

103^D CONGRESS
1ST SESSION

H. R. 191

To reform the United States health care delivery and financing system, to increase access to health care and affordable health insurance, to contain costs of health care in a manner that improves health care, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

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

A BILL

To reform the United States health care delivery and financing system, to increase access to health care and affordable health insurance, to contain costs of health care in a manner that improves health care, and for other purposes.

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 “American Consumers Health Care Reform Act of 1993”.

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

Sec. 1. Short title; table of contents.

TITLE I—IMMEDIATE HEALTH CARE REFORMS

Subtitle A—Expansion of Medicaid Program

Sec. 101. Transition of State medicaid programs to State long-term care programs.

Sec. 102. Establishment of Federal medical assistance program for acute care.

Subtitle B—Medicare Reform

Sec. 111. Improved efficiency through consolidation of administration of parts A and B.

Sec. 112. Provider payment reforms to address inconsistent incentives.

Subtitle C—Health Benefit Plan Reform

PART 1—PREEMPTION OF STATE MANDATORY BENEFIT LAWS AND ANTI-MANAGED CARE LAWS

Sec. 121. Preemption from insurance mandates for qualified small employer purchasing groups.

Sec. 122. Removing restrictions on managed care.

PART 2—RESTRICTION ON PRE-EXISTING CONDITION PROVISIONS FOR EMPLOYER HEALTH INSURANCE

Sec. 123. Limitation on pre-existing condition clauses; assurance of continuity of coverage.

PART 3—SMALL EMPLOYER INSURANCE MARKET REFORMS

Sec. 124. Acceptance of all small employers seeking coverage; offering of minimum benefit package.

Sec. 125. Use of community-rated premiums.

PART 4—ESTABLISHMENT OF STANDARDS; ENFORCEMENT; GENERAL DEFINITIONS

Sec. 126. Establishment of standards.

Sec. 127. Enforcement.

Subtitle D—Medical Malpractice Reform

PART 1—GENERAL PROVISIONS

Sec. 131. Federal reform of medical malpractice liability actions.

Sec. 132. Definitions.

Sec. 133. Effective date.

PART 2—UNIFORM STANDARDS FOR MEDICAL MALPRACTICE LIABILITY ACTIONS

Sec. 141. Statute of limitations.

Sec. 142. Requirement for initial resolution of action through alternative dispute resolution.

Sec. 143. Relation to alternative dispute resolution of Federal agencies.

Sec. 144. Mandatory pre-trial settlement conference.

- Sec. 145. Calculation and payment of damages.
- Sec. 146. Treatment of attorney's fees and other costs.
- Sec. 147. Joint and several liability.
- Sec. 148. Uniform standard for determining negligence.
- Sec. 149. Application of medical practice guidelines in malpractice liability actions.
- Sec. 150. Special provision for certain obstetric services.
- Sec. 151. Preemption.

PART 3—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS (ADR)

- Sec. 161. Basic requirements for ADR.
- Sec. 162. Certification of State systems.
- Sec. 163. Reports on implementation and effectiveness of alternative dispute resolution systems.

PART 4—OTHER REQUIREMENTS AND PROGRAMS

- Sec. 171. Facilitating development and use of medical practice guidelines.
- Sec. 172. Permitting State professional societies to participate in disciplinary activities.
- Sec. 173. Requirements for risk management programs.
- Sec. 174. Grants for medical safety promotion.
- Sec. 175. Study of barriers to voluntary service by physicians.

Subtitle E—Medical Education Reform

- Sec. 181. Limitation on medicare hospital payment for direct and indirect graduate medical education support and Federal assistance for insured medical student loans for non-primary care physicians.
- Sec. 182. State comprehensive health professions education plans.

Subtitle F—Public Delivery System

- Sec. 183. Identification of medically underserved populations.
- Sec. 184. State comprehensive plans for medically underserved populations.
- Sec. 185. Publicly-funded health centers serving medically underserved areas.
- Sec. 186. Office of disease prevention and health promotion.
- Sec. 187. Consolidation of Federal activities relating to nutrition.
- Sec. 188. Demonstration projects on health care decisionmaking.
- Sec. 189. Action plan on health promotion and disease prevention.

Subtitle G—Public Disclosure

- Sec. 191. Development of national standards for disclosure of health care information; implementation by States.
- Sec. 192. Data submission and collection.
- Sec. 193. Data dissemination and publication.
- Sec. 194. Access to data.
- Sec. 195. Definitions.

Subtitle H—Tax Incentives to Provide Only Minimum Benefits

- Sec. 198. Denial of employer tax deduction for providing health care coverage in excess of minimum benefits and denial of employee exclusion for such excess coverage.

Sec. 199. Deduction for health insurance costs of self-employed individuals made permanent and increased to extent of costs for minimum benefits.

TITLE II—NATIONAL HEALTH CARE REFORM PROPOSALS

Subtitle A—National Health Care Reform Commission

Sec. 201. Establishment.

Sec. 202. Establishment of national goals; consultations; improved coordination; evaluation and recommendations on demonstration projects.

Sec. 203. Establishment of minimum benefit package.

Subtitle B—Demonstration Projects on Alternative Financing and Delivery Systems

Sec. 211. Establishment of demonstration projects.

Sec. 212. Process.

Sec. 213. Priorities.

Sec. 214. Scope and duration of projects.

Sec. 215. Waivers of certain laws.

Sec. 216. Reports and evaluations.

1 **TITLE I—IMMEDIATE HEALTH**
 2 **CARE REFORMS**
 3 **Subtitle A—Expansion of Medicaid**
 4 **Program**

5 **SEC. 101. TRANSITION OF STATE MEDICAID PROGRAMS TO**
 6 **STATE LONG-TERM CARE PROGRAMS.**

7 (a) IN GENERAL.—Title XIX of the Social Security
 8 Act is amended by adding at the end the following new
 9 section:

10 “ACUTE CARE TRANSITION TO FEDERAL MEDICAL
 11 ASSISTANCE PROGRAM

12 “SEC. 1931. (a) PHASE-IN OF EXPANDED ELIGI-
 13 BILITY.—

14 “(1) 2-YEAR PHASE IN.—

15 “(A) IN GENERAL.—Notwithstanding any
 16 other provision of this title, subject to sub-

1 section (e), for calendar quarters beginning on
2 or after the first day of the first effective fiscal
3 year (as defined in subparagraph (C)), each
4 State medical assistance plan under section
5 1902 shall provide for medical assistance under
6 the plan to all eligible individuals (as defined in
7 paragraph (2)) who are residents of the State.

8 “(B) TRANSFER OF COVERAGE.—Notwith-
9 standing any other provision of this title, effec-
10 tive on the first day of the third effective fiscal
11 year—

12 “(i) no payment shall be made to a
13 State under section 1903(a) for medical
14 assistance, other than—

15 “(I) medical assistance with re-
16 spect to outpatient prescription drugs
17 and biologicals, and

18 “(II) medical assistance with re-
19 spect to home health care services,
20 nursing facility services, home and
21 community care (under section 1929),
22 community supported living arrange-
23 ments services (described in section
24 1930), home and community-based
25 services (described in section 1915),

1 and other items and services that re-
2 late to long-term care and are not
3 covered under part B of this title; and

4 “(ii) no State is obligated to make
5 available medical assistance under this
6 part for items and services for which pay-
7 ment may not be made under clause (i).

8 “(C) FIRST, SECOND, AND THIRD EFFEC-
9 TIVE FISCAL YEARS DEFINED.—In this section,
10 the terms ‘first effective fiscal year’, ‘second ef-
11 fective fiscal year’, and ‘third effective fiscal
12 year’ means the first, second, and third fiscal
13 years, respectively, that begin more than 180
14 days after the date of the enactment of this sec-
15 tion.

16 “(2) ELIGIBLE INDIVIDUAL DEFINED.—

17 “(A) IN GENERAL.—In this section, the
18 term ‘eligible individual’ means an individual—

19 “(i) is a citizen or national of the
20 United States, an alien lawfully admitted
21 for permanent residence, or an alien other-
22 wise permanently residing in the United
23 States under color of law;

24 “(ii) whose income (as determined
25 under section 1612 for purposes of the

1 supplemental security income program,
2 subject to subparagraph (C)) does not ex-
3 ceed the applicable income level (specified
4 in subparagraph (B)); and

5 “(iii) whose resources (as determined
6 under section 1613 for purposes of the
7 supplemental security income program) do
8 not exceed the maximum amount of re-
9 sources that an individual may have and
10 obtain benefits under that program.

11 “(B) APPLICABLE INCOME LEVEL.—

12 “(i) IN GENERAL.—Subject to clause
13 (ii), the applicable income level is, for serv-
14 ices furnished in—

15 “(I) the first effective fiscal year,
16 60 percent of the Federal poverty
17 level (as defined in subparagraph
18 (D)), and

19 “(II) the second effective fiscal
20 year, 70 percent of the Federal pov-
21 erty level.

22 “(ii) SPECIAL RULES FOR PREGNANT
23 WOMEN AND CHILDREN.—With respect to
24 services related to pregnancy and children

1 under 19 years of age, the applicable in-
2 come level is, for services furnished in—

3 “(I) the first effective fiscal year,
4 150 percent of the Federal poverty
5 level (as defined in subparagraph
6 (C)), and

7 “(II) the second effective fiscal
8 year, 170 percent of the Federal pov-
9 erty level.

10 “(C) INCOME DETERMINATION.—In deter-
11 mining income, costs incurred for medical care
12 or for any other type of remedial care shall be
13 taken into account and deducted from income
14 otherwise determined.

15 “(D) FEDERAL POVERTY LEVEL DE-
16 FINED.—In this section, the term ‘Federal pov-
17 erty level’ means the official poverty line (as de-
18 fined by the Office of Management and Budget,
19 and revised annually in accordance with section
20 673(2) of the Omnibus Budget Reconciliation
21 Act of 1981) applicable to a family of the size
22 involved.

23 “(3) RELATION TO ALTERNATIVE ELIGI-
24 BILITY.—Nothing in this section shall be construed
25 as restricting the eligibility under other provisions of

1 this title of individuals for medical assistance under
2 this part.

3 “(b) SERVICES FOR WHICH MEDICAL ASSISTANCE
4 PROVIDED.—Notwithstanding any other provision of this
5 title, the medical assistance made available under this sec-
6 tion—

7 “(1) subject to paragraph (2), shall include
8 medical assistance for the same amount, duration,
9 and scope of services as are provided under the
10 State plan to individuals described in section
11 1902(a)(10)(A)(i), but

12 “(2) shall not include medical assistance for
13 nursing facility services or home health care services.

14 “(c) COST-SHARING.—

15 “(1) NO COST-SHARING FOR PREGNANCY-RE-
16 LATED SERVICES, PREVENTIVE SERVICES, AND CHIL-
17 DREN.—There shall be no cost-sharing imposed with
18 respect to—

19 “(A) services related to pregnancy,

20 “(B) preventive services, or

21 “(C) services furnished to children under
22 19 years of age.

23 “(2) NOMINAL COST-SHARING FOR THE POOR-
24 EST INDIVIDUALS.—There shall be no cost-sharing
25 (other than nominal cost-sharing, within the mean-

1 ing of section 1916(a)(3)) imposed with respect to
2 services furnished to individuals whose income is de-
3 termined to be less than 50 percent of the Federal
4 poverty level.

5 “(3) COST-SHARING FOR OTHER SERVICES AND
6 POPULATIONS.—

7 “(A) IN GENERAL.—With respect to eligi-
8 ble individuals not described in paragraph (2)
9 with respect to services not described in para-
10 graph (1), there shall be imposed the following
11 cost-sharing:

12 “(i) For outpatient services, there
13 shall be a copayment of \$5 for each visit,
14 or \$10 in the case of a nonemergency visit
15 to a hospital emergency room.

16 “(ii) For inpatient hospital services,
17 there shall be a copayment of \$50 for each
18 inpatient hospital admission.

19 “(B) LIMIT ON COST-SHARING.—In no
20 case shall the cost-sharing imposed under sub-
21 paragraph (A)—

22 “(i) for an individual (whether or not
23 the individual is a member of a family) ex-
24 ceed \$500 in any calendar year, or

1 “(ii) collectively for all members of a
2 family exceed \$1,000 in any calendar year.

3 “(d) CHANGES IN FEDERAL MEDICAL ASSISTANCE
4 PERCENTAGE.—

5 “(1) INCREASE FOR ACUTE CARE SERVICES.—

6 Subject to subsection (e), the Federal medical assist-
7 ance percentage for each of the 50 States and the
8 District of Columbia for medical assistance for acute
9 care services (described in paragraph (3)) shall be
10 increased, for calendar quarters occurring in—

11 “(A) the first effective fiscal year, by a
12 percentage equal to 20 percent of the difference
13 between 100 percentage points and the Federal
14 medical assistance percentage otherwise applica-
15 ble (without regard to this subsection), or

16 “(B) the second effective fiscal year, by a
17 percentage equal to 40 percent of the difference
18 between 100 percentage points and the Federal
19 medical assistance percentage otherwise applica-
20 ble (without regard to this subsection).

21 “(2) DECREASE IN FMAP FOR OUTPATIENT
22 PRESCRIPTION DRUGS AND LONG-TERM CARE SERV-
23 ICES.—The Federal medical assistance percentage
24 for each of the 50 States and the District of Colum-
25 bia for medical assistance for items and services

1 (other than assistance for acute care services), for
2 calendar quarters occurring in—

3 “(A) the first effective fiscal year, by a
4 percentage equal to 5 percent of the Federal
5 medical assistance percentage otherwise applica-
6 ble (without regard to this subsection), or

7 “(B) the second effective fiscal year, by a
8 percentage equal to 10 percent of the Federal
9 medical assistance percentage otherwise applica-
10 ble (without regard to this subsection).

11 “(3) ASSISTANCE FOR ACUTE CARE SERVICES
12 DEFINED.—In this subsection, the term ‘assistance
13 for acute care services’ means—

14 “(A) medical assistance for services de-
15 scribed in section 1905(a), other than for serv-
16 ices described in subclause (I) or (II) of sub-
17 section (a)(1)(B)(i) of this section, and

18 “(B) medical assistance relating to medi-
19 care cost-sharing.

20 “(4) CONSTRUCTION.—The changes in the Fed-
21 eral medical assistance percentage provided under
22 this subsection shall only apply for purposes of this
23 title.

24 “(e) REQUIREMENT FOR CONTINUATION OF LONG-
25 TERM CARE ASSISTANCE.—No individual residing in a

1 State shall be eligible for medical assistance under this
2 section, and the State shall not be eligible for an increase
3 in the Federal medical assistance percentage under sub-
4 section (d)(1) for a calendar quarter, unless—

5 “(1) the State continues to provide for medical
6 assistance under this part with respect to home
7 health care services and nursing facility services, and

8 “(2) such assistance is provided consistent with
9 standards adopted under section 205 of the Amer-
10 ican Consumers Health Care Reform Act of 1992.”.

11 (b) FEDERAL STANDARDS FOR STATE LONG-TERM
12 CARE PROGRAMS.—The Secretary of Health and Human
13 Services, in consultation with representatives of States, in-
14 dustry, and the beneficiary community, shall develop
15 standards that shall apply, pursuant to section 1931(e)(2)
16 of the Social Security Act, to State long-term care plans
17 under part A of title XIX of such Act at the end of the
18 10-year transition period provided under the amendment
19 made by subsection (a).

20 (c) REPORT ON IMPACT OF DECREASE IN FMAP FOR
21 OUTPATIENT PRESCRIPTION DRUGS.—The Secretary of
22 Health and Human Services shall submit to Congress, not
23 later than 2 years after the date of the enactment of this
24 Act, a report that—

1 (1) evaluates the impact on the States of the
2 decrease, provided under the amendment made by
3 subsection (a), in the Federal medical assistance
4 percentage for medical assistance for outpatient pre-
5 scription drugs, and

6 (2) makes such recommendations for changes in
7 this Act (including the amendments made by this
8 Act) in order to avoid any significant adverse impact
9 on States that continue to provide medical assistance
10 for outpatient prescription drugs to individuals in
11 need of such assistance.

12 (d) CONFORMING AMENDMENTS.—

13 (1) Section 1905(a) of such Act (42 U.S.C.
14 1396d(a)) is amended, in the matter before para-
15 graph (1), by striking “or” at the end of clause (ix),
16 by inserting “or” at the end of clause (x), and by
17 inserting after clause (x) the following new clause:

18 “(xi) individuals described in section 1931(a),”.

19 (2) Section 1905(b) of such Act is amended by
20 striking “The term” and inserting “Subject to sec-
21 tion 1931(d), the term”.

22 **SEC. 102. ESTABLISHMENT OF FEDERAL MEDICAL ASSIST-**
23 **ANCE PROGRAM FOR ACUTE CARE.**

24 (a) IN GENERAL.—Title XIX of the Social Security
25 Act is amended—

1 (1) by inserting after the heading the following:

2 “PART A—STATE MEDICAL ASSISTANCE PROGRAMS”;

3 AND

4 (2) by adding at the end the following new part:

5 “PART B—FEDERAL MEDICAL ASSISTANCE PROGRAM

6 “ESTABLISHMENT OF PROGRAM

7 “SEC. 1951. (a) IN GENERAL.—This part establishes
8 a Federal medical assistance program to provide medical
9 assistance for acute care services to all poor individuals
10 in the United States and to provide medical assistance for
11 medicare cost-sharing for certain medicare beneficiaries.

12 “(b) APPROPRIATIONS.—There are authorized to be
13 appropriated, without fiscal year limitation, such sums as
14 may be necessary to carry out this part.

15 “(c) EFFECTIVE DATE.—The provisions of this part
16 shall first apply to medical assistance for services or medi-
17 care cost-sharing furnished during calendar quarters be-
18 ginning on or after the first day of the third effective fiscal
19 year (as defined in subsection (d)).

20 “(d) THIRD AND FOURTH EFFECTIVE FISCAL YEARS
21 DEFINED.—In this part, the terms ‘third effective fiscal
22 year’ and ‘fourth effective fiscal year’ mean the third and
23 fourth fiscal years, respectively, that begin more than 180
24 days after the date of the enactment of this part.

25 “ELIGIBILITY

26 “SEC. 1952. (a) IN GENERAL.—

1 “(1) GENERAL MEDICAL ASSISTANCE.—Subject
2 to section 1957, the Secretary shall provide for pay-
3 ment under this part for costs of the items and serv-
4 ices described in section 1953 furnished to eligible
5 individuals (as defined in subsection (b)).

6 “(2) MEDICAL ASSISTANCE WITH MEDICARE
7 COST-SHARING FOR CERTAIN MEDICARE BENE-
8 FICIARIES.—

9 “(A) IN GENERAL.—The Secretary shall
10 provide for payment under this part for—

11 “(i) medicare cost-sharing (as defined
12 in section 1905(p)(3)) for qualified medi-
13 care beneficiaries who reside in one of the
14 50 States or the District of Columbia;

15 “(ii) medicare cost-sharing described
16 in section 1905(p)(3)(A)(i) for qualified
17 disabled and working individuals described
18 in section 1905(s) residing in one of the 50
19 States or the District of Columbia; and

20 “(iii) for medicare cost-sharing de-
21 scribed in section 1905(p)(3)(A)(ii) for in-
22 dividuals residing in one of the 50 States
23 or the District of Columbia who would be
24 qualified medicare beneficiaries described
25 in section 1905(p)(1) but for the fact that

1 their income exceeds 100 percent, but is
2 less than 120 percent, of the official pov-
3 erty line (referred to in such section) for a
4 family of the size involved.

5 “(B) SPECIAL RULES.—In applying sub-
6 paragraph (A)—

7 “(i) the income level that is deemed to
8 be applied under section 1905(p)(1)(B) is
9 100 percent of the official poverty line (as
10 defined by the Office of Management and
11 Budget, and revised annually in accord-
12 ance with section 673(2) of the Omnibus
13 Budget Reconciliation Act of 1981) appli-
14 cable to a family of the size involved, and

15 “(ii) the term ‘medicare cost-sharing’
16 described in section 1905(p)(3)(A) may in-
17 clude, as determined by the Secretary and
18 for purposes of clauses (i) and (iii) of sub-
19 paragraph (A) only, premiums for enroll-
20 ment of a qualified medicare beneficiary
21 with an eligible organization under section
22 1876.

23 “(b) ELIGIBLE INDIVIDUAL DEFINED.—

24 “(1) IN GENERAL.—In this section, the term
25 ‘eligible individual’ means an individual—

1 “(A) is a citizen or national of the United
2 States, an alien lawfully admitted for perma-
3 nent residence, or an alien otherwise perma-
4 nently residing in the United States under color
5 of law;

6 “(B) whose income (as determined under
7 section 1612 for purposes of the supplemental
8 security income program, subject to paragraph
9 (3)) does not exceed the applicable income level
10 (specified in paragraph (2)); and

11 “(C) whose resources (as determined under
12 section 1613 for purposes of the supplemental
13 security income program) do not exceed the
14 maximum amount of resources that an individ-
15 ual may have and obtain benefits under that
16 program.

17 “(2) APPLICABLE INCOME LEVEL.—

18 “(A) IN GENERAL.—Subject to subpara-
19 graph (B), the applicable income level is, for
20 services furnished in—

21 “(i) the third effective fiscal year, 80
22 percent of the Federal poverty level (as de-
23 fined in paragraph (4)),

24 “(ii) the fourth effective fiscal year,
25 90 percent of the Federal poverty level, or

1 “(iii) any subsequent fiscal year, is
2 100 percent of the Federal poverty level.

3 “(B) SPECIAL RULES FOR PREGNANT
4 WOMEN AND CHILDREN.—With respect to serv-
5 ices related to pregnancy and children under 19
6 years of age, the applicable income level is 185
7 percent of the Federal poverty level (as defined
8 in paragraph (4)).

9 “(3) INCOME DETERMINATION.—In determining
10 income, costs incurred for medical care or for any
11 other type of remedial care (recognized by the Sec-
12 retary) shall be taken into account and deducted
13 from income otherwise determined.

14 “(4) FEDERAL POVERTY LEVEL DEFINED.—In
15 this section, the term ‘Federal poverty level’ means
16 the official poverty line (as defined by the Office of
17 Management and Budget, and revised annually in
18 accordance with section 673(2) of the Omnibus
19 Budget Reconciliation Act of 1981) applicable to a
20 family of the size involved.

21 “SERVICES COVERED

22 “SEC. 1953. (a) IN GENERAL.—Subject to subsection
23 (b), items and services described in this section are the
24 care and services listed in paragraphs (1) through (5),
25 (17), and (21) of section 1905(a).

1 “(b) EXCLUSION OF LONG-TERM CARE SERVICES.—
2 Items and services described in this section do not in-
3 clude—

4 “(1) nursing facility services described in sec-
5 tion 1905(a)(4)(A), and

6 “(2) home health care services described in sec-
7 tion 1905(a)(7).

8 “(c) AMOUNT, DURATION, AND SCOPE.—There shall
9 be no fixed limitation on the amount, duration, and scope
10 of medically necessary services described in subsection (a).

11 “PAYMENTS; COST-SHARING

12 “SEC. 1954. (a) PAYMENT LEVEL.—

13 “(1) IN GENERAL.—Subject to cost-sharing
14 under subsection (c) and the succeeding provisions
15 of this subsection, the payment amount for services
16 under this part for medical assistance under section
17 1952(a)(1) shall be the same as the payment
18 amount that would be made under title XVIII for
19 such services (determined without regard to
20 deductibles and coinsurance and copayments under
21 such title).

22 “(2) PHASE-IN OF PAYMENT RATES.—During
23 the first 2 fiscal years in which this part applies, the
24 Secretary shall provide for such adjustment in pay-
25 ment rates so that—

1 “(A) during the first fiscal year, the rates
2 are based—

3 “(i) $\frac{2}{3}$ on the rates applied under
4 part A during the previous fiscal year (in-
5 creased by the same percentage as the per-
6 centage increase in payment rates under
7 title XVIII from the previous fiscal year to
8 such first fiscal year), and

9 “(ii) $\frac{1}{3}$ on the rates applied under
10 title XVIII (as adjusted under paragraph
11 (3)) during such first fiscal year; and

12 “(B) during the second fiscal year, the
13 rates are based—

14 “(i) $\frac{1}{3}$ on the rates applied under
15 part A during the second previous fiscal
16 year (increased by the same percentage as
17 the percentage increase in payment rates
18 under title XVIII from the second previous
19 fiscal year to such second), and

20 “(ii) $\frac{2}{3}$ on the rates applied under
21 title XVIII (as adjusted under paragraph
22 (3)) during such second fiscal year.

23 “(3) ADJUSTMENT OF MEDICARE PAYMENT
24 RATES.—The Secretary shall adjust the payment
25 rates established under title XVIII and applied

1 under this part in order to take into account dif-
2 ferences in the demographic and geographic charac-
3 teristics between the individuals covered under such
4 title and the individuals covered under this part.

5 “(b) PARTICIPATION AND MANDATORY ASSIGN-
6 MENT.—In the case of medical assistance made available
7 under section 1952(a)(1), payment may only be made
8 under this part for services furnished by a provider that—

9 “(1) meets such conditions as the Secretary es-
10 tablishes, based on conditions of participation of pro-
11 viders, physicians, and suppliers established for pur-
12 poses of title XVIII, and

13 “(2) has entered into a participation agreement
14 under which the provider agrees to accept the pay-
15 ment amounts established under this section (includ-
16 ing cost-sharing under subsection (c)) as payment in
17 full for covered services.

18 “(c) COST-SHARING.—In the case of medical assist-
19 ance made available under section 1952(a)(1)—

20 “(1) NO COST-SHARING FOR PREGNANCY-RE-
21 LATED SERVICES, PREVENTIVE SERVICES, AND CHIL-
22 DREN.—There shall be no cost-sharing imposed with
23 respect to—

24 “(A) services related to pregnancy,

25 “(B) preventive services, or

1 “(C) services furnished to children under
2 19 years of age.

3 “(2) NOMINAL COST-SHARING FOR THE POOR-
4 EST INDIVIDUALS.—There shall be no cost-sharing
5 (other than nominal cost-sharing, within the mean-
6 ing of section 1916(a)(3)) imposed with respect to
7 services furnished to individuals whose income is de-
8 termined to be less than 50 percent of the Federal
9 poverty level.

10 “(3) COST-SHARING FOR OTHER SERVICES AND
11 POPULATIONS.—

12 “(A) IN GENERAL.—With respect to eligi-
13 ble individuals not described in paragraph (2)
14 with respect to services not described in para-
15 graph (1), there shall be imposed the following
16 cost-sharing:

17 “(i) For outpatient services, there
18 shall be a copayment of \$5 for each visit,
19 or \$10 in the case of a nonemergency visit
20 to a hospital emergency room.

21 “(ii) For inpatient hospital services,
22 there shall be a copayment of \$50 for each
23 inpatient hospital admission.

1 “(B) LIMIT ON COST-SHARING.—In no
2 case shall the cost-sharing imposed under sub-
3 paragraph (A)—

4 “(i) for an individual (whether or not
5 the individual is a member of a family) ex-
6 ceed \$500 in any calendar year, or

7 “(ii) collectively for all members of a
8 family exceed \$1,000 in any calendar year.

9 “ADMINISTRATION

10 “SEC. 1955. (a) ELIGIBILITY DETERMINATIONS.—

11 The Secretary shall provide for determinations of eligi-
12 bility for benefits under this part for individuals residing
13 in a State to be made through the same administrative
14 entity that provides for determinations of eligibility for
15 supplemental security income benefits under title XVI for
16 residents of that State.

17 “(b) PAYMENTS.—The Secretary shall provide for
18 payments to providers under this part through the single
19 entity (or entities) responsible under section 111 of the
20 American Consumers Health Care Reform Act of 1992 for
21 administrative functions under title XVIII, in the same
22 manner as such entities provide for payments to providers
23 under such title.

24 “USE OF ALTERNATIVE DELIVERY SYSTEMS

25 “SEC. 1956. (a) IN GENERAL.—The Secretary shall
26 take such steps as may be appropriate to encourage the

1 development and application of managed care arrange-
2 ments to the provision of covered services under this part
3 to individuals eligible under section 1952(a)(1).

4 “(b) TYPES OF MANAGED CARE ARRANGEMENTS.—

5 “(1) IN GENERAL.—Managed care arrange-
6 ments under this section shall include—

7 “(A) primary care case-management ar-
8 rangements (which meet standards established
9 by the Secretary), and

10 “(B) health maintenance organizations and
11 competitive medical plans (which meet stand-
12 ards established by the Secretary).

13 In establishing standards for primary care case-man-
14 agement arrangements and for maintenance organi-
15 zations and competitive medical plans, the Secretary
16 shall take into account the standards established for
17 such arrangements and for such organizations and
18 plans under this title and title XVIII, respectively.

19 “(2) CAPITATION PAYMENTS.—Comprehensive
20 managed care arrangements (including health main-
21 tenance organizations and competitive medical
22 plans) shall include capitation payments at a level
23 equivalent to the level of payments which would be
24 made for individuals covered under this part and not
25 enrolled under such an arrangement.

1 “(3) CONSTRUCTION.—Nothing in this sub-
2 section shall be construed as limiting the number or
3 proportion of individuals covered under this part
4 who may be enrolled under a managed care arrange-
5 ment under this subsection.

6 “STATE MAINTENANCE OF EFFORT REQUIRED;

7 REDUCTION IN FMAP FOR LONG-TERM CARE SERVICES

8 “SEC. 1957. (a) IN GENERAL.—No individual resid-
9 ing in a State shall be eligible for medical assistance under
10 this part (other than under section 1952(a)(2)), unless—

11 “(1) the State continues to provide for medical
12 assistance under part A with respect to home health
13 care services and nursing facility services; and

14 “(2) the State provides for payment to the Sec-
15 retary of the amount specified under subsection (b).

16 Payments shall be made under paragraph (2) by States
17 on a quarterly basis based on estimates made by the Sec-
18 retary and subsequent payments shall be adjusted to re-
19 flect amounts by which previous payments were greater,
20 or less than, the amount of payment which should have
21 been made.

22 “(b) MAINTENANCE OF EFFORT AMOUNT.—

23 “(1) IN GENERAL.—The amount specified
24 under this subsection for a State for a calendar
25 quarter is the greater of—

1 “(A) the State share (as specified under
2 paragraph (2)) of the total amount of expendi-
3 tures made by the Secretary for residents of the
4 State during the quarter under this part, or

5 “(B) the State amount specified under
6 paragraph (3), reduced by the amount of pay-
7 ments made by the State (less any Federal pay-
8 ments to the State) under part A for the quar-
9 ter.

10 “(2) STATE SHARE.—

11 “(A) IN GENERAL.—Subject to subpara-
12 graph (C), the ‘State share’ for a State for a
13 calendar quarter is 100 percent less the Federal
14 percentage specified in subparagraph (B) for
15 the State for the quarter.

16 “(B) FEDERAL PERCENTAGE DEFINED.—
17 The Federal percentage specified in this sub-
18 paragraph for a State or the District of Colum-
19 bia for a quarter is—

20 “(i) the Federal medical assistance
21 percentage specified in section 1905(b)
22 (determined without regard to section
23 1931(d)) for the State for the quarter, in-
24 creased by

1 “(ii) a percentage equal to the per-
2 centage specified in subparagraph (C) of
3 the difference between 100 percentage
4 points and the Federal medical assistance
5 percentage described in clause (i).

6 “(C) PHASE IN.—The percentage specified
7 in this subparagraph for calendar quarters oc-
8 curring in—

9 “(i) the third effective fiscal year is
10 50 percent;

11 “(ii) each of the next 3 succeeding fis-
12 cal years, is the percentage specified in
13 this subparagraph for the calendar quar-
14 ters occurring in the previous fiscal year
15 increased by 10 percent;

16 “(iii) each of the next 3 succeeding
17 fiscal years, is the percentage specified in
18 this subparagraph for the calendar quar-
19 ters occurring in the previous fiscal year
20 increased by 5 percent; and

21 “(iv) each succeeding fiscal year, is
22 100 percent.

23 “(3) PAYMENT AMOUNT.—

24 “(A) IN GENERAL.—The payment amount
25 specified under this paragraph for a State for

1 a quarter in a fiscal year is equal to the prod-
2 uct of—

3 “(i) the average, per capita payment
4 level made under this title for the last full
5 fiscal year before the first effective fiscal
6 year, increased by the percentage specified
7 in subparagraph (B), and

8 “(ii) the population of the State.

9 “(B) PERCENTAGE INCREASE.—The per-
10 centage specified in this subparagraph for a fis-
11 cal year is the percentage increase in the
12 consumer price index for all urban consumers
13 (all items; U.S. city average) between the mid-
14 point of the fiscal year described in subpara-
15 graph (A)(i) to the midpoint of the fiscal year
16 involved.

17 “(c) DECREASE IN FMAP FOR SERVICES NOT COV-
18 ERED UNDER PART.—

19 “(1) IN GENERAL.—Notwithstanding any other
20 provision of law, the Federal medical assistance per-
21 centage for each of the 50 States and the District
22 of Columbia for medical assistance for services for
23 which benefits are not available under this part shall
24 be, for calendar quarters occurring in a fiscal year
25 (beginning with the third effective fiscal year), the

1 percentage specified in paragraph (2) of the Federal
2 medical assistance percentage otherwise applicable
3 (without regard to this part).

4 “(2) PHASE OUT PERCENTAGE.—The percent-
5 age specified in this paragraph for calendar quarters
6 occurring in—

7 “(A) the third and fourth effective fiscal
8 years is 85 and 80 percent, respectively;

9 “(B) each of the next 4 succeeding fiscal
10 years, is the percentage specified in this para-
11 graph for the calendar quarters occurring in the
12 previous fiscal year decreased by 10 percentage
13 points;

14 “(C) the next succeeding fiscal year, is 20
15 percent; and

16 “(D) each succeeding fiscal year, is 0 per-
17 cent.”.

18 (b) STUDY AND REPORT MAINTENANCE OF EFFORT
19 FORMULA.—

20 (1) STUDY.—The Secretary of Health and
21 Human Services shall provide for a study on the ef-
22 fect of the State maintenance-of-effort requirements
23 (under subsections (a) and (b) of section 1957(b) of
24 the Social Security Act, as added by subsection (a))
25 on different States and on the relation of the total

1 amount of maintenance of effort to the long-term
2 care needs in each State.

3 (2) REPORT.—Not later than 2 years after the
4 date of the enactment of this Act, the Secretary
5 shall submit to Congress a report on such study.
6 The Secretary shall include in such report such rec-
7 ommendations for adjustments in the requirements
8 of such subsections as may be appropriate to limit
9 the effort required of States to some indicator based
10 on the needs for long-term care services in each
11 State.

12 **Subtitle B—Medicare Reform**

13 **SEC. 111. IMPROVED EFFICIENCY THROUGH CONSOLIDA-** 14 **TION OF ADMINISTRATION OF PARTS A AND** 15 **B.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services shall take such steps as may be necessary
18 to consolidate the administration of parts A and B of the
19 medicare program over a 5-year period.

20 (b) COMBINATION OF INTERMEDIARY AND CARRIER
21 FUNCTIONS.—In taking such steps, the Secretary shall
22 contract with a single entity that combines the
23 intermediary and carrier functions in each area except
24 where the Secretary finds that special regional or national
25 contracts are appropriate.

1 (c) REPORT ON LEGISLATION REQUIRED.—Not later
2 than 1 year after the date of the enactment of this Act,
3 the Secretary shall submit to Congress a report specifying
4 such legislative changes as may be required in order to
5 carry out this section.

6 **SEC. 112. PROVIDER PAYMENT REFORMS TO ADDRESS IN-**
7 **CONSISTENT INCENTIVES.**

8 (a) DEVELOPMENT OF PAYMENT PROPOSALS.—The
9 Secretary of Health and Human Services shall develop
10 payment proposals that eliminate inconsistent incentives
11 that now exist under the medicare program. Such payment
12 proposals shall include the following:

13 (1) Proposals that ensure appropriate, consist-
14 ent, and complimentary payment incentives for pay-
15 ments for hospital services and payments for physi-
16 cian services.

17 (2) Proposals that eliminate inconsistent pay-
18 ment policies for the same service at different sites.

19 (3) Proposals that instill appropriate incentives
20 as regards the growth in service capacity and appro-
21 priate use of services.

22 (4) Proposals that are consistent with the goals
23 of ensuring both access to appropriate high quality
24 of care throughout an episode of illness and cost ef-
25 ficiency in the care delivered.

1 (b) REPORT.—Not later than 1 year after the date
2 of the enactment of this Act, the Secretary shall submit
3 to Congress a description of such proposals. The Secretary
4 shall include in the report such recommendations with re-
5 spect to such proposals as the Secretary determines to be
6 appropriate and shall specify such legislative changes as
7 may be required in order to implement such recommenda-
8 tions.

9 **Subtitle C—Health Benefit Plan**
10 **Reform**

11 PART 1—PREEMPTION OF STATE MANDATORY BENEFIT
12 LAWS AND ANTI-MANAGED CARE LAWS

13 **SEC. 121. PREEMPTION FROM INSURANCE MANDATES FOR**
14 **QUALIFIED SMALL EMPLOYER PURCHASING**
15 **GROUPS.**

16 (a) QUALIFIED SMALL EMPLOYER PURCHASING
17 GROUP DEFINED.—For purposes of this section, an asso-
18 ciation is a qualified small employer purchasing group if—

19 (1) the association submits an application to
20 the Secretary of Health and Human Services at such
21 time and in such form as the Secretary may require;
22 and

23 (2) on the basis of information contained in the
24 application and any other information the Secretary
25 may require, the Secretary determines that—

1 (A) the association is administered solely
2 under the authority and control of its member
3 employers,

4 (B) the association's membership consists
5 solely of employers with not more than 100 em-
6 ployees (except that an employer member of the
7 group may retain its membership in the group
8 if, after the Secretary determines that the asso-
9 ciation meets the requirements of this para-
10 graph, the number of employees of the employer
11 member increases to more than 100),

12 (C) with respect to each State in which its
13 members are located, the association consists of
14 not fewer than 100 employers, and

15 (D) at the time the association submits its
16 application, the health benefit plans with re-
17 spect to the employer members of the associa-
18 tion are in compliance with applicable State
19 laws relating to health benefit plans.

20 (b) PREEMPTION FROM INSURANCE MANDATES.—

21 (1) FINDING.—Congress finds that employer
22 purchasing groups organized for the purpose of ob-
23 taining health insurance for employer members af-
24 fect interstate commerce.

1 (2) PREEMPTION OF STATE MANDATES.—In the
2 case of a qualified small employer purchasing group
3 described in subsection (a), no provision of State law
4 shall apply that requires the offering, as part of the
5 health benefit plan with respect to an employer
6 member of such a group, of any services, category
7 of care, or services of any class or type of provider.

8 (3) PREEMPTION OF PROVISIONS PROHIBITING
9 EMPLOYER GROUPS FROM PURCHASING HEALTH IN-
10 SURANCE.—In the case of a qualified small employer
11 purchasing group described in subsection (a), no
12 provision of State or local law shall apply that pro-
13 hibits a group of employers from purchasing health
14 insurance with respect to member employers of the
15 group or their employees.

16 (c) EFFECTIVE DATE.—This section shall take effect
17 60 days after the date of the enactment of this Act.

18 **SEC. 122. REMOVING RESTRICTIONS ON MANAGED CARE.**

19 (a) PREEMPTION OF STATE LAW PROVISIONS.—Sub-
20 ject to subsection (c), the following provisions of State law
21 are preempted and may not be enforced:

22 (1) RESTRICTIONS ON REIMBURSEMENT RATES
23 OR SELECTIVE CONTRACTING.—Any law that re-
24 stricts the ability of a carrier to negotiate reimburse-

1 ment rates with providers or to contract selectively
2 with one provider or a limited number of providers.

3 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-
4 CIAL INCENTIVES.—Any law that limits the financial
5 incentives that a health benefit plan may require a
6 beneficiary to pay when a non-plan provider is used
7 on a non-emergency basis.

8 (3) RESTRICTIONS ON UTILIZATION REVIEW
9 METHODS.—Any law that—

10 (A) prohibits utilization review of any or
11 all treatments and conditions,

12 (B) requires that such review be made (i)
13 by a resident of the State in which the treat-
14 ment is to be offered or by an individual li-
15 censed in such State, or (ii) by a physician in
16 any particular specialty or with any board cer-
17 tified specialty of the same medical specialty as
18 the provider whose services are being reviewed,

19 (C) requires the use of specified standards
20 of health care practice in such reviews or re-
21 quires the disclosure of the specific criteria used
22 in such reviews,

23 (D) requires payments to providers for the
24 expenses of responding to utilization review re-
25 quests, or

1 (E) imposes liability for delays in perform-
2 ing such review.

3 Nothing in subparagraph (B) shall be construed as
4 prohibiting a State from (i) requiring that utilization
5 review be conducted by a licensed health care profes-
6 sional or (ii) requiring that any appeal from such a
7 review be made by a licensed physician or by a li-
8 censed physician in any particular specialty or with
9 any board certified specialty of the same medical
10 specialty as the provider whose services are being re-
11 viewed.

12 (b) GAO STUDY.—

13 (1) IN GENERAL.—The Comptroller General
14 shall conduct a study of the benefits and cost effec-
15 tiveness of the use of managed care in the delivery
16 of health services.

17 (2) REPORT.—By not later than 4 years after
18 the date of the enactment of this Act, the Comptrol-
19 ler General shall submit a report to Congress on the
20 study conducted under paragraph (1) and shall in-
21 clude in the report such recommendations (including
22 whether the provisions of subsection (a) should be
23 extended) as may be appropriate.

1 (c) SUNSET.—Unless otherwise provided, subsection
2 (a) shall not apply 5 years after the date of the enactment
3 of this Act.

4 PART 2—RESTRICTION ON PRE-EXISTING CONDITION
5 PROVISIONS FOR EMPLOYER HEALTH INSURANCE

6 **SEC. 123. LIMITATION ON PRE-EXISTING CONDITION**
7 **CLAUSES; ASSURANCE OF CONTINUITY OF**
8 **COVERAGE.**

9 (a) LIMITATIONS ON TREATMENT OF PRE-EXISTING
10 CONDITIONS.—A carrier may not impose (or require an
11 employer to impose through a waiting period for coverage
12 under a health benefit policy or similar requirement) a
13 limitation or exclusion of benefits under an employer
14 health benefit plan relating to treatment of a condition
15 based on the fact that the condition pre-existed the effec-
16 tiveness of the policy if—

17 (1) the condition relates to a condition that was
18 not diagnosed or treated within 6 months before the
19 date of coverage under the plan;

20 (2) the limitation or exclusion extends over
21 more than 6 months after the date of coverage
22 under the plan;

23 (3) the limitation or exclusion applies to an in-
24 dividual who, as of the date of birth, was covered
25 under the plan or is under 19 years of age; or

1 (4) the limitation or exclusion relates to preg-
2 nancy.

3 In the case of an individual who is eligible for coverage
4 under an employer health benefit plan but for a waiting
5 period imposed by the employer, in applying paragraphs
6 (1) and (2), the individual shall be treated as have been
7 covered under the plan as of the earliest date of the begin-
8 ning of the waiting period.

9 (b) ASSURANCE OF CONTINUITY OF COVERAGE
10 THROUGH PREVIOUS SATISFACTION OF PRE-EXISTING
11 CONDITION REQUIREMENT.—

12 (1) IN GENERAL.—Each carrier shall waive any
13 period applicable to a pre-existing condition for simi-
14 lar benefits with respect to an individual to the ex-
15 tent that the individual was covered for the condi-
16 tion under any health benefit plan (as defined in
17 paragraph (3)) that was in effect before the date of
18 the enrollment under the carrier's plan.

19 (2) CONTINUOUS COVERAGE REQUIRED.—

20 (A) IN GENERAL.—Paragraph (1) shall no
21 longer apply if there is a continuous period of
22 more than 60 days (or, in the case of an indi-
23 vidual described in subparagraph (C), 6
24 months) on which the individual was not cov-
25 ered under a health benefit plan.

1 (B) TREATMENT OF WAITING PERIODS.—

2 In applying subparagraph (A), any waiting pe-
3 riod imposed by an employer before an em-
4 ployee is eligible to be covered under a policy
5 shall be treated as a period in which the em-
6 ployee was covered under a health benefit plan.

7 (C) JOB TERMINATION.—An individual is
8 described in this subparagraph if the individual
9 loses coverage under an employer health plan
10 due to termination of employment.

11 (3) EXCLUSION OF CASH-ONLY AND DREAD
12 DISEASE POLICIES.—In this subsection, the term
13 “health benefit plan” does not include any insurance
14 which is offered primarily to provide—

15 (A) coverage for a specified disease or ill-
16 ness, or

17 (B) hospital or fixed indemnity policy, un-
18 less the Secretary (or in the case of a plan in
19 a State, the State) determines that such a pol-
20 icy provides sufficiently comprehensive coverage
21 of a benefit so that it should be treated as a
22 health benefit plan under this subsection.

1 (c) RESTRICTIONS OF ENROLLMENT PERMITTED IN
2 THE CASE OF CERTAIN ASSOCIATION COVERAGE.—In the
3 case of an health benefit plan offered through an associa-
4 tion which is composed exclusively of employers (which
5 may include self-employed individuals) and which has been
6 formed for purposes other than obtaining health insur-
7 ance, the carrier is not required to offer the plan with re-
8 spect to individuals who are not employees of such employ-
9 ers or self-employed members of the association, or their
10 dependents.

11 (d) TREATMENT OF HEALTH MAINTENANCE ORGA-
12 NIZATIONS.—

13 (1) GEOGRAPHIC LIMITATIONS.—A health
14 maintenance organization may deny enrollment with
15 respect to an individual if the individual is residing
16 outside the service area of the organization, but only
17 if such denial is applied uniformly without regard to
18 health status or insurability.

19 (2) SIZE LIMITS.—A health maintenance orga-
20 nization may apply to the Secretary to cease enroll-
21 ing new employer groups or individuals in its in-
22 sured health benefit plan (or in a geographic area
23 served by the plan) if—

24 (A) it ceases to enroll any new employer
25 groups or individuals, and

1 (B) it can demonstrate that its financial or
2 administrative capacity to serve previously en-
3 rolled groups and individuals (and additional in-
4 dividuals who will be expected to enroll because
5 of affiliation with such previously enrolled
6 groups) will be impaired if it is required to en-
7 roll new employer groups or individuals.

8 **SEC. 125. USE OF COMMUNITY-RATED PREMIUMS.**

9 (a) COHESIVE RATING SYSTEM AND ACTUARIAL
10 CERTIFICATION.—

11 (1) IN GENERAL.—The premiums (including
12 reference premium rate, as defined in subsection
13 (b)(2)) and age-sex adjustments under subsection (c)
14 for all small employer health plans of the same car-
15 rier shall—

16 (A) be established based on a single cohe-
17 sive rating system which is applied consistently
18 for all small employers and is designed not to
19 treat small employers differently based on
20 health status or risk status; and

21 (B) be actuarially certified annually.

22 (2) ACTUARIAL CERTIFIED DEFINED.—For
23 purposes of paragraph (1)(B), a plan is considered
24 to be “actuarially certified” if there is a written
25 statement, by a member of the American Academy

1 of Actuaries or other individual acceptable to the
2 Secretary that a small employer carrier is in compli-
3 ance with this section, based upon the individual's
4 examination, including a review of the appropriate
5 records and of the actuarial assumptions and meth-
6 ods utilized by the carrier in establishing premium
7 rates for applicable health plans.

8 (b) USE OF COMMUNITY-RATED REFERENCE PRE-
9 MIUM RATES.—

10 (1) IN GENERAL.—The reference premium rate
11 charged for a small employer health plan with simi-
12 lar benefits in a community for a type of family en-
13 rollment (described in subsection (d)) shall be the
14 same for all small employers.

15 (2) REFERENCE PREMIUM RATE.—In this sec-
16 tion, the term “reference premium rate” means, for
17 a rating period in a community, the lowest premium
18 rate charged or which could have been charged by
19 the small employer carrier to small employers under
20 a rating system in the community for health plans
21 with the same or similar coverage. The reference
22 premium rate is determined without regard to any
23 adjustment for age or sex described in subsection
24 (c).

1 (c) AGE AND SEX ADJUSTMENT TO COMMUNITY-
2 RATING.—

3 (1) IN GENERAL.—Subject to paragraph (2), a
4 small employer health plan may provide for an ad-
5 justment to the reference premium rate based on
6 age and gender of covered individuals. Any such ad-
7 justment shall be applied consistently to all small
8 employers.

9 (2) LIMITATION ON ADJUSTMENT.—The adjust-
10 ment under paragraph (1) may not result, with re-
11 spect to small employer health plans with similar
12 benefits in a community, in a premium rate for the
13 most expensive age-sex group exceeding 133 percent
14 of the premium rate for the least expensive age-sex
15 group.

16 (d) TYPES OF FAMILY ENROLLMENT.—Each small
17 employer health plan shall permit enrollment of (and shall
18 compute premiums separately for) individuals based on
19 each of the following beneficiary classes:

20 (1) 1 adult.

21 (2) A married couple without children.

22 (3) A married couple with 1 or more children,
23 or 1 adult with 1 or more children.

1 (e) COMMUNITY.—For purposes of this section, the
2 term “community” means a geographic area designated
3 by the Secretary as—

4 (1) encompassing one or more adjacent metro-
5 politan statistical areas, or

6 (2) the remaining area within each State (that
7 is not designated within any community under para-
8 graph (1));

9 except that the Secretary may designate an entire State
10 as a community if such a designation would better carry
11 out the purposes of this title. The Secretary from time
12 to time may change the boundaries of communities des-
13 igned under paragraph (1) or (2) for such purposes.
14 There shall be no administrative or judicial review of the
15 designation of communities under this subsection.

16 PART 4—ESTABLISHMENT OF STANDARDS;
17 ENFORCEMENT; GENERAL DEFINITIONS

18 **SEC. 126. ESTABLISHMENT OF STANDARDS.**

19 (a) ROLE OF NAIC.—The Secretary shall request the
20 National Association of Insurance Commissioners to de-
21 velop, within 9 months after the date of the enactment
22 of this Act, model regulations that specify standards to
23 carry out parts 2 and 3 of this subtitle. If the Association
24 develops such regulations specifying such standards within
25 such period, the Secretary shall review such standards to

1 determine if they meet such requirements. Such review
2 shall be completed within 30 days after the date the regu-
3 lations are developed. Unless the Secretary determines
4 within such period that the standards do not meet the re-
5 quirements, such standards shall serve as the standards
6 under section 127.

7 (b) CONTINGENCY.—If the Association does not de-
8 velop such model regulations within such period or the
9 Secretary determines that such regulations do not meet
10 the requirements described in subsection (a), the Sec-
11 retary shall specify, within 15 months after the date of
12 the enactment of this Act, standards to carry out parts
13 2 and 3 of this subtitle.

14 (c) EFFECTIVE DATE.—The standards provided
15 under this section shall apply to small employer health
16 benefit plans offered in a State on or after the date the
17 standards are implemented in the State under section 127
18 and to such plans renewed on or after 4 years after the
19 date such standards are implemented in the State under
20 such section.

21 **SEC. 127. ENFORCEMENT.**

22 (a) PRIMARY APPLICATION OF STANDARDS TO IN-
23 SURED PLANS THROUGH STATES.—

24 (1) IN GENERAL.—Each State shall submit to
25 the Secretary, by the deadline specified in paragraph

1 (B), a report on the implementation and enforce-
2 ment of the standards established under section 126
3 with respect to insured employer health benefit plans
4 offered not later than such deadline.

5 (2) DEADLINE FOR REPORT.—

6 (A) 1 YEAR AFTER STANDARDS ESTAB-
7 LISHED.—Subject to subparagraph (B), the
8 deadline under this paragraph is 1 year after
9 the date standards are established under section
10 126.

11 (B) EXCEPTION FOR LEGISLATION.—In
12 the case of a State which the Secretary identi-
13 fies, in consultation with the National Associa-
14 tion of Insurance Commissioners, as—

15 (i) requiring State legislation (other
16 than legislation appropriating funds) in
17 order for carriers and health benefit plans
18 offered to small employers to meet the
19 standards established under section 126,
20 but

21 (ii) having a legislature which is not
22 scheduled to meet in 1993 in a legislative
23 session in which such legislation may be
24 considered,

1 the date specified in this paragraph is the first
2 day of the first calendar quarter beginning after
3 the close of the first legislative session of the
4 State legislature that begins on or after Janu-
5 ary 1, 1993. For purposes of the previous sen-
6 tence, in the case of a State that has a 2-year
7 legislative session, each year of such session
8 shall be deemed to be a separate regular ses-
9 sion of the State legislature.

10 (b) MORE STRINGENT STATE STANDARDS PER-
11 MITTED.—A State may, under this section, implement
12 standards that are more stringent than the standards es-
13 tablished under section 126.

14 (c) FEDERAL ROLE.—

15 (1) INSURED PLANS.—If the Secretary deter-
16 mines that a State has failed to submit a report by
17 the deadline specified under subsection (a) or finds
18 that the State no longer is carrying out its respon-
19 sibility under the respective subsection, the Sec-
20 retary shall notify the State and provide the State
21 a period of 30 days in which to submit such report
22 or to carry out its responsibilities under the respec-
23 tive subsection. If, after such 30-day period, the Sec-
24 retary finds that such a failure has not been cor-
25 rected, the Secretary shall provide for such mecha-

1 nism for the implementation and enforcement of the
2 standards established under section 126 in the State
3 with respect to insured employer health benefit plans
4 as the Secretary determines to be appropriate. Such
5 standards shall apply to health benefit plans offered
6 or renewed on or after 3 months after the applicable
7 deadlines established under section 126(c).

8 (2) SELF-INSURED PLANS.—The Secretary
9 shall provide for such mechanism for the implemen-
10 tation and enforcement of the standards established
11 under section 126 in the State with respect to em-
12 ployer health benefit plans that are not subject to
13 regulation by a State (or by the Secretary under
14 paragraph (1)) as the Secretary determines to be ap-
15 propriate. Such standards shall apply to such health
16 benefit plans offered or renewed on or after 1 year
17 after the date standards are established under sec-
18 tion 126.

19 (d) FEDERAL ENFORCEMENT THROUGH EXCISE
20 TAX.—

21 (1) IN GENERAL.—Chapter 43 of the Internal
22 Revenue Code of 1986 (relating to qualified pension,
23 etc., plans) is amended by adding at the end thereof
24 the following new section:

1 **“SEC. 4980C. FAILURE BY CARRIER TO COMPLY WITH EM-**
2 **PLOYER HEALTH INSURANCE STANDARDS.**

3 “(a) IMPOSITION OF TAX.—There is hereby imposed
4 a tax on the failure of—

5 “(1) any carrier to comply with the standards
6 established under section 126 of the American Con-
7 sumers Health Care Reform Act of 1993 to carry
8 out part 2 of subtitle B of such Act, or

9 “(2) any small employer carrier in any Federal
10 standard State to comply with the standards estab-
11 lished under such section to carry out part 3 of such
12 subtitle.

13 “(b) AMOUNT OF TAX.—The tax imposed by—

14 “(1) subsection (a)(1) shall be equal to 25 per-
15 cent of the amounts received by the health benefit
16 plan (during the period such failure persists), or

17 “(2) subsection (a)(2) shall be equal to 25 per-
18 cent of the amounts received by the carrier (during
19 the period such failure persists) for providing any
20 health benefit plan with respect to any employer in
21 the Federal standard State.

22 “(c) LIABILITY FOR TAX.—The tax imposed by—

23 “(1) subsection (a)(1) shall be paid by the per-
24 son issuing the health benefit plan, or

25 “(2) subsection (a)(2) shall be paid by the car-
26 rier.

1 “(d) EXCEPTIONS.—

2 “(1) CORRECTIONS WITHIN 30 DAYS.—No tax
3 shall be imposed by subsection (a) by reason of any
4 failure if—

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

7 “(B) such failure is corrected within the
8 30-day period beginning on earliest date the
9 carrier knew, or exercising reasonable diligence
10 would have known, that such failure existed.

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

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

18 “(1) CARRIER; ETC.—The terms ‘carrier’,
19 ‘small employer carrier’, ‘health benefit plan’, and
20 ‘small employer’ have the meanings given such terms
21 in section 128 of the American Consumers Health
22 Care Reform Act of 1993.

23 “(2) FEDERAL STANDARD STATE.—The term
24 ‘Federal standard State’ means any State with re-
25 spect to which a determination is in effect under sec-

1 tion 127(c)(1)) of the American Consumers Health
2 Care Reform Act of 1993.”.

3 (2) CLERICAL AMENDMENT.—The table of sec-
4 tions for chapter 43 of such Code is amended by
5 adding at the end thereof the following new items:

“Sec. 4980C. Failure by carrier to comply with employer health
insurance standards in States.”.

6 **SEC. 128. DEFINITIONS.**

7 In this subtitle (except as otherwise provided):

8 (1) The term “carrier” means any entity which
9 provides health insurance or health benefits in a
10 State, and includes a licensed insurance company, a
11 prepaid hospital or medical service plan, a health
12 maintenance organization, the plan sponsor of a
13 multiple employer welfare arrangement or an em-
14 ployee benefit plan (as defined under the Employee
15 Retirement Income Security Act of 1974), or any
16 other entity providing a plan of health insurance
17 subject to State insurance regulation.

18 (2)(A) Subject to subparagraph (B), the term
19 “employer health benefit plan” means a health bene-
20 fit plan (including an employee welfare benefit plan,
21 as defined in section 3(1) of the Employee Retire-
22 ment Income Security Act of 1974) which is offered
23 to employees through an employer and for which the
24 employer provides for any contribution to such plan

1 or any premium for such plan are deducted by the
2 employer from compensation to the employee.

3 (B) A State may provide (for a plan in a State)
4 that the term “employer health benefit plan” does
5 not include an association plan (as defined in sub-
6 paragraph (C)).

7 (C) For purposes of subparagraph (B), the
8 term “association plan” means a health benefit plan
9 offered by an organization to its members if the or-
10 ganization was formed other than for purposes of
11 purchasing insurance.

12 (3) The term “full-time employee” means, with
13 respect to an employer, an individual who normally
14 is employed for at least 30 hours per week by the
15 employer.

16 (4) The term “health benefit plan” means any
17 hospital or medical expense incurred policy or certifi-
18 cate, hospital or medical service plan contract, or
19 health maintenance subscriber contract, or a mul-
20 tiple employer welfare arrangement or employee ben-
21 efit plan (as defined under the Employee Retirement
22 Income Security Act of 1974) which provides bene-
23 fits with respect to health care services, but does not
24 include—

1 (A) coverage only for accident, dental, vi-
2 sion, disability income, or long-term care insur-
3 ance, or any combination thereof,

4 (B) medicare supplemental health insur-
5 ance,

6 (C) coverage issued as a supplement to li-
7 ability insurance,

8 (D) worker's compensation or similar in-
9 surance, or

10 (E) automobile medical-payment insurance,
11 or any combination thereof.

12 (5) The term "health maintenance organiza-
13 tion" includes a carrier that meets specified stand-
14 ards and that offers to provide health services on a
15 prepaid, at-risk basis primarily through a defined set
16 of providers.

17 (6) The term "insured health benefit plan"
18 means any health benefit plan provided through in-
19 surance, and includes a prepaid hospital or medical
20 service plan, the health benefit plan of a health
21 maintenance organization, and a multiple employer
22 welfare arrangement.

23 (7) The term "Secretary" means the Secretary
24 of Health and Human Services.

1 (8) The term “small employer” means an entity
2 actively engaged in business which, on at least 50
3 percent of its working days during the preceding
4 year, employed fewer than 100 full-time employees,
5 and includes a self-employed individual. For pur-
6 poses of determining if an employer is a small em-
7 ployer, rules similar to the rules of subsection (b)
8 and (c) of section 414 of the Internal Revenue Code
9 of 1986 shall apply.

10 (9) The term “small employer carrier” means a
11 carrier with respect to the issuance of a small em-
12 ployer health benefit plan.

13 (10) The term “small employer health benefit
14 plan” means an employer health benefit plan which
15 provides coverage to one or more full-time employees
16 of a small employer.

17 (11) The term “State” means the 50 States,
18 the District of Columbia, Puerto Rico, the Virgin Is-
19 lands, Guam, and American Samoa.

20 (12) The term “State commissioner of insur-
21 ance” includes a State superintendent of insurance.

1 **Subtitle D—Medical Malpractice**
2 **Reform**

3 PART 1—GENERAL PROVISIONS

4 **SEC. 131. FEDERAL REFORM OF MEDICAL MALPRACTICE**
5 **LIABILITY ACTIONS.**

6 (a) CONGRESSIONAL FINDINGS.—

7 (1) EFFECT ON INTERSTATE COMMERCE.—

8 Congress finds that the health care and insurance
9 industries are industries affecting interstate com-
10 merce and the medical malpractice litigation systems
11 existing throughout the United States affect inter-
12 state commerce by contributing to the high cost of
13 health care and premiums for malpractice insurance
14 purchased by health care providers.

15 (2) EFFECT ON FEDERAL SPENDING.—Con-

16 gress finds that the medical malpractice litigation
17 systems existing throughout the United States have
18 a significant effect on the amount, distribution, and
19 use of Federal funds because of—

20 (A) the large number of individuals who
21 receive health care benefits under programs op-
22 erated or financed by the Federal Government;

23 (B) the large number of individuals who
24 benefit because of the exclusion from Federal

1 taxes of the amounts spent by their employers
2 to provide them with health insurance benefits;

3 (C) the large number of health care provid-
4 ers and health care professionals who provide
5 items or services for which the Federal Govern-
6 ment makes payments; and

7 (D) the large number of such providers
8 and professionals who have received direct or
9 indirect financial assistance from the Federal
10 Government because of their status as such
11 professionals or providers.

12 (b) APPLICABILITY.—This subtitle shall apply with
13 respect to any medical malpractice liability claim and to
14 any medical malpractice liability action brought in any
15 State or Federal court, except that this subtitle shall not
16 apply to—

17 (1) a claim or action for damages arising from
18 a vaccine-related injury or death to the extent that
19 title XXI of the Public Health Service Act applies to
20 the action; or

21 (2) a claim or action in which the plaintiff's
22 sole allegation is an allegation of an injury arising
23 from the use of a medical product.

24 (c) PREEMPTION OF STATE LAW.—Subject to section
25 151, this subtitle supersedes State law only to the extent

1 that State law differs from any provision of law estab-
2 lished by or under this subtitle. Any issue that is not gov-
3 erned by any provision of law established by or under this
4 subtitle shall be governed by otherwise applicable State or
5 Federal law.

6 (d) FEDERAL COURT JURISDICTION NOT ESTAB-
7 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in
8 this subtitle shall be construed to establish any jurisdiction
9 in the district courts of the United States over medical
10 malpractice liability actions on the basis of sections 1331
11 or 1337 of title 28, United States Code.

12 **SEC. 132. DEFINITIONS.**

13 As used in this subtitle:

14 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
15 TEM; ADR.—The term “alternative dispute resolution
16 system” or “ADR” means a system established by
17 a State that provides for the resolution of medical
18 malpractice liability claims in a manner other than
19 through medical malpractice liability actions.

20 (2) CLAIMANT.—The term “claimant” means
21 any person who alleges a medical malpractice liabil-
22 ity claim, or, in the case of an individual who is de-
23 ceased, incompetent, or a minor, the person on
24 whose behalf such a claim is alleged.

1 (3) ECONOMIC DAMAGES.—The term “economic
2 damages” means damages paid to compensate an in-
3 dividual for losses for hospital and other medical ex-
4 penses, lost wages, lost employment, and other pecu-
5 niary losses.

6 (4) HEALTH CARE PROFESSIONAL.—The term
7 “health care professional” means any individual who
8 provides health care services in a State and who is
9 required by State law or regulation to be licensed or
10 certified by the State to provide such services in the
11 State.

12 (5) HEALTH CARE PROVIDER.—The term
13 “health care provider” means any organization or
14 institution that is engaged in the delivery of health
15 care services in a State and that is required by State
16 law or regulation to be licensed or certified by the
17 State to engage in the delivery of such services in
18 the State.

19 (6) INJURY.—The term “injury” means any ill-
20 ness, disease, or other harm that is the subject of
21 a medical malpractice liability action or claim.

22 (7) MEDICAL MALPRACTICE LIABILITY AC-
23 TION.—The term “medical malpractice liability ac-
24 tion” means a civil action (other than an action in
25 which the plaintiff’s sole allegation is an allegation

1 of an intentional tort) brought in a State or Federal
2 court against a health care provider or health care
3 professional (regardless of the theory of liability on
4 which the action is based) in which the plaintiff al-
5 leges a medical malpractice liability claim.

6 (8) MEDICAL MALPRACTICE LIABILITY
7 CLAIM.—The term “medical malpractice liability
8 claim” means a claim in which the claimant alleges
9 that injury was caused by the provision of (or the
10 failure to provide) health care services.

11 (9) MEDICAL PRODUCT.—The term “medical
12 product” means a device (as defined in section
13 201(h) of the Federal Food, Drug, and Cosmetic
14 Act) or a drug (as defined in section 201(g)(1) of
15 the Federal Food, Drug, and Cosmetic Act).

16 (10) NONECONOMIC DAMAGES.—The term
17 “noneconomic damages” means damages paid to
18 compensate an individual for losses for physical and
19 emotional pain, suffering, inconvenience, physical
20 impairment, mental anguish, disfigurement, loss of
21 enjoyment of life, loss of consortium, and other
22 nonpecuniary losses, but does not include punitive
23 damages.

24 (11) SECRETARY.—The term “Secretary”
25 means the Secretary of Health and Human Services.

1 (12) STATE.—The term “State” means each of
2 the several States, the District of Columbia, the
3 Commonwealth of Puerto Rico, the Virgin Islands,
4 Guam, and American Samoa.

5 **SEC. 133. EFFECTIVE DATE.**

6 (a) IN GENERAL.—Except as provided in subsection
7 (b) and sections 149, 172, and 173, this subtitle shall
8 apply with respect to claims accruing or actions brought
9 on or after the expiration of the 3-year period that begins
10 on the date of the enactment of this Act.

11 (b) EXCEPTION FOR STATES REQUESTING EARLIER
12 IMPLEMENTATION OF REFORMS.—

13 (1) APPLICATION.—A State may submit an ap-
14 plication to the Secretary requesting the early imple-
15 mentation of this subtitle with respect to claims or
16 actions brought in the State.

17 (2) DECISION BY SECRETARY.—The Secretary
18 shall issue a response to a State’s application under
19 paragraph (1) not later than 90 days after receiving
20 the application. If the Secretary determines that the
21 State meets the requirements of this subtitle at the
22 time of submitting its application, the Secretary
23 shall approve the State’s application, and this sub-
24 title shall apply with respect to actions brought in
25 the State on or after the expiration of the 90-day

1 period that begins on the date the Secretary issues
2 the response. If the Secretary denies the State's ap-
3 plication, the Secretary shall provide the State with
4 a written explanation of the grounds for the deci-
5 sion.

6 PART 2—UNIFORM STANDARDS FOR MEDICAL
7 MALPRACTICE LIABILITY ACTIONS

8 **SEC. 141. STATUTE OF LIMITATIONS.**

9 (a) IN GENERAL.—No medical malpractice liability
10 claim may be brought after the expiration of the 2-year
11 period that begins on the date the alleged injury that is
12 the subject of the action should reasonably have been dis-
13 covered, but in no event after the expiration of the 4-year
14 period that begins on the date the alleged injury occurred.

15 (b) EXCEPTION FOR MINORS.—In the case of an al-
16 leged injury suffered by a minor who has not attained 6
17 years of age, no medical malpractice liability claim may
18 be brought after the expiration of the 2-year period that
19 begins on the date the alleged injury that is the subject
20 of the action should reasonably have been discovered, but
21 in no event after the date on which the minor attains 10
22 years of age.

1 **SEC. 142. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**
2 **TION THROUGH ALTERNATIVE DISPUTE RES-**
3 **OLUTION.**

4 (a) IN GENERAL.—No medical malpractice liability
5 action may be brought in any State court unless the medi-
6 cal malpractice liability claim that is the subject of the
7 action has been initially resolved under an alternative dis-
8 pute resolution system certified by the Secretary under
9 section 162(b).

10 (b) INITIAL RESOLUTION OF CLAIMS UNDER
11 ADR.—For purposes of subsection (a), an action is “ini-
12 tially resolved” under an alternative dispute resolution
13 system if—

14 (1) the ADR reaches a decision on whether the
15 defendant is liable to the plaintiff for damages; and

16 (2) if the ADR determines that the defendant
17 is liable, the ADR determines the amount of dam-
18 ages assessed against the defendant.

19 (c) PROCEDURES FOR FILING ACTIONS.—

20 (1) DEADLINE.—No medical malpractice liabil-
21 ity action may be brought unless the action is filed
22 in a court of competent jurisdiction not later than
23 90 days after an opinion resolving the medical mal-
24 practice liability claim that is the subject of the ac-
25 tion is issued under the applicable alternative dis-
26 pute resolution system.

1 (2) COURT OF COMPETENT JURISDICTION.—

2 For purposes of paragraph (1), the term “court of
3 competent jurisdiction” means—

4 (A) with respect to actions filed in a State
5 court, the appropriate State trial court; and

6 (B) with respect to actions filed in a Fed-
7 eral court, the appropriate United States dis-
8 trict court.

9 (d) STATUS OF ADR DECISION.—The decision
10 reached under an alternative dispute resolution system
11 shall, for purposes of enforcement by a court of competent
12 jurisdiction, have the same status in the court as the ver-
13 dict of a medical malpractice liability action adjudicated
14 in a State or Federal trial court.

15 (e) TREATMENT OF ADR DECISION.—

16 (1) REQUIREMENTS FOR GOING FORWARD WITH
17 ACTION.—In order to bring a medical malpractice li-
18 ability action to contest the decision made under the
19 previous alternative dispute resolution system with
20 respect to a medical malpractice liability claim, the
21 party contesting the decision must—

22 (A) show that—

23 (i) the decision was procured by cor-
24 ruption, fraud, or undue means,

1 (ii) there was partiality or corruption
2 under the system,

3 (iii) there was other misconduct under
4 the system that materially prejudiced the
5 party's rights, or

6 (iv) the decision was based on an
7 error of law; or

8 (B) present new evidence before the trier
9 of fact that was not available for presentation
10 under the ADR system.

11 (2) BURDEN OF PROOF.—In any medical mal-
12 practice liability action, the trier of fact shall uphold
13 the decision made under the previous alternative dis-
14 pute resolution system with respect to the claim that
15 is the subject of the action unless the party contest-
16 ing the decision proves by a preponderance of the
17 evidence that the decision was incorrect.

18 **SEC. 143. RELATION TO ALTERNATIVE DISPUTE RESOLU-**
19 **TION OF FEDERAL AGENCIES.**

20 (a) MANDATORY APPLICATION OF FEDERAL ADR IN
21 MALPRACTICE CLAIMS AGAINST UNITED STATES.—Sec-
22 tion 2672 of title 28, United States Code, is amended by
23 striking the period at the end of the first paragraph and
24 inserting the following: “, except that each Federal agency
25 shall use arbitration or such alternative means of dispute

1 resolution to settle any tort claim against the United
2 States consisting of a medical malpractice liability claim
3 (as defined in section 132(8) of the American Consumers
4 Health Care Reform Act of 1992).”.

5 (b) TRANSMITTAL OF INFORMATION OF MAL-
6 PRACTICE CLAIMS RESOLVED UNDER FEDERAL ADR.—
7 Section 584 of title 5, United States Code, as added by
8 section 4(b) of the Administrative Dispute Resolution Act
9 (Public Law 101–552), is amended by adding at the end
10 the following new subsection:

11 “(k) Each agency shall transmit on a regular basis
12 to the Administrator for Health Care Policy and Research
13 information on issues in controversy consisting of medical
14 malpractice liability claims (as defined in section 132(8)
15 of the American Consumers Health Care Reform Act of
16 1992) that are resolved under the agency’s dispute resolu-
17 tion proceeding under this subchapter, in a manner that
18 assures that the identity of the parties to such proceedings
19 shall not be revealed.”.

20 **SEC. 144. MANDATORY PRE-TRIAL SETTLEMENT CON-**
21 **FERENCE.**

22 (a) IN GENERAL.—Before the beginning of the trial
23 phase of any medical malpractice liability action, the par-
24 ties shall attend a conference called by the court for pur-

1 poses of determining whether grounds exist upon which
2 the parties may negotiate a settlement for the action.

3 (b) REQUIRING PARTIES TO SUBMIT SETTLEMENT
4 OFFERS.—At the conference called pursuant to subsection
5 (a), each party to a medical malpractice liability action
6 shall present an offer of settlement for the action.

7 **SEC. 145. CALCULATION AND PAYMENT OF DAMAGES.**

8 (a) LIMITATION ON NONECONOMIC DAMAGES.—The
9 total amount of noneconomic damages that may be award-
10 ed to a plaintiff and the members of the plaintiff's family
11 for losses resulting from the injury which is the subject
12 of a medical malpractice liability action may not exceed
13 \$250,000, regardless of the number of parties against
14 whom the action is brought or the number of actions
15 brought with respect to the injury.

16 (b) TREATMENT OF PUNITIVE DAMAGES.—

17 (1) LIMITATION ON AMOUNT.—The total
18 amount of punitive damages that may be imposed
19 under a medical malpractice liability action may not
20 exceed twice the total of the damages awarded to the
21 plaintiff and the members of the plaintiff's family.

22 (2) PAYMENTS TO STATE FOR MEDICAL QUAL-
23 ITY ASSURANCE ACTIVITIES.—

24 (A) IN GENERAL.—Any punitive damages
25 imposed under a medical malpractice liability

1 action shall be paid to the State in which the
2 action is brought.

3 (B) ACTIVITIES DESCRIBED.—A State
4 shall use amount paid pursuant to subpara-
5 graph (A) to carry out activities to assure the
6 safety and quality of health care services pro-
7 vided in the State, including (but not limited
8 to)—

9 (i) licensing or certifying health care
10 professionals and health care providers in
11 the State;

12 (ii) operating alternative dispute reso-
13 lution systems;

14 (iii) carrying out public education pro-
15 grams relating to medical malpractice and
16 the availability of alternative dispute reso-
17 lution systems in the State; and

18 (iv) carrying out programs to reduce
19 malpractice-related costs for retired provid-
20 ers or other providers volunteering to pro-
21 vide services in medically underserved
22 areas.

23 (C) MAINTENANCE OF EFFORT.—A State
24 shall use any amounts paid pursuant to sub-
25 paragraph (A) to supplement and not to replace

1 amounts spent by the State for the activities
2 described in subparagraph (B).

3 (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—If
4 more than \$100,000 in damages for expenses to be in-
5 curred in the future is awarded to the plaintiff in a medi-
6 cal malpractice liability action, the defendant shall provide
7 for payment for such damages on a periodic basis deter-
8 mined appropriate by the court (based upon projections
9 of when such expenses are likely to be incurred), unless
10 the court determines that it is not in the plaintiff's best
11 interests to receive payments for such damages on such
12 a periodic basis.

13 (d) MANDATORY OFFSETS FOR DAMAGES PAID BY
14 A COLLATERAL SOURCE.—

15 (1) IN GENERAL.—The total amount of dam-
16 ages received by a plaintiff in a medical malpractice
17 liability action shall be reduced (in accordance with
18 paragraph (2)) by any other payment that has been
19 or will be made to the individual to compensate the
20 plaintiff for the injury that was the subject of the
21 action, including payment under—

22 (A) Federal or State disability or sickness
23 programs;

24 (B) Federal, State, or private health insur-
25 ance programs;

- 1 (C) private disability insurance programs;
2 (D) employer wage continuation programs;
3 and
4 (E) any other source of payment intended
5 to compensate the plaintiff for such injury.

6 (2) AMOUNT OF REDUCTION.—The amount by
7 which an award of damages to a plaintiff shall be re-
8 duced under paragraph (1) shall be—

9 (A) the total amount of any payments
10 (other than such award) that have been made
11 or that will be made to the plaintiff to com-
12 pensate the plaintiff for the injury that was the
13 subject of the action; minus

14 (B) the amount paid by the plaintiff (or by
15 the spouse, parent, or legal guardian of the
16 plaintiff) to secure the payments described in
17 subparagraph (A).

18 **SEC. 146. TREATMENT OF ATTORNEY'S FEES AND OTHER**
19 **COSTS.**

20 (a) LIMITATION ON ATTORNEY'S FEES.—If the
21 plaintiff in a medical malpractice liability action has en-
22 tered into an agreement with the plaintiff's attorney to
23 pay the attorney's fees on a contingency basis, the attor-
24 ney's fees for the action may not exceed—

1 (1) 25 percent of the first \$150,000 of any
2 award or settlement paid to the plaintiff; or

3 (2) 15 percent of any additional amounts paid
4 to the plaintiff.

5 (b) AWARDING ATTORNEY'S FEES AND OTHER
6 COSTS TO WINNING PARTY.—

7 (1) IN GENERAL.—If the court in a medical
8 malpractice liability action upholds a ruling of the
9 alternative dispute resolution system with respect to
10 whether or not a health care professional or health
11 care provider committed malpractice or with respect
12 to the amount of damages awarded, the court shall
13 require the party that contested the ruling to pay to
14 the opposing party the costs incurred by the oppos-
15 ing party under the action, including attorney's fees,
16 fees paid to expert witnesses, and other litigation ex-
17 penses (but not including court costs, filing fees, or
18 other expenses paid directly by the party to the
19 court, or any fees or costs associated with the reso-
20 lution of the claim that is the subject of the action
21 under the alternative dispute resolution system).

22 (2) PERMITTING COURT TO WAIVE OR MODIFY
23 IMPOSITION OF COSTS.—A court may issue a written
24 order waiving or modifying the application of para-
25 graph (1) to a party if the court finds that the appli-

1 cation of such paragraph to the party would con-
2 stitute an undue hardship, or if the medical mal-
3 practice liability action raised a novel issue of law.
4 The order shall specify the grounds for the court's
5 decision to waive or modify the application of such
6 paragraph.

7 **SEC. 147. JOINT AND SEVERAL LIABILITY.**

8 The liability of each defendant in a medical mal-
9 practice liability action shall be several only and shall not
10 be joint, and each defendant shall be liable only for the
11 amount of damages allocated to the defendant in direct
12 proportion to the defendant's percentage of responsibility
13 (as determined by the trier of fact).

14 **SEC. 148. UNIFORM STANDARD FOR DETERMINING NEG-**
15 **LIGENCE.**

16 A defendant in a medical malpractice liability action
17 may not be found to have acted negligently unless the de-
18 fendant's conduct at the time of providing the health care
19 services that are the subject of the action was not reason-
20 able.

21 **SEC. 149. APPLICATION OF MEDICAL PRACTICE GUIDE-**
22 **LINES IN MALPRACTICE LIABILITY ACTIONS.**

23 (a) USE OF GUIDELINES AS AFFIRMATIVE DE-
24 FENSE.—In any medical malpractice liability action, it
25 shall be a complete defense to any allegation that the de-

1 defendant was negligent that, in the provision of (or the fail-
2 ure to provide) the services that are the subject of the
3 action, the defendant followed the appropriate practice
4 guideline.

5 (b) RESTRICTION ON GUIDELINES CONSIDERED AP-
6 PROPRIATE.—

7 (1) GUIDELINES SANCTIONED BY SEC-
8 RETARY.—For purposes of subsection (a), a practice
9 guideline may not be considered appropriate with re-
10 spect to actions brought during a year unless the
11 Secretary has sanctioned the use of the guideline for
12 purposes of an affirmative defense to medical mal-
13 practice liability actions brought during the year in
14 accordance with paragraph (2) or (3).

15 (2) PROCESS FOR SANCTIONING GUIDELINES.—
16 Not less frequently than October 1 of each year (be-
17 ginning with 1993), the Secretary, shall review the
18 practice guidelines and standards developed by the
19 Administrator for Health Care Policy and Research
20 pursuant to section 1142 of the Social Security Act,
21 and shall sanction those guidelines which the Sec-
22 retary considers appropriate for purposes of an af-
23 firmative defense to medical malpractice liability ac-
24 tions brought during the next calendar year as ap-

1 appropriate practice guidelines for purposes of sub-
2 section (a).

3 (3) USE OF STATE GUIDELINES.—Upon the ap-
4 plication of a State, the Secretary may sanction
5 practice guidelines selected by the State for purposes
6 of an affirmative defense to medical malpractice li-
7 ability actions brought in the State as appropriate
8 practice guidelines for purposes of subsection (a) if
9 the guidelines meet such requirements as the Sec-
10 retary may impose.

11 (c) PROHIBITING APPLICATION OF FAILURE TO FOL-
12 LOW GUIDELINES AS PRIMA FACIE EVIDENCE OF NEG-
13 LIGENCE.—No plaintiff in a medical malpractice liability
14 action may be deemed to have presented prima facie evi-
15 dence that a defendant was negligent solely by showing
16 that the defendant failed to follow the appropriate practice
17 guideline.

18 **SEC. 150. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**
19 **SERVICES.**

20 (a) IMPOSITION OF HIGHER STANDARD OF PROOF.—

21 (1) IN GENERAL.—In the case of a medical
22 malpractice liability action relating to services pro-
23 vided during labor or the delivery of a baby, if the
24 defendant health care professional did not previously
25 treat the plaintiff for the pregnancy, the trier of fact

1 may not find that the defendant committed mal-
2 practice and may not assess damages against the de-
3 fendant unless the malpractice is proven by clear
4 and convincing evidence.

5 (2) APPLICABILITY TO GROUP PRACTICES OR
6 AGREEMENTS AMONG PROVIDERS.—For purposes of
7 paragraph (1), a health care professional shall be
8 considered to have previously treated an individual
9 for a pregnancy if the professional is a member of
10 a group practice whose members previously treated
11 the individual for the pregnancy or is providing serv-
12 ices to the individual during labor or the delivery of
13 a baby pursuant to an agreement with another pro-
14 fessional.

15 (b) CLEAR AND CONVINCING EVIDENCE DEFINED.—
16 In subsection (a), the term “clear and convincing evi-
17 dence” is that measure or degree of proof that will
18 produce in the mind of the trier of fact a firm belief or
19 conviction as to the truth of the allegations sought to be
20 established, except that such measure or degree of proof
21 is more than that required under preponderance of the evi-
22 dence, but less than that required for proof beyond a rea-
23 sonable doubt.

24 (c) EFFECTIVE DATE.—This section shall apply to
25 claims accruing or actions brought on or after the expira-

1 tion of the 2-year period that begins on the date of the
2 enactment of this Act.

3 **SEC. 151. PREEMPTION.**

4 (a) IN GENERAL.—This part supersedes any State
5 law only to the extent that State law—

6 (1) permits the recovery of a greater amount of
7 damages by a plaintiff;

8 (2) permits the collection of a greater amount
9 of attorneys' fees by a plaintiff's attorney;

10 (3) establishes a longer period during which a
11 medical malpractice liability claim may be initiated;
12 or

13 (4) establishes a stricter standard for determin-
14 ing whether a defendant was negligent or for deter-
15 mining the liability of defendants described in sec-
16 tion 150(a) in actions described in such section.

17 (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
18 OF LAW OR VENUE.—Nothing in subsection (a) shall be
19 construed to—

20 (1) waive or affect any defense of sovereign im-
21 munity asserted by any State under any provision of
22 law;

23 (2) waive or affect any defense of sovereign im-
24 munity asserted by the United States;

1 (3) affect the applicability of any provision of
2 the Foreign Sovereign Immunities Act of 1976;

3 (4) preempt State choice-of-law rules with re-
4 spect to claims brought by a foreign nation or a citi-
5 zen of a foreign nation; or

6 (5) affect the right of any court to transfer
7 venue or to apply the law of a foreign nation or to
8 dismiss a claim of a foreign nation or of a citizen
9 of a foreign nation on the ground of inconvenient
10 forum.

11 PART 3—REQUIREMENTS FOR STATE ALTERNATIVE
12 DISPUTE RESOLUTION SYSTEMS (ADR)

13 **SEC. 161. BASIC REQUIREMENTS FOR ADR.**

14 (a) IN GENERAL.—A State’s alternative dispute reso-
15 lution system meets the requirements of this section if the
16 system—

17 (1) applies to all medical malpractice liability
18 claims under the jurisdiction of the State courts;

19 (2) requires that a written opinion resolving the
20 dispute be issued that contains findings of fact relat-
21 ing to the dispute;

22 (3) requires individuals who hear and resolve
23 claims under the system to meet such qualifications
24 as the State may require (in accordance with regula-
25 tions of the Secretary);

1 (4) is approved by the State or by local govern-
2 ments in the State;

3 (5) with respect to a State system that consists
4 of multiple dispute resolution procedures—

5 (A) permits the parties to a dispute to se-
6 lect the procedure to be used for the resolution
7 of the dispute under the system, and

8 (B) if the parties do not agree on the pro-
9 cedure to be used for the resolution of the dis-
10 pute, assigns a particular procedure to the par-
11 ties;

12 (6) provides for the transmittal to the State
13 agency responsible for monitoring or disciplining
14 health care professionals and health care providers
15 of any findings made under the system that such a
16 professional or provider committed malpractice, un-
17 less, during the 90-day period beginning on the date
18 the system resolves the claim against the profes-
19 sional or provider, the professional or provider
20 brings a medical malpractice liability action contest-
21 ing the decision made under the system; and

22 (7) provides for the regular transmittal to the
23 Administrator for Health Care Policy and Research
24 of information on disputes resolved under the sys-

1 tem, in a manner that assures that the identity of
2 the parties to a dispute shall not be revealed.

3 (b) APPLICATION OF MALPRACTICE LIABILITY
4 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—
5 The provisions of part 2 shall apply with respect to claims
6 brought under a State’s alternative dispute resolution sys-
7 tem in the same manner as such provisions apply with
8 respect to medical malpractice liability actions brought in
9 the State.

10 **SEC. 162. CERTIFICATION OF STATE SYSTEMS.**

11 (a) IN GENERAL.—Not later than October 1 of each
12 year (beginning with 1993), the Secretary, in consultation
13 with the Attorney General, shall determine whether a
14 State’s alternative dispute resolution system meets the re-
15 quirements of this part for the following calendar year.

16 (b) BASIS FOR CERTIFICATION.—The Secretary shall
17 certify a State’s alternative dispute resolution system
18 under this subsection if the Secretary determines under
19 subsection (a) that the system meets the requirements of
20 section 161.

21 **SEC. 163. REPORTS ON IMPLEMENTATION AND EFFECTIVE-**
22 **NESS OF ALTERNATIVE DISPUTE RESOLU-**
23 **TION SYSTEMS.**

24 (a) IN GENERAL.—Not later than 5 years after the
25 date of the enactment of this Act, the Secretary shall pre-

1 pare and submit to Congress a report describing and eval-
2 uating State alternative dispute resolution systems oper-
3 ated pursuant to this part.

4 (b) CONTENTS OF REPORT.—The Secretary shall in-
5 clude in the report prepared and submitted under sub-
6 section (a)—

7 (1) information on—

8 (A) the effect of such systems on the cost
9 of health care within the State,

10 (B) the impact of such systems on the ac-
11 cess of individuals to health care within the
12 State, and

13 (C) the effect of such systems on the qual-
14 ity of health care provided within such State;
15 and

16 (2) to the extent that such report does not pro-
17 vide information on no-fault systems operated by
18 States as alternative dispute resolution systems pur-
19 suant to this part, an analysis of the feasibility and
20 desirability of establishing a system under which
21 medical malpractice liability claims shall be resolved
22 on a no-fault basis.

1 PART 4—OTHER REQUIREMENTS AND PROGRAMS

2 **SEC. 171. FACILITATING DEVELOPMENT AND USE OF**
3 **MEDICAL PRACTICE GUIDELINES.**

4 (a) INCREASE IN AUTHORIZATION OF APPROPRIA-
5 TIONS.—Section 1142(i)(1) of the Social Security Act (42
6 U.S.C. 1320b–12(i)(1)) is amended by striking subpara-
7 graphs (D) and (E) and inserting the following:

8 “(D) \$158,000,000 for fiscal year 1993 (of
9 which \$10,000,000 shall be used for sanction-
10 ing practice guidelines for purposes of an af-
11 firmative defense in medical malpractice liabil-
12 ity actions);

13 “(E) \$200,000,000 for fiscal year 1994 (of
14 which \$20,000,000 shall be used for sanction-
15 ing practice guidelines for purposes of an af-
16 firmative defense in medical malpractice liabil-
17 ity actions); and

18 “(F) \$20,000,000 for fiscal year 1995, to
19 be used for sanctioning practice guidelines for
20 purposes of an affirmative defense in medical
21 malpractice liability actions.”.

22 (b) CONSIDERATION OF MALPRACTICE LIABILITY
23 DATA IN DEVELOPING AND UPDATING GUIDELINES.—
24 Section 1142(c)(5) of such Act (42 U.S.C. 1320b–
25 12(c)(5)) is amended by striking “claims data” and all

1 that follows through “patients” and inserting the follow-
2 ing: “claims data, data on clinical and functional status
3 of patients, and data on medical malpractice liability ac-
4 tions”.

5 (c) DEVELOPMENT OF REPORTING FORMS FOR
6 STATE ADR SYSTEMS.—The Secretary, in consultation
7 with the Administrator for Health Care Policy and Re-
8 search, shall develop a standard reporting form to be used
9 by State alternative dispute resolution systems in trans-
10 mitting information to the Administrator pursuant to sec-
11 tion 161(a)(6) on disputes resolved under such systems.

12 (d) STUDY OF EFFECT OF GUIDELINES ON MEDICAL
13 MALPRACTICE.—

14 (1) STUDY.—The Secretary shall conduct a
15 study of the effect of the use of the medical practice
16 guidelines developed by the Administrator for Health
17 Care Policy and Research on the incidence of and
18 the costs associated with medical malpractice.

19 (2) REPORTS.—(A) Not later than 1 year after
20 the date of the enactment of this Act, the Secretary
21 shall submit an interim report to Congress describ-
22 ing the availability and use of medical practice
23 guidelines and the aggregate costs associated with
24 medical malpractice.

1 (B) Not later than 5 years after the date of the
2 enactment of this Act, the Secretary shall submit a
3 report to Congress on the study conducted under
4 paragraph (1), together with recommendations re-
5 garding expanding the use of medical practice guide-
6 lines for determining the liability of health care pro-
7 fessionals and health care providers for medical mal-
8 practice.

9 **SEC. 172. PERMITTING STATE PROFESSIONAL SOCIETIES**
10 **TO PARTICIPATE IN DISCIPLINARY ACTIVI-**
11 **TIES.**

12 (a) **ROLE OF PROFESSIONAL SOCIETIES.**—Notwith-
13 standing any other provision of State or Federal law, a
14 State agency responsible for the conduct of disciplinary
15 actions for a type of health care practitioner may enter
16 into agreements with State or county professional societies
17 of such type of health care practitioner to permit such so-
18 cieties to participate in the licensing of such health care
19 practitioner, and to review any health care malpractice ac-
20 tion, health care malpractice claim or allegation, or other
21 information concerning the practice patterns of any such
22 health care practitioner. Any such agreement shall comply
23 with subsection (b).

24 (b) **REQUIREMENTS OF AGREEMENTS.**—Any agree-
25 ment entered into under subsection (a) for licensing activi-

1 ties or the review of any health care malpractice action,
2 health care malpractice claim or allegation, or other infor-
3 mation concerning the practice patterns of a health care
4 practitioner shall provide that—

5 (1) the health care professional society conducts
6 such activities or review as expeditiously as possible;

7 (2) after the completion of such review, such so-
8 ciety shall report its findings to the State agency
9 with which it entered into such agreement;

10 (3) the conduct of such activities or review and
11 the reporting of such findings be conducted in a
12 manner which assures the preservation of confiden-
13 tiality of health care information and of the review
14 process; and

15 (4) no individual affiliated with such society is
16 liable for any damages or injury directly caused by
17 the individual's actions in conducting such activities
18 or review.

19 (c) AGREEMENTS NOT MANDATORY.—Nothing in
20 this section may be construed to require a State to enter
21 into agreements with societies described in subsection (a)
22 to conduct the activities described in such subsection.

23 (d) EFFECTIVE DATE.—This section shall take effect
24 2 years after the date of the enactment of this Act.

1 **SEC. 173. REQUIREMENTS FOR RISK MANAGEMENT PRO-**
2 **GRAMS.**

3 (a) REQUIREMENTS FOR PROVIDERS.—Each State
4 shall require each health care professional and health care
5 provider providing services in the State to participate in
6 a risk management program to prevent and provide early
7 warning of practices which may result in injuries to pa-
8 tients or which otherwise may endanger patient safety.

9 (b) REQUIREMENTS FOR INSURERS.—Each State
10 shall require each entity which provides health care profes-
11 sional or provider liability insurance to health care profes-
12 sionals and health care providers in the State to—

13 (1) establish risk management programs based
14 on data available to such entity or sanction pro-
15 grams of risk management for health care profes-
16 sionals and health care providers provided by other
17 entities; and

18 (2) require each such professional or provider,
19 as a condition of maintaining insurance, to partici-
20 pate in one program described in paragraph (1) at
21 least once in each 3-year period.

22 (c) EFFECTIVE DATE.—This section shall take effect
23 2 years after the date of the enactment of this Act.

24 **SEC. 174. GRANTS FOR MEDICAL SAFETY PROMOTION.**

25 (a) RESEARCH ON MEDICAL INJURY PREVENTION
26 AND COMPENSATION.

1 (1) IN GENERAL.—The Secretary shall make
2 grants for the conduct of basic research in the pre-
3 vention of and compensation for injuries resulting
4 from health care professional or health care provider
5 malpractice, and research of the outcomes of health
6 care procedures.

7 (2) PREFERENCE FOR RESEARCH ON CERTAIN
8 ACTIVITIES.—In making grants under paragraph
9 (1), the Secretary shall give preference to applica-
10 tions for grants to conduct research on the behavior
11 of health care providers and health care profes-
12 sionals in carrying out their professional duties and
13 of other participants in systems for compensating in-
14 dividuals injured by medical malpractice, the effects
15 of financial and other incentives on such behavior,
16 the determinants of compensation system outcomes,
17 and the costs and benefits of alternative compensa-
18 tion policy options.

19 (3) APPLICATION.—The Secretary may not
20 make a grant under paragraph (1) unless an appli-
21 cant submits an application to the Secretary at such
22 time, in such form, in such manner, and containing
23 such information as the Secretary may require.

24 (b) GRANTS FOR LICENSING AND DISCIPLINARY AC-
25 TIVITIES.—

1 (1) IN GENERAL.—The Secretary shall make
2 grants to States to assist States in improving the
3 State’s ability to license and discipline health care
4 professionals.

5 (2) USES FOR GRANTS.—A State may use a
6 grant awarded under subsection (a) to develop and
7 implement improved mechanisms for monitoring the
8 practices of health care professionals or for conduct-
9 ing disciplinary activities.

10 (3) TECHNICAL ASSISTANCE.—The Secretary
11 shall provide technical assistance to States receiving
12 grants under paragraph (1) to assist them in evalu-
13 ating their medical practice acts and procedures and
14 to encourage the use of efficient and effective early
15 warning systems and other mechanisms for detecting
16 practices which endanger patient safety and for dis-
17 ciplining health care professionals.

18 (4) APPLICATIONS.—The Secretary may not
19 make a grant under paragraph (1) unless the appli-
20 cant submits an application to the Secretary at such
21 time, in such form, in such manner, and containing
22 such information as the Secretary shall require.

23 (c) GRANTS FOR PUBLIC EDUCATION PROGRAMS.—

24 (1) IN GENERAL.—The Secretary shall make
25 grants to States and to local governments, private

1 nonprofit organizations, and health professional
2 schools (as defined in paragraph (3)) for—

3 (A) educating the general public about the
4 appropriate use of health care and realistic ex-
5 pectations of medical intervention;

6 (B) educating the public about the re-
7 sources and role of health care professional li-
8 censing and disciplinary boards in investigating
9 claims of incompetence or health care mal-
10 practice; and

11 (C) developing programs of faculty train-
12 ing and curricula for educating health care pro-
13 fessionals in quality assurance, risk manage-
14 ment, and medical injury prevention.

15 (2) APPLICATIONS.—The Secretary may not
16 make a grant under paragraph (1) unless the appli-
17 cant submits an application to the Secretary at such
18 time, in such form, in such manner, and containing
19 such information as the Secretary shall require.

20 (3) HEALTH PROFESSIONAL SCHOOL DE-
21 FINED.—In paragraph (1), the term “health profes-
22 sional school” means a school of nursing (as defined
23 in section 853(2) of the Public Health Service Act)
24 or a school or program described in section 799(1)
25 of such Act.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated not more than
3 \$15,000,000 for each of the first 5 fiscal years beginning
4 on or after the date of the enactment of this Act for grants
5 under this section.

6 **SEC. 175. STUDY OF BARRIERS TO VOLUNTARY SERVICE BY**
7 **PHYSICIANS.**

8 (a) STUDY.—The Secretary shall conduct a study to
9 determine the factors preventing or discouraging physi-
10 cians (whether practicing or retired) from volunteering to
11 provide health care services in medically underserved
12 areas.

13 (b) REPORTS.—(1) Not later than 1 year after the
14 date of the enactment of this Act, the Secretary shall sub-
15 mit an interim report to Congress on the study conducted
16 under subsection (a), together with the Secretary's rec-
17 ommendations for actions to increase the number of physi-
18 cians volunteering to provide health care services in medi-
19 cally underserved areas.

20 (2) Not later than 5 years after the date of the enact-
21 ment of this Act, the Secretary shall submit a final report
22 to Congress on the study conducted under subsection (a)
23 (taking into account the effects of this subtitle on the inci-
24 dence and costs of medical malpractice), together with the
25 Secretary's recommendations for actions to increase the

1 number of physicians volunteering to provide health care
2 services in medically underserved areas.

3 **Subtitle E—Medical Education**
4 **Reform**

5 **SEC. 181. LIMITATION ON MEDICARE HOSPITAL PAYMENT**
6 **FOR DIRECT AND INDIRECT GRADUATE MED-**
7 **ICAL EDUCATION SUPPORT AND FEDERAL**
8 **ASSISTANCE FOR INSURED MEDICAL STU-**
9 **DENT LOANS FOR NON-PRIMARY CARE PHY-**
10 **SICIANS.**

11 (a) MEDICARE DIRECT GRADUATE MEDICAL EDU-
12 CATION FUNDING.—Section 1886(h) of the Social Secu-
13 rity Act (42 U.S.C. 1395ww(h)) is amended—

14 (1) in paragraph (1), by inserting “subject to
15 paragraph (6),” after “1861(v),”, and

16 (2) by adding at the end the following new
17 paragraph:

18 “(6) TRANSITION TO EQUAL ASSISTANCE FOR
19 PRIMARY CARE.—

20 “(A) PLAN.—The Secretary shall develop a
21 plan for adjusting payments made under this
22 section in a manner that—

23 “(i) results, for each fiscal year begin-
24 ning more than 10 years after the date of
25 the enactment of this paragraph, in aggre-

1 gate expenditures under this subsection for
2 approved medical residency training pro-
3 grams in primary care fields equal to 50
4 percent of the aggregate expenditures
5 under this subsection for all training pro-
6 grams, and

7 “(ii) does not result in expenditures
8 under this section exceeding the expendi-
9 tures that would otherwise have been made
10 under this subsection without regard to
11 this paragraph.

12 Within 1 year after the date of the enactment
13 of this paragraph, the Secretary shall submit a
14 report to Congress on the plan developed under
15 this subparagraph.

16 “(B) IMPLEMENTATION.—Unless the Con-
17 gress otherwise provides by law, the Secretary
18 is authorized to implement the plan developed
19 under subparagraph (A).”.

20 (b) MEDICARE INDIRECT MEDICAL EDUCATION
21 FUNDING.—Section 1886(d)(5)(B) of such Act is amend-
22 ed by adding at the end the following new clause:

23 “(v) Notwithstanding the previous provisions of
24 this subparagraph, the Secretary shall develop a

1 plan for adjusting additional payments made under
2 this subparagraph in a manner that—

3 “(I) results, for each fiscal year beginning
4 more than 10 years after the date of the enact-
5 ment of this clause, in aggregate expenditures
6 under this subparagraph for indirect costs of
7 medical education of physicians in primary care
8 fields equal to 50 percent of the aggregate addi-
9 tional payments under this subparagraph, and

10 “(II) does not result in additional pay-
11 ments under this subparagraph exceeding the
12 payments that would otherwise have been made
13 under this subparagraph without regard to this
14 clause.

15 Within 1 year after the date of the enactment of this
16 clause, the Secretary shall submit a report to Con-
17 gress on the plan developed under this clause. Un-
18 less the Congress otherwise provides by law, the Sec-
19 retary is authorized to implement the plan developed
20 under this clause.”.

21 (c) INSURED STUDENT LOANS.—Section 702 of the
22 Public Health Service Act is amended by adding at the
23 end the following new subsection:

24 “(d)(1) The Secretary shall develop and implement
25 a plan for the insuring of loans under this subpart in a

1 manner that results in aggregate new loans made for each
2 fiscal year beginning more than 10 years after the date
3 of the enactment of this subsection and for installments
4 with respect to such loans pursuant to lines of credit under
5 this subpart for students at schools of medicine for stu-
6 dents in primary care fields equal to 50 percent of the
7 aggregate of such loans and installments for students in
8 any medical field at such schools of medicine.

9 “(2) Within 1 year after the date of the enactment
10 of this subsection, the Secretary shall submit a report to
11 Congress on the plan developed under paragraph (1). Un-
12 less the Congress otherwise provides by law, the Secretary
13 is authorized to implement the plan developed under para-
14 graph (1).”.

15 **SEC. 182. STATE COMPREHENSIVE HEALTH PROFESSIONS**
16 **EDUCATION PLANS.**

17 Each State shall develop a comprehensive plan to
18 identify the health personnel needs of the residents of the
19 State, addressing shortages of and specialty requirements
20 for health care providers.

21 **Subtitle F—Public Delivery System**

22 **SEC. 183. IDENTIFICATION OF MEDICALLY UNDERSERVED**
23 **POPULATIONS.**

24 The Secretary of Health and Human Services,
25 through the Public Health Service, shall develop national

1 standards to identify medically underserved populations
2 and the areas in which such populations are.

3 **SEC. 184. STATE COMPREHENSIVE PLANS FOR MEDICALLY**
4 **UNDERSERVED POPULATIONS.**

5 (a) IN GENERAL.—Each State shall develop a com-
6 prehensive plan for addressing the health care needs of
7 populations identified, under the standards established
8 under section 183, as medically underserved.

9 (b) USE OF RESOURCES.—Each such plan shall uti-
10 lize, in the most efficient manner possible, the current re-
11 sources of Federal, State, and local governments, includ-
12 ing local public health clinics.

13 **SEC. 185. PUBLICLY-FUNDED HEALTH CENTERS SERVING**
14 **MEDICALLY UNDERSERVED AREAS.**

15 (a) OBJECTIVE.—It is the policy of the Congress to
16 provide for at least one publicly-funded health center in
17 each area identified, under section 186, as serving medi-
18 cally underserved populations.

19 (b) ADDITIONAL AUTHORIZATION OF APPROPRIA-
20 TIONS.—In addition to the amounts otherwise authorized,
21 there are authorized to be appropriated such additional
22 amounts to provide for such additional grants under sec-
23 tions 329, 330, and 340 of the Public Health Service Act
24 (relating to migrant health, community health centers,
25 and grant programs for certain health services for the

1 homeless) as may be required to carry out the policy stat-
2 ed in subsection (a).

3 **SEC. 186. OFFICE OF DISEASE PREVENTION AND HEALTH**
4 **PROMOTION.**

5 (a) IN GENERAL.—Section 1701(a)(11) of the Public
6 Health Service Act (42 U.S.C. 300u(a)(11)) is amended—

7 (1) by striking “and” at the end of subpara-
8 graph (C),

9 (2) by redesignating subparagraph (D) as sub-
10 paragraph (E), and

11 (3) by inserting after subparagraph (C) the fol-
12 lowing new subparagraph:

13 “(D) promote individual responsibility in
14 personal health care and in the use of valuable
15 health care resources; and”.

16 (b) FUNDING.—It is the sense of the Congress that
17 the amounts that are appropriated pursuant to section
18 1701(b) of the Public Health Service Act should be in-
19 creased for fiscal year 1993 and each fiscal year thereafter
20 in a manner sufficient to permit the Office of Disease Pre-
21 vention and Health Promotion to carry out—

22 (1) its duties under section 1701(a)(1)(D) of
23 such Act (as amended by subsection (a)), and

24 (2) the activities for which additional funding
25 was requested in the President’s request for appro-

1 demonstration projects to test alternative ways of promot-
2 ing informed decisionmaking by providers and patients on
3 the appropriate utilization of expensive life-sustaining
4 technology.

5 (b) PRIORITIES.—The demonstration projects under
6 subsection (a) shall include at least the following dem-
7 onstrations projects:

8 (1) A demonstration project, based on the
9 “Health Decisions U.S.A.” demonstration, to edu-
10 cate the public about the implications of utilizing
11 new medical technologies and to measure the effects
12 of such education on individual behavior.

13 (2) A demonstration project to improve the va-
14 lidity and reliability of computerized data systems
15 designed to permit patients and their families to as-
16 sess the likely outcomes of using particular medical
17 technologies.

18 (3) A demonstration project to test the efficacy
19 of educating individuals in various settings, includ-
20 ing—

21 (A) the home,

22 (B) a physician’s office, and

23 (C) upon admission to a health care facil-
24 ity,

1 about their rights under State law to make decisions
2 regarding their medical treatment.

3 (4) A demonstration project that provides for
4 participation by experts on medical ethics in the de-
5 velopment of clinical practice guidelines.

6 (c) REPORTS AND EVALUATIONS.—The Secretary
7 shall submit to Congress—

8 (1) an annual report on the status of each dem-
9 onstration project conducted under this section, and

10 (2) a final report to the Congress on each such
11 project not later than one year after the close of the
12 project.

13 The reports required by paragraph (2) shall be accom-
14 panied by such recommendations for legislation as the
15 Secretary determines to be appropriate to promote in-
16 formed decisionmaking by physicians and patients on the
17 utilization of medical technologies.

18 (d) FUNDING.—There are authorized to be appro-
19 priated such sums as may be necessary to carry out this
20 section.

21 **SEC. 189. ACTION PLAN ON HEALTH PROMOTION AND DIS-**
22 **EASE PREVENTION.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services shall develop an action plan for reducing
25 the incidence in the United States of the following health

1 risk factors which have been identified in the publication

2 Healthy People, 2000:

3 (1) Smoking.

4 (2) High blood pressure.

5 (3) High blood cholesterol.

6 (4) Overweight.

7 (5) Sedentary lifestyle.

8 (6) High fat diet.

9 (7) Inadequate childhood immunization.

10 (8) Heavy use of alcohol.

11 (9) Failure to use seat belts.

12 (b) REVIEW OF FEDERAL POLICIES.—In developing
13 the action plan under subsection (a), the Secretary shall
14 identify current Federal policies that may hinder attain-
15 ment of the goals of the plan and shall consult with the
16 agencies responsible for the implementation of these poli-
17 cies.

18 (c) REPORTS.—The Secretary shall—

19 (1) transmit the action plan required by sub-
20 section (a) to the Congress not later than one year
21 after the date of the enactment of this Act, and

22 (2) submit to the Congress at least every 2
23 years thereafter a report that—

1 (A) describes progress made toward reduc-
2 ing the incidence of the health risk factors spec-
3 ified in such subsection, and

4 (B) includes recommendations for such
5 regulatory and legislative changes and other ac-
6 tions that should be taken to reduce further the
7 incidence of these health risk factors.

8 **Subtitle G—Public Disclosure**

9 **SEC. 191. DEVELOPMENT OF NATIONAL STANDARDS FOR** 10 **DISCLOSURE OF HEALTH CARE INFORMA-** 11 **TION; IMPLEMENTATION BY STATES.**

12 (a) NATIONAL STANDARDS.—

13 (1) IN GENERAL.—The Secretary of Health and
14 Human Services shall establish standards for the
15 collection and disclosure of health care data pursu-
16 ant to this subtitle.

17 (2) ELEMENTS OF STANDARDS.—In establish-
18 ing such standards, the Secretary shall develop—

19 (A) a computerized system for use in the
20 collection, analysis, and disclosure of data col-
21 lected pursuant to this subtitle;

22 (B) a uniform claims format for use by all
23 data sources and providers in billing for health
24 care services for which data are required to be
25 submitted pursuant to this subtitle;

1 (C) a mechanism—

2 (i) to avoid duplicative reporting of
3 data for health care services furnished
4 under titles XVIII and XIX of the Social
5 Security Act, and

6 (ii) to coordinate and integrate the
7 data collected for such services with the
8 data collected for other health care serv-
9 ices; and

10 (D) a methodology for use in measuring
11 the quality and effectiveness of health care serv-
12 ices furnished by providers.

13 (b) STATE IMPLEMENTATION.—

14 (1) APPLICATION.—Any State desiring to per-
15 form the data collection and disclosure functions
16 specified in this subtitle for data sources and provid-
17 ers in the State may submit an application to the
18 Secretary. Such application shall be in a form and
19 manner specified by the Secretary.

20 (2) APPROVAL AND FINANCIAL ASSISTANCE.—If
21 the Secretary determines that the State has dem-
22 onstrated in its application that it has the ability to
23 carry out such functions and to comply with the
24 standards and other requirements of this subtitle—

1 (A) the Secretary shall approve such appli-
2 cation,

3 (B) the State shall become responsible for
4 the performance of the data collection and dis-
5 closure functions specified in this subtitle for
6 data sources and providers in the State, and

7 (C) the Secretary shall provide the State
8 with financial assistance in such amount as is
9 reasonably sufficient to carry out such functions
10 in the State.

11 (3) IMPLEMENTATION IN CASE OF NO QUALIFY-
12 ING STATE.—If, with respect to a State, an applica-
13 tion has not been approved under paragraph (2), the
14 Secretary shall become responsible for the perform-
15 ance of the data collection and disclosure functions
16 specified in this subtitle for data sources and provid-
17 ers in the State.

18 (4) RESPONSIBLE GOVERNMENTAL ENTITY DE-
19 FINED.—In this subtitle, the term “responsible gov-
20 ernmental entity” means for data sources and pro-
21 viders in a State—

22 (A) the State, if it has been granted such
23 responsibility under paragraph (2), or

24 (B) the Secretary, if the State has not
25 been granted such responsibility.

1 (c) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as may be
3 necessary to carry out this subtitle (including providing
4 financial assistance to qualifying States under subsection
5 (b)(2)).

6 **SEC. 192. DATA SUBMISSION AND COLLECTION.**

7 (a) SUBMISSION OF DATA.—The responsible govern-
8 mental entity shall collect, and data sources shall submit
9 to such entity, all data required in this section, according
10 to uniform submission formats, coding systems and other
11 technical specifications necessary to render the incoming
12 data substantially valid, consistent, compatible and man-
13 ageable using electronic data processing according to data
14 submission schedules, such schedules to avoid, to the ex-
15 tent possible, submission of identical data from more than
16 one data source, established and promulgated by the Sec-
17 retary pursuant to section 191(a)(2).

18 (b) UNIFORM CLAIMS FORMAT.—The Secretary shall
19 adopt, within 180 days of the date of the enactment of
20 this Act, a uniform claims format. The Secretary shall fur-
21 nish such format to all data sources and the form shall
22 be utilized and maintained by all data sources for all serv-
23 ices covered under this subtitle. Such form shall have such
24 fields as may be necessary to provide all of the data set
25 forth in subsections (c) and (d).

1 (c) DATA ELEMENTS.—For each covered service, the
2 responsible governmental entity shall collect the following
3 data elements:

4 (1) Uniform patient identifier, continuous
5 across multiple episodes and providers.

6 (2) Patient date of birth.

7 (3) Patient sex.

8 (4) Patient ZIP Code number.

9 (5) Date of admission.

10 (6) Date of discharge.

11 (7) Principal and up to four secondary diag-
12 noses by standard code.

13 (8) Principal procedure by standard code and
14 date.

15 (9) Up to three secondary procedures by stand-
16 ard codes and dates.

17 (10) Uniform health care facility identifier, con-
18 tinuous across episodes, patients, and providers.

19 (11) Uniform identifier of admitting physician,
20 by unique physician identification number estab-
21 lished by the Secretary, continuous across episodes,
22 patients, and providers.

23 (12) Uniform identifier of consulting physi-
24 cians, by unique physician identification number es-

1 established by the Secretary, continuous across epi-
2 sodes, patients, and providers.

3 (13) Total charges of health care facility, seg-
4 regated into major categories, including room and
5 board, radiology, laboratory, operating room, drugs,
6 medical supplies and other goods and services ac-
7 cording to guidelines specified by the Secretary.

8 (14) Actual payments to health care facility,
9 segregated, if available, according to the categories
10 specified in paragraph (13).

11 (15) Charges of each physician or professional
12 rendering service relating to an incident of hos-
13 pitalization or treatment in an ambulatory service
14 facility.

15 (16) actual payments to each physician or pro-
16 fessional rendering service pursuant to paragraph
17 (15).

18 (17) Uniform identifier of primary payor.

19 (18) ZIP Code number of facility where health
20 care service is rendered.

21 (19) Uniform identifier for payor group con-
22 tract number.

23 (20) Patient discharge status.

1 (21) Provider service effectiveness and provider
2 quality pursuant to section 191(a)(2)(D) and sub-
3 section (d).

4 (d) PROVIDER QUALITY AND PROVIDER SERVICE EF-
5 FECTIVENESS DATA ELEMENTS.—In carrying out its duty
6 to collect data on provider quality and provider service ef-
7 fectiveness under subsection (c)(21), the responsible gov-
8 ernmental entity shall utilize the methodology developed
9 under section 191(a)(2)(D).

10 (e) RESERVE FIELD UTILIZATION AND ADDITION OR
11 DELETION OF DATA ELEMENTS.—The Secretary shall in-
12 clude in the uniform claims format a reserve field. The
13 Secretary may utilize the reserve field by adding other
14 data elements beyond those specified in subsection (d) or
15 the Secretary may delete data elements from the format
16 pursuant to regulation after obtaining a cost-benefit anal-
17 ysis of the proposed addition or deletion which shall in-
18 clude the cost to data sources of any proposed additions.

19 (f) OTHER DATA REQUIRED TO BE SUBMITTED.—
20 Providers are hereby required to submit and the respon-
21 sible governmental entity shall collect the following addi-
22 tional data, if such data is not available to the entity from
23 public records:

1 (1) Audited annual financial reports of all hos-
2 pitals and ambulatory service facilities providing cov-
3 ered services.

4 (2) Additional data including data which can be
5 used to provide at least the following information:

6 (A) The incidence of medical and surgical
7 procedures in the population for individual pro-
8 viders.

9 (B) Physicians who provide covered serv-
10 ices and accept medical assistance patients.

11 (C) Physicians who provide covered serv-
12 ices and accept medicare assignment as full
13 payment.

14 (D) Status of licensure and accreditation
15 of hospitals and ambulatory service facilities.

16 (E) Mortality rates for specified diagnoses
17 and treatments, grouped by severity, for indi-
18 vidual providers.

19 (F) Rates of infection for specified diag-
20 noses and treatments, grouped by severity, for
21 individual providers.

22 (G) Morbidity rates for specified diagnoses
23 and treatments, grouped by severity, for indi-
24 vidual providers.

1 (H) Readmission rates for specified diag-
2 noses and treatments, grouped by severity, for
3 individual providers.

4 (I) Rate of incidence of postdischarge pro-
5 fessional care for selected diagnoses and treat-
6 ments, grouped by severity, for individual pro-
7 viders.

8 (g) ALLOWANCE FOR CLARIFICATION OR DIS-
9 SENTS.—The responsible governmental entity shall main-
10 tain a file of written statements submitted by data sources
11 who wish to provide an explanation of data that they feel
12 might be misleading or misinterpreted. The entity shall
13 provide access to such file to any person and shall, where
14 practical, in the entity's reports and data files indicate the
15 availability of such statements. When the entity agrees
16 with such statements, the entity shall correct the appro-
17 priate data and comments in its data files and subsequent
18 reports.

19 (h) AVAILABILITY OF DATA.—Nothing in this sub-
20 title shall prohibit a purchaser from obtaining from its
21 health care insurer, nor relieve such a health care insurer
22 from the obligation of providing such purchaser, on terms
23 consistent with past practices, data previously provided or
24 additional data not currently provided to such provider by

1 such insurer pursuant to any existing or future arrange-
2 ment, agreement, or understanding.

3 **SEC. 193. DATA DISSEMINATION AND PUBLICATION.**

4 (a) PUBLIC REPORTS.—Subject to the restrictions on
5 access to data in section 194 and utilizing the data col-
6 lected under section 192 as well as other data, records,
7 and matters of record available to it, the responsible gov-
8 ernmental entity shall prepare and issue public reports ac-
9 cording to the following provisions:

10 (1) The responsible governmental entity shall,
11 for every provider and within appropriate geographic
12 areas (approved by the Secretary) and for those in-
13 patient and outpatient services which, when ranked
14 by order of frequency, account for at least 65 per-
15 cent of all covered services and which, when ranked
16 by order of total payments account for at least 65
17 percent of total payments, prepare and issue quar-
18 terly reports that at least provide information on the
19 following:

20 (A) Comparisons among all providers of
21 payments received, charges, population-based
22 admission or incidence rates, and provider serv-
23 ice effectiveness, such comparisons to be
24 grouped according to diagnosis and severity,

1 and to identify each provider by name and type
2 or specialty.

3 (B) Comparisons among all providers, ex-
4 cept physicians, of inpatient and outpatient
5 charges and payments for room and board, an-
6 cillary services, drugs, equipment and supplies
7 and total services, such comparisons to be
8 grouped according to provider quality and pro-
9 vider service effectiveness and according to di-
10 agnosis and severity, and to identify each health
11 care facility by name and type.

12 (C) Until the methodology to measure pro-
13 vider quality and provider service effectiveness
14 is developed under section 191(a)(2)(D), com-
15 parisons among all providers, grouped accord-
16 ing to diagnosis, procedure, and severity, which
17 identify facilities by name and type and physi-
18 cians by name and specialty, of charges and
19 payment received, readmission rates, mortality
20 rates, morbidity rates, and infection rates.

21 (D) The incidence rate of selected medical
22 or surgical procedures, the provider service ef-
23 fectiveness and the payments received for other
24 providers, identified by the name and type of

1 specialty, for which these elements vary signifi-
2 cantly from the norms for all providers.

3 (2) In preparing reports under paragraph (1),
4 the responsible governmental entity shall ensure that
5 factors which have the effect of either reducing pro-
6 vider revenue or increasing provider costs, and other
7 factors beyond a provider's control which reduce the
8 provider competitiveness in the market place, are ex-
9 plained in the reports. The entity shall also ensure
10 that any clarifications and dissents submitted by in-
11 dividual providers under section 192(g) are noted in
12 any reports that include release of data on that indi-
13 vidual provider.

14 (3) The responsible governmental entity shall,
15 for all providers and within appropriate geographic
16 areas approved under paragraph (1), prepare and
17 issue quarterly reports that at least provide informa-
18 tion on the following:

19 (A) The number of physicians, by spe-
20 cialty, on the staff of each hospital or ambula-
21 tory service facility and those physicians on the
22 staff that accept medicare assignment as full
23 payment and that accept medical assistance pa-
24 tients.

1 (B) The status of hospitals respecting ac-
2 creditation and licensure.

3 If such entity is not the Secretary, the entity shall
4 transmit a copy of each report under this paragraph
5 to the Secretary.

6 (4) The responsible governmental entity shall
7 publish all reports issued under paragraph (3) in the
8 same periodical publication in which regulations of
9 the governmental entity are published and shall pub-
10 lish, in at least one newspaper of general circulation
11 in each approved geographic area, reports on the
12 providers in that area and areas adjacent to it. In
13 addition, the responsible governmental entity shall
14 advertise the availability of these reports and the
15 charge for duplication in such periodical publication
16 and in at least one newspaper of general circulation
17 in each such approved geographic area at least once
18 in each calendar quarter.

19 (b) RAW DATA REPORTS AND CONSUMER ACCESS TO
20 DATA.—The responsible governmental entity shall provide
21 special reports derived from raw data and a means for
22 computer-to-computer access to raw data to any pur-
23 chaser, pursuant to section 194(f). The responsible gov-
24 ernmental entity shall provide such reports and computer-
25 to-computer access, at the entity's discretion, to other par-

1 ties, pursuant to section 194(g). The entity shall provide
2 these special reports and computer-to-computer access in
3 as timely a fashion as the entity's responsibilities to pub-
4 lish the public reports required in this section will allow.
5 Any such provision of special reports or computer-to-com-
6 puter access by the council shall be made only subject to
7 the restrictions on access to raw data set forth in section
8 194(b) and only after payment for costs of preparation
9 or duplication pursuant to section 194 (f) or (g).

10 **SEC. 194. ACCESS TO DATA.**

11 (a) PUBLIC ACCESS.—The information and data re-
12 ceived by a responsible governmental entity under this
13 subtitle shall be utilized by the entity for the benefit of
14 the public. Subject to the specific limitations set forth in
15 this section, the entity shall make determinations on re-
16 quests for information in favor of access.

17 (b) LIMITATIONS ON ACCESS.—Unless specifically
18 provided in this subtitle, the responsible governmental en-
19 tity shall not release—

20 (1) any raw data that does not simultaneously
21 disclose payment, as well as provider quality and
22 provider service effectiveness information;

23 (2) any raw data of the entity which could rea-
24 sonably be expected to reveal the identity of an indi-
25 vidual patient;

1 (3) any raw data which could reasonably be ex-
2 pected to reveal the identity of any purchaser, other
3 than a purchaser requesting data on its own group
4 or an entity entitled to such purchaser's data pursu-
5 ant to subsection (f);

6 (4) any raw data relating to actual payments to
7 any identified provider made by any purchaser, ex-
8 cept that this paragraph shall not apply to access by
9 a purchaser requesting data on the group for which
10 it purchases or otherwise provides covered services
11 or to access to that same data by an entity entitled
12 to the purchaser's data pursuant to subsection (f);
13 and

14 (5) any raw data disclosing discounts or dif-
15 ferentials between payments accepted by providers
16 for services and their billed charges obtained by
17 identified payors from identified providers unless
18 comparable data on all other payors is also released
19 and the entity determines that the release of such
20 information is not prejudicial or inequitable to any
21 individual payor or provider or group thereof.

22 In making determinations under paragraph (5), the entity
23 shall consider that the purpose of this subtitle is primarily
24 concerned with the analysis and dissemination of pay-
25 ments to providers, not with discounts.

1 (c) UNAUTHORIZED USE OF DATA.—Any person who
2 knowingly releases data violating the patient confidential-
3 ity, actual payments, discount data or raw data safeguards
4 set forth in this section to an unauthorized person is sub-
5 ject to imprisonment of not more than 5 years, or fine
6 according to title 18, United States Code.

7 (d) UNAUTHORIZED ACCESS TO DATA.—Should any
8 person inadvertently or by error of a responsible govern-
9 mental entity gain access to data that violates the safe-
10 guards set forth in this section, the data must immediately
11 be returned, without duplication, to the entity with proper
12 notification.

13 (e) PUBLIC ACCESS TO RECORDS.—All public records
14 prepared by the entity shall be available to the public for
15 a reasonable fee, not to exceed the cost of duplication.

16 (f) ACCESS TO RAW DATA BY PURCHASERS.—Sub-
17 ject to the limitations on access set forth in subsection
18 (b), the responsible governmental entity shall provide ac-
19 cess to its raw data to purchasers in accordance with the
20 following procedure:

21 (1) Special reports derived from raw data of the
22 entity shall be provided by the entity to any pur-
23 chaser requiring such reports.

24 (2) A means to enable computer-to-computer
25 access by any purchaser to raw data shall be devel-

1 oped, adopted, and implemented by the entity, and
2 the entity shall provide such access to raw data to
3 any purchaser upon request.

4 (3) In the event that any employer obtains from
5 the entity, pursuant to paragraph (1) or (2), data
6 pertaining to the employer's employees and their de-
7 pendents for whom the employer purchases or other-
8 wise provides covered services and who are rep-
9 resented by a certified collective bargaining rep-
10 resentative, such collective bargaining representative
11 shall be entitled to that same data, after payment of
12 fees as specified in paragraph (4). Likewise, should
13 a certified collective bargaining representative obtain
14 from the entity, pursuant to paragraph (1) or (2),
15 data pertaining to members of the collective bargain-
16 ing unit and their dependents who are employed by
17 and for whom covered services are purchased or oth-
18 erwise provided by any employer, the employer shall
19 be entitled to that same data, after payment of fees
20 as specified in paragraph (4).

21 (4) In providing for access to raw data, the re-
22 sponsible governmental entity shall charge the pur-
23 chasers which originally obtained such access a fee
24 sufficient to cover the costs to prepare and provide
25 special reports requested pursuant to paragraph (1)

1 or to provide computer-to-computer access to its raw
2 data requested pursuant to paragraph (2). Should a
3 second or subsequent party or parties request this
4 same information pursuant to paragraph (3), the en-
5 tity shall charge such party a fee sufficient to cover
6 only the costs of duplicating the original access.

7 (g) ACCESS TO RAW DATA BY OTHER PARTIES.—
8 Subject to the limitations on access to raw data set forth
9 in subsection (b), the responsible governmental entity may
10 provide special reports derived from raw data or computer-
11 to-computer access to parties other than purchasers. The
12 entity shall publish regulations that set forth the criteria
13 and the procedure the entity shall use in making deter-
14 minations on such access. In providing such access, the
15 entity shall charge the party requesting the access a fee
16 sufficient to cover the entity's costs of providing such ac-
17 cess.

18 **SEC. 195. DEFINITIONS.**

19 In this subtitle:

20 (1) The term “ambulatory service facility”
21 means a licensed facility, not part of a hospital,
22 which provides medical, diagnostic, or surgical treat-
23 ment to patients not requiring hospitalization, in-
24 cluding ambulatory surgical facilities, ambulatory
25 imaging or diagnostic centers, birthing centers, free-

1 standing emergency rooms, and any other facilities
2 providing ambulatory care which charge a separate
3 facility charge. Such term does not include the of-
4 fices of private physicians or dentists, whether for
5 individual or group practices.

6 (2) The terms “charge” and “rate” means
7 amounts billed by a provider for specific goods or
8 services provided to a patient, prior to any adjust-
9 ment for contractual allowances.

10 (3) The term “covered services” means any
11 health care services or procedures connected with
12 episodes of illness that require either inpatient hos-
13 pital care or major ambulatory service such as sur-
14 gical, medical, or major radiological procedures, in-
15 cluding any initial and followup outpatient services
16 associated with the episode of illness before, during,
17 or after inpatient hospital care or major ambulatory
18 service. The term does not include routine outpatient
19 services connected with episodes of illness that do
20 not require hospitalization or major ambulatory serv-
21 ice.

22 (4) The term “data source” means a hospital,
23 ambulatory service facility, physician, health mainte-
24 nance organization, hospital or medical service plan,
25 commercial insurer, self-insured employer providing

1 health or accident coverage, administrator of a self-
2 insured or partially self-insured health or accident
3 plan providing covered services, any health and wel-
4 fare fund that provides health or accident benefits or
5 insurance pertaining to covered services, and any
6 other payor for covered services in the United States
7 other than an individual.

8 (5) The term “health care facility” means a
9 general or special hospital, including tuberculosis
10 and psychiatric hospitals, kidney disease treatment
11 centers, including freestanding hemodialysis units,
12 and ambulatory service facilities, and hospices (both
13 profit and nonprofit).

14 (6) The term “health maintenance organiza-
15 tion” means an organized system which combines
16 the delivery and financing of health care and which
17 provides basic health care services to voluntarily en-
18 rolled subscribers for a fixed prepaid fee.

19 (7) The term “hospital” means any institution
20 licensed in a State as a hospital, including hospitals
21 for tuberculosis, mental disease or chronic illness.

22 (8) The term “major ambulatory service”
23 means surgical or medical procedures, including di-
24 agnostic and therapeutic radiological procedures,
25 commonly performed in hospitals or ambulatory

1 service facilities, which are not of a type commonly
2 performed or which cannot be safely performed in
3 physicians' offices and which require special facilities
4 such as operating rooms or suites or special equip-
5 ment such as fluoroscopic equipment or computed
6 tomographic scanners, or a postprocedure recovery
7 room or short-term convalescent room.

8 (9) The term "medical procedure incidence var-
9 iation" means a variation in the incidence in the
10 population of specific medical, surgical, and radio-
11 logical procedures in any given year, expressed as a
12 deviation from the norm, as these terms are defined
13 in the classical statistical definition of "variation,"
14 "incidence," "deviation", and "norm".

15 (10) The term "payment" means payments that
16 providers actually accept for their services, exclusive
17 of charity care, rather than the charges they bill.

18 (11) The term "payor" means any person or
19 entity, including health care insurers and pur-
20 chasers, that make direct payments to providers for
21 covered services.

22 (12) The term "physician" means an individual
23 licensed under State law to practice medicine and
24 surgery.

1 (13) The term “provider” means a hospital, an
2 ambulatory service facility, or a physician.

3 (14) The term “provider quality” means the ex-
4 tent to which a provider renders care that, within
5 the capabilities of modern medicine, obtains for pa-
6 tients medically acceptable outcomes and prognoses,
7 adjusted for patient severity, and treats patients
8 compassionately and responsively.

9 (15) The term “provider service effectiveness”
10 means the effectiveness of services rendered by a
11 provider, determined by measurement of the medical
12 outcome of patients grouped by severity receiving
13 those services.

14 (16) The term “purchaser” means any corpora-
15 tion, labor organization or other entity that pur-
16 chases benefits which provide covered services for an
17 employee or member, either through a health care
18 insurer or by means of a self-funded program of
19 benefits, and a certified bargaining representative
20 that represents a group or groups of employees for
21 whom employers purchase a program of benefits
22 which provide covered services, but excluding health
23 care insurers.

1 (17) The terms “raw data” and “data” mean
2 data collected by a responsible governmental entity
3 under section 192 in the form initially received.

4 (18) The term “responsible governmental en-
5 tity” has the meaning given such term in section
6 191(b)(4).

7 (19) The term “severity” means, in any patient,
8 the measurable degree of the potential for failure of
9 one or more vital organs.

10 (20) The term “Secretary” means the Secretary
11 of Health and Human Services.

12 (21) The term “State” means the 50 States
13 and the District of Columbia.

14 **Subtitle H—Tax Incentives to**
15 **Provide Only Minimum Benefits**

16 **SEC. 198. DENIAL OF EMPLOYER TAX DEDUCTION FOR PRO-**
17 **VIDING HEALTH CARE COVERAGE IN EXCESS**
18 **OF MINIMUM BENEFITS AND DENIAL OF EM-**
19 **PLOYEE EXCLUSION FOR SUCH EXCESS COV-**
20 **ERAGE.**

21 (a) DENIAL OF DEDUCTION.—Section 162 of the In-
22 ternal Revenue Code of 1986 (relating to trade or business
23 expenses) is amended by redesignating subsection (m) as
24 subsection (n) and by inserting after subsection (l) the fol-
25 lowing new subsection:

1 “(m) EXPENSES FOR PROVIDING HEALTH CARE IN
2 EXCESS OF MINIMUM BENEFITS.—No deduction shall be
3 allowed under this chapter for expenses incurred to pro-
4 vide health care for any employee of the taxpayer (or any
5 beneficiary of such employee) to the extent such expenses
6 are attributable to benefits that are not within the mini-
7 mum benefit package which has become effective under
8 section 203(a)(2) of the American Consumers Health Care
9 Reform Act of 1993.”

10 (b) DENIAL OF EXCLUSION.—The text of section 106
11 of such Code is amended to read as follows:

12 “(a) IN GENERAL.—Gross income of an employee
13 does not include employer-provided coverage under an ac-
14 cident or health plan.

15 “(b) NO EXCLUSION FOR HEALTH CARE COVERAGE
16 IN EXCESS OF MINIMUM BENEFITS.—Subsection (a) shall
17 not apply to the extent coverage is provided for benefits
18 that are not within the minimum benefit package which
19 has become effective under section 203(a)(2) of the Amer-
20 ican Consumers Health Care Reform Act of 1993.”

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to taxable years beginning on or
23 after the first day of the second calendar year beginning
24 after the date of the enactment of this Act, but shall not
25 apply to taxable years beginning before the date the mini-

1 mum benefit package has become effective under section
2 203(a)(2) of this Act.

3 **SEC. 199. DEDUCTION FOR HEALTH INSURANCE COSTS OF**
4 **SELF-EMPLOYED INDIVIDUALS MADE PERMA-**
5 **NENT AND INCREASED TO EXTENT OF COSTS**
6 **FOR MINIMUM BENEFITS.**

7 (a) DEDUCTION MADE PERMANENT.—

8 (1) IN GENERAL.—Subsection (l) of section 162
9 of the Internal Revenue Code of 1986 (relating to
10 special rules for health insurance costs of self-em-
11 ployed individuals) is amended by striking paragraph
12 (6).

13 (2) TECHNICAL AMENDMENT.—Paragraph (2)
14 of section 110(a) of the Tax Extension Act of 1991
15 is hereby repealed.

16 (3) EFFECTIVE DATE.—The amendments made
17 by this subsection shall apply to taxable years begin-
18 ning after December 31, 1991.

19 (b) INCREASE IN DEDUCTION FOR MINIMUM BENE-
20 FITS.—

21 (1) IN GENERAL.—Subsection (l) of section 162
22 of such Code is amended by adding at the end there-
23 of the following new paragraph:

24 “(6) FULL DEDUCTION FOR COSTS OF MINIMUM
25 BENEFIT PACKAGE.—Paragraph (1) shall be applied

1 without regard to ‘25 percent of’ with respect to
2 costs attributable to benefits that are within the
3 minimum benefit package which has become effective
4 under section 203(a)(2) of the American Con-
5 sumers Health Care Reform Act of 1993.”

6 (2) EFFECTIVE DATE.—The amendment made
7 by paragraph (1) shall apply to taxable years begin-
8 ning on or after the first day of the second calendar
9 year beginning after the date of the enactment of
10 this Act, but shall not apply to taxable years begin-
11 ning before the date the minimum benefit package
12 has become effective under section 203(a)(2) of this
13 Act.

14 **TITLE II—NATIONAL HEALTH**
15 **CARE REFORM PROPOSALS**
16 **Subtitle A—National Health Care**
17 **Reform Commission**

18 **SEC. 201. ESTABLISHMENT.**

19 (a) ESTABLISHMENT.—There is established an inde-
20 pendent commission to be known as the National Health
21 Care Reform Commission (in this title referred to as the
22 “Commission”).

23 (b) DUTIES.—The Commission shall carry out the
24 duties specified for it in this subtitle.

25 (c) APPOINTMENT.—

1 (1) COMPOSITION.—

2 (A) SIZE AND MANNER OF APPOINT-
3 MENT.—The Commission shall consist of—

4 (i) five members to be appointed by
5 the President, by and with the advice and
6 consent of the Senate, one of whom shall,
7 at the time of appointment, be designated
8 as Chairperson of the Commission;

9 (ii) two members to be appointed by
10 the Speaker of the House of Representa-
11 tives upon the recommendations of the Ma-
12 jority Leader and Minority Leader of the
13 House of Representatives; and

14 (iii) two members to be appointed by
15 the President pro tempore of the Senate
16 upon the recommendations of the Majority
17 Leader and Minority Leader of the Senate.

18 (B) POLITICAL AFFILIATION.—At no time
19 shall more than three of the members appointed
20 by the President, one of the members appointed
21 by the Speaker of the House of Representatives,
22 or one of the members appointed by the Presi-
23 dent pro tempore of the Senate be members of
24 the same political party.

1 (C) MEMBERSHIP QUALIFICATIONS.—The
2 membership of the Commission shall consist of
3 individuals who are of recognized standing and
4 distinction and who possess the demonstrated
5 capacity to discharge the duties imposed on the
6 Commission, and shall include persons possess-
7 ing substantial knowledge or expertise in health
8 care delivery, health care insurance, or health
9 care economics. No individual who is otherwise
10 an officer or full-time employee of the United
11 States shall serve as a member of the Commis-
12 sion. No member while serving on the Commis-
13 sion may receive financial gain from direct in-
14 vestments, employment or associations from
15 any entity with demonstrable financial interest
16 in matters over which the Commission has ju-
17 risdiction.

18 (D) CHAIRPERSON.—The Chairperson of
19 the Commission shall designate a member of
20 the Commission to act as Vice Chairperson of
21 the Commission.

22 (E) QUORUM.—A majority of the members
23 of the Commission shall constitute a quorum,
24 but a lesser number may conduct hearings.

1 (F) TERM.—Members of the Commission
2 shall be appointed for a term of 5 years, except
3 that with respect to the members first ap-
4 pointed—

5 (i) the Chairperson and 2 members, 1
6 each appointed under clauses (ii) and (iii)
7 of paragraph (1)(A), respectively, shall be
8 appointed for a term of 5 years;

9 (ii) 3 members, 1 each appointed
10 under clauses (i), (ii) and (iii) of para-
11 graph (1)(A), respectively, shall be ap-
12 pointed for a term of 4 years; and

13 (iii) the remaining members shall be
14 appointed for a term of 3 years.

15 (G) VACANCY.—A vacancy in the Commis-
16 sion shall not affect its powers, but shall be
17 filled in the same manner as the original ap-
18 pointment, but the individual appointed shall
19 serve only for the unexpired portion of the term
20 for which the individual's predecessor was ap-
21 pointed.

22 (2) EFFECTIVE DATE.—Appointments to the
23 Commission shall be made no later than 90 days
24 after the date of enactment of this Act.

1 (d) MEETINGS.—The Commission shall meet at the
2 call of the Chairperson, or at the call of a majority of the
3 members of the Commission; but meetings shall not be
4 held less frequently than once in each calendar month
5 which begins after a majority of the membership of the
6 Commission has been appointed.

7 (e) HEARINGS.—In carrying out its duties under this
8 section, the Commission, or any duly authorized commit-
9 tee thereof, is authorized to hold such hearings, sit and
10 act at such times and places, and take such testimony,
11 with respect to matters with respect to which it has a re-
12 sponsibility under this title, as the Commission or such
13 committee may deem advisable. The Chairperson of the
14 Commission or any member authorized by the Chairperson
15 may administer oaths or affirmations to witnesses appear-
16 ing before the Commission or before any committee there-
17 of.

18 (f) PAY AND TRAVEL EXPENSES.—

19 (1) PAY.—

20 (A) MEMBERS.—Each member, other than
21 the Chairperson, shall be paid at a rate equal
22 to the daily equivalent of the minimum annual
23 rate of basic pay payable for level IV of the Ex-
24 ecutive Schedule under section 5315 of title 5,
25 United States Code, for each day (including

1 travel time) during which the member is en-
2 gaged in the actual performance of duties vest-
3 ed in the Commission.

4 (B) CHAIRPERSON.—The Chairperson
5 shall be paid for each day referred to in sub-
6 paragraph (A) at a rate equal to the daily
7 equivalent of the minimum annual rate of basic
8 pay payable for level III of the Executive
9 Schedule under section 5314 of title 5, United
10 States Code.

11 (2) TRAVEL EXPENSES.—Members shall receive
12 travel expenses, including per diem in lieu of subsist-
13 ence, in accordance with sections 5702 and 5703 of
14 title 5, United States Code.

15 (g) STAFF.—

16 (1) APPOINTMENT.—The Commission may em-
17 ploy and fix the compensation of an Executive Direc-
18 tor and such other personnel (not to exceed 25) as
19 may be necessary to carry out the duties of the
20 Commission. The employment and compensation of
21 such Director and personnel are not subject to the
22 provisions of title 5, United States Code, governing
23 appointments in the competitive service.

24 (2) DETAIL OF PERSONNEL FROM FEDERAL
25 AGENCIES.—Upon request of the Commission, the

1 head of any Federal department or agency may de-
2 tail any of the personnel of that department or agen-
3 cy to the Commission to assist the Commission in
4 carrying out its duties under this title.

5 (3) FEDERAL AGENCY ASSISTANCE.—The
6 Comptroller General of the United States, the Sec-
7 retary of Health and Human Services, and the Ad-
8 ministrator of General Services shall provide assist-
9 ance on a reimbursable basis, including the detailing
10 of employees, to the Commission in accordance with
11 an agreement entered into with the Commission.

12 (h) OTHER AUTHORITY.—

13 (1) CONSULTANT SERVICES.—The Commission
14 may procure by contract, to the extent funds are
15 available, the temporary or intermittent services of
16 experts or consultants pursuant to section 3109 of
17 title 5, United States Code.

18 (2) PROPERTY MATTERS.—The Commission
19 may lease space and acquire personal property to the
20 extent funds are available.

21 (i) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated such sums as may be
23 necessary to carry out the purposes of this section.

1 **SEC. 202. ESTABLISHMENT OF NATIONAL GOALS; CON-**
2 **SULTATIONS; IMPROVED COORDINATION;**
3 **EVALUATION AND RECOMMENDATIONS ON**
4 **DEMONSTRATION PROJECTS.**

5 (a) IN GENERAL.—The Commission shall develop na-
6 tional health care goals in order to—

7 (1) improve access to necessary health care
8 services;

9 (2) safeguard and improve the quality of health
10 care services; and

11 (3) control the cost of health care services.

12 (b) CONSULTATIONS.—In carrying out the respon-
13 sibilities assigned to it under this Act, the Commission
14 shall seek out and consider recommendations from a broad
15 range of interested individuals and organizations, includ-
16 ing organizations representing health care consumers,
17 health care providers, health care carriers, representatives
18 of State health programs, public health professionals, and
19 the general public.

20 (c) IMPROVEMENT IN COORDINATION.—The Com-
21 mission shall examine steps that can be taken to better
22 coordinate the activities of the Secretary of Health and
23 Human Services and other Departments and agencies in
24 promotion of the national health care goals developed
25 under subsection (a) in order to meet the goals stated in
26 the report “Healthy People, 2000”.

1 (d) EVALUATION AND RECOMMENDATIONS CON-
2 CERNING DEMONSTRATION PROJECTS.—The Commission
3 shall—

4 (1) advise the Secretary on the demonstration
5 projects established under subtitle B,

6 (2) assist the Secretary in the evaluation of
7 such projects, and

8 (3) make recommendations regarding changes
9 that should be made in laws or regulations as a re-
10 sult of such evaluations.

11 **SEC. 203. ESTABLISHMENT OF MINIMUM BENEFIT PACK-**
12 **AGE.**

13 (a) PROPOSAL.—

14 (1) SUBMISSION.—Not later than 1 year after
15 the date of the enactment of this Act, the Commis-
16 sion shall develop and submit to Congress a legisla-
17 tive proposal that specifies a minimum benefit pack-
18 age consistent with this section to be used for pur-
19 poses of—

20 (A) the demonstration project established
21 under section 211(c)(1),

22 (B) implementing subtitle C of title I, and

23 (C) determining the tax treatment under
24 the Internal Revenue Code of 1986 (as amend-
25 ed by section 198) of amounts paid by an em-

1 ployer on behalf of an employee for health in-
2 surance benefits in excess of the minimum ben-
3 efit package.

4 (2) IMPLEMENTATION.—The minimum benefit
5 package submitted under this paragraph (1) shall
6 not become effective for the purposes specified in
7 subparagraphs (B) and (C) of such paragraph un-
8 less a joint resolution approving such package is en-
9 acted in accordance with the procedures set forth in
10 subsection (d).

11 (b) BENEFITS.—The services included in the benefit
12 package shall include—

13 (1) coverage for preventive, diagnostic, and
14 therapeutic services found to be medically appro-
15 priate and cost effective, and

16 (2) cost-sharing that provides an appropriate
17 incentive to avoid unnecessary care while avoiding
18 excessive cost-sharing by individuals with cata-
19 strophic illnesses.

20 (c) CONGRESSIONAL CONSIDERATION OF COMMIS-
21 SION PROPOSAL.—

22 (1) RULES OF HOUSE OF REPRESENTATIVES
23 AND SENATE.—This subsection is enacted by the
24 Congress—

1 (A) as an exercise of the rulemaking power
2 of the House of Representatives and the Sen-
3 ate, respectively, and as such is deemed a part
4 of the rules of each House, respectively, but ap-
5 plicable only with respect to the procedure to be
6 followed in that House in the case of approval
7 resolutions described in paragraph (2), and su-
8 persedes other rules only to the extent that
9 such rules are inconsistent therewith; and

10 (B) with full recognition of the constitu-
11 tional right of either House to change the rules
12 (so far as relating to the procedure of that
13 House) at any time, in the same manner and
14 to the same extent as in the case of any other
15 rule of that House.

16 (2) TERMS OF THE RESOLUTION.—For pur-
17 poses of subsection (a), the term “approval resolu-
18 tion” means only a joint resolution of the two
19 Houses of the Congress, providing in—

20 (A) the matter after the resolving clause of
21 which is as follows: “That the Congress ap-
22 proves the recommendations of the National
23 Commission on Health Care Reform as submit-
24 ted by the Commission on
25 _____”, the blank

1 space being filled in with the appropriate date;
2 and

3 (B) the title of which is as follows: “Joint
4 Resolution approving the recommendation of
5 the National Commission on Health Care Re-
6 form”.

7 (3) INTRODUCTION AND REFERRAL.—On the
8 day on which the recommendation of the Commis-
9 sion is transmitted to the House of Representatives
10 and the Senate, an approval resolution with respect
11 to such recommendation shall be introduced (by re-
12 quest) in the House of Representatives by the Ma-
13 jority Leader of the House, for himself and the Mi-
14 nority Leader of the House, or by Members of the
15 House designated by the Majority Leader of the
16 House, for himself and the Minority Leader of the
17 House, or by Members of the House designated by
18 the Majority Leader and Minority Leader of the
19 House; and shall be introduced (by request) in the
20 Senate by the Majority Leader of the Senate, for
21 himself and the Minority Leader of the Senate, or
22 by Members of the Senate designated by the Major-
23 ity Leader and Minority Leader of the Senate. If ei-
24 ther House is not in session on the day on which
25 such recommendation is transmitted, the approval

1 resolution with respect to such recommendation shall
2 be introduced in the House, as provided in the pre-
3 ceding sentence, on the first day thereafter on which
4 the House is in session. The approval resolution in-
5 troduced in the House of Representatives and the
6 Senate shall be referred to the appropriate commit-
7 tees of each House.

8 (4) AMENDMENTS PROHIBITED.—No amend-
9 ment to an approval resolution shall be in order in
10 either the House of Representatives or the Senate;
11 and no motion to suspend the application of this
12 subsection shall be in order in either House, nor
13 shall it be in order in either House for the Presiding
14 Officer to entertain a request to suspend the appli-
15 cation of this subsection by unanimous consent.

16 (5) PERIOD FOR COMMITTEE AND FLOOR CON-
17 sideration.—

18 (A) IN GENERAL.—Except as provided in
19 subparagraph (B), if the committee or commit-
20 tees of either House to which an approval reso-
21 lution has been referred have not reported it at
22 the close of the 45th day after its introduction,
23 such committee or committees shall be auto-
24 matically discharged from further consideration
25 of the approval resolution and it shall be placed

1 on the appropriation calendar. A vote on final
2 passage of the approval resolution shall be
3 taken in each House on or before the close of
4 the 45th day after the approval resolution is re-
5 ported by the committees or committee of that
6 House to which it was referred, or after such
7 committee or committees have been discharged
8 from further consideration of the approval reso-
9 lution. If prior to the passage by one House of
10 an approval resolution of that House, that
11 House receives the same approval resolution
12 from the other House then—

13 (i) the procedure in that House shall
14 be the same as if no approval resolution
15 had been received from the other House;
16 but

17 (ii) the vote on final passage shall be
18 on the approval resolution of the other
19 House.

20 (B) COMPUTATION OF DAYS.—For pur-
21 poses of subparagraph (A), in computing a
22 number of days in either House, there shall be
23 excluded any day on which the House is not in
24 session.

1 (6) FLOOR CONSIDERATION IN THE HOUSE OF
2 REPRESENTATIVES.—

3 (A) MOTION TO PROCEED.—A motion in
4 the House of Representatives to proceed to the
5 consideration of an approval resolution shall be
6 highly privileged and not debatable. An amend-
7 ment to the motion shall not be in order, nor
8 shall it be in order to move to reconsider the
9 vote by which the motion is agreed to or dis-
10 agreed to.

11 (B) DEBATE.—Debate in the House of
12 Representatives on an approval resolution shall
13 be limited to not more than 20 hours, which
14 shall be divided equally between those favoring
15 and those opposing the bill or resolution. A mo-
16 tion further to limit debate shall not be debat-
17 able. It shall not be in order to move to recom-
18 mit an approval resolution or to move to recon-
19 sider the vote by which an approval resolution
20 is agreed to or disagreed to.

21 (C) MOTION TO POSTPONE.—Motions to
22 postpone, made in the House of Representatives
23 with respect to the consideration of an approval
24 resolution, and motions to proceed to the con-

1 consideration of other business, shall be decided
2 without debate.

3 (D) APPEALS.—All appeals from the deci-
4 sions of the Chair relating to the application of
5 the Rules of the House of Representatives to
6 the procedure relating to an approval resolution
7 shall be decided without debate.

8 (E) GENERAL RULES APPLY.—Except to
9 the extent specifically provided in the preceding
10 provisions of this paragraph, consideration of
11 an approval resolution shall be governed by the
12 Rules of the House of Representatives applica-
13 ble to other bills and resolutions in similar cir-
14 cumstances.

15 (7) FLOOR CONSIDERATION IN THE SENATE.—

16 (A) MOTION TO PROCEED.—A motion in
17 the Senate to proceed to the consideration of an
18 approval resolution shall be privileged and not
19 debatable. An amendment to the motion shall
20 not be in order, nor shall it be in order to move
21 to reconsider the vote by which the motion is
22 agreed to or disagreed to.

23 (B) GENERAL DEBATE.—Debate in the
24 Senate on an approval resolution, and all debat-
25 able motions and appeals in connection there-

1 with, shall be limited to not more than 20
2 hours. The time shall be equally divided be-
3 tween, and controlled by, the Majority Leader
4 and the Minority Leader or their designees.

5 (C) DEBATE OF MOTIONS AND APPEALS.—

6 Debate in the Senate on any debatable motion
7 or appeal in connection with an approval resolu-
8 tion shall be limited to not more than 1 hour,
9 to be equally divided between, and controlled
10 by, the mover and the manager of the approval
11 resolution, except that in the event the manager
12 of the approval resolution is in favor of any
13 such motion or appeal, the time in opposition
14 thereto, shall be controlled by the Minority
15 Leader or his designee. Such leaders, or either
16 of them, may, from time under their control on
17 the passage of an approval resolution, allot ad-
18 ditional time to any Senator during the consid-
19 eration of any debatable motion or appeal.

20 (D) OTHER MOTIONS.—A motion in the

21 Senate to further limit debate is not debatable.
22 A motion to recommit an approval resolution is
23 not in order.

1 (8) POINT OF ORDER REQUIRING
2 SUPERMAJORITY FOR MODIFICATIONS TO REC-
3 OMMENDATION ONCE APPROVED.—

4 (A) IN GENERAL.—It shall not be in order
5 in the House of Representatives or the Senate
6 to consider any amendment to the provisions of
7 this Act except as provided in subparagraph
8 (B).

9 (B) WAIVER.—The point of order de-
10 scribed in subparagraph (A) may be waived or
11 suspended in the House of Representatives or
12 the Senate only, by the affirmative vote of
13 three-fifths of the Members duly chosen and
14 sworn.

15 **Subtitle B—Demonstration**
16 **Projects on Alternative Financ-**
17 **ing and Delivery Systems**

18 **SEC. 211. ESTABLISHMENT OF DEMONSTRATION**
19 **PROJECTS.**

20 Not later than 1 year after the date of the enactment
21 of this Act, the Secretary of Health and Human Services
22 (in this subtitle referred to as the “Secretary”) shall es-
23 tablish such demonstration projects as may be necessary
24 to test alternative methods for organizing the structure

1 of the health care financing and delivery system of the
2 United States.

3 **SEC. 212. PROCESS.**

4 (a) IN GENERAL.—In carrying out section 211, the
5 Secretary—

6 (1) may initiate demonstration projects under
7 this subtitle, and

8 (2) may seek applications from States desiring
9 to test alternative health care financing and delivery
10 systems within their jurisdictions.

11 (b) STATE APPLICATIONS.—

12 (1) IN GENERAL.—A State seeking approval of
13 a demonstration project under this subtitle shall file
14 an application in such form, in such manner, and at
15 such time as the Secretary may require.

16 (2) EVALUATION.—In evaluating an application
17 submitted under paragraph (1) for a project, the
18 Secretary shall take into account support for the
19 project by the citizens of a State as evidenced by the
20 enactment of legislation providing for implementa-
21 tion of an alternative health care financing and de-
22 livery system in every political subdivision of the
23 State.

1 (c) CONSULTATION.—Before making a final deter-
2 mination on approving a demonstration project under this
3 subtitle, the Secretary shall—

4 (1) consult with policy experts about any waiv-
5 ers necessary under section 215(a),

6 (2) consult with the Secretary of Labor and the
7 Attorney General about any waivers necessary under
8 subsections (b) and (c) of section 215, respectively,

9 (3) provide an opportunity for all parties that
10 would be affected by the demonstration project to
11 express their views, and

12 (4) in the case of a project initiated by the Sec-
13 retary, obtain the approval of the State regarding
14 any changes in the rules applicable to the State plan
15 approved under title XIX of the Social Security Act.

16 (d) NO INCREASE IN FEDERAL EXPENDITURES.—
17 The Secretary may not establish or approve a demonstra-
18 tion project under this subtitle unless the Secretary deter-
19 mines that the total amount expended by the Federal gov-
20 ernment under titles XVIII and XIX of the Social Security
21 Act for such project (other than amounts expended for the
22 evaluation of the projects under section 216(b)) will not
23 exceed the total amount that would have been expended
24 under such titles but for such project.

1 **SEC. 213. PRIORITIES.**

2 In establishing and approving demonstration projects
3 under this subtitle, the Secretary shall make it a priority
4 to work cooperatively with States to secure locations to
5 conduct the following:

6 (1) **BASICARE HEALTH ACCESS DEMONSTRATION PROJECT.**—A demonstration project under
7 which—
8

9 (A) the costs associated with the purchase
10 of coverage for the minimum benefit package
11 established under section 203 would be fully
12 tax-deductible, and

13 (B) the costs associated with the purchase
14 of coverage not included in the minimum bene-
15 fit package would be deductible by the employer
16 but not the employee.

17 (2) **MANAGED COMPETITION DEMONSTRATION**
18 **PROJECT.**—A demonstration project that—

19 (A) provides for competition among com-
20 munity health partnerships offered to individ-
21 uals and employers through health insurance
22 purchasing cooperatives;

23 (B) provides for premiums that are com-
24 munity-rated and for the adjustment of pre-
25 miums paid to plans based on the risk charac-
26 teristics of individuals enrolled in the plan;

1 (C) limits the tax benefits for employer
2 contributions to the lowest price of a commu-
3 nity health partnership offered in an area; and

4 (D) provides for the systematic reporting
5 and public dissemination of information on the
6 performance of plans in meeting the health care
7 needs of enrollees.

8 (3) MEDICAL SAVINGS ACCOUNT DEMONSTRA-
9 TION PROJECT.—A demonstration project that pro-
10 vides that—

11 (A) contributions made by an employer on
12 behalf of an employee to a medical savings ac-
13 count, in lieu of payment for health insurance
14 premiums, are treated as excludable from in-
15 come for purposes of determining the income
16 tax and employment tax liability of the em-
17 ployee, and

18 (B) such account may be used for the pur-
19 chase of health care insurance or out-of-pocket
20 health care expenses.

21 (4) COORDINATED CARE NETWORKS DEM-
22 ONSTRATION PROJECT.—A demonstration project
23 that provides health care services through a network
24 of regional health care providers in a manner that

1 promotes the greatest efficiencies in the utilization
2 of expensive services and technology.

3 **SEC. 214. SCOPE AND DURATION OF PROJECTS.**

4 The demonstration projects conducted under this
5 subtitle shall be of such scope and duration as may be
6 necessary to test and evaluate the approach tested under
7 the project.

8 **SEC. 215. WAIVERS OF CERTAIN LAWS.**

9 (a) **MEDICARE AND MEDICAID LAWS.**—The Sec-
10 retary may waive such provisions of titles XVIII (other
11 than provisions relating to the eligibility for, and the scope
12 of, benefits under such title) and XIX of the Social Secu-
13 rity Act as may be necessary to implement a demonstra-
14 tion project under this subtitle.

15 (b) **ERISA.**—The Secretary of Labor may waive sec-
16 tion 514(a) of the Employee Retirement Income Security
17 Act of 1974 (as that provision limits the application of
18 State laws to employee benefit plans) to the extent nec-
19 essary to permit a State to implement a demonstration
20 project under this subtitle.

21 (c) **ANTITRUST LAWS.**—

22 (1) **IN GENERAL.**—Subject to paragraph (2),
23 the Attorney General may waive such provisions
24 of—

25 (A) the Sherman Act,

1 (B) the Clayton Act, and
2 (C) the Federal Trade Commission Act,
3 as may be necessary to permit a State to implement
4 a demonstration project under this subtitle.

5 (2) DETERMINATION REQUIRED.—A provision
6 specified in paragraph (1) may be waived only if the
7 Attorney General determines that the demonstration
8 project would reduce health care costs on a system-
9 wide basis.

10 **SEC. 216. REPORTS AND EVALUATIONS.**

11 (a) CONGRESSIONAL REPORTS.—The Secretary shall
12 submit to the Congress—

13 (1) annually a report on the status of each
14 demonstration project being conducted under this
15 subtitle, and

16 (2) a final report on each such project not later
17 than 1 year after the close of the project.

18 (b) INDEPENDENT EVALUATION.—

19 (1) IN GENERAL.—The Secretary shall arrange
20 for an independent evaluation of each demonstration
21 project conducted under this subtitle and for the
22 submission of the evaluation to the National Health
23 Care Reform Commission (established under section
24 201) not later than 1 year after the close of the
25 project.

1 (2) TRANSFER OF FUNDS.—The Secretary shall
2 provide for the transfer from the Federal Hospital
3 Insurance Trust Fund of such sums as may be nec-
4 essary to provide for the evaluation of demonstration
5 projects conducted under this subtitle (without re-
6 gard to amounts appropriated in advance in appro-
7 priation Acts).

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