Title VI PREMIUM CAPS; PREMIUM-BASED FINANCING; AND PLAN PAYMENTS Table of Contents

Section 6000 GENERAL DEFINITIONS.

(a) Definitions Relating to Bids. In this title:

(1) Accepted bid. The term "accepted bid" means the bid which is agreed to between a regional alliance health plan and a regional alliance for coverage of the comprehensive benefit package in the alliance area under subpart A of part 1.

(2) Final accepted bid. The term "final accepted bid" means the accepted bid, taking into account any voluntary reduction in such bid made under section 6004(e).

(3) Weighted average accepted bid. The term "weighted average accepted bid" means, for a regional alliance for a year, the average of the accepted bids for all regional alliance health plans offered by such alliance, weighted to reflect the relative enrollment of regional alliance eligible individuals among such plans.

(4) Reduced weighted average accepted bid. The term "reduced weighted average accepted bid", for a health plan offered by a regional alliance for a year, is the lesser of

(A) the weighted average accepted bid for the regional alliance for the year (determined using the final accepted bids as the accepted bids), or

(B) the regional alliance per capita target for the year.

(b) Weighted Average Premium.In this title, the term "weighted average premium" means, for a class of family enrollment and with respect to a regional alliance for a year, the product of

(1) reduced weighted average accepted bid (as defined in subsection (a)(4));

(2) the uniform per capita conversion factor (established under section 1341(b)) for the alliance; and

(3) the premium class factor established by the Board for that class under section 1531.

(c) Incorporation of Other Definitions. Except as otherwise provided in this title, the definitions of terms in subtitle J of title I of this Act shall apply to this title. Title VI, Subtitle A

Subtitle A Premium Caps

Part 1 REGIONAL ALLIANCE HEALTH EXPENDITURES

Subpart A Computation of Targets and Accepted Bids

Section 6001 COMPUTATION OF REGIONAL ALLIANCE INFLATION FACTORS.

(a) Computation.

(1) In general. This section provides for the computation of factors that limit the growth of premiums for the comprehensive benefit package in regional alliance health plans. The Board shall compute and publish, not later than March 1 of each year (beginning with 1995) the regional alliance inflation factor (as defined in paragraph (2)) for each regional alliance for the following year.

(2) Regional alliance inflation factor. In this part, the term "regional alliance inflation factor" means, for a year for a regional alliance--

(A) the general health care inflation factor for the year (as defined in paragraph (3));

(B) adjusted under subsection (c) (to take into account material changes in the demographic and socio-economic characteristics of the population of alliance eligible individuals);

(C) decreased by the percentage adjustment (if any) provided with respect to the regional alliance under subsection (d) (relating to adjustment for previous excess expenditures); and

(D) in the case of the year 2001, increased by a factor that the Board determines to reflect the ratio of (i) the actuarial value of the increase in benefits provided in that year under the comprehensive benefit package to (ii) the actuarial value of the benefits that would have been in such package in the year without regard to the increase. For purposes of subparagraph (D)(i), the actuarial value of the increase with respect to mental illness and substance abuse services (included within the comprehensive benefit package) shall not exceed an actuarial value based on the amount of the total expenditures that would have been made in 2001 by States and subdivisions of States for mental illness and substance abuse services (included in such package as of 2001) if this Act had not been enacted.

(3) General health care inflation factor.

(A) 1996 through 2000. In this part, the term "general health care inflation factor", for a year, means the percentage increase in the CPI (as specified under subsection (b)) for the year plus the following:

(i) For 1996, 1.5 percentage points.

(ii) For 1997, 1.0 percentage points.

(iii) For 1998, 0.5 percentage points.

(iv) For 1999 and for 2000, 0 percentage points.

(B) Years after 2000.

(i) Recommendation to congress. In 1999, the Board shall submit to Congress recommendations on what the general health care inflation factor should be for years beginning with 2001.

(ii) Failure of congress to act. If the Congress fails to

enact a law specifying the general health care inflation factor for a year after 2000, the Board, in January of the year before the year involved, shall compute such factor for the year involved. Such factor shall be the product of the factors described in subparagraph (C) for that fiscal year, minus 1.

(C) Factors. The factors described in this subparagraph for a year are the following:

(i) CPI. 1 plus the percentage change in the CPI for the year, determined based upon the percentage change in the average of the CPI for the 12-month period ending with August 31 of the previous fiscal year over such average for the preceding 12-month period.

(ii) Real gdp per capita. 1 plus the average annual percentage change in the real, per capita gross domestic product of the United States during the 3-year period ending in the preceding calendar year, determined by the Board based on data supplied by the Department of Commerce.

(b) Projection of Increase in CPI.

(1) In general. For purposes of this section, the Board shall specify, as of the time of publication, the annual percentage increase in the CPI (as defined in section 1902(9)) for the following year.

(2) Data to be used. Such increase shall be the projection of the CPI contained in the budget of the United States transmitted by the President to the Congress in the year.

(c) Special Adjustment for Material Changes in Demographic Characteristics of Population.

(1) Adjustment for corporate alliance opt-in.

(A) In general. The Board shall develop a method for adjusting the regional alliance inflation factor for each regional alliance in order to reflect material changes in the demographic characteristics of regional alliance eligible individuals residing in the alliance area (in comparison with such characteristics for the previous year) as a result of one or more corporate alliances terminating an election under section 1313.

(B) Basis for adjustments. Adjustments under this paragraph (whether an increase or decrease) shall be based on the characteristics and factors used for making adjustments in payments under section 6124.

(2) Adjustment for regional trend compared to national trend.

(A) In general. The Board shall develop a method for adjusting the regional alliance inflator factor for each regional alliance in order to reflect material changes in the demographic characteristics (including at least age, gender, and socio-economic status) and health status of regional alliance eligible individuals residing in the alliance area in comparison with the average change in such characteristics for such individuals residing in the United States. The adjustment under this paragraph shall be for changes not taken into account in the adjustment under paragraph (1).

(B) Neutral adjustment. Such method (and any annual adjustment under this paragraph) shall be designed to result in the adjustment effected under this paragraph for a year not changing the weighted average of the regional alliance inflation factors.

(3) Application. The Board shall provide, on an annual basis, for an adjustment of regional alliance inflation factors under this subsection using such methods.

(d) Consultation Process. The Board shall have a process for consulting with representatives of States and regional alliances before establishing the regional alliance inflation factors for each year under this section.

Section 6002 BOARD DETERMINATION OF NATIONAL PER CAPITA BASELINE PREMIUM TARGET.

(a) In General. Not later than January 1, 1995, the Board shall determine a national per capita baseline premium target. Such target is equal to

(1) the national average per capita current coverage health expenditures (determined under subsection (b)),

(2) updated under subsection (c).

(b) Determination of National Average Per Capita Current Coverage Health Expenditures.

(1) In general. The Board shall determine the national average per capita current coverage health expenditures equal to

(A) total covered current health care expenditures (described in paragraph (2)), divided by

(B) the estimated population in the United States of regional alliance eligible individuals (as determined by the Board as of 1993 under paragraph (4)) for whom such expenditures were determined. The population under subparagraph (B) shall not include SSI recipients or AFDC recipients.

(2) Current health care expenditures. For purposes of paragraph (1)(A), the Board shall determine current health care expenditures as follows:

(A) Determination of total expenditures.The Board shall first determine the amount of total payments made for items and services included in the comprehensive benefit package (determined without regard to cost sharing) in the United States in 1993.

(B) Removal of certain expenditures not to be covered through regional alliances. The amount so determined shall be decreased by the proportion of such amount that is attributable to any of the following:

(i) Medicare beneficiaries (other than such beneficiaries who are regional alliance eligible individuals).

(ii) AFDC recipients or SSI recipients.

(iii) Expenditures which are paid for through workers' compensation or automobile or other liability insurance.

(iv) Expenditures by parties (including the Federal Government) that the Board determines will not be payable by regional alliance health plans for coverage of the comprehensive benefit package under this Act.

(C) Addition of projected expenditures for uninsured and underinsured individuals.The amount so determined and adjusted shall be increased to take into account increased

utilization of, and expenditures for, items and services covered under the comprehensive benefit package likely to occur, as a result of coverage under a regional alliance health plan of individuals who, as of 1993 were uninsured or underinsured with respect to the comprehensive benefit package. In making such determination, such expenditures shall be based on the estimated average cost for such services in 1993 (and not on private payment rates established for such services). In making such determination, the estimated amount of uncompensated care in 1993 shall be removed and will not include adjustments to offset payments below costs by public programs.

(D) Addition of health plan and alliance costs of administration. The amount so determined and adjusted shall be increased by an estimated percentage (determined by the Board, but no more than 15 percent) that reflects the proportion of premiums that are required for health plan and regional alliance administration (including regional alliance costs for administration of income-related premium discounts and cost sharing reductions) and for State premium taxes (which taxes shall be limited to such amounts in 1993 as are attributable to the health benefits to be included in the comprehensive benefit package).

(E) Decrease for cost sharing. The amount so determined and adjusted shall be decreased by a percentage that reflects (i) the estimated average percentage of total amounts payable for items and services covered under the comprehensive benefit package that will be payments in the form of cost sharing under a higher cost sharing plan, and (ii) the percentage reduction in utilization estimated to result from the application of high cost sharing.

(3) Special rules.

(A) Benefits used. The determinations under this section shall be based on the comprehensive benefit package as in effect in 1996.

(B) Assuming no change in expenditure pattern.The determination under paragraph (2) shall be made without regard to any change in the pattern of expenditures that may result from the enrollment of AFDC recipients and SSI recipients in regional alliance health plans.

(4) Eligible individuals. In this subsection, the

determination of who are regional alliance eligible individuals under this subsection shall be made as though this Act was fully in effect in each State as of 1993.

(c) Updating.

(1) In general. Subject to paragraph (3), the Board shall update the amount determined under subsection (b)(1) for each of 1994 and 1995 by the appropriate update factor described in paragraph (2) for the year.

(2) Appropriate update factor. In paragraph (1), the appropriate update factor for a year is 1 plus the annual percentage increase for the year (as determined by the Secretary, based on actual or projected information) in private sector health care spending for items and included in the comprehensive benefit package (as of 1996).

(3) Limit. The total, cumulative update under this subsection shall not exceed 15 percent.

Section 6003 DETERMINATION OF ALLIANCE PER CAPITA PREMIUM TARGETS.

(a) Initial Determination. Not later than January 1, 1995, the Board shall determine, for each regional alliance for 1996, a regional alliance per capita premium target. Such target shall equal

(1) the national per capita baseline premium target (determined by the Board under section 6002),

(2) updated by the regional alliance inflation factor (as determined under section 6001(a)(2)) for 1996, and

(3) adjusted by the adjustment factor for the regional alliance (determined under subsection (c)).

(b) Subsequent Determinations.

(1) Determination. Not later than March 1 of each year (beginning with 1996) the Board shall determine, for each regional alliance for the succeeding year a regional alliance per capita premium target.

(2) General rule. Subject to subsection (e), such target

shall equal

(A) the regional alliance per capita target determined under this section (without regard to subsection (e)) for the regional alliance for the previous year,

(B) updated by the regional alliance inflation factor (as determined in section 6001(a)) for the year.

(3) Adjustment for previous excess rate of increase in expenditures. Such target for a year is subject to a decrease under section 6001(d).

(c) Adjustment Factors for Regional Alliances for Initial Determination.

(1) In general. The Board shall establish an adjustment factor for each regional alliance in a manner consistent with this subsection.

(2) Considerations. In establishing the factor for each regional alliance, the Board shall consider, using information of the type described in paragraph (3), the difference between the national average of the factors taken into account in determining the national per capita baseline premium target and such factors for the regional alliance, including variations in health care expenditures and in rates of uninsurance and underinsurance in the different alliance areas and including variations in the proportion of expenditures for services provided by academic health centers in the different alliance areas.

(3) Type of information. The type of information described in this paragraph is

(A) information on variations in premiums across States and across alliance areas within a State (based on surveys and other data);

(B) information on variations in per capita health spending by State, as measured by the Secretary;

(C) information on variations across States in per capita spending under the medicare program and in such spending among alliance areas within a State under such program; and

(D) area rating factors commonly used by actuaries.

(4) Application of factors in neutral manner. The application of the adjustment factors under this subsection for 1996 shall be done in a manner so that the weighted average of the regional alliance per capita premium targets for 1996 is equal to the national per capita baseline premium target determined under section 6002. Such weighted average shall be based on the Board's estimate of the expected distribution of alliance eligible individuals (taken into account under section 6002) among the regional alliances.

(5) Consultation process. The Board shall have a process for consulting with representatives of States and regional alliances before establishing the adjustment for regional alliances under this subsection.

(d) Treatment of Certain States.

(1) Non-alliance states. In the case of a State that is not a participating State or otherwise has not established regional alliances, the entire State shall be treated under the provisions of this part as composing a single regional alliance.

(2) Changes in alliance boundaries. In the case of a State that changes the boundaries of its regional alliances (including the establishment of such alliances after 1996), the Board shall provide a method for computing a regional alliance per capita premium target for each regional alliance affected by such change in a manner that

(A) reflects the factors taken into account in establishing the adjustment factors for regional alliances under subsection (c), and

(B) results in the weighted average of the newly computed regional targets for the regional alliances affected by the change equal to the weighted average of the regional targets for the regional alliances as previously established.

(e) Adjustment for Previous Excess Rate of Increase in Expenditures.

(1) In general. If the actual weighted average accepted bid for a
regional alliance for a year (as determined by the Board based on actual enrollment in the first month of the year)

exceeds the regional alliance per capita premium target (determined under this section) for the year, then the regional alliance per capita premium target shall be reduced, by \1/2\ of the excess percentage (described in paragraph (2)) for the year, for each of the 2 succeeding years.

(2) Excess percentage. The excess percentage described in this paragraph for a year is the percentage by which

(A) the actual weighted average accepted bid (referred to in paragraph (1)) for a regional alliance for the year, exceeds

(B) the regional alliance per capita premium target (determined under this section) for the year.

Section 6004 ALLIANCE INITIAL BIDDING AND NEGOTIATION PROCESS.

(a) Bidding Process.

(1) Obtaining bids.

(A) In general. Not later than July 1 before the first year, and not later than August 1 of each succeeding year, the regional alliance shall have obtained premium bids from each plan seeking to participate as a regional alliance health plan with respect to the alliance in the following year.

(B) Disclosure. In obtaining such bids, a regional alliance may determine to disclose (or not to disclose) the regional alliance per capita premium target for the regional alliance (determined under section 6003) for the year involved.

(C) Condition. Each bid submitted by a plan under this subsection shall be conditioned upon the plan's agreement to accept any payment reduction that may be imposed under section 6011.

(2) Negotiation process. Following the bidding process under paragraph (1), a State may provide for negotiations with health plans relating to the premiums to be charged by such plans. Such negotiations may result in the resubmission of bids, but in no case shall a health plan resubmit a bid that exceeds its prior bid.

(3) Legally binding bids. All bids submitted under this subsection must be legally binding with respect to the plans involved.

(4) Acceptance. The final bid submitted by a plan under this subsection shall be considered to be the final accepted bid, except as provided in subsection (e).

(5) Assistance. The Board shall provide regional alliances with such information and technical assistance as may assist such alliances in the bidding process under this subsection.

(b) Submission of Information to Board. By not later than September 1 of each year for which bids are obtained under subsection (a), each regional alliance shall submit to the Board a report that discloses

(1) information regarding the final bids obtained under subsection (a) by the different plans;

(2) (A) for the first year, any information the Board may request concerning an estimation of the enrollment likely in each such plan of alliance eligible individuals who will be offered enrollment in a health plan by alliance in the first year, or

(B) for a succeeding year, the actual distribution of enrollment of alliance eligible individuals in regional alliance health plans in the year in which the report is transmitted; and

(3) limitations on capacity of regional alliance health plans.

(c) Computation of Weighted Average Accepted Bid.

(1) In general. For each regional alliance the Board shall determine a weighted average accepted bid for each year for which bids are obtained under subsection (a). Such determination shall be based on information on accepted bids for the year, submitted under subsection (b)(1), and shall take into account, subject to paragraph (2), the information on enrollment distribution submitted under subsection (b)(2).

(2) Enrollment distribution rules. In making the determination under paragraph (1) for a regional alliance, the Board shall establish rules respecting the treatment of

enrollment in plans that are discontinued or are newly offered.

(d) Notice to Certain Alliances.

(1) In general. By not later than October 1 of each year for which bids are obtained, the Board shall notify a regional alliance

(A) if the weighted average accepted bid (determined under subsection (c)) for the alliance is greater than the regional alliance per capita premium target for the alliance (determined under section 6003) for the year, and

(B) of the reduced weighted average accepted bid for the alliance.

(2) Notice of premium reductions. If notice is provided to a regional alliance under paragraph (1), the Board shall notify the regional alliance and each noncomplying plan of any plan payment reduction computed under section 6011 for such a plan and the opportunity to voluntarily reduce the accepted bid under subsection (e) in order to avoid such a reduction.

(e) Voluntary Reduction of Accepted Bid (Final Accepted Bid). After the Board has determined under subsection (c) the weighted average accepted bid for a regional alliance and the Board has determined plan payment reductions, before such date as the Board may specify (in order to provide for an open enrollment period), a noncomplying plan has the opportunity to voluntarily reduce its accepted bid by the amount of the plan payment reduction that would otherwise apply to the plan. Such reduction shall not affect the amount of the plan payment reduction for any other plan for that year.

Section 6005 STATE FINANCIAL INCENTIVES.

(a) Election. Any participating State may elect to assume responsibility for containment of health care expenditures in the State consistent with this part. Such responsibility shall include submitting annual reports to the Board on any activities undertaken by the State to contain such expenditures. A participating State may regulate the rates charged by providers furnishing health care items and services to all private payers. Such regulation of rates may not cause a corporate alliance health plan to be charged, directly or indirectly, rates different from those charged other health plans for the same

items and services or otherwise discriminate against corporate alliance health plans.

(b) Financial Incentive. In the case of a State that has made an election under subsection (a), if the Board determines for a particular year (beginning with the first year) that the statewide weighted average of the reduced weighted average accepted bids (based on actual average enrollment for the year), for regional alliances in the State, is less than the statewide weighted average of the regional alliance per capita premium targets (based upon such enrollment) for such alliances for the year, then the amount of the State maintenance-of-effort payment under section 9001(b), for the following year, shall be reduced by \1/2\ of the product of

(1) (A) the amount by which the amount of such statewide average target exceeds the amount of such statewide average accepted bid, divided by (B) the amount of such target; and

(2) the total of the amount of the Federal payments made in that particular year to regional alliances in the State under subtitle B of title IX.

Section 6006 RECOMMENDATIONS TO ELIMINATE REGIONAL VARIATIONS IN ALLIANCE TARGETS DUE TO VARIATION IN PRACTICE PATTERNS; CONGRESSIONAL CONSIDERATION.

(a) Establishment of Advisory Commission on Regional Variations in Health Expenditures. The chair of the Board shall establish, by not later than 60 days after the date of appointment of the first chair, an advisory commission on regional variations in health expenditures.

(b) Composition. The advisory commission shall be composed of consumers, employers, providers, representatives of health plans, States, regional alliances, individuals with expertise in the financing of health care, individuals with expertise in the economics of health care, and representatives of diverse geographic areas.

(c) Elimination of Regional Variation in Premiums Due to Practice Pattern.

(1) Commission study. The advisory commission shall examine methods of eliminating variation in regional alliance per capita premium targets due to variation in practice patterns, not

due to other factors (such as health care input prices and demographic factors), by 2002.

(2) Commission report. The advisory commission shall submit to the Board a report that specifies one or more methods for eliminating the variation described in paragraph (1).

(3) Board recommendations.The Board shall submit to Congress, by not later July 1, 1995, detailed recommendations respecting the specific method to be used to eliminate the variation described in paragraph (1) by 2002. Such recommendations may take into account regional variations in demographic or health status and in health care input prices, based on the availability of accurate proxies for measuring price variation. In taking into account health care input prices, the Board shall explain what percentage of variation found should be adjusted and what percentage of the premium should be adjusted.

(d) Congressional Consideration.

(1) In general. Detailed recommendations submitted under subsection (c)(3) shall apply under this subtitle 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 Board submits recommendations under subsection (e)(3) 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 National Health Board concerning elimination of regional variation in regional alliance premiums, as submitted by the Board 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 National Health Board concerning elimination of regional variation in regional alliance premiums, as submitted by the Board 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)(3)) 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)(3)); 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 Board submits a recommendation under subsection (c)(3).

(e) Elimination of Regional Variation State Payment Amounts.

(1) Commission study. The advisory commission shall examine methods of reducing variation among State in the level of payments required under subtitle A of title IX by 2002. The commission shall examine methods of reducing variation due to practice patterns, historical differences in the rates of reimbursement to providers, and in the amount, duration, and scope of benefits covered under State medicaid plans.

(2) Commission report. The advisory commission shall submit to the Board a report that specifies one or more methods for reducing the variation described in paragraph (1).

(3) Board recommendations. The Board shall submit to Congress, by not later July 1, 1995, detailed recommendations respecting the specific method to be used to reduce the variation described in paragraph (1) by 2002 in a budget neutral manner with respect to total government payments and payments by the Federal Government. In submitting recommendations under this paragraph, the Board shall consider the fiscal capacity of the States.

(4) Congressional consideration.

(A) In general.Subject to the succeeding provisions of this paragraph, the provisions of subsection (d) shall apply to recommendations under paragraph (3) in the same manner as they apply to recommendations under subsection (c)(3).

(B) Special rules. In applying subparagraph (A)

(i) the following shall be substituted for the matter after the resolving clause described in subsection (d)(2)(B): "That Congress disapproves the recommendations of the National Health Board concerning reduction of regional variation in State payments, as submitted by the Board on XXXXXXX."; and

(ii) the following shall be substituted for the title described in subsection (d)(2)(C): "Joint resolution disapproving recommendations of the National Health Board concerning reducing regional variation in State payments, as submitted by the Board on XXXXXXX.".

(f) Information. The advisory commission shall provide the Board, States, and regional alliances with information about regional differences in health care costs and practice patterns.

Section 6007 REFERENCE TO LIMITATION ON ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN DETERMINATIONS.

For limitation on administrative and judicial review of certain determinations under this part, see section 5232.

Subpart B Plan and Provider Payment Reductions to Maintain Expenditures within Targets

Section 6011 PLAN PAYMENT REDUCTION.

(a) Plan Payment Reduction. In order to assure that payments to regional alliance health plans by a regional alliance are consistent with the applicable regional alliance per capita target for the alliance (computed under this subtitle), each noncomplying plan (as defined in subsection (b)(2)) for a year is subject to a reduction in plan payment (under section 1351) by the amount equal to plan payment reduction specified in subsection (c) for the year.

(b) Noncomplying Alliance and Noncomplying Plan Defined. In this part:

(1) Noncomplying alliance. The term "noncomplying alliance" means, for a year, a regional alliance for which the weighted average accepted bid (computed under section 6004(c)) exceeds the regional alliance per capita premium target for the year.

(2) Noncomplying plan. The term "noncomplying plan" means, for a year, a regional alliance health plan offered through a noncomplying alliance if the final accepted bid for the year exceeds the maximum complying bid (as defined in subsection (d)) for the year. No plan shall be a noncomplying plan for a year before the first year in which the plan is offered by a regional alliance.

(c) Amount of Plan Payment Reduction.

(1) In general. The amount of the plan payment reduction, for a noncomplying plan offered by an alliance, is the alliance-wide reduction percentage (as defined in paragraph (2)) of the excess bid amount (as defined in paragraph (3)) for the plan.

(2) Alliance-wide reduction percentage.

(A) In general. In paragraph (1), the term "alliance-wide reduction percentage" means, for a noncomplying plan offered by an alliance for a year

(i) the amount by which (I) the weighted average accepted bid (computed under section 6004(c)(1)) for the alliance for the year, exceeds (II) the regional alliance per capita target for the alliance for the year; divided by

(ii) the sum, for noncomplying plans offered by the alliance,

of the plan proportions of alliance excess bid amounts (described in subparagraph (B)(i)) for the year.

(B) Plan proportion of alliance excess bid amount described.

(i) In general. The "plan proportion of alliance excess bid amount" described in this clause, for a noncomplying plan, is the product of

(I) the excess bid amount (as defined in paragraph (3)) for the plan, and

(II) the plan enrollment proportion (as defined in clause (ii)) for the plan.

(ii) Plan enrollment proportion. In clause (i)(II), the term

"plan enrollment proportion" means, with respect to a health plan offered by a regional alliance, the total enrollment of alliance eligible individuals enrolled in such plan expressed as a percentage of the total enrollment of alliance eligible individuals in all regional alliance plans offered by the alliance. Such proportion shall be computed based on the information used in computing the weighted average accepted bid for the alliance under section 6004(c)(1).

(3) Excess bid amount. In this subsection, the "excess bid amount", with respect to a noncomplying plan for a year, is the amount by which

(A) the accepted bid for the year (not taking into account any voluntary reduction under section 6004(e)), exceeds

(B) the maximum complying bid (as defined in subsection (d)) for the plan for the year.

(d) Maximum Complying Bid.

(1) First year. In this part for the first year, the "maximum complying bid" for each plan offered by a regional alliance, is the regional alliance per capita premium target for the alliance (determined under section 6003) for the year.

(2) Subsequent years. In this part, subject to paragraph (3), for a subsequent year, the "maximum complying bid", for a

plan offered by an alliance for a year, is the sum of the following:

(A) Net previous year accepted bid for plan. The accepted bid for the previous year (not taking into account any voluntary reduction under section 6004(e)), minus the amount of any plan payment reduction for the plan for that year.

(B) Alliance-wide inflation allowance. The amount by which

(i) the regional alliance per capita premium target for the year, exceeds

(ii) such target for the previous year, or, if less, the weighted average accepted bid (computed under section 6004(c)(1)) for such year.

(3) Special rules for new plans.

(A) In general. Subject to subparagraph (B), in the case of a plan that is first offered by a regional alliance in a year after the first year the maximum complying bid shall be the regional alliance per capita premium target for the year.

(B) Authority. The Board or a State may establish rules to modify the application of subparagraph (A) for regional alliance health plans in the State in order

(i) to prevent abusive premium practices by entities previously offering plans, or

(ii) to encourage the availability of all types of plans in the State and to permit establishment of new plans.

Section 6012 PROVIDER PAYMENT REDUCTION.

(a) Participating Providers.

(1) In general. Each regional alliance health plan, as part of its contract under section 1406(e) with any participating provider (as defined in section 1407(c), or group of participating providers) shall

(A) include a provision that provides that if the plan is a noncomplying plan for a year, payments to the provider

(or group) shall be reduced by the applicable network reduction percentage (described in paragraph (2)) for the year, and

(B) not include any provision which the State determines otherwise varies the payments to such providers (or group) because of, or in relation to, a plan payment reduction under section 6011 or otherwise is intended to nullify the effect of subparagraph (A). The Board may issue regulations relating to the requirements of this paragraph.

(2) Applicable network reduction percentage.

(A) In general. Subject to subparagraph (B), the "applicable network reduction percentage", with respect to participating providers of a noncomplying plan for a year is

(i) the plan payment reduction amount for the plan for the year (as determined under section 6011(c)), divided by

(ii) the final accepted bid for the plan for the year, adjusted under subparagraph (B).

(B) Induced volume offset. The Board shall provide for an appropriate increase of the percentage reduction computed under subparagraph (A) to take into account any estimated increase in volume of services provided that may reasonably be anticipated as a consequence of applying a reduction in payment under this subsection. The Board may compute and apply such increase differently for different classes of providers or services or different types of health plans (as the Board may define).

(b) Other Providers.

(1) In general. Each regional alliance health plan that is a noncomplying plan in a year shall provide for a reduction in the amount of payments to providers (or groups of providers) that are not participating providers under the applicable alliance fee schedule under section 1406(c)(3) by the applicable nonnetwork reduction percentage (described in paragraph (2)) for the year.

(2) Applicable nonnetwork reduction percentage.

(A) In general. Subject to subparagraph (B), the "applicable nonnetwork reduction percentage", with respect to nonparticipating providers of a noncomplying plan for a year is

(i) the plan payment reduction amount for the plan for the year (as determined under section 6011(c)), divided by

(ii) the final accepted bid for the plan for the year, adjusted under subparagraph (B).

(B) Induced volume offset. The Board shall provide for an appropriate increase of the percentage reduction computed under subparagraph (A) to take into account any estimated increase in volume of services provided that may reasonably be anticipated as a consequence of applying a reduction in payment under this subsection. The Board may compute and apply such increase differently for different classes of providers or services or different types of health plans (as the Board may define).

(c) Application to Cost Sharing and to Balance Billing Restrictions. For purposes of applying section 1406(d) (relating to balance billing limitations) and part 3 of subtitle B of title I (relating to computation of cost sharing), the payment basis otherwise used for computing any limitation on billing or cost sharing shall be such payment basis as adjusted by any reductions effected under this section.

Part 2 CORPORATE ALLIANCES HEALTH EXPENDITURES

Section 6021 CALCULATION OF PREMIUM EQUIVALENTS.

(a) In General. By January 1, 1998, the Board shall develop a methodology for calculating an annual per capita expenditure equivalent for amounts paid for coverage for the comprehensive benefit package within a corporate alliance.

(b) Adjustment Permitted. Such methodology shall permit a corporate alliance to petition the Secretary of Labor for an adjustment of the inflation adjustment that would otherwise apply to compensate for material changes in the demographic characteristics of the eligible individuals receiving coverage through the alliance.

(c) Reporting. In 2001 and each subsequent year, each corporate alliance shall report to the Secretary of Labor, in a form and manner specified by the Secretary, the average of the annual per capita expenditure equivalent for the previous 3-year period.

Section 6022 TERMINATION OF CORPORATE ALLIANCE FOR EXCESS INCREASE IN EXPENDITURES.

(a) Termination.

(1) In general. If a corporate alliance has two excess years (as defined in subsection (b)) in a 3-year-period, then, effective beginning with the second year following the second excess year in such period

(A) the Secretary of Labor shall terminate the corporate alliance, and

(B) employers that were corporate alliance employers with respect to such corporate alliance shall become regional alliance employers (unless, in the case of a corporate alliance with a plan sponsor described in subparagraph (B) or (C) of section 1311(b)(1), the employers become corporate alliance employers of another such corporate alliance).

(2) Initial 3-year-period. Paragraph (1) shall first apply to the 3-year-period beginning with 1998.

(3) Special subsequent treatment for large employers.In the case of corporate alliance employers described in paragraph (1)(B) that are large employers, the employer premium payments under section 6121 are subject to adjustment under section 6124.

(4) No further election. If a corporate alliance of a large employer is terminated under this subsection, no employer that is a corporate alliance employer for that alliance is eligible to be a sponsor of a corporate alliance.

(b) Excess Year.

(1) In general. In subsection (a), the term "excess year" means, for a corporate alliance, a year (after 2000) for which

(A) the rate of increase for the corporate alliance (specified in paragraph (2)) for the year, exceeds

(B) the national corporate inflation factor (specified in paragraph (3)) for the year.

(2) Rate of increase for corporate alliance.The rate of

increase for a corporate alliance for a year, specified in this paragraph, is the percentage by which

(A) the average of the annual per capita expenditure equivalent for the corporate alliance (reported under section 6021(c)) for the 3-year period ending with such year, exceeds

(B) the average of the annual per capita expenditure equivalent for the corporate alliance (reported under such subsection) for the 3-year period ending with the previous year.

(3) National corporate inflation factor. The national corporate inflation factor for a year, specified in this paragraph, is the average of the general health care inflation factors (as defined in section 6001(a)(3)) for each of the 3 years ending with such year.

Part 3 TREATMENT OF SINGLE-PAYER STATES

Section 6031 SPECIAL RULES FOR SINGLE-PAYER STATES.

In the case of a Statewide single-payer State, for purposes of section 1222, the Board shall compute a Statewide per capita premium target for each year in the same manner as a regional alliance per capita premium target is determined under section 6003.

Part 4 TRANSITION PROVISIONS

Section 6041 MONITORING PRICES AND EXPENDITURES.

(a) In General. The Secretary shall establish a program to monitor prices and expenditures in the health care system in the United States.

(b) Reports. The Secretary shall periodically report to the President on

(1) the rate of increase in expenditures in each sector of the health care system, and

(2) how such rates compare with rate of overall increase in health care spending and rate of increase in the consumer price index.

(c) Access to Information.

(1) In general. The Secretary may obtain, through surveys or otherwise, information on prices and expenditures for health care services. The Secretary may compel health care providers and third party payers to disclose such information as is necessary to carry out the program under this section.

(2) Confidentiality. Non-public information obtained under this subsection with respect to individual patients is confidential.

(d) Periodic Reports. The Secretary shall periodically issue public reports on the matters described in subsection (b).
Title VI, Subtitle B

Subtitle B Premium-Related Financings

Part 1 FAMILY PREMIUM PAYMENTS

Subpart A Family Share

Section 6101 FAMILY SHARE OF PREMIUM.

(a) Requirement. Each family enrolled in a regional alliance health plan or in a corporate alliance health plan in a class of family enrollment is responsible for payment of the family share of premium payable respecting such enrollment. Such premium may be paid by an employer or other person on behalf of such a family.

(b) Family Share of Premium Defined.

(1) In general. In this subtitle, the term "family share of premium" means, with respect to enrollment of a family

(A) in a regional alliance health plan, the amount specified in paragraph (2) for the class, or

(B) in a corporate alliance health plan, the amount specified in paragraph (3) for the class.

(2) Regional alliance.

(A) In general. The amount specified in this paragraph for a health plan based on a class of family enrollment is the sum of the base amounts described in subparagraph (B)

reduced (but not below zero) by the sum of the amounts described in subparagraph (C).

(B) Base. The base amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) Regional alliance premium. The premium specified in section 6102(a) with respect to such class of enrollment.

(ii) Family collection shortfall. 20 percent of the family collection shortfall add-on (computed under section 6107 for such class).

(C) Credits and discounts. The amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) Alliance credit. The amount of the alliance credit under section 6103(a).

(ii) Income related discount. The amount of any income-related discount provided under section 6104(a)(1).

(iii) Excess premium credit. The amount of any excess premium credit provided under section 6105.

(iv) Corporate alliance opt-in credit. The amount of any corporate alliance opt-in credit provided under section 6106.

(v) Additional credit for ssi and afdc recipients. In the case of an SSI or AFDC family or for whom the amount described in clause (ii) is equal to the amount described in section 6104(b)(1)(A), the amount described in subparagraph (B)(ii).

(D) Limit on miscellaneous credits. In no case shall the family share, due to credits under subparagraph (C), be less than zero.

(3) Corporate alliance.

(A) In general. The amount specified in this paragraph for a health plan based on a class of family enrollment is the premium described in subparagraph (B) reduced (but not below zero) by the sum of the amounts described in subparagraph (C).

(B) Premium. The premium described in this subparagraph (for a plan for a class of enrollment) is premium specified under section 1384 with respect to the plan and class of enrollment involved.

(C) Credits and discounts. The amounts described in this subparagraph (for a plan for a class of enrollment) are as follows:

(i) Alliance credit. The amount of the alliance credit under section 6103(b).

(ii) Income related discount. The amount of any income-related discount provided under section 6104(a)(2).

Section 6102 AMOUNT OF PREMIUM.

(a) Regional Alliance. The amount of the premium charged by a regional alliance for all families in a class of family enrollment under a regional alliance health plan offered by the alliance is equal to the product of

(1) the final accepted bid for the plan (as defined in section 6000(a)(2)),

(2) the uniform per capita conversion factor (specified under section 1341(b)) for the alliance, and

(3) the premium class factor established by the Board for that class under section 1531.

(b) Reference to Corporate Alliance Premium Provisions. The amount of the premium charged by a corporate alliance for all families in a class of family enrollment under a corporate alliance health plan offered by the alliance is specified under section 1384.

(c) Special Rules for Divided Families. In the case of an individual who is a qualifying employee of an employer, if the individual has a spouse or child who is not treated as part of the individual's family because of section 1012

(1) the combined premium for both families under this section shall be computed as though such section had not applied if such combined premium is less than the total of the premiums

otherwise applicable (without regard to this subsection),

(2) the regional alliance shall divide such combined premium between the families proportionally (consistent with rules established by the Board), and

(3) in such case, credits and other amounts shall be pro-rated in a manner consistent with rules established by the Board.

Section 6103 ALLIANCE CREDIT.

(a) Regional Alliances. The credit provided under this section for a family enrolled in a regional alliance health plan through a regional alliance for a class of family enrollment is equal to 80 percent of the weighted average premium (as defined in section 6000(b)) for health plans offered by the alliance for the class.

(b) Corporate Alliances. The credit provided under this section for a family enrolled in a corporate alliance health plan for a class of family enrollment is equal to the minimum employer premium payment required under section 6131 with respect to the family.

Section 6104 PREMIUM DISCOUNT BASED ON INCOME.

(a) In General.

(1) Enrollees in regional alliance health plans. Each family enrolled with a regional alliance health plan is entitled to a premium discount under this section, in the amount specified in subsection (b), if the family

(A) is an AFDC or SSI family,

(B) is determined, under subpart D of part 3 of subtitle D of title I, to have family adjusted income below 150 percent of the applicable poverty level, or

(C) is a family described in subsection (c)(3) for which the family obligation amount under subsection (c) for the year would otherwise exceed a specified percent of family adjusted income described in such subsection.

(2) Enrollees in corporate alliance health plans.

(A) In general. Subject to subparagraph (B), each family enrolled with a corporate alliance health plan in a class of family enrollment by virtue of the full-time employment of a low-wage employee (as defined in subparagraph (B)) is entitled to a premium discount under this section in the amount (if any) by which

(i) 95 percent of the premium (specified in section 1384) for the least expensive corporate alliance health plan that is offered to the employee and that is a lower or combination cost sharing plan (as defined in paragraphs (7) and (20) of section 1902 for that class and premium area), exceeds

(ii) the alliance credit under section 6103(b) for that class.

(B) Low-wage employee defined.

(i) In general. In this paragraph, the term "low-wage employee" means, with respect to an employer, an employee who is employed on a full-time basis and who is receiving wages (as defined in section 1901(a)(1)(A)) for employment for the employer, as determined under subparagraph (C)(ii)), at an annual rate of less than $15,000 (as adjusted under clause (ii)).

(ii) Indexing. For a year after 1994, the dollar amount specified in clause (i) shall be increased or decreased by the same percentage as the percentage increase or decrease by which the average CPI (described in section 1902(9)) 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.

(C) Timing of determination.

(i) In general. The determination of whether or not an employee is a low-wage employee shall be made, in accordance with rules of the Secretary of Labor, at the time of initial enrollment and shall also be made at the time of each subsequent open enrollment period, on the basis of the wages payable by the employer at that time.

(ii) Effective date. Such determination shall apply as of the effective date of the initial enrollment, or, in the case of an open enrollment period, as of the effective date of changes in enrollment during such period.

(3) No liability for indians and certain veterans and military personnel.

(A) In general. In the case of an individual described in subparagraph (B), because the applicable health plan does not impose any premium for such an individual, the individual is not eligible for any premium discount under this section.

(B) Individuals described. An individual described in this subparagraph is

(i) an electing veteran (as defined in section 1012(d)(1)) who is enrolled under a health plan of the Department of Veterans Affairs and who, under the laws and rules as in effect as of December 31, 1994, has a service-connected disability or who is unable to defray the expenses of necessary care as determined under section 1722(a) of title 38, United States Code,

(ii) active duty military personnel (as defined in section 1012(d)(2)), and

(iii) an electing Indian (as defined in section 1012(d)(3)).

(4) Monthly application to afdc and ssi families. Paragraph (1)(A) (and the family obligation amount under subsection (c) insofar as it relates to an AFDC or SSI family) shall be applied to the premium or family obligation amount only for months in which the family is such an AFDC or SSI family.

(b) Amount of Premium Discount for Regional Alliance Health Plans.

(1) In general. Subject to the succeeding paragraphs of this subsection, the amount of the premium discount under this subsection for a family enrolled in a regional alliance health plan under a class of family enrollment is equal to

(A) 20 percent of the weighted average premium for regional alliance health plans offered by the regional alliance for that class of enrollment, increased by any amount provided under paragraph (2); reduced (but not below zero) by

(B) the sum of

(i) the family obligation amount described in subsection (c), and

(ii) the amount of any employer payment (not required under part 2) towards the family share of premiums for covered members of the family.

(2) Increase to assure enrollment in at-or-below-average-cost plan. If a regional alliance determines that a family eligible for a discount under this section is unable to enroll in a at-or-below-average-cost plan (as defined in paragraph (3)) that serves the area in which the family resides, the amount of the premium discount under this subsection is increased but only to such amount as will permit the family to enroll in a regional alliance health plan without the need to pay a family share of premium under this part in excess of the sum described in paragraph (1)(B).

(3) At-or-below-average-cost plan defined. In this section, the term "at-or-below-average-cost plan" means a regional alliance health plan the premium for which does not exceed, for the class of family enrollment involved, the weighted average premium for the regional alliance.

(c) Family Obligation Amount.

(1) Determination. Subject to paragraphs (2) and (3), the family obligation amount under this subsection is determined as follows:

(A) No obligation if income below income threshold amount or if afdc or ssi family.If the family adjusted income (as defined in section 1372(d)) of the family is less than the income threshold amount (specified in paragraph (4)) or if the family is an AFDC or SSI family, the family obligation amount is zero.

(B) Income above income threshold amount. If such income is at least such income threshold amount and the family is not an AFDC or SSI family, the family obligation amount is the sum of the following:

(i) For income (above income threshold amount) up to the poverty level. The product of the initial marginal rate (specified in paragraph (2)) and the amount by which

(I) the family adjusted income (not including any

portion that exceeds the applicable poverty level for the class of family involved), exceeds

(II) such income threshold amount.

(ii) Graduated phase out of discount up to 150 percent of poverty level. The product of the final marginal rate (specified in paragraph (2)) and the amount by which the family adjusted income exceeds 100 percent (but is less than 150 percent) of the applicable poverty level.

(2) Marginal rates. In paragraph (1)

(A) Individual marginal rates. For a year for an individual class of enrollment

(i) Initial marginal rate. The initial marginal rate is the ratio of

(I) 3 percent of the applicable poverty level for the individual class of enrollment for the year, to

(II) the amount by which such poverty level exceeds such income threshold amount.

(ii) Final marginal rate. The final marginal rate is the ratio of

(I) the amount by which the general family share (as defined in subparagraph (C)) for an individual class of enrollment exceeds 3 percent of the applicable poverty level (for an individual class of enrollment for the year); to

(II) 50 percent of such poverty level.

(B) Family marginal rates .For a year for a family class of enrollment (as defined in section 1011(c)(2)(A))

(i) Initial marginal rate. The initial marginal rate is the ratio of

(I) 3 percent of the applicable poverty level for a dual parent class of enrollment for the year, to

(II) the amount by which such poverty level exceeds such income threshold amount.

(ii) Final marginal rate. The final marginal rate is the ratio of

(I) the amount by which the general family share (as defined in subparagraph (C)) for a dual parent class of enrollment exceeds 3 percent of the applicable poverty level (for such a class for the year); to

(II) 50 percent of such poverty level.

(C) General family share. In subparagraphs (A) and (B), the term "general family share" means, for a class, the weighted average premium for the class minus the alliance credit (determined without regard to this section).

(3) Limitation to 3.9 percent for all families.

(A) In general.

(i) Families with income below 150 percent of poverty. In the case of a family with family adjusted income of less than 150 percent of the applicable poverty level, in no case shall the family obligation amount under this subsection for the year exceed 3.9 percent (adjusted under subparagraph (C)) of the amount of such adjusted income.

(ii) Other families with income below $40,000. In the case of a family with family adjusted income of at least 150 percent of the applicable poverty level but less than $40,000 (adjusted under subparagraph (B)) for a year, the family obligation amount under this subsection for the year is equal to 3.9 percent (adjusted under subparagraph (C)) of the amount of such adjusted income.

(B) Indexing of dollar amounts.

(i) In general. For a year after 1994, the dollar amounts specified in subparagraph (A)(i) and in section 6113(d)(1)(B) shall be increased or decreased by the same percentage as the percentage increase or decrease by which the average CPI (described in section 1902(9)) 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.

(ii) Rounding. The dollar amounts adjusted under this

subparagraph shall be rounded each year to the nearest multiple of $100.

(C) Indexing of percentage.

(i) In general. The percentage specified in subparagraph (A) shall be adjusted for any year after 1994 so that the percentage for the year bears the same ratio to the percentage so specified as the ratio of

(I) 1 plus the general health care inflation factor (as defined in section 6001(a)(3)) for the year, bears to

(II) 1 plus the percentage specified in section 1136(b) (relating to indexing of dollar amounts related to cost sharing) for the year.

(ii) Rounding. Any adjustment under clause (i) for a year shall be rounded to the nearest multiple of \1/10\ of 1 percentage point.

(4) Income threshold amount.

(A) In general. For purposes of this subtitle, the income threshold amount specified in this paragraph is $1,000 (adjusted under subparagraph (B)) .

(B) Indexing. For a year after 1994, the income threshold amount specified in subparagraph (A) shall be increased or decreased by the same percentage as the percentage increase or decrease by which the average CPI (described in section 1902(9)) 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.

(C) Rounding. Any increase or decrease under subparagraph (B) for a year shall be rounded to the nearest multiple of $10.