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FOLDER TITLE:
Standard Benefits Amendment

2014-0209-S
ms758

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
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Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Jen-

Here is the info you requested.

Jess

Subtitle B—Benefits

SEC. 1101. QUALIFIED HEALTH COVERAGE.

In this Act, the term "qualified health coverage" means health coverage that—

(1) provides—

(A) at least standard coverage consistent with section 1102, or

(B) at least high-deductible coverage consistent with section 1103; and

(2) meets other requirements of subtitle A applicable to the coverage and the carrier or group health plan providing the coverage.

SEC. 1102. STANDARD COVERAGE.

(a) IN GENERAL.—Health insurance coverage is considered to provide standard coverage consistent with this subsection if—

(1) benefits under such coverage are provided within at least each of the required categories of benefits described in paragraph (1) of subsection (b) and consistent with such subsection;

(2) the actuarial value of the benefits meets the requirements of subsection (c),

(3) the benefits comply with the minimum requirements specified in subsection (d), and

(4) the benefits do not violate the anti-discrimination rules described in section 1105.

(b) REQUIRED CATEGORIES OF COVERED BENEFITS.—

(1) IN GENERAL.—The categories of covered benefits described in this paragraph are the types of benefits specified in subparagraphs (A), (B), (C), (D), and (F) of paragraph (1), and subparagraphs (E) and (F) of paragraph (2), of section 8904(a) of title 5, United States Code (relating to types of benefits required to be in health insurance offered to Federal employees).

(2) COVERAGE OF TREATMENTS IN APPROVED RESEARCH TRIALS.—

(A) IN GENERAL.—Coverage of the routine medical costs (as defined in subparagraph (B)) associated with the delivery of treatments shall be considered to be medically appropriate only if the treatment is part of an approved research trial (as defined in subparagraph (C)).

(B) ROUTINE MEDICAL COSTS DEFINED.—In subparagraph (A), the term "routine medical costs" means the cost of health services required to provide treatment according to the design of the trial, except those costs normally paid for by other funding sources (as defined by the Secretary). Such costs do not include the cost of the investigational agent, devices or procedures themselves, the costs of any nonhealth services that might be required for a person to receive the treatment, or the costs of managing the research.

(C) APPROVED RESEARCH TRIAL DEFINED.—In subparagraph (A), the term "approved research trial" means a trial—

(i) conducted for the primary purpose of determining the safety, effectiveness, efficacy, or health outcomes of a treatment, compared with the best available alternative treatment, and

(ii) approved by the Secretary.

A trial is deemed to be approved under clause (ii) if it is approved by the National Institutes of Health, the Food and Drug Administration (through an investigational new drug exemption), the Department of Veterans Affairs, or by a qualified nongovernmental research entity (as identified in guidelines issued by one or more of the National Institutes of Health).

1. Exclusion of benefits

Under this chapter only "government-wide" plans are required to include benefits for expenses incurred for health services of catastrophic nature, namely, "service benefit" and "indemnity benefit" plans, and their requirement was not applicable to "employee organization" plan for special agents of the Federal Bureau of Investigation and, in any event, even when governmentwide plan is involved, it may be appropriate for the Office of Personnel Management to balance catastrophic coverage requirement against other statutory concerns. Tackitt v. Prudential Ins. Co. of America, D.C.Ga.1984, 595 F.Supp. 887.

Although Office of Personnel Management may exclude benefit under this chapter that is inordinately expensive in relation to value of services received, Office's decision must be scrutinized to determine whether cost justification is supported by facts and whether it is proceeding rationally and reasonably in light of purpose and objective of this chapter. American Federation of Government Emp., AFL–CIO v. Devine, D.C.D.C.1981, 525 F.Supp. 250.

There is no implied provision under the Health Benefits Act, 5 U.S.C.A. §§ 8901–8913, for payment of compensation to federal employee for unwanted coverage in health insurance premiums voluntarily paid. Rosano v. U.S., 1985, 9 Cl.Ct. 137, affirmed 800 F.2d 1126, certiorari denied 107 S.Ct. 1350, 480 U.S. 907, 94 L.Ed.2d 521.

2. Funding of health plan

Joint resolution of Congress making continuing appropriations for fiscal year 1982 did not prohibit Office of Personnel Management from funding coverage for therapeutic abortions or incurring administrative expenses in administration of any health plan including such coverage. American Federation of Government Emp., AFL–CIO v. Devine, D.C.D.C.1981, 525 F.Supp. 250.

3. Determination of necessary benefits

Consistent with underlying purposes of this chapter, Office of Personnel Management may and should consider cost to government in determining what health benefits for federal employees are necessary or desirable. National Federation of Federal Employees v. Devine, 1981, 679 F.2d 907, 220 U.S.App.D.C. 89.

4. Approval of plans

Office of Personnel Management, charged with approval of health benefit plans for federal employees, must act in manner consistent with goals and policies of the Federal Employees Health Benefits Act, two of such competing goals being catastrophic coverage and low premiums. Tackitt v. Prudential Ins. Co. of America, C.A.11 (Ga.) 1985, 758 F.2d 1572.

5. Review

In view of fact, inter alia, that Office of Personnel Management in approving benefit changes requested by FBI agents' benefit association and by insurer by whom the health benefit plan was underwritten in part, considered competing goals of catastrophic coverage and low premiums, and in view of fact that the benefit association was faced with 30.3 percent premium increase if existing plan continued, approval of plan whereby the association was able to operate 8.5% decrease in premiums to 20,000 members other than plaintiff was not arbitrary or capricious though a $75,000 burden was placed upon plaintiff who had received home nursing care since 1977 and who would have been fully reimbursed for same until 1982. Tackitt v. Prudential Ins. Co. of America, C.A.11 (Ga.) 1985, 758 F.2d 1572.

§ 8903a. Additional health benefits plans

(a) In addition to any plan under section 8903 of this title, the Office of Personnel Management may contract for or approve one or more health benefits plans under this section.

(b) A plan under this section may not be contracted for or approved unless it—

(1) is sponsored or underwritten, and administered, in whole or substantial part, by an employee organization described in section 8901(8)(B) of this title;

(2) offers benefits of the types named by paragraph (1) or (2) of section 8904 of this title or both;

(3) provides for benefits only by paying for, or providing reimbursement for, the cost of such benefits (as provided for under paragraph (1) or (2) of section 8903 of this title) or a combination thereof; and

(4) is available only to individuals who, at the time of enrollment, are full members of the organization and to members of their families.

(c) A contract for a plan approved under this section shall require the carrier—

(1) to enter into an agreement approved by the Office with an underwriting subcontractor licensed to issue group health insurance in all the States and the District of Columbia; or

(2) to demonstrate ability to meet reasonable minimum financial standards prescribed by the Office.

(d) For the purpose of this section, an individual shall be considered a full member of an organization if such individual is eligible to exercise all rights and privileges incident to full membership in such organization (determined without regard to the right to hold elected office).

(Added Pub.L. 99–53, § 1(b)(1), June 17, 1985, 99 Stat. 93.)

HISTORICAL AND STATUTORY NOTES

Legislative History

For legislative history and purpose of Pub.L. 99–53, see 1985 U.S. Code Cong. and Adm. News, p. 81.

CROSS REFERENCES

Medicare premiums deducted from civil service retirement annuities, reimbursement of enrollees under plan described in this section, see section 1395s(d)(1) of Title 42, The Public Health and Welfare.

Restored disability annuitants, enrollment in health benefits plan described in this section, see section 8908(c) of this title.

§ 8904. Types of benefits

(a) The benefits to be provided under plans described by section 8903 of this title may be of the following types:

(1) **Service benefit plan.**—

(A) Hospital benefits.

(B) Surgical benefits.

(C) In-hospital medical benefits.

(D) Ambulatory patient benefits.

(E) Supplemental benefits.

(F) Obstetrical benefits.

(2) **Indemnity benefit plan.**—

(A) Hospital care.

(B) Surgical care and treatment.

(C) Medical care and treatment.

(D) Obstetrical benefits.

(E) Prescribed drugs, medicines, and prosthetic devices.

(F) Other medical supplies and services.

(3) **Employee organization plans.**—Benefits of the types named under paragraph (1) or (2) of this subsection or both.

(4) **Comprehensive medical plans.**—Benefits of the types named under paragraph (1) or (2) of this subsection or both.

All plans contracted for under paragraphs (1) and (2) of this subsection shall include benefits both for costs associated with care in a general hospital and for other health services of a catastrophic nature.

(b)(1)(A) A plan, other than a prepayment plan described in section 8903(4) of this title, may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not covered to receive Medicare hospital and insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), to pay a charge imposed by any health care provider, for inpatient hospital services which are covered for purposes of benefit payments under this chapter and part A of title XVIII of the Social Security Act, to the extent that such charge exceeds applicable limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Hospital providers who have in force participation agreements with the Secretary of Health and Human Services consistent with sections 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), whereby the participating provider accepts Medicare benefits as full payment for covered items and services after applicable patient copayments under section 1813 of such Act (42 U.S.C. 1395e) have been satisfied, shall accept equivalent benefit payments and enrollee copayments under this chapter as full payment for services described in the preceding sentence. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a hospital is found to knowingly and willfully violate this subsection

on a repeated basis and the Secretary may invoke appropriate sanctions in accordance with section 1866(b)(2) of the Social Security Act (42 U.S.C. 1395cc(b)(2)) and applicable regulations.

(B)(i) A plan, other than a prepayment plan described in section 8903(4), may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not entitled to Medicare supplementary medical insurance benefits under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), to pay a charge imposed for physicians' services (as defined in section 1848(j) of such Act, 42 U.S.C. 1395w–4(j)) which are covered for purposes of benefit payments under this chapter and under such part, to the extent that such charge exceeds the fee schedule amount under section 1848(a) of such Act (42 U.S.C. 1395w–4(a)).

(ii) Physicians and suppliers who have in force participation agreements with the Secretary of Health and Human Services consistent with section 1842(h)(1) of such Act (42 U.S.C. 1395u(h)(1)), whereby the participating provider accepts Medicare benefits (including allowable deductible and coinsurance amounts) as full payment for covered items and services shall accept equivalent benefit and enrollee cost-sharing under this chapter as full payment for services described in clause (i). Physicians and suppliers who are nonparticipating physicians and suppliers for purposes of part B of title XVIII of such Act shall not impose charges that exceed the limiting charge under section 1848(g) of such Act (42 U.S.C. 1395w–4(g)) with respect to services described in clause (i) provided to enrollees described in such clause. The Office of Personnel Management shall notify a physician or supplier who is found to have violated this clause and inform them of the requirements of this clause and sanctions for such a violation. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a physician or supplier is found to knowingly and willfully violate this clause on a repeated basis and the Secretary of Health and Human Services may invoke appropriate sanctions in accordance with sections 1128A(a) and 1848(g)(1) of such Act (42 U.S.C. 1320a–7a(a), 1395w–4(g)(1)) and applicable regulations.

(C) If the Secretary of Health and Human Services determines that a violation of this subsection warrants excluding a provider from participation for a specified period under title XVIII of the Social Security Act, the Office shall enforce a corresponding exclusion of such provider for purposes of this chapter.

(2) Notwithstanding any other provision of law, the Secretary of Health and Human Services and the Director of the Office of Personnel Management, and their agents, shall exchange any information necessary to implement this subsection.

(3)(A) Not later than December 1, 1991, and periodically thereafter, the Secretary of Health and Human Services (in consultation with the Director of the Office of Personnel Management) shall supply to carriers of plans described in paragraphs (1) through (3) of section 8903 the Medicare program information necessary for them to comply with paragraph (1).

(B) For purposes of this paragraph, the term "Medicare program information" includes (i) the limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww) and the identity of hospitals which have in force agreements with the Secretary of Health and Human Services consistent with section 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), and (ii) the fee schedule amounts and limiting charges for physicians' services established under section 1848 of such Act (42 U.S.C. 1395w–4) and the identity of participating physicians and suppliers who have in force agreements with such Secretary under section 1842(h) of such Act (42 U.S.C. 1395u(h)).

(4) The Director of the Office of Personnel Management shall enter into an arrangement with the Secretary of Health and Human Services, to be effective before the first day of the fifth month that begins before each contract year, under which—

(A) physicians and suppliers (whether or not participating) under the Medicare program will be notified of the requirements of paragraph (1)(B);

(B) enforcement procedures will be in place to carry out such paragraph (including enforcement of protections against overcharging of beneficiaries); and

(C) Medicare program information described in paragraph (3)(B)(ii) will be supplied to carriers under paragraph (3)(A).

(As amended Pub.L. 101–508, Title VII, § 7002(f)(1), Nov. 5, 1990, 104 Stat. 1388–330; Pub.L. 102–378, § 2(76), Oct. 2, 1992, 106 Stat. 1355; Pub.L. 103–66, Title XI, § 11003(a), Aug. 10, 1993, 107 Stat. 409.)

HISTORICAL AND STATUTORY NOTES

References in Text

The Social Security Act, referred to in subsec. (b), is Act Aug. 14, 1935, c. 531, 49 Stat. 620, as amended. Title XVIII of the Social Security Act is classified to subchapter XVIII (section 1395 et seq.) of chapter 7 of Title 42, The Public Health and Welfare. Parts A and B of Title XVIII of such Act are classified generally to part A (section 1395c et seq.) and part B (section 1395j et seq.) of subchapter XVIII of chapter 7 of Title 42. Sections 1128A, 1842, and 1848 of such Act are classified to sections 1320a-7a, 1395u, and 1395w-4, respectively, of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

1993 Amendments

Subsec. (b)(1). Pub.L. 103–66, § 11003(a)(1), designated existing text as subpar. (A) and added subpars. (B) and (C).

Subsec. (b)(3)(B). Pub.L. 103–66, § 11003(a)(2)(A), designated portion of existing text as cl. (i).

Pub.L. 103–66, § 11003(a)(2)(B), added cl. (ii).

Subsec. (b)(4). Pub.L. 103–66, § 11003(a)(3), added par. (4).

1992 Amendments

Subsec. (a). Pub.L. 102–378, § 2(76), substituted "this subsection" for "this section".

Subsec. (a)(3). Pub.L. 102–378, § 2(76), substituted "this subsection" for "this section".

Subsec. (a)(4). Pub.L. 102–378, § 2(76), substituted "this subsection" for "this section".

1990 Amendment

Pub.L. 101–508 designated existing provisions as subsec. (a) and added subsec. (b).

Effective Date of 1993 Amendments

Section 11003(b) of Pub.L. 103–66 provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to contract years beginning on or after January 1, 1995."

Effective Date of 1992 Amendments

Amendment by Pub.L. 102–378 effective Oct. 2, 1992, see section 9(a) of Pub.L. 102–378, set out as a note under section 6303 of this title.

Impact Of Amendments By Title VII Of The Omnibus Budget Reconciliation Act Of 1990

Amendments deemed exceptions to prohibition of counting as savings the transfer of government actions from one year to another imposed under section 202 of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987, see section 7301 of Pub.L. 101–508, set out as a note under section 2101 of this title.

Mental Health, Alcoholism, and Drug Addiction Benefits; Congressional Findings; Sense of Congress

Pub.L. 99–251, Title I, § 107, Feb. 27, 1986, 100 Stat. 16, provided that:

"**(a) Findings.**—The Congress finds that—

"(1) the treatment of mental illness, alcoholism, and drug addition are basic health care services which are needed by approximately 40,000,000 Americans each year;

"(2) treatment of mental illness, alcoholism, and drug addiction is increasingly successful;

"(3) timely and appropriate treatment of mental illness, alcoholism, and drug addiction is cost effective in terms of restored productivity, reduced utilization of other health services, and reduced social dependence; and

"(4) mental illness is a problem of grave concern to the people of the United States and is widely but unnecessarily feared and misunderstood.

"**(b) Sense of the Congress.**—It is the sense of the Congress—

"(1) that participants in the Federal employees health benefits program should receive adequate benefits coverage for treatment of mental illness, alcoholism, and drug addiction; and

"(2) that the Office of Personnel Management should encourage participating health benefits plans to provide adequate benefits relating to treatment of mental illness, alcoholism, and drug addiction (including benefits relating to coverage for inpatient and outpatient treatment and catastrophic protection benefits)."

Legislative History

For legislative history and purpose of Pub.L. 101–508, see 1990 U.S. Code Cong. and Adm. News, p. 2017. See, also, Pub.L. 103–66, 1993 U.S. Code Cong. and Adm. News, p. 378.

CROSS REFERENCES

Additional health benefit plans, offer of benefits of the type named in this section as prerequisite to contract or approval, see section 8903a(b)(2) of this title.

§ 8905. Election of coverage

(a) An employee may enroll in an approved health benefits plan described by section 8903 of this title either as an individual or for self and family.

Original version

and other health professionals of the process followed in the provision of health services;

"(9) provide medical social services for its members and encourage and actively provide for its members health education services, education in the appropriate use of health services, and education in the contribution each member can make to the maintenance of his own health;

"(10) provide, or make arrangements for, continuing education for its health professional staff; and

"(11) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

"DEFINITIONS

"SEC. 1302. For purposes of this title:

"(1) The term 'basic health services' means—

"(A) physician services (including consultant and referral services by a physician);

"(B) inpatient and outpatient hospital services;

"(C) medically necessary emergency health services;

"(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

"(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

"(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

"(G) home health services; and

"(H) preventive health services (including voluntary family planning services, infertility services, preventive dental care for children, and children's eye examinations conducted to determine the need for vision correction).

If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, or podiatrist, a health maintenance organization may provide such service through a dentist, optometrist, or podiatrist (as the case may be) licensed to provide such service. For purposes of this paragraph, the term 'home health services' means health services provided at a member's home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the health maintenance organization. A health maintenance organization is authorized, in connection with the prescription of drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such service, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.

"(2) The term 'supplemental health services' means—

"(A) services of facilities for intermediate and long-term care;

"(B) vision care not included as a basic health service under paragraph (1)(A) or (1)(H);

"(C) dental services not included as a basic health service under paragraph (1)(A) or (1)(H);

"(D) mental health services not included as a basic health service under paragraph (1)(D);

"(E) long-term physical medicine and rehabilitative services (including physical therapy); and

"(F) the provision of prescription drugs prescribed in the course of the provision by the health maintenance organization of a basic health service or a service described in the preceding subparagraphs of this paragraph.

If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, or podiatrist, a health maintenance organization may provide such service through an optometrist, dentist, or podiatrist (as the case may be) licensed to provide such service. A health maintenance organization is authorized, in connection with the prescription or provision of prescription drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such services, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.

"(3) The term 'member' when used in connection with a health maintenance organization means an individual who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with the organization under which the organization assumes the responsibility for the provision to such individual of basic health services and of such supplemental health services as may be contracted for.

"(4) The term 'medical group' means a partnership, association, or other group—

"(A) which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, optometrists, and podiatrists) as are necessary for the provision of health services for which the group is responsible;

"(B) a majority of the members of which are licensed to practice medicine or osteopathy; and

"(C) the members of which (i) as their principal professional activity and as a group responsibility engage in the coordinated practice of their profession for a health maintenance organization; (ii) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other plan; (iii) share medical and other records and substantial portions of major equipment and of professional, technical, and administrative staff; (iv) utilize such additional professional personnel, allied health professions personnel, and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services of the members of the group; and (v) arrange for and encourage continuing education in the field of clinical medicine and related areas for the members of the group.

"(5) The term 'individual practice association' means a partnership, corporation, association, or other legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optome-

try, or other health profession in a State and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide—

"(A) that such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

"(B) to the extent feasible (i) that such persons shall utilize such additional professional personnel, allied health professions personnel, and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services of the persons who are parties to the arrangement, (ii) for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff, and (iii) for the arrangement and encouragement of the continuing education of such persons in the field of clinical medicine and related areas.

"(6) The term 'section 314(a) State health planning agency' means the agency of a State which administers or supervises the administration of a State's health planning functions under a State plan approved under section 314(a) (hereinafter in this title referred to as a 'section 314(a) plan'); and the term 'section 314(b) areawide health planning agency' means a public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b) (hereinafter in this title referred to as a 'section 314(b) plan'). 80 Stat. 1181; 84 Stat. 1304. 42 USC 246.

"(7) The term 'medically underserved population' means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Such a designation may be made by the Secretary only after consideration of the comments (if any) of (A) each section 314(a) State health planning agency whose section 314(a) plan covers (in whole or in part) such urban or rural area or the area in which such population group resides, and (B) each section 314(b) areawide health planning agency whose section 314(b) plan covers (in whole or in part) such urban or rural area or the area in which such population group resides.

"(8) The term 'community rating system' means a system of fixing rates of payments for health services. Under such a system rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized in the next sentence, such rates must be equivalent for all individuals and for all families of similar composition. The following differentials in rates of payments may be established under such system:

"(A) Nominal differentials in such rates may be established to reflect the different administrative costs of collecting payments from the following categories of members:

"(i) Individual members (including their families).

"(ii) Small groups of members (as determined under regulations of the Secretary).

"(iii) Large groups of members (as determined under regulations of the Secretary).

"(B) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of title 10, United States Code, or under any other governmental program (other than the health benefits program authorized by chapter 89 of title 5, United States Code) or any health 80 Stat. 863. 80 Stat. 600. 5 USC 8901.

benefits program for employees of States, political subdivisions of States, and other public entities.

"(9) The term 'non-metropolitan area' means an area no part of which is within an area designated as a standard metropolitan statistical area by the Office of Management and Budget and which does not contain a city whose population exceeds fifty thousand individuals.

"GRANTS AND CONTRACTS FOR FEASIBILITY SURVEYS

"SEC. 1303. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private entities for projects for surveys or other activities to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations.

"(b) An application for a grant or contract under this section shall contain—

"(1) assurances satisfactory to the Secretary that, in conducting surveys or other activities with assistance under a grant or contract under this section, the applicant will (A) cooperate with the section 314(b) areawide health planning agency (if any) whose section 314(b) plan covers (in whole or in part) the area for which the survey or other activity will be conducted, and (B) notify the medical society serving such area of such surveys or other activities; and

80 Stat. 1181; 84 Stat. 1304. 42 USC 246.

"(2) such other information as the Secretary may by regulation prescribe.

"(c) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application or proposal is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population.

Limitations.

"(d)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants and contracts made under this section:

"(A) If a project has been assisted with a grant or contract under subsection (a), the Secretary may not make any other grant or enter into any other contract under this section for such project.

"(B) Any project for which a grant is made or contract entered into must be completed within twelve months from the date the grant is made or contract entered into.

"(2) The Secretary may make not more than one additional grant or enter into not more than one additional contract for a project for which a grant has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

"(e) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) shall be determined by the Secretary, except that (1) the amount to be paid by the United States under any single grant or contract for any project may not exceed $50,000, and (2) the aggregate of the amounts to be paid by the United States for any project under such subsection under grants or contracts, or both, may not exceed the greater of (A) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (B) in the case of a project for a health maintenance organization which will serve a medically underserved

gations of the health maintenance organization and if the Secretary determines that the other organization meets such other requirements as the Secretary determines are necessary."

Study on Health Maintenance Organization Program

Pub.L. 99–660, Title VIII, § 813, Nov. 14, 1986, 100 Stat. 3801, provided that:

"(a) The Secretary of Health and Human Services shall provide for the conduct of a study to assess the operation and impact of the provisions of title XIII of the Public Health Service Act [this subchapter]. The study shall—

"(1) assess the attitudes of employers and employees toward prepaid health benefits plans, particularly health maintenance organization plans;

"(2) examine the operation of the community rating approach and the impact of such approach on the membership composition and competitiveness of health maintenance organizations qualified under such title;

"(3) analyze the effects of the dual choice option provided in section 1310 of such Act [42 U.S.C.A. § 300e–9] on health maintenance organizations and on other health benefits plans;

"(4) assess the approach used to add services no longer considered to be experimental to basic health services for health maintenance organizations qualified under such title, particularly with respect to the addition of organ transplants to such basic health services and the impact of such addition on the competitiveness of such health maintenance organizations; and

"(5) examine the effect of minimum benefit requirements, underwriting restrictions, restrictions on cost sharing, and the requirement that services be provided without limitation as to time or cost on the competitiveness of health maintenance organizations qualified under such title.

"(b) Within 18 months after the date of enactment of this Act [Nov. 14, 1986], the Secretary shall prepare and transmit to the Congress a report which describes the findings and conclusions of the study conducted under subsection (a) and contains such recommendations for legislative and regulatory action as the Secretary considers appropriate.

"(c) Any contract entered into under this section shall be to such extent or in such amounts as are provided in appropriation Acts."

[Section 815(b) of Pub.L. 99–660 provided in part that provisions of this note shall be effective Nov. 14, 1986, see section 815(b) of Pub.L. 99–660, set out as a note under section 300e–1 of this title.]

CROSS REFERENCES

Annual report requirement, see 42 USCA § 300e–14.
Application contents requirements for loan or loan guarantee under this subchapter, see 42 USCA § 300e–5.
Contract terms, duration, termination, and effective date, health maintenance organizations and competitive medical plans, see 42 USCA § 1395mm.
Determination of deficiency, continued regulation of health maintenance organizations, see 42 USCA § 300e–11.
Disclosing entity as meaning entity which is health maintenance organization as defined in this section, see 42 USCA § 1320a–3.
Entities operating as health maintenance organizations; restrictive State laws and practices, see 42 USCA § 300e–10.
Other entities considered health maintenance organizations for purposes of this subchapter, see 42 USCA § 300e–6.
Qualified health maintenance organization defined for purposes of this section, see 42 USCA § 300e–9.
Shared health facility defined as not including health maintenance organization as defined in this section, see 42 USCA § 1301.

LIBRARY REFERENCES

American Digest System

Medical and hospital insurance in general, see Insurance ⇐467.4.
Power to make health regulations in general, see Health and Environment ⇐20.

Most recent version of Public Health Service Act

Encyclopedias

Health regulations; duty and power of federal government, see C.J.S. Health and Environment § 4.
Risks or causes of loss; health insurance, see C.J.S. Insurance § 893.

Law Reviews

Competitive providers of managed healthcare. Jan L. Weinstock, 118 N.J.Law. 11 (Feb.1987).
Redefining full and fair disclosure of HMO benefits and limitations. S. Fred Figa and Howard M. Tag, 14 Seton Hall Legis.J. 151 (1990).
Should third party payors of health care services disclose cost control mechanisms to potential beneficiaries. Edward B. Hirshfield, 14 Seton Hall Legis.J. 115 (1990).

WESTLAW ELECTRONIC RESEARCH

Health and environment cases: 199k[add key number].
Insurance cases: 217k[add key number].
See, also, WESTLAW guide following the Explanation pages of this volume.

NOTES OF DECISIONS

Negligence 2
Rules and regulations 1

1. Rules and regulations

Regulations promulgated pursuant to this subchapter are intended to insure equal treatment of health maintenance organizations in each of the several states, but should not be interpreted to require strict compliance in states where the method of computing the state's contribution to such an organization already guarantees that equality. Health Care Plan, Inc. v. Bahou, 1983, 459 N.Y.S.2d 497, 92 A.D.2d 142, affirmed as modified 462 N.E.2d 128, 473 N.Y.S.2d 951, 61 N.Y.2d 814.

2. Negligence

Allegations, resting on theory that since health maintenance organization had represented itself to be a "nonprofit" organization and in fact had system whereby individual doctors were encouraged, by incentive payment plan, to be conservative with reference to unnecessary tests and treatments, failed to state cause of action on theo, that plaintiffs had been fraudulently le to believe they would receive "the best quality" of care and treatment. Pulvers v. Kaiser Foundation Health Plan, 1979, 160 Cal.Rptr. 392, 99 C.A.3d 560.

§ 300e–1. Definitions

For purposes of this subchapter:

(1) The term "basic health services" means—

(A) physician services (including consultant and referral services by a physician);

(B) inpatient and outpatient hospital services;

(C) medically necessary emergency health services;

(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(G) home health services; and

(H) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction.

Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not necessary for the protection of individual health. The Secretary shall publish in the Federal Register each determination made by him under the preceding sentence. If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, podiatrist, psychologist, or other health care personnel, a health maintenance organization may provide such service through a dentist, optometrist, podiatrist, psychologist, or other health care personnel (as the case may be) licensed to provide such service. Such term includes a health service directly associated with an organ transplant only if such organ transplant was required to be included in basic health services on April 15, 1985. For purposes of this paragraph, the term "home health services" means health services provided at a member's home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the health maintenance organization.

(2) The term "supplemental health services" means any health service which is not included as a basic health service under paragraph (1) of this section. If a health service provided by a physician may also be provided under applicable State law by a dentist, optometrist, podiatrist, psychologist, or other health care personnel, a health maintenance organization may provide such service through an optometrist, dentist, podiatrist, psychologist, or other health care personnel (as the case may be) licensed to provide such service.

(3) The term "member" when used in connection with a health maintenance organization means an individual who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with the organization under which the organization assumes the responsibility for the provision to such individual of basic health services and of such supplemental health services as may be contracted for.

(4) The term "medical group" means a partnership, association, or other group—

(A) which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, optometrists, podiatrists, and psychologists) as are necessary for the provision of health services for which the group is responsible;

(B) a majority of the members of which are licensed to practice medicine or osteopathy; and

(C) the members of which (i) as their principal professional activity engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility for the delivery of health services to members of a health maintenance organization, except that this clause does not apply before the end of the forty-eight month period beginning after the month in which the health maintenance oranization[1] becomes a qualified health maintenance organization as defined in section 300e–9(d) of this title, or as authorized by the Secretary in accordance with regulations that take into consideration the unusual circumstances of the group; (ii) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other similar plan unrelated to the provision of specific health services; (iii) share medical and other records and substantial portions of major equipment and of professional, technical, and administrative staff; (iv) arrange for and encourage continuing education in the field of clinical medicine and related areas for the members of the group; and (v) establish an arrangement whereby a member's enrollment status is not known to the health professional who provides health services to the member.

(5) The term "individual practice association" means a partnership, corporation, association, or other legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optometry, psychology, or other health profession in a State and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide—

(A) that such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(B) to the extent feasible, for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff.

(6) The term "health systems agency" means an entity which is designated in accordance with section 300*l*–4 of this title.

(7) The term "medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Such a designation may be made by the Secretary only after consideration of the comments (if any) of (A) each State health planning and development agency which covers (in whole or in part) such urban or rural area or the area in which such population group resides, and (B) each health systems agency designated for a health service area which covers (in whole or in part) such urban or rural area or the area in which such population group resides.

(8)(A) The term "community rating system" means the systems, described in subparagraphs (B) and (C), of fixing rates of payments for health services. A health maintenance organization may fix its rates of payments under the system described in subparagraph (B) or (C) or under both such systems, but a health maintenance organization may use only one such system for fixing its rates of payments for any one group.

(B) A system of fixing rates of payment for health services may provide that the rates shall be fixed on a per-person or per-family basis and may authorize the rates to vary with the number of persons in a family, but, except as authorized in subparagraph (D), such rates must be equivalent for all individuals and for all families of similar composition.

(C) A system of fixing rates of payment for health services may provide that the rates shall be fixed for individuals and families by groups. Except as authorized in subparagraph (D), such rates must be equivalent for all individuals in the same group and for all families of similar composition in the same group. If a health maintenance organization is to fix rates of payment for individuals and families by groups, it shall—

(i)(I) classify all of the members of the organization into classes based on factors which the health maintenance organization determines predict the differences in the use of health services by the individuals or families in each class and which have not been disapproved by the Secretary,

(II) determine its revenue requirements for providing services to the members of each class established under subclause (I), and

(III) fix the rates of payments for the individuals and families of a group on the basis of a composite of the organization's revenue requirements determined under subclause (II) for providing services to them as members of the classes established under subclause (I), or

(ii) fix the rates of payments for the individuals and families of a group on the basis of the organization's revenue requirements for providing services to the group, except that the rates of payments for the individuals and families of a group of less than 100 persons may not be fixed at rates greater than 110 percent of the rate that would be fixed for such individuals and families under subparagraph (B) or clause (i) of this subparagraph.

The Secretary shall review the factors used by each health maintenance organization to establish classes under clause (i). If the Secretary determines that any such factor may not reasonably be used to predict the use of the health services by individuals and families, the Secretary shall disapprove such factor for such purpose. If a health maintenance organization is to fix rates of payment for a group under clause (ii), it shall, upon request of the entity with which it contracts to provide services to such group, disclose to that entity the method and data used in calculating the rates of payment.

(D) The following differentials in rates of payments may be established under the systems described in subparagraphs (B) and (C):

(i) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of members:

(I) Individual members (including their families).

(II) Small groups of members (as determined under regulations of the Secretary).

(III) Large groups of members (as determined under regulations of the Secretary).

(ii) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.

(iii) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of Title 10 or under any other governmental program (other than the health benefits program authorized by chapter 89 of Title 5) or any health benefits program for employees of States, political subdivisions of States, and other public entities.

(9) The term "non-metropolitan area" means an area no part of which is within an area designated as a standard metropolitan statistical area by the Office of Management and Budget and which does not contain a city whose population exceeds fifty thousand individuals.

(July 1, 1944, c. 373, Title XIII, § 1302, as added Dec. 29, 1973, Pub.L. 93–222, § 2, 87 Stat. 917, and amended Oct. 8, 1976, Pub.L. 94–460, Title I, §§ 102(b), 104, 105(b), (c), 106, 117(b)(1), (2), 90 Stat. 1946–1948, 1955; Nov. 1, 1978, Pub.L. 95–559, § 11(e), 92 Stat. 2139; Aug. 13, 1981, Pub.L. 97–35, Title IX, § 942(f)–(j), 95 Stat. 574, 575; Jan. 4, 1983, Pub.L. 97–414, § 9(c), 96 Stat. 2064; Nov. 14, 1986, Pub.L. 99–660, Title VIII, §§ 812(a), 814, 100 Stat. 3801, 3802; Oct. 24, 1988, Pub.L. 100–517, § 6(b), 102 Stat. 2579.)

[1] So in original. Probably should be "organization".

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1973 Act. Senate Report No. 93–129 and Senate Conference Report No. 93–621, see 1973 U.S.Code Cong. and Adm.News, p. 3033.

1976 Act. House Report No. 94–518 and House Conference Report No. 94–1513, see 1976 U.S.Code Cong. and Adm.News, p. 4312.

1978 Act. Senate Report No. 95–837 and House Conference Report No. 95–1784, see 1978 U.S.Code Cong. and Adm.News, p. 4935.

1981 Act. Senate Report No. 97–139 and House Conference Report No. 97–208, see 1981 U.S.Code Cong. and Adm.News, p. 396.

1983 Act. House Report No. 97–840, see 1982 U.S.Code Cong. and Adm.News, p. 3577.

1986 Act. Senate Report No. 99–380, Related Reports, and Statement by President, see 1986 U.S.Code Cong. and Adm. News, p. 6287.

1988 Act. Senate Report No. 100–304, see 1988 U.S.Code Cong. and Adm.News, p. 3231.

Codifications

Section 942(i) of Pub.L. 97–35, set out in the credit of this section, was amended by section 9(c) of Pub.L. 97–414 to correct an error in the directory language of Pub.L. 97–35. No change in the text of this section was involved.

Amendments

1988 Amendment. Par. (8)(C), Third Sent. Pub.L. 100–517, § 6(b)(1), designated existing provisions as cl. (i); redesignated former cl. (i) as subcl. (I) of cl. (i) and former cls. (ii) and (iii) as subcls. (II) and (III) of cl. (i); substituted in redesignated subcl. (II), "subclause (I)" for "clause (i)" and subcl. (III), "subclause (II)" and "subclause (I)" for "clause (ii)" and "clause (i)", respectively; and added cl. (ii).

Sixth Sent. Pub.L. 100–517, § 6(b)(2), added the sixth sentence requiring a HMO, when requested, to disclose to a group entity the method and data used in calculating the rates of payment for a group under cl. (ii).

1986 Amendment. Par. (1). Pub.L. 99–660, § 812(a), inserted provision including in basic health services a health service directly associated with an organ transplant only if such organ transplant was required to be included in basic health services on Apr. 15, 1985.

Pub.L. 99–660, § 814(a), inserted "psychologist," after "podiatrist," in two places.

Par. (2). Pub.L. 99–660, § 814(a), inserted "psychologist," after "podiatrist," in two places.

Par. (4)(A). Pub.L. 99–660, § 814(b), substituted "podiatrists, and psychologists" for "and podiatrists".

Par. (5). Pub.L. 99–660, § 814(c), inserted "psychology," after "optometry,".

1981 Amendment. Par. (1). Pub.L. 97–35, § 942(f), struck out provisions authorizing health maintenance organizations to maintain, etc., drug use profiles of members.

Par. (2). Pub.L. 97–35, § 942(g), substituted provisions defining term to include services not included under par. (1), for provisions defining term with respect to enumerated specific services, and substituted "health service provided by a physician" for "service of a physician described in the preceding sentence."

Par. (4)(C)(i). Pub.L. 97–35, § 942(h), added provisions relating to applicability to qualified organizations.

Par. (5)(B). Pub.L. 97–35, § 942(i), struck out "(i)" following "feasible", and cl. (ii), which related to continuing education.

Par. (8). Pub.L. 97–35, § 942(j), reorganized and restructured provisions and, among many changes, provided for determinations based upon subpars. (B) and (C), and set out determinations respecting differentials contained in former subpars. (B) and (C) as subpar. (D).

1978 Amendment. Par. (1). Pub.L. 95–559 added provisions that such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not necessary for the protection of individual health and that the Secretary publish in the Federal Register each determination made by him under the preceding sentence.

1976 Amendment. Par. (1). Pub.L. 94–460, § 104(a), substituted reference to immunization, well-child care from birth, periodic health evaluations for adults, and children's ear examinations conducted to determine need for hearing correction for reference to preventive dental care for children in (H) and, in the provisions following subpar. (H), added reference to "other health care personnel".

Par. (2). Pub.L. 94–460, § 104(b), substituted "basic health service" for "basic health service under paragraph (1)(A) or (1)(H)" in subpars. (B) and (C), added subpar. (G), and inserted reference to "other health care personnel" in the provisions following subpar. (G).

Par. (4)(C). Pub.L. 94–460, §§ 102(b)(1), 106, substituted "as their principal professional activity engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility for the delivery of health services to members of a health maintenance organization" for "as their principal professional activity and as a group responsibility engage in the coordinated practice of their profession for a health maintenance organization" in cl. (i), substituted "similar plan unrelated to the provision of specific health services" for "plan" in cl. (ii), struck out former cl. (iv) which covered the utilization of additional professional personnel, allied health professions personnel, and other health personnel as are available and appropriate for the effective and efficient delivery of the services of the members of the group, redesignated former cl. (v) as (iv), and added cl. (v).

Par. (5)(B). Pub.L. 94–460, § 102(b)(2), struck out former cl. (i) which covered the utilization of additional professional personnel, allied health professions personnel, and other personnel as are available and appropriate for the effective and efficient delivery of the services of the persons who are parties to the arrangement, and redesignated former cls. (ii) and (iii) as (i) and (ii), respectively.

Par. (6). Pub.L. 94–460, § 117(b)(1), substituted provisions defining "health systems agency" for provisions defining "section 314 (a) State health planning agency" and "section 314(b) areawide health planning agency".

Par. (7). Pub.L. 94–460, § 117(b)(2), substituted "State health planning and development agency which" for "section 314(a) State health planning agency whose section 314(a) plan" and "health systems agency designated for a health service area which" for "section 314(b) areawide health planning agency whose section 314(b) plan".

Par. (8). Pub.L. 94–460, § 105(b), (c), substituted "to reflect differences in marketing costs and the different administrative costs" for "to reflect the different administrative costs" in subpar. (A) preceding cl. (i), added subpar. (B), and redesignated former subpar. (B) as (C).

Effective and Termination Dates

1986 Act. Section 812(b)(1) of Pub.L. 99–660, which provided that amendment by subsection (a), amending this section, was to take effect on Oct. 1, 1985, and was to cease to be in effect on Apr. 1,

1988, was repealed by Pub.L. 100–517, § 6(a), Oct. 24, 1988, 102 Stat. 2579.

Section 815 of Pub.L. 99–660 provided that:

"**(a)** Except as provided in subsection (b) and section 812(b) [enacting provisions set out as notes under this section], this title and the amendments made by this title [amending sections 300e–1, 300e–4, 300e–5, 300e–6, 300e–7, 300e–8, 300e–9, 300e–10, 300e–16, and 300e–17 of this title, repealing sections 300e–2, 300e–3, and 300e–4a of this title, and enacting provisions set out as notes under sections 201, 300e, 300e–1, 300e–4a, and 300e–5 of this title] shall take effect on October 1, 1985.

"**(b)** Section 813 [enacting a provision set out as a note under section 300e of this title] shall take effect on the date of the enactment of this Title [Nov. 14, 1986]."

1976 Act. Amendment by Pub.L. 94–460 effective Oct. 8, 1976, except that amendment of pars. (1) and (2) of this section by section 104 of Pub.L. 94–460 and the amendment of pars. (4)(C) and (5)(B) of this section by sections 102 and 106 of Pub.L. 94–460 shall apply with respect to grants, contracts, loans, and loan guarantees made under sections 300e–2, 300e–3, and 300e–4 of this title for fiscal years beginning after Sept. 30, 1976, shall apply with respect to health benefit plans offered under section 300e–9 of this title after Sept. 30, 1976, and shall take effect for purposes of section 300e–11 of this title on Oct. 1, 1976, see § 118 of Pub.L. 94–460, set out as a note under section 300e of this title.

Basic Health Service Status of Certain Organ Transplant Services After April 1, 1988

Section 812(b)(2) of Pub.L. 99–660, which had provided that after Apr. 1, 1988, for purposes of this subchapter, no health service directly associated with an organ transplant shall be considered to be a basic health service if such service would otherwise have been added as a basic health service between Apr. 15, 1985, and Apr. 1, 1988, was repealed by Pub.L. 100–517, section 6(a), Oct. 24, 1988, 102 Stat. 2579.

Construction

Section 816 of Pub.L. 99–660 provided that: "The provisions of this title and of the amendments made by this title [See Effective Date of 1986 Amendment note set out under this section.] do not authorize the appropriation of any funds for fiscal year 1986."

Reports Respecting Medically Underserved Areas and Population Groups and Non-Metropolitan Areas

Section 5 of Pub.L. 93–222 provided that the Secretary of Health, Education, and Welfare report to Congress the criteria used in the designation of medically underserved areas and population groups for purposes of par. (7) of this section by Dec. 29, 1973, and report to Congress the areas and population groups designated under par. (7) of this section, the comments of State and area-wide health planning agencies, and areas which meet the definitional standards of par. (9) of this section for non-metropolitan areas by Dec. 29, 1974, and that the Office of Management and Budget may review such reports before their submission to Congress.

Requirement of Study With Respect to Minority Health and Acquired Immune Deficiency Syndrome.

Pub.L. 100–607, Title II, § 251, Nov. 4, 1988, 102 Stat. 3108, as amended by Pub.L. 100–690, Title II, § 2602(b), Nov. 18, 1988, 102 Stat. 4234, provided that:

"**(a) In general.**—The Secretary of Health and Human Services, acting through the Director of the Office of Minority Health, shall conduct a study for the purpose of determining—

"**(1)** the level of knowledge within minority communities concerning acquired immune deficiency syndrome, the risks of the transmission of the etiologic agent for such syndrome, and the means of reducing such risk; and

"**(2)** the effectiveness of Federal, State, and local prevention programs with respect to acquired immune deficiency syndrome in minority communities.

"**(b) Report.**—The Secretary shall, not later than 12 months after the date of the enactment of this Title [Nov. 4, 1988], complete the study required in subsection (a) and submit to the Congress a report describing the findings made as a result of the study."

CROSS REFERENCES

Adjusted community rate defined for purposes of this section, see 42 USCA § 1395mm.

Rural health clinic as including facility that is designated by the Secretary, under this section, as area with shortage of personal health services, see 42 USCA § 1395x.

LIBRARY REFERENCES

American Digest System

Medical and hospital insurance in general, see Insurance ⇐467.4.

Power to make health regulations in general, see Health and Environment ⇐20.

Encyclopedias

Health regulations; duty and power of federal government, see C.J.S. Health and Environment § 4.

Risks or causes of loss; health insurance, see C.J.S. Insurance § 893.

Law Reviews

Should third party payors of health care services disclose cost control mechanisms to potential beneficiaries. Edward B. Hirshfield, 14 Seton Hall Legis.J. 115 (1990).

WESTLAW ELECTRONIC RESEARCH

Health and environment cases: 199k[add key number].

Insurance cases: 217k[add key number].

See, also, WESTLAW guide following the Explanation pages of this volume.

§§ 300e–2, 300e–3. Repealed. Pub.L. 99–660, Title VIII, § 803(a), Nov. 14, 1986, 100 Stat. 3799

HISTORICAL AND STATUTORY NOTES

Section 300e–2, Act July 1, 1944, c. 373, Title XIII, § 1303, as added Dec. 29, 1973, Pub.L. 93–222, § 2, 87 Stat. 920, and amended Oct. 8, 1976, Pub.L. 94–460, Title I, §§ 107(a), 109(d)(1), 117(b)(3), 90 Stat. 1948, 1950, 1955; Aug. 13, 1981, Pub.L. 97–35, Title IX, § 947(a), 95 Stat. 577, related to grants and contracts for feasibility surveys.

Section 300e–3, Act July 1, 1944, c. 373, Title XIII, § 1304, as added Dec. 29, 1973, Pub.L. 93–222, § 2, 87 Stat. 921, and amended Apr. 21, 1976, Pub.L. 94–273, § 40, 90 Stat. 381; Oct. 8, 1976, Pub.L. 94–460, Title I, §§ 107(b), 108(a), (b), (d)(1), 109(d)(2), (3), (e), 113(a), 117(b)(4), 90 Stat. 1948–1950, 1953, 1955; Nov. 1, 1978, Pub.L. 95–559, §§ 2(a), 3(a), (b), (c)(1), (2)(A), (C), 6, 92 Stat. 2131, 2134; Nov. 1, 1978, Pub.L. 95–559, § 3(c)(2)(B), 92 Stat. 2131; July 10, 1979, Pub.L. 96–32, § 2(a), 93 Stat. 82; Aug. 13, 1981, Pub.L. 97–35, Title IX, §§ 941(c), 947(b), 95 Stat. 573, 577, related to grants, contracts, and loan guarantees for planning and initial development costs.

Effective Date of Repeal

Repeal not applicable to any grant made or contract entered into under this subchapter before Oct. 1, 1985, see section 803(c) of Pub.L. 99–660, set out as a note under section 300e–5 of this title.

Repeal effective Oct. 1, 1985, see section 815(a) of Pub.L. 99–660, set out as a note under section 300e–1 of this title.

SUBCHAPTER XI—HEALTH MAINTENANCE ORGANIZATIONS

CROSS REFERENCES

Guarantee of principal and interest on mortgages as function of National Mortgage Association, see 12 USCA § 1721.
Qualified health maintenance organization defined for purposes of state plans for medical assistance, see 42 USCA § 1396a.

§ 300e. Requirements of health maintenance organizations

(a) "Health maintenance organization" defined

For purposes of this subchapter, the term "health maintenance organization" means a public or private entity which is organized under the laws of any State and which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b) of this section, and (2) is organized and operated in the manner prescribed by subsection (c) of this section.

(b) Manner of supplying basic and supplemental health services to members

A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this subchapter, basic and supplemental health services to its members in the following manner:

(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary. If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A) of this section, the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member

when obtaining a basic health service from such a physician. A health maintenance organization may include a health service, defined as a supplemental health service by section 300e–1(2) of this title, in the basic health services provided its members for a basic health services payment described in the first sentence. In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 300e–9(d) of this title) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health organization. The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.

(2) For such payment or payments (hereinafter in this subchapter referred to as "supplemental health services payments") as the health maintenance organization may require in addition to the basic health services payment, the organization may provide to each of its members any of the health services which are included in supplemental health services (as defined in section 300e–1(2) of this title). Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education,

except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 300e–9(d) of this title) provided comprehensive health services on a prepaid basis, the requirement of this sentence shall not apply to such entity during the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization.

(3)(A) Except as provided in subparagraph (B), at least 90 percent of the services of a physician which are provided as basic health services shall be provided through—

(i) members of the staff of the health maintenance organization,

(ii) a medical group (or groups),

(iii) an individual practice association (or associations),

(iv) physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or

(v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

(B) Subparagraph (A) does not apply to the provision of the services of a physician—

(i) which the health maintenance organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or

(ii) which are provided a member of the organization in a manner other than that prescribed by subparagraph (A) because of an emergency which made it medically necessary that the service be provided to the member before it could be provided in a manner prescribed by subparagraph (A).

(C) Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require, but only to the extent that such requirements are designed to insure the delivery of quality health care services and sound fiscal management.

(D) For purposes of this paragraph the term "health professional" means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

(4) Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a nonmetropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(5) To the extent that a natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel, or resources.

(c) Organizational requirements

Each health maintenance organization shall—

(1)(A) have—

(i) a fiscally sound operation, and

(ii) adequate provision against the risk of insolvency, which is satisfactory to the Secretary, and **(B)** have administrative and managerial arrangements satisfactory to the Secretary;

(2) assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may (A) obtain insurance or make other arrangements for the cost of providing to any member basic health services the aggregate value of which exceeds $5,000 in any year, (B) obtain insurance or make other arrangements for

the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, (C) obtain insurance or make other arrangements for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year, and (D) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions;

(3)(A) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary), and (B) carry out enrollment of members who are entitled to medical assistance under a State plan approved under Title XIX of the Social Security Act [42 U.S. C.A. § 1396 et seq.] in accordance with procedures approved under regulations promulgated by the Secretary;

(4) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

(5) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

(6) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services;

(7) adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization—

(A) a contractual arrangement with any hospital that is regularly used by the members of such organization pro-

hibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;

(B) insolvency insurance, acceptable to the Secretary;

(C) adequate financial reserve, acceptable to the Secretary; and

(D) other arrangements, acceptable to the Secretary, to protect members,

except that the requirements of this paragraph shall not apply to a health maintenance organization if applicable State law provides the members of such organization with protection from liability for payment of any fees which are the legal obligation of such organization; and

(8) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

The Secretary shall issue regulations stating the circumstances under which the Secretary, in administering paragraph (1)(A), will consider the resources of an organization which owns or controls a health maintenance organization. Such regulations shall require as a condition to consideration of resources that an organization which owns or controls a health maintenance organization shall provide satisfactory assurances that it will assume the financial obligations of the health maintenance organization.

(July 1, 1944, c. 373, Title XIII, § 1301, as added Dec. 29, 1973, Pub.L. 93-222, § 2, 87 Stat. 914, and amended Oct. 8, 1976, Pub.L. 94-460, Title I, §§ 101, 102(a), 103, 105(a), 90 Stat. 1945-1947; Nov. 1, 1978, Pub.L. 95-559, §§ 9(b), 10, 11(a)-(d), 92 Stat. 2137-2139; July 10, 1979, Pub.L. 96-32, § 2(b), 93 Stat. 82; Aug. 13, 1981, Pub.L. 97-35, Title IX, § 942(a)(1), (2), (b)-(e), 95 Stat. 573, 574; Oct. 24, 1988, Pub.L. 100-517, §§ 2-3, 4(a), 5(a)(1), (2), (b), 102 Stat. 2578, 2579.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1973 Act. Senate Report No. 93–129 and Senate Conference Report No. 93–621, see 1973 U.S.Code Cong. and Adm.News, p. 3033.

1976 Act. House Report No. 94–518 and House Conference Report No. 94–1513, see 1976 U.S.Code Cong. and Adm.News, p. 4312.

1978 Act. Senate Report No. 95–837 and House Conference Report No. 95–1784, see 1978 U.S.Code Cong. and Adm.News, p. 4935.

1979 Act. House Report No. 96–187, see 1979 U.S.Code Cong. and Adm.News, p. 348.

1981 Act. Senate Report No. 97–139 and House Conference Report No. 97–208, see 1981 U.S.Code Cong. and Adm.News, p. 396.

1988 Act. Senate Report No. 100–304, see 1988 U.S.Code Cong. and Adm.News, p. 3231.

References in Text

The Social Security Act, referred to in subsec. (c)(3)(B), is Act Aug. 14, 1935, c. 531, 49 Stat. 620, as amended. Title XIX of the Social Security Act is classified generally to subchapter XIX (section 1396 et seq.) of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Amendments

1988 Amendment. Subsec. (a). Pub.L. 100–517, § 2, substituted "public or private entity which is organized under the laws of any State and" for "legal entity".

Subsec. (b)(1). Pub.L. 100–517, § 3, inserted a second sentence providing for payment of a reasonable deductible by a member when obtaining a basic health service from a physician not described in subsec. (b)(3)(A) of this section.

Subsec. (b)(3)(A). Pub.L. 100–517, § 4(a), substituted "at least 90 percent of the services of a physician" for "the services of a physician".

Subsec. (c)(1)(A). Pub.L. 100–517, § 5(a)(1), designated existing provision as subpar. (A) and cls. (i) and (ii).

Subsec. (c)(5) to (9). Pub.L. 100–517, § 5(b), repealed par. (5), which required the policymaking body of a private HMO to be made up of at least one-third of the members of the organization and to include an equitable representation of members from medically underserved populations served by the organization; and which required the advisory board of a policymaking body of a public HMO to meet identical requirements and provided for delegation of policymaking authority to such advisory board; and redesignated as pars. (5) to (8) former pars. (6) to (9).

Subsec. (c) following (9). Pub.L. 100–517, § 5(a)(2), added provisions respecting issuance of regulations.

1981 Amendment. Subsec. (b). Pub.L. 97–35, § 942(a)(1), (2), (b), (c), in par. (3)(A)(iv) struck out reference to subpar. (C), in par. (3)(B) substituted "(B)" for "(B)(i)", "(i)" for "(I)", "(ii)" for "(II)", and struck out cl. (ii), which related to the forty-eight-month period after qualification as an organization, struck out par. (3)(C), which related to the expiration of the first four fiscal years as a qualified organization, redesignated par. (3)(D) as (3)(C) and, as so redesignated, substituted requirements respecting delivery and fiscal management, for requirements respecting appropriate continuing education, redesignated par. (3)(E) as (3)(D), and in par. (4) added provisions relating to service areas located in nonmetropolitan area, and substituted "with reasonable promptness" for "promptly as appropriate".

Subsec. (c). Pub.L. 97–35, § 942(d)(1), (e), in par. (2) substituted provisions specifying requirements with respect to insurance, etc., for provisions generalizing such insurance, etc., requirements, and added cl. (D), struck out par. (4), which related to open enrollment period, redesignated pars. (5) to (8) as (4) to (7), respectively, added par. (8), struck out pars. (9) and (10), which related to medical, social and health education services, and continuing education, respectively, and redesignated par. (11) as (9).

Subsec. (d). Pub.L. 97–35, § 942(d)(2), struck out subsec. (d), which related to requirements, etc., respecting open enrollment period.

1979 Amendment. Subsec. (b)(3). Pub.L. 96–32 amended directory language of § 11(a) of Pub.L. 95–559 by substituting reference to section "1301" for "1310" of the Public Health Service Act, as the section to be amended, and required no change in text because the amendment made by Pub.L. 95–559 had been executed to this section as the probable intent of Congress.

1978 Amendment. Subsec. (b)(1). Pub.L. 95–559, §§ 10(a), 11(b), inserted "except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education," following "the requirement of clause (C)" and added provisions permitting the health maintenance organization to seek reimbursement for the cost of services provided to a member who is entitled to benefits under a workmen's compensation law or insurance policy.

Subsec. (b)(2). Pub.L. 95–559, § 10(a), inserted "unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education," following "community rating system".

Subsec. (b)(3). Pub.L. 95–559, § 11(a), as amended by Pub.L. 96–32, added provisions limiting the health maintenance organization from entering into contracts for health services with physicians other than members of the staff of the health maintenance organization, medical groups, or individual practice associations.

Subsec. (b)(4). Pub.L. 95–559, § 11(c), substituted "basic and supplemental" for "basic or supplemental" and "if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition" for "if it was medically necessary that the services be provided before it could secure them through the organization".

Subsec. (b)(5). Pub.L. 95–559, § 11(d), added subsec. (b)(5).

Subsec. (c)(1). Pub.L. 95–559, § 10(b), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (c)(3). Pub.L. 95–559, § 9(b), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (c)(6). Pub.L. 95–559, § 10(c), designated existing provisions as subpar. (A) and, in subpar. (A) as so designated, inserted "in the case of a private health maintenance organization," preceding "be organized in such" and substituted "(i)" for "(A)" and "(ii)" for "(B)", and added subpar. (B).

1976 Amendment. Subsec. (b)(1). Pub.L. 94–460, §§ 101(a), 105(a)(1), provided that a health maintenance organization may include a health service, defined as a supplemental health service by § 300e–1(2) of this title, in the basic health services provided its members for a basic health service payment described in the first sentence, and also provided that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of § 300e–9(d) of this title) provided comprehensive health services on a prepaid basis, the requirement of clause (C) would not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health organization.

Subsec. (b)(2). Pub.L. 94–460, §§ 101(b), 105(a)(2), substituted "the organization may provide to each of its members any of the health services which are included in supplemental health services (as defined in section 300e–1(2) of this title)" for "the organization shall provide to each of its members each health service (A) which is included in supplemental health services (as defined in section 300e–1(2) of this title), (B) for which the required health manpower are available in the area served by the organization and (C) for the provision of which the member has contracted with the organization" and added "except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 300e–9(d) of this title) provided comprehensive health services on a prepaid basis, the requirement of this sentence shall not apply to such entity during the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization" following "Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system".

Subsec. (b)(3). Pub.L. 94–460, § 102(a), added references to health professionals who have contracted with the

health maintenance organization for the provision of such services and to the combination of staff, medical groups, individual practice associations, or health professionals under contract with the health maintenance organization, and added provisions allowing a health maintenance organization, during the thirty-six month period beginning with the month following the month in which the organization becomes a qualified health maintenance organization (within the meaning of § 300e-9(d) of this title), to provide basic and supplemental health services through an entity which but for the requirement of § 300e-1(4)(C)(i) of this title would be a medical group for purposes of this subchapter, directing that after the expiration of such period, the organization may provide basic or supplemental health services through such an entity only if authorized by the Secretary in accordance with regulations which take into consideration the unusual circumstances of such entity, directing that a health maintenance organization may not, in any of its fiscal years, enter into contracts with health professionals or entities other than medical groups or individual practice associations if the amounts paid under such contracts for basic and supplemental health services exceed fifteen percent of the total amount to be paid in such fiscal year by the health maintenance organization to physicians for the provision of basic and supplemental health services, or, if the health maintenance organization principally serves a rural area, thirty percent of such amount, except that the sentence would not apply to the entering into of contracts for the purchase of basic and supplemental health services through an entity which but for the requirements of § 300e-1(4)(C)(i) of this title would be a medical group for purposes of this subchapter, and directing that contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services include such provisions as the Secretary may require (including provisions requiring appropriate continuing education.).

Subsec. (b)(4). Pub.L. 94–460, § 101(c), substituted "and only such supplemental health services as members have contracted for" for "and supplemental health services in the case of the members who have contracted therefor."

Subsec. (c)(4). Pub.L. 94–460, § 103(a), substituted provisions making a simple reference to an open enrollment period in accordance with the provisions of subsec. (d) of this section for provisions spelling out in detail the requirements for a health maintenance organization with regard to an open enrollment period.

Subsec. (d). Pub.L. 94–460, § 103(b), added subsec. (d).

Effective Dates

1976 Act. Section 118 of Pub.L. 94–460, as amended by Pub.L. 96–88, Title V, section 509(b), 93 Stat. 695, Oct. 17, 1979, provided that:

"**(a)** Except as provided in subsection (b), the amendments made by this title [enacting section 300e-15 of this title and amending this section and sections 300e-1 to 300e-11, 300e-13, and 300n-1 of this title, and section 8902 of Title 5, Government Organization and Employees] shall take effect on the date of the enactment of this Act [Oct. 8, 1976].

"**(b)(1)** The amendments made by sections 101 [amending subsec. (b)(1), (2), and (4) of this section], 102 [amending subsec. (b)(3) of this section and section 300e-1(4)(C), (5)(B) of this title], 103 [amending subsec. (c)(4) and enacting subsec. (d) of this section], 104 [amending section 300e-1(1), (2) of this title], and 106 [amending section 300e-1(4)(C) of this title] shall (A) apply with respect to grants, contracts, loans, and loan guarantees made under sections 1303, 1304, and 1305 of the Public Health Service Act [sections 300e-2, 300e-3, and 300e-4 of this title] for fiscal years beginning after September 30, 1976, (B) apply with respect to health benefit plans offered under section 1310 of such Act [section 300e-9 of this title] after such date, and (C) for purposes of section 1312 [section 300e-11 of this title] take effect October 1, 1976.

"**(2)** Subsection (d) of section 1301 of the Public Health Service Act [subsec. (d) of this section] (added by section 103(b) of this Act) shall take effect with respect to fiscal years of health maintenance organizations beginning on or after the date of the enactment of this Act [Oct. 8, 1976].

"**(3)** The amendments made by section 107 [amending sections 300e-2(e), 300e-3(b)(1)(A), (2)(A), and 300e-4(a)(1), (2) of this title] shall apply with respect to grants, contracts, loans, and loan guarantees made under sections 1303, 1304, and 1305 of the Public Health Service Act [sections 300e-2, 300e-3, and 300e-4 of this title] for fiscal years beginning after September 30, 1976.

"**(4)** The amendments made by sections 109(a)(1) [amending section 300e-4(a)(1), (2) of this title] and 109(c) [amending section 300e-7(a)(1)(A), (b)(2)(D) of this title] shall apply with respect to loan guarantees made under section 1305 of the Public Health Service Act [section 300e-4 of this title] after September 30, 1976.

"**(5)** The amendment made by section 109(e) [amending section 300e-3(b)(2)(D) of this title] shall apply with respect to projects assisted under section 1304 of the Public Health Service Act [section 300e-3 of this title] after September 30, 1976.

"**(6)** The amendments made by paragraphs (1) and (2) of section 110(a) [amending section 300e-9(a), (b)(1), (2) of this title] shall apply with respect to calendar quarters which begin after the date of the enactment of this Act [Oct. 8, 1976].

"**(7)** The amendments made by paragraphs (3) and (4) of section 110 [amending subsec. (c) and enacting subsecs. (e) to (h) of section 300e-9 of this title] shall apply with respect to failures of employers to comply with section 1310(a) of the Public Health Service Act [section 300e-9 of this title] after the date of the enactment of this Act [Oct. 8, 1976].

"**(8)** The amendment made by section 111 [amending subsecs. (a) and (b) and enacting subsec. (c) of section 300e-11 of this title] shall apply with respect to determinations of the Secretary of Health and Human Services described in section 1312(a) of the Public Health Service Act [section 300e-11(a) of this title] and made after the date of the enactment of this Act [Oct. 8, 1976]."

Short Title

1988 Amendment. For Short Title of Pub.L. 100–517, as the "Health Maintenance Organization Amendments of 1988", see section 1(a) of Pub.L. 100–517, set out as a note under section 201 of this title.

1978 Amendment. For Short Title of Pub.L. 95–559 as the "Health Maintenance Organization Amendments of 1978", see section 1 of Pub.L. 95–559, set out as a Short Title of 1978 Amendment note under section 201 of this title.

1976 Amendment. For Short Title of Pub.L. 94–460 which substantially amended this subchapter, as the "Health Maintenance Organization Amendments of 1976", see section 1(a) of Pub.L. 94–460, set out as a Short Title of 1976 Amendment note under section 201 of this title.

1973 Act. For Short Title of Pub.L. 93–222, which enacted this subchapter, see section 1 of Pub.L. 93–222, set out as a Short Title of 1973 Amendments note under section 201 of this title.

Health Care Quality Assurance Programs Study

Section 4 of Pub.L. 93–222, provided that the Secretary of Health, Education, and Welfare contract for the conduct of a study of health care quality assurance programs and submit a final report to specific committees of Congress by Jan. 31, 1976.

Qualification of Health Maintenance Organization Contingent Upon Controlling Organization's Assumption of Financial Obligations and Meeting Other Requirements

Section 5(a)(3) of Pub.L. 100–517 provided that:

"During the period prior to the effective date of regulations issued under section 1301(c) of the Public Health Service Act [subsec. (c) of this section] (as amended by paragraph (2)), the Secretary of Health and Human Services shall consider the application for qualification under section 1301(c)(1)(A) of such Act [subsec. (c)(1)(A) of this section] of a health maintenance organization—

"**(A)** which is owned or controlled by another organization, and

"**(B)** which requests that the resources of the other organization be considered in determining its qualification under such section,

if the Secretary receives satisfactory assurances from the other organization that it will assume the financial obli-

gations of the health maintenance organization and if the Secretary determines that the other organization meets such other requirements as the Secretary determines are necessary."

Study on Health Maintenance Organization Program

Pub.L. 99-660, Title VIII, § 813, Nov. 14, 1986, 100 Stat. 3801, provided that:

"(a) The Secretary of Health and Human Services shall provide for the conduct of a study to assess the operation and impact of the provisions of title XIII of the Public Health Service Act [this subchapter]. The study shall—

"(1) assess the attitudes of employers and employees toward prepaid health benefits plans, particularly health maintenance organization plans;

"(2) examine the operation of the community rating approach and the impact of such approach on the membership composition and competitiveness of health maintenance organizations qualified under such title;

"(3) analyze the effects of the dual choice option provided in section 1310 of such Act [42 U.S.C.A. § 300e-9] on health maintenance organizations and on other health benefits plans;

"(4) assess the approach used to add services no longer considered to be experimental to basic health services for health maintenance organizations qualified under such title, particularly with respect to the addition of organ transplants to such basic health services and the impact of such addition on the competitiveness of such health maintenance organizations; and

"(5) examine the effect of minimum benefit requirements, underwriting restrictions, restrictions on cost sharing, and the requirement that services be provided without limitation as to time or cost on the competitiveness of health maintenance organizations qualified under such title.

"(b) Within 18 months after the date of enactment of this Act [Nov. 14, 1986], the Secretary shall prepare and transmit to the Congress a report which describes the findings and conclusions of the study conducted under subsection (a) and contains such recommendations for legislative and regulatory action as the Secretary considers appropriate.

"(c) Any contract entered into under this section shall be to such extent or in such amounts as are provided in appropriation Acts."

[Section 815(b) of Pub.L. 99-660 provided in part that provisions of this note shall be effective Nov. 14, 1986, see section 815(b) of Pub.L. 99-660, set out as a note under section 300e-1 of this title.]

CROSS REFERENCES

Annual report requirement, see 42 USCA § 300e-14.
Application contents requirements for loan or loan guarantee under this subchapter, see 42 USCA § 300e-5.
Contract terms, duration, termination, and effective date, health maintenance organizations and competitive medical plans, see 42 USCA § 1395mm.
Determination of deficiency, continued regulation of health maintenance organizations, see 42 USCA § 300e-11.
Disclosing entity as meaning entity which is health maintenance organization as defined in this section, see 42 USCA § 1320a-3.
Entities operating as health maintenance organizations; restrictive State laws and practices, see 42 USCA § 300e-10.
Other entities considered health maintenance organizations for purposes of this subchapter, see 42 USCA § 300e-6.
Qualified health maintenance organization defined for purposes of this section, see 42 USCA § 300e-9.
Shared health facility defined as not including health maintenance organization as defined in this section, see 42 USCA § 1301.

LIBRARY REFERENCES

American Digest System

Medical and hospital insurance in general, see Insurance ⇐467.4.
Power to make health regulations in general, see Health and Environment ⇐20.

Encyclopedias

Health regulations; duty and power of federal government, see C.J.S. Health and Environment § 4.
Risks or causes of loss; health insurance, see C.J.S. Insurance § 893.

Law Reviews

Competitive providers of managed healthcare. Jan L. Weinstock, 18 N.J.Law. 11 (Feb.1987).
Redefining full and fair disclosure of HMO benefits and limitations. S. Fred Figa and Howard M. Tag, 14 Seton Hall Legis.J. 151 (1990).
Should third party payors of health care services disclose cost control mechanisms to potential beneficiaries. Edward B. Hirshfield, 14 Seton Hall Legis.J. 115 (1990).

WESTLAW ELECTRONIC RESEARCH

Health and environment cases: 199k[add key number].
Insurance cases: 217k[add key number].
See, also, WESTLAW guide following the Explanation pages of this volume.

NOTES OF DECISIONS

Negligence 2
Rules and regulations 1

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1. Rules and regulations

Regulations promulgated pursuant to this subchapter are intended to insure equal treatment of health maintenance organizations in each of the several states, but should not be interpreted to require strict compliance in states where the method of computing the state's contribution to such an organization already guarantees that equality. Health Care Plan, Inc. v. Bahou, 1983, 459 N.Y.S.2d 497, 92 A.D.2d 142, affirmed as modified 462 N.E.2d 128, 473 N.Y.S.2d 951, 61 N.Y.2d 814.

2. Negligence

Allegations, resting on theory that since health maintenance organization had represented itself to be a "nonprofit" organization and in fact had system whereby individual doctors were encouraged, by incentive payment plan, to be conservative with reference to unnecessary tests and treatments, failed to state cause of action on theory that plaintiffs had been fraudulently led to believe they would receive "the best quality" of care and treatment. Pulvers v. Kaiser Foundation Health Plan, 1979, 160 Cal.Rptr. 392, 99 C.A.3d 560.

§ 300e-1. Definitions

For purposes of this subchapter:

(1) The term "basic health services" means—

(A) physician services (including consultant and referral services by a physician);

(B) inpatient and outpatient hospital services;

(C) medically necessary emergency health services;

(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

State-Mandated Benefits to Insurers by Enactment Year

Covered Provider	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA	HI	ID	IL
Acupuncturist		90			85*								
Chiropractor	75	83	87	71	76	75	89	83	86	80			82
Dentist	75	83	89	81	78	75	75		74	74	74		89
Licensed Professional				75									82
Nurse (RN)			83			90							
Nurse Midwife		81	85		81	87	84	88	83				
Nurse Anesthetist	85		85			87			89				
Nurse Practitioner		88	85		91	87	84	90					
Nurse, Psychiatric					82	87	84						
Occupational Therapist		87			78		82						
Optometrist	65*	76	77	71	81	75	75	65	89	81	67	67	80
Oral Surgeon													82
Osteopath		83		71		75			87				82
Physical Therapist		87			81		75		92				
Podiatrist	75		77	75	78	75		65	74	75		67	89
Professional Counselor				91	81		92						
Psychologist	82		87	75	91	79	75			80	84		82
Public Facilities	71		87	81	82		84		89			90	
Social Worker					76	91	75						90
Speech Therapist				85	78								
Covered Benefit	**AL**	**AK**	**AZ**	**AR**	**CA**	**CO**	**CT**	**DE**	**FL**	**GA**	**HI**	**ID**	**IL**
Alcoholism Treatment	75*	88		87	88	76*	74*		79		88		82
Ambulance Transport							83						90
Ambulatory Surgery			74	81					77		74		
Anti-Abortion												83	
Breast Reconstruction			81		78*				87				80
Cleft Palate					91	87						85	
Diabetic Education					81								
Drug Abuse Treatment		88		87*	88		90		79		88		
Home Health Care			82		76*	84*	78						
Hospice Care						84*							
Fertility/ In Vitro				87	89*		89*				88		91*
Long Term Care													
Mammography		91*	88	89*	81	89	88	93	88	92	90	92	91
Maternity			77	76	76*	89	76			78	74	76	76
Mental Health Care				83	86	76	87		84*	84	88		77*
Orthotics/Prosthetics					85		87		87				
Pap Smears					91			88		92			
Prescription Drugs													
Rehabilitation Services							82*						
2nd Surgical Opinion													
TMJ Disorders				84						83*			
Well-Child Care				89*	86		89		86		88		
Extended Coverage	**AL**	**AK**	**AZ**	**AR**	**CA**	**CO**	**CT**	**DE**	**FL**	**GA**	**HI**	**ID**	**IL**
Adopted Children			85	87	88		91		88	88	91		81
Continuation/Dependents			91	85	76	90	82		91	81			85
Continuation/Employee				85	84	90	76		75	92	74	75	84
Conversion to Nongroup			88	85	83	75	75		82	86			91
Dependent Students							82		92	78			
Handicapped Dependents			75	69	71		71		70	72	68	72	67
Newborns	75	75	74	83	71	75	74	74	84	74	74	74	75
Non-Custodial Children				91	91				89				
Miscellaneous		2	3	2	6		2	1		2			2
Total in Force	**9**	**15**	**20**	**28**	**41**	**23**	**32**	**9**	**25**	**19**	**15**	**10**	**24**

* Indicates mandated offer. Sources: Blue Cross and Blue Shield Association, Health Insurance Association of America, Life & Health Compliance Association, Thompson Group Rating Manual, state insurance departments. Regulatory citations for all but the most recent mandates are available.

State Mandated Benefits for Insurers by Enactment Year

Covered Provider	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT
Acupuncturist						92							91
Chiropractor	90	86	73	83	75	89	73	87	79	88	80	78	83
Dentist	74	88	73	73	89	75	73	75		76	74	78	83
Licensed Professional			73				83						
Nurse (RN)		89								83			
Nurse Midwife					84		78	85		83			87
Nurse Anesthetist							84			83			87
Nurse Practitioner			90				79			88	80		87
Nurse, Psychiatric						83	83	86					
Occupational Therapist					91		83						
Optometrist	74	93	73	73	72	92	73	75	65	73	66	78	83
Oral Surgeon													
Osteopath	74			73			73			73			83
Physical Therapist					91		83						
Podiatrist	74		73		72		73	75	68	76		78	83
Professional Counselor							85				74		87
Psychologist	85		74		75	75	73	75	68	89	74	83	81
Public Facilities	85					79	82		68	73	68		73
Social Worker			89		71	83	77	86			92		85
Speech Therapist					91							84	
Covered Benefit	**IN**	**IA**	**KS**	**KY**	**LA**	**ME**	**MD**	**MA**	**MI**	**MN**	**MS**	**MO**	**MT**
Alcoholism Treatment			91	74*	80*	87	88	73	82	82	74	91	87
Ambulance Transport					80								
Ambulatory Surgery				73	77					76		81	
Anti-Abortion				79						81		83	
Breast Reconstruction						91			85	80			
Cleft Palate	85				89		82			88			
Diabetic Education		84											
Drug Abuse Treatment			91		80	83	88*		82*	82		91*	87
Home Health Care				82*		77*	82	86		76			81*
Hospice Care							82		84*				
Fertility/ In Vitro							89	87					
Long Term Care				92*									
Mammography	91*	89	88	90	91	91	91	87	89*	88		90	91
Maternity		76	77			75	75	85		73		93	
Mental Health Care			91	83*	85*	83	93	76		87	91	91	81
Orthotics/Prosthetics							78		85				
Pap Smears			88		91			87		88			
Prescription Drugs													
Rehabilitation Services					91*	87*		86					
2nd Surgical Opinion							85			79			
TMJ Disorders				80			89			87	91		
Well-Child Care		93			92		92	88		88		89*	91
Extended Coverage	**IN**	**IA**	**KS**	**KY**	**LA**	**ME**	**MD**	**MA**	**MI**	**MN**	**MS**	**MO**	**MT**
Adopted Children	89		90		91		91	75		83		91	91
Continuation Dependents		86	84	80	83	91	77	76	89	77		69	
Continuation Employee		86	84	80	92	86	79	76	89	73		85	81
Conversion to Nongroup		86	83	74	92	82	79		89	77		81	81
Dependent Students					78					91			
Handicapped Dependents	86			88	72		77	65	66	69	72	67	71
Newborns	76	74	74	76	73	76	77	74	75	73	74	74	73
Non-Custodial Children						89				88		88	
Miscellaneous		1			1	1	2	4	1	3		1	1
Total In Force	12	13	19	17	28	22	37	28	17	36	13	22	25

Reprints of these tables are available from the publisher by calling Health Benefits Letter, Capitol Publications Inc. at (703)683-4100.

State Mandated Benefits for Insurers by Enactment Year

Covered Provider	NE	NY	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI
Acupuncturist		75			91						89		
Chiropractor	67	72	09	80	84	75	73	79	80	89		71	87
Dentist	75	75	75	79	77	75	75		73	88	71	71	
Licensed Professional		75			89					83			90
Nurse (RN)		85		84	87	84	73	85				86	
Nurse Midwife				92	85	82			84	71		82	
Nurse Anesthetist					87							86	
Nurse Practitioner			35		87		93				79	86	91
Nurse, Psychiatric					87		93	89				86	91
Occupational Therapist													
Optometrist	69	75	69	67	77	75	73		80	71	71	78	
Oral Surgeon								89					
Osteopath	67	75	69		77				80	89		71	91
Physical Therapist				75		73						78	
Podiatrist	69	75	69		77	75	73		80	89		71	91
Professional Counselor			83										
Psychologist	76	80	75	73	77	71	77	87	74	71	75	88	
Public Facilities	84		77			77	75		76		81	89	
Social Worker		87	83		89	85	93	89		82	89		
Speech Therapist													
Covered Benefit	**NE**	**NY**	**NH**	**NJ**	**NM**	**NY**	**NC**	**ND**	**OH**	**OK**	**OR**	**PA**	**RI**
Alcoholism Treatment	80	83		77	83	83*	84	89	78		87	86	80
Ambulance Transport		89			79					84	87		
Ambulatory Surgery		75				77*				76			
Anti-Abortion	91							79				82	83
Breast Reconstruction		83		83		75							
Cleft Palate							82						
Diabetic Education											87		
Drug Abuse Treatment		83				87	84*	89			87	89	87
Home Health Care		75		77	77*	75							84
Hospice Care		89				85*							
Fertility/ In Vitro													91
Long Term Care						77					87		
Mammography		89	83	91	90	89	91	89	92	89	93	89	89
Maternity		77	77	88*		76	77	89	79	78	73	77	78
Mental Health Care			81			77*		89	83		87		91
Orthotics/Prosthetics											81		
Pap Smears		89			93		91		92		93		89
Prescription Drugs								78					
Rehabilitation Services													
2nd Surgical Opinion				80		76							83
TMJ Disorders		89			89			89*					
Well-Child Care						93			93			92	88
Extended Coverage	**NE**	**NY**	**NH**	**NJ**	**NM**	**NY**	**NC**	**ND**	**OH**	**OK**	**OR**	**PA**	**RI**
Adopted Children		89			88		91	87	89	86	91		82
Continuation/Dependents	89	80	86	80	83	85	83	87		88	87		83
Continuation/Employee	89	89	86		83	85		81	84	86	85		91
Conversion to Nongroup	78	80		80	83	81	82	83	84	81	81	76	78
Dependent Students	78							81					
Handicapped Dependents	75	76	69	66	69	89	73	83	71	82		68	78
Newborns	75	76	75	75	75	89	73	79	74	75	75	76	79
Non-Custodial Children											89		91
Miscellaneous			2	2		1			3	1	2	1	1
Total In Force	**15**	**37**	**19**	**19**	**26**	**28**	**21**	**21**	**22**	**20**	**25**	**23**	**25**

* Indicates mandated offer. Sources: Blue Cross and Blue Shield Association, Health Insurance Association of America, Life & Health Compliance Association, Managed Group Rating Manual, state insurance departments. Regulatory citations for all but the most recent mandates are available.

State Mandated Benefits by Insurers by Enactment Year

Covered Provider	[illegible]	SD	[illegible]N	[illegible]	UT	VT	VA	WA	WV	WI	WY	Total
Acupuncturist												7
Chiropractor	80	70	[illegible]5	71	75		88	83	73	87		45
Dentist		70	[illegible]4	81	75		88	74	73	92	71	43
Licensed Professional		80			85						71	11
Nurse (RN)								81	83			13
Nurse Midwife		80			79			81	91			22
Nurse Anesthetist		89						81	91			12
Nurse Practitioner		80							91	91		20
Nurse, Psychiatric							89					12
Occupational Therapist								89				6
Optometrist	85	70	[illegible]5	71	75		77	65	73	75		46
Oral Surgeon	80											3
Osteopath		70		58					91			21
Physical Therapist							87	83				11
Podiatrist	79	70	[illegible]1	77	75		79	83	73			37
Professional Counselor			[illegible]4	83			87					10
Psychologist		89	[illegible]4	77	75		77	71			85	39
Public Relations				83				87		80	75	25
Social Worker		88	[illegible]5	87	75		87					24
Speech Therapist			[illegible]5	83			89	89				8
Covered Benefit	**[illegible]C**	**SD**	**[illegible]N**	**TX**	**UT**	**VT**	**VA**	**WA**	**WV**	**WI**	**WY**	
Alcoholism Treatment		79*	[illegible]2*	91	86	85	80*	87	82	88		40
Ambulance Transport												7
Ambulatory Surgery					76							12
Anti-Abortion												8
Breast Reconstruction								85				11
Cleft Palate										76		9
Diabetic Education										91		4
Drug Abuse Treatment			[illegible]2*	91	86*		93	87		88		27
Home Health Care				87		76*		83	81*	78		20
Hospice Care								83				6
Fertility In Vitro				87								9
Long Term Care												3
Mammography		91	39	87		91	90*	89	89	90		44
Maternity			[illegible]4	77	81	89	78	77		82*		34
Mental Health Care			[illegible]0*	91		76*	93	83*	90*	88		31
Orthotics/Prosthetics												6
Pap Smears									88			14
Prescription Drugs				91						90		3
Rehabilitation Services									90			5
2nd Surgical Opinion												5
TMJ Disorders			[illegible]8	89		82		89*	89			14
Well-Child Care							90*					17
Extended Coverage	**SC**	**SD**	**TX**	**TX**	**UT**	**VT**	**VA**	**WA**	**WV**	**WI**	**WY**	
Adopted Children		83		91	85		91	86		90	89	31
Continuation/Dependents	78	80	86	89	86	84	88	80	83	80	81	40
Continuation/Employee	89	88	80	85	86	84	88	73	82	90		40
Conversion to Polygroup	78	79	80	77	79		88	84	83	80	83	40
Dependent Students										89		8
Handicapped Dependents	70	69	69	[illegible]1	75	76	74	69	75	75	71	42
Newborns	74	76	74	[illegible]3	77	75	76	84	75	76	89	50
Non-Custodial Children				[illegible]1						88	89	11
Miscellaneous			2	2				2		3		57
Total In Force	9	19	21	[illegible]8	18	10	22	29	21	25	10	1063

Reprints of these tables are available from the publisher by calling Health Benefits Letter, Capitol Publications Inc. at (703)683-4100.

Miscellaneous Benefit Mandates by State and Enactment Year

AK	naturopath; 1983		maternity benefits for natural mother on adoptive parents policy; 1986		respiratory care practitioner; 1990
	dental, vision, hearing coverage for public employees; enacted 1983, subsidy in 1986	AZ	Azydothymidine (AZT), if prescription drugs are covered; 1988		lead screening; 1992
AR	phenylketonuria; 1987		sickle cell anemia (in children); 1980	CA	Azydothymidine (AZT), if prescription drugs are covered; 1987
	loss or impairment of speech or hearing; 1985	DE	prostate-specific antigen tests; 1992		Alzheimer's Disease; 1988
CT	home health aides; 1984	GA	heart transplants; 1988		sterilization; 1979
	leukemia, tumors; 1979		prostate-specific antigen tests; 1992		special footwear; 1991
IL	contraceptive coverage (expense due to pregnancy); 1980	IA	skilled nursing care; 1984	MO	loss or impairment of speech or hearing; 1991
	organ transplants; 1984	LA	transliterator for deaf/mute patients when receiving medical care; 1991	NH	hair pieces (for alopecia areata); 1993
MA	cochlear rehabilitation; 1986	MH	hair pieces (for alopecia areata); 1987		bone marrow transplants in treatment of breast cancer; 1992
	gastrointestinal or ulcerative colitis; 1977		phenylketonuria; 1985	NJ	Wilm's Tumor; 1980
	phenylketonuria; 1984		nursing care for patients dependent on ventilators; 1988		hemophilia home treatment; 1987
	bone marrow transplants in treatment of breast cancer; 1993	MI	antineoplastic therapy; 1989	NY	cancer treatments; 1983
ME	cochlear rehabilitation; 1988	MT	phenylketonuria; 1990	OH	kidney disease treatment; 1972
OR	craniofacial prosthetic services; 1985	MO	blood products; 1978		mechanotherapist; 1988
	Tourette Syndrome; 1985		Alzheimers Disease; 1987		homemaker's disability (expense due to incapacity); 1976
TN	loss or impairment of speech or hearing; 1983	PA	cancer chemotherapy; 1989	RI	lead screening; 1991
	sterilization; 1978	OK	Christian Science treatment; 1988	WI	kidney disease treatment; 1976
TX	loss of impairment of speech or hearing; 1987	WA	phenylketonuria; 1988		skilled nursing care; 1979
	dependent grandchildren; 1989		prenatal testing for genetic disorders; 1990		dependent grandchildren; 1986

Sources: Health Insurance Association of America, Life and Health Compliance Association, state insurance departments.

EXPECTED NICKLES AMENDMENT ON INSURANCE COVERAGE

Senator Nickles is expected to offer an amendment that would permit individuals to retain their current insurance policies, even if these policies to do not compiy with the standards established under the Mitchell bill. He will claim that this amendment will prevent the government from forcing people to give up a policy that they like and want to keep.

What Nickles' amendment would actually do is allow insurance companies to continue to offer policies with pre-existing condition exclusions, lifetime limits, and fine print that denies health benefits when people need them most.

NICKLES AMENDMENT IS THE "FINE PRINT PROTECTION ACT"

1) Everyone should be able to keep their current coverage

We agree strongly that no one should force you to give up a policy that you like. And, we want to ensure that the policy you hold is not a lemon -- it should be there when you need it.

Our goal is to be sure that other Americans have the type of protections against lemon policies that members of Congress and all Federal employees have.

We set safety and quality standards for all kinds of products. Baby food can't have glass in it, children's pajamas can't be flammable, cars must have seat belts. Insurance policies can't have loopholes and fine print that deny you health care when you need it most.

[Cite examples of insurance company denials of coverage]

2) Protect consumers, not fraudulent insurance companies

Republicans and Democrats alike agree that the insurance industry has to change the way it does business. Every health reform bill that's been introduced includes tough consumer protections from insurance abuses -- this amendment is a step in the wrong direction.

Under the Nickles amendment, dishonest insurance companies are the winners and the American people are the losers:

Take for example, a family who hits their policy's lifetime limit one year after they have a child with a serious heart condition. You're out of luck. The family loses its coverage.

3) The Mitchell bill moves us in the right direction

The Mitchell benefit package is not a one size fits all package. In fact, under this bill, everyone will be guaranteed the same kind of choices that Members of Congress have -- like an HMO, a traditional fee-for-service plan that lets you go to the doctor of your choice, or a combination of the two.

QUESTIONS

WHY IS THE GOVERNMENT FORCING PEOPLE TO BUY COVERAGE THEY DON'T NEED AND CAN'T AFFORD?

We are not forcing people to buy coverage they do not need.
We are requiring insurance companies to sell policies that cover what they say they cover. No excuses, no loopholes, no fine print.

Health insurance is for the accidents and illnesses you hope and pray never happen, but if they do, you want your insurance to cover you. No excuses, no loopholes, no fine print.

WHY SHOULD WE HAVE A ONE-SIZE-FITS-ALL PLAN IMPOSED BY THE GOVERNMENT?

We shouldn't and we don't. Under the Mitchell bill, everyone will be guaranteed the same kind of choices that Members of Congress have -- like an HMO, a traditional fee-for-service plan that lets you go to the doctor of your choice, or a combination of the two.

Under the Mitchell bill, individuals would always be able to buy supplemental policies to tailor their coverage to meet their needs.

All Americans that don't want to pay for a standard plan can choose alternative, lower cost plans that cover their health care needs after a high deductible.

But no matter what choice you make, you ought to be secure that the coverage you paid for will be there when you need it.

Before the
UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON SMALL BUSINESS

Statement of
Gary Sprague

Mr. Chairman and members of the Committee, my name is Gary Sprague and I am President of T.G. Trucking, Co. I have three trucks I run in a five state area. We are located in upstate New York. I am also a Director of Owner-Operator Independent Drivers Association, Inc. ("OOIDA") which represents over 29,000 members nationwide. I am proud that my Association has joined the Small Business Coalition for Health Care Reform.

To me this national debate we are having about health care reform is not about politics--it is about survival. My employees and myself do not currently have health care coverage. The reason we do not is simple, the present benefit packages available to my employees and myself are too expensive and, they do not work. Health care coverage that is available to me today would cost twenty-five percent of my payroll. With worker's compensation at eighteen percent of present payroll, and personal liability insurance at five percent of gross income. It is plain to see that affordable health care for small businesses adds a cost that my business cannot bear.

What people have difficulty understanding is that if my health care costs were at seven percent of my payroll, as predicted under the Clinton Plan, I would be able to create a new job tomorrow. Health care reform is a dollars and sense issue. Of the 29,000 members of OOIDA that I represent, over forty-five percent do not have health care of any kind. Most cannot afford it while others cannot get it. As independent business men and women, owner-operators need to be able to get health care coverage that they can afford and that actually pays the bill.

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. statement	Personal (Partial) (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Jennifer Klein
OA/Box Number: 6877

FOLDER TITLE:
Standard Benefits Amendment

2014-0209-S
ms758

RESTRICTION CODES

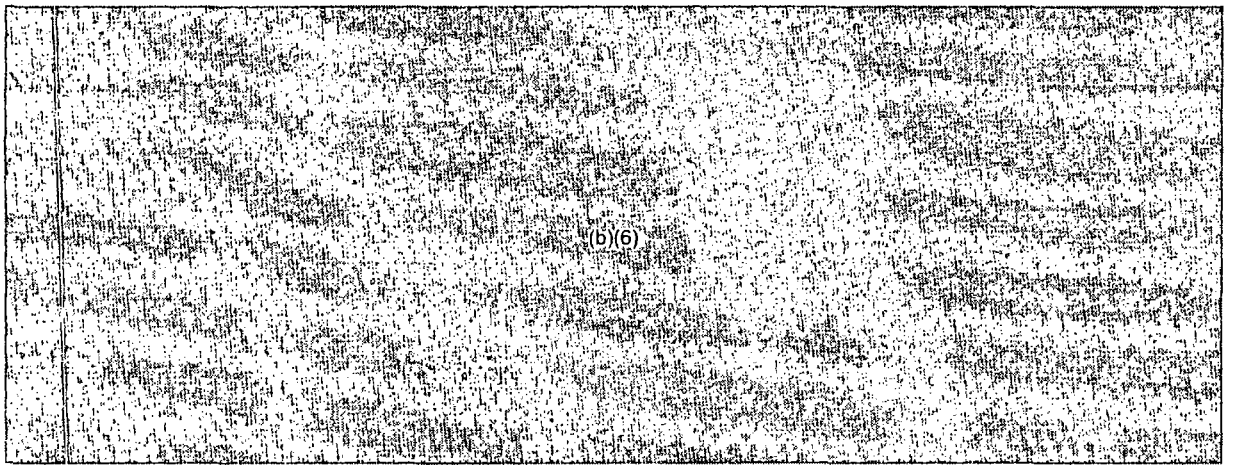
Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]



I do not think that a insurance company should be able to take away a man's livelihood. Today any insurance carrier can say one day or three years into an illness, sorry its pre-existing - - Goodbye!

The situation that I encountered is not unique--it happens all the time. No American should have to risk losing all they have worked for (as I did) when they or a family member go to see a doctor or develops an illness.

This is why I've followed the health care reform debate so closely. I find out now that Congress may be learning toward some of these halfway reforms which I know failed in New York.

My small business needs a health care program that includes universal coverage. I cannot offer health care coverage to my employees if other motor carriers in my area do not. The trucking business today is very competitive and, if my rates include health care costs while the rates of other carriers do not, I am at a disadvantage and will not survive. We need to have everyone covered and we need it now, not in the year 2000.

The trucking industry has a huge turn over of employees. I believe that a major reason is that the industry has few employers that offer health care coverage. In my own business, because I do not offer health care, I cannot keep good drivers. They go with larger companies,

or to other industries, with benefit packages. This turn over is costly. Others that would like to work for me have pre-existing conditions and are afraid to leave other companies to work for me.

Many of the members of OOIDA operate as sole proprietors and independent contractors. I would like to briefly address both issues.

With regard to sole proprietors, I am pleased to see that the Congress finally appears ready to correct a blatant injustice and permit 100 percent deduction of health care costs. This has long been the case for costs for employees, and it is simply not fair to treat self-employed persons differently.

With regard to the employees vs. independent contractor debate, this is a long standing issue. I recognize that there is a concern that mandating health care coverage through employers may cause some to attempt to reclassify employee, the Congress should not act until the evidence is in. for that reason, our Association believes that the best course of action is to wait, and to require the Department of the Treasury to study the issue and to report back to the Congress in two years as to the extent of the problem (if it develops), and how to fix it.

While you hear a lot of small businesses tell you that they can't afford health care coverage, I do not think it makes any difference whether you drive a truck or sell pizzas or computers, health care is necessary to be competitive in the business world today. In whatever health care bill finally becomes law, we must have universal coverage, it must be affordable, and it must be portable.

103rd CONGRESS
2nd Session

AMDT ------

Statement of Purpose: To

IN THE SENATE OF THE UNITED STATES

MR. NICKLES, for himself, and Mr. ----------

submitted the following amendment:

==========

viz: On page 145 line 3, insert after the word "subtitle" the following:

"(except for: (1) the requirements that any employer-offered plan provide a standard benefits package established under subtitle C; (2) the prohibition against an employer offering an alternative standard benefits package established under subtitle C; and (3) the prohibition against an employer self-insuring cost-sharing benefits)."

NICKLES AMENDMENT

3. SELF-INSURANCE FOR COST-SHARING SUPPLEMENTAL COVERAGE

Background

The Mitchell Bill prohibits community-rated employers from offering supplemental coverage for cost-sharing to their employees through self-insurance. The reason is to prevent the premiums of community-rated health plans from increasing because of the higher utilization that would occur because the cost-sharing under the plan is being reduced or eliminated.

Employers can offer supplemental coverage for cost-sharing by purchasing it from the insurer offering the standard benefits. This allows that insurer to build in the costs of the extra utilization into the price of the supplemental coverage.

The effect of the Nickles amendment would be to significantly increase community-rated premiums (and therefore the cost of subsidies).

- If community-rated employers can self-insure cost-sharing benefits, their employees will use more health care services, which will increase the premiums offered by community-rated insurers.
  - ▸ The effect of the Nickles amendment would be to increase the costs of community-rated coverage for everyone.
  - ▸ Employers that self-insure cost-sharing benefits would be able to reap the benefits of providing "first-dollar" coverage while bearing only a fraction of the costs.
- The Nickles amendment would reduce the cost-containment effects of the cost-sharing in community-rated health plans.
- The Nickles amendment, by increasing premiums, would increase the federal government's costs of providing subsidies.

liability and provide the tax credit as additional income in the employees' paycheck, so they could purchase insurance.

Family Security Benefit Requirements

- Society should not have to pay the price for irresponsible individuals who refuse to purchase insurance and then expect us to pick up the tab when they become seriously ill or injured. Every individual and family would be required to have minimum health insurance coverage to cover medically necessary "acute medical care," including:

  - Physician services
  - Inpatient, outpatient, and emergency hospital services and appropriate alternatives to hospitalization
  - Inpatient and outpatient prescription drugs
  - A maximum deductible amount of $1,000 for an individual and $2,000 for a family and an out-of-pocket limit of $5,000. These amounts would be indexed to inflation in future years.

- For Medical Savings Accounts, or MSAs, the Consumer Choice plan would provide the same basic 25% tax credit for deposits. Each household would be permitted to have one MSA and to make an annual deposit no greater than the sum of $3,000 plus $500 for each dependent. The funds in an MSA could be used to pay medical bills not covered by their insurance plans, and to pay health insurance premiums.

- Transitional Rules: In order to provide individuals and families with secure, portable benefits, insurers and employers who currently provide health insurance coverage would be required to offer policyholders the option of converting their existing coverage to an individual or family plan. Employers would also be required to add the value of the coverage they now offer to their workers' wages. Thus, workers could take their coverage with them when they changed jobs or could use the money to buy a different plan that better suited their needs.

Employer Provisions

- Individuals and families could still purchase health insurance through their employers. This would not be their only option, since they would be able to receive the same tax relief if they purchased coverage on their own or through other groups such as unions, churches, farm bureaus, business coalitions, professional associations, or through some other group — similar to the choices that more than 10 million Federal employees, retirees and their families have today.

people with preexisting conditions, or engaging in any other discriminatory sales practices.

- Health insurance underwriting would be limited, allowing insurers to vary premiums only on the basis of age, sex and geography. However, because of the importance of prevention and healthy lifestyles, the legislation would allow insurers to give incentive discounts to promote healthy behavior, prevent or delay the onset of illness, or provide for screening or early detection of illness.

- Certain state laws pertaining to mandated benefits and services, anti-managed care laws, and mandated cost-sharing would be preempted.

Tax Credits

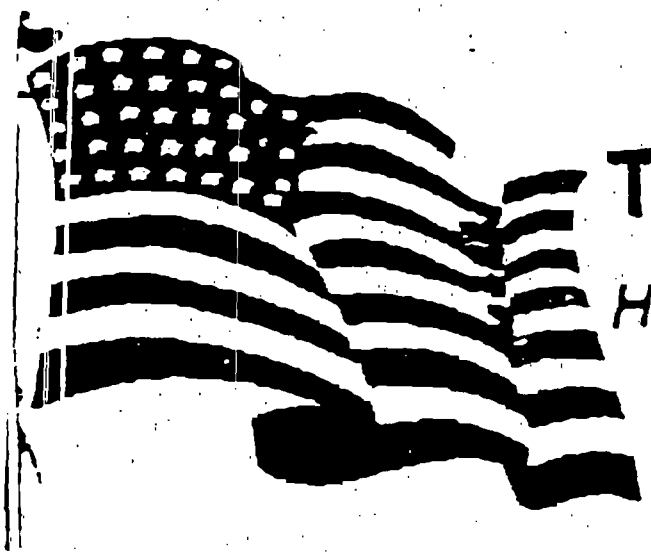
- Individual tax credits would replace the current tax exclusion for company-sponsored health plans.

- Tax credits, which would become available on January 1, 1997, would be structured to give all Americans a basic level of tax relief on all of their health expenses, with greater tax relief targeted to those individuals and families who, because of illness or below average incomes, face proportionately higher health expense relative to their income. The credits would be structured as follows:

Health Insurance Premiums and Unreimbursed Medical Expenses as a Percent of Gross Income	**Percent Reimbursed**
Below 10 percent	**25 percent**
10 to 20 percent	**50 percent**
20 percent or more	**75 percent**

- At a minimum, for every $100 which is spent on health insurance premiums, or contributed to a Medical Savings Account (MSA), or spent on ANY out-of-pocket medical expenses, the individual or family would pay $25 less in taxes. The greater the ratio of health costs to income, the greater the tax benefits. Low-wage persons with higher percentage health costs would receive greater benefits. The tax credit would be as much as $75 per $100 spent on health care, and would be refundable as explained below.

- The credits are refundable, meaning that if the value of the credit is more than an individual's or family's tax liability, the government would pay the difference. Much like the treatment of the Earned Income Tax Credit (EITC), employers would reduce their tax



The White House

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PAGES:
(Including
This Page) 2

of family income, the percentage credit also would rise. The structure of this sliding scale credit is much like the child care credit in today's tax code.

Version #3 is a combination of the first two. A voucher and flat rate credit would apply to insurance costs only, and a sliding scale credit to out-of-pocket costs. This version would encourage families to buy a basic plan, but give them a bigger incentive to accept higher deductibles and copayments.[7]

✓ The minimum benefits package required by law

Table 2 indicates the minimum benefits package that would be required by law under the Heritage proposal, as chosen by Heritage analysts and priced by Lewin/ICF. For a family of four this plan is estimated to cost $277.33 per month or $3,327.84 per year, so it is by no means a "bare bones" plan. It should be noted that the plan has been priced on a per capita basis. In practice family plans cost less than the total would be if each member bought a separate plan. So the cost for a family in the model is probably an overestimate in some cases. Equivalent coverage options would be permitted. For instance, instead of 75 percent coverage for physician services, a plan may have a higher percentage, but a

Table 2
Basic Plan Required by Law

Minimum standard coverage required for all Americans.

- $1,000 deductible ($2,000 per family).
- $5,000 cost-sharing maximum.

Benefit	Coinsurance
Inpatient Hospital Services (365-day per stay maximum)	80%
Outpatient Hospital Services	80%
Hospital Alternatives (extended or home health care)	Yes
Physician Services	75%
Prenatal/Well-Baby/ Well-Child Care	75%
Diagnostic Tests	75%
Prescription Drugs (inpatient)	75%
Emergency Services	100%
Mental Health Care	Not Covered
Dental Care	Not Covered
Vision Care	Not Covered

Average monthly cost of the plan is $69.33 per person.

Actuarial equivalent alternatives are permitted.

Note: Individuals covered by a government health program such as Medicare and Medicaid are exempt from these coverage requirements.

Actuarially equivalent plans are ones with different coverage or benefit levels than those specified here, but whose total cost is the same for individuals with the same actuarial characteristics such as age, sex, and geographic location.

7 A copayment, or coinsurance, is the percentage of an otherwise insured medical bill that must be paid by the patient.

EXPECTED NICKLES AMENDMENT ON INSURANCE COVERAGE

Senator Nickles is expected to offer an amendment that would permit individuals to retain their current insurance policies, even if these policies to do not comply with the standards established under the Mitchell bill. He will claim that this amendment will prevent the government from forcing people to give up a policy that they like and want to keep.

What Nickles' amendment would actually do is allow insurance companies to continue to offer policies with pre-existing condition exclusions, lifetime limits, and fine print that denies health benefits when people need them most.

NICKLES AMENDMENT IS THE "FINE PRINT PROTECTION ACT"

1) Everyone should be able to keep their current coverage

We agree strongly that no one should force you to give up a policy that you like. And, we want to ensure that the policy you hold is not a lemon -- it should be there when you need it.

Our goal is to be sure that other Americans have the type of protections against lemon policies that members of Congress and all Federal employees have.

We set safety and quality standards for all kinds of products. Baby food can't have glass in it, children's pajamas can't be flammable, cars must have seat belts. Insurance policies can't have loopholes and fine print that deny you health care when you need it most.

[Cite examples of insurance company denials of coverage]

2) Protect consumers, not fraudulent insurance companies

Republicans and Democrats alike agree that the insurance industry has to change the way it does business. Every health reform bill that's been introduced includes tough consumer protections from insurance abuses -- this amendment is a step in the wrong direction.

Under the Nickles amendment, dishonest insurance companies are the winners and the American people are the losers.

Take for example, a family who hits their policy's lifetime limit one year after they have a child with a serious heart condition. You're out of luck. The family loses its coverage.

3) The Mitchell bill moves us in the right direction

The Mitchell benefit package is not a one size fits all package. In fact, under this bill, everyone will be guaranteed the same kind of choices that Members of Congress have -- like an HMO, a traditional fee-for-service plan that lets you go to the doctor of your choice, or a combination of the two.

QUESTIONS

WHY IS THE GOVERNMENT FORCING PEOPLE TO BUY COVERAGE THEY DON'T NEED AND CAN'T AFFORD?

We are not forcing people to buy coverage they do not need.
We are requiring insurance companies to sell policies that cover what they say they cover. No excuses, no loopholes, no fine print.

Health insurance is for the accidents and illnesses you hope and pray never happen, but if they do, you want your insurance to cover you. No excuses, no loopholes, no fine print.

WHY SHOULD WE HAVE A ONE-SIZE-FITS-ALL PLAN IMPOSED BY THE GOVERNMENT?

We shouldn't and we don't. Under the Mitchell bill, everyone will be guaranteed the same kind of choices that Members of Congress have -- like an HMO, a traditional fee-for-service plan that lets you go to the doctor of your choice, or a combination of the two.

But no matter what choice you make, you ought to be secure that the coverage you paid for will there when you need it. You ought to be sure that your doctor decides what treatment is right for you medically ~~not or appropriate~~ -- not some insurance company that sells a policy with loopholes and fine print.

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THE NEED FOR A STANDARD BENEFIT PACKAGE

A standard benefit package means security.

- Under the Mitchell bill, health plans offer a standard benefit package. This lets all Americans know what is covered. No longer will people have to wade through insurance company fine print only to discover that a service is not covered just as they need it the most.
- Coverage alone does not does not help a woman who does not get the mammogram she needs to detect her breast cancer early enough to save her life because preventive services are not covered. Coverage alone does not help an individual who can't get life saving medicine because prescription drugs are not covered.
- In contrast to the Mitchell bill, the Dole bill allows insurance companies to continue to deny coverage of certain benefits -- effectively excluding people who need those benefits from their plans.

A standard benefit package helps make insurance affordable.

- With a standard benefit package, insurance companies can't choose only "good risks" for one plan and steer older or sicker people into another plan -- a plan that ends up being unaffordable to those who need it.
- The attached chart compares the actuarial value and the premium cost of Blue Cross Standard and Blue Cross High Option. (Kennedy's office has this chart.)
  - Both of these plans provide comprehensive benefits. But the high option provides better coverage for prescription drugs and mental health services. And the standard option provides dental benefits, while the high option does not.
  - Overall the actuarial value of the two options is nearly identical -- a difference of $71 per year, or about 3%.
  - However, the high option premium is $1,540 more than the standard option premium -- that's 70% higher. That's because plans with better drug coverage tend to attract older, sicker people while plans with dental coverage attract families with children.

A standard benefit package means that consumers can make good and informed decisions between health plans.

- A standard benefit package is a critical part of competition. Under the Nickles' amendment, like today, consumers can't tell whether a higher cost plan has better benefits -- or just higher cost people in the plan or higher profits. When insurance companies offer everyone a defined set of benefits, consumers can compare plans on price and quality, and insurance companies have to compete by providing high quality health care at an affordable price.

The experts agree on the need for a standard benefits package.

- Consumers Union, the Alliance for Managed Competition (which includes AETNA, CIGNA, MetLife, Prudential, and Travelers), the Blue Cross Blue Shield Association, the Group Health Association of America and the Health Insurance Association of America, all agree that a standard benefits package is the best approach.
  (Kennedy's office getting letters saying this.)

The Cooper-Gingrich Plan Doesn't Control Costs

Under the Cooper-Gingrich plan, Americans will continue to face skyrocketing health costs. The costs of millions of uninsured Americans will be shifted onto private premiums; insurance companies will continue to keep their high profits and middle class Americans will continue to face health insurance premiums that rise much faster than their incomes.

Cooper-Gingrich Allows Insurance Companies to Determine What They Will Cover and What They Won't Cover

- A critical component of injecting market forces into the health care system is standardizing a basic benefits package. Cooper-Gingrich leaves the content of the benefits package up to the insurance companies. So just like under the current system, people can't tell whether higher-cost plans have better benefits, or higher insurance company profits. When insurance companies must all offer everyone a defined set of benefits, consumers are able to pick their own plan based on quality and price, which forces insurance companies to compete. This competition drives down costs, as insurance companies squeeze out inefficiencies so that they can attract people through high quality, low cost coverage.

No Real Cost Containment without Universal Coverage

- Unless we substantially reduce the number of uninsured, costs just won't come down. And Cooper-Gingrich will leave well over 24 million Americans without health coverage. So under their plan we'll still have:

  Cost Shifting: American families and businesses that pay for private insurance will still have billions of dollars of uncompensated care shifted onto their premiums.

  Too Little Preventive Care: The millions of Americans who remain uninsured under Cooper-Bilirakis will not face incentives to seek out cost-effective preventive care that has been shown to reduce health costs. And Cooper-Gingrich encourages individuals and employers to buy Medical Savings Accounts, which discourage even insured individuals from using preventive care.

  Expensive Emergency Room Visits: The uninsured will still seek out care in expensive hospital emergency rooms at three times the cost of visits to a doctor's office.

  No Real Competition: Insurance companies will continue to compete on who can cover the healthiest people instead of on price and quality as they would with a standard benefits package.

No Guarantee of Cost Containment for Families, Businesses, and Government

- The leadership of both the House and the Senate took cost containment seriously -- and had mechanisms that guaranteed that costs would never skyrocket out of control again. Cooper-Gingrich, however, leaves Americans with no more security than they have today: middle class Americans have no guarantee that their coverage will always be affordable.

Unrealistic Financing: Cooper Makes Promises It Can't Pay For

- Because Cooper is not going to bring costs under control, there is no guarantee that Americans will not face rising deficits as government health costs continue to skyrocket. Plans like Cooper claim to provide subsidies to increase coverage, but they don't have the financing mechanisms to back up their promises, leaving Congress with three choices (1) increase the deficit, (2) increase taxes, or (3) leave more Americans out of the system.

The Cooper-Gingrich Short-Changes Older Americans

The Cooper-Gingrich bill uses significant Medicare savings to finance reforms, yet provides no new benefits for older Americans. No help with prescription drugs. No help with long-term care. And nothing to keep insurance companies from charging older people much higher rates than younger people. Instead, Medicare money will be used to expand access to low-income individuals, not to help the older Americans Medicare was created to serve.

Raids Medicare To Pay Others' Bills

- The Cooper-Gingrich bill takes significant money out of Medicare, but it uses it to pay other bills instead of providing new benefits and a strengthened Medicare program. The Cooper-Gingrich bill provides no coverage for prescription drugs, and no new long-term care program.

Forces Millions of Seniors to Choose Between Food and Medicine

- The Cooper-Gingrich bill does not add prescription drug coverage to Medicare -- leaving millions of older Americans with no help paying for costly prescriptions. Prescription drug costs are the highest out-of-pocket expense for three out of four seniors, and the Cooper-Gingrich plan would provide no help, forcing millions of older Americans to continue to choose between food and medicine.

Leaves Older Americans at Risk of Entering Nursing Homes

- The Cooper-Gingrich bill does nothing to extend long-term care coverage to the home and community -- where most seniors live and where most want to stay. With no long-term care program, older Americans in need of assistance will continue to face no choice but to enter nursing homes.

Insurance Companies Can Still Gouge Seniors

- The Cooper-Gingrich bill would leave the insurance companies in charge -- allowing them to deny coverage for pre-existing conditions six months,[1] to raise rates indiscriminately, to decide which benefits to cover and which to exclude. His plan would let insurance companies charge older Americans much higher premiums than younger people -- three to four times higher.

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[1] While most universal coverage plans use pre-existing condition limitations as a necessary transition tool before universal coverage is reached, the Michel bill never achieves universal coverage -- it never even comes close. Thus, the exclusions in the Michel bill will never go away.

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COOPER/BILIRAKIS: SMALL BUSINESSES STILL BEAR BURDEN

SUMMARY: Today, small businesses bear the burden of our health care system. Insurance companies are in the driver's seat and small businesses get discriminated against -- often charged more than large businesses for the same coverage. Under Cooper, insurance companies still make the rules -- and small businesses still pay more. Today, premiums for small businesses rise unchecked year after year. With no effective cost containment, the Cooper bill promises more of the same.

No Discounts to Help the Smallest Businesses Afford Coverage

- Unlike the House proposal -- which provides millions to help small businesses to provide coverage -- this plan offers no small business subsidies.

No Guarantee of Affordable Coverage

- The Cooper bill lacks any cost containment that would bring down skyrocketing health costs -- denying small businesses the assurance that they could purchase quality affordable coverage for their employees and their own families. A recent analysis concluded that, with incremental reform, "***in the years ahead, 30 percent of small businesses currently providing insurance will drop their insurance coverage because of the high cost.***" ("Small Business and the National Health Care Reform Debate," Health Affairs, Spring 1992)

No Guarantee of Small Business Bargaining Power and Better Rates:

- The Cooper proposal does not guarantee small businesses that they will be able to join voluntary purchasing groups -- to give them the power to negotiate the same rates large businesses get today. They can continue to pay much more for the same coverage. [p. 130]

- Small firms with older workers -- who may still be charged 4 times more than other workers -- will still pay much more than other firms.

Responsible Small Businesses Pay More to Cover Free Riders

- Under Cooper's proposal, small businesses continue to pay a "hidden tax" as costs are shifted from businesses that don't provide to those that do. Until all firms take responsibility, small firms that provide coverage for their workers will continue to pay extra to pick up the costs for employees at firms that don't provide. Small businesses would also continue pay even more to cover the uncompensated care costs that remain in the system when millions of Americans have no insurance.

If One Worker Gets Sick, Small Businesss Still Denied Protection

- Under the Michel bill, insurance companies will still be able to raise rates for an employer with more than 100 employees, even if just one worker get sick. Firms in this category will continue to see high and unpredictable insurance costs.

Cooper Limits Choice for Employees of Small Business

- In today's market, small employers often can't offer their employees any choice at all. Both of

the leadership proposals allow small businesses to enroll their employees in the Federal Employees program -- dramatically expanding choices with over 300 choices nationwide. Cooper's proposal denies small businesses employees the same choices he gets.

The Cooper-Bilirakis Bill Fails To Achieve Universal Coverage

The new Cooper-Bilirakis proposal will do very little to get to universal coverage. According to the bill's own authors, it would cover only 88% of the population -- just a 3% increase and only 7 million more Americans covered. Health reform that helps only 3% of the population get covered -- while providing less security to people with insurance -- is not real reform. The Cooper-Bilirakis bill will cover some of the poor but force middle class people to choose between no insurance or higher premiums. In fact, millions of workers will be dropped from their employer's insurance, and those who manage to stay insured will face higher premiums than under a universal system.

More than 32 million people will go without insurance

- This proposal might cover an additional 7 million more Americans -- only helping a mere 3% of the population. The bill aims to go further, but it is vastly underfunded. If only an additional 3% of the population gets covered, at least 32 million Americans -- most in working families -- would remain without insurance. And the bill would leave every American at risk of losing their insurance.

The middle class will be left behind

- As the Congressional Budget Office pointed out with Cooper's original proposal, the middle-class -- not the poor -- are the ones who are left behind. As CBO stated in its original analysis of the Cooper plan, "health insurance coverage would probably be more limited for middle-income people than the rich or poor." (CBO, 5/94)

Millions now covered by their job would be dropped from their insurance

- As costs continue to rise, more and more people will lose their coverage. According to one study of the original Cooper proposal, the bill would cause over one million Americans a month to lose their insurance. [Families USA, 6/94]

Cost shifting continues

- With a portion of the population remaining uninsured, per capita insurance costs for the insured population would be higher, compared with universal coverage. People with insurance will continue to pay for those without.

If you lose your job, you're out of luck.

- The Cooper/Bilirakis bill claims to achieve portability. But the definition of portability is extremely limited. If you lose your job, you can keep your insurance -- if you pay for it all yourself. That's like saying you can take the company car with you when you switch jobs -- as long as you've got the money to buy it.

The Cooper-Gingrich Plan Leaves Insurance Companies In Charge

The Cooper-Gingrich bill falls far short of solving the health care problem that has so many American families at risk today. It does not eliminate "pre-existing condition" exclusions. It does not eliminate insurance company loopholes and fine print -- they can still exclude coverage for some diseases and treatments. Insurers still charge one business more than another business, one family more than another family. And insurance companies decide which benefits are covered and which are not. In other words, the insurance companies are still in charge.

Protects Insurance Company Loopholes and Fine Print

The Cooper-Gingrich plan allows insurance companies to exclude coverage for some diseases or treatmen In fact, unlike most bills, which at least describe a standard benefits package, the Cooper bill allows insurance companies to offer any benefits package they want. State laws guaranteeing benefits are wiped out. Millions of Americans will continue to face the nightmare of insurance claims coming back: "Sorry, not covered."

Insurance Companies Could Still Charge Whatever They Want, and Still Raise Rates Year after Year

- The Cooper-Gingrich bill ignores cost containment -- there is nothing to keep insurance companies from continually raising rates year after year. In addition, insurance companies can still charge some families and businesses more than others.

Insurance Companies Could Still Deny Coverage to Small Businesses and Individuals

- Insurance companies can decide that they want to avoid the small business sector altogether and refuse to sell insurance to any small business or individual. That limits business choices, limits family choices, and frustrates competition.

- In addition, an insurer can cancel coverage for small businesses and individuals by stopping coverage in one or both of those markets. No individual or small business would be secure in their coverage.

Loopholes Protect Insurance Companies Profits, Not Middle Class Families

- The Coope-Gingrich plan limits, but does not eliminate, the ability of insurance companies to deny coverage for "pre-existing conditions" [to six months]. While all agree that pre-existing condition limitations are necessary for the transition to universal coverage, the Cooper-Gingrich bill will **never** achieve universal coverage, and exclusions will never go away.

No Protection For Small Business or Individual Insurance Rates

- A "vicious spiral" will lead to very high premiums in the community-rated market and will encourage healthier people to drop coverage. Employers with young, healthy employees will likely stay out of the community-rated pool and self-insure. In addition, other groups can come together to opt out of the community-rated pool, leaving even fewer people in the pool.

Workers Could Still Lose Their Insurance When They Lose Their Job

- Although the Cooper-Gingrich plan theoretically allows people to "take insurance with them" when they leave a job (portability), this provision only helps those who can pay the full premium themselves. That is not realistic for most people, since they can't afford the full cost of coverage, especially if they are without a job. In fact, most workers have that

protection now, either through state insurance laws or through COBRA coverage. But as a recent study by the Department of Labor shows, only one in five can take advantage of it -- the rest can't afford it.

Insurers Could Still Charge Older Workers Far More Than Younger Workers

- The Cooper-Gingrich bill allows insurance companies to charge older workers three to four times more than younger workers.

Americans With Insurance Would Still Be at Risk of Losing It

- The real bottomline is that under the Cooper-Gingrich bill, everyone remains at risk of losing the insurance they have now -- because under a non-universal system, no one is guaranteed protection.

COOPER BILIRAKIS: NO HELP FOR MIDDLE-CLASS FAMILIES

SUMMARY: Under the Cooper plan, millions of middle-class families would still be unable to obtain affordable health coverage. And, with no promise of effective cost containment, families will have no guarantee that -- even if they're lucky enough to have insurance today -- they will be able to afford that same insurance tomorrow.

Families Left Unprotected From Rising Costs

- The leadership of both the House and Senate took cost containment seriously -- and set up a competitive system with mechanisms to guarantee that costs won't continue to skyrocket. The Cooper proposal, however, does nothing to reverse the trend in rising costs -- giving middle class Americans no guarantee that affordable health care will always be within their reach.

- A recent study warned: ***"Middle income families that currently have insurance will pay more under partial reform*** *than under reform that includes universal coverage."* [Lewin-VHI, for Catholic Health Association, 7/18/94]

- Cooper preserves the status quo: the poor get health care, the rich buy insurance, and the middle-class has to go it alone. For example, under Cooper, a middle class family earning $35,000 could face premiums of almost $6,800 per year. This same family would pay $944 under the House bill.

Doesn't Protect Workers Who Lose Their Job

- Under the Cooper/Bilirakis bill, if you lose your job, you could also lose your insurance. They claim insur is "portable" because if you switch jobs or lose your job, you are technically allowed to take your insuranc with you. But without financial assistance -- especially for people between jobs -- that is an empty promis Most workers have that protection today but a recent Labor Department study showed only one in every fi people can take advantage of it -- the rest simply can't afford to.

Loopholes Protect Insurance Companies Profits, Not Middle Class Families

- The Cooper plan limits, <u>but does not eliminate</u>, the ability of insurance companies to deny coverage for "pre-existing conditions" [to six months]. While all agree that pre-existing condition limitations are necessary for the transition to universal coverage, the Cooper bill will <u>never</u> achieve universal coverage, and exclusions will never go away.

- Unlike the House leadership bill, lifetime limits on insurance are permitted. This loophole bails out the insurance companies, but comes at the expense of families. In part because of lifetime limits, thousands of families each year find that medical bills send them into bankruptcy. These families are not helped by Cooper/Bilirakis.

Forces People With Insurance To Continue To Pay For Those Without

- Under Cooper everyone is at risk of losing their insurance -- and more than a million per month will. As today, their unpaid bills will be shifted onto those with private insurance. Universal coverage is the only way to stop people with insurance from paying for those without.

Family Premium Payments Cooper vs. Gephardt

BACKGROUND DATA

I. Premiums

	Cooper/B	Gephardt
Individual	$2,500	$2,140
Couple	$5,000	$4,280
Single Parent	$3,976	$4,170
Family of 4	$6,796	$5,670
Child	$1,500	

Source: 1994 figures; Gephardt premium is CBO estimate of Ways and Mean proposal
Cooper premium estimates based on CBO, 4/94

II. Subsidy Schedules

Cooper/Bilirakis Subsidies available on a sliding scale to individuals with incomes below 200% of poverty and children with incomes below 240% of poverty.

Gephardt Sliding scale based on poverty level up to 240% of poverty. Pay 100 of premium below poverty level, sliding scale between 100 to 240%.

III. Poverty Levels

	Cooper/B	Gephardt
Individual	$7,179	
Couple	$9,713	
Single Parent	$12,247	
Family of 4	$14,137	$16,000

Source: 1994 data
Note: A little off per Linda B b/c they were estimated; consistent
Welfare Stuff -- Ricard Bevere 56150, 54688

IV. Formulas [Dollar per percentage point]

	Gephardt	Cooper/B
Individual		
Couple		
Single Parent		
Family of 4	40.50	67.96

Family Premium Payments Cooper vs. Gephardt

GEPHARDT

Family of 4 Income	Premium	Subsidy (Calc)	Subsidy (Real)	Total Payment	Family Share
$12,500	$5,670	$6,556	$5,670	$0	$0
$16,000	$5,670	$5,670	$5,670	$0	$0
$20,000	$5,670	$4,658	$4,658	$1,013	$203
$25,000	$5,670	$3,392	$3,392	$2,278	$456
$30,000	$5,670	$2,126	$2,126	$3,544	$709
$35,000	$5,670	$861	$861	$4,809	$962
$40,000	$5,670	($405)	$0	$5,670	$1,134

Family Premium Payments Cooper vs. Gephardt

COOPER/BILIRAKIS

Family of 4 Income	Family Premium	Couple Premium	2 Child Premium	Family Subsidy	Child Subsidy	Family Payment
$12,500	$6,796	$5,000	3,000	$6,796	$3,000	$0
$16,000	$6,796	$5,000	3,000	$5,900	$2,718	$896
$20,000	$6,796	$5,000	3,000	$3,978	$2,111	$2,818
$25,000	$6,796	$5,000	3,000	$1,574	$1,353	$5,222
$30,000	$6,796	$5,000	3,000	$0	$596	$6,200
$35,000	$6,796	$5,000	3,000	$0	$0	$6,796
$40,000	$6,796	$5,000	3,000	$0	$0	$6,796

Note: Does not include 25% individual tax deduction for previously uninsured families.

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

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FAX: 456-2878

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TALKING POINTS - STANDARD BENEFITS PACKAGE

--I strongly believe that benefits should be specified in the legislation so that the American people will know what is covered.

--I support the Majority Leader's effort to design a benefits package that is a compromise between the benefits language in the Finance bill and the Labor Committee bill.

-It specifies 16 general categories of benefits and guarantees that the benefit package designed by the Board will be as generous as the benefits Members of Congress get today.

--The Mitchell substitute leaves many of the details of coverage to the National Health Benefits Board, yet retains important details of coverage in the legislation.

--For example, to encourage the use of cost effective primary care, no cost sharing is allowed for preventive services or prenatal care. To ensure that people with congenital disabilities are not overlooked, services such as rehabilitation and extended care will be covered for individuals with congenital conditions.

--These details are extremely important to ensure that the Board defines a benefit package that emphasizes and encourages the use of preventive care and meets the particular needs of women, children, persons with disabilities and other vulnerable populations.

--If we do not specify these important details in the legislation, there is a danger that the Board may define a benefits package designed to meet the needs of the "average" person, as many insurance companies do today. We must have a benefits package that encourages primary and preventive care, protects children, women, and persons with disabilities.

ONE SIZE FITS ALL

--We have heard a lot of talk about a **"one size fits all"** benefit package. We've heard other Senators say things like "I don't want to buy coverage for mental health coverage because I don't need it." The problem is that we can't always predict what kinds of services we are going to need.

-- We are all susceptible to accidents and illness. The point of having insurance is to protect us, no matter what happens. Can you predict whether you or a member of your family will get cancer? NO. Can you predict whether you will be in a car accident and need major surgery and rehabilitation? NO.

--Standardizing the benefits package guarantees that all Americans will have the coverage they need, when they need it.

CHOICE OF THREE PLANS IN THE MITCHELL BILL

--The Mitchell bill does not create a "one size fits all" benefit. In fact, under this bill, everyone would be guaranteed a choice of at least three plans, including at least one plan that lets you go to the doctor of your choice.

-- The Mitchell bill guarantees all Americans choice of health plans and providers.

-- A choice of three plans is MORE choice than most people have today. Here in the Senate, we tend to forget that not everyone has as many choices as we do.

-- In fact, Peat Marwick found that 85 % of firms that offer insurance today only offer ONE plan -- let me repeat that - 85 % of firms today that offer insurance only offer ONE plan.

--The Mitchell plan would guarantee choice of at least 3 health plans for <u>all</u> Americans. Only 7 percent of employers offer 3 or more health plan choices to their employees today.

(Chart attached - blown up chart in cloakroom.)

MOST FIRMS OFFER ONLY ONE CHOICE OF PLAN

Percentage of Firms Offering Choice of Any Type of Health Plan

NUMBER OF PLANS OFFERED	% of FIRMS
1	83.6%
2	9.5%
3 or more	6.9%

Kaiser/KPMG Peat Marwick Employer Survey on Health Reform, June 1994

SUPPORT FOR STANDARD BENEFIT PACKAGE

-- What I can't understand is why some of our colleagues oppose a standard benefit package when almost all health plans before the Senate include a standard benefit package and when it has such broad support outside the beltway.

--Standardizing and simplifying the complexities of the benefit packages, is something that has broad support among the consumer groups, insurance companies, AND health care providers across the country.

--Consumers Union has repeatedly testified before House and Senate Committees in strong support of standardizing benefits.

--The Alliance for Managed Competition, which includes AETNA, CIGNA, MetLife, Prudential, and Travelers insurance companies, as well as the Blue Cross Blue Shield Association, the Group Health Association of American and the Health Insurance Association of America, ALL AGREE THAT THE BEST APPROACH IS TO ESTABLISH A STANDARD BENEFIT PACKAGE.

-- Why is it that so many of my colleagues across the aisle are so hesitant to guarantee the American people the same basic benefits they provide to us today?

ADVERSE SELECTION - CHERRY PICKING

-- A standard benefit package also helps combat the "cherry picking" problem that happens today when health plans try to vary the benefit design in ways that steer healthy people into one plan and sicker people into another.

-- For example, plans with better drug coverage tend to attract older, sicker people while plans with better dental coverage tend to attract healthy, young families with children.

-- By varying the benefits like this, health plans try to segment the market, making insurance unaffordable for those who need it most. (Go to Blue Cross/Blue Shield chart on actuarial value and premium differences)

TALKING POINTS ON ADVERSE SELECTION CHART

-- This chart compares the actuarial value and the premium cost of Blue Cross Standard and Blue Cross High option.

-- Both of these plans provide a comprehensive set of benefits. However, there are some differences between them.

-- For example, the high option provides somewhat better coverage for prescription drugs and mental health services. On the other hand, the standard option provides dental benefits, but the high option does not.

-- Overall the actuarial value of the two options is nearly identical -- a difference of $71 per year, or about 3%.

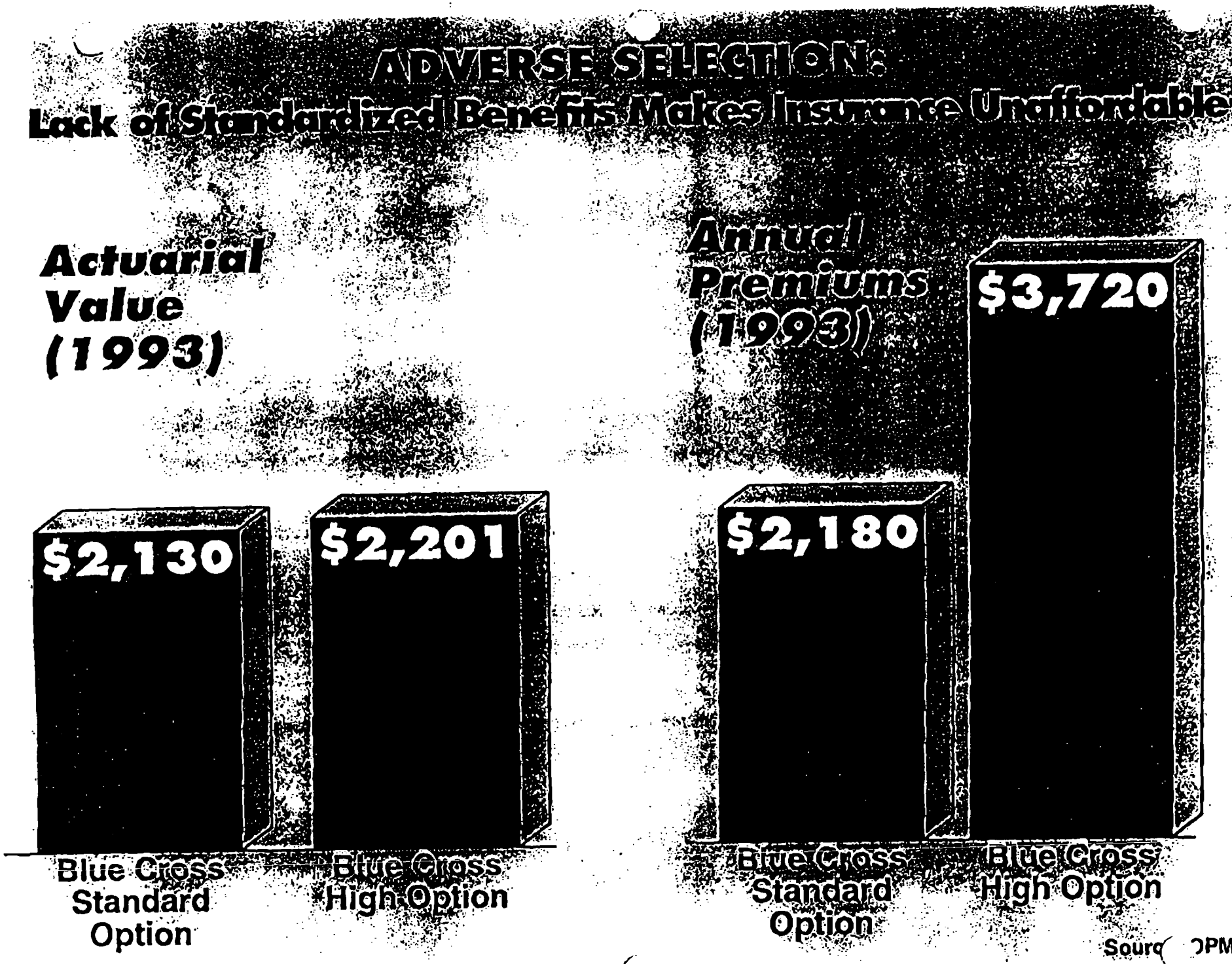
-- However, the high option premiums are $1,540 more than the standard option premiums -- that's 70% higher.

-- The reason for the higher premiums is the benefit differences. Plans with better drug coverage tend to attract older, sicker people while plans with dental coverage tend to attract families with children.

-- Varying the benefits even slightly, as in this case, allows plans to steer young healthy people into one plan and older people into another, making insurance unaffordable for those who need it most.

-- This is why we need to develop a single standard package -- to prevent this kind of steering and cherrypicking by plans, and ensure affordable comprehensive coverage for all Americans - healthy and sick, young and old.

ADVERSE SELECTION:
Lack of Standardized Benefits Makes Insurance Unaffordable



AMENDMENT TO STRIKE BENEFITS

ARGUMENT: Strike the benefits package from the legislation. Argument against cost and that it is not a appropriate for Congress to dictate a single "one-size fits all" benefits package to individuals and employers.

REBUTTAL:

This amendment strikes the core of this bill. Universal coverage is an empty promise if the benefit package is not adequate. Every hard-working American family deserves health care coverage that meets their needs and 39 million people don't get that in this country today.

Without a defined benefit package, there are no guarantees about what insurance will cover and what will be left to individuals and families.

People need to know what is in the benefits package being considered by Congress, so they can evaluate the impact of health reform on their families and know what we are voting on.

An insurance card does not help a women who does not get the mammogram she needs to detect her breast cancer early enough to save her life because preventive services are not covered. An insurance card does not help you if you need high-cost, life-saving drugs, and pharmaceuticals are not included in the benefit package.

If benefits are not adequate, people won't have real access to health care. Many families will delay getting care or be forced to go without care. That's exactly what we are trying to prevent with health care reform.

The standard benefits package in the Mitchell bill is equal to the most popular plan in the Federal Employees Health Benefit Program. This standard plan assures all Americans that they will get coverage as good as Members of Congress and the President get.

The Mitchell bill provides essential information about benefits coverage. It specifes that preventive services--the most cost-effective part of our health care system -- are covered without copayments. The specific coverage of preventive services will be based on recommendations by the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and other preventive services experts.

The standard benefits package in the Mitchell bill assures families that immunizations will be covered without copays and guarantees people with disabilities that comprehensive outpatient rehabilitation therapy is covered. The Mitchell bill specifies that these therapies are available for people with congenital conditions as well as people who become disabled due to an illness or injury. The American people deserve to know that.

The standard benefits package specifies that outpatient rehabilitation is covered for people who are still improving their function, for people that need therapy to prevent future deterioration and for people that need therapy to maintain their current level of functioning. These are not minute details -- they are essential to all current and future members of the disability community.

Without a standard benefit package, anyone who lives with a disability, a mental illness, or a substance abuse problem will not be assured that any benefit package designed by the insurance industry will meet their needs.

Most insurance companies do not design benefit packages for people who need care -- they design benefit packages to make a profit. We see today what some insurance companies do when given the flexibility to design a benefit package, they include fine print to exclude the sick and do not cover the specialized care that millions of Americans need. Is that the kind of systematic profiteering that we are condoning in the United States Senate when we say "let the marketplace work"?

The standard benefit package in the Mitchell bill is a package that the American people can depend on. Americans want to know what their insurance going to cover - they do not want to deal with insurance company fine print to figure out what is covered and what is not.

I urge the Senate to reject this amendment to strike the standard benefits package. Voting for this amendment means a vote against guaranteeing affordable health coverage for all Americans to meet their health care needs, whether they are young or old, healthy or sick.

discrimination. "mental health"
free to write out conditions.

Except that nothing in the above shall ~~prohibit~~ be construed as allowing the renewal or sale of a policy that does not meet the standards of this ~~Act~~ Act, including ~~prohibiting~~ abusive practices, lifetime limits, or exclusion of services included in the FEHBP Blue Cross/Blue Shield policy provided to a majority OF members of ~~this Act~~ Congress.

TALKING POINTS AGAINST NICKLES SECOND DEGREE AMENDMENT TO DODD

--Senator Nickles claims his amendment guarantees choice for the American people. In fact, his amendment does not guarantee choice for the American people, but for insurance companies.

--This amendment would allow insurance companies to continue their current policies indefinitely -- including such abuses as imposing pre-existing condition exclusions, charging sky-high rates for people who become sick.

--That is a choice that we should not allow insurance companies to have. One of the major goals of reform is to end the harmful, discriminatory practices that deny coverage for people who need it most.

--Virtually every bill under consideration before the Senate today requires insurance companies to make significant improvements in their existing policies to better protect the American people.

--In addition a number of the bills include a standardized benefit package, including a bill offered by Senator Chafee, which was cosponsored by more than a dozen other Republican Senators including Senator Dole, as well as bills offered by Senator Kassebaum and Senator Durenberger.

--In fact, Senators Kassebaum and Chafee spoke in favor of a standardized benefit package earlier today.

--A similar amendment was soundly defeated by a large, bipartisan majority in the Labor Committee bill