105TH CONGRESS
2D SESSION

S. 2074

To guarantee for all Americans quality, affordable, and comprehensive health care coverage.

IN THE SENATE OF THE UNITED STATES

MAY 13, 1998

Mr. WELLSTONE introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To guarantee for all Americans quality, affordable, and comprehensive health care coverage.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Healthy Americans Act''.

(b) TABLE OF CONTENTS.—The table of contents of the Act is as follows:

TITLE I—STATE UNIVERSAL HEALTH INSURANCE COVERAGE PROGRAMS—PHASE I

Subtitle A—Expansion of SCHIP To Provide Health Insurance Coverage to Additional Individuals

SEC. 101. PHASE I STATE UNIVERSAL HEALTH INSURANCE COVERAGE PLANS.

Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended—

(1) by striking the title heading and inserting the following:

"TITLE XXI—STATE HEALTH INSURANCE PROGRAMS

"PART A—STATE CHILDREN'S HEALTH INSURANCE PROGRAM";

and

(2) by adding at the end the following:

"PART B—STATE UNIVERSAL HEALTH INSURANCE COVERAGE PROGRAM—PHASE I

"SEC. 2121. PURPOSE; STATE PLANS.

"(a) PURPOSE.—The purpose of this part is to provide funds to participating States to enable those States to initiate and expand State-administered systems of

health insurance coverage for individuals and families with incomes at or below 300 percent of the poverty line.

''(b) PHASE I STATE UNIVERSAL COVERAGE PLAN REQUIRED.—A State is not eligible for a payment under section 2125(a) unless the State has submitted to the Secretary a plan that—

''(1) sets forth how the State intends to use the funds provided under this part to expand the State children's health insurance program under part A to provide universal health insurance coverage to eligible individuals and families within the State consistent with the provisions of this part; and

''(2) has been approved under section 2122(d).

''SEC. 2122. PLAN REQUIREMENTS.

''(a) IN GENERAL.—A phase I State universal health insurance coverage plan shall include a description, consistent with the requirements of this part, of the following:

''(1) INFORMATION ON THE CURRENT LEVEL OF HEALTH INSURANCE COVERAGE.—

''(A) The current level of health insurance coverage within the State as determined under subsection (b) and the base coverage gap for the year involved as determined under subsection (b)(4).

"(B) Current State efforts to provide or obtain health care coverage for uncovered individuals, including the steps the State is taking to identify and enroll all uncovered individuals who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships.

"(2) DETAILS OF, AND TIMELINES FOR, THE PHASE I STATE UNIVERSAL COVERAGE PLAN.—

"(A) The activities that the State intends to carry out using funds received under this part, including how the State will coordinate efforts under the program under this part with existing State efforts to increase the health care coverage of individuals.

"(B) Consistent with subsection (c), the manner in which the State will reduce the base coverage gap for the year involved, including a timetable with specified targets for reducing the base coverage gap by 50 percent in 2 years and 100 percent in 4 years.

"(3) DETAILS REGARDING MAINTENANCE OF PRIVATE LEVELS OF FINANCIAL SUPPORT.—The manner in which the State will ensure that employers within the State will continue to provide existing

levels of financial support toward the health insurance premiums required for coverage of their employees.

''(4) DETAILS OF, AND TIMELINES FOR, STATE OUTREACH PROGRAMS.—The manner in which, including a timetable, the State will institute outreach programs funded under section 121 of the Healthy Americans Act.

''(5) DESCRIPTION OF THE PHASE II PLAN.—A description of the process that will be used to develop the phase II State universal health insurance coverage plan required under part C, including the timelines for developing the plan.

''(6) OTHER MATTERS.—Any other matter determined appropriate by the Secretary.

''(b) CURRENT LEVEL OF COVERAGE.—

''(1) IN GENERAL.—The Secretary, using the most recent Medical Expenditure Panel Survey conducted by the Agency for Health Care Policy and Research, another survey selected by the Secretary, or an alternative system approved under paragraph (3), shall determine the percentage of the population of the State that is currently covered by a health insurance plan or program.

''(2) BIANNUAL SURVEY.—The Secretary, acting through the Agency for Health Care Policy and Research, shall provide for the conduct of the Medical Expenditure Panel Survey (or another survey selected by the Secretary) not less than biannually to make coverage determinations for purposes of paragraph (1).

''(3) USE OF ALTERNATIVE SYSTEM.—The Secretary shall permit a State to utilize an alternative population-based monitoring system to make determinations with respect to coverage in the State for purposes of paragraph (1) if the Secretary, acting through the Health Care Financing Administration, determines that such system meets or exceeds the methodological standards utilized in the Medical Expenditure Panel Survey.

''(4) BASE COVERAGE GAP.—For purposes of subsection (a)(1)(A), the base coverage gap for a State shall be equal to 100 percent of the eligible individuals and families in the State for the year involved that have income equal to or less than 300 percent of the poverty line, less the current level of coverage for those individuals and families for such year as determined under paragraph (1).

''(c) REDUCING THE LEVEL OF UNINSURED INDIVIDUALS.—

''(1) IN GENERAL.—To be eligible to receive funds under this part, a State shall agree to administer a phase I State universal health insurance coverage plan with a goal of providing health care coverage for 100 percent of the eligible individuals and families who reside in the State and who have income that is equal to or less than 300 percent of the poverty line by not later than September 30, 2003.

''(2) PERMISSIBLE ACTIVITIES.—A State may use amounts provided under this part for any activities consistent with this part that are appropriate to enroll individuals in health plans and health programs to meet the targets contained in the State plan under subsection (a)(2)(B), including through the use of direct payments to health plans or providers of services.

''(d) PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF PHASE I STATE PLAN.—The provisions of section 2106 apply to a phase I State plan under this part in the same manner as they apply to a State plan under part A, except that no phase I State plan may be effective earlier than October 1, 1998, and all phase I

State plans must be submitted for approval by not later than September 30, 1999.

"SEC. 2123. COVERAGE REQUIREMENTS FOR PHASE I STATE PLANS.

"(a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE.—Health insurance coverage provided under this part shall consist of any of the following:

"(1) BENCHMARK COVERAGE.—Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b).

"(2) BENCHMARK-EQUIVALENT COVERAGE.—Health benefits coverage that satisfies the requirements of section 2103(a)(2).

"(3) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the individuals and families residing in the State who have income at or below 300 percent of the poverty line.

"(b) COST-SHARING.—

"(1) DESCRIPTION; GENERAL CONDITIONS.—

"(A) DESCRIPTION.—A phase I State universal health insurance coverage plan shall include a description, consistent with this sub-

section, of the amount (if any) of premiums, deductibles, coinsurance, and other cost-sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

''(B) PROTECTION FOR LOWER INCOME INDIVIDUALS AND FAMILIES.—The phase I State plan may only vary premiums, deductibles, coinsurance, and other cost-sharing based on the income of the individuals and families eligible under the plan in a manner that does not favor individuals and families with higher income over individuals and families with lower income.

''(2) LIMITATIONS ON PREMIUMS AND COST-SHARING.—

''(A) INDIVIDUALS AND FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—In the case of an individual or family whose income is at or below 150 percent of the poverty line, the State plan may not impose—

''(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) (with respect to individuals described in such section); and

"(ii) a deductible, cost-sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

"(B) OTHER INDIVIDUALS AND FAMILIES.—For individuals and families not described in subparagraph (A), subject to paragraph (1)(B), any premiums, deductibles, cost-sharing or similar charges imposed under the phase I State plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing imposed under this part with respect to all individuals in a family may not exceed 5 percent of the family's income for the year involved.

"(c) APPLICATION OF CERTAIN REQUIREMENTS.—

"(1) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—The phase I State universal health insurance coverage plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

''(2) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

''SEC. 2124. ALLOTMENTS.

''(a) APPROPRIATION.—For the purpose of providing allotments to States under this part, there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(1) $39,000,000,000 for fiscal year 1999;

''(2) $45,000,000,000 for fiscal year 2000;

''(3) $59,000,000,000 for fiscal year 2001; and

''(4) $59,900,000,000 for fiscal year 2002 and each succeeding fiscal year thereafter.

''(b) BASE STATE ALLOCATION.—

''(1) IN GENERAL.—From the amount appropriated under subsection (a) for a fiscal year for purposes of carrying out the program under this part, after application of subsection (e), the Secretary shall allot to each State with a phase I State universal health insurance coverage plan approved

under this part an amount equal to the sum of the amounts determined under paragraphs (2) and (3).

''(2) DETERMINATION OF COST OF INDIVIDUAL COVERAGE.—The amount determined under this paragraph is the amount equal to—

''(A) the product of—

''(i) the designated Federal participation rate for the State as determined under subsection (c) and adjusted under subsection (d);

''(ii) the estimated cost for the minimum benefits package required to comply under section 2123, not to exceed the sum of—

''(I) the total annual Government and employee contributions required for individual health benefits coverage under the Blue Cross/Blue Shield standard service benefit plan offered under chapter 89 of title 5, United States Code (adjusted for age, as the Secretary determines appropriate); and

''(II) the estimated average cost-sharing expense for an individual; and

''(iii) the estimated number of eligible individuals to be enrolled in the phase I State plan; less

''(B) the sum of—

''(i) the individual health insurance contribution and cost-sharing payments to be made in accordance with section 2123(b); and

''(ii) any applicable employer contribution to such payments.

''(3) DETERMINATION OF COST OF FAMILY COVERAGE.—The amount determined under this paragraph is the amount equal to—

''(A) the product of—

''(i) the designated Federal participation rate for the State as determined under subsection (c) and adjusted under subsection (d);

''(ii) the estimated cost for the minimum benefits package required to comply under section 2123, not to exceed the sum of—

''(I) the total annual Government and employee contributions required for family health benefits coverage

under the Blue Cross/Blue Shield standard service benefit plan offered under chapter 89 of title 5, United States Code (adjusted for age, as the Secretary determines appropriate); and

''(II) the estimated average cost-sharing expense for a family; and

''(iii) the aggregate of the estimated number of eligible families to be enrolled in the phase I State plan; less

''(B) the sum of—

''(i) the family health insurance contribution and cost-sharing payments to be made in accordance with section 2123(b); and

''(ii) any applicable employer contribution to such payments.

''(c) FEDERAL PARTICIPATION RATE.—For purposes of subsection (b)(1), the Federal participation rate for a State for a fiscal year shall be equal to the enhanced FMAP determined for the State under section 2105(b).

''(d) ENHANCED STATE ALLOCATION.—

''(1) BASED ON CLOSURE OF BASE COVERAGE GAP.—

"(A) IN GENERAL.—The Secretary shall adjust the amount of the Federal participation rate under subsection (c) based on the decrease in the base coverage gap in the State. An adjustment under the preceding sentence shall apply for the 2 succeeding fiscal years.

"(B) AMOUNT OF ADJUSTMENT.—The amount of the Federal participation rate under subsection (c) with respect to a State for a fiscal year shall be increased by—

"(i) 1 percentage point if the base coverage gap of the State has decreased by at least 50 percent by the date that is 2 years after the date the Secretary approves the phase I State plan; and

"(ii) 3 percentage points if the base coverage gap of the State has decreased by 100 percent by the date that is 4 years after the date the Secretary approves the phase I State plan.

"(C) FULL COVERAGE.—For purposes of subparagraph (B)(ii), a State shall be deemed to have decreased its base coverage gap by 100 percent if the Secretary determines that—

''(i) 98 percent of all residents of the State who have individual or family income that is equal to or less than 300 percent of the poverty line are provided health insurance coverage under the phase I State plan; and

''(ii) the remaining 2 percent of such residents is served by alternative health care delivery systems as demonstrated by the State.

''(2) BASED ON EXPENDITURES FOR COVERAGE.—

''(A) IN GENERAL.—The Secretary shall adjust annually the amount of the Federal participation rate under subsection (c) if the State can demonstrate that qualified plans have spent a sufficient percentage of total premium income to provide covered health benefits in the prior year.

''(B) AMOUNT.—The amount of the Federal participation rate under subsection (b) with respect to a State for a fiscal year shall be increased by—

''(i) 0.25 percentage points if all qualified plans in the State expend at least

85 percent of total income received from premiums (excluding all costs for marketing, advertising, promotion, health plan administration, profits, or capital accumulation) on the provision of covered health benefits; and

''(ii) 0.5 percentage points if all qualified plans in the State expend at least 90 percent of total income received from premiums (excluding all costs for marketing, advertising, promotion, health plan administration, profits, or capital accumulation) on the provision of covered health benefits.

''(e) GRANTS TO INDIAN TRIBES AND NATIVE HAWAIIAN ORGANIZATIONS.—

''(1) IN GENERAL.—From the amounts appropriated under subsection (a) for a fiscal year, the Secretary shall reserve not more than 3 percent to make grants to Indian tribes and Native Hawaiian organizations for development and implementation of universal health insurance coverage plans for members of such tribes and organizations.

''(2) PLAN.—To be eligible to receive a grant under paragraph (1), an Indian tribe or Native Hawaiian organization shall submit a universal health

insurance coverage plan to the Secretary at such time, in such manner, and containing such information, as the Secretary may require.

''(3) REGULATIONS.—The Secretary shall issue regulations specifying the requirements of this part that apply to Indian tribes and Native Hawaiian organizations receiving grants under paragraph (1).

''SEC. 2125. ADMINISTRATION.

''(a) PAYMENTS.—

''(1) QUARTERLY.—The Secretary shall make quarterly payments to each State with a phase I State plan approved under this part, from its allotment under section 2124.

''(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this part for each quarter on the basis of advance estimates by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''(3) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this subsection shall be construed as preventing a State from claiming as expenditures in the

quarter expenditures that were incurred in a previous quarter.

''(b) COORDINATION.—The Secretary shall coordinate activities carried out under this part with activities carried out under titles XVIII, XIX, and part A, and under other Federal health programs.

''(c) REPORT.—Not later than January 1, 2000, and each January 1 thereafter, the Secretary, in consultation with the General Accounting Office and the Congressional Budget Office, shall prepare and submit to the appropriate committees of Congress a report on the number of States receiving payments under this part for the year for which the report is being prepared as well as the level of insurance coverage attained by each such State.

''SEC. 2126. DEFINITIONS.

''In this part:

''(1) POVERTY LINE.—The term 'poverty line' means the poverty line as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)) applicable to an individual or a family of the size involved.

''(2) ELIGIBLE INDIVIDUALS AND FAMILIES.—The term 'eligible individuals and families' means an individual or family who—

''(A) is (or consists of) a resident of the State involved;

''(B) has a family income that does not exceed 300 percent of the poverty line;

''(C) is (or consists of) a citizen of the United States, a legal resident alien, or an individual otherwise residing in the United States under the authority of Federal law; and

''(D) in the case of an individual, is not eligible for benefits under the medicare program under title XVIII or for medical assistance under the medicaid program under title XIX (other than under the application of section 1905(u)(4)).

''(3) PHASE I STATE PLAN.—The term 'phase I State plan' means the State universal health insurance coverage plan submitted under section 2121(b).

''(4) QUALIFIED PLAN.—The term 'qualified plan' means a health insurance plan that satisfies the coverage requirements described under section 2123 and participates in a phase I State plan.''.

Subtitle B—State Health Coverage Outreach Programs

SEC. 111. GRANTS FOR STATE HEALTH COVERAGE OUTREACH PROGRAMS.

(a) AUTHORITY TO AWARD GRANTS.—The Secretary of Health and Human Services shall award grants to States to establish State-administered outreach programs to maximize the enrollment of—

(1) eligible individuals in the State medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) eligible children in the State children's health insurance program under part A of title XXI of such Act (42 U.S.C. 1397aa et seq.); and

(3) eligible individuals and families in the phase I State universal health insurance coverage program under part B of title XXI of such Act (as added by section 101).

(b) STATE OUTREACH PLAN REQUIRED.—

(1) IN GENERAL.—A State is not eligible for a grant under this section unless—

(A) the State has submitted to the Secretary a plan that sets forth how the State intends to use the funds provided under this section to promote outreach efforts to maximize

the enrollment of eligible individuals for the State programs described in subsection (a) within the State; and

(B) the State notifies the Secretary that, not later than September 30, 1999, the State shall submit a phase I State universal health insurance coverage plan for approval by the Secretary in accordance with the requirements of part B of title XXI of the Social Security Act (as added by section 101).

(2) USE OF FUNDS.—Funds provided under this section may be used for any purpose that is intended to promote the outreach described in paragraph (1)(A) and is approved by the Secretary, including—

(A) implementing the use of a single application form to determine the eligibility of an individual or family for assistance or benefits under public health insurance programs and health insurance programs that involve public-private partnerships;

(B) providing for the stationing of eligibility workers at sites such as hospitals, health clinics, and schools, at which individuals receive health care or related services; and

(C) reimbursing localities and nonprofit entities for training and administrative costs associated with outreach activities.

(c) APPROPRIATION.—For the purpose of providing grants to States under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated $3,400,000,000 for each of fiscal years 1999 through 2002.

TITLE II—UNIVERSAL, AFFORDABLE, COMPREHENSIVE HEALTH CARE—PHASE II

SEC. 201. PHASE II STATE PLANS.

Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.), as amended by section 101, is amended by adding at the end the following:

''PART C—STATE UNIVERSAL HEALTH INSURANCE COVERAGE PROGRAM—PHASE II

''Subpart 1—Phase II State Universal Health Insurance Coverage Plans

''SEC. 2131. PURPOSE; STATE PLANS.

''(a) PURPOSE.—The purpose of this part is to provide funds to participating States to enable those States to establish State-administered systems to ensure universal health insurance coverage.

''(b) PHASE II STATE UNIVERSAL HEALTH INSURANCE COVERAGE PLAN REQUIRED.—A State is not eligible for a payment under section 2135(a) unless the State has submitted to the Secretary a plan that—

''(1) sets forth how the State intends to use the funds provided under this part to ensure universal, affordable, and comprehensive health insurance coverage to eligible residents of the State consistent with the provisions of this part; and

''(2) has been approved under section 2132(d).

''SEC. 2132. PLAN REQUIREMENTS.

''(a) IN GENERAL.—A phase II State universal health insurance coverage plan shall include a description, consistent with the requirements of this part, of the following:

''(1) INFORMATION ON THE CURRENT LEVEL OF HEALTH INSURANCE COVERAGE.—

''(A) The current level of health insurance coverage within the State as determined under section 2122(b)(1).

''(B) The base coverage gap for the year involved for the State, as determined under subsection (b).

''(C) Current State efforts to provide or obtain health care coverage for uncovered indi-

viduals, including the steps the State is taking to identify and enroll all uncovered individuals who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships.

''(2) DETAILS OF, AND TIMELINES FOR, THE PHASE II STATE UNIVERSAL COVERAGE PLAN.—

''(A) The activities that the State intends to carry out using funds received under this part, including how the State will coordinate efforts under the program under this part with existing State efforts to increase the health care coverage of individuals.

''(B) Consistent with subsection (c), the manner in which the State will reduce the base coverage gap for the year involved, including a timetable with specified targets for reducing the base coverage gap by 100 percent on or before September 30, 2004.

''(3) DETAILS REGARDING MAINTENANCE OF PRIVATE LEVELS OF FINANCIAL SUPPORT AND ENSURING THAT BENEFITS ARE OBTAINED.—

''(A) The manner in which the State will ensure that employers within the State will continue to provide existing levels of financial sup-

port toward the health insurance premiums required for coverage of their employees, which may include any of the following:

''(i) programs and activities to encourage the voluntary provision of employment-based health insurance coverage with voluntary employer contributions;

''(ii) State laws requiring employers to provide employment-based health insurance coverage for employees with required minimum premium contributions by such employers;

''(iii) State laws requiring employers to make payments to a health insurance purchasing fund or program for health insurance; and

''(iv) other methods devised by the State.

''(B) The manner in which the State will ensure that individuals with family income that exceeds the income level for eligibility for health insurance coverage provided under a phase I State universal health insurance coverage plan under part B will obtain health benefits coverage.

''(4) DETAILS OF, AND TIMELINES FOR, GUARANTEEING A MINIMUM BENEFITS PACKAGE THAT INCLUDES PARITY, INCOME PROTECTIONS, AND PATIENT PROTECTIONS FOR ALL STATE RESIDENTS.—

''(A) The manner in which, including a timetable, the State will institute a statewide minimum benefits requirement that includes mental health and substance abuse treatment parity, as described in subpart 2.

''(B) The manner in which, including a timetable, the State will institute a statewide maximum out-of-pocket expenses requirement that is based on individual and family income level, as described in subpart 3.

''(5) OTHER MATTERS.—Any other matter determined appropriate by the Secretary.

''(b) BASE COVERAGE GAP.—For purposes of subsection (a)(1)(B), the base coverage gap for a State for a year shall be equal to 100 percent of the eligible residents of the State for the year involved, less the current level of coverage for those residents for such year as determined under section 2122(b)(1).

''(c) REDUCING THE LEVEL OF UNINSURED INDIVIDUALS.—

''(1) IN GENERAL.—To be eligible to receive funds under this part, a State shall agree to administer a phase II State universal health insurance coverage program with a goal of ensuring, not later than September 30, 2004, health care coverage for 100 percent of the eligible residents of the State under a qualified plan or qualified program.

''(2) PERMISSIBLE ACTIVITIES.—A State may use amounts provided under this part for any activities consistent with this part that are appropriate to enroll individuals in health plans and health programs to meet the targets contained in the State plan under subsection (a)(2)(B), including through the use of direct payments to health plans or providers of services.

''(d) PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF PHASE II STATE PLAN.—The provisions of section 2106 apply to a phase II State plan under this part in the same manner as they apply to a State plan under part A, except that no phase II State plan may be effective earlier than October 1, 2001, and all phase II State plans must be submitted for approval by not later than September 30, 2002.

"SEC. 2133. QUALIFIED PLANS AND QUALIFIED PROGRAMS.

"(a) IN GENERAL.—To be eligible to receive funds under this part, a State shall establish and implement procedures to certify—

"(1) private and public health care plans as qualified plans; and

"(2) public health care programs as qualified programs.

"(b) REQUIREMENTS.—The procedures implemented under subsection (a) shall ensure that a plan or program is not certified under this section unless such plan or program—

"(1) provides benefits that satisfy the requirements of subpart 2; and

"(2) complies with the income protections that limit out-of-pocket expenditures under subpart 3.

"(c) DECERTIFICATION.—The Secretary shall promulgate regulations for the decertification of qualified plans or qualified programs for violations of the requirements of this part.

"SEC. 2134. ALLOTMENTS.

"(a) APPROPRIATION.—For the purpose of providing allotments to States under this part, there is appropriated, out of any money in the Treasury not otherwise appropriated—

"(1) $25,100,000,000 for fiscal year 2002; and

''(2) $37,700,000,000 for fiscal year 2003 and each succeeding fiscal year thereafter.

''(b) BASE STATE ALLOCATION.—

''(1) IN GENERAL.—From the amount appropriated under subsection (a) for a fiscal year for purposes of carrying out the program under this part, after application of subsection (e), the Secretary shall allot to each State with a phase II State universal health insurance coverage plan approved under this part an amount equal to the sum of the amounts determined under paragraphs (2) and (3).

''(2) DETERMINATION OF COST OF INDIVIDUAL COVERAGE.—The amount determined under this paragraph is the amount equal to—

''(A) the product of—

''(i) the designated Federal participation rate for the State as determined under subsection (c) and adjusted under subsection (d);

''(ii) the estimated cost for the minimum benefits package required to comply under section 2133, not to exceed the sum of—

''(I) the total annual Government and employee contributions required

for individual health benefits coverage under the Blue Cross/Blue Shield standard service benefit plan offered under chapter 89 of title 5, United States Code (adjusted for age, as the Secretary determines appropriate); and

''(II) the estimated average cost-sharing expense for an individual; and

''(iii) the estimated number of eligible individuals to be enrolled in the phase I State plan; less

''(B) the sum of—

''(i) the individual health insurance contribution and cost-sharing payments to be made in accordance with section 2152; and

''(ii) any applicable employer contribution to such payments.

''(3) DETERMINATION OF COST OF FAMILY COVERAGE.—The amount determined under this paragraph is the amount equal to—

''(A) the product of—

''(i) the designated Federal participation rate for the State as determined under

subsection (c) and adjusted under subsection (d);

''(ii) the estimated cost for the minimum benefits package required to comply under section 2133, not to exceed the sum of—

''(I) the total annual Government and employee contributions required for family health benefits coverage under the Blue Cross/Blue Shield standard service benefit plan offered under chapter 89 of title 5, United States Code (adjusted for age, as the Secretary determines appropriate); and

''(II) the estimated average cost-sharing expense for a family; and

''(iii) the aggregate of the estimated number of eligible families to be enrolled in the phase I State plan; less

''(B) the sum of—

''(i) the family health insurance contribution and cost-sharing payments to be made in accordance with section 2152; and

"(ii) any applicable employer contribution to such payments.

"(c) FEDERAL PARTICIPATION RATE.—For purposes of subsection (b)(1), the Federal participation rate for a State for a fiscal year shall be equal to the enhanced FMAP determined for the State under section 2105(b).

"(d) ENHANCED STATE ALLOCATION.—

"(1) BASED ON EXPENDITURES FOR COVERAGE.—The Secretary shall adjust annually the amount of the Federal participation rate under subsection (c) if the State can demonstrate that qualified plans or qualified programs have spent a sufficient percentage of total premium income to provide covered health benefits in the prior year.

"(2) AMOUNT.—The amount of the Federal participation rate under subsection (b) with respect to a State for a fiscal year shall be increased by—

"(A) 0.25 percentage points if all qualified plans or qualified programs in the State expend at least 85 percent of total income received from premiums (excluding all costs for marketing, advertising, promotion, health plan administration, profits, or capital accumulation) on the provision of covered health benefits; and

''(B) 0.5 percentage points if all qualified plans or qualified programs in the State expend at least 90 percent of total income received from premiums (excluding all costs for marketing, advertising, promotion, health plan administration, profits, or capital accumulation) on the provision of covered health benefits.

''(e) GRANTS TO INDIAN TRIBES AND NATIVE HAWAIIAN ORGANIZATIONS.—

''(1) IN GENERAL.—From the amounts appropriated under subsection (a) for a fiscal year, the Secretary shall reserve not more than 3 percent to make grants to Indian tribes and Native Hawaiian organizations for development and implementation of universal health insurance coverage plans for members of such tribes and organizations.

''(2) PLAN.—To be eligible to receive a grant under paragraph (1), an Indian tribe or Native Hawaiian organization shall submit a universal health insurance coverage plan to the Secretary at such time, in such manner, and containing such information, as the Secretary may require.

''(3) REGULATIONS.—The Secretary shall issue regulations specifying the requirements of this part

that apply to Indian tribes and Native Hawaiian organizations receiving grants under paragraph (1).''.

SEC. 202. STATE LAW REQUIRING A MINIMUM BENEFITS PACKAGE THAT INCLUDES PARITY.

Part C of title XXI of the Social Security Act, as added by section 201, is amended by adding at the end the following:

''Subpart 2—Minimum Benefits Package That Includes Parity

''SEC. 2141. MINIMUM BENEFITS PACKAGE THAT INCLUDES PARITY.

''Each State that submits a phase II State universal health insurance coverage plan under subpart 1 shall, as of the date that the State submits the State plan, have in effect a State law that requires any health plan that is offered in the State to—

''(1) offer benefits to enrollees under the plan that are at least actuarially equivalent (determined without regard to benefits offered to comply with the requirements of section 2142) to benefits offered under chapter 89 of title 5, United States Code; and

''(2) satisfy the requirements of section 2142.

"SEC. 2142. PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS.

"(a) IN GENERAL.—A health plan (or health insurance coverage offered in connection with such a plan) shall include mental health and substance abuse treatment benefits that are at least equal to the medical and surgical benefits provided by or in connection with the plan. The requirement for such parity of benefits shall apply to the imposition of aggregate lifetime limits, annual limits, deductibles, copayments, and other cost-sharing, limitations on the number of visits or hospital days allowed under or in connection with the plan, and any other benefit-related requirements as the Secretary may designate.

"(b) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a health plan that offers a participant or beneficiary 2 or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

"(c) DEFINITIONS.—In this section:

"(1) AGGREGATE LIFETIME LIMIT.—The term 'aggregate lifetime limit' means, with respect to benefits under a health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

''(2) ANNUAL LIMIT.—The term 'annual limit' means, with respect to benefits under a health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

''(3) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance abuse benefits.

''(4) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

''(5) SUBSTANCE ABUSE BENEFITS.—The term 'substance abuse benefits' means benefits with respect to treatment of substance abuse or chemical dependency.''.

SEC. 203. STATE LAW REQUIRING LIMITATIONS ON PREMIUMS AND COST-SHARING.

Part C of title XXI of the Social Security Act, as amended by section 202, is amended by adding at the end the following:

"Subpart 3—Limitations on Premiums and Cost-Sharing

"SEC. 2151. LIMITATIONS ON PREMIUMS AND COST-SHARING.

''Each State that submits a phase II State universal health insurance coverage plan under subpart 1 shall, as of the date that the State submits the State plan, have in effect a State law that satisfies the requirements of section 2152.

"SEC. 2152. LIMITATION ON PREMIUMS AND COST-SHARING.

''(a) LIMITATION.—A State that receives payments under this part shall ensure that no individual or family who enrolls in a qualified plan or under a qualified program shall be required to pay in excess of the maximum health insurance contribution determined under subsection (b) with respect to any premiums, deductibles, copayments, or cost-sharing imposed on the individual or family.

''(b) MAXIMUM HEALTH INSURANCE CONTRIBUTION.—For purposes of subsection (a), the maximum health insurance contribution of an individual or family shall be an amount equal to—

''(1) if the family income of the individual or family involved is less than 100 percent of the poverty line, 0.5 percent of the gross annual income of such individual or family;

''(2) if the family income of the individual or family involved is at least 100 percent, but less than 200 percent, of the poverty line, 3 percent of the gross annual income of such individual or family;

''(3) if the family income of the individual or family involved is at least 200 percent, but less than 400 percent, of the poverty line, 5 percent of the gross annual income of such individual or family; and

''(4) if the family income of the individual or family involved is at least 400 percent of the poverty line, 7 percent of the gross annual income of such individual or family.''.

SEC. 204. ADMINISTRATION OF, AND DEFINITIONS FOR, PHASE II STATE PLANS.

Part C of title XXI of the Social Security Act, as amended by section 203, is amended by adding at the end the following:

''Subpart 4—Administration; Definitions

''SEC. 2155. ADMINISTRATION.

''(a) PAYMENTS.—

''(1) QUARTERLY.—The Secretary shall make quarterly payments to each State with a phase II State plan approved under this part, from its allotment under section 2134.

''(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this part for each quarter on the basis of advance estimates by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''(3) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this subsection shall be construed as preventing a State from claiming as expenditures in the quarter expenditures that were incurred in a previous quarter.

''(b) COORDINATION.—The Secretary shall coordinate activities carried out under this part with activities carried out under titles XVIII, XIX, and parts A and B, and under other Federal health programs.

''(c) REPORT.—Not later than January 1, 2003, and each January 1 thereafter, the Secretary, in consultation with the General Accounting Office and the Congressional Budget Office, shall prepare and submit to the appro-

priate committees of Congress a report on the number of States receiving payments under this part for the year for which the report is being prepared as well as the level of insurance coverage attained by each such State.

"SEC. 2156. DEFINITIONS.

"In this part:

"(1) HEALTH PLAN.—The term 'health plan' includes any organization that seeks to arrange for, or provide for the financing and coordinated delivery of, health care services directly or through a contracted health provider panel, and shall include health maintenance organizations, preferred provider organizations, single service health maintenance organizations, single service preferred provider organizations, other entities such as provider-hospital or hospital-provider organizations, employee welfare benefit plans (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), and multiple employer welfare plans or other association plans, as well as carriers.

"(2) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 2126(1).

"(3) ELIGIBLE RESIDENTS OF THE STATE.—The term 'eligible residents of the State' means an individual who—

''(A) is a resident of the State involved;

''(B) is a citizen of the United States, a legal resident alien, or an individual otherwise residing in the United States under the authority of Federal law; and

''(C) is not eligible for benefits under the medicare program under title XVIII, for medical assistance under the medicaid program under title XIX, or for health insurance coverage under a phase I State plan under part B.

''(4) QUALIFIED PLAN.—The term 'qualified plan' means a health insurance plan certified under section 2133 to provide coverage to eligible residents of the State under this part and participates in a phase II State plan.

''(5) QUALIFIED PROGRAM.—The term 'qualified program' means a health care program certified under section 2133 to provide coverage to eligible residents of the State under this part and participates in a phase II State plan.

''(6) PHASE II STATE PLAN.—The term 'phase II State plan' means the phase II State universal health insurance coverage plan submitted under section 2131(b).''.

SEC. 205. SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL TO EXPAND MEDICARE BENEFITS.

Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal containing such technical and conforming amendments as are necessary to, with respect to a State, as of the date that the State's phase II universal health insurance coverage plan under part C of title XXI of the Social Security Act is first effective in the State—

(1) apply the limitation on premiums and cost-sharing established under section 2152 of the Social Security Act to individuals who are residents of the State and who are entitled to, or eligible for, items and services under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) provide coverage for outpatient prescription drugs for such individuals under the medicare program; and

(3) provide full mental health and substance abuse treatment parity to such individuals under the medicare program, consistent with section 2142 of the Social Security Act.

TITLE III—PATIENT PROTECTIONS

SEC. 301. DEFINITIONS.

Unless specifically provided otherwise, as used in this title:

(1) CARRIER.—The term ''carrier'' means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of section 833(c)(2) of Internal Revenue Code of 1986 as in effect before the date of the enactment of this Act), a health maintenance organization, or other entity licensed or certified by the State to provide health insurance or health benefits.

(2) COVERED INDIVIDUAL.—The term ''covered individual'' means a member, enrollee, subscriber, covered life, patient or other individual eligible to receive benefits under a health plan.

(3) EMERGENCY SERVICES.—The term ''emergency services'' means those health care services that are provided to a patient after the sudden onset of a health condition that manifests itself by symptoms of sufficient severity, including severe pain, and the absence of such immediate health care attention could reasonably be expected, to result in—

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily function; or

(C) serious dysfunction of any bodily organ or part.

(4) HEALTH PLAN.—The term ''health plan'' includes any organization that seeks to arrange for, or provide for the financing and coordinated delivery of, health care services directly or through a contracted health provider panel, and shall include health maintenance organizations, preferred provider organizations, single service health maintenance organizations, single service preferred provider organizations, other entities such as provider-hospital or hospital-provider organizations, employee welfare benefit plans (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), and multiple employer welfare plans or other association plans, as well as carriers.

(5) HEALTH PROVIDER.—The term ''health provider'' means an individual who is licensed or certified under State law to provide health care services and who is operating within the scope of such licensure or certification.

(6) MANAGED CARE PLAN.—

(A) IN GENERAL.—The term ''managed care plan'' means a plan operated by a managed care entity (as defined in subparagraph (B)), that provides for the financing and delivery of health care services to persons enrolled in such plan through—

(i) arrangements with selected providers to furnish health care services;

(ii) explicit standards for the selection of participating providers;

(iii) organizational arrangements for ongoing quality assurance, utilization review programs, and dispute resolution; and

(iv) financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.

(B) MANAGED CARE ENTITY.—The term ''managed care entity'' includes a licensed insurance company, hospital or medical service plan (including provider and provider-hospital networks), health maintenance organization, an employer or employee organization, or a man-

aged care contractor (as defined in subparagraph (C)), that operates a managed care plan.

(C) MANAGED CARE CONTRACTOR.—The term ''managed care contractor'' means a person that—

(i) establishes, operates, or maintains a network of participating providers;

(ii) conducts or arranges for utilization review activities; and

(iii) contracts with an insurance company, a hospital or health service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(7) PROVIDER NETWORK.—The term ''provider network'' means, with respect to a health plan that restricts access, those providers who have entered into a contract or agreement with the plan under which such providers are obligated to provide items and services under the plan to eligible individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services unless specifically provided otherwise.

(9) SPECIALIZED TREATMENT EXPERTISE.—The term ''specialized treatment expertise'' means expertise in diagnosing and treating unusual diseases and conditions, diagnosing and treating diseases and conditions that are usually difficult to diagnose or treat, and providing other specialized health care.

(10) SPONSOR.—The term ''sponsor'' means a carrier or employer that provides a health plan.

(11) UTILIZATION REVIEW.—The term ''utilization review'' means a set of formal techniques designed to monitor and evaluate the clinical necessity, appropriateness and efficiency of health care services, procedures, providers and facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case .

Subtitle A—Utilization Management

SEC. 311. DEFINITIONS.

As used in this subtitle:

(1) ADVERSE DETERMINATION.—The term ''adverse determination'' means a determination that an admission to or continued stay at a hospital or that another health care service that is required has been reviewed and, based upon the information provided, does not meet the requirements for clinical necessity, appropriateness, level of care, or effectiveness.

(2) AMBULATORY REVIEW.—The term ''ambulatory review'' means utilization review of health care services performed or provided in an outpatient setting.

(3) APPEALS PROCEDURE.—The term ''appeals procedure'' means a formal process under which a covered individual (or an individual acting on behalf of a covered individual), attending provider or facility may appeal an adverse utilization review decision rendered by the health plan or its designee utilization review organization.

(4) CARE COORDINATOR.—The term ''care coordinator'' means a health provider who performs case management functions in consultation with the interdisciplinary health care team, the patient, family, and community.

(5) CASE MANAGEMENT.—The term ''case management'' means a coordinated set of activities con-

ducted for the individual patient management of serious, complicated, protracted or chronic health conditions that provides cost-effective and benefit-maximizing treatments for extremely resource-intensive conditions.

(6) CLINICAL REVIEW CRITERIA.—The term ''clinical review criteria'' means the recorded (written or otherwise) screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health plan to determine necessity and appropriateness of health care services.

(7) COMPARABLE.—The term ''comparable'' means a health provider who is licensed or certified in a manner that permits the provider to authorize the equipment, services, or procedures that are the subject of a review.

(8) CONCURRENT REVIEW.—The term ''concurrent review'' means utilization review conducted during a patient's hospital stay or course of treatment.

(9) DISCHARGE PLANNING.—The term ''discharge planning'' means the formal process for determining, coordinating and managing the care a patient receives following the discharge of the patient from a facility.

(10) FACILITY.—The term ''facility'' means an institution or health care setting providing the prescribed health care services under review. Such term includes hospitals and other licensed inpatient facilities, ambulatory surgical or treatment centers, skilled nursing facilities, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health care settings.

(11) PROSPECTIVE REVIEW.—The term ''prospective review'' means utilization review conducted prior to an admission or a course of treatment.

(12) RETROSPECTIVE REVIEW.—The term ''retrospective review'' means utilization review conducted after health care services have been provided to a patient. Such term does not include the retrospective review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding and adjudication for payment.

(13) SECOND OPINION.—The term ''second opinion'' means an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed health service to assess the clinical neces-

sity and appropriateness of the initial proposed health service.

(14) UTILIZATION REVIEW ORGANIZATION.—The term ''utilization review organization'' means an entity that conducts utilization review.

SEC. 312. REQUIREMENT FOR UTILIZATION REVIEW PROGRAM.

A health plan shall have in place a utilization review program that meets the requirements of this subtitle and that is certified by the State.

SEC. 313. STANDARDS FOR UTILIZATION REVIEW.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services, in consultation with the Secretary of Labor (referred to in this subtitle as the ''Secretaries''), shall establish standards for the establishment, operation, and certification and periodic recertification of health plan utilization review programs.

(b) ALTERNATIVE STANDARDS.—

(1) IN GENERAL.—A State may certify a health plan as meeting the standards established under subsection (a) if the State determines that the health plan has met the utilization standards required for accreditation as applied by a nationally recognized, independent, nonprofit accreditation entity.

(2) REVIEW BY STATE.—A State that makes a determination under paragraph (1) shall periodically review the standards used by the private accreditation entity to ensure that such standards meet or exceed the standards established by the Secretaries under this subtitle.

(c) UTILIZATION REVIEW PROGRAM REQUIREMENTS.—The standards developed by the Secretaries under subsection (a) shall require that utilization review programs comply with the following:

(1) DOCUMENTATION.—A health plan shall provide a written description of the utilization review program of the plan, including a description of—

(A) any activities assigned from the health plan to other entities;

(B) the policies and procedures used under the program to evaluate clinical necessity; and

(C) the clinical review criteria, information sources, and the process used to review and approve the provision of health care services under the program.

(2) PROHIBITION.—With respect to the administration of the utilization review program, a health plan may not employ utilization reviewers or contract with a utilization management organization if

the conditions of employment or the contract terms include financial incentives to reduce or limit the provision of clinically necessary or appropriate services to covered individuals.

(3) REVIEW AND MODIFICATION.—A health plan shall develop procedures for periodically reviewing and modifying the utilization review of the plan. Such procedures shall provide for the participation of providers and consumers in the health plan in the development and review of utilization review policies and procedures.

(4) DECISION PROTOCOLS.—

(A) IN GENERAL.—A utilization review program shall develop and apply recorded (written or otherwise) utilization review decision protocols. Such protocols shall be based on sound health care evidence.

(B) PROTOCOL CRITERIA.—The clinical review criteria used under the utilization review decision protocols to assess the appropriateness of health care services shall be clearly documented and available to participating health providers upon request. Such protocols shall include a mechanism for assessing the consistency of the application of the criteria used under the

protocols across reviewers, and a mechanism for periodically updating such criteria.

(5) REVIEW AND DECISIONS.—

(A) REVIEW.—The procedures applied under a utilization review program with respect to the preauthorization and concurrent review of the necessity and appropriateness of health care devices, services or procedures, shall require that qualified, comparable health care providers supervise review decisions. With respect to a decision to deny the provision of health care devices, services or procedures, a comparable provider shall conduct a subsequent review to determine the clinical appropriateness of such a denial. Comparable health providers from the appropriate specialty area shall be utilized in the review process.

(B) DECISIONS.—All utilization review decisions shall be made in a timely manner, as determined appropriate when considering the urgency of the situation.

(C) ADVERSE DETERMINATIONS.—With respect to utilization review, an adverse determination or noncertification of an admission, continued stay, or service shall be clearly docu-

mented, including the specific clinical or other reason for the adverse determination or noncertification, and be available to the covered individual and the affected provider or facility. A health plan may not deny or limit coverage with respect to a service that the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would have otherwise been covered by the plan had such prior authorization or a second opinion been obtained.

(D) NOTIFICATION OF DENIAL.—A health plan shall provide a covered individual with timely notice of an adverse determination or noncertification of an admission, continued stay, or service. Such a notification shall include information concerning the utilization review program appeals procedure as well as the telephone number for the Office.

(6) REQUESTS FOR AUTHORIZATION.—A health plan utilization review program shall ensure that requests by covered individuals or providers for prior authorization of a nonemergency service shall be answered in a timely manner after such request is received. If utilization review personnel are not avail-

able in a timely fashion, any health care services provided shall be considered approved.

(7) NEW TECHNOLOGIES.—A utilization review program shall implement policies and procedures to evaluate the appropriate use of new health care technologies or new applications of established technologies, including health care procedures, drugs, and devices. The program shall ensure that appropriate providers participate in the development of technology evaluation criteria.

(8) SPECIAL RULE.—Where prior authorization for a service or other covered item is obtained under a program under this section, the service shall be considered to be covered unless there was intentional fraud or intentionally incorrect information provided at the time such prior authorization was obtained. If a provider intentionally supplied the incorrect information that led to the authorization of clinically unnecessary care, the provider shall be prohibited from collecting payment directly from the enrollee, and shall reimburse the plan and subscriber for any payments or copayments the provider may have received.

(d) HEALTH PLAN REQUIREMENTS.—

(1) DISCLOSURE OF INFORMATION.—

(A) PROSPECTIVE COVERED INDIVIDUALS.—A health plan shall, with respect to any materials distributed to prospective covered individuals, include a summary of the utilization review procedures of the plan.

(B) COVERED INDIVIDUALS.—A health plan shall, with respect to any materials distributed to newly covered individuals, include a clear and comprehensive description of utilization review procedures of the plan and a statement of patient rights and responsibilities with respect to such procedures.

(C) STATE OFFICIALS.—

(i) IN GENERAL.—A health plan shall disclose to the State insurance commissioner, or other designated State official, the health plan utilization review program policies, procedures, and reports required by the State for certification.

(ii) STREAMLINING OF PROCEDURES.—To the extent practicable, a State shall implement procedures to streamline the process by which a health plan documents compliance with the requirements of this title, including procedures to condense

the number of documents filed with the State concerning such compliance.

(2) TOLL-FREE NUMBER.—A health plan shall have a membership card which shall have printed on the card the toll-free telephone number that a covered individual should call to receive precertification utilization review decisions.

(3) EVALUATION.—A health plan shall establish mechanisms to evaluate the effects of the utilization review program of the plan through the use of member satisfaction data or through other appropriate means.

(e) EMERGENCY CARE.—

(1) EMERGENCY MEDICAL CONDITION.—For purposes of this section the term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) placing the health of the individual (or, with respect to a pregnant woman, the health

of the woman or her unborn child) in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(2) PREAUTHORIZATION.—With respect to emergency services furnished in a hospital emergency department, a health plan shall not require prior authorization for the provision of such services if the enrollee arrived at the emergency department with symptoms that reasonably suggested an emergency medical condition based on the judgment of a prudent layperson, regardless of whether the hospital was affiliated with the health plan. All procedures performed during the evaluation and treatment of an emergency medical condition shall be covered under the health plan.

Subtitle C—Health Plan Standards

SEC. 321. HEALTH PLAN STANDARDS.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services, in conjunction with the Secretary of Labor (referred to in this subtitle as the ''Secretaries''), shall establish standards for the certification and periodic

recertification of health plans, including standards which require plans to meet the requirements of this subtitle.

(b) STATE CERTIFICATION.—

(1) IN GENERAL.—A State shall provide for the certification of health plans if the certifying authority designated by the State determines that the plan meets the applicable requirements of this title.

(2) REQUIREMENT.—Effective on January 1, 1999, a health plan sponsor may only offer a health plan in a State if such plan is certified by the State under paragraph (1).

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

SEC. 322. MINIMUM SOLVENCY REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (b), each State shall apply minimum solvency requirements to all health plans offered or operating within the State to ensure the fiscal integrity of such plans. A health plan shall meet the financial reserve requirements that are established by the State to assure proper payment for health care services provided under the plan. Such requirements may include plan participation in a mechanism to

provide for indemnification of plan failures even if a plan has met the reserve requirements.

(b) FEDERAL STANDARDS.—The Secretaries shall establish minimum solvency standards that shall apply to all self-insured health plans. Such standards shall at least meet the solvency requirements established by the National Association of Insurance Commissioners.

SEC. 323. INFORMATION ON TERMS OF PLAN.

(a) IN GENERAL.—A health plan shall provide prospective covered individuals with written information concerning the terms and conditions of the health plan to enable such individuals to make informed decisions with respect to a certain system of health care delivery. Such information shall be standardized so that prospective covered individuals may compare the attributes of all such plans offered within the coverage area.

(b) UNDERSTANDABILITY.—Information provided under this section, whether written or oral shall be easily understandable, truthful, linguistically appropriate and objective with respect to the terms used. Descriptions provided in such information shall be consistent with standards developed for supplemental insurance coverage under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(c) REQUIRED INFORMATION.—Information required under this section shall include information concerning—

(1) coverage provisions, benefits, and any exclusions by category of service or product;

(2) plan loss ratios with an explanation that such ratios reflect the percentage of the premiums expended for health services;

(3) prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post-payment review and procedures that may lead the patient to be denied coverage for, or not be provided, a particular service or product;

(4) an explanation of how plan design impacts enrollees, including information on the financial responsibility of covered individuals for payment for coinsurance or other out-of-plan services;

(5) covered individual satisfaction statistics, including disenrollment statistics and satisfaction statistics from those who disenroll;

(6) advance directives and organ donation;

(7) the characteristics and availability of health care providers and institutions participating in the plan, including descriptions of the financial arrangements or contractual provisions with hospitals, utili-

zation review organizations, physicians, or any other provider of health care services that would affect the services offered, referral or treatment options, or provider's fiduciary responsibility to patients, including financial incentives regarding the provision of services; and

(8) quality indicators for the plan and for participating health providers under the plan, including population-based statistics such as immunization rates and performance measures such as survival after surgery, adjusted for case mix.

SEC. 324. ACCESS.

(a) IN GENERAL.—A health plan shall demonstrate that the plan has a sufficient number, distribution, and variety of qualified health care providers to ensure that all covered health care services will be available and accessible in a timely manner to adults, infants, children, and individuals with disabilities enrolled in the plan. Plans shall make reasonable efforts to address issues of cultural competence and appropriateness with respect to providers.

(b) AVAILABILITY OF SERVICES.—A health plan shall ensure that services covered under the plan are available in a timely manner that ensures a continuity of care, are accessible within a reasonable proximity to the residences of the enrollees, are available within reasonable hours of

operation, and include emergency and urgent care services when clinically necessary and available which shall be accessible within the service area 24-hours a day, seven days a week.

(c) SPECIALIZED TREATMENT.—A health plan shall demonstrate that plan enrollees have meaningful access, when clinically indicated in the judgment of the treating health provider, to specialized treatment expertise.

(d) CHRONIC CONDITIONS.—

(1) IN GENERAL.—Any process established by a health plan to coordinate care and control costs may not impose an undue burden on enrollees with chronic health conditions. The plan shall ensure a continuity of care and shall, when clinically indicated in the judgment of the treating health provider, ensure ongoing direct access to relevant specialists for continued care.

(2) CARE COORDINATOR.—In the case of an enrollee who has a severe, complex, or chronic condition, the health plan shall determine, based on the judgment of the treating health provider, whether it is clinically necessary or appropriate to use a care coordinator from an interdisciplinary team.

(e) REQUIREMENT.—

(1) IN GENERAL.—The requirements of this section may not be waived and shall be met in all areas where the health plan has enrollees, including rural areas. With respect to children, such services shall include pediatric and pediatric specialty services.

(2) OUT-OF-NETWORK SERVICES.—If a health plan fails to meet the requirements of this section, the plan shall arrange for the provision of out-of-network services to enrollees in a manner that provides enrollees with access to services in accordance with the principles and parameters set forth in this section.

SEC. 325. CREDENTIALING FOR HEALTH PROVIDERS.

(a) IN GENERAL.—A health plan shall credential health providers furnishing health care services under the plan.

(b) CREDENTIALING PROCESS.—

(1) IN GENERAL.—A health plan shall establish a credentialing process. Such process shall ensure that a health provider is credentialed prior to that provider being listed as a health provider in the health plan's marketing materials, in accordance with recorded (written or otherwise) policies and procedures.

(2) RESPONSIBILITY CHIEF HEALTH CARE OFFICER.—The chief health care officer of the health plan, or another designated health provider, shall have responsibility for the credentialing of health providers under the plan.

(3) UNIFORM APPLICATIONS.—A State shall develop a basic uniform application that shall be used by all health plans in the State for credentialing purposes.

(4) STANDARDS.—

(A) IN GENERAL.—Credentialing decisions under a health plan shall be based on objective standards with input from health providers credentialed under the plan. Information concerning all application and credentialing policies and procedures shall be made available for review by the health providers involved upon written request.

(B) RIGHT TO REVIEW INFORMATION.—A health provider who undergoes the credentialing process shall have the right to review the basis information, including the sources of that information, that was used to meet the designated credentialing criteria.

SEC. 326. GRIEVANCE PROCEDURES.

(a) IN GENERAL.—A health plan shall adopt a timely and organized system for resolving complaints and formal grievances filed by covered individuals. Such system shall include—

(1) recorded (written or otherwise) procedures for registering and responding to complaints and grievances in a timely manner;

(2) documentation concerning the substance of complaints, grievances, and actions taken concerning such complaints and grievances, which shall be in writing, and be available upon request to the Office for Consumer Information, Counseling and Assistance with Health Care;

(3) procedures to ensure a resolution of a complaint or grievance;

(4) the compilation and analysis of complaint and grievance data;

(5) procedures to expedite the complaint process if the complaint involves a dispute about the coverage of an immediately and urgently needed service; and

(6) procedures to ensure that if an enrollee orally notifies a health plan about a complaint, the plan (if requested) must send the enrollee a complaint form that includes the telephone numbers and

addresses of member services, a description of the plan's grievance procedure, and the telephone number of the Officer for Consumer Information, Counseling and Assistance with Health Care where enrollees may register complaints.

(b) APPEAL PROCESS.—A health plan shall adopt an appeals process to enable covered individuals and providers to appeal decisions that are adverse to the covered individuals. Such a process shall include—

(1) the right to a review by a grievance panel;

(2) the right to a second review with a different panel, independent from the health plan; and

(3) an expedited process for review in emergency cases.

The Secretaries shall develop guidelines for the structure and requirements applicable to the independent review panel.

(c) NOTIFICATION.—With respect to the complaint, grievance, and appeals processes required under this section, a health plan shall, upon the request of a covered individual, provide the individual a written decision concerning a complaint, grievance, or appeal in a timely fashion.

(d) NON-IMPEDIMENT TO BENEFITS.—The complaint, grievance, and appeals processes established in ac-

cordance with this section may not be used in any fashion to discourage, prevent, or deny a covered individual from receiving clinically necessary care in a timely manner.

(e) DUE PROCESS WITH RESPECT TO CREDENTIALING.—

(1) RECEIPT OF INFORMATION.—A health provider who is subject to credentialing under section 325 shall, upon written request, receive from the health plan any information obtained by the plan during the credentialing process that, as determined by the credentialing committee, does not meet the credentialing standards of the plan, or that varies substantially from the information provided to the health plan by the health provider.

(2) SUBMISSION OF CORRECTIONS.—A health plan shall have a formal, recorded (written or otherwise) process by which a health provider may submit supplemental information to the credentialing committee if the health provider determines that erroneous or misleading information has been previously submitted. The health provider may request that such information be reconsidered in the evaluation for credentialing purposes.

(3) NO ENTITLEMENT.—

(A) IN GENERAL.—A health provider is not entitled to be selected or retained by a health plan as a participating or contracting provider whether or not such provider meets the credentialing standards established under section 325.

(B) ECONOMIC CONSIDERATIONS.—If economic considerations, including the health care provider's patterns of expenditure per patient, are part of a selection decision, objective criteria shall be used in examining such considerations and a written description of such criteria shall be provided to applicants, participating health providers, and enrollees. Any economic profiling of health providers must be adjusted to recognize case mix, severity of illness, and the age and gender of patients of a health provider's practice that may account for higher or lower than expected costs, to the extent appropriate data in this regard is available to the health plan.

(4) TERMINATION, REDUCTION, OR WITHDRAWAL.—

(A) PROCEDURES.—A health plan shall develop and implement procedures for the report-

ing, to appropriate authorities, of serious quality deficiencies that result in the suspension or termination of a contract with a health provider.

(B) REVIEW.—A health plan shall develop and implement policies and procedures under which the plan reviews the contract privileges of health providers who—

(i) have seriously violated policies and procedures of the health plan;

(ii) have lost their privilege to practice with a contracting institutional provider; or

(iii) otherwise pose a threat to the quality of service and care provided to the enrollees of the health plan.

At a minimum, the policies and procedures implemented under this subparagraph shall meet the requirements of the Health Care Quality Improvement Act of 1986.

(C) COMMUNICATION.—Health plans shall not restrict nor inhibit communication between providers and patients or penalize a provider making public the failure of the health plan to comply with the provisions of this title.

(D) LIABILITY.—A health plan shall not require a provider to sign any type of hold-harmless agreement as a requirement for participation in the health plan.

(E) DUE PROCESS.—The policies and procedures implemented under subparagraph (B) shall include requirements for the timely notification of the affected health provider of the reasons for the reduction, withdrawal, or termination of privileges, and shall provide the health provider with the right to appeal initially to the health plan and subsequently, upon failure to resolve a dispute, to an independent entity, the determination of reduction, withdrawal, or termination. No reduction, withdrawal, or termination of privileges shall be made without cause.

(F) AVAILABILITY.—A written copy of the policies and procedures implemented under this paragraph shall be made available to a health provider on request prior to the time at which the health provider contracts to provide services under the plan.

SEC. 327. CONFIDENTIALITY STANDARDS.

(a) IN GENERAL.—A health plan shall ensure that the confidentiality of specified enrollee patient information and records is protected.

(b) POLICIES AND PROCEDURES.—A health plan shall have written confidentiality policies and procedures. Such policies and procedures shall, at a minimum—

(1) protect the confidentiality of enrollee patient information within the administrative structure of the health plan with special attention to sensitive health conditions and history;

(2) protect health care record information;

(3) protect claim information;

(4) establish requirements for the release of information; and

(5) inform health plan employees of the confidentiality policies and procedures and enforce compliance with such policies and procedures.

(c) PATIENT CARE PROVIDERS AND FACILITIES.—A health plan shall ensure that providers, offices, and facilities responsible for providing covered items or services to plan enrollees have implemented policies and procedures to prevent the unauthorized or inadvertent disclosure of confidential patient information to individuals who should not have access to such information.

(d) RELEASE OF INFORMATION.—An enrollee in a health plan shall have the opportunity to approve or disapprove the release of identifiable personal patient information by the health plan, except where such release is required under applicable law.

SEC. 328. DISCRIMINATION.

(a) ENROLLEES.—A health plan (network or non-network) may not discriminate or engage (directly or through contractual arrangements) in any activity, including the selection of service area, that has the effect of discriminating against an individual on the basis of race, culture, national origin, gender, language, socio-economic status, age, disability, health status including genetic information, or anticipated utilization of health services.

(b) PROVIDERS.—A health plan may not discriminate in the selection of members of the health provider or provider network (and in establishing the terms and conditions for membership in the network) of the plan based on—

(1) the race, national origin, culture, age, or disability of the health provider; or

(2) the socio-economic status, disability, health status, or anticipated utilization of health services of the patients of the health provider.

SEC. 329. PROHIBITION ON SELECTIVE MARKETING.

A health plan may not engage in marketing or other practices intended to discourage or limit the issuance of health plans to individuals on the basis of health condition, geographic area, industry, or other risk factors.

Subtitle D—Miscellaneous Provisions

SEC. 331. ENFORCEMENT.

(a) IN GENERAL.—A State shall prohibit the offering or issuance of any health plan in such State if such plan does not—

(1) have in place a utilization review program that is certified by the State as meeting the requirements of subtitle A;

(2) comply with the standards developed under subtitle B;

(3) have in place a credentialing program that meets the requirements of section 325;

(4) comply with the requirements of subtitle C; and

(5) meet any other requirements determined appropriate by the Secretary.

(b) SELF-INSURED PLANS.—The Secretary of Labor may take corrective action to terminate or disqualify a self-insured plan that does not meet the standards developed under this title.

SEC. 332. PREEMPTION.

Nothing in this title shall be construed to preempt any State law, or the implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the provisions of this title.

SEC. 333. EFFECTIVE DATES; REGULATIONS.

(a) IN GENERAL.—Except as otherwise provided in this section, this title shall take effect on the date of enactment of this Act.

(b) STANDARDS.—The standards and programs required under this title shall apply to health plans beginning on January 1, 1999.

(c) OTHER REQUIREMENTS.—The requirements of this subtitle shall apply to health plans beginning on January 1, 1999.

(d) REGULATIONS.—The Secretaries described in section 313(a) may promulgate regulations to carry out this Act.

TITLE IV—MISCELLANEOUS

SEC. 401. NONAPPLICATION OF ERISA.

The provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) shall not apply with respect to health benefits provided under a group health plan (as defined in section 733(a) of that Act (29 U.S.C. 1191b(a)) qualified to offer such benefits under a phase I State universal health insurance coverage

plan under part B of title XXI of the Social Security Act or under a phase II State universal health insurance coverage plan under part C of title XXI of that Act.

SEC. 402. SENSE OF CONGRESS REGARDING OFFSETS.

It is the sense of Congress that any sums necessary for the implementation of this Act, and the amendments made by this Act, should be offset by—

(1) reductions in unnecessary tax benefits available only to individuals and large corporations that are in the maximum tax brackets;

(2) increases in taxes from the sale of tobacco products;

(3) elimination of duplicative and wasteful military spending; and

(4) direct savings in health care expenditures resulting from the implementation of this Act.

○