(b) GRANT FUNDS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 6037(a)(2), is amended by adding at the end the following new subsection:

"(y) PAYMENTS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—

"(1) PAYMENTS.—In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1916A(e)(5)(B)), or networks of such providers.

"(2) LIMITATION.—The total amount of payments under this subsection shall not exceed $50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

"(3) PREFERENCE.—In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

"(A) serve rural or underserved areas where beneficiaries under this title may not have regular access to providers of primary care services; or

"(B) are in partnership with local community hospitals.

"(4) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a).".

42 USC 1396b note.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to non-emergency services furnished on or after January 1, 2007.

SEC. 6044. USE OF BENCHMARK BENEFIT PACKAGES.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by section 6035, is amended by redesignating section 1937 as section 1938 and by inserting after section 1936 the following new section:

42 USC 1396v.

"STATE FLEXIBILITY IN BENEFIT PACKAGES

42 USC 1396u–7.

"SEC. 1937. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—

"(1) AUTHORITY.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals within one or more groups of individuals specified by the State through enrollment in coverage that provides—

"(i) benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and

"(ii) for any child under 19 years of age who is covered under the State plan under section

1902(a)(10)(A), wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r).

"(B) LIMITATION.—The State may only exercise the option under subparagraph (A) for an individual eligible under an eligibility category that had been established under the State plan on or before the date of the enactment of this section.

"(C) OPTION OF WRAP-AROUND BENEFITS.—In the case of coverage described in subparagraph (A), a State, at its option, may provide such wrap-around or additional benefits as the State may specify.

"(D) TREATMENT AS MEDICAL ASSISTANCE.—Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1905(a).

"(2) APPLICATION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this title through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within 1 or more groups of such individuals.

"(B) LIMITATION ON APPLICATION.—A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

"(i) MANDATORY PREGNANT WOMEN.—The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i).

"(ii) BLIND OR DISABLED INDIVIDUALS.—The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

"(iii) DUAL ELIGIBLES.—The individual is entitled to benefits under any part of title XVIII.

"(iv) TERMINALLY ILL HOSPICE PATIENTS.—The individual is terminally ill and is receiving benefits for hospice care under this title.

"(v) ELIGIBLE ON BASIS OF INSTITUTIONALIZATION.—The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(vi) MEDICALLY FRAIL AND SPECIAL MEDICAL NEEDS INDIVIDUALS.—The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).

"(vii) BENEFICIARIES QUALIFYING FOR LONG-TERM CARE SERVICES.—The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C).

"(viii) CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES AND CHILDREN RECEIVING FOSTER CARE OR ADOPTION ASSISTANCE.—The individual is an individual with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

"(ix) TANF AND SECTION 1931 PARENTS.—The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect on or after the welfare reform effective date defined in section 1931(i)).

"(x) WOMEN IN THE BREAST OR CERVICAL CANCER PROGRAM.—The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

"(xi) LIMITED SERVICES BENEFICIARIES.—The individual—

"(I) qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII); or

"(II) is not a qualified alien (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v).

"(C) FULL-BENEFIT ELIGIBLE INDIVIDUALS.—

"(i) IN GENERAL.—For purposes of this paragraph, subject to clause (ii), the term 'full-benefit eligible individual' means for a State for a month an individual who is determined eligible by the State for medical assistance for all services defined in section 1905(a) which are covered under the State plan under this title for such month under section 1902(a)(10)(A) or under any other category of eligibility for medical assistance for all such services under this title, as determined by the Secretary.

"(ii) EXCLUSION OF MEDICALLY NEEDY AND SPEND-DOWN POPULATIONS.—Such term shall not include an individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

"(b) BENCHMARK BENEFIT PACKAGES.—

"(1) IN GENERAL.—For purposes of subsection (a)(1), each of the following coverages shall be considered to be benchmark coverage:

"(A) FEHBP-EQUIVALENT HEALTH INSURANCE COVERAGE.—The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

"(B) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

"(C) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

"(i) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

"(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

"(D) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.

"(2) BENCHMARK-EQUIVALENT COVERAGE.—For purposes of subsection (a)(1), coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

"(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and services within each of the following categories of basic services:

"(i) Inpatient and outpatient hospital services.

"(ii) Physicians' surgical and medical services.

"(iii) Laboratory and x-ray services.

"(iv) Well-baby and well-child care, including age-appropriate immunizations.

"(v) Other appropriate preventive services, as designated by the Secretary.

"(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

"(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

"(i) Coverage of prescription drugs.

"(ii) Mental health services.

"(iii) Vision services.

"(iv) Hearing services.

"(3) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

"(A) by an individual who is a member of the American Academy of Actuaries;

"(B) using generally accepted actuarial principles and methodologies;

"(C) using a standardized set of utilization and price factors;

"(D) using a standardized population that is representative of the population involved;

"(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

"(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

"(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

"(4) COVERAGE OF RURAL HEALTH CLINIC AND FQHC SERVICES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless—

"(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1905(a)(2); and

"(B) payment for such services is made in accordance with the requirements of section 1902(bb).".

42 USC 1396u–7 note.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on March 31, 2006.

CHAPTER 5—STATE FINANCING UNDER MEDICAID

SEC. 6051. MANAGED CARE ORGANIZATION PROVIDER TAX REFORM.

(a) IN GENERAL.—Section 1903(w)(7)(A)(viii) of the Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

"(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).".

42 USC 1396b note.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendment made by subsection (a) shall be effective as of the date of the enactment of this Act.

(2) DELAY IN EFFECTIVE DATE.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a State specified in subparagraph (B), the amendment made by subsection (a) shall be effective as of October 1, 2009.

(B) SPECIFIED STATES.—For purposes of subparagraph (A), the States specified in this subparagraph are States that have enacted a law providing for a tax on the services