/* Part 3 of 4 of Title I follows. */

Section 1373 APPLICATION FOR PREMIUM DISCOUNTS AND REDUCTION IN LIABILITIES TO ALLIANCES.

(a) In General. Any regional alliance eligible family may apply for a determination of the family adjusted income of the family, for the purpose of establishing eligibility for a premium discount under section 6104 or a reduction in liability under section 6113.

(b) Timing. Such an application may be filed at such times as an application for a cost sharing reduction may be filed under section 1372(b) and also may be filed after the end of the year to obtain a rebate for excess premium payments made during a year.

(c) Approval of Application.

(1) In general. A regional alliance shall approve an application of a family under this section filed in a month

(A) for a premium discount under section 6104, if the application demonstrates that family adjusted income of the family (as determined under paragraph (2)) is (or is expected to be) less than 150 percent of the applicable poverty level, or

(B) for a reduction in liability under section 6113, if the application demonstrates that the wage-adjusted income (as defined in subsection 6113(d)) of the family (as determined under paragraph (2)) is (or is expected to be) less than 250 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) and the statement of estimated income for the year (filed under section 1374(c)), consistent with rules specified by the Secretary.

(d) Requirement for Periodic Confirmation and Verification and Notices. The provisions of subsection (e) of section 1372 shall apply under this section in the same manner as it applies under such section, except that any reference to family adjusted income is deemed a reference to wage-adjusted income.

Section 1374 GENERAL PROVISIONS RELATING TO APPLICATION PROCESS.

(a) Distribution of Applications. Each regional alliance shall distribute applications under this subpart directly to consumers and through employers, banks, and designated public agencies.

(b) To Whom Application Made. Applications under this subpart shall be filed, by person or mail, with a regional alliance or an agency designated by the State for this purpose. The application may be submitted with an application to enroll with a health plan under this subtitle or separately.

(c) Income Statement. Each application shall include a declaration of estimated annual income for the year involved.

(d) Form and Contents. An application for a discount or reduction under this subpart shall be in a form and manner specified by the Secretary and shall require the provision of information necessary to make the determinations required under this subpart.

(e) Frequency of Applications.

(1) In general. An application under this subpart may be filed at any time during the year (including, in the case of section 1373, during the reconciliation process).

(2) Correction of income. Nothing in paragraph (1) shall be construed as preventing an individual or family from, at any time, submitting an application to reduce the amount of premium discount or reduction of liability under this subpart based upon an increase in income from that stated in the previous application.

(f) Timing of Reductions and Discounts.

(1) In general. Subject to reconciliation under section 1375, premium discounts and cost sharing reductions under this subpart shall be applied to premium payments required (and for expenses incurred) after the date of approval of the application under this subpart.

(2) AFDC and ssi recipients. In the case of an AFDC or SSI family, in applying paragraph (1), the date of approval of benefits under the AFDC or SSI program shall be considered the date of approval of an application under this subpart.

(g) Verification. The Secretary shall provide for verification, on a sample basis or other basis, of the information supplied in applications under this part. This verification shall be separate from the reconciliation provided under section 1375.

(h) Help in Completing Applications. Each regional alliance shall assist individuals in the filing of applications and income reconciliation statements under this subpart.

(i) Penalties for Inaccurate Information.

(1) Interest for understatements. Each individual who knowingly understates income reported in an application to a regional alliance under this subpart or otherwise makes a material misrepresentation of information in such an application shall be liable to the alliance for excess payments made based on such understatement or misrepresentation, and for interest on such excess payments at a rate specified by the Secretary.

(2) Penalties for misrepresentation. In addition to the liability established under paragraph (1), each individual who knowingly misrepresents material information in an application under this subpart to a regional alliance shall be liable to the State in which the alliance is located for $2,000 or, if greater, three times the excess payments made based on such misrepresentation. The State shall provide for the transfer of a significant portion of such amount to the regional alliance involved.

Section 1375 END-OF-YEAR RECONCILIATION FOR PREMIUM DISCOUNT AND REPAYMENT REDUCTION WITH ACTUAL INCOME.

(a) In General. In the case of a family whose application for a premium discount or reduction of liability for a year has been approved before the end of the year under this subpart, the family shall, subject to subsection (c) and by the deadline specified in section 1344(b) file with the regional alliance an income reconciliation statement to verify the family's adjusted income or wage-adjusted income, as the case may be, for the previous year. Such a statement shall contain such information as the Secretary may specify. Each regional alliance shall coordinate the submission of such statements with the notice and payment of family payments due under section 1344.

(b) Reconciliation of Premium Discount and Liability Assistance Based on Actual Income. Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to a family, the regional alliance shall compute the amount of premium discount or reduction in liability that should have been provided under section 6104 or section 6113 with respect for the family for the year involved. If the amount of such discount or liability reduction computed is

(1) greater than the amount that has been provided, the family is liable to the regional alliance to pay (directly or through an increase in future

family share of premiums or other payments) a total amount equal to the amount of the excess payment, or

(2) less than the amount that has been provided, the regional alliance shall pay to the family (directly or through a reduction in future family share of premiums or other payments) a total amount equal to the amount of the deficit.

(c) No Reconciliation for AFDC and SSI Families; No Reconciliation for Cost Sharing Reductions. No reconciliation statement is required under this section

(1) with respect to cost sharing reductions provided under section 1372, or

(2) for a family that only claims a premium discount or liability reduction under this subpart on the basis of being an AFDC or SSI family.

(d) Disqualification for Failure to File. In the case of any family that is required to file a statement under this section in a year and that fails to file such a statement by the deadline specified, members of the family shall not be eligible for premium reductions under section 6104 or reductions in liability under section 6113 until such statement is filed. A regional alliance, using rules established by the Secretary, shall waive the application of this subsection if the family establishes, to the satisfaction of the alliance under such rules, good cause for the failure to file the statement on a timely basis.

(e) Penalties for False Information. Any individual that provides false information in a statement under subsection (a) is subject to the same liabilities as are provided under section 1374(h) for a misrepresentation of material fact described in such section.

(f) Notice of Requirement. Each regional alliance (directly or in coordination with other regional alliances) shall provide for written notice, at the end of each year, of the requirement of this section to each family which had received premium discount or reduction in liability under this subpart in any month during the preceding year and to which such requirement applies.

(g) Transmittal of Information; Verification.

(1) In general. Each participating State shall transmit annually to the Secretary such information relating to the income of families for the previous year as the Secretary may require to verify such income under this subpart.

(2) Verification. Each participating State may use such information as it

has available to it to assist regional alliances in verifying income of families with applications filed under this subpart. The Secretary of the Treasury may, consistent with section 6103 of the Internal Revenue Code of 1986, permit return information to be disclosed and used by a participating State in verifying such income but only in accordance with such section and only if the information is not directly disclosed to a regional alliance.

(h) Construction. Nothing in this section shall be construed as authorizing reconciliation of any cost sharing reduction provided under this subpart.

Part 4 RESPONSIBILITIES AND AUTHORITIES OF CORPORATE ALLIANCES

Section 1381 CONTRACTS WITH HEALTH PLANS.

(a) Contracts with Plans. Subject to section 1382, each corporate alliance may

(1) offer to individuals eligible to enroll under section 1311(c) coverage under an appropriate self-insured health plan (as defined in section 1400(b)), or

(2) negotiate with a State-certified health plan to enter into a contract with the plan for the enrollment of such individuals under the plan, or do both.

(b) Terms of Contracts with State-Certified Health Plans. Contracts under this section between a corporate alliance and a State-certified health plan may contain such provisions (not inconsistent with the requirements of this title) as the alliance and plan may provide, except that in no case does such contract remove the obligation of the sponsor of the corporate alliance to provide for health benefits to corporate alliance eligible individuals consistent with this part.

Section 1382 OFFERING CHOICE OF HEALTH PLANS FOR ENROLLMENT.

(a) In General. Each corporate alliance must provide to each eligible enrollee with respect to the alliance a choice of health plans among the plans which have contracts with the alliance under section 1381.

(b) Offering of Plans by Alliances. A corporate alliance shall include among its health plan offerings for any eligible enrollee at least 3 health plans to enrollees, of which the alliance must offer

(1) at least one fee-for-service plan (as defined in section 1322(b)(2));

and

(2) at least two health plans that are not fee-for-service plans.

Section 1383 ENROLLMENT; ISSUANCE OF HEALTH SECURITY CARD.

(a) In General.

(1) Enrollment of alliance eligible individuals. Each corporate alliance shall assure that each alliance eligible individual with respect to the alliance is enrolled in a corporate alliance health plan offered by the alliance, 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 such individuals at the time they first become alliance eligible individuals with respect to the alliance.

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

(b) Response to Point-of-Service Notices. If a corporate alliance is notified under section 1323(b)(2) regarding an individual who has received services and appears to be a corporate alliance eligible individual

(1) the alliance shall promptly ascertain the individual's eligibility as a corporate alliance eligible individual; and

(2) if the alliance determines that the individual is a corporate alliance eligible individual

(A) the alliance shall promptly provide for the enrollment of the individual in a health plan offered by the alliance (and notify the Secretary of Labor of such enrollment), and

(B) the alliance shall forward the claim for payment for the services to the health plan in which the individual is so enrolled and the plan shall make payment to the provider for such claim (in a manner consistent with requirements of the Secretary of Labor).

(c) Annual Open Enrollment; Enrollment of Family Members; Oversubscription of Plans. The provisions of subsections (d) through (f) of section 1323 shall apply to a corporate alliance in the same manner as such provisions apply to a regional alliance.

(d) Termination.

(1) In general. The provisions of section 1323(g)(1) shall apply to a corporate alliance in the same manner as such provisions apply to a regional alliance.

(2) Failure to pay premiums. If a corporate alliance fails to make premium payments to a health plan, the plan, after reasonable written notice to the alliance and the Secretary of Labor, may terminate coverage (and any contract with the alliance under this part). If such coverage is terminated the corporate alliance is responsible for the prompt enrollment of alliance eligible individuals whose coverage is terminated in another corporate alliance health plan.

(e) Corporate Alliance Transition. Each corporate alliance must provide coverage

(1) as of the first day of any month in which an individual first becomes a corporate alliance eligible individual, and

(2) through the end of the month in the case of a corporate alliance eligible individual who loses such eligibility during the month.

Section 1384 COMMUNITY-RATED PREMIUMS WITHIN PREMIUM AREAS.

(a) Application of Community-Rated Premiums. The premiums charged by a corporate alliance for enrollment in a corporate alliance health plan (not taking into account any employer premium payment required under section 6131) shall vary only by class of family enrollment (specified in section 1011(c)) and by premium area.

(b) Designation of Premium Areas.

(1) Designation. Each corporate alliance shall designate premium areas to be used for the imposition of premiums (and calculation of employer premium payments) under this Act.

(2) Conditions. The boundaries of such areas shall reasonably reflect labor market areas or health care delivery areas and shall be consistent with rules the Secretary of Labor establishes (consistent with paragraph (3)) so that within such areas there are not substantial differences in average per capita health care expenditures.

(3) Anti-redlining. The provisions of paragraphs (4) and (5) of section 1202(b) (relating to redlining and metropolitan statistical areas) shall apply

to the establishment of premium areas in the same manner as they apply to the establishment of the boundaries of regional alliance areas.

(c) Applications of Classes of Enrollment.

(1) In general. The premiums shall be applied under this section based on class of family enrollment and shall vary based on such class in accordance with factors specified by the corporate alliance.

(2) Basis for factors. Such factors shall be the same in each premium area and shall take into account such appropriate considerations (including the considerations the Board takes into account in the establishment of premium class factors under section 1531 and the costs of regional alliance health plans providing the comprehensive benefit package for families enrolled in the different classes) as the alliance considers appropriate, consistent with rules the Secretary of Labor establishes.

(d) Special Treatment of Multiemployer Alliances. The Secretary of Labor shall provide for such exceptions to the requirements of this section in the case of a corporate alliance with a sponsor described in section 1311(b)(1)(B) as may be appropriate to reflect the unique and historical relationship between the employers and employees under such alliances.

Section 1385 ASSISTANCE FOR LOW-WAGE FAMILIES.

Each corporate alliance shall make an additional contribution towards the enrollment in health plans of the alliance by certain low-wage families in accordance with section 6131(b)(2).

Section 1386 CONSUMER INFORMATION AND MARKETING; DATA COLLECTION AND QUALITY; ADDITIONAL DUTIES.

The provisions of sections 1325(a), 1327, and 1328 shall apply to a corporate alliance in the same manner as such provisions apply to a regional alliance.

Section 1387 PLAN AND INFORMATION REQUIREMENTS.

(a) In General. A corporate alliance shall provide a written submission to the Secretary of Labor (in such form as the Secretary may require) detailing how the corporate alliance will carry out its activities under this part.

(b) Annual Information. A corporate alliance shall provide to the Secretary of Labor each year, in such form and manner as the Secretary may require, such information as the Secretary may require in order to monitor the

compliance of the alliance with the requirements of this part.

(c) Annual Notice of Employees or Participants.

(1) Corporate alliance. Each corporate alliance shall submit to the Secretary of Labor, by not later than March 1 of each year, information on the number of full-time employees or participants obtaining coverage through the alliance as of January 1 of that year.

(2) Employers that become large employers. Each employer that is not a corporate alliance but employs 5,000 full-time employees as of January 1 of a year, shall submit to the Secretary of Labor, by not later than March 1 of the year, information on the number of such employees.

Section 1388 MANAGEMENT OF FUNDS; RELATIONS WITH EMPLOYEES.

(a) Management of Funds. The management of funds by a corporate alliance shall be subject to the applicable fiduciary requirements of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, together with the applicable enforcement provisions of part 5 of subtitle B of title I of such Act.

(b) Management of Finances and Records; Accounting System. Each corporate alliance shall comply with standards relating to the management of finances and records and accounting systems as the Secretary of Labor shall specify.

Section 1389 COST CONTROL.

Each corporate alliance shall control covered expenditures in a manner that meets the requirements of part 2 of subtitle A of title VI.

Section 1390 PAYMENTS BY CORPORATE ALLIANCE EMPLOYERS TO CORPORATE ALLIANCES.

(a) Large Employer Alliances. In the case of a corporate alliance with a sponsor described in section 1311(b)(1)(A), the sponsor shall provide for the funding of benefits, through insurance or otherwise, consistent with section 6131, the applicable solvency requirements of sections 1394, 1395, and 1396, and any rules established by the Secretary of Labor.

(b) Other Alliances. In the case of a corporate alliance with a sponsor described in subparagraph (B) or (C) of section 1311(b)(1), a corporate alliance employer shall make payment of the employer premiums required

under section 6131 under rules established by the corporate alliance, which rules shall be consistent with rules established by the Secretary of Labor.

Section 1391 COORDINATION OF PAYMENTS.

(a) Payments of Certain Amounts to Regional 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 regional alliance health plan, the corporate alliance (which receives employer premium payments from such corporate alliance employer with respect to such employee) shall pay to the regional alliance the amounts so paid.

(b) Payments of Certain Amounts to Corporate Alliances. In the case of a married couple in which one spouse is a qualifying employee of a corporate alliance employer and the other spouse is a qualifying employee of another corporate alliance employer, the corporate alliance of the corporate alliance health plan in which the couple is not enrolled shall pay to the corporate alliance of the plan in which the couple is enrolled any employer premium payments received from such corporate alliance employer with respect to such employee.

Section 1392 APPLICABILITY OF ERISA ENFORCEMENT MECHANISMS FOR ENFORCEMENT OF CERTAIN REQUIREMENTS.

The provisions of sections 502 (relating to civil enforcement) and 504 (relating to investigative authority) of the Employee Retirement Income Security Act of 1974 shall apply to enforcement by the Secretary of Labor of this part in the same manner and to same extent as such provisions apply to enforcement of title I of such Act.

Section 1393 APPLICABILITY OF CERTAIN ERISA PROTECTIONS TO ENROLLED INDIVIDUALS.

The provisions of sections 510 (relating to interference with rights protected under Act) and 511 (relating to coercive interference) of the Employee Retirement Income Security Act of 1974 shall apply, in relation to the provisions of this Act, with respect to individuals enrolled under corporate alliance health plans in the same manner and to the same extent as such provisions apply, in relation to the provisions of the Employee Retirement Income Security Act of 1974, with respect to participants and beneficiaries under employee welfare benefit plans covered by title I of such Act.

Section 1394 DISCLOSURE AND RESERVE REQUIREMENTS.

(a) In General. The Secretary of Labor shall ensure that each corporate alliance health plan which is a self-insured plan maintains plan assets in trust as provided in section 403 of the Employee Retirement Income Security Act of 1974

(1) without any exemption under section 403(b)(4) of such Act, and

(2) in amounts which the Secretary determines are sufficient to provide at any time for payment to health care providers of all outstanding balances owed by the plan at such time. The requirements of the preceding sentence may be met through letters of credit, bonds, or other appropriate security to the extent provided in regulations of the Secretary.

(b) Disclosure. Each self-insured corporate alliance health plan shall notify the Secretary at such time as the financial reserve requirements of this section are not being met. The Secretary may assess a civil money penalty of not more than $100,000 against any corporate alliance for any failure to provide such notification in such form and manner and within such time periods as the Secretary may prescribe by regulation.

Section 1395 TRUSTEESHIP BY THE SECRETARY OF INSOLVENT CORPORATE ALLIANCE HEALTH PLANS.

(a) Appointment of Secretary as Trustee for Insolvent Plans. Whenever the Secretary of Labor determines that a corporate alliance health plan which is a self-insured plan will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of the Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint the Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the enrolled individuals or health care providers or to avoid any unreasonable deterioration of the financial condition of the plan or any unreasonable increase in the liability of the Corporate Alliance Health Plan Insolvency Fund. The trusteeship of the Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

(b) Powers as Trustee. The Secretary of Labor, upon appointment as trustee under subsection (a), shall have the power

(1) to do any act authorized by the plan, this Act, or other applicable provisions of law to be done by the plan administrator or any trustee of the

plan,

(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

(4) to do such other acts as the Secretary deems necessary to continue operation of the plan without increasing the potential liability of the Corporate Alliance Health Plan Insolvency Fund, if such acts may be done under the provisions of the plan,

(5) to require the corporate alliance, the plan administrator, any contributing employer, and any employee organization representing covered individuals to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

(6) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

(7) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

(8) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

(9) to terminate the plan and liquidate the plan assets in accordance with applicable provisions of this Act and other provisions of law, to restore the plan to the responsibility of the corporate alliance, or to continue the trusteeship,

(10) to provide for the enrollment of individuals covered under the plan in an appropriate regional alliance health plan, and

(11) to do such other acts as may be necessary to comply with this Act or any order of the court and to protect the interests of enrolled individuals and health care providers.

(c) Notice of Appointment. As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to

(1) the plan administrator,

(2) each enrolled individual,

(3) each employer who may be liable for contributions to the plan, and

(4) each employee organization which, for purposes of collective bargaining, represents enrolled individuals.

(d) Additional Duties. Except to the extent inconsistent with the provisions of this Act or part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or as may be otherwise ordered by the court, the Secretary of Labor, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of such part 4.

(e) Other Proceedings. An application by the Secretary of Labor under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

(f) Jurisdiction of Court.

(1) In general. Upon the filing of an application for the appointment as trustee or the issuance of a decree under this subsection, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this subsection, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary of Labor as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsoring alliance, or property of such plan or alliance, and any other suit against any receiver, conservator, or trustee of the plan, the sponsoring alliance, or property of the plan or alliance. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsoring alliance or any other suit against the plan or the alliance.

(2) Venue. An action under this subsection may be brought in the judicial district where the plan administrator resides or does business or

where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

(g) Personnel. In accordance with regulations of the Secretary of Labor, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

Section 1396 GUARANTEED BENEFITS UNDER TRUSTEESHIP OF THE SECRETARY.

(a) In General. Subject to subsection (b), the Secretary of Labor shall guarantee the payment of all benefits under a corporate alliance health plan which is a self-insured plan while such plan is under the Secretary's trusteeship under section 1395.

(b) Limitations. Any increase in the amount of benefits under the plan resulting from a plan amendment which was made, or became effective, whichever is later, within 180 days (or such other reasonable time as may be prescribed in regulations of the Secretary of Labor) before the date of the Secretary's appointment as trustee of the plan shall be disregarded for purposes of determining the guarantee under this section.

(c) Corporate Alliance Health Plan Insolvency Fund.

(1) Establishment. The Secretary of Labor shall establish a Corporate Alliance Health Plan Insolvency Fund (hereinafter in this part referred to as the "Fund") from which the Secretary shall authorize payment of all guaranteed benefits under this section.

(2) Receipts and disbursements.

(A) Receipts. The Fund shall be credited with

(i) funds borrowed under paragraph (3),

(ii) assessments collected under section 1397, and

(iii) earnings on investment of the Fund.

(B) Disbursements.The Fund shall be available

(i) for making such payments as the Secretary of Labor determines are necessary to pay benefits guaranteed under this section,

(ii) to repay the Secretary of the Treasury such sums as may be borrowed (together with interest thereon) under paragraph (3), and

(iii) to pay the operational and administrative expenses of the Fund.

(3) Borrowing authority.At the direction of the Secretary of Labor, the Fund may, to the extent necessary to carry out the purposes of paragraph (1), issue to the Secretary of the Treasury notes or other obligations, in such forms and denominations, bearing such maturities, and subject to such terms and conditions as may be prescribed by the Secretary of the Treasury. The total balance of the Fund obligations outstanding at any time shall not exceed $500,000,000. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of such notes or other obligations by the Fund. The Secretary of the Treasury shall purchase any notes or other obligations issued by the Fund under this paragraph, and for that purpose the Secretary of the Treasury may use as a public debt transaction the proceeds from the sale of any securities issued under chapter 31 of title 31, United States Code and the purposes for which securities may be issued under such chapter are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by such Secretary under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States.

(4) Investment authority. Whenever the Secretary of Labor determines that the moneys of the Fund are in excess of current needs, such Secretary may request the investment of such amounts as such Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States, but, until all borrowings under paragraph (3) have been repaid, the obligations in which such excess moneys are invested may not yield a rate of return in excess of the rate of interest payable on such borrowings.

Section 1397 IMPOSITION AND COLLECTION OF PERIODIC ASSESSMENTS ON SELF-INSURED CORPORATE ALLIANCE PLANS.

(a) Imposition of Assessments. Upon a determination that additional receipts to the Fund are necessary in order to enable the Fund to repay amounts borrowed by the Fund under section 1396(c)(3) while maintaining a balance sufficient to ensure the solvency of the Fund, the Secretary of Labor may impose assessments under this section. The Secretary shall prescribe

from time to time such schedules of assessment rates and bases for the application of such rates as may be necessary to provide for such repayments.

(b) Uniformity of Assessments. The assessment rates so prescribed by the Secretary for any period shall be uniform for all plans, except that the Secretary may vary the amount of such assessments by category, or waive the application of such assessments by category, taking into account differences in the financial solvency of, and financial reserves maintained by, plans in each category.

(c) Limitation on Amount of Assessment. The total amount assessed against a corporate alliance health plan under this section during a year may not exceed 2 percent of the total premiums paid to the plan with respect to corporate alliance eligible individuals enrolled with the plan during the year.

(d) Payment of Assessments.

(1) Obligation to pay. The designated payor of each plan shall pay the assessments imposed by the Secretary of Labor under this section with respect to that plan when they are due. Assessments under this section are payable at the time, and on an estimated, advance, or other basis, as determined by the Secretary. Assessments shall continue to accrue until the plan's assets are distributed pursuant to a termination procedure or the Secretary is appointed to serve as trustee of the plan under section 1395.

(2) Late payment charges and interest.

(A) Late payment charges. If any assessment is not paid when it is due, the Secretary of Labor may assess a late payment charge of not more than 100 percent of the assessment payment which was not timely paid.

(B) Waivers. Subparagraph (A) shall not apply to any assessment payment made within 60 days after the date on which payment is due, if before such date, the designated payor obtains a waiver from the Secretary of Labor based upon a showing of substantial hardship arising from the timely payment of the assessment. The Secretary may grant a waiver under this subparagraph upon application made by the designated payor, but the Secretary may not grant a waiver if it appears that the designated payor will be unable to pay the assessment within 60 days after the date on which it is due.

(C) Interest. If any assessment is not paid by the last date prescribed for a payment, interest on the amount of such assessment at the rate imposed under section 6601(a) of the Internal Revenue Code of 1986 shall

be paid for the period from such last date to the date paid.

(e) Civil Action upon Nonpayment. If any designated payor fails to pay an assessment when due, the Secretary of Labor may bring a civil action in any district court of the United States within the jurisdiction of which the plan assets are located, the plan is administered, or in which a defendant resides or is found, for the recovery of the amount of the unpaid assessment, any late payment charge, and interest, and process may be served in any other district. The district courts of the United States shall have jurisdiction over actions brought under this subsection by the Secretary without regard to the amount in controversy.

(f) Guarantee Held Harmless. The Secretary of Labor shall not cease to guarantee benefits on account of the failure of a designated payor to pay any assessment when due.

(g) Designated Payor Defined.

(1) In general. For purposes of this section, the term "designated payor" means--

(A) the employer or plan administrator in any case in which the eligible sponsor of the corporate alliance health plan is described in subparagraph (A) of section 1311(b)(1); and

(B) the contributing employers or the plan administrator in any case in which the eligible sponsor of the corporate alliance is described in subparagraph (B) or (C) of section 1311(b)(1).

(2) Controlled groups. If an employer is a member of a controlled group, each member of such group shall be jointly and severally liable for any assessments required to be paid by such employer. For purposes of the preceding sentence, the term "controlled group" means any group treated as a single employer
under subsection (b), (c), (m), or (o) of section 414 of the
Internal Revenue Code of 1986.

Section 1398 PAYMENTS TO FEDERAL GOVERNMENT BY MULTIEMPLOYER CORPORATE ALLIANCES FOR ACADEMIC HEALTH CENTERS AND GRADUATE MEDICAL EDUCATION.

(a) In General. A corporate alliance with an eligible sponsor described in section 1311(b)(1)(B) shall make payment to the Secretary of an amount equivalent to the amount (as estimated based on rules established by the Secretary and based on the annual per capita expenditure equivalent

calculated under section 6021) that would have been payable by the alliance under section 1353 if the alliance were a regional alliance.

(b) Reference to Exemption from Assessment. For provision exempting certain corporate alliance employers participating in an alliance described in subsection (a) from an assessment under section 3461 of the Internal Revenue Code of 1986, as added by section 7121 of this Act, see section 3461(c)(1) of such Code.
Title I, Subtitle E

Subtitle E Health Plans

Section 1400 HEALTH PLAN DEFINED.

(a) In General. In this Act, the term "health plan" means a plan that provides the comprehensive benefit package and meets the requirements of parts 1, 3, and 4 applicable to health plans.

(b) Appropriate Self-Insured Health Plan. In this Act, the term "appropriate self-insured health plan" means a group health plan (as defined in section 3(42) of the Employee Retirement Income Security Act of 1974) which is a self-insured health plan and with respect to which the applicable requirements of title I of the Employee Retirement Income Security Act of 1974 are met.

(c) State-Certified Health Plan. In this Act, the term "State-certified health plan" means a health plan that has been certified by a State under section 1203(a) (or, in the case in which the Board is exercising certification authority under section 1522(b), that has been certified by the Board).

(d) Applicable Regulatory Authority Defined. In this subtitle, the term "applicable regulatory authority" means

(1) with respect to a self-insured health plan, the Secretary of Labor, or

(2) with respect to a State-certified health plan, the State authority responsible for certification of the plan.

Part 1 REQUIREMENTS RELATING TO COMPREHENSIVE BENEFIT PACKAGE

Section 1401 APPLICATION OF REQUIREMENTS.

No plan shall be treated under this Act as a health plan

(1) unless the plan is a self-insured plan or a State-certified plan; or

(2) on and after the effective date of a finding by the applicable regulatory authority that the plan has failed to comply with such applicable requirements.

Section 1402 REQUIREMENTS RELATING TO ENROLLMENT AND COVERAGE.

(a) No Underwriting.

(1) In general. Subject to paragraph (2), each health plan offered by a regional alliance or a corporate alliance must accept for enrollment every alliance eligible individual who seeks such enrollment. No plan may engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics, such as health status, anticipated need for health care, age, occupation, or affiliation with any person or entity.

(2) Capacity limitations. With the approval of the applicable regulatory authority, a health plan may limit enrollment because of the plan's capacity to deliver services or to maintain financial stability. If such a limitation is imposed, the limitation may not be imposed on a basis referred to in paragraph (1).

(b) No Limits on Coverage; No Pre-Existing Condition Limits. A health plan may not

(1) terminate, restrict, or limit coverage for the comprehensive benefit package in any portion of the plan's service area for any reason, including nonpayment of premiums;

(2) cancel coverage for any alliance eligible individual until that individual is enrolled in another applicable health plan;

(3) exclude coverage of an alliance eligible individual because of existing medical conditions;

(4) impose waiting periods before coverage begins; or

(5) impose a rider that serves to exclude coverage of particular individuals.

(c) Antidiscrimination.

(1) In general. No health plan may discriminate, or engage (directly or through contractual arrangements) in any activity, including the selection of

a service area, that has the effect of discriminating, against an individual on the basis of race, national origin, sex, language, socio-economic status, age, disability, health status, or anticipated need for health services.

(2) Selection of providers for plan network. In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health plan may not engage in any practice that has the effect of discriminating against a provider

(A) based on the race, national origin, sex, language, age, or disability of the provider; or

(B) based on the socio-economic status, disability, health status, or anticipated need for health services of a patient of the provider.

(3) Business necessity. Except in the case of intentional discrimination, it shall not be a violation of this subsection, or of any regulation issued under this subsection, for any person to take any action otherwise prohibited under this subsection, if the action is required by business necessity.

(4) Regulations. Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue regulations to carry out this subsection.

(d) Requirements for Plans Offering Lower Cost Sharing. Each health plan that offers enrollees the lower cost sharing schedule referred to in section 1131

(1) shall apply such schedule to all items and services in the comprehensive benefit package;

(2) shall offer enrollees the opportunity to obtain coverage for out-of-network items and services (as described in subsection (f)(2)); and

(3) notwithstanding section 1403, in the case of an enrollee who obtains coverage for such items and services, may charge an alternative premium to take into account such coverage.

(e) Treatment of Cost Sharing. Each health plan, in providing benefits in the comprehensive benefit package

(1) shall include in its payments to providers, such additional reimbursement as may be necessary to reflect cost sharing reductions to which individuals are entitled under section 1371, and

(2) shall maintain such claims or encounter records as may be necessary to audit the amount of such additional reimbursements and the individuals for which such reimbursement is provided.

(f) In-Network and Out-of-Network Items and Services Defined.

(1) In-network items and services. For purposes of this Act, the term "in-network", when used with respect to items or services described in this subtitle, means items or services provided to an individual enrolled under a health plan by a health care provider who is a member of a provider network of the plan (as defined in paragraph (3)).

(2) Out-of-network items and services. For purposes of this Act, the term "out-of network", when used with respect to items or services described in this subtitle, means items or services provided to an individual enrolled under a health plan by a health care provider who is not a member of a provider network of the plan (as defined in paragraph (3)).

(3) Provider network defined. A "provider network" means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services in the comprehensive benefit package to individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

(g) Relation to Detention. A health plan is not required to provide any reimbursement to any detention facility for services performed in that facility for detainees in the facility.

Section 1403 COMMUNITY RATING.

(a) Regional Alliance Health Plans. Each regional alliance health plan may not vary the premium imposed with respect to residents of an alliance area, except as may be required under section 6102(a) with respect to different types of individual and family coverage under the plan.

(b) Corporate Alliance Health Plans. Each corporate alliance health plan may not vary the premium imposed with respect to individuals enrolled in the plan, except as may be required under section 1384 with respect to different types of individual and family coverage under the plan.

Section 1404 MARKETING OF HEALTH PLANS; INFORMATION.

(a) Regional Alliance Marketing Restrictions.

(1) In general. The contract entered into between a regional alliance

and a regional alliance health plan shall prohibit the distribution by the health plan of marketing materials within the regional alliance that contain false or materially misleading information and shall provide for prior approval by the regional alliance of any marketing materials to be distributed by the plan.

(2) Entire market. A health plan offered by a regional alliance may not distribute marketing materials to an area smaller than the entire area served by the plan.

(3) Prohibition of tie-ins. A regional alliance health plan, and any agency of such a plan, may not seek to influence an individual's choice of plans in conjunction with the sale of any other insurance.

(b) Information Available.

(1) In general. Each regional alliance health plan must provide to the regional alliance and make available to alliance eligible individuals and health care professionals complete and timely information concerning the following:

(A) Costs.

(B) The identity, locations, qualifications, and availability of participating providers.

(C) Procedures used to control utilization of services and expenditures.

(D) Procedures for assuring and improving the quality of care.

(E) Rights and responsibilities of enrollees.

(F) Information on the number of plan members who disenroll from the plan.

(2) Prohibition against certification of plans providing inaccurate information. No regional alliance health plan may be a State-certified health plan under this title if the State determines that the plan submitted materially inaccurate information under paragraph (1).

(c) Advance Directives. Each self-insured health plan and each State-certified health plan shall meet the requirement of section 1866(f) of the Social Security Act (relating to maintaining written policies and procedures respecting advance directives) in the same manner as such requirement

relates to organizations with contracts under section 1876 of such Act.

Section 1405 GRIEVANCE PROCEDURE.

(a) In General. Each health plan must establish a grievance procedure for enrollees to use in pursuing complaints. Such procedure shall be consistent with subtitle C of title V.

(b) Additional Remedies. If the grievance procedure fails to resolve an enrollee's complaint

(1) in the case of an enrollee of a regional alliance health plan, the enrollee has the option of seeking assistance from the office of the ombudsman for the regional alliance established under section 1326(a), and

(2) the enrollee may pursue additional legal remedies, including those provided under subtitle C of title V.

Section 1406 HEALTH PLAN ARRANGEMENTS WITH PROVIDERS.

(a) Requirement. Each health plan must enter into such agreements with health care providers or have such other arrangements as may be necessary to assure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled with the plan.

(b) Emergency and Urgent Care Services.

(1) In general. Each health plan must cover emergency and urgent care services provided to enrollees, without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the plan to provide items or services to enrollees of the plan and in the case of emergency services without regard to prior authorization.

(2) Payment amounts. In the case of emergency and urgent care provided to an enrollee outside of a health plan's service area, the payment amounts of the plan shall be based on the fee for service rate schedule established by the regional alliance for the alliance area where the services were provided.

(c) Application of Fee Schedule.

(1) In general. Subject to paragraph (2), each regional alliance health plan or corporate alliance health plan that provides for payment for services on a fee-for-service basis shall make such payment in the amounts provided under the fee schedule established by the regional alliance under section

1322(c) (or, in the case of a plan offered in a State that has established a Statewide fee schedule under section 1322(c)(3), under such Statewide fee schedule).

(2) Reduction for providers voluntarily reducing charges. If a provider under a health plan voluntarily agrees to reduce the amount charged to an individual enrolled under the plan, the plan shall reduce the amount otherwise determined under the fee schedule applicable under paragraph (1) by the proportion of the reduction in such amount charged.

(3) Reduction for noncomplying plan. Each regional alliance health plan that is a noncomplying plan shall provide for reductions in payments under the fee schedule to providers that are not participating providers in accordance with section 6012(b).

(d) Prohibition Against Balance Billing; Requirement of Direct Billing.

(1) Prohibition of balance billing. A provider may not charge or collect from an enrollee a fee in excess of the applicable payment amount under the applicable fee schedule under subsection (c), and the health plan and its enrollees are not legally responsible for payment of any amount in excess of such applicable payment amount for items and services covered under the comprehensive benefits package.

(2) Direct billing. A provider may not charge or collect from an enrollee amounts that are payable by the health plan (including any cost sharing reduction assistance payable by the plan) and shall submit charges to such plan in accordance with any applicable requirements of part 1 of subtitle B of title V (relating to health information systems).

(3) Coverage under agreements with plans. The agreements or other arrangements entered into under subsection (a) between a health plan and the health care providers providing the comprehensive benefit package to individuals enrolled with the plan shall prohibit a provider from engaging in balance billing described in paragraph (1).

(e) Imposition of Participating Provider Assessment in Case of a Noncomplying Plan. Each regional alliance health plan shall provide that if the plan is a noncomplying plan for a year under section 6012, payments to participating providers shall be reduced by the applicable network reduction percentage under such section.

Section 1407 PREEMPTION OF CERTAIN STATE LAWS RELATING TO HEALTH PLANS.

(a) Laws Restricting Plans Other Than Fee-for-Service Plans. Except as may otherwise be provided in this section, no State law shall apply to any services provided under a health plan that is not a fee-for-service plan (or a fee-for-service component of a plan) if such law has the effect of prohibiting or otherwise restricting plans from

(1) except as provided in section 1203, limiting the number and type of health care providers who participate in the plan;

(2) requiring enrollees to obtain health services (other than emergency services) from participating providers or from providers authorized by the plan;

(3) requiring enrollees to obtain a referral for treatment by a specialized physician or health institution;

(4) establishing different payment rates for participating providers and providers outside the plan;

(5) creating incentives to encourage the use of participating providers; or

(6) requiring the use of single-source suppliers for pharmacy, medical equipment, and other health products and services.

(b) Preemption of State Corporate Practice Acts. Any State law related to the corporate practice of medicine and to provider ownership of health plans or other providers shall not apply to arrangements between health plans that are not fee-for-service plans and their participating providers.

(c) Participating Provider Defined. In this title, a "participating provider" means, with respect to a health plan, a provider of health care services who is a member of a provider network of the plan (as described in section 1402(f)(3)).

Section 1408 FINANCIAL SOLVENCY.

Each regional alliance health plan must

(1) meet or exceed minimum capital requirements established by States under section 1204(a);

(2) in the case of a plan operating in a State, must participate in the guaranty fund established by the State under section 1204(c); and

(3) meet such other requirements relating to fiscal soundness as the State may establish (subject to the establishment of any alternative standards by the Board).

Section 1409 REQUIREMENT FOR OFFERING COST SHARING POLICY.

Each regional alliance health plan shall offer a cost sharing policy (as defined in section 1421(b)(2)) to each eligible family enrolled under the plan.

Section 1410 QUALITY ASSURANCE.

Each health plan shall comply with such quality assurance requirements as are imposed under subtitle A of title V with respect to such a plan.

Section 1411 PROVIDER VERIFICATION.

Each health plan shall

(1) verify the credentials of practitioners and facilities;

(2) ensure that all providers participating in the plan meet applicable State licensing and certification standards;

(3) oversee the quality and performance of participating providers, consistent with section 1410; and

(4) investigate and resolve consumer complaints against participating providers.

Section 1412 CONSUMER DISCLOSURES OF UTILIZATION MANAGEMENT PROTOCOLS.

Each health plan shall disclose to enrollees (and prospective enrollees) the protocols used by the plan for controlling utilization and costs.

Section 1413 CONFIDENTIALITY, DATA MANAGEMENT, AND REPORTING.

(a) In General. Each health plan shall comply with the confidentiality, data management, and reporting requirements imposed under subtitle B of title V.

(b) Treatment of Electronic Information.

(1) Accuracy and reliability. Each health plan shall take such measures as may be necessary to ensure that health care information in electronic

form that the plan, or a member of a provider network of the plan, collects for or transmits to the Board under subtitle B of title V is accurate and reliable.

(2) Privacy and security. Each health plan shall take such measures as may be necessary to ensure that health care information described in paragraph (1) is not distributed to any individual or entity in violation of a standard promulgated by the Board under part 2 of subtitle B of title V.

Section 1414 PARTICIPATION IN REINSURANCE SYSTEM.

Each regional alliance health plan of a State that has established a reinsurance system under section 1203(g) shall participate in the system in the manner specified by the State.

Part 2 REQUIREMENTS RELATING TO SUPPLEMENTAL INSURANCE

Section 1421 IMPOSITION OF REQUIREMENTS ON SUPPLEMENTAL INSURANCE.

(a) In General. An entity may offer a supplemental insurance policy but only if

(1) in the case of a supplemental health benefit policy (as defined in subsection (b)(1)), the entity and the policy meet the requirements of section 1422; and

(2) in the case of a cost sharing policy (as defined in subsection (b)(2)), the entity and the policy meet the requirements of section 1423.

(b) Policies Defined.

(1) Supplemental health benefit policy.

(A) In general. In this part, the term "supplemental health benefit policy" means a health insurance policy or health benefit plan offered to an alliance eligible individual which provides

(i) coverage for services and items not included in the comprehensive benefit package, or

(ii) coverage for items and services included in such package but not covered because of a limitation in amount, duration, or scope provided under this title, or both.

(B) Exclusions. Such term does not include the following:

(i) A cost sharing policy (as defined in paragraph (2)).

(ii) A long-term care insurance policy (as defined in section 2304(10)).

(iii) Insurance that limits benefits with respect to specific diseases (or conditions).

(iv) Hospital or nursing home indemnity insurance.

(v) A medicare supplemental policy (as defined in section 1882(g) of the Social Security Act).

(vi) Insurance with respect to accidents.

(2) Cost sharing policy. In this part, the term "cost means a health insurance policy or health benefit plan offered to an alliance eligible individual which provides coverage for deductibles, coinsurance, and copayments imposed as part of the comprehensive benefit package under subtitle B, whether imposed under a higher cost sharing plan or with respect to out-of-network providers.

Section 1422 STANDARDS FOR SUPPLEMENTAL HEALTH BENEFIT POLICIES.

(a) Prohibiting Duplication of Coverage.

(1) In general. No health plan, insurer, or any other person may offer

(A) to any eligible individual a supplemental health benefit policy that duplicates any coverage provided in the comprehensive benefit package; or

(B) to any medicare-eligible individual a supplemental health benefit policy that duplicates any coverage provided under the medicare program.

(2) Exception for medicare-eligible individuals. For purposes of this subsection, for the period in which an individual is a medicare-eligible individual and also is an alliance eligible individual (and is enrolled under a regional alliance or corporate alliance health plan), paragraph (1)(A) (and not paragraph (1)(B)) shall apply.

(b) No Limitation on Individuals Offered Policy.

(1) In general. Except as provided in paragraph (2), each entity offering

a supplemental health benefit policy must accept for enrollment every individual who seeks such enrollment, subject to capacity and financial limits.

(2) Exception for certain offerors. Paragraph (1) shall not apply to any supplemental health benefit policy offered to an individual only on the basis of

(A) the individual's employment (in the case of a policy offered by the individual's employer); or

(B) the individual's membership or enrollment in a fraternal, religious, professional, educational, or other similar organization.

(c) Restrictions on Marketing Abuses. Not later than January 1, 1996, the Board shall develop (in consultation with the States) minimum standards that prohibit marketing practices by entities offering supplemental health benefit policies that involve:

(1) Providing monetary incentives for or tying or otherwise conditioning the sale of the policy to enrollment in a regional alliance health plan of the entity.

(2) Using or disclosing to any party information about the health status or claims experience of participants in a regional alliance health plan for the purpose of marketing such a policy.

(d) Civil Monetary Penalty. An entity that knowingly and willfully violates any provision of this section with respect to the offering of a supplemental health benefit policy to any individual shall be subject to a civil monetary penalty (not to exceed $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.

Section 1423 STANDARDS FOR COST SHARING POLICIES.

(a) Rules for Offering of Policies. Subject to subsection (f), a cost sharing policy may be offered to an individual only if

(1) the policy is offered by the regional alliance health plan in which the individual is enrolled;

(2) the regional alliance health plan offers the policy to all individuals enrolled in the plan;

(3) the plan offers each such individual a choice of a policy that provides standard coverage and a policy that provides maximum coverage (in accordance with standards established by the Board); and

(4) the policy is offered only during the annual open enrollment period for regional alliance health plans (described in section 1323(d)(1)).

(b) Prohibition of Coverage of Copayments. Each cost sharing policy may not provide any benefits relating to any copayments established under the table of copayments and coinsurance under section 1135.

(c) Equivalent Coverage for All Services. Each cost sharing policy must provide coverage for items and services in the comprehensive benefit package to the same extent as the policy provides coverage for all items and services in the package.

(d) Requirements for Pricing.

(1) In general. The price of any cost sharing policy shall

(A) be the same for each individual to whom the policy is offered;

(B) take into account any expected increase in utilization resulting from the purchase of the policy by individuals enrolled in the regional alliance health plan; and

(C) not result in a loss-ratio of less than 90 percent.

(2) Loss-ratio defined. In paragraph (1)(C), a "loss-ratio" is the ratio of the premium returned to the consumer in payout relative to the total premium collected.

(e) Loss of State Certification for Regional Alliance Health Plans Failing to Meet Standards. A State may not certify a regional alliance health plan that offers a cost sharing policy unless the plan and the policy meet the standards described in this section.

(f) Special Rules for FEHBP Supplemental Plans. Subsection (a) shall not apply to an FEHBP supplemental plan described in section 8203(f)(1), but only if the plan meets the following requirements:

(1) The plan must be offered to all individuals to whom such a plan is

required to be offered under section 8203.

(2) The plan must offer each such individual a choice of a policy that provides standard coverage and a policy that provides maximum coverage (in accordance with standards established by the Board under subsection (a)(3)).

(3) The plan is offered only during the annual open enrollment period for regional alliance health plans (described in section 1323(d)(1)).

(4) (A) The price of the plan shall include an amount, established in accordance with rules established by the Board in consultation with the Office of Personnel Management, that takes into account any expected increase in utilization of the items and services in the comprehensive benefit package resulting from the purchase of the plan by individuals enrolled in a regional alliance health plan.

(B) The plan provides for payment, in a manner specified by the Board in the case of an individual enrolled in the plan and in a regional alliance health plan, to the regional alliance health plan of an amount equivalent to the additional amount described in subparagraph (A).

Part 3 REQUIREMENTS RELATING TO ESSENTIAL COMMUNITY PROVIDERS

Section 1431 HEALTH PLAN REQUIREMENT.

(a) In General. Subject to section 1432, each health plan shall, with respect to each electing essential community provider (as defined in subsection (d), other than a provider of school health services) located within the plan's service area, either

(1) enter into a written provider participation agreement (described in subsection (b)) with the provider, or

(2) enter into a written agreement under which the plan shall make payment to the provider in accordance with subsection (c).

(b) Participation Agreement. A participation agreement between a health plan and an electing essential community provider under this subsection shall provide that the health plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers participating in the health plan with respect to each of the following:

(1) The scope of services for which payment is made by the plan to the

provider.

(2) The rate of payment for covered care and services.

(3) The availability of financial incentives to participating providers.

(4) Limitations on financial risk provided to other participating providers.

(5) Assignment of enrollees to participating providers.

(6) Access by the provider's patients to providers in medical specialties or subspecialties participating in the plan.

(c) Payments for Providers Without Participation Agreements.

(1) In general. Payment in accordance with this subsection is payment based, as elected by the electing essential community provider, either

(A) on the fee schedule developed by the applicable regional alliance (or the State) under section 1322(c), or

(B) on payment methodologies and rates used under the applicable Medicare payment methodology and rates (or the most closely applicable methodology under such program as the Secretary of Health and Human Services specifies in regulations).

(2) No application of gate-keeper limitations. Payment in accordance with this subsection may be subject to utilization review, but may not be subject to otherwise applicable gate-keeper requirements under the plan.

(d) Election.

(1) In general. In this part, the term "electing essential community provider" means, with respect to a health plan, an essential community provider that elects this subpart to apply to the health plan.

(2) Form of election. An election under this subsection shall be made in a form and manner specified by the Secretary, and shall include notice to the health plan involved. Such an election may be made annually with respect to a health plan, except that the plan and provider may agree to make such an election on a more frequent basis.

(e) Special Rule for Providers of School Health Services. A health plan shall pay, to each provider of school health services located in the plan's service

area an amount determined by the Secretary for such services furnished to enrollees of the plan.

Section 1432 SUNSET OF REQUIREMENT.

(a) In General. Subject to subsection (d), the requirement of section 1431 shall only apply to health plans offered by a health alliance during the 5-year period beginning with the first year in which any health plan is offered by the alliance.

(b) Studies. In order to prepare recommendations under subsection (c), the Secretary shall conduct studies regarding essential community providers, including studies that assess

(1) the definition of essential community provider,

(2) the sufficiency of the funding levels for providers, for both covered and uncovered benefits under this Act,

(3) the effects of contracting requirements relating to such providers on such providers, health plans, and enrollees,

(4) the impact of the payment rules for such providers, and

(5) the impact of national health reform on such providers.

(c) Recommendations to Congress. The Secretary shall submit to Congress, by not later than March 1, 2001, specific recommendations respecting whether, and to what extent, section 1431 should continue to apply to some or all essential community providers. Such recommendations may include a description of the particular types of such providers and circumstances under which such section should continue to apply.

(d) Congressional Consideration.

(1) In general. Recommendations submitted under subsection (c) shall apply under this part (and may supersede the provisions of subsection (a)) unless a joint resolution (described in paragraph (2)) disapproving such recommendations is enacted, in accordance with the provisions of paragraph (3), before the end of the 60-day period beginning on the date on which such recommendations were submitted. For purposes of applying the preceding sentence and paragraphs (2) and (3), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

(2) Joint resolution of disapproval. A joint resolution described in this paragraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the Secretary submits recommendations under subsection (c) and

(A) which does not have a preamble;

(B) the matter after the resolving clause of which is as follows: "That Congress disapproves the recommendations of the Secretary of Health and Human Services concerning the continued application of certain essential community provider requirements under section 1431 of the Health Security Act, as submitted by the Secretary on XXXXXXX.", the blank space being filled in with the appropriate date; and

(C) the title of which is as follows: "Joint resolution disapproving recommendations of the Secretary of Health and Human Services concerning the continued application of certain essential community provider requirements under section 1431 of the Health Security Act, as submitted by the Secretary on XXXXXXX.", the blank space being filled in with the appropriate date.

(3) Procedures for consideration of resolution of disapproval. Subject to paragraph (4), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in paragraph (2) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(4) Special rules. For purposes of applying paragraph (3) with respect to such provisions

(A) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of recommendations under subsection (c)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to an appropriate Committee of the Senate (specified by the Majority Leader of the Senate at the time of submission of recommendations under subsection (c)); and

(B) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the Secretary submits recommendations under subsection (c).

Part 4 REQUIREMENTS RELATING TO WORKERS' COMPENSATION AND

AUTOMOBILE MEDICAL LIABILITY COVERAGE

Section 1441 REFERENCE TO REQUIREMENTS RELATING TO WORKERS COMPENSATION SERVICES.

Each health plan shall meet the applicable requirements of part 2 of subtitle A of title X (relating to provision of workers compensation services to enrollees).

Section 1442 REFERENCE TO REQUIREMENTS RELATING TO AUTOMOBILE MEDICAL LIABILITY SERVICES.

Each health plan shall meet the applicable requirements of part 2 of subtitle B of title X (relating to provision of automobile medical liability services to enrollees).
Title I, Subtitle F

Subtitle F Federal Responsibilities

Part 1 NATIONAL HEALTH BOARD

Subpart A Establishment of National Health Board

Section 1501 CREATION OF NATIONAL HEALTH BOARD; MEMBERSHIP.

(a) In General. There is hereby created in the Executive Branch a National Health Board.

(b) Composition. The Board is composed of 7 members appointed by the President, by and with the advice and consent of the Senate.

(c) Chair. The President shall designate one of the members as chair. The chair serves a term concurrent with that of the President. The chair may serve a maximum of 3 terms. The chair shall serve as the chief executive officer of the Board.

(d) Terms.

(1) In general. Except as provided in paragraphs (2) and (4), the term of each member of the Board, except the chair, is 4 years and begins when the term of the predecessor of that member ends.

(2) Initial terms. The initial terms of the members of the Board (other than the chair) first taking office after the date of the enactment of this Act,

shall expire as designated by the President, two at the end of one year, two at the end of two years, and two at the end of three years.

(3) Reappointment. A member (other than the chair) may be reappointed for one additional term.

(4) Continuation in office. Upon the expiration of a term of office, a member shall continue to serve until a successor is appointed and qualified.

(e) Vacancies.

(1) In general. Whenever a vacancy shall occur, other than by expiration of term, a successor shall be appointed by the President, by and with the consent of the Senate, to fill such vacancy, and is appointed for the remainder of the term of the predecessor.

(2) No impairment of function. A vacancy in the membership of the Board does not impair the authority of the remaining members to exercise all of the powers of the Board.

(3) Acting chair. The Board may designate a Member to act as chair during any period in which there is no chair designated by the President.

(f) Meetings; Quorum.

(1) Meetings. At meetings of the Board the chair shall preside, and in the absence of the chair, the Board shall elect a member to act as chair pro tempore.

(2) Quorum. Four members of the Board shall constitute a quorum thereof.

Section 1502 QUALIFICATIONS OF BOARD MEMBERS.

(a) Citizenship. Each member of the Board shall be a citizen of the United States.

(b) Basis of Selection. Board members will be selected on the basis of their experience and expertise in relevant subjects, including the practice of medicine, nursing, or other clinical practices, health care financing and delivery, state health systems, consumer protection, business, law, and delivery of care to vulnerable populations.

(c) Exclusive Employment. During the term of appointment, Board members shall serve as employees of the Federal Government and shall hold

no other employment.

(d) Prohibition of Conflict of Interest. A member of the Board may not have a pecuniary interest in or hold an official relation to any health care plan, health care provider, insurance company, pharmaceutical company, medical equipment company, or other affected industry. Before entering upon the duties as a member of the Board, the member shall certify under oath compliance with this requirement.

(e) Post-Employment Restrictions. After leaving the Board, former members are subject to post-employment restrictions applicable to comparable Federal employees.

(f) Compensation of Board Members. Each member of the Board (other than the chair) shall receive an annual salary at the annual rate payable from time to time for level IV of the Executive Schedule. The chair of the Board, during the period of service as chair, shall receive an annual salary at the annual rate payable from time to time for level III of the Executive Schedule.

Section 1503 GENERAL DUTIES AND RESPONSIBILITIES.

(a) Comprehensive Benefit Package.

(1) Interpretation. The Board shall interpret the comprehensive benefit package, adjust the delivery of preventive services under section 1153, and take such steps as may be necessary to assure that the comprehensive benefit package is available on a uniform national basis to all eligible individuals.

(2) Recommendations. The Board may recommend to the President and the Congress appropriate revisions to such package. Such recommendations may reflect changes in technology, health care needs, health care costs, and methods of service delivery.

(b) Administration of Cost Containment Provisions.The Board shall oversee the cost containment requirements of subtitle A of title VI and certify compliance with such requirements.

(c) Coverage and Families. The Board shall develop and implement standards relating to the eligibility of individuals for coverage in applicable health plans under subtitle A of title I and may provide such additional exceptions and special rules relating to the treatment of family members under section 1012 as the Board finds appropriate.

(d) Quality Management and Improvement. The Board shall establish and

have ultimate responsibility for a performance-based system of quality management and improvement as required by section 5001.

(e) Information Standards. The Board shall develop and implement standards to establish national health information system to measure quality as required by section 5101.

(f) Participating State Requirements. Consistent with the provisions of subtitle C, the Board shall

(1) establish requirements for participating States,

(2) monitor State compliance with those requirements,

(3) provide technical assistance, and in a manner that ensures access to the comprehensive benefit package for all eligible individuals.

(g) Development of Premium Class Factors.The Board shall establish premium class factors under subpart D of this part.

(h) Development of Risk-Adjustment Methodology. The Board shall develop a methodology for the risk-adjustment of premium payments to regional alliance health plans in accordance with subpart E of this part.

(i) Financial Requirements. The Board shall establish minimum capital requirements and requirements for guaranty funds under subpart F of this part.

(j) Standards for Health Plan Grievance Procedures. The Board shall establish standards for health plan grievance procedures that are used by enrollees in pursuing complaints.

Section 1504 ANNUAL REPORT.

(a) In General. The Board shall prepare and send to the President and Congress an annual report addressing the overall implementation of the new health care system.

(b) Matters to be Included. The Board shall include in each annual report under this section the following:

(1) Information on Federal and State implementation.

(2) Data related to quality improvement.

(3) Recommendations or changes in the administration, regulation and laws related to health care and coverage.

(4) A full account of all actions taken during the previous year.

Section 1505 POWERS.

(a) Staff; Contract Authority. The Board shall have authority, subject to the provisions of the civil-service laws and chapter 51 and subchapter III of chapter 53 of title 5, United States Code, to appoint such officers and employees as are necessary to carry out its functions. To the extent provided in advance in appropriations Acts, the Board may contract with any person (including an agency of the Federal Government) for studies and analysis as required to execute its functions. Any employee of the Executive Branch may be detailed to the Board to assist the Board in carrying out its duties.

(b) Establishment of Advisory Committees. The Board may establish advisory committees.

(c) Access to Information. The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out its functions, to the extent such information is otherwise available to a department or agency of the United States. Upon request of the chair, the head of that department or agency shall furnish that information to the Board.

(d) Delegation of Authority. Except as otherwise provided in this Act, the Board may delegate any function to such officers and employees as the Board may designate and may authorize such successive redelegations of such functions with the Board as the Board deems to be necessary or appropriate. No delegation of functions by the Board shall relieve the Board of responsibility for the administration of such functions.

(e) Rulemaking. The National Health Board is authorized to establish such rules as may be necessary to carry out this Act.

Section 1506 FUNDING.

(a) Authorization of Appropriations. There are authorized to be appropriated to the Board such sums as may be necessary for fiscal years 1994, 1995, 1996, 1997, and 1998.

(b) Submission of Budget. Under the procedures of chapter 11 of title 31, United States Code, the budget for the Board for a fiscal year shall be reviewed by the Director of the Office of Management and Budget and

submitted to the Congress as part of the President's submission of the Budget of the United States for the fiscal year.