

103<sup>D</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 727

To amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for pregnant women and children through employment-based insurance and through a State-based health plan.

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## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 2, 1993

Mr. MATSUI introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, and Education and Labor

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## A BILL

To amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for pregnant women and children through employment-based insurance and through a State-based health plan.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4       (a) SHORT TITLE.—This Act may be cited as the  
5       “Children and Pregnant Women Health Insurance Act of  
6       1993”.

1 (b) TABLE OF CONTENTS.—The table of contents of  
 2 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—REQUIRING EMPLOYERS TO PROVIDE HEALTH  
 INSURANCE COVERAGE FOR PREGNANT WOMEN AND CHILDREN

Sec. 101. “Pay-or-play” requirement.

Sec. 102. Meeting requirement through enrollment of employees and families  
 under qualified employer health plans.

“TITLE XXI—REQUIREMENT FOR ENROLLMENT OF EMPLOYEES  
 UNDER A QUALIFIED EMPLOYER HEALTH PLAN

“Sec. 2100. Relation to ‘pay-or-play’ requirement.

“PART A—EMPLOYER REQUIREMENT TO ENROLL EMPLOYEES AND FAMILIES  
 IN A QUALIFIED EMPLOYER HEALTH PLAN

“Sec. 2101. Application to full-time employees.

“Sec. 2102. Application to part-time employees.

“Sec. 2103. Application to seasonal and temporary employees.

“Sec. 2104. Treatment of all family members as a unit; uniform treatment  
 of full-time employees and of part-time employees.

“Sec. 2105. Application of requirement to employers of different sizes.

“Sec. 2106. Timing of enrollment; period of coverage.

“PART B—REQUIREMENTS FOR QUALIFIED EMPLOYER HEALTH PLANS

“Sec. 2121. Qualified employer health plan defined.

“Sec. 2122. Requirements relating to employee premiums and cost-sharing.

“PART C—STANDARDS FOR QUALIFIED HEALTH PLANS

“Sec. 2151. Certification of qualified health plans.

“Sec. 2152. Treatment of family as a unit; coverage period; health plan  
 cards.

“Sec. 2153. Requirement respecting required health services.

“Sec. 2154. Requirements respecting limits on pre-existing condition exclu-  
 sions and coverage standards for required health services.

“Sec. 2155. Requirements respecting limits on cost-sharing.

“Sec. 2156. Payment rates.

“Sec. 2157. Coordination and portability of health coverage under quali-  
 fied health plans.

“Sec. 2158. Consumer protections.

“Sec. 2159. Preemption of certain State and Federal requirements.

“Sec. 2160. Use of uniform claims forms.

“PART D—DEFINITIONS AND MISCELLANEOUS

“Sec. 2181. Definitions.

“Sec. 2182. Nonapplication to residents of Puerto Rico and territories.

TITLE II—PROVISION OF HEALTH INSURANCE FOR PREGNANT  
WOMEN AND CHILDREN THROUGH STATE CHILDREN AND  
PREGNANT WOMEN HEALTH PLANS

Sec. 201. State children and pregnant women health plans.

“TITLE XXII—STATE CHILDREN AND PREGNANT WOMEN  
HEALTH PLANS

“Sec. 2200. Establishment of State children and pregnant women health  
plans.

“PART A—PLAN REQUIREMENTS RELATING TO ELIGIBILITY AND  
ENROLLMENT

“Sec. 2201. General requirements; application process.

“Sec. 2202. Coverage period; termination of enrollment.

“Sec. 2203. Requirement of health insurance coverage.

“PART B—BENEFITS

“Sec. 2211. Covered health services.

“Sec. 2212. Preventive care services.

“Sec. 2213. Major medical services.

“Sec. 2214. Extended medical services.

“Sec. 2215. Scope of coverage.

“PART C—PAYMENTS FOR BENEFITS; DEDUCTIBLE, COINSURANCE, AND  
STOP-LOSS PROTECTION FOR REQUIRED HEALTH SERVICES

“Sec. 2221. Payment rates.

“Sec. 2222. Application of deductible.

“Sec. 2223. Coinsurance for major medical services and extended medical  
services.

“Sec. 2224. Limit on cost-sharing for required health services.

“Sec. 2225. Exclusions.

“Sec. 2226. Application of particular qualified health plan requirements.

“PART D—PREMIUMS; FEDERAL CHILDREN AND PREGNANT WOMEN  
HEALTH INSURANCE TRUST FUND

“Sec. 2231. Premiums.

“Sec. 2232. Collection of premiums.

“Sec. 2233. Federal Children and Pregnant Women Health Insurance  
Trust Fund.

“Sec. 2234. Transfer payments in the case of multiple employers.

“Sec. 2235. Use of uniform claims forms.

“Sec. 2236. Payments to States.

“PART E—ASSISTANCE FOR LOW-INCOME INDIVIDUALS

“Sec. 2241. Assistance for individuals enrolled on a non-employment basis.

“Sec. 2242. Assistance for individuals covered under qualified employer  
health plans.

“Sec. 2243. Applications for assistance.

“Sec. 2244. Reconciliation of premium assistance through use of income  
statements.

“Sec. 2245. Treatment of certain cash assistance recipients.

“Sec. 2246. Computation of family adjusted total income.

“PART F—ADMINISTRATIVE PROVISIONS

“Sec. 2261. General administration through insurance companies.

“Sec. 2262. Quality assurance.

“Sec. 2263. Beneficiary claims safeguards.

“Sec. 2264. Administrative efficiency standards.

“Sec. 2265. Health maintenance organizations.

“Sec. 2266. Program integrity; miscellaneous provisions.

“Sec. 2267. Demonstration project authority.

“PART G—DEFINITIONS AND MISCELLANEOUS

“Sec. 2281. Incorporation of certain definitions used in other health-related titles.

“Sec. 2282. Other definitions.

“Sec. 2283. Nonapplication to residents of Puerto Rico and territories.

Sec. 202. Coordination between State children and pregnant women health plans and medicaid plans.

TITLE III—HEALTH INSURANCE REFORM FOR SMALL EMPLOYERS

Sec. 301. Excise tax on premiums received on health insurance policies which do not meet certain requirements.

Sec. 302. Group health insurance standards.

“TITLE XXIII—INSURANCE REFORM FOR SMALL EMPLOYERS

“Sec. 2301. Application of requirements to insured small employer health plans.

“Sec. 2302. Establishment of standards.

“Sec. 2303. Enrollment practice and guaranteed renewability requirements for small employer health plans.

“Sec. 2304. Rating practices for small employer health plans.

“Sec. 2305. Basic benefit package for small employer health plans.

“Sec. 2306. Miscellaneous disclosure and record-keeping requirements for small employer health plans.

“Sec. 2307. Nonapplication in Puerto Rico and the territories.

“Sec. 2308. Definitions.

1 **TITLE I—REQUIRING EMPLOY-**  
 2 **ERS TO PROVIDE HEALTH IN-**  
 3 **SURANCE COVERAGE FOR**  
 4 **PREGNANT WOMEN AND**  
 5 **CHILDREN**

6 **SEC. 101. “PAY-OR-PLAY” REQUIREMENT.**

7 (a) PREMIUM TAXES.—

1           (1) IN GENERAL.—Subtitle C of the Internal  
2 Revenue Code of 1986 (relating to employment  
3 taxes) is amended by inserting after chapter 21 the  
4 following new chapter:

5           **“CHAPTER 21A—CHILDREN AND**  
6 **PREGNANT WOMEN HEALTH PLAN TAXES**

“Sec. 3151. Imposition of tax.

“Sec. 3152. Definitions and special rules.

7 **“SEC. 3151. IMPOSITION OF TAX.**

8           “(a) IMPOSITION OF TAX.—In addition to other  
9 taxes, if an employee of any employer is not covered under  
10 a qualified employer health plan of such employer—

11           “(1) TAX ON EMPLOYERS.—There is hereby im-  
12 posed on such employer, with respect to having such  
13 employee in his employ, a tax equal to 3.2 percent  
14 of the wages paid by such employer to such em-  
15 ployee.

16           “(2) TAX ON EMPLOYEES.—There is hereby im-  
17 posed on the income of such employee a tax equal  
18 to 1 percent of the wages received by such employee  
19 from such employer.

20           “(3) WAGES TAKEN INTO ACCOUNT.—Wages  
21 shall be taken into account under this subsection  
22 only to the extent attributable to the period during  
23 which such employee is not covered under a qualified  
24 employer health plan of such employer.

1 “(b) EXCEPTIONS.—

2 “(1) TRANSITION.—The taxes imposed by this  
3 section shall not take effect before the date on which  
4 the requirements of part A of title XXI of the Social  
5 Security Act apply with respect to the employer  
6 under section 2105(a) of such Act.

7 “(2) EMPLOYEES COVERED BY ANOTHER EM-  
8 PLOYER’S PLAN.—The taxes imposed by subsection  
9 (a)(2) of this section shall not apply to wages paid  
10 to any employee of an employer for any period such  
11 employee is covered by a qualified employer health  
12 plan of another employer (whether as an employee  
13 or family member of an employee).

14 “(3) EMPLOYEES COVERED BY FEDERAL  
15 HEALTH PLAN.—The taxes imposed by this section  
16 shall not apply to wages paid to any employee of the  
17 United States if, by reason of such employment (or  
18 the employment of a family member), the em-  
19 ployee—

20 “(A) is enrolled in a health benefits plan  
21 under chapter 89 of title 5, United States Code,  
22 or

23 “(B) is provided medical and dental bene-  
24 fits under chapter 55 of title 10 of such Code.

1 **“SEC. 3152. DEFINITIONS AND SPECIAL RULES.**

2 “(a) WAGES.—For purposes of this chapter, the term  
3 ‘wages’ has the meaning given such term by section  
4 3121(a) except that—

5 “(1) the modifications of subsection (b) shall  
6 apply in determining whether any service is employ-  
7 ment, and

8 “(2) the applicable contribution base under sec-  
9 tion 3121(x)(2) (relating to hospital insurance) shall  
10 be used under section 3121(a)(1) for purposes of  
11 this chapter.

12 “(b) EMPLOYMENT.—For purposes of this chapter—

13 “(1) IN GENERAL.—Except as modified in  
14 paragraph (2), the term ‘employment’ has the mean-  
15 ing given such term by section 3121(b).

16 “(2) MODIFICATIONS.—The modifications re-  
17 ferred to in this paragraph are that—

18 “(A) paragraphs (5), (6), (7), (8), and (9)  
19 of section 3121(b) shall not apply, and

20 “(B) subsections (r) and (w) of section  
21 3121 shall not apply.

22 “(c) EMPLOYEE; EMPLOYER.—For purposes of this  
23 chapter, the terms ‘employee’ and ‘employer’ have the  
24 same meanings as such terms have for purposes of chapter  
25 21.

1       “(d) QUALIFIED EMPLOYER HEALTH PLAN.—For  
2 purposes of this chapter, the term ‘qualified employer  
3 health plan’ has the meaning given such term in section  
4 2121(a) of the Social Security Act.

5       “(e) DEDUCTION FROM WAGES.—Rules similar to  
6 the rules of section 3102 shall apply to the tax imposed  
7 by section 3151(a)(2).

8       “(f) OTHER RULES.—

9           “(1) IN GENERAL.—Rules similar to the rules  
10 of sections 3123, 3125, and 3126, and subsections  
11 (q) and (s) of section 3121, shall apply for purposes  
12 of this chapter.

13           “(2) DEPOSITS.—The deposit requirements  
14 under section 6302 applicable to the taxes imposed  
15 by chapter 21 shall apply to the taxes imposed by  
16 this chapter.

17           “(3) MULTIPLE EMPLOYERS.—

18           “(A) IN GENERAL.—Except to the extent  
19 inconsistent with subparagraph (B), rules simi-  
20 lar to the rules of section 6413 shall apply to  
21 the tax imposed by section 3151(a)(2).

22           “(B) CONTRIBUTION BASE TO APPLY TO  
23 WAGES OF ENTIRE FAMILY.—In applying sec-  
24 tion 6413(c)(1) for purposes of subparagraph  
25 (A), the employee and the employee’s spouse

1 and children (as defined in section 2282 of the  
2 Social Security Act) shall be treated as 1 em-  
3 ployee. The credit or refund allowable by reason  
4 of the preceding sentence shall be allocated  
5 among such individuals in such manner as the  
6 Secretary may by regulations prescribe.”

7 (2) CLERICAL AMENDMENT.—The table of  
8 chapters for such subtitle C is amended by inserting  
9 after the item relating to chapter 21 the following  
10 new item:

“Chapter 21A. Children and pregnant women health plan taxes.”

11 (b) PENALTY TAXES.—

12 (1) IN GENERAL.—Chapter 47 of such Code is  
13 amended by adding at the end thereof the following  
14 new section:

15 **“SEC. 5000A. FAILURE TO ENROLL EMPLOYEES AND DE-**  
16 **PENDENTS UNDER STATE CHILDREN AND**  
17 **PREGNANT WOMEN HEALTH PLAN.**

18 “(a) IN GENERAL.—If the tax imposed by section  
19 3151 applies to wages (as defined in section 3152) paid  
20 by an employer to any individual, there is hereby imposed  
21 a tax on the failure by the employer to provide to the State  
22 in which the individual resides (in such form and manner  
23 as such Secretary may specify and no later than the date  
24 enrollment under a qualified employer health plan is re-  
25 quired under section 2105(a) of the Social Security Act)

1 completed application forms for enrollment with the State  
2 children and pregnant women health plan (under title  
3 XXII of such Act) of employees (and family members) re-  
4 quired to be enrolled under such section and not enrolled  
5 under a qualified employer health plan.

6 “(b) AMOUNT OF TAX.—

7 “(1) IN GENERAL.—The amount of the tax im-  
8 posed by subsection (a) on any failure with respect  
9 to an employee shall be \$100 for each day in the  
10 noncompliance period with respect to such failure.

11 “(2) NONCOMPLIANCE PERIOD.—For purposes  
12 of this section, the term ‘noncompliance period’  
13 means, with respect to any failure, the period—

14 “(A) beginning on the date such failure 1st  
15 occurs, and

16 “(B) ending on the date such failure is  
17 corrected.

18 “(c) LIABILITY FOR TAX.—The employer shall be lia-  
19 ble for the tax imposed by subsection (a).

20 “(d) EXCEPTIONS.—

21 “(1) TAX NOT TO APPLY WHERE FAILURE NOT  
22 DISCOVERED EXERCISING REASONABLE DILI-  
23 GENCE.—No tax shall be imposed by subsection (a)  
24 on any failure during any period for which it is es-  
25 tablished to the satisfaction of the Secretary that the

1 employer did not know, and exercising reasonable  
2 diligence would not have known, that such failure  
3 existed.

4 “(2) TAX NOT TO APPLY TO FAILURES COR-  
5 RECTED WITHIN 30 DAYS.—No tax shall be imposed  
6 by subsection (a) on any failure if—

7 “(A) such failure was due to reasonable  
8 cause and not to willful neglect, and

9 “(B) such failure is corrected during the  
10 1st 30 days of the noncompliance period with  
11 respect to such failure.

12 “(3) WAIVER BY SECRETARY.—In the case of a  
13 failure which is due to reasonable cause and not to  
14 willful neglect, the Secretary may waive part or all  
15 of the tax imposed by subsection (a) to the extent  
16 that the payment of such tax would be unduly bur-  
17 densome relative to the failure involved.”

18 (c) DEFICIENCY PROCEDURES TO APPLY TO CHAP-  
19 TER 47.—

20 (1) The following provisions of the Internal  
21 Revenue Code of 1986 are each amended by striking  
22 “or 44” each place it appears and inserting “44, or  
23 47”:

24 (A) Subsections (a) and (b)(2) of section  
25 6211.

1 (B) Section 6212(a).

2 (C) Subsections (a) and (g) of section  
3 6213.

4 (D) Subsections (c) and (d) of section  
5 6214.

6 (E) Section 6161(b)(1).

7 (F) Section 6344(a)(1).

8 (G) Subsections (a) and (b)(1) of section  
9 6512.

10 (H) Section 7422(e).

11 (2) Sections 6211(a) and 6862(a) of such Code  
12 are each amended by striking “and 44” and insert-  
13 ing “44, and 47”.

14 (3) Paragraph (1) of section 6212(b) of such  
15 Code is amended—

16 (A) by striking “or chapter 44” and insert-  
17 ing “chapter 44, or chapter 47”, and

18 (B) by striking “chapter 44, and this chap-  
19 ter” and inserting “chapter 44, chapter 47, and  
20 this chapter”.

21 (4) Paragraph (1) of section 6212(c) of such  
22 Code is amended by striking “or of chapter 44 tax  
23 for the same taxable period” and inserting “, of  
24 chapter 44 tax for the same taxable period, or of

1 chapter 47 for each act or failure to act to which the  
2 petition relates”.

3 (d) CLERICAL AMENDMENTS.—

4 (1) So much of chapter 47 of such Code as pre-  
5 cedes subsection (a) of section 5000 is amended to  
6 read as follows:

7 **“CHAPTER 47—TAXES RELATING TO**  
8 **GROUP HEALTH PLANS**

“Sec. 5000. Contributions to nonconforming large group health  
plans.

“Sec. 5000A. Failure to enroll employees under State children  
and pregnant women health plan.

9 **“SEC. 5000. CONTRIBUTIONS TO NONCONFORMING LARGE**  
10 **GROUP HEALTH PLANS.”**

11 (2) The table of chapters for subtitle D of such  
12 Code is amended by striking the item relating to  
13 chapter 47 and inserting the following:

“Chapter 47. Taxes relating to group health plans.”

14 (e) EFFECTIVE DATE.—The amendments made by  
15 this section shall apply to remuneration paid after Decem-  
16 ber 31, 1994.

17 **SEC. 102. MEETING REQUIREMENT THROUGH ENROLL-**  
18 **MENT OF EMPLOYEES AND FAMILIES UNDER**  
19 **QUALIFIED EMPLOYER HEALTH PLANS.**

20 The Social Security Act is amended by adding at the  
21 end the following new title:

1 “TITLE XXI—REQUIREMENT FOR ENROLL-  
2 MENT OF EMPLOYEES UNDER A QUALI-  
3 FIED EMPLOYER HEALTH PLAN

4 **“SEC. 2100. RELATION TO ‘PAY-OR-PLAY’ REQUIREMENT.**

5 “If an employer fails to enroll employees (and family  
6 members) under a qualified employer health plan in ac-  
7 cordance with this title—

8 “(1) the employer and employee are each liable  
9 for payment of an excise tax under section 3151(a)  
10 of the Internal Revenue Code of 1986, and

11 “(2) the employer is required, under section  
12 5000A of such Code, to provide information nec-  
13 essary to enroll such employees and family members  
14 under the State children and pregnant women health  
15 plan under title XXII for the State in which the em-  
16 ployee resides.

17 “PART A—EMPLOYER REQUIREMENT TO ENROLL EM-  
18 PLOYEES AND FAMILIES IN A QUALIFIED EM-  
19 PLOYER HEALTH PLAN

20 **“SEC. 2101. APPLICATION TO FULL-TIME EMPLOYEES.**

21 “(a) UNMARRIED EMPLOYEES.—

22 “(1) IN GENERAL.—Except as provided in this  
23 part, each employer shall, in accordance with this  
24 title, enroll each of its full-time employees who is un-  
25 married in a qualified employer health plan.

1 “(2) MULTIPLE FULL-TIME EMPLOYMENT.—

2 “(A) EACH OFFERS QUALIFIED PLAN.—In  
3 the case of an unmarried individual who is a  
4 full-time employee of more than 1 employer, if  
5 more than 1 such employer offers the employee  
6 enrollment under a qualified employer health  
7 plan—

8 “(i) the individual shall elect (in a  
9 manner specified by the Secretary) the  
10 qualified employer health plan under which  
11 the individual (and family members) will  
12 be enrolled;

13 “(ii) a nonenrolling employer—

14 “(I) is not obligated to enroll the  
15 employee (and family members) under  
16 its qualified employer health plan (if  
17 any) and may not charge the individ-  
18 ual any premiums for required cov-  
19 erage under the qualified employer  
20 health plan, and

21 “(II) is not liable for any tax  
22 under section 3151(a)(1) of the Inter-  
23 nal Revenue Code of 1986 but is lia-  
24 ble for a nonenrolling employer pre-

1 mium under section 2234(a)(1)(A);  
2 and

3 “(iii) the enrolling employer is eligible  
4 for a enrolling employer subsidy under sec-  
5 tion 2234(a)(1)(B).

6 “(B) ONLY 1 OFFERS QUALIFIED PLAN.—  
7 In the case of an unmarried individual who is  
8 a full-time employee of more than 1 employer,  
9 if only 1 employer offers the employee enroll-  
10 ment under a qualified employer health plan—

11 “(i) the individual shall be enrolled  
12 under such plan and, pursuant to sub-  
13 section (b)(2) of section 3151 of the Inter-  
14 nal Revenue Code of 1986, is not subject  
15 to taxes under subsection (a)(2) of such  
16 section with respect to employment with  
17 nonenrolling employers, and

18 “(ii) the enrolling employer is eligible  
19 for a enrolling employer subsidy under sec-  
20 tion 2234(a)(1)(B).

21 “(b) MARRIED EMPLOYEES.—

22 “(1) IN GENERAL.—Except as provided in this  
23 part, each employer shall, in accordance with this  
24 title, enroll each of its full-time employees who is  
25 married in a qualified employer health plan.

1           “(2) BOTH FULL-TIME EMPLOYEES.—In the  
2 case of married individuals, if both are full-time em-  
3 ployees of 1 or more employers, rules established by  
4 the Secretary based on the rules under subsection  
5 (a)(2) for multiple employment of unmarried individ-  
6 uals shall apply.

7           “(c) CONSTRUCTION.—Nothing in this section shall  
8 be construed as preventing the nonenrolling plan from  
9 supplementing the benefits of the enrolling plan.

10          “(d) DEFINITIONS.—In this section, the terms ‘en-  
11 rolling employer’ and ‘enrolling plan’ mean, with respect  
12 to an individual or a married couple, the employer that  
13 offers the qualified employer health plan in which the indi-  
14 vidual or couple is enrolled under subsection (a)(2)(A)(i)  
15 or (b)(2) and such plan, respectively, and the terms  
16 ‘nonenrolling employer’ and ‘nonenrolling plan’ mean the  
17 other employer and other qualified employer health plan,  
18 respectively.

19          **“SEC. 2102. APPLICATION TO PART-TIME EMPLOYEES.**

20          “(a) APPLICATION OF FULL-TIME EMPLOYEE  
21 RULES.—Subject to subsection (b), the provisions of sec-  
22 tion 2101 shall apply to part-time employees in the same  
23 manner as they apply to full-time employees.

24          “(b) SEPARATE TREATMENT OF PART-TIME AND  
25 FULL-TIME EMPLOYEES UNDER QUALIFIED EMPLOYER

1 HEALTH PLANS.—For rule regarding separate, but uni-  
2 form, treatment of full-time and part-time employees (and  
3 family members), see section 2104(b).

4 **“SEC. 2103. APPLICATION TO SEASONAL AND TEMPORARY**  
5 **EMPLOYEES.**

6 “(a) ENROLLMENT UNDER QUALIFIED EMPLOYER  
7 HEALTH PLAN NOT AFFECTING APPLICATION OF EXCISE  
8 TAX.—The enrolling by an employer of an employee des-  
9 ignated under subsection (b) as a seasonal or temporary  
10 employee (as defined in section 2181(b)(3)), whether a  
11 part-time or full-time employee, under the qualified em-  
12 ployer health plan of the employer shall not be considered,  
13 for purposes of section 3151 of the Internal Revenue Code  
14 of 1986, coverage of the employee under a qualified em-  
15 ployer health plan.

16 “(b) DESIGNATION OF SEASONAL OR TEMPORARY  
17 EMPLOYEES.—Each employer shall designate, at the time  
18 of initial employment and in a manner specified by the  
19 Secretary, if the individual is to be treated under this title  
20 and title XXII as a seasonal or temporary employee. The  
21 Secretary shall provide appropriate sanctions (that may  
22 include civil money penalties) for the knowing designation  
23 as seasonal or temporary employees of individuals who are  
24 not of seasonal or temporary employees.

1 **“SEC. 2104. TREATMENT OF ALL FAMILY MEMBERS AS A**  
2 **UNIT; UNIFORM TREATMENT OF FULL-TIME**  
3 **EMPLOYEES AND OF PART-TIME EMPLOYEES.**

4 “(a) TREATMENT OF ALL FAMILY MEMBERS AS  
5 UNIT.—

6 “(1) IN GENERAL.—In accordance with section  
7 2152(a), enrollment of an employee in a qualified  
8 employer health plan shall include enrollment of the  
9 other family members of the employee. The fact that  
10 an employee is not a pregnant woman or a child (or  
11 has any family members who are pregnant women or  
12 children) does not permit or prevent the enrollment  
13 of the employee under the qualified employer health  
14 plan in accordance with this part.

15 “(2) TREATMENT OF CHILDREN.—In the case  
16 of an individual who is a child, the employer of the  
17 child is not required to enroll the child in a qualified  
18 employer health plan by virtue of the part-time or  
19 full-time employment of the child (whether or not  
20 the parent of the child is a full-time or part-time  
21 employee). However, the employer is liable for taxes  
22 under section 3151(a)(1) of the Internal Revenue  
23 Code of 1986 (or payment of a nonenrolling em-  
24 ployer premium under section 2234(a)(1)(A)) with  
25 respect to such employment, and the child is, subject

1 to section 3151(b)(2) of such Code, liable for taxes  
2 under section 3151(a)(2) of such Code.

3 “(b) UNIFORM TREATMENT OF FULL-TIME EMPLOY-  
4 EES AND OF PART-TIME EMPLOYEES.—Except as author-  
5 ized under sections 2101 and 2102 (insofar as they permit  
6 certain multiple-employed individuals to elect coverage  
7 under qualified employer health plans) and as provided  
8 under section 2103 and subsection (a)(2) of this section,  
9 an employer health plan is not a qualified employer health  
10 plan if the plan—

11 “(1) enrolls some (but not all) full-time employ-  
12 ees (and family members) required to be enrolled  
13 under this part, or

14 “(2) enrolls some (but not all) part-time em-  
15 ployees (and family members) required to be enrolled  
16 under this part.

17 However, a plan may be a qualified employer health plan  
18 and enroll only full-time employees (and family members),  
19 but not part-time employees (and family members).

20 **“SEC. 2105. APPLICATION OF REQUIREMENT TO EMPLOY-**  
21 **ERS OF DIFFERENT SIZES.**

22 “(a) IN GENERAL.—Except as provided in subsection  
23 (b), the requirements of this part apply—

24 “(1) as of January 1, 1995, to large employers  
25 (as defined in section 2181(c)(3));

1           “(2) as of January 1, 1996, to medium-size em-  
2           ployers (as defined in section 2181(c)(2)) that nor-  
3           mally employ at least 50 employees on a typical  
4           business day during the calendar year;

5           “(3) as of January 1, 1997, to medium-size em-  
6           ployers not described in paragraph (2); and

7           “(4) as of January 1, 1998, to small employers  
8           (as defined in section 2181(c)(1)).

9           “(b) **TRANSITION FOR COLLECTIVE BARGAINING**  
10 **AGREEMENTS.**—The requirements of this part shall not  
11 apply to employers with respect to their employees, insofar  
12 as such employees are covered under a collective bargain-  
13 ing agreement ratified before the date of the enactment  
14 of this title, earlier than the date of termination of such  
15 agreement (determined without regard to any extension  
16 thereof agreed to after such date of enactment).

17 **“SEC. 2106. TIMING OF ENROLLMENT; PERIOD OF COV-**  
18 **ERAGE.**

19           “(a) **TIMING OF ENROLLMENT; NOTICES.**—

20           “(1) **IN GENERAL.**—Enrollment under this part  
21 shall occur not later than the date on which the em-  
22 ployment, for which such enrollment is required  
23 under this part, commences.

24           “(2) **REFERENCE TO DISCLOSURE REQUIRE-**  
25 **MENT.**—For requirement for disclosure to employees

1 of information respecting the availability of low-in-  
2 come assistance under part E of title XXII, see sec-  
3 tion 2158(a)(1).

4 “(b) PERIOD OF COVERAGE.—

5 “(1) BEGINNING OF COVERAGE.—Coverage  
6 under a qualified employer health plan shall begin in  
7 accordance with section 2152(b).

8 “(2) TERMINATION OF COVERAGE.—

9 “(A) IN GENERAL.—If an enrollment is ef-  
10 fected under this part on the basis of employ-  
11 ment, coverage under such enrollment may be  
12 terminated, subject to subparagraph (B), on the  
13 last day of the month (or of any subsequent  
14 month) during which such employment is termi-  
15 nated.

16 “(B) NOTICE REQUIRED.—Effective on the  
17 date specified in section 2157(b)(2), coverage  
18 under a qualified employer health plan shall not  
19 be terminated unless notice has been provided  
20 to the Secretary, as required in section  
21 2157(b)(1), of such termination at least 7 days  
22 before the last day of the month in which em-  
23 ployment is terminated (or, if later, 7 days be-  
24 fore the last day of the month in which the cov-  
25 erage is terminated).



1 qualified employer health plan that is an insured  
2 plan or that is a self-insured plan.

3 “(2) MEDIUM-SIZE AND SMALL EMPLOYERS.—  
4 A medium-size or small employer may meet the re-  
5 quirements of this title only through a qualified em-  
6 ployer health plan that is an insured plan that im-  
7 poses premiums only in accordance with sections  
8 2122 and 2304.

9 “(3) INSURED PLAN DEFINED.—The term ‘in-  
10 sured plan’ has the meaning given the term ‘applica-  
11 ble accident and health insurance contract’ in sec-  
12 tion 5000B(e)(1) of the Internal Revenue Code of  
13 1986.

14 **“SEC. 2122. REQUIREMENTS RELATING TO EMPLOYEE PRE-**  
15 **MIUMS AND COST-SHARING.**

16 “(a) ENROLLEE PREMIUMS AND COST-SHARING  
17 PERMITTED.—

18 “(1) IN GENERAL.—A qualified employer health  
19 plan may require an enrollee to pay for—

20 “(A) premiums for coverage under the  
21 plan, but only if the premiums do not exceed  
22 the limitations imposed under this section, and

23 “(B) cost-sharing amounts for coverage  
24 under the plan, but only if the cost-sharing does  
25 not exceed the limitations on deductibles,

1 copayments, and coinsurance imposed with re-  
2 spect to qualified health plans under section  
3 2155.

4 “(2) TREATMENT OF ADDITIONAL, REQUIRED  
5 COVERAGE.—If a qualified employer health plan pro-  
6 vides benefits in addition to the benefits required  
7 under this title and the employee is not permitted  
8 the option of not accepting such additional benefits,  
9 the plan—

10 “(A) may not impose a premium, for such  
11 required and additional benefits, that exceeds  
12 the premiums that may be imposed for the  
13 basic benefits, and

14 “(B) shall assure that cost-sharing is not  
15 imposed with respect to required health services  
16 once the cost-sharing limit has been reached in  
17 a year with respect to benefits for such services.

18 “(3) NONDISCRIMINATION IN PREMIUM  
19 AMOUNTS.—Under a qualified employer health plan,  
20 no employee may be charged a different premium for  
21 similar benefits in the same employer health plan for  
22 the same beneficiary class based on the age, sex, or  
23 health status of the employee (or number, age, sex,  
24 or health status of family members).

25 “(b) LIMITATION ON PREMIUMS.—

1           “(1) MONTHLY PREMIUM LIMITED TO 20 PER-  
2           CENT OF ACTUARIAL RATE.—

3           “(A) IN GENERAL.—A qualified employer  
4           health plan may not require an employee to pay  
5           a premium—

6                   “(i) for coverage for a period of longer  
7                   than one month, or

8                   “(ii) the amount of which on a month-  
9                   ly basis exceeds 20 percent of the monthly  
10                  actuarial rate (as defined under subpara-  
11                  graph (B)).

12           “(B) MONTHLY ACTUARIAL RATE DE-  
13           FINED.—For purposes of this subsection, the  
14           term ‘monthly actuarial rate’ means, with re-  
15           spect to a qualified employer health plan in a  
16           plan year, the average monthly per enrollee  
17           amount that the plan estimates, for enrollees  
18           under the plan during the year, would be nec-  
19           essary to pay for the total benefits required  
20           during the year under the plan (with respect to  
21           required health services), including administra-  
22           tive costs for the provision of such benefits and  
23           an appropriate amount for a contingency mar-  
24           gin.

1           “(C) UNIFORM APPLICATION REGARDLESS  
2           OF FAMILY COMPOSITION.—For purposes of  
3           subparagraph (B), a qualified employer health  
4           plan shall provide for the premium to be ap-  
5           plied, and the monthly actuarial rate described  
6           in such subparagraph to be estimated, for re-  
7           quired health services for all covered individuals  
8           within a family (without regard to the age, sex,  
9           health status, or number of such individuals  
10          covered within the family).

11          “(3) LIABILITY FOR PAYMENT OF PREMIUMS.—  
12          An employee enrolled under a qualified employer  
13          health plan is liable for payment of premiums re-  
14          quired under that plan in accordance with this sub-  
15          section. In no case shall an employee be liable for  
16          premiums with respect to a qualified employer  
17          health plan, other than the portion of the premium  
18          which may be imposed on the employee consistent  
19          with this section.

20          “(4) WITHHOLDING PERMITTED.—No provision  
21          of State law shall prevent an employer of an em-  
22          ployee enrolled under a qualified employer health  
23          plan from withholding the amount of any premium  
24          due by the employee under this subsection from the  
25          wages paid the employee.

1           “(5) CONSTRUCTION.—Nothing in this section  
2 shall be construed—

3           “(A) as preventing an employer from pay-  
4 ing part or all of the employee premium for re-  
5 quired health services or other health services,  
6 or

7           “(B) subject to subsection (a), from re-  
8 quiring an employee to pay for all or part of the  
9 premium for benefits for services other than re-  
10 quired health services.

11 “PART C—STANDARDS FOR QUALIFIED HEALTH PLANS

12 “**SEC. 2151. CERTIFICATION OF QUALIFIED HEALTH PLANS.**

13           “(a) QUALIFIED HEALTH PLAN DEFINED.—For  
14 purposes of this title, the term ‘qualified health plan’  
15 means a health plan that the Secretary certifies, upon ap-  
16 plication by the plan, to meet the requirements of this  
17 part.

18           “(b) REVIEW AND RECERTIFICATION.—The Sec-  
19 retary shall establish procedures for the periodic review  
20 and recertification of plans as qualified health plans.

21           “(c) TERMINATION OF CERTIFICATION.—The Sec-  
22 retary shall terminate the certification of a qualified  
23 health plan if the Secretary determines that the plan no  
24 longer meets the requirements for certification. Before  
25 effecting a termination, the Secretary shall provide the

1 plan notice and opportunity for a hearing on the proposed  
2 termination.

3 **“SEC. 2152. TREATMENT OF FAMILY AS A UNIT; COVERAGE**  
4 **PERIOD; HEALTH PLAN CARDS.**

5 “(a) TREATMENT OF FAMILY AS A UNIT.—

6 “(1) IN GENERAL.—Subject to paragraph (2),  
7 enrollment of an individual in a qualified health plan  
8 shall include enrollment of the other family members  
9 (as defined in section 2282(3)) of the individual.

10 “(2) TREATMENT OF INELIGIBLE INDIVID-  
11 UALS.—Nothing in paragraph (1) shall be construed  
12 as requiring a qualified health plan (or permitting a  
13 State children and pregnant women health plan) to  
14 enroll individuals who are not eligible individuals (as  
15 defined in section 2282(2)).

16 “(b) BEGINNING OF COVERAGE.—

17 “(1) IN GENERAL.—In the case of an individual  
18 enrolled under any qualified health plan, subject to  
19 subsection (c), the benefits under the plan shall first  
20 become available for required health services fur-  
21 nished beginning on the first day of the month fol-  
22 lowing the month of enrollment.

23 “(2) SPECIAL RULES.—The Secretary shall pro-  
24 vide for such standards as may be necessary to pro-  
25 vide for the allocation of responsibility among quali-

1       fied health plans (including State children and preg-  
2       nant women health plans) in the case of an inpatient  
3       hospital stay, or in the case in which a single pay-  
4       ment amount is made for other services provided  
5       over a period of time, that begins during the period  
6       of coverage under one qualified health plan and ends  
7       during a period of coverage under another qualified  
8       health plan.

9       “(c) STANDARDS TO REFLECT CHANGES IN FAMILY  
10      AND EMPLOYMENT STATUS.—

11           “(1) IN GENERAL.—Under standards estab-  
12           lished by the Secretary consistent with this sub-  
13           section, qualified health plans shall provide for ap-  
14           propriate changes in the coverage of family members  
15           to take into account—

16                   “(A) changes in family composition or sta-  
17                   tus, including marriage, divorce (or legal sepa-  
18                   ration), birth or adoption of children, and the  
19                   aging of children into adulthood, and

20                   “(B) changes in employment status.

21           “(2) MONTHLY CHANGES.—Except as specifi-  
22           cally provided in this subsection, such standards  
23           shall be designed—

24                   “(A) to effect a change in enrollment (or  
25                   status of enrollment) as of the first day of the

1 first month (or, in order to provide for notice  
2 and an opportunity for coordination among  
3 plans, a later month) following the date of the  
4 event causing the change,

5 “(B) to prevent any periods of noncoverage  
6 under any qualified health plans, and

7 “(C) to provide, in the case of a change of  
8 family status such as marriage, divorce, or legal  
9 separation, for accounting and crediting of cost-  
10 sharing among family members (described in  
11 section 2157(c)) in an equitable and admin-  
12 istrable manner.

13 “(3) TREATMENT OF NEWBORNS.—

14 “(A) BIRTH TO WOMAN DURING PERIOD  
15 OF COVERAGE.—Any child born to a woman  
16 during the period of coverage under a qualified  
17 health plan shall, as of the date of birth, be  
18 automatically enrolled and covered for benefits  
19 under the plan.

20 “(B) BIRTH TO WOMAN WITHOUT COV-  
21 ERAGE.—Any child born in the United States to  
22 a woman who is not, at the time of birth, en-  
23 rolled under a qualified health plan shall be  
24 automatically enrolled and covered for benefits  
25 under the State children and pregnant women

1 health plan for the State in which the child is  
2 born as of the date of birth if an application for  
3 such enrollment is made not later than 60 days  
4 after the date of birth or, if later, the end of  
5 the year in which the child is born.

6 “(4) ADOPTION.—

7 “(A) TREATMENT OF VOLUNTARY RELIN-  
8 QUISHMENT.—Any child who is voluntarily re-  
9 linquished to a public or private agency shall,  
10 upon the application by the agency, be enrolled  
11 and covered for benefits under the State chil-  
12 dren and pregnant women health plan for the  
13 State in which the child resides as of the date  
14 of the relinquishment, until the date of the  
15 child’s placement for adoption.

16 “(B) TREATMENT OF ADOPTED CHIL-  
17 DREN.—Any child who is placed for adoption  
18 with an individual during the period the individ-  
19 ual is enrolled and covered under a qualified  
20 health plan shall, as of the date of the place-  
21 ment for adoption, be treated as the child of the  
22 individual and be automatically enrolled and  
23 covered under such plan.

24 “(5) PLACEMENT IN CUSTODY OF PUBLIC  
25 AGENCY PURSUANT TO COURT ORDER OR OTHER-

1 WISE.—Any child who is removed from the family  
2 and placed in the temporary custody of a public  
3 agency pursuant to a court order or otherwise shall,  
4 upon application by the public agency on or after the  
5 date of the removal and placement with the public  
6 agency, be deemed to be automatically enrolled and  
7 covered for benefits under the State plan under title  
8 XXII as of the date of the application, until the  
9 child is returned to the family or placed for adop-  
10 tion.

11 “(6) TREATMENT OF LEGAL WARDS, FOSTER  
12 CHILDREN, ETC.—In cases not described in para-  
13 graph (4) or (5), the Secretary shall establish stand-  
14 ards relating to the time an individual described in  
15 section 2282(1)(B)(ii) is treated as the child of the  
16 person with custody and such other standards as  
17 may be necessary to assure the proper coordination  
18 of enrollment of children and other individuals  
19 among qualified health plans and State children and  
20 pregnant women health plans.

21 “(d) HEALTH PLAN CARDS.—In conjunction with en-  
22 rollment of individuals under a qualified health plan, the  
23 plan shall provide for the issuance of a card which may  
24 be used for purposes of identification of such enrollment

1 and the processing of claims for benefits under the plan.

2 Such card shall—

3 “(1) identify (as appropriate) the types of bene-  
4 fits to which the individual is entitled under the  
5 plan, and

6 “(2) contain such other information as the Sec-  
7 retary (and the plan) shall specify.

8 **“SEC. 2153. REQUIREMENT RESPECTING REQUIRED**  
9 **HEALTH SERVICES.**

10 “(a) REQUIREMENT.—Each qualified health plan  
11 must provide for benefits for at least all required health  
12 services (as defined in section 2211(a)(2)), in accordance  
13 with standards established under section 2211(d).

14 “(b) TREATMENT OF ADDITIONAL BENEFITS.—  
15 Nothing in this section shall be construed as preventing  
16 a qualified health plan from including benefits in addition  
17 to benefits for required health services.

18 **“SEC. 2154. REQUIREMENTS RESPECTING LIMITS ON PRE-**  
19 **EXISTING CONDITION EXCLUSIONS AND COV-**  
20 **ERAGE STANDARDS FOR REQUIRED HEALTH**  
21 **SERVICES.**

22 “(a) IN GENERAL.—Except as provided under sub-  
23 section (b), a qualified health plan—

24 “(1) may not deny, limit, or condition the cov-  
25 erage under (or benefits of) the plan with respect to

1 required health services based on the health status,  
2 claims experience, receipt of health care, medical his-  
3 tory, or lack of evidence of insurability, of an indi-  
4 vidual, and

5 “(2) may not provide for exclusions from cov-  
6 erage for required health services that are more re-  
7 strictive than the exclusions for such services under  
8 part C of title XXII.

9 “(b) PROHIBITION OF PRE-EXISTING CONDITION EX-  
10 CLUSIONS.—A qualified health plan may not exclude cov-  
11 erage with respect to required health services related to  
12 treatment of a pre-existing condition.

13 **“SEC. 2155. REQUIREMENTS RESPECTING LIMITS ON COST-**  
14 **SHARING.**

15 “(a) IN GENERAL.—Subject to subsection (b), a  
16 qualified health plan may not impose premiums,  
17 deductibles, copayments, or coinsurance with respect to re-  
18 quired health services in excess of the premiums permitted  
19 under this title and the deductible and coinsurance per-  
20 mitted under part C of title XXII with respect to such  
21 services (not taking into account any low-income assist-  
22 ance provided under part E of title XXII).

23 “(b) ACTUARIALLY EQUIVALENCE PERMITTED FOR  
24 EXTENDED MEDICAL SERVICES.—

1           “(1) IN GENERAL.—A plan may provide for dif-  
2           ferent premiums, deductibles, and copayments with  
3           respect to extended medical services if the actuarial  
4           value of such benefits (as defined in paragraph (3))  
5           is not less than the equivalent of the actuarial value  
6           of such benefits provided under the plan if this sub-  
7           section did not apply. The previous sentence shall  
8           not be construed as permitting a plan to provide for  
9           a limit on cost-sharing in excess of the limit pro-  
10          vided under section 2224.

11          “(2) GUIDELINES.—The Secretary shall estab-  
12          lish guidelines for the application of paragraph (1).  
13          Each State shall provide standards (consistent with  
14          such guidelines) for the application of paragraph (1)  
15          to plans offered in the State.

16          “(3) ACTUARIAL VALUE OF BENEFITS DE-  
17          FINED.—In paragraph (1), the ‘actuarial value of  
18          benefits’ of a plan is the amount by which the total  
19          of the amounts payable as benefits under the plan  
20          for extended medical services exceeds the amount of  
21          the premiums, deductibles, copayments, and coinsur-  
22          ance payable by the employee under the plan that  
23          are attributable to such services, as determined on  
24          an actuarial basis per enrollee for a plan year.

1 (4) EXTENDED MEDICAL SERVICES DEFINED.—

2 In this subsection, the term ‘extended medical serv-  
3 ices’ has the meaning given such term in section  
4 2214(a).

5 “(c) CONSTRUCTION FOR OTHER THAN REQUIRED  
6 HEALTH SERVICES.—Nothing in this section shall be con-  
7 strued as preventing a qualified health plan from provid-  
8 ing for deductibles, coinsurance, and copayments or other  
9 restrictions with respect to services other than required  
10 health services that are different from those permitted  
11 with respect to required health services.

12 **“SEC. 2156. PAYMENT RATES.**

13 “(a) IN GENERAL.—A qualified health plan shall  
14 make payment for required health services based on the  
15 payment rates established under part C of title XXII.

16 “(b) TREATMENT OF HEALTH MAINTENANCE ORGA-  
17 NIZATIONS.—Subsection (a) shall not apply to a plan of  
18 an eligible organization (as defined in section 1876(b))  
19 which provides for enrollee protections which are at least  
20 as great as the enrollee protections provided under section  
21 2265 (but without the application of section 2265(b)(5)  
22 or 1876(c)(3)(B)).

1 **“SEC. 2157. COORDINATION AND PORTABILITY OF HEALTH**  
2 **COVERAGE UNDER QUALIFIED HEALTH**  
3 **PLANS.**

4 “(a) IN GENERAL.—Each qualified health plan shall  
5 provide for coordination of—

6 “(1) enrollment and termination of enrollment  
7 among the qualified health plans and State children  
8 and pregnant women health plans, and

9 “(2) application of deductibles and limitations  
10 on cost-sharing among such plans,

11 in accordance with standards established by the Secretary  
12 consistent with this section.

13 “(b) REQUIREMENT OF NOTICES WITH RESPECT TO  
14 COVERAGE.—

15 “(1) IN GENERAL.—Each qualified health plan  
16 shall provide notice at the time an individual’s cov-  
17 erage under the plan begins or is terminated. Such  
18 notice shall be provided (in a form and manner and  
19 at a time specified by the Secretary)—

20 “(A) to the individual (or in the case of en-  
21 rollment only of a child or children, to the par-  
22 ent enrolling the child or children), and

23 “(B) effective (on the date specified in  
24 paragraph (2)) to the Secretary.

1 The notice under this paragraph shall include the  
2 names and other identifying information of family  
3 members whose coverage is affected by the change.

4 “(2) DATE OF REQUIREMENT FOR NOTICE TO  
5 STATE CHILDREN AND PREGNANT WOMEN HEALTH  
6 PLANS.—The date specified in this paragraph is  
7 January 1, 1995, or, with respect to a qualified em-  
8 ployer health plan of an employer, the date the re-  
9 quirements of part A apply with respect to the em-  
10 ployer under section 2105(a).

11 “(3) NOTICE TO BENEFICIARY AND OTHER  
12 QUALIFIED HEALTH PLANS UPON OBTAINING COV-  
13 ERAGE.—In the case of an individual who begins  
14 coverage under a qualified employer health plan (or  
15 under a State children and pregnant women health  
16 plan on an employment basis), when the Secretary  
17 receives notice under paragraph (1)(B)—

18 “(A) if, at the time of obtaining such cov-  
19 erage, the individual is enrolled on a non-em-  
20 ployment basis in a State children and pregnant  
21 women health plan, the Secretary shall notify  
22 the individual that coverage for such services on  
23 such a basis or for such benefits shall be termi-  
24 nated effective on the date of coverage under  
25 such a plan, and

1           “(B) the Secretary shall provide for notice  
2           to any other qualified health plan in which the  
3           Secretary knows the individual is enrolled of the  
4           fact of such new coverage.

5           “(4) NOTICES OF TERMINATION.—Each notice  
6           of termination under paragraph (1) shall include—

7                   “(A) the effective date of the termination,  
8                   “(B) in the case of notice to the Secretary,  
9                   sufficient information to permit enrollment of  
10                  the individuals affected under a State children  
11                  and pregnant women health plan, and

12                   “(C) in the case of an individual whose  
13                  coverage under the plan is terminated other  
14                  than at the end of a calendar year, the account-  
15                  ing statement produced under subsection (c)(2).

16          “(c) ACCOUNTING FOR COST-SHARING.—

17                  “(1) IN GENERAL.—Each qualified health plan  
18                  shall provide for an ongoing accounting, for each en-  
19                  rollee (and enrolled family members) on a calendar  
20                  year basis, of expenses incurred for required health  
21                  services that are counted towards the deductible es-  
22                  tablished under section 2222 and that are counted  
23                  towards the cost-sharing limit established under sec-  
24                  tion 2224. The amount credited for each account  
25                  shall be determined in accordance with standards es-

1        established by the Secretary in order to provide con-  
2        sistency among qualified health plans and to pro-  
3        mote portability of benefits across qualified health  
4        plans.

5            “(2) STATEMENT OF ACCOUNT BALANCE.—In  
6        the case of an individual whose coverage under the  
7        plan is terminated other than at the end of a cal-  
8        endar year, the qualified health plan shall produce  
9        an accounting statement (in a uniform manner es-  
10       established by the Secretary) of the amounts that are  
11       credited under the plan towards such deductible and  
12       cost-sharing limitations for the year for each enrollee  
13       (and family members) involved, in accordance with  
14       the accounting under paragraph (1).

15            “(3) CREDITING OF PREVIOUS EXPENSES TO-  
16        WARDS DEDUCTIBLES AND COINSURANCE.—Each  
17        qualified health plan shall, in the case of an individ-  
18        ual who is enrolled under the plan after the begin-  
19        ning of a year, credit, against the deductible and  
20        cost-sharing limit for required health services under  
21        its plan, the amounts previously accounted against  
22        the deductible and cost-sharing limit under another  
23        qualified health plan for the calendar year. The  
24        credit under this subparagraph shall be based on the  
25        accounting statement produced under paragraph (2).

1       “(d) COVERAGE UNDER A STATE CHILDREN AND  
2 PREGNANT WOMEN HEALTH PLAN.—

3           “(1) IN GENERAL.—Except as provided in this  
4 subsection, each State children and pregnant women  
5 health plan shall enroll each eligible individual (as  
6 defined in section 2282(2)) who resides in the State  
7 and whose coverage under a qualified health plan or  
8 under title XVIII is terminated, effective on the date  
9 following the effective date of termination of cov-  
10 erage under such plan.

11          “(2) OBTAINING ALTERNATE COVERAGE.—  
12 Paragraph (1) shall not apply if the individual pro-  
13 vides satisfactory evidence that the individual has  
14 obtained coverage through another qualified health  
15 plan or is a medicare beneficiary enrolled under part  
16 B of title XVIII.

17          “(3) NO AUTOMATIC ENROLLMENT DURING  
18 TRANSITION.—Paragraphs (1) and (2) shall not  
19 apply to terminations occurring before January 1,  
20 1998. During the period before January 1, 1998, be-  
21 fore an individual described in paragraph (1) enrolls  
22 under a State children and pregnant women health  
23 plan, the State shall provide the individual with a  
24 notice of the minimum enrollment period required  
25 under section 2202(b)(3).

1           “(4) REFERENCE TO ADDITIONAL REQUIRE-  
2           MENTS.—For addition enrollment requirements for  
3           State children and pregnant women health plans, see  
4           sections 2152(c)(3)(B), 2152(c)(4)(A), and  
5           2152(c)(5).

6           “(e) PROVISION OF INFORMATION ON ENROLLEES.—  
7           Each qualified health plan shall provide the Secretary and  
8           applicable State children and pregnant women health  
9           plans with such information as the Secretary may require  
10          in order to ascertain whether (and the amount of) any  
11          transfer payments to be made under section 2234.

12          **“SEC. 2158. CONSUMER PROTECTIONS.**

13          “(a) DISCLOSURE REQUIREMENTS FOR EMPLOYER  
14          PLANS.—

15                 “(1) NOTICE OF AVAILABILITY OF LOW-INCOME  
16                 ASSISTANCE.—At the time of enrollment of an em-  
17                 ployee under a qualified employer health plan, the  
18                 plan (directly or through the employer) shall provide  
19                 the employee with a notice (in a form specified by  
20                 the Secretary) of the low-income assistance available  
21                 under part E of title XXII with respect to enroll-  
22                 ment under the plan.

23                 “(2) FOR SMALL EMPLOYER PLANS.—In the  
24                 case of a qualified employer health plan that is of-  
25                 fered to a small employer, the plan may not be is-

1 sued or sold to the employer unless the employer has  
2 been provided the following information:

3 “(A) A description of the benefits covered  
4 in the plan and cost-sharing required with re-  
5 spect to such benefits.

6 “(B) A comparison of the benefits and  
7 cost-sharing described in subparagraph (A) with  
8 required health services.

9 “(3) STANDARD FORMAT.—The disclosures  
10 under paragraphs (1) and (2) shall be made in a  
11 uniform format established by the Secretary.

12 “(4) VIOLATIONS.—Any entity that violates  
13 paragraph (1) or (2) is subject to a civil money pen-  
14 alty of an amount not to exceed \$5,000 with respect  
15 to each such violation. The provisions of section  
16 1128A (other than the first sentence of subsection  
17 (a) and other than subsection (b)) shall apply to a  
18 civil money penalty under the previous sentence in  
19 the same manner as such provisions apply to a pen-  
20 alty or proceeding under section 1128A(a).

21 “(b) EFFECTIVE GRIEVANCE PROCEDURES.—Each  
22 qualified health plan shall provide for effective procedures  
23 for hearing and resolving grievances between the plan and  
24 individuals enrolled under the plan.

1       “(c) RESTRICTION ON CERTAIN PHYSICIAN INCEN-  
2 TIVE PLANS.—

3           “(1) IN GENERAL.—A health plan is not a  
4 qualified health plan if it operates a physician incen-  
5 tive plan (as defined in paragraph (2)) unless the re-  
6 quirements specified in clauses (i) through (iii) of  
7 section 1876(i)(8)(A) are met (in the same manner  
8 as they apply to eligible organizations under section  
9 1876).

10          “(2) PHYSICIAN INCENTIVE PLAN DEFINED.—  
11 In this subsection, the term ‘physician incentive  
12 plan’ means any compensation or other financial ar-  
13 rangement between the qualified health plan and a  
14 physician or physician group that may directly or in-  
15 directly have the effect of reducing or limiting serv-  
16 ices provided with respect to individuals enrolled  
17 under the plan.

18       “(d) ENROLLEE FINANCIAL PROTECTION.—

19           “(1) SOLVENCY PROTECTION FOR INSURED  
20 PLANS.—In the case of a qualified health plan that  
21 is an insured plan (as defined by the Secretary) and  
22 is issued in a State, in order for the plan to be cer-  
23 tified under this part the Secretary must find that  
24 the State has established satisfactory protection of

1 enrollees with respect to potential insolvency of the  
2 plan.

3 “(2) PROTECTION AGAINST PROVIDER  
4 CLAIMS.—In the case of a failure of a qualified  
5 health plan to make payments with respect to re-  
6 quired health services, under standards established  
7 by the Secretary, an individual who is enrolled under  
8 the plan is not liable to any health care provider or  
9 practitioner with respect to the provision of required  
10 health services for payments in excess of the amount  
11 for which the enrollee would have been liable if the  
12 plan were to have made payments in a timely man-  
13 ner.

14 **“SEC. 2159. PREEMPTION OF CERTAIN STATE AND FEDERAL**  
15 **REQUIREMENTS.**

16 “(a) BENEFIT AND COVERAGE RULES.—Effective as  
17 of January 1, 1995, no State shall establish or enforce  
18 any law or regulation that—

19 “(1) requires the offering, as part of a qualified  
20 employer health plan with respect to any pregnant  
21 woman or child, of any services, category of care, or  
22 services of any class or type of provider that is dif-  
23 ferent from the benefits required to be provided  
24 under section 2153,

1           “(2) specifies the individuals to be covered  
2           under a qualified employer health plan or the dura-  
3           tion of such coverage, or

4           “(3) requires a right of conversion from a quali-  
5           fied employer health plan to an individual qualified  
6           health plan.

7           “(b) STATE DEFINED.—In subsection (a), the term  
8           ‘State’ means the 50 States and the District of Columbia.

9           **“SEC. 2160. USE OF UNIFORM CLAIMS FORMS.**

10          “Each qualified health plan shall provide for submis-  
11          sion of claims using uniform claims forms developed by  
12          the Secretary.

13          “PART D—DEFINITIONS AND MISCELLANEOUS

14          **“SEC. 2181. DEFINITIONS.**

15          “(a) WAGES, EMPLOYMENT, ETC.—In this title—

16                 “(1) WAGES.—The term ‘wages’ has the mean-  
17                 ing given such term by section 3121(a) of the Inter-  
18                 nal Revenue Code of 1986, except that—

19                         “(A) the modifications of subsection (b)  
20                         shall apply in determining whether any service  
21                         is employment, and

22                         “(B) the applicable contribution base  
23                         under section 3121(x)(2) of such Code (relating  
24                         to hospital insurance) shall be used under sec-  
25                         tion 3121(a)(1) for purposes of this title.

1 “(2) EMPLOYMENT.—

2 “(A) IN GENERAL.—Except as modified in  
3 subparagraph (B), the term ‘employment’ has  
4 the meaning given such term by section  
5 3121(b) of the Internal Revenue Code of 1986.

6 “(B) MODIFICATIONS.—The modifications  
7 referred to in this paragraph are that—

8 “(i) paragraphs (5), (6), (7), (8), and  
9 (9) of section 3121(b) of such Code shall  
10 not apply, and

11 “(ii) subsections (r) and (w) of section  
12 3121 of such Code shall not apply.

13 “(C) TREATMENT OF FEDERAL EMPLOY-  
14 MENT.—In applying subparagraph (A), the  
15 term ‘employment’ shall not be considered to  
16 include service performed in the employ of the  
17 United States if, in connection with the per-  
18 formance of such service (or the service of a  
19 family member), the individual—

20 “(i) is enrolled in a health benefits  
21 plan under chapter 89 of title 5, United  
22 States Code, or

23 “(ii) is provided medical and dental  
24 benefits under chapter 55 of title 10, Unit-  
25 ed States Code.

1           “(3) EMPLOYEE; EMPLOYER.—The terms ‘em-  
2           ployee’ and ‘employer’ have the same meanings as  
3           such terms have for purposes of chapter 21 of the  
4           Internal Revenue Code of 1986.

5           “(b) DEFINITIONS RELATING TO EMPLOYEES.—In  
6           this title:

7           “(1) FULL-TIME EMPLOYEE.—The term ‘full-  
8           time employee’ means, with respect to an employer,  
9           an employee who normally performs on a monthly  
10          basis at least 25 hours of service per week for that  
11          employer.

12          “(2) PART-TIME EMPLOYEE.—The term ‘part-  
13          time employee’ means, with respect to an employer,  
14          an employee who is not a full-time employee.

15          “(3) SEASONAL OR TEMPORARY EMPLOYEE.—  
16          The term ‘seasonal or temporary employee’ means,  
17          with respect to an employer, an employee who is em-  
18          ployed by the employer for not more than 4 months  
19          in any 12-month period; except that the Secretary  
20          may extend such period to up to 6 months in any  
21          12-month period in the case of employment that is  
22          sporadic, irregular, and seasonal in nature.

23          “(4) TREATMENT OF CONSULTANTS AND CON-  
24          TRACTORS.—The term ‘employee’ includes an indi-  
25          vidual who is a consultant or contractor of an em-

1        employer if the Secretary determines that the consult-  
2        ing arrangement or contract was entered into to  
3        avoid the requirements of this title.

4            “(5) EXCLUSION OF FOREIGN EMPLOYMENT.—  
5        The term ‘employee’ does not include an individ-  
6        ual—

7            “(A) who is not a citizen or resident of the  
8            United States with respect to service performed  
9            outside the United States, or

10           “(B) who is a citizen or resident of the  
11           United States with respect to services per-  
12           formed outside the United States for an em-  
13           ployer other than an American employer (as de-  
14           fined in section 3121(h) of the Internal Reve-  
15           nue Code of 1986).

16           “(c) DEFINITIONS RELATING TO SIZE OF EM-  
17        PLOYER.—In this title:

18           “(1) SMALL EMPLOYER.—The term ‘small em-  
19           ployer’ means, with respect to a calendar year, an  
20           employer that normally employs fewer than 25 em-  
21           ployees on a typical business day during the cal-  
22           endar year.

23           “(2) MEDIUM-SIZE EMPLOYER.—The term ‘me-  
24           dium-size employer’ means, with respect to a cal-  
25           endar year, an employer that normally employs at

1 least 25, but fewer than 101, employees on a typical  
2 business day during the calendar year.

3 “(3) LARGE EMPLOYER.—The term ‘large em-  
4 ployer’ means an employer that is not a small em-  
5 ployer or a medium-size employer.

6 “(4) APPLICATION OF CONTROLLED GROUP  
7 RULES.— For purposes of determining if an em-  
8 ployer is a small, medium-size, or large employer or  
9 the number of hours an individual is normally em-  
10 ployed with respect to an employer, rules similar to  
11 the rules of subsection (b) and (c) of section 414 of  
12 the Internal Revenue Code of 1986 shall apply.

13 “(d) STATE CHILDREN AND PREGNANT WOMEN  
14 HEALTH PLAN.—The term ‘State children and pregnant  
15 women health plan’ has the meaning of the term ‘State  
16 plan’ under section 2200(c).

17 “(e) INCORPORATION OF DEFINITIONS.—Except as  
18 otherwise provided in this title, the terms defined in sec-  
19 tion 2282 shall apply under this title in the same manner  
20 as they apply under title XXII.

21 **“SEC. 2182. NONAPPLICATION TO RESIDENTS OF PUERTO**  
22 **RICO AND TERRITORIES.**

23 “The provisions of this title shall not apply with re-  
24 spect to an employee who is not a resident of one of the  
25 50 States or the District of Columbia.”.

1 **TITLE II—PROVISION OF**  
2 **HEALTH INSURANCE FOR**  
3 **PREGNANT WOMEN AND**  
4 **CHILDREN THROUGH STATE**  
5 **CHILDREN AND PREGNANT**  
6 **WOMEN HEALTH PLANS**

7 **SEC. 201. STATE CHILDREN AND PREGNANT WOMEN**  
8 **HEALTH PLANS.**

9 The Social Security Act is amended by adding after  
10 the title added by section 102 the following new title:

11 “TITLE XXII—STATE CHILDREN AND  
12 PREGNANT WOMEN HEALTH PLANS

13 **“SEC. 2200. ESTABLISHMENT OF STATE CHILDREN AND**  
14 **PREGNANT WOMEN HEALTH PLANS.**

15 “(a) IN GENERAL.—By not later than January 1,  
16 1995, each State shall establish and maintain a pro-  
17 gram—

18 “(1) to assure the provision in accordance with  
19 this title of health insurance for pregnant women  
20 and children lawfully residing in the State who are  
21 not covered under a qualified employer health plan  
22 or under a Federal health plan, and

23 “(2) to provide low-income assistance under  
24 part E for eligible individuals enrolled under a quali-



1 individuals residing in the State who are not enrolled in  
2 a qualified employer health plan or in a Federal  
3 health plan (as defined in section 2282(4)).

4 “(2) UNIFORM RULES FOR RESIDENCY.—The  
5 Secretary shall establish uniform rules respecting  
6 the determination of the residence of eligible individ-  
7 uals for purposes of this title.

8 “(c) APPLICATION PROCESS.—

9 “(1) OPEN ENROLLMENT.—Eligible individuals  
10 residing in a State may enroll under the State plan  
11 at any time.

12 “(2) ENROLLMENT.—The filing by an eligible  
13 individual of an application for enrollment under a  
14 State plan shall (except as the Secretary may pro-  
15 vide) constitute enrollment under the plan. Such an  
16 application may be filed with the State by mail or  
17 at such locations as the State may specify.

18 “(3) AVAILABILITY OF APPLICATIONS.—Each  
19 State shall make applications for enrollment under  
20 the State plan available—

21 “(A) at out-reach sites (such as provider  
22 and practitioner locations), and

23 “(B) at other locations (including post of-  
24 fices) accessible to a broad cross-section of indi-  
25 viduals eligible to enroll.

1 The Secretary, to the extent practicable, shall make  
2 applications for enrollment under State plans avail-  
3 able at local offices of the Social Security Adminis-  
4 tration.

5 “(4) APPLICATION FOR LOW-INCOME ASSIST-  
6 ANCE.—An application for enrollment under a State  
7 plan may (but need not) be accompanied by an ap-  
8 plication for low-income assistance under part E.

9 “(d) ENROLLMENT TERMS.—

10 “(1) ENROLLMENT UNDER TITLE ON AN EM-  
11 PLOYMENT AND NON-EMPLOYMENT BASIS DE-  
12 FINED.—An eligible individual is considered, for pur-  
13 poses of this title, to be enrolled under a State  
14 plan—

15 “(A) on an ‘employment basis’ only if the  
16 individual is enrolled by an employer pursuant  
17 to the requirement of section 5000A of the In-  
18 ternal Revenue Code of 1986, or

19 “(B) on a ‘non-employment basis’ in any  
20 other case.

21 “(2) ENROLLMENT UNDER A QUALIFIED EM-  
22 PLOYER HEALTH PLAN DEFINED.—An individual is  
23 considered, for purposes of this title, to be ‘enrolled  
24 under a qualified employer health plan’ if—

1           “(A) the individual is enrolled under a  
2           qualified employer health plan (as defined in  
3           section 2281(b)(4)) as an employee (or family  
4           member of an employee),

5           “(B) the employer is required to provide  
6           for such enrollment under part A of title XXI,  
7           and

8           “(C) the amount of the employee share of  
9           the premium is limited under section 2122(b).

10 **“SEC. 2202. COVERAGE PERIOD; TERMINATION OF ENROLL-**  
11 **MENT.**

12           “(a) BEGINNING OF COVERAGE.—Each State plan  
13 shall provide for a period of coverage for eligible individ-  
14 uals under the plan in the manner specified for qualified  
15 health plans under section 2152(b).

16           “(b) TERMINATION OF ENROLLMENT DURING TRAN-  
17 SITION PERIOD.—

18           “(1) IN GENERAL.—Before January 1, 1998,  
19           except as provided in paragraph (3)—

20           “(A) an individual enrolled under a State  
21           plan may terminate enrollment on a non-em-  
22           ployment basis by providing written notice to  
23           the State that the individual—

24           “(i) no longer wishes to be enrolled in  
25           the plan, or

1           “(ii) is enrolled under a qualified em-  
2           ployer health plan or is a medicare bene-  
3           ficiary; and

4           “(B) a State plan may terminate enroll-  
5           ment on a non-employment basis of an individ-  
6           ual, after providing the individual (or the indi-  
7           vidual’s representative) written notice, for fail-  
8           ure to pay premiums required with respect to  
9           such enrollment.

10          The termination of enrollment of an individual shall  
11          terminate the enrollment of other family members  
12          enrolled with the individual.

13           “(2) EFFECTIVE DATE OF TERMINATION.—A  
14          termination of enrollment under paragraph (1)(A)  
15          shall take effect at the close of the month following  
16          the month in which the notice is filed. A termination  
17          of enrollment under paragraph (1)(B) shall take ef-  
18          fect on a date (determined under regulations of the  
19          Secretary) after the date written notice of such ter-  
20          mination has been provided to the enrollee (or the  
21          enrollee’s representative). Such regulations shall pro-  
22          vide a grace period of at least 1 month after the  
23          date of written notice in which overdue premiums  
24          may be paid and coverage continued.

1           “(3) MINIMUM PERIOD OF ENROLLMENT DUR-  
2           ING TRANSITION.—Subject to paragraph (4), before  
3           January 1, 1998—

4           “(A) IN GENERAL.—An individual (other  
5           than a pregnant woman or newborn) who is en-  
6           rolled under a State plan on a non-employment  
7           basis may not terminate enrollment less than  
8           12 months after the date of the enrollment.

9           “(B) PREGNANT WOMEN AND  
10           NEWBORNS.—In the case of a pregnant woman  
11           who is enrolled under a State plan on a non-  
12           employment basis—

13           “(i) the enrollment of the woman may  
14           not be terminated earlier than the end of  
15           the month in which the 60-day period, be-  
16           ginning on the last day of the pregnancy,  
17           ends; and

18           “(ii) the newborn child shall be  
19           deemed enrolled for purposes of this title  
20           as of the date of birth, and such enroll-  
21           ment may not be terminated earlier than  
22           the end of the month in which the child’s  
23           first birthday occurs.

24           “(4) TERMINATION PERMITTED IF COVERED  
25           UNDER QUALIFIED EMPLOYER HEALTH PLAN.—The

1 minimum period of enrollment under paragraph (3)  
2 shall not apply if, at the time of termination of en-  
3 rollment, the individual is immediately covered under  
4 a qualified employer health plan which will provide  
5 coverage during the minimum period for which en-  
6 rollment is otherwise required under such para-  
7 graph.

8 “(c) TERMINATION OF ENROLLMENT AFTER TRAN-  
9 SITION PERIOD.—For limitations on termination of enroll-  
10 ment under this title on or after January 1, 1998, see  
11 section 2203(c).

12 **“SEC. 2203. REQUIREMENT OF HEALTH INSURANCE COV-  
13 ERAGE.**

14 “(a) REQUIREMENT FOR ALL ELIGIBLE INDIVID-  
15 UALS.—

16 “(1) IN GENERAL.—Effective on and after the  
17 date specified in subsection (e), each eligible individ-  
18 ual (as defined in section 2282(2)) who is not an ex-  
19 cepted individual (as defined in paragraph (2)), is  
20 deemed to have enrolled in the State plan in which  
21 the individual resides as of such date or as soon  
22 thereafter as the individual is not an excepted indi-  
23 vidual. If such an individual has not filed an applica-  
24 tion for enrollment under a State plan by such date,  
25 the Secretary shall provide a means to collect infor-

1       mation sufficient to effect such enrollment as soon  
2       as possible after such date.

3           “(2) EXCEPTED INDIVIDUALS.—For purposes  
4       of paragraph (1), the term ‘excepted individual’  
5       means an individual who is enrolled under a quali-  
6       fied employer health plan or under a Federal health  
7       plan.

8           “(b) AUTOMATIC CONTINUING ENROLLMENT.—For  
9       provisions relating to coordination of enrollment among  
10      qualified health plans and State plans and assuring con-  
11      tinuous coverage for required health services (and port-  
12      ability of health insurance benefits among such plans), see  
13      section 2157 (made applicable to State plans by section  
14      2226).

15          “(c) LIMITATION ON TERMINATION OF ENROLL-  
16      MENT.—Effective on the date specified in subsection (e)—

17           “(1) EMPLOYMENT-BASED ENROLLMENT.—An  
18      individual enrolled under a State plan on an employ-  
19      ment basis may not elect to terminate such enroll-  
20      ment.

21           “(2) NON-EMPLOYMENT BASIS.—An individual  
22      enrolled under a State plan on a non-employment  
23      basis may not terminate such enrollment unless—

1           “(A) the individual is no longer an eligible  
2 individual because of age or termination of  
3 pregnancy,

4           “(B) the individual is no longer eligible to  
5 be enrolled under the plan because of a change  
6 of immigration or residency status, or

7           “(C) the individual demonstrates to the  
8 satisfaction of the Secretary that the individual  
9 is a medicare beneficiary or is enrolled under a  
10 qualified employer health plan or a Federal  
11 health plan.

12       “(d) ENFORCEMENT.—

13           “(1) MONITORING OF INDIVIDUAL TAX RE-  
14 TURNS.—The Secretary of the Treasury shall re-  
15 quire the filing of such information as may be nec-  
16 essary to establish compliance with subsection (a).

17           “(2) RETROACTIVE ENROLLMENT.—If such an  
18 individual has not provided evidence of enrollment in  
19 a qualified employer health plan or Federal health  
20 plan, the Secretary—

21           “(A) shall instruct the State to enroll the  
22 individual pursuant to the filing of such return,  
23 and

24           “(B) shall instruct the State to require  
25 payment of twice the amounts of premiums that

1 would have been paid if the person had been en-  
2 rolled on a timely basis, unless the individual  
3 has established to the satisfaction of the State  
4 good cause for the failure to enroll on a timely  
5 basis.

6 “(e) EFFECTIVE DATE OF REQUIREMENT.—The  
7 date specified in this subsection is January 1, 1998.

8 “PART B—BENEFITS

9 “**SEC. 2211. COVERED HEALTH SERVICES.**

10 “(a) REQUIRED HEALTH SERVICES.—

11 “(1) IN GENERAL.—Except as provided in the  
12 succeeding provisions of this part and part C, in the  
13 case of eligible individuals enrolled under a State  
14 plan, the State plan shall provide for payments in  
15 accordance with this title for the following health  
16 services:

17 “(A) Preventive care services (as defined in  
18 section 2212(a)).

19 “(B) Major medical services (as defined in  
20 section 2213(a)).

21 “(C) Extended medical services (as defined  
22 in section 2214(a)).

23 “(2) REQUIRED HEALTH SERVICES DEFINED.—  
24 In this title and title XXI, the term ‘required health  
25 services’ means the health services described in para-

1 graph (1), subject to the deductible and coinsurance  
2 permitted with respect to such services under part  
3 C.

4 “(b) REQUIRED OUTREACH SERVICES.—In addition  
5 to the required health services under subsection (a), each  
6 State plan shall provide (or make payment) for outreach  
7 services to link low-income enrolled individuals with need-  
8 ed required health services. Such outreach services shall  
9 include—

- 10 “(1) transportation,  
11 “(2) child care at service sites,  
12 “(3) translation services,  
13 “(4) case/care coordination,  
14 “(5) screening followups, and  
15 “(6) health promotions.

16 “(c) OPTIONAL ADDITIONAL SOCIAL SERVICES.—In  
17 addition, each State plan may provide (or make payment)  
18 for social services (such as family psycho-social supports,  
19 therapeutic foster care, pediatric day treatment, parent  
20 training, and in-home crisis management) necessary to as-  
21 sure the health of enrolled individuals.

22 “(d) STANDARDS.—The Secretary shall establish  
23 standards with respect to required health services. The  
24 standards shall be applied under this title and title XXI.

1 **“SEC. 2212. PREVENTIVE CARE SERVICES.**

2 “(a) DEFINED.—In this title, the term ‘preventive  
3 care services’ means the following items and services fur-  
4 nished in accordance with any applicable periodicity sched-  
5 ule established under subsection (b):

6 “(1) Child preventive care, including—

7 “(A) routine office visits,

8 “(B) routine immunizations, and

9 “(C) routine laboratory tests.

10 “(2) Prenatal care, including care of all com-  
11 plications of pregnancy.

12 “(3) Care of newborn infants, including attend-  
13 ance at high-risk deliveries and normal newborn  
14 care.

15 “(4) Family planning services.

16 “(5) Child abuse assessment.

17 “(6) Preventive dental care for children.

18 “(b) PERIODICITY SCHEDULES.—

19 “(1) PEDIATRIC CARE.—With respect to pre-  
20 ventive care services furnished to children, the Sec-  
21 retary shall establish a schedule of periodicity which  
22 reflects the general, appropriate frequency with  
23 which such care should be provided routinely to  
24 healthy children. Such schedule shall be established  
25 in consultation with the American Academy of Pedi-  
26 atrics.

1           “(2) PRENATAL CARE.—With respect to preven-  
2           tive care services for pregnant women, the Secretary  
3           shall establish a schedule of periodicity which re-  
4           flects the appropriate frequency with which such  
5           care should be provided to pregnant women, taking  
6           into account age and other risk factors. Such sched-  
7           ule shall be established in consultation with the  
8           American College of Obstetricians and Gyne-  
9           cologists.

10          “(c) NO APPLICATION OF DEDUCTIBLE OR COINSUR-  
11          ANCE.—In accordance with sections 2222(b) and 2223(b),  
12          a State plan may not impose deductibles or coinsurance  
13          with respect to preventive care services.

14          **“SEC. 2213. MAJOR MEDICAL SERVICES.**

15          “(a) DEFINED.—In this title, the term ‘major medi-  
16          cal services’ means the following items and services (to  
17          the extent they are not preventive care services and subject  
18          to subsection (b)):

19                 “(1) Inpatient and outpatient hospital services.

20                 “(2) Physicians’ services.

21                 “(3) Professional services of certified nurse  
22                 midwives, nurse practitioners, and other health pro-  
23                 fessionals (to the extent authorized under State  
24                 law).

1           “(4) Diagnostic tests (including laboratory  
2 tests).

3           “(5) Ambulance.

4           “(6) Short-term home health services.

5           “(7) Medical and surgical supplies and durable  
6 medical equipment.

7           “(8) Corrective eyeglasses and lenses and hear-  
8 ing aids.

9           “(9) Prescription drugs, insulin, and medically  
10 recommended nutritional supplements.

11          “(10) Acute dental care.

12          “(b) TREATMENT OF MENTAL HEALTH SERVICES,  
13 SUBSTANCE ABUSE SERVICES, AND DEVELOPMENTAL  
14 AND LEARNING DISABILITY SERVICES AS EXTENDED  
15 MEDICAL SERVICES.—Major medical services do not in-  
16 clude items and services for the treatment of mental ill-  
17 ness, for the treatment of substance abuse, or for the  
18 treatment of developmental and learning disabilities, but  
19 do include psychiatric services. However, such services for  
20 such treatment are included in the definition of extended  
21 medical services under section 2214(a).

22          “(c) APPLICATION OF DEDUCTIBLE AND COINSUR-  
23 ANCE.—In accordance with sections 2222 and 2223, a  
24 State plan may impose deductibles and coinsurance with

1 respect to major medical services, subject to the limits  
2 specified in such sections.

3 **“SEC. 2214. EXTENDED MEDICAL SERVICES.**

4 “(a) DEFINED.—In this title, the term ‘extended  
5 medical services’ means the following items and services  
6 (to the extent they are not preventive care services and  
7 subject to subsection (b)):

8 “(1) Items and services described in section  
9 2213(a) for the treatment of mental illness or sub-  
10 stance abuse and treatment of development and  
11 learning disabilities (other than the educational com-  
12 ponent of such treatment).

13 “(2) Orthodontia (other than cosmetic ortho-  
14 dontia).

15 “(3) Substance abuse services.

16 “(4) Speech, occupational, and physical ther-  
17 apy.

18 “(5) Hospice care.

19 “(6) Respite care.

20 “(7) Short-term skilled nursing facility services.

21 “(8) Nutritional assessment and counseling.

22 “(b) PLAN OF CARE REQUIREMENT.—A State plan  
23 shall provide for coverage of extended medical services  
24 only in accordance with a plan of care which—

1           “(1) is developed in cooperation with the at-  
2           tending primary care physician, and

3           “(2) applies to all required health services.

4           “(c) APPLICATION OF DEDUCTIBLE AND COINSUR-  
5 ANCE.—In accordance with sections 2222 and 2223, a  
6 State plan may impose a deductible and coinsurance with  
7 respect to extended medical services, subject to the limits  
8 specified in such sections.

9           **“SEC. 2215. SCOPE OF COVERAGE.**

10          “(a) NO AMOUNT, DURATION OR SCOPE LIMITA-  
11 TIONS.—A State plan may not impose any limitation on  
12 the amount, duration, or scope for required health serv-  
13 ices.

14          “(b) CONSTRUCTION.—Subsection (a) shall not be  
15 construed as requiring coverage of—

16           “(1) preventive care services in a frequency  
17 greater than the frequency specified in the appro-  
18 priate periodicity schedule established under section  
19 2212(b),

20           “(2) extended medical services which are not  
21 specified in a plan of care under section 2214(b), or

22           “(3) major medical services or extended medical  
23 services which are not reasonable and medically nec-  
24 essary.

1       “(c) FREEDOM OF CHOICE OF PROVIDERS AND  
2 PRACTITIONERS.—

3           “(1) IN GENERAL.—Any individual entitled to  
4 benefits under a State plan with respect to required  
5 health services may obtain benefits for such services  
6 provided by any provider or practitioner who is  
7 qualified to provide (and receive payment with re-  
8 spect to) such services under the plan.

9           “(2) TREATMENT OF ENROLLMENT WITH  
10 HEALTH MAINTENANCE ORGANIZATIONS AND COM-  
11 PETITIVE MEDICAL PLANS.—Nothing in paragraph  
12 (1) shall be construed to prohibit a health mainte-  
13 nance organization or competitive medical plan from  
14 limiting, under a contract entered into pursuant to  
15 section 2265, the number of providers or practition-  
16 ers for which benefits for services are paid.

17 “PART C—PAYMENTS FOR BENEFITS; DEDUCTIBLE, CO-  
18 INSURANCE, AND STOP-LOSS PROTECTION FOR RE-  
19 QUIRED HEALTH SERVICES

20 “**SEC. 2221. PAYMENT RATES.**

21       “(a) USE OF MEDICARE PAYMENT RULES; ETC.—  
22 Subject to adjustment in payment rates under this section  
23 and subject to differences in deductibles and coinsurance  
24 between a State plan and title XVIII—

1           “(1) in the case of physicians’ services and in-  
2           patient hospital services, the provisions of section  
3           1848 and 1886 (relating to payment for physicians’  
4           services and to hospitals for inpatient hospital serv-  
5           ices, respectively) shall apply under a State plan to  
6           physicians’ services and inpatient hospital services in  
7           the same manner as they apply under title XVIII;

8           “(2) in the case of other required health serv-  
9           ices for which payment may be made under title  
10          XVIII, such title shall apply to payment under a  
11          State plan in the same manner as they apply to pay-  
12          ment under title XVIII;

13          “(3) in the case of other required health serv-  
14          ices for which payment may not be made under title  
15          XVIII, the Secretary shall establish payment rules  
16          that shall apply under State plans that are similar  
17          to the payment rules for similar services under such  
18          title; and

19          “(4) in the case of services described in sub-  
20          sections (b) and (c) of section 2211, each State shall  
21          establish adequate payment rates (as defined by the  
22          Secretary).

23          There shall be no administrative or judicial review of the  
24          payment rates or rules established under this section (in-

1 cluding adjustments made under subsections (b), (c), and  
2 (d).

3 “(b) ADJUSTMENT OF MEDICARE PAYMENT RATES  
4 FOR PHYSICIANS’ SERVICES.—

5 “(1) IN GENERAL.—For purposes of establish-  
6 ing payment rates for physicians’ services under  
7 State plans and qualified employer health plans, the  
8 Secretary, by regulation and in accordance with this  
9 subsection, shall adjust the payment rates otherwise  
10 established under section 1848 to take into ac-  
11 count—

12 “(A) differences between the population  
13 served under title XVIII and the population re-  
14 ceiving benefits under State plans or under  
15 qualified employer health plans, and

16 “(B) such other appropriate factors as the  
17 Secretary deems appropriate to assure the  
18 availability of quality health care under such  
19 plans.

20 “(2) REPORT BY PHYSICIAN PAYMENT REVIEW  
21 COMMISSION.—The Physician Payment Review Com-  
22 mission, in its recommendations to Congress under  
23 section 1845(b) in the year before the first year in  
24 which this title is effective, shall include rec-  
25 ommendations on—

1           “(A) the relative value units that should be  
2           applied (under paragraph (1)) with respect to  
3           pediatric, obstetrical, and other physicians’  
4           services, and

5           “(B) data that should be collected in order  
6           to evaluate the number of such units for such  
7           services.

8           The Commission shall include, in its subsequent rec-  
9           ommendations under section 1845(b), such rec-  
10          ommendations with respect to the payment for phy-  
11          sicians’ services under State plans and qualified em-  
12          ployer health plans as it deems appropriate.

13          “(3) SECRETARIAL PUBLICATION.—The Sec-  
14          retary shall cause to be published in the Federal  
15          Register—

16                 “(A) before June 1 before the first year in  
17                 which this title is effective, the relative value  
18                 units proposed to be applied during such first  
19                 year under State plans and qualified employer  
20                 health plans, and

21                 “(B) after consideration of public com-  
22                 ments submitted pursuant to such proposal and  
23                 before October 1 before such year, the relative  
24                 value units to be applied during such first year  
25                 under such plans.

1           “(4) SECRETARIAL REVIEW AND REVISION.—  
2           The Secretary shall provide for the periodic review  
3           and adjustment of the relative value units to be ap-  
4           plied under State plans and qualified employer  
5           health plans in the same manner and frequency as  
6           provided under section 1848(c)(2)(B), except that  
7           such review shall first be conducted each year during  
8           the first 3 years and not less often than every 5  
9           years thereafter.

10           “(5) NATIONAL ADVISORY COMMITTEE.—The  
11           Secretary shall establish a national advisory commit-  
12           tee, composed of pediatricians, family physicians,  
13           and obstetricians, and experts and advocates on ma-  
14           ternal and child health—

15                   “(A) to review recommendations made by  
16                   the Physician Payment Review Commission  
17                   under paragraph (2), and

18                   “(B) to advise the Secretary respecting (i)  
19                   the appropriate payment amounts (including  
20                   the conversion factor) to be established under  
21                   this section for pediatric, obstetrical, and other  
22                   physicians’ services, and (ii) factors that influ-  
23                   ence the adequacy of health care expenditures  
24                   for children and pregnant women (such as qual-  
25                   ity of care and distribution of services).

1       “(c) ADJUSTMENT OF MEDICARE PAYMENT RATES  
2 FOR INPATIENT HOSPITAL SERVICES.—

3           “(1) IN GENERAL.—For purposes of payment  
4 for inpatient hospital services, the Secretary, by reg-  
5 ulation and in accordance with this section, shall ad-  
6 just the payment rates otherwise established under  
7 title XVIII to take into account—

8           “(A) differences between the population  
9 served under that title and the population re-  
10 ceiving benefits under State plans or qualified  
11 employer health plans, and

12           “(B) such other appropriate factors (such  
13 as the special circumstances of hospitals the in-  
14 patients of which are predominantly children)  
15 as the Secretary deems appropriate to assure  
16 the availability of quality health care under  
17 such plans.

18           “(2) REPORT BY PROSPECTIVE PAYMENT AS-  
19 SESSMENT COMMISSION.—The Prospective Payment  
20 Assessment Commission, in its report to Congress  
21 under section 1886(e)(3)(A) in the year before the  
22 first year in which this title is effective, shall include  
23 its recommendations on—

24           “(A) the adjustments that should be made  
25 under paragraph (1) in the payment methodol-

1           ogy for inpatient hospital services in order to  
2           take into account differences and appropriate  
3           factors referred to in such paragraph, and data  
4           that should be collected in order to establish ap-  
5           propriate weighting factors for diagnosis-related  
6           groups used under this section, and

7                   “(B) whether, and if so how, payment for  
8           inpatient hospital services of childrens’ hospitals  
9           (described in section 1886(d)(1)(B)(iii)) may be  
10          made under State plans and qualified employer  
11          health plans using the prospective payment  
12          methodology described in section 1886(d).

13          The Commission shall include, in its subsequent re-  
14          ports under section 1886(e)(3)(A), such rec-  
15          ommendations with respect to payment for inpatient  
16          hospital services under State plans and qualified em-  
17          ployer health plans as it deems appropriate.

18                   “(3) SECRETARIAL PUBLICATIONS.—The Sec-  
19          retary shall provide for the publication, in the man-  
20          ner and time specified under section 1886(e)(5), of  
21          adjustments proposed to be made (and to be made)  
22          under this subsection for the calendar year begin-  
23          ning in each fiscal year.

24                   “(4) REPORT ON USE OF PROSPECTIVE PAY-  
25          MENT METHODOLOGY.—By not later than April 1 of

1 the first year in which this title is effective, the Sec-  
2 retary shall submit to Congress a report on whether,  
3 and if so how, payment for inpatient hospital serv-  
4 ices of childrens' hospitals (described in section  
5 1886(d)(1)(B)(iii)) may be made under State plans  
6 and qualified employer health plans using the pro-  
7 spective payment methodology described in section  
8 1886(d).

9 “(d) ADJUSTMENT OF MEDICARE PAYMENT RATES  
10 FOR OTHER SERVICES.—For purposes of payment for  
11 services under subsection (a)(2), the Secretary by regula-  
12 tion shall adjust the payment rates otherwise established  
13 under title XVIII to take into account—

14 “(1) differences between the population served  
15 under that title and the population receiving benefits  
16 under State plans and qualified employer health  
17 plans, and

18 “(2) such other appropriate factors as the Sec-  
19 retary deems appropriate to assure the availability of  
20 quality health care under such plans.

21 “(e) TREATMENT OF HEALTH MAINTENANCE ORGA-  
22 NIZATIONS.—Subsection (a) shall not apply to a plan of  
23 an eligible organization (as defined in section 1876(b))  
24 which provides for enrollee protections which are at least  
25 as great as the enrollee protections provided under section

1 2265 (but without the application of section 2265(b)(5)  
2 or 1876(c)(3)(B)).

3 **“SEC. 2222. APPLICATION OF DEDUCTIBLE.**

4 “(a) IN GENERAL.—Except as provided in this sec-  
5 tion and part E, a State plan may provide for an annual  
6 deductible with respect to expenses for required health  
7 services of members of a family, but the amount of such  
8 deductible may not exceed \$200 with respect to any fam-  
9 ily.

10 “(b) DEDUCTIBLE DOES NOT APPLY TO PREVEN-  
11 TIVE CARE SERVICES OR OUTREACH AND OPTIONAL  
12 SERVICES.—The deductible established under subsection  
13 (a) may not be applied to preventive health services or to  
14 services provided under subsection (b) or (c) of section  
15 2211.

16 **“SEC. 2223. COINSURANCE FOR MAJOR MEDICAL SERVICES**  
17 **AND EXTENDED MEDICAL SERVICES.**

18 “(a) COINSURANCE RATES.—Subject to subsection  
19 (b), section 2224, and part E, a State plan may require  
20 coinsurance with respect to payment for required health  
21 services, but the coinsurance percentage may not exceed—

22 “(1) 20 percent for major medical services, and

23 “(2) 30 percent for extended medical services.

24 “(b) NO COINSURANCE FOR PREVENTIVE CARE  
25 SERVICES OR OUTREACH AND OPTIONAL SERVICES.—

1 There shall be no coinsurance under this title in the case  
2 of preventive care services provided consistent with any  
3 applicable periodicity schedule or to services provided  
4 under subsection (b) or (c) of section 2211.

5 **“SEC. 2224. LIMIT ON COST-SHARING FOR REQUIRED**  
6 **HEALTH SERVICES.**

7 “(a) LIMITATION.—Whenever in a calendar year the  
8 expenses of family members for the deductible and coin-  
9 surance with respect to required health services under a  
10 State plan and furnished during the year equals \$3,000,  
11 payment of benefits under the plan for the family mem-  
12 bers for required health services furnished during the re-  
13 mainder of the year shall be paid without the application  
14 of any coinsurance.

15 “(b) CREDITING FOR EXPENSES INCURRED UNDER  
16 QUALIFIED EMPLOYER HEALTH PLANS.—For provision  
17 relating to the accounting of cost-sharing incurred for re-  
18 quired health services furnished under this title and the  
19 crediting under this title of cost-sharing incurred for such  
20 services furnished under other qualified health plans, see  
21 section 2157(c).

22 **“SEC. 2225. EXCLUSIONS.**

23 “(a) IN GENERAL.—Except as provided in this sec-  
24 tion, section 1862 shall apply to expenses incurred for  
25 items and services provided under this title in the same

1 manner as such section applies to items and services pro-  
2 vided under title XVIII.

3 “(b) PREVENTIVE SERVICES.—In the case of preven-  
4 tive services provided consistent with the applicable perio-  
5 dicity schedule—

6 “(1) such services shall be considered to be rea-  
7 sonable and medically necessary, and

8 “(2) shall not be subject to exclusion through  
9 the operation of paragraph (1), (7), or (12) of sec-  
10 tion 1862(a) (as incorporated under paragraph (1)).

11 “(c) USE OF SAME NATIONAL COVERAGE DECISION  
12 REVIEW PROCESS.—The provisions of section 1869(b)(3)  
13 shall apply under this title in the same manner as they  
14 apply under title XVIII. Any determination under such  
15 title that, under subsection (a), would apply under this  
16 title shall not be subject to review under this subsection.

17 **“SEC. 2226. APPLICATION OF PARTICULAR QUALIFIED**  
18 **HEALTH PLAN REQUIREMENTS.**

19 “Section 2152 (relating to treatment of family mem-  
20 bers as a unit; coverage period; and health plan cards)  
21 and section 2157 (relating to coordination and portability  
22 of health coverage under qualified health plans) shall  
23 apply to a State plan in the same manner as they apply  
24 to a qualified health plan.

1       “PART D—PREMIUMS; FEDERAL CHILDREN AND  
2 PREGNANT WOMEN HEALTH INSURANCE TRUST FUND

3 **“SEC. 2231. PREMIUMS.**

4       “(a) AMOUNT OF PREMIUMS.—

5           “(1) IN GENERAL.—Except as provided in this  
6 section (and section 2234 with respect to  
7 nonenrolling employer premiums), the premium to  
8 be charged for enrollment under a State plan on a  
9 non-employment basis of all covered individuals in a  
10 family is such rate as the plan may establish. Such  
11 rate shall not vary based on the age, sex, health sta-  
12 tus, or number of covered individuals within a fam-  
13 ily, but may vary based on the community (as de-  
14 fined in subsection (b)) in the State in which the  
15 family is residing.

16           “(2) CREDIT FOR EMPLOYMENT TAXES PAID  
17 FOR PART-TIME AND SEASONAL OR TEMPORARY EM-  
18 PLOYEES.—

19           “(A) IN GENERAL.—Subject to subpara-  
20 graph (C), in the case of an individual who is  
21 a covered employee (as defined in subparagraph  
22 (B)), the premium to be charged for enrollment  
23 under this title on a non-employment basis is—

24           “(i) the rate otherwise applicable  
25 under paragraph (1), less the amount of

1 the taxes paid by the individual and all  
2 employers with respect to the employee  
3 (and family members of the employee)  
4 under section 3151(a) of the Internal Rev-  
5 enue Code of 1986, or

6 “(ii) 20 percent of such actuarial rate,  
7 whichever is greater.

8 “(B) COVERED EMPLOYEE DEFINED.—In  
9 subparagraph (A), the term ‘covered employee’  
10 means an individual—

11 “(i) who is employed by one or more  
12 employers as a part-time employee or as a  
13 seasonal or temporary employee, and

14 “(ii) none of whose employers is en-  
15 rolling part-time employees or seasonal or  
16 temporary employees, respectively, under a  
17 qualified employer health plan, but all of  
18 which are required to pay a tax with re-  
19 spect to such employees under section  
20 3151(a)(1) of the Internal Revenue Code  
21 of 1986,

22 and includes eligible individuals who are family  
23 members of such an employee.

1           “(C) LIMIT ON PREMIUM WHERE PREMIUM  
2           SUBSIDY.—In no case shall the premium under  
3           subparagraph (A) exceed—

4                   “(i) the rate otherwise applicable  
5                   under paragraph (1), reduced by

6                   “(ii) the amount of any premium sub-  
7                   sidy under part E.

8           “(b) COMMUNITY.—For purposes of this section, the  
9           term ‘community’ means a geographic area designated by  
10          the Secretary as—

11                   “(1) encompassing one or more adjacent metro-  
12                   politan statistical areas, or

13                   “(2) the remaining area within each State (that  
14                   is not designated within any community under para-  
15                   graph (1));

16          except that the Secretary may designate an entire State  
17          as a community if such a designation would better carry  
18          out the purposes of this title and title XXIII. The Sec-  
19          retary from time to time may change the boundaries of  
20          communities designated under paragraph (1) or (2) for  
21          such purposes. There shall be no administrative or judicial  
22          review of the designation of communities under this sub-  
23          section.

24          **“SEC. 2232. COLLECTION OF PREMIUMS.**

25                   “(a) INDIVIDUAL ENROLLMENT.—

1           “(1) IN GENERAL.—In the case of individuals  
2 enrolled on a non-employment basis under a State  
3 plan, the State plan shall require for the payment of  
4 premiums on a monthly or quarterly basis. To the  
5 maximum extent feasible, the State plan shall ar-  
6 range for payment of such premiums through auto-  
7 matic withholding from income sources or accounts  
8 with financial institutions.

9           “(2) COLLECTION OF UNPAID PREMIUMS.—

10           “(A) TRANSMISSION OF INFORMATION TO  
11 SECRETARY OF THE TREASURY.—In the case of  
12 premium amounts owing and unpaid under this  
13 subsection, the State shall inform the Secretary,  
14 who shall inform the Secretary of the Treasury  
15 of the individuals owing such amounts and the  
16 amounts owed.

17           “(B) COLLECTION.—The Secretary of the  
18 Treasury shall assess and collect the amounts  
19 referred to in subparagraph (A) in the same  
20 manner as taxes imposed by subtitle C of the  
21 Internal Revenue Code of 1986.

22           “(b) NONENROLLING EMPLOYER PREMIUMS.—

23           “(1) IN GENERAL.—In the case of nonenrolling  
24 employer premiums owed under section 2234, the

1 applicable State plan shall require the payment of  
2 premiums on a monthly or quarterly basis.

3 “(2) COLLECTION OF UNPAID PREMIUMS.—

4 “(A) TRANSMISSION OF INFORMATION TO  
5 SECRETARY OF THE TREASURY.—In the case of  
6 premium amounts owing and unpaid under this  
7 subsection, the State shall inform the Secretary,  
8 who shall inform the Secretary of the Treasury  
9 of the employers owing such amounts and the  
10 amounts owed.

11 “(B) COLLECTION.—The Secretary of the  
12 Treasury shall assess and collect the amounts  
13 referred to in subparagraph (A) in the same  
14 manner as taxes imposed by subtitle C of the  
15 Internal Revenue Code of 1986.

16 “(c) DEPOSIT.—Premiums collected under this sec-  
17 tion by the Secretary of the Treasury shall be credited  
18 to the State plan to which the premiums are owing.

19 **“SEC. 2233. FEDERAL CHILDREN AND PREGNANT WOMEN**  
20 **HEALTH INSURANCE TRUST FUND.**

21 “(a) ESTABLISHMENT.—

22 “(1) IN GENERAL.—There is hereby created on  
23 the books of the Treasury of the United States a  
24 trust fund to be known as the ‘Federal Children and  
25 Pregnant Women Health Insurance Trust Fund’ (in

1 this section referred to as the ‘Trust Fund’). The  
2 Trust Fund shall consist of such gifts and bequests  
3 as may be made as provided in paragraph (3) and  
4 such amounts as may be deposited in, or appro-  
5 priated to, the Trust Fund as provided in this part.

6 “(2) DEPOSIT OF TAXES.—There are hereby  
7 appropriated to the Trust Fund amounts equivalent  
8 to 100 percent of the taxes imposed by—

9 “(A) part VIII of subchapter A of chapter  
10 1 of the Internal Revenue Code of 1986, and

11 “(B) sections 3151, 5000A, and 5000B of  
12 such Code.

13 The amounts appropriated by the preceding sentence  
14 shall be transferred from time to time from the gen-  
15 eral fund in the Treasury to the Trust Fund, such  
16 amounts to be determined on the basis of estimates  
17 by the Secretary of the Treasury of the taxes, paid  
18 to or deposited into the Treasury; and proper adjust-  
19 ments shall be made in amounts subsequently trans-  
20 ferred to the extent prior estimates were in excess  
21 of or were less than the taxes specified in such sen-  
22 tence.

23 “(3) AUTHORIZATION TO ACCEPT GIFTS.—The  
24 Managing Trustee of the Trust Fund is authorized  
25 to accept on behalf of the United States money gifts

1 and bequests made unconditionally to the Trust  
2 Fund, for the benefit of the Trust Fund, or any ac-  
3 tivity financed through the Trust Fund.

4 “(b) INCORPORATION OF PROVISIONS.—

5 “(1) IN GENERAL.—Subject to paragraph (2),  
6 the provisions of subsections (b) through (j) of sec-  
7 tion 1817 shall apply to the Trust Fund in the same  
8 manner as they apply to the Federal Hospital Insur-  
9 ance Trust Fund.

10 “(2) EXCEPTIONS.—In applying paragraph  
11 (1)—

12 “(A) the Board of Trustees and Managing  
13 Trustee of the Trust Fund shall be composed of  
14 the members of the Board of Trustees and the  
15 Managing Trustee, respectively, of the Federal  
16 Hospital Insurance Trust Fund; and

17 “(B) any reference in section 1817 to the  
18 Federal Hospital Insurance Trust Fund, to title  
19 XVIII (or part A thereof), or (in subsection  
20 (f)(1)) to section 3102(b) of the Internal Reve-  
21 nue Code of 1986 is deemed a reference to the  
22 Trust Fund under this section, this title, and to  
23 section 3151(a)(2) of such Code, respectively.

1 **“SEC. 2234. TRANSFER PAYMENTS IN THE CASE OF MUL-**  
2 **TIPLE EMPLOYERS.**

3 “(a) TREATMENT OF MULTIPLE EMPLOYMENT  
4 WHERE EMPLOYEE COVERED UNDER A QUALIFIED EM-  
5 PLOYER HEALTH PLAN.—

6 “(1) IN GENERAL.—In the case of a multiple-  
7 employed individual (as defined in subsection (d)(1))  
8 who is covered under a qualified employer health  
9 plan of an employer—

10 “(A) each nonenrolling employer (as de-  
11 fined in subsection (d)(2)) that offers coverage  
12 under a qualified employer health plan shall pay  
13 to the State plan in which the individual resides  
14 the nonenrolling employer premium specified in  
15 subsection (b);

16 “(B) the enrolling employer is entitled to  
17 receive from such State plan the enrolling em-  
18 ployer subsidy specified in subsection (c); and

19 “(C) there will be no tax imposed on the  
20 wages of the individual under section  
21 3151(a)(2) of the Internal Revenue Code of  
22 1986 with respect to wages paid during the pe-  
23 riod of such coverage.

24 “(2) APPLICATION ON A MONTHLY BASIS.—The  
25 premiums and subsidies provided under this sub-

1 section shall be paid with respect to a monthly pe-  
2 riod of coverage.

3 “(b) AMOUNT OF NONENROLLING EMPLOYER PRE-  
4 MIUM.—

5 “(1) IN GENERAL.—The amount of the  
6 nonenrolling employer premium described in this  
7 subsection is the applicable percent (as defined in  
8 paragraph (2)) of the rate (established under section  
9 2231(a)) applicable to the employee in the State in  
10 which the employee resides.

11 “(2) APPLICABLE PERCENT DEFINED.—For  
12 purposes of paragraph (1), the term ‘applicable per-  
13 cent’ means, with respect to an employee who is—

14 “(A) a full-time employee of the employer,  
15 40 percent, or

16 “(B) a part-time employee of the employer,  
17 20 percent.

18 “(c) AMOUNT OF ENROLLING EMPLOYER SUB-  
19 SIDY.—

20 “(1) IN GENERAL.—The amount of the enroll-  
21 ing employer subsidy described in this subsection is  
22 the applicable percent (as defined in paragraph (2))  
23 of the rate (established under section 2231(a)) appli-  
24 cable to the employee in the State in which the em-  
25 ployee resides.

1           “(2) APPLICABLE PERCENT DEFINED.—For  
2 purposes of paragraph (1), the term ‘applicable per-  
3 cent’ means, with respect to a multiple-employed em-  
4 ployee who (or whose spouse) is—

5                   “(A) a full-time employee of a nonenrolling  
6 employer, 40 percent, or

7                   “(B) not a full-time employee of a  
8 nonenrolling employer, but is a part-time em-  
9 ployee of a nonenrolling employer, 20 percent;  
10 except that in no case shall the applicable percent  
11 with respect to a multiple-employed employee (in-  
12 cluding the employee’s spouse) exceed 40 percent.

13           “(d) DEFINITIONS.—In this section:

14                   “(1) MULTIPLE-EMPLOYED INDIVIDUAL.—The  
15 term ‘multiple-employed individual’ means an indi-  
16 vidual who in a month is an employee (whether part-  
17 time or full-time) and—

18                   “(A) who is also employed (whether part-  
19 time or full-time) by 1 or more other employer,  
20 or

21                   “(B) whose spouse or parent is also an em-  
22 ployee (whether part-time or full-time) of 1 or  
23 more employers.

24                   “(2) NONENROLLING EMPLOYER.—The term  
25 ‘nonenrolling employer’ means, with respect to a

1 multiple-employed individual who is enrolled under a  
2 qualified employer health plan of an employer, any  
3 employer of such individual other than such em-  
4 ployer.

5 **“SEC. 2235. USE OF UNIFORM CLAIMS FORMS.**

6 “Each State plan shall provide for submission of  
7 claims under the plan based on uniform claims forms de-  
8 veloped by the Secretary (after consultation with insurers  
9 and States).

10 **“SEC. 2236. PAYMENTS TO STATES.**

11 “(a) IN GENERAL.—Each State which has in effect  
12 a State plan that meets the requirements of this title is  
13 entitled to receive from the Federal Children and Preg-  
14 nant Women Health Insurance Trust Fund a quarterly  
15 amount equal to the sum of the amounts described in sub-  
16 sections (b)(1) and (c)(1).

17 “(b) PAYMENT FOR REQUIRED HEALTH SERV-  
18 ICES.—

19 “(1) IN GENERAL.—The amounts described in  
20 this subparagraph is 100 percent of the amount ex-  
21 pended during the quarter under the State plan for  
22 required health services (other than administrative  
23 expenses), less the amounts specified in paragraphs  
24 (2) and (3).

1           “(2) STATE MAINTENANCE OF EFFORT  
2 AMOUNT.—The amount specified in this paragraph  
3 for a State for a quarter in a fiscal year is  $\frac{1}{4}$  of the  
4 amount of expenditures (net of Federal payments)  
5 that would have been made for required health bene-  
6 fits for eligible individuals under title XIX during  
7 the fiscal year if this title were not in effect in the  
8 year. The Secretary shall annually determine, for  
9 each State, the amount specified under the preced-  
10 ing sentence and shall take into account inflation in  
11 the provision of required health services that has oc-  
12 curred.

13           “(3) PREMIUMS COLLECTED.—The amount  
14 specified in this paragraph for a State for a quarter  
15 is the amount of premiums collected under the State  
16 plan in the quarter.

17           “(c) PAYMENT FOR OUTREACH AND OPTIONAL  
18 SERVICES AND ADMINISTRATIVE COSTS.—

19           “(1) IN GENERAL.—The amount described in  
20 this paragraph is the percentage (specified in para-  
21 graph (2)) of the expenditures under the plan for  
22 other than required health services as found nec-  
23 essary by the Secretary to carry out the provision of  
24 this title and for the proper and efficient administra-  
25 tion of the State plan.

1           “(2) FEDERAL MATCHING RATE.—The percent-  
2           age specified in this paragraph for a State is the  
3           sum of—

4                   “(A) the percentage that would apply to  
5                   the class of expenses under section 1903(a) (as  
6                   in effect on the date of the enactment of this  
7                   title), and

8                   “(B) for calendar quarters in—

9                           “(i) 1995 or 1996, 10 percent,

10                           “(ii) 1997, 7.5 percent,

11                           “(iii) 1998, 5 percent, or

12                           “(iv) 1999, 2.5 percent.

13           “(d) PAYMENT RULES.—Payments to States under  
14           this section shall be made in accordance with rules similar  
15           to the rules provided under section 1903 for payments to  
16           States with plans under title XIX.

17           “PART E—ASSISTANCE FOR LOW-INCOME INDIVIDUALS

18           “**SEC. 2241. ASSISTANCE FOR INDIVIDUALS ENROLLED ON A**

19                           **NON-EMPLOYMENT BASIS.**

20                   “(a) INDIVIDUALS WITH INCOME BELOW 133 PER-  
21                   CENT OF POVERTY LEVEL.—Except as otherwise pro-  
22                   vided in this section, in the case of an individual—

23                           “(1) who is enrolled under a State plan on a  
24                           non-employment basis, and

1           “(2) whose family adjusted total income (as de-  
2           fined in section 2246(2)) does not exceed 133 per-  
3           cent of the official poverty line (as defined in section  
4           2282(5)),

5 the State plan shall waive the premiums imposed under  
6 section 2231(a) and any deductible or coinsurance under  
7 the plan for the individual and the individual’s family.

8           “(b) PREGNANT WOMEN AND INFANTS BELOW 185  
9 PERCENT OF POVERTY LEVEL.—In the case of a preg-  
10 nant woman or child under 1 year of age—

11           “(1) who is enrolled under a State plan on a  
12           non-employment basis, and

13           “(2) whose family adjusted total income (as de-  
14           fined in section 2246(2)) does not exceed the per-  
15           centage (established by the State under section  
16           1902(l)(2)(A)(i) as of the date of the enactment of  
17           this title) of the official poverty line (as defined in  
18           section 2282(5)),

19 the State plan shall waive any deductible or coinsurance  
20 under the plan for such individual. In addition, in the case  
21 of individuals described in the previous sentence, a State  
22 plan may provide for a reduction in the premium otherwise  
23 established (taking into account the reduction required  
24 under subsection (c)).

1       “(c) INDIVIDUALS WITH INCOME BELOW 400 PER-  
2 CENT OF POVERTY.—In the case of an individual not de-  
3 scribed in subsection (a), who is enrolled under this title  
4 on a non-employment basis, and whose family adjusted  
5 total income is less than 400 percent of the official poverty  
6 line, the State plan shall provide for reductions in pre-  
7 miums, deductibles, and coinsurance as follows:

8               “(1) PREMIUMS REDUCTION FOR INDIVIDUALS  
9 WITH INCOME BELOW 400 PERCENT OF POVERTY.—  
10 The premium amount under section 2231(a) shall be  
11 reduced by the premium subsidy percentage (as de-  
12 fined in subsection (c)(1)(B)) of the premium  
13 amount otherwise applied. Any reduction in pre-  
14 mium under this paragraph shall be rounded to the  
15 nearest multiple of \$5.

16               “(2) REDUCTION IN DEDUCTIBLE FOR INDIVID-  
17 UALS WITH INCOME BELOW 200 PERCENT OF POV-  
18 ERTY.—If the individual is not described in sub-  
19 section (b), the deductible under section 2222 shall  
20 be reduced by the general subsidy percentage (as de-  
21 fined in subsection (d)(2)) of the deductible other-  
22 wise applied. Any reduction in a deductible under  
23 this paragraph shall be rounded to the nearest mul-  
24 tiple of \$10.

1           “(3) REDUCTION IN COINSURANCE FOR INDI-  
2           VIDUALS WITH INCOME BELOW 200 PERCENT OF  
3           POVERTY.—If the individual is not described in sub-  
4           section (b), the percentage coinsurance applied  
5           under section 2223 shall be reduced by the general  
6           subsidy percentage multiplied by the percentage co-  
7           insurance otherwise applied. In applying this para-  
8           graph, the general subsidy percentage shall be  
9           rounded to the nearest multiple of 5 percent.

10          “(d) DEFINITIONS.—In this section and section  
11          2242—

12                 “(1) GENERAL SUBSIDY PERCENTAGE.—The  
13                 term ‘general subsidy percentage’ means the number  
14                 of percentage points by which the family’s adjusted  
15                 total income (expressed as a percent of the applica-  
16                 ble official poverty line) is less than 200 percent. If  
17                 such income is equal to or greater than 200 percent  
18                 of the applicable official poverty line, the general  
19                 subsidy percentage shall be 0.

20                 “(2) PREMIUM SUBSIDY PERCENTAGE.—The  
21                 term ‘premium subsidy percentage’ means the ratio  
22                 (expressed as a percentage) of—

23                         “(A) 400 percent minus the family’s ad-  
24                         justed total income (expressed as a percent of  
25                         the applicable official poverty line), to

1 “(B) 267 percent.

2 **“SEC. 2242. ASSISTANCE FOR INDIVIDUALS COVERED**  
3 **UNDER QUALIFIED EMPLOYER HEALTH**  
4 **PLANS.**

5 “(a) IN GENERAL.—In the case of an eligible individ-  
6 ual who is enrolled under a qualified employer health plan  
7 or under a State plan on an employment basis, the State  
8 plan shall provide for—

9 “(1) payment (in a manner specified by the  
10 Secretary) of the amount of the premium subsidy  
11 under subsection (b) to the individual or another  
12 family member, or, in the case described in sub-  
13 section (b)(1)(D), the employer, and

14 “(2) in the case of a qualified employer health  
15 plan, payment to the qualified employer health plan  
16 of the amount of the deductible and coinsurance  
17 subsidy under subsection (c) or, in the case of the  
18 State plan, a reduction in the deductible and coin-  
19 surance amounts otherwise established in the  
20 amount specified under section 2241.

21 Such subsidies shall apply to premiums, deductibles, and  
22 coinsurance for the individual and family member covered  
23 on an employment basis under the employer plan or under  
24 the State plan.

25 “(b) PREMIUM SUBSIDY.—

1           “(1) TREATMENT UNDER QUALIFIED EM-  
2 PLOYER HEALTH PLAN.—In the case of an eligible  
3 individual who is enrolled under a qualified employer  
4 health plan—

5           “(A) AMOUNT.—The amount of the pre-  
6 mium subsidy under this subsection is the pre-  
7 mium subsidy percentage (as defined in section  
8 2241(d)(2)) of the employee share of the pre-  
9 mium. Any premium subsidy under this para-  
10 graph which is not a multiple of \$5 shall be  
11 rounded to the nearest multiple of \$5.

12           “(B) USE OF LEAST EXPENSIVE QUALI-  
13 FIED PLAN.—In applying subparagraph (A),  
14 the amount of the premium subsidy shall be  
15 based on the qualified employer health plan  
16 available to the employee with the smallest pre-  
17 mium payment required of the employee.

18           “(C) FREQUENCY OF PAYMENT.—Except  
19 as provided in subparagraph (D), the premium  
20 subsidy under this subsection shall be paid not  
21 less frequently than quarterly or, if the amount  
22 of the premium subsidy on a monthly basis ex-  
23 ceeds \$20, monthly.

1           “(D) OPTIONAL, DIRECT COORDINATION  
2 WITH EMPLOYERS.—In the case of an em-  
3 ployee—

4           “(i) who is enrolled under a qualified  
5 employer health plan,

6           “(ii) who is entitled to assistance  
7 under this part,

8           “(iii) whose employer agrees to enter  
9 into an arrangement with the State plan  
10 under this subparagraph, and

11           “(iv) who assigns (in the manner  
12 specified by the Secretary) rights to pre-  
13 mium subsidies under this subsection to  
14 the employer,

15 the State shall enter into an arrangement with  
16 the employer under which (I) the employer  
17 agrees to reduce premiums otherwise imposed  
18 with respect to the individual by the amount of  
19 the subsidy, and (II) the State agrees to make  
20 payment (not less often than monthly) to the  
21 employer of the amount of such premium sub-  
22 sidy.

23           “(2) TREATMENT UNDER STATE PLAN.—In the  
24 case of an eligible individual who is enrolled on an  
25 employment basis under a State plan—

1           “(A) AMOUNT.—The amount of the pre-  
2           mium subsidy under this subsection is the pre-  
3           mium subsidy percentage (as defined in section  
4           2241(d)(2)) of the taxes paid under section  
5           3151(a)(2) of the Internal Revenue Code of  
6           1986.

7           “(B) FREQUENCY OF PAYMENT.—The pre-  
8           mium subsidy under this subsection shall be  
9           paid not less frequently than quarterly or, if the  
10          amount of the premium subsidy on a monthly  
11          basis exceeds \$20, monthly.

12          “(c) DEDUCTIBLE AND COINSURANCE SUBSIDY.—

13           “(1) DEDUCTIBLE SUBSIDY AMOUNT.—The  
14           amount of the deductible subsidy under this sub-  
15           section is the general subsidy percentage (as defined  
16           in section 2241(d)(1)) of the deductible otherwise  
17           applied. Any deductible subsidy under this para-  
18           graph that is not a multiple of \$10 shall be rounded  
19           to the nearest multiple of \$10.

20           “(2) COINSURANCE SUBSIDY AMOUNT.—The  
21           amount of the coinsurance subsidy under this sub-  
22           section is the product of the general subsidy percent-  
23           age, the percentage coinsurance otherwise applied,  
24           and the payment amount permitted for required  
25           health services. In applying this paragraph, the gen-

1       eral subsidy percentage shall be rounded to the near-  
2       est multiple of 5 percent.

3               “(3) DIRECT COORDINATION BY QUALIFIED EM-  
4       PLOYER HEALTH PLAN REQUIRED.—In the case of  
5       an individual enrolled under a qualified employer  
6       health plan, the plan shall provide for—

7               “(A) acceptance of information, electroni-  
8       cally, from the State on the amount of the de-  
9       ductible and coinsurance subsidy for individuals  
10      (and family members),

11              “(B) a reduction in the deductibles and co-  
12      insurance otherwise imposed to reflect the de-  
13      ductible and coinsurance subsidies to which the  
14      individual and family members are entitled,

15              “(C) reasonably prompt payment of bills  
16      for which such charges have been made, and

17              “(D) transmission of such information as  
18      is necessary to indicate the amount of the de-  
19      ductible and coinsurance subsidies provided  
20      under the plan for specified individuals.

21      In return, the State plan shall provide for payment,  
22      not less often than monthly, to the qualified em-  
23      ployer health plan of the amount of payments made  
24      by the qualified employer health plan for deductible  
25      and coinsurance subsidies under this subsection.

1 **“SEC. 2243. APPLICATIONS FOR ASSISTANCE.**

2       “(a) IN GENERAL.—Subject to section 2245, any in-  
3 dividual who seeks assistance under this part (with respect  
4 to himself or herself or a family member) shall submit a  
5 written application, by person or mail, to the State plan  
6 in the State in which the individual (for whom the assist-  
7 ance is sought) is residing. The application may be sub-  
8 mitted with an application to enroll under the State plan  
9 or separately.

10       “(b) BASIS FOR DETERMINATION.—Subject to sec-  
11 tion 2245 and reconciliation under section 2244, eligibility  
12 for assistance under this part shall be based on 4 times  
13 the family adjusted total income (as defined in section  
14 2246(2)) during the 3 months preceding the month in  
15 which the application is filed.

16       “(c) FORM AND CONTENTS.—An application for as-  
17 sistance under this part shall be in a form and manner  
18 specified under the State plan (consistent with guidelines  
19 established by the Secretary) and shall require—

20               “(1) the provision of information necessary to  
21               make the determinations described in subsection (b),

22               “(2) the provision of information respecting any  
23               qualified employer health plan in which the individ-  
24               ual is enrolled, and

1           “(3) the individual (if enrolled under such a  
2           plan) to assign rights for deductible and coinsurance  
3           subsidies under this part to such plan.

4   Such form also shall include an option to execute, as part  
5   of completing the form and in order to meet the condition  
6   described in section 2242(b)(1)(D)(iv), an assignment of  
7   an individual’s right for premium subsidies under this part  
8   to an employer.

9           “(d) FREQUENCY OF APPLICATIONS.—

10           “(1) IN GENERAL.—An application for assist-  
11           ance under this part may be filed at any time during  
12           the year and may be resubmitted (but, except as  
13           provided in paragraph (3), not more frequently than  
14           once every 3 months) based upon a change of in-  
15           come or family composition.

16           “(2) NEED TO REAPPLY.—In the case of an in-  
17           dividual who—

18                   “(A) is entitled to assistance under this  
19                   section in September of a year, and

20                   “(B) wishes to remain eligible for benefits  
21                   for months beginning with January of the fol-  
22                   lowing year,

23           the individual (or a family member) must file with  
24           the State plan in October of that preceding year a  
25           new application for assistance. If an individual fails

1 to file a new application under this paragraph, an  
2 application for such assistance with respect to any  
3 family member may not be filed during November or  
4 December of that preceding year.

5 “(3) CORRECTION OF INCOME.—Nothing in  
6 paragraph (1) shall be construed as preventing an  
7 individual or family from, at any time, submitting an  
8 application to reduce the amount of assistance under  
9 this part based upon an increase in income from  
10 that stated in the previous application.

11 “(e) TIMING OF ASSISTANCE.—

12 “(1) IN GENERAL.—If an application for assist-  
13 ance under this part is filed—

14 “(A) on or before the 15th day of a month,  
15 assistance under this part shall be available for  
16 premiums for months after such month and,  
17 with respect to the deductible and coinsurance,  
18 for expenses incurred after such month; or

19 “(B) after the 15th day of a month, assist-  
20 ance under this part shall be available for pre-  
21 miums for months after the month following  
22 such month and, with respect to the deductible  
23 and coinsurance, for expenses incurred after  
24 such following month.

1           “(2) WELFARE RECIPIENTS.—In the case of an  
2 individual or family with respect to whom an appli-  
3 cation for assistance is not required because of sec-  
4 tion 2245, in applying paragraph (1), the date of ap-  
5 proval of aid or benefits described in such section  
6 shall be considered the date of filing of an applica-  
7 tion for assistance under this part.

8           “(f) VERIFICATION.—Each State plan shall provide  
9 (consistent with guidelines of the Secretary) for verifica-  
10 tion, on a sample basis or other basis, of the information  
11 supplied in applications under this part. This verification  
12 shall be separate from the reconciliation provided under  
13 section 2244.

14           “(g) HELP IN COMPLETING APPLICATIONS.—Each  
15 State plan shall provide for grants to public or private  
16 nonprofit entities that will make available assistance to in-  
17 dividuals and families in filing applications for assistance  
18 under this part. Each plan shall make grants in a manner  
19 that provides such assistance at a variety of sites (such  
20 as low-income housing projects and shelters for homeless  
21 individuals) that are readily accessible to individuals and  
22 families eligible for assistance under this part. The  
23 amounts paid under such grants shall be considered, for  
24 purposes of section 2236(c)(1), to be expenses reasonably  
25 required in the administration of this title.

1 “(h) PENALTIES FOR INACCURATE INFORMATION.—

2 “(1) INTEREST FOR UNDERSTATEMENTS.—

3 Each individual who knowingly understates income  
4 reported in an application for assistance under this  
5 part or otherwise makes a material misrepresenta-  
6 tion of information in such an application shall be  
7 liable to the State plan for excess payments made  
8 based on such understatement or misrepresentation,  
9 and for interest on such excess payments at a rate  
10 specified by the Secretary.

11 “(2) PENALTIES FOR MISREPRESENTATION.—

12 In addition to any penalty under paragraph (1),  
13 each individual who knowingly misrepresents mate-  
14 rial information in an application for assistance  
15 under this part shall be liable to the State plan for  
16 \$1,000 or, if greater, three times the excess pay-  
17 ments made based on such misrepresentation.

18 “(i) FILING OF APPLICATION DEFINED.—Except as  
19 provided in subsection (e)(2), for purposes of this part,  
20 an application under this part is considered to be ‘filed’  
21 on the date on which the complete application, including  
22 all documentation required to act on the application, has  
23 been filed with the State plan.

1 **“SEC. 2244. RECONCILIATION OF PREMIUM ASSISTANCE**  
2 **THROUGH USE OF INCOME STATEMENTS.**

3 “(a) REQUIREMENT FOR FILING OF INCOME STATE-  
4 MENT.—Subject to section 2245, in the case of a family  
5 which is receiving low-income assistance under this part  
6 for any month in a year, a member of the family shall  
7 file with the State plan, by not later than April 15 of the  
8 following year, a statement that verifies the family’s total  
9 adjusted family income for the taxable year ending during  
10 the previous year. Such a statement shall provide informa-  
11 tion necessary to determine the family adjusted total in-  
12 come during the year and the number of family members  
13 in the family as of the last day of the year.

14 “(b) RECONCILIATION OF PREMIUM ASSISTANCE  
15 BASED ON ACTUAL INCOME.—Based on and using the in-  
16 come reported in the statement filed under subsection (a)  
17 with respect to a family or individual, subject to section  
18 2245, each State plan shall compute the amount of assist-  
19 ance that should have been provided under this part with  
20 respect to premiums for the family in the year involved.  
21 If the amount of such assistance computed is—

22 “(1) greater than the amount of premium as-  
23 sistance provided, the State plan shall provide for  
24 payment (directly or through a credit against future  
25 premiums owed) to the family or individual involved  
26 of an amount equal to the amount of the deficit, or

1           “(2) less than the amount of assistance pro-  
2           vided, the State plan shall require the family or indi-  
3           vidual to pay (directly or through an increase in fu-  
4           ture premiums owed) to the plan an amount equal  
5           to the amount of the excess payment.

6           “(c) DISQUALIFICATION FOR FAILURE TO FILE.—  
7           Subject to section 2245, in the case of any family that  
8           is required to file an information statement under sub-  
9           section (a) in a year and that fails to file such a statement  
10          by the deadline specified in such subsection, no member  
11          of the family shall be eligible for assistance under this part  
12          after May 1 of such year. A State plan shall waive the  
13          application of this subsection if the family establishes, to  
14          the satisfaction of the State, good cause for the failure  
15          to file the statement on a timely basis.

16          “(d) PENALTIES FOR FALSE INFORMATION.—Any  
17          individual that provides false information in a statement  
18          under subsection (a) is subject to a criminal penalty to  
19          the same extent as a criminal penalty may be imposed  
20          under section 1128B(a) with respect to a person described  
21          in clause (ii) of such section.

22          “(e) NOTICE OF REQUIREMENT.—Each State plan  
23          shall provide for written notice, in March of each year,  
24          of the requirement of subsection (a) to each family which

1 received assistance under this part in any month during  
2 the preceding year and to which such requirement applies.

3 “(f) TRANSMITTAL OF INFORMATION.—The Sec-  
4 retary of the Treasury shall transmit annually to the Sec-  
5 retary such information relating to the adjusted total in-  
6 come of individuals for the taxable year ending in the pre-  
7 vious year as may be necessary for State plans to verify  
8 the reconciliation of assistance under this section. The  
9 Secretary shall provide for transmission of such informa-  
10 tion to State plans for their use in performing such rec-  
11 onciliation.

12 “(g) CONSTRUCTION.—Nothing in this section shall  
13 be construed as authorizing reconciliation of assistance  
14 provided with respect to deductibles and coinsurance.

15 **“SEC. 2245. TREATMENT OF CERTAIN CASH ASSISTANCE**  
16 **RECIPIENTS.**

17 “In the case of a family that has been determined  
18 to be eligible for aid under part A or E of title IV or an  
19 individual who has been determined to be eligible for sup-  
20 plemental security income benefits under title XVI—

21 “(1) the family or individual is deemed, without  
22 the need to file an application for assistance under  
23 section 2243, to have adjusted total income below  
24 100 percent of the official poverty line applicable to  
25 a family of the size involved,

1           “(2) the family or individual need not file a  
2 statement under section 2244(a), and

3           “(3) the assistance received by the family or in-  
4 dividual is not subject to reconciliation under section  
5 2244(b).

6 **“SEC. 2246. COMPUTATION OF FAMILY ADJUSTED TOTAL**  
7 **INCOME.**

8           “In this part:

9           “(1) ADJUSTED TOTAL INCOME.—The term  
10 ‘adjusted total income’ means—

11                   “(A) adjusted gross income (as defined in  
12 section 62(a) of the Internal Revenue Code of  
13 1986), determined without the application of  
14 paragraphs (6) and (7) of such section and  
15 without the application of section 162(l) of such  
16 Code, plus

17                   “(B) the amount of social security benefits  
18 (described in section 86(d) of such Code) which  
19 is not includable in gross income under section  
20 86 of such Code.

21           “(2) FAMILY ADJUSTED TOTAL INCOME.—The  
22 term ‘family adjusted total income’ means, with re-  
23 spect to an individual, the sum of the adjusted total  
24 income for the individual and all the other family  
25 members.

1           “PART F—ADMINISTRATIVE PROVISIONS

2   **“SEC. 2261. GENERAL ADMINISTRATION THROUGH INSUR-**  
3                           **ANCE COMPANIES.**

4           “(a) IN GENERAL.—Except as otherwise provided in  
5 this part, each State shall provide, to the maximum extent  
6 practicable, for the administration of the State plan under  
7 this title through arrangements with at least 2 insurance  
8 companies, or, if there are not 2 qualified insurance com-  
9 panies able to administer the plan in the State, 1 such  
10 insurance company. Nothing in this section shall be con-  
11 strued as preventing or prohibiting States in a region from  
12 jointly contracting with 2 or more insurance companies  
13 to administer the State plans of the several States in the  
14 region.

15           “(b) OUTREACH AND OPTIONAL SERVICES.—Each  
16 State shall provide directly for the administration of the  
17 State plan with respect to—

18                   “(1) the provision of, or payment for, outreach  
19 services under section 2212(b), and

20                   “(2) the provision of, or payment for, optional  
21 services under section 2212(c).

22           “(c) LOW INCOME ASSISTANCE.—Each State shall  
23 provide for the determination of low-income assistance  
24 under part E to be made by entities, specifically des-  
25 ignated by the State, that are independent of such insur-

1 ance companies and that will assure the confidentiality of  
2 information provided in conjunction with obtaining such  
3 assistance.

4 **“SEC. 2262. QUALITY ASSURANCE.**

5 “(a) IN GENERAL.—Each State plan shall provide for  
6 the application of methods that assure the quality of the  
7 services provided under the plan.

8 “(b) PEER REVIEW.—Such methods shall include—

9 “(1) peer review of professional services, and

10 “(2) such other methods as the Secretary finds  
11 cost-effective in order to reduce unnecessary tests  
12 and procedures.

13 **“SEC. 2263. BENEFICIARY CLAIMS SAFEGUARDS.**

14 “(a) NOTICE OF CLAIMS DENIALS.—Each State plan  
15 shall provide an individual with written notice concerning  
16 the denial of a claim submitted by the individual under  
17 the plan. Such notice shall include the reasons for the de-  
18 nial.

19 “(b) PROCESS FOR REVIEW.—Each State plan shall  
20 use a fair process for the timely review of claims denied  
21 under the plan.

22 “(c) CLAIM FOR CARE NEEDED FOR LIFE-THREAT-  
23 ENING ILLNESS.—In cases in which the failure to provide  
24 required health services promptly would be life-threatening  
25 or result in a risk of permanent disability of an individual

1 enrolled under a State plan, the individual is entitled to  
2 a decision as to whether benefits are available under the  
3 plan with respect to such services not later than 1 day  
4 after supplying the State plan with all requested informa-  
5 tion. In the event of a denial of coverage for such services,  
6 the individual shall be entitled to an expedited review of  
7 an appeal of such denial within 5 days.

8 “(d) APPEALS.—Each individual is entitled to appeal  
9 the denial of a claim submitted by the individual under  
10 the State plan. The Secretary shall promulgate regulations  
11 establishing procedures to be utilized for appealing denials  
12 of claims under this title that are similar to the procedures  
13 established under title XVIII for appealing denials of  
14 claims under such title.

15 **“SEC. 2264. ADMINISTRATIVE EFFICIENCY STANDARDS.**

16 “Each State plan shall be administered in a manner  
17 consistent with administrative efficiency and simplicity, in  
18 accordance with standards specified by the Secretary.  
19 Such standards shall incorporate goals for the reduction  
20 of administrative waste and duplication.

21 **“SEC. 2265. HEALTH MAINTENANCE ORGANIZATIONS.**

22 “(a) IN GENERAL.—Except as provided in this sec-  
23 tion, section 1876 shall apply to individuals enrolled under  
24 a State plan in the same manner as such section applies

1 to individuals entitled to benefits under part A, and en-  
2 rolled under part B, of title XVIII.

3 “(b) APPLICATION.—In applying section 1876 under  
4 this section—

5 “(1) the provisions of such section relating only  
6 to individuals enrolled under part B of title XVIII  
7 shall not apply;

8 “(2) any reference to a Trust Fund established  
9 under title XVIII and to benefits with respect to any  
10 services under such title is deemed a reference to the  
11 Federal Children and Pregnant Women Health In-  
12 surance Trust Fund and to health insurance benefits  
13 with respect to required health services under this  
14 title;

15 “(3) the adjusted average per capita cost shall  
16 be determined on the basis of benefits under this  
17 title;

18 “(4) subsections (f) and (h) of such section  
19 shall not apply;

20 “(5) in applying subsection (c)(3)(B) of such  
21 section, an eligible organization may require a mini-  
22 mum period of enrollment (of not greater than 6  
23 months) during which an individual may not  
24 disenroll other than for cause or unless enrollment  
25 under this title is terminated; and

1           “(6) the Secretary shall establish such rules as  
2           may be necessary to apply such section to different  
3           State plans.

4   **“SEC. 2266. PROGRAM INTEGRITY; MISCELLANEOUS PROVI-**  
5                                   **SIONS.**

6           “Sections 1124, 1124A, 1126, and 1128 through  
7   1128B (relating to fraud and abuse) shall apply to this  
8   title in the same manner as they apply to title XIX.

9   **“SEC. 2267. DEMONSTRATION PROJECT AUTHORITY.**

10          “(a) DEMONSTRATION PROJECT AUTHORITY.—

11               “(1) IN GENERAL.—Subject to the approval of  
12               the Secretary, States are authorized to conduct dem-  
13               onstration projects—

14                       “(A) to improve the delivery and quality of  
15                       health care services under this title, and

16                       “(B) to increase the efficiency and effec-  
17                       tiveness of methods of payment for such serv-  
18                       ices.

19               Subject to paragraph (2), the Secretary may waive  
20               such requirements of this title as may be necessary  
21               to carry out such demonstration projects.

22               “(2) LIMITATION.—The Secretary does not  
23               have the authority under paragraph (1)—

24                       “(A) to reduce the benefits available under  
25                       part B, or



1       “(b) INCORPORATION OF CERTAIN EMPLOYMENT-  
2 RELATED DEFINITIONS IN TITLE XXI.—In this title, ex-  
3 cept as otherwise provided, the definitions of the following  
4 terms contained in title XXI apply for purposes of this  
5 title:

6           “(1) EMPLOYEE.—The term ‘employee’ as de-  
7 fined in section 2181(a)(3).

8           “(2) FULL-TIME EMPLOYEE.—The term ‘full-  
9 time employee’ as defined in section 2181(b)(1).

10          “(3) PART-TIME EMPLOYEE.—The term ‘part-  
11 time employee’ as defined in section 2181(b)(2).

12          “(4) QUALIFIED EMPLOYER HEALTH PLAN.—  
13 The term ‘qualified employer health plan’ as defined  
14 in section 2121(a).

15          “(5) SEASONAL OR TEMPORARY EMPLOYEE.—  
16 The term ‘seasonal or temporary employee’ as de-  
17 fined in section 2181(b)(3).

18          “(6) WAGES.—The term ‘wages’ as defined in  
19 section 2181(a)(1).

20 **“SEC. 2282. OTHER DEFINITIONS.**

21       “In this title:

22           “(1) CHILD.—The term ‘child’ means, with re-  
23 spect to a person who is not a child, an individual—

24               “(A) who under 22 years of age;

1           “(B)(i) who is the child of the person or  
2           the person’s spouse, or

3           “(ii) who is the legal ward of the person or  
4           the person’s spouse; and

5           “(C) who is not in the legal custody of an-  
6           other individual.

7           The Secretary shall establish, by regulation, such  
8           rules as are appropriate with respect to the treat-  
9           ment of foster children, emancipated minors, chil-  
10          dren in the process of adoption, and other unmar-  
11          ried individuals under 22 years of age under similar  
12          circumstances as children for purposes of this title.

13          “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
14          individual’ means an individual who—

15                 “(A) is a pregnant woman or child, and

16                 “(B) is (i) a citizen or national of the  
17                 United States, (ii) an alien lawfully admitted  
18                 for permanent residence, or (iii) an alien other-  
19                 wise residing permanently in the United States  
20                 under color of law.

21          “(3) FAMILY; FAMILY MEMBER.—The terms  
22          ‘family’ and ‘family member’ mean an individual and  
23          the individual’s spouse, and includes all the individ-  
24          ual’s children.

1           “(4) FEDERAL HEALTH PLAN.—The term ‘Fed-  
2           eral health plan’ means a health plan of, or contrib-  
3           uted to by, the Federal Government on behalf of its  
4           employees, retirees, and their family members, and  
5           includes—

6                   “(A) the Federal employees health insur-  
7                   ance program under chapter 89 of title 5, Unit-  
8                   ed States Code,

9                   “(B) the program for the provision of med-  
10                  ical and dental benefits under chapter 55 of  
11                  title 10, United States Code, and

12                  “(C) the program for the provision of hos-  
13                  pital care and medical services by the Depart-  
14                  ment of Veterans Affairs under chapter 17 of  
15                  title 38, United States Code.

16           “(5) OFFICIAL POVERTY LINE.—The term ‘offi-  
17           cial poverty line’ means, for an individual in a fam-  
18           ily, the official poverty line (as defined by the Office  
19           of Management and Budget, and revised annually in  
20           accordance with section 673(2) of the Omnibus  
21           Budget Reconciliation Act of 1981) applicable to a  
22           family of the size involved.

23           “(6) PREGNANT WOMAN.—The term ‘pregnant  
24           woman’ means a woman—

1           “(A) beginning on the date of verification  
2           of pregnancy (as determined in a manner speci-  
3           fied by the Secretary), and

4           “(B) ending on the last day of the month  
5           in which the 60-day period (beginning on the  
6           date of the termination of the pregnancy) ends.

7           “(7) SPOUSE.—The term ‘spouse’ means, with  
8           respect to an individual, the individual to which the  
9           individual is married. Marital status shall be deter-  
10          mined in accordance with section 7703 of the Inter-  
11          nal Revenue Code of 1986.

12   **“SEC. 2283. NONAPPLICATION TO RESIDENTS OF PUERTO**  
13                   **RICO AND TERRITORIES.**

14          “The provisions of this title shall not apply to an indi-  
15          vidual who is not a resident of one of the 50 States or  
16          the District of Columbia.”.

17   **SEC. 202. COORDINATION BETWEEN STATE CHILDREN AND**  
18                   **PREGNANT WOMEN HEALTH PLANS AND**  
19                   **MEDICAID PLANS.**

20          (a) IN GENERAL.—

21               (1) LIMITING FEDERAL FINANCIAL PARTICIPA-  
22               TION FOR SERVICES COVERED UNDER STATE CHIL-  
23               DREN AND PREGNANT WOMEN HEALTH PLANS.—  
24               Section 1903(i) of the Social Security Act (42  
25               U.S.C. 1396b(i)) is amended—

1 (A) in the paragraph (10) inserted by sec-  
2 tion 4401(a)(1)(B) of Omnibus Budget Rec-  
3 conciliation Act of 1990, by striking all that fol-  
4 lows “1927(g)” and inserting a semicolon;

5 (B) by redesignating the paragraph (10)  
6 added by section 4701(b)(2) as paragraph (11),  
7 by transferring and inserting it after the para-  
8 graph (10) inserted by section 4401(a)(1)(B) of  
9 Omnibus Budget Reconciliation Act of 1990,  
10 and by striking all that follows “with respect to  
11 hospitals or facilities” and inserting a semi-  
12 colon;

13 (C) by transferring and inserting the para-  
14 graph (12) inserted by section 4752(a)(2) of  
15 Omnibus Budget Reconciliation Act of 1990  
16 after paragraph (11), as redesignated by sub-  
17 paragraph (B), and by striking the period at  
18 the end and inserting a semicolon;

19 (D) by redesignating the paragraph (14)  
20 inserted by section 4752(e) of Omnibus Budget  
21 Reconciliation Act of 1990 as paragraph (13),  
22 by transferring and inserting it after paragraph  
23 (12), and by striking the period at the end and  
24 inserting a semicolon;

1 (E) by redesignating the paragraph (11)  
2 inserted by section 4801(e)(16)(A) of Omnibus  
3 Budget Reconciliation Act of 1990 as para-  
4 graph (14), by transferring and inserting it  
5 after paragraph (13), and by striking the period  
6 at the end and inserting “; or”; and

7 (F) by inserting after paragraph (14), as  
8 so redesignated, the following new paragraph:

9 “(15) with respect to items and services for  
10 which payment is made under State children and  
11 pregnant women health plans under title XXII.”.

12 (2) CLARIFICATION OF NONDUPLICATION OF  
13 MEDICAL ASSISTANCE WITH BENEFITS UNDER  
14 STATE CHILDREN AND PREGNANT WOMEN HEALTH  
15 PLANS.—Title XIX of such Act is amended by add-  
16 ing at the end the following new section:

17 “NONDUPLICATION OF BENEFITS WITH STATE CHILDREN  
18 AND PREGNANT WOMEN HEALTH PLANS

19 “SEC. 1931. Notwithstanding any other provision of  
20 this title, a State is not required under its plan under sec-  
21 tion 1902(a) to provide medical assistance for items and  
22 services for which payment is made under its state chil-  
23 dren and pregnant women health plan under title XXII.”.

24 (3) CLARIFICATION OF APPLICATION OF THIRD-  
25 PARTY PAYOR RULES TO QUALIFIED HEALTH  
26 PLANS.—Section 1902(a)(25)(A) of such Act (42

1 U.S.C. 1396a(a)(25)(A)) is amended by inserting  
2 “and qualified health plans certified under part C of  
3 title XXI” after “health insurers”.

4 (b) CONTINUATION OF MEDICAID BENEFITS NOT  
5 COVERED UNDER STATE CHILDREN AND PREGNANT  
6 WOMEN HEALTH PLANS.—Nothing in this Act shall be  
7 construed as—

8 (1) changing the eligibility of individuals for  
9 medical assistance under title XIX of the Social Se-  
10 curity Act, or

11 (2) subject to the amendments made by sub-  
12 section (a), changing the amount, duration, or scope  
13 of medical assistance required (or permitted) to be  
14 provided under such title.

15 **TITLE III—HEALTH INSURANCE**  
16 **REFORM FOR SMALL EM-**  
17 **PLOYERS**

18 **SEC. 301. EXCISE TAX ON PREMIUMS RECEIVED ON**  
19 **HEALTH INSURANCE POLICIES WHICH DO**  
20 **NOT MEET CERTAIN REQUIREMENTS.**

21 (a) IN GENERAL.—Chapter 47 of the Internal Reve-  
22 nue Code of 1986 (relating to taxes on group health  
23 plans), as amended by section 101(b) of this Act, is fur-  
24 ther amended by adding at the end thereof the following  
25 new section:

1 **“SEC. 5000B. FAILURE TO SATISFY CERTAIN STANDARDS**  
2 **FOR HEALTH INSURANCE.**

3 “(a) GENERAL RULE.—In the case of any person is-  
4 suing applicable accident and health insurance contracts,  
5 there is hereby imposed a tax on the failure of such person  
6 to meet at any time during any taxable year the applicable  
7 requirements of title XXIII of the Social Security Act. The  
8 Secretary of Health and Human Services shall determine  
9 whether any contract meets the requirements of such title.

10 “(b) AMOUNT OF TAX.—

11 “(1) IN GENERAL.—The amount of tax imposed  
12 by subsection (a) by reason of 1 or more failures  
13 during a taxable year shall be equal to 50 percent  
14 of the gross premiums received during such taxable  
15 year with respect to all accident and health insur-  
16 ance contracts issued by the person on whom such  
17 tax is imposed.

18 “(2) GROSS PREMIUMS.—For purposes of para-  
19 graph (1), gross premiums shall include any consid-  
20 eration received with respect to any accident and  
21 health insurance contract.

22 “(c) LIMITATION ON TAX.—

23 “(1) TAX NOT TO APPLY WHERE FAILURE NOT  
24 DISCOVERED EXERCISING REASONABLE DILI-  
25 GENCE.—No tax shall be imposed by subsection (a)  
26 with respect to any failure for which it is established

1 to the satisfaction of the Secretary that the person  
2 on whom the tax is imposed did not know, and exer-  
3 cising reasonable diligence would not have known,  
4 that such failure existed.

5 “(2) TAX NOT TO APPLY WHERE FAILURES  
6 CORRECTED WITHIN 30 DAYS.—No tax shall be im-  
7 posed by subsection (a) with respect to any failure  
8 if—

9 “(A) such failure was due to reasonable  
10 cause and not to willful neglect, and

11 “(B) such failure is corrected during the  
12 30-day period beginning on the 1st date any of  
13 the persons on whom the tax is imposed knew,  
14 or exercising reasonable diligence would have  
15 known, that such failure existed.

16 “(3) WAIVER BY SECRETARY.—In the case of a  
17 failure which is due to reasonable cause and not to  
18 willful neglect, the Secretary may waive part or all  
19 of the tax imposed by subsection (a).

20 “(d) LIABILITY FOR TAX.—The person issuing the  
21 applicable accident and health contract with respect to  
22 which a failure occurs shall be liable for the tax imposed  
23 by subsection (a).

24 “(e) DEFINITIONS.—For purposes of this section—

1           “(1) IN GENERAL.—The term ‘applicable acci-  
2           dent and health insurance contract’ means a con-  
3           tract under which a person authorized under appli-  
4           cable State insurance law provides a health insur-  
5           ance plan or arrangement to any group consisting of  
6           more than 2 individuals. Such term does not include  
7           any self-insured plan of an employer and does not  
8           include a qualified health maintenance organization  
9           (as defined in section 1310(d) of the Public Health  
10          Service Act).

11           “(2) CERTAIN CONTRACTS NOT COVERED.—The  
12          term ‘applicable accident and health insurance con-  
13          tract’ does not include any contract—

14                   “(A) which provides for accident only, den-  
15                   tal only, or disability only coverage,

16                   “(B) which provides coverage as a supple-  
17                   ment to liability insurance,

18                   “(C) which provides insurance arising out  
19                   of a workmens’ compensation or similar law, or  
20                   automobile medical-payment insurance, or

21                   “(D) which provides insurance which is re-  
22                   quired by law to be contained under any self-  
23                   insured plan of an employer.”

1 (b) CLERICAL AMENDMENT.—The table of sections  
 2 for such chapter 47 is amended by adding at the end  
 3 thereof the following new item:

“Sec. 5000B. Failure to satisfy certain standards for health in-  
 surance.”

4 **SEC. 302. GROUP HEALTH INSURANCE STANDARDS.**

5 The Social Security Act is amended by adding at the  
 6 end the following new title:

7 “TITLE XXIII—INSURANCE REFORM FOR  
 8 SMALL EMPLOYERS

9 **“SEC. 2301. APPLICATION OF REQUIREMENTS TO INSURED  
 10 SMALL EMPLOYER HEALTH PLANS.**

11 “(a) PLAN UNDER STATE REGULATORY PROGRAM  
 12 OR CERTIFIED BY THE SECRETARY.—No insured small  
 13 employer health plan may be issued in a State on or after  
 14 the effective date specified in subsection (c) (and no new  
 15 contract may be offered under such plan with respect to  
 16 any small employer beginning on or after such effective  
 17 date) unless—

18 “(1) the Secretary determines that the State  
 19 has established a regulatory program that—

20 “(A) provides for the application and en-  
 21 forcement of the applicable standards estab-  
 22 lished under section 2302 (to carry out the re-  
 23 quirements of this title), and

1           “(B) meets the requirements of section  
2           2302(b),

3           by such effective date, or

4           “(2) if the State has not established such a pro-  
5           gram, the plan has been certified by the Secretary  
6           (in accordance with such procedures as the Sec-  
7           retary establishes) as meeting the applicable stand-  
8           ards established under section 2302 by such effective  
9           date.

10          “(b) PLAN DISAPPROVED UNDER LOOK-BEHIND AU-  
11          THORITY.—If the Secretary determines, under section  
12          2302(c)(2), that small employer health plan does not meet  
13          the applicable requirements of this title on or after such  
14          effective date, regardless of whether or not the State has  
15          taken any action with respect to such noncompliance, no  
16          new contracts may be offered to small employers under  
17          the plan on or after the date of the determination.

18          “(c) SANCTIONS.—

19                 “(1) TAX.—For application of excise tax in the  
20                 case of a nonconforming plan, see section 5000B of  
21                 the Internal Revenue Code of 1986.

22                 “(2) NOTICE TO EMPLOYER IN THE CASE OF  
23                 INSURED PLANS.—If tax is imposed under section  
24                 5000B of the Internal Revenue Code of 1986, the  
25                 Secretary of the Treasury shall provide for notice to

1 be provided to each employer which meets the re-  
2 quirement of part A of title XXI through coverage  
3 under the plan of the imposition of the tax.

4 “(3) LOSS OF STATUS AS QUALIFIED EM-  
5 PLOYER HEALTH PLAN.—

6 “(A) IN GENERAL.—If an employment-re-  
7 lated health plan is determined to be in viola-  
8 tion of subsection (a) and is not determined to  
9 have come into compliance with the applicable  
10 standards within 6 months after the date of the  
11 initial determination of such a violation, the  
12 plan shall no longer be treated as a qualified  
13 employer health plan under title XXI as of the  
14 end of such 6-month period.

15 “(B) NO ENFORCEMENT OF INSURANCE  
16 CONTRACTS.—In the case of an employer that  
17 is required, under part A of title XXI, to pro-  
18 vide enrollment under a qualified employer  
19 health plan and that meets such requirement  
20 through an insured plan that is determined to  
21 be in violation of subsection (a)—

22 “(i) if such plan is not brought into  
23 compliance within 30 days after the date of  
24 the violation, the employer may terminate  
25 by notice the contract with the plan and is

1 not liable for payment of any additional  
2 amounts under the plan, and

3 “(ii) if such plan no longer qualifies  
4 as a qualified employer health plan, such  
5 contract shall be terminated and the em-  
6 ployer is not liable for payment of any  
7 amounts for periods in which the plan no  
8 longer qualifies as a qualified employer  
9 health plan.

10 “(4) DISQUALIFICATION FROM STATE PLAN AD-  
11 MINISTRATION.—If an employment-related health  
12 plan is determined to be in violation of subsection  
13 (a) and is not determined to have come into compli-  
14 ance with the applicable standards within 6 months  
15 after the date of the initial determination of such a  
16 violation, the plan shall no longer be eligible to ad-  
17 minister a State plan under title XXII as of the end  
18 of such 6-month period.

19 “(d) EFFECTIVE DATE.—The effective date specified  
20 in this subsection is January 1, 1995.

21 **“SEC. 2302. ESTABLISHMENT OF STANDARDS.**

22 “(a) ESTABLISHMENT OF STANDARDS.—

23 “(1) NAIC.—The Secretary shall request the  
24 NAIC—

1           “(A) to develop specific standards, in the  
2           form of a model Act and model regulations, to  
3           implement the requirements of this title, and

4           “(B) to report to the Secretary on such de-  
5           velopment,

6           by not later than October 1 of the year following the  
7           year in which this title is enacted. If the NAIC de-  
8           velops such standards within such period and the  
9           Secretary finds that such standards implement the  
10          requirements of this title, such standards shall be  
11          the standards applied under section 2301.

12          “(2) SECRETARY.—If the NAIC fails to develop  
13          and report on such standards by such date or the  
14          Secretary finds that such standards do not imple-  
15          ment the requirements of this title, the Secretary  
16          shall develop and publish, by not later than Novem-  
17          ber 15 of the year following the year in which this  
18          title is enacted, such standards. Such standards  
19          shall then be the standards applied under section  
20          2301.

21          “(b) ADDITIONAL ELEMENTS OF REGULATORY PRO-  
22          GRAMS.—

23                 “(1) IN GENERAL.—For purposes of section  
24                 2301(a)(1)(B), a State regulatory program shall in-  
25                 clude the following:

1 “(A) Enforcement under the program—

2 “(i) shall be designed in a manner so  
3 as to secure compliance with the standards  
4 within 30 days after the date of a finding  
5 of noncompliance with such standards, and

6 “(ii) shall provide for notice to the  
7 Secretary in cases where such compliance  
8 is not secured within such 30-day period.

9 “(B) A toll-free telephone which provides  
10 for—

11 “(i) a system for the receipt and dis-  
12 position of consumer and provider com-  
13 plaints or inquiries regarding compliance  
14 of health plans with the requirements of  
15 this title, and

16 “(ii) information to small employers  
17 about carriers that offer small employer  
18 health plans in the area covered by the  
19 regulatory authority.

20 Such system shall provide for the recording of  
21 consumer and provider complaints in accord-  
22 ance with a uniform methodology developed by  
23 the NAIC and recognized by the Secretary.

24 “(2) SECRETARIAL AUTHORITY.—In the case of  
25 a State without a regulatory program approved

1 under subsection (a), the Secretary shall provide for  
2 the establishment of the toll-free telephone informa-  
3 tion and complaint system described in paragraph  
4 (1)(B).

5 “(c) SECRETARIAL REVIEW.—

6 “(1) PERIODIC REVIEW OF STATE REGULATORY  
7 PROGRAMS.—The Secretary periodically shall review  
8 State regulatory programs to determine if they con-  
9 tinue to meet the standards referred to in subsection  
10 (a) and the requirements of subsection (b). If the  
11 Secretary finds that a State regulatory program no  
12 longer meets such standards and requirements, be-  
13 fore making a final determination, the Secretary  
14 shall provide the State an opportunity to adopt such  
15 a plan of correction as would permit the program to  
16 continue to meet such standards and requirements.  
17 If the Secretary makes a final determination that  
18 the State regulatory program, after such an oppor-  
19 tunity, fails to meet such standards and require-  
20 ments, the Secretary shall assume responsibility  
21 under section 2301(a)(2) with respect to plans in  
22 the State.

23 “(2) LOOK-BEHIND AUTHORITY.—In the case  
24 of a State with a regulatory program found by the  
25 Secretary to meet the standards and requirements

1 under this title, the Secretary nonetheless is author-  
2 ized to determine whether or not individual insured  
3 employment-related health plans in the State have  
4 failed to comply with the applicable requirements of  
5 this title.

6 “(d) GAO AUDITS.—The Comptroller General shall  
7 conduct periodic audits on a sample of State regulatory  
8 programs to determine their compliance with the require-  
9 ments of this section. The Comptroller General shall re-  
10 port to the Secretary and Congress on the findings in such  
11 audits.

12 **“SEC. 2303. ENROLLMENT PRACTICE AND GUARANTEED RE-**  
13 **NEWABILITY REQUIREMENTS FOR SMALL EM-**  
14 **PLOYER HEALTH PLANS.**

15 “(a) REGISTRATION WITH APPLICABLE REGULATORY  
16 AUTHORITY.—

17 “(1) IN GENERAL.—Each small employer car-  
18 rier (as defined in section 2308(b)(3)) shall register  
19 with the applicable regulatory authority for each  
20 State in which it issues or offers a small employer  
21 health plan.

22 “(2) NO PREEMPTION OF STATE INFORMATION  
23 REQUIREMENTS.—Nothing in paragraph (1) shall be  
24 construed as preventing the applicable regulatory  
25 authority from requiring such additional information

1 in conjunction with, or apart from, the registration  
2 required under paragraph (1) as the applicable regu-  
3 latory authority may be authorized to require under  
4 State law.

5 “(b) GUARANTEED ISSUE.—

6 “(1) IN GENERAL.—Subject to the succeeding  
7 provisions of this subsection, a carrier that offers a  
8 health plan to small employers located in a commu-  
9 nity must offer the same plan to any other small  
10 employer located in the community.

11 “(2) TREATMENT OF HEALTH MAINTENANCE  
12 ORGANIZATIONS.—

13 “(A) GEOGRAPHIC LIMITATIONS.—A  
14 health maintenance organization may deny cov-  
15 erage under a plan to a small employer whose  
16 employees are located outside the service area  
17 of the organization, but only if such denial is  
18 applied uniformly without regard to health sta-  
19 tus or insurability.

20 “(B) SIZE LIMITS.—A health maintenance  
21 organization may apply to the applicable regu-  
22 latory authority to cease enrolling new small  
23 employer groups in its small employer health  
24 plan (or in a geographic area served by the  
25 plan) if it can demonstrate that its financial or

1 administrative capacity to serve previously en-  
2 rolled groups and individuals (and additional in-  
3 dividuals who will be expected to enroll because  
4 of affiliation with such previously enrolled  
5 groups) will be impaired if it is required to en-  
6 roll new groups.

7 “(3) GROUNDS FOR REFUSAL TO ISSUE OR  
8 RENEW.—

9 “(A) IN GENERAL.—A carrier may refuse  
10 to issue or renew or terminate a plan only for—

11 “(i) nonpayment of premiums,

12 “(ii) fraud or misrepresentation, and

13 “(iii) failure to meet minimum partici-  
14 pation rates (consistent with subparagraph  
15 (B)).

16 “(B) MINIMUM PARTICIPATION RATES.—A  
17 carrier may require, with respect to a small em-  
18 ployer health plan, that a minimum percentage  
19 of full-time, permanent employees eligible to en-  
20 roll under the plan be enrolled, so long as such  
21 percentage is enforced uniformly for all employ-  
22 ment groups of comparable size.

23 “(c) MINIMUM PLAN PERIOD.—A carrier may not  
24 offer to, or issue with respect to, a small employer a small  
25 employer health plan with a term of less than 12 months.

1 “(d) GUARANTEED RENEWABILITY.—

2 “(1) IN GENERAL.—

3 “(A) GENERAL RULE.—Subject to the suc-  
4 ceeding provisions of this subsection, each small  
5 employer health plan must be renewed, at the  
6 option of the employer or employment-related  
7 organization described in section 2308(a)(2),  
8 unless the plan is terminated for the reasons  
9 specified in subsection (b)(3)(A) or under sub-  
10 paragraph (B).

11 “(B) TERMINATION OF BLOCK OF BUSI-  
12 NESS.—A carrier need not renew a health plan  
13 with respect to such an employer or employ-  
14 ment-related organization if the carrier—

15 “(i) is terminating the block of busi-  
16 ness that includes the plan, and

17 “(ii) provides notice to the employer  
18 or organization covered under the plan of  
19 such termination at least 90 days before  
20 the date of expiration of the plan.

21 In the case of such a termination, the insurer  
22 may not provide for issuance of any small em-  
23 ployer health plan in any block of business dur-  
24 ing the 5-year period beginning on the date of  
25 termination of such block of business.

1           “(C) CONSTRUCTION RESPECTING ADDI-  
2           TIONAL STATE DISCLOSURE REQUIREMENTS.—  
3           Subparagraph (B)(ii) shall not be construed as  
4           preventing the applicable regulatory authority  
5           from specifying the information to be included  
6           in the notice under such subparagraph or in re-  
7           quiring such notice to be provided at an earlier  
8           date.

9           “(2) NOTICE AND SPECIFICATION OF RATES  
10          AND ADMINISTRATIVE CHANGES.—

11           “(A) NOTICE.—The small employer carrier  
12           of a small employer health plan shall provide  
13           for notice, at least 30 days before the date of  
14           expiration of the health plan, of the terms for  
15           renewal of the plan. Except with respect to  
16           rates and administrative changes, the terms of  
17           renewal (including benefits) shall be the same  
18           as the terms of issuance.

19           “(B) RENEWAL RATES SAME AS ISSUANCE  
20           RATES.—The carrier may change the terms for  
21           such renewal, but the premium rates charged  
22           with respect to such renewal shall be the same  
23           as that for a new issue.

24           “(C) RATES CANNOT CHANGE MORE  
25           OFTEN THAN MONTHLY.—

1           “(i) IN GENERAL.—A small employer  
2 carrier may not change the premium rates  
3 established with respect to any block of  
4 business for a small employer health plan  
5 more often than monthly.

6           “(ii) APPLICATION OF NEW RATES.—  
7 In the case of a plan issued which becomes  
8 effective in a month, the premium rates es-  
9 tablished under clause (i) for that month  
10 shall apply to all months during the 12-  
11 month period beginning with that month.  
12 In the case of a plan renewal which is ef-  
13 fective for a 12-month period beginning  
14 with a month, the premium rates estab-  
15 lished under clause (i) with respect to that  
16 month shall apply to all months during 12-  
17 month renewal period.

18           “(3) PERIOD OF RENEWAL.—The period of re-  
19 newal of each small employer health plan shall be for  
20 a period of not less than 12 months.

21           “(e) NO DISCRIMINATION BASED ON HEALTH STA-  
22 TUS FOR CERTAIN SERVICES.—An small employer health  
23 plan may not deny, limit, or condition the coverage under  
24 (or benefits of) the plan with respect to required health  
25 services based on the health status, claims experience, re-

1 ceipt of health care, medical history, or lack of evidence  
2 of insurability, of an individual.

3 **“SEC. 2304. RATING PRACTICES FOR SMALL EMPLOYER**  
4 **HEALTH PLANS.**

5 “(a) COHESIVE RATING SYSTEM AND ACTUARIAL  
6 CERTIFICATION.—

7 “(1) IN GENERAL.—The premiums (including  
8 reference premium rate, as defined in section  
9 2308(c)(6)) for all small employer health plans of  
10 the same entity shall—

11 “(A) be established based on a single cohe-  
12 sive rating system which is applied consistently  
13 for all employer groups and is designed not to  
14 treat groups, after the second effective year (as  
15 defined in subsection (c)), differently based on  
16 health status or risk status; and

17 “(B) be actuarially certified annually.

18 “(2) ACTUARIAL CERTIFIED DEFINED.—For  
19 purposes of paragraph (1)(B), a plan is considered  
20 to be ‘actuarially certified’ if there is a written state-  
21 ment, by a member of the American Academy of Ac-  
22 tuaries or other individual acceptable to the applica-  
23 ble regulatory authority that a small employer car-  
24 rier is in compliance with this section, based upon  
25 the individual’s examination, including a review of

1 the appropriate records and of the actuarial assump-  
2 tions and methods utilized by the carrier in estab-  
3 lishing premium rates for applicable health plans.

4 “(b) USE OF COMMUNITY-RATING.—

5 “(1) IN GENERAL.—Except as provided in para-  
6 graph (2):

7 “(A) COMMUNITY RATING WITHIN A  
8 BLOCK OF BUSINESS.—The reference premium  
9 rate charged for a small employer health plan  
10 with similar benefits in a community within a  
11 block of business shall be the same for all small  
12 employers and shall be the same regardless of  
13 the age, sex, health status, or number of indi-  
14 viduals in the family covered under the plan.

15 “(B) LIMITING VARIATION ON REFERENCE  
16 PREMIUM RATES AMONG BLOCKS OF BUSI-  
17 NESS.—

18 “(i) IN GENERAL.—Except as pro-  
19 vided in clause (iii), the reference premium  
20 rate charged for small employer health  
21 plans with similar benefits in any commu-  
22 nity for the most expensive block of busi-  
23 ness shall not exceed 120 percent of such  
24 rate charged for such plan for the least ex-  
25 pensive block of business.

1           “(ii) ROLE OF REGULATORY AUTHOR-  
2           ITY.—An applicable regulatory authority  
3           that is a State may reduce or eliminate the  
4           percent variation otherwise permitted  
5           under clause (i).

6           “(iii) EXCEPTION.—Clause (i) shall  
7           not apply to a block of business—

8                   “(I) if the block is one for which  
9                   the carrier does not reject, and never  
10                  has rejected, small employers included  
11                  within the definition of employers eli-  
12                  gible for the block of business or oth-  
13                  erwise eligible employees and depend-  
14                  ents who enroll on a timely basis,

15                   “(II) the carrier does not invol-  
16                  untarily transfer, and never has invol-  
17                  untarily transferred, a health plan  
18                  into or out of the block of business,  
19                  and

20                   “(III) that block of business was  
21                  available for purchase as of the date  
22                  of the enactment of this title.

23           “(2) TRANSITION.—Notwithstanding paragraph  
24           (1)—

1           “(A) during the first effective year (as de-  
2           fined in subsection (c)), the premium rate for  
3           any employer may be as much as, but may not  
4           exceed, 150 percent of the reference premium  
5           rate for such plans in the same community for  
6           similar benefits in the same block of business,  
7           or

8           “(B) during the second effective year, the  
9           premium rate for any employer may be as much  
10          as, but may not exceed, 122 percent of the ref-  
11          erence premium rate for such plans in the same  
12          community for similar benefits in the same  
13          block of business.

14          “(3) ESTABLISHMENT OF BLOCKS OF BUSI-  
15          NESS.—For the purpose of establishing premiums  
16          for small employer health plans with similar cov-  
17          erage, the small employer carrier may establish  
18          blocks of business based only on one or more of the  
19          following characteristics:

20                 “(A) Plans that are marketed by clearly  
21                 different sales forces.

22                 “(B) Plans that have been acquired from  
23                 another carrier as a distinct group.

24                 “(C) Plans that are managed care plans.

1           “(D) Plans within another distinct group,  
2           if the applicable regulatory authority finds that  
3           establishment of such a group will enhance the  
4           efficiency and fairness of the small employer in-  
5           surance marketplace.

6           “(c) EFFECTIVE YEARS DEFINED.—In this section,  
7           the terms ‘first effective year’ and ‘second effective year’  
8           mean 1995 and 1996, respectively.

9           **“SEC. 2305. BASIC BENEFIT PACKAGE FOR SMALL EM-**  
10           **PLOYER HEALTH PLANS.**

11           “(a) BENEFITS AND COST-SHARING IN QUALIFIED  
12           HEALTH PLANS.—Except as provided in subsection (b),  
13           no small employer health plan may be issued to a small  
14           employer by a carrier unless—

15           “(1) the plan provides for benefits for all re-  
16           quired health services (as defined in section  
17           2211(a));

18           “(2) the plan does not impose cost-sharing with  
19           respect to required health services in excess of the  
20           deductibles and coinsurance permitted under title  
21           XXI with respect to such services (not taking into  
22           account any low-income assistance under part E of  
23           title XXII); and

24           “(3) the carrier makes available to the employer  
25           a small employer health plan that, subject to sub-

1 section (b), only provides the benefits for required  
2 health services and the maximum cost-sharing con-  
3 sistent with paragraphs (1) and (2).

4 “(b) ADDITIONAL, OPTIONAL MINIMUM SERVICES.—  
5 In meeting the requirement of subsection (a)(3), a small  
6 employer health plan may include such additional items  
7 and services as the small employer carrier can dem-  
8 onstrate to the satisfaction of the applicable regulatory au-  
9 thority that inclusion of such items and services will facili-  
10 tate appropriate hospital discharges or avoid unnecessary  
11 hospitalization.

12 **“SEC. 2306. MISCELLANEOUS DISCLOSURE AND RECORD-**  
13 **KEEPING REQUIREMENTS FOR SMALL EM-**  
14 **PLOYER HEALTH PLANS.**

15 “(a) DISCLOSURE TO EMPLOYERS.—

16 “(1) GENERAL DISCLOSURE.—Each small em-  
17 ployer carrier shall disclose to each small employer  
18 before issuing a small employer health plan the fol-  
19 lowing:

20 “(A) The availability (pursuant to the re-  
21 quirement of section 2305(a)(3)) of a plan in-  
22 cluding only required health services.

23 “(B) The limits, imposed under section  
24 2304, on the premiums permitted to be charged  
25 for such plans.

1           “(C) The rights of guaranteed issue and  
2           renewability provided under section 2303.

3           Such disclosure shall be in addition to any disclosure  
4           required generally of qualified health plans under  
5           section 2158(a)(2).

6           “(2) SPECIFIC DISCLOSURE UPON REQUEST.—  
7           Each small employer carrier shall disclose to each  
8           small employer, upon request, information concern-  
9           ing the blocks of business established with respect to  
10          small employer health plans and the applicable pre-  
11          miums for such plans.

12          “(3) STANDARD FORMAT.—The disclosure  
13          under paragraph (1) shall be made in a uniform for-  
14          mat established by the Secretary, after consultation  
15          with the NAIC.

16          “(b) INFORMATION FILED WITH APPLICABLE REGU-  
17          LATORY AUTHORITY.—

18                 “(1) IN GENERAL.—Each small employer car-  
19                 rier shall disclose to the applicable regulatory au-  
20                 thority, in a manner specified by the Secretary, in-  
21                 formation concerning—

22                         “(1) blocks of business established, and

23                         “(2) applicable premiums for small employer  
24                 health plans.

1           “(2) ADDITIONAL INFORMATION.—Nothing in  
2 this subsection shall be construed as limiting the in-  
3 formation which an applicable regulatory authority  
4 may require to be reported by small employer car-  
5 riers.

6 **“SEC. 2307. NONAPPLICATION IN PUERTO RICO AND THE**  
7 **TERRITORIES.**

8           “‘This title shall not apply outside the 50 States or  
9 the District of Columbia.

10 **“SEC. 2308. DEFINITIONS.**

11           “(a) HEALTH PLAN AND OTHER DEFINITIONS RE-  
12 LATING TO HEALTH PLANS.—In this title:

13           “(1) HEALTH PLAN.—The term ‘health plan’  
14 means any hospital or medical expense incurred pol-  
15 icy or certificate, hospital or medical service plan  
16 contract, health maintenance subscriber contract,  
17 other employee welfare plan (as defined in the Em-  
18 ployee Retirement Income Security Act of 1964), or  
19 any other health insurance arrangement, but does  
20 not include—

21           “(A) accident-only, credit, dental, or dis-  
22 ability income insurance,

23           “(B) coverage issued as a supplement to li-  
24 ability insurance,

1           “(C) worker’s compensation or similar in-  
2           surance, or

3           “(D) automobile medical-payment insur-  
4           ance.

5           “(2) EMPLOYMENT-RELATED HEALTH PLAN.—

6           The term ‘employment-related health plan’ means  
7           any health plan provided or arranged for or contrib-  
8           uted to by the employer or an employment-related  
9           organization to provide health benefits (directly or  
10          indirectly) for the employer’s employees and depend-  
11          ents, but only insofar as such benefits provide re-  
12          quired health care services for pregnant women and  
13          children.

14          “(3) INSURED EMPLOYMENT-RELATED HEALTH

15          PLAN.—The term ‘insured employment-related  
16          health plan’ means an employment-related health  
17          plan that has been provided by a person authorized  
18          under applicable State insurance law, and does not  
19          include any self-insured employment-related health  
20          plan.

21          “(4) SELF-INSURED EMPLOYMENT-RELATED

22          HEALTH PLAN.—The term ‘self-insured employment-  
23          related health plan’ means an employment-related  
24          health plan which is an employee welfare benefit  
25          plan (as defined in the Employee Retirement Income

1 Security Act of 1964) and in which the employer or  
2 employment-related group assumes the underwriting  
3 risk for the plan (whether or not there is any rein-  
4 surance or similar mechanism to underwrite a por-  
5 tion of that risk).

6 “(5) SMALL EMPLOYER HEALTH PLAN.—The  
7 term ‘small employer health plan’ means an insured  
8 employment-related health plan insofar as it offers  
9 benefits with respect to any small employer, as de-  
10 fined in subsection (c)(8), or the employees of a  
11 small employer.

12 “(b) CARRIER; HEALTH MAINTENANCE ORGANIZA-  
13 TION; AND OTHER DEFINITIONS RELATING TO CAR-  
14 RIERS.—In this part:

15 “(1) CARRIER.—The term ‘carrier’ means any  
16 person that offers a health plan, whether through in-  
17 surance or otherwise, including a licensed insurance  
18 company, a prepaid hospital or medical service plan,  
19 a health maintenance organization, and a multiple  
20 employer welfare arrangement.

21 “(2) HEALTH MAINTENANCE ORGANIZATION.—  
22 The term ‘health maintenance organization’ has the  
23 meaning given the term ‘eligible organization’ in sec-  
24 tion 1876(b).

1           “(3) SMALL EMPLOYER CARRIER.—The term  
2           ‘small employer carrier’ means any carrier which of-  
3           fers a small employer health plan.

4           “(c) GENERAL DEFINITIONS.—In this part:

5           “(1) APPLICABLE REGULATORY AUTHORITY.—  
6           The term ‘applicable regulatory authority’ means,  
7           with respect to a health plan offered in a State, the  
8           State commissioner or superintendent of insurance  
9           or other State authority responsible for regulation of  
10          health insurance, or, if the Secretary is exercising  
11          authority under section 2301(a)(2) in the State, the  
12          Secretary.

13          “(2) BLOCK OF BUSINESS.—The term ‘block of  
14          business’ means all, or a distinct grouping of, small  
15          employers as shown on the records of the small em-  
16          ployer carrier, if established consistent with section  
17          2304(b)(3).

18          “(3) COMMUNITY.—The term ‘community’ has  
19          the meaning given such term in section 2231(b).

20          “(4) FULL-TIME EMPLOYEE.—The term ‘full-  
21          time employee’ has the meaning given such term in  
22          section 2181(b)(1).

23          “(5) NAIC.—The term ‘NAIC’ means the Na-  
24          tional Association of Insurance Commissioners.

1           “(6) REFERENCE PREMIUM RATE.—The term  
 2           ‘reference premium rate’ means, for each block of  
 3           business for a rating period in a community, the  
 4           lowest premium rate charged or which could have  
 5           been charged by the small employer carrier to small  
 6           employers in that block under a rating system for  
 7           that block of business in the community for health  
 8           plans with the same or similar coverage.

9           “(8) SMALL EMPLOYER.—The term ‘small em-  
 10          ployer’ has the meaning given such term in section  
 11          2181(c)(1) and also includes a medium-size em-  
 12          ployer (as defined in section 2181(c)(2)).

13          “(9) STATE.—The term ‘State’ means the 50  
 14          States and the District of Columbia.”.

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