Title VIII HEALTH AND HEALTH-RELATED PROGRAMS OF THE FEDERAL GOVERNMENT

Table of Contents

(a) Establishment of Plans. (1) Chapter 55 of title 10, United States Code, is amended by inserting after section 1073 the following new section:

"1073a. Uniformed Services Health Plans: establishment and coordination with national health care reform

"(a) Establishment Authorized.(1) The Secretary of Defense, in consultation with the other administering Secretaries, may establish one or more Uniformed Services Health Plans pursuant to this section in order to provide health care services to members of the uniformed services on active duty for a period of more than 30 days and persons described in subsection (e)(2).

"(2) The establishment and operation of a Uniformed Services Health Plan shall be carried out in accordance with regulations prescribed by the Secretary of Defense, in consultation with the other administering Secretaries. The Secretary shall assure that such regulations conform, to the maximum extent practicable, to the requirements for health plans set forth in the Health Security Act.

"(b) Use of Uniformed Services Facilities and Other Health Care Providers. (1) A Uniformed Services Health Plan may rely upon the use of facilities of the uniformed services for the provision of health care services to persons enrolled in the plan, supplemented by the use of civilian health care providers or health plans under agreements entered into by the Secretary of Defense.

"(2) An agreement with a civilian health care provider or a health plan under paragraph (1) may be entered into without regard to provisions of law requiring the use of competitive procedures. An agreement with a health plan may provide for the sharing of resources with the health plan that is a party to the agreement.

"(c) Health Care Services Under a Plan. (1) Subject to paragraph (2), a Uniformed Services Health Plan shall provide to persons enrolled in the plan at least the items and services in the comprehensive benefit package under the Health Security Act.

"(2)(A) In addition, a Uniformed Services Health Plan shall guarantee to each person described in subparagraph (B) who is enrolled in the plan those health care services that the person would be entitled to receive under this chapter in the absence of this section. In the case of a person described in subparagraph (B) who is a covered beneficiary, such health care services shall consist of the types of health care services described in section

1079(a) of this title.

"(B) A person referred to in subparagraph (A) is a member of the uniformed services on active duty for a period of more than 30 days as of December 31, 1994, or any person who is a covered beneficiary as of that date, who is (or afterwards becomes) enrolled in a Uniformed Services Health Plan.

"(d) Preemption of Conflicting State Requirements. In carrying out responsibilities under the Health Security Act, a State (or State-established entity)

"(1) may not impose any standard or requirement on a Uniformed Services Health Plan that is inconsistent with this section or any regulation prescribed under this section or other Federal law regarding the operation of this section; and

"(2) may not deny certification of a Uniformed Services Health Plan as a health plan under the Health Security Act on the basis of a conflict between a rule of a State or health alliance and this section or any regulation prescribed under this section or other Federal law regarding the operation of this section.

"(e) Enrollment. (1) Except as authorized by the administering Secretary concerned, each member of a uniformed service on active duty for a period of more than 30 days shall be required to enroll in a Uniformed Services Health Plan available to the member.

"(2) After enrolling members described in paragraph (1), opportunities for further enrollment in a Uniformed Services Health Plan shall be offered by the administering Secretaries to covered beneficiaries in the following order of priority:

"(A) Spouses and children of members of the uniformed services who are on active duty for a period of more than 30 days.

"(B) Persons described in subsection (c) of section 1086 of this title. The administering Secretary concerned may disregard the exclusion set forth in subsection (d)(1) of such section in the case of a person described in subsection (c) of such section who is enrolled in the supplementary medical insurance program under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.).

"(3) With respect to a member described in paragraph (1) or a covered beneficiary described in paragraph (2) who enrolls in a Uniformed Services Health Plan, participation in such a plan

shall be the exclusive source of health care services available to the member or person under this chapter.

"(f) Effect of Failure to Enroll. (1) Except as provided in paragraph (2), if a person described in subsection (e)(2) declines the opportunity offered by the administering Secretaries to enroll in a Uniformed Services Health Plan, the person shall not be entitled or eligible for health care services in facilities of the uniformed services or pursuant to a contract entered into under this chapter. However, nothing in this paragraph shall be construed to effect the right of a person to a premium payment by the Secretary of Defense if the person is enrolled in another health plan under the Health Security Act and is otherwise entitled to such a payment under subsection (h).

"(2) A person described in subsection (e)(2) who is enrolled with a health plan that is not a Uniformed Services Health Plan may receive the items and services in the comprehensive benefit package in a facility of the uniformed services only if

"(A) the Secretary of Defense authorizes the provision of a particular item or service in the package to the person;

"(B) the Secretary determines that the provision of the item or service involved will not interfere with the provision of health care services to members of the uniformed services or persons enrolled in a Uniformed Services Health Plan; and

"(C) the health plan in which the person is enrolled agrees to pay the actual and full cost of the items and services in the package actually provided to the person.

"(3) The administering Secretaries shall assure that all rights and entitlements under this chapter of any person described in subsection (e)(2) are fully preserved if the person

"(A) is not offered the opportunity to enroll in a Uniformed Services Health Plan; and

"(B) is not otherwise enrolled in a health plan provided through a health alliance under the Health Security Act.

"(g) Special Rule for Other Payers. (1)(A) In the case of a person who is enrolled in the supplementary medical insurance program under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) and who is also enrolled in a Uniformed Services Health Plan, Medicare shall be responsible for making a premium payment on behalf of the person. The payment responsibilities of Medicare under this paragraph shall be in the

same amounts and under the same terms and conditions under which the Secretary of Health and Human Services makes payments to eligible organizations with a risk-sharing contract under section 1876 of the Social Security Act. A premium payment by Medicare under this paragraph shall be the person's exclusive benefit under Medicare.

"(B) In this paragraph, the term `Medicare' means any program administered under title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.).

"(2) Nothing in this section shall affect the payment of the retiree discount under the Health Security Act on behalf of a person who is enrolled in a Uniformed Services Health Plan if the person is otherwise eligible for the retiree discount.

"(h) Payment Responsibilities of the Secretary. (1) In the case of a person described in subsection (e)(2) who is not enrolled in a Uniformed Services Health Plan, the Secretary may make a premium payment for the person's enrollment through a health alliance in another health plan. In determining the amount of the payment, the Secretary shall consider the amount of any retiree discount payable under the Health Security Act on behalf of the person and the amount of any premium credits attributable to employer payments with respect to employment of the person.

"(2) The Secretary shall not make a payment pursuant to this subsection in connection with any person enrolled in a health plan of the Department of Veterans Affairs or a health program of the Indian Health Service.

"(i) Payment Responsibilities of Persons Enrolled in a Uniformed Services Health Plan. (1) In the case of an active duty member who is enrolled in a Uniformed Services Health Plan, the administering Secretaries may not impose or collect from the member a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge) other than subsistence charges authorized under section 1075 of this title.

"(2) Subject to paragraph (3), persons described in subsection (e)(2) who are enrolled in a Uniformed Services Health Plan shall have such payment responsibilities as the Secretary establishes, but not to exceed payment of a family share under section 1343 of a premium and cost sharing. Payment obligations established under this paragraph may not exceed those obligations otherwise required under the national standards for health plans established pursuant to the Health Security Act.

"(3)(A) Persons described in subsection (e)(2) who enroll in a Uniformed Services Health Plan and who (in the absence of this section) would be covered beneficiaries under section 1079 or 1086 of this title continuously since December 31, 1994, shall have, as a group, out-of-pocket costs in 1995 no greater than the lesser of

"(i) the out-of-pocket costs in effect for such beneficiaries under section 1075, 1078, 1079(b), or 1086(b) of this title (whichever applies) on December 31, 1994; and

"(ii) those obligations otherwise required under the national standards for health plans established pursuant to the Health Security Act.

"(B) Members of the uniformed services on active duty as of December 31, 1994, who afterward become covered beneficiaries under section 1079 or 1086 of this title (or would become covered beneficiaries in the absence of this section) without a break in eligibility for health care services under this chapter shall have, as a group, out-of-pocket costs as covered beneficiaries no higher than the out-of-pocket costs in effect for similarly situated covered beneficiaries described in subparagraph (A).

"(C) The limitation on out-of-pocket costs established pursuant to subparagraph (A) may be adjusted for years after 1995 by an appropriate economic index, as determined by the Secretary of Defense.

"(4) The Secretary of Defense shall establish the payment requirements under paragraph (2), and enforce the limitations on such requirements specified in paragraph (3), in regulations prescribed pursuant to subsection (a).

"(j) Financial Account. There is hereby established in the Department of Defense a financial account to which shall be credited all premium payments and other receipts from other payers and beneficiaries made in connection with any person enrolled in a Uniformed Services Health Plan. The account shall be administered by the Secretary of Defense, and funds in the account may be used by the Secretary for any purpose directly related to the delivery and financing of health care services under this chapter, including operations, maintenance, personnel, procurement, contributions toward construction projects, and related costs. Funds in the account shall remain available until expended.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to

section 1073 the following new item:

"1073a. Uniformed Services Health Plans: establishment and coordination with national health care reform.".

(b) Definition. Section 1072 of such title is amended by adding at the end the following new paragraph:

"(6) The term `Uniformed Services Health Plan' means a plan established by the Secretary of Defense under section 1073a(a) of this title in order to provide health care services to members of the uniformed services on active and other covered beneficiaries under this chapter.".

(c) Report on Establishment. If the Secretary of Defense determines to establish any Uniformed Services Health Plan under section 1073a of title 10, United States Code, as added by subsection (a), the Secretary shall submit to Congress a report describing the Plans proposed to be initially offered under such section. The report required by this subsection shall be submitted not later than 30 days before the date on which the Secretary first issues proposed rules under subsection (a) of such section to establish any such Plan.

Subtitle B Department of Veterans Affairs

Section 8101 BENEFITS AND ELIGIBILITY THROUGH DEPARTMENT OF VETERANS AFFAIRS MEDICAL SYSTEM.

(a) DVA As a Participant in Health Care Reform.

(1) In general. Title 38, United States Code, is amended by inserting after chapter 17 the following new chapter: Title VIII, Subtitle B

"CHAPTER 18--ELIGIBILITY AND BENEFITS UNDER HEALTH SECURITY ACT

"SUBCHAPTER I--GENERAL

"1801.Definitions.

"SUBCHAPTER II--ENROLLMENT

"1811. Enrollment: veterans.

"1812. Enrollment: CHAMPVA eligibles.

"1813. Enrollment: family members.

"SUBCHAPTER III--BENEFITS

"1821. Benefits for VA enrollees.

"1822. Chapter 17 benefits.

"1823. Supplemental benefits packages and policies.

"1824. Limitation regarding veterans enrolled with health plans outside Department.

"SUBCHAPTER IV--FINANCIAL MATTERS

"1831.Premiums, copayments, etc..

"1832.Medicare coverage and reimbursement.

"1833.Recovery of cost of certain care and services.

"1834.Health Plan Funds.

"SUBCHAPTER I--GENERAL

"1801. Definitions

"For purposes of this chapter:

"(1) The term `health plan' means an entity that has been certified under the Health Security Act as a health plan.

"(2) The term `VA health plan' means a health plan that is operated by the Secretary under section 7341 of this title.

"(3) The term `VA enrollee' means an individual enrolled under the Health Security Act in a VA health plan.

"SUBCHAPTER II--ENROLLMENT

"1811. Enrollment: veterans

"Each veteran who is an eligible individual within the meaning of section 1001 of the Health Security Act may enroll with a VA health plan. A veteran who wants to receive the comprehensive benefit package through the Department shall enroll with a VA health plan.

"1812. Enrollment: CHAMPVA eligibles

"An individual who is eligible for benefits under section

1713 of this title and who is eligible to enroll in a health plan pursuant to section 1001 of the Health Security Act may enroll under that Act with a VA health plan in the same manner as a veteran.

"1813. Enrollment: family members

"(a) The Secretary may authorize a VA health plan to enroll members of the family of an enrollee under section 1811 or 1812 of this title, subject to payment of premiums, deductibles, copayments, and coinsurance as required under the Health Security Act.

"(b) For purposes of subsection (a), an enrollee's family is those individuals (other than the enrollee) included within the term `family' as defined in section 1011(b) of the Health Security Act.

"SUBCHAPTER III--BENEFITS

"1821. Benefits for VA enrollees

"The Secretary shall ensure that each VA health plan provides to each individual enrolled with it the items and services in the comprehensive benefit package under the Health Security Act.

"1822. Chapter 17 benefits

"The Secretary shall provide to veterans the care and services that are authorized to be provided under chapter 17 of this title in accordance with the terms and conditions applicable to that veteran and that care under such chapter, notwithstanding that such care and services are not included in the comprehensive benefit package.

"1823. Supplemental benefits packages and policies

"A VA health plan may offer supplemental health benefits policies for health care services not provided under chapter 17 of this title and cost sharing policies consistent with the requirements of part 2 of subtitle E of title I of the Health Security Act.

"1824. Limitation regarding veterans enrolled with health plans outside Department

"A veteran who is residing in a regional alliance area in which the Department operates a health plan and who is enrolled in a health plan that is not operated by the Department may be

provided the items and services in the comprehensive benefit package by a VA health plan only if the plan is reimbursed for the actual and full cost of the care provided.

"SUBCHAPTER IV--FINANCIAL MATTERS

"1831. Premiums, copayments, etc.

"(a) In the case of a veteran described in subsection (b) who is a VA enrollee, the Secretary may not impose or collect from the veteran a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge). The Secretary shall make such arrangements as necessary with health alliances in order to carry out this subsection.

"(b) The veterans referred to in subsection (a) are the following:

"(1) Any veteran with a service-connected disability.

"(2) Any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty.

"(3) Any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section.

"(4) Any veteran who is a former prisoner of war.

"(5) Any veteran of the Mexican border period or World War I.

"(6) Any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

"(c) In the case of a VA enrollee who is not described in subsection (b), the Secretary shall charge premiums and establish copayments, deductibles, and coinsurance amounts. The premium rate, and the rates for deductibles and copayments, for each VA health plan shall be established by that health plan based on rules established by the health alliance under which it is operating.

"(d) In the case of a veteran with a service-connected disability who is enrolled in a VA health plan and who has net earnings from self-employment, the Secretary shall, under

regulations prescribed by the Secretary, provide for a reduction in any premium payment (or alliance credit repayment) owed by the veteran under section 6126 or 6111 of the Health Security Act by virtue of the veteran's net earnings from self-employment.

"1832. Medicare coverage and reimbursement

"(a) For purposes of any program administered by the Secretary of Health and Human Services under title XVIII of the Social Security Act, a Department facility shall be deemed to be a Medicare provider.

"(b)(1) A VA health plan shall be considered to be a Medicare HMO.

"(2) For purposes of this section, the term `Medicare HMO' means an eligible organization under section 1876 of the Social Security Act.

"(c) In the case of care provided to a veteran other than a veteran described in section 1831(b) of this title who is eligible for benefits under the Medicare program under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall reimburse a VA health plan or Department health-care facility providing services as a Medicare provider or Medicare HMO in the same amounts and under the same terms and conditions as that Secretary reimburses other Medicare providers or Medicare HMOs, respectively. The Secretary of Health and Human Services shall include with each such reimbursement a Medicare explanation of benefits.

"(d) When the Secretary provides care to a veteran for which the Secretary receives reimbursement under this section, the Secretary shall require the veteran to pay to the Department any applicable deductible or copayment that is not covered by Medicare.

"1833. Recovery of cost of certain care and services

"(a) In the case of an individual provided care or services through a VA health plan who has coverage under a supplemental health insurance policy pursuant to part 2 of subtitle E of title I of the Health Security Act or under any other provision of law, or who has coverage under a Medicare supplemental health insurance plan (as defined in the Health Security Act) or under any other provision of law, the Secretary has the right to recover or collect charges for care or services (as determined by the Secretary, but not including care or services for a service-connected disability) from the party providing that coverage to

the extent that the individual (or the provider of the care or services) would be eligible to receive payment for such care or services from such party if the care or services had not been furnished by a department or agency of the United States.

"(b) The provisions of subsections (b) through (f) of section 1729 of this title shall apply with respect to claims by the United States under subsection (a) in the same manner as they apply to claims under subsection (a) of that section.

"1834. Health Plan Fund

"(a) There is hereby established in the Treasury a revolving fund to be known as the `Department of Veterans Affairs Health Plan Fund'.

"(b) Any amount received by the Department by reason of the furnishing of health care by a VA health plan or the enrollment of an individual with a VA health plan (including amounts received as premiums, premium discount payments, copayments or coinsurance, and deductibles, amounts received as third-party reimbursements, and amounts received as reimbursements from another health plan for care furnished to one of its enrollees) shall be credited to the revolving fund.

"(c) Notwithstanding subsection (b), the Department may not retain amounts received for care furnished to a VA enrollee in a case in which the costs of such care have been covered by appropriations. Such amounts shall be deposited in the General Fund of the Treasury.

"(d) Amounts in the revolving fund are hereby made available for the expenses of the delivery by a VA health plan of the items and services in the comprehensive benefit package and any supplemental benefits package or policy offered by that health plan.".

(2) The table of chapters at the beginning of part II of title 38, United States Code, is amended by inserting after the item relating to chapter 17 the following new item:

"18. Benefits and Eligibility Under Health Security Act 1801.".

(b) Preservation of Existing Benefits for Facilities Not Operating as Health Plans. (1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1704 the following new section:

"1705. Facilities not operating within health plans; veterans not

eligible to enroll in health plans

"The provisions of this chapter shall apply with respect to the furnishing of care and services

"(1) by any facility of the Department that is not operating as or within a health plan certified as a health plan under the Health Security Act; and

"(2) by any facility of the Department (whether or not operating as or within a health plan certified as a health plan under the Health Security Act) in the case of a veteran who is not an eligible individual with the meaning of section 1001 of the Health Security Act.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1704 the following new item:

"1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans.".

Section 8102 ORGANIZATION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES AS HEALTH PLANS.

(a) In General. Chapter 73 of title 38, United States Code, is amended

(1) by redesignating subchapter IV as subchapter V; and

(2) by inserting after subchapter III the following new subchapter:

"SUBCHAPTER IV--PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"7341. Organization of health care facilities as health plans

"(a) The Secretary shall organize health plans and operate Department facilities as or within health plans under the Health Security Act. The Secretary shall prescribe regulations establishing standards for the operation of Department health care facilities as or within health plans under that Act. In prescribing those standards, the Secretary shall assure that they conform, to the maximum extent practicable, to the requirements for health plans generally set forth in part 1 of subtitle E of title I of the Health Security Act.

"(b) Within a geographic area or region, health care

facilities of the Department located within that area or region may be organized to operate as a single health plan encompassing all Department facilities within that area or region or may be organized to operate as several health plans.

"(c) In carrying out responsibilities under the Health Security Act, a State (or a State-established entity)

"(1) may not impose any standard or requirement on a VA health plan that is inconsistent with this section or any regulation prescribed under this section or other Federal laws regarding the operation of this section; and

"(2) may not deny certification of a VA health plan under the Health Security Act on the basis of a conflict between a rule of a State or health alliance and this section or regulations prescribed under this section or other Federal laws regarding the operation of this section.

"7342. Contract authority for facilities operating as or within health plans

"The Secretary may enter into a contract (without regard to provisions of law requiring the use of competitive procedures) for the provision of services by a VA health plan in any case in which the Secretary determines that such contracting is more cost-effective than providing such services directly through Department facilities or when such contracting is necessary because of geographic inaccessibility.

"7343. Resource sharing authority: facilities operating as or within health plans

"The Secretary may enter into agreements under section 8153 of this title with other health care plans, with health care providers, and with other health industry organizations, and with individuals, for the sharing of resources of the Department through facilities of the Department operating as or within health plans.

"7344. Administrative and personnel flexibility

"(a) In order to carry out this subchapter, the Secretary may

"(1) carry out administrative reorganizations of the Department without regard to those provisions of section 510 of this title following subsection (a) of that section; and

"(2) enter into contracts for the performance of services

previously performed by employees of the Department without regard to section 8110(c) of this title.

"(b) The Secretary may establish alternative personnel systems or procedures for personnel at facilities operating as or with health plans under the Health Security Act whenever the Secretary considers such action necessary in order to carry out the terms of that Act, except that the Secretary shall provide for preference eligibles (as defined in section 2108 of title 5, United States Code) in a manner comparable to the preference for such eligibles under subchapter I of chapter 33, and subchapter I of chapter 35, of such title.

"(c) Subject to the provisions of section 1404 of the Health Security Act, the Secretary may carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department operating as or within health plans. Such activities may only be carried out using nonappropriated funds.

"7345. Veterans Health Care Investment Fund

"(a) There is hereby authorized to be appropriated to the Department, in addition to amounts otherwise authorized to be appropriated to the Department for VA health plans, such amounts as are necessary for the Secretary of the Treasury to fulfill the requirement of subsection (b).

"(b) For each of fiscal years 1995, 1996, and 1997, the Secretary of the Treasury shall, subject to subsection (a), credit to a special fund (in this section referred to as the `Fund') of the Treasury an amount equal to

"(1) $1,000,000,000 for fiscal year 1995;

"(2) $600,000,000 for fiscal year 1996; and

"(3) $1,700,000,000 for fiscal year 1997.

"(c)(1) Subject to paragraph (2), amounts in the Fund shall be available to the Secretary only for the VA health plans authorized under this chapter.

"(2) For fiscal year 1995, 1996, or 1997, the amount credited to the Fund for the fiscal year shall be available for use by the Secretary under paragraph (1) only if appropriations Acts for that fiscal year, without addition of amounts provided under subsection (a) for the Fund, provide new budget authority for the Department of Veterans Affairs Medical Care account, for that

fiscal year, of no less than the amount for that account proposed in the budget of the President for that fiscal year under section 1105 of title 31.

"(d) The Secretary shall submit to Congress, no later than March 1, 1997, a report concerning the operation of the Department of Veterans Affairs health care system in preparing for, and operating under, national health care reform under the Health Security Act during fiscal years 1995 and 1996. The report shall include a discussion of

"(1) the adequacy of amounts in the Fund for the operation of VA health plans;

"(2) the quality of care provided by such plans;

"(3) the ability of such plans to attract patients; and

"(4) the need (if any) for additional funds for the Fund in fiscal years after fiscal year 1997.

"7346. Funding provisions: grants and other sources of assistance

"The Secretary may apply for and accept, if awarded, any grant or other source of funding that is intended to meet the needs of special populations and that but for this section is unavailable to facilities of the Department or to health plans operated by the Government if funds obtained through the grant or other source of funding will be used through a facility of the Department operating as or within a health plan.".

(b) Clerical Amendment. The table of sections at the beginning of chapter 73 is amended by striking out the item relating to the heading for subchapter IV and inserting in lieu thereof the following:

"Subchapter IV--Participation as Part of National Health Care Reform

"7341. Organization of health care facilities as health plans.

"7342. Contract authority for facilities operating as or within health plans.

"7343. Resource sharing authority: facilities operating as or within health plans.

"7344. Administrative and personnel flexibility.

"7345.Veterans Health Care Investment Fund.

"7346. Funding provisions: grants and other sources of assistance.

"Subchapter V--Research Corporations".

(c) Transition Provision.The limitation in the second sentence of section 7344(c) of title 38, United States Code, as added by subsection (a), shall not apply during fiscal year 1994.
Title VIII, Subtitle C

Subtitle C Federal Employees Health Benefits Program

Section 8201 DEFINITIONS.

Except as otherwise specifically provided, in this subtitle:

(1) Abroad. The term "abroad" means outside the United States.

(2) Annuitant, etc. The terms "annuitant", "employee", and "Government", have the same respective meanings as are given such terms by section 8901 of title 5, United States Code (as last in effect).

(3) Employees health benefits fund. The term "Employees Health Benefits Fund" means the fund under section 8909 of title 5, United States Code (as last in effect).

(4) FEHBP. The term "FEHBP" means the health insurance program under chapter 89 of title 5, United States Code (as last in effect).

(5) FEHBP plan. The term "FEHBP plan" has the same meaning as is given the term "health benefits plan" by section 8901(6) of title 5, United States Code (as last in effect).

(6) FEHBP termination date. The term "FEHBP termination date" means the date (specified in section 8202) after which FEHBP ceases to be in effect.

(7) Retired employees health benefits fund. The term "Retired Employees Health Benefits Fund" means the fund under section 8 of the Retired Federal Employees Health Benefits Act (Public Law 86-724; 74 Stat. 851), as last in effect.

(8) RFEHBP. The term "RFEHBP" means the health insurance program under the Retired Federal Employees Health Benefits Act.

Section 8202 FEHBP TERMINATION.

Chapter 89 of title 5, United States Code, is repealed effective as of December 31, 1997, and all contracts under such chapter shall terminate not later than such date.

Section 8203 TREATMENT OF FEDERAL EMPLOYEES, ANNUITANTS, AND OTHER INDIVIDUALS (WHO WOULD OTHERWISE HAVE BEEN ELIGIBLE FOR FEHBP) UNDER HEALTH PLANS.

(a) Applicability.This section sets forth rules applicable, after the FEHBP termination date, with respect to individuals who

(1) are eligible individuals under section 1001; and

(2) but for this subtitle, would be eligible to enroll in an FEHBP plan.

(b) Federal Employees.

(1) Same treatment as non-federal employees. A Federal employee shall be treated in the same way, for purposes of provisions of this Act outside of this subtitle, as if that individual were a non-Federal employee, including for purposes of any requirements relating to enrollment, family premium payments, and employer premium payments.

(2) Employer premium payments. Any employer premium payment required with respect to the employment of a Federal employee shall be payable from the appropriation or fund from which any Government contribution on behalf of such employee would have been payable under FEHBP.

(3) Offer of fehbp supplemental plans. The Federal Government shall offer to Federal employees one or more FEHBP supplemental plans developed under subsection (f)(1).

(4) Definitions.In this subsection:

(A) Federal employee.The term "Federal employee" means an "employee" as defined by section 8201.

(B) Non-federal employee.The term "non-Federal employee" means an "employee" as defined by section 1901.

(c) Annuitants.

(1) Health plan.

(A) Authority to make certain withholdings from annuities.

(i) In general. The Office of Personnel Management may, on the request of an annuitant enrolled in a health plan, withhold from the annuity of such annuitant any premiums required for such enrollment. The Office shall forward any amounts so withheld to the appropriate fund or as otherwise indicated in the request. A request under this subparagraph shall contain such information, and otherwise be made in such form and manner, as the Office shall by regulation prescribe.

(ii) References. Any reference in clause (i) to the Office of Personnel Management shall, for purposes of any annuity (including monthly compensation under subchapter I of chapter 81 of title 5, United States Code) payable under provisions of law which are administered by a Government entity other than the Office, be considered to be a reference to such other Government entity.

(B) Payment of alliance credit liability for annuitants below age 55. In the case of an annuitant who does not satisfy the eligibility requirements under section 6114, a Government contribution shall be made equal to such amount as is necessary to reduce the employee's liability under section 6111 to zero.

(2) FEHBP supplemental plan.

(A) Current annuitants.

(i) In general. Each current annuitant

(I) shall be eligible to enroll in FEHBP supplemental plans developed under subsection (f)(1); and

(II) shall be eligible for the Government contribution amount described in clause (ii) toward the premium for such a plan.

(ii) Government contribution amount. The Office of Personnel Management shall specify a level of Government contribution under this subparagraph for an FEHBP supplemental plan. Such level

(I) shall reasonably reflect the portion of the Government contributions (last provided under FEHBP) attributable to the portion of FEHBP benefits which the plan is designed to replace; and

(II) shall be applied toward premiums for such a plan.

(B) Future annuitants.In the case of a future annuitant, the Federal Government shall offer to such an annuitant one or more FEHBP supplemental plans developed under subsection (f)(1).

(C) Definitions. In this paragraph:

(i) Current annuitant. The term "current annuitant" means an individual who is residing in a State on January 1, 1998, and, on the day before such date, was

(I) enrolled in an FEHBP plan as an annuitant; or

(II) covered under an FEHBP plan as a family member (but only if such individual would otherwise have been eligible to enroll in an FEHBP plan as an annuitant).

(ii) Future annuitant. The term "future annuitant" means an annuitant who is not a current annuitant.

(d) Individuals Who Would Not Be Eligible for a Government Contribution Under FEHBP.

(1) In general. In the case of an individual described in paragraph (2)

(A) the Federal Government may, but is not required to, offer one or more FEHBP supplemental plans developed under subsection (f)(1); and

(B) no Government contribution shall be payable with respect to the premium for such a plan.

(2) Applicability.This subsection shall apply with respect to any individual who (but for this subtitle) would be eligible to enroll in an FEHBP plan, but would not be eligible for a Government contribution toward any such plan.

(e) Medicare-Eligible Individuals.

(1) Current medicare-eligible individuals.

(A) In general. Each current medicare-eligible individual

(i) shall be eligible to enroll in medicare supplemental plans developed under subsection (f)(2); and

(ii) if such individual would (but for this subtitle) have been eligible for a Government contribution under FEHBP (assuming such individual were then enrolled thereunder), shall be eligible for the Government medicare contribution amount described in subparagraph (B) toward the premium for such a plan or toward the premium for enrollment with an eligible organization under a risk-sharing contract under section 1876 of the Social Security Act).

(B) Medicare contribution amount. The Office of Personnel Management shall specify a level of Government contribution under this paragraph for an FEHBP medicare supplemental plan. Such level

(i) shall reasonably reflect the portion of the Government contributions (last provided under FEHBP) attributable to the portion of FEHBP benefits which the plan is designed to replace; and

(ii) except as otherwise provided in paragraph (3), shall be applied toward premiums for such a plan.

(2) Future medicare-eligible individuals. In the case of a future medicare-eligible individual, the Federal Government may, but is not required to

(A) offer to such a medicare-eligible individual one or more FEHBP medicare supplemental plans developed under subsection (f)(2); and

(B) make a Government contribution with respect to the premium for such a plan.

(3) Application of contribution toward medicare hmo option.

(A) Election. A medicare-eligible individual may elect to have the amount of the Government contribution described in paragraph (1)(B) or referred to in paragraph (2)(B) applied toward premiums for enrollment with an eligible organization under a risk-sharing contract under section 1876 of the Social Security Act.

(B) Level contribution rule. The level of such Government contribution on behalf of an individual shall be determined without taking into account any election under

subparagraph (A).

(4) Definitions. In this subsection:

(A) Current medicare-eligible individual. The term "current medicare-eligible individual" means an individual who is residing in a State on January 1, 1998, and, on the day before such date, was a medicare-eligible individual.

(B) Future medicare-eligible individual. The term "future medicare-eligible individual" means a medicare-eligible individual who is not a current medicare-eligible individual.

(5) Inapplicability. Subsections (b) through (d) shall not apply with respect to a medicare-eligible individual.

(f) Development of Supplemental Plans.

(1) FEHBP supplemental plans. The Office of Personnel Management shall develop one or more FEHBP supplemental plans which are supplemental health benefit policies or cost sharing policies (as defined in section 1421(b)). Each such plan shall

(A) be consistent with the applicable requirements of part 2 of subtitle E of title I (including the requirements under section 1423(f)); and

(B) reflect (taking into consideration the benefits in the comprehensive benefit package) the overall level of benefits last generally afforded under FEHBP.

(2) FEHBP medicare supplemental plans. The Office of Personnel Management shall develop one or more medicare supplemental plans. Each such plan shall

(A) offer benefits which shall include the core group of basic benefits identified under section 1882(p)(2) of the Social Security Act; and

(B) reflect (taking into consideration the benefits provided under the medicare program) the overall level of benefits last generally afforded under FEHBP.

(g) Authorization of appropriations. The Government contributions authorized by this section on behalf of an annuitant (including an annuitant who is a medicare-eligible individual) shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

(h) Fund.

(1) Establishment. There shall be established in the Treasury of the United States a fund into which shall be paid all contributions relating to any

(A) FEHBP supplemental plan developed under subsection (f)(1);

(B) FEHBP medicare supplemental plan developed under subsection (f)(2); or

(C) health insurance program established under section 8204.

(2) Administration and use.The fund shall be administered by the Office of Personnel Management, and any monies in the fund shall be available for purposes of the plan or program (referred to in paragraph (1)) to which they are attributable.

Section 8204 TREATMENT OF INDIVIDUALS RESIDING ABROAD.

(a) In General. After the FEHBP termination date, individuals residing abroad who (but for this subtitle) would be eligible to enroll in an FEHBP plan shall be eligible for health insurance under a program which the Office of Personnel Management shall by regulation establish.

(b) Requirement. To the extent practicable, coverage and benefits provided to individuals under such program shall be equal to the coverage and benefits which would be available to them if they were residing in the United States.

(c) Government Contributions. Any Government contribution payable under such program shall be made from the appropriation or fund from which any Government contribution would have been payable under FEHBP (if any) on behalf of the individual involved, except that, in the case of an annuitant, any such contribution shall be payable from amounts appropriated pursuant to section 8203(g).

Section 8205 TRANSITION AND SAVINGS PROVISIONS.

(a) Employees Health Benefits Fund.

(1) Temporary continued availability. Notwithstanding

section 8202, the Employees Health Benefits Fund shall be maintained, and amounts in such Fund shall remain available, after the FEHBP termination date, for such period of time as the Office of Personnel Management considers necessary in order to satisfy any outstanding claims.

(2) Final disbursement. After the end of the period referred to in paragraph (1), any amounts remaining in the Fund shall be disbursed (between the Government and former participants in FEHBP) in accordance with a plan which the Office shall prepare, consistent with the cost-sharing ratio between the Government and plan enrollees during the final contract term. The details of any such plan shall be submitted to the President and the Congress at least 1 year before the date of its proposed implementation.

(b) Proceedings. After the FEHBP termination date, chapter 89 of title 5, United States Code (as last in effect) shall be considered to have remained in effect for purposes of any suit, action, or other proceeding with respect to any liability incurred or violation which occurred on or before such date.

(c) RFEHBA.

(1) Repeal. The Retired Federal Employees Health Benefits Act (Public Law 86-724; 74 Stat. 849) is repealed effective as of the FEHBP termination date.

(2) Related provisions.After the FEHBP termination date

(A) the Retired Employees Health Benefits Fund shall temporarily remain available, and amounts in that fund shall subsequently be disbursed, in a manner comparable to that provided for under subsection (a); and

(B) retired employees who (but for this subtitle) would be eligible for coverage under the Retired Federal Employees Health Benefits Act shall be treated, for purposes of this subtitle, as if they were annuitants (subject to any differences in the overall level of coverage or benefits last generally afforded to annuitants under FEHBP and to retired employees under RFEHBP, respectively).

(3) Regulations. Regulations prescribed under section 8206 to carry out this subsection shall include any necessary provisions relating to individuals residing abroad.

Section 8206 REGULATIONS.

The Office of Personnel Management shall prescribe any regulations which may be necessary to carry out this subtitle.

Section 8207 TECHNICAL AND CONFORMING AMENDMENTS.

(a) OPM's Annual Report on FEHBP. Subsection (c) of section 1308 of title 5, United States Code, is repealed.

(b) Other References to FEHBP. Any reference in any provision of law to the health insurance program under chapter 89 of title 5, United States Code (or any aspect of such program) shall be considered to be a reference to the health insurance program under this subtitle (or corresponding aspect), subject to such clarification as may be provided, or except as may otherwise be provided, in regulations prescribed by the agency or other authority responsible for the administration of such provision.

(c) Omnibus Budget Reconciliation Act of 1993. Effective as of the date of the enactment of this Act, section 11101(b)(3) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66; 107 Stat. 413) is amended by striking "September 30, 1998" and inserting "December 31, 1997".

(d) Effective Date. Except as provided in subsection (c), this section and the amendments made by this section shall take effect on the day after the FEHBP termination date.

Title VIII, Subtitle D

Subtitle D Indian Health Service

Section 8301 DEFINITIONS.

For the purposes of this subtitle

(1) the term "health program of the Indian Health Service" means a program which provides health services under this Act through a facility of the Indian Health Service, a tribal organization under the authority of the Indian Self-Determination Act or a self-governance compact, or an urban Indian program;

(2) the term "reservation" means the reservation of any federally recognized Indian tribe, former Indian reservations in Oklahoma, and lands held by incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.);

(3) the term "urban Indian program" means any program

operated pursuant to title V of the Indian Health Care Improvement Act; and

(4) the terms "Indian", "Indian tribe", "tribal organization", "urban Indian", "urban Indian organization", and "service unit" have the same meaning as when used in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

Section 8302 ELIGIBILITY AND HEALTH SERVICE COVERAGE OF INDIANS.

(a) Eligibility.An eligible individual, as defined in section 1001(c), is eligible to enroll in a health program of the Indian Health Service if the individual is

(1) an Indian, or a descendent of a member of an Indian tribe who belongs to and is regarded as an Indian by the Indian community in which the individual lives, who resides on or near an Indian reservation or in a geographical area designated by statute as meeting the requirements of being on or near an Indian reservation notwithstanding the lack of an Indian reservation;

(2) an urban Indian; or

(3) an Indian described in section 809(b) of the Indian Health Care Improvement Act (25 U.S.C. 1679(b)).

(b) Election.An individual described in subsection (a) may elect a health
program of the Indian Health Service instead of a health plan.

(c) Enrollment for Benefits. An individual who elects a health program of the Indian Health Service under subsection (b) shall enroll in such program through a service unit, tribal organization, or urban Indian program. An individual who enrolls in such program is not subject to any charge for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services provided under such program.

(d) Payments by Individuals Who Do not Enroll. If an individual described in subsection (a) does not enroll in a health program of the Indian Health Service, no payment shall be made by the Indian Health Service to the individual (or on behalf of the individual) with respect to premiums charged for enrollment in an applicable health plan or any other cost of health services under the applicable health plan which the individual is required to pay.

Section 8303 SUPPLEMENTAL INDIAN HEALTH CARE BENEFITS.

(a) In General. All individuals described in sections 8302(a) remain eligible for such benefits under the laws administered by the Indian Health Service as supplement the comprehensive benefit package. The individual shall not be subject to any charge or any other cost for such benefits.

(b) Authorization of Appropriations. In addition to amounts otherwise authorized to be appropriated, there is authorized to be appropriated to carry out this section $180,000,000 for fiscal year 1995, $200,000,000 for each of the fiscal years 1996 through 1999, and such sums as may be necessary for fiscal year 2000 and each fiscal year thereafter.

Section 8304 HEALTH PLAN AND HEALTH ALLIANCE REQUIREMENTS.

(a) Comprehensive Benefit Package. The Secretary shall ensure that the comprehensive benefit package is provided by all health programs of the Indian Health Service effective January 1, 1999, notwithstanding section 1001(a).

(b) Applicable Requirements of Health Plans. In addition to subsection (a), the Secretary shall determine which other requirements relating to health plans apply to health programs of the Indian Health Service.

(c) Certification. Effective January 1, 1999, all health programs of the Indian Health Service must meet the certification requirements for health plans, as required by the Secretary under this section, as certified from time to time by the Secretary. Before January 1, 1999, all such health programs shall, to the extent practicable, meet such certification requirements.

(d) Health Alliance Requirements. The Secretary shall determine which requirements relating to health alliances apply to the Indian Health Service.

Section 8305 EXEMPTION OF TRIBAL GOVERNMENTS AND TRIBAL ORGANIZATIONS FROM EMPLOYER PAYMENTS.

A tribal government and a tribal organization under the Indian Self-Determination and Educational Assistance Act or a self-governance compact shall be exempt from making employer premium payments as an employer under section 6121.

Section 8306 PROVISION OF HEALTH SERVICES TO NON-

ENROLLEES AND NON-INDIANS.

(a) Contracts With Health Plans.

(1) In general. A health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program may enter into a contract with a health plan for the provision of health care services to individuals enrolled in such health plan if the program, unit, or organization determines that the provision of such health services will not result in a denial or diminution of health services to any individual described in section 8302(a) who is enrolled for health services provided by such program, unit, or organization.

(2) Reimbursement. Any contract entered into pursuant to paragraph (1) shall provide for reimbursement to such program, unit, or organization in accordance with the essential community provider provisions of section 1431(c), as determined by the Secretary.

(b) Family Treatment.

(1) Determination to open enrollment. A health program of the Indian Health Service may open enrollment to family members of individuals described in section 8302(a).

(2) Election. If a health program of the Indian Health Service opens enrollment to family members of individuals described in section 8302(a), an individual described in that section may elect family enrollment in the health program instead of in a health plan.

(3) Enrollment.

(A) In general. An individual who elects family enrollment under paragraph (2) in a health program of the Indian Health Service shall enroll in such program.

(B) Applicable individual charges. The individual who enrolls in such program under subparagraph (A) is not subject to any charge for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services provided under such program attributable to the individual, but the family members who are not eligible for a health program of the Indian Health Service under section 8302(a) are subject to all such charges.

(C) Applicable employer charges. Employers, other

than tribal governments and tribal organizations exempt under section 8305, are liable for making employer premium payments as an employer under section 6121 in the case of any family member enrolled under this subsection who is not eligible for a health program of the Indian Health Service under section 8302(a).

(4) Premium.

(A) Establishment and collection. The Secretary shall establish premiums for all family members enrolled in a health program of the Indian Health Service under this paragraph who are not eligible for a health program of the Indian Health Service under section 8302(a). The Secretary shall collect each premium payment owed under this paragraph.

(B) Reduction. The Secretary shall provide for a process for premium reduction which is the same as the process, and uses the same standards, used by regional alliances for the areas in which individuals described in subparagraph (A) reside, except that in computing the family share of the premiums the Secretary shall use the lower of the premium quoted or the reduced weighted average accepted bid for the reference regional alliance.

(C) Payment by secretary. The Secretary shall provide for payment to each health program of the Indian Health Service, in the same manner as payments under section 6201, amounts equivalent to the amount of payments that would have been made to a regional alliance if the individuals described in subparagraph (A) were enrolled in a regional alliance health plan (with a final accepted bid equal to the reduced weighted average accepted bid premium for the regional alliance).

(c) Essential Community Provider.

(1) Health services. If a health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program elects to be an essential community provider under section 1431, an individual described in paragraph (2) enrolled in a health plan other than a health program of the Indian Health Service may receive health services from that essential community provider.

(2) Individual covered. An individual referred to in paragraph (1) is an individual who

(A) is described in section 8302(a); or

(B) is a family member described in subsection (b)

who does not enroll in a health program of the Indian Health Service.

Section 8307 PAYMENT BY OTHER PAYERS.

(a) Payment for Services Provided by Indian Health Service Programs. Nothing in this subtitle shall be construed as amending section 206, 401, or 402 of the Indian Health Care Improvement Act (relating to payments on behalf of Indians for health services from other Federal programs or from other third party payers).

(b) Payment for Services Provided by Contractors. Nothing in this subtitle shall be construed as affecting any other provision of law, regulation, or judicial or administrative interpretation of law or policy concerning the status of the Indian Health Service as the payer of last resort for Indians eligible for contract health services under a health program of the Indian Health Service.

Section 8308 CONTRACTING AUTHORITY.

Section 601(d)(1)(B) of the Indian Health Care Improvement Act (25 U.S.C. 1661(d)(1)(B)) is amended by inserting "(including personal services for the provision of direct health care services)" after "goods and services".

Section 8309 CONSULTATION.

The Secretary shall consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities.

Section 8310 INFRASTRUCTURE.

(a) Facilities. The Secretary, acting through the Indian Health Service, may expend amounts appropriated pursuant to section 8313 for the construction and renovation of hospitals, health centers, health stations, and other facilities for the purpose of improving and expanding such facilities to enable the delivery of the full array of items and services guaranteed in the comprehensive benefit package.

(b) Capital Financing.There is established in the Indian Health Service a revolving loan program. Under the program, the Secretary, acting through the Indian Health Service, shall provide guaranteed loans under such terms and conditions as the Secretary may prescribe to providers within the Indian Health

Service system to improve and expand health care facilities to enable the delivery of the full array of items and services guaranteed in the comprehensive benefit package.

Section 8311 FINANCING.

(a) Establishment of Fund. Each health program of the Indian Health Service shall establish a comprehensive benefit package fund (hereafter in this section referred to as the "fund").

(b) Deposits. There shall be deposited into the fund the following:

(1) All amounts received as employer premium payments pursuant to section 1351(e)(3).

(2) All amounts received as family premium payments and premium discount payments pursuant to section 8306(b)(4).

(3) All amounts appropriated for the fund for the purpose of providing the comprehensive benefit package to individuals enrolled in a health program of the Indian Health Service.

(4) Any other amount received with respect to health services for the comprehensive benefit package.

(c) Administration and Expenditures.

(1) Management. The fund shall be managed by the health program of the Indian Health Service.

(2) Expenditures. Expenditures may be made from the fund to provide for the delivery of the items and services of the comprehensive benefit package under the health program of the Indian Health Service.

(3) Availability of funds. Amounts in the fund established by a service unit of the Indian Health Service under this section shall be available without further appropriation and shall remain available until expended for payments for the delivery of the items and services in the comprehensive benefit package.

Section 8312 RULE OF CONSTRUCTION.

Unless otherwise provided by this Act, no part of this Act shall be construed to rescind or otherwise modify any obligations, findings, or purposes contained in the Indian Health

Care Improvement Act (25 U.S.C. 1601 et seq.) and in the Indian Self-Determination and Education Assistance Act.

Section 8313 AUTHORIZATIONS OF APPROPRIATIONS.

(a) Authorization of Appropriations. For the purpose of carrying out this subtitle, there are authorized to be appropriated $40,000,000 for fiscal year 1995, $180,000,000 for fiscal year 1996, and $200,000,000 for each of the fiscal years 1997 through 2000.

(b) Relation to Other Funds. The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purposes of carrying out this subtitle.

Section 8314 PAYMENT OF PREMIUM DISCOUNT EQUIVALENT AMOUNTS FOR UNEMPLOYED INDIANS.

(a) Determination. The Secretary shall determine (and certify to the Secretary of the Treasury) for each fiscal year (beginning with fiscal year 1998) an amount equivalent to the aggregate amount of the premium discounts (established in section 6104) that would have been paid to individuals described in subsection (c) if such individuals had been enrolled in regional alliance health plans.

(b) Payment. For each fiscal year for which an amount is certified to the Secretary of the Treasury under subsection (a), from the funds available under section 9102, such Secretary shall pay the amount so certified to the Indian Health Service for the purpose of providing the comprehensive benefit package.

(c) Individual Described. For purposes of this section, an individual described in this subsection is an individual described in section 8302(a) who is not a qualifying employee or a family member of such an employee.

Title VIII, Subtitle E

Subtitle E Amendments to the Employee Retirement Income Security Act of 1974

Section 8401 GROUP HEALTH PLAN DEFINED.

Section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

"(42) The term `group health plan' means an employee welfare benefit plan which provides medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.".

Section 8402 LIMITATION ON COVERAGE OF GROUP HEALTH PLANS UNDER TITLE I OF ERISA.

(a) In General. Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended

(1) in subsection (a), by striking "subsection (b)" and inserting "subsections (b) and (c)";

(2) in subsection (b), by striking "The provisions" and inserting "Except as provided in subsection (c), the provisions"; and

(3) by adding at the end the following new subsection:

"(c) Coverage of Group Health Plans.

"(1) Limited inclusion.This title shall apply to a group health plan only to the extent provided in this subsection.

"(2) Coverage under certain provisions with respect to certain plans.

"(A) In general. Except as provided in subparagraph (B), parts 1, 4, and 6 of subtitle B shall apply to

"(i) a group health plan which is maintained by

"(I) a corporate alliance (as defined in section 1311(a) of the Health Security Act), or

"(II) a member of a corporate alliance (as so defined) whose eligible sponsor is described in section 1311(b)(1)(C) (relating to rural electric cooperatives and rural telephone cooperative associations), and

"(ii) a group health plan not described in clause (i) which provides benefits which are permitted under paragraph (4) of section 1003 of the Health Security Act.

"(B) Inapplicability with respect to state-certified health plans. Subparagraph (A) shall not apply with respect to any plan or portion thereof which consists of a State-certified health

plan (as defined in section 1400(c) of the Health Security Act). The Secretary shall provide by regulation for treatment as a separate group health plan of any arrangement which would otherwise be treated under this title as part of a group health plan to the extent necessary to carry out the purposes of this title.

"(3) Civil actions by corporate alliance participants, beneficiaries, and fiduciaries and by the secretary.

"(A) In general.Except as provided in subparagraph (B), in the case of a group health plan to which parts 1, 4, and 6 of subtitle B apply under paragraph (2), section 502 shall apply with respect to a civil action described in such section brought

"(i) by a participant, beneficiary, or fiduciary under such plan, or

"(ii) by the Secretary.

"(B) Exception where review is otherwise available under health security act. Subparagraph (A) shall not apply with respect to any cause of action for which, under section 5202(d) of the Health Security Act, proceedings under sections 5203 and 5204 of such Act pursuant to complaints filed under section 5202(b) of such Act, and review under section 5205 of such Act of determinations made under such section 5204, are the exclusive means of review.

"(4) Definitions and enforcement provisions.Sections 3, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, and 511 and the preceding subsections of this section shall apply to a group health plan to the extent necessary to effectively carry out, and enforce the requirements under, the provisions of this title as they apply pursuant to this subsection.

"(5) Applicability of preemption rules.Section 514 shall apply in the case of any group health plan to which parts 1, 4, and 6 of subtitle B apply under paragraph (2).".

(b) Reporting and Disclosure Requirements Applicable to Group Health Plans.

(1) In general. Part 1 of subtitle B of title I of such Act is amended

(A) in the heading for section 110 (29 U.S.C. 1030), by adding "by pension plans" at the end;

(B) by redesignating section 111 (29 U.S.C. 1031) as section 112; and

(C) by inserting after section 110 the following new section:

"special rules for group health plans

"Sec. 111. (a) In General.The Secretary may by regulation provide special rules for the application of this part to group health plans which are consistent with the purposes of this title and the Health Security Act and which take into account the special needs of participants, beneficiaries, and health care providers under such plans.

"(b) Expeditious Reporting and Disclosure.Such special rules may include rules providing for

"(1) reductions in the periods of time referred to in this part,

"(2) increases in the frequency of reports and disclosures required under this part, and

"(3) such other changes in the provisions of this part as may result in more expeditious reporting and disclosure of plan terms and changes in such terms to the Secretary and to plan participants and beneficiaries, to the extent that the Secretary determines that the rules described in this subsection are necessary to ensure timely reporting and disclosure of information consistent with the purposes of this part and the Health Security Act as they relate to group health plans.

"(c) Additional Requirements. Such special rules may include rules providing for reporting and disclosure to the Secretary and to participants and beneficiaries of additional information or at additional times with respect to group health plans to which this part applies under section 4(c)(2), if such reporting and disclosure would be comparable to and consistent with similar requirements applicable under the Health Security Act with respect to plans maintained by regional alliances (as defined in such section 1301 of such Act) and applicable regulations of the Secretary of Health and Human Services prescribed thereunder.".

(2) Clerical amendment. The table of contents in section 1 of such Act is amended by striking the items relating to sections 110 and 111 and inserting the following new items:

"Sec.110. Alternative methods of compliance by pension plans.

"Sec.111. Special rules for group health plans.

"Sec.112. Repeal and effective date.".

(d) Exclusion of Plans Maintained by Regional Alliances from Treatment as Multiple Employer Welfare Arrangements. Section 3(40)(A) of such Act (29 U.S.C. 1002(40)(A)) is amended

(1) in clause (ii), by striking "or";

(2) in clause (iii), by striking the period and inserting ", or"; and

(3) by adding after clause (iii) the following new clause:

"(iv) by a regional alliance (as defined in section 1301 of the Health Security Act).".

Section 8403 AMENDMENTS RELATING TO CONTINUATION COVERAGE.

(a) Period of Coverage. Subparagraph (D) of section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(1)) is amended

(1) by striking "or" at the end of clause (i), by striking the period at the end of clause (ii) and inserting ", or", and by adding at the end the following new clause:

"(iii) eligible for coverage under a comprehensive benefit package described in section 1101 of the Health Security Act.", and

(2) by striking "or medicare entitlement" in the heading and inserting ", medicare entitlement, or health security act eligibility".

(b) Qualified Beneficiary.Section 607(3) of such Act (29 U.S.C. 1167(3)) is amended by adding at the end the following new subparagraph:

"(D) Special rule for individuals covered by health security act. The term `qualified beneficiary' shall not include any individual who, upon termination of coverage under a group health plan, is eligible for coverage under a comprehensive benefit package described in section 1101 of the Health Security Act."

(c) Repeal Upon Implementation of Health Security Act.

(1) In general. Part 6 of subtitle B of title I of such Act (29 U.S.C. 601 et seq.) is amended by striking sections 601 through 608 and by redesignating section 609 as section 601.

(2) Conforming amendments.

(A) Section 502(a)(7) of such Act (29 U.S.C. 1132(a)(7)) is amended by striking "609(a)(2)(A)" and inserting "601(a)(2)(A)".

(B) Section 502(c)(1) is amended by striking "paragraph (1) or (4) of section 606 or".

(C) Section 514 of such Act (29 U.S.C. 1144) is amended by striking "609" each place it appears in subsections (b)(7) and (b)(8) and inserting "601".

(D) The table of contents in section 1 of such Act is amended by striking the items relating to sections 601 through 609 and inserting the following new item:

"Sec. 601. Additional standards for group health plans."

(d) Effective Date.

(1) Subsections (a) and (b).The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act.

(2) Subsection (c). The amendments made by subsection (c) shall take effect on the earlier of

(A) January 1, 1998, or

(B) the first day of the first calendar year following the calendar year in which all States have in effect plans under which individuals are eligible for coverage under a comprehensive benefit package described in section 1101 of this Act.

Section 8404 ADDITIONAL AMENDMENTS RELATING TO GROUP HEALTH PLANS.

(a) Regulations of the National Health Board Regarding Cases of Adoption.Section 601(c) of the Employee Retirement Income Security Act of 1974 (as redesignated by section 8403) is amended by adding at the end the following new paragraph:

"(4) Regulations by national health board. The preceding provisions of this subsection shall apply except to the extent otherwise provided in regulations of the National Health Board under the Health Security Act.".

(b) Coverage of Pediatric Vaccines. Section 601(d) of such Act (as redesignated by section 8403) is amended by adding at the end the following new sentence: "The preceding sentence shall cease to apply to a group health plan upon becoming a corporate alliance health plan pursuant to an effective election of the plan sponsor to be a corporate alliance under section 1311 of the Health Security Act.".

(c) Technical Corrections. Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993

(1) Subsection (a)(2)(B)(ii) of section 609 of the Employee Retirement Income Security Act of 1974 is amended by striking "section 13822" and inserting "section 13623".

(2) Subsection (a)(4) of such section 609 is amended by striking "section 13822" and inserting "section 13623".

(3) Subsection (d) of such section 609 is amended by striking "section 13830" and inserting "section 13631".

Section 8405 PLAN CLAIMS PROCEDURES.

Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended

(1) by inserting "(a) In General." after "Sec. 503."; and

(2) by adding at the end the following new subsection:

"(b) Group Health Plans.In addition to the requirements of subsection (a), a group health plan to which parts 1 and 4 apply under section 4(c)(2) shall comply with the requirements of section 5201 of the Health Security Act (relating to health plan claims procedure).".

Section 8406 EFFECTIVE DATES.

Except as otherwise provided in this subtitle, the amendments made by this section shall take effect on the earlier of

(1) January 1, 1998, or

(2) such date or dates as may be prescribed in regulations of the National Health Board in connection with plans whose participants or beneficiaries reside in any State which becomes a participating State under section 1200 of this Actbefore January 1, 1998.

Title VIII, Subtitle F

Subtitle F Special Fund for WIC Program

Section 8501 ADDITIONAL FUNDING FOR SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC).

(a) Authorization of Additional Appropriations. There is hereby authorized to be appropriated for the special supplemental food program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966, in addition to amounts otherwise authorized to be appropriated for such program, such amounts as are necessary for the Secretary of the Treasury to fulfill the requirements of subsection (b).

(b) WIC Fund.

(1) Credit. For each of fiscal years 1996 through 2000, the Secretary of the Treasury shall credit to a special fund of the Treasury an amount equal to

(A) $254,000,000 for fiscal year 1996,

(B) $407,000,000 for fiscal year 1997,

(C) $384,000,000 for fiscal year 1998,

(D) $398,000,000 for fiscal year 1999, and

(E) $411,000,000 for fiscal year 2000.

(2) Availability. Subject to paragraph (3), amounts in such fund

(A) shall be available only for the program authorized under section 17 of the Child Nutrition Act of 1966, exclusive of activities authorized under section 17(m) of such Act, and

(B) shall be paid to the Secretary of Agriculture for such purposes.

(3) Limitation. For a fiscal year specified in paragraph (1), the amount credited to such fund for the fiscal year shall be available for use in such program only if appropriations Acts for the fiscal year, without the addition of amounts provided under subsection (a) for the fund, provide new budget authority for the program of no less than

(A) $3,660,000,000 for fiscal year 1996,

(B) $3,759,000,000 for fiscal year 1997,

(C) $3,861,000,000 for fiscal year 1998,

(D) $3,996,000,000 for fiscal year 1999, and

(E) $4,136,000,000 for fiscal year 2000.