

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.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the  
5 “Healthy Americans Act”.

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

Sec. 1. Short title; table of contents.

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.

Subtitle B—State Health Coverage Outreach Programs

Sec. 111. Grants for State health coverage outreach programs.

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

Sec. 201. Phase II State plans.

Sec. 202. State law requiring a minimum benefits package that includes parity.

Sec. 203. State law requiring limitations on premiums and cost-sharing.

Sec. 204. Administration of, and definitions for, phase II State plans.

Sec. 205. Secretarial submission of legislative proposal to expand medicare benefits.

TITLE III—PATIENT PROTECTIONS

Sec. 301. Definitions.

Subtitle A—Utilization Management

Sec. 311. Definitions.

Sec. 312. Requirement for utilization review program.

Sec. 313. Standards for utilization review.

Subtitle C—Health Plan Standards

Sec. 321. Health plan standards.

Sec. 322. Minimum solvency requirements.

Sec. 323. Information on terms of plan.

Sec. 324. Access.

Sec. 325. Credentialing for health providers.

Sec. 326. Grievance procedures.

Sec. 327. Confidentiality standards.

Sec. 328. Discrimination.

Sec. 329. Prohibition on selective marketing.

Subtitle D—Miscellaneous Provisions

Sec. 331. Enforcement.

Sec. 332. Preemption.

Sec. 333. Effective dates; regulations.

TITLE IV—MISCELLANEOUS

Sec. 401. Nonapplication of ERISA.

Sec. 402. Sense of Congress regarding offsets.

1 **TITLE I—STATE UNIVERSAL**  
 2 **HEALTH INSURANCE COV-**  
 3 **ERAGE PROGRAMS—PHASE I**  
 4 **Subtitle A—Expansion of SCHIP To**  
 5 **Provide Health Insurance Cov-**  
 6 **erage to Additional Individuals**

7 **SEC. 101. PHASE I STATE UNIVERSAL HEALTH INSURANCE**  
 8 **COVERAGE PLANS.**

9 Title XXI of the Social Security Act (42 U.S.C.  
 10 1397aa et seq.) is amended—

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

13 **“TITLE XXI—STATE HEALTH**  
 14 **INSURANCE PROGRAMS**

15 **“PART A—STATE CHILDREN’S HEALTH INSURANCE**  
 16 **PROGRAM”;**

17 and

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

19 **“PART B—STATE UNIVERSAL HEALTH INSURANCE**  
 20 **COVERAGE PROGRAM—PHASE I**

21 **“SEC. 2121. PURPOSE; STATE PLANS.**

22 **“(a) PURPOSE.—**The purpose of this part is to pro-  
 23 vide funds to participating States to enable those States  
 24 to initiate and expand State-administered systems of

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

3 “(b) PHASE I STATE UNIVERSAL COVERAGE PLAN  
 4 REQUIRED.—A State is not eligible for a payment under  
 5 section 2125(a) unless the State has submitted to the Sec-  
 6 retary a plan that—

7 “(1) sets forth how the State intends to use the  
 8 funds provided under this part to expand the State  
 9 children’s health insurance program under part A to  
 10 provide universal health insurance coverage to eligi-  
 11 ble individuals and families within the State consist-  
 12 ent with the provisions of this part; and

13 “(2) has been approved under section 2122(d).

14 **“SEC. 2122. PLAN REQUIREMENTS.**

15 “(a) IN GENERAL.—A phase I State universal health  
 16 insurance coverage plan shall include a description, con-  
 17 sistent with the requirements of this part, of the following:

18 “(1) INFORMATION ON THE CURRENT LEVEL  
 19 OF HEALTH INSURANCE COVERAGE.—

20 “(A) The current level of health insurance  
 21 coverage within the State as determined under  
 22 subsection (b) and the base coverage gap for  
 23 the year involved as determined under sub-  
 24 section (b)(4).

1           “(B) Current State efforts to provide or  
2           obtain health care coverage for uncovered indi-  
3           viduals, including the steps the State is taking  
4           to identify and enroll all uncovered individuals  
5           who are eligible to participate in public health  
6           insurance programs and health insurance pro-  
7           grams that involve public-private partnerships.

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

10           “(A) The activities that the State intends  
11           to carry out using funds received under this  
12           part, including how the State will coordinate ef-  
13           forts under the program under this part with  
14           existing State efforts to increase the health care  
15           coverage of individuals.

16           “(B) Consistent with subsection (c), the  
17           manner in which the State will reduce the base  
18           coverage gap for the year involved, including a  
19           timetable with specified targets for reducing the  
20           base coverage gap by 50 percent in 2 years and  
21           100 percent in 4 years.

22           “(3) DETAILS REGARDING MAINTENANCE OF  
23           PRIVATE LEVELS OF FINANCIAL SUPPORT.—The  
24           manner in which the State will ensure that employ-  
25           ers within the State will continue to provide existing

1 levels of financial support toward the health insur-  
2 ance premiums required for coverage of their em-  
3 ployees.

4 “(4) DETAILS OF, AND TIMELINES FOR, STATE  
5 OUTREACH PROGRAMS.—The manner in which, in-  
6 cluding a timetable, the State will institute outreach  
7 programs funded under section 121 of the Healthy  
8 Americans Act.

9 “(5) DESCRIPTION OF THE PHASE II PLAN.—A  
10 description of the process that will be used to de-  
11 velop the phase II State universal health insurance  
12 coverage plan required under part C, including the  
13 timelines for developing the plan.

14 “(6) OTHER MATTERS.—Any other matter de-  
15 termined appropriate by the Secretary.

16 “(b) CURRENT LEVEL OF COVERAGE.—

17 “(1) IN GENERAL.—The Secretary, using the  
18 most recent Medical Expenditure Panel Survey con-  
19 ducted by the Agency for Health Care Policy and  
20 Research, another survey selected by the Secretary,  
21 or an alternative system approved under paragraph  
22 (3), shall determine the percentage of the population  
23 of the State that is currently covered by a health in-  
24 surance plan or program.

1           “(2) BIENNIAL SURVEY.—The Secretary, act-  
2           ing through the Agency for Health Care Policy and  
3           Research, shall provide for the conduct of the Medi-  
4           cal Expenditure Panel Survey (or another survey se-  
5           lected by the Secretary) not less than biennially to  
6           make coverage determinations for purposes of para-  
7           graph (1).

8           “(3) USE OF ALTERNATIVE SYSTEM.—The Sec-  
9           retary shall permit a State to utilize an alternative  
10          population-based monitoring system to make deter-  
11          minations with respect to coverage in the State for  
12          purposes of paragraph (1) if the Secretary, acting  
13          through the Health Care Financing Administration,  
14          determines that such system meets or exceeds the  
15          methodological standards utilized in the Medical Ex-  
16          penditure Panel Survey.

17          “(4) BASE COVERAGE GAP.—For purposes of  
18          subsection (a)(1)(A), the base coverage gap for a  
19          State shall be equal to 100 percent of the eligible in-  
20          dividuals and families in the State for the year in-  
21          volved that have income equal to or less than 300  
22          percent of the poverty line, less the current level of  
23          coverage for those individuals and families for such  
24          year as determined under paragraph (1).

1       “(c) REDUCING THE LEVEL OF UNINSURED INDIVID-  
2 UALS.—

3           “(1) IN GENERAL.—To be eligible to receive  
4 funds under this part, a State shall agree to admin-  
5 ister a phase I State universal health insurance cov-  
6 erage plan with a goal of providing health care cov-  
7 erage for 100 percent of the eligible individuals and  
8 families who reside in the State and who have in-  
9 come that is equal to or less than 300 percent of the  
10 poverty line by not later than September 30, 2003.

11           “(2) PERMISSIBLE ACTIVITIES.—A State may  
12 use amounts provided under this part for any activi-  
13 ties consistent with this part that are appropriate to  
14 enroll individuals in health plans and health pro-  
15 grams to meet the targets contained in the State  
16 plan under subsection (a)(2)(B), including through  
17 the use of direct payments to health plans or provid-  
18 ers of services.

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



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

3 **“SEC. 2123. COVERAGE REQUIREMENTS FOR PHASE I**  
4 **STATE PLANS.**

5 “(a) **REQUIRED SCOPE OF HEALTH INSURANCE COV-**  
6 **ERAGE.**—Health insurance coverage provided under this  
7 part shall consist of any of the following:

8 “(1) **BENCHMARK COVERAGE.**—Health benefits  
9 coverage that is equivalent to the benefits coverage  
10 in a benchmark benefit package described in section  
11 2103(b).

12 “(2) **BENCHMARK-EQUIVALENT COVERAGE.**—  
13 Health benefits coverage that satisfies the require-  
14 ments of section 2103(a)(2).

15 “(3) **SECRETARY-APPROVED COVERAGE.**—Any  
16 other health benefits coverage that the Secretary de-  
17 termines, upon application by a State, provides ap-  
18 propriate coverage for the individuals and families  
19 residing in the State who have income at or below  
20 300 percent of the poverty line.

21 “(b) **COST-SHARING.**—

22 “(1) **DESCRIPTION; GENERAL CONDITIONS.**—

23 “(A) **DESCRIPTION.**—A phase I State uni-  
24 versal health insurance coverage plan shall in-  
25 clude a description, consistent with this sub-

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

5 “(B) PROTECTION FOR LOWER INCOME IN-  
6 DIVIDUALS AND FAMILIES.—The phase I State  
7 plan may only vary premiums, deductibles, coin-  
8 surance, and other cost-sharing based on the in-  
9 come of the individuals and families eligible  
10 under the plan in a manner that does not favor  
11 individuals and families with higher income over  
12 individuals and families with lower income.

13 “(2) LIMITATIONS ON PREMIUMS AND COST-  
14 SHARING.—

15 “(A) INDIVIDUALS AND FAMILIES WITH IN-  
16 COME BELOW 150 PERCENT OF POVERTY  
17 LINE.—In the case of an individual or family  
18 whose income is at or below 150 percent of the  
19 poverty line, the State plan may not impose—

20 “(i) an enrollment fee, premium, or  
21 similar charge that exceeds the maximum  
22 monthly charge permitted consistent with  
23 standards established to carry out section  
24 1916(b)(1) (with respect to individuals de-  
25 scribed in such section); and

1           “(ii) a deductible, cost-sharing, or  
2           similar charge that exceeds an amount  
3           that is nominal (as determined consistent  
4           with regulations referred to in section  
5           1916(a)(3), with such appropriate adjust-  
6           ment for inflation or other reasons as the  
7           Secretary determines to be reasonable).

8           “(B) OTHER INDIVIDUALS AND FAMI-  
9           LIES.—For individuals and families not de-  
10          scribed in subparagraph (A), subject to para-  
11          graph (1)(B), any premiums, deductibles, cost-  
12          sharing or similar charges imposed under the  
13          phase I State plan may be imposed on a sliding  
14          scale related to income, except that the total  
15          annual aggregate cost-sharing imposed under  
16          this part with respect to all individuals in a  
17          family may not exceed 5 percent of the family’s  
18          income for the year involved.

19          “(c) APPLICATION OF CERTAIN REQUIREMENTS.—

20                 “(1) RESTRICTION ON APPLICATION OF PRE-  
21          EXISTING CONDITION EXCLUSIONS.—The phase I  
22          State universal health insurance coverage plan shall  
23          not permit the imposition of any preexisting condi-  
24          tion exclusion for covered benefits under the plan.

1           “(2) COMPLIANCE WITH OTHER REQUIRE-  
2           MENTS.—Coverage offered under this section shall  
3           comply with the requirements of subpart 2 of part  
4           A of title XXVII of the Public Health Service Act  
5           insofar as such requirements apply with respect to  
6           a health insurance issuer that offers group health in-  
7           surance coverage.

8   **“SEC. 2124. ALLOTMENTS.**

9           “(a) APPROPRIATION.—For the purpose of providing  
10          allotments to States under this part, there is appropriated,  
11          out of any money in the Treasury not otherwise appro-  
12          priated—

13                 “(1) \$39,000,000,000 for fiscal year 1999;

14                 “(2) \$45,000,000,000 for fiscal year 2000;

15                 “(3) \$59,000,000,000 for fiscal year 2001; and

16                 “(4) \$59,900,000,000 for fiscal year 2002 and  
17          each succeeding fiscal year thereafter.

18          “(b) BASE STATE ALLOCATION.—

19                 “(1) IN GENERAL.—From the amount appro-  
20          priated under subsection (a) for a fiscal year for  
21          purposes of carrying out the program under this  
22          part, after application of subsection (e), the Sec-  
23          retary shall allot to each State with a phase I State  
24          universal health insurance coverage plan approved

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

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

6 “(A) the product of—

7 “(i) the designated Federal participa-  
8 tion rate for the State as determined under  
9 subsection (c) and adjusted under sub-  
10 section (d);

11 “(ii) the estimated cost for the mini-  
12 mum benefits package required to comply  
13 under section 2123, not to exceed the sum  
14 of—

15 “(I) the total annual Government  
16 and employee contributions required  
17 for individual health benefits coverage  
18 under the Blue Cross/Blue Shield  
19 standard service benefit plan offered  
20 under chapter 89 of title 5, United  
21 States Code (adjusted for age, as the  
22 Secretary determines appropriate);  
23 and

24 “(II) the estimated average cost-  
25 sharing expense for an individual; and

1           “(iii) the estimated number of eligible  
2 individuals to be enrolled in the phase I  
3 State plan; less

4           “(B) the sum of—

5                 “(i) the individual health insurance  
6 contribution and cost-sharing payments to  
7 be made in accordance with section  
8 2123(b); and

9                 “(ii) any applicable employer contribu-  
10 tion to such payments.

11           “(3) DETERMINATION OF COST OF FAMILY COV-  
12 ERAGE.—The amount determined under this para-  
13 graph is the amount equal to—

14                 “(A) the product of—

15                         “(i) the designated Federal participa-  
16 tion rate for the State as determined under  
17 subsection (e) and adjusted under sub-  
18 section (d);

19                         “(ii) the estimated cost for the mini-  
20 mum benefits package required to comply  
21 under section 2123, not to exceed the sum  
22 of—

23                                 “(I) the total annual Government  
24 and employee contributions required  
25 for family health benefits coverage

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

7 “(II) the estimated average cost-  
 8 sharing expense for a family; and

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

12 “(B) the sum of—

13 “(i) the family health insurance con-  
 14 tribution and cost-sharing payments to be  
 15 made in accordance with section 2123(b);  
 16 and

17 “(ii) any applicable employer contribu-  
 18 tion to such payments.

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

23 “(d) ENHANCED STATE ALLOCATION.—

24 “(1) BASED ON CLOSURE OF BASE COVERAGE  
 25 GAP.—

1           “(A) IN GENERAL.—The Secretary shall  
2 adjust the amount of the Federal participation  
3 rate under subsection (c) based on the decrease  
4 in the base coverage gap in the State. An ad-  
5 justment under the preceding sentence shall  
6 apply for the 2 succeeding fiscal years.

7           “(B) AMOUNT OF ADJUSTMENT.—The  
8 amount of the Federal participation rate under  
9 subsection (c) with respect to a State for a fis-  
10 cal year shall be increased by—

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

16               “(ii) 3 percentage points if the base  
17 coverage gap of the State has decreased by  
18 100 percent by the date that is 4 years  
19 after the date the Secretary approves the  
20 phase I State plan.

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



1           “(i) 98 percent of all residents of the  
 2           State who have individual or family income  
 3           that is equal to or less than 300 percent  
 4           of the poverty line are provided health in-  
 5           surance coverage under the phase I State  
 6           plan; and

7           “(ii) the remaining 2 percent of such  
 8           residents is served by alternative health  
 9           care delivery systems as demonstrated by  
 10          the State.

11          “(2) BASED ON EXPENDITURES FOR COV-  
 12          ERAGE.—

13           “(A) IN GENERAL.—The Secretary shall  
 14           adjust annually the amount of the Federal par-  
 15           ticipation rate under subsection (c) if the State  
 16           can demonstrate that qualified plans have spent  
 17           a sufficient percentage of total premium income  
 18           to provide covered health benefits in the prior  
 19           year.

20           “(B) AMOUNT.—The amount of the Fed-  
 21           eral participation rate under subsection (b) with  
 22           respect to a State for a fiscal year shall be in-  
 23           creased by—

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

1           85 percent of total income received from  
2           premiums (excluding all costs for market-  
3           ing, advertising, promotion, health plan ad-  
4           ministration, profits, or capital accumula-  
5           tion) on the provision of covered health  
6           benefits; and

7                   “(ii) 0.5 percentage points if all quali-  
8                   fied plans in the State expend at least 90  
9                   percent of total income received from pre-  
10                  miums (excluding all costs for marketing,  
11                  advertising, promotion, health plan admin-  
12                  istration, profits, or capital accumulation)  
13                  on the provision of covered health benefits.

14           “(e) GRANTS TO INDIAN TRIBES AND NATIVE HA-  
15           WAIIAN ORGANIZATIONS.—

16                   “(1) IN GENERAL.—From the amounts appro-  
17                  priated under subsection (a) for a fiscal year, the  
18                  Secretary shall reserve not more than 3 percent to  
19                  make grants to Indian tribes and Native Hawaiian  
20                  organizations for development and implementation of  
21                  universal health insurance coverage plans for mem-  
22                  bers of such tribes and organizations.

23                   “(2) PLAN.—To be eligible to receive a grant  
24                  under paragraph (1), an Indian tribe or Native Ha-  
25                  waiian organization shall submit a universal health

1 insurance coverage plan to the Secretary at such  
2 time, in such manner, and containing such informa-  
3 tion, as the Secretary may require.

4 “(3) REGULATIONS.—The Secretary shall issue  
5 regulations specifying the requirements of this part  
6 that apply to Indian tribes and Native Hawaiian or-  
7 ganizations receiving grants under paragraph (1).

8 **“SEC. 2125. ADMINISTRATION.**

9 “(a) PAYMENTS.—

10 “(1) QUARTERLY.—The Secretary shall make  
11 quarterly payments to each State with a phase I  
12 State plan approved under this part, from its allot-  
13 ment under section 2124.

14 “(2) ADVANCE PAYMENT; RETROSPECTIVE AD-  
15 JUSTMENT.—The Secretary may make payments  
16 under this part for each quarter on the basis of ad-  
17 vance estimates by the State and such other inves-  
18 tigation as the Secretary may find necessary, and  
19 may reduce or increase the payments as necessary to  
20 adjust for any overpayment or underpayment for  
21 prior quarters.

22 “(3) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—  
23 Nothing in this subsection shall be construed as pre-  
24 venting a State from claiming as expenditures in the

1 quarter expenditures that were incurred in a pre-  
2 vious quarter.

3 “(b) COORDINATION.—The Secretary shall coordi-  
4 nate activities carried out under this part with activities  
5 carried out under titles XVIII, XIX, and part A, and  
6 under other Federal health programs.

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

15 **“SEC. 2126. DEFINITIONS.**

16 “In this part:

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

22 “(2) ELIGIBLE INDIVIDUALS AND FAMILIES.—  
23 The term ‘eligible individuals and families’ means an  
24 individual or family who—

1           “(A) is (or consists of) a resident of the  
2 State involved;

3           “(B) has a family income that does not ex-  
4 ceed 300 percent of the poverty line;

5           “(C) is (or consists of) a citizen of the  
6 United States, a legal resident alien, or an indi-  
7 vidual otherwise residing in the United States  
8 under the authority of Federal law; and

9           “(D) in the case of an individual, is not el-  
10 igible for benefits under the medicare program  
11 under title XVIII or for medical assistance  
12 under the medicaid program under title XIX  
13 (other than under the application of section  
14 1905(u)(4)).

15           “(3) PHASE I STATE PLAN.—The term ‘phase I  
16 State plan’ means the State universal health insur-  
17 ance coverage plan submitted under section 2121(b).

18           “(4) QUALIFIED PLAN.—The term ‘qualified  
19 plan’ means a health insurance plan that satisfies  
20 the coverage requirements described under section  
21 2123 and participates in a phase I State plan.”.

1     **Subtitle B—State Health Coverage**  
2                     **Outreach Programs**

3     **SEC. 111. GRANTS FOR STATE HEALTH COVERAGE OUT-**  
4                     **REACH PROGRAMS.**

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

9                     (1) eligible individuals in the State medicaid  
10             program under title XIX of the Social Security Act  
11             (42 U.S.C. 1396 et seq.);

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

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

19             (b) **STATE OUTREACH PLAN REQUIRED.**—

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

22                             (A) the State has submitted to the Sec-  
23             retary a plan that sets forth how the State in-  
24             tends to use the funds provided under this sec-  
25             tion to promote outreach efforts to maximize

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

4 (B) the State notifies the Secretary that,  
5 not later than September 30, 1999, the State  
6 shall submit a phase I State universal health in-  
7 surance coverage plan for approval by the Sec-  
8 retary in accordance with the requirements of  
9 part B of title XXI of the Social Security Act  
10 (as added by section 101).

11 (2) USE OF FUNDS.—Funds provided under  
12 this section may be used for any purpose that is in-  
13 tended to promote the outreach described in para-  
14 graph (1)(A) and is approved by the Secretary, in-  
15 cluding—

16 (A) implementing the use of a single appli-  
17 cation form to determine the eligibility of an in-  
18 dividual or family for assistance or benefits  
19 under public health insurance programs and  
20 health insurance programs that involve public-  
21 private partnerships;

22 (B) providing for the stationing of eligi-  
23 bility workers at sites such as hospitals, health  
24 clinics, and schools, at which individuals receive  
25 health care or related services; and

1 (C) reimbursing localities and nonprofit  
 2 entities for training and administrative costs as-  
 3 sociated with outreach activities.

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

9 **TITLE II—UNIVERSAL, AFFORD-**  
 10 **ABLE, COMPREHENSIVE**  
 11 **HEALTH CARE—PHASE II**

12 **SEC. 201. PHASE II STATE PLANS.**

13 Title XXI of the Social Security Act (42 U.S.C.  
 14 1397aa et seq.), as amended by section 101, is amended  
 15 by adding at the end the following:

16 “PART C—STATE UNIVERSAL HEALTH INSURANCE  
 17 COVERAGE PROGRAM—PHASE II

18 **“Subpart 1—Phase II State Universal Health**  
 19 **Insurance Coverage Plans**

20 **“SEC. 2131. PURPOSE; STATE PLANS.**

21 “(a) PURPOSE.—The purpose of this part is to pro-  
 22 vide funds to participating States to enable those States  
 23 to establish State-administered systems to ensure univer-  
 24 sal health insurance coverage.



1       “(b) PHASE II STATE UNIVERSAL HEALTH INSUR-  
 2 ANCE COVERAGE PLAN REQUIRED.—A State is not eligi-  
 3 ble for a payment under section 2135(a) unless the State  
 4 has submitted to the Secretary a plan that—

5           “(1) sets forth how the State intends to use the  
 6 funds provided under this part to ensure universal,  
 7 affordable, and comprehensive health insurance cov-  
 8 erage to eligible residents of the State consistent  
 9 with the provisions of this part; and

10          “(2) has been approved under section 2132(d).

11 **“SEC. 2132. PLAN REQUIREMENTS.**

12       “(a) IN GENERAL.—A phase II State universal  
 13 health insurance coverage plan shall include a description,  
 14 consistent with the requirements of this part, of the follow-  
 15 ing:

16           “(1) INFORMATION ON THE CURRENT LEVEL  
 17 OF HEALTH INSURANCE COVERAGE.—

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

21           “(B) The base coverage gap for the year  
 22 involved for the State, as determined under  
 23 subsection (b).

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

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

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

8           “(A) The activities that the State intends  
9           to carry out using funds received under this  
10          part, including how the State will coordinate ef-  
11          forts under the program under this part with  
12          existing State efforts to increase the health care  
13          coverage of individuals.

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

20          “(3) DETAILS REGARDING MAINTENANCE OF  
21          PRIVATE LEVELS OF FINANCIAL SUPPORT AND EN-  
22          SURING THAT BENEFITS ARE OBTAINED.—

23          “(A) The manner in which the State will  
24          ensure that employers within the State will con-  
25          tinue to provide existing levels of financial sup-

1 port toward the health insurance premiums re-  
2 quired for coverage of their employees, which  
3 may include any of the following:

4 “(i) programs and activities to encour-  
5 age the voluntary provision of employment-  
6 based health insurance coverage with vol-  
7 untary employer contributions;

8 “(ii) State laws requiring employers to  
9 provide employment-based health insurance  
10 coverage for employees with required mini-  
11 mum premium contributions by such em-  
12 ployers;

13 “(iii) State laws requiring employers  
14 to make payments to a health insurance  
15 purchasing fund or program for health in-  
16 surance; and

17 “(iv) other methods devised by the  
18 State.

19 “(B) The manner in which the State will  
20 ensure that individuals with family income that  
21 exceeds the income level for eligibility for health  
22 insurance coverage provided under a phase I  
23 State universal health insurance coverage plan  
24 under part B will obtain health benefits cov-  
25 erage.

1           “(4) DETAILS OF, AND TIMELINES FOR, GUAR-  
2 ANTEERING A MINIMUM BENEFITS PACKAGE THAT IN-  
3 CLUDES PARITY, INCOME PROTECTIONS, AND PA-  
4 TIENT PROTECTIONS FOR ALL STATE RESIDENTS.—

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

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

15           “(5) OTHER MATTERS.—Any other matter de-  
16 termined appropriate by the Secretary.

17           “(b) BASE COVERAGE GAP.—For purposes of sub-  
18 section (a)(1)(B), the base coverage gap for a State for  
19 a year shall be equal to 100 percent of the eligible resi-  
20 dents of the State for the year involved, less the current  
21 level of coverage for those residents for such year as deter-  
22 mined under section 2122(b)(1).

23           “(c) REDUCING THE LEVEL OF UNINSURED INDIVID-  
24 UALS.—

1           “(1) IN GENERAL.—To be eligible to receive  
2 funds under this part, a State shall agree to admin-  
3 ister a phase II State universal health insurance cov-  
4 erage program with a goal of ensuring, not later  
5 than September 30, 2004, health care coverage for  
6 100 percent of the eligible residents of the State  
7 under a qualified plan or qualified program.

8           “(2) PERMISSIBLE ACTIVITIES.—A State may  
9 use amounts provided under this part for any activi-  
10 ties consistent with this part that are appropriate to  
11 enroll individuals in health plans and health pro-  
12 grams to meet the targets contained in the State  
13 plan under subsection (a)(2)(B), including through  
14 the use of direct payments to health plans or provid-  
15 ers of services.

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

1 **“SEC. 2133. QUALIFIED PLANS AND QUALIFIED PROGRAMS.**

2 “(a) IN GENERAL.—To be eligible to receive funds  
3 under this part, a State shall establish and implement pro-  
4 cedures to certify—

5 “(1) private and public health care plans as  
6 qualified plans; and

7 “(2) public health care programs as qualified  
8 programs.

9 “(b) REQUIREMENTS.—The procedures implemented  
10 under subsection (a) shall ensure that a plan or program  
11 is not certified under this section unless such plan or pro-  
12 gram—

13 “(1) provides benefits that satisfy the require-  
14 ments of subpart 2; and

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

17 “(c) DECERTIFICATION.—The Secretary shall pro-  
18 mulgate regulations for the decertification of qualified  
19 plans or qualified programs for violations of the require-  
20 ments of this part.

21 **“SEC. 2134. ALLOTMENTS.**

22 “(a) APPROPRIATION.—For the purpose of providing  
23 allotments to States under this part, there is appropriated,  
24 out of any money in the Treasury not otherwise appro-  
25 priated—

26 “(1) \$25,100,000,000 for fiscal year 2002; and

1           “(2) \$37,700,000,000 for fiscal year 2003 and  
2 each succeeding fiscal year thereafter.

3           “(b) BASE STATE ALLOCATION.—

4           “(1) IN GENERAL.—From the amount appro-  
5 priated under subsection (a) for a fiscal year for  
6 purposes of carrying out the program under this  
7 part, after application of subsection (e), the Sec-  
8 retary shall allot to each State with a phase II State  
9 universal health insurance coverage plan approved  
10 under this part an amount equal to the sum of the  
11 amounts determined under paragraphs (2) and (3).

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

15           “(A) the product of—

16           “(i) the designated Federal participa-  
17 tion rate for the State as determined under  
18 subsection (c) and adjusted under sub-  
19 section (d);

20           “(ii) the estimated cost for the mini-  
21 mum benefits package required to comply  
22 under section 2133, not to exceed the sum  
23 of—

24           “(I) the total annual Government  
25 and employee contributions required

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

8 “(II) the estimated average cost-  
 9 sharing expense for an individual; and

10 “(iii) the estimated number of eligible  
 11 individuals to be enrolled in the phase I  
 12 State plan; less

13 “(B) the sum of—

14 “(i) the individual health insurance  
 15 contribution and cost-sharing payments to  
 16 be made in accordance with section 2152;  
 17 and

18 “(ii) any applicable employer contribu-  
 19 tion to such payments.

20 “(3) DETERMINATION OF COST OF FAMILY COV-  
 21 ERAGE.—The amount determined under this para-  
 22 graph is the amount equal to—

23 “(A) the product of—

24 “(i) the designated Federal participa-  
 25 tion rate for the State as determined under



1 subsection (c) and adjusted under sub-  
2 section (d);

3 “(ii) the estimated cost for the mini-  
4 mum benefits package required to comply  
5 under section 2133, not to exceed the sum  
6 of—

7 “(I) the total annual Government  
8 and employee contributions required  
9 for family health benefits coverage  
10 under the Blue Cross/Blue Shield  
11 standard service benefit plan offered  
12 under chapter 89 of title 5, United  
13 States Code (adjusted for age, as the  
14 Secretary determines appropriate);  
15 and

16 “(II) the estimated average cost-  
17 sharing expense for a family; and

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

21 “(B) the sum of—

22 “(i) the family health insurance con-  
23 tribution and cost-sharing payments to be  
24 made in accordance with section 2152; and

1                   “(ii) any applicable employer contribu-  
2                   tion to such payments.

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

7           “(d) ENHANCED STATE ALLOCATION.—

8                   “(1) BASED ON EXPENDITURES FOR COV-  
9                   ERAGE.—The Secretary shall adjust annually the  
10                  amount of the Federal participation rate under sub-  
11                  section (c) if the State can demonstrate that quali-  
12                  fied plans or qualified programs have spent a suffi-  
13                  cient percentage of total premium income to provide  
14                  covered health benefits in the prior year.

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

18                                  “(A) 0.25 percentage points if all qualified  
19                                  plans or qualified programs in the State expend  
20                                  at least 85 percent of total income received  
21                                  from premiums (excluding all costs for market-  
22                                  ing, advertising, promotion, health plan admin-  
23                                  istration, profits, or capital accumulation) on  
24                                  the provision of covered health benefits; and

1           “(B) 0.5 percentage points if all qualified  
2           plans or qualified programs in the State expend  
3           at least 90 percent of total income received  
4           from premiums (excluding all costs for market-  
5           ing, advertising, promotion, health plan admin-  
6           istration, profits, or capital accumulation) on  
7           the provision of covered health benefits.

8           “(e) GRANTS TO INDIAN TRIBES AND NATIVE HA-  
9           WAIIAN ORGANIZATIONS.—

10           “(1) IN GENERAL.—From the amounts appro-  
11           priated under subsection (a) for a fiscal year, the  
12           Secretary shall reserve not more than 3 percent to  
13           make grants to Indian tribes and Native Hawaiian  
14           organizations for development and implementation of  
15           universal health insurance coverage plans for mem-  
16           bers of such tribes and organizations.

17           “(2) PLAN.—To be eligible to receive a grant  
18           under paragraph (1), an Indian tribe or Native Ha-  
19           waiian organization shall submit a universal health  
20           insurance coverage plan to the Secretary at such  
21           time, in such manner, and containing such informa-  
22           tion, as the Secretary may require.

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

1 that apply to Indian tribes and Native Hawaiian or-  
 2 ganizations receiving grants under paragraph (1).”.

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

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

8 **“Subpart 2—Minimum Benefits Package That**  
 9 **Includes Parity**

10 **“SEC. 2141. MINIMUM BENEFITS PACKAGE THAT INCLUDES**  
 11 **PARITY.**

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

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

22 “(2) satisfy the requirements of section 2142.

1 **“SEC. 2142. PARITY IN MENTAL HEALTH AND SUBSTANCE**  
2 **ABUSE BENEFITS.**

3 “(a) IN GENERAL.—A health plan (or health insur-  
4 ance coverage offered in connection with such a plan) shall  
5 include mental health and substance abuse treatment ben-  
6 efits that are at least equal to the medical and surgical  
7 benefits provided by or in connection with the plan. The  
8 requirement for such parity of benefits shall apply to the  
9 imposition of aggregate lifetime limits, annual limits,  
10 deductibles, copayments, and other cost-sharing, limita-  
11 tions on the number of visits or hospital days allowed  
12 under or in connection with the plan, and any other bene-  
13 fit-related requirements as the Secretary may designate.

14 “(b) SEPARATE APPLICATION TO EACH OPTION OF-  
15 FERED.—In the case of a health plan that offers a partici-  
16 pant or beneficiary 2 or more benefit package options  
17 under the plan, the requirements of this section shall be  
18 applied separately with respect to each such option.

19 “(c) DEFINITIONS.—In this section:

20 “(1) AGGREGATE LIFETIME LIMIT.—The term  
21 ‘aggregate lifetime limit’ means, with respect to ben-  
22 efits under a health plan or health insurance cov-  
23 erage, a dollar limitation on the total amount that  
24 may be paid with respect to such benefits under the  
25 plan or health insurance coverage with respect to an  
26 individual or other coverage unit.

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

8           “(3) MEDICAL OR SURGICAL BENEFITS.—The  
9 term ‘medical or surgical benefits’ means benefits  
10 with respect to medical or surgical services, as de-  
11 fined under the terms of the plan or coverage (as the  
12 case may be), but does not include mental health or  
13 substance abuse benefits.

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

20           “(5) SUBSTANCE ABUSE BENEFITS.—The term  
21 ‘substance abuse benefits’ means benefits with re-  
22 spect to treatment of substance abuse or chemical  
23 dependency.”.

1 **SEC. 203. STATE LAW REQUIRING LIMITATIONS ON PRE-**  
 2 **MIUMS AND COST-SHARING.**

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

6 **“Subpart 3—Limitations on Premiums and Cost-**  
 7 **Sharing**

8 **“SEC. 2151. LIMITATIONS ON PREMIUMS AND COST-SHAR-**  
 9 **ING.**

10 “Each State that submits a phase II State universal  
 11 health insurance coverage plan under subpart 1 shall, as  
 12 of the date that the State submits the State plan, have  
 13 in effect a State law that satisfies the requirements of sec-  
 14 tion 2152.

15 **“SEC. 2152. LIMITATION ON PREMIUMS AND COST-SHARING.**

16 “(a) **LIMITATION.**—A State that receives payments  
 17 under this part shall ensure that no individual or family  
 18 who enrolls in a qualified plan or under a qualified pro-  
 19 gram shall be required to pay in excess of the maximum  
 20 health insurance contribution determined under subsection  
 21 (b) with respect to any premiums, deductibles, copay-  
 22 ments, or cost-sharing imposed on the individual or family.

23 “(b) **MAXIMUM HEALTH INSURANCE CONTRIBU-**  
 24 **TION.**—For purposes of subsection (a), the maximum  
 25 health insurance contribution of an individual or family  
 26 shall be an amount equal to—

1           “(1) if the family income of the individual or  
2 family involved is less than 100 percent of the pov-  
3 erty line, 0.5 percent of the gross annual income of  
4 such individual or family;

5           “(2) if the family income of the individual or  
6 family involved is at least 100 percent, but less than  
7 200 percent, of the poverty line, 3 percent of the  
8 gross annual income of such individual or family;

9           “(3) if the family income of the individual or  
10 family involved is at least 200 percent, but less than  
11 400 percent, of the poverty line, 5 percent of the  
12 gross annual income of such individual or family;  
13 and

14           “(4) if the family income of the individual or  
15 family involved is at least 400 percent of the poverty  
16 line, 7 percent of the gross annual income of such  
17 individual or family.”.

18 **SEC. 204. ADMINISTRATION OF, AND DEFINITIONS FOR,**

19 **PHASE II STATE PLANS.**

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

23 **“Subpart 4—Administration; Definitions**

24 **“SEC. 2155. ADMINISTRATION.**

25           “(a) PAYMENTS.—



1           “(1) QUARTERLY.—The Secretary shall make  
2           quarterly payments to each State with a phase II  
3           State plan approved under this part, from its allot-  
4           ment under section 2134.

5           “(2) ADVANCE PAYMENT; RETROSPECTIVE AD-  
6           JUSTMENT.—The Secretary may make payments  
7           under this part for each quarter on the basis of ad-  
8           vance estimates by the State and such other inves-  
9           tigation as the Secretary may find necessary, and  
10          may reduce or increase the payments as necessary to  
11          adjust for any overpayment or underpayment for  
12          prior quarters.

13          “(3) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—  
14          Nothing in this subsection shall be construed as pre-  
15          venting a State from claiming as expenditures in the  
16          quarter expenditures that were incurred in a pre-  
17          vious quarter.

18          “(b) COORDINATION.—The Secretary shall coordi-  
19          nate activities carried out under this part with activities  
20          carried out under titles XVIII, XIX, and parts A and B,  
21          and under other Federal health programs.

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

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

5 **“SEC. 2156. DEFINITIONS.**

6 “In this part:

7 “(1) HEALTH PLAN.—The term ‘health plan’  
8 includes any organization that seeks to arrange for,  
9 or provide for the financing and coordinated delivery  
10 of, health care services directly or through a con-  
11 tracted health provider panel, and shall include  
12 health maintenance organizations, preferred provider  
13 organizations, single service health maintenance or-  
14 ganizations, single service preferred provider organi-  
15 zations, other entities such as provider-hospital or  
16 hospital-provider organizations, employee welfare  
17 benefit plans (as defined in section 3(1) of the Em-  
18 ployee Retirement Income Security Act of 1974 (29  
19 U.S.C. 1002(1)), and multiple employer welfare  
20 plans or other association plans, as well as carriers.

21 “(2) POVERTY LINE.—The term ‘poverty line’  
22 has the meaning given that term in section 2126(1).

23 “(3) ELIGIBLE RESIDENTS OF THE STATE.—  
24 The term ‘eligible residents of the State’ means an  
25 individual who—

1           “(A) is a resident of the State involved;

2           “(B) is a citizen of the United States, a  
3           legal resident alien, or an individual otherwise  
4           residing in the United States under the author-  
5           ity of Federal law; and

6           “(C) is not eligible for benefits under the  
7           medicare program under title XVIII, for medi-  
8           cal assistance under the medicaid program  
9           under title XIX, or for health insurance cov-  
10          erage under a phase I State plan under part B.

11          “(4) QUALIFIED PLAN.—The term ‘qualified  
12          plan’ means a health insurance plan certified under  
13          section 2133 to provide coverage to eligible residents  
14          of the State under this part and participates in a  
15          phase II State plan.

16          “(5) QUALIFIED PROGRAM.—The term ‘quali-  
17          fied program’ means a health care program certified  
18          under section 2133 to provide coverage to eligible  
19          residents of the State under this part and partici-  
20          pates in a phase II State plan.

21          “(6) PHASE II STATE PLAN.—The term ‘phase  
22          II State plan’ means the phase II State universal  
23          health insurance coverage plan submitted under sec-  
24          tion 2131(b).”.

1 **SEC. 205. SECRETARIAL SUBMISSION OF LEGISLATIVE PRO-**  
2 **POSAL TO EXPAND MEDICARE BENEFITS.**

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

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

18 (2) provide coverage for outpatient prescription  
19 drugs for such individuals under the medicare pro-  
20 gram; and

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

# TITLE III—PATIENT PROTECTIONS

## 3 SEC. 301. DEFINITIONS.

4 Unless specifically provided otherwise, as used in this  
5 title:

6 (1) CARRIER.—The term “carrier” means a li-  
7 censed insurance company, a hospital or medical  
8 service corporation (including an existing Blue Cross  
9 or Blue Shield organization, within the meaning of  
10 section 833(c)(2) of Internal Revenue Code of 1986  
11 as in effect before the date of the enactment of this  
12 Act), a health maintenance organization, or other  
13 entity licensed or certified by the State to provide  
14 health insurance or health benefits.

15 (2) COVERED INDIVIDUAL.—The term “covered  
16 individual” means a member, enrollee, subscriber,  
17 covered life, patient or other individual eligible to re-  
18 ceive benefits under a health plan.

19 (3) EMERGENCY SERVICES.—The term “emer-  
20 gency services” means those health care services  
21 that are provided to a patient after the sudden onset  
22 of a health condition that manifests itself by symp-  
23 toms of sufficient severity, including severe pain,  
24 and the absence of such immediate health care at-  
25 tention could reasonably be expected, to result in—

1 (A) placing the patient’s health in serious  
2 jeopardy;

3 (B) serious impairment to bodily function;  
4 or

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

7 (4) HEALTH PLAN.—The term “health plan”  
8 includes any organization that seeks to arrange for,  
9 or provide for the financing and coordinated delivery  
10 of, health care services directly or through a con-  
11 tracted health provider panel, and shall include  
12 health maintenance organizations, preferred provider  
13 organizations, single service health maintenance or-  
14 ganizations, single service preferred provider organi-  
15 zations, other entities such as provider-hospital or  
16 hospital-provider organizations, employee welfare  
17 benefit plans (as defined in section 3(1) of the Em-  
18 ployee Retirement Income Security Act of 1974 (29  
19 U.S.C. 1002(1)), and multiple employer welfare  
20 plans or other association plans, as well as carriers.

21 (5) HEALTH PROVIDER.—The term “health  
22 provider” means an individual who is licensed or cer-  
23 tified under State law to provide health care services  
24 and who is operating within the scope of such licen-  
25 sure or certification.

1 (6) MANAGED CARE PLAN.—

2 (A) IN GENERAL.—The term “managed  
3 care plan” means a plan operated by a man-  
4 aged care entity (as defined in subparagraph  
5 (B)), that provides for the financing and deliv-  
6 ery of health care services to persons enrolled in  
7 such plan through—

8 (i) arrangements with selected provid-  
9 ers to furnish health care services;

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

12 (iii) organizational arrangements for  
13 ongoing quality assurance, utilization re-  
14 view programs, and dispute resolution; and

15 (iv) financial incentives for persons  
16 enrolled in the plan to use the participat-  
17 ing providers and procedures provided for  
18 by the plan.

19 (B) MANAGED CARE ENTITY.—The term  
20 “managed care entity” includes a licensed in-  
21 surance company, hospital or medical service  
22 plan (including provider and provider-hospital  
23 networks), health maintenance organization, an  
24 employer or employee organization, or a man-

1           aged care contractor (as defined in subpara-  
2           graph (C)), that operates a managed care plan.

3           (C) MANAGED CARE CONTRACTOR.—The  
4           term “managed care contractor” means a per-  
5           son that—

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

8                     (ii) conducts or arranges for utiliza-  
9                     tion review activities; and

10                    (iii) contracts with an insurance com-  
11                    pany, a hospital or health service plan, an  
12                    employer, an employee organization, or any  
13                    other entity providing coverage for health  
14                    care services to operate a managed care  
15                    plan.

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



1           (8) SECRETARY.—The term “Secretary” means  
2 the Secretary of Health and Human Services unless  
3 specifically provided otherwise.

4           (9) SPECIALIZED TREATMENT EXPERTISE.—  
5 The term “specialized treatment expertise” means  
6 expertise in diagnosing and treating unusual dis-  
7 eases and conditions, diagnosing and treating dis-  
8 eases and conditions that are usually difficult to di-  
9 agnose or treat, and providing other specialized  
10 health care.

11          (10) SPONSOR.—The term “sponsor” means a  
12 carrier or employer that provides a health plan.

13          (11) UTILIZATION REVIEW.—The term “utiliza-  
14 tion review” means a set of formal techniques de-  
15 signed to monitor and evaluate the clinical necessity,  
16 appropriateness and efficiency of health care serv-  
17 ices, procedures, providers and facilities. Techniques  
18 may include ambulatory review, prospective review,  
19 second opinion, certification, concurrent review, case  
20 .

## 21                   **Subtitle A—Utilization** 22                   **Management**

### 23 **SEC. 311. DEFINITIONS.**

24           As used in this subtitle:

1           (1) ADVERSE DETERMINATION.—The term “ad-  
2       verse determination” means a determination that an  
3       admission to or continued stay at a hospital or that  
4       another health care service that is required has been  
5       reviewed and, based upon the information provided,  
6       does not meet the requirements for clinical necessity,  
7       appropriateness, level of care, or effectiveness.

8           (2) AMBULATORY REVIEW.—The term “ambu-  
9       latory review” means utilization review of health  
10      care services performed or provided in an outpatient  
11      setting.

12          (3) APPEALS PROCEDURE.—The term “appeals  
13      procedure” means a formal process under which a  
14      covered individual (or an individual acting on behalf  
15      of a covered individual), attending provider or facil-  
16      ity may appeal an adverse utilization review decision  
17      rendered by the health plan or its designee utiliza-  
18      tion review organization.

19          (4) CARE COORDINATOR.—The term “care co-  
20      ordinator” means a health provider who performs  
21      case management functions in consultation with the  
22      interdisciplinary health care team, the patient, fam-  
23      ily, and community.

24          (5) CASE MANAGEMENT.—The term “case man-  
25      agement” means a coordinated set of activities con-

1 ducted for the individual patient management of se-  
2 rious, complicated, protracted or chronic health con-  
3 ditions that provides cost-effective and benefit-maxi-  
4 mizing treatments for extremely resource-intensive  
5 conditions.

6 (6) CLINICAL REVIEW CRITERIA.—The term  
7 “clinical review criteria” means the recorded (writ-  
8 ten or otherwise) screening procedures, decision ab-  
9 stracts, clinical protocols and practice guidelines  
10 used by the health plan to determine necessity and  
11 appropriateness of health care services.

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

17 (8) CONCURRENT REVIEW.—The term “concur-  
18 rent review” means utilization review conducted dur-  
19 ing a patient’s hospital stay or course of treatment.

20 (9) DISCHARGE PLANNING.—The term “dis-  
21 charge planning” means the formal process for de-  
22 termining, coordinating and managing the care a pa-  
23 tient receives following the discharge of the patient  
24 from a facility.

1           (10) FACILITY.—The term “facility” means an  
2 institution or health care setting providing the pre-  
3 scribed health care services under review. Such term  
4 includes hospitals and other licensed inpatient facili-  
5 ties, ambulatory surgical or treatment centers,  
6 skilled nursing facilities, residential treatment cen-  
7 ters, diagnostic, laboratory and imaging centers and  
8 rehabilitation and other therapeutic health care set-  
9 tings.

10           (11) PROSPECTIVE REVIEW.—The term “pro-  
11 spective review” means utilization review conducted  
12 prior to an admission or a course of treatment.

13           (12) RETROSPECTIVE REVIEW.—The term “ret-  
14 rospective review” means utilization review con-  
15 ducted after health care services have been provided  
16 to a patient. Such term does not include the retro-  
17 spective review of a claim that is limited to an eval-  
18 uation of reimbursement levels, veracity of docu-  
19 mentation, accuracy of coding and adjudication for  
20 payment.

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



1           (2) REVIEW BY STATE.—A State that makes a  
2           determination under paragraph (1) shall periodically  
3           review the standards used by the private accredita-  
4           tion entity to ensure that such standards meet or ex-  
5           ceed the standards established by the Secretaries  
6           under this subtitle.

7           (c) UTILIZATION REVIEW PROGRAM REQUIRE-  
8           MENTS.—The standards developed by the Secretaries  
9           under subsection (a) shall require that utilization review  
10          programs comply with the following:

11           (1) DOCUMENTATION.—A health plan shall pro-  
12          vide a written description of the utilization review  
13          program of the plan, including a description of—

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

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

18                   (C) the clinical review criteria, information  
19                   sources, and the process used to review and ap-  
20                   prove the provision of health care services under  
21                   the program.

22           (2) PROHIBITION.—With respect to the admin-  
23          istration of the utilization review program, a health  
24          plan may not employ utilization reviewers or con-  
25          tract with a utilization management organization if

1 the conditions of employment or the contract terms  
2 include financial incentives to reduce or limit the  
3 provision of clinically necessary or appropriate serv-  
4 ices to covered individuals.

5 (3) REVIEW AND MODIFICATION.—A health  
6 plan shall develop procedures for periodically review-  
7 ing and modifying the utilization review of the plan.  
8 Such procedures shall provide for the participation  
9 of providers and consumers in the health plan in the  
10 development and review of utilization review policies  
11 and procedures.

12 (4) DECISION PROTOCOLS.—

13 (A) IN GENERAL.—A utilization review  
14 program shall develop and apply recorded (writ-  
15 ten or otherwise) utilization review decision pro-  
16 tocols. Such protocols shall be based on sound  
17 health care evidence.

18 (B) PROTOCOL CRITERIA.—The clinical re-  
19 view criteria used under the utilization review  
20 decision protocols to assess the appropriateness  
21 of health care services shall be clearly docu-  
22 mented and available to participating health  
23 providers upon request. Such protocols shall in-  
24 clude a mechanism for assessing the consistency  
25 of the application of the criteria used under the

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

3 (5) REVIEW AND DECISIONS.—

4 (A) REVIEW.—The procedures applied  
5 under a utilization review program with respect  
6 to the preauthorization and concurrent review  
7 of the necessity and appropriateness of health  
8 care devices, services or procedures, shall re-  
9 quire that qualified, comparable health care  
10 providers supervise review decisions. With re-  
11 spect to a decision to deny the provision of  
12 health care devices, services or procedures, a  
13 comparable provider shall conduct a subsequent  
14 review to determine the clinical appropriateness  
15 of such a denial. Comparable health providers  
16 from the appropriate specialty area shall be uti-  
17 lized in the review process.

18 (B) DECISIONS.—All utilization review de-  
19 cisions shall be made in a timely manner, as de-  
20 termined appropriate when considering the ur-  
21 gency of the situation.

22 (C) ADVERSE DETERMINATIONS.—With re-  
23 spect to utilization review, an adverse deter-  
24 mination or noncertification of an admission,  
25 continued stay, or service shall be clearly docu-



1           mented, including the specific clinical or other  
2           reason for the adverse determination or noncer-  
3           tification, and be available to the covered indi-  
4           vidual and the affected provider or facility. A  
5           health plan may not deny or limit coverage with  
6           respect to a service that the enrollee has al-  
7           ready received solely on the basis of lack of  
8           prior authorization or second opinion, to the ex-  
9           tent that the service would have otherwise been  
10          covered by the plan had such prior authoriza-  
11          tion or a second opinion been obtained.

12           (D) NOTIFICATION OF DENIAL.—A health  
13          plan shall provide a covered individual with  
14          timely notice of an adverse determination or  
15          noncertification of an admission, continued  
16          stay, or service. Such a notification shall in-  
17          clude information concerning the utilization re-  
18          view program appeals procedure as well as the  
19          telephone number for the Office.

20           (6) REQUESTS FOR AUTHORIZATION.—A health  
21          plan utilization review program shall ensure that re-  
22          quests by covered individuals or providers for prior  
23          authorization of a nonemergency service shall be an-  
24          swered in a timely manner after such request is re-  
25          ceived. If utilization review personnel are not avail-

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

3 (7) NEW TECHNOLOGIES.—A utilization review  
4 program shall implement policies and procedures to  
5 evaluate the appropriate use of new health care tech-  
6 nologies or new applications of established tech-  
7 nologies, including health care procedures, drugs,  
8 and devices. The program shall ensure that appro-  
9 priate providers participate in the development of  
10 technology evaluation criteria.

11 (8) SPECIAL RULE.—Where prior authorization  
12 for a service or other covered item is obtained under  
13 a program under this section, the service shall be  
14 considered to be covered unless there was intentional  
15 fraud or intentionally incorrect information provided  
16 at the time such prior authorization was obtained. If  
17 a provider intentionally supplied the incorrect infor-  
18 mation that led to the authorization of clinically un-  
19 necessary care, the provider shall be prohibited from  
20 collecting payment directly from the enrollee, and  
21 shall reimburse the plan and subscriber for any pay-  
22 ments or copayments the provider may have re-  
23 ceived.

24 (d) HEALTH PLAN REQUIREMENTS.—

25 (1) DISCLOSURE OF INFORMATION.—

1 (A) PROSPECTIVE COVERED INDIVID-  
2 UALS.—A health plan shall, with respect to any  
3 materials distributed to prospective covered in-  
4 dividuals, include a summary of the utilization  
5 review procedures of the plan.

6 (B) COVERED INDIVIDUALS.—A health  
7 plan shall, with respect to any materials distrib-  
8 uted to newly covered individuals, include a  
9 clear and comprehensive description of utiliza-  
10 tion review procedures of the plan and a state-  
11 ment of patient rights and responsibilities with  
12 respect to such procedures.

13 (C) STATE OFFICIALS.—

14 (i) IN GENERAL.—A health plan shall  
15 disclose to the State insurance commis-  
16 sioner, or other designated State official,  
17 the health plan utilization review program  
18 policies, procedures, and reports required  
19 by the State for certification.

20 (ii) STREAMLINING OF PROCE-  
21 DURES.—To the extent practicable, a State  
22 shall implement procedures to streamline  
23 the process by which a health plan docu-  
24 ments compliance with the requirements of  
25 this title, including procedures to condense

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

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

8           (3) EVALUATION.—A health plan shall establish  
9           mechanisms to evaluate the effects of the utilization  
10          review program of the plan through the use of mem-  
11          ber satisfaction data or through other appropriate  
12          means.

13          (e) EMERGENCY CARE.—

14           (1) EMERGENCY MEDICAL CONDITION.—For  
15           purposes of this section the term ‘emergency medical  
16           condition’ means a medical condition manifesting  
17           itself by acute symptoms of sufficient severity (in-  
18           cluding severe pain) such that a prudent layperson  
19           (including the parent of a minor child or the guard-  
20           ian of a disabled individual), who possesses an aver-  
21           age knowledge of health and medicine, could reason-  
22           ably expect the absence of immediate medical atten-  
23           tion to result in—

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

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

3 (B) serious impairment to bodily functions,

4 or

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

7 (2) PREAUTHORIZATION.—With respect to  
8 emergency services furnished in a hospital emer-  
9 gency department, a health plan shall not require  
10 prior authorization for the provision of such services  
11 if the enrollee arrived at the emergency department  
12 with symptoms that reasonably suggested an emer-  
13 gency medical condition based on the judgment of a  
14 prudent layperson, regardless of whether the hos-  
15 pital was affiliated with the health plan. All proce-  
16 dures performed during the evaluation and treat-  
17 ment of an emergency medical condition shall be  
18 covered under the health plan.

## 19 **Subtitle C—Health Plan Standards**

### 20 **SEC. 321. HEALTH PLAN STANDARDS.**

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

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

3 (b) STATE CERTIFICATION.—

4 (1) IN GENERAL.—A State shall provide for the  
5 certification of health plans if the certifying author-  
6 ity designated by the State determines that the plan  
7 meets the applicable requirements of this title.

8 (2) REQUIREMENT.—Effective on January 1,  
9 1999, a health plan sponsor may only offer a health  
10 plan in a State if such plan is certified by the State  
11 under paragraph (1).

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

16 **SEC. 322. MINIMUM SOLVENCY REQUIREMENTS.**

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

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

3 (b) FEDERAL STANDARDS.—The Secretaries shall es-  
4 tablish minimum solvency standards that shall apply to  
5 all self-insured health plans. Such standards shall at least  
6 meet the solvency requirements established by the Na-  
7 tional Association of Insurance Commissioners.

8 **SEC. 323. INFORMATION ON TERMS OF PLAN.**

9 (a) IN GENERAL.—A health plan shall provide pro-  
10 spective covered individuals with written information con-  
11 cerning the terms and conditions of the health plan to en-  
12 able such individuals to make informed decisions with re-  
13 spect to a certain system of health care delivery. Such in-  
14 formation shall be standardized so that prospective cov-  
15 ered individuals may compare the attributes of all such  
16 plans offered within the coverage area.

17 (b) UNDERSTANDABILITY.—Information provided  
18 under this section, whether written or oral shall be easily  
19 understandable, truthful, linguistically appropriate and  
20 objective with respect to the terms used. Descriptions pro-  
21 vided in such information shall be consistent with stand-  
22 ards developed for supplemental insurance coverage under  
23 title XVIII of the Social Security Act (42 U.S.C. 1395  
24 et seq.).

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

3 (1) coverage provisions, benefits, and any exclu-  
4 sions by category of service or product;

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

8 (3) prior authorization or other review require-  
9 ments including preauthorization review, concurrent  
10 review, post-service review, post-payment review and  
11 procedures that may lead the patient to be denied  
12 coverage for, or not be provided, a particular service  
13 or product;

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

18 (5) covered individual satisfaction statistics, in-  
19 cluding disenrollment statistics and satisfaction sta-  
20 tistics from those who disenroll;

21 (6) advance directives and organ donation;

22 (7) the characteristics and availability of health  
23 care providers and institutions participating in the  
24 plan, including descriptions of the financial arrange-  
25 ments or contractual provisions with hospitals, utili-



1 zation review organizations, physicians, or any other  
2 provider of health care services that would affect the  
3 services offered, referral or treatment options, or  
4 provider's fiduciary responsibility to patients, includ-  
5 ing financial incentives regarding the provision of  
6 services; and

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

12 **SEC. 324. ACCESS.**

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

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

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

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

9 (d) CHRONIC CONDITIONS.—

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

18 (2) CARE COORDINATOR.—In the case of an en-  
19 rollee who has a severe, complex, or chronic condi-  
20 tion, the health plan shall determine, based on the  
21 judgment of the treating health provider, whether it  
22 is clinically necessary or appropriate to use a care  
23 coordinator from an interdisciplinary team.

24 (e) REQUIREMENT.—

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

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

14 **SEC. 325. CREDENTIALING FOR HEALTH PROVIDERS.**

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

18           (b) CREDENTIALING PROCESS.—

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

1           (2) RESPONSIBILITY CHIEF HEALTH CARE OF-  
2           FICER.—The chief health care officer of the health  
3           plan, or another designated health provider, shall  
4           have responsibility for the credentialing of health  
5           providers under the plan.

6           (3) UNIFORM APPLICATIONS.—A State shall de-  
7           velop a basic uniform application that shall be used  
8           by all health plans in the State for credentialing  
9           purposes.

10          (4) STANDARDS.—

11                (A) IN GENERAL.—Credentialing decisions  
12                under a health plan shall be based on objective  
13                standards with input from health providers  
14                credentialed under the plan. Information con-  
15                cerning all application and credentialing policies  
16                and procedures shall be made available for re-  
17                view by the health providers involved upon writ-  
18                ten request.

19                (B) RIGHT TO REVIEW INFORMATION.—A  
20                health provider who undergoes the credentialing  
21                process shall have the right to review the basis  
22                information, including the sources of that infor-  
23                mation, that was used to meet the designated  
24                credentialing criteria.

1 **SEC. 326. GRIEVANCE PROCEDURES.**

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

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

9 (2) documentation concerning the substance of  
10 complaints, grievances, and actions taken concerning  
11 such complaints and grievances, which shall be in  
12 writing, and be available upon request to the Office  
13 for Consumer Information, Counseling and Assist-  
14 ance with Health Care;

15 (3) procedures to ensure a resolution of a com-  
16 plaint or grievance;

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

19 (5) procedures to expedite the complaint proc-  
20 ess if the complaint involves a dispute about the cov-  
21 erage of an immediately and urgently needed service;  
22 and

23 (6) procedures to ensure that if an enrollee  
24 orally notifies a health plan about a complaint, the  
25 plan (if requested) must send the enrollee a com-  
26 plaint form that includes the telephone numbers and

1 addresses of member services, a description of the  
2 plan's grievance procedure, and the telephone num-  
3 ber of the Officer for Consumer Information, Coun-  
4 seling and Assistance with Health Care where enroll-  
5 ees may register complaints.

6 (b) APPEAL PROCESS.—A health plan shall adopt an  
7 appeals process to enable covered individuals and provid-  
8 ers to appeal decisions that are adverse to the covered in-  
9 dividuals. Such a process shall include—

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

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

13 (3) an expedited process for review in emer-  
14 gency cases.

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

18 (c) NOTIFICATION.—With respect to the complaint,  
19 grievance, and appeals processes required under this sec-  
20 tion, a health plan shall, upon the request of a covered  
21 individual, provide the individual a written decision con-  
22 cerning a complaint, grievance, or appeal in a timely fash-  
23 ion.

24 (d) NON-IMPEDIMENT TO BENEFITS.—The com-  
25 plaint, grievance, and appeals processes established in ac-

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

4 (e) DUE PROCESS WITH RESPECT TO  
5 CREDENTIALING.—

6 (1) RECEIPT OF INFORMATION.—A health pro-  
7 vider who is subject to credentialing under section  
8 325 shall, upon written request, receive from the  
9 health plan any information obtained by the plan  
10 during the credentialing process that, as determined  
11 by the credentialing committee, does not meet the  
12 credentialing standards of the plan, or that varies  
13 substantially from the information provided to the  
14 health plan by the health provider.

15 (2) SUBMISSION OF CORRECTIONS.—A health  
16 plan shall have a formal, recorded (written or other-  
17 wise) process by which a health provider may submit  
18 supplemental information to the credentialing com-  
19 mittee if the health provider determines that erro-  
20 neous or misleading information has been previously  
21 submitted. The health provider may request that  
22 such information be reconsidered in the evaluation  
23 for credentialing purposes.

24 (3) NO ENTITLEMENT.—

1 (A) IN GENERAL.—A health provider is  
2 not entitled to be selected or retained by a  
3 health plan as a participating or contracting  
4 provider whether or not such provider meets the  
5 credentialing standards established under sec-  
6 tion 325.

7 (B) ECONOMIC CONSIDERATIONS.—If eco-  
8 nomic considerations, including the health care  
9 provider’s patterns of expenditure per patient,  
10 are part of a selection decision, objective cri-  
11 teria shall be used in examining such consider-  
12 ations and a written description of such criteria  
13 shall be provided to applicants, participating  
14 health providers, and enrollees. Any economic  
15 profiling of health providers must be adjusted  
16 to recognize case mix, severity of illness, and  
17 the age and gender of patients of a health pro-  
18 vider’s practice that may account for higher or  
19 lower than expected costs, to the extent appro-  
20 priate data in this regard is available to the  
21 health plan.

22 (4) TERMINATION, REDUCTION, OR WITH-  
23 DRAWAL.—

24 (A) PROCEDURES.—A health plan shall de-  
25 velop and implement procedures for the report-



1 ing, to appropriate authorities, of serious qual-  
2 ity deficiencies that result in the suspension or  
3 termination of a contract with a health pro-  
4 vider.

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

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

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

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

16 At a minimum, the policies and procedures im-  
17 plemented under this subparagraph shall meet  
18 the requirements of the Health Care Quality  
19 Improvement Act of 1986.

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

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

5           (E) DUE PROCESS.—The policies and pro-  
6           cedures implemented under subparagraph (B)  
7           shall include requirements for the timely notifi-  
8           cation of the affected health provider of the rea-  
9           sons for the reduction, withdrawal, or termi-  
10          nation of privileges, and shall provide the health  
11          provider with the right to appeal initially to the  
12          health plan and subsequently, upon failure to  
13          resolve a dispute, to an independent entity, the  
14          determination of reduction, withdrawal, or ter-  
15          mination. No reduction, withdrawal, or termi-  
16          nation of privileges shall be made without  
17          cause.

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

1 **SEC. 327. CONFIDENTIALITY STANDARDS.**

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

5 (b) POLICIES AND PROCEDURES.—A health plan  
6 shall have written confidentiality policies and procedures.

7 Such policies and procedures shall, at a minimum—

8 (1) protect the confidentiality of enrollee pa-  
9 tient information within the administrative structure  
10 of the health plan with special attention to sensitive  
11 health conditions and history;

12 (2) protect health care record information;

13 (3) protect claim information;

14 (4) establish requirements for the release of in-  
15 formation; and

16 (5) inform health plan employees of the con-  
17 fidentiality policies and procedures and enforce com-  
18 pliance with such policies and procedures.

19 (c) PATIENT CARE PROVIDERS AND FACILITIES.—

20 A health plan shall ensure that providers, offices, and fa-  
21 cilities responsible for providing covered items or services  
22 to plan enrollees have implemented policies and procedures  
23 to prevent the unauthorized or inadvertent disclosure of  
24 confidential patient information to individuals who should  
25 not have access to such information.

1 (d) RELEASE OF INFORMATION.—An enrollee in a  
2 health plan shall have the opportunity to approve or dis-  
3 approve the release of identifiable personal patient infor-  
4 mation by the health plan, except where such release is  
5 required under applicable law.

6 **SEC. 328. DISCRIMINATION.**

7 (a) ENROLLEES.—A health plan (network or non-net-  
8 work) may not discriminate or engage (directly or through  
9 contractual arrangements) in any activity, including the  
10 selection of service area, that has the effect of discriminat-  
11 ing against an individual on the basis of race, culture, na-  
12 tional origin, gender, language, socio-economic status, age,  
13 disability, health status including genetic information, or  
14 anticipated utilization of health services.

15 (b) PROVIDERS.—A health plan may not discriminate  
16 in the selection of members of the health provider or pro-  
17 vider network (and in establishing the terms and condi-  
18 tions for membership in the network) of the plan based  
19 on—

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

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

1 **SEC. 329. PROHIBITION ON SELECTIVE MARKETING.**

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

6 **Subtitle D—Miscellaneous**  
7 **Provisions**

8 **SEC. 331. ENFORCEMENT.**

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

12 (1) have in place a utilization review program  
13 that is certified by the State as meeting the require-  
14 ments of subtitle A;

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

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

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

21 (5) meet any other requirements determined ap-  
22 propriate by the Secretary.

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

1 **SEC. 332. PREEMPTION.**

2 Nothing in this title shall be construed to preempt  
3 any State law, or the implementation of such a State law,  
4 that provides protections for individuals that are equiva-  
5 lent to or stricter than the provisions of this title.

6 **SEC. 333. EFFECTIVE DATES; REGULATIONS.**

7 (a) IN GENERAL.—Except as otherwise provided in  
8 this section, this title shall take effect on the date of enact-  
9 ment of this Act.

10 (b) STANDARDS.—The standards and programs re-  
11 quired under this title shall apply to health plans begin-  
12 ning on January 1, 1999.

13 (c) OTHER REQUIREMENTS.—The requirements of  
14 this subtitle shall apply to health plans beginning on Janu-  
15 ary 1, 1999.

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

19 **TITLE IV—MISCELLANEOUS**

20 **SEC. 401. NONAPPLICATION OF ERISA.**

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

1 plan under part B of title XXI of the Social Security Act  
2 or under a phase II State universal health insurance cov-  
3 erage plan under part C of title XXI of that Act.

4 **SEC. 402. SENSE OF CONGRESS REGARDING OFFSETS.**

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

8 (1) reductions in unnecessary tax benefits avail-  
9 able only to individuals and large corporations that  
10 are in the maximum tax brackets;

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

13 (3) elimination of duplicative and wasteful mili-  
14 tary spending; and

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

○