/* Title I of the Health Security Act follows. This section provides the basic benefit package and universal coverage. */

Title I HEALTH CARE SECURITY

Table of Contents

Subtitle A Universal Coverage and Individual Responsibility

Part 1 Universal Coverage

Section 1001 Entitlement to health benefits

Section 1002 Individual responsibilities

Section 1003 Protection of consumer choice

Section 1004 Applicable health plan providing coverage

Section 1005 Treatment of other nonimmigrants

Section 1006 Effective date of entitlement

Part 2 Treatment of Families and Special Rules

Section 1011 General rule of enrollment of family in same health plan

Section 1012 Treatment of certain families

Section 1013 Multiple employment situations

Section 1014 Treatment of residents of States with statewide single-payer systems

Subtitle B Benefits

Part 1 Comprehensive Benefit Package

Section 1101 Provision of comprehensive benefits by plans

Part 2 Description of Items and Services Covered

Section 1111 Hospital services

Section 1112 Services of health professionals

Section 1113 Emergency and ambulatory medical and surgical services

Section 1114 Clinical preventive services

Section 1115 Mental illness and substance abuse services

Section 1116 Family planning services and services for pregnant women

Section 1117 Hospice care

Section 1118 Home health care

Section 1119 Extended care services

Section 1120 Ambulance services

Section 1121 Outpatient laboratory, radiology, and diagnostic services

Section 1122 Outpatient prescription drugs and biologicals

Section 1123 Outpatient rehabilitation services

Section 1124 Durable medical equipment and prosthetic and orthotic devices

Section 1125 Vision care

Section 1126 Dental care

Section 1127 Health education classes

Section 1128 Investigational treatments

Part 3 Cost Sharing

Section 1131 Cost sharing

Section 1132 Lower cost sharing

Section 1133 Higher cost sharing

Section 1134 Combination cost sharing

Section 1135 Table of copayments and coinsurance

Section 1136 Indexing dollar amounts relating to cost sharing

Part 4 Exclusions

Section 1141 Exclusions

Part 5 Role of the National Health Board

Section 1151 Definition of benefits

Section 1152 Acceleration of expanded benefits

Section 1153 Authority with respect to clinical preventive services

Section 1154 Establishment of standards regarding medical necessity

Part 6 Additional Provisions Relating to Health Care Providers

Section 1161 Override of restrictive State practice laws

Section 1162 Provision of items or services contrary to religious belief or moral conviction

Subtitle C State Responsibilities

1200 Participating State

Part 1 General State Responsibilities

Section 1201 General State responsibilities

Section 1202 State responsibilities with respect to alliances

Section 1203 State responsibilities relating to health plans

Section 1204 Financial solvency; fiscal oversight; guaranty fund

Section 1205 Restrictions on funding of additional benefits

Part 2 Requirements for State Single-payer Systems

Section 1221 Single-payer system described

Section 1222 General requirements for single-payer systems

Section 1223 Special rules for States operating statewide single-payer system

Section 1224 Special rules for alliance-specific single-payer systems

Subtitle D   Health Alliances

Section 1300 Health alliance defined

Part 1   Establishment of Regional and Corporate Alliances

Sub Part A   REGIONAL ALLIANCES

Section 1301 Regional alliance defined

Section 1302 Board of directors

Section 1303 Provider advisory boards for regional alliances

Sub Part B   CORPORATE ALLIANCES

Section 1311 Corporate alliance defined; individuals eligible for coverage through corporate alliances; additional definitions

Section 1312 Timing of elections

Section 1313 Termination of alliance election

Part 2   General Responsibilities and Authorities of Regional Alliances

Section 1321 Contracts with health plans

Section 1322 Offering choice of health plans for enrollment; establishment of fee-for-service schedule

Section 1323 Enrollment rules and procedures

Section 1324 Issuance of health security cards

Section 1325 Consumer information and marketing

Section 1326 Ombudsman

Section 1327 Data collection; quality

Section 1328 Additional duties

Section 1329 Additional authorities for regional alliances to address needs in areas with inadequate health services; prohibition of insurance role

Section 1330 Prohibition against self-dealing and conflicts of interest

Part 3   Authorities and Responsibilities of Regional Alliances Relating to Financing and Income Determinations

Sub Part A   COLLECTION OF FUNDS

Section 1341 Information and negotiation and acceptance of bids

Section 1342 Calculation and publication of general family share and general employer premium amounts

Section 1343 Determination of family share for families

Section 1344 Notice of family payments due

Section 1345 Collections

Section 1346 Coordination among regional alliances

Sub Part B   PAYMENTS

Section 1351 Payment to regional alliance health plans

Section 1352 Alliance administrative allowance percentage

Section 1353 Payments to the Federal Government for academic health centers and graduate medical education

Sub Part C   FINANCIAL MANAGEMENT

Section 1361 Management of finances and records

Sub Part D REDUCTIONS IN COST SHARING; INCOME DETERMINATIONS

Section 1371 Reduction in cost sharing for low-income families

Section 1372 Application process for cost sharing reductions

Section 1373 Application for premium discounts and reduction in liabilities to alliances

Section 1374 General provisions relating to application process

Section 1375 End-of-year reconciliation for premium discount and repayment reduction with actual income

Part 4 Responsibilities and Authorities of Corporate Alliances

Section 1381 Contracts with health plans

Section 1382 Offering choice of health plans for enrollment

Section 1383 Enrollment; issuance of health security card

Section 1384 Community-rated premiums within premium areas

Section 1385 Assistance for low-wage families

Section 1386 Consumer information and marketing; data collection and quality; additional duties

Section 1387 Plan and information requirements

Section 1388 Management of funds; relations with employees

Section 1389 Cost control

Section 1390 Payments by corporate alliance employers to corporate alliances

Section 1391 Coordination of payments

Section 1392 Applicability of ERISA enforcement mechanisms for enforcement of certain requirements

Section 1393 Applicability of certain ERISA protections to enrolled individuals

Section 1394 Disclosure and reserve requirements

Section 1395 Trusteeship by the Secretary of insolvent corporate alliance health plans

Section 1396 Guaranteed benefits under trusteeship of the Secretary

Section 1397 Imposition and collection of periodic assessments on self-insured corporate alliance plans

Section 1398 Payments to Federal government by multiemployer corporate alliances for academic health centers and graduate medical education

Subtitle E   Health Plans

Section 1400 Health plan defined

Part 1   Requirements Relating to Comprehensive Benefit Package

Section 1401 Application of requirements

Section 1402 Requirements relating to enrollment and coverage

Section 1403 Community rating

Section 1404 Marketing of health plans; information

Section 1405 Grievance procedure

Section 1406 Health plan arrangements with providers

Section 1407 Preemption of certain State laws relating to health plans

Section 1408 Financial solvency

Section 1409 Requirement for offering cost sharing policy

Section 1410 Quality assurance

Section 1411 Provider verification

Section 1412 Consumer disclosures of utilization management protocols

Section 1413 Confidentiality, data management, and reporting

Section 1414 Participation in reinsurance system

Part 2 Requirements Relating to Supplemental Insurance

Section 1421 Imposition of requirements on supplemental insurance

Section 1422 Standards for supplemental health benefit policies

Section 1423 Standards for cost sharing policies

Part 3 Requirements Relating to Essential Community Providers

Section 1431 Health plan requirement

Section 1432 Sunset of requirement

Part 4 Requirements Relating to Workers' Compensation and Automobile Medical Liability Coverage

Section 1441 Reference to requirements relating to workers compensation services

Section 1442 Reference to requirements relating to automobile medical liability services

Subtitle F Federal Responsibilities

Part 1 National Health Board

Sub Part A ESTABLISHMENT OF NATIONAL HEALTH BOARD

Section 1501 Creation of National Health Board; membership

Section 1502 Qualifications of board members

Section 1503 General duties and responsibilities

Section 1504 Annual report

Section 1505 Powers

Section 1506 Funding

Sub Part B RESPONSIBILITIES RELATING TO REVIEW AND APPROVAL OF STATE SYSTEMS

Section 1511 Federal review and action on State systems

Section 1512 Failure of participating States to meet conditions for compliance

Section 1513 Reduction in payments for health programs by Secretary of Health and Human Services

Section 1514 Review of Federal determinations

Section 1515 Federal support for State implementation

Sub Part C RESPONSIBILITIES IN ABSENCE OF STATE SYSTEMS

Section 1521 Application of subpart

Section 1522 Federal assumption of responsibilities in non-participating States

Section 1523 Imposition of surcharge on premiums under federally-operated system

Section 1524 Return to State operation

Sub Part D ESTABLISHMENT OF CLASS FACTORS FOR CHARGING PREMIUMS

Section 1531 Premium class factors

Sub Part E RISK ADJUSTMENT AND REINSURANCE METHODOLOGY FOR PAYMENT OF PLANS

Section 1541 Development of a risk adjustment and reinsurance methodology

Section 1542 Incentives to enroll disadvantaged groups

Section 1543 Advisory committee

Section 1544 Research and demonstrations

Section 1545 Technical assistance to States and alliances

Sub Part F   RESPONSIBILITIES FOR FINANCIAL REQUIREMENTS

Section 1551 Capital standards for regional alliance health plan

Section 1552 Standard for guaranty funds

Part 2   Responsibilities of Department of Health and Human Services

Sub Part A   GENERAL RESPONSIBILITIES

Section 1571 General responsibilities of Secretary of Health and Human Services

Section 1572 Advisory council on breakthrough drugs

Sub Part B   CERTIFICATION OF ESSENTIAL COMMUNITY PROVIDERS

Section 1581 Certification

Section 1582 Categories of providers automatically certified

Section 1583 Standards for additional providers

Section 1584 Certification process; review; termination of certifications

Section 1585 Notification of health alliances and participating States

Part 3   Specific Responsibilities of Secretary of Labor

Section 1591 Responsibilities of Secretary of Labor

Subtitle G   Employer Responsibilities

Section 1601 Payment requirement

Section 1602 Requirement for information reporting

Section 1603 Requirements relating to new employees

Section 1604 Auditing of records

Section 1605 Prohibition of certain employer discrimination

Section 1606 Prohibition on self-funding of cost sharing by regional alliance employers

Section 1607 Equal voluntary contribution requirement

Section 1608 Employer retiree obligation

Section 1609 Enforcement

Subtitle J   General Definitions; Miscellaneous Provisions

Part 1   General Definitions

Section 1901 Definitions relating to employment and income

Section 1902 Other general definitions

Subtitle B   Miscellaneous Provisions

Section 1911 Use of interim, final regulations

Section 1912 Social Security Act references

Subtitle A   Universal Coverage and Individual Responsibility

Part 1   UNIVERSAL COVERAGE

Section 1001   ENTITLEMENT TO HEALTH BENEFITS.

(a) In General.In accordance with this part, each eligible individual is entitled to the comprehensive benefit package under subtitle B through the applicable health plan in which the individual is enrolled consistent with this title.

(b) Health Security Card.Each eligible individual is entitled to a health security card to be issued by the alliance or other entity that offers the applicable health plan in which the individual is enrolled.

(c) Eligible Individual Defined.In this Act, the term "eligible individual" means an individual who is residing in the United States and who is--

(1) a citizen or national of the United States;

(2) an alien permanently residing in the United States under color of law (as defined in section 1902(1)); or

(3) a long-term nonimmigrant (as defined in section 1902(19)).

(d) Treatment of Medicare-Eligible Individuals.Subject to section 1012(a), a medicare-eligible individual is entitled to health benefits under the medicare program instead of the entitlement under subsection (a).

(e) Treatment of Prisoners.A prisoner (as defined in section 1902(26)) is entitled to health care services provided by the authority responsible for the prisoner instead of the entitlement under subsection (a).

Section 1002 INDIVIDUAL RESPONSIBILITIES.

(a) In General.In accordance with this Act, each eligible individual (other than a medicare-eligible individual)

(1) must enroll in an applicable health plan for the individual, and

(2) must pay any premium required, consistent with this Act, with respect to such enrollment.

(b) Limitation on Disenrollment.No eligible individual shall be disenrolled from an applicable health plan until the individual

(1) is enrolled under another applicable health plan, or

(2) becomes a medicare-eligible individual.

Section 1003 PROTECTION OF CONSUMER CHOICE.

Nothing in this Act shall be construed as prohibiting the following:

(1) An individual from purchasing any health care services.

(2) An individual from purchasing supplemental insurance (offered consistent with this Act) to cover health care services not included within the comprehensive benefit package.

(3) An individual who is not an eligible individual from purchasing health insurance (other than through a regional alliance).

(4) Employers from providing coverage for benefits in addition to the comprehensive benefit package (subject to part 2 of subtitle E).

Section 1004 APPLICABLE HEALTH PLAN PROVIDING COVERAGE.

(a) Specification of Applicable Health Plan.Except as otherwise provided:

(1) General rule: regional alliance health plans.The applicable health plan for a family is a regional alliance health plan for the alliance area in which the family resides.

(2) Corporate alliance health plans.In the case of a family member that is eligible to enroll in a corporate alliance health plan under section 1311(c), the applicable health plan for the family is such a corporate alliance health plan.

(b) Choice of Plans for Certain Groups.

(1) Military personnel and families.For military personnel and families who elect a Uniformed Services Health Plan of the Department of Defense under section 1073a(d) of title 10, United States Code, as inserted by section 8001(a) of this Act, that plan shall be the applicable health plan.

(2) Veterans.For veterans and families who elect to enroll in a veterans health plan under section 1801 of title 38, United States Code, as inserted by section 8101(a) of this Act, that plan shall be the applicable health plan.

(3) Indians.For those individuals who are eligible to enroll, and who elect to enroll, in a health program of the Indian Health Service under section 8302(b) or 8306(b), that program shall be the applicable health plan.

Section 1005 TREATMENT OF OTHER NONIMMIGRANTS.

(a) Undocumented Aliens Ineligible for Benefits.An undocumented alien is not eligible to obtain the comprehensive benefit package through enrollment in a health plan pursuant to this Act.

(b) Diplomats and Other Foreign Government Officials.Subject to conditions established by the National Health Board in consultation with the Secretary of State, a nonimmigrant under subparagraph (A) or (G) of section 101(a)(15) of the Immigration and Nationality Act may obtain the comprehensive benefit package through enrollment in the regional alliance health plan for the alliance area in which the nonimmigrant resides.

(c) Reciprocal Treatment of Other Nonimmigrants.With respect to those classes of individuals who are lawful nonimmigrants but who are not long-term nonimmigrants (as defined in section 1902(19)) or described in subsection (b), such individuals may obtain such benefits through enrollment with regional alliance health plans only in accordance with such reciprocal agreements between the United States and foreign states as may be entered into.

Section 1006 EFFECTIVE DATE OF ENTITLEMENT.

(a) Regional Alliance Eligible Individuals.

(1) In general.In the case of regional alliance eligible individuals residing in a State, the entitlement under this part (and requirements under section 1002) shall not take effect until the State becomes a participating State (as defined in section 1200).

(2) Transitional rule for corporate alliances.

(A) In general.In the case of a State that becomes a participating State before the general effective date (as defined in subsection (c)) and for periods before such date, under rules established by the Board, an individual who is covered under a plan (described in subparagraph (C)) based on the individual (or the individual's spouse) being a qualifying employee of a qualifying employer, the individual shall not be treated under this Act as a regional alliance eligible individual.

(B) Qualifying employer defined.In subparagraph (A), the term "qualifying employer" means an employer that

(i) is described in section 1311(b)(1)(A), or is participating in a multiemployer plan described in section 1311(b)(1)(B) or plan described in section 1311(b)(1)(C), and

(ii) provides such notice to the regional alliance involved as the Board specifies.

(C) Benefits plan described.A plan described in this subparagraph as an employee benefit plan that

(i) provides (through insurance or otherwise) the comprehensive benefit package, and

(ii) provides an employer contribution of at least 80 percent of the premium (or premium equivalent) for coverage.

(b) Corporate Alliance Eligible Individuals.

(1) In general. In the case of corporate alliance eligible individuals, the entitlement under this part shall not take effect until the general effective date.

(2) Transition.For purposes of this Act and before the general effective date, in the case of an eligible individual who resides in a participating State, the individual is deemed a regional alliance eligible individual until the individual becomes a corporate alliance eligible individual, unless subsection (a)(2)(A) applies to the individual.

(c) General Effective Date Defined.In this Act, the term "general effective date" means January 1, 1998.

Part 2 TREATMENT OF FAMILIES AND SPECIAL RULES

Section 1011 GENERAL RULE OF ENROLLMENT OF FAMILY IN SAME HEALTH PLAN.

(a) In General.Except as provided in this part or otherwise, all members of the same family (as defined in subsection (b)) shall be enrolled in the same applicable health plan.

(b) Family Defined.In this Act, unless otherwise provided, the term "family"

(1) means, with respect to an eligible individual who is not a child (as defined in subsection (c)), the individual; and

(2) includes the following persons (if any):

(A) The individual's spouse if the spouse is an

eligible individual.

(B) The individual's children (and, if applicable, the children of the individual's spouse) if they are eligible individuals.

(c) Classes of Family Enrollment; Terminology.

(1) In general.In this Act, each of the following is a separate class of family enrollment:

(A) Coverage only of an individual (referred to in this Act as the "individual" enrollment or class of enrollment).

(B) Coverage of a married couple without children (referred to in this Act as the "couple-only" enrollment or class of enrollment).

(C) Coverage of an unmarried individual and one or more children (referred to in this Act as the "single parent" enrollment or class of enrollment).

(D) Coverage of a married couple and one or more children (referred to in this Act as the "dual parent" enrollment or class of enrollment).

(2) References to family and couple classes of enrollment.In this Act:

(A) Family.The terms "family enrollment" and "family class of enrollment", refer to enrollment in a class of enrollment described in subparagraph (B), (C), or (D) of paragraph (1).

(B) Couple.The term "couple class of enrollment" refers to enrollment in a class of enrollment described in subparagraph (B) or (D) of paragraph (1).

(d) Spouse; Married; Couple.

(1) In general. In this Act, the terms "spouse" and "married" mean, with respect to a person, another individual who is the spouse of the person or married to the person, as determined under applicable State law.

(2) Couple. The term "couple" means an individual and the

individual's spouse.

(e) Child Defined.

(1) In general.In this Act, except as otherwise provided, the term "child" means an eligible individual who (consistent with paragraph (3))

(A) is under 18 years of age (or under 24 years of age in the case of a full-time student), and

(B) is a dependent of an eligible individual.

(2) Application of State law. Subject to paragraph (3), determinations of whether a person is the child of another person shall be made in accordance with applicable State law.

(3) National rules.The National Health Board may establish such national rules respecting individuals who will be treated as children under this Act as the Board determines to be necessary. Such rules shall be consistent with the following principles:

(A) Step and foster child.A child includes a step child or foster child who is an eligible individual living with an adult in a regular parent-child relationship.

(B) Disabled child. A child includes an unmarried dependent eligible individual regardless of age who is incapable of self-support because of mental or physical disability which existed before age 21.

(C) Certain 3-generation families.A child includes the grandchild of an individual, if the parent of the grandchild is a child and the parent and grandchild are living with the grandparent.

(D) Treatment of emancipated minors and married individuals. An emancipated minor or married individual shall not be treated as a child.

(E) Children placed for adoption. A child includes a child who is placed for adoption with an eligible individual.

(f) Additional Rules. The Board shall provide for such additional exceptions and special rules, including rules relating

to

(1) families in which members are not residing in the same area or in which children are not residing with their parents,

(2) the treatment of eligible individuals who are under 19 years of age and who are not a dependent of an eligible individual,

(3) changes in family composition occurring during a year, and

(4) treatment of children of parents who are separated or divorced, as the Board finds appropriate.

Section 1012 TREATMENT OF CERTAIN FAMILIES.

(a) Treatment of Medicare-Eligible Individuals Who are Qualifying Employees or Spouses of Qualifying Employees.

(1) In general. Except as specifically provided, in the case of an individual who is an individual described in paragraph (2) with respect to 2 consecutive months in a year (and it is anticipated would be in the following month and in such following month would be a medicare-eligible individual but for this paragraph), the individual shall not be treated as a medicare-eligible individual under this Act during such following month and the remainder of the year.

(2) Individual described. An individual described in this paragraph with respect to a month is an individual who is a qualifying employee or the spouse or family member of a qualifying employee in the month.

(b) Separate Treatment for Certain Groups of Individuals.In the case of a family that includes one or more individuals in a group described in subsection (c)

(1) all the individuals in each such group within the family shall be treated collectively as a separate family, and

(2) all the individuals not described in any such group shall be treated collectively as a separate family.

(c) Groups of Individuals Described. Each of the following is

a group of individuals described in this subsection:

(1) AFDC recipients (as defined in section 1902(3)).

(2) Disabled SSI recipients (as defined in section 1902(13)) .

(3) SSI recipients (as defined in section 1902(33)) who are not disabled SSI recipients.

(4) Electing veterans (as defined in subsection (d)(1)).

(5) Active duty military personnel (as defined in subsection (d)(2)).

(6) Electing Indians (as defined in subsection (d)(3)).

(7) Prisoners (as defined in section 1902(26)).

(d) Special Rules.In this Act:

(1) Electing veterans.

(A) Defined. Subject to subparagraph (B), the term "electing veteran" means a veteran who makes an election to enroll with a health plan of the Department of Veterans Affairs under chapter 18 of title 38, United States Code, as added by section 8101(a)(1).

(B) Family exception.Subparagraph (A) shall not apply with respect to coverage under a health plan referred to in such subparagraph if, for the area in which the electing veteran resides, such health plan offers coverage to family members of an electing veteran and the veteran elects family enrollment under such plan (instead of individual enrollment).

(2) Active duty military personnel.

(A) In general. Subject to subparagraph (B), the term "active duty military personnel" means an individual on active duty in the Uniformed Services of the United States.

(B) Exception. If an individual described in subparagraph (A) elects family coverage under section 1073a(e)(2)(A) of title 10, United States Code (as added by section 8001(a)), then paragraph (5) of subsection (c) shall not apply

with respect to such coverage.

(3) Electing indians.

(A) In general.Subject to subparagraph (B), the term "electing Indian" means an eligible individual who makes an election under section 8302(b) of this Act.

(B) Family election for all individuals eligible to elect. No such election shall be made with respect to an individual in a family (as defined without regard to this section) unless such election is made for all eligible individuals (described in section 8302(a)) who are family members of the family.

(4) Multiple choice. Eligible individuals who are permitted to elect coverage under more than one health plan or program referred to in this subsection may elect which of such plans or programs will be the applicable health plan under this Act.

(e) Qualifying Students.

(1) In general.In the case of a qualifying student (described in paragraph (2)), the student may elect to enroll in a regional alliance health plan offered by the regional alliance for the area in which the school is located.

(2) Qualifying student.In paragraph (1), the term "qualifying student" means an individual who

(A) but for this subsection would receive coverage under a health plan as a child of another person, and

(B) is a full-time student at a school in an alliance area that is different from the alliance area (or, in the case of a corporate alliance, such coverage area as the Board may specify) providing the coverage described in subparagraph (A).

(3) Payment rules.

(A) Continued treatment as family.Except as provided in subparagraph (B), nothing in this subsection shall be construed as affecting the payment liabilities between families and health alliances or between health alliances and health plans.

(B) Transfer payment. In the case of an election under paragraph (1), for transfer payments see section 1346(e).

(f) Spouses Living in Different Alliance Areas. The Board shall provide for such special rules in applying this Act in the case of a couple in which the spouses reside in different alliance areas as the Board finds appropriate.

Section 1013 MULTIPLE EMPLOYMENT SITUATIONS.

(a) Multiple Employment of an Individual. In the case of an individual who

(1) (A) is not married or (B) is married and whose spouse is not a qualifying employee (as defined in section 1901(b)(1)),

(2) is not a child, and

(3) who is a qualifying employee both of a regional alliance employer and of a corporate alliance employer (or of 2 corporate alliance employers), the individual may elect the applicable health plan to be either a regional alliance health plan (for the alliance area in which the individual resides) or a corporate alliance health plan (for an employer employing the individual).

(b) Multiple Employment Within a Family.

(1) Married couple with employment with a regional alliance employer and with a corporate alliance employer.In the case of a married individual

(A) who is a qualifying employee of a regional alliance employer and whose spouse is a qualifying employee of a corporate alliance employer, or

(B) who is a qualifying employee of a corporate alliance employer and whose spouse is an qualifying employee of a regional alliance employer, the individual and the individual's spouse may elect the applicable health plan to be either a regional alliance health plan (for the alliance area in which the couple resides) or a corporate alliance health plan (for an employer employing the individual or the spouse).

(2) Married couple with different corporate alliance

employers. In the case of a married individual

(A) who is a qualifying employee of a corporate alliance employer, and

(B) whose spouse is a qualifying employee of a different corporate alliance employer, the individual and the individual's spouse may elect the applicable health plan to be a corporate alliance health plan for an employer employing either the individual or the spouse.

Section 1014 TREATMENT OF RESIDENTS OF STATES WITH STATEWIDE SINGLE-PAYER SYSTEMS.

(a) Universal Coverage. Notwithstanding the previous provisions of this title, except as provided in part 2 of subtitle C, in the case of an individual who resides in a State that has a Statewide single-payer system under section 1223, universal coverage shall be provided consistent with section 1222(3).

(b) Individual Responsibilities.In the case of an individual who resides in a single-payer State, the responsibilities of such individual under such system shall supersede the obligations of the individual under section 1002.

Title I, Subtitle B

Subtitle B Benefits

Part 1 COMPREHENSIVE BENEFIT PACKAGE

Section 1101 PROVISION OF COMPREHENSIVE BENEFITS BY PLANS.

(a) In General. The comprehensive benefit package shall consist of the following items and services (as described in part 2), subject to the cost sharing requirements described in part 3, the exclusions described in part 4, and the duties and authority of the National Health Board described in part 5:

(1) Hospital services (described in section 1111).

(2) Services of health professionals (described in section 1112).

(3) Emergency and ambulatory medical and surgical services (described in section 1113).

(4) Clinical preventive services (described in section 1114).

(5) Mental illness and substance abuse services (described in section 1115).

(6) Family planning services and services for pregnant women (described in section 1116).

(7) Hospice care (described in section 1117).

(8) Home health care (described in section 1118).

(9) Extended care services (described in section 1119).

(10) Ambulance services (described in section 1120).

(11) Outpatient laboratory, radiology, and diagnostic services (described in section 1121).

(12) Outpatient prescription drugs and biologicals (described in section 1122).

(13) Outpatient rehabilitation services (described in section 1123).

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

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

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

(17) Health education classes (described in section 1127).

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

(b) No Other Limitations or Cost Sharing. The items and services in the comprehensive benefit package shall not be subject to any duration or scope limitation or any deductible, copayment, or coinsurance amount that is not required or

authorized under this Act.

(c) Health Plan. Unless otherwise provided in this subtitle, for purposes of this subtitle, the term "health plan" has the meaning given such term in section 1400.

Part 2 DESCRIPTION OF ITEMS AND SERVICES COVERED

Section 1111 HOSPITAL SERVICES.

(a) Coverage.The hospital services described in this section are the following items and services:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

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

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

(c) Definitions. For purposes of this subtitle:

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

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

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(2), a facility operated by the Department of Veterans Affairs that is primarily engaged in providing services to inpatients that are equivalent to the services provided by a hospital defined in such section 1861(e); and

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

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

Section 1112 SERVICES OF HEALTH PROFESSIONALS.

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

(1) inpatient and outpatient health professional services, including consultations, that are provided in

(A) a home, office, or other ambulatory care setting; or

(B) an institutional setting; and

(2) services and supplies (including drugs and biologicals which cannot be self-administered) furnished as an incident to such health professional services, of kinds which are commonly furnished in the office of a health professional and are commonly either rendered without charge or included in the bill of such professional.

(b) Limitation. The items and services described in this section do not include items or services that are described in any other section of this part. An item or service that is described in section 1114 but is not provided consistent with a periodicity schedule for such item or service specified in such section or under section 1153 may be covered under this section if the item or service otherwise meets the requirements of this section.

(c) Definitions.Unless otherwise provided in this Act, for purposes of this Act:

(1) Health Professional. The term "health professional" means an individual who provides health professional services.

(2) Health Professional Services.The term "health professional services" means professional services that

(A) are lawfully provided by a physician; or

(B) would be described in subparagraph (A) if provided by a physician, but are provided by another person who is legally authorized to provide such services in the State in which the services are provided.

Section 1113 EMERGENCY AND AMBULATORY MEDICAL AND SURGICAL SERVICES.

The emergency and ambulatory medical and surgical services described in this section are the following items and services provided by a health facility that is not a hospital and that is legally authorized to provide the services in the State in which they are provided:

(1) 24-hour a day emergency services.

(2) Ambulatory medical and surgical services.

Section 1114 CLINICAL PREVENTIVE SERVICES.

(a) Coverage. The clinical preventive services described in this section are

(1) an item or service for high risk populations (as defined by the National Health Board) that is specified and defined by the Board under section 1153, but only when the item or service is provided consistent with any periodicity schedule for the item or service promulgated by the Board;

(2) except as modified by the National Health Board under section 1153, an age-appropriate immunization, test, or clinician visit specified in one of subsections (b) through (h) that is provided consistent with any periodicity schedule for the item or service specified in the applicable subsection or by the National Health Board under section 1153; and

(3) an immunization, test, or clinician visit that is provided to an individual during an age range other than the age range for such immunization, test, or clinician visit that is specified in one of subsections (b) through (h), but only when provided consistent with any requirements for such immunizations, tests, and clinician visits established by the National Health Board under section 1153.

(b) Individuals Under 3. For an individual under 3 years of age:

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

(A) Diphtheria.

(B) Tetanus.

(C) Pertussis.

(D) Polio.

(E) Haemophilus influenzae type B.

(F) Measles.

(G) Mumps.

(H) Rubella.

(I) Hepatitis B.

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

(A) 1 hematocrit.

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

(3) Clinician visits. The clinician visits specified in this subsection are 1 clinician visit for an individual who is newborn and 7 other clinician visits.

(c) Individuals Age 3 to 5. For an individual at least 3 years of age, but less than 6 years of age:

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

(A) Diphtheria.

(B) Tetanus.

(C) Pertussis.

(D) Polio.

(E) Measles.

(F) Mumps.

(G) Rubella.

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

(3) Clinician visits. The clinician visits specified in this subsection are 3 clinician visits.

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

(e) Individuals Age 13 to 19. For an individual at least 13 years of age, but less than 20 years of age:

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

(A) Tetanus.

(B) Diphtheria.

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

(A) Papanicolaou smears and pelvic exams, for females

who have reached childbearing age and are at risk for cervical cancer, every 3 years, but

(i) annually until 3 consecutive negative smears have been obtained, if medically necessary; and

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

(B) Annual screening for chlamydia and gonorrhea for females who have reached childbearing age and are at risk for fertility related infectious illnesses.

(3) Clinician visits. The clinician visits specified in this subsection are 3 clinician visits.

(f) Individuals Age 20 to 39. For an individual at least 20 years of age, but less than 40 years of age:

(1) Immunizations.The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

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

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

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

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

(B) Annual screening for chlamydia and gonorrhea for females who are at risk for fertility related infectious illnesses.

(C) Cholesterol every 5 years.

(3) Clinician visits.The clinician visits specified in this subsection are 1 clinician visit every 3 years.

(g) Individuals Age 40 to 49. For an individual at least 40 years of age, but less than 50 years of age:

(1) Immunizations. The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

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

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

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

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

(B) Annual screening for chlamydia and gonorrhea for females who are at risk for fertility related infectious illnesses.

(C) Cholesterol every 5 years.

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

(h) Individuals Age 50 to 65.For an individual at least 50 years of age, but less than 65 years of age:

(1) Immunizations.The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

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

(A) Papanicolaou smears and pelvic exams for females every 2 years.

(B) Mammograms for females every 2 years.

(C) Cholesterol every 5 years.

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

(i) Individuals Age 65 or Older. For an individual at least 65 years of age who is enrolled under a health plan:

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

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

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

(i) Influenza.

(ii) Pneumococcal invasive disease.

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

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

(B) Mammograms for females every 2 years.

(C) Cholesterol every 5 years.

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

(j) Clinician Visit. For purposes of this section, the term "clinician visit" includes the following health professional services (as defined in section 1112(c)):

(1) A complete medical history.

(2) An appropriate physical examination.

(3) Risk assessment.

(4) Targeted health advice and counseling, including nutrition counseling.

(5) The administration of age-appropriate immunizations and tests specified in subsections (b) through (h).

(k) Immunizations and Tests Not Administered During Clinician

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

Section 1115 MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.

(a) Coverage.The mental illness and substance abuse services that are described in this section are the following items and services for eligible individuals, as defined in section 1001(c), who satisfy the eligibility requirements in subsection (b):

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

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

(3) Outpatient mental illness and substance abuse treatment (described in subsection (e)), including case management, screening and assessment, crisis services, and collateral services.

(b) Eligibility. The eligibility requirements referred to in subsection (a) are as follows:

(1) Inpatient, residential, nonresidential, and outpatient treatment. An eligible individual is eligible to receive coverage for inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment (except case management and collateral services) if the individual

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

(B) is experiencing, or is at significant risk of experiencing, functional impairment in family, work, school, or community activities. For purposes of this paragraph, an

individual who has a diagnosable mental disorder or a diagnosable substance abuse disorder, is receiving treatment for such disorder, but does not satisfy the functional impairment criterion in subparagraph (B) shall be treated as satisfying such criterion if the individual would satisfy such criterion without such treatment.

(2) Case management. An eligible individual is eligible to receive coverage for case management if

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

(B) the individual is eligible to receive coverage for, and is receiving, outpatient mental illness and substance abuse treatment with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder.

(3) Screening and assessment and crisis services. All eligible individuals enrolled under a health plan are eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of screening and assessment and crisis services.

(4) Collateral services. An eligible individual is eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of collateral services if the individual is a family member (described in section 1011(b)) of an individual who is receiving inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment.

(c) Inpatient and Residential Treatment.

(1) Definition. For purposes of this subtitle, the term "inpatient and residential mental illness and substance abuse treatment" means the items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to--

(A) an inpatient of a hospital, psychiatric hospital, residential treatment center, residential detoxification center, crisis residential program, or mental illness residential

treatment program; or

(B) a resident of a therapeutic family or group treatment home or community residential treatment and recovery center for substance abuse. The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient and residential mental illness and substance abuse treatment when provided to such an inpatient or resident.

(2) Limitations. Coverage for inpatient and residential mental illness and substance abuse treatment is subject to the following limitations:

(A) Residential mental illness treatment.Such treatment, when provided with respect to a diagnosable mental disorder in a setting that is not a hospital or a psychiatric hospital, is covered only to avert the need for, or as an alternative to, treatment in a hospital or a psychiatric hospital, as determined by a health professional designated by the health plan in which the individual receiving such treatment is enrolled.

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

(C) Least restrictive setting.Such treatment is covered only when

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

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

(D) Annual limit. Prior to January 1, 2001, such treatment is subject to an aggregate annual limit of 30 days. A maximum of 30 additional days of such treatment shall be covered for an individual if a health professional designated by the

health plan in which the individual is enrolled determines in advance that

(i) the individual poses a threat to his or her own life or the life of another individual; or

(ii) the medical condition of the individual requires inpatient treatment in a hospital or a psychiatric hospital in order to initiate, change, or adjust pharmacological or somatic therapy.

(E) Inpatient hospital treatment for substance abuse. Such treatment, when provided in a hospital or a psychiatric hospital with respect to a diagnosable substance abuse disorder, is covered under this section only for detoxification requiring the management of psychiatric conditions associated with withdrawal from alcohol or drugs. The items and services described in this section do not include medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is covered under section 1111).

(d) Intensive Nonresidential Treatment.

(1) Definition.For purposes of this subtitle, the term "intensive nonresidential mental illness and substance abuse treatment" means diagnostic or therapeutic items or services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to an individual--

(A) participating in a partial hospitalization program, a day treatment program, a psychiatric rehabilitation program, or an ambulatory detoxification program; or

(B) receiving home-based mental illness services or behavioral aide mental illness services. The National Health Board shall specify those health professional services described in section 1112 that shall be treated as intensive nonresidential mental illness and substance abuse treatment when provided to such an individual.

(2) Limitations. Coverage for intensive nonresidential mental illness and substance abuse treatment is subject to the following limitations:

(A) Discretion of plan.An individual shall receive

coverage for such treatment if a health professional designated by the health plan in which the individual is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment.

(B) Treatment purposes. Such treatment is covered only when provided

(i) to avert the need for, or as an alternative to, treatment in residential or inpatient settings;

(ii) to facilitate the earlier discharge of an individual receiving inpatient or residential care;

(iii) to restore the functioning of an individual with a diagnosable mental disorder or a diagnosable substance abuse disorder; or

(iv) to assist such an individual to develop the skills and gain access to the support services the individual needs to achieve the maximum level of functioning of the individual within the community.

(C) Annual limit.

(i) In general. Prior to January 1, 2001, the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 2 covered days of intensive nonresidential mental illness and substance abuse treatment that are provided to the individual, until such number is reduced to zero.

(ii) Additional days.After the number of covered days referred to in clause (i) has been reduced to zero with respect to an individual, the individual shall receive coverage for a maximum of 60 days of intensive nonresidential mental illness and substance abuse treatment if a health professional designated by the health plan in which the individual is enrolled determines that the individual should receive such treatment.

(D) Detoxification.Intensive nonresidential mental illness and substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(E) Out-of-pocket maximum. Prior to January 1, 2001, expenses for intensive nonresidential mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle if such treatment is provided

(i) with respect to a diagnosable substance abuse disorder; or

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

(e) Outpatient Treatment.

(1) Definition. For purposes of this subtitle, the term "outpatient mental illness and substance abuse treatment" means the following services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder in an outpatient setting:

(A) Screening and assessment.

(B) Diagnosis.

(C) Medical management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

(I) Collateral services.

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

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

(B) Discretion of plan. An individual shall receive coverage for outpatient mental illness and substance abuse treatment consisting of substance abuse counseling and relapse prevention if a health professional designated by the health plan in which the individual is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment. This subparagraph does not apply to group therapy covered pursuant to subparagraph (C)(ii)(II).

(C) Annual limits.

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

(ii) Substance abuse counseling and relapse prevention.

(I) In general.Except as provided in subclause (II), the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits for substance abuse counseling and relapse prevention that are covered for the individual under subparagraph (B).

After such number has been reduced to zero, no visits for substance abuse counseling and relapse prevention may be covered, except as provided in subclause (II).

(II) Group therapy. Prior to January 1, 2001, substance abuse counseling and relapse prevention consisting of

group therapy is subject to a separate aggregate annual limit of 30 visits, if such therapy occurs within 12 months after the individual has received, with respect to a diagnosable substance abuse disorder, inpatient and residential mental illness and substance abuse treatment or intensive nonresidential mental illness and substance abuse treatment. The provisions of clause (i) and subclause (I) do not apply to therapy that is described in the preceding sentence.

(D) Detoxification.Outpatient mental illness and substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(E) Out-of-pocket maximum.Prior to January 1, 2001, expenses for outpatient mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle.

(f) Other Definitions.For purposes of this subtitle:

(1) Case management.The term "case management" means services that assist individuals in gaining access to needed medical, social, educational, and other services.

(2) Diagnosable mental disorder and diagnosable substance abuse disorder. The terms "diagnosable mental disorder" and "diagnosable substance abuse disorder" mean a disorder that--

(A) is listed in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised or a revised version of such manual (except V Codes for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment);

(B) is the equivalent of a disorder described in subparagraph (A), but is listed in the International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition or a revised version of such text; or

(C) is listed in any authoritative text specifying diagnostic criteria for mental disorders or substance abuse disorders that is identified by the National Health Board.

(3) Psychiatric hospital.The term "psychiatric hospital" has the meaning given such term in section 1861(f) of the Social Security Act, except that such term shall include

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

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(2), a facility operated by the Department of Veterans Affairs that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital; and

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

Section 1116 FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN.

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

(1) Voluntary family planning services.

(2) Contraceptive devices that

(A) may only be dispensed upon prescription; and

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

(3) Services for pregnant women.

Section 1117 HOSPICE CARE.

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

Section 1118 HOME HEALTH CARE.

(a) Coverage. The home health care described in this section is

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

(2) home infusion drug therapy services described in section 1861(ll) of the Social Security Act (as inserted by section 2005).

(b) Limitations. Coverage for home health care is subject to the following limitations:

(1) Inpatient treatment alternative. Such care is covered only as an alternative to inpatient treatment in a hospital, skilled nursing facility, or rehabilitation facility after an illness or injury.

(2) Reevaluation. At the end of each 60-day period of home health care, the need for continued care shall be reevaluated by the person who is primarily responsible for providing the home health care. Additional periods of care are covered only if such person determines that the requirement in paragraph (1) is satisfied.

Section 1119 EXTENDED CARE SERVICES.

(a) Coverage.The extended care services described in this section are the items and services described in section 1861(h) of the Social Security Act when provided to an inpatient of a skilled nursing facility or a rehabilitation facility.

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

(1) Hospital alternative.Such services are covered only

as an alternative to inpatient treatment in a hospital after an illness or injury.

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

(c) Definitions. For purposes of this subtitle:

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

(2) Skilled nursing facility.The term "skilled nursing facility" means an institution (or a distinct part of an institution) which is primarily engaged in providing to residents

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

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

Section 1120 AMBULANCE SERVICES.

(a) Coverage. The ambulance services described in this section are the following items and services:

(1) Ground transportation by ambulance.

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

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

(b) Limitations.Coverage for ambulance services is subject to the following limitations:

(1) Medical indication.Ambulance services are covered only in cases in which the use of an ambulance is indicated by the medical condition of the individual concerned.

(2) Air transport. Air transportation is covered only in cases in which there is no other method of transportation or

where the use of another method of transportation is contra-indicated by the medical condition of the individual concerned.

(3) Water transport. Water transportation is covered only in cases in which there is no other method of transportation or where the use of another method of transportation is contra-indicated by the medical condition of the individual concerned.

Section 1121 OUTPATIENT LABORATORY, RADIOLOGY, AND DIAGNOSTIC SERVICES.

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

Section 1122 OUTPATIENT PRESCRIPTION DRUGS AND BIOLOGICALS.

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

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

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

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

(ii) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia; or

(iii) such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing

in publications which have been identified for purposes of this clause by the Secretary; and

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

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

(b) Revision of Compendia List.The Secretary may revise the list of compendia in subsection (a)(1)(A)(ii) designated as appropriate for identifying medically accepted indications for drugs.

(c) Blood clotting factors.For purposes of this subtitle, the term "blood clotting factors" has the meaning given such term in section 1861(s)(2)(I) of the Social Security Act.

Section 1123 OUTPATIENT REHABILITATION SERVICES.

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

(1) outpatient occupational therapy;

(2) outpatient physical therapy; and

(3) outpatient speech pathology services for the purpose of attaining or restoring speech.

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

(1) Restoration of capacity or minimization of limitations. Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury.

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

Section 1124 DURABLE MEDICAL EQUIPMENT AND

PROSTHETIC AND ORTHOTIC DEVICES.

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

(1) durable medical equipment, including accessories and supplies necessary for repair, function, and maintenance of such equipment;

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

(3) accessories and supplies which are used directly with a prosthetic device to achieve the therapeutic benefits of the prosthesis or to assure the proper functioning of the device;

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

(5) artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition; and

(6) fitting and training for use of the items described in paragraphs (1) through (5).

(b) Limitation. An item or service described in this section is covered only if it improves functional ability or prevents further deterioration in function.

(c) Durable Medical Equipment.For purposes of this subtitle, the term "durable medical equipment" has the meaning given such term in section 1861(n) of the Social Security Act.

Section 1125 VISION CARE.

(a) Coverage. The vision care described in this section is routine eye examinations, diagnosis, and treatment for defects in vision.

(b) Limitation. Eyeglasses and contact lenses are covered only for individuals less than 18 years of age, according to a periodicity schedule established by the Board.

Section 1126 DENTAL CARE.

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

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

(2) Prevention and diagnosis of dental disease, including oral dental examinations, radiographs, dental sealants, fluoride application, and dental prophylaxis. (3) Treatment of dental disease, including routine fillings, prosthetics for genetic defects, periodontal maintenance, and endodontic services.

(4) Space maintenance procedures to prevent orthodontic complications.

(5) Interceptive orthodontic treatment to prevent severe malocclusion.

(b) Limitations.Coverage for dental care is subject to the following limitations:

(1) Prevention and diagnosis. Prior to January 1, 2001, the items and services described in subsection (a)(2) are covered only for individuals less than 18 years of age. On or after such date, such items and services are covered for all eligible individuals enrolled under a health plan, except that dental sealants are not covered for individuals 18 years of age or older.

(2) Treatment of dental disease. Prior to January 1, 2001, the items and services described in subsection (a)(3) are covered only for individuals less than 18 years of age. On or after such date, such items and services are covered for all eligible individuals enrolled under a health plan, except that endodontic services are not covered for individuals 18 years of age or older.

(3) Space maintenance.The items and services described in subsection (a)(4) are covered only for individuals at least 3 years of age, but less than 13 years of age and

(A) are limited to posterior teeth;

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

(C) do not include a space maintainer that is placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

(4) Interceptive orthodontic treatment.Prior to January 1, 2001, the items and services described in subsection (a)(5) are not covered. On or after such date, such items and services are covered only for individuals at least 6 years of age, but less than 12 years of age.

Section 1127 HEALTH EDUCATION CLASSES.

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

(b) Discretion of Plan. A health plan may offer education and training classes at its discretion.

(c) Construction.This section shall not be construed to include or limit education or training that is provided in the course of the delivery of health professional services (as defined in section 1112(c)).

Section 1128 INVESTIGATIONAL TREATMENTS.

(a) Coverage. Subject to subsection (b), the items and services described in this subsection are qualifying investigational treatments that are administered for a life-threatening disease, disorder, or other health condition (as defined by the National Health Board).

(b) Discretion of Plan. A health plan may cover an investigational treatment described in subsection (a) at its discretion.

(c) Routine Care During Investigational Treatments. The comprehensive benefit package includes an item or service described in any other section of this part, subject to the limitations and cost sharing requirements applicable to the item or service, when the item or service is provided to an individual in the course of an investigational treatment, if

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

(2) the item or service would have been provided to the individual even if the individual were not receiving the investigational treatment.

(d) Definitions. For purposes of this subtitle:

(1) Qualifying investigational treatment. The term "qualifying investigational treatment" means a treatment

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

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

(2) Approved research trial. The term "approved research trial" means

(A) a research trial approved by the Secretary of Health and Human Services, the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity as defined in guidelines of the National Institutes of Health; or

(B) a peer-reviewed and approved research program, as defined by the Secretary of Health and Human Services, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for the treatment to be medically necessary or appropriate.

Part 3 COST SHARING

Section 1131 COST SHARING.

(a) In General. Each health plan shall offer to individuals enrolled under the plan one, but not more than one, of the following cost sharing schedules, which schedule shall be offered to all such enrollees:

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

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

(3) Combination cost sharing (described in section 1134).

(b) Cost Sharing for Low-Income Families. For provisions relating to reducing cost sharing for certain low-income families, see section 1371.

(c) Deductibles, Cost Sharing, and Out-of-Pocket Limits on Cost Sharing.

(1) Application on an annual basis.The deductibles and out-of-pocket limits on cost sharing for a year under the schedules referred to in subsection (a) shall be applied based upon expenses incurred for items and services furnished in the year.

(2) Individual and family general deductibles.

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

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

(C) Countable expense.In this paragraph, the term "countable expense" means, with respect to an individual for a

year, an expense for an item or service covered by the comprehensive benefit package that is subject to the general deductible and for which, but for such deductible and any other cost sharing under this subtitle, a health plan is liable for payment. The amount of countable expenses for an individual for a year under this paragraph shall not exceed the individual general deductible for the year.

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

(4) Individual and family limits on cost sharing.

(A) Individual. Subject to subparagraph (B), with respect to an individual enrolled under a health plan (regardless of the class of enrollment), the individual out-of-pocket limit on cost sharing in the cost sharing schedule offered by the plan represents the amount of expenses that the individual may be required to incur under the plan in a year because of a general deductible, separate deductibles, copayments, and coinsurance before the plan may no longer impose any cost sharing with respect to items or services covered by the comprehensive benefit package that are provided to the individual, except as provided in subsections (d)(2)(E) and (e)(2)(E) of section 1115.

(B) Family. In the case of an individual enrolled under a health plan under a family class of enrollment (as defined in section 1011(c)(2)(A)), the family out-of-pocket limit on cost sharing in the cost sharing schedule offered by the plan represents the amount of expenses that members of the individual's family, in the aggregate, may be required to incur under the plan in a year because of a general deductible, separate deductibles, copayments, and coinsurance before the plan may no longer impose any cost sharing with respect to items or services covered by the comprehensive benefit package that are provided to any member of the individual's family, except as provided in subsections (d)(2)(E) and (e)(2)(E) of section 1115.

Section 1132 LOWER COST SHARING.

(a) In General. The lower cost sharing schedule referred to

in section 1131 that is offered by a health plan

(1) may not include a deductible;

(2) shall have

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

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

(3) except as provided in paragraph (4)

(A) shall prohibit payment of any coinsurance; and

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

(4) shall require payment of coinsurance for an out-of-network item or service (as defined in section 1402(f)) in an amount that is a percentage (determined under subsection (b)) of the applicable payment rate for the item or service established under section 1322(c), but only if the item or service is subject to coinsurance under the higher cost sharing schedule described in section 1133.

(b) Out-of-Network Coinsurance Percentage.

(1) In general. The National Health Board shall determine a percentage referred to in subsection (a)(4). The percentage

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

(B) shall be the same with respect to all out-of-network items and services that are subject to coinsurance, except as provided in paragraph (2).

(2) Exception. The National Health Board may provide for a percentage that is greater than a percentage determined under paragraph (1) in the case of an out-of-network item or service for which, under the higher cost sharing schedule described in section 1133, the coinsurance is greater than 20 percent of the applicable payment rate.

Section 1133 HIGHER COST SHARING.

(a) In General. The higher cost sharing schedule referred to in section 1131 that is offered by a health plan

(1) shall have an annual individual general deductible of $200 and an annual family general deductible of $400 that apply with respect to expenses incurred for all items and services in the comprehensive benefit package except

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

(B) an item or service described in paragraph (5), (6), or (7) with respect to which a deductible does not apply;

(2) shall require an individual to incur expenses during each episode of inpatient and residential mental illness and substance abuse treatment (described in section 1115(c)) equal to the cost of one day of such treatment before the plan provides benefits for such treatment to the individual;

(3) shall require an individual to incur expenses during each episode of intensive nonresidential mental illness and substance abuse treatment (described in section 1115(d)) equal to the cost of one day of such treatment before the plan provides benefits for such treatment to the individual;

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

(5) shall require an individual to incur expenses in a year for dental care described in section 1126, except the items and services for prevention and diagnosis of dental disease described in section 1126(a)(2), equal to $50 before the plan provides benefits for such care to the individual;

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

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

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

(9) shall have

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

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

(10) shall prohibit payment of any copayment; and

(11) subject to section 1152, shall require payment of the coinsurance for an item or service (if any) that is specified for the item or service in the table under section 1135.

(b) Episodes of Treatment.

(1) Inpatient and residential treatment. For purposes of subsection (a)(2), an episode of inpatient and residential mental illness and substance abuse treatment shall be considered to begin on the date an individual is admitted to a facility for such treatment and to end on the date the individual is discharged from the facility.

(2) Intensive nonresidential treatment. For purposes of subsection (a)(3), an episode of intensive nonresidential mental illness and substance abuse treatment

(A) shall be considered to begin on the date an individual begins participating in a program described in section 1115(d)(1)(A) and to end on the date the individual ceases such participation; or

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

Section 1134 COMBINATION COST SHARING.

(a) In General.The combination cost sharing schedule referred to in section 1131 that is offered by a health plan

(1) shall have

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

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

(2) otherwise shall require different cost sharing for in-network items and services than for out-of-network items and services.

(b) In-Network Items and Services.With respect to an in-network item or service (as defined in section 1402(f)(1)), the combination cost sharing schedule that is offered by a health plan (1) may not apply a deductible;

(2) shall prohibit payment of any coinsurance; and

(3) shall require payment of a copayment in accordance with the lower cost sharing schedule described in section 1132.

(c) Out-of-Network Items and Services.With respect to an out-of-network item or service (as defined in section 1402(f)(2)), the combination cost sharing schedule that is offered by a health plan

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

(2) shall prohibit payment of any copayment; and

(3) shall require payment of coinsurance in accordance with such schedule.

Section 1135 TABLE OF COPAYMENTS AND COINSURANCE.

(a) In General.The following table specifies, for different items and services, the copayments and coinsurance referred to in sections 1132 and 1133:

Copayments and Coinsurance for Items and Services

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

section 1115(d)(2)(C)(ii)....

Copayments and Coinsurance for Items and Services-Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Intensive nonresidential mental illness and substance abuse treatment provided pursuant to section 1115(d)(2)(C)(ii)....	1115	$25 per visit	50% of applicable payment rate
Outpatient mental illness and substance abuse treatment (except psychotherapy, collateral services, and case management)..	1115	$10 per visit	20% of applicable payment rate
Outpatient psychotherapy and collateral services...	1115	$25 per visit until January 1, 2001, and $10 per visit thereafter	50% of applicable payment rate until January 1, 2001, and 20% thereafter
Case management	1115	No copayment	No coinsurance
Family planning and services for pregnant women (except clinician visits and assiociated services related to prenatal care and 1 postpartum visit)....	1116	$10 per visit	20% of applicable payment rate
Clinician visits and associated services related to prenatal care and 1 post-partum visit	1116	No copayment	No coinsurance
Hospice care	1117	No copayment	20% of applicable payment rate
Home health care	1118	No copayment	20% of applicable payment rate
Extended care services	1119	No copayment	20% of applicable payment rate

Copayments and Coinsurance for Items and Services- Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Ambulance services	1120	No copayment	20% of applicable payment rate
Outpatient laboratory,radiology, and diagnostic services	1121	No copayment	20% of applicable payment rate
Outpatient prescription drugs and biologicals	1122	$5 per prescription	20% of applicable payment rate
Outpatient rehabilitation services	1123	$10 per visit	20% of applicable payment rate
Durable medical equipment and prosthetic and orthotic devices	1124	No copayment	20% of applicable payment rate
Vision care (No additional charge for 1 set of necessary eye-glasses for an individual less than 18 years of age)	1125	$10 per visit	20% of applicable payment rate
Dental care (except space maintenance procedures and interceptive orthodontic treatment)	1126	$10 per visit	20% of applicable payment rate
Space maintenance procedures and interceptive orthodontic treatment	1126	$20 per visit	40% of applicable payment rate
Health education classes	1127	All cost sharing rules determined by plans	All cost sharing rules determined by plans

Investigational treatment for life-threatening condition	1128	All cost sharing rules determined by plans	All cost sharing rules determined by plans

(b) Applicable Payment Rate. For purposes of this section, the term "applicable payment rate", when used with respect to an item or service, means the applicable payment rate for the item or service established under section 1322(c).

Section 1136 INDEXING DOLLAR AMOUNTS RELATING TO COST SHARING.

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

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

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

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

(2) more than $200, but less than $500, to the nearest multiple of $5, or

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

(d) Factor.

(1) In general.The factor described in this subsection for a year is 1 plus the general health care inflation factor (as specified in section 6001(a)(3) and determined under paragraph (2)) for the year.

(2) Determination.In computing such factor for a year, the percentage increase in the CPI for a year (referred to in section 6001(b)) shall be determined based upon the percentage increase in the average of the CPI for the 12-month period ending

with August 31 of the previous year over such average for the preceding 12-month period.

Part 4 EXCLUSIONS

Section 1141 EXCLUSIONS.

(a) Medical Necessity. The comprehensive benefit package does not include

(1) an item or service that is not medically necessary or appropriate; or

(2) an item or service that the National Health Board may determine is not medically necessary or appropriate in a regulation promulgated under section 1154.

(b) Additional Exclusions. The comprehensive benefit package does not include the following items and services:

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

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

(A) required to correct a congenital anomaly; or

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

(i) accidental injury;

(ii) disease; or

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

(3) Hearing aids.

(4) Eyeglasses and contact lenses for individuals at least 18 years of age.

(5) In vitro fertilization services.

(6) Sex change surgery and related services.

(7) Private duty nursing.

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

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

Part 5 ROLE OF THE NATIONAL HEALTH BOARD

Section 1151 DEFINITION OF BENEFITS.

(a) In General.The National Health Board may promulgate such regulations or establish such guidelines as may be necessary to assure uniformity in the application of the comprehensive benefit package across all health plans.

(b) Flexibility in Delivery. The regulations or guidelines under subsection

(a) shall permit a health plan to deliver covered items and services to individuals enrolled under the plan using the providers and methods that the plan determines to be appropriate.

Section 1152 ACCELERATION OF EXPANDED BENEFITS.

(a) In General. Subject to subsection (b), at any time prior to January 1, 2001, the National Health Board, in its discretion, may by regulation expand the comprehensive benefit package by

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

(2) requiring that a cost sharing schedule described in part 3 of this subtitle reflect (wholly or in part) any of the cost sharing requirements that apply to the schedule as of January 1, 2001. No such expansion shall be effective except as of January 1 of a year.

(b) Condition. The Board may not expand the benefit package under subsection (a) which is to become effective with respect to a year, by adding any item or service or altering any cost

sharing schedule, unless the Board estimates that the additional increase in per capita health care expenditures resulting from the addition or alteration, for each regional alliance for the year, will not cause any regional alliance to exceed its per capita target (as determined under section 6003).

Section 1153 AUTHORITY WITH RESPECT TO CLINICAL PREVENTIVE SERVICES.

(a) In General. With respect to clinical preventive services described in section 1114, the National Health Board

(1) shall specify and define specific items and services as clinical preventive services for high risk populations and shall establish and update a periodicity schedule for such items and services;

(2) shall update the periodicity schedules for the age-appropriate immunizations, tests, and clinician visits specified in subsections (b) through (h) of such section;

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

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

(b) Consultation.In performing the functions described in subsection (a), the National Health Board shall consult with experts in clinical preventive services.

Section 1154 ESTABLISHMENT OF STANDARDS REGARDING MEDICAL NECESSITY.

The National Health Board may promulgate such regulations as may be necessary to carry out section 1141(a)(2) (relating to the exclusion of certain services that are not medically necessary or appropriate).

Part 6 ADDITIONAL PROVISIONS RELATING TO HEALTH CARE PROVIDERS

Section 1161 OVERRIDE OF RESTRICTIVE STATE PRACTICE

LAWS.

No State may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals.

Section 1162 PROVISION OF ITEMS OR SERVICES CONTRARY TO RELIGIOUS BELIEF OR MORAL CONVICTION.

A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.

Title I, Subtitle C

Subtitle C State Responsibilities

Section 1200 PARTICIPATING STATE.

(a) In General. For purposes of the approval of a State health care system by the Board under section 1511, a State is a "participating State" if the State meets the applicable requirements of this subtitle.

(b) Submission of System Document.

(1) In general. In order to be approved as a participating State under section 1511, a State shall submit to the National Health Board a document (in a form and manner specified by the Board) that describes the State health care system that the State is establishing (or has established).

(2) Deadline.If a State is not a participating State with a State health care system in operation by January 1, 1998, the provisions of subpart C of part 1 of subtitle F (relating to responsibilities in absence of State systems) shall take effect.

(3) Submission of information subsequent to approval. A State approved as a participating State under section 1511 shall submit to the Board an annual update to the State health care system not later than February 15 of each year following the first year for which the State is a participating State. The update shall contain

(A) such information as the Board may require to

determine that the system shall meet the applicable requirements of this Act for the succeeding year; and

(B) such information as the Board may require to determine that the State operated the system during the previous year in accordance with the Board's approval of the system for such previous year.

Part 1 GENERAL STATE RESPONSIBILITIES

Section 1201 GENERAL STATE RESPONSIBILITIES.

The responsibilities for a participating State are as follows:

(1) Regional alliances.Establishing one or more regional alliances (in accordance with section 1202).

(2) Health plans. Certifying health plans (in accordance with section 1203).

(3) Financial solvency of plans.Assuring the financial solvency of health plans (in accordance with section 1204).

(4) Administration. Designating an agency or official charged with coordinating the State responsibilities under this Act.

(5) Workers compensation and automobile insurance. Conforming State laws to meet the requirements of subtitles A and B of title X (relating to medical benefits under workers compensation and automobile insurance).

(6) Other responsibilities. Carrying out other responsibilities of participating States specified under this Act.

Section 1202 STATE RESPONSIBILITIES WITH RESPECT TO ALLIANCES.

(a) Establishment of Alliances.

(1) In general. A participating State shall

(A) establish and maintain one or more regional alliances in accordance with this section and subtitle D, and ensure that such alliances meet the requirements of this Act; and

(B) designate alliance areas in accordance with subsection (b).

(2) Deadline. A State may not be a participating State for a year unless the State has established such alliances by March 1 of the previous year.

(b) Alliance Areas.

(1) In general.In accordance with this subsection, each State shall designate a geographic area assigned to each regional alliance. Each such area is referred to in this Act as an "alliance area".

(2) Population required.

(A) In general. Each alliance area shall encompass a population large enough to ensure that the alliance has adequate market share to negotiate effectively with health plans providing the comprehensive benefit package to eligible individuals who reside in the area.

(B) Treatment of consolidated metropolitan statistical areas. An alliance area that includes a Consolidated Metropolitan Statistical Area within a State is presumed to meet the requirement of subparagraph (A).

(3) Single alliance in each area. No geographic area may be assigned to more than one regional alliance.

(4) Boundaries.In establishing boundaries for alliance areas, the State may not discriminate on the basis of or otherwise take into account race, age, language, religion, national origin, socio-economic status, disability, or perceived health status.

(5) Treatment of metropolitan areas.The entire portion of a metropolitan statistical area located in a State shall be included in the same alliance area.

(6) No portions of State permitted to be outside alliance area. Each portion of the State shall be assigned to a regional alliance under this subsection.

(c) State Coordination of Regional Alliances. One or more

States may allow or require two or more regional alliances to coordinate their operations, whether such alliances are in the same or different States. Such coordination may include adoption of joint operating rules, contracting with health plans, enforcement activities, and establishment of fee schedules for health providers.

(d) Assistance in Collection of Amounts Owed to Alliances. Each State shall assure that the amounts owed to regional alliances in the State are collected and paid to such alliances.

(e) Assistance in Eligibility Verifications.

(1) In general. Each State shall assure that the determinations of eligibility for cost sharing assistance (and premium discounts and cost sharing reductions for families) are made by regional alliances in the State on the basis of the best information available to the alliances and the State.

(2) Provision of information. Each State shall use the information available to the State under section 6103(l)(7)(D)(x) of the Internal Revenue Code of 1986 to assist regional alliances in verifying such eligibility status.