/* Part two of Title I of the Health Security Act follows. */

(f) Special Requirements for Alliances With Single-Payer System. If the State operates an alliance-specific single-payer system (as described in part 2), the State shall assure that the regional alliance in which the system is operated meets the requirements for such an alliance described in section 1224(b).

(g) Payment of Shortfalls for Certain Administrative Errors. Each participating State is financially responsible, under section 9201(c)(2), for administrative errors described in section 9201(e)(2).

Section 1203 STATE RESPONSIBILITIES RELATING TO HEALTH PLANS.

(a) Criteria for Certification.

(1) In general. For purposes of this section, a participating State shall establish and publish the criteria that are used in the certification of health plans under this section.

(2) Requirements. Such criteria shall be established with respect to

(A) the quality of the plan,

(B) the financial stability of the plan,

(C) the plan's capacity to deliver the comprehensive benefit package in the designated service area,

(D) other applicable requirements for health plans under parts 1, 3, and 4 of subtitle E, and

(E) other requirements imposed by the State consistent with this part.

(b) Certification of Health Plans.A participating State shall certify each plan as a regional alliance health plan that it determines meets the criteria for certification established and published under subsection (a).

(c) Monitoring. A participating State shall monitor the performance of each State-certified regional alliance health plan to ensure that it continues to meet the criteria for certification.

(d) Limitations on Authority. A participating State may not

(1) discriminate against a plan based on the domicile of the entity offering of the plan; and

(2) regulate premium rates charged by health plans, except as may be required under title VI (relating to the enforcement of cost containment rules for plans in the State) or as may be necessary to ensure that plans meet financial solvency requirements under section 1408.

(e) Assuring Adequate Access to a Choice of Health Plans.

(1) General access.

(A) In general. Each participating State shall ensure that

(i) each regional alliance eligible family has adequate access to enroll in a choice of regional alliance health plans providing services in the area in which the individual resides, including (to the maximum extent practicable) adequate access to a plan whose premium is at or below the weighted average premium for plans in the regional alliance, and

(ii) each such family that is eligible for a premium discount under section 6104(b) is provided a discount in accordance with such section (including an increase in such discount described in section 6104(b)(2)).

(B) Authority. In order to carry out its responsibility under subparagraph (A), a participating State may require, as a condition of entering into a contract with a regional alliance under section 1321, that one or more certified regional alliance health plans cover all (or selected portions) of the alliance area.

(2) Access to plans using centers of excellence. Each participating State may require, as a condition of entering into a contract with a regional alliance under section 1321, that one or more certified health plans provide access (through reimbursement, contracts, or otherwise) of enrolled individuals to services of centers of excellence (as designated by the State in accordance with rules promulgated by the Secretary).

(3) Use of incentives to enroll and serve disadvantaged

groups. A State may provide

(A) for an adjustment to the risk-adjustment methodology under section 1541(b) and other financial incentives to regional alliance health plans to ensure that such plans enroll individuals who are members of disadvantaged groups, and

(B) for appropriate extra services, such as outreach to encourage enrollment and transportation and interpreting services to ensure access to care, for certain population groups that face barriers to access because of geographic location, income levels, or racial or cultural differences.

(f) Coordination of Workers' Compensation Services and Automobile Insurance. Each participating State shall comply with the responsibilities regarding workers' compensation and automobile insurance specified in subtitles A and B of title X.

(g) Implementation of Mandatory Reinsurance System. If the risk adjustment and reinsurance methodology developed under section 1541 includes a mandatory reinsurance system, each participating State shall establish a reinsurance program consistent with such methodology and any additional standards established by the Board.

(h) Requirements for Plans Offering Supplemental Insurance. Notwithstanding any other provision of this Act a State may not certify a regional alliance health plan under this section if

(1) the plan (or any entity with which the plan is affiliated under such rules as the Board may establish) offers a supplemental health benefit policy (as defined in section 1421(b)(1)) that fails to meet the applicable requirements for such a policy under part 2 of subtitle E (without regard to the State in which the policy is offered); or

(2) the plan offers a cost sharing policy (as defined in section 1421(b)(2)) that fails to meet the applicable requirements for such a policy under part 2 of subtitle E.

Section 1204 FINANCIAL SOLVENCY; FISCAL OVERSIGHT; GUARANTY FUND.

(a) Capital Standards. A participating State shall establish capital standards for health plans that meet minimum Federal requirements established by the National Health Board under sections 1503(i) and 1551(a).

(b) Reporting and Auditing Requirements. Each participating State shall define financial reporting and auditing requirements and requirements for fund reserves adequate to monitor the financial status of plans.

(c) Guaranty Fund.

(1) Establishment. Each participating State shall ensure that there is a guaranty fund that meets the requirements established by the Board under sections 1503(i) and 1552, in order to provide financial protection to health care providers and others in the case of a failure of a regional alliance health plan.

(2) Assessments to provide funds. In the case of a failure of one or more regional alliance health plans, the State may require each regional alliance health plan within the State to pay an assessment to the State in an amount not to exceed 2 percent of the premiums of such plans paid by or on behalf of regional alliance eligible individuals during a year for so long as necessary to generate sufficient revenue to cover any outstanding claims against the failed plan.

(d) Procedures in Event of Plan Failure.

(1) In general. A participating State shall assure that, in the event of the failure of a regional alliance health plan in the State, eligible individuals enrolled in the plan will be assured continuity of coverage for the comprehensive benefit package.

(2) Designation of state agency.A participating State shall designate an agency of State government that supervises or assumes control of the operation of a regional alliance health plan in the case of the failure of the plan.

(3) Protections for health care providers and enrollees. Each participating State shall assure that in the case of a plan failure

(A) the guaranty fund shall pay health care providers for items and services covered under the comprehensive benefit package for enrollees of the plan for which the plan is otherwise obligated to make payment;

(B) after making all payments required to be made to

providers under subparagraph (A), the guaranty fund shall make payments for the operational, administrative, and other costs and debts of the plan (in accordance with requirements imposed by the State based on rules promulgated by the Board);

(C) such health care providers have no legal right to seek payment from eligible individuals enrolled in the plan for any such covered items or services (other than the enrollees' obligations under cost sharing arrangements); and

(D) health care providers are required to continue caring for such eligible individuals until such individuals are enrolled in a new health plan.

(4) Plan failure. For purposes of this section, the failure of a health plan means the current or imminent inability of the plan to pay claims.

Section 1205 RESTRICTIONS ON FUNDING OF ADDITIONAL BENEFITS.

If a participating State provides benefits (either directly or through regional alliance health plans or otherwise) in addition to those covered under the comprehensive benefit package, the State may not provide for payment for such benefits through funds provided under this Act.

Part 2 REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

Section 1221 SINGLE-PAYER SYSTEM DESCRIBED.

The Board shall approve the application of a State to operate a single-payer system if the Board finds that the system

(1) meets the requirements of section 1222;

(2) (A) meets the requirements for a Statewide single-payer system under section 1223, in the case of a system offered throughout a State; or

(B) meets the requirements for an alliance-specific single-payer system under section 1224, in the case of a system offered in a single alliance of a State.

Section 1222 GENERAL REQUIREMENTS FOR SINGLE-PAYER SYSTEMS.

Each single-payer system shall meet the following requirements:

(1) Establishment by state. The system is established under State law, and State law provides for mechanisms to enforce the requirements of the system.

(2) Operation by state. The system is operated by the State or a designated agency of the State.

(3) Enrollment of eligible individuals.

(A) Mandatory enrollment of all regional alliance individuals. The system provides for the enrollment of all eligible individuals residing in the State (or, in the case of an alliance-specific single-payer system, in the alliance area) for whom the applicable health plan would otherwise be a regional alliance health plan.

(B) Optional enrollment of medicare-eligible individuals. At the option of the State, the system may provide for the enrollment of medicare-individuals residing in the State (or, in the case of an alliance-specific single-payer system, in the alliance area) if the Secretary of Health and Human Services has approved an application submitted by the State under section 1893 of the Social Security Act (as added by section 4001(a)) for the integration of medicare beneficiaries into plans of the State. Nothing in this subparagraph shall be construed as requiring that a State have a single-payer system in order to provide for such integration.

(C) Optional enrollment of corporate alliance individuals in statewide plans. At the option of the State, a Statewide single-payer system may provide for the enrollment of individuals residing in the State who are otherwise eligible to enroll in a corporate alliance health plan under section 1311.

(D) Options included in State system document. A State may not exercise any of the options described in subparagraphs (A) or (B) for a year unless the State included a description of the option in the submission of its system document to the Board or the year under section 1200(b).

(E) Exclusion of certain individuals.A single-payer system may not require the enrollment of electing veterans, active duty military personnel, and electing Indians (as defined in 1012(d)).

(4) Direct payment to providers.

(A) In general. With respect to providers who furnish items and services included in the comprehensive benefit package to individuals enrolled in the system, the State shall make payments directly to such providers and assume (subject to subparagraph (B)) all financial risk associated with making such payments.

(B) Capitated payments permitted. Nothing in subparagraph (A) shall be construed to prohibit providers furnishing items and services under the system from receiving payments from the plan on a capitated, at-risk basis based on prospectively determined rates.

(5) Provision of comprehensive benefit package.

(A) In general. The system shall provide for coverage of the comprehensive benefit package, including the cost sharing provided under the package (subject to subparagraph (B)), to all individuals enrolled in the system.

(B) Imposition of reduced cost sharing. The system may decrease the cost sharing otherwise provided in the comprehensive benefit package with respect to any class of individuals enrolled in the system or any class of services included in the package, so long as the system does not increase the cost sharing otherwise imposed with respect to any other class of individuals or services.

(6) Cost containment. The system shall provide for mechanisms to ensure, in a manner satisfactory to the Board, that

(A) per capita expenditures for items and services in the comprehensive benefit package under the system for a year (beginning with the first year) do not exceed an amount equivalent to the regional alliance per capita premium target that is determined under section 6003 (based on the State being a single regional alliance) for the year;

(B) the per capita expenditures described in subparagraph (A) are computed and effectively monitored; and

(C) automatic, mandatory, nondiscretionary reductions in payments to health care providers will be imposed to the extent required to assure that such per capita

expenditures do not exceed the applicable target referred to in subparagraph (A).

(7) Requirements generally applicable to health plans.The system shall meet the requirements applicable to a health plan under section 1400(a), except that

(A) the system does not have the authority provided to health plans under section 1402(a)(2) (relating to permissible limitations on the enrollment of eligible individuals on the basis of limits on the plan's capacity);

(B) the system is not required to meet the requirements of section 1404(a) (relating to restrictions on the marketing of plan materials); and

(C) the system is not required to meet the requirements of section 1408 (relating to plan solvency).

Section 1223 SPECIAL RULES FOR STATES OPERATING STATEWIDE SINGLE-PAYER SYSTEM.

(a) In General. In the case of a State operating a Statewide single-payer system

(1) the State shall operate the system throughout the State through a single alliance;

(2) except as provided in subsection (b), the State shall meet the requirements for participating States under part 1; and

(3) the State shall assume the functions described in subsection (c) that are otherwise required to be performed by regional alliances in participating States that do not operate a Statewide single-payer system.

(b) Exceptions to Certain Requirements for Participating States. In the case of a State operating a Statewide single-payer system, the State is not required to meet the following requirements otherwise applicable to participating States under part 1:

(1) Establishment of alliances. The requirements of section 1202 (relating to the establishment of alliances).

(2) Health plans. The requirements of section 1203

(relating to health plans), other than the requirement of subsection (f) of such section (relating to coordination of workers' compensation services and automobile liability insurance).

(3) Financial solvency. The requirements of section 1204 (relating to the financial solvency of health plans in the State).

(c) Assumption by State of Certain Requirements Applicable to Regional Alliances. A State operating a Statewide single-payer system shall be subject to the following requirements otherwise applicable to regional to alliances in other participating States:

(1) Enrollment; issuance of health security cards.The requirements of subsections (a) and (c) of section 1323 and section 1324 shall apply to the State, eligible individuals residing in the State, and the single-payer system operated by the State in the same manner as such requirements apply to a regional alliance, alliance eligible individuals, and regional alliance health plans.

(2) Reductions in cost sharing for low-income individuals. The requirement of section 1371 shall apply to the State in the same manner as such requirement applies to a regional alliance.

(3) Data collection; quality. The requirements of section 1327 shall apply to the State and the single-payer system operated by the State in the same manner as such requirement applies to a regional alliance and health plans offered through a regional alliance.

(4) Anti-discrimination; coordination. The requirements of section 1328 shall apply to the State in the same manner as such requirements apply with respect to a regional alliance.

(d) Financing.

(1) In general. A State operating a Statewide single-payer system shall provide for the financing of the system using, at least in part, a payroll-based financing system that requires employers to pay at least the amount that the employers would be required to pay if the employers were subject to the requirements of subtitle B of title VI.

(2) Use of financing methods. Such a State may use, consistent with paragraph (1), any other method of financing.

(e) Single-Payer State Defined.In this Act, the term "single-payer State" means a State with a Statewide single-payer system in effect that has been approved by the Board in accordance with this part.

Section 1224 SPECIAL RULES FOR ALLIANCE-SPECIFIC SINGLE-PAYER SYSTEMS.

(a) In General. In the case of a State operating an alliance-specific single-payer system

(1) the State shall meet the requirements for participating States under part 1; and

(2) the regional alliance in which the system is operated shall meet the requirements of subsection (b).

(b) Requirements for Alliance in Which System Operates. A regional alliance in which an alliance-specific single payer system is operated shall meet the requirements applicable to regional alliances under subtitle D, except that the alliance is not required to meet the following requirements of such subtitle:

(1) Contracts with health plans. The requirements of section 1321 (relating to contracts with health plans).

(2) Choice of health plans offered. The requirements of subsections (a) or (b) of section 1322 (relating to offering a choice of health plans to eligible enrollees).

(3) Establishment of ombudsman office. The requirements of section 1326(a) (relating to the establishment of an office of ombudsman).

(4) Addressing needs of areas with inadequate health services. The regional alliance does not have any of the authorities described in subsections (a) and (b) of section 1329 (relating to adjusting payments to plans and encouraging the establishment of new plans).

Title I, Subtitle D

Subtitle D Health Alliances

Section 1300 HEALTH ALLIANCE DEFINED.

In this Act, the term "health alliance" means a regional alliance (as defined in section 1301) and a corporate alliance (as defined in section 1311).

Part 1 ESTABLISHMENT OF REGIONAL AND CORPORATE ALLIANCES

Subpart A Regional Alliances

Section 1301 REGIONAL ALLIANCE DEFINED.

In this Act, the term "regional alliance" means a non-profit organization, an independent state agency, or an agency of the State which

(1) meets the applicable organizational requirements of this subpart, and

(2) is carrying out activities consistent with part 2.

Section 1302 BOARD OF DIRECTORS.

(a) In General. A regional alliance must be governed by a Board of Directors appointed consistent with the provisions of this subpart. All powers vested in a regional alliance under this Act shall be vested in the Board of Directors.

(b) Membership.

(1) In general. Such a Board of Directors shall consist of (A) members who represent employers whose employees purchase health coverage through the alliance, including self-employed individuals who purchase such coverage; and

(B) members who represent individuals who purchase such coverage, including employees who purchase such coverage.

(2) Equal representation of employers and consumers. The number of members of the Board described under subparagraph (A) of paragraph (1) shall be the same as the number of members described in subparagraph (B) of such paragraph.

(c) No Conflict of Interest Permitted. An individual may not serve as a member of the Board of Directors if the individual is one of the following (or an immediate family member of one of the following):

(1) A health care provider.

(2) An individual who is an employee or member of the Board of Directors of, has a substantial ownership in, or derives substantial income from, a health care provider, health plan, pharmaceutical company, or a supplier of medical equipment, devices, or services.

(3) A person who derives substantial income from the provision of health care.

(4) (A) A member or employee of an association, law firm, or other institution or organization that represents the interests of one or more health care providers, health plans or others involved in the health care field, or (B) an individual who practices as a professional in an area involving health care.

Section 1303 PROVIDER ADVISORY BOARDS FOR REGIONAL ALLIANCES.

Each regional alliance must establish a provider advisory board consisting of representatives of health care providers and professionals who provide
covered services through health plans offered by the alliance.

Subpart B Corporate Alliances

Section 1311 CORPORATE ALLIANCE DEFINED; INDIVIDUALS ELIGIBLE FOR COVERAGE THROUGH CORPORATE ALLIANCES; ADDITIONAL DEFINITIONS.

(a) Corporate Alliance Defined.In this Act, the term "corporate alliance" means an eligible sponsor (as defined in subsection (b)) if

(1) the sponsor elects, in a form and manner specified by the Secretary of Labor consistent with this subpart, to be treated as a corporate alliance under this title and such election has not been terminated under section 1313; and

(2) the sponsor has filed with the Secretary of Labor a document describing how the sponsor shall carry out activities as such an alliance consistent with part 4.

(b) Eligible Sponsors.

(1) In general.In this subpart, each of the following is an eligible sponsor:

(A) Large employer. An employer that

(i) is a large employer (as defined in subsection (e)(2)) as of the date of an election under subsection (a)(1), and

(ii) is not an excluded employer described in paragraph (2).

(B) Plan sponsor of a multiemployer plan. A plan sponsor described in section 3(16)(B)(iii) of Employee Retirement Income Security Act of 1974, but only with respect to a group health plan that is a multiemployer plan (as defined in subsection (e)(3)) maintained by the sponsor and only if

(i) such plan offered health benefits as of September 1, 1993, and

(ii) as of both September 1, 1993, and January 1, 1996, such plan has more than 5,000 active participants in the United States, or the plan is maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering more than 5,000 employees.

(C) Rural electric cooperative and rural telephone cooperative association. A rural electric cooperative or a rural telephone cooperative association, but only with respect to a group health plan that is maintained by such cooperative or association (or members of such cooperative or association) and only if such plan

(i) offered health benefits as of September 1, 1993, and

(ii) as of both September 1, 1993, and January 1, 1996, has more than 5,000 full-time employees in the United States entitled to health benefits under the plan.

(2) Excluded employers. For purposes of paragraph (1)(A), any of the following are excluded employers described in this paragraph:

(A) An employer whose primary business is employee leasing.

(B) The Federal government (other than the United

States Postal Service).

(C) A State government, a unit of local government, and an agency or instrumentality of government, including any special purpose unit of government.

(c) Individuals Eligible to Enroll in Corporate Alliance Health Plans. For purposes of part 1 of subtitle A, subject to subsection (d)

(1) Full-time employees of large employers. Each eligible individual who is a full-time employee (as defined in section 1901(b)(2)(C)) of a large employer that has an election in effect as a corporate alliance is eligible to enroll in a corporate alliance health plan offered by such corporate alliance.

(2) Multiemployer alliances.

(A) Participants. Each participant and beneficiary (as defined in subparagraph (B)) under a multiemployer plan, with respect to which an eligible sponsor of the plan described in subsection (b)(1)(B) has an election in effect as a corporate alliance, is eligible to enroll in a corporate alliance health plan offered by such corporate alliance.

(B) Participant and beneficiary defined. In subparagraph (A), the terms "participant" and "beneficiary" have the meaning given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

(3) Full-time employees of rural cooperative alliances. Each full-time employee of a member of a rural electric cooperative or rural telephone cooperative association which has an election in effect as a corporate alliance (and each full-time employee of such a cooperative or association) is eligible to enroll in a corporate alliance health plan offered by such corporate alliance.

(4) Ineligible to enroll in regional alliance health plan. Except as provided in section 1013, a corporate alliance eligible individual is not eligible to enroll under a regional alliance health plan.

(d) Exclusion of Certain Individuals. In accordance with rules of the Board, the following individuals shall not be treated as corporate alliance eligible individuals:

(1) AFDC recipients.

(2) SSI recipients.

(3) Individuals who are described in section 1004(b) (relating to veterans, military personnel, and Indians) and who elect an applicable health plan described in such section.

(4) Employees who are seasonal or temporary workers (as defined by the Board), other than such workers who are treated as corporate alliance eligible individuals pursuant to a collective bargaining agreement (as defined by the Secretary of Labor).

(e) Definitions Relating to Corporate Alliances.In this subtitle, except as otherwise provided:

(1) Group health plan. The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries (as defined in section 3 of the Employee Retirement Income Security Act of 1974) directly or through insurance, reimbursement, or otherwise.

(2) Large employer. The term "large employer" means an employer that has more than 5,000 full-time employees in the United States. Such term includes the United States Postal Service.

(3) Multiemployer plan.The term "multiemployer plan" has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such Act.

(4) Rural electric cooperative.The term "rural electric cooperative" has the meaning given such term in section 3(40)(A)(iv) of the Employee Retirement Income Security Act of 1974.

(5) Rural telephone cooperative associations. The term "rural telephone cooperative association" has the meaning given such term in section 3(40)(A)(v) of the Employee Retirement Income Security Act of 1974.

Section 1312 TIMING OF ELECTIONS.

(a) For Large Employers.

(1) Current large employers.

(A) In general. In the case of an employer that is an eligible sponsor described in section 1311(b)(1)(A) as of the most recent January 1 prior to the general effective date, the sponsor's election to be a corporate alliance under such section must be made and filed with the Secretary of Labor not later than the date specified in subparagraph (B).

(B) Deadline for notice. The date specified in this subparagraph is January 1 of the second year preceding the general effective date or, in the case of a State that elects to become a participating State before the general effective date, not later than one month later than the date specified for States under section 1202(a)(2).

(2) New large employers. In the case of an employer that is not an eligible sponsor described in section 1311(b)(1)(A) as of the most recent January 1 prior to the general effective date, but first becomes such a sponsor as of a subsequent date, the election to be a corporate alliance under such section must be made and filed with the Secretary of Labor not later than March 1 of the year following the year in which the employer first becomes such a sponsor.

(3) Application of option. The Secretary of Labor shall promulgate rules regarding how the option described in section 1311(c)(1)(B) will be applied to the determination of whether an employer is a large employer before an election is made under section 1311.

(b) For Multiemployer Plans and Rural Cooperatives. In the case of an eligible sponsor described in section 1311(b)(1)(B) or (C), the sponsor's election to be a corporate alliance under such section must be made and filed with the Secretary of Labor not later than March 1, 1996.

(c) Effective Date of Election. An election made under subsection (a) or (b) shall be effective for coverage provided under health plans on and after January 1 of the year following the year in which the election is made.

(d) One-time Election. If an eligible sponsor fails to make the election on a timely manner under subsection (a) or (b), the sponsor may not make such election at any other time.

Section 1313 TERMINATION OF ALLIANCE ELECTION.

(a) Termination for Insufficient Number of Full-Time Employees or Participants. If a corporate alliance reports under section 1387(c), that there were fewer than 4,800 full-time employees (or, active participants, in the case of one or more plans offered by a corporate alliance which is an eligible sponsor described in section 1311(b)(1)(B)) who are enrolled in a health plan through the alliance, the election under this part with respect to the alliance shall terminate.

(b) Termination for Failure to Meet Requirements.

(1) In general. If the Secretary of Labor finds that a corporate alliance has failed substantially to meet the applicable requirements of this subtitle, the Secretary shall terminate the election under this part with respect to the alliance

(2) Excess increase in premium equivalent.If the Secretary of Labor finds that the alliance is in violation of the requirements of section 6022 (relating to prohibition against excess increase in premium expenditures), the Secretary shall terminate the alliance in accordance with such section.

(c) Elective Termination. A corporate alliance may terminate an election under this part by filing with the National Health Board and the Secretary of Labor a notice of intent to terminate.

(d) Effective Date of Termination. In the case of a termination of an election under this section, in accordance with rules established by the Secretary of Labor

(1) subject to section 6022(a)(1), the termination shall take effect as of the effective date of enrollments in regional alliance health plans made during the next open enrollment period (as provided in section 1323(d)), and

(2) the enrollment of eligible individuals in corporate alliance health plans of the corporate alliance shall be terminated as of such date and such individuals shall be enrolled in other applicable health plans effective on such date.

(e) Notice to Board. If an election with respect to a corporate alliance is terminated pursuant to subsection (a) or subsection (b), the Secretary of Labor shall notify the National

Health Board of the termination of the election.

Part 2 GENERAL RESPONSIBILITIES AND AUTHORITIES OF REGIONAL ALLIANCES

Section 1321 CONTRACTS WITH HEALTH PLANS.

(a) Contracts with Plans.

(1) In general. In order to assure the availability of the comprehensive benefit package to eligible individuals residing in the alliance area in a cost-effective manner, except as provided in this section, each regional alliance shall negotiate with any willing State-certified health plan to enter into a contract with the alliance for the enrollment under the plan of eligible individuals in the alliance area. Subject to paragraph (2), a regional alliance shall not enter into any such contract with a health plan that is not a State-certified health plan.

(2) Treatment of certain plans. Each regional alliance shall enter into a contract under this section with any veterans health plan of the Department of Veterans Affairs and with a Uniformed Services Health Plan of the Department of Defense, that offers the comprehensive benefit package to eligible individuals residing in the alliance area if the appropriate official requests to enter into such a contract.

(b) General Conditions for Denial of Contract by a Regional Alliance. A regional alliance is not required under this section to offer a contract with a health plan if

(1) the alliance finds that the proposed bid exceeds 120 percent of the regional alliance per capita prremium target (as determined under section 6003); or

(2) the plan has failed to comply with requirements under prior contracts with the alliance, including failing to offer coverage for all the services in the comprehensive benefit package in the entire service area of the plan.

Section 1322 OFFERING CHOICE OF HEALTH PLANS FOR ENROLLMENT; ESTABLISHMENT OF FEE-FOR-SERVICE SCHEDULE.

(a) In General. Each regional alliance must provide to each eligible enrollee (as defined in section 1902(14)) with respect to the alliance a choice of health plans among the plans which

have contracts in effect with the alliance under section 1321 (in the case of a regional alliance) or section 1341 (in the case of a corporate alliance).

(b) Offering of Plans by Regional Alliances.

(1) In general. Each regional alliance shall include among its health plan offerings at least one fee-for-service plan (as defined in paragraph (2)).

(2) Fee-for-service plan defined.

(A) In general. For purposes of this Act, the term "fee-for-service plan" means a health plan that--

(i) provides coverage for all items and services included in the comprehensive benefit package that are furnished by any lawful health care provider of the enrollee's choice, subject to reasonable restrictions (described in subparagraph (B)), and

(ii) makes payment to such a provider without regard to whether or not there is a contractual arrangement between the plan and the provider.

(B) Reasonable restrictions described. The reasonable restrictions on coverage permitted under a fee-for-service plan (as specified by the National Health Board) are as follows:

(i) Utilization review.

(ii) Prior approval for specified services.

(iii) Exclusion of providers on the basis of poor quality of care, based on evidence obtainable by the plan. Clause (ii) shall not be construed as permitting a plan to require prior approval for non-primary health care services through a gatekeeper or other process.

(c) Establishment of Fee-for-Service Schedule.

(1) In general. Except in the case of regional alliances of a State that has established a Statewide fee schedule under paragraph (3), each regional alliance shall establish a fee schedule setting forth the payment rates applicable to services furnished during a year to individuals enrolled in fee-for-service plans (or to services furnished under the fee-for-service

component of any regional alliance health plan) for use by regional alliance health plans under section 1406(c) and corporate alliance health plans providing services subject to the schedule in the regional alliance area.

(2) Negotiation with providers. The fee schedule under paragraph (1) shall be established after negotiations with providers, and (subject to paragraphs (5) and (6)) providers may collectively negotiate the fee schedule with the regional alliance.

(3) Use of statewide schedule. At the option of a State, the State may establish its own statewide fee schedule which shall apply to all fee-for-service plans offered by regional alliances and corporate alliances in the State instead of alliance-specific schedules established under paragraph (1).

(4) Annual revision. A regional alliance or State (as the case may be) shall annually update the payment rates provided under the fee schedule established pursuant to paragraph (1) or paragraph (3).

(5) Activities treated as State action or efforts intended to influence government action.The establishment of a fee schedule under this subsection by a regional alliance of a State shall be considered to be pursuant to a clearly articulated and affirmatively expressed State policy to displace competition and to be actively supervised by the State, and conduct by providers respecting the establishment of the fee schedule, including collective negotiations by providers with the regional alliance (or the State) pursuant to paragraph (2), shall be considered as efforts intended to influence governmental action.

(6) No boycott permitted. Nothing in this subsection shall be construed to permit providers to threaten or engage in any boycott.

(7) Negotiations defined. In this subsection, "negotiations" are the process by which providers collectively and jointly meet, confer, consult, discuss, share information, among and between themselves in order to agree on information to be provided, presentations to be made, and other such activities with respect to regional alliances (or States) relating to the establishment of the fee schedule (but not including any activity that constitutes engaging in or threatening to engage in a boycott), as well as any and all collective and joint meetings, discussions, presentations, conferences, and consultations

between or among providers and any regional alliance (or State) for the purpose of establishing the fee schedule described in this subsection.

(d) Prospective Budgeting of Fee-for-Service.

(1) In general. The fee schedule established by a regional alliance or a State under subsection (c) may be based on prospective budgeting described in paragraph (2).

(2) Prospective budgeting described. Under prospective budgeting (A) the regional alliance or State (as the case may be) shall negotiate with health providers annually to develop a budget for the designated fee-for-service plan;

(B) the negotiated budget shall establish spending targets for each sector of health expenditures made by the plan; and

(C) if the regional alliance or State (as the case may be) determines that the utilization of services under the plan is at a level that will result in expenditures under the plan exceeding the negotiated budget, the plan shall reduce the amount of payments otherwise made to providers (through a withhold or delay in payments or adjustments) in such a manner and by such amounts as necessary to assure that expenditures will not exceed the budget.

(3) Use of prospective budgeting exclusive. If a regional alliance or State establishes the fee schedule for fee-for-service plans on the basis of prospective budgeting under this subsection, payment for all services provided by fee-for-service plans in the alliance or State shall be determined on such basis.

Section 1323 ENROLLMENT RULES AND PROCEDURES.

(a) In General.Each regional alliance shall assure that each regional alliance eligible individual who resides in the alliance area is enrolled in a regional alliance health plan and shall establish and maintain methods and procedures, consistent with this section, sufficient to assure such enrollment. Such methods and procedures shall assure the enrollment of alliance eligible individuals at the time they first become eligible enrollees in the alliance area, including individuals at the time of birth, at the time they move into the alliance area, and at the time of reaching the age of individual eligibility as an eligible

enrollee (and not merely as a family member). Each regional alliance shall establish procedures, consistent with subtitle A, for the selection of a single health plan in which all members of a family are enrolled.

(b) Point of Service Enrollment Mechanism.

(1) In general. Each regional alliance shall establish a point-of-service enrollment mechanism (meeting the requirements of this subsection) for enrolling eligible individuals who are not enrolled in a health plan of the alliance when the individual seeks health services.

(2) Requirements of mechanism. Under such a mechanism, if an eligible individual seeks to receive services (included in the comprehensive benefit package) from a provider in an alliance area and does not present evidence of enrollment under any applicable health plan, or if the provider has no evidence of the individual's enrollment under any such plan, the following rules shall apply:

(A) Notice to alliance. Consistent with part 2 of subtitle B of title V, the provider

(i) shall provide the regional alliance with information relating to the identity of the eligible individual, and

(ii) may request payment from the regional alliance for the furnishing of such services.

(B) Initial determination of eligibility and enrollment status. The regional alliance shall determine

(i) if the individual is an alliance eligible individual for the alliance, and

(ii) if the individual is enrolled under an applicable health plan (including a corporate alliance health plan).

(C) Treatment of alliance eligible individuals.If the regional alliance determines that the individual is an alliance eligible individual with respect to the alliance and

(i) is enrolled under a regional alliance health plan of the alliance, the alliance shall forward the claim to the health plan involved and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and

the plan shall make payment to the provider for the services furnished to the individual as described in paragraph (3)(C));

(ii) is not enrolled under a regional alliance health plan of the alliance but is required to be so enrolled in a specific health plan as a family member under section 1011, the alliance shall record the individual's enrollment under such specific plan, shall forward the claim to such plan, and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and the plan shall make payment to the provider for the services furnished to the individual as described in paragraph (3)(C)); or

(iii) is not enrolled under such a plan and is not described in clause (ii), the point-of-service enrollment procedures described in paragraph (3) shall apply.

(D) Treatment of individuals enrolled under health plans of other alliances. If the regional alliance determines that the individual is not an alliance eligible individual with respect to the alliance but the individual is enrolled

(i) under a regional alliance health plan of another alliance, the alliance shall forward the claim to the other regional alliance and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and the plan shall make payment to the provider for the services furnished to the individual as described in paragraph (3)(C)); or

(ii) under a corporate alliance health plan, the alliance shall forward the claim to the corporate alliance involved and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and the plan shall make payment to the provider for the services furnished to the individual as described in section 1383(b)(2)(B)).

(E) Treatment of other alliance eligible individuals not enrolled in health plan. If the regional alliance determines that the individual is not an alliance eligible individual with respect to the alliance and the individual is an alliance eligible individual with respect to another health alliance but is not enrolled in a health plan of such alliance, the regional alliance shall forward the claim to the other alliance involved and shall notify the provider (and the individual) of the forwarding of such claim and the requirement for prompt enrollment of the individual under an applicable health plan of

such alliance pursuant to the procedures described in paragraph

(3) (in the case of a regional alliance) or in section 1383(b) (in the case of a corporate alliance).

(F) Treatment of all other individuals. The National Board shall promulgate rules regarding the responsibilities of regional alliances relating to individuals whose applicable health plan is not an alliance plan and other individuals the alliance is unable to identify as eligible individuals.

(3) Point-of-service enrollment procedures described. The point-of-service enrollment procedures under this paragraph are as follows:

(A) Not later than 10 days after the date an alliance is notified of the receipt of services by an unenrolled eligible individual, the alliance provides the individual with materials describing health plans offered through the alliance.

(B) The individual shall be provided a period of 30 days in which to enroll in a health plan of the individual's choice. If the individual fails to so enroll during such period, the alliance shall enroll the individual in a health plan of the alliance selected on a random basis.

(C) Using the fee-for-service schedule adopted by the alliance under section 1322(c), the health plan in which the individual is enrolled under this subparagraph shall reimburse the provider who provided the services referred to in subparagraph (A) to the same extent as if the individual had been enrolled under the plan at the time of provision of the services.

(c) Enrollment of New Residents.

(1) In general. Each regional alliance shall establish procedures for enrolling regional alliance eligible individuals who move into the alliance area.

(2) Long-term residents. Such procedures shall assure that regional alliance eligible individuals who intend to reside in the alliance area for longer than 6 months shall register with the regional alliance for the area and shall enroll in a regional alliance health plan offered by the alliance.

(3) Short-term residents. Such procedures shall permit eligible individuals who intend to reside in the alliance area

for more than 3 months but less than 6 months to choose among the following options:

(A) To continue coverage through the health plan in which such individual is previously enrolled, in which case coverage for care in the area of temporary residence may be limited to emergency services and urgent care.

(B) To register with the regional alliance and enroll in a regional alliance health plan offered by the alliance.

(C) To change enrollment in the previous alliance area to enrollment in a health plan of such alliance that provides for coverage on a fee-for-service basis of services provided outside the area of that alliance.

(d) Changes in Enrollment.

(1) Annual open enrollment period to change plan enrollment. Each regional alliance shall hold an annual open enrollment period during which each eligible enrollee in the alliance has the opportunity to choose among health plans offered through the alliance, according to rules to be promulgated by the National Health Board.

(2) Disenrollment for cause. In addition to the annual open enrollment period held under paragraph (1), each regional alliance shall establish procedures under which alliance eligible individuals enrolled in a plan may disenroll from the plan for good cause at any time during a year and enroll in another plan of the alliance. Such procedures shall be implemented in a manner that ensures continuity of coverage for the comprehensive benefit package for such individuals during the year.

(e) Enrollment of Family Members. Each regional alliance shall provide for the enrollment of all family members in the same plan, consistent with part 2 of subtitle A.

(f) Oversubscription of Plans.

(1) In general. Each regional alliance shall establish a method for establishing enrollment priorities in the case of a health plan that does not have sufficient capacity to enroll all eligible individuals seeking enrollment.

(2) Preference for current members. Such method shall

provide that in the case of such an oversubscribed plan

(A) individuals already enrolled in the plan are given priority in continuing enrollment in the plan, and

(B) other individuals who seek enrollment during an applicable enrollment period are permitted to enroll in accordance with a random selection method, up to the enrollment capacity of the plan.

(g) Termination of Enrollment.

(1) In general. Each regional alliance shall establish special enrollment procedures to permit alliance eligible individuals to change the plan in which they are enrolled in the case of the termination of coverage under a plan, in a manner that ensures the individuals' continuation of coverage for the comprehensive benefit package.

(2) Failure of a corporate alliance. Each regional alliance shall establish special enrollment procedures to permit individuals, who become alliance eligible individuals as a result of the failure of a corporate alliance, to enroll promptly in regional alliance health plans in a manner that ensures the individuals' continuation of coverage for the comprehensive benefit package.

(h) Limitation on Offering of Coverage to Ineligible Individuals. A regional alliance may not knowingly offer coverage under a regional alliance health plan or other health insurance or health benefits to an individual who is not an eligible individual. Nothing in this section shall be construed as affecting the ability of a regional alliance health plan or other health plan to offer coverage to such individuals without any financial payment or participation by a regional alliance.

(i) Enforcement of Enrollment Requirement. In the case of a regional alliance eligible individual who fails to enroll in an applicable health plan as required under section 1002(a)

(1) the applicable regional alliance shall enroll the individual in a regional alliance health plan (selected by the alliance consistent with this Act and with any rules established by the Board), and

(2) such alliance shall require the payment of twice the amount of the family share of premiums that would have been

payable under subtitle B of title VI if the individual had enrolled on a timely basis in the plan, unless the individual has established to the satisfaction of the alliance good cause for the failure to enroll on a timely basis.

Section 1324 ISSUANCE OF HEALTH SECURITY CARDS.

A regional alliance is responsible for the issuance of health security cards to regional alliance eligible individuals under section 1001(b).

Section 1325 CONSUMER INFORMATION AND MARKETING.

(a) Consumer Information.

(1) In general. Before each open enrollment period, each regional alliance shall make available to eligible enrollees information, in an easily understood and useful form, that allows such enrollees (and other alliance eligible individuals) to make valid comparisons among health plans offered by the alliance.

(2) Information to be included.Such information must include, in the same format for each plan, such information as the National Health Board shall require, including at least the following:

(A) The cost of the plan, including premiums and average out-of-pocket expenses.

(B) The characteristics and availability of health care professionals and institutions participating in the plan.

(C) Any restrictions on access to providers and services under the plan.

(D) A summary of the annual quality performance report, established pursuant to section 5005(c)(1), which contains measures of quality presented in a standard format.

(b) Marketing. Each regional alliance shall, consistent with section 1404, review and approve or disapprove the distribution of any materials used to market health plans offered through the alliance.

Section 1326 OMBUDSMAN.

(a) Establishment. Each regional alliance must establish and

maintain an office of an ombudsman to assist consumers in dealing with problems that arise with health plans and the alliance.

(b) Optional Financing Through Voluntary Contribution. At the option of the State in which a regional alliance is located, the alliance

(1) shall permit alliance eligible individuals to designate that one dollar of the premium paid for enrollment in the individual's regional alliance health plan for the operation of the office of the alliance's ombudsman; and

(2) shall apply any such amounts towards the establishment and operation of such office.

Section 1327 DATA COLLECTION; QUALITY.

Each regional alliance shall comply with requirements of subtitles A and B of title V (relating to quality, information systems, and privacy), and shall take appropriate steps to ensure that health plans offered through the alliance comply with such requirements.

Section 1328 ADDITIONAL DUTIES.

(a) Anti-Discrimination. In carrying out its activities under this part, a regional alliance may not discriminate against health plans on the basis of race, sex, national origin, religion, mix of health professionals, location of the plan's headquarters, or (except as specifically provided in this part) organizational arrangement.

(b) Coordination of Enrollment Activities. Each regional alliance shall coordinate, in a manner specified by the National Health Board, with other health alliances its activities, including enrollment and disenrollment activities, in a manner that ensures continuous, nonduplicative coverage of alliance eligible individuals in health plans and that minimizes administrative procedures and paperwork.

Section 1329 ADDITIONAL AUTHORITIES FOR REGIONAL ALLIANCES TO ADDRESS NEEDS IN AREAS WITH INADEQUATE HEALTH SERVICES; PROHIBITION OF INSURANCE ROLE.

(a) Payment Adjustment. In order to ensure that plans are available to all eligible individuals residing in all portions of the alliance area, a regional alliance may adjust payments to

plans or use other financial incentives to encourage health plans to expand into areas that have inadequate health services.

(b) Encouraging New Plans. Subject to subsection (c), in order to encourage the establishment of a new health plan in an area that has inadequate health services, an alliance may

(1) organize health providers to create such a plan in such an area a new health plan targeted at such an area,

(2) provide assistance with setting up and administering such a plan, and

(3) arrange favorable financing for such a plan.

(c) Prohibition of Regional Alliances Bearing Risk. A regional alliance may not bear insurance risk.

Section 1330 PROHIBITION AGAINST SELF-DEALING AND CONFLICTS OF INTEREST.

(a) Promulgation of Standards. The Board shall promulgate standards of conduct in accordance with subsection (b) for any administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any regional alliance.

(b) Requirements for Standards. The standards of conduct referred to in subsection (a) shall set forth

(1) the types of investment interests, ownership interests, affiliations or other employment that would be improper for an individual described in subsection (a) to hold during the time of the individual's service or employment with an alliance; and

(2) the circumstances that will constitute impermissible conflicts of interest or self-dealing by such employees in performing their official duties and functions for any regional alliance.

(c) Civil Monetary Penalty. Any individual who engages in an activity that the individual knows or has reason to know is in violation of the regulations and standards promulgated by the Board pursuant to subsections (a) and (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such violation. The provisions of section 1128A of the Social Security

Act (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

Part 3 AUTHORITIES AND RESPONSIBILITIES OF REGIONAL ALLIANCES RELATING TO FINANCING AND INCOME DETERMINATIONS

Subpart A Collection of Funds

Section 1341 INFORMATION AND NEGOTIATION AND ACCEPTANCE OF BIDS.

(a) Information Provided to Plans Before Soliciting Bids.

(1) In general. Each regional alliance shall make available, by April 1 of each year, to each plan that indicates an interest in submitting a premium bid under section 6004 in the year, information (including information described in paragraph (2)) that the Board specifies as being necessary to enable a plan to estimate, based upon an accepted bid, the amounts payable to such a plan under section 1351.

(2) Information to be included. Such information shall include the following:

(A) The demographic and other characteristics of regional alliance eligible individuals for the regional alliance.

(B) The uniform per capita conversion factor for the regional alliance (established under subsection (b)).

(C) The premium class factors (established by the Board under section 1531).

(D) The regional alliance inflation factor (determined under section 6001(a)).

(E) The risk-adjustment factors and reinsurance methodology and payment amounts (published under subsection (c)) to be used by the regional alliance in computing blended plan per capita rates (in accordance with section 6201).

(F) The plan bid proportion, the AFDC proportion, the SSI proportion, the AFDC per capita premium amount, and the SSI per capita premium amount, for the year, as computed under subtitle D of title VI.

(G) The alliance administrative allowance percentage, computed under section 1352(b).

(b) Determination of Uniform Per Capita Conversion Factor. Each regional alliance shall specify, not later than April 1 of each year (beginning with the year before the first year) a uniform per capita conversion factor to be used under section 6102(a)(2) in converting the accepted bid for each plan for the year into the premium for an individual enrollment for such plan for the year. SSI or AFDC recipients shall not be included for purposes of computing the conversion factor.

(c) Determination of Risk-Adjustment Factors and Reinsurance Payment

Amounts. Each regional alliance shall compute and publish the risk-adjustment factors and reinsurance payment amounts to be used by the regional alliance in computing blended plan per capita rates under section 6201.

(d) Solicitation of Bids. Each regional alliance shall solicit and negotiate, consistent with section 6004, with each regional alliance health plan a bid for the payment rate on a per capita basis for the comprehensive benefit package for all alliance eligible individuals in the alliance area.

Section 1342 CALCULATION AND PUBLICATION OF GENERAL FAMILY SHARE AND GENERAL EMPLOYER PREMIUM AMOUNTS.

(a) Calculation of Components in General Family Share and General Employer Premiums.

(1) Family share. Each regional alliance shall compute the following components of the general family share of premiums (as defined in subsection (b)(1)(B)):

(A) Plan premiums. For each plan offered, the premium for the plan for each class of family enrollment (including the amount of any family collection shortfall).

(B) Alliance credit. The alliance credit amount for each class of family enrollment, under section 6103.

(C) Excess premium credit.The amount of any excess premium credit provided under section 6105 for each class of family enrollment.

(D) Corporate alliance opt-in credit.The amount of any corporate alliance opt-in credit provided under section 6106 for each class of family enrollment.

(2) Employer premiums. Each regional alliance shall compute the following components of the general employer premium payment amount (as defined in subsection (b)(2)(B)):

(A) Base employer monthly premium per worker.The base employer monthly premium determined under section 6122 for each class of family enrollment.

(B) Employer collection shortfall add-on. The employer collection shortfall add-on computed under section 6125(b).

(b) Publication.

(1) Family share.

(A) In general. Each regional alliance shall publish, before the open enrollment period in each year, the general family share of the premium (as defined in subparagraph (B)) for each class of family enrollment for each regional alliance health plan to be offered by the alliance in the following year.

(B) General family share of premium defined. In this subpart, the term "general family share of premium" means the family share of premium under section 6101 computed without regard to section 6104 and without regard to section 6101(b)(2)(C)(v).

(2) Employer premium.

(A) In general. Each regional alliance shall publish, in December before each year (beginning with December before the first year) the general employer premium payment amount (as defined in subparagraph (B)) for each class of family enrollment for the following year.

(B) General employer premium payment amount defined. In this subpart, the term "general employer premium payment amount" means the employer premium payment under section 6121 computed, as an amount per full-time equivalent worker, without regard to sections 6124 through 6126.

Section 1343 DETERMINATION OF FAMILY SHARE FOR FAMILIES.

(a) Amount of Family Share.The amount charged by a regional alliance to a family for a class of family enrollment (specified under section 1011(c)) under a regional alliance health plan is equal to the family share of premium established under section 6101(a) for the family. Based upon the information described in this section, each regional alliance shall determine the amount required to be paid under section 6101 and under section 6111 for each year for families enrolling in regional alliance health plans.

(b) Family Share Amount. The amount required to be paid under section 6101, with respect to each family, takes into account

(1) the general family share of premium (as defined in section 1342(b)(1)(B)) for the class of enrollment involved;

(2) any income-related discount provided under section 6104(a)(1) for the family; and

(3) whether or not the family is an SSI or AFDC family.

(c) Alliance Credit Repayment Amount. The amount of the alliance credit repayment amount under section 6111, with respect to each family, takes into account the following:

(1) The number of months of enrollment, and class of enrollment, in regional alliance health plans, used in determining the amount of the alliance credit under section 6103 for the family.

(2) Reductions in liability under section 6111(b) based on employer premium payments based on net earnings from self-employment for the family.

(3) Reductions in liability under section 6112 based on months of employment for the family.

(4) Limitations in liability under section 6113 on the basis of the adjusted family income for the family.

(5) The elimination of liability in the case of certain retirees and qualified spouses and children under section 6114.

(6) The elimination of liability in the case of certain working medicare beneficiaries under section 6115.

(d) Access to Necessary Information to Make Determination. Information required for an alliance to make the determination under subsection (a) shall be based on information obtained or maintained by the alliance in the conduct of its business, including the following:

(1) Information required for income-related determinations shall be obtained under subpart B.

(2) Information on SSI and AFDC recipients under subsection (e).

(3) Information submitted on a monthly and annual basis by employers under section 1602.

(4) Information submitted by self-employed individuals on net earnings from self-employment under section 1602(d).

(5) Applications for premium reductions under section 6114.

(6) Information concerning medicare-eligible individuals under subsection (f).

(7) Any income-related discount provided under section 6104(a)(1) for the family.

(8) Whether or not the family is an SSI or AFDC family.

(e) Information Concerning Cash Assistance Status. Each participating State and the Secretary shall make available (in a time and manner specified by the Secretary) to each regional alliance such information as may be necessary to determine and verify whether an individual is an AFDC or SSI recipient for a month in a year.

(f) Information Concerning Medicare-Eligible Individuals.

(1) Information to regional alliances. The Secretary shall make available to regional alliances (through regional information centers or otherwise) information necessary to determine

(A) whether an individual is a medicare-eligible

individual,

(B) the eligibility of individuals for the special treatment under section 6115,

(C) if medicare-eligible individuals are described in section 1012(a), and

(D) the amounts of payments owed the alliance under section 1894 of the Social Security Act, added by section 4003.

(2) Information to secretary. Each regional alliance shall make available to the Secretary (through the national information system under section 5101 or otherwise) information relating to the enrollment of individuals who would be medicare-eligible individuals but for section 1012(a).

(g) Alliance Accounting System.

(1) In general. Each regional alliance shall establish an accounting system that meets standards established by the Secretary.

(2) Specifics. Such system shall collect information, on a timely basis for each individual enrolled (and, to the extent required by the Secretary, identified and required to be enrolled) in a regional alliance health plan regarding

(A) the applicable premium for such enrollment,

(B) family members covered under such enrollment,

(C) the premium payments made by (or on behalf of) the individual for such enrollment,

(D) employer premium payments made respecting the employment of the individual and other employer contributions made respecting such enrollment, and

(E) any government contributions made with respect to such enrollment (including contributions for electing veterans and active duty military personnel).

(3) End-of-year reporting. Such system shall provide for a report, at the end of each year, regarding the total premiums imposed, and total amounts collected, for individuals enrolled under regional health alliance plans, in such manner as

identifies net amounts that may be owed to the regional alliance.

Section 1344 NOTICE OF FAMILY PAYMENTS DUE.

(a) Family Statements.

(1) Notice of no amount owed. If the regional alliance determines under section 1343 that a family has paid any family share required under section 6101 and is not required to repay any amount under section 6111 for a year, the alliance shall provide notice of such determination to the family. Such notice shall include a prominent statement that the family is not required to make any additional payment and is not required to file any additional information with the regional alliance.

(2) Notice of amount owed.

(A) In general. If the regional alliance determines that a family has not paid the entire family share required under section 6101 or is required to repay an amount under section 6111 for a year, the alliance shall provide to the family a notice of such determination.

(B) Information on amount due. Such notice shall include detailed information regarding the amount owed, the basis for the computation (including the amount of any reductions that have been made in the family's liability under subtitle B of title VI), and the date the amount is due and the manner in which such amount is payable.

(C) Information on discounts and reductions available. Such notice shall include

(i) information regarding the discounts and reductions available (under sections 6104, 6112, 6113, 6114, and 6115) to reduce or eliminate any liability, and

(ii) a worksheet which may be used to calculate reductions in liability based on income under sections 6104 and 6113.

(3) Inclusion of income reconciliation form for families provided premium discounts.

(A) In general. A notice under this subsection shall include, in the case of a family that has been provided a premium discount under section 6104 (or section 6113) for the previous year, an income reconciliation statement (for use under section

1375) to be completed and returned to the regional alliance (along with any additional amounts owed) by the deadline specified in subsection (b). Such form shall require the submission of such information as the Secretary specifies to establish or verify eligibility for such premium discount.

(B) Other families. Any family which has not been provided such a discount but may be eligible for such a discount may submit such an income reconciliation statement and, if eligible, receive a rebate of the amount of excess family share paid for the previous year.

(C) Additional information.The alliance shall permit a family to provide additional information relating to the amount of such reductions or the income of the family (insofar as it may relate to a premium discount or reduction in liability under section 6104 or 6113).

(4) Timing of notice. Notices under this subsection shall be mailed to each family at least 45 days before the deadline specified in subsection (b).

(b) Deadline for Payment. The deadline specified in this subsection for amounts owed for a year is such date as the Secretary may specify, taking into account the dates when the information specified in section 1343 becomes available to compute the amounts owed and to file income reconciliation statements under section 1375. Amounts not paid by such deadline are subject to interest and penalty.

(c) Change in Regional Alliance. In the case of a family that during a year changes the regional alliance through which the family obtains coverage under a regional alliance health plan, the Secretary shall establish rules which provide that the regional alliance in which the family last obtained such coverage in a year

(1) is responsible for recovering amounts due under this subpart for the year (whether or not attributable to periods of coverage obtained through that alliance);

(2) shall obtain such information, through the health information system implemented under section 5101, as the alliance may require in order to compute the amount of any liability owed under this subpart (taking into account any reduction in such amount under this section), and

(3) shall provide for the payment to other regional alliances of such amounts collected as may be attributable to amounts owed for periods of coverage obtained through such alliances.

(d) No Loss of Coverage. In no case shall the failure to pay amounts owed under this subsection result in an individual's or family's loss of coverage under this Act.

(e) Dispute Resolution. Each regional alliance shall establish a fair hearing mechanism for the resolution of disputes concerning amounts owed the alliance under this subpart.

Section 1345 COLLECTIONS.

(a) In General. Each regional alliance is responsible for the collection of all amounts owed the alliance (whether by individuals, employers, or others and whether on the basis of premiums owed, incorrect amounts of discounts or premium, cost sharing, or other reductions made, or otherwise). No amounts are payable by the Federal Government under this Act (including section 9102) with respect to the failure to collect any such amounts. Each regional alliance shall use credit and collection procedures, including the imposition of interest charges and late fees for failure to make timely payment, as may be necessary to collect amounts owed to the alliance. States assist regional alliances in such collection process under section 1202(d).

(b) Collection of Family Share.

(1) Withholding.

(A) In general. In the case of a family that includes a qualifying employee of an employer, the employer shall deduct from the wages of the qualifying employee (in a manner consistent with any rules of the Secretary of Labor) the amount of the family share of the premium for the plan in which the family is enrolled.

(B) Multiple employment. In the case of a family that includes more than one qualifying employee, the family shall choose the employer to which subparagraph (A) will apply.

(C) Payment. Amounts withheld under this paragraph shall be maintained in a manner consistent with standards established by the Secretary of Labor and paid to the regional alliance involved in a manner consistent with the payment of

employer premiums under subsection (c).

(D) Satisfaction of liability. An amount deducted from wages of a qualifying employee by an employer is deemed to have been paid by the employee and to have satisfied the employee's obligation under subsection (a) to the extent of such amount.

(2) Other methods. In the case of a family that does not include a qualifying employee, the regional alliance shall require payment to be made prospectively. Such payment may be required to be made not less frequently than monthly. The Secretary may issue regulations in order to assure the timely and accurate collection of the family share due.

(c) Timing and Method of Payment of Employer Premiums.

(1) Frequency of payment. Payment of employer premiums under section 6121 for a month shall be made not less frequently than monthly (or quarterly in the case of such payments made by virtue of section 6126). The Secretary of Labor may establish a method under which employers that pay wages on a weekly or biweekly basis are permitted to make such employer payments on such a weekly or biweekly basis.

(2) Electronic transfer. A regional alliance may require those employers that have the capacity to make payments by electronic transfer to make payments under this subsection by electronic transfer.

(d) Assistance.

(1) Employer collections. The Secretary of Labor shall provide regional alliances with such technical and other assistance as may promote the efficient collection of all amounts owed such alliances under this Act by employers. Such assistance may include the assessment of civil monetary penalties, not to exceed $5,000 or three times the amount of the liability owed, whichever is greater, in the case of repeated failure to pay (as specified in rules of the Secretary of Labor).

(2) Family collections. Except as provided in paragraph (1), the Secretary shall provide regional alliances with such technical and other assistance as may promote the efficient collection of other amounts owed such alliances under this Act. Such assistance may include the assessment of civil monetary penalties, not to exceed $5,000 or three times the amount of the

liability owed, whichever is greater, in the case of repeated failure to pay (as specified in rules of the Secretary).

(e) Receipt of Miscellaneous Amounts. For payments to regional alliances by

(1) States, see subtitle A of title IX, and

(2) the Federal Government, see subtitle B of such title and section 1894 of the Social Security Act (as added by section 4003).

Section 1346 COORDINATION AMONG REGIONAL ALLIANCES.

(a) In General. The regional alliance which offers the regional alliance health plan in which a family is enrolled in December of each year (in this section referred to as the "final alliance") is responsible for the collection of any amounts owed by the family under this subpart, without regard to whether the family resided in the alliance area during the entire year.

(b) Provision of Information in the Case of Change of Residence. In the case of a family that moves from one alliance area to another alliance area during a year, each regional alliance (other than the final alliance) is responsible for providing to the final alliance (through the national information system under section 5101 or otherwise) such information as the final alliance may require in order to determine the liability (and reductions in liability under section 6112) attributable to alliance credits provided by such regional alliance.

(c) Distribution of Proceeds. In accordance with rules established by the Secretary, in consultation with the Secretary of Labor, the final alliance shall provide for the distribution of amounts collected under this subpart with respect to families in a year in an equitable manner among the regional alliances that provided health plan coverage to the families in the year.

(d) Expediting Process. In order to reduce paperwork and promote efficiency in the collection of amounts owed regional alliances under this subpart, the Secretary may require or permit regional alliances to share such information (through the national information system under Section 5101 or otherwise) as the Secretary determines to be cost-effective, subject to such confidentiality restrictions as may otherwise apply.

(e) Students. In the case of a qualifying student who makes

an election described in section 1012(e)(1) (relating to certain full-time students who are covered under the plan of a parent but enrolled in a health plan offered by a different regional alliance from the one in which the parent is enrolled), the regional alliance that offered the plan to the parent shall provide for transfers of an appropriate portion of the premium (determined in accordance with procedures specified by the Board) to the other regional alliance in order to compensate that alliance for the provision of such coverage.

(f) Payments of Certain Amounts to Corporate Alliances. In the case of a married couple in which one spouse is a qualifying employee of a regional alliance employer and the other spouse is a qualifying employee of a corporate alliance employer, if the couple is enrolled with a corporate alliance health plan the regional alliance (which receives employer premium payments from such regional alliance employer with respect to such employee) shall pay to the corporate alliance the amounts so paid (or would be payable by the employer if section 6123 did not apply).

Subpart B Payments

Section 1351 PAYMENT TO REGIONAL ALLIANCE HEALTH PLANS.

(a) Computation of Blended Plan Per Capita Payment Amount. For purposes of making payments to plans under this section, each regional alliance shall compute, under section 6201(a), a blended plan per capita payment amount for each regional alliance health plan for enrollment in the alliance for a year.

(b) Amount of Payment to Plans.

(1) In general. Subject to subsection (e) and section 6121(b)(5)(B), each regional alliance shall provide for payment to each regional alliance health plan, in which an alliance eligible individual is enrolled, an amount equal to the net blended rate (described in paragraph (2)) adjusted (consistent with subsection (c)) to take into account the relative actuarial risk associated with the coverage with respect to the individual.

(2) Net blended rate. The net blended rate described in this paragraph is the blended plan per capita payment amount (determined under section 6201(a)), reduced by

(A) such amount multiplied by the sum of

(i) the administrative allowance percentage for the regional alliance, computed by the alliance under section 1352(b), and

(ii) 1.5 percentage points; and

(B) any plan payment reduction imposed under section 6011 for the plan for the year.

(c) Application of Risk Adjustment and Reinsurance Methodology. Each regional alliance shall use the risk adjustment methodology developed under section 1541 in making payments to regional alliance health plans under this section, except as provided in section 1542.

(d) Application of Portion of Set Aside. Amounts attributable to subsection (b)(2)(A)(ii) are paid to the Federal Government (for academic health centers and graduate medical education) under section 1353.

(e) Treatment of Veterans, Military, and Indian Health Plans and Programs.

(1) Veterans health plan. In applying this subtitle (and title VI) in the case of a regional alliance health plan that is a veterans health plan of the Department of Veterans Affairs, the following rules apply:

(A) For purposes of applying subtitle A of title VI, families enrolled under the plan shall not be taken into account.

(B) The provisions of subtitle A of title VI shall not apply to the plan, other than such provisions as require the plan to submit a per capita amount for each regional alliance area on a timely basis, which amount shall be treated as the final accepted bid of the plan for the area for purposes of subtitle B of such title and this subtitle. This amount shall not be subject to negotiation and not subject to reduction under section 6011.

(C) For purposes of computing the blended plan per capita payment amount under section 6201(a), the AFDC and SSI proportions (under section 6202(a)) are deemed to be 0 percent.

(2) Uniformed services health plan. In applying this subtitle (and title VI) in the case of a regional alliance health plan that is a Uniformed Services Health Plan of the Department of Defense, the following rules apply:

(A) For purposes of applying subtitle A of title VI, families enrolled under the plan shall not be taken into account.

(B) The provisions of subtitle A of title VI shall not apply to the plan, other than such provisions as require the plan to submit a per capita amount on a timely basis, which amount shall be treated as the final accepted bid of the plan for the area involved for purposes of subtitle B of such title and this subtitle. This amount shall not be subject to negotiation and not subject to reduction under section 6011. The Board, in consultation with the Secretary of Defense, shall establish rules relating to the area (or areas) in which such a bid shall apply.

(C) For purposes of computing the blended plan per capita payment amount under section 6201(a), the AFDC and SSI proportions (under section 6202(a)) are deemed to be 0 percent.

(3) Indian health programs. In applying this subtitle (and title VI) in the case of a health program of the Indian Health Service, the following rules apply:

(A) Except as provided in this paragraph, the plan shall not be considered or treated to be a regional alliance health plan and for purposes of applying title VI, families enrolled under the program shall not be taken into account.

(B) In accordance with rules established by the Secretary, regional alliances shall act as agents for the collection of employer premium payments (including payments of corporate alliance employers) required under subtitle B of title VI with respect to qualifying employees who are enrolled under a health program of the Indian Health Service. The Secretary shall permit such alliances to retain a nominal fee to compensate them for such collection activities. In applying this subparagraph, the family share of premium for such employees is deemed to be zero for electing Indians (as defined in section 1012(d)(3)) and for other employees is the amount of the premium established under section 8306(b)(4)(A), employees are deemed to be residing in the area of residence (or area of employment), as specified under rules of the Secretary, and the class of enrollment shall be such class (or classes) as specified under rules of the Secretary.

Section 1352 ALLIANCE ADMINISTRATIVE ALLOWANCE PERCENTAGE.

(a) Specification by Alliance. Before obtaining bids under section 6004 from health plans for a year, each regional alliance shall establish the administrative allowance for the operation of the regional alliance in the year.

(b) Administrative Allowance Percentage. Subject to subsection (c), the regional alliance shall compute an administrative allowance percentage for each year equal to

(1) the administrative allowance determined under subsection (a) for the year, divided by

(2) the total of the amounts payable to regional alliance health plans under subpart A (as estimated by the alliance and determined without regard to section 1345(d)).

(c) Limitation to 2\1/2\ percent.In no case shall an administrative allowance percentage exceed 2.5 percent.

Section 1353 PAYMENTS TO THE FEDERAL GOVERNMENT FOR ACADEMIC HEALTH CENTERS AND GRADUATE MEDICAL EDUCATION.

Each regional alliance shall make payment to the Secretary of an amount equal to the reduction in payments by the alliance to regional alliance health plan attributable to section 1351(b)(2)(A)(ii).

Subpart C Financial Management

Section 1361 MANAGEMENT OF FINANCES AND RECORDS.

(a) In General. Each regional alliance shall comply with standards established under section 1571(b) (relating to the management of finances, maintenance of records, accounting practices, auditing procedures, and financial reporting) and under section 1591(d) (relating to employer payments).

(b) Specific Provisions. In accordance with such standards

(1) Financial statements.

(A) In general. Each regional alliance shall publish periodic audited financial statements.

(B) Annual financial audit.

(i) In general. Each regional alliance shall have an annual

financial audit conducted by an independent auditor in accordance with generally accepted auditing standards.

(ii) Publication. A report on each such audit shall be made available to the public at nominal cost.

(iii) Required actions for deficiencies. If the report from such an audit does not bear an unqualified opinion, the alliance shall take such steps on a timely basis as may be necessary to correct any material deficiency identified in the report.

(C) Eligibility error rates. Each regional alliance shall make eligibility determinations for premium discounts, liability reductions, and cost sharing reductions under sections 6104 and 6123, section 6113, and section 1371, respectively, in a manner that maintains the error rates below an applicable maximum permissible error rate specified by the Secretary (or the Secretary of Labor with respect to section 6123). In specifying such a rate, the Secretary shall take into account maximum permissible error rates recognized by the Federal Government under comparable State-administered programs.

(2) Safeguarding of funds. Each regional alliance shall safeguard family, employer, State, and Federal government payments to the alliance in accordance with fiduciary standards and shall hold such payments in financial institutions and instruments that meet standards recognized or established by the Secretary, in consultation with the Secretaries of Labor and the Treasury and taking into account current Federal laws and regulations relating to fiduciary responsibilities and financial management of public funds.

(3) Contingencies. Each regional alliance shall provide that any surplus of funds resulting from an estimation discrepancy described in section 9201(e)(1), up to a reasonable amount specified by the Secretary, shall be held in a contingency fund established by the alliance and used to fund any future shortfalls resulting from such a discrepancy.

(4) Auditing of employer payments.

(A) In general.Each regional alliance is responsible for auditing the records of regional alliance employers to assure that employer payments (including the payment of amounts withheld) were made in the appropriate amount as provided under subpart A of part 2 of subtitle B of title VI.

(B) Employers with employees residing in different alliance areas. In the case of a regional alliance employer which has employees who reside in more than one alliance area, the Secretary of Labor, in consultation with the Secretary, shall establish a process for the coordination of regional alliance auditing activities among the regional alliances involved.

(C) Appeal. In the case of an audit conducted by a regional alliance on an employer under this paragraph, an employer or other regional alliance that is aggrieved by the determination in the audit is entitled to review of such audit by the Secretary of Labor in a manner to be provided by such Secretary.

Subpart D Reductions in Cost Sharing; Income Determinations

Section 1371 REDUCTION IN COST SHARING FOR LOW-INCOME FAMILIES.

(a) Reduction.

(1) In general. Subject to subsection (b), in the case of a family that is enrolled in a regional alliance health plan and that is either (A) an AFDC or SSI family or (B) is determined under this subpart to have family adjusted income below 150 percent of the applicable poverty level, the family is entitled to a reduction in cost sharing in accordance with this section.

(2) Timing of reduction. The reduction in cost sharing shall only apply to items and services furnished after the date the application for such reduction is approved under section 1372(c) and before the date of termination of the reduction under this subpart, or, in the case of an AFDC or SSI family, during the period in which the family is such a family.

(3) Information to providers and plans. Each regional alliance shall provide, through electronic means and otherwise, health care providers and regional alliance health plans with access to such information as may be necessary in order to provide for the cost sharing reductions under this section.

(b) Limitation. No reduction in cost sharing under subsection (c)(1) shall be available for families residing in an alliance area if the regional alliance for the area determines that there are sufficient low-cost plans (as defined in section 6104(b)(3)) that are lower or combination cost sharing plans

available in the alliance area to enroll AFDC and SSI families and families with family adjusted income below 150 percent of the applicable poverty level.

(c) Amount of Cost Sharing Reduction.

(1) In general. Subject to paragraph (2), the reduction in cost sharing under this section shall be such reduction as will reduce cost sharing to the level of a lower or combination cost sharing plan.

(2) Special treatment of certain afdc and ssi families. In the case of an AFDC or SSI family enrolled in a lower or combination cost sharing plan or receiving a reduction in cost sharing under paragraph (1), the amount of copayment applied with respect to an item or service (other than with respect to hospital emergency room services for which there is no emergency medical condition, as defined in section 1867(e)(1) of the Social Security Act) shall be an amount equal to 20 percent of the copayment amount otherwise applicable under sections 1135 and 1136, rounded to the nearest dollar.

(d) Administration.

(1) In general. In the case of an approved family (as defined in section 1372(b)(3)) enrolled in a regional alliance health plan, the regional alliance shall pay the plan for cost sharing reductions (other than cost sharing reductions under subsection (c)(2)) provided under this section and included in payments made by the plan to its providers.

(2) Estimated payments, subject to reconciliation. Such payment shall be made initially on the basis of reasonable estimates of cost sharing reductions incurred by such a plan with respect to approved families and shall be reconciled not less often than quarterly based on actual claims for items and services provided.

(e) No Cost Sharing for Indians and Certain Veterans and Military Personnel. The provisions of section 6104(a)(3) shall apply to cost sharing reductions under this section in the same manner as such provisions apply to premium discounts under section 6104.

Section 1372 APPLICATION PROCESS FOR COST SHARING REDUCTIONS.

(a) Application.

(1) In general. A regional alliance eligible family may apply for a determination of the family adjusted income of the family, for the purpose of establishing eligibility for cost sharing reductions under section 1371.

(2) Form. An application under this section shall include such information as may be determined by the regional alliance (consistent with rules developed by the Secretary) and shall include at least information about the family's employment status and income.

(b) Timing.

(1) In general. An application under this section may be filed at such times as the Secretary may provide, including during any open enrollment period, at the time of a move, or after a change in life circumstances (such as unemployment or divorce) affecting class of enrollment or amount of family share or repayment amount.

(2) Consideration. Each regional alliance shall approve or disapprove an application under this section, and notify the applicant of such decision, within such period (specified by the Secretary) after the date of the filing of the application.

(3) Approved family defined. In this section and section 1371, the term "approved family" means a family for which an application under this section is approved, until the date of termination of such approval under this section.

(c) Approval of Application.

(1) In general. A regional alliance shall approve an application of a family under this section filed in a month if the application demonstrates that the family adjusted income of the family (as defined in subsection (d) and determined under paragraph (2)) is (or is expected to be) less than 150 percent of the applicable poverty level.

(2) Use of current income. In making the determination under paragraph (1), a regional alliance shall take into account the income for the previous 3-month period and current wages from employment (if any), consistent with rules specified by the Secretary.

(d) Family Adjusted Income.

(1) In general. Except as provided in paragraph (4), in this Act the term "family adjusted income" means, with respect to a family, the sum of the adjusted incomes (as defined in paragraph (2)) for all members of the family (determined without regard to section 1012).

(2) Adjusted income. In paragraph (1), the term "adjusted income" means, with respect to an individual, adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)

(A) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code, and

(B) increased by the amount of interest received or accrued by the individual which is exempt from tax.

(3) Presence of additional dependents.At the option of an individual, a family may include (and not be required to separate out) the income of other individuals who are claimed as dependents of the family for income tax purposes, but such individuals shall not be counted as part of the family for purposes of determining the size of the family.

(e) Requirement for Periodic Confirmation and Verification and Notices.

(1) Confirmation and verification requirement. The continued eligibility of a family for cost sharing reductions under this section is conditioned upon the family's eligibility being (A) confirmed periodically by the regional alliance, and

(B) verified (through the filing of a new application under this section) by the regional alliance at the time income reconciliation statements are required to be filed under section 1375.

(2) Rules. The Secretary shall issue rules related to the manner in which alliances confirm and verify eligibility under this section.

(3) Notices of changes in income and employment status.

(A) In general. Each approved family shall promptly notify the regional alliance of any material increase (as defined

by the Secretary) in the family adjusted income.

(B) Response. If a regional alliance receives notice under subparagraph (A) (or from an employer under section 1602(b)(3)(A)(i)) or otherwise receives information indicating a potential significant change in the family's employment status or increase in adjusted family income, the regional alliance shall promptly take steps necessary to reconfirm the family's eligibility.

(f) Termination of Cost Sharing Reduction. The regional alliance shall, after notice to the family, terminate the reduction of cost sharing under this subpart for an approved family if the family fails to provide for confirmation or verification or notice required under subsection (c) on a timely basis or the alliance otherwise determines that the family is no longer eligible for such reduction. The previous sentence shall not prevent the family from subsequently reapplying for cost sharing reduction under this section.

(g) Treatment of AFDC and SSI Recipients.

(1) No application required. AFDC and SSI families are not required to make an application under this section.

(2) Notice requirement. Each State (and the Secretary) shall notify each regional alliance, in a manner specified by the Secretary, of the identity (and period of eligibility under the AFDC or SSI programs) of each AFDC and SSI recipient, unless such a recipient elects (in a manner specified by the Secretary) not to accept the reduction of cost sharing under this section.