

1 health plan for an employer employing either the in- 1
2 dividual or the spouse. 2

3 **SEC. 1014. TREATMENT OF RESIDENTS OF STATES WITH** 3
4 **STATEWIDE SINGLE-PAYER SYSTEMS.** 4

5 (a) **UNIVERSAL COVERAGE.**—Notwithstanding the 5
6 previous provisions of this title, except as provided in part 6
7 2 of subtitle C, in the case of an individual who resides 7
8 in a State that has a Statewide single-payer system under 8
9 section 1223, universal coverage shall be provided consist- 9
10 ent with section 1222(3). 10

11 (b) **INDIVIDUAL RESPONSIBILITIES.**—In the case of 11
12 an individual who resides in a single-payer State, the re- 12
13 sponsibilities of such individual under such system shall 13
14 supersede the obligations of the individual under section 14
15 1002. 15

16 **Subtitle B—Benefits** 16

17 **PART 1—COMPREHENSIVE BENEFIT PACKAGE** 17

18 **SEC. 1101. PROVISION OF COMPREHENSIVE BENEFITS BY** 18
19 **PLANS.** 19

20 (a) **IN GENERAL.**—The comprehensive benefit pack- 20
21 age shall consist of the following items and services (as 21
22 described in part 2), subject to the cost sharing require- 22
23 ments described in part 3, the exclusions described in part 23
24 4, and the duties and authority of the National Health 24
25 Board described in part 5: 25

- 1 (1) Hospital services (described in section
2 1111).
- 3 (2) Services of health professionals (described
4 in section 1112).
- 5 (3) Emergency and ambulatory medical and
6 surgical services (described in section 1113).
- 7 (4) Clinical preventive services (described in
8 section 1114).
- 9 (5) Mental illness and substance abuse services
10 (described in section 1115).
- 11 (6) Family planning services and services for
12 pregnant women (described in section 1116).
- 13 (7) Hospice care (described in section 1117).
- 14 (8) Home health care (described in section
15 1118).
- 16 (9) Extended care services (described in section
17 1119).
- 18 (10) Ambulance services (described in section
19 1120).
- 20 (11) Outpatient laboratory, radiology, and diag-
21 nostic services (described in section 1121).
- 22 (12) Outpatient prescription drugs and
23 biologicals (described in section 1122).
- 24 (13) Outpatient rehabilitation services (de-
25 scribed in section 1123).

1 (14) Durable medical equipment and prosthetic
2 and orthotic devices (described in section 1124).

3 (15) Vision care (described in section 1125).

4 (16) Dental care (described in section 1126).

5 (17) Health education classes (described in sec-
6 tion 1127).

7 (18) Investigational treatments (described in
8 section 1128).

9 (b) NO OTHER LIMITATIONS OR COST SHARING.—

10 The items and services in the comprehensive benefit pack-
11 age shall not be subject to any duration or scope limitation
12 or any deductible, copayment, or coinsurance amount that
13 is not required or authorized under this Act.

14 (c) HEALTH PLAN.—Unless otherwise provided in
15 this subtitle, for purposes of this subtitle, the term “health
16 plan” has the meaning given such term in section 1400.

17 **PART 2—DESCRIPTION OF ITEMS AND SERVICES**

18 **COVERED**

19 **SEC. 1111. HOSPITAL SERVICES.**

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

22 (1) Inpatient hospital services.

23 (2) Outpatient hospital services.

24 (3) 24-hour a day hospital emergency services.

(b) LIMITATION.—The hospital services described in this section do not include hospital services provided for the treatment of a mental or substance abuse disorder (which are subject to section 1115), except for medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is not covered under such section).

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

(1) HOSPITAL.—The term “hospital” has the meaning given such term in section 1861(e) of the Social Security Act, except that such term shall include—

(A) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(1), a facility of the uniformed services under title 10, United States Code, that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in such section 1861(e);

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(2), a facility operated by the Department of Veterans Affairs that is primarily engaged in provid-

ing services to inpatients that are equivalent to the services provided by a hospital defined in such section 1861(e); and

(C) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(3), a facility operated by the Indian Health Service that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in such section 1861(e).

(2) INPATIENT HOSPITAL SERVICES.—The term “inpatient hospital services” means items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when provided to an inpatient of a hospital. The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient hospital services when provided to an inpatient of a hospital.

SEC. 1112. SERVICES OF HEALTH PROFESSIONALS.

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

1 (1) inpatient and outpatient health professional
 2 services, including consultations, that are provided
 3 in—
 4 (A) a home, office, or other ambulatory
 5 care setting; or
 6 (B) an institutional setting; and
 7 (2) services and supplies (including drugs and
 8 biologicals which cannot be self-administered) fur-
 9 nished as an incident to such health professional
 10 services, of kinds which are commonly furnished in
 11 the office of a health professional and are commonly
 12 either rendered without charge or included in the bill
 13 of such professional.
 14 (b) LIMITATION.—The items and services described
 15 in this section do not include items or services that are
 16 described in any other section of this part. An item or
 17 service that is described in section 1114 but is not pro-
 18 vided consistent with a periodicity schedule for such item
 19 or service specified in such section or under section 1153
 20 may be covered under this section if the item or service
 21 otherwise meets the requirements of this section.
 22 (c) DEFINITIONS.—Unless otherwise provided in this
 23 Act, for purposes of this Act:

①

This needs to be an

or
(1) Emerg. services or

(2) Amb. med. or
amb. surg. service

② What about clinic
provide for
soc. serv?

1 (1) HEALTH PROFESSIONAL.—The term
2 “health professional” means an individual who pro-
3 vides health professional services.

4 (2) HEALTH PROFESSIONAL SERVICES.—The
5 term “health professional services” means profes-
6 sional services that—

7 (A) are lawfully provided by a physician; or

8 (B) would be described in subparagraph

9 (A) if provided by a physician, but are provided
10 by another person who is legally authorized to
11 provide such services in the State in which the
12 services are provided.

13 **SEC. 1113. EMERGENCY AND AMBULATORY MEDICAL AND**
14 **SURGICAL SERVICES.**

15 The emergency and ambulatory medical and surgical
16 services described in this section are the following items
17 and services provided by a health facility that is not a hos-
18 pital and that is legally authorized to provide the services
19 in the State in which they are provided:

20 (1) 24-hour a day emergency services.

21 (2) Ambulatory medical and surgical services.

22 **SEC. 1114. CLINICAL PREVENTIVE SERVICES.**

23 (a) COVERAGE.—The clinical preventive services de-
24 scribed in this section are—

The term 1 (1) an item or service for high risk populations
al who pro- 2 (as defined by the National Health Board) that is
3 specified and defined by the Board under section
ICES.—The 4 1153, but only when the item or service is provided
ans profes- 5 consistent with any periodicity schedule for the item
6 or service promulgated by the Board;

physician; or 7 (2) except as modified by the National Health
bparagraph 8 Board under section 1153, an age-appropriate im-
are provided 9 munization, test, or clinician visit specified in one of
authorized to 10 subsections (b) through (h) that is provided consist-
n which the 11 ent with any periodicity schedule for the item or
12 service specified in the applicable subsection or by
EDICAL AND 13 the National Health Board under section 1153; and

14 (3) an immunization, test, or clinician visit that
and surgical 15 is provided to an individual during an age range
owing items 16 other than the age range for such immunization,
is not a hos- 17 test, or clinician visit that is specified in one of sub-
the services 18 sections (b) through (h), but only when provided
19 consistent with any requirements for such immuniza-
s. 20 tions, tests, and clinician visits established by the
21 National Health Board under section 1153.

22 (b) INDIVIDUALS UNDER 3.—For an individual
23 under 3 years of age:

1 (1) IMMUNIZATIONS.—The immunizations spec-
2 ified in this subsection are age-appropriate immuni-
3 zations for the following illnesses:

4 (A) Diphtheria.

5 (B) Tetanus.

6 (C) Pertussis.

7 (D) Polio.

8 (E) Haemophilus influenzae type B.

9 (F) Measles.

10 (G) Mumps.

11 (H) Rubella.

12 (I) Hepatitis B.

13 (2) TESTS.—The tests specified in this sub-
14 section are as follows:

15 (A) 1 hematocrit.

16 (B) 2 blood tests to screen for blood lead
17 levels for individuals who are at risk for lead
18 exposure.

19 (3) CLINICIAN VISITS.—The clinician visits
20 specified in this subsection are 1 clinician visit for
21 an individual who is newborn and 7 other clinician
22 visits.

23 (c) INDIVIDUALS AGE 3 TO 5.—For an individual at
24 least 3 years of age, but less than 6 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are age-appropriate immunizations for the following illnesses:

(A) Diphtheria.

(B) Tetanus.

(C) Pertussis.

(D) Polio.

(E) Measles.

(F) Mumps.

(G) Rubella.

(2) TESTS.—The tests specified in this subsection are 1 urinalysis.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 3 clinician visits.

(d) INDIVIDUALS AGE 6 TO 12.—For an individual at least 6 years of age, but less than 13 years of age, the clinician visits specified in this subsection are 3 clinician visits.

(e) INDIVIDUALS AGE 13 TO 19.—For an individual at least 13 years of age, but less than 20 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are age-appropriate immunizations for the following illnesses:

(A) Tetanus.

(B) Diphtheria.

1 (2) TESTS.—The tests specified in this sub-
2 section are as follows:

3 (A) Papanicolaou smears and pelvic exams,
4 for females who have reached childbearing age
5 and are at risk for cervical cancer, every 3
6 years, but—

7 (i) annually until 3 consecutive nega-
8 tive smears have been obtained, if medi-
9 cally necessary; and

10 (ii) annually for females who are at
11 risk for fertility related infectious illnesses.

12 (B) Annual screening for chlamydia and
13 gonorrhea for females who have reached child-
14 bearing age and are at risk for fertility related
15 infectious illnesses.

16 (3) CLINICIAN VISITS.—The clinician visits
17 specified in this subsection are 3 clinician visits.

18 (f) INDIVIDUALS AGE 20 TO 39.—For an individual
19 at least 20 years of age, but less than 40 years of age:

20 (1) IMMUNIZATIONS.—The immunizations spec-
21 ified in this subsection are booster immunizations
22 against tetanus and diphtheria every 10 years.

23 (2) TESTS.—The tests specified in this sub-
24 section are as follows:

1 (A) Papanicolaou smears and pelvic exams
2 for females every 3 years, but—

3 (i) annually if an abnormal smear has
4 been obtained, until 3 consecutive negative
5 smears have been obtained; and

6 (ii) annually for females who are at
7 risk for fertility related infectious illnesses.

8 (B) Annual screening for chlamydia and
9 gonorrhea for females who are at risk for fertil-
10 ity related infectious illnesses.

11 (C) Cholesterol every 5 years.

12 (3) CLINICIAN VISITS.—The clinician visits
13 specified in this subsection are 1 clinician visit every
14 3 years.

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

17 (1) IMMUNIZATIONS.—The immunizations spec-
18 ified in this subsection are booster immunizations
19 against tetanus and diphtheria every 10 years.

20 (2) TESTS.—The tests specified in this sub-
21 section are as follows:

22 (A) Papanicolaou smears and pelvic exams
23 for females every 2 years, but—

1	(i) annually if an abnormal smear has	1
2	been obtained, until 3 consecutive negative	2
3	smears have been obtained; and	3
4	(ii) annually for females who are at	4
5	risk for fertility related infectious illnesses.	5
6	(B) Annual screening for chlamydia and	6
7	gonorrhea for females who are at risk for fertil-	7
8	ity related infectious illnesses.	8
9	(C) Cholesterol every 5 years.	9
10	(3) CLINICIAN VISITS.—The clinician visits	10
11	specified in this subsection are 1 clinician visit every	11
12	2 years.	12
13	(h) INDIVIDUALS AGE 50 TO 65.—For an individual	13
14	at least 50 years of age, but less than 65 years of age:	14
15	(1) IMMUNIZATIONS.—The immunizations spec-	15
16	ified in this subsection are booster immunizations	16
17	against tetanus and diphtheria every 10 years.	17
18	(2) TESTS.—The tests specified in this sub-	18
19	section are as follows:	19
20	(A) Papanicolaou smears and pelvic exams	20
21	for females every 2 years.	21
22	(B) Mammograms for females every 2	22
23	years.	23
24	(C) Cholesterol every 5 years.	24
		25

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

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

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

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

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

(i) Influenza.

(ii) Pneumococcal invasive disease.

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

(A) Papanicolaou smears and pelvic exams for females who are at risk for cervical cancer every 2 years.

(B) Mammograms for females every 2 years.

(C) Cholesterol every 5 years.

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

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

- (1) A complete medical history.
- (2) An appropriate physical examination.
- (3) Risk assessment.
- (4) Targeted health advice and counseling, including nutrition counseling.
- (5) The administration of age-appropriate immunizations and tests specified in subsections (b) through (h).

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

SEC. 1115. MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.

(a) COVERAGE.—The mental illness and substance abuse services that are described in this section are the

1 following items and services for eligible individuals, as de-
2 fined in section 1001(c), who satisfy the eligibility require-
3 ments in subsection (b):

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

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

10 (3) Outpatient mental illness and substance
11 abuse treatment (described in subsection (e)), in-
12 cluding case management, screening and assessment,
13 crisis services, and collateral services.

14 (b) ELIGIBILITY.—The eligibility requirements re-
15 ferred to in subsection (a) are as follows:

16 (1) INPATIENT, RESIDENTIAL,
17 NONRESIDENTIAL, AND OUTPATIENT TREATMENT.—

18 An eligible individual is eligible to receive coverage
19 for inpatient and residential mental illness and sub-
20 stance abuse treatment, intensive nonresidential
21 mental illness and substance abuse treatment, or
22 outpatient mental illness and substance abuse treat-
23 ment (except case management and collateral serv-
24 ices) if the individual—

1 (A) has, or has had during the 1-year pe- 1
2 riod preceding the date of such treatment, a 2
3 diagnosable mental disorder or a diagnosable 3
4 substance abuse disorder; and 4

5 (B) is experiencing, or is at significant risk 5
6 of experiencing, functional impairment in fam- 6
7 ily, work, school, or community activities. 7

8 For purposes of this paragraph, an individual who 8
9 has a diagnosable mental disorder or a diagnosable 9
10 substance abuse disorder, is receiving treatment for 10
11 such disorder, but does not satisfy the functional im- 11
12 pairment criterion in subparagraph (B) shall be 12
13 treated as satisfying such criterion if the individual 13
14 would satisfy such criterion without such treatment. 14

15 (2) CASE MANAGEMENT.—An eligible individual 15
16 is eligible to receive coverage for case management 16
17 if— 17

18 (A) a health professional designated by the 18
19 health plan in which the individual is enrolled 19
20 determines that the individual should receive 20
21 such services; and 21

22 (B) the individual is eligible to receive cov- 22
23 erage for, and is receiving, outpatient mental 23
24 illness and substance abuse treatment with re- 24

ar pe- 1 spect to a diagnosable mental disorder or a
ent, a 2 diagnosable substance abuse disorder.

osable 3 (3) SCREENING AND ASSESSMENT AND CRISIS
4 SERVICES.—All eligible individuals enrolled under a
t risk 5 health plan are eligible to receive coverage for out-
fam- 6 patient mental illness and substance abuse treat-
7 ment consisting of screening and assessment and
8 crisis services.

osable 9 (4) COLLATERAL SERVICES.—An eligible indi-
it for 10 vidual is eligible to receive coverage for outpatient
al im- 11 mental illness and substance abuse treatment con-
all be 12 sisting of collateral services if the individual is a
vidual 13 family member (described in section 1011(b)) of an
ment. 14 individual who is receiving inpatient and residential
vidual 15 mental illness and substance abuse treatment, inten-
ement 16 sive nonresidential mental illness and substance
17 abuse treatment, or outpatient mental illness and
18 substance abuse treatment.

19 (c) INPATIENT AND RESIDENTIAL TREATMENT.—

20 (1) DEFINITION.—For purposes of this subtitle,
21 the term “inpatient and residential mental illness
22 and substance abuse treatment” means the items
23 and services described in paragraphs (1) through (3)
24 of section 1861(b) of the Social Security Act when

1 provided with respect to a diagnosable mental dis-
2 order or a diagnosable substance abuse disorder to—

3 (A) an inpatient of a hospital, psychiatric
4 hospital, residential treatment center, residen-
5 tial detoxification center, crisis residential pro-
6 gram, or mental illness residential treatment
7 program; or

8 (B) a resident of a therapeutic family or
9 group treatment home or community residential
10 treatment and recovery center for substance
11 abuse.

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

17 (2) LIMITATIONS.—Coverage for inpatient and
18 residential mental illness and substance abuse treat-
19 ment is subject to the following limitations:

20 (A) RESIDENTIAL MENTAL ILLNESS
21 TREATMENT.—Such treatment, when provided
22 with respect to a diagnosable mental disorder in
23 a setting that is not a hospital or a psychiatric
24 hospital, is covered only to avert the need for,
25 or as an alternative to, treatment in a hospital

or a psychiatric hospital, as determined by a health professional designated by the health plan in which the individual receiving such treatment is enrolled.

(B) RESIDENTIAL SUBSTANCE ABUSE TREATMENT.—Such treatment, when provided with respect to a diagnosable substance abuse disorder in a setting that is not a hospital or a psychiatric hospital, is covered only if a health professional designated by the health plan in which the individual receiving such treatment is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment.

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

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

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

(D) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment is subject to an aggregate

1 annual limit of 30 days. A maximum of 30 ad-
2 ditional days of such treatment shall be covered
3 for an individual if a health professional des-
4 ignated by the health plan in which the individ-
5 ual is enrolled determines in advance that—

6 (i) the individual poses a threat to his
7 or her own life or the life of another indi-
8 vidual; or

9 (ii) the medical condition of the indi-
10 vidual requires inpatient treatment in a
11 hospital or a psychiatric hospital in order
12 to initiate, change, or adjust pharma-
13 cological or somatic therapy.

14 (E) INPATIENT HOSPITAL TREATMENT
15 FOR SUBSTANCE ABUSE.—Such treatment,
16 when provided in a hospital or a psychiatric
17 hospital with respect to a diagnosable substance
18 abuse disorder, is covered under this section
19 only for detoxification requiring the manage-
20 ment of psychiatric conditions associated with
21 withdrawal from alcohol or drugs. The items
22 and services described in this section do not in-
23 clude medical detoxification as required for the
24 management of medical conditions associated

1 with withdrawal from alcohol or drugs (which is
2 covered under section 1111).

3 (d) INTENSIVE NONRESIDENTIAL TREATMENT.—

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

10 (A) participating in a partial hospitaliza-
11 tion program, a day treatment program, a psy-
12 chiatric rehabilitation program, or an ambula-
13 tory detoxification program; or

14 (B) receiving home-based mental illness
15 services or behavioral aide mental illness serv-
16 ices.

17 The National Health Board shall specify those
18 health professional services described in section 1112
19 that shall be treated as intensive nonresidential men-
20 tal illness and substance abuse treatment when pro-
21 vided to such an individual.

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

1 (A) DISCRETION OF PLAN.—An individual 1
2 shall receive coverage for such treatment if a 2
3 health professional designated by the health 3
4 plan in which the individual is enrolled deter- 4
5 mines (based on criteria that the plan may 5
6 choose to employ) that the individual should re- 6
7 ceive such treatment. 7

8 (B) TREATMENT PURPOSES.—Such treat- 8
9 ment is covered only when provided— 9

10 (i) to avert the need for, or as an al- 10
11 ternative to, treatment in residential or in- 11
12 patient settings; 12

13 (ii) to facilitate the earlier discharge 13
14 of an individual receiving inpatient or resi- 14
15 dential care; 15

16 (iii) to restore the functioning of an 16
17 individual with a diagnosable mental dis- 17
18 order or a diagnosable substance abuse 18
19 disorder; or 19

20 (iv) to assist such an individual to de- 20
21 velop the skills and gain access to the sup- 21
22 port services the individual needs to 22
23 achieve the maximum level of functioning 23
24 of the individual within the community. 24

25 (C) ANNUAL LIMIT.— 25

1 (i) IN GENERAL.—Prior to January 1,
2 2001, the number of covered days of inpa-
3 tient and residential mental illness and
4 substance abuse treatment that are avail-
5 able to an individual under the 30-day
6 limit described in the first sentence of sub-
7 section (c)(2)(D) shall be reduced by 1 day
8 for each 2 covered days of intensive
9 nonresidential mental illness and substance
10 abuse treatment that are provided to the
11 individual, until such number is reduced to
12 zero.

13 (ii) ADDITIONAL DAYS.—After the
14 number of covered days referred to in
15 clause (i) has been reduced to zero with re-
16 spect to an individual, the individual shall
17 receive coverage for a maximum of 60 days
18 of intensive nonresidential mental illness
19 and substance abuse treatment if a health
20 professional designated by the health plan
21 in which the individual is enrolled deter-
22 mines that the individual should receive
23 such treatment.

24 (D) DETOXIFICATION.—Intensive
25 nonresidential mental illness and substance

1 abuse treatment consisting of detoxification is 1
2 covered only if it is provided in the context of 2
3 a treatment program. 3

4 (E) OUT-OF-POCKET MAXIMUM.—Prior to 4
5 January 1, 2001, expenses for intensive 5
6 nonresidential mental illness and substance 6
7 abuse treatment that an individual incurs prior 7
8 to satisfying a deductible applicable to such 8
9 treatment, and copayments and coinsurance 9
10 paid by or on behalf of the individual for such 10
11 treatment, may not be applied toward any an- 11
12 nual out-of-pocket limit on cost sharing under 12
13 any cost sharing schedule described in part 3 of 13
14 this subtitle if such treatment is provided— 14

15 (i) with respect to a diagnosable sub- 15
16 stance abuse disorder; or 16

17 (ii) pursuant to subparagraph (C)(ii). 17

18 (e) OUTPATIENT TREATMENT.— 18

19 (1) DEFINITION.—For purposes of this subtitle, 19
20 the term “outpatient mental illness and substance 20
21 abuse treatment” means the following services pro- 21
22 vided with respect to a diagnosable mental disorder 22
23 or a diagnosable substance abuse disorder in an out- 23
24 patient setting: 24

25 (A) Screening and assessment. 25

(B) Diagnosis.

(C) Medical management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

(I) Collateral services.

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

(A) HEALTH PROFESSIONAL SERVICES.—

Such treatment is covered only when it constitutes health professional services (as defined in section 1112(c)(2)).

(B) DISCRETION OF PLAN.—An individual

shall receive coverage for outpatient mental illness and substance abuse treatment consisting of substance abuse counseling and relapse prevention if a health professional designated by the health plan in which the individual is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment. This subpara-

graph does not apply to group therapy covered pursuant to subparagraph (C)(ii)(II).

(C) ANNUAL LIMITS.—

(i) PSYCHOTHERAPY AND COLLATERAL SERVICES.—Prior to January 1, 2001, psychotherapy and collateral services are subject to an aggregate annual limit of 30 visits per individual. Additional visits may be covered, at the discretion of the health plan in which the individual receiving treatment is enrolled, to prevent hospitalization or to facilitate earlier hospital release, for which the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits. After such number has been reduced to zero, no additional visits under the preceding sentence may be covered.

(ii) SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION.—

(I) IN GENERAL.—Except as provided in subclause (II), the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits for substance abuse counseling and relapse prevention that are covered for the individual under subparagraph (B). After such number has been reduced to zero, no visits for substance abuse counseling and relapse prevention may be covered, except as provided in subclause (II).

(II) GROUP THERAPY.—Prior to January 1, 2001, substance abuse counseling and relapse prevention consisting of group therapy is subject to a separate aggregate annual limit of 30 visits, if such therapy occurs within 12 months after the individual has received, with respect to a diagnosable

1 substance abuse disorder, inpatient
2 and residential mental illness and sub-
3 stance abuse treatment or intensive
4 nonresidential mental illness and sub-
5 stance abuse treatment. The provi-
6 sions of clause (i) and subclause (I)
7 do not apply to therapy that is de-
8 scribed in the preceding sentence.

9 (D) DETOXIFICATION.—Outpatient mental
10 illness and substance abuse treatment consist-
11 ing of detoxification is covered only if it is pro-
12 vided in the context of a treatment program.

13 (E) OUT-OF-POCKET MAXIMUM.—Prior to
14 January 1, 2001, expenses for outpatient men-
15 tal illness and substance abuse treatment that
16 an individual incurs prior to satisfying a de-
17 ductible applicable to such treatment, and
18 copayments and coinsurance paid by or on be-
19 half of the individual for such treatment, may
20 not be applied toward any annual out-of-pocket
21 limit on cost sharing under any cost sharing
22 schedule described in part 3 of this subtitle.

23 (f) OTHER DEFINITIONS.—For purposes of this sub-
24 title:

1 (1) CASE MANAGEMENT.—The term “case man-
2 agement” means services that assist individuals in
3 gaining access to needed medical, social, educational,
4 and other services.

5 (2) DIAGNOSABLE MENTAL DISORDER AND
6 DIAGNOSABLE SUBSTANCE ABUSE DISORDER.—The
7 terms “diagnosable mental disorder” and
8 “diagnosable substance abuse disorder” mean a dis-
9 order that—

10 (A) is listed in the Diagnostic and Statis-
11 tical Manual of Mental Disorders, Third Edi-
12 tion, Revised or a revised version of such man-
13 ual (except V Codes for Conditions Not Attrib-
14 utable to a Mental Disorder That Are a Focus
15 of Attention or Treatment);

16 (B) is the equivalent of a disorder de-
17 scribed in subparagraph (A), but is listed in the
18 International Classification of Diseases, 9th Re-
19 vision, Clinical Modification, Third Edition or a
20 revised version of such text; or

21 (C) is listed in any authoritative text speci-
22 fying diagnostic criteria for mental disorders or
23 substance abuse disorders that is identified by
24 the National Health Board.

1 (3) PSYCHIATRIC HOSPITAL.—The term “psy-
2 chiatric hospital” has the meaning given such term
3 in section 1861(f) of the Social Security Act, except
4 that such term shall include—

5 (A) in the case of an item or service pro-
6 vided to an individual whose applicable health
7 plan is specified pursuant to section 1004(b)(1),
8 a facility of the uniformed services under title
9 10, United States Code, that is engaged in pro-
10 viding services to inpatients that are equivalent
11 to the services provided by a psychiatric hos-
12 pital;

13 (B) in the case of an item or service pro-
14 vided to an individual whose applicable health
15 plan is specified pursuant to section 1004(b)(2),
16 a facility operated by the Department of Veter-
17 ans Affairs that is engaged in providing services
18 to inpatients that are equivalent to the services
19 provided by a psychiatric hospital; and

20 (C) in the case of an item or service pro-
21 vided to an individual whose applicable health
22 plan is specified pursuant to section 1004(b)(3),
23 a facility operated by the Indian Health Service
24 that is engaged in providing services to inpa-

tients that are equivalent to the services provided by a psychiatric hospital.

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

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

(1) Voluntary family planning services.

(2) Contraceptive devices that—

(A) may only be dispensed upon prescription; and

(B) are subject to approval by the Secretary of Health and Human Services under the Federal Food, Drug, and Cosmetic Act.

(3) Services for pregnant women.

SEC. 1117. HOSPICE CARE.

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

1 SEC. 1118. HOME HEALTH CARE.

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

4 (1) the items and services described in section
5 1861(m) of the Social Security Act; and

6 (2) home infusion drug therapy services de-
7 scribed in section 1861(ll) of the Social Security Act
8 (as inserted by section 2005).

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

11 (1) **INPATIENT TREATMENT ALTERNATIVE.**—

12 Such care is covered only as an alternative to inpa-
13 tient treatment in a hospital, skilled nursing facility,
14 or rehabilitation facility after an illness or injury.

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

22 SEC. 1119. EXTENDED CARE SERVICES.

23 (a) **COVERAGE.**—The extended care services de-
24 scribed in this section are the items and services described
25 in section 1861(h) of the Social Security Act when pro-

vided to an inpatient of a skilled nursing facility or a rehabilitation facility.

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

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

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

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

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

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

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

(B) rehabilitation services to residents for rehabilitation from illness or injury.

1 **SEC. 1120. AMBULANCE SERVICES.**

2 (a) **COVERAGE.**—The ambulance services described in
3 this section are the following items and services:

4 (1) Ground transportation by ambulance.

5 (2) Air transportation by an aircraft equipped
6 for transporting an injured or sick individual.

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

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

11 (1) **MEDICAL INDICATION.**—Ambulance services
12 are covered only in cases in which the use of an am-
13 bulance is indicated by the medical condition of the
14 individual concerned.

15 (2) **AIR TRANSPORT.**—Air transportation is cov-
16 ered only in cases in which there is no other method
17 of transportation or where the use of another meth-
18 od of transportation is contra-indicated by the medi-
19 cal condition of the individual concerned.

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

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

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

SEC. 1122. OUTPATIENT PRESCRIPTION DRUGS AND BIOLOGICALS.

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

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

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

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

(ii) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hos-

1 pital Formulary Service-Drug Information,
2 the American Medical Association Drug
3 Evaluations, the United States Pharma-
4 copoeia-Drug Information, and other au-
5 thoritative compendia as identified by the
6 Secretary, unless the Secretary has deter-
7 mined that the use is not medically appro-
8 priate or the use is identified as not indi-
9 cated in one or more such compendia; or

10 (iii) such use is medically accepted
11 based on supportive clinical evidence in
12 peer reviewed medical literature appearing
13 in publications which have been identified
14 for purposes of this clause by the Sec-
15 retary; and

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

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

22 (b) REVISION OF COMPENDIA LIST.—The Secretary
23 may revise the list of compendia in subsection (a)(1)(A)(ii)
24 designated as appropriate for identifying medically accept-
25 ed indications for drugs.

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

SEC. 1123. OUTPATIENT REHABILITATION SERVICES.

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

- (1) outpatient occupational therapy;
- (2) outpatient physical therapy; and
- (3) outpatient speech pathology services for the purpose of attaining or restoring speech.

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

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

- (2) REEVALUATION.—At the end of each 60-day period of outpatient rehabilitation services, the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that functioning is improving.

1 **SEC. 1124. DURABLE MEDICAL EQUIPMENT AND PROS-**
2 **THETIC AND ORTHOTIC DEVICES.**

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

5 (1) durable medical equipment, including acces-
6 sories and supplies necessary for repair, function,
7 and maintenance of such equipment;

8 (2) prosthetic devices (other than dental de-
9 vices) which replace all or part of the function of an
10 internal body organ (including colostomy bags and
11 supplies directly related to colostomy care), including
12 replacement of such devices;

13 (3) accessories and supplies which are used di-
14 rectly with a prosthetic device to achieve the thera-
15 peutic benefits of the prosthesis or to assure the
16 proper functioning of the device;

17 (4) leg, arm, back, and neck braces;

18 (5) artificial legs, arms, and eyes, including re-
19 placements if required because of a change in the
20 patient's physical condition; and

21 (6) fitting and training for use of the items de-
22 scribed in paragraphs (1) through (5).

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

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

SEC. 1125. VISION CARE.

(a) COVERAGE.—The vision care described in this section is diagnosis and treatment for defects in vision.

(b) LIMITATION.—Eyeglasses and contact lenses are covered only for individuals less than 18 years of age.

SEC. 1126. DENTAL CARE.

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

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

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

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

1 (4) Space maintenance procedures to prevent
2 orthodontic complications.

3 (5) Interceptive orthodontic treatment to pre-
4 vent severe malocclusion.

5 (b) LIMITATIONS.—Coverage for dental care is sub-
6 ject to the following limitations:

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

15 (2) TREATMENT OF DENTAL DISEASE.—Prior
16 to January 1, 2001, the items and services described
17 in subsection (a)(3) are covered only for individuals
18 less than 18 years of age. On or after such date,
19 such items and services are covered for all eligible
20 individuals enrolled under a health plan, except that
21 endodontic services are not covered for individuals
22 18 years of age or older.

23 (3) SPACE MAINTENANCE.—The items and
24 services described in subsection (a)(4) are covered

prevent only for individuals at least 3 years of age, but less
2 than 13 years of age and—

to pre- (A) are limited to posterior teeth;

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

(C) do not include a space maintainer that
is placed within 6 months of the expected erup-
tion of the permanent posterior tooth con-
cerned.

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

SEC. 1127. HEALTH EDUCATION CLASSES.

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

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

3 (c) CONSTRUCTION.—This section shall not be con-
4 strued to include or limit education or training that is pro-
5 vided in the course of the delivery of health professional
6 services (as defined in section 1112(c)).

7 **SEC. 1128. INVESTIGATIONAL TREATMENTS.**

8 (a) COVERAGE.—Subject to subsection (b), the items
9 and services described in this subsection are qualifying in-
10 vestigational treatments that are administered for a life-
11 threatening disease, disorder, or other health condition (as
12 defined by the National Health Board).

13 (b) DISCRETION OF PLAN.—A health plan may cover
14 an investigational treatment described in subsection (a) at
15 its discretion.

16 (c) ROUTINE CARE DURING INVESTIGATIONAL
17 TREATMENTS.—The comprehensive benefit package in-
18 cludes an item or service described in any other section
19 of this part, subject to the limitations and cost sharing
20 requirements applicable to the item or service, when the
21 item or service is provided to an individual in the course
22 of an investigational treatment, if—

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

1 (2) the item or service would have been pro-
2 vided to the individual even if the individual were
3 not receiving the investigational treatment.

4 (d) DEFINITIONS.—For purposes of this subtitle:

5 (1) QUALIFYING INVESTIGATIONAL TREAT-
6 MENT.—The term “qualifying investigational treat-
7 ment” means a treatment—

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

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

12 (2) APPROVED RESEARCH TRIAL.—The term
13 “approved research trial” means—

14 (A) a research trial approved by the Sec-
15 retary of Health and Human Services, the Di-
16 rector of the National Institutes of Health, the
17 Commissioner of the Food and Drug Adminis-
18 tration, the Secretary of Veterans Affairs, the
19 Secretary of Defense, or a qualified nongovern-
20 mental research entity as defined in guidelines
21 of the National Institutes of Health; or

22 (B) a peer-reviewed and approved research
23 program, as defined by the Secretary of Health
24 and Human Services, conducted for the primary
25 purpose of determining whether or not a treat-

1 ment is safe, efficacious, or having any other
2 characteristic of a treatment which must be
3 demonstrated in order for the treatment to be
4 medically necessary or appropriate.

5 **PART 3—COST SHARING**

6 **SEC. 1131. COST SHARING.**

7 (a) **IN GENERAL.**—Each health plan shall offer to in-
8 dividuals enrolled under the plan one, but not more than
9 one, of the following cost sharing schedules, which sched-
10 ule shall be offered to all such enrollees:

11 (1) Lower cost sharing (described in section
12 1132).

13 (2) Higher cost sharing (described in section
14 1133).

15 (3) Combination cost sharing (described in sec-
16 tion 1134).

17 (b) **COST SHARING FOR LOW-INCOME FAMILIES.**—
18 For provisions relating to reducing cost sharing for certain
19 low-income families, see section 1371.

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

22 (1) **APPLICATION ON AN ANNUAL BASIS.**—The
23 deductibles and out-of-pocket limits on cost sharing
24 for a year under the schedules referred to in sub-

section (a) shall be applied based upon expenses incurred for items and services furnished in the year.

(2) INDIVIDUAL AND FAMILY GENERAL DEDUCTIBLES.—

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

(B) FAMILY.—In the case of an individual enrolled under a health plan under a family class of enrollment (as defined in section 1011(c)(2)(A)), the individual general deductible under subparagraph (A) shall not apply to countable expenses incurred by any member of the individual's family in a year at such time as the family has incurred, in the aggregate, countable expenses in the amount of the family general deductible for the year.

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

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

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

(A) INDIVIDUAL.—Subject to subparagraph (B), with respect to an individual en-

1 rolled under a health plan (regardless of the
2 class of enrollment), the individual out-of-pocket
3 limit on cost sharing in the cost sharing
4 schedule offered by the plan represents the
5 amount of expenses that the individual may be
6 required to incur under the plan in a year be-
7 cause of a general deductible, separate
8 deductibles, copayments, and coinsurance before
9 the plan may no longer impose any cost sharing
10 with respect to items or services covered by the
11 comprehensive benefit package that are pro-
12 vided to the individual, except as provided in
13 subsections (d)(2)(E) and (e)(2)(E) of section
14 1115.

15 (B) FAMILY.—In the case of an individual
16 enrolled under a health plan under a family
17 class of enrollment (as defined in section
18 1011(c)(2)(A)), the family out-of-pocket limit
19 on cost sharing in the cost sharing schedule of-
20 fered by the plan represents the amount of ex-
21 penses that members of the individual's family,
22 in the aggregate, may be required to incur
23 under the plan in a year because of a general
24 deductible, separate deductibles, copayments,
25 and coinsurance before the plan may no longer

1 impose any cost sharing with respect to items
2 or services covered by the comprehensive benefit
3 package that are provided to any member of the
4 individual's family, except as provided in sub-
5 sections (d)(2)(E) and (e)(2)(E) of section
6 1115.

7 **SEC. 1132. LOWER COST SHARING.**

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

11 (1) may not include a deductible;

12 (2) shall have—

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

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

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

18 (A) shall prohibit payment of any coinsur-
19 ance; and

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

24 (4) shall require payment of coinsurance for an
25 out-of-network item or service (as defined in section

1 1402(f)) in an amount that is a percentage (deter-
2 mined under subsection (b)) of the applicable pay-
3 ment rate for the item or service established under
4 section 1322(c), but only if the item or service is
5 subject to coinsurance under the higher cost sharing
6 schedule described in section 1133.

7 (b) OUT-OF-NETWORK COINSURANCE PERCENT-
8 AGE.—

9 (1) IN GENERAL.—The National Health Board
10 shall determine a percentage referred to in sub-
11 section (a)(4). The percentage—

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

13 (B) shall be the same with respect to all
14 out-of-network items and services that are sub-
15 ject to coinsurance, except as provided in para-
16 graph (2).

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

1 **SEC. 1133. HIGHER COST SHARING.**

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

5 (1) shall have an annual individual general de-
6 ductible of \$200 and an annual family general de-
7 ductible of \$400 that apply with respect to expenses
8 incurred for all items and services in the comprehen-
9 sive benefit package except—

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

13 (B) an item or service described in para-
14 graph (5), (6), or (7) with respect to which a
15 deductible does not apply;

16 (2) shall require an individual to incur expenses
17 during each episode of inpatient and residential
18 mental illness and substance abuse treatment (de-
19 scribed in section 1115(c)) equal to the cost of one
20 day of such treatment before the plan provides bene-
21 fits for such treatment to the individual;

22 (3) shall require an individual to incur expenses
23 during each episode of intensive nonresidential men-
24 tal illness and substance abuse treatment (described
25 in section 1115(d)) equal to the cost of one day of

1 such treatment before the plan provides benefits for
2 such treatment to the individual;

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

8 (5) shall require an individual to incur expenses
9 in a year for dental care described in section 1126,
10 except the items and services for prevention and di-
11 agnosis of dental disease described in section
12 1126(a)(2), equal to \$50 before the plan provides
13 benefits for such care to the individual;

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

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

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

22 (9) shall have—

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

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

3 (10) shall prohibit payment of any copayment;
4 and

5 (11) subject to section 1152, shall require pay-
6 ment of the coinsurance for an item or service (if
7 any) that is specified for the item or service in the
8 table under section 1135.

9 (b) EPISODES OF TREATMENT.—

10 (1) INPATIENT AND RESIDENTIAL TREAT-
11 MENT.—For purposes of subsection (a)(2), an epi-
12 sode of inpatient and residential mental illness and
13 substance abuse treatment shall be considered to
14 begin on the date an individual is admitted to a fa-
15 cility for such treatment and to end on the date the
16 individual is discharged from the facility.

17 (2) INTENSIVE NONRESIDENTIAL TREAT-
18 MENT.—For purposes of subsection (a)(3), an epi-
19 sode of intensive nonresidential mental illness and
20 substance abuse treatment—

21 (A) shall be considered to begin on the
22 date an individual begins participating in a pro-
23 gram described in section 1115(d)(1)(A) and to
24 end on the date the individual ceases such par-
25 ticipation; or

limit on
1 (B) shall be considered to begin on the
2 date an individual begins receiving home-based
3 or behavioral aide services described in section
4 1115(d)(1)(B) and to end on the date the indi-
5 vidual ceases to receive such services.

6 **SEC. 1134. COMBINATION COST SHARING.**

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

TREAT-
10 (1) shall have—

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

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

red to
15 (2) otherwise shall require different cost shar-
16 ing for in-network items and services than for out-
17 of-network items and services.

TREAT-
18 (b) IN-NETWORK ITEMS AND SERVICES.—With re-
19 spect to an in-network item or service (as defined in sec-
20 tion 1402(f)(1)), the combination cost sharing schedule
21 that is offered by a health plan—

on the
22 (1) may not apply a deductible;

a pro-
23 (2) shall prohibit payment of any coinsurance;

and to
24 and

1 (3) shall require payment of a copayment in ac-
 2 cordance with the lower cost sharing schedule de-
 3 scribed in section 1132.

4 (c) OUT-OF-NETWORK ITEMS AND SERVICES.—With
 5 respect to an out-of-network item or service (as defined
 6 in section 1402(f)(2)), the combination cost sharing sched-
 7 ule that is offered by a health plan—

8 (1) shall require an individual and a family to
 9 incur expenses before the plan provides benefits for
 10 the item or service in accordance with the
 11 deductibles under the higher cost sharing schedule
 12 described in section 1133;

13 (2) shall prohibit payment of any copayment;
 14 and

15 (3) shall require payment of coinsurance in ac-
 16 cordance with such schedule.

17 **SEC. 1135. TABLE OF COPAYMENTS AND COINSURANCE.**

18 (a) IN GENERAL.—The following table specifies, for
 19 different items and services, the copayments and coinsur-
 20 ance referred to in sections 1132 and 1133:

21

Copayments and Coinsurance for Items and Services

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Inpatient hospital services	1111	No copayment	20 percent of applicable payment rate
Outpatient hospital services ...	1111	\$10 per visit	20 percent of applicable payment rate

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Hospital emergency room services	1111	\$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Services of health professionals	1112	\$10 per visit	20 percent of applicable payment rate
Emergency services other than hospital emergency room services	1113	\$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Ambulatory medical and surgical services	1113	\$10 per visit	20 percent of applicable payment rate
Clinical preventive services	1114	No copayment	No coinsurance
Inpatient and residential mental illness and substance abuse treatment	1115	No copayment	20 percent of applicable payment rate
Intensive nonresidential mental illness and substance abuse treatment (except treatment provided pursuant to section 1115(d)(2)(C)(ii))	1115	No copayment	20 percent of applicable payment rate
Intensive nonresidential mental illness and substance abuse treatment provided pursuant to section 1115(d)(2)(C)(ii)	1115	\$25 per visit	50 percent of applicable payment rate
Outpatient mental illness and substance abuse treatment (except psychotherapy, collateral services, and case management)	1115	\$10 per visit	20 percent of applicable payment rate
Outpatient psychotherapy and collateral services	1115	\$25 per visit until January 1, 2001, and \$10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Case management	1115	No copayment	No coinsurance
Family planning and services for pregnant women (except clinician visits and associated services related to prenatal care and 1 post-partum visit)	1116	\$10 per visit	20 percent of applicable payment rate
Clinician visits and associated services related to prenatal care and 1 post-partum visit	1116	No copayment	No coinsurance
Hospice care	1117	No copayment	20 percent of applicable payment rate
Home health care	1118	No copayment	20 percent of applicable payment rate
Extended care services	1119	No copayment	20 percent of applicable payment rate
Ambulance services	1120	No copayment	20 percent of applicable payment rate
Outpatient laboratory, radiology, and diagnostic services	1121	No copayment	20 percent of applicable payment rate
Outpatient prescription drugs and biologicals	1122	\$5 per prescription	20 percent of applicable payment rate
Outpatient rehabilitation services	1123	\$10 per visit	20 percent of applicable payment rate
Durable medical equipment and prosthetic and orthotic devices	1124	No copayment	20 percent of applicable payment rate
Vision care	1125	\$10 per visit (No additional charge for 1 set of necessary eyeglasses for an individual less than 18 years of age)	20 percent of applicable payment rate
Dental care (except space maintenance procedures and interceptive orthodontic treatment)	1126	\$10 per visit	20 percent of applicable payment rate
Space maintenance procedures and interceptive orthodontic treatment	1126	\$20 per visit	40 percent of applicable payment rate

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Health education classes	1127	All cost sharing rules determined by plans	All cost sharing rules determined by plans
Investigational treatment for life-threatening condition ...	1128	All cost sharing rules determined by plans	All cost sharing rules determined by plans

(b) **APPLICABLE PAYMENT RATE.**—For purposes of this section, the term “applicable payment rate”, when used with respect to an item or service, means the applicable payment rate for the item or service established under section 1322(c).

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

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

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

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

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

2 (2) more than \$200, but less than \$500, to the

3 nearest multiple of \$5, or

4 (3) \$500 or more, to the nearest multiple of
5 \$10.

6 (d) FACTOR.—

7 (1) IN GENERAL.—The factor described in this
8 subsection for a year is 1 plus the general health
9 care inflation factor (as specified in section
10 6001(a)(3) and determined under paragraph (2)) for
11 the year.

12 (2) DETERMINATION.—In computing such fac-
13 tor for a year, the percentage increase in the CPI
14 for a year (referred to in section 6001(b)) shall be
15 determined based upon the percentage increase in
16 the average of the CPI for the 12-month period end-
17 ing with August 31 of the previous year over such
18 average for the preceding 12-month period.

19 **PART 4—EXCLUSIONS**

20 **SEC. 1141. EXCLUSIONS.**

21 (a) MEDICAL NECESSITY.—The comprehensive bene-
22 fit package does not include—

23 (1) an item or service that is not medically nec-
24 essary or appropriate; or

1 (2) an item or service that the National Health
2 Board may determine is not medically necessary or
3 appropriate in a regulation promulgated under sec-
4 tion 1154.

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

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

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

13 (A) required to correct a congenital anom-
14 aly; or

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

17 (i) accidental injury;

18 (ii) disease; or

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

21 (3) Hearing aids.

22 (4) Eyeglasses and contact lenses for individ-
23 uals at least 18 years of age.

24 (5) In vitro fertilization services.

25 (6) Sex change surgery and related services.

1 (7) Private duty nursing.

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

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

10 **PART 5—ROLE OF THE NATIONAL HEALTH**

11 **BOARD**

12 **SEC. 1151. DEFINITION OF BENEFITS.**

13 (a) IN GENERAL.—The National Health Board may
14 promulgate such regulations or establish such guidelines
15 as may be necessary to assure uniformity in the applica-
16 tion of the comprehensive benefit package across all health
17 plans.

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

23 **SEC. 1152. ACCELERATION OF EXPANDED BENEFITS.**

24 (a) IN GENERAL.—Subject to subsection (b), at any
25 time prior to January 1, 2001, the National Health

Board, in its discretion, may by regulation expand the comprehensive benefit package by—

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

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

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

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

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

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

1 (1) shall specify and define specific items and
2 services as clinical preventive services for high risk
3 populations and shall establish and update a perio-
4 dicity schedule for such items and services;

5 (2) shall update the periodicity schedules for
6 the age-appropriate immunizations, tests, and clini-
7 cian visits specified in subsections (b) through (h) of
8 such section;

9 (3) shall establish rules with respect to coverage
10 for an immunization, test, or clinician visit that is
11 not provided to an individual during the age range
12 for such immunization, test, or clinician visit that is
13 specified in one of subsections (b) through (h) of
14 such section; and

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

19 (b) CONSULTATION.—In performing the functions de-
20 scribed in subsection (a), the National Health Board shall
21 consult with experts in clinical preventive services.

22 **SEC. 1154. ESTABLISHMENT OF STANDARDS REGARDING**
23 **MEDICAL NECESSITY.**

24 The National Health Board may promulgate such
25 regulations as may be necessary to carry out section

1a 1141(a)(2) (relating to the exclusion of certain services
2 that are not medically necessary or appropriate).

3 **PART 6—ADDITIONAL PROVISIONS RELATING TO**
4 **HEALTH CARE PROVIDERS**

5 **SEC. 1161. OVERRIDE OF RESTRICTIVE STATE PRACTICE**
6 **LAWS.**

7 No State may, through licensure or otherwise, re-
8 strict the practice of any class of health professionals be-
9 yond what is justified by the skills and training of such
10 professionals.

11 **SEC. 1162. PROVISION OF ITEMS OR SERVICES CONTRARY**
12 **TO RELIGIOUS BELIEF OR MORAL CONVIC-**
13 **TION.**

14 A health professional or a health facility may not be
15 required to provide an item or service in the comprehen-
16 sive benefit package if the professional or facility objects
17 to doing so on the basis of a religious belief or moral con-
18 viction.

19 **Subtitle C—State Responsibilities**

20 **SEC. 1200. PARTICIPATING STATE.**

21 (a) IN GENERAL.—For purposes of the approval of
22 a State health care system by the Board under section
23 1511, a State is a “participating State” if the State meets
24 the applicable requirements of this subtitle.

25 (b) SUBMISSION OF SYSTEM DOCUMENT.—