/* The conclusion of Title I of the HSA follows. */

Subpart B Responsibilities Relating to Review and Approval of State Systems

Section 1511 FEDERAL REVIEW AND ACTION ON STATE SYSTEMS.

(a) Approval of State Systems by National Board.

(1) In general. The National Health Board shall approve a State health care system for which a document is submitted under section 1200(b) unless the Board finds that the system (as set forth in the document) does not (or will not) provide for the State meeting the responsibilities for participating States under this Act.

(2) Regulations. The Board shall issue regulations, not later than July 1, 1995, prescribing the requirements for State health care systems under parts 2 and 3 of subtitle C, except that in the case of a document submitted under section 1200(b) before the date of issuance of such regulations, the Board shall take action on such document notwithstanding the fact that such regulations have not been issued.

(3) No approval permitted for years prior to 1996. The Board may not approve a State health care system under this subpart for any year prior to 1996.

(b) Review of Completeness of Documents.

(1) In general. If a State submits a document under subsection (a)(1), the Board shall notify the State, not later than 7 working days after the date of submission, whether or not the document is complete and provides the Board with sufficient information to approve or disapprove the document.

(2) Additional information on incomplete document. If the Board notifies a State that the State's document is not complete, the State shall be provided such additional period (not to exceed 45 days) as the Board may by regulation establish in which to submit such additional information as the Board may require. Not later than 7 working days after the State submits the additional information, the Board shall notify the State respecting the completeness of the document.

(c) Action on Completed Documents.

(1) In general. The Board shall make a determination (and notify the State) on whether the State's document provides for implementation of a

State system that meets the applicable requirements of subtitle C

(A) in the case of a State that did not require the additional period described in subsection (b)(2) to file a complete document, not later than 90 days after notifying a State under subsection (b) that the State's document is complete, or

(B) in the case of a State that required the additional period described in subsection (b)(2) to file a complete document, not later than 90 days after notifying a State under subsection (b) that the State's document is complete.

(2) Plans deemed approved. If the Board does not meet the applicable deadline for making a determination and providing notice under paragraph (1) with respect to a State's document, the Board shall be deemed to have approved the State's document for purposes of this Act.

(d) Opportunity to Respond to Rejected Document.

(1) In general. If (within the applicable deadline under subsection (c)(1)) the Board notifies a State that its document does not provide for implementation of a State system that meets the applicable requirements of subtitle C, the Board shall provide the State with a period of 30 days in which to submit such additional information and assurances as the Board may require.

(2) Deadline for response. Not later than 30 days after receiving such additional information and assurances, the Board shall make a determination (and notify the State) on whether the State's document provides for implementation of a State system that meets the applicable requirements of subtitle C.

(3) Plan deemed approved. If the Board does not meet the deadline established under paragraph (2) with respect to a State, the Board shall be deemed to have approved the State's document for purposes of this Act.

(e) Approval of Previously Terminated States. If the Board has approved a State system under this part for a year but subsequently terminated the approval of the system under section 1512(b)(2), the Board shall approve the system for a succeeding year if the State

(1) demonstrates to the satisfaction of the Board that the failure that formed the basis for the termination no longer exists, and

(2) provides reasonable assurances that the types of actions (or

inactions) which formed the basis for such termination will not recur.

(f) Revisions to State System.

(1) Submission. A State may revise a system approved for a year under this section, except that such revision shall not take effect unless the State has submitted to the Board a document describing such revision and the Board has approved such revision.

(2) Actions on amendments. Not later than 60 days after determination submitted under paragraph (1), the Board shall make a decision (and notify the State) on whether the implementation of the State system, as proposed to be revised, meets the applicable requirements of subtitle C. If the Board fails to meet the requirement of the preceding sentence, the Board shall be deemed to have approved the implementation of the State system as proposed to be revised.

(3) Rejection of amendments.Subsection (d) shall apply to an amendment submitted under this subsection in the same manner as it applies to a completed document submitted under subsection (b).

(g) Notification of Non-Participating States.If a State fails to submit a document for a State system by the deadline referred to in section 1200, or such a document is not approved under subsection (c), the Board shall immediately notify the Secretary of Health and Human Services of the State's failure for purposes of applying subpart C in that State.

Section 1512 FAILURE OF PARTICIPATING STATES TO MEET CONDITIONS FOR COMPLIANCE.

(a) In General. In the case of a participating State, if the Board determines that the operation of the State system under subtitle C fails to meet the applicable requirements of this Act, sanctions shall apply against the State in accordance with subsection (b).

(b) Type of Sanction Applicable. The sanctions applicable under this part are as follows:

(1) If the Board determines that the State's failure does not substantially jeopardize the ability of eligible individuals in the State to obtain coverage for the comprehensive benefit package

(A) the Board may order a regional alliance in the State to comply with applicable requirements of this Act and take such additional measures to assure compliance with such requirements as the Board may impose, if

the Board determines that the State's failure relates to a requirement applicable to a regional alliance in the State, or

(B) if the Board does not take the action described in subparagraph (A) (or if the Board takes the action and determines that the action has not remedied the violation that led to the imposition of the sanction), the Board shall notify the Secretary of Health and Human Services, who shall reduce payments with respect to the State in accordance with section 1513.

(2) If the Board determines that the failure substantially jeopardizes the ability of eligible individuals in the State to obtain coverage for the comprehensive benefit package

(A) the Board shall terminate its approval of the State system; and

(B) the Board shall notify the Secretary of Health and Human Services, who shall assume the responsibilities described in section 1522.

(c) Termination of Sanction.

(1) Compliance by State. A State against which a sanction is imposed may submit information at any time to the Board to demonstrate that the failure that led to the imposition of the sanction has been corrected.

(2) Termination of sanction. If the Board determines that the failure that led to the imposition of a sanction has been corrected

(A) in the case of the sanction described in subsection (b)(1)(A), the Board shall notify the regional alliance against which the sanction is imposed; or

(B) in the case of any other sanction described in subsection (b), the Board shall notify the Secretary of Health and Human Services.

(d) Protection of Access to Benefits.The Board and the Secretary of Health and Human Services shall exercise authority to take actions under this section with respect to a State only in a manner that assures the continuous coverage of eligible individuals under regional alliance health plans.

Section 1513 REDUCTION IN PAYMENTS FOR HEALTH PROGRAMS BY SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) In General. Upon receiving notice from the Board under section 1512(b)(1)(B), the Secretary of Health and Human Services shall reduce the amount of any of the payments described in subsection (b) that would

otherwise be made to individuals and entities in the State by such amount as the Secretary determines to be appropriate.

(b) Payments Described. The payments described in this subsection are as follows:

(1) Payments to academic health centers in the State under subtitle B of title III.

(2) Payments to individuals and entities in the State for health research activities under section 301 and title IV of the Public Health Service Act.

(3) Payments to hospitals in the State under part 4 of subtitle E of title III (relating to payments to hospitals serving vulnerable populations)

Section 1514 REVIEW OF FEDERAL DETERMINATIONS.

Any State or alliance affected by a determination by the Board under this subpart may appeal such determination in accordance with section 5231.

Section 1515 FEDERAL SUPPORT FOR STATE IMPLEMENTATION.

(a) Planning Grants.

(1) In general. Not later than 90 days after the date of the enactment of this Act, the Secretary shall make available to each State a planning grant to assist a State in the development of a health care system to become a participating State under subtitle C.

(2) Formula. The Secretary shall establish a formula for the distribution of funds made available under this subsection.

(3) Authorization of appropriations. There are authorized to be appropriated $50,000,000 in each of fiscal years 1995 and 1996 for grants under this subsection.

(b) Grants for Start-up Support.

(1) In general. The Secretary shall make available to States, upon their enacting enabling legislation to become participating States, grants to assist in the establishment of regional alliances.

(2) Formula. The Secretary shall establish a formula for the distribution of funds made available under this subsection.

(3) State matching funds required. Funds are payable to a State under this subsection only if the State provides assurances, satisfactory to the Secretary, that amounts of State funds (at least equal to the amount made available under this subsection) are expended for the purposes described in paragraph (1).

(4) Authorization of appropriations. There are authorized to be appropriated $313,000,000 for fiscal year 1996, $625,000,000 for fiscal year 1997, and $313,000,000 for fiscal year 1998 for grants under this subsection.

Subpart C Responsibilities in Absence of State Systems

Section 1521 APPLICATION OF SUBPART.

(a) Initial Application. This subpart shall apply with respect to a State as of January 1, 1998, unless

(1) the State submits a document for a State system under section 1511(a)(1) by July 1, 1997, and

(2) the Board determines under section 1511 that such system meets the requirements of part 1 of subtitle C.

(b) Termination of Approval of System of Participating State. In the case of a participating State for which the Board terminates approval of the State system under section 1512(b)(2), this subpart shall apply with respect to the State as of such date as is appropriate to assure the continuity of coverage for the comprehensive benefit package for eligible individuals in the State.

Section 1522 FEDERAL ASSUMPTION OF RESPONSIBILITIES IN NON-PARTICIPATING STATES.

(a) Notice. When the Board determines that this subpart will apply to a State for a calendar year, the Board shall notify the Secretary of Health and Human Services.

(b) Establishment of Regional Alliance System. Upon receiving notice under subsection (a), the Secretary shall take such steps, including the establishment of regional alliances, and compliance with other requirements applicable to participating States under subtitle C, as are necessary to ensure that the comprehensive benefit package is provided to eligible individuals in the State during the year.

(c) Requirements for Alliances. Subject to section 1523, any regional

alliance established by the Secretary pursuant to this section must meet all the requirements applicable under subtitle D to a regional alliance established and operated by a participating State, and the Secretary shall have the authority to fulfill all the functions of such an alliance.

(d) Establishment of Guaranty Fund.

(1) Establishment. The Secretary must ensure that there is a guaranty fund that meets the requirements established by the Board under section 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 under a regional alliance established and operated by the Secretary under this section.

(2) Assessments to provide guaranty funds. In the case of a failure of one or more regional alliance health plans under a regional alliance established and operated by the Secretary under this section, the Secretary may require each regional alliance health plan under the alliance to pay an assessment to the Secretary 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.

Section 1523 IMPOSITION OF SURCHARGE ON PREMIUMS UNDER FEDERALLY-OPERATED SYSTEM.

(a) In General. If this subpart applies to a State for a calendar year, the premiums charged under the regional alliance established and operated by the Secretary in the State shall be equal to premiums that would otherwise be charged under a regional alliance established and operated by the State, increased by 15 percent. Such 15 percent increase shall be used to reimburse the Secretary for any administrative or other expenses incurred as a result of establishing and operating the system.

(b) Treatment of Surcharge as Part of Premium. For purposes of determining the compliance of a State for which this subpart applies in a year with the requirements for budgeting under subtitle A of title VI for the year, the 15 percent increase described in subsection (a) shall be treated as part of the premium for payment to a regional alliance.

Section 1524 RETURN TO STATE OPERATION.

(a) Application Process. After the establishment and operation of an alliance system by the Secretary in a State under section 1522, the State may at any time apply to the Board for the approval of a State system in

accordance with the procedures described in section 1511.

(b) Timing. If the Board approves the system of a State for which the Secretary has operated an alliance system during a year, the Secretary shall terminate the operation of the system, and the State shall establish and operate its approved system, as of January 1 of the first year beginning after the Board approves the State system. The termination of the Secretary's system and the operation of the State's system shall be conducted in a manner that assures the continuous coverage of eligible individuals in the State under regional alliance health plans.

Subpart D Establishment of Class Factors for Charging Premiums

Section 1531 PREMIUM CLASS FACTORS.

(a) In General.For each class of family enrollment (as specified in section 1011(c)), for purposes of title VI, the Board shall establish a premium class factor that reflects, subject to subsection (b), the relative actuarial value of the comprehensive benefit package of the class of family enrollment compared to such value of such package for individual enrollment.

(b) Conditions. In establishing such factors, the factor for the class of individual enrollment shall be 1 and the factor for the couple-only class of family enrollment shall be 2.

Subpart E Risk Adjustment and Reinsurance Methodology for Payment of Plans

Section 1541 DEVELOPMENT OF A RISK ADJUSTMENT AND REINSURANCE METHODOLOGY.

(a) Development.

(1) Initial development. Not later than April 1, 1995, the Board shall develop a risk adjustment and reinsurance methodology in accordance with this subpart.

(2) Improvements. The Board shall make such improvements in such methodology as may be appropriate to achieve the purposes described in subsection (b)(1).

(b) Methodology.

(1) Purposes. Such methodology shall provide for the adjustment of payments to regional alliance health plans for the purposes of

(A) assuring that payments to such plans reflect the expected relative utilization and expenditures for such services by each plan's enrollees compared to the average utilization and expenditures for regional alliance eligible individuals, and

(B) protecting health plans that enroll a disproportionate share of regional alliance eligible individuals with respect to whom expected utilization of health care services (included in the comprehensive benefit package) and expected health care expenditures for such services are greater than the average level of such utilization and expenditures for regional alliance eligible individuals.

(2) Factors to be considered. In developing such methodology, the Board shall take into account the following factors:

(A) Demographic characteristics.

(B) Health status.

(C) Geographic area of residence.

(D) Socio-economic status.

(E) Subject to paragraph (5), (i) the proportion of enrollees who are SSI recipients and (ii) the proportion of enrollees who are AFDC recipients.

(F) Any other factors determined by the Board to be material to the purposes described in paragraph (1).

(3) Zero sum. The methodology shall assure that the total payments to health plans by the regional alliance after application of the methodology are the same as the amount of payments that would have been made without application of the methodology.

(4) Prospective adjustment of payments. The methodology, to the extent possible and except in the case of a mandatory reinsurance system described in subsection (c), shall be applied in manner that provides for the prospective adjustment of payments to health plans.

(5) Treatment of ssi/afdc adjustment. The Board is not required to apply the factor described in clause (i) or (ii) of paragraph (2)(E) if the Board determines that the application of the other risk adjustment factors described in paragraph (2) is sufficient to adjust premiums to take into account the enrollment in plans of AFDC recipients and SSI recipients.

(6) Special consideration for mental illness. In developing the methodology under this section, the Board shall give consideration to the unique problems of adjusting payments to health plans with respect to individuals with mental illness.

(7) Special consideration for veterans, military, and indian health plans. In developing the methodology under this section, the Board shall give consideration to the special enrollment and funding provisions relating to plans described in section 1004(b).

(8) Adjustment to account for use of estimates. Subject to section 1361(b)(3) (relating to establishment of regional alliance reserve funds), if the total payments made by a regional alliance to all regional alliance health plans in a year under section 1351(b) exceeds, or is less than, the total of such payments estimated by the alliance in the application of the methodology under this subsection, because of a difference between

(A) the alliance's estimate of the distribution of enrolled families in different risk categories (assumed in the application of risk factors under this subsection in making payments to regional alliance health plans), and

(B) the actual distribution of such enrolled families in such categories, the methodology under this subsection shall provide for an adjustment in the application of such methodology in the second succeeding year in a manner that would reduce, or increase, respectively, by the amount of such excess (or deficit) the total of such payments made by the alliance to all such plans.

(c) Mandatory Reinsurance.

(1) In general. The methodology developed under this section may include a system of mandatory reinsurance, but may not include a system of voluntary reinsurance.

(2) Requirement in certain cases. If the Board determines that an adequate system of prospective adjustment of payments to health plans to account for the health status of individuals enrolled by regional alliance health plans cannot be developed (and ready for implementation) by the date specified in subsection (a)(1), the Board shall include a mandatory reinsurance system as a component of the methodology. The Board may thereafter reduce or eliminate such a system at such time as the Board determines that an adequate prospective payment adjustment for health status has been developed and is ready for implementation.

(3) Reinsurance system. The Board, in developing the methodology for

a mandatory reinsurance system under this subsection, shall

(A) provide for health plans to make payments to state-established reinsurance programs for the purpose of reinsuring part or all of the health care expenses for items and services included in the comprehensive benefit package for specified classes of high-cost enrollees or specified high-cost treatments or diagnoses; and

(B) specify the manner of creation, structure, and operation of the system in each State, including

(i) the manner (which may be prospective or retrospective) in which health plans make payments to the system, and

(ii) the type and level of reinsurance coverage provided by the system.

(d) Confidentiality of Information. The methodology shall be developed in a manner consistent with privacy standards promulgated under section 5120(a). In developing such standards, the Board shall take into account any potential need of alliances for certain individually identifiable health information in order to carry out risk-adjustment and reinsurance activities under this Act, but only to the minimum extent necessary to carry out such activities and with protections provided to minimize the identification of the individuals to whom the information relates.

Section 1542 INCENTIVES TO ENROLL DISADVANTAGED GROUPS.

The Board shall establish standards under which States may provide (under section 1203(e)(3)) for an adjustment in the risk-adjustment methodology developed under section 1541 in order to provide a financial incentive for regional alliance health plans to enroll individuals who are members of disadvantaged groups.

Section 1543 ADVISORY COMMITTEE.

(a) In General. The Board shall establish an advisory committee to provide technical advice and recommendations regarding the development and modification of the risk adjustment and reinsurance methodology developed under this subpart.

(b) Composition. Such advisory committee shall consist of 15 individuals and shall include individuals who are representative of health plans, regional alliances, consumers, experts, employers, and health providers.

Section 1544 RESEARCH AND DEMONSTRATIONS.

The Secretary shall conduct and support research and demonstration projects to develop and improve, on a continuing basis, the risk adjustment and reinsurance methodology under this subpart.

Section 1545 TECHNICAL ASSISTANCE TO STATES AND ALLIANCES.

The Board shall provide technical assistance to States and regional alliances in implementing the methodology developed under this subpart.

Subpart F Responsibilities for Financial Requirements

Section 1551 CAPITAL STANDARDS FOR REGIONAL ALLIANCE HEALTH PLAN.

(a) In General.The Board shall establish, in consultation with the States, minimum capital requirements for regional alliance health plans, for purposes of section 1204(a).

(b) $500,000 Minimum. Subject to subsection (c), under such requirements there shall be not less than $500,000 of capital maintained for each plan offered in each alliance area, regardless of whether or not the same sponsor offered more than one of such plans.

(c) Additional Capital Requirements. The Board may require additional capital for factors likely to affect the financial stability of health plans, including the following:

(1) Projected plan enrollment and number of providers participating in the plan.

(2) Market share and strength of competition.

(3) Extent and nature of risk-sharing with participating providers and the financial stability of risk-sharing providers.

(4) Prior performance of the plan, risk history, and liquidity of assets.

(d) Development of Standards by NAIC. The Board may request the National Association of Insurance Commissioners to develop model standards for the additional capital requirements described in subsection (c) and to present such standards to the Board not later than July 1, 1995. The Board may accept such standards as the standards to be applied under subsection (c) or modify the standards in any manner it finds appropriate.

Section 1552 STANDARD FOR GUARANTY FUNDS.

(a) In General. In consultation with the States, the Board shall establish standards for guaranty funds established by States under section 1204(c).

(b) Guaranty Fund Standards. The standards established under subsection (a) for a guaranty fund shall include the following:

(1) Each fund must have a method to generate sufficient resources to pay health providers and others in the case of a failure of a health plan (as described in section 1204(d)(4)) in order to meet obligations with respect to

(A) services rendered by the health plan for the comprehensive benefit package, including any supplemental coverage for cost sharing provided by the health plan, and

(B) services rendered prior to health plan insolvency and services to patients after the insolvency but prior to their enrollment in other health plans.

(2) The fund is liable for all claims against the plan by health care providers with respect to their provision of items and services covered under the comprehensive benefit package to enrollees of the failed plan. Such claims, in full, shall take priority over all other claims. The fund also is liable, to the extent and in the manner provided in accordance with rules established by the Board, for other claims, including other claims of such providers and the claims of contractors, employees, governments, or any other claimants.

(3) The fund stands as a creditor for any payments owed the plan to the extent of the payments made by the fund for obligations of the plan.

(4) The fund has authority to borrow against future assessments (payable under section 1204(c)(2)) in order to meet the obligations of failed plans participating in the fund.

Part 2 RESPONSIBILITIES OF DEPARTMENT OF HEALTH AND HUMAN SERVICES

Subpart A General Responsibilities

Section 1571 GENERAL RESPONSIBILITIES OF SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) In General. Except as otherwise specifically provided under this Act (or

with respect to administration of provisions in the Internal Revenue Code of 1986 or in the Employee Retirement Income Security Act of 1974), the Secretary of Health and Human Services shall administer and implement all of the provisions of this Act, except those duties delegated to the National Health Board, any other executive agency, or to any State.

(b) Financial Management Standards. The Secretary, in consultation with the Secretaries of Labor and the Treasury, shall establish, for purposes of section 1361, standards relating to the management of finances, maintenance of records, accounting practices, auditing procedures, and financial reporting for health alliances. Such standards shall take into account current Federal laws and regulations relating to fiduciary responsibilities and financial management of funds.

(c) Auditing Regional Alliance Performance. The Secretary shall perform periodic financial and other audits of regional alliances to assure that such alliances are carrying out their responsibilities under this Act consistent with this Act. Such audits shall include audits of alliance performance in the areas of

(1) assuring enrollment of all regional alliance eligible individuals in health plans,

(2) management of premium and cost sharing discounts and reductions provided; and

(3) financial management of the alliance, including allocation of collection shortfalls.

Section 1572 ADVISORY COUNCIL ON BREAKTHROUGH DRUGS.

(a) In General. The Secretary shall appoint an Advisory Council on Breakthrough Drugs (in this section referred to as the "Council") that will examine the reasonableness of launch prices of new drugs that represent a breakthrough or significant advance over existing therapies.

/* This section if passed potentially might affect the launch of significant AIDS treatments-- consider the controversy over the price of Retrovir (TM) brand of AZT.

(b) Duties. (1) At the request of the Secretary, or a member of the Council, the Council shall make a determination regarding the reasonableness of launch prices of a breakthrough drug. Such a determination shall be based on

(A) prices of other drugs in the same therapeutic class;

(B) cost information supplied by the manufacturer;

(C) prices of the drug in countries specified in section 802(b)(4)(A) of the Federal Food, Drug, and Cosmetic Act;

(D) projected prescription volume, economies of scale, product stability, special manufacturing requirements and research costs;

(E) cost effectiveness relative to the cost of alternative course of treatment options, including non-pharmacological medical interventions; and

(F) improvements in quality of life offered by the new product, including ability to return to work, ability to perform activities of daily living, freedom from attached medical devices, and other appropriate measurements of quality of life improvements.

(2) The Secretary shall review the determinations of the Council and publish the results of such review along with the Council's determination (including minority opinions) as a notice in the Federal Register.

(c) Membership. The Council shall consist of a chair and 12 other persons, appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Council shall include a representative from the pharmaceutical industry, consumer organizations, physician organizations, the hospital industry, and the managed care industry. Other individuals appointed by the Secretary shall be recognized experts in the fields of health care economics, pharmacology, pharmacy, and prescription drug reimbursement. Only one member of the Council may have direct or indirect financial ties to the pharmaceutical industry.

(d) Term of Appointments. Appointments shall be for a term of 3 years, except that the Secretary may provide initially for such shorter terms as will ensure that the terms of not more than 5 members expire in any one year.

(e) Compensation. Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary are provided such reimbursements under the Social Security Act.

(f) No Termination. Notwithstanding the provisions of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise specified in law.

Subpart B Certification of Essential Community Providers

Section 1581 CERTIFICATION.

(a) In General. For purposes of this Act, the Secretary shall certify as an "essential community provider" any health care provider or organization that

(1) is within any of the categories of providers and organizations specified in section 1582(a), or

(2) meets the standards for certification under section 1583(a).

(b) Timely Establishment of Process. The Secretary shall take such actions as may be necessary to permit health care providers and organizations to be certified as essential community providers in a State before the beginning of the first year for the State.

Section 1582 CATEGORIES OF PROVIDERS AUTOMATICALLY CERTIFIED.

(a) In General. The categories of providers and organizations specified in this subsection are as follows:

(1) Migrant health centers. A recipient or subrecipient of a grant under section 329 of the Public Health Service Act.

(2) Community health centers. A recipient or subrecipient of a grant under section 330 of the Public Health Service Act.

(3) Homeless program providers. A recipient or subrecipient of a grant under section 340 of the Public Health Service Act.

(4) Public housing providers. A recipient or subrecipient of a grant under section 340A of the Public Health Service Act.

(5) Family planning clinics. A recipient or subrecipient of a grant under title X of the Public Health Service Act.

(6) Indian health programs. A service unit of the Indian Health Service, a tribal organization, or an urban Indian program, as defined in the Indian Health Care Improvement Act.

(7) AIDS providers under ryan white act. A public or private nonprofit health care provider that is a recipient or subrecipient of a grant under title XXVI of the Public Health Service Act.

/* This section automatically provides for the certification of funds under the Ryan White Act. The Ryan White Act is contained in the statutes menu. */

(8) Maternal and child health providers.A public or private nonprofit entity that provides prenatal care, pediatric care, or ambulatory services to children, including children with special health care needs, and that receives funding for such care or services under title V of the Social Security Act.

(9) Federally qualified health center; rural health clinic. A Federally-qualified health center or a rural health clinic (as such terms are defined in section 1861(aa) of the Social Security Act).

(10) Provider of school health services.A provider of school health services that receives funding for such services under subtitle G of title III.

(11) Community practice network. A qualified community practice network receiving development funds under subtitle E of title III.

(b) Subrecipient Defined. In this subpart, the term "subrecipient" means, with respect to a recipient of a grant under a particular authority, an entity that--

(1) is receiving funding from such a grant under a contract with the principal recipient of such a grant, and

(2) meets the requirements established to be a recipient of such a grant.

(c) Health Professional Defined. In this subpart, the term "health professional" means a physician, nurse, nurse practitioner, certified nurse midwife, physician assistant, psychologist, dentist, pharmacist, and other health care professional recognized by the Secretary.

Section 1583 STANDARDS FOR ADDITIONAL PROVIDERS.

(a) Standards. The Secretary shall publish standards for the certification of additional categories of health care providers and organizations as essential community providers, including the categories described in subsection (b). Such a health care provider or organization shall not be certified unless the Secretary determines, under such standards, that health plans operating in the area served by the applicant would not otherwise be able to assure adequate access to items and services included in the comprehensive benefit package if such a provider was not so certified.

(b) Categories To Be Included. The categories described in this subsection are as follows:

(1) Health professionals. Health professionals

(A) located in an area designated as a health professional shortage area (under section 332 of the Public Health Service Act), or

(B) providing a substantial amount of health services (as determined in accordance with standards established by the Secretary) to a medically underserved population (as designated under section 330 of such Act).

(2) Institutional providers. Public and private nonprofit hospitals and other institutional health care providers located in such an area or providing health services to such a population.

(3) Other providers. Other public and private nonprofit agencies and organizations that

(A) are located in such an area or providing health services to such a population, and

(B) provide health care and services essential to residents of such an area or such populations.

Section 1584 CERTIFICATION PROCESS; REVIEW; TERMINATION OF CERTIFICATIONS.

(a) Certification Process.

(1) Publication of procedures. The Secretary shall publish, not later than 6 months after the date of the enactment of this Act, the procedures to be used by health care professionals, providers, agencies, and organizations seeking certification under this subpart, including the form and manner in which an application for such certification is to be made.

(2) Timely determination. The Secretary shall make a determination upon such an application not later than 60 days (or 15 days in the case of a certification for an entity described in section 1582) after the date the complete application has been submitted. The determination on an application for certification of an entity described in section 1582 shall only involve the verification that the entity is an entity described in such section.

(b) Review of Certifications. The Secretary shall periodically review whether professionals, providers, agencies, and organizations certified under

this subpart continue to meet the requirements for such certification.

(c) Termination or Denial of Certification.

(1) Preliminary finding. If the Secretary preliminarily finds that an entity seeking certification under this section does not meet the requirements for such certification or such an entity certified under this subpart fails to continue to meet the requirements for such certification, the Secretary shall notify the entity of such preliminary finding and permit the entity an opportunity, under subtitle C of title V, to rebut such findings.

(2) Final determination. If, after such opportunity, the Secretary continues to find that such an entity continues to fail to meet such requirements, the Secretary shall terminate the certification and shall notify the entity, regional alliances, and corporate alliances of such termination and the effective date of the termination.

Section 1585 NOTIFICATION OF HEALTH ALLIANCES AND PARTICIPATING STATES.

(a) In General. Not less often than annually the Secretary shall notify each participating State and each health alliance of essential community providers that have been certified under this subpart.

(b) Contents. Such notice shall include sufficient information to permit each health alliance to notify health plans of the identify of each entity certified as an essential community provider, including

(1) the location of the provider within each plan's service area,

(2) the health services furnished by the provider, and

(3) other information necessary for health plans to carry out part 3 of subtitle E.

Part 3 SPECIFIC RESPONSIBILITIES OF SECRETARY OF LABOR.

Section 1591 RESPONSIBILITIES OF SECRETARY OF LABOR.

(a) In General. The Secretary of Labor is responsible

(1) under subtitle G, for the enforcement of requirements applicable to employers under regional alliances (including requirements relating to payment of premiums) and the administration of corporate alliances;

(2) under subtitle D, with respect to elections by eligible sponsors to become corporate alliances and the termination of such elections;

(3) under section 1395, for the temporary assumption of the operation of self-insured corporate alliance health plans that are insolvent;

(4) under section 1396, for the establishment and administration of Corporate Alliance Health Plan Insolvency Fund;

(5) for carrying out any other responsibilities assigned to the Secretary under this Act; and

(6) for administering title I of the Employee Retirement Income Security Act of 1974 as it relates to group health plans maintained by corporate alliances.

(b) Agreements with States. The Secretary of Labor may enter into agreements with States in order to enforce responsibilities of employers and corporate alliances, and requirements of corporate alliance health plans, under subtitle B of title I of the Employee Retirement Income Security Act of 1974.

(c) Consultation with Board. In carrying out activities under this Act with respect to corporate alliances, corporate alliance health plans, and employers, the Secretary of Labor shall consult with the National Health Board.

(d) Employer-Related Requirements.

(1) In general. The Secretary of Labor, in consultation with the Secretary, shall be responsible for assuring that employers

(A) make payments of any employer premiums (and withhold and make payment of the family share of premiums with respect to qualifying employees) as required under this Act, including auditing of regional alliance collection activities with respect to such payments,

(B) submit timely reports as required under this Act, and

(C) otherwise comply with requirements imposed on employers under this Act.

(2) Audit and similar authorities.The Secretary of Labor

(A) may carry out such audits (directly or through contract) and such

investigations of employers and health alliances,

(B) may exercise such authorities under section 504 of Employee Retirement Income Security Act of 1974 (in relation to activities under this Act),

(C) may, with the permission of the Board, provide (through contract or otherwise) for such collection activities (in relation to amounts owed to regional alliances and for the benefit of such alliances), and

(D) may impose such civil penalties under section 1345(d)(1), as may be necessary to carry out such Secretary's responsibilities under this section.

(e) Authority. The Secretary of Labor is authorized to issue such regulations as may be necessary to carry out section 1607 and responsibilities of the Secretary under this Act (including under title XI).

Title I, Subtitle G

Subtitle G Employer Responsibilities

Section 1601 PAYMENT REQUIREMENT.

(a) In General. Each employer shall provide for payments required under section 6121 or 6131 in accordance with the applicable provisions of this Act.

(b) Employers in Single-Payer States. In the case of an employer with respect to employees who reside in a single-payer State, the responsibilities of such employer under such system shall supersede the obligations of the employer under subsection (a), except as the Board may provide.

(c) Employers Participating in Regional Alliances Through Multiemployer Plans. In the case of an employer participating in a multiemployer plan, which plan elects to serve as a regional alliance employer on behalf of its participating employers, the employer's payment obligation under section 6121 shall be deemed satisfied if the employer pays to the multiemployer plan at least the premium payment amount specified in section 6121(b) and the plan has assumed legal obligations of such an employer under such section.

Section 1602 REQUIREMENT FOR INFORMATION REPORTING.

(a) Reporting of End-of-Year Information to Qualifying Employees.

(1) In general. Each employer shall provide to each individual who was a

qualifying employee of the employer during any month in the previous year information described in paragraph (2) with respect to the employee.

(2) Information to be supplied. The information described in this paragraph, with respect to a qualifying employee, is the following (as specified by the Secretary):

(A) Regional alliance information. With respect to each regional alliance through which the individual obtained health coverage:

(i) The total number of months of full-time equivalent employment (as determined under section 1901(b)(2)) for each class of enrollment.

(ii) The amount of wages attributable to qualified employment and the amount of covered wages (as defined in paragraph (4)).

(iii) The total amount deducted from wages and paid for the family share of the premium.

(iv) Such other information as the Secretary of Labor may specify.

(B) Corporate alliance information. With respect to a qualifying employee who obtains coverage through a corporate alliance health plan:

(i) The total number of months of full-time equivalent employees (as determined under section 1901(b)(2)) for each class of enrollment.

(ii) Such other information as the Secretary of Labor may specify.

(3) Alliance specific information. In the case of a qualifying employee with respect to whom an employer made employer premium payments during the year to more than one regional alliance, the information under this subsection shall be reported separately with respect to each such alliance.

(4) Covered wages defined. In this section, the term "covered wages"means wages paid an employee of an employer during a month in which the employee was a qualifying employee of the employer.

(b) Reporting of Information for Use of Regional Alliances.

(1) In general. Each employer (including corporate alliance employers) shall provide under subsection (f) on behalf of each regional alliance information described in paragraph (2) on an annual basis, information described in paragraph (3) on a monthly basis, and information described in

paragraph (4) on a one-time basis, with respect to the employment of qualifying employees in each year, month, or other time, respectively.

(2) Information to be supplied on an annual basis.The information described in this paragraph, with respect to an employer, is the following (as specified by the Secretary of Labor):

(A) Regional alliance information. With respect to each regional alliance to which employer premium payments were payable in the year:

(i) For each qualifying employee in the year

(I) The total number of months of full-time equivalent employment (as determined under section 1901(b)(2)) for the employee for each class of enrollment.

(II) The total amount deducted from wages and paid for the family share of the premium of the qualifying employee.

(ii) The total employer premium payment made under section 6121 for the year with respect to the employment of all qualifying employees residing in the alliance area and, in the case of an employer that has obtained (or seeks to obtain) a premium discount under section 6123, the total employer premium payment that would have been owed for such employment for the year but for such section.

(iii) The number of full-time equivalent employees (determined under section 1901(b)(2)) for each class of family enrollment in the year (and for each month in the year in the case of an employer that has obtained or is seeking a premium discount under section 6123).

(iv) In the case of an employer to which section 6124 applies in a year, such additional information as the Secretary of Labor may require for purposes of that section.

(v) The amounts paid (and payable) pursuant to section 6125.

(vi) The amount of covered wages for each qualifying employee.

(3) Information on a monthly basis.

(A) In general. The information described in this paragraph for a month for an employer is such information as the Secretary of Labor may specify regarding

(i) the identity of each eligible individual who changed qualifying employee status with respect to the employer in the month; and

(ii) in the case of such an individual described in subparagraph (B)(i)

(I) the regional alliance for the alliance area in which the individual resides, and

(II) the individual's class of family enrollment.

(B) Changes in qualifying employee status described. For purposes of subparagraph (A), an individual is considered to have changed qualifying employee status in a month if the individual either (i) is a qualifying employee of the employer in the month and was not a qualifying employee of the employer in the previous month, or (ii) is not a qualifying employee of the employer in the month but was a qualifying employee of the employer in the previous month.

(4) Initial information. Each employer, at such time before the first year in which qualifying employees of the employer are enrolled in regional alliance health plans as the Board may specify, shall provide for the reporting of such information relating to employment of eligible individuals as the Board may specify.

(c) Reconciliation of Employer Premium Payments.

(1) Provision of information. Each employer (whether or not the employer claimed (or claims) an employer premium discount under section 6123 for a year) that is liable for employer premium payments to a regional alliance for any month in a year shall provide the alliance with such information as the alliance may require (consistent with rules of the Secretary of Labor) to determine the appropriate amount of employer premium payments that should have been made for all months in the year (taking into account any employer premium discount under section 6123 for the employer).

(2) Deadline. Such information shall be provided not later than the beginning of February of the following year with the payment to be made for that month.

(3) Reconciliation.

(A) Continuing employers. Based on such information, the employer shall adjust the amount of employer premium payment made in the month in which the information is provided to reflect the amount by which the

payments in the previous year were greater or less than the amount of payments that should have been made.

(B) Discontinuing employers. In the case of a person that ceases to be an employer in a year, such adjustment shall be made in the form of a payment to, or from, the alliance involved.

(4) Special treatment of self-employed individuals. Except as the Secretary of Labor may provide, individuals who are employers only by virtue of the operation of section 6126 shall have employer premium payments attributable to such section reconciled (in the manner previously described in this subsection) under the process for the collection of the family share of premiums under section 1344 rather than under this subsection.

(d) Special Rules for Self-Employed.

(1) In general. In the case of an individual who is treated as an employer under section 6126, the individual shall provide, under subsection (f) on behalf of each regional alliance, information described in paragraph (2) with respect to net earnings from self-employment income of the individual in each year.

(2) Information to be supplied. The information described in this paragraph, with respect to an individual, is such information as may be necessary to compute the amount payable under section 6131 by virtue of section 6126.

(e) Form. Information shall be provided under this section in such electronic or other form as the Secretary specifies. Such specifications shall be done in a manner that, to the maximum extent practicable, simplifies administration for small employers.

(f) Information Clearinghouse Functions.

(1) Designation. The Board shall provide for the use of the regional centers (which are part of the electronic data network under section 5103) to perform information clearinghouse functions under this section with respect to employers and regional and corporate alliances.

(2) Functions. The functions referred to in paragraph (1) shall include

(A) receipt of information submitted by employers under subsection (b) on an annual (or one-time) basis,

(B) from the information received, transmittal of information required

to regional alliances, and

(C) such other functions as the Board specifies.

(g) Deadline. Information required to be provided by an employer for a year under this section

(1) to a qualifying employee shall be provided not later than the date the employer is required under law to provide for statements under section 6051 of the Internal Revenue Code of 1986 for that year, or

(2) to a health alliance (through a regional center) shall be provided not later than the date by which information is required to be filed with the Secretary pursuant to agreements under section 232 of the Social Security Act for that year.

(h) Notice to Certain Individuals Who Are Not Employees.

(1) In general. A person that carries on a trade or business shall notify in writing each individual described in paragraph (2) that the person is not obligated to make any employer health care premium payment (under section 6121) in relation to the services performed by the individual for the person.

(2) Individual described. An individual described in this paragraph, with respect to a person, is an individual who normally performs services for the person in the person's trade or business for more than 40 hours per month but who is not an employee of the person (within the meaning of section 1901(a)).

(3) Timing; effective date. Such notice shall be provided within a reasonable time after the individual begins performing services forthe person, except that in no event is such a notice required to be provided with respect to services performed before January 1, 1998.

(4) Exceptions. The Secretary shall issue regulations providing exceptions to the notice requirement of paragraph (1) with respect to individuals performing services on an irregular, incidental, or casual basis.

(5) Model notice. The Secretary shall publish a model notice that is easily understood by the average reader and that persons may use to satisfy the requirements of paragraph (1).

Section 1603 REQUIREMENTS RELATING TO NEW EMPLOYEES.

(a) Completion of Enrollment Information Form. At the time an individual is hired as a qualifying employee of a regional alliance employer, the employer shall obtain from the individual the following information (pursuant to rules established by the Secretary of Labor):

(1) The identity of the individual.

(2) The individual's alliance area of residence and whether the individual has moved from another alliance area.

(3) The class of family enrollment applicable to the individual.

(4) The health plan (and health alliance) in which the individual is enrolled at that time.

(5) If the individual has moved from another alliance area, whether the individual intends to enroll in a regional alliance health plan.

(b) Transmittal of Information to Alliance.

(1) In general. Each employer shall transmit the information obtained under subsection (a) to the regional alliance for the alliance area in which the qualifying employee resides (or will reside at the time of initial employment).

(2) Deadline. Such information shall be transmitted within 30 days of the date of hiring of the employee.

(3) Form. Information under this section may be forwarded in electronic form to a regional alliance.

(c) Provision of Enrollment Form and Information. In the case of an individual described in subsection (a)(5), the employer shall provide the individual, at the time of hiring, with

(1) such information regarding the choice of, and enrollment in, regional alliance health plans, and

(2) such enrollment form, as the regional alliance provides to the employer.

Section 1604 AUDITING OF RECORDS.

Each regional alliance employer shall maintain such records, and provide the regional alliance for the area in which the employer maintains the principal place of employment (as specified by the Secretary of Labor) with

access to such records, as may be necessary to verify and audit the information reported under this subtitle.

Section 1605 PROHIBITION OF CERTAIN EMPLOYER DISCRIMINATION.

No employer may discriminate with respect to an employee on the basis of the family status of the employee or on the basis of the class of family enrollment selected with respect to the employee.

Section 1606 PROHIBITION ON SELF-FUNDING OF COST SHARING BENEFITS BY REGIONAL ALLIANCE EMPLOYERS.

(a) Prohibition. A regional alliance employer (and a corporate alliance employer with respect to employees who are regional alliance eligible individuals) may provide benefits to employees that consist of the benefits included in a cost sharing policy (as defined in section 1421(b)(2)) only through a contribution toward the purchase of a cost sharing policy which is funded primarily through insurance.

(b) Individual and Employer Responsibilities. In the case of an individual who resides in a single-payer State and an employer with respect to employees who reside in such a State, the responsibilities of such individual and employer under such system shall supersede the obligations of the individual and employer under this subtitle.

Section 1607 EQUAL VOLUNTARY CONTRIBUTION REQUIREMENT.

(a) In General.

(1) Equal voluntary employer premium payment requirement.

(A) Regional alliance health plans. If an employer makes available a voluntary employer premium payment (as defined in subsection (d)) on behalf of a full-time employee (as defined in section 1901(b)(2)(C)) who is enrolled in a regional alliance health plan of a regional alliance in a class of family enrollment, the employer shall make available such a voluntary employer premium payment in the same dollar amount to all qualifying employees (as defined in section 1901(b)(1)) of the employer who are enrolled in any regional alliance health plan of the same alliance in the same class of family enrollment.

(B) Corporate alliance health plans. If a corporate alliance employer makes available a voluntary employer premium payment on behalf of a full-time employee who is enrolled in a corporate alliance health plan of a corporate alliance in a class of family enrollment in a premium area

(designated under section 1384(b)), the employer shall make available such a voluntary employer premium payment in the same dollar amount to all qualifying employees of the employer enrolled in any corporate alliance health plan of the same alliance in the same class of family enrollment in the same premium area.

(C) Treatment of part-time employees. In applying subparagraphs (A) and (B) in the case of a qualifying employee employed on a part-time basis (within the meaning of section 1901(b)(2)(A)(ii)), the dollar amount shall be equal to the full-time employment ratio (as defined in section 1901(b)(2)(B)) multiplied by the dollar amount otherwise required.

(2) Limit on voluntary employer premium payments.

(A) Regional alliance health plans. An employer may not make available a voluntary employer premium payment on behalf of an employee (enrolled in a regional alliance health plan of a regional alliance in a class of family enrollment) in an amount that exceeds the maximum amount that could be payable as the family share of premium (described in section 6101(b)(2)) for the most expensive regional alliance health plan of the same alliance for the same class of family enrollment.

(B) Corporate alliance health plans. An employer may not make available a voluntary employer premium payment on behalf of an employee (enrolled in a corporate alliance health plan of a corporate alliance in a class of family enrollment in a premium area, designated under section 1384) in an amount that exceeds the maximum amount that could be payable as the family share of premium (described in section 6101(b)(3)) for the most expensive corporate alliance health plan of the same alliance for the same class of family enrollment in the same premium area.

(C) Exclusion of plans without material enrollment. Subparagraphs (A) and (B) shall not take into account any health plan that does not have material enrollment (as determined in accordance with regulations of the Secretary of Labor).

(3) Nondiscrimination among plans selected. An employer may not discriminate in the wages or compensation paid, or other terms or conditions of employment, with respect to an employee based on the health plan (or premium of such a plan) in which the employee is enrolled.

(b) Rebate Required in Certain Cases.

(1) In general.Subject to subsection (c), if

(A) an employer makes available a voluntary employer premium payment on behalf of an employee, and

(B) (i) the sum of the amount of the applicable alliance credit (under section 6103) and the voluntary employer premium payment, exceeds (ii) the premium for the plan selected, the employer must rebate to the employee an amount equal to the excess described in subparagraph (B).

(2) Rebates.

(A) In general. Any rebate provided under paragraph (1) shall be treated, for purposes of the Internal Revenue Code of 1986, as wages described in section 3121(a) of such Act.

(B) Treatment of multiple full-time employment in a family. In the case of

(i) an individual who is an employee of more than one employer, or

(ii) a couple for which both spouses are employees, if more than one employer provides for voluntary employer premium payments, the individual or couple may elect to have paragraph (1) applied with respect to all employment.

(c) Exception for Collective Bargaining Agreement. Subsections (a) and (b) (other than subsection (a)(2)) shall not apply with respect to voluntary employer premium payments made pursuant to a bona fide collective bargaining agreement.

(d) Voluntary Employer Premium Payment. In this section, the term "voluntary employer premium payment" means any payment designed to be used exclusively (or primarily) towards the cost of the family share of premiums for a health plan. Such term does not include any employer premiums required to be paid under part 3 of subtitle B of title VI.

Section 1608 EMPLOYER RETIREE OBLIGATION.

(a) In General. If an employer was providing, as of October 1, 1993, a threshold payment (specified in subsection (c)) for a person who was a qualifying retired beneficiary (as defined in subsection (b)) as of such date, the employer shall pay, to or on behalf of that beneficiary for each month beginning with January 1998, an amount that is not less than the amount specified in subsection (d), but only if and for so long as the person remains a qualifying retired beneficiary.

(b) Qualifying Retired Beneficiary. In this section, the term "qualifying retired beneficiary" means a person who is an eligible retiree or qualified spouse or child (as such terms are defined in subsections (b) and (c) of section 6114).

(c) Threshold Payment. The term "threshold payment" means, for an employer with respect to a health benefit plan providing coverage to a qualifying retired beneficiary, a payment

(1) for coverage of any item or service described in section 1101, and

(2) the amount of which is at least 20 percent of the amount of the premium (or premium equivalent) for such coverage with respect to the beneficiary (and dependents).

(d) Amount. The amount specified in this subsection is 20 percent of the weighted average premium for the regional alliance in which the beneficiary resides and for the applicable class of family enrollment.

(e) Nature of Obligation. The requirement of this section shall be in addition to any other requirement imposed on an employer under this Act or otherwise.

(f) Protection of Collective Bargaining Rights. Nothing in this Act (including this section) shall be construed as affecting collective bargaining rights or rights under collective bargaining agreements.

Section 1609 ENFORCEMENT.

In the case of a person that violates a requirement of this subtitle, the Secretary of Labor may impose a civil money penalty, in an amount not to exceed $10,000, for each violation with respect to each individual.

Subtitle J General Definitions; Miscellaneous Provisions

Part 1 GENERAL DEFINITIONS

Section 1901 DEFINITIONS RELATING TO EMPLOYMENT AND INCOME.

(a) In General. Except as otherwise specifically provided, in this Act the following definitions and rules apply:

(1) Employer, employee, employment, and wages defined. Except as provided in this section

(A) the terms "wages" and "employment" have the meanings given such terms under section 3121 of the Internal Revenue Code of 1986,

(B) the term "employee" has the meaning given such term under section 3121 of such Code, subject to the provisions of chapter 25 of such Code, and

(C) the term "employer" has the same meaning as the term "employer" as used in such section 3121.

(2) Exceptions. For purposes of paragraph (1)

(A) Employment.

(i) Employment included. Paragraphs (1), (2), (5), (7) (other than clauses (i) through (iv) of subparagraph (C) and clauses (i) through (v) of subparagraph (F)), (8), (9), (10), (11), (13), (15), (18), and (19) of section 3121(b) of the Internal Revenue Code of 1986 shall not apply.

(ii) Exclusion of inmates as employees. Employment shall not include services performed in a penal institution by an inmate thereof or in a hospital or other health care institution by a patient thereof.

(B) Wages.

(i) In general. Paragraph (1) of section 3121(a) of the Internal Revenue Code of 1986 shall not apply.

(ii) Tips not included. The term "wages" does not include cash tips.

(C) Exclusion of employees outside the united states. The term "employee" does not include an individual who does not reside in the United States.

(D) Exclusion of foreign employment. The term "employee" does not include an individual

(i) with respect to service, if the individual is not a citizen or resident of the United States and the service is performed outside the United States, or

(ii) with respect to service, if the individual is a citizen or resident of the United States and the service is performed outside the United States for an employer other than an American employer (as defined in section 3121(h) of the Internal Revenue Code of 1986).

(3) Aggregation rules for employers.For purposes of this Act

(A) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

(B) under regulations of the Secretary of Labor, all employees of organizations which are under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer. The regulations prescribed under subparagraph (B) shall be based on principles similar to the principles which apply to taxable organizations under subparagraph (A).

(4) Employer premium. The term "employer premium" refers to the premium established and imposed under part 2 of subtitle B of title VI.

(b) Qualifying Employee; Full-Time Employment.

(1) Qualifying employee.

(A) In general. In this Act, the term "qualifying employee" means, with respect to an employer for a month, an employee (other than a covered child, as defined in subparagraph (C)) who is employed by the employer for at least 40 hours (as determined under paragraph (3)) in the month.

(B) No special treatment of medicare beneficiaries, ssi recipients, afdc recipients, and others.Subparagraph (A) shall apply regardless of whether or not the employee is a medicare-eligible individual, an SSI recipient, an AFDC recipient, an individual described in section 1004(b), an eligible individual or is authorized to be so employed.

(C) Covered child defined. In subparagraph (A), the term "covered child" means an eligible individual who is a child and is enrolled under a health plan as a family member described in section 1011(b)(2)(B).

(2) Full-time equivalent employees; part-time employees.

(A) In general. For purposes of this Act, a qualifying employee who is employed by an employer

(i) for at least 120 hours in a month, is counted as 1 full-time equivalent employee for the month and shall be deemed to be employed on a full-time basis, or

(ii) for at least 40 hours, but less than 120 hours, in a month, is counted as a fraction of a full-time equivalent employee in the month equal to the full-time employment ratio (as defined in subparagraph (B)) for the employee and shall be deemed to be employed on a part-time basis.

(B) Full-time employment ratio defined. For purposes of this Act, the term "full-time employment ratio" means, with respect to a qualifying employee of an employer in a month, the lesser of 1 or the ratio of

(i) the number of hours of employment such employee is employed by such employer for the month (as determined under paragraph (3)), to

(ii) 120 hours.

(C) Full-time employee. For purposes of this Act, the term "full-time employee" means, with respect to an employer, an employee who is employed on a full-time basis (as specified in subparagraph (A)) by the employer.

(D) Consideration of industry practice. As provided under rules established by the Board, an employee who is not described in subparagraph (C) shall be considered to be employed on a full-time basis by an employer (and to be a full-time employee of an employer) for a month (or for all months in a 12-month period) if the employee is employed by that employer on a continuing basis that, taking into account the structure or nature of the employment in the industry, represents full time employment.

(3) Hours of employment.

(A) In general. For purposes of this Act, the Board shall specify the method for computing hours of employment for employees of an employer consistent with this paragraph. The Board shall take into account rules used for purposes of applying the Fair Labor Standards Act.

(B) Hourly wage earners. In the case of an individual who receives compensation (in the form of hourly wages or compensation) for the performance of services, the individual is considered to be "employed" by an employer for an hour if compensation is payable with respect to that hour of employment, without regard to whether or not the employee is actually performing services during such hours.

(4) Treatment of salaried employees and employees paid on contingent or bonus arrangements. In the case of an employee who receives compensation on a salaried basis or on the basis of a commission (or other

contingent or bonus basis), rather than an hourly wage, the Board shall establish rules for the conversion of the compensation to hours of employment, taking into account the minimum monthly compensation levels for workers employed on a full-time basis under the Fair Labor Standards Act and other factors the Board considers relevant.

(c) Definitions Relating to Self-Employment.In this Act:

(1) Net earnings from self-employment. The term "net earnings from self-employment" has the meaning given such term under section 1402(a) of the Internal Revenue Code of 1986.

(2) Self-employed individual. The term "self-employed individual" means, for a year, an individual who has net earnings from self-employment for the year.

Section 1902 OTHER GENERAL DEFINITIONS.

Except as otherwise specifically provided, in this Act the following apply:

(1) Alien permanently residing in the united states under color of law. The term "alien permanently residing in the United States under color of law" means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

(A) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(B) An alien who is granted asylum under section 208 of such Act.

(C) An alien whose deportation is withheld under section 243(h) of such Act.

(D) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(E) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

(F) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(G) An alien within such other classification of permanent resident aliens as the National Health Board may establish by regulation.

(2) AFDC family.The term "AFDC family" means a family composed entirely of one or more AFDC recipients.

(3) AFDC recipient. The term "AFDC recipient" means, for a month, an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act for the month.

(4) Alliance area. The term "alliance area" means the area served by a regional alliance and specified under section 1202(b).

(5) Alliance eligible individual. The term "alliance eligible individual" means, with respect to a health alliance, an eligible individual with respect to whom the applicable health plan is a health plan offered by or through such alliance and does not include a prisoner.

(6) Applicable health plan. The term "applicable health plan" means, with respect to an eligible individual, the health plan specified pursuant to section 1004 and part 2 of subtitle A.

(7) Combination cost sharing plan. The term "combination cost sharing plan" means a health plan that provides combination cost sharing schedule (consistent with section 1134).

(8) Comprehensive benefit package. The term "comprehensive benefit package" means the package of health benefits provided under subtitle B.

(9) Consumer price index; cpi. The terms consumer price index" and "CPI" mean the Consumer Price Index for all urban consumers (U.S. city average), as published by the Bureau of Labor Statistics.

(10) Corporate alliance eligible individual. The term "corporate alliance eligible individual" means, with respect to a corporate alliance, an eligible individual with respect to whom the corporate alliance is the applicable health plan.

(11) Corporate alliance employer. The term "corporate alliance employer" means, with respect to a corporate alliance, an employer of an individual who is a participant in a corporate alliance health plan of that alliance.

(12) Corporate alliance health plan. The term "corporate alliance health plan" means a health plan offered by a corporate alliance/.

(13) Disabled ssi recipient. The term "disabled SSI recipient" means an individual who

(A) is an SSI recipient, and

(B) has been determined to be disabled for purposes of the supplemental security income program (under title XVI of the Social Security Act).

(14) Eligible enrollee. The term "eligible enrollee" means, with respect to an health plan offered by a health alliance, an alliance eligible individual, but does not include such an individual if the individual is enrolled under such a plan as the family member of another alliance eligible individual.

(15) Essential community provider. The term "essential community provider" means an entity certified as such a provider under subpart B of part 2 of subtitle F.

(16) Fee-for-service plan. The term "fee-for-service plan" means a health plan described in section 1322(b)(2)(A).

(17) First year. The term "first year" means, with respect to

(A) a State that is a participating State in a year before 1998, the year in which the State first is a participating State, or

(B) any other State, 1998.

(18) Higher cost sharing plan. The term "higher cost sharing plan" means a health plan that provides a higher cost sharing schedule (consistent with section 1133).

(19) Long-term nonimmigrant. The term "long-term nonimmigrant" means a nonimmigrant described in subparagraph (E), (H), (I), (J), (K), (L), (M), (N), (O), (Q), or (R) of section 101(a)(15) of the Immigration and Nationality Act or an alien within such other classification of nonimmigrant as the National Health Board may establish by regulation.

(20) Lower cost sharing plan. The term "lower cost sharing plan" means a health plan that provides a lower cost sharing schedule (consistent with section 1132).

(21) Medicare program. The term "medicare program" means the health insurance program under title XVIII of the Social Security Act.

(22) Medicare-eligible individual. The term "medicare-eligible individual" means, subject to section 1012(a), an individual who is entitled to benefits under part A of the medicare program.

(23) Move. The term "move" means, respect to an individual, a change of residence of the individual from one alliance area to another alliance area.

(24) National health board; board. The terms "National Health Board" and "Board" mean the National Health Board created under section 1501.

(25) Poverty level.

(A) In general. The term "applicable poverty level" means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved (as determined under subparagraph (B)) for 1994 adjusted by the percentage increase or decrease described in subparagraph (C) for the year involved.

(B) Family size. In applying the applicable poverty level to

(i) an individual enrollment, the family size is deemed to be one person;

(ii) a couple-only enrollment, the family size is deemed to be two persons;

(iii) a single parent enrollment, the family size is deemed to be three persons; or

(iv) a dual parent enrollment, the family size is deemed to be four persons.

(C) Percentage adjustment. The percentage increase or decrease described in this subparagraph for a year is the percentage increase or decrease by which the average CPI for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31, 1993.

(D) Rounding. Any adjustment made under subparagraph (A) for a year shall be rounded to the nearest multiple of $100.

(26) Prisoner. The term "prisoner" means, as specified by the Board, an eligible individual during a period of imprisonment under Federal, State, or

local authority after conviction as an adult.

(27) Regional alliance eligible individual. The term "regional alliance eligible individual" means an eligible individual with respect to whom a regional alliance health plan is an applicable health plan.

(28) Regional alliance employer. The term "regional alliance employer" means, with respect to an employee, an employer that is not a corporate alliance employer with respect to such employee.

(29) Regional alliance health plan. The term "regional alliance health plan" means a health plan offered by a regional alliance.

(30) Reside.

(A) An individual is considered to reside in the location in which the individual maintains a primary residence (as established under rules of the National Health Board).

(B) Under such rules and subject to section 1323(c), in the case of an individual who maintains more than one residence, the primary residence of the individual shall be determined taking into account the proportion of time spent at each residence.

(C) In the case of a couple only one spouse of which is a qualifying employee, except as the Board may provide, the residence of the employee shall be the residence of the couple.

(31) Secretary. The term "Secretary" means the Secretary of Health and Human Services.

(32) SSI family. The term "SSI family" means a family composed entirely of one or more SSI recipients.

(33) SSI recipient. The term "SSI recipient" means, for a month, an individual

(A) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

(B) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 930966 for the month, or

(C) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such

Act) for the month.

(34) State. The term "State" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(35) State medicaid plan. The term "State medicaid plan" means a plan of medical assistance of a State approved under title XIX of the Social Security Act.

(36) Undocumented alien. The term "undocumented alien" means an alien who is not a long-term nonimmigrant, a diplomat, or described in section 1005(c).

(37) United States. The term "United States" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and Northern Mariana Islands.

Subtitle B Miscellaneous Provisions

Section 1911 USE OF INTERIM, FINAL REGULATIONS.

In order to permit the timely implementation of the provisions of this Act, the National Health Board, the Secretary of Health and Human Services, the Secretary of Labor are each authorized to issue regulations under this Act on an interim basis that become final on the date of publication, subject to change based on subsequent public comment.

Section 1912 SOCIAL SECURITY ACT REFERENCES.

Except as may otherwise be provided, any reference in this title, or in IV or VI, to a provision of the Social Security Act shall be to that provision of the Social Security Act as in effect on the date of the enactment of this Act.