(2) TESTS.—The tests specified in this subsection are as follows:

(A) Annual Papanicolaou smears, pelvic exams, and clinical breast examinations for females.

(B) Annual screening for chlamydia and gonorrhea for females who are at risk for fertility related infectious illnesses.

Cost

(C) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every 3 years.

(g) INDIVIDUALS AGE 40 TO 49.—For an individual at least 40 years of age, but less than 50 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) Annual Papanicolaou smears, pelvic exams, and clinical breast examinations for females.

(B) Annual screening for chlamydia and gonorrhea for females who are at risk for fertility related infectious illnesses.

Cost

(C) Mammograms for females every 2 years.

(D) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every 2 years.

(h) INDIVIDUALS AGE 50 TO 65.—For an individual at least 50 years of age, but less than 65 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) Annual Papanicolaou smears, pelvic exams, and clinical breast examinations for females.

(B) Annual mammograms for females.

(C) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every 2 years.

(i) INDIVIDUALS AGE 65 OR OLDER.—For an individual at least 65 years of age who is enrolled under a health plan:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are as follows:

(A) Booster immunizations against tetanus and diphtheria every 10 years.

(B) Age-appropriate immunizations for the following illnesses:

(i) Influenza.

(ii) Pneumococcal invasive disease.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) Annual Papanicolaou smears, pelvic exams, and clinical breast examinations for females.

(B) Annual mammograms for females.

(C) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every year.

(j) CLINICIAN VISIT.—For purposes of this section, the term "clinician visit" includes the following health professional services (as defined in section 1112(c)):

(1) A complete medical history.

(2) An appropriate physical examination.

(3) Risk assessment.

(4) Targeted health advice and counseling, including nutrition counseling.

(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 (j)(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), who satisfy the eligibility requirements in subsection (b):

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

(2) Intensive nonresidential mental illness and substance abuse treatment (described in subsection (d)).

(3) Outpatient mental illness and substance abuse treatment (described in subsection (e)), 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 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; 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—

(A) a health professional designated by the health plan in which the individual is enrolled determines that the individual should receive such services; and

(B) the individual is eligible to receive coverage for, and is receiving, outpatient 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) INPATIENT AND RESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "inpatient and residential 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—

(A) an inpatient of a hospital, psychiatric hospital, residential treatment center, residential detoxification center, crisis residential program, or mental illness residential treatment program; or

(B) a resident of a therapeutic family or group treatment home or community residential

treatment and recovery center for substance abuse.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient and residential mental illness and substance abuse treatment when provided to such an inpatient or resident.

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

(A) RESIDENTIAL MENTAL ILLNESS TREATMENT.—Such treatment, when provided with respect to a diagnosable mental disorder in a setting that is not a hospital or a psychiatric hospital, is covered only to avert the need for, or as an alternative to, treatment in a hospital or a psychiatric hospital, as determined by a health professional designated by the health plan in which the individual receiving such treatment is enrolled.

(B) RESIDENTIAL SUBSTANCE ABUSE TREATMENT.—Such treatment, when provided with respect to a diagnosable substance abuse disorder in a setting that is not a hospital or a psychiatric hospital, is covered only if a

health professional designated by the health plan in which the individual receiving such treatment is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment.

(C) 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.

(D) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment is subject to an aggregate annual limit of 30 days. A maximum of 30 additional days of such treatment shall be covered for an individual if a health professional designated by the health plan in which the individual is enrolled determines in advance that—

(i) the individual poses a threat to his or her own life or the life of another individual; or

(ii) the medical condition of the individual requires inpatient treatment in a hospital or a psychiatric hospital in order to initiate, change, or adjust pharmacological or somatic therapy.

(E) 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).

(d) 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.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as intensive nonresidential mental illness and substance abuse treatment when provided to such an individual.

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

(A) DISCRETION OF PLAN.—An individual shall receive coverage for such treatment if a health professional designated by the health plan in which the individual is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment.

(B) 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.

(C) ANNUAL LIMIT.—

(i) IN GENERAL.—Prior to January 1, 2001, the number of covered days of inpatient and 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 (c)(2)(D) shall be reduced by 1 day for each 2 covered days of intensive nonresidential mental illness and substance

abuse treatment that are provided to the individual, until such number is reduced to zero.

(ii) ADDITIONAL DAYS.—After the number of covered days referred to in clause (i) has been reduced to zero with respect to an individual, the individual shall receive coverage for a maximum of 60 days of intensive nonresidential mental illness and substance abuse treatment if a health professional designated by the health plan in which the individual is enrolled determines that the individual should receive such treatment.

(D) 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.

(E) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for intensive nonresidential mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance

paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle if such treatment is provided—

(i) with respect to a diagnosable substance abuse disorder; or

(ii) pursuant to subparagraph (C)(ii).

(e) 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) Medical management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

(I) Collateral services.

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

AND HEALTH FACILITY SERVICES.

(A) HEALTH PROFESSIONAL SERVICES.—Such treatment is covered only when it constitutes health professional services (as defined in section 1112(c)(2)) or when provided by a health facility that is legally authorized to provide the services in the state in which they are provided.

(B) DISCRETION OF PLAN.—An individual shall receive coverage for outpatient mental illness and substance abuse treatment consisting of substance abuse counseling and relapse prevention if a health professional designated by the health plan in which the individual is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment. This subparagraph does not apply to group therapy covered pursuant to subparagraph (C)(ii)(II).

(C) ANNUAL LIMITS.—

(i) PSYCHOTHERAPY AND COLLATERAL SERVICES.—Prior to January 1, 2001, psychotherapy and collateral services are subject to an aggregate annual limit of 30 visits per individual. Additional visits may be covered, at the discretion of the

health plan in which the individual receiving treatment is enrolled, to prevent hospitalization or to facilitate earlier hospital release, for which the number of covered days of inpatient and 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 (c)(2)(D) shall be reduced by 1 day for each 4 visits. After such number has been reduced to zero, no additional visits under the preceding sentence may be covered.

(ii) SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION.—

(I) IN GENERAL.—Except as provided in subclause (II), the number of covered days of inpatient and 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 (c)(2)(D) shall be reduced by 1 day for each 4 visits for substance abuse counseling and relapse preven-

Prior to Jan. 1, 2001

tion that are covered for the individual under subparagraph (B). After such number has been reduced to zero, no visits for substance abuse counseling and relapse prevention may be covered, except as provided in subclause (II).

(II) GROUP THERAPY.—Prior to January 1, 2001, substance abuse counseling and relapse prevention consisting of group therapy is subject to a separate aggregate annual limit of 30 visits, if such therapy occurs within 12 months after the individual has received, with respect to a diagnosable substance abuse disorder, inpatient and residential mental illness and substance abuse treatment or intensive nonresidential mental illness and substance abuse treatment. The provisions of clause (i) and subclause (I) do not apply to therapy that is described in the preceding sentence.

(D) DETOXIFICATION.—Outpatient mental illness and substance abuse treatment consist-

ing of detoxification is covered only if it is provided in the context of a treatment program.

(E) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for outpatient mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle.

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

(1) REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.—The mental illness and substance abuse services described in this section shall be included in the comprehensive benefit package with respect to an eligible individual under 22 years of age only if such services are provided through an organized system of care described in paragraph (2).

Cost ?

(2) REQUIREMENTS FOR SYSTEMS OF CARE.—In this subsection, an "organized system of care" is a community-based system established by an appli-

cable health plan for the provision of mental illness and substance abuse services described in this section 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 of multiple agencies and providers that serve the needs of children in the area (including agencies and providers involved with child welfare, education, juvenile 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 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 through multidisciplinary or

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 children under 22 years of age.

(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.

(g) 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, Third Edi-

tion, 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) 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.

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

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

(1) Voluntary family planning services.

(2) Contraceptive devices that—

(A) may only be dispensed upon prescription; and

(B) are subject to approval by the Secretary of Health and Human Services 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 or injury.~~] cost

(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 ALTERNATIVE.—Such services are covered only as an alternative to inpatient treatment in a hospital ~~after an illness or injury~~.

(2) ANNUAL LIMIT.—Such services are subject to an aggregate annual limit of 100 days.

(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 or injury~~. Such term shall include a unit of a hospital (as defined in section 1111(c)(1).

(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—

(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 or injury~~.

SEC. 1120. TRANSPORTATION SERVICES.

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

(1) Ambulance services consisting of—

(A) Ground transportation by ambulance;

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

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

(2) Inter-island air transportation (consisting of one round-trip for one complete series of treatments) in cases in which there is no other reasonable method of transportation available in order for an individual to receive an item or service described in this subtitle that is not available on the island on which the individual resides.

(3) Inter-island air transportation necessary for one companion to accompany an individual described in paragraph (2) in cases in which the individual is less than 18 years of age or otherwise incapable of traveling alone.

(b) LIMITATIONS.—Coverage for ambulance services described in subsection (a)(1) is subject to the following limitations:

(1) MEDICAL INDICATION.—Such 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.—Ambulance services consisting of air transportation are 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.

Cost

Why not apply this std to inter-island air transport.?

(3) WATER TRANSPORT.—Ambulance services consisting of 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 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.

(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; and

(3) outpatient speech ~~pathology~~ (-language) services ~~for the purpose of attaining or restoring speech.~~ and audiology services

(4) outpatient vision-related rehabilitation services.

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

(1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS.—The services described in

cost

paragraphs (1), (2), and (3) of subsection (a) include only items or services used to maintain or restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder, or other health condition.

(2) RESTORATION OR PREVENTION OF DETERIORATION IN FUNCTIONING.—The services described in subsection (a)(4) include only items or services used to restore, or prevent deterioration in, independent functioning. Cost

(3) REEVALUATION.—At the end of each 60-day period of outpatient rehabilitation services, 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 functioning is improving or being maintained. Cost

SEC. 1124. DURABLE MEDICAL EQUIPMENT AND PROSTHETIC AND ORTHOTIC DEVICES.

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

(1) durable medical equipment, ~~including repair of equipment that is damaged and replacement~~ of ~~equipment that is worn out or damaged;~~ and

~~(2) accessories and supplies that are used directly with durable medical equipment or that are necessary for repair, function, and maintenance of such equipment;~~

(3) prosthetic devices (other than dental devices) which replace all or part of the function of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices;

~~(4) accessories and supplies which are used~~ directly ~~with a prosthetic device to achieve the therapeutic benefits of the prosthesis or to assure the proper functioning of the device;~~

(5) leg, arm, back, and neck braces;

(6) artificial legs, arms, and eyes~~, including replacements if required because of a change in the patient's physical condition; and~~

(7) fitting and training for use of the items described in paragraphs (1) through (6).

(b) LIMITATION.—An item or service described in this section is covered only if it—

(1) improves functional ability; or

(2) prevents, minimizes, or stabilizes further deterioration in function.

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

(B) Replacements 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;

(c) DURABLE MEDICAL EQUIPMENT.—For purposes of this subtitle, the term "durable medical equipment" includes the equipment described in section 1861(n) of the Social Security Act, bathtub lifts, grab bars, and mobility canes.

but limited to use "in home"

SEC. 1125. VISION AND HEARING CARE.

(a) COVERAGE.—

(1) VISION CARE.—The vision care described in this section is routine eye examinations, diagnosis, and treatment for defects in vision.

(2) HEARING CARE.—The hearing care described in this section is hearing aids, but only upon a determination of a certified audiologist or physician that a hearing problem exists and is caused by a condition that can be corrected by use of a hearing aid.

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

Cost?
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.01 to single
.02 couple
1.76 1 ad. fam
1.50 2 ad. fam
Is this right given their language?

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~~ congenital defects, periodontal maintenance, and endodontic services.

(4) Space maintenance procedures to prevent orthodontic complications.

(5) Interceptive orthodontic treatment to prevent severe malocclusion.

(6) Any other dental care for individuals with a seizure disorder that is required because of an illness, injury, disorder, or other health condition that results from such seizure disorder.

(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;

(B) involve maintenance of a space or spaces for permanent posterior teeth that would otherwise be prevented from normal eruption if the space were not maintained; and

(C) do not include a space maintainer that is placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

(4) INTERCEPTIVE ORTHODONTIC TREATMENT.—Prior to January 1, 2001, the items and services described in subsection (a)(5) are not covered. On or after such date, such items and services are covered only for individuals at least 6 years of age, but less than 12 years of age.

SEC. 1127. HEALTH EDUCATION CLASSES.

(a) COVERAGE.—Subject to subsection (b), the items and services described in this section are health education and training classes to encourage the reduction of behavioral risk factors and to promote healthy activities. Such education and training classes may include smoking cessation, nutrition counseling, stress management, support groups, and physical training classes.

(b) DISCRETION OF PLAN.—A health plan may offer education and training classes at its discretion.

(c) CONSTRUCTION.—This section shall not be construed to include or limit education or training that is provided in the course of the delivery of health professional services (as defined in section 1112(c)).

SEC. 1128. INVESTIGATIONAL TREATMENTS.

(a) COVERAGE.—The items and services described in this subsection are qualifying investigational treatments that are administered for a life-threatening disease, dis-

order, or other health condition (as defined by the National Health Board).

(b) ROUTINE CARE DURING INVESTIGATIONAL TREATMENTS.—The comprehensive benefit package includes an item or service described in any other section of this part, subject to the limitations and cost sharing requirements applicable to the item or service, when the item or service is provided to an individual in the course of an investigational treatment, if—

(1) the treatment is a qualifying investigational treatment; and

(2) the item or service would have been provided to the individual even if the individual were not receiving the investigational treatment.

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

(1) QUALIFYING INVESTIGATIONAL TREATMENT.—The term "qualifying investigational treatment" means a treatment—

(A) the effectiveness of which has not been determined; and

(B) that is under clinical investigation as part of an approved research trial.

(2) APPROVED RESEARCH TRIAL.—The term "approved research trial" means—

(A) a research trial approved by the Secretary of Health and Human Services, the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity as defined in guidelines of the National Institutes of Health; or

(B) a peer-reviewed and approved research program, as defined by the Secretary of Health and Human Services, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for the treatment to be medically necessary or appropriate.

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).

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(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 1271.

(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 countable expenses incurred by any member of the individual's family in a year at such time as the family has incurred, in the aggregate, countable expenses in the amount of the family general deductible for the year.

(C) COUNTABLE EXPENSE.—In this paragraph, the term "countable expense" means, with respect to an individual for a year, an expense for an item or service covered by the comprehensive benefit package that is subject to the general deductible and for which, but for such deductible and any other cost sharing under this subtitle, a health plan is liable for payment. The amount of countable expenses for an individual for a year under this paragraph shall not exceed the individual general deductible for the year.

(3) COINSURANCE AND COPAYMENTS.—After a general or separate deductible that applies to an item or service covered by the comprehensive benefit package has been satisfied for a year, subject to paragraph (4), coinsurance and copayments are amounts (expressed as a percentage of an amount otherwise payable or as a dollar amount, respectively) that an individual may be required to pay with respect to the item or service.

(4) INDIVIDUAL AND FAMILY LIMITS ON COST SHARING.—

(A) INDIVIDUAL.—Subject to subparagraph (B), with respect to an individual enrolled under a health plan (regardless of the class of enrollment), the individual out-of-pocket limit on cost sharing in the cost sharing schedule offered by the plan represents the amount of expenses that the individual may be required to incur under the plan in a year because of a general deductible, separate deductibles, copayments, and coinsurance before the plan may no longer impose any cost sharing with respect to items or services covered by the comprehensive benefit package that are provided to the individual, except as provided in

subsections (d)(2)(E) and (e)(2)(E) of section 1115.

(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 family out-of-pocket limit on cost sharing in the cost sharing schedule offered by the plan represents the amount of expenses that members of the individual's family, in the aggregate, may be required to incur under the plan in a year because of a general deductible, separate deductibles, copayments, and coinsurance before the plan may no longer impose any cost sharing with respect to items or services covered by the comprehensive benefit package that are provided to any member of the individual's family, except as provided in subsections (d)(2)(E) and (e)(2)(E) of section 1115.

SEC. 1132. LOWER COST SHARING.

(a) IN GENERAL.—The lower cost sharing schedule referred to in section 1131 that is offered by a health plan—

(1) may not include a deductible;

(2) shall have—

(A) an annual individual out-of-pocket limit on cost sharing of $1500; and

(B) an annual family out-of-pocket limit on cost sharing of $3000;

(3) except as provided in paragraph (4)—

(A) shall prohibit payment of any coinsurance; and

(B) subject to section 1152, shall require payment of the copayment for an item or service (if any) that is specified for the item or service in the table under section 1135; and

(4) shall require payment of coinsurance for an out-of-network item or service (as defined in section 1902(34)) in an amount that is a percentage (determined under subsection (b)) of the applicable payment rate for the item or service established under section 1225, but only if the item or service is subject to coinsurance under the higher cost sharing schedule described in section 1133.

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(b) OUT-OF-NETWORK COINSURANCE PERCENTAGE.—

(1) IN GENERAL.—The National Health Board shall determine a percentage referred to in subsection ~~(a)~~(4). The percentage—

(A) may not be less than 20 percent; and

(B) shall be the same with respect to all out-of-network items and services that are subject to coinsurance, except as provided in paragraph (2).

(2) EXCEPTION.—The National Health Board may provide for a percentage that is greater than a percentage determined under paragraph (1) in the case of an out-of-network item or service for which, under the higher cost sharing schedule described in section 1133, the coinsurance is greater than 20 percent of the applicable payment rate.

SEC. 1133. HIGHER COST SHARING.

(a) IN GENERAL.—The higher cost sharing schedule referred to in section 1131 that is offered by a health plan—

(1) shall have an annual individual general deductible of $200 and an annual family general deductible of $400 that apply with respect to expenses incurred for all items and services in the comprehensive benefit package except—

(A) an item or service with respect to which a separate individual deductible applies under paragraph (2), (3), or (4); or

(B) an item or service described in paragraph (5), (6), or (7) with respect to which a deductible does not apply;

(2) prior to Jan. 1, 2001 shall require an individual to incur expenses during each episode of inpatient and residential mental illness and substance abuse treatment (described in section 1115(c)) equal to the cost of one day of such treatment before the plan provides benefits for such treatment to the individual;

(3) prior to Jan. 1, 2001 shall require an individual to incur expenses during each episode of intensive nonresidential mental illness and substance abuse treatment (described in section 1115(d)) equal to the cost of one day of such treatment before the plan provides benefits for such treatment to the individual;

(4) shall require an individual to incur expenses in a year for outpatient prescription drugs and biologicals (described in section 1122) equal to $250 before the plan provides benefits for such items to the individual;

(5) shall require an individual to incur expenses in a year for dental care described in section 1126, except the items and services for prevention and diagnosis of dental disease described in section

1126(a)(2), equal to $50 before the plan provides benefits for such care to the individual;

(6) may not require any deductible for clinical preventive services (described in section 1114);

(7) may not require any deductible for voluntary family planning services, clinician visits and associated services related to prenatal care, or 1 post-partum visit under section 1116;

(8) may not require any deductible for the items and services for prevention and diagnosis of dental disease described in section 1126(a)(2);

(9) shall have—

(A) an annual individual out-of-pocket limit on cost sharing of $1500; and

(B) an annual family out-of-pocket limit on cost sharing of $3000;

(10) shall prohibit payment of any copayment; and

(11) subject to section 1152, shall require payment of the coinsurance for an item or service (if any) that is specified for the item or service in the table under section 1135.

(b) EPISODES OF TREATMENT.—

(1) INPATIENT AND RESIDENTIAL TREATMENT.—For purposes of subsection (a)(2), an epi-

sode of inpatient and residential mental illness and substance abuse treatment shall be considered to begin on the date an individual is admitted to a facility for such treatment and to end on the date the individual is discharged from the facility.

(2) INTENSIVE NONRESIDENTIAL TREATMENT.—For purposes of subsection (a)(3), an episode of intensive nonresidential mental illness and substance abuse treatment—

(A) shall be considered to begin on the date an individual begins participating in a program described in section 1115(d)(1)(A) and to end on the date the individual ceases such participation; or

(B) shall be considered to begin on the date an individual begins receiving home-based or behavioral aide services described in section 1115(d)(1)(B) and to end on the date the individual ceases to receive such services.

SEC. 1134. COMBINATION COST SHARING.

(a) IN GENERAL.—The combination cost sharing schedule referred to in section 1131 that is offered by a health plan—

(1) shall have—

(A) an annual individual out-of-pocket limit on cost sharing of $1500; and

(B) an annual family out-of-pocket limit on cost sharing of $3000; and

(2) otherwise shall require different cost sharing for in-network items and services than for out-of-network items and services.

(b) IN-NETWORK ITEMS AND SERVICES.—With respect to an in-network item or service (as defined in section 1902(24)), the combination cost sharing schedule that is offered by a health plan—

(1) may not apply a deductible;

(2) shall prohibit payment of any coinsurance; and

(3) shall require payment of a copayment in accordance with the lower cost sharing schedule described in section 1132.

(c) OUT-OF-NETWORK ITEMS AND SERVICES.—With respect to an out-of-network item or service (as defined in section 1902(34), the combination cost sharing schedule that is offered by a health plan—

(1) shall require an individual and a family to incur expenses before the plan provides benefits for the item or service in accordance with the

deductibles under the higher cost sharing schedule described in section 1133;

(2) shall prohibit payment of any copayment; and

(3) shall require payment of coinsurance in accordance with such schedule.

SEC. 1135. TABLE OF COPAYMENTS AND COINSURANCE.

(a) IN GENERAL.—The following table specifies, for different items and services, the copayments and coinsurance referred to in sections 1132 and 1133:

Copayments and Coinsurance for Items and Services

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Inpatient hospital services	1111	No copayment	20 percent of applicable payment rate
Outpatient hospital services ..	1111	$10 per visit	20 percent of applicable payment rate
Hospital emergency room services	1111	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Services of health professionals	1112	$10 per visit	20 percent of applicable payment rate
Emergency services other than hospital emergency room services	1113	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Ambulatory medical and surgical services	1113	$10 per visit	20 percent of applicable payment rate
Clinical preventive services	1114	No copayment	Review: No coinsurance

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Inpatient and residential mental illness and substance abuse treatment	1115	No copayment	20 percent of applicable payment rate
Intensive nonresidential mental illness and substance abuse treatment (except treatment provided pursuant to section 1115(d)(2)(C)(ii))	1115	No copayment	20 percent of applicable payment rate
Intensive nonresidential mental illness and substance abuse treatment provided pursuant to section 1115(d)(2)(C)(ii)	1115	Until Jan. 1, 2001, and $10 per visit thereafter $25 per visit	20% 50 percent of applicable payment rate
Outpatient mental illness and substance abuse treatment (except psychotherapy, collateral services, and case management)	1115	$10 per visit	20 percent of applicable payment rate
Outpatient psychotherapy and collateral services	1115	$25 per visit until January 1, 2001, and $10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter
Case management	1115	No copayment	No coinsurance
Family planning and services for pregnant women (except voluntary family planning services, clinician visits and associated services related to prenatal care, and 1 post-partum visit)	1116	$10 per visit	20 percent of applicable payment rate
Voluntary family planning services, clinician visits and associated services related to prenatal care, and 1 post-partum visit	1116	No copayment	No coinsurance
Hospice care	1117	No copayment	20 percent of applicable payment rate
Home health care	1118	No copayment	20 percent of applicable payment rate
Extended care services	1119	No copayment	20 percent of applicable payment rate
Transportation services	1120	No copayment	20 percent of applicable payment rate
Outpatient laboratory, radiology, and diagnostic services	1121	No copayment	20 percent of applicable payment rate

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Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Outpatient prescription drugs and biologicals	1122	$5 per prescription	20 percent of applicable payment rate
Outpatient rehabilitation services	1123	$10 per visit	20 percent of applicable payment rate
Durable medical equipment and prosthetic and orthotic devices	1124	No copayment	20 percent of applicable payment rate
Vision and hearing care	1125	$10 per visit (No additional charge for 1 set of necessary eyeglasses for an individual less than 18 years of age)	20 percent of applicable payment rate
Dental care (except space maintenance procedures and interceptive orthodontic treatment)	1126	$10 per visit	20 percent of applicable payment rate
Space maintenance procedures and interceptive orthodontic treatment	1126	$20 per visit	40 percent of applicable payment rate
Health education classes	1127	All cost sharing rules determined by plans	All cost sharing rules determined by plans
Investigational treatment for life-threatening condition	1128	All cost sharing rules determined by plans	All cost sharing rules determined by plans

(b) APPLICABLE PAYMENT RATE.—For purposes of this section, the term "applicable payment rate", when used with respect to an item or service, means the applicable payment rate for the item or service established under section 1225.

SEC. 1136. INDEXING DOLLAR AMOUNTS RELATING TO COST SHARING.

(a) IN GENERAL.—Any deductible, copayment, out-of-pocket limit on cost sharing, or other amount expressed in dollars in this subtitle for items or services provided in a year after 1994 shall be such amount increased by the percentage specified in subsection (b) for the year.

(b) PERCENTAGE.—The percentage specified in this subsection for a year is equal to the product of the factors described in subsection (d) for the year and for each previous year after 1994, minus 1.

(c) ROUNDING.—Any increase (or decrease) under subsection (a) shall be rounded, in the case of an amount specified in this subtitle of—

(1) $200 or less, to the nearest multiple of $1,

(2) more than $200, but less than $500, to the nearest multiple of $5, or

(3) $500 or more, to the nearest multiple of $10.

(d) FACTOR.—

(1) IN GENERAL.—The factor described in this subsection for a year is 1 plus the general health care inflation factor (as specified in section 6001(a)(3) and determined under paragraph (2)) for the year.

(2) DETERMINATION.—In computing such factor for a year, the percentage increase in the CPI for a year (referred to in section 6001(b)) shall be determined based upon the percentage increase in the average of the CPI for the 12-month period ending with August 31 of the previous year over such average for the preceding 12-month period.

PART 4—EXCLUSIONS

SEC. 1141. EXCLUSIONS.

(a) MEDICAL NECESSITY.—The comprehensive benefit package does not include—

(1) an item or service that is not medically necessary or appropriate; or

(2) an item or service that the National Health Board may determine is not medically necessary or appropriate in a regulation promulgated under section 1154.

(b) ADDITIONAL EXCLUSIONS.—The comprehensive benefit package does not include the following items and services:

(1) Custodial care, except in the case of hospice care under section 1117.

(2) Surgery and other procedures performed solely for cosmetic purposes and hospital or other services incident thereto, unless—

(A) required to correct a congenital anomaly; or

(B) required to restore or correct a part of the body that has been altered as a result of—

(i) accidental injury;

(ii) disease; or

(iii) surgery that is otherwise covered under this subtitle.

(3) Hearing aids for individuals at least 18 years of age.

(4) Eyeglasses and contact lenses for individuals at least 18 years of age.

(5) In vitro fertilization services.

(6) Sex change surgery and related services.

(7) Private duty nursing.

(8) Personal comfort items, except in the case of hospice care under section 1117.

(9) Any dental procedures involving orthodontic care, inlays, gold or platinum fillings, bridges, crowns, pin/post retention, dental implants, surgical periodontal procedures, or the preparation of the mouth for the fitting or continued use of dentures, except as specifically described in section 1126.

PART 5—ROLE OF THE NATIONAL HEALTH BOARD

SEC. 1151. DEFINITION OF BENEFITS.

(a) IN GENERAL.—The National Health Board may promulgate such regulations or establish such guidelines as may be necessary to assure uniformity in the application of the comprehensive benefit package across all health plans.

(b) FLEXIBILITY IN DELIVERY.—The regulations or guidelines under subsection (a) shall permit a health plan to deliver covered items and services to individuals enrolled under the plan using the providers and methods that the plan determines to be appropriate.

SEC. 1152. ACCELERATION OF EXPANDED BENEFITS.

(a) IN GENERAL.—Subject to subsection (b), at any time prior to January 1, 2001, the National Health Board, in its discretion, may by regulation expand the comprehensive benefit package by—

(1) adding any item or service that is added to the package as of January 1, 2001; and

(2) requiring that a cost sharing schedule described in part 3 of this subtitle reflect (wholly or in part) any of the cost sharing requirements that apply to the schedule as of January 1, 2001.

No such expansion shall be effective except as of January 1 of a year.

(b) CONDITION.—The Board may not expand the benefit package under subsection (a) which is to become effective with respect to a year, by adding any item or service or altering any cost sharing schedule, unless the Board estimates that the additional increase in per capita health care expenditures resulting from the addition or alteration, with respect to each community-rating area for the year, will not cause any community-rating area to exceed its per capita target (as determined under section 6003).

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SEC. 1153. AUTHORITY WITH RESPECT TO CLINICAL PREVENTIVE SERVICES.

(a) IN GENERAL.—With respect to clinical preventive services described in section 1114, the National Health Board—

(1) shall specify and define specific items and services as clinical preventive services for high risk populations and shall establish and update a periodicity schedule for such items and services;

(2) shall update the periodicity schedules for the age-appropriate immunizations, tests, and clinician visits specified in subsections (b) through (h) of such section;

(3) shall establish rules with respect to coverage for an immunization, test, or clinician visit that is

not provided to an individual during the age range for such immunization, test, or clinician visit that is specified in one of subsections (b) through (h) of such section; and

(4) may otherwise modify the items and services described in such section, taking into account age and other risk factors, but may not modify the cost sharing for any such item or service.

(b) CONSULTATION.—In performing the functions described in subsection (a), the National Health Board shall consult with experts in clinical preventive services and environmental and occupational health.

SEC. 1154. ESTABLISHMENT OF STANDARDS REGARDING MEDICAL NECESSITY.

The National Health Board may promulgate such regulations as may be necessary to carry out section 1141(a)(2) (relating to the exclusion of certain services that are not medically necessary or appropriate).

PART 6—ADDITIONAL PROVISIONS RELATING TO HEALTH CARE PROVIDERS

SEC. 1161. OVERRIDE OF RESTRICTIVE STATE PRACTICE LAWS.

No State may, through licensure or otherwise, restrict the practice of any class of health professionals ~~be-~~ (otherwise recognized as a class of providers by such state)

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yond what is justified by the skills and training of such professionals.

SEC. 1162. PROVISION OF ITEMS OR SERVICES CONTRARY TO RELIGIOUS BELIEF OR MORAL CONVICTION.

A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.