amended by section 2001(b))—

(A) except that, for purposes of this section, a medically accepted indication with respect to the use of a covered outpatient drug includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

(i) the drug has been approved by the Food and Drug Administration; and

(ii) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia; or

(iii) such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this clause by the Secretary; and

(B) notwithstanding any exclusion from coverage that may be made with respect to such a drug under title XVIII of such Act pursuant to section 1862(a)(18) of such Act.

(2) Blood clotting factors when provided on an outpatient basis.

★ (3) Medical foods prescribed by a physician that comply with the requirements of the Federal Food, Drug, and Cosmetic Act and that treat inborn errors of metabolism identified by the Secretary as rendering a person unable to sustain life without significant mental or physical impairment by the ingestion of conventional foods.

Medical
FOODS

★ (4) Accessories and supplies that are used directly with drugs and biologics to achieve the therapeutic benefit of such drugs or biologics.

Accessories
and Supplies

SP (b) REVISION OF COMPENDIA LIST.—The Secretary may revise the list of compendia in subsection (a)(1)(A)(ii) designated as appropriate for identifying medically accepted indications for drugs.

(c) BLOOD CLOTTING FACTORS.—For purposes of this subtitle, the term "blood clotting factors" has the meaning given such term in section 1861(s)(2)(I) of the Social Security Act.

SEC. 1123. OUTPATIENT REHABILITATION SERVICES.

(a) COVERAGE.—The outpatient rehabilitation services described in this section are—

- (1) outpatient occupational therapy;
- (2) outpatient physical therapy;
- (3) outpatient respiratory therapy; and
- (4) outpatient speech-language pathology services and audiology services.

(b) LIMITATIONS.—Coverage for outpatient rehabilitation services is subject to the following limitations:

(1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS.—Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder or other health condition.

(2) MAINTENANCE OF FUNCTION OR PREVENTION OF DETERIORATION.—To the extent that the services described in paragraph (1) are for the purpose of maintaining functioning or preventing deterioration, such services shall be limited to—

(A) the initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional;

(B) the designing by the qualified rehabilitation health professional of a maintenance or prevention program that is appropriate considering the capacity and tolerance of the patient and the treatment objectives;

(C) the instruction of the patient, family members, or support personnel in carrying out the program; and

(D) reevaluations.

(3) REEVALUATION.—

(A) IN GENERAL.—At the end of each 60-day period of outpatient rehabilitation services (other than services described in paragraph (2)), the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied.

(B) QUALIFIED REHABILITATION HEALTH PROFESSIONAL.—Periodically, outpatient rehabilitation services described in paragraph (2) shall be reevaluated by a qualified rehabilitation health professional.

SEC. 1124. DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.

(a) COVERAGE.—The items and services described in this section are—

- (1) durable medical equipment;
- (2) prosthetic devices (other than dental devices) which replace all or part of the function of an internal body organ (including devices that are surgically inserted, devices that are physically attached to the body, such as colostomy bags and

in order for the treatment to be medically necessary or appropriate.

Nothing in this section shall be construed as limiting the authority of the Commissioner of Food and Drugs over clinical investigations of products within the Commissioner's jurisdiction.

SEC. 1129. EXTRA CONTRACTUAL SERVICES

(a) **IN GENERAL.**—A health plan may provide coverage to individuals enrolled under the plan for extra-contractual items and services determined appropriate by the plan and the individual, or in appropriate circumstances the parent or legal guardian of the individual.

(b) **DEFINITION.**—As used in this section, the term "extra-contractual items and services" means, with respect to a health plan, case management services and those medically appropriate alternatives (either alternative items or services or alternative care settings) to traditional covered items or services that are determined by the health plan to be the most cost effective way to provide appropriate treatment to the enrolled individual.

(c) **DISPUTED CLAIMS.**—A decision by a health plan to permit or deny the provision of extra-contractual services shall not be subject to a benefit determination review or other review unless such review involves a claim of discrimination under this Act.

SEC. 1130. HEARING AIDS FOR CHILDREN

(a) **IN GENERAL.**—A health plan shall provide coverage to individuals under the age of 18 enrolled under the plan for hearing care items and services described in subsection (b).

(b) **HEARING CARE.**—The hearing care items and services described in this subsection is routine ear examinations and diagnosis for defects in hearing as part of a physician visit and hearing aids for individuals up to age 18 when recommended by a physician or audiologist.

PART 3—COST SHARING

SEC. 1131. COST SHARING

(a) **IN GENERAL.**—Each health plan shall offer to individuals enrolled under the plan one, but not more than one, of the following cost sharing schedules, which schedule shall be offered to all such enrollees:

- (1) Lower cost sharing (described in section 1132).
- (2) Higher cost sharing (described in section 1133).
- (3) Combination cost sharing (described in section 1134).

(b) **COST SHARING FOR LOW-INCOME FAMILIES.**—For provisions relating to reducing cost sharing for certain low-income families, see section 1281.

(c) **DEDUCTIBLES, COST SHARING, AND OUT-OF-POCKET LIMITS ON COST SHARING.**—

(1) **APPLICATION ON AN ANNUAL BASIS.**—The deductibles and out-of-pocket limits on cost sharing for a year under the schedules referred to in subsection (a) shall be applied based upon expenses incurred for items and services furnished in the year.

(2) **INDIVIDUAL AND FAMILY GENERAL DEDUCTIBLES.**—

(A) **INDIVIDUAL.**—Subject to subparagraph (B), with respect to an individual enrolled under a health plan (regardless of the class of enrollment), any individual general deductible in the cost sharing schedule offered by the plan represents the amount of countable expenses (as defined in subparagraph (C)) that the individual may be required to incur in a year before the plan incurs liability for expenses for such items and services furnished to the individual.

(B) **FAMILY.**—In the case of an individual enrolled under a health plan under a family class of enrollment (as defined in section 1011(c)(2)(A)), the individual general deductible under subparagraph (A) shall not apply to count-

SEC. 1506. GRIEVANCE PROCEDURE.

(a) **IN GENERAL.**—Each health plan must establish a grievance procedure for enrollees to use in pursuing complaints. Such procedure shall be consistent with subtitle C of title V.

(b) **ADDITIONAL REMEDIES.**—If the grievance procedure fails to resolve an enrollee's complaint—

(1) in the case of an enrollee of a community-rate health plan, the enrollee has the option of seeking assistance from the office of the ombudsman for the State established under section 1208(a), and

(2) the enrollee may pursue additional legal remedies, including those provided under subtitle C of title V.

SEC. 1507. HEALTH PLAN ARRANGEMENTS WITH PROVIDERS.

(a) **IN GENERAL.**—Plans shall ensure that all health care providers reimbursed by the plan are authorized under State law to provide applicable services.

(b) **REQUIREMENTS FOR NONNETWORK PLANS.**—Each health plan must enter into such agreements with an appropriate mix, number, and distribution of qualified health professionals or have such other arrangements as may be necessary to ensure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled in the plan.

(c) **REQUIREMENTS FOR NETWORK PLANS.**—A health plan that requires coinsurance for an out-of-network item or service shall comply with the following requirements:

(1) **AGREEMENTS.**—Each health plan must enter into such agreements with an appropriate mix, number, and distribution of qualified health professionals or have such other arrangements in network as may be necessary to ensure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled in the plan.

(2) **GATEKEEPER.**—With respect to each health plan that utilizes a gatekeeper or similar process to approve health care services prior to or following the provision of such services, such gatekeepers shall include specialists or a care coordinator from an interdisciplinary team if medically necessary or appropriate given the nature, severity, or complexity of each patient's chronic disease, disorder, or other health condition.

(3) **CONTINUED CARE.**—Each health plan shall develop a process to ensure the access of enrollees to relevant specialists for the continued care of patient-enrollees with chronic diseases, disorders, or health conditions without gatekeeper approval prior to each visit, when medically indicated.

(4) **ELIGIBLE CENTERS OF SPECIALIZED TREATMENT EXPERTISE.**

(A) **IN GENERAL.**—Each health plan shall provide access through agreements (as defined in subparagraph (B)) to eligible centers of specialized treatment expertise (as defined in subparagraphs (C) and (D)), including centers outside the health care coverage area (or) State, to ensure that enrollees receive the specialized treatment expertise of such centers when medically indicated. A health plan shall be deemed to be in accordance with this paragraph if the agreement of such plan provides that, with respect to health conditions within the specialized treatment expertise of the center involved, the plan will, at the enrollees request—

(i) refer medical cases involving such conditions to such center;

(ii) inform plan members of the availability of referral care; and

(iii) establish an appeal mechanism in which plan participants may challenge denials of referrals to such center or may request that their specialized care be provided at an alternative center as described in subparagraph (E).

gatekeeper

Direct Access to Specialist

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In section 1507(c)(3), insert "the continued care is" before "medically indicated".

In section 1507(c)(4)(a)(iii), insert "consistent with subtitle C of title 5 of this Act" after "mechanism".

In section 1507(e)(1), strike "paragraph (2)" and insert "paragraphs (2) and (3)".

In section 1507(e), insert after paragraph (1) the following new paragraph and redesignate the remaining paragraph accordingly:

(2) RULE OF CONSTRUCTION.—Nothing in the paragraph (1) shall be construed to prevent a health plan from providing for a different basis or level of payment than the fee schedule established under section 1234 as part of a contractual agreement with participating providers under the plan.

In section 1507(f)(2), add after the period the following: "An individual or entity who furnishes ancillary health services may not present or cause to be presented, a claim, bill, or demand for payment to any person other than the enrollee receiving such services, or to the health plan of the enrollee."

Strike section 1510 and insert the following new section:

SEC. 1510. REQUIREMENT RELATED TO COST SHARING OBLIGATIONS.

An enrollee that incurs cost sharing expenses in a month in excess of \$250, may request that a health plan establish a payment plan so that the enrollee is not required to pay more than \$250 in any one month. For individuals who have submitted and been approved for a reduction in cost sharing under section 1282(c), community-rated plans must accept such requests and may not charge any interest or finance charges on out of pocket expenses financed under this section.

In the heading for section 1513(a), strike "CONSUMER".

In section 1513(a), insert "providers and" after "disclose to".

In section 1602(b), strike "and individuals with disabilities" and insert ", individuals with disabilities, and individuals in rural and urban underserved areas".

In section 1611(a)(2), strike "parts 2 and 3 of".

(4) establishing different payment rates for participating providers and providers outside the plan;

(5) creating incentives to encourage the use of participating providers; or

(6) requiring the use of single-source suppliers for pharmacy, medical equipment, and other health products and services.

(b) **PREEMPTION OF STATE CORPORATE PRACTICE ACTS.**—Any State law related to the corporate practice of medicine and to provider ownership of health plans or other providers shall not apply to arrangements between health plans that are not fee-for-service plans and their participating providers.

(c) **PARTICIPATING PROVIDER DEFINED.**—In this title, a "participating provider" means, with respect to a health plan, a provider of health care services who is a member of a provider network of the plan.

SEC. 1509. FINANCIAL SOLVENCY.

Each carrier that provides a health plan and operates in a State must—

(1) meet or exceed minimum capital requirements established by States under section 1204(a);

(2) in the case of a carrier operating in a State, must participate in the guaranty fund established by the State under section 1204(c); and

(3) meet such other requirements relating to fiscal soundness as the State may establish (subject to the establishment of any alternative standards by the Board).

SEC. 1510. REQUIREMENT RELATED TO COST SHARING OBLIGATIONS.

An enrollee that incurs cost sharing expenses in a month in excess of $\frac{1}{12}$ of the applicable annual out of pocket limit on cost sharing (as defined in sections 1132, 1133 and 1134), may request that a health plan establish a payment plan so that the enrollee is not required to pay more than $\frac{1}{12}$ of the applicable annual out of pocket limit on cost sharing in any one month. Community-rated health plans must accept such requests from such individuals and may not charge any interest or finance charges on out of pocket expenses financed under this section.

SEC. 1511. QUALITY ASSURANCE.

Each health plan shall comply with such quality assurance requirements as are imposed under subtitle A of title V with respect to such a plan.

SEC. 1512. PROVIDER VERIFICATION.

Each health plan shall—

(1) verify the credentials of practitioners and facilities;

(2) ensure that all providers participating in the plan meet applicable State licensing and certification standards;

(3) ensure that each health care provider participating in the plan annually discloses information regarding operations, ownership, finances, and workforce necessary to evaluate the providers compliance with this Act;

(4) oversee the quality and performance of participating providers, consistent with section 1511; and

(5) investigate and resolve consumer complaints against participating providers.

SEC. 1513. UTILIZATION MANAGEMENT PROTOCOLS AND PHYSICIAN INCENTIVE PLANS.

(a) **REQUIRING CONSUMER DISCLOSURE.**—Each health plan shall disclose to enrollees (and prospective enrollees) the protocols and financial incentives used by the plan, including physician incentive plans (as defined in subsection (b)), for controlling utilization and costs.

(b) **PHYSICIAN INCENTIVE PLAN DEFINED.**—As used in this section, the term "physician incentive plan" means any compensation arrangement between a health plan 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.

(c) **LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.**—A 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 subsection (b)) 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 as an inducement to reduce or limit medically necessary services provided to individuals enrolled with the organization.

(2) If the 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 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.

SEC. 1514. CONFIDENTIALITY, DATA MANAGEMENT, AND REPORTING.

(a) **IN GENERAL.**—Each health plan shall comply with the confidentiality, data management, and reporting requirements imposed under subtitle B of title V.

(b) **TREATMENT OF ELECTRONIC INFORMATION.**—

(1) **ACCURACY AND RELIABILITY.**—Each health plan shall take such measures as may be necessary to ensure that health care information in electronic form that the plan, or a member of a provider network of the plan, collects for or transmits to the Board under subtitle B of title V is accurate and reliable.

(2) **PRIVACY AND SECURITY.**—Each health plan shall take such measures as may be necessary to ensure that health care information described in paragraph (1) is not distributed to any individual or entity in violation of a standard promulgated by the Board under part 2 of subtitle B of title V.

SEC. 1515. PARTICIPATION IN RISK ADJUSTMENT AND REINSURANCE SYSTEM.

Each community-rated health plan shall participate in the risk adjustment and reinsurance system established under section 1641 in the manner specified by the State.

SEC. 1516. CONTRACTS WITH CONSUMER PURCHASING COOPERATIVES.

(a) **CONTRACTS WITH COOPERATIVES.**—A community-rated health plan provided by a carrier shall enter into contracts with each cooperative in the designated service area served by the plan seeking such a contract in accordance with section 1202 (consistent with section 1311(a)(1)).

(b) **PRICING.**—No plan shall offer a bid to a cooperative that is more than the filed per capita community rate (as described in section 6000(a)(1)).

PART 2—REQUIREMENTS RELATING TO SUPPLEMENTAL INSURANCE

SEC. 1521. IMPOSITION OF REQUIREMENTS ON SUPPLEMENTAL INSURANCE.

(a) **IN GENERAL.**—An entity may offer a supplemental insurance policy but only if—

(C) The term "medical specialty" includes all medical, surgical, and other physician specialties and subspecialties.

SEC. 3012. ANNUAL AUTHORIZATION OF NUMBER OF SPECIALTY POSITIONS; REQUIREMENTS REGARDING PRIMARY HEALTH CARE

(a) **ANNUAL AUTHORIZATION OF NUMBER OF POSITIONS.**—In the case of each medical specialty, the National Council shall, pursuant to section 3011, designate for each academic year the number of individuals nationwide who are authorized to be enrolled in eligible programs. The preceding sentence is subject to subsection (c)(2).

(b) **PRIMARY HEALTH CARE.**—

(1) **IN GENERAL.**—Subject to paragraph (2), in carrying out subsection (a) for an academic year, the National Council shall ensure that, of the class of training participants entering eligible programs for academic year 2000-2001 or any subsequent academic year, the percentage of such class that completes eligible programs in primary health care is not less than 55 percent (without regard to the academic year in which the members of the class complete the programs).

(2) **RULE OF CONSTRUCTION.**—The requirement of paragraph (1) regarding a percentage applies in the aggregate to training participants entering eligible programs for the academic year involved, and not individually to any eligible program.

(c) **DESIGNATIONS REGARDING 3-YEAR PERIODS.**—

(1) **DESIGNATION PERIODS.**—For each medical specialty, the National Council shall make the annual designations under subsection (a) for periods of 3 academic years.

(2) **INITIAL PERIOD.**—The first designation period established by the National Council after the date of the enactment of this Act shall be the academic years 2000-2001 through 2002-03.

(d) **CERTAIN CONSIDERATIONS IN DESIGNATING ANNUAL NUMBERS.**—

(1) **IN GENERAL.**—Factors considered by the National Council in designating the annual number of specialty positions for an academic year for a medical specialty shall include the extent to which there is a need for additional practitioners in the specialty, as indicated by the following:

(A) The characteristics of diseases, disorders, or health conditions treated, including—

(i) the incidence and prevalence (in the general population and in various other populations) of the diseases, disorders, or other health conditions with which the specialty is concerned;

(ii) the intensity of care required for each of these diseases, disorders, or health conditions;

(iii) the relevant training received and experience attained by primary care and specialist physicians in caring for each of these diseases, disorders, or health conditions; and

(iv) when sufficient data becomes available, the extent to which individuals with certain diseases, disorders, or health conditions have better health outcomes when treated by health specialists than by primary care physicians.

(B) The number of physicians who will be practicing in the specialty in the academic year.

(C) The number of physicians who will be practicing in the specialty at the end of the 5-year period beginning on the first day of the academic year.

(2) **RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.**—In designating the annual number of specialty positions for an academic year for a medical specialty, the National Council shall consider the recommendations of organizations representing physicians in the specialty and the recommendations of or-

ganizations representing consumers of the services of such physicians.

(3) **TOTAL OF RESPECTIVE ANNUAL NUMBERS.**—

(A) For academic year 2000-2001 and subsequent academic years, the National Council shall ensure that the total of the respective annual numbers designated under subsection (a) for an academic year is a total that—

- (i) bears a relationship to the number of individuals who graduated from medical schools in the United States in the preceding academic year; and
- (ii) is consistent with the purposes of this subpart.

(B) For each of the academic years 2000-2001 through 2004-05, the total determined under subparagraph (A) shall be reduced by a percentage determined by the National Council.

(e) **INTERIM VOLUNTARY TARGETS.**—

(1) **ESTABLISHMENT.**—Not later than July 1, 1996, the National Council shall establish targets with respect to the aggregate number of individuals enrolled in approved physician training programs for each specialty to be achieved by the year 2000.

(2) **VOLUNTARY COMPLIANCE.**—Specialties that meet and continue to be in compliance with the aggregate targets established under paragraph (1), as determined by the National Council, shall not be subject to the mandatory allocation system described in section 3013.

(3) **MEASURE OF COMPLIANCE.**—To be considered in compliance with the targets under paragraph (2), a specialty shall demonstrate, not later than July 1, 1998, that the number of individuals enrolled in approved physician training programs of the specialty is not less than the number of individuals enrolled in such programs as of July 1, 1994, increased or decreased, as the case may be, by 45 percent of the difference between such enrollment and the target enrollment established under paragraph (1) and, not later than January 1, 2000, have increased or decreased by 90 percent of such difference, and, by January 1, 2001, are deemed by the National Council to be in compliance with the target.

(4) **LOSS OF COMPLIANCE.**—The National Council may, at any time, determine that a specialty is not in compliance with the targets established under paragraph (1) and initiate, with respect to that specialty, the system of mandatory allocations described under section 3013.

(f) **STUDY.**—Not later than January 1, 2005, the Secretary shall arrange for the completion, by the Institute of Medicine or other similar entity, of an independent study concerning the effect of medical workforce regulation and planning. The results of such study together with recommendations concerning the appropriateness of modifying or eliminating workforce regulations shall be compiled in a report and transmitted by the Secretary to the President and the Congress.

(g) **DEFINITIONS.**—For purposes of this subtitle:

(1) The term "annual number of specialty positions", with respect to a medical specialty, means the number designated by the National Council under subsection (a) for eligible programs for the academic year involved.

(2) The term "designation period" means a 3-year period under subsection (c)(1) for which designations under subsection (a) are made by the National Council.

(3) The term "primary health care" means the following medical specialties: Family medicine, general internal medicine, general pediatrics, general medicine, obstetrics and gynecology and medical specialties, if any, that have been designated to be medical shortage specialties or protected medical specialties by the Council on Graduate Medical Education, or other similar physician advisory body authorized by Congress to provide an

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ongoing assessment of physician workforce trends, and identify needs and be advisory to the Secretary, the Committee on Labor and Human Resources and the Committee on Finance of the Senate and the Committee of Energy and Commerce and the Committee on Ways and Means of the House of Representatives.

(4) The term "specialty position" means a position as a training participant.

(5) The term "training participant" means an individual who is enrolled in an approved physician training program.

SEC. 3013. ALLOCATIONS AMONG SPECIALITIES AND PROGRAMS.

(a) **IN GENERAL.**—For each academic year, the National Council shall for each medical specialty make allocations among eligible programs of the annual number of specialty positions that the Council has designated for such year. The preceding sentence is subject to subsection (b)(3).

(b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

(1) **IN GENERAL.**—For each medical specialty, the National Council shall make the annual allocations under subsection (a) for periods of 3 academic years.

(2) **ADVANCE NOTICE TO PROGRAMS.**—With respect to the first academic year of an allocation period established by the National Council, the National Council shall, not later than July 1 of the preceding academic year, notify each eligible program of the allocations made for the program for each of the academic years of the period.

(3) **INITIAL PERIOD.**—The first allocation period established by the National Council after the date of the enactment of this Act shall be the academic years 2000-2001 through 2002-03.

(c) CERTAIN CONSIDERATIONS.—

(1) **GEOGRAPHIC AREAS; QUALITY OF PROGRAMS.**—In making allocations under subsection (a) for eligible programs of the various geographic areas, the National Council shall include among the factors considered the historical distribution among the areas of approved physician training programs, and the quality of such programs.

(2) **UNDERREPRESENTATION OF MINORITY GROUPS AND WOMEN.**—In making an allocation under subsection (a) for an eligible program, the National Council shall include among the factors considered the following:

(A) The extent to which the population of training participants in the program includes training participants who are members of racial or ethnic minority groups and women.

(B) With respect to a racial or ethnic group or women represented among the training participants, the extent to which the group is underrepresented in the field of medicine generally and in the various medical specialties.

(3) **RECOMMENDATIONS OF PRIVATE ORGANIZATIONS.**—In making allocations under subsection (a) for eligible programs, the National Council shall consider the recommendations of organizations representing physicians in the medical specialties and the recommendations of organizations representing consumers of the services of such physicians.

(d) **DEFINITIONS.**—For purposes of this subtitle, the term "allocation period" means a 3-year period under subsection (b)(1) for which allocations under subsection (a) are made by the National Council.

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FROM L-4

AMENDMENT NO. ____

Calendar No. ____

Purpose: To make technical and miscellaneous changes to title III of the bill.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. ____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Mr. KENNEDY

Viz:

In section 3012(g), strike paragraph (3) and insert the following new paragraph:

(3) The term "primary health care" means the following medical specialties: Family medicine, general internal medicine, general pediatrics, geriatric medicine, obstetrics and gynecology. Psychiatry shall also be included as a primary health care medical specialty so long as it is designated to be a medical shortage specialty or protected medical specialty by the Council on Graduate Medical Education, or other similar physician advisory body authorized by Congress to provide an ongoing assessment of physician workforce trends, and identify needs and be advisory to the Secretary, the Committee on Labor and Human Resources and the Committee on Finance of the Senate and the Committee of Energy and Commerce and the Committee on Ways and Means of the House of Representatives. Only those participants in programs with a significant primary care training emphasis will be considered to have completed an eligible program in primary care for the purposes of section 3012(b)(1). Determination of meeting the definition of a "significant primary care training emphasis" will be made by the National Board.

Appendix M

3

1 SEC. 5002. NATIONAL GOALS AND PERFORMANCE MEAS- 2 URES OF QUALITY.

3 (a) IN GENERAL.—The National Quality Council
4 shall develop a set of national goals and performance
5 measures of quality for both the general population and
6 for population subgroups defined by demographic charac-
7 teristics and health status. The goals and measures shall
8 incorporate standards identified by the Secretary of
9 Health and Human Services for meeting public health ob-
10 jectives utilizing, but not limited to, goals delineated in
11 Healthy People 2000.

12 (b) SUBJECT OF MEASURES.—National measures of
13 quality performance shall be selected in a manner that
14 provides statistical and other information on at least the
15 following subjects:

16 (1) Outcomes of health care services and proce-
17 dures.

18 (2) Health promotion.

19 (3) Prevention of diseases, disorders, and other
20 health conditions.

21 (4) Access to care and appropriateness of care.

22 SEC. 5003. STANDARDS AND PERFORMANCE MEASURES 23 FOR HEALTH PLANS.

24 (a) IN GENERAL.—The National Quality Council
25 shall establish national standards and performance meas-
26 ures for health plans, which may be used to assess the

(2) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary, or

(3) items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(f) **PAYMENT FOR SERVICES.**—A State plan may provide for the use of—

- (1) vouchers,
- (2) cash payments directly to individuals with disabilities,
- (3) capitation payments to health plans, and
- (4) payment to providers,

to pay for covered services.

(g) **PERSONAL ASSISTANCE SERVICES.**—

(1) **IN GENERAL.**—In this section, the term "personal assistance services" means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, and cueing with activities of daily living and for people with primarily mental, cognitive or sensory impairments such instrumental activities of daily living as deemed necessary or appropriate, whether agency-administered or consumer-directed (as defined in paragraph (2)). Such services shall include services that are determined to be necessary to help all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions,

(2) **CONSUMER-DIRECTED.**—In this part:

(A) **IN GENERAL.**—The term "consumer-directed" means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the option of the service recipient, trained) by the individual receiving the services.

(B) **STATE RESPONSIBILITIES.**—A State plan shall ensure that where services are provided in a consumer-directed manner, the State shall create or contract with an entity, other than the consumer or the individual provider, to—

(i) inform both recipients and providers of rights and responsibilities under all applicable Federal labor and tax law; and

(ii) assume responsibility for providing effective billing, payments for services, tax withholding, unemployment insurance, and workers' compensation coverage, and act as the employer of the home care provider.

(C) **RIGHT OF CONSUMERS.**—Notwithstanding the State responsibilities described in subparagraph (B), service recipients, and, where appropriate, their designated representative, shall retain the right to independently select, hire, terminate, and direct (including manage, train, schedule, and verify services provided) the work of a home care provider.

(3) **AGENCY ADMINISTERED.**—The term "agency-administered" means, with respect to such services, services that are not consumer-directed.

SEC. 2105. COST SHARING.

(a) **NO COST SHARING FOR POOREST.**—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (c)) less than 150 percent of the official poverty level (referred to in section 1902(30)) applicable to a family of the size involved (determined without regard to section 1902(30)(B)).

(b) **SLIDING SCALE FOR REMAINDER.**—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

three or more activities of daily living (as defined in subsection (c)), and

(B) is expected to require such assistance, supervision, or cueing over a period of at least 90 days.

(2) **INDIVIDUALS WITH SEVERE COGNITIVE OR MENTAL IMPAIRMENT.**—An individual of any age—

(A) whose score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, indicates either severe cognitive impairment or severe mental impairment, or both;

(B) who—

(i) requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living,

(ii) requires hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies, or

(iii) displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; and

(C) who is expected to meet the requirements of subparagraphs (A) and (B) over a period of at least 90 days. Not later than 2 years after the date of enactment of this Act, the Secretary shall make recommendations regarding the most appropriate duration of disability under this paragraph.

(3) **INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.**—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

(4) **YOUNG CHILDREN WITH SEVERE DISABILITIES.**—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition that limits functioning in a manner that is comparable in severity to the standards established under paragraphs (1), (2), or (3), and

(B) is expected to have such a disability or condition and require such services over a period of at least 90 days.

(b) **DETERMINATION.**—

(1) **IN GENERAL.**—In formulating eligibility criteria under subsection (a), the Secretary shall establish criteria for assessing the functional level of disability among all categories of individuals with disabilities that are comparable in severity, regardless of the age or the nature of the disabling condition of the individual. The determination of whether an individual is an individual with disabilities shall be made, by persons or entities specified under the State plan, using a uniform protocol consisting of an initial screening and preliminary assessment specified by the Secretary. A State may not impose cost sharing with respect to the preliminary assessment. A State may collect additional information, at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 2104(b) or for other purposes. The State shall establish a fair hearing process for appeals of such determinations.

(2) **INDIVIDUALS WITH COMPARABLE DISABILITIES.**—Not more than 2 percent of a State's allotment for services under this part may be expended for the provision of services to individuals with severe disabilities that are comparable in severity to the criteria described in subsection (a), but who fail to meet the criteria described in any single category.

(3) **PERIODIC REASSESSMENT.**—The determination that an individual is an individual with disabilities shall be considered to be effective under the State plan for a period of not more

(i) the services made available under the plan,
 (ii) the extent and manner in which such services are allocated and made available to individuals with disabilities, and

(iii) the manner in which services under the plan are coordinated with each other and with health and long-term care services available outside the plan for individuals with disabilities.

(C) **TAKING INTO ACCOUNT INFORMAL CARE.**—A State plan may take into account, in determining the amount and array of services made available to covered individuals with disability, the availability of informal care. Any individual care plan that includes informal care shall be required to verify the availability of the informal care.

(D) **ALLOCATION.**—The State plan—

(i) shall specify how it will allocate services under the plan, during and after the 7-fiscal-year phase-in period beginning with fiscal year 1996, among covered individuals with disabilities;

(ii) shall attempt to meet the needs of individuals with a variety of disabilities and, within the limits of available funding, be sufficient in amount, duration, and scope to provide a substantial assistance in living independently;

(iii) shall include services that are determined to be necessary to help all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions;

(iv) shall demonstrate that services are allocated equitably, in accordance with the needs assessment required under subparagraph (A), and

(v) shall ensure that—

(I) the proportion of the population of low-income individuals with disabilities in the State that represents individuals with disabilities who are provided home and community-based services either under the plan, under the State medicaid plan, or under both, is not less than,

(II) the proportion of the population of the State that represents individuals who are low-income individuals.

(E) **LIMITATION ON LICENSURE OR CERTIFICATION.**—The State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements which the Secretary finds not to be necessary for the health and safety of individuals with disabilities.

(F) **CONSUMER CHOICE.**—To the extent feasible, the State shall follow the choice of an individual with disabilities (or that individual's designated representative who may be a family member) regarding which covered services to receive and the providers who will provide such services.

(3) **COST SHARING.**—The plan shall impose cost sharing with respect to covered services only in accordance with section 2105.

(4) **TYPES OF PROVIDERS AND REQUIREMENTS FOR PARTICIPATION.**—The plan shall specify—

(A) the types of service providers eligible to participate in the program under the plan, which shall include consumer-directed providers, except that the plan—

(i) may not limit such benefits to services provided by registered nurses or licensed practical nurses; and

(ii) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

(B) any requirements for participation applicable to each type of service provider.

SEC. 2110. FEDERAL EVALUATIONS.

Not later than December 31, 2000, December 31, 2003, and each December 31 thereafter, the Secretary shall provide to Congress analytical reports that evaluate—

(1) the extent to which individuals with low incomes and disabilities are equitably served;

(2) the adequacy and equity of service plans to individuals with similar levels of disability across States;

(3) the comparability of program participation across States, described by level and type of disability; and

(4) the ability of service providers to sufficiently meet the demand for services.

Not later than 18 months after the date of enactment of this Act, the Secretary shall report to Congress concerning the feasibility of providing reimbursement under health plans and other payers of health services for full geriatric assessment, when recommended by a physician.

Subpart B—State Programs for Extended Services for Children With Special Health Care Needs

SEC. 2111. STATE PROGRAMS FOR EXTENDED SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS.

(a) **PURPOSE.**—The purpose of this subpart is to provide financial assistance to the States to assist each State in developing and implementing, or expanding and enhancing, a family-centered, culturally competent, community-centered, comprehensive statewide system of extended services and benefits for children with special health care needs.

(b) **PAYMENT.**—Each State that has a plan for the provision of extended services for children with special health care needs submitted to and approved by the Secretary under section 2114 is entitled to payment subject to section 2117. Approval of a plan shall be contingent upon adequacy of funding and fulfillment of criteria established and published by the Secretary.

SEC. 2112. EXTENDED SERVICES COVERED UNDER THE STATE PLAN.

(a) **SPECIFICATION.**—

(1) **IN GENERAL.**—Subject to the succeeding provisions of this section, the State plan under this subpart shall specify—

(A) the extended services available under the plan to eligible children, and

(B) any limits with respect to such services.

(2) **FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.**—Subject to subsection (e)(1)(B), such services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

(b) **REQUIREMENT FOR NEEDS ASSESSMENT AND PLAN OF CARE.**—

(1) **IN GENERAL.**—The State plan shall provide for extended services to an eligible child only if—

(A) a comprehensive assessment of the child's need for home and community-based services (regardless of whether all needed services are available under the plan) has been made,

(B) an individualized plan of care based on such assessment is developed, and

(C) such services are provided consistent with such plan of care.

(2) **INVOLVEMENT OF INDIVIDUALS.**—The individualized plan of care under paragraph (1)(B) for an eligible child shall—

(A) be developed by qualified individuals (specified under the State plan),

(B) be developed and implemented in close consultation with the child's designated representative and the child where appropriate,

(C) be approved by the child's designated representative and the child where appropriate, and

(D) be reviewed and updated not less often than every 6 months.

(3) **PLAN OF CARE.**—The plan of care under paragraph (1)(B) shall—

(A) specify which services specified under the individual plan will be provided under the State plan under this part.

(B) identify (to the extent possible) how the child will be provided any services specified under the plan of care and not provided under the State plan, and

(C) specify how the provision of services to the child under the plan will be coordinated with the provision of other health care services to the child.

The State shall make reasonable efforts to identify and arrange for services described in subparagraph (B). Nothing in this subsection shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(c) **EXTENDED SERVICES COVERED UNDER THE STATE PLAN.**—

(1) **IN GENERAL.**—The State plan shall include the following extended services:—

(A) Developmentally appropriate personal assistance services that are family centered and provided in a culturally competent manner, and which meet the standards of 2104(g).

(B) Care management.

(C) Homemaker and chore assistance.

(D) Home modifications.

(E) Respite services.

(F) Assistive technology devices and assistive technology services as defined in the Technology Related Assistance for Individuals with Disabilities Act.

(G) Habilitation and rehabilitation.

(H) Home health services.

(I) Transportation.

(J) Any other care or assistive services (approved by the Secretary) that the State determines will help maximize a child's ability to function independently, appropriately, and effectively in an age-appropriate manner, or will facilitate the caregiver's ability to care for the child outside of an institution.

(2) **CRITERIA FOR SELECTION OF SERVICES.**—The State plan shall specify—

(A) the methods and standards used to select the types, and the amount, duration, and scope, of services to be covered under the plan and to be available to eligible children, and

(B) how the types, and the amount, duration, and scope, of services specified meet the needs of eligible children.

(d) **NO INDIVIDUAL ENTITLEMENT.**—Nothing in this section shall be construed to create an entitlement for eligible children.

(e) **EXCLUSIONS AND LIMITATIONS.**—

(1) **IN GENERAL.**—A State plan may not provide for coverage of—

(A) room and board,

(B) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary, or

(C) items and services for which the child may receive payment under title I or title IV of this Act.

(f) **PAYMENT FOR SERVICES.**—A State plan may provide for the use of—

(1) vouchers,

- (2) cash payments directly to a child's designated representative,
 - (3) capitation payments to health plans, and
 - (4) payment to providers,
- to pay for covered services.

SEC. 2113. CHILDREN ELIGIBLE FOR SERVICES.

(a) ELIGIBILITY CRITERIA.—

(1) **IN GENERAL.**—Children with special health care needs shall be eligible for extended services and benefits under this subpart.

(2) **CHILD WITH SPECIAL HEALTH CARE NEEDS.**—As used in this subpart, the term "child with special health care needs" means an individual between the ages of birth to 21 years who—

(A) is not eligible for medical assistance under title IV of this Act;

(B) has a significant functional limitation under paragraph (3); and

(C) is in need of extended services under paragraph (4).

(3) **SIGNIFICANT FUNCTIONAL LIMITATION.**—

(A) **IN GENERAL.**—As used in this subpart, the term "significant functional limitation" means—

(i) in the case of an individual 6 years of age or older, a significant physical or mental impairment as defined pursuant to State policy to the extent that such policy is established without regard to type of disability; and

(ii) in the case of infants and young children, birth to age 5, inclusive, a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in a disability if services are not provided.

(B) **PRESUMPTIVE SIGNIFICANT FUNCTIONAL LIMITATION.**—An individual who has a disability or who is blind pursuant to the eligibility requirements of title XVI of the Social Security Act (42 U.S.C. 1381 et seq.) shall be considered to have—

(i) in the case of an individual 6 years of age or older, a significant physical or mental impairment as defined pursuant to State policy to the extent that such policy is established without regard to type of disability; and

(ii) in the case of infants and young children, birth to age 5, inclusive, a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in a disability if services are not provided.

(4) **CHILD IN NEED OF EXTENDED SERVICES.**—As used in this subpart, the term "child in need of extended services" means an individual between the ages of birth to 21 years of age who requires services identified in section 2112(c) in order to maximize or restore function, or prevent or limit disability.

SEC. 2114. APPLICATION AND ADMINISTRATION.

(a) **APPLICATION FOR STATE PARTICIPATION.**—

(1) **IN GENERAL.**—A State desiring a grant under this subpart shall submit an application, as an addendum to the State application under section 2102, identifying in the State plan—

(A) the population to be served under this subpart;

(B) the manner in which funds made available would be utilized, and the services to be provided;

(C) how the State will define individuals qualified to develop individualized pediatric plans of care as defined in section 2112(b)(3); and

(D) how the State will assure that the range of services available under section 2112 will also be available to individuals with disabilities under the age of 21 who are eligi-

ble for services under subpart A to the maximum extent possible consistent with funds available to carry out subpart A; and

(E) any other information the Secretary may require.

(2) **EVALUATION OF PROGRAM.**—An applicant under this section shall agree to provide an evaluation of the effectiveness, including cost effectiveness when measurable, of offering the benefits and services under the State plan to children with special health care needs.

(b) **NUMBER OF PROGRAMS.**—

(1) **REQUEST FOR APPLICATIONS.**—The Secretary shall publish a request for applications under this section not later than 1 year after the date of the enactment of this Act.

(2) **MAXIMUM NUMBER OF GRANTS.**—The Secretary shall make grants available under this subpart for the maximum number of State programs, in accordance with the current funding level in section 2117, that is compatible with services and benefits to be offered under section 2112 for eligible children with special health care needs residing in such State.

(3) **FORMULA.**—The provisions of subsection (b)(2) shall remain in effect through fiscal year 2003, at which time the Secretary shall establish a formula by which to distribute funds under this subpart, in accordance with section 2117, to all States that have a plan approved in accordance with section 2111 to provide the benefits described in section 2112.

(c) **ADMINISTRATION.**—

(1) **STATE AGENCY.**—The State shall designate a State agency or designee to administer (or to supervise the administration of) the program under this subpart.

(2) **COORDINATION.**—The State agency or designee shall specify how the agency or designee will coordinate its activities with health plans and other service providers, and with the agency administering subpart A.

(3) **REQUIREMENT FOR COORDINATION OF CARE.**—The State program under this subpart shall provide for coordinated services and benefits as described in section 2112 to a family with children with special health care needs integrating services whenever possible in accordance with section 2102(a)(9)(C).

SEC. 2115. COST-SHARING.

(a) **NO COST SHARING FOR POOREST.**—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (c)) less than 150 percent of the official poverty level (referred to in section 1902(30)(A)) applicable to a family of the size involved (determined without regard to section 1902(30)(B)).

(b) **SLIDING SCALE FOR REMAINDER.**—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

(1) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 200 percent, of such official poverty line (as so applied);

(2) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of such official poverty line (as so applied); and

(3) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such official poverty line (as so applied).

(c) **DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.**—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. In making these income determinations, the State shall at a minimum comply with standards established by the Secretary. Such standards shall include a uniform Federal definition of income and shall allow deductions from income for disability-related expenses not covered under other titles of this Act as promulgated by the Secretary.

(d) **RECOMMENDATION FOR REDUCTIONS.**—The Secretary shall make recommendations to the States as how to reduce cost-sharing based on income standards established under subsection (c) for individuals with extraordinary out of pocket costs for whom the cost-sharing provisions of section 2115 could jeopardize their ability to take advantage of the services offered under this Act.

(e) **REQUEST FOR PAYMENT PLAN.**—If copayments under subsection (b) for services utilized by the child pursuant to section 2112(b)(3) exceed 10 percent of the child's income or the income of their designated representative—

(1) the child or child's designated representative may request that the State provide a payment schedule for these amounts that shall not exceed 10 percent of monthly income, and

(2) States may accept such requests from individuals and provide payment plans without interest or finance charges.

SEC. 2118. PROGRAM EVALUATION.

The Secretary shall evaluate the programs under this subpart, and shall submit to Congress interim reports detailing the utilization, cost, and cost efficiency of the programs.

SEC. 2117. TOTAL FEDERAL BUDGET AND FEDERAL ALLOTMENT TO STATES.

(a) **TOTAL FEDERAL BUDGET.**—The amount available to carry out State plans under this subpart shall be an amount equal to the total of a 2 per cent set-aside from the amounts for each fiscal year beginning in fiscal year 1996 pursuant to section 2109.

(b) **FEDERAL MATCHING PERCENTAGE.**—States shall contribute to the program an amount consistent with the requirements in section 2108(b)(1).

(c) **REMAINING FUNDS.**—Funds remaining under subsection (a) at the end of each fiscal year shall be made available to States under section 2108 for the following fiscal year.

PART 2—LONG-TERM CARE INSURANCE IMPROVEMENT AND ACCOUNTABILITY

SEC. 2201. SHORT TITLE.

This part may be cited as the "Long-Term Care Insurance Improvement and Accountability Act".

SEC. 2202. ESTABLISHMENT OF FEDERAL STANDARDS FOR LONG-TERM CARE INSURANCE.

The Public Health Service Act is amended by adding at the end thereof the following new title:

"TITLE XXVII—LONG-TERM CARE

"PART 1—LONG-TERM CARE INSURANCE STANDARDS

"Subpart A—Promulgation of Standards and Model Benefits

"SEC. 2701. STANDARDS.

"(a) APPLICATION OF STANDARDS.—

"(1) NAIC.—

"(A) **IN GENERAL.**—The Secretary shall request that the National Association of Insurance Commissioners (hereafter in this part referred to as the 'NAIC')—

"(i) develop specific standards that incorporate the requirements of this part; and

"(ii) report to the Secretary concerning such standards.

"(B) **APPLICATION.**—If, within 12 months after the date of the enactment of this part, the NAIC develops the model

(1) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 200 percent, of such official poverty line (as so applied);

(2) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of such official poverty line (as so applied); and

(3) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such official poverty line (as so applied).

(c) **RECOMMENDATION OF THE SECRETARY.**—The Secretary shall make recommendations to the States as to how to reduce cost-sharing for individuals with extraordinary out-of-pocket costs for whom the cost-sharing provisions of section 2105 could jeopardize their ability to take advantage of the services offered under this Act. The Secretary shall establish a methodology for reducing the cost-sharing burden for individuals with exceptionally high out-of-pocket costs under this Act.

(d) **DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.**—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. Such standards shall include a uniform Federal definition of income and any allowable deductions from income.

SEC. 2106. QUALITY ASSURANCE AND SAFEGUARDS.

(a) **QUALITY ASSURANCE.**—The State plan shall specify how the State will ensure and monitor the quality of services, including—

(1) safeguarding the health and safety of individuals with disabilities,

(2) the minimum standards for agency providers and how such standards will be enforced,

(3) the minimum competency requirements for agency provider employees who provide direct services under this part and how the competency of such employees will be enforced,

(4) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services,

(5) participation in quality assurance activities, and

(6) specifying the role of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) in assuring quality of services and protecting the rights of individuals with disabilities.

(b) **FEDERAL STANDARDS.**—The State plan shall adhere to Federal quality standards in the following areas:

(1) Case review of a specified sample of client records.

(2) Random home visits for a specified percentage of cases.

(3) The mandatory reporting of abuse, neglect, or exploitation.

(4) The establishment of a formal client grievance mechanism, including a fair hearing process.

(5) State licensure or certification for agency providers that offer home health services.

(6) Minimum training requirements for agency-directed home care workers.

(7) The development of a registry of provider agencies or home care workers against whom any complaints have been sustained, which shall be available to the public.

(8) Sanctions to be imposed on States or providers, including disqualification from the program, if minimum standards are not met.

(9) Surveys of client satisfaction.

(10) State optional training programs for informal caregivers.

(c) **FUNDING.**—A State that is entitled to a payment in accordance with section 2108 shall receive a separate allocation that may be expended only for client advocacy activities. The State may use

such funds to augment the budgets of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) or may establish a separate and independent agency to administer a new program designed to advocate for client rights.

(d) FUNCTIONS.—

(1) IN GENERAL.—A client advocacy office established under this section shall—

(A) identify, investigate, and resolve complaints that—

(i) are made by, or on behalf of, clients; and

(ii) relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the clients (including the welfare and rights of the clients with respect to the appointment and activities of guardians and representative payees), of—

(I) providers, or representatives of providers, of long-term care services;

(II) public agencies, or

(III) health and social service agencies;

(B) provide services to assist the clients in protecting the health, safety, welfare, and rights of the clients;

(C) inform the clients about means of obtaining services provided by providers or agencies described in subparagraph (A)(ii) or services described in subparagraph (B);

(D) ensure that the clients have regular and timely access to the services provided through the office and that the clients and complainants receive timely responses from representatives of the office to complaints; and

(E) represent the interests of the clients before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the clients.—with regard to the provisions of this

(2) CONTRACTS AND ARRANGEMENTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the State agency may establish and operate the office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.

(B) LICENSING AND CERTIFICATION ORGANIZATIONS; ASSOCIATIONS.—With the exception of public agencies, the State agency may not enter into the contract or other arrangement described in subparagraph (A) with an agency or organization that is responsible for licensing, certifying, or providing long-term care services in the State.

(e) SAFEGUARDS.—

(1) CONFIDENTIALITY.—The State plan shall provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan (including performance reviews under section 2602).

(2) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide safeguards against physical, emotional, or financial abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with disabilities). All providers of services shall be required to register with the State agency.

(f) ISSUANCE OF REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall issue regulations implementing the quality provisions of this section.

SEC. 2107. ADVISORY GROUPS.

(a) FEDERAL ADVISORY GROUP.—

Title and related concerns under this Act.

(2) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary, or

(3) items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(f) PAYMENT FOR SERVICES.—A State plan may provide for the use of—

(1) vouchers,

(2) cash payments directly to individuals with disabilities,

(3) capitation payments to health plans, and

(4) payment to providers,

to pay for covered services.

(g) PERSONAL ASSISTANCE SERVICES.—

(1) IN GENERAL.—In this section, the term "personal assistance services" means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, and cueing with activities of daily living and for people with primarily mental, cognitive or sensory impairments such instrumental activities of daily living as deemed necessary or appropriate, whether agency-administered or consumer-directed (as defined in paragraph (2)).

(2) Such services shall include services that are determined to be necessary to help all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions,

(2) CONSUMER-DIRECTED.—In this part:

(A) IN GENERAL.—The term "consumer-directed" means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the option of the service recipient, trained) by the individual receiving the services.

(B) STATE RESPONSIBILITIES.—A State plan shall ensure that where services are provided in a consumer-directed manner, the State shall create or contract with an entity, other than the consumer or the individual provider, to—

(i) inform both recipients and providers of rights and responsibilities under all applicable Federal labor and tax law; and

(ii) assume responsibility for providing effective billing, payments for services, tax withholding, unemployment insurance, and workers' compensation coverage, and act as the employer of the home care provider.

(C) RIGHT OF CONSUMERS.—Notwithstanding the State responsibilities described in subparagraph (B), service recipients, and, where appropriate, their designated representative, shall retain the right to independently select, hire, terminate, and direct (including manage, train, schedule, and verify services provided) the work of a home care provider.

(3) AGENCY ADMINISTERED.—The term "agency-administered" means, with respect to such services, services that are not consumer-directed.

SEC. 2105. COST SHARING.

(a) NO COST SHARING FOR POOREST.—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (c)) less than 150 percent of the official poverty level (referred to in section 1902(30)), applicable to a family of the size involved (determined without regard to section 1902(30)(B)).

(b) SLIDING SCALE FOR REMAINDER.—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

(1) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 200 percent, of such official poverty line (as so applied);

(2) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of such official poverty line (as so applied); and

(3) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such official poverty line (as so applied).

(c) **RECOMMENDATION OF THE SECRETARY.**—The Secretary shall make recommendations to the States as to how to reduce cost-sharing for individuals with extraordinary out-of-pocket costs for whom the cost-sharing provisions of section 2105 could jeopardize their ability to take advantage of the services offered under this Act. The Secretary shall establish a methodology for reducing the cost-sharing burden for individuals with exceptionally high out-of-pocket costs under this Act.

(d) **DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.**—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. Such standards shall include a uniform Federal definition of income and any allowable deductions from income.

SEC. 2106. QUALITY ASSURANCE AND SAFEGUARDS.

(a) **QUALITY ASSURANCE.**—The State plan shall specify how the State will ensure and monitor the quality of services, including—

(1) safeguarding the health and safety of individuals with disabilities,

(2) the minimum standards for agency providers and how such standards will be enforced,

(3) the minimum competency requirements for agency provider employees who provide direct services under this part and how the competency of such employees will be enforced,

(4) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services,

(5) participation in quality assurance activities, and

(6) specifying the role of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) in assuring quality of services and protecting the rights of individuals with disabilities.

(b) **FEDERAL STANDARDS.**—The State plan shall adhere to Federal quality standards in the following areas:

(1) Case review of a specified sample of client records.

(2) Random home visits for a specified percentage of cases.

(3) The mandatory reporting of abuse, neglect, or exploitation.

(4) The establishment of a formal client grievance mechanism, including a fair hearing process.

(5) State licensure or certification for agency providers that offer home health services.

(6) Minimum training requirements for agency-directed home care workers.

(7) The development of a registry of provider agencies or home care workers against whom any complaints have been sustained, which shall be available to the public.

(8) Sanctions to be imposed on States or providers, including disqualification from the program, if minimum standards are not met.

(9) Surveys of client satisfaction.

(10) State optional training programs for informal caregivers.

(c) **FUNDING.**—A State that is entitled to a payment in accordance with section 2108 shall receive a separate allocation that may be expended only for client advocacy activities. The State may use

(2) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary, or

(3) items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(f) **PAYMENT FOR SERVICES.**—A State plan may provide for the use of—

(1) vouchers,

(2) cash payments directly to individuals with disabilities,

(3) capitation payments to health plans, and

(4) payment to providers.

to pay for covered services.

(g) **PERSONAL ASSISTANCE SERVICES.**—

(1) **IN GENERAL.**—In this section, the term "personal assistance services" means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, and cueing with activities of daily living and for people with primarily mental, cognitive or sensory impairments such instrumental activities of daily living as deemed necessary or appropriate, whether agency-administered or consumer-directed (as defined in paragraph (2)). Such services shall include services that are determined to be necessary to help all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions,

(2) **CONSUMER-DIRECTED.**—In this part:

(A) **IN GENERAL.**—The term "consumer-directed" means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the option of the service recipient, trained) by the individual receiving the services.

(B) **STATE RESPONSIBILITIES.**—A State plan shall ensure that where services are provided in a consumer-directed manner, the State shall create or contract with an entity, other than the consumer or the individual provider, to—

(i) inform both recipients and providers of rights and responsibilities under all applicable Federal labor and tax law; and

(ii) assume responsibility for providing effective billing, payments for services, tax withholding, unemployment insurance, and workers' compensation coverage, and act as the employer of the home care provider.

(C) **RIGHT OF CONSUMERS.**—Notwithstanding the State responsibilities described in subparagraph (B), service recipients, and, where appropriate, their designated representative, shall retain the right to independently select, hire, terminate, and direct (including manage, train, schedule, and verify services provided) the work of a home care provider.

(3) **AGENCY ADMINISTERED.**—The term "agency-administered" means, with respect to such services, services that are not consumer-directed.

SEC. 2105. COST SHARING.

(a) **NO COST SHARING FOR POOREST.**—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (c)) less than 150 percent of the official poverty level (referred to in section 1902(30)) applicable to a family of the size involved (determined without regard to section 1902(30)(B)).

(b) **SLIDING SCALE FOR REMAINDER.**—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

(1) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 200 percent, of such official poverty line (as so applied);

(2) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of such official poverty line (as so applied); and

(3) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such official poverty line (as so applied).

(c) **RECOMMENDATION OF THE SECRETARY.**—The Secretary shall make recommendations to the States as to how to reduce cost-sharing for individuals with extraordinary out-of-pocket costs for whom the cost-sharing provisions of section 2105 could jeopardize their ability to take advantage of the services offered under this Act. The Secretary shall establish a methodology for reducing the cost-sharing burden for individuals with exceptionally high out-of-pocket costs under this Act.

(d) **DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.**—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. Such standards shall include a uniform Federal definition of income and any allowable deductions from income.

SEC. 2106. QUALITY ASSURANCE AND SAFEGUARDS.

(a) **QUALITY ASSURANCE.**—The State plan shall specify how the State will ensure and monitor the quality of services, including—

(1) safeguarding the health and safety of individuals with disabilities,

(2) the minimum standards for agency providers and how such standards will be enforced,

(3) the minimum competency requirements for agency provider employees who provide direct services under this part and how the competency of such employees will be enforced,

(4) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services,

(5) participation in quality assurance activities, and

(6) specifying the role of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) in assuring quality of services and protecting the rights of individuals with disabilities.

(b) **FEDERAL STANDARDS.**—The State plan shall adhere to Federal quality standards in the following areas:

(1) Case review of a specified sample of client records.

(2) Random home visits for a specified percentage of cases.

(3) The mandatory reporting of abuse, neglect, or exploitation.

(4) The establishment of a formal client grievance mechanism, including a fair hearing process.

(5) State licensure or certification for agency providers that offer home health services.

(6) Minimum training requirements for agency-directed home care workers.

(7) The development of a registry of provider agencies or home care workers against whom any complaints have been sustained, which shall be available to the public.

(8) Sanctions to be imposed on States or providers, including disqualification from the program, if minimum standards are not met.

(9) Surveys of client satisfaction.

(10) State optional training programs for informal caregivers.

(c) **FUNDING.**—A State that is entitled to a payment in accordance with section 2108 shall receive a separate allocation that may be expended only for client advocacy activities. The State may use

- (2) cash payments directly to a child's designated representative,
 - (3) capitation payments to health plans, and
 - (4) payment to providers,
- to pay for covered services.

SEC. 2113. CHILDREN ELIGIBLE FOR SERVICES.

(a) ELIGIBILITY CRITERIA.—

(1) **IN GENERAL.**—Children with special health care needs shall be eligible for extended services and benefits under this subpart.

(2) **CHILD WITH SPECIAL HEALTH CARE NEEDS.**—As used in this subpart, the term "child with special health care needs" means an individual between the ages of birth to 21 years who—

(A) is not eligible for medical assistance under title IV of this Act;

(B) has a significant functional limitation under paragraph (3); and

(C) is in need of extended services under paragraph (4).

(3) **SIGNIFICANT FUNCTIONAL LIMITATION.**—

(A) **IN GENERAL.**—As used in this subpart, the term "significant functional limitation" means—

(i) in the case of an individual 6 years of age or older, a significant physical or mental impairment as defined pursuant to State policy to the extent that such policy is established without regard to type of disability; and

(ii) in the case of infants and young children, birth to age 5, inclusive, a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in a disability if services are not provided.

(B) **PRESUMPTIVE SIGNIFICANT FUNCTIONAL LIMITATION.**—An individual who has a disability or who is blind pursuant to the eligibility requirements of title XVI of the Social Security Act (42 U.S.C. 1381 et seq.) shall be considered to have—

(i) in the case of an individual 6 years of age or older, a significant physical or mental impairment as defined pursuant to State policy to the extent that such policy is established without regard to type of disability; and

(ii) in the case of infants and young children, birth to age 5, inclusive, a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in a disability if services are not provided.

(4) **CHILD IN NEED OF EXTENDED SERVICES.**—As used in this subpart, the term "child in need of extended services" means an individual between the ages of birth to 21 years of age who requires services identified in section 2112(c) in order to maximize or restore function, or prevent or limit disability.

SEC. 2114. APPLICATION AND ADMINISTRATION.

(a) **APPLICATION FOR STATE PARTICIPATION.**—

(1) **IN GENERAL.**—A State desiring a grant under this subpart shall submit an application, as an addendum to the State application under section 2102, identifying in the State plan—

(A) the population to be served under this subpart;

(B) the manner in which funds made available would be utilized, and the services to be provided;

(C) how the State will define individuals qualified to develop individualized pediatric plans of care as defined in section 2112(b)(3); and

(D) how the State will assure that the range of services available under section 2112 will also be available to individuals with disabilities under the age of 21 who are eligi-

ble for services under subpart A to the maximum extent possible consistent with funds available to carry out subpart A; and

(E) any other information the Secretary may require.

(2) **EVALUATION OF PROGRAM.**—An applicant under this section shall agree to provide an evaluation of the effectiveness, including cost effectiveness when measurable, of offering the benefits and services under the State plan to children with special health care needs.

(b) **NUMBER OF PROGRAMS.**—

(1) **REQUEST FOR APPLICATIONS.**—The Secretary shall publish a request for applications under this section not later than 1 year after the date of the enactment of this Act.

(2) **MAXIMUM NUMBER OF GRANTS.**—The Secretary shall make grants available under this subpart for the maximum number of State programs, in accordance with the current funding level in section 2117, that is compatible with services and benefits to be offered under section 2112 for eligible children with special health care needs residing in such State.

(3) **FORMULA.**—The provisions of subsection (b)(2) shall remain in effect through fiscal year 2003, at which time the Secretary shall establish a formula by which to distribute funds under this subpart, in accordance with section 2117, to all States that have a plan approved in accordance with section 2111 to provide the benefits described in section 2112.

(c) **ADMINISTRATION.**—

(1) **STATE AGENCY.**—The State shall designate a State agency or designee to administer (or to supervise the administration of) the program under this subpart.

(2) **COORDINATION.**—The State agency or designee shall specify how the agency or designee will coordinate its activities with health plans and other service providers, and with the agency administering subpart A.

(3) **REQUIREMENT FOR COORDINATION OF CARE.**—The State program under this subpart shall provide for coordinated services and benefits as described in section 2112 to a family with children with special health care needs integrating services whenever possible in accordance with section 2102(a)(9)(C).

SEC. 2115. COST-SHARING.

(a) **NO COST SHARING FOR POOREST.**—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (c)) less than 150 percent of the official poverty level (referred to in section 1902(30)(A)) applicable to a family of the size involved (determined without regard to section 1902(30)(B)).

(b) **SLIDING SCALE FOR REMAINDER.**—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

(1) at a rate of 10 percent for individuals with disabilities with income not less than 150 percent, and less than 200 percent, of such official poverty line (as so applied);

(2) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of such official poverty line (as so applied); and

(3) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such official poverty line (as so applied).

(c) **DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.**—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. In making these income determinations, the State shall at a minimum comply with standards established by the Secretary. Such standards shall include a uniform Federal definition of income and shall allow deductions from income for disability-related expenses not covered under other titles of this Act as promulgated by the Secretary.

(5) **BUDGET.**—The plan shall specify how the State will manage Federal and State funds available under the plan for each fiscal year during the period beginning with fiscal year 1996 and ending with fiscal year 2003 and for each 5-fiscal-year periods thereafter to serve all categories of individuals with disabilities and meet the requirements of this subsection. If the Secretary makes an adjustment under section 2109(a)(5)(C) for a year, each State shall update the specifications under this paragraph to reflect the impact of such an adjustment.

(6) **PROVIDER REIMBURSEMENT.**—

(A) **PAYMENT METHODS.**—The plan shall specify the payment methods to be used to reimburse providers for services furnished under the plan. Such methods may include retrospective reimbursement on a fee-for-service basis, prepayment on a capitation basis, payment by cash or vouchers to individuals with disabilities, or any combination of these methods. In the case of payment for consumer-directed services, including the use of cash or vouchers, the plan shall specify how the plan will assure compliance with applicable employment tax and health care coverage provisions.

(B) **PAYMENT RATES.**—The plan shall specify the methods and criteria to be used to set payment rates for—

(i) agency administered services furnished under the plan; and

(ii) consumer-directed services furnished under the plan, including cash payments or vouchers to individuals with disabilities, except that such payments shall be adequate to cover amounts required under the applicable employment tax provisions of the Internal Revenue Code of 1986 (as added or amended by title VII of the Health Security Act) and the health care coverage provisions under this Act.

(C) **PLAN PAYMENT AS PAYMENT IN FULL.**—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established pursuant to subparagraph (B)) and any cost sharing permitted or provided for under section 2105 as payment in full for services furnished under the plan.

(7) **QUALITY ASSURANCE AND SAFEGUARDS.**—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with section 2106.

(8) **ADVISORY GROUP.**—The State plan shall—

(A) assure the establishment and maintenance of an advisory group under section 2107(b), and

(B) include the documentation prepared by the group under section 2107(b)(4).

(9) **ADMINISTRATION AND ACCESS.**—

(A) **STATE AGENCY.**—The plan shall designate a State agency or agencies to administer (or to supervise the administration of) the plan.

(B) **INFORMATION AND ASSISTANCE CENTER.**—The plan shall provide for a single point of access to information about the system for individuals with disabilities. The plan may designate separate entry points for individuals under the age of 22, for individuals age 65 years and older, or for other appropriate classification of individuals.

(C) **COORDINATION.**—The plan shall specify how it will—

(i) integrate services provided under the plan, including eligibility prescreening, service coordination, and referrals for individuals with disabilities who are ineligible for services under this part, with the State medicaid plan, titles V and XX of the Social Security

Act, programs under the Older Americans Act of 1965, programs under the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, and any other Federal or State programs that provide services or assistance targeted to individuals with disabilities, and

(ii) coordinate with health plans.

(D) **ADMINISTRATIVE EXPENDITURES.**—Effective beginning with fiscal year 2003, the plan shall contain assurances that not more than 10 percent of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

(10) **REPORTS AND INFORMATION TO SECRETARY; AUDITS.**—The plan shall provide that the State will furnish to the Secretary—

(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this part, including the processing of claims under the plan, and

(B) such data and information as the Secretary may require in a uniform format as specified by the Secretary.

(11) **USE OF STATE FUNDS FOR MATCHING.**—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this part.

(12) **HEALTH CARE WORKER REDEPLOYMENT REQUIREMENT.**—The plan provides for compliance with the requirement of section [3074(a)].

(13) **TERMINOLOGY.**—The plan shall adhere to uniform definitions of terms, as specified by the Secretary.

(b) **APPROVAL OF PLANS.**—The Secretary shall approve a plan submitted by a State if the Secretary determines that the plan—

(1) was developed by the State after a public comment period of not less than 30 days, and

(2) meets the requirements of subsection (a).

The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before January 1, 1996, shall be effective as of January 1, 1996). In order to budget funds allotted under this part, the Secretary may establish a deadline for the submission of such a plan before the beginning of a fiscal year as a condition of its approval effective with that fiscal year. Any significant changes to the State plan shall be submitted to the Secretary in the form of plan amendments and shall be subject to approval by the Secretary.

(c) **MONITORING.**—The Secretary shall annually monitor the compliance of State plans with the requirements of this subtitle according to specified performance standards. States that fail to comply with such requirements may be subject to the withholding of Federal funds for services or administration until such time as compliance is achieved.

(d) **TECHNICAL ASSISTANCE.**—The Secretary shall ensure the availability of ongoing technical assistance to States under this section. Such assistance shall include serving as a clearinghouse for information regarding successful practices in providing long-term care services.

(e) **REGULATIONS.**—The Secretary shall issue such regulations as may be appropriate to carry out this part on a timely basis.

SEC. 2103. INDIVIDUALS WITH DISABILITIES DEFINED.

(a) **IN GENERAL.**—In this part, the term "individual with disabilities" means any individual within one or more of the following 4 categories of individuals:

(1) **INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.**—Except as provided in section 2103(a)(4) an individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform

SEC. 3072. APPLICABILITY OF PART 1 PROVISIONS.

(a) **IN GENERAL.**—The provisions of part 1 apply to the program carried out under section 3071 to the same extent and in the same manner as such provisions apply to the program carried out under part 1, subject to the subsequent provisions of this section. Section 3061 does not apply for purposes of the preceding sentence.

(b) **NATIONAL COUNCIL.**—With respect to section 3001 as applied to this part, the council shall be known as the National Council on Graduate Nurse Education (in this part referred to as the "National Council"). The provisions of section 851 of the Public Health Service Act regarding the composition of the council under such section apply to the composition of the National Council to the same extent and in the same manner as such provisions apply to the council under such section 851.

(c) **ALLOCATION OF GRADUATE NURSE TRAINING POSITIONS; FORMULA PAYMENTS FOR OPERATING COSTS.**—With respect to subparts B and C of part 1 as applied to this part—

(1) the funding agreement described in section 3011 is to be made by graduate nurse training programs;

(2) designations under section 3012 and allocations under section 3013 apply to graduate nurse training positions; and

PART 3—RELATED PROGRAMS**Subpart A—Workforce Development****SEC. 3081. PROGRAMS OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.**

(a) **IN GENERAL.**—

(1) **FUNDING.**—For purposes of carrying out the programs described in this section, there is authorized to be appropriated \$100,000,000 for each of the fiscal years 1995 and 1996, and \$150,000,000 for each of the fiscal years 1997 through 2000 (in addition to amounts that may otherwise be authorized to be appropriated for carrying out the programs).

(2) **ADMINISTRATION.**—The programs described in this section and carried out with amounts made available under subsection (a) shall be carried out by the Secretary of Health and Human Services.

(b) **PRIMARY CARE PHYSICIAN AND PHYSICIAN ASSISTANT TRAINING.**—For purposes of subsection (a), the programs described in this section include programs to support projects to train additional numbers of primary care physicians and physician assistants, including projects to enhance community-based generalist training for medical students, residents, and practicing physicians; to retrain mid-career physicians previously certified in a nonprimary care medical specialty; to expand the supply of physicians with special training to serve in rural and inner-city medically underserved areas; to support expansion of service-linked educational networks that train a range of primary care providers in community settings; to provide for training in managed care, cost-effective practice management, and continuous quality improvement; to provide interdisciplinary training for medical students, residents or practicing physicians, and dental students, residents, and dental hygienists, to deliver primary care to individuals with ~~mental retardation and other developmental disabilities who are more than 18 years of age~~; and to develop additional information on primary care workforce issues as required to meet future needs in health care.

(c) **TRAINING OF UNDERREPRESENTED MINORITIES AND DISADVANTAGED PERSONS.**—For purposes of subsection (a), the programs described in this section include a program to support projects to increase the number of underrepresented minority and disadvantaged persons in medicine, osteopathy, dentistry, advanced practice nursing, public health, psychology, and other health professions, including projects to provide continuing financial assistance for such persons entering health professions training programs; for

mental, physical, and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age.

financial assistance for facility renovation or construction; to increase support for recruitment and retention of such persons in the health professions; to maintain efforts to foster interest in health careers among such persons at the preprofessional level; and to increase the number of minority health professions faculty at programs that have a significant number of underrepresented minorities.

(d) **NURSE TRAINING.**—For purposes of subsection (a), the programs described in this section include a program to support projects to support midlevel provider training and address priority nursing workforce needs, including projects to train additional nurse practitioners and nurse midwives; to support baccalaureate-level nurse training programs providing preparation for careers in teaching, community health service, and specialized clinical care; to train additional nurse clinicians and nurse anesthetists; to support interdisciplinary school-based community nursing programs; and to promote research on nursing workforce issues.

(e) **INAPPROPRIATE PRACTICE BARRIERS; FULL UTILIZATION OF SKILLS.**—For purposes of subsection (a), the programs described in this section include a program—

(1) to develop and encourage the adoption of model professional practice statutes for advanced practice nurses and physician assistants, and to otherwise support efforts to remove inappropriate barriers to practice by such nurses and such physician assistants; and

(2) to promote the full utilization of the professional education and clinical skills of advanced practice nurses and physician assistants.

(f) **OTHER PROGRAMS.**—For purposes of subsection (a), the programs described in this section include a program to train health professionals and administrators in managed care, cost-effective practice management, continuous quality improvement practices, and provision of culturally sensitive care.

(g) **RELATIONSHIP TO EXISTING PROGRAMS.**—This section may be carried out through programs established in title VII or VIII of the Public Health Service Act, as appropriate and as consistent with the purposes of such programs.

(h) **MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES.**—Title VII of the Public Health Service Act is amended by inserting after section 778, the following new section:

"SEC. 779. MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES.

(a) **IN GENERAL.**—The Secretary may make grants and enter into contracts with university affiliated programs, schools of medicine, and schools of dentistry to assist in meeting the costs of such programs or schools to—

"(1) improve the interdisciplinary training of primary care physicians and dentists in the health care services needs of individuals with ~~mental retardation and other developmental disabilities who are more than 18 years of age,~~

"(2) develop, evaluate, and disseminate curricula relating to the health care service needs of individuals with mental retardation and other developmental disabilities who are more than 18 years of age;

"(3) support the training and retraining of faculty to provide such instruction; and

"(4) support continuing education of health professional who provide health care services and support to individuals with mental retardation and other developmental disabilities who are more than 18 years of age.

"(b) **AUTHORIZATION OF APPROPRIATIONS.**—For purposes of carrying out this section, there are authorized to be appropriated, \$10,000,000 for each of the fiscal years 1995 through 2000."

SEC. 3082. PROGRAMS OF THE SECRETARY OF LABOR.

(a) **IN GENERAL.**—

mental, physical, and
developmental disabilities
including mental
retardation, particularly
those who are more
than 18 years of age

(II) Such counselor shall solicit job openings from local health care industry employers, maintain frequent contacts with these and other employers, and monitor and update all job listings appropriate for displaced health care and health insurance industry workers seeking employment.

(III) The local employment service agency or one-stop career center shall provide directly, or facilitate the provision of, labor exchange services to displaced health care and insurance industry workers, including assessment, counseling, testing, job-search assistance, job referral and placement, and referral to training and educational programs, where appropriate.

(IV) The Secretary of Labor shall develop performance goals for the effective performance of such job banks with respect to the number and quality of jobs listed, the degree of participation by employers in the affected community, and success in placement of job bank users in jobs listed, taking into account specific geographic, economic and labor market characteristics of the community served.

 In section 3081(b), strike "mental retardation and other developmental disabilities who are more than 18 years of age" and insert "mental, physical, and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age"

In section 3081(c), after "OF UNDERREPRESENTED" insert "RACIAL AND ETHNIC".

In section 3081(c), after "and to increase the number of" insert "racial and ethnic".

In section 3081(c), after "significant number of underrepresented" insert "racial and ethnic".

 In the amendment made by section 3081(h), after "individuals with" in subsection (a)(1), strike "mental retardation and other developmental disabilities who are more than 18 years of age" and insert "mental, physical, and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age"

In section 3083(d)(2)(C), strike "health care" and all that follows and insert "labor organizations representing health care industry workers to be appointed by the Secretary of Labor."

In section 3083(d)(2)(D), strike "Secretaries" and insert "the Secretary of Health and Human Services".

worksite health promotion discount program (in accordance with section 1207).

(7) **WORKERS COMPENSATION AND AUTOMOBILE INSURANCE.**—Conforming State laws to meet the requirements of subtitles A and B of title X (relating to medical benefits under workers compensation and automobile insurance).

(8) **OTHER RESPONSIBILITIES.**—Carrying out other responsibilities of participating States specified under this Act.

SEC. 1202. ASSURING COMMUNITY-RATED PREMIUMS THROUGH ESTABLISHMENT OF HEALTH CARE COVERAGE AREAS.

(a) **IN GENERAL.**—In accordance with this section, a participating State shall provide for the division of the State into 1 or more health care coverage areas. Each portion of the State shall be within 1, and only 1, health care coverage area. The State may revise the boundaries of such areas from time to time consistent with this subsection.

(b) **MULTIPLE AREAS.**—With respect to a health care coverage area—

(1) no metropolitan statistical area in a State may be incorporated into more than 1 such area in the State;

(2) the number of individuals residing within such an area may not be less than 250,000 and

(3) no area incorporated in a health care coverage area may be incorporated into another such area.

(c) **BOUNDARIES.**—

(1) **IN GENERAL.**—In establishing boundaries for health care coverage areas, a State may not discriminate on the basis of or otherwise take into account race, age, language, religion, national origin, socio-economic status, disability, sexual orientation, or perceived health status. Such restrictions shall not prohibit States from establishing health care coverage area boundaries such that underserved and vulnerable populations are better served.

(2) **TREATMENT OF CONSOLIDATED METROPOLITAN STATISTICAL AREAS.**—A health care coverage area that includes all of a Consolidated Metropolitan Statistical Area that is within a State is presumed to meet the requirement of paragraph (1).

(d) **SYSTEM DOCUMENT.**—States shall specify the boundaries of proposed health care coverage areas as a part of their system implementation document filed with the Board under section 2000(b).

SEC. 1203. STATE RESPONSIBILITIES RELATING TO HEALTH PLANS.

(a) **CRITERIA FOR CERTIFICATION.**—

(1) **IN GENERAL.**—For purposes of this section, a participating State shall establish and publish the criteria that are used in the certification of health plans under this section.

(2) **REQUIREMENTS.**—At a minimum, such criteria shall be established with respect to—

(A) the quality of the plan, including plan performance with respect to the national measures of quality performance and performance standards designated by the National Quality Management Council,

(B) the financial stability of the plan in accordance with Federal financial standards established by the Board under sections 1603(i) and 1651(a),

(C) the plan's capacity to deliver the comprehensive benefit package throughout the designated service area, with an appropriate mix, number, and distribution of qualified providers,

(D) the disclosure of information by health care providers as required under this Act;

(E) all other applicable requirements for health plans under this Act, and

(F) other requirements imposed by the State consistent with this part.

(b) **CERTIFICATION AND RECERTIFICATION.**—

(1) **CERTIFICATION.**—A participating State shall certify each plan as a community-rated health plan that it determines meets the criteria for certification established and published under subsection (a).

(2) **RECERTIFICATION.**—A participating State shall—

(A) review the continued compliance of each plan with the certification requirements and recertify each plan as a community-rated health plan not less frequently than once during every 3-year period if the State determines that the plan continues to meet the criteria for certification established and published under subsection (a), including demonstrating that the policies of the plan have not discriminated on the basis of any of the categories described in section 1502;

(B) review enrollee disenrollment from health plans in order to determine whether there is a pattern of disenrollment that does not reflect the distribution of such plans' reenrolling members with respect to age, income, health condition, prior utilization of health services, place of residence and other potential risk characteristics.

Evidence of any of the disenrollment patterns described in subparagraph (B) may be cause for the denial of a recertification or for the application of one or more interim sanctions described in subsection (c).

(c) **MONITORING.**—A participating State shall monitor the performance of each State-certified community-rated health plan to ensure that it continues to meet the criteria for certification. If during such monitoring the State determined that a health plan fails to deliver care of adequate quality, either with respect to the overall enrollment population or vulnerable population, fails to meet applicable standards relating to financial solvency and stability, or fails to meet any other criteria for certification or recertification, the State shall impose sanctions on the plan. Such sanctions may include fines and the limitation or prohibition of further enrollment until such time as the plan develops and complies with a corrective action plan.

(d) **LIMITATIONS ON AUTHORITY.**—A participating State may not—

(1) discriminate against a plan based on the domicile of the entity offering of the plan; or

(2) regulate premium rates charged by health plans, except as may be required under title VI (relating to the enforcement of cost containment rules for plans in the State) or as may be necessary to ensure that plans meet financial solvency requirements under section 1509.

(e) **ASSURING ADEQUATE ACCESS TO A CHOICE OF HEALTH PLANS.**—

(1) **GENERAL ACCESS.**—

(A) **IN GENERAL.**—Each participating State shall ensure that—

(i) each community rate eligible individual has adequate access to a choice of community-rated health plans providing services with reasonable proximity to the residence of the individual, including residences, including (to the maximum extent practicable) adequate access to a plan whose premium is at or below the weighted average premium for plans in the health care coverage area, and

(ii) each such family that is eligible for a premium discount under section 6104(b) is provided a discount in accordance with such section (including an increase in such discount described in section 6104(b)(2)).

(B) **AUTHORITY.**—In order to carry out its responsibility under subparagraph (A), a participating State may require that one or more certified community-rated health plans

Sub

with respect to any



SEC. 1506. GRIEVANCE PROCEDURE.

(a) **IN GENERAL.**—Each health plan must establish a grievance procedure for enrollees to use in pursuing complaints. Such procedure shall be consistent with subtitle C of title V.

(b) **ADDITIONAL REMEDIES.**—If the grievance procedure fails to resolve an enrollee's complaint—

(1) in the case of an enrollee of a community-rate health plan, the enrollee has the option of seeking assistance from the office of the ombudsman for the State established under section 1208(a), and

(2) the enrollee may pursue additional legal remedies, including those provided under subtitle C of title V.

SEC. 1507. HEALTH PLAN ARRANGEMENTS WITH PROVIDERS.

(a) **IN GENERAL.**—Plans shall ensure that all health care providers reimbursed by the plan are authorized under State law to provide applicable services.

(b) **REQUIREMENTS FOR NONNETWORK PLANS.**—Each health plan must enter into such agreements with an appropriate mix, number, and distribution of qualified health professionals or have such other arrangements as may be necessary to ensure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled in the plan.

(c) **REQUIREMENTS FOR NETWORK PLANS.**—A health plan that requires coinsurance for an out-of-network item or service shall comply with the following requirements:

(1) **AGREEMENTS.**—Each health plan must enter into such agreements with an appropriate mix, number, and distribution of qualified health professionals or have such other arrangements in network as may be necessary to ensure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled in the plan.

(2) **GATEKEEPER.**—With respect to each health plan that utilizes a gatekeeper or similar process to approve health care services prior to or following the provision of such services, such gatekeepers shall include specialists or a care coordinator from an interdisciplinary team if medically necessary or appropriate given the nature, severity, or complexity of each patient's chronic disease, disorder, or other health condition.

(3) **CONTINUED CARE.**—Each health plan shall develop a process to ensure the access of enrollees to relevant specialists for the continued care of patient-enrollees with chronic diseases, disorders, or health conditions without gatekeeper approval prior to each visit, when medically indicated.

(4) **ELIGIBLE CENTERS OF SPECIALIZED TREATMENT EXPERTISE.**—

(A) **IN GENERAL.**—Each health plan shall provide access through agreements (as defined in subparagraph (B)) to eligible centers of specialized treatment expertise (as defined in subparagraphs (C) and (D)), including centers outside the health care coverage area or State, to ensure that enrollees receive the specialized treatment expertise of such centers when medically indicated. A health plan shall be deemed to be in accordance with this paragraph if the agreement of such plan provides that, with respect to health conditions within the specialized treatment expertise of the center involved, the plan will, at the enrollees request—

(i) refer medical cases involving such conditions to such center;

(ii) inform plan members of the availability of referral care; and

(iii) establish an appeal mechanism in which plan participants may challenge denials of referrals to such center or may request that their specialized care be provided at an alternative center as described in subparagraph (E).

Consistent
with
Subtitle C of Title
~~II~~ V of this
Act

(B) **AGREEMENTS.**—An agreement between a health plan and a center of specialized treatment expertise shall—

(i) be a written provider participation agreement with the center; or

(ii) be a written agreement under which the plan shall make payment to the center such that services provided will be reimbursable at the plan's normal rate for equivalent services or, with respect to a plan that does not pay providers on a fee-for-service basis, based on the fee schedule established by the health care coverage area (or the State) in the area where the services are provided.

(C) **SPECIALIZED TREATMENT EXPERTISE.**—For purposes of this subtitle, the term "specialized treatment expertise", with respect to the treatment of a health condition by an academic health center or teaching hospital, means expertise in diagnosing and treating unusual diseases or conditions, diagnosing and treating diseases or conditions which are unusually difficult to diagnose or treat, and providing other specialized health care.

(D) **ELIGIBLE CENTERS.**—Eligible centers under this paragraph shall be designated to diagnose and provide care for patients with specified categories of conditions and diseases. Such centers may include academic health centers and teaching hospitals that meet strict objective criteria established by the Secretary including—

(i) specialized credentials for caring for patients with the specified categories of conditions and diseases;

(ii) staff with experience in caring for a significant number of patients with the specified categories of conditions and diseases; and

(iii) excellent measured outcomes in the diagnosis and treatment of patients with the specified categories of conditions and diseases.

(E) **ACCESS TO ALTERNATIVE CENTERS.**—

(i) **IN GENERAL.**—Patients in need of specialized treatment expertise may request that specialized care be provided at an alternative center. As used in this subparagraph, the term "alternate center" means a center of specialized treatment expertise with which the health plan of the patient does not have a written agreement as described in subparagraph (B). Plans shall have a procedure for making decisions regarding such requests and have an appeals process for patients who are refused coverage at an alternative center for specialized treatment.

(ii) **REIMBURSEMENT.**—Care provided at an alternative center shall be reimbursed by the health plan at the plan's normal rate for equivalent services or, with respect to a plan that does not pay providers on a fee-for-service basis, based on the fee schedule established by the State in the health care coverage area where the services are provided.

(F) **LIMITATION.**—A State may not establish rules or policies that require or encourage health plans to give preference to centers of specialized treatment expertise within the State or within the health care coverage area.

(d) **EMERGENCY AND URGENT CARE SERVICES.**—

(1) **IN GENERAL.**—Each health plan must cover emergency and urgent care services provided to enrollees, without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the plan to provide items or services to enrollees of the plan and in the case of emergency services without regard to prior authorization.

(2) **PAYMENT AMOUNTS.**—In the case of emergency and urgent care provided to an enrollee outside of a health plan's serv-

In section 1507(c)(3), insert "the continued care is" before "medically indicated".

In section 1507(c)(4)(a)(iii), insert "consistent with subtitle C of title 5 of this Act" after "mechanism".

In section 1507(e)(1), strike "paragraph (2)" and insert "paragraphs (2) and (3)".

In section 1507(e), insert after paragraph (1) the following new paragraph and redesignate the remaining paragraph accordingly:

(2) **RULE OF CONSTRUCTION.**—Nothing in the paragraph (1) shall be construed to prevent a health plan from providing for a different basis or level of payment than the fee schedule established under section 1234 as part of a contractual agreement with participating providers under the plan.

In section 1507(f)(2), add after the period the following: "An individual or entity who furnishes ancillary health services may not present or cause to be presented, a claim, bill, or demand for payment to any person other than the enrollee receiving such services, or to the health plan of the enrollee."

Strike section 1510 and insert the following new section:

SEC. 1510. REQUIREMENT RELATED TO COST SHARING OBLIGATIONS.

An enrollee that incurs cost sharing expenses in a month in excess of \$250, may request that a health plan establish a payment plan so that the enrollee is not required to pay more than \$250 in any one month. For individuals who have submitted and been approved for a reduction in cost sharing under section 1282(c), community-rated plans must accept such requests and may not charge any interest or finance charges on out of pocket expenses financed under this section.

In the heading for section 1513(a), strike "CONSUMER".

In section 1513(a), insert "providers and" after "disclose to".

In section 1602(b), strike "and individuals with disabilities" and insert ", individuals with disabilities, and individuals in rural and urban underserved areas".

In section 1611(a)(2), strike "parts 2 and 3 of".

(1) The plan must be offered to all individuals to whom such a plan is required to be offered under section 8203.

(2) The plan must offer each such individual a choice of a policy that provides standard coverage and a policy that provides maximum coverage (in accordance with standards established by the Board under subsection (a)(3)).

(3) The plan is offered only during the annual open enrollment period for community-rated health plans (described in section 1232(d)(1)).

(4)(A) The price of the plan shall include an amount, established in accordance with rules established by the Board in consultation with the Office of Personnel Management, that takes into account any expected increase in utilization of the items and services in the comprehensive benefit package resulting from the purchase of the plan by individuals enrolled in a community-rated health plan.

(B) The plan provides for payment, in a manner specified by the Board in the case of an individual enrolled in the plan and in a community-rated health plan, to the community-rated health plan of an amount equivalent to the additional amount described in subparagraph (A).

PART 3—REQUIREMENTS RELATING TO ESSENTIAL COMMUNITY PROVIDERS

SEC. 1531. HEALTH PLAN REQUIREMENT.

(a) **IN GENERAL.**—Each health plan shall, with respect to each electing essential community provider (as defined in subsection (d), other than a provider of school health services) located within the plan's service area, either—

(1) enter into a written provider participation agreement (described in subsection (b)) with the provider, or

(2) enter into a written agreement under which the plan shall make payment to the provider in accordance with subsection (c).

(b) **PARTICIPATION AGREEMENT.**—A participation agreement between a health plan and an electing essential community provider under this subsection shall provide that the health plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers participating in the health plan with respect to each of the following:

(1) The scope of services for which payment is made by the plan to the provider.

(2) The rate of payment for covered care and services.

(3) The availability of financial incentives to participating providers.

(4) Limitations on financial risk provided to other participating providers.

(5) Assignment of enrollees to participating providers.

(6) Access by the provider's patients to providers in medical specialties or subspecialties participating in the plan.

(c) **PAYMENTS FOR PROVIDERS WITHOUT PARTICIPATION AGREEMENTS.**—

(1) **IN GENERAL.**—Payment in accordance with this subsection is payment based, as elected by the electing essential community provider, either—

(A) on the fee schedule developed by the State under section 1234(c), or

(B) on payment methodologies and rates used under the applicable Medicare payment methodology and rates (or the most closely applicable methodology under such program as the Secretary of Health and Human Services specifies in regulations).

(2) **SPECIAL RULE FOR FEDERALLY QUALIFIED HEALTH CENTERS.**—With respect to each federally qualified health center (as such term is defined in section 1861(aa) of the Social Security

Act) that is an essential community provider, a health plan shall make payments based on the reasonable cost rates applicable under section 1833(a)(3) of the Social Security Act, except that the federally qualified health center may accept other payment amounts.

(3) **NO APPLICATION OF GATE-KEEPER LIMITATIONS.**—Payment in accordance with this subsection may be subject to utilization review, but may not be subject to otherwise applicable gate-keeper requirements under the plan.

(d) **ELECTION.**—

(1) **IN GENERAL.**—In this part, the term “electing essential community provider” means, with respect to a health plan, an essential community provider that elects this subpart to apply to the health plan.

(2) **FORM OF ELECTION.**—An election under this subsection shall be made in a form and manner specified by the Secretary, and shall include notice to the health plan involved. Such an election may be made annually with respect to a health plan, except that the plan and provider may agree to make such an election on a more frequent basis.

(e) **SPECIAL RULE FOR PROVIDERS OF SCHOOL HEALTH SERVICES.**—A health plan shall pay, to each provider of school health services located in the plan’s service area an amount determined by the Secretary for such services furnished to enrollees of the plan.

SEC. 1532. RECOMMENDATION ON CONTINUATION OF REQUIREMENT.

(a) **STUDIES.**—In order to prepare recommendations under subsection (b), the Secretary shall conduct studies regarding essential community providers, including studies that assess—

- (1) the definition of essential community provider,
- (2) the sufficiency of the funding levels for providers, including the special rule for federally qualified health centers under section 1531(c)(2), for both covered and uncovered benefits under this Act,
- (3) the effects of contracting requirements relating to such providers on such providers, health plans, and enrollees,
- (4) the impact of the payment rules for such providers, and
- (5) the impact of national health reform on such providers.

(b) **RECOMMENDATIONS TO CONGRESS.**—The Secretary shall submit to Congress, by not later than March 1, 2001, specific recommendations respecting whether, and to what extent, section 1531 should continue to apply to some or all essential community providers. Such recommendations may include a description of the particular types of such providers and circumstances under which such section should continue to apply.

PART 4—REQUIREMENTS RELATING TO WORKERS’ COMPENSATION AND AUTOMOBILE MEDICAL LIABILITY COVERAGE

SEC. 1541. REFERENCE TO REQUIREMENTS RELATING TO WORKERS COMPENSATION SERVICES.

Each health plan shall meet the applicable requirements of part 2 of subtitle A of title X (relating to provision of workers compensation services to enrollees).

SEC. 1542. REFERENCE TO REQUIREMENTS RELATING TO AUTOMOBILE MEDICAL LIABILITY SERVICES.

Each health plan shall meet the applicable requirements of part 2 of subtitle B of title X (relating to provision of automobile medical liability services to enrollees).

pointed by the Secretary are provided such reimbursements under the Social Security Act.

(f) **NO TERMINATION.**—Notwithstanding the provisions of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise specified in law.

Subpart B—Certification of Essential Community Providers

SEC. 1681. CERTIFICATION.

For purposes of this Act, the Secretary shall certify as an "essential community provider" any health care provider or organization that—

(1) is within any of the categories of providers and organizations specified in section 1682(a), or

(2) meets the standards for certification under section 1683(a).

SEC. 1682. CATEGORIES OF PROVIDERS AUTOMATICALLY CERTIFIED.

(a) **IN GENERAL.**—The categories of providers and organizations, including subrecipients, specified in this subsection are as follows:

(1) covered entities as defined in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), except that subsections (a)(4)(L)(iii) and (a)(7) of such section shall not apply;

(2) school-based clinics under title III of this Act;

(3) nonprofit hospitals meeting the criteria for public hospitals which are eligible entities under section 340B of the Public Health Service Act, and children's hospitals meeting comparable criteria determined appropriate by the Secretary;

(4) mental health and substance abuse providers ~~designated by the State as qualified to provide any of the services described in section 1115;~~

(5) runaway homeless youth centers or transitional living programs for homeless youth providing health services under the Runaway Homeless Youth Act of 1974 (42 U.S.C. 5701 et seq.); and

(6) public or nonprofit maternal and child health providers that receive funding under title V of the Social Security Act; and

(b) **SUBRECIPIENT DEFINED.**—In this subpart, the term "subrecipient" means, with respect to a recipient of a grant under a particular authority, an entity that—

(1) is receiving funding from such a grant under a contract with the principal recipient of such a grant, and

(2) meets the requirements established to be a recipient of such a grant.

(c) **HEALTH PROFESSIONAL DEFINED.**—In this subpart, the term "health professional" means a physician, nurse, nurse practitioner, certified nurse midwife, physician assistant, psychologist, dentist, pharmacist, and other health care professional recognized by the Secretary.

(d) **CHILDREN'S HOSPITAL DEFINED.**—In this subpart, the term "children's hospital" means those hospitals whose inpatients are certified by the Secretary or the State to be predominantly under the age of 18.

SEC. 1683. STANDARDS FOR ADDITIONAL PROVIDERS.

(a) **STANDARDS.**—The Secretary shall publish standards for the certification of additional categories of health care providers and organizations as essential community providers, including the categories described in subsection (b). Such a health care provider or organization shall not be certified unless the Secretary determines, under such standards, that health plans operating in the area served by the applicant would not otherwise be able to assure adequate access to items and services included in the comprehensive benefit package if such a provider was not so certified.

except that subsection (a)(4)(L)(iii) of such section shall not apply

INSERT LANGUAGE FROM Z-9

clinical social worker

receiving funds under title V of XIX of the Public Health Service Act

(7) rural health clinics as defined under section 1861(aa)(2) of the Social Security Act

(b) **CATEGORIES TO BE INCLUDED.**—The categories described in this subsection are as follows:

(1) **CERTAIN HEALTH PROFESSIONALS.**—A health professional who—

(A) for at least 20 hours per week—

(i) is located in an area (or areas) designated as a health professional shortage area (under section 332 of the Public Health Service Act) or serves a population (or populations) designated as a medically underserved population (under section 330 of the Public Health Service Act); or

(ii) (I) is located or provides services in a neighborhood or community whose residents are at risk of underservice; ~~and~~

(II) is available to patients at such location on evenings and weekends; and

(B) if the health professional is a physician—

(i) is licensed to practice in the jurisdiction; and

(ii) is either—

(I) granted privileges to practice at one or more hospitals; or

(II) has a consultation and referral arrangement with one or more physicians who are granted privileges to practice at one or more hospitals.

(2) **INSTITUTIONAL PROVIDERS.**—Public and private nonprofit hospitals and other public and nonprofit institutional health care providers, including family planning clinics, located in health professional shortage areas (as defined under section 332 of the Public Health Service Act) or providing health services to medically underserved populations (as defined under title III of this Act).

(3) **OTHER PROVIDERS.**—Other public and private nonprofit agencies and organizations that—

(A) are located in such an area or providing health services to such a population, and

(B) provide health care and services essential to residents of such an area or such populations.

SEC. 1684. CERTIFICATION PROCESS; REVIEW; TERMINATION OF CERTIFICATIONS.

(a) **CERTIFICATION PROCESS.**—

(1) **PUBLICATION OF PROCEDURES.**—The Secretary shall publish, not later than 6 months after the date of the enactment of this Act, the procedures to be used by health care professionals, providers, agencies, and organizations seeking certification under this subpart, including the form and manner in which an application for such certification is to be made.

(2) **TIMELY DETERMINATION.**—The Secretary shall make a determination upon such an application not later than 60 days (or 15 days in the case of a certification for an entity described in section 1682) after the date the complete application has been submitted. The determination on an application for certification of an entity described in section 1682 shall only involve the verification that the entity is an entity described in such section.

(b) **REVIEW OF CERTIFICATIONS.**—The Secretary shall periodically review whether professionals, providers, agencies, and organizations certified under this subpart continue to meet the requirements for such certification.

(c) **TERMINATION OR DENIAL OF CERTIFICATION.**—

(1) **PRELIMINARY FINDING.**—If the Secretary preliminarily finds that an entity seeking certification under this section does not meet the requirements for such certification or such an entity certified under this subpart fails to continue to meet the requirements for such certification, the Secretary shall notify the entity of such preliminary finding and permit the entity an opportunity, under subtitle C of title V, to rebut such findings.

(2) **FINAL DETERMINATION.**—If, after such opportunity, the Secretary continues to find that such an entity continues to fail to meet such requirements, the Secretary shall terminate the certification and shall notify the entity, the State, large group sponsors, of such termination and the effective date of the termination.

SEC. 1685. NOTIFICATION OF PARTICIPATING STATES.

(a) **IN GENERAL.**—Not less often than annually the Secretary shall notify each participating State of essential community providers that have been certified under this subpart.

(b) **CONTENTS.**—Such notice shall include sufficient information to permit each State to notify health plans of the identity of each entity certified as an essential community provider, including—

(1) the location of the provider within each plan's service area,

(2) the health services furnished by the provider, and

(3) other information necessary for health plans to carry out part 3 of subtitle E.

Subpart C—Workplace Wellness Programs

SEC. 1686. WORKPLACE WELLNESS PROGRAM.

(a) **IN GENERAL.**—The Secretary shall perform responsibilities required under this Act with respect to the development of certification criteria and other duties required under this Act relating to workplace wellness programs.

(b) **APPLICATION OF SECTION.**—Employers maintaining qualified worksite health promotion programs meeting the requirements of subsection (e) shall be entitled to the worksite health promotion rebate specified in subsection (c).

(c) **EMPLOYER HEALTH PROMOTION REBATE.**—Employers maintaining a qualified worksite health promotion programs shall be paid a rebate by the State in an amount determined using the methodology developed by the Secretary.

(d) **REQUIREMENTS FOR QUALIFIED WORKSITE HEALTH PROMOTION PROGRAMS.**—

(1) **ESTABLISHMENT OF LEVELS.**—The Secretary shall establish not less than two levels of qualified worksite health promotion programs and determine the program elements (or combination of program elements) necessary for an employer to qualify at each level. In establishment such levels, the Secretary shall take into consideration the special characteristics of small businesses (as defined in section 6123(c)) and incorporate provisions providing small businesses the opportunity to qualify at all levels.

(2) **PROGRAM ELEMENTS.**—Program elements that the Secretary should consider for inclusion in qualified worksite health promotion programs are the following:

(A) Education, screening, counseling, follow-up, treatment or referral programs to reduce lifestyle and other modifiable risk factors such as cholesterol, inactivity, nutrition and weight management, HIV, sexually transmitted diseases, cancer prevention, or smoking.

(B) Education, screening, counseling, follow-up, monitoring or referral for chronic health risks or problems such as high blood pressure or diabetes.

(C) Promotion of exercise and fitness through education or the provision of exercise facilities at the worksite, adjoining the worksite, or at a proximate location with transportation provided from the worksite.

(D) Employee assistance programs that provide counseling and assistance with respect to other areas of personal concern that may adversely affect job performance such as substance abuse, stress or parenting.

(E) Workplace health and safety education and prevention programs that go beyond those required by law.

(B) The Commissioner of Food and Drugs.

(C) The Director of the Centers for Disease Control and Prevention.

(D) The Administrator of the Health Care Financing Administration.

(E) The Under Secretary of Commerce for Technology.

(F) The Director of the Congressional Office of Technology Assessment.

(d) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as may be necessary to carry out this section.

In subpart A of part 2 of subtitle G of title I, add the following new sections:

SEC. 1673. ADVISORY OPINIONS.

(a) **IN GENERAL.**—Community- and provider-based plans shall be eligible to receive advisory opinions from appropriate Federal entities concerning whether their arrangement complies with Federal self-referral and anti-trust laws.

(b) **REGULATIONS.**—The Secretary shall issue regulations setting forth the procedures for obtaining advisory opinions described in subsection (a).

(c) **TIMING OF OPINIONS.**—Advisory opinions shall be issued not later than 90 days after receipt of a request for such opinions from a plan.

(d) **FEES.**—Applicants shall pay a fee, the amount of which to be determined by the Secretary, to cover the costs of providing the opinion.

SEC. 1674. REPORTS.

(a) **DENTAL CARE.**—The Secretary shall undertake a study to determine the costs of providing preventative and restorative dental care to adults with cognitive and developmental disabilities and shall determine the best oral health care practice and the cost or savings of providing such care prior to 2001. The Secretary shall report to the National Health Board and the Congress not later than September 1, 1995 concerning such study.

(b) **IN VITRO FERTILIZATION.**—The Secretary shall undertake a study to determine the costs of providing coverage for in vitro fertilization in the comprehensive benefits package. The Secretary shall report to the National Health Board and the Congress not later than September 1, 1995 concerning such study.

 In section 1681²(a)(3), insert after "Health Service Act," the following: "nonprofit hospitals with a minimum of 200 beds, located in urban areas where (A) the cumulative total of its services provided to individuals who are entitled to benefits under title XVIII of the Social Security Act or under a State plan under title XIX of such Act equals a minimum of 65 percent and (B) a minimum of 20 percent of its services are provided to individuals eligible for assistance under such title XIX, a Medicare dependent small rural hospital under section 1886(d)(8)(iii) of such Act, except that in administering this paragraph with respect to such section the Secretary shall replace '60 percent' in subclause (IV) with '70 percent'.

In section 1681(a)(5), by striking "and" at the end thereof.

AMENDMENT NO. ____

Calendar No. ____

Purpose: To make various technical and miscellaneous changes.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. ____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Mr. KENNEDY

Viz:

1 In section 1682(a)(3), insert after "Health Service
2 Act," the following: "except that subsection (a)(4)(L)(iii)
3 of such section shall not apply,".

4 In section 1682(a)(7), strike "public and private.
5 nonprofit".

1 In section 1683(b)(1), strike subparagraph (C) and
2 modify the previous subparagraphs accordingly.

3 In section 3412(c)(3), insert “, except that subsection
4 (a)(4)(~~L~~)(iii) of such section shall not apply,” after “Act”.

5 In section 3412(e), insert “for awards to” after
6 “funds available”.

7 In section 3412(e), strike “1861(aa)” and insert
8 “1861(a)(4)”.

In section 1681(a)(6), by striking the period and inserting “; and”.

By adding at the end of section 1681(a), the following new paragraph:

“(7) public and private, nonprofit rural health clinics as defined under section 1861(aa)(2) of the Social Security Act.”.

In section 1681(a)(4), strike “designated” and all that follows through “1115” and insert “receiving funds under title V of XIX of the Public Health Service Act”.

In section 1682(c), insert “clinical social worker” after “pharmacist”.

In section 1683(b)(1)(A)(II), strike “; and” and insert a semicolon.

In section 1683(b)(1)(B)(I), strike “; or” and insert a semicolon.

At the end of section 1683(b)(1), add the following new subparagraph:

“(C) is a rural health clinic as defined in section 1861(aa)(2) of the Social Security Act.”.

In section 1687(a)(1), strike “6127(d)” and insert “1207”.

In section 1687(a), strike paragraph (2) and insert the following new paragraph:

“(2) employers maintaining qualified programs receive a rebate annually, based on the average worksite health promotion discount in the health care coverage area, weighted by the enrollment of employees of all employers offering certified wellness programs in the area.”.

At the end of section 1687(c), add the following new paragraph:

(3) Ensure that any wellness discount offered by health plans are not taken into account in the Board’s determination of plan and area compliance with the per-capita premium targets described in subtitle A of title VI of this Act.

In section 1695, insert “(a) IN GENERAL.—” before “A health”.