UNITED ST. .S SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES

Amendment: RESTRUCTURING AND STREAMLINING / AMENDMENT TO TITLE I

Sponsor: Bingaman, Jeffords, Dodd, Wofford, and Kennedy

Result: Accepted 9-8

MEMBER	YEA	NEA	YEA BY PROXY	NEA BY PROXY
Kennedy, Edward (MA)	x			
Pell, Claiborne (RI)	x			
Metzenbaum, Howard (OH)		x		
Dodd, Christopher (CT)	x			
Simon, Paul (IL)	x			
Harkin, Tom (IA)	x			
Mikulski, Barbara (MD)	x			
Bingaman, Jeff (NM)	x			
Wellstone, Paul (MN)		x		
Wofford, Harris (PA)	x			
Kassebaum, Nancy (KS)		x		
Jeffords, James (VT)	x			
Coats, Dan (IN)		x		
Gregg, Judd (NH)		x		
Thurmond, Strom (SC)		x		
Hatch, Orrin (UT)		x		
Durenberger, David (MN)		x		
Total	9	8		

AMENDMENT TO TITLE I HEALTH SECURITY ACT

June 9, 1994

RESTRUCTURING and STREAMLINING: Senator Bingaman may propose the following amendment to Title I, Sub-titles C, D, and F:

A. OVERVIEW:

- Sub-titles C, D, E, and F of Title I establish state responsibilities as well as the rules for cooperatives, large group sponsors, and health plans. In the Chairman's Mark, these functions are specified in extensive detail. States are burdened with establishing complex systems to manage the system and assure compliance.

- In contrast to the regulatory approach contained in the Mark, this amendment focuses responsibility on health plans, rather than the states:

  - Plans are required to demonstrate compliance with uniform national standards.

  - States are given flexibility to certify cooperatives that meet local needs.

- Under this amendment, employers and individuals may obtain health coverage through cooperatives or directly from plans.

B. FUNDAMENTALS: To assure fairness, the amendment requires health plans:

- Not discriminate on the basis of medical history;
- Accept all applicants;
- Provide access to medically necessary or appropriate services;
- Offer a modified community-rated premium.

C. SPECIFICS:

- **Subtitle C -- State Responsibilities**

The amendment places general plan responsibilities with the states. States establish or designate at least one purchasing cooperative (but have the flexibility to designate more), certify health plans, administer risk adjustment and premium adjustment

programs. The amendment gives states oversight authority over plan and cooperative enrollment procedures, quality reporting, and service in health provider shortage areas. States will not collect payment from individuals and employers. Rather, individuals and employers will pay plans directly or through purchasing cooperatives.

■ Subtitle D -- Purchasing Cooperatives

States establish or designate consumer purchasing cooperatives Employers designate at least one cooperative for their employees and are also required to offer their employees a range of three health plans (one must be fee-for-service). Individuals are free choose a different cooperative or purchase coverage directly from a plan or through an agent if they desire.

Cooperatives will enter into agreements with health plans, make payments to plans, and coordinate enrollment with other plans. Cooperatives do not pay providers, certify plans, or assume financial risk. States may certify more than one cooperative in a health care coverage area, and they may compete on the basis of service and administrative efficiency. States certifying only one cooperative may designate that cooperative a "negotiating cooperative" which will negotiate with plans on the basis of cost and quality. Unless designated a negotiating cooperative, each cooperative must accept all eligible plans at their community rate.

■ Subtitle E -- Large Group Purchasers

Employer Size: A new category has been established for determining whether an employer is required to participate in the community-rated pool or whether the employer can "opt" into an experience-rated system:

Under 500: must participate in the community-rated pool;

500 to 1000: may elect to join community-rated pool or may opt to be experience-rated. Employers opting for the experience rate will be assessed the 1 percent large employer share and will not be eligible to receive employer contribution subsidies.

Over 1000: must experience rate in the market. Because employers may not chose to opt into the community-rated pool, they will be eligible to receive employer contribution subsidies (based on individual wages).

■ Subtitle F -- Health Plans

Health plans must:

- serve the entire health care coverage area and cannot discriminate in enrollment or benefits;
- meet financial solvency requirements;

- establish effective grievance procedures;
- establish standard premiums;
- demonstrate ability to administer the plan and conduct utilization management;
- monitor access;
- where appropriate, utilize risk adjustment;

During the transition to the new system, a modified community-rate will be used. At the end of four years, the modified-rate will terminate and pure community-rating will be in place. However, the Secretary of Health and Human Services may make recommendations to the Congress regarding the continuation or termination of the age adjuster.

All health plans must offer the comprehensive benefits package and establish adequate provider networks. Health plans may offer supplemental plans but may not replicate coverage in the comprehensive benefits plan. Supplemental plans cannot use incentives to increase enrollment in standard health plan.

"RESTRUCTURING AND STREAMLINING"

Comparison of Proposals

KEY PROVISIONS	CHAIRMAN'S MARK	BINGAMAN/JEFFORDS/DODD WOFFORD/KENNEDY PROPOSAL	JEFFORDS, KASSEBAUM, DURENBERGER PROPOSAL
Health Plan Principles Established	None articulated	Clearly articulated	None articulated
Certification of Health Plans	State	State w/Fed "plan"	State
Establishment of HCCA's	State: Size set at 250,000	State: Size set at 150,000	State: Size set at 100,000
Establishment of Purchasing Cooperatives	States shall establish in each HCCA, and may not establish more than two - inclusive of FEHBP	States "shall" certify at least one	States "may" establish
Consumer Information	State to make available	State to make available	Purchasing cooperative to make available
Grievance Procedures Related to Benefit Claims	Title V	Plan to establish	Plan to establish
Consumer Advocate	Secretary responsibility, inc: est. of Nat'l Center of Consumer Advocacy	Retains provisions of Mark	Deleted

KEY PROVISIONS	CHAIRMAN'S MARK	BINGAMAN/JEFFORDS/DODD WOFFORD/KENNEDY PROPOSAL	JEFFORDS, KASSEBAUM, DURENBERGER PROPOSAL
Marketing of Health Plans	State: information must be available to entire market	State Assures: information must be available to entire market	Purchasing Cooperative: information must be available to entire market
Open Enrollment	Yes - eligible individuals	Yes - eligible individuals	Yes - eligible individuals
Reductions in Cost Sharing	Provides for reduction in cost sharing for families below 200% of applicable poverty level	Retains provisions of Mark	Deleted
Risk Adjustment	State established program	State	State established program
Financial Solvency	State standards subject to approval of the National Health Board	State standards subject to approval of the National Health Board	Plans to meet capital requirements established by Secretary
FEHBP	Available as a purchasing cooperative	Open plan - enrollment available to anyone	Deleted
Requirement for State Single-Payer Systems	Provides for state establishment and operation	Retains provisions of Mark	Deleted

KEY PROVISIONS	CHAIRMAN'S MARK	BINGAMAN/JEFFORDS/DODD WOFFORD/KENNEDY PROPOSAL	JEFFORDS, KASSEBAUM, DURENBERGER PROPOSAL
State Insurance Market Reform	No provision	No provision	State

AMENDMENT NO. ____ Calendar No. ____

Purpose: To modify subtitles C, D, E, and F of title I.

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. BINGAMAN (for himself, Mr. JEFFORDS, Mr. DODD, Mr. WOFFORD, and Mr. KENNEDY—)

Viz:

In subtitle A of title I, insert the following new section after section 1003 and redesignate the remaining sections and references thereto, accordingly

SEC. 1004. HEALTH PLAN PRINCIPLES.

In accordance with this Act, the following principles shall apply to all health plans

(1) No health plan may discriminate on the basis of medical history, pre-existing medical conditions, or genetic predisposition to medical conditions.

(2) A health plan—

(A) shall offer an annual open enrollment period and accept all eligible individuals for coverage;

(B) shall not impose a rider that serves to exclude coverage to an individual, and

(C) shall not impose waiting periods before coverage begins.

(3) A health plan shall ensure that all medically necessary or appropriate services, as defined in the benefits package, are provided, including access to specialty care.

(4) Health benefits coverage shall be portable from one health plan to another

In part 5 of subtitle B of title I, add the following new section at the end thereof:

SEC. 1155. BALANCED BILLING.

The Board shall provide for methods to ensure the prohibition of balanced billing.

Strike all of subtitle C, except for sections 1200, 1208, 1209, 1231, 1233, and 1236 and part 2, and insert the following and redesignate the remaining sections and parts and references thereto accordingly:

Subtitle C—State Responsibilities

PART 1—GENERAL STATE RESPONSIBILITIES

SEC. 1201. GENERAL STATE RESPONSIBILITIES.

A participating State is responsible for:

(1) HEALTH CARE COVERAGE AREA.—Establishing one or more health care coverage areas (in accordance with section 1202).

(2) HEALTH PLANS.—Registering and overseeing health plans in accordance with subtitle F.

(3) PROVIDERS.—Assessing such licensing fees as may be necessary to adequately fund State health profession boards. (Nothing in this paragraph shall preempt State authority to license or register health care providers.) State health professional boards shall—

(A) investigate complaints with a reasonable probability of validity, and issue appropriate sanctions;

(B) have adequate public, consumer, and non-physician representatives; and

(E) report all final disciplinary actions to the National Practitioner Data Bank.

(4) PREMIUM ADJUSTMENT.—Administering risk adjustment, reinsurance and other premium adjustment programs consistent with this Act.

(5) COOPERATIVES.—Certification of at least one consumer purchasing cooperative in each area, consistent with the provisions of subtitle D.

(6) 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.

(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 150,000; 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 shall comply with the antidiscrimination requirements of section 1915.

(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).

(3) COORDINATING MULTIPLE HEALTH CARE COVERAGE AREAS.—Nothing in this section shall be construed as preventing a State from coordinating the activities of one or more health care coverage areas in the State.

(4) INTERSTATE HEALTH CARE COVERAGE AREAS.—Health care coverage areas with respect to interstate areas shall be established in accordance with rules established by the Board.

SEC. 1203. USE OF INCENTIVES.

(a) USE OF INCENTIVES TO ENROLL AND SERVE DISADVANTAGED GROUPS.—A State may provide—

(1) for an adjustment to the risk-adjustment methodology under section 1641(b), or in accordance with the standards under section 1642, and other financial incentives to community-rated health plans to ensure that such plans enroll individuals who are members of disadvantaged groups or populations vulnerable to discrimination due to their health status, and

(2) for appropriate extra services, such as outreach to encourage enrollment and transportation and interpreting services to ensure access to care, for certain population groups that face barriers to access because of geographic location, income levels, disability or racial or cultural differences.

(b) USE OF INCENTIVES TO ADDRESS NEEDS IN AREAS WITH INADEQUATE HEALTH SERVICES.—

(1) PAYMENT ADJUSTMENT.—To ensure that plans are available to all eligible individuals residing in all portions of a health care coverage area, a State may adjust payments to plans or use other financial incentives to encourage health plans to expand into areas that have inadequate health services.

(2) ENCOURAGING NEW PLANS.—Subject to section 1202(c), to encourage the establishment of a new health plan in an area that has inadequate health services, a State may—

(A) organize health providers to create such a plan in such an area that is targeted at such area;

(B) provide assistance with the establishment and administration of such a plan; and

(C) arrange favorable financing for such a plan.

SEC. 1204. RESTRICTIONS ON FUNDING OF ADDITIONAL BENEFITS.

If a participating State provides benefits (either directly or through community-rated health plans or otherwise) in addition to those covered under the comprehensive benefit package, the State may not provide for payment for such benefits through funds provided under this Act

SEC. 1205. CONSUMER INFORMATION AND MARKETING.

(a) CONSUMER INFORMATION.—Before each open enrollment period, each State shall ensure the availability to eligible enrollees of information, in an easily understood and useful form, that allows such enrollees (and other community-rate eligible individuals) to make valid comparisons among community-rated health plans offered in the State, including information about plan price, the characteristics and availability of participating health professionals and institutions, any restrictions on access to providers or services and a summary of the annual quality performance report described in section 5005(c)(1). Such information shall be made available in a brochure, published not less often than annually. In the case of a health care coverage area that includes a significant number or proportion of residents with limited English speaking proficiency, the State shall ensure the availability of all written materials in languages other than English as appropriate to the health care coverage area.

(b) MARKETING.—Each State shall, consistent with section 1512, ensure that materials used to market community-rated health plans in the State are factually accurate and not misleading.

SEC. 1206. STATE RESPONSIBILITIES WITH RESPECT TO WORKSITE HEALTH PROMOTION DISCOUNTS.

Each State shall provide for the administration of wellness discounts in accordance with rules established by the Secretary in accordance with section 1687. Such duties shall include the receipt of employer self-certification forms, enforcement of compliance, dispute resolution and implementation of wellness discounts in a manner consistent with section 1687.

PART 3—FAMILY CHOICE AND FAIR ENROLLMENT

SEC. 1232. OVERSIGHT OF HEALTH PLAN ENROLLMENT ACTIVITIES.

(a) IN GENERAL.—Each participating State shall provide for the general oversight of health plan enrollment activities, implement regulations promulgated by the Board under section 1660, and assure that each community-rated individual who resides in the State is enrolled in a community-rated plan or other applicable health plan of the individual's choosing.

(b) ENROLLMENT THROUGH PROVIDERS.—Each State shall establish a mechanism for enrolling eligible individuals who are not enrolled in a plan when the individual seeks health services in accordance with rules promulgated by the Board.

(c) OVERSUBSCRIPTION OF PLANS.—

(1) IN GENERAL.—A participating State shall establish—

(A) a method to determine the enrollment capacity of health plans based on the financial capacity of the carrier sponsoring the plan and, in the case of a plan with an integrated health network, the service capacity of the provider network, and

(B) priorities for enrollment in the case of oversubscribed plans, consistent with this subsection.

(2) PRIORITIES IN CASE OF PLAN OVERSUBSCRIPTION.—

(A) IN GENERAL.—The State shall establish a method for establishing enrollment priorities in the case of a health plan that is permitted to limit enrollment under this subsection. Except as provided in subparagraph (B), such priorities shall not take into account personal characteristics of potential enrollees, such as health status, socio-economic status, anticipated need for health care, age, occupation, or affiliation with any person or entity.

(B) PRIORITIES.—Such method shall provide that in the case of such an oversubscribed plan—

(i) families already enrolled in the plan are given priority in continuing enrollment in the plan,

(ii) other individuals who seek enrollment during an applicable enrollment period are permitted to enroll, up to the enrollment capacity of the plan, in accordance with a method that provides equal opportunity for all families who seek enrollment during the enrollment period, regardless of when during the period or the method by which the enrollment has been sought, and

(iii) to the extent practicable, such method shall offer families the opportunity to designate a second or later preference for a health plan in the case enrollment under a preferred plan is not possible due to limits on capacity under this subsection.

(d) ENFORCEMENT OF ENROLLMENT REQUIREMENT.—In the case of a community-rated individual who resides in a State and fails to enroll in an applicable health plan as required under section 1002(a)—

(1) the State shall ensure that an individual is enrolled in a community-rated plan (selected by the State consistent with this Act and with any rules established by the Board), and

(2) such State shall require the payment of an amount equal to twice the family share of premiums that would have

been payable under subtitle B of title VI if the individual had enrolled on a timely basis in the plan, unless the individual establishes to the satisfaction of the State good cause for the failure to enroll on a timely basis.

The State shall provide, from the amounts collected under paragraph (2), for payments to plans under subsection (b).

(e) COORDINATION OF INFORMATION ON ENROLLMENT.—A participating State shall assure that information concerning the enrollment of community-rating individuals residing in the State is obtained and coordinated consistent with the requirements of subtitle B of title V.

(f) COORDINATION OF ENROLLMENT ACTIVITIES.—Each State shall coordinate its activities, including enrollment and disenrollment activities, with other States in a manner specified by the National Health Board that ensures continuous, nonduplicative coverage of community-rated and experience-rated individuals in health plans and that minimizes administrative procedures and paperwork.

SEC. 1236. RESPONSIBILITY FOR PREMIUM COLLECTIONS.

A State shall be responsible for assisting health plans and cooperatives in the collection of premium payments. A State may establish administrative systems (including arrangements with private entities) to facilitate the collection of premiums from employers and families and the distribution of such premiums to health plans, consistent with rules promulgated by the Board.

SEC. 1237. CALCULATION AND PUBLICATION OF GENERAL FAMILY SHARE AND GENERAL EMPLOYER PREMIUM AMOUNTS.

(a) FAMILY SHARE.—Each State shall compute and publish the following components of the general family share of premiums for each health care coverage area designated by the State:

(1) PLAN PREMIUMS.—For each plan offered, the applicable premiums for such plan for each class of family enrollment (including the amount of any family collection shortfall).

(2) QUALIFIED WORKSITE HEALTH PROMOTION.—For each plan offered, the premium discount for each level of qualified worksite health promotion program.

(3) FAMILY CREDIT.—The family credit amount for each class of family enrollment, under section 6103.

(4) EXCESS PREMIUM CREDIT.—The amount of any excess premium credit provided under section 6105 for each class of family enrollment.

(5) LARGE GROUP SPONSOR OPT-IN CREDIT.—The amount of any large group sponsor opt-in credit provided under section 6106 for each class of family enrollment.

(b) EMPLOYER PREMIUMS.—Each State shall compute and publish the following components of the general employer premium payment amount for each health care coverage area designated by the State:

(1) BASE EMPLOYER MONTHLY PREMIUM PER WORKER.—The base employer monthly premium determined under section 6122 for each class of family enrollment.

(2) QUALIFIED WORKSITE HEALTH PROMOTION.—The base monthly premium discount for each level of qualified worksite health promotion program.

(3) EMPLOYER COLLECTION SHORTFALL ADD-ON.—The employer collection shortfall add-on computed under section 6125(b)

SEC. 1238. NO LOSS OF COVERAGE.

In no case shall the failure to pay amounts owed under this title result in an individual's or family's loss of coverage under this Act.

SEC. 1239. RECONCILIATION OF FAMILY SHARE.

(a) IN GENERAL.—Each State shall provide for the reconciliation of family payments in cases where the State determines that

there has been an overpayment or underpayment by or on the behalf of such families in accordance with rules promulgated by the Board.

(b) PROVISIONS.—In carrying out subsection (a), a State shall provide notice of amounts owed or due to such families, distribute information on the availability of premium discounts and reductions to such families and include income reconciliation forms for families that are provided with premium discounts.

(c) NOTICE OF AMOUNT OWED.—If a State determines under section 1251 that a family has paid any family share required under section 6101 and is not required to repay any amount under section 6111 for a year, the State shall provide notice of such determination to the family. Such notice shall include a prominent statement that the family is not required to make any additional payment and is not required to file any additional information with the State.

(d) COORDINATION OF PAYMENTS FOR FAMILIES THE HAVE CHANGED RESIDENCE OVER THE YEAR.—The State in which the community-rated plan in which a family is enrolled in December of each year (in this section referred to as the "final State") is responsible for the collection of any amounts owed by the family under this subpart, without regard to whether the family resided in the State during the entire year in accordance with rules promulgated by the Board.

SEC. 1240. COORDINATION WITH STATE AND FEDERAL PAYMENTS.

Any amounts otherwise owed under this Act to a State is deemed to be owed and payable to the State or to the appropriate contracting entity, as the Board determines to be appropriate.

SEC. 1241. PAYMENT TO HEALTH PLANS.

(a) IN GENERAL.—States shall develop payment adjustment mechanisms necessary for ensuring that payments to health plans are appropriate and sufficient.

(b) ADJUSTMENTS.—Mechanisms under subsection (a) shall include methods for risk adjustment and reinsurance (in accordance with section 1641 and 1642), the payment of subsidies (in accordance with subtitle B of title VI), per capita payment adjustments to reflect each area's share of AFDC and SSI beneficiaries (in accordance with subtitle C of title VI), and other adjustments necessary to reconcile the amounts collected by plans with the amounts plans are owed.

SEC. 1242. ADMINISTRATIVE ALLOWANCE PERCENTAGE.

(a) SPECIFICATION BY STATE.—Before obtaining bids under section 6004 from health plans for a year, each State shall establish the administrative allowance, the State administrative functions with respect to the oversight of health plan enrollment, the determination of subsidy eligibility, and other responsibilities under this Act.

(b) ADMINISTRATIVE ALLOWANCE PERCENTAGE.—Subject to subsection (c), the State shall compute an administrative allowance percentage for each year equal to—

(1) the administrative allowance determined under subsection (a) for the year, divided by

(2) the total of the amounts payable to community-rated health plans under subpart A (as estimated by the State).

(c) LIMITATION TO 1.5 PERCENT.—In no case shall an administrative allowance percentage exceed 1.5 percent.

(d) DISTRIBUTION OF PERCENTAGE.—The administrative allowance percentage shall be divided as follows:

(1) 1.48 percent for State administrative functions, and

(2) .02 percent for the Office of the Consumer Advocate described in section 1207.

(e) RECEIPT OF FUNDS.—A State shall perform the duties required of States under this Act as a condition of receiving funds described in subsection (d)(1).

PART 4—REDUCTIONS IN COST SHARING AND PREMIUMS

SEC. 1281. REDUCTION IN COST SHARING AND PREMIUMS FOR LOW-INCOME FAMILIES.

(a) REDUCTION.—

(1) IN GENERAL.—Subject to subsection (b), in the case of a family that is enrolled in a community-rated health plan and that is either (A) an AFDC or SSI family or (B) is determined under this subpart to have family adjusted income below 200 percent of the applicable poverty level, the family is entitled to a reduction in cost sharing in accordance with this section.

(2) TIMING OF REDUCTION.—The reduction in cost sharing shall only apply to items and services furnished after the date the application for such reduction is approved under section 1282(c) and before the date of termination of the reduction under this subpart, or, in the case of an AFDC or SSI family, during the period in which the family is such a family.

(3) INFORMATION TO PROVIDERS AND PLANS.—Each State shall provide, through electronic means and otherwise, health care providers and community-rated health plans with access to such information as may be necessary in order to provide for the cost sharing reductions under this section.

(b) LIMITATION.—No reduction in cost sharing under subsection (c)(1) shall be available for—

(1) families residing in a health care coverage area if the cooperative for the area determines that there are sufficient low-cost plans (as defined in section 6104(b)(3)) that are lower or combination cost sharing plans available in the area to enroll AFDC and SSI families and families with family adjusted income below 150 percent of the applicable poverty level; or

(2) for families with family adjusted income between 150 and 200 percent of the applicable poverty level.

(c) AMOUNT OF COST SHARING REDUCTION.—

(1) IN GENERAL.—Subject to paragraph (2), the reduction in cost sharing under this section shall be such reduction as will reduce cost sharing to the level of a lower or combination cost sharing plan.

(2) SPECIAL TREATMENT OF CERTAIN FAMILIES.—

(A) AFDC, SSI AND FAMILIES BELOW POVERTY.—In the case of a family that—

(i) is enrolled in a community-rated health plan;

(ii) is an AFDC, SSI family or a family that is determined under this subpart to have a family adjusted income below 100 percent of the applicable poverty level, and

(iii) is enrolled in a lower or combination cost sharing plan or receiving a reduction in cost sharing under paragraph (1);

the amount of copayment applied with respect to an item or service other than with respect to hospital emergency room services for which there is no emergency medical condition, as defined in section 1867(e)(1) of the Social Security Act, shall be an amount equal to 20 percent of the copayment amount otherwise applicable under sections 1135 and 1136, rounded to the nearest dollar.

(B) FAMILIES WITH INCOMES BETWEEN 100 AND 150 PERCENT OF POVERTY.—In the case of a family that—

(i) is enrolled in a community-rated health plan;

(ii) is determined under this subpart to have family adjusted income between 100 and 150 percent of the applicable poverty level;

(iii) is not an AFDC or SSI family; and

(iv) is enrolled in a lower or combination cost sharing plan or receiving a reduction in cost sharing under paragraph (1).

the amount of copayment applied with respect to an item or service (other than with respect to hospital emergency room services for which there is no emergency medical condition, as defined in section 1867(e)(1) of the Social Security Act) shall be an amount equal to 20 percent of the copayment amount otherwise applicable under sections 1135 and 1136, rounded to the nearest dollar.

(C) FAMILIES WITH INCOMES BETWEEN 150 AND 200 PERCENT OF POVERTY.—In the case of a family that—

(i) is enrolled in a community-rated health plan;

(ii) is determined under this subpart to have family adjusted income between 150 and 200 percent of the applicable poverty level; and

(iii) is not an AFDC or SSI family;

the amount of copayment applied with respect to an item or service (other than with respect to hospital emergency room services for which there is no emergency medical condition, as defined in section 1867(e)(1) of the Social Security Act) shall be an amount equal to 40 percent of the copayment amount otherwise applicable under sections 1135 and 1136, rounded to the nearest dollar.

(d) ADMINISTRATION.—

(1) IN GENERAL.—In the case of an approved family (as defined in section 1282(b)(3)) enrolled in a community-rated health plan, the State shall pay the plan for cost sharing reductions (other than cost sharing reductions under subsection (c)(2)(A), (B) and (C)) provided under this section out of Federal subsidy payments provided in section 9100(b)(2)(A). Payments made by health plans to providers shall include appropriate payments for cost sharing reductions.

(2) ESTIMATED PAYMENTS, SUBJECT TO RECONCILIATION.—Such payment shall be made initially on the basis of reasonable estimates of cost sharing reductions incurred by such a plan with respect to approved families and shall be reconciled not less often than quarterly based on actual claims for items and services provided.

(e) NO COST SHARING FOR INDIANS AND CERTAIN VETERANS AND MILITARY PERSONNEL.—The provisions of section 6104(a)(3) shall apply to cost sharing reductions under this section in the same manner as such provisions apply to premium discounts under section 6104.

SEC. 1282. APPLICATION PROCESS FOR COST-SHARING REDUCTIONS AND PREMIUM DISCOUNTS.

(a) IN GENERAL.—A community-rated family may apply for a determination of the family adjusted income of the family, for the purpose of establishing eligibility for cost sharing reductions under section 1281, and for premium discounts and reductions in liability under sections 6104 and 6113.

(b) ACTION ON APPLICATION.—States shall act on such applications and ensure due process in a manner prescribed by the Board.

(c) HELP IN COMPLETING APPLICATIONS.—Each State shall ensure adequate distribution and assist individuals in the filing of applications and income reconciliation statements under this subpart.

(d) PENALTIES FOR INACCURATE INFORMATION.—

(1) INTEREST FOR UNDERSTATEMENTS.—Each individual who knowingly understates income reported in an application to a State under this subpart or otherwise makes a material misrepresentation of information in such an application shall be liable to the State for excess payments made based on such understatement or misrepresentation, and for interest on such excess payments at a rate specified by the Secretary.

(2) PENALTIES FOR MISREPRESENTATION.—In addition to the liability established under paragraph (1), each individual who knowingly misrepresents material information in an application under this subpart to a State shall be liable to the State

for $2,000 or, if greater, three times the excess payments made based on such misrepresentation.

SEC. 1283. END-OF-YEAR RECONCILIATION.

(a) IN GENERAL.—In the case of a family whose application for a premium discount or reduction of liability for a year has been approved before the end of the year under this subpart, the family shall, subject to subsection (c) and by the deadline specified in section 1238 file with the State an income reconciliation statement to verify the family's adjusted income or wage-adjusted income, as the case may be, for the previous year. Such a statement shall contain such information as the Secretary may specify. Each State shall coordinate the submission of such statements with the notice and payment of family payments due under section 1238.

(b) RECONCILIATION OF PREMIUM DISCOUNT AND LIABILITY ASSISTANCE BASED ON ACTUAL INCOME.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to a family, the State shall compute the amount of premium discount or reduction in liability that should have been provided under section 6104 or section 6113 with respect for the family for the year involved. If the amount of such discount or liability reduction computed is—

(1) greater than the amount that has been provided, the family is liable to pay (directly or through an increase in future family share of premiums or other payments) a total amount equal to the amount of the excess payment, or

(2) less than the amount that has been provided, the State shall pay to the family (directly or through a reduction in future family share of premiums or other payments) a total amount equal to the amount of the deficit.

(c) NO RECONCILIATION FOR AFDC AND SSI FAMILIES; NO RECONCILIATION FOR COST SHARING REDUCTIONS.—No reconciliation statement is required under this section—

(1) with respect to cost sharing reductions provided under section 1282, or

(2) for a family that only claims a premium discount or liability reduction under this subpart on the basis of being an AFDC or SSI family

(d) DISQUALIFICATION FOR FAILURE TO FILE.—In the case of any family that is required to file a statement under this section in a year and that fails to file such a statement by the deadline specified, members of the family shall not be eligible for premium reductions under section 6104 or reductions in liability under section 6113 until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the family establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

(e) PENALTIES FOR FALSE INFORMATION.—Any individual that provides false information in a statement under subsection (a) is subject to the same liabilities as are provided under section _____ for a misrepresentation of material fact described in such section.

(f) NOTICE OF REQUIREMENT.—Each State shall provide for written notice, at the end of each year, of the requirement of this section to each family which had received premium discount or reduction in liability under this subpart in any month during the preceding year and to which such requirement applies.

(g) TRANSMITTAL OF INFORMATION; VERIFICATION.—

(1) IN GENERAL.—Each participating State shall transmit annually to the Secretary such information relating to the income of families for the previous year as the Secretary may require to verify such income under this subpart.

(2) VERIFICATION.—Each participating State may use such information as it has available to it, including information made available to the State under section 6103(l)(7)(D)(x) of the Internal Revenue Code of 1986, in verifying income of families with applications filed under this subpart. The Secretary of the

Treasury may, consistent with section 6103 of the Internal Revenue Code of 1986, permit return information to be disclosed and used by a participating State in verifying such income but only in accordance with such section.

(h) CONSTRUCTION.—Nothing in this section shall be construed as authorizing reconciliation of any cost sharing reduction provided under this subpart.

Strike all of subtitle D except for part 3, and insert the following and redesignate the remaining part and references thereto accordingly:

Subtitle D—Consumer Purchasing Cooperatives

PART 1—GENERAL REQUIREMENTS

SEC. 1301. DESIGNATION AND ORGANIZATION OF COOPERATIVES.

(a) DESIGNATION OF COOPERATIVES.—A State shall certify consumer purchasing cooperatives (in this Act referred to as "cooperatives") in accordance with this part. Each cooperative shall be chartered under State law and operated as a not-for-profit corporation.

(b) BOARD OF DIRECTORS.—Each cooperative shall be governed by a Board of Directors to be composed equally of representatives of small employers, eligible employees, and eligible individuals.

(c) MEMBERSHIP.—A cooperative shall accept all eligible employers and eligible individuals residing within the area served by the cooperative as members if such employers, employees or individuals request such membership. Members of a cooperative shall have voting rights consistent with rules established by the State.

(d) DUTIES OF COOPERATIVES.—Each cooperative shall—

(1) enter into agreements with health plans under section 1302;

(2) enter into agreements with community-rated employers;

(3) enroll eligible individuals in health plans;

(4) make payments to health plans on behalf of community-rate eligible individuals;

(5) provide for coordination with other cooperatives;

(6) provide information on health plans, in accordance with section 1205, and

(7) carry out other functions provided for under this title.

(e) LIMITATION ON ACTIVITIES.—A cooperative shall not—

(1) perform any activity (including review, approval, or enforcement) relating to payment rates for providers;

(2) perform any activity (including certification or enforcement) relating to compliance of health plans with the requirements of this Act,

(3) assume insurance risk; or

(4) perform other activities identified by the State as being inconsistent with the performance of its duties under this Act.

(f) RULES OF CONSTRUCTION.—

(1) SINGLE ORGANIZATION SERVING MULTIPLE HEALTH CARE COVERAGE AREA.—Nothing in this section shall be construed as preventing a single not-for-profit corporation from being the cooperative for more than one health care coverage area.

(2) MULTIPLE COOPERATIVES.—Noting in this section shall be construed to prevent a State from designating or establishing more than one cooperative in a health care coverage area.

(3) VOLUNTARY PARTICIPATION.—Nothing in this section shall be construed as requiring any individual or small employer to purchase a health plan exclusively through a cooperative.

SEC. 1302. AGREEMENTS WITH HEALTH PLANS.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (2)(A) and subsection (c)—

(A) each cooperative for a health care coverage area shall enter into an agreement under this section with each certified community-rated health plan that serves residents of the health care coverage area; and

(B) a cooperative may not refuse to enter into such an agreement with a health plan which is registered with a State as offering coverage in the health care coverage area, nor may a community-rated health plan refuse to enter into an agreement with a cooperative in accordance with section 1518.

(2) COMMUNITY-RATED PREMIUM.—A cooperative shall offer plans at the community-rate (as defined in section 6000(a)(3)) filed by the plan.

(3) TERMINATION OF AGREEMENT.—The State shall establish a process for the termination of agreements entered into under this section and a process for appealing such termination under this paragraph. In accordance with rules established by the State—

(A) a cooperative may terminate an agreement with a health plan if the health plan's registration for the health care coverage area involved is terminated or if the health plan fails to fulfill the requirements of the agreement; and

(B) a health plan may appeal the termination of an agreement with a cooperative under this paragraph to the State in accordance with rules and procedures established by the State.

(b) RECEIPT OF GROSS PREMIUMS.—

(1) IN GENERAL.—Under an agreement under this section between a cooperative and a health plan, payment of premiums shall be made directly to the cooperative in accordance with rules promulgated by the Board.

(2) FORWARDING OF PREMIUMS.—Under an agreement under this section between a health plan and a cooperative, the cooperative shall forward to each health plan in which an eligible individual has been enrolled the amounts collected on the behalf of enrollees in such plans.

(c) NEGOTIATING COOPERATIVES.—

(1) IN GENERAL.—A State may designate a cooperative as a "negotiating cooperative" if such cooperative is the sole State-certified cooperative in a health care coverage area.

(2) AUTHORITIES AND RESPONSIBILITIES OF NEGOTIATING COOPERATIVES.—

(A) IN GENERAL.—Negotiating cooperatives may exclude plans from the plans offered to cooperative members if such cooperatives offer at least three plans, including at least one fee-for-service plan as required under section 1231(a)(1)B.

(B) PREMIUMS.—A health plan may, through negotiations with a negotiating cooperative, offer to individuals enrolled through such cooperative a premium that is less than the community-rated premium, but in no case shall a plan bid a premium to a negotiating cooperative that is higher that the community-rated premium.

SEC. 1303. AGREEMENTS WITH SMALL EMPLOYERS.

(a) IN GENERAL.—Cooperatives for each health care coverage area shall offer to enter into an agreement under this section with each small employer that employs individuals in the area and that desires to join the cooperative. Each arrangement between a small employer and a cooperative shall include provisions consistent with the requirements of this section.

(b) ELECTION OF ENROLLMENT.—Qualified employees of a small employer may elect to enroll in a plan offered through the coopera-

SEC. 1302. AGREEMENTS WITH HEALTH PLANS.

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(1) IN GENERAL.—Except as provided in paragraph (2)(A) and subsection (c)—

(A) each cooperative for a health care coverage area shall enter into an agreement under this section with each certified community-rated health plan that serves residents of the health care coverage area; and

(B) a cooperative may not refuse to enter into such an agreement with a health plan which is registered with a State as offering coverage in the health care coverage area, nor may a community-rated health plan refuse to enter into an agreement with a cooperative in accordance with section 1518.

(2) COMMUNITY-RATED PREMIUM.—A cooperative shall offer plans at the community-rate (as defined in section 6000(a)(3)) filed by the plan.

(3) TERMINATION OF AGREEMENT.—The State shall establish a process for the termination of agreements entered into under this section and a process for appealing such termination under this paragraph. In accordance with rules established by the State—

(A) a cooperative may terminate an agreement with a health plan if the health plan's registration for the health care coverage area involved is terminated or if the health plan fails to fulfill the requirements of the agreement; and

(B) a health plan may appeal the termination of an agreement with a cooperative under this paragraph to the State in accordance with rules and procedures established by the State.

(b) RECEIPT OF GROSS PREMIUMS.—

(1) IN GENERAL.—Under an agreement under this section between a cooperative and a health plan, payment of premiums shall be made directly to the cooperative in accordance with rules promulgated by the Board.

(2) FORWARDING OF PREMIUMS.—Under an agreement under this section between a health plan and a cooperative, the cooperative shall forward to each health plan in which an eligible individual has been enrolled the amounts collected on the behalf of enrollees in such plans.

(c) NEGOTIATING COOPERATIVES.—

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(2) AUTHORITIES AND RESPONSIBILITIES OF NEGOTIATING COOPERATIVES.—

(A) IN GENERAL.—Negotiating cooperatives may exclude plans from the plans offered to cooperative members if such cooperatives offer at least three plans, including at least one fee-for-service plan as required under section 1231(a)(1)(B).

(B) PREMIUMS.—A health plan may, through negotiations with a negotiating cooperative, offer to individuals enrolled through such cooperative a premium that is less than the community rated premium, but in no case shall a plan bid a premium to a negotiating cooperative that is higher that the community-rated premium.

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(a) IN GENERAL.—Cooperatives for each health care coverage area shall offer to enter into an agreement under this section with each small employer that employs individuals in the area and that desires to join the cooperative. Each arrangement between a small employer and a cooperative shall include provisions consistent with the requirements of this section.

(b) ELECTION OF ENROLLMENT.—Qualified employees of a small employer may elect to enroll in a plan offered through the coopera-

tive with which the employer has entered into an agreement, through a health plan directly, through an agent, or through another cooperative. The cooperative shall be responsible for forwarding premium payments to the appropriate plan.

(c) FORWARDING INFORMATION ON ELIGIBLE EMPLOYEES.—Under an agreement under this section between an employer and a cooperative, the employer must forward to the appropriate cooperative such information as may be required by the Secretary.

SEC. 1304. ENROLLING INDIVIDUALS IN HEALTH PLANS THROUGH A COOPERATIVE.

(a) IN GENERAL.—Each cooperative shall offer eligible individuals the opportunity to enroll in any health plan which has an agreement with the cooperative for the health care coverage area in which the individual resides.

(b) ENROLLMENT PROCESS.—Each cooperative shall establish an enrollment process in accordance with rules established by the Secretary, including a process for enrolling those qualified employees those qualified employees of a community-rated employer who elect not to participate in the cooperative with which the employer has entered into an agreement.

(c) ENROLLMENT FEES.—The Board shall promulgate rules regarding payment of cooperative fees by employers exercising an election under section 1303(b).

SEC. 1305. COOPERATIVE FEE.

(a) IN GENERAL.—Each cooperative shall charge members a uniform membership fee to cover the cost of activities undertaken by the cooperative.

(b) DISCLOSURE.—Each cooperative shall, prior to the time of enrollment, publish the membership fee of such cooperative. Such fees shall be calculated and identified as a separate charge from the premium charged by the health plans offered by the cooperative. A comparison of fees charged by each cooperative in a health care coverage area shall be incorporated into the plan brochure described in section 1205.

SEC. 1306. COORDINATION AMONG COOPERATIVES.

The State shall establish rules consistent with this section for coordination among cooperatives with respect to enrollment, payment of premiums, and provision of out-of-area benefits and services.

SEC. 1307. THIRD-PARTY CONTRACTING TO PERFORM DUTIES.

(a) IN GENERAL.—Each cooperative may contract with qualified, independent third parties for any service necessary to carry out the powers and duties of the cooperative pursuant to the requirements established under this section.

(b) RESTRICTION ON PERSONS ELIGIBLE FOR THIRD-PARTY CONTRACT.—No person may act, directly or through an affiliated company, both as a health plan serving the cooperative and as an independent third party contractor as described in subsection (a) within a given health care coverage area.

Strike subtitle E of title I except for sections 1401(c) (which shall be redesignated accordingly), 1403, 1404, and 1415 and insert the following

Subtitle E—Large Group Purchasers

SEC. 1400. EMPLOYER PRINCIPALS.

Except as provided in this Act, employers shall be responsible for ensuring the enrollment of eligible employees in a health plan and such other duties and responsibilities as may be required under this Act.

PART 1—DEFINITIONS AND RESPONSIBILITIES OF LARGE GROUP PURCHASERS

SEC. 1401. DEFINITIONS.

As used in this subtitle:

(1) GROUP HEALTH PLAN.—The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries (as defined in section 3 of the Employee Retirement Income Security Act of 1974) directly or through insurance, reimbursement, or otherwise.

(2) LARGE EMPLOYER GROUP SPONSOR.—The term "large employer group sponsor" means an employer with more than 1000 full-time employees. A large employer group sponsor may offer either a State qualified health plan, a self-insured health plan, or a combination of both types of plans as a group health plan.

(3) SMALL EMPLOYER.—The term "small employer" means an employer with 500 or less full-time employees. A small employer shall offer three qualified health plans, one of which shall be a fee-for-service plan, at the HCCA adjusted community rate and join a purchasing cooperative. Each small employer group purchaser shall meet the applicable enrollment requirements developed under section 13____.

(4) DUAL CHOICE EMPLOYER.—

(A) IN GENERAL.—The term "dual choice employer" means an employer with more than 500 but less than 1000 full-time employees.

(B) ELECTION.—A dual choice employer may elect to be considered as either a small employer group purchaser or a large employer group purchaser for purposes of this Act. The status of the employer as a small employer or a large employer after such an election shall remain in effect for a period of not less than 3 years. If the number of full-time employees of the employer changes during the coverage year, the status of the employer shall be retained throughout that year. A dual choice employer electing to be a large group sponsor shall not be eligible for discounts under title VI.

(5) EMPLOYER SPONSORED HEALTH PLAN.—The term "employer sponsored health plan" means a group health plan with an enrollment of at least 500 individuals that is established and maintained by a large employer. The health plan may be operated as a fee-for-service plan, managed care network plan, or managed care network with a point of service option plan. The employer shall retain the risk and meet the solvency, reserve and guarantee fund requirements specified by the Secretary of Labor.

(6) MULTIEMPLOYER PLAN.—

(A) IN GENERAL.—The term "multiemployer plan" has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such Act.

(B) PLAN SPONSOR OF A MULTIEMPLOYER PLAN.—The term "plan sponsor of a multiemployer plan" means a plan sponsor described in section 3(16)(B)(iii) of the Employee Retirement Income Security Act of 1974, but only with respect to a group health plan that is a multiemployer plan and only if—

(i) such plan provided health benefits as of September 1, 1993, and

(ii) as of both September 1, 1993, and January 1, 1996, such plan covers more than 1,000 full-time em-

ployees in the United States, or the plan is maintained by one of more affiliates of the same labor organization, or one or more affiliates of labor organization representing employees in the same industry, covering more than 1,000 employees.

Each multiemployer plan sponsor shall meet the applicable standards developed under section 1306.

(7) RURAL ELECTRIC COOPERATIVE AND RURAL TELEPHONE COOPERATIVE ASSOCIATION.—

(A) RURAL ELECTRIC COOPERATIVE.—The term "rural electric cooperative" has the meaning given such term in section 3(40)(A)(iv) of the Employee Retirement Income Security Act of 1974.

(B) RURAL TELEPHONE COOPERATIVE ASSOCIATIONS.—The term "rural telephone cooperative association" has the meaning given such term in section 3(40)(A)(v) of the Employee Retirement Income Security Act of 1974.

(C) REQUIREMENT.—A rural electric cooperative or a rural telephone cooperative association shall be considered an eligible sponsor under this subtitle, but only with respect to a group health plan that is maintained by such cooperative or association (or members of such cooperative or association) and only if such plan—

(i) offered health benefits as of September 1, 1993, and

(ii) meets the applicable standards for an association health plan under section _____.

SEC. 1402. TIMING OF EMPLOYER ELECTIONS.

Not later than 6 months after the date of enactment of this Act, the Secretary of Labor shall promulgate regulations for employer elections.

SEC. 1403. EMPLOYEE ENROLLMENT REQUIREMENTS.

(a) ESTABLISHMENT OF EMPLOYER ENROLLMENT FUNCTION.—Each large group sponsor shall make available enrollment in at least three health plans, one of which shall be a fee-for-service plan, to each eligible employee of such employer (a small employer may meet the requirement of the previous sentence only through qualified health plans).

(b) FORWARDING INFORMATION.—

(1) INFORMATION REGARDING PLANS.—An employer must provide each employee of such employer (including any part-time or seasonal employee) with information regarding all qualified health plans offered in the HCCA in which the employer is located and, if the employee resides in another HCCA, information regarding how to obtain information on qualified health plans offered to residents of such other HCCA.

(2) INFORMATION REGARDING EMPLOYEES.—An employer must forward the name and address (and any other necessary identifying information specified by the Secretary) of each eligible employee—

(A) to the qualified health plan in which such employee is enrolled or

(B) to the cooperative (if any) through which such enrollment is made

(c) PAYROLL DEDUCTION.—The employer, upon authorization by the employee, shall provide for the deduction, from the employee's wages or other compensation, of the premium amount due (less any employer contribution) to the plan or purchasing group. This subsection shall only apply to plans made available by the employer.

(d) NO REQUIREMENT TO ENROLL IN EMPLOYER-PROVIDED PLAN.—An eligible employee of a small employer may elect not to enroll in a qualified health plan offered by an employer under this section. Such an employee may enroll in a qualified health plan offered through a purchasing cooperative of the employers choosing.

SEC. 1404. RESPONSIBILITIES AND AUTHORITY OF EMPLOYER GROUP PURCHASERS.

(a) OFFER OF PLANS.—

(1) IN GENERAL.—Each employer shall make available to each eligible employee the three health plans, once of which shall be a fee-for-service plan. Nothing in this section shall be construed to prevent a large employer from complying with this subsection through the offering of plans provided by a single insurer.

(2) SELECTION OF PLANS BY MAJORITY OF EMPLOYEES.Each employer shall make the selections of health plans under this subsection on an annual basis. In making each such selection, the large employer shall comply with any selection made by at least 50 percent of the eligible employees of the large employer. The Secretary of Labor shall prescribe rules which shall govern the manner in which employees may make such a selection.

(b) SPECIFIC REQUIREMENTS OF LARGER EMPLOYER GROUP PURCHASERS.—

(1) CONTRACTS WITH PLANS.—Each large employer group purchaser may—

(A) negotiate with a State certified health plan to enter into a contract with the plan for the enrollment of such individuals under the plan; or

(B) offer to individuals an appropriate employer sponsored health plan.

or both.

(2) PLAN AND INFORMATION REQUIREMENTS.—

(A) IN GENERAL.—An employer group purchaser shall provide a written submission to the Secretary of Labor (in such form as the Secretary may require) detaining how the large employer group sponsor will carry out its activities under this part

(B) ANNUAL INFORMATION.—An employer group sponsor shall provide to the Secretary of Labor each year, in such form and manner as the Secretary may require, such information as the Secretary may require in order to monitor the compliance of the sponsor with the requirements of this part

(C) ANNUAL NOTICE OF EMPLOYEES OR PARTICIPANTS.—Each large group sponsor shall submit to the Secretary of Labor, by not later than March 1 of each year, information on the number of full-time employees or participants obtaining coverage through the purchaser as of January 1 of that year

(3) MANAGEMENT OF FUNDS.—

(A) MANAGEMENT OF FUNDS.—The management of funds by an large group purchaser shall be subject to the applicable fiduciary requirements of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, together with the applicable enforcement provisions of part 5 of subtitle B of title I of such Act.

(B) MANAGEMENT OF FINANCES AND RECORDS; ACCOUNTING SYSTEM.—Each large group purchaser shall comply with standards relating to the management of finances and records and accounting systems as the Secretary of Labor shall specify

SEC. 1405. DEVELOPMENT OF LARGE EMPLOYER PURCHASING GROUPS

(a) IN GENERAL.—Nothing in this title shall be construed as prohibiting 2 or more large employers from forming a purchasing group with respect to the employees of such employer or employers. Such entities shall comply with the requirements applicable to large employer sponsored health plans under this subtitle.

(b) NO USE OF INDIVIDUAL AND SMALL EMPLOYER PURCHASING GROUPS.—A large employer shall be ineligible to purchase health

insurance through an individual and small employer purchasing cooperative, except as provided in subtitle E.

PART 2—REQUIREMENTS FOR LARGE EMPLOYER GROUP HEALTH PLANS

SEC. 1406. ESTABLISHMENT OF STANDARDS APPLICABLE TO LARGE EMPLOYER PURCHASER GROUP HEALTH PLANS.

(a) ESTABLISHMENT OF STANDARDS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop and publish standards applicable to large employer plans relating to the requirements described in paragraph (2). The Secretary shall develop and publish such standards by not later than the date that is 6 months after the date of enactment of this Act. Such standards shall be the certified health plan standards applicable under this part.

(2) REQUIREMENTS SPECIFIED.—The requirements referred to in paragraph (1) are applicable plan requirements specified in subtitle F.

(b) ESTABLISHMENT OF STANDARDS BY SECRETARY OF LABOR.—

(1) IN GENERAL.—The Secretary of Labor shall develop and publish standards applicable to large employer plans relating to the requirements specified in paragraph (2). The Secretary shall develop and publish such standards by not later than the date that is 6 months after the date of enactment of this Act. Such standards shall be the health plan standards applicable under this part.

(2) REQUIREMENTS SPECIFIED.—The requirements referred to in paragraph (1) are requirements specified in the following provisions:

(A) Relating to financial solvency or such standards similar to the standards established under such section as the Secretary of Labor specifies, except that such standards shall be consistent with the applicable rules under section 404 of the Employee Retirement Income Security Act of 1974.

(B) Relating to payment of premiums.

(C) Relating to claims grievance procedures.

(D) Relating to required offer of different benefit packages.

Such requirements as they relate to health plans shall be comparable to those under subtitle F.

SEC. 1407. CORRECTIVE ACTIONS FOR LARGER EMPLOYER GROUP HEALTH PLANS.

(a) IN GENERAL.—The plan sponsor of each large employer plan shall determine semiannually whether the requirements of this part are met. In any case in which the plan sponsor determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary of Labor makes such a determination and so notifies the plan sponsor, the plan sponsor shall, within 90 days after making such determination or receiving such notification, notify such Secretary (in such form and manner as such Secretary may prescribe by regulation) of a description of the corrective actions (if any) that the plan sponsor has taken or plans to take in response to such recommendations. The plan sponsor shall thereafter report to such Secretary, in such form and frequency as such Secretary may specify to the plan sponsor, regarding corrective action taken by the plan sponsor until such requirements are met. Such Secretary may make a determination that a large employer plan has ceased to be a large employer plan only if such Secretary is satisfied that the necessary corrective action cannot reasonably be expected to occur on a timely basis necessary to avoid failure to provide benefits for which the plan is obligated.

(b) DISQUALIFIED OR TERMINATION OF PLAN.—

(1) IN GENERAL.—In any case in which the plan sponsor of a large employer plan determines that there is reason to believe that the plan will cease to be a large employer sponsored health plan or will terminate, the plan sponsor shall so inform the Secretary of Labor, shall develop a plan for winding up the affairs of the plan in connection with such disqualification or termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and shall submit such plan in writing to such Secretary. Actions required under this subparagraph shall be taken in such form and manner as may be prescribed in regulations jointly prescribed by such Secretary.

(2) ACTIONS REQUIRED IN CONNECTION WITH DISQUALIFICATION OR TERMINATION.—

(A) IN GENERAL.—In any case in which—

(i) the Secretary of Labor has been notified under paragraph (1) of a failure of a large employer sponsored health plan to meet the requirements of this part and has not been notified by the plan sponsor that corrective action has restored compliance with such requirements, and

(ii) such Secretary determines that the continuing failure to meet such requirements can be reasonably expected to result in a continuing failure to pay benefits for which the plan is obligated,

the plan sponsor and the large employer shall comply with the requirements of subparagraph (B) or (C), as applicable.

(B) ACTIONS BY PLAN SPONSOR.—Upon a determination by the Secretary of Labor under subparagraph (A)(ii), the plan sponsor shall, at the direction of such Secretary, terminate the plan and, in the course of the termination, take such actions as such Secretary may require as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely payment of all benefits for which the plan is obligated.

(C) ACTIONS BY LARGE EMPLOYER.—Upon a determination by the Secretary of Labor under subparagraph (A)(ii), the large employer shall provide for such contingency coverage for all eligible employees of the employer in accordance with regulations which shall be prescribed in joint regulations of such Secretary. Such regulations may provide for temporary coverage of such employees under a plan provided by a purchasing group in the appropriate area, a plan provided under chapter 89 of title 5, United States Code, or other appropriate means established in such regulations.

SEC. 1408. ERISA APPLICABILITY TO LARGE EMPLOYER GROUP HEALTH PLANS.

(a) REPORTING AND DISCLOSURE REQUIREMENTS APPLICABLE TO GROUP HEALTH PLANS.—

(1) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(A) in the heading for section 110, by adding "BY PENSION PLANS" at the end,

(B) by redesignating section 111 as section 112; and

(C) by inserting after section 110 the following new section:

"SPECIAL RULES FOR GROUP HEALTH PLANS

"SEC. 111. IN GENERAL.—The Secretary shall by regulation provide special rules for the application of this part to group health plans which are consistent with the purposes of this title and the Health Security Act and which take into account the special needs of participants, beneficiaries and health care providers under such plans.

"(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—Such special rules may include rules providing for—

"(1) reductions in the periods of time referred to in this part,

"(2) increases in the frequency of reports and disclosures required under this part, and

"(3) such other changes in the provisions of this part as may result in more expeditious reporting and disclosure of plan terms and changes in such terms to the Secretary and to plan participants and beneficiaries,

to the extent that the Secretary determines that the rules described in this subsection are necessary to ensure timely reporting and disclosure of information consistent with the purposes of this part and the Health Security Act as they relate to group health plans.

"(c) ADDITIONAL REQUIREMENTS.—Such special rules may include rules providing for reporting and disclosure to the Secretary and to participants and beneficiaries of additional information or at additional times with respect to group health plans to which this part applies under section _____, if such reporting and disclosure would be comparable to and consistent with similar requirements applicable under the Health Security Act with respect to small employer plans and applicable regulations of the Secretary of Health and Human Services prescribed thereunder.".

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by striking the items relating to sections 110 and 111 and inserting the following new items:

"Sec. 110 Alternative methods of compliance by pension plans.

"Sec. 111 Special rules for group health plans.

"Sec. 112 Repeal and effective date.".

(b) APPLICABILITY OF ERISA ENFORCEMENT MECHANISMS FOR ENFORCEMENT OF CERTAIN REQUIREMENTS.—The provisions of sections 502 (relating to civil enforcement) and 504 (relating to investigative authority) of the Employee Retirement Income Security Act of 1974 shall apply to enforcement by the Secretary of Labor of this part in the same manner and to same extent as such provisions apply to enforcement of title I of such Act.

(c) APPLICABILITY OF CERTAIN ERISA PROTECTIONS TO ENROLLED INDIVIDUALS.—The provisions of sections 510 (relating to interference with rights protected under Act) and 511 (relating to coercive interference) of the Employee Retirement Income Security Act of 1974 shall apply, in relation to the provisions of this Act, with respect to individuals enrolled under large group sponsor health plans in the same manner and to the same extent as such provisions apply, in relation to the provisions of the Employee Retirement Income Security Act of 1974, with respect to participants and beneficiaries under employee welfare benefit plans covered by title I of such Act.

(d) APPLICABILITY OF PREEMPTION RULES.—Section 514 of the Employee Retirement Income Security Act of 1974 shall apply in the case of any group health plan of a large employer, except to the extent that such section is inconsistent with the requirements of this Act.

SEC. 1409. DISCLOSURE AND RESERVE REQUIREMENTS FOR LARGE EMPLOYER SPONSORED HEALTH PLANS.

(a) IN GENERAL.—The Secretary of Labor shall ensure that each large group sponsor health plan which is an employer sponsored health plan maintains plan assets in trust as provided in section 403 of the Employee Retirement Income Security Act of 1974—

(1) without any exemption under section 403(b)(4) of such Act, and

(2) in amounts which the Secretary determines are sufficient to provide at any time for payment to health care providers of all outstanding balances owed by the plan at such time and consistent with standards for State certified health plans.

The requirements of the preceding sentence may be met through letters of credit, bonds, or other appropriate security to the extent provided in regulations of the Secretary.

(b) DISCLOSURE.—Each employer sponsored health plan shall notify the Secretary at such time as the financial reserve requirements of this section are not being met. The Secretary may assess a civil money penalty of not more than $100,000 against any large group sponsor for any failure to provide such notification in such form and manner and within such time periods as the Secretary may prescribe by regulation.

SEC. 1410. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT LARGE EMPLOYER SPONSORED HEALTH PLANS.

(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary of Labor determines that a large employer sponsored health plan will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of the Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint the Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the enrolled individuals or health care providers or to avoid any unreasonable deterioration of the financial condition of the plan or any unreasonable increase in the liability of the large group sponsor Health Plan Insolvency Fund. The trusteeship of the Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

(b) POWERS AS TRUSTEE.—The Secretary of Labor, upon appointment as trustee under subsection (a), shall have the power—

(1) to do any act authorized by the plan, this Act, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

(4) to do such other acts as the Secretary deems necessary to continue operation of the plan without increasing the potential liability of the large group sponsor Health Plan Insolvency Fund, if such acts may be done under the provisions of the plan,

(5) to require the large group sponsor, the plan administrator, any contributing employer, and any employee organization representing covered individuals to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

(6) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

(7) to commence prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

(8) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

(9) to terminate the plan and liquidate the plan assets in accordance with applicable provisions of this Act and other provisions of law, to restore the plan to the responsibility of the large group sponsor or to continue the trusteeship,

(10) to provide for the enrollment of individuals covered under the plan in an appropriate health plan, and

(11) to do such other acts as may be necessary to comply with this Act or any order of the court and to protect the interests of enrolled individuals and health care providers.

(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

(1) the plan administrator,

(2) each enrolled individual,

(3) each employer who may be liable for contributions to the plan, and

(4) each employee organization which, for purposes of collective bargaining, represents enrolled individuals.

(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this Act or part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or as may be otherwise ordered by the court, the Secretary of Labor, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of such part 4.

(e) OTHER PROCEEDINGS.—An application by the Secretary of Labor under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

(f) JURISDICTION OF COURT.—

(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this subsection, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this subsection, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary of Labor as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the large group sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the large group sponsor or any other suit against the plan or the sponsor.

(2) VENUE.—An action under this subsection may be brought in the judicial district where the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

(g) PERSONNEL.—In accordance with regulations of the Secretary of Labor, the Secretary shall appoint, retain, and reasonably compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

PART 3—REVISION OF COBRA CONTINUATION COVERAGE REQUIREMENTS

SEC. 1411. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) PERIOD OF COVERAGE.—Subparagraph (D) of section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161(2)) is amended—

(1) by striking "or" at the end of clause (i), by striking the period at the end of clause (ii) and inserting ", or", and by adding at the end the following new clause:

"(iii) eligible for coverage under a qualified health plan in accordance with title I of the Health Security Act.";

(2) by adding at the end thereof the following:

An individual terminated by a large group sponsor must elect by the date of the termination to either remain in the plan of the sponsor for a period of not to exceed 12 months or until the individual is reemployed, whichever is less, or purchase from another plan in the marketplace."; and

(3) by striking "OR MEDICARE ENTITLEMENT" in the heading and inserting ", MEDICARE ENTITLEMENT, OR QUALIFIED HEALTH PLAN ELIGIBILITY".

(b) QUALIFIED BENEFICIARY.—Section 607(3) of such Act (29 U.S.C. 1167(2)) is amended by adding at the end the following new subparagraph:

"(D) SPECIAL RULE FOR INDIVIDUALS COVERED BY HEALTH SECURITY ACT.—The term 'qualified beneficiary' shall not include any individual who, upon termination of coverage under a group health plan, is eligible for coverage under a qualified health plan in accordance with title I of the Health Security Act."

(c) REPEAL UPON IMPLEMENTATION OF ACT.—

(1) IN GENERAL.—Part 6 of subtitle B of title I of such Act (29 U.S.C. 601 et seq.) is amended by striking sections 601 through 608 and by redesignating section 609 as section 601.

(2) CONFORMING AMENDMENTS.—

(A) Section 502(a)(7) of such Act (29 U.S.C. 1132(a)(7)) is amended by striking "609(a)(2)(A)" and inserting "601(a)(2)(A)".

(B) Section 502(c)(1) is amended by striking "paragraph (1) or (4) of section 606".

(C) Section 514 of such Act (29 U.S.C. 1144) is amended by striking "609" each place it appears in subsections (b)(7) and (b)(8) and inserting "601".

(D) The table of contents in section 1 of such Act is amended by striking the items relating to sections 601 through 609 and inserting the following new item:

"Sec. 601. Additional standards for group health plans."

(d) EFFECTIVE DATE —

(1) SUBSECTIONS (a) AND (b).—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act.

(2) SUBSECTION (c).—The amendments made by subsection (c) shall take effect on the first January 1 following the deadline specified in section 1301(c)(2) of this Act.

SEC. 1412. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.

(a) PERIOD OF COVERAGE.—Subparagraph (D) of section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb–2(2)) is amended—

(1) by striking "or" at the end of clause (i), by striking the period at the end of clause (ii) and inserting ", or", and by adding at the end the following new clause:

"(iii) eligible for coverage under a qualified health plan in accordance with title I of the Health Security Act." and

(2) by striking "OR MEDICARE ENTITLEMENT" in the heading and inserting ", MEDICARE ENTITLEMENT, OR QUALIFIED HEALTH PLAN ELIGIBILITY".

(b) QUALIFIED BENEFICIARY.—Section 2208(3) of such Act (42 U.S.C. 300bb–8(3)) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE FOR INDIVIDUALS COVERED BY ACT.—The term 'qualified beneficiary' shall not include any individual who, upon termination of coverage under a group health plan, is eligible for coverage under a qualified

health plan in accordance with title I of the Health Security Act.".

(c) REPEAL UPON IMPLEMENTATION OF HEALTH SECURITY ACT.—

(1) IN GENERAL.—Title XXII of such Act (42 U.S.C. 300bb–1 et seq.) is hereby repealed.

(2) CONFORMING AMENDMENT.—The table of contents of such Act is amended by striking the item relating to title XXII.

(d) EFFECTIVE DATE.—

(1) SUBSECTIONS (a) AND (b).—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act.

(2) SUBSECTION (c).—The amendments made by subsection (c) shall take effect on the first January 1 following the deadline specified in section 1401(c)(2) of this Act.

Strike all of subtitle F, except for subsection (b) of section 1502 which shall be transferred to the appropriate place in subtitle G, sections 1507 and 1513, and part 3, and insert the following and redesignate the remaining sections and parts and references thereto accordingly:

Subtitle F—Health Plans

SEC. 1500. HEALTH PLAN DEFINED.

(a) IN GENERAL.—In this Act, the term "health plan" means a plan that provides the comprehensive benefit package and meets the requirements of parts 1, 3, and 4 applicable to health plans.

(b) STATE-CERTIFIED HEALTH PLAN.—In this Act, the term "State-certified health plan" means a health plan that has been registered by a State under section 1502 (or, in the case in which the Board is exercising certification authority under section 1522(b), that has been certified by the Board).

(c) DOMICILIARY STATE.—For purposes this section, the State which has certified a cooperative is the State in which the cooperative is domiciled.

PART 1—REQUIREMENTS FOR HEALTH PLANS

SEC. 1501. QUALIFIED HEALTH PLAN.

(a) IN GENERAL.—A health plan must be certified under this title as meeting the applicable standards established under section 1402 for a qualified plan

(b) SPECIAL RULES FOR LARGE GROUP SPONSORS.—For special rules regarding the application of similar standards to large group sponsors, see part 1 of subtitle E.

(c) CONSTRUCTION.—Whenever in this title a requirement or standard is imposed on a health plan, the requirement or standard is deemed to have been imposed on the insurer or health plan sponsor of the plan in relation to that plan.

SEC. 1502. APPLICATION OF REQUIREMENTS.

No plan shall be treated under this Act as a health plan—

(1) unless the plan is a self-insured plan or a State-certified plan; or

(2) on and after the effective date of a finding by the applicable regulatory authority that the plan has failed to comply with such applicable requirements.

SEC. 1503. ESTABLISHMENT OF STANDARDS.

In order for a health plan to be eligible to be certified as a health plan by a State, the health plan shall meet the following standards, as detailed in regulations promulgated by the National Health Board The plan shall—

(1) provide, in accordance with section 1514(c), for the effective delivery of covered services throughout each designated service area for which it is registered;

(2) provide, in accordance with section 1503, for coverage of the comprehensive benefits package described in subtitle B;

(3) provide, in accordance with title V, for the collection and reporting of data;

(4) not discriminate in enrollment or benefits, as required under section 1505;

(5) establish community-rated premiums for the standard benefits, in accordance with section 1506;

(6) meet financial solvency and financial management standards promulgated by the Board, in accordance with section 1508;

(7) provide for effective grievance procedures in accordance with section 1509;

(8) demonstrate an ability to ensure that enrollees have adequate access to providers of health care, in accordance with sections 1514 and _____;

(9) meet information and marketing requirements, in accordance with section 1515;

(10) meet requirements for open enrollment, availability, and renewability, in accordance with sections 1004 and 1514;

(11) meet requirements with respect to rural and underserved areas in accordance with section 1519;

(12) meet requirements with respect to participation in a payment adjustment program in accordance with section 1516;

(13) meet quality standards in accordance with section 1512;

(14) enter into agreements with cooperatives; and

(15) meet other applicable requirements of this Act pursuant to the Board or to regulations promulgated by the Secretary.

SEC. 1504. MONITORING.

A participating State shall monitor the performance of each State-certified 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 of vulnerable population, fails to meet applicable standards relating to financial solvency and stability, or fails to meet any other criteria for registration or reregistration, 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.

SEC. 1505. CERTIFICATION AND REVOCATION OF HEALTH PLAN CERTIFICATION.

(a) CERTIFICATION.—A participating State shall—

(1) review the continued compliance of each plan with the certification requirements and recertify each 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, including demonstrating that the policies of the plan have not discriminated on the basis of any of the categories described in section 1915; and

(2) 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 certification or for the application of one or more interim sanctions.

(b) REVOCATION.—The State may revoke a plan's certification as a certified health plan for any health care coverage area or refuse

to recertify a plan only upon a determination by the State that the health plan no longer meets the requirements of this section, pursuant to procedures established by the Board.

SEC. 1506. ASSOCIATION HEALTH PLANS.

(a) APPLICATION.—This section shall apply to any association health plan that is in operation on June 1, 1994 and that meets the requirements for being considered an multiple employer welfare arrangement under section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)).

(b) APPLICATION OF STANDARDS.—An association health plan shall, at the option of the plan, meet the requirements of a plan or cooperative under this Act.

(c) REQUIREMENTS.—The sponsoring entity of the association health plan—

(1) shall be organized and maintained in good faith, with appropriate bylaws that specifically state the purpose, as a trade association, industry association, professional association, chamber of commerce, a religious organization, or a public entity association and that the entity has been established and maintained for substantial purposes other than to provide the health care required under this section; and

(2) is and has been in operation (together with its immediate predecessor, if any) for a continuous period of not less than 3 years and receives the active support of its membership.

(d) TREATMENT OF EXISTING ENTITIES.—Any arrangement that, as of June 1, 1994, has been in effect for not less than 18 months and with respect to which there is a pending application with the State insurance commissioner for a certificate of operation as a health plan, shall be treated for purposes of this subtitle as a qualified health plan (if such plan otherwise meets the requirements of this Act) unless the State can demonstrate that—

(1) fraudulent or material misrepresentations have been made in the application which are hazardous to the State;

(2) a disqualification of the sponsor of the applicant entity has occurred;

(3) the plan that is the subject of the application, on its face, fails to meet the requirements for a complete application; or

(4) a financial impairment exists with respect to the applicant that is sufficient to demonstrate the applicant's inability to continue its operations.

(e) TREATMENT OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

(1) QUALIFIED HEALTH PLANS.—The Secretary shall promulgate regulations that prohibit the insuring of employees under a multiple employer welfare arrangement as defined under section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)) unless the arrangement meets the standards for qualified health plans under subtitle F.

(2) REPEAL OF ERISA PROVISIONS.—

(A) Paragraph 40) of section 3 of such Act (29 U.S.C. 1002(40)) is repealed.

(B) Paragraph 6 of section 514(b) of such Act (29 U.S.C. 1144(b)(6)) is repealed.

SEC. 1507. SPECIFIED STANDARD BENEFITS; SUPPLEMENTAL BENEFITS AND COST-SHARING POLICIES.

(a) STANDARD BENEFITS AND OTHER REQUIREMENTS.—A State shall not accept the registration of a health plan as a certified health plan unless the plan provides the comprehensive benefits package required under this Act.

(b) TREATMENT OF SUPPLEMENTARY HEALTH BENEFITS.—

(1) IN GENERAL.—Subsection (a) shall not be construed as preventing a health plan, carrier, or insurer from offering (in a manner that is separate from the offering of health plans) supplemental insurance policies, pursuant to the State certification plan and regulations promulgated by the Board.

(2) NO DUPLICATIVE HEALTH BENEFITS.—A health plan or any other carrier or insurer may not offer any policy for supplementary health benefits under paragraph (1) that duplicates the comprehensive benefits.

(3) REGULATION OF SUPPLEMENTAL PLANS.—The Secretary shall provide appropriate rules for the regulation of supplemental benefit policies and plans, including rules providing for the guaranteed issue and the community rating of supplemental policies.

(c) TREATMENT OF COST-SHARING POLICIES.—

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

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

(B) the certified health plan offers the policy to all individuals enrolled in the plan;

(C) the plan offers 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); and

(D) the policy is offered only during the annual open enrollment period for community-rated health plans (described in section 1232(d)(1)).

(2) PROHIBITION OF COVERAGE OF COPAYMENTS.—Each cost sharing policy may not provide any benefits relating to any copayments established under the table of copayments and coinsurance under section 1135.

(3) EQUIVALENT COVERAGE FOR ALL SERVICES.—Each cost sharing policy must provide coverage for items and services in the comprehensive benefit package to the same extent as the policy provides coverage for all items and services in the package.

(4) REQUIREMENTS FOR PRICING.—

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

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

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

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

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

SEC. 1508. COLLECTION, PROVISION OF STANDARDIZED INFORMATION, AND CONFIDENTIALITY.

Each health plan must provide information required to evaluate the performance of the health plan, in accordance with title V.

SEC. 1509. PROHIBITION OF DISCRIMINATION.

(a) IN GENERAL.—No health plan may discriminate or engage (directly or through contractual arrangements) in any activity, including the selection of a service area, enrollment, or the provision of benefits, that has the effect of discriminating against an individual in violation of section 1915.

(b) ANTIDISCRIMINATION.—

(1) IN GENERAL.—No health plan may discriminate on the basis of—

(A) the method through which a family seeks enrollment under the plan, or

(B) the provider's status as a member of a health care profession for the purposes of selecting among providers of health services for membership in a provider network, provided that the State authorities members of that profession to render the services in question and that such services are

covered in the comprehensive benefits package described in subtitle B.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1)(B) shall be construed as requiring any health plan to:

(A) include in a network any individual provider;

(B) establish any defined ratio of different categories of health professionals;

(C) reimburse different categories of health professionals on a similar basis; or

(D) regulate the utilization review or internal quality standards of the health plan.

SEC. 1510. QUALITY ASSURANCE STANDARDS.

(a) IN GENERAL.—Each health plan shall comply with the plan performance standards consistent with subtitle A of title V. Each health plan shall establish procedures, including ongoing quality improvement procedures, to ensure that the health care services provided to enrollees under the plan will be provided under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice and the quality standards established under subtitle A of title V.

(b) INTERNAL QUALITY ASSURANCE PROGRAM.—Each health plan shall establish, and communicate to its enrollees and its providers, an ongoing internal program, including periodic reporting, to monitor and evaluate the quality and cost effectiveness of its health care services, pursuant to standards established by the National Quality Council.

SEC. 1511. COMMUNITY-RATING.

(a) IN GENERAL.—The Secretary shall promulgate regulations for community rating as modified by age. Such regulations shall terminate on December 31, 1998, except that the Board at any time may make a recommendation to Congress to maintain a form of modified community rating during the transition.

(b) MARKETING FEES.—Notwithstanding this section, a health plan may impose a marketing fee for individuals enrolling in a plan through an agent. Such fees shall be a uniform percentage of the premium established under section 6102(a)(1). In no case shall a plan impose a marketing fee for individuals enrolled through a cooperative or through the direct enrollment process pursuant to section 1660.

SEC. 1512. FINANCIAL SOLVENCY REQUIREMENTS AND CONSUMER PROTECTION AGAINST PROVIDER CLAIMS.

(a) SOLVENCY PROTECTION.—Each health plan shall meet financial solvency requirements to assure protection of enrollees with respect to potential insolvency. Health plans must provide a financial plan and meet capital requirements established by the Secretary. The Secretary shall establish insolvency standards to ensure the protection of enrollees. Health plans may utilize reinsurance, provide risk sharing, and other appropriate measures established by the Secretary.

(b) PROTECTION AGAINST PROVIDER CLAIMS.—In the case of a failure of a health plan to make payments with respect to the standard benefits for any reason, an individual who is enrolled under the plan is not liable to any health care provider with respect to the provision of health services within such set of standard benefits for payments in excess of the amount for which the enrollee would have been liable if the plan were to have made payments in a timely manner.

SEC. 1513. GRIEVANCE MECHANISMS.

A health plan shall establish grievance procedures that enrollees may utilize in pursing complaints in accordance with subtitle C of title V.

SEC. 1514. ACCESS TO CARE.

(a) POINT-OF-SERVICE OPTION.—Each health plan that is a low-cost sharing plan (as described in section 1131) shall offer enrollees the opportunity to obtain coverage for out-of-network items

and services, except that such point-of-service option must be offered, and priced separately from the benefits offered through the plan's network. A health plan providing coverage to an enrollee for out-of-network items and services may charge an alternative premium and require alternative cost-sharing to take into account such coverage, consistent with regulations promulgated by the Secretary.

(b) TREATMENT OF COST-SHARING.—Each health plan, in providing benefits in the comprehensive benefit package shall include in its payments to providers, such additional reimbursement as may be necessary to reflect cost sharing reductions to which individuals are entitled under section 1281.

(c) DEFINITIONS.—

(1) OUT-OF-NETWORK ITEMS AND SERVICES.—For purposes of this Act, the term "out-of network", when used with respect to items or services described in this subtitle, means items or services provided to an individual enrolled under a health plan by a health care provider who is not a member of a provider network of the plan (as defined in paragraph (2)).

(2) PROVIDER NETWORK DEFINED.—A "provider network" means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services in the comprehensive benefit package to individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

SEC. 1515. INFORMATION AND MARKETING STANDARDS.

(a) IN GENERAL.—Each health plan shall provide information in accordance with section 1205 and make available a more detailed plan description, including quality reports required under section 5005(a), in accordance with rules promulgated by the Board.

(b) MARKETING METHODS; ADVERTISING MATERIALS.—A health plan may utilize direct marketing, agency, or other arrangements to distribute health plan information, subject to applicable State fair marketing practices laws and standards established by the State, including standards to prevent selective marketing. All advertising, promotional materials, and other communications with health plan members and the general public must be factually accurate and responsive to the needs of served populations. A health plan may not distribute marketing materials to an area smaller than the entire designated service area of the plan.

(c) PAYMENT OF AGENT COMMISSIONS.—A health plan—

(1) may pay a commission or other remuneration to an agent or broker in marketing the plan to individuals or groups, but

(2) may not vary such remuneration based, directly or indirectly, on the anticipated or actual claims experience associated with the group or individuals to which the plan was sold.

SEC. 1516. OPEN ENROLLMENT; AVAILABILITY, AND RENEWABILITY.

(a) REQUIREMENT OF OPEN ENROLLMENT.—Each health plan shall establish an enrollment process consistent with this paragraph. To be certified as a health plan, the plan shall accept the enrollment of any eligible individual (including individuals enrolling directly with the plan or through a cooperative) in accordance with the enrollment procedures established by the State and by the Secretary.

(b) RENEWABILITY. LIMITATION ON TERMINATION.—Subject to subsections (c) and (e), coverage of eligible individuals under a health plan in a health care coverage area shall be renewed at the option of such eligible individuals, and coverage may not be terminated except after notice and in accordance with subsection (e).

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan which is a network plan may deny enrollment under the plan to an eligible individual who is located outside a service area of the plan, but only if such denial is applied uniformly.

(2) SERVICE AREAS.—The State shall establish standards, consistent with guidelines promulgated by the Secretary, for the designation by network plans of service areas in order to prevent discrimination based on health status of individuals or their need for health services.

(d) ENROLLMENT ASSURANCE.—A health plan must enroll individuals in a manner that ensures that each eligible individual in the service area of the plan has a fair chance to enroll with the plan in compliance with section 1660 and applicable rules and procedures established by the State.

(e) TERMINATION OF PLANS.—A health plan may elect not to renew or make available a health plan in a health care coverage area, or not to utilize a particular type of delivery system in a health care coverage area, but only if the health plan—

(1) elects not to renew all of its health plans in such health care coverage area or not to use the delivery system in such health care coverage area; and

(2) provides notice to the State and each individual covered under the plan of such termination at least 180 days before the date of expiration of either the plan or use of the delivery system.

In such case, a health plan may not provide for the issuance of any health plan in such health care coverage area, or to utilize such delivery system in that health care coverage area during a 5-year period beginning on the date of the termination of the last plan not so renewed. For purposes of this paragraph the term "delivery system" means an open-network, closed network, or nonnetwork health care delivery system.

SEC. 1517. ADMINISTRATIVE PROVISIONS.

(a) CAPABILITY.—Each health plan shall demonstrate to the certifying authority the capability to administer the plan.

(b) UTILIZATION MANAGEMENT.—Each health plan shall demonstrate to the certifying authority, through written management procedures, an appropriate utilization management process. The Secretary shall establish guidelines under this subsection for utilization management.

SEC. 1518. INFORMATION REGARDING A PATIENT'S RIGHT TO SELF-DETERMINATION IN HEALTH CARE SERVICES.

Each health plan shall provide written information to each individual enrolling in such plan of such individual's right under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives (as defined in section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3))), and the written policies of the qualified health plan with respect to such right.

SEC. 1519. RURAL AND MEDICALLY UNDERSERVED AREAS.

(a) IN GENERAL.—If, in accordance with appropriate rules established by the Secretary, a State determines that there is inadequate access in the provision of health services by health plans in any area of a State, the State may authorize—

(1) a health plan to be the only health plan in the area; or

(2) two or more health plans to take joint action to develop and implement a program.

(b) MEDICALLY UNDERSERVED AREA DEFINED.—For purposes of this subtitle the term "medically underserved area" means an urban or rural area designated by the Board as an area with a shortage of health professional or of health services or facilities.

SEC. 1520. PAYMENT ADJUSTMENTS.

Each health plan shall participate in any risk adjustment, reinsurance, or other premium adjustment program implemented by the State. Provisions of this section concerning risk adjustment and reinsurance shall not apply to health plans offered by large group sponsors.

SEC. 1521. PREEMPTION OF CERTAIN STATE LAWS RELATING TO HEALTH PLANS.

(a) LAWS RESTRICTING PLANS OTHER THAN FEE-FOR-SERVICE PLANS.—Except as may otherwise be provided in this section, no State law shall apply to any services provided under a health plan that is not a fee-for-service plan (or a fee-for-service component of a plan) if such law has the effect of prohibiting or otherwise restricting plans from—

(1) limiting the number and type of health care providers who participate in the plan;

(2) requiring enrollees to obtain health services (other than emergency services) from participating providers or from providers authorized by the plan;

(3) requiring enrollees to obtain a referral for treatment by a specialized physician or health institution;

(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. 1522. CONTRACTS WITH CONSUMER PURCHASING COOPERATIVES.

(a) CONTRACTS WITH COOPERATIVES.—A certified 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.

(b) PRICING.—No health 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)

In section 1660, insert the following new subsections after subsection (b) and redesignate the remaining subsection accordingly:

(c) DIRECT ENROLLMENT —

(1) IN GENERAL —The Board shall establish methods and procedures for the direct enrollment of individuals in the health plans of their choice

(2) ENROLLMENT PROCESSES.—The Board shall provide standards for State to ensure the broad availability of enrollment forms, including direct enrollment through the mail, and other such processes as the Board may designate.

(3) NO MARKETING FEE.—Individuals enrolling in plans through the processes described in paragraph (2) shall be eligible for the community-rated premium (described in section 6000) filed by the health plan selected by the individual, without incurring a marketing fee, a surcharge or any other payment that represents an addition to the community-rated premium, whether such charge is imposed by the health plan, an agent of the plan or any other entity.

(d) DISENROLLMENT FOR CAUSE.—

(1) IN GENERAL —In addition to the annual open enrollment period held under subsection (a), the Board shall establish procedures by which eligible individuals enrolled in a plan may disenroll from the plan for good cause (as defined by Board) at

any time during a year and enroll in another plan. Such procedures shall be implemented by participating States in a manner that ensures continuity of coverage for the comprehensive benefit package for such individuals during the year.

(2) DISENROLLMENT FOR CAUSE.—

(A) IN GENERAL.—In addition to the periods of authorized change in enrollment under paragraph (1), the National Health Board shall define good cause and establish procedures under which eligible individuals enrolled in a health plan provided by a carrier may disenroll from the plan for good cause at any time during a year and enroll in another applicable health plan.

(B) ASSURING CONTINUITY OF COVERAGE.—The procedures under this paragraph shall be implemented in a manner that ensures continuity of coverage for the comprehensive benefit package for individuals changing enrollment during the year.

(C) ADDITIONAL REMEDIES.—The Board may provide rules under which an individual who changes enrollment from a plan for good cause due to a pattern of underservice under a plan, the carrier providing the health plan is liable, to the subsequent health plan in which the individual is enrolled, for excess costs (as identified in accordance with such rules) during a reasonable period of the anticipated duration of enrollment with the original health plan.

In section 1421, strike "cooperative health plan" and insert "community-rated health plan".

In section 1421, strike "contracting entity (as described in section 1252)" and insert "community-rated plan".

In section 1701 add the following new subsection:

(d) Employers may discharge their obligation under subsection (a) by making an appropriate payment to the consumer purchasing cooperative in the health care coverage area where the predominate number of the employer's qualifying employees reside.

Transfer section 1204(d)(2) to the section 1902 and redesignate such accordingly

Transfer subsection (d) of section 1255 and subsections (b) and (c) of section 1256 to subtitle H of title I and redesignate such as new subsections in the following new section.

SEC. 1711. PAYMENT ARRANGEMENTS.

Transfer subsection (g) of section 1255 to subpart A of part 2 of subtitle G of title I and redesignate such as the following new section:

SEC. 1673. ASSISTANCE WITH FAMILY COLLECTIONS.

Transfer subsection (c) of section 1256 to part 3 of subtitle G of title I and redesignate such as the following new section:

SEC. 1692. ASSISTANCE WITH EMPLOYER COLLECTIONS.

Transfer section 1261 to subtitle C of title VI and redesignate such as section 6203.

Transfer paragraph (3) of section 1271(b) to title IX and redesignate such as section 9202.

Transfer paragraph (4) of section 1271(b) to section 1691(d)(2) and redesignate such as paragraph (3).

In section 1701, add the following new subsection at the end thereof:

(d) DISCHARGE OF OBLIGATION.—Employers may discharge their payment obligation under subsection (a) by paying plans directly or by making payments to a consumer purchasing cooperative.

In subpart A of part 1 of title VI, add the following new section:

SEC. 6008. APPLICATION OF MARKETING AND COOPERATIVE FEES.

Cooperative fees (as described in section 1305) and health plan marketing fees (as described in section 1506) shall not be incorporated into the calculation of plan and health care coverage areas' compliance with the premium targets established in this part.