

103D CONGRESS
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H. R. 3600

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 20, 1993

Mr. GEPHARDT (for himself, Mr. BONIOR, Mr. HOYER, Mr. FAZIO, Mrs. KENNELLY, Mr. LEWIS of Georgia, Mr. RICHARDSON, Mr. DINGELL, Mr. ROSTENKOWSKI, Mr. FORD of Michigan, Mr. WAXMAN, Mrs. COLLINS of Illinois, Mr. STARK, Mr. WILLIAMS, Mr. CLAY, Mr. BROOKS, Mr. MOAKLEY, Mr. ABERCROMBIE, Mr. ACKERMAN, Mr. ANDREWS of Maine, Mr. BARRETT of Wisconsin, Mr. BERMAN, Mr. BILBRAY, Mr. BLACKWELL, Mr. BORSKI, Mr. BROWN of California, Ms. BROWN of Florida, Mr. CARDIN, Mr. CLYBURN, Mr. COYNE, Mr. DE LUGO, Ms. DELAURO, Mr. DEUTSCH, Mr. DICKS, Mr. DIXON, Mr. DURBIN, Mr. EDWARDS of California, Mr. ENGEL, Ms. ENGLISH of Arizona, Ms. ESHOO, Mr. FALEOMAVAEGA, Mr. FILNER, Mr. FLAKE, Mr. FOGLIETTA, Mr. FRANK of Massachusetts, Mr. GEJDENSON, Mr. GIBBONS, Mr. HASTINGS, Mr. HILLIARD, Mr. HINCHEY, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSTON of Florida, Mr. KANJORSKI, Mr. KREIDLER, Mr. LaFALCE, Mr. LANTOS, Mr. LEVIN, Ms. LONG, Mr. MARTINEZ, Mr. MATSUI, Ms. MCKINNEY, Mrs. MEEK, Mr. MINGE, Mrs. MINK, Mr. MURPHY, Mr. MURTHA, Ms. NORTON, Mr. OBERSTAR, Mr. OBEY, Mr. OWENS, Mr. PASTOR, Mr. PAYNE of New Jersey, Mr. RAHALL, Mr. RANGEL, Mr. REYNOLDS, Mr. ROMERO-BARCELÓ, Mr. RUSH, Mr. SABO, Mr. SAWYER, Mr. SCOTT, Mr. SERRANO, Ms. SHEPHERD, Mr. SKAGGS, Ms. SLAUGHTER, Mr. SMITH of Iowa, Mr. STOKES, Mr. STRICKLAND, Mr. STUDDS, Mr. SWIFT, Mr. SYNAR, Mr. THORNTON, Mrs. THURMAN, Mr. TRAFICANT, Mr. UNDERWOOD, Mrs. UNSOELD, Mr. VENTO, Mr. WATT, Mr. WHEAT, Mr. WISE, and Mr. YATES) introduced the following bill; which was referred jointly to the Committee on Energy and Commerce, to the Committee on Ways and Means, and to the Committee on Education and Labor for consideration of such provisions in titles I, III, VI, VIII, X, and XI as fall within its jurisdiction pursuant to clause 1(g) of rule X; and concurrently, for a period ending not later than two weeks after all three committees of joint referral report to the House (or a later time

if the Speaker so designates), to the Committee on Armed Services for consideration of subtitle A of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(e) of rule X, to the Committee on Veterans' Affairs for consideration of subtitle B of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(u) of rule X, to the Committee on Post Office and Civil Service for consideration of subtitle C of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(o) of rule X, to the Committee on Natural Resources for consideration of subtitle D of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(n) of rule X, to the Committee on the Judiciary for consideration of subtitles C through F of title V and such other provisions as fall within its jurisdiction pursuant to clause 1(l) of rule X, to the Committee on Rules for consideration of sections 1432(d), 6006(f), and 9102(e)(5), and to the Committee on Government Operations for consideration of subtitle B of title V and section 5401

FEBRUARY 4, 1994

Additional sponsors: Mr. CARR of Michigan and Mr. SWETT

A BILL

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

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

SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUB-TITLES.

(a) SHORT TITLE.—This Act may be cited as the “Health Security Act”.

(b) TABLE OF TITLES AND SUBTITLES IN ACT.—The following are the titles and subtitles contained in this Act:

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1 **SEC. 2. FINDINGS.**

2 The Congress finds as follows:

3 (1) Under the current health care system in the
4 United States—

5 (A) individuals risk losing their health care
6 coverage when they move, when they lose or
7 change jobs, when they become seriously ill, or
8 when the coverage becomes unaffordable;

9 (B) continued escalation of health care
10 costs threatens the economy of the United
11 States, undermines the international competi-
12 tiveness of the Nation, and strains Federal,
13 State, and local budgets;

14 (C) an excessive burden of forms, paper-
15 work, and bureaucratic procedures confuses
16 consumers and overwhelms health care pro-
17 viders;

18 (D) fraud and abuse sap the strength of
19 the health care system; and

20 (E) health care is a critical part of the
21 economy of the United States and interstate
22 commerce, consumes a significant percentage of
23 public and private spending, and affects all in-
24 dustries and individuals in the United States.

25 (2) Under any reform of the health care
26 system—

1 (A) health insurance and high quality
2 health care should be secure, uninterrupted,
3 and affordable for all individuals in the United
4 States;

5 (B) comprehensive health care benefits
6 that meet the full range of health needs, includ-
7 ing primary, preventive, and specialized care,
8 should be available to all individuals in the
9 United States;

10 (C) the current high quality of health care
11 in the United States should be maintained;

12 (D) individuals in the United States should
13 be afforded a meaningful opportunity to choose
14 among a range of health plans, health care pro-
15 viders, and treatments;

16 (E) regulatory and administrative burdens
17 should be reduced;

18 (F) the rapidly escalating costs of health
19 care should be contained without sacrificing
20 high quality or impeding technological improve-
21 ments;

22 (G) competition in the health care industry
23 should ensure that health plans and health care
24 providers are efficient and charge reasonable
25 prices;

1 (H) a partnership between the Federal
2 Government and each State should allow the
3 State and its local communities to design an ef-
4 fective, high-quality system of care that serves
5 the residents of the State;

6 (I) all individuals should have a responsi-
7 bility to pay their fair share of the costs of
8 health care coverage;

9 (J) a health care system should build on
10 the strength of the employment-based coverage
11 arrangements that now exist in the United
12 States;

13 (K) the penalties for fraud and abuse
14 should be swift and severe; and

15 (L) an individual's medical information
16 should remain confidential and should be pro-
17 tected from unauthorized disclosure and use.

18 **SEC. 3. PURPOSES.**

19 The purposes of this Act are as follows:

20 (1) To guarantee comprehensive and secure
21 health care coverage.

22 (2) To simplify the health care system for con-
23 sumers and health care professionals.

(3) To control the cost of health care for employers, employees, and others who pay for health care coverage.

4 (4) To promote individual choice among health
5 plans and health care providers.

6 (5) To ensure high quality health care.

(6) To encourage all individuals to take responsibility for their health care coverage.

9 **TITLE I—HEALTH CARE**
10 **SECURITY**

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1 **TITLE I—HEALTH CARE**
2 **SECURITY**
3 **Subtitle A—Universal Coverage**
4 **and Individual Responsibility**
5 **PART 1—UNIVERSAL COVERAGE**

6 **SEC. 1001. ENTITLEMENT TO HEALTH BENEFITS.**

7 (a) IN GENERAL.—In accordance with this part, each
8 eligible individual is entitled to the comprehensive benefit
9 package under subtitle B through the applicable health
10 plan in which the individual is enrolled consistent with this
11 title.

12 (b) HEALTH SECURITY CARD.—Each eligible indi-
13 vidual is entitled to a health security card to be issued
14 by the alliance or other entity that offers the applicable
15 health plan in which the individual is enrolled.

16 (c) ELIGIBLE INDIVIDUAL DEFINED.—In this Act,
17 the term “eligible individual” means an individual who is
18 residing in the United States and who is—

19 (1) a citizen or national of the United States;

20 (2) an alien permanently residing in the United
21 States under color of law (as defined in section
22 1902(1)); or

23 (3) a long-term nonimmigrant (as defined in
24 section 1902(19)).

1 (d) TREATMENT OF MEDICARE-ELIGIBLE INDIVID-
2 UALS.—Subject to section 1012(a), a medicare-eligible in-
3 dividual is entitled to health benefits under the medicare
4 program instead of the entitlement under subsection (a).

5 (e) TREATMENT OF PRISONERS.—A prisoner (as de-
6 fined in section 1902(26)) is entitled to health care serv-
7 ices provided by the authority responsible for the prisoner
8 instead of the entitlement under subsection (a).

9 **SEC. 1002. INDIVIDUAL RESPONSIBILITIES.**

10 (a) IN GENERAL.—In accordance with this Act, each
11 eligible individual (other than a medicare-eligible indi-
12 vidual)—

13 (1) must enroll in an applicable health plan for
14 the individual, and

15 (2) must pay any premium required, consistent
16 with this Act, with respect to such enrollment.

17 (b) LIMITATION ON DISENROLLMENT.—No eligible
18 individual shall be disenrolled from an applicable health
19 plan until the individual—

20 (1) is enrolled under another applicable health
21 plan, or

22 (2) becomes a medicare-eligible individual.

23 **SEC. 1003. PROTECTION OF CONSUMER CHOICE.**

24 Nothing in this Act shall be construed as prohibiting
25 the following:

1 (1) An individual from purchasing any health
2 care services.

3 (2) An individual from purchasing supplemental
4 insurance (offered consistent with this Act) to cover
5 health care services not included within the com-
6 prehensive benefit package.

7 (3) An individual who is not an eligible indi-
8 vidual from purchasing health insurance (other than
9 through a regional alliance).

10 (4) Employers from providing coverage for ben-
11 efits in addition to the comprehensive benefit pack-
12 age (subject to part 2 of subtitle E).

13 **SEC. 1004. APPLICABLE HEALTH PLAN PROVIDING COV-**
14 **ERAGE.**

15 (a) SPECIFICATION OF APPLICABLE HEALTH
16 PLAN.—Except as otherwise provided:

17 (1) GENERAL RULE: REGIONAL ALLIANCE
18 HEALTH PLANS.—The applicable health plan for a
19 family is a regional alliance health plan for the alli-
20 ance area in which the family resides.

21 (2) CORPORATE ALLIANCE HEALTH PLANS.—In
22 the case of a family member that is eligible to enroll
23 in a corporate alliance health plan under section
24 1311(c), the applicable health plan for the family is
25 such a corporate alliance health plan.

1 (b) CHOICE OF PLANS FOR CERTAIN GROUPS.—

2 (1) MILITARY PERSONNEL AND FAMILIES.—For
3 military personnel and families who elect a Uni-
4 formed Services Health Plan of the Department of
5 Defense under section 1073a(d) of title 10, United
6 States Code, as inserted by section 8001(a) of this
7 Act, that plan shall be the applicable health plan.

8 (2) VETERANS.—For veterans and families who
9 elect to enroll in a veterans health plan under sec-
10 tion 1801 of title 38, United States Code, as in-
11 serted by section 8101(a) of this Act, that plan shall
12 be the applicable health plan.

13 (3) INDIANS.—For those individuals who are el-
14 igible to enroll, and who elect to enroll, in a health
15 program of the Indian Health Service under section
16 8302(b) or 8306(b), that program shall be the appli-
17 cable health plan.

18 **SEC. 1005. TREATMENT OF OTHER NONIMMIGRANTS.**

19 (a) UNDOCUMENTED ALIENS INELIGIBLE FOR BEN-
20 EFITS.—An undocumented alien is not eligible to obtain
21 the comprehensive benefit package through enrollment in
22 a health plan pursuant to this Act.

23 (b) DIPLOMATS AND OTHER FOREIGN GOVERNMENT
24 OFFICIALS.—Subject to conditions established by the Na-
25 tional Health Board in consultation with the Secretary of

1 State, a nonimmigrant under subparagraph (A) or (G) of
2 section 101(a)(15) of the Immigration and Nationality Act
3 may obtain the comprehensive benefit package through en-
4 rollment in the regional alliance health plan for the alli-
5 ance area in which the nonimmigrant resides.

6 (c) RECIPROCAL TREATMENT OF OTHER NON-
7 IMMIGRANTS.—With respect to those classes of individuals
8 who are lawful nonimmigrants but who are not long-term
9 nonimmigrants (as defined in section 1902(19)) or de-
10 scribed in subsection (b), such individuals may obtain such
11 benefits through enrollment with regional alliance health
12 plans only in accordance with such reciprocal agreements
13 between the United States and foreign states as may be
14 entered into.

15 **SEC. 1006. EFFECTIVE DATE OF ENTITLEMENT.**

16 (a) REGIONAL ALLIANCE ELIGIBLE INDIVIDUALS.—

17 (1) IN GENERAL.—In the case of regional alli-
18 ance eligible individuals residing in a State, the enti-
19 tlement under this part (and requirements under
20 section 1002) shall not take effect until the State
21 becomes a participating State (as defined in section
22 1200).

23 (2) TRANSITIONAL RULE FOR CORPORATE ALLI-
24 ANCES.—

1 (A) IN GENERAL.—In the case of a State
2 that becomes a participating State before the
3 general effective date (as defined in subsection
4 (c)) and for periods before such date, under
5 rules established by the Board, an individual
6 who is covered under a plan (described in sub-
7 paragraph (C)) based on the individual (or the
8 individual’s spouse) being a qualifying employee
9 of a qualifying employer, the individual shall
10 not be treated under this Act as a regional alli-
11 ance eligible individual.

12 (B) QUALIFYING EMPLOYER DEFINED.—In
13 subparagraph (A), the term “qualifying em-
14 ployer” means an employer that—

15 (i) is described in section
16 1311(b)(1)(A), or is participating in a
17 multiemployer plan described in section
18 1311(b)(1)(B) or plan described in section
19 1311(b)(1)(C), and

20 (ii) provides such notice to the re-
21 gional alliance involved as the Board speci-
22 fies.

23 (C) BENEFITS PLAN DESCRIBED.—A plan
24 described in this subparagraph is an employee
25 benefit plan that—

1 (i) provides (through insurance or
2 otherwise) the comprehensive benefit pack-
3 age, and

4 (ii) provides an employer contribution
5 of at least 80 percent of the premium (or
6 premium equivalent) for coverage.

7 (b) CORPORATE ALLIANCE ELIGIBLE INDIVID-
8 UALS.—

9 (1) IN GENERAL.—In the case of corporate alli-
10 ance eligible individuals, the entitlement under this
11 part shall not take effect until the general effective
12 date.

13 (2) TRANSITION.—For purposes of this Act and
14 before the general effective date, in the case of an
15 eligible individual who resides in a participating
16 State, the individual is deemed a regional alliance el-
17 igible individual until the individual becomes a cor-
18 porate alliance eligible individual, unless subsection
19 (a)(2)(A) applies to the individual.

20 (c) GENERAL EFFECTIVE DATE DEFINED.—In this
21 Act, the term “general effective date” means January 1,
22 1998.

1 **PART 2—TREATMENT OF**
2 **FAMILIES AND SPECIAL RULES**
3 **SEC. 1011. GENERAL RULE OF ENROLLMENT OF FAMILY IN**
4 **SAME HEALTH PLAN.**

5 (a) IN GENERAL.—Except as provided in this part
6 or otherwise, all members of the same family (as defined
7 in subsection (b)) shall be enrolled in the same applicable
8 health plan.

9 (b) FAMILY DEFINED.—In this Act, unless otherwise
10 provided, the term “family”—

11 (1) means, with respect to an eligible individual
12 who is not a child (as defined in subsection (c)), the
13 individual; and

14 (2) includes the following persons (if any):

15 (A) The individual’s spouse if the spouse is
16 an eligible individual.

17 (B) The individual’s children (and, if appli-
18 cable, the children of the individual’s spouse) if
19 they are eligible individuals.

20 (c) CLASSES OF FAMILY ENROLLMENT; TERMI-
21 NOLOGY.—

22 (1) IN GENERAL.—In this Act, each of the fol-
23 lowing is a separate class of family enrollment:

1 (A) Coverage only of an individual (re-
2 ferred to in this Act as the “individual” enroll-
3 ment or class of enrollment).

4 (B) Coverage of a married couple without
5 children (referred to in this Act as the “couple-
6 only” enrollment or class of enrollment).

7 (C) Coverage of an unmarried individual
8 and one or more children (referred to in this
9 Act as the “single parent” enrollment or class
10 of enrollment).

11 (D) Coverage of a married couple and one
12 or more children (referred to in this Act as the
13 “dual parent” enrollment or class of enroll-
14 ment).

15 (2) REFERENCES TO FAMILY AND COUPLE
16 CLASSES OF ENROLLMENT.—In this Act:

17 (A) FAMILY.—The terms “family enroll-
18 ment” and “family class of enrollment”, refer
19 to enrollment in a class of enrollment described
20 in subparagraph (B), (C), or (D) of paragraph
21 (1).

22 (B) COUPLE.—The term “couple class of
23 enrollment” refers to enrollment in a class of
24 enrollment described in subparagraph (B) or
25 (D) of paragraph (1).

1 (d) SPOUSE; MARRIED; COUPLE.—

2 (1) IN GENERAL.—In this Act, the terms
3 “spouse” and “married” mean, with respect to a
4 person, another individual who is the spouse of the
5 person or married to the person, as determined
6 under applicable State law.

7 (2) COUPLE.—The term “couple” means an in-
8 dividual and the individual’s spouse.

9 (e) CHILD DEFINED.—

10 (1) IN GENERAL.—In this Act, except as other-
11 wise provided, the term “child” means an eligible in-
12 dividual who (consistent with paragraph (3))—

13 (A) is under 18 years of age (or under 24
14 years of age in the case of a full-time student),
15 and

16 (B) is a dependent of an eligible individual.

17 (2) APPLICATION OF STATE LAW.—Subject to
18 paragraph (3), determinations of whether a person
19 is the child of another person shall be made in ac-
20 cordance with applicable State law.

21 (3) NATIONAL RULES.—The National Health
22 Board may establish such national rules respecting
23 individuals who will be treated as children under this
24 Act as the Board determines to be necessary. Such

1 rules shall be consistent with the following prin-
2 ciples:

3 (A) STEP AND FOSTER CHILD.—A child in-
4 cludes a step child or foster child who is an eli-
5 gible individual living with an adult in a regular
6 parent-child relationship.

7 (B) DISABLED CHILD.—A child includes
8 an unmarried dependent eligible individual re-
9 gardless of age who is incapable of self-support
10 because of mental or physical disability which
11 existed before age 21.

12 (C) CERTAIN 3-GENERATION FAMILIES.—A
13 child includes the grandchild of an individual, if
14 the parent of the grandchild is a child and the
15 parent and grandchild are living with the
16 grandparent.

17 (D) TREATMENT OF EMANCIPATED MI-
18 NORS AND MARRIED INDIVIDUALS.—An emanci-
19 pated minor or married individual shall not be
20 treated as a child.

21 (E) CHILDREN PLACED FOR ADOPTION.—
22 A child includes a child who is placed for adop-
23 tion with an eligible individual.

1 (f) ADDITIONAL RULES.—The Board shall provide
2 for such additional exceptions and special rules, including
3 rules relating to—

4 (1) families in which members are not residing
5 in the same area or in which children are not resid-
6 ing with their parents,

7 (2) the treatment of eligible individuals who are
8 under 19 years of age and who are not a dependent
9 of an eligible individual,

10 (3) changes in family composition occurring
11 during a year, and

12 (4) treatment of children of parents who are
13 separated or divorced,

14 as the Board finds appropriate.

15 **SEC. 1012. TREATMENT OF CERTAIN FAMILIES.**

16 (a) TREATMENT OF MEDICARE-ELIGIBLE INDIVID-
17 UALS WHO ARE QUALIFYING EMPLOYEES OR SPOUSES OF
18 QUALIFYING EMPLOYEES.—

19 (1) IN GENERAL.—Except as specifically pro-
20 vided, in the case of an individual who is an indi-
21 vidual described in paragraph (2) with respect to 2
22 consecutive months in a year (and it is anticipated
23 would be in the following month and in such fol-
24 lowing month would be a medicare-eligible individual
25 but for this paragraph), the individual shall not be

1 treated as a medicare-eligible individual under this
2 Act during such following month and the remainder
3 of the year.

4 (2) INDIVIDUAL DESCRIBED.—An individual de-
5 scribed in this paragraph with respect to a month is
6 an individual who is a qualifying employee or the
7 spouse or family member of a qualifying employee in
8 the month.

9 (b) SEPARATE TREATMENT FOR CERTAIN GROUPS
10 OF INDIVIDUALS.—In the case of a family that includes
11 one or more individuals in a group described in subsection
12 (c)—

13 (1) all the individuals in each such group within
14 the family shall be treated collectively as a separate
15 family, and

16 (2) all the individuals not described in any such
17 group shall be treated collectively as a separate fam-
18 ily.

19 (c) GROUPS OF INDIVIDUALS DESCRIBED.—Each of
20 the following is a group of individuals described in this
21 subsection:

22 (1) AFDC recipients (as defined in section
23 1902(3)).

24 (2) Disabled SSI recipients (as defined in sec-
25 tion 1902(13)) .

1 (3) SSI recipients (as defined in section
2 1902(33)) who are not disabled SSI recipients.

3 (4) Electing veterans (as defined in subsection
4 (d)(1)).

5 (5) Active duty military personnel (as defined
6 in subsection (d)(2)).

7 (6) Electing Indians (as defined in subsection
8 (d)(3)).

9 (7) Prisoners (as defined in section 1902(26)).

10 (d) SPECIAL RULES.—In this Act:

11 (1) ELECTING VETERANS.—

12 (A) DEFINED.—Subject to subparagraph
13 (B), the term “electing veteran” means a vet-
14 eran who makes an election to enroll with a
15 health plan of the Department of Veterans Af-
16 fairs under chapter 18 of title 38, United
17 States Code, as added by section 8101(a)(1).

18 (B) FAMILY EXCEPTION.—Subparagraph
19 (A) shall not apply with respect to coverage
20 under a health plan referred to in such sub-
21 paragraph if, for the area in which the electing
22 veteran resides, such health plan offers cov-
23 erage to family members of an electing veteran
24 and the veteran elects family enrollment under
25 such plan (instead of individual enrollment).

1 (2) ACTIVE DUTY MILITARY PERSONNEL.—

2 (A) IN GENERAL.—Subject to subpara-
3 graph (B), the term “active duty military per-
4 sonnel” means an individual on active duty in
5 the Uniformed Services of the United States.

6 (B) EXCEPTION.—If an individual de-
7 scribed in subparagraph (A) elects family cov-
8 erage under section 1073a(e)(2)(A) of title 10,
9 United States Code (as added by section
10 8001(a)), then paragraph (5) of subsection (c)
11 shall not apply with respect to such coverage.

12 (3) ELECTING INDIANS.—

13 (A) IN GENERAL.—Subject to subpara-
14 graph (B), the term “electing Indian” means
15 an eligible individual who makes an election
16 under section 8302(b) of this Act.

17 (B) FAMILY ELECTION FOR ALL INDIVID-
18 UALS ELIGIBLE TO ELECT.—No such election
19 shall be made with respect to an individual in
20 a family (as defined without regard to this sec-
21 tion) unless such election is made for all eligible
22 individuals (described in section 8302(a)) who
23 are family members of the family.

24 (4) MULTIPLE CHOICE.—Eligible individuals
25 who are permitted to elect coverage under more than

1 one health plan or program referred to in this sub-
2 section may elect which of such plans or programs
3 will be the applicable health plan under this Act.

4 (e) QUALIFYING STUDENTS.—

5 (1) IN GENERAL.—In the case of a qualifying
6 student (described in paragraph (2)), the student
7 may elect to enroll in a regional alliance health plan
8 offered by the regional alliance for the area in which
9 the school is located.

10 (2) QUALIFYING STUDENT.—In paragraph (1),
11 the term “qualifying student” means an individual
12 who—

13 (A) but for this subsection would receive
14 coverage under a health plan as a child of an-
15 other person, and

16 (B) is a full-time student at a school in an
17 alliance area that is different from the alliance
18 area (or, in the case of a corporate alliance,
19 such coverage area as the Board may specify)
20 providing the coverage described in subpara-
21 graph (A).

22 (3) PAYMENT RULES.—

23 (A) CONTINUED TREATMENT AS FAM-
24 ILY.—Except as provided in subparagraph (B),
25 nothing in this subsection shall be construed as

1 affecting the payment liabilities between fami-
2 lies and health alliances or between health alli-
3 ances and health plans.

4 (B) TRANSFER PAYMENT.—In the case of
5 an election under paragraph (1), for transfer
6 payments see section 1346(e).

7 (f) SPOUSES LIVING IN DIFFERENT ALLIANCE
8 AREAS.—The Board shall provide for such special rules
9 in applying this Act in the case of a couple in which the
10 spouses reside in different alliance areas as the Board
11 finds appropriate.

12 **SEC. 1013. MULTIPLE EMPLOYMENT SITUATIONS.**

13 (a) MULTIPLE EMPLOYMENT OF AN INDIVIDUAL.—
14 In the case of an individual who—

15 (1)(A) is not married or (B) is married and
16 whose spouse is not a qualifying employee (as de-
17 fined in section 1901(b)(1)),

18 (2) is not a child, and

19 (3) who is a qualifying employee both of a re-
20 gional alliance employer and of a corporate alliance
21 employer (or of 2 corporate alliance employers),

22 the individual may elect the applicable health plan to be
23 either a regional alliance health plan (for the alliance area
24 in which the individual resides) or a corporate alliance
25 health plan (for an employer employing the individual).

1 (b) MULTIPLE EMPLOYMENT WITHIN A FAMILY.—

2 (1) MARRIED COUPLE WITH EMPLOYMENT
3 WITH A REGIONAL ALLIANCE EMPLOYER AND WITH
4 A CORPORATE ALLIANCE EMPLOYER.—In the case of
5 a married individual—

6 (A) who is a qualifying employee of a re-
7 gional alliance employer and whose spouse is a
8 qualifying employee of a corporate alliance em-
9 ployer, or

10 (B) who is a qualifying employee of a cor-
11 porate alliance employer and whose spouse is a
12 qualifying employee of a regional alliance em-
13 ployer,

14 the individual and the individual's spouse may elect
15 the applicable health plan to be either a regional alli-
16 ance health plan (for the alliance area in which the
17 couple resides) or a corporate alliance health plan
18 (for an employer employing the individual or the
19 spouse).

20 (2) MARRIED COUPLE WITH DIFFERENT COR-
21 PORATE ALLIANCE EMPLOYERS.—In the case of a
22 married individual—

23 (A) who is a qualifying employee of a cor-
24 porate alliance employer, and

1 (B) whose spouse is a qualifying employee
2 of a different corporate alliance employer,
3 the individual and the individual's spouse may elect
4 the applicable health plan to be a corporate alliance
5 health plan for an employer employing either the in-
6 dividual or the spouse.

7 **SEC. 1014. TREATMENT OF RESIDENTS OF STATES WITH**
8 **STATEWIDE SINGLE-PAYER SYSTEMS.**

9 (a) **UNIVERSAL COVERAGE.**—Notwithstanding the
10 previous provisions of this title, except as provided in part
11 2 of subtitle C, in the case of an individual who resides
12 in a State that has a Statewide single-payer system under
13 section 1223, universal coverage shall be provided con-
14 sistent with section 1222(3).

15 (b) **INDIVIDUAL RESPONSIBILITIES.**—In the case of
16 an individual who resides in a single-payer State, the re-
17 sponsibilities of such individual under such system shall
18 supersede the obligations of the individual under section
19 1002.

Subtitle B—Benefits

PART 1—COMPREHENSIVE

BENEFIT PACKAGE

SEC. 1101. PROVISION OF COMPREHENSIVE BENEFITS BY PLANS.

(a) IN GENERAL.—The comprehensive benefit package shall consist of the following items and services (as described in part 2), subject to the cost sharing requirements described in part 3, the exclusions described in part 4, and the duties and authority of the National Health Board described in part 5:

(1) Hospital services (described in section 1111).

(2) Services of health professionals (described in section 1112).

(3) Emergency and ambulatory medical and surgical services (described in section 1113).

(4) Clinical preventive services (described in section 1114).

(5) Mental illness and substance abuse services (described in section 1115).

(6) Family planning services and services for pregnant women (described in section 1116).

(7) Hospice care (described in section 1117).

1 (8) Home health care (described in section
2 1118).

3 (9) Extended care services (described in section
4 1119).

5 (10) Ambulance services (described in section
6 1120).

7 (11) Outpatient laboratory, radiology, and diag-
8 nostic services (described in section 1121).

9 (12) Outpatient prescription drugs and
10 biologicals (described in section 1122).

11 (13) Outpatient rehabilitation services (de-
12 scribed in section 1123).

13 (14) Durable medical equipment and prosthetic
14 and orthotic devices (described in section 1124).

15 (15) Vision care (described in section 1125).

16 (16) Dental care (described in section 1126).

17 (17) Health education classes (described in sec-
18 tion 1127).

19 (18) Investigational treatments (described in
20 section 1128).

21 (b) NO OTHER LIMITATIONS OR COST SHARING.—

22 The items and services in the comprehensive benefit pack-
23 age shall not be subject to any duration or scope limitation
24 or any deductible, copayment, or coinsurance amount that
25 is not required or authorized under this Act.

1 (c) HEALTH PLAN.—Unless otherwise provided in
2 this subtitle, for purposes of this subtitle, the term “health
3 plan” has the meaning given such term in section 1400.

4 **PART 2—DESCRIPTION OF ITEMS**
5 **AND SERVICES COVERED**

6 **SEC. 1111. HOSPITAL SERVICES.**

7 (a) COVERAGE.—The hospital services described in
8 this section are the following items and services:

9 (1) Inpatient hospital services.

10 (2) Outpatient hospital services.

11 (3) 24-hour a day hospital emergency services.

12 (b) LIMITATION.—The hospital services described in
13 this section do not include hospital services provided for
14 the treatment of a mental or substance abuse disorder
15 (which are subject to section 1115), except for medical de-
16 toxification as required for the management of medical
17 conditions associated with withdrawal from alcohol or
18 drugs (which is not covered under such section).

19 (c) DEFINITIONS.—For purposes of this subtitle:

20 (1) HOSPITAL.—The term “hospital” has the
21 meaning given such term in section 1861(e) of the
22 Social Security Act, except that such term shall
23 include—

24 (A) in the case of an item or service pro-
25 vided to an individual whose applicable health

1 plan is specified pursuant to section 1004(b)(1),
2 a facility of the uniformed services under title
3 10, United States Code, that is primarily en-
4 gaged in providing services to inpatients that
5 are equivalent to the services provided by a hos-
6 pital defined in such section 1861(e);

7 (B) in the case of an item or service pro-
8 vided to an individual whose applicable health
9 plan is specified pursuant to section 1004(b)(2),
10 a facility operated by the Department of Vet-
11 erans Affairs that is primarily engaged in pro-
12 viding services to inpatients that are equivalent
13 to the services provided by a hospital defined in
14 such section 1861(e); and

15 (C) in the case of an item or service pro-
16 vided to an individual whose applicable health
17 plan is specified pursuant to section 1004(b)(3),
18 a facility operated by the Indian Health Service
19 that is primarily engaged in providing services
20 to inpatients that are equivalent to the services
21 provided by a hospital defined in such section
22 1861(e).

23 (2) INPATIENT HOSPITAL SERVICES.—The term
24 “inpatient hospital services” means items and serv-
25 ices described in paragraphs (1) through (3) of sec-

1 tion 1861(b) of the Social Security Act when pro-
2 vided to an inpatient of a hospital. The National
3 Health Board shall specify those health professional
4 services described in section 1112 that shall be
5 treated as inpatient hospital services when provided
6 to an inpatient of a hospital.

7 **SEC. 1112. SERVICES OF HEALTH PROFESSIONALS.**

8 (a) **COVERAGE.**—The items and services described in
9 this section are—

10 (1) inpatient and outpatient health professional
11 services, including consultations, that are provided
12 in—

13 (A) a home, office, or other ambulatory
14 care setting; or

15 (B) an institutional setting; and

16 (2) services and supplies (including drugs and
17 biologicals which cannot be self-administered) fur-
18 nished as an incident to such health professional
19 services, of kinds which are commonly furnished in
20 the office of a health professional and are commonly
21 either rendered without charge or included in the bill
22 of such professional.

23 (b) **LIMITATION.**—The items and services described
24 in this section do not include items or services that are
25 described in any other section of this part. An item or

1 service that is described in section 1114 but is not pro-
2 vided consistent with a periodicity schedule for such item
3 or service specified in such section or under section 1153
4 may be covered under this section if the item or service
5 otherwise meets the requirements of this section.

6 (c) DEFINITIONS.—Unless otherwise provided in this
7 Act, for purposes of this Act:

8 (1) HEALTH PROFESSIONAL.—The term
9 “health professional” means an individual who pro-
10 vides health professional services.

11 (2) HEALTH PROFESSIONAL SERVICES.—The
12 term “health professional services” means profes-
13 sional services that—

14 (A) are lawfully provided by a physician; or

15 (B) would be described in subparagraph

16 (A) if provided by a physician, but are provided
17 by another person who is legally authorized to
18 provide such services in the State in which the
19 services are provided.

20 **SEC. 1113. EMERGENCY AND AMBULATORY MEDICAL AND**
21 **SURGICAL SERVICES.**

22 The emergency and ambulatory medical and surgical
23 services described in this section are the following items
24 and services provided by a health facility that is not a hos-

1 pital and that is legally authorized to provide the services
2 in the State in which they are provided:

3 (1) 24-hour a day emergency services.

4 (2) Ambulatory medical and surgical services.

5 **SEC. 1114. CLINICAL PREVENTIVE SERVICES.**

6 (a) **COVERAGE.**—The clinical preventive services de-
7 scribed in this section are—

8 (1) an item or service for high risk populations
9 (as defined by the National Health Board) that is
10 specified and defined by the Board under section
11 1153, but only when the item or service is provided
12 consistent with any periodicity schedule for the item
13 or service promulgated by the Board;

14 (2) except as modified by the National Health
15 Board under section 1153, an age-appropriate im-
16 munization, test, or clinician visit specified in one of
17 subsections (b) through (h) that is provided con-
18 sistent with any periodicity schedule for the item or
19 service specified in the applicable subsection or by
20 the National Health Board under section 1153; and

21 (3) an immunization, test, or clinician visit that
22 is provided to an individual during an age range
23 other than the age range for such immunization,
24 test, or clinician visit that is specified in one of sub-
25 sections (b) through (h), but only when provided

1 consistent with any requirements for such immuniza-
2 tions, tests, and clinician visits established by the
3 National Health Board under section 1153.

4 (b) INDIVIDUALS UNDER 3.—For an individual
5 under 3 years of age:

6 (1) IMMUNIZATIONS.—The immunizations spec-
7 ified in this subsection are age-appropriate immuni-
8 zations for the following illnesses:

9 (A) Diphtheria.

10 (B) Tetanus.

11 (C) Pertussis.

12 (D) Polio.

13 (E) *Haemophilus influenzae* type B.

14 (F) Measles.

15 (G) Mumps.

16 (H) Rubella.

17 (I) Hepatitis B.

18 (2) TESTS.—The tests specified in this sub-
19 section are as follows:

20 (A) 1 hematocrit.

21 (B) 2 blood tests to screen for blood lead
22 levels for individuals who are at risk for lead
23 exposure.

24 (3) CLINICIAN VISITS.—The clinician visits
25 specified in this subsection are 1 clinician visit for

1 an individual who is newborn and 7 other clinician
2 visits.

3 (c) INDIVIDUALS AGE 3 TO 5.—For an individual at
4 least 3 years of age, but less than 6 years of age:

5 (1) IMMUNIZATIONS.—The immunizations spec-
6 ified in this subsection are age-appropriate immuni-
7 zations for the following illnesses:

8 (A) Diphtheria.

9 (B) Tetanus.

10 (C) Pertussis.

11 (D) Polio.

12 (E) Measles.

13 (F) Mumps.

14 (G) Rubella.

15 (2) TESTS.—The tests specified in this sub-
16 section are 1 urinalysis.

17 (3) CLINICIAN VISITS.—The clinician visits
18 specified in this subsection are 3 clinician visits.

19 (d) INDIVIDUALS AGE 6 TO 12.—For an individual
20 at least 6 years of age, but less than 13 years of age,
21 the clinician visits specified in this subsection are 3 clini-
22 cian visits.

23 (e) INDIVIDUALS AGE 13 TO 19.—For an individual
24 at least 13 years of age, but less than 20 years of age:

1 (1) IMMUNIZATIONS.—The immunizations spec-
2 ified in this subsection are age-appropriate immuni-
3 zations for the following illnesses:

4 (A) Tetanus.

5 (B) Diphtheria.

6 (2) TESTS.—The tests specified in this sub-
7 section are as follows:

8 (A) Papanicolaou smears and pelvic exams,
9 for females who have reached childbearing age
10 and are at risk for cervical cancer, every 3
11 years, but—

12 (i) annually until 3 consecutive nega-
13 tive smears have been obtained, if medi-
14 cally necessary; and

15 (ii) annually for females who are at
16 risk for fertility related infectious illnesses.

17 (B) Annual screening for chlamydia and
18 gonorrhea for females who have reached child-
19 bearing age and are at risk for fertility related
20 infectious illnesses.

21 (3) CLINICIAN VISITS.—The clinician visits
22 specified in this subsection are 3 clinician visits.

23 (f) INDIVIDUALS AGE 20 TO 39.—For an individual
24 at least 20 years of age, but less than 40 years of age:

1 (1) IMMUNIZATIONS.—The immunizations spec-
2 ified in this subsection are booster immunizations
3 against tetanus and diphtheria every 10 years.

4 (2) TESTS.—The tests specified in this sub-
5 section are as follows:

6 (A) Papanicolaou smears and pelvic exams
7 for females every 3 years, but—

8 (i) annually if an abnormal smear has
9 been obtained, until 3 consecutive negative
10 smears have been obtained; and

11 (ii) annually for females who are at
12 risk for fertility related infectious illnesses.

13 (B) Annual screening for chlamydia and
14 gonorrhea for females who are at risk for fer-
15 tility related infectious illnesses.

16 (C) Cholesterol every 5 years.

17 (3) CLINICIAN VISITS.—The clinician visits
18 specified in this subsection are 1 clinician visit every
19 3 years.

20 (g) INDIVIDUALS AGE 40 TO 49.—For an individual
21 at least 40 years of age, but less than 50 years of age:

22 (1) IMMUNIZATIONS.—The immunizations spec-
23 ified in this subsection are booster immunizations
24 against tetanus and diphtheria every 10 years.

1 (2) TESTS.—The tests specified in this sub-
2 section are as follows:

3 (A) Papanicolaou smears and pelvic exams
4 for females every 2 years, but—

5 (i) annually if an abnormal smear has
6 been obtained, until 3 consecutive negative
7 smears have been obtained; and

8 (ii) annually for females who are at
9 risk for fertility related infectious illnesses.

10 (B) Annual screening for chlamydia and
11 gonorrhea for females who are at risk for fer-
12 tility related infectious illnesses.

13 (C) Cholesterol every 5 years.

14 (3) CLINICIAN VISITS.—The clinician visits
15 specified in this subsection are 1 clinician visit every
16 2 years.

17 (h) INDIVIDUALS AGE 50 TO 65.—For an individual
18 at least 50 years of age, but less than 65 years of age:

19 (1) IMMUNIZATIONS.—The immunizations spec-
20 ified in this subsection are booster immunizations
21 against tetanus and diphtheria every 10 years.

22 (2) TESTS.—The tests specified in this sub-
23 section are as follows:

24 (A) Papanicolaou smears and pelvic exams
25 for females every 2 years.

1 (B) Mammograms for females every 2
2 years.

3 (C) Cholesterol every 5 years.

4 (3) CLINICIAN VISITS.—The clinician visits
5 specified in this subsection are 1 clinician visit every
6 2 years.

7 (i) INDIVIDUALS AGE 65 OR OLDER.—For an indi-
8 vidual at least 65 years of age who is enrolled under a
9 health plan:

10 (1) IMMUNIZATIONS.—The immunizations spec-
11 ified in this subsection are as follows:

12 (A) Booster immunizations against tetanus
13 and diphtheria every 10 years.

14 (B) Age-appropriate immunizations for the
15 following illnesses:

16 (i) Influenza.

17 (ii) Pneumococcal invasive disease.

18 (2) TESTS.—The tests specified in this sub-
19 section are as follows:

20 (A) Papanicolaou smears and pelvic exams
21 for females who are at risk for cervical cancer
22 every 2 years.

23 (B) Mammograms for females every 2
24 years.

25 (C) Cholesterol every 5 years.

1 (3) CLINICIAN VISITS.—The clinician visits
2 specified in this subsection are 1 clinician visit every
3 year.

4 (j) CLINICIAN VISIT.—For purposes of this section,
5 the term “clinician visit” includes the following health pro-
6 fessional services (as defined in section 1112(c)):

7 (1) A complete medical history.

8 (2) An appropriate physical examination.

9 (3) Risk assessment.

10 (4) Targeted health advice and counseling, in-
11 cluding nutrition counseling.

12 (5) The administration of age-appropriate im-
13 munizations and tests specified in subsections (b)
14 through (h).

15 (k) IMMUNIZATIONS AND TESTS NOT ADMINISTERED
16 DURING CLINICIAN VISIT.—Notwithstanding subsection
17 (i)(5), the clinical preventive services described in this sec-
18 tion include an immunization or test described in this sec-
19 tion that is administered to an individual consistent with
20 any periodicity schedule for the immunization or test dur-
21 ing the age range specified for the immunization or test,
22 and any administration fee for such immunization or test,
23 even if the immunization or test is not administered dur-
24 ing a clinician visit.

1 **SEC. 1115. MENTAL ILLNESS AND SUBSTANCE ABUSE SERV-**
2 **ICES.**

3 (a) **COVERAGE.**—The mental illness and substance
4 abuse services that are described in this section are the
5 following items and services for eligible individuals, as de-
6 fined in section 1001(c), who satisfy the eligibility require-
7 ments in subsection (b):

8 (1) Inpatient and residential mental illness and
9 substance abuse treatment (described in subsection
10 (c)).

11 (2) Intensive nonresidential mental illness and
12 substance abuse treatment (described in subsection
13 (d)).

14 (3) Outpatient mental illness and substance
15 abuse treatment (described in subsection (e)), in-
16 cluding case management, screening and assessment,
17 crisis services, and collateral services.

18 (b) **ELIGIBILITY.**—The eligibility requirements re-
19 ferred to in subsection (a) are as follows:

20 (1) **INPATIENT, RESIDENTIAL, NONRESIDEN-**
21 **TIAL, AND OUTPATIENT TREATMENT.**—An eligible
22 individual is eligible to receive coverage for inpatient
23 and residential mental illness and substance abuse
24 treatment, intensive nonresidential mental illness
25 and substance abuse treatment, or outpatient mental
26 illness and substance abuse treatment (except case

1 management and collateral services) if the
2 individual—

3 (A) has, or has had during the 1-year pe-
4 riod preceding the date of such treatment, a
5 diagnosable mental disorder or a diagnosable
6 substance abuse disorder; and

7 (B) is experiencing, or is at significant risk
8 of experiencing, functional impairment in fam-
9 ily, work, school, or community activities.

10 For purposes of this paragraph, an individual who
11 has a diagnosable mental disorder or a diagnosable
12 substance abuse disorder, is receiving treatment for
13 such disorder, but does not satisfy the functional im-
14 pairment criterion in subparagraph (B) shall be
15 treated as satisfying such criterion if the individual
16 would satisfy such criterion without such treatment.

17 (2) CASE MANAGEMENT.—An eligible individual
18 is eligible to receive coverage for case management
19 if—

20 (A) a health professional designated by the
21 health plan in which the individual is enrolled
22 determines that the individual should receive
23 such services; and

24 (B) the individual is eligible to receive cov-
25 erage for, and is receiving, outpatient mental

1 illness and substance abuse treatment with re-
2 spect to a diagnosable mental disorder or a
3 diagnosable substance abuse disorder.

4 (3) SCREENING AND ASSESSMENT AND CRISIS
5 SERVICES.—All eligible individuals enrolled under a
6 health plan are eligible to receive coverage for out-
7 patient mental illness and substance abuse treat-
8 ment consisting of screening and assessment and
9 crisis services.

10 (4) COLLATERAL SERVICES.—An eligible indi-
11 vidual is eligible to receive coverage for outpatient
12 mental illness and substance abuse treatment con-
13 sisting of collateral services if the individual is a
14 family member (described in section 1011(b)) of an
15 individual who is receiving inpatient and residential
16 mental illness and substance abuse treatment, inten-
17 sive nonresidential mental illness and substance
18 abuse treatment, or outpatient mental illness and
19 substance abuse treatment.

20 (c) INPATIENT AND RESIDENTIAL TREATMENT.—

21 (1) DEFINITION.—For purposes of this subtitle,
22 the term “inpatient and residential mental illness
23 and substance abuse treatment” means the items
24 and services described in paragraphs (1) through (3)
25 of section 1861(b) of the Social Security Act when

1 provided with respect to a diagnosable mental dis-
2 order or a diagnosable substance abuse disorder to—

3 (A) an inpatient of a hospital, psychiatric
4 hospital, residential treatment center, residen-
5 tial detoxification center, crisis residential pro-
6 gram, or mental illness residential treatment
7 program; or

8 (B) a resident of a therapeutic family or
9 group treatment home or community residential
10 treatment and recovery center for substance
11 abuse.

12 The National Health Board shall specify those
13 health professional services described in section 1112
14 that shall be treated as inpatient and residential
15 mental illness and substance abuse treatment when
16 provided to such an inpatient or resident.

17 (2) LIMITATIONS.—Coverage for inpatient and
18 residential mental illness and substance abuse treat-
19 ment is subject to the following limitations:

20 (A) RESIDENTIAL MENTAL ILLNESS
21 TREATMENT.—Such treatment, when provided
22 with respect to a diagnosable mental disorder in
23 a setting that is not a hospital or a psychiatric
24 hospital, is covered only to avert the need for,
25 or as an alternative to, treatment in a hospital

1 or a psychiatric hospital, as determined by a
2 health professional designated by the health
3 plan in which the individual receiving such
4 treatment is enrolled.

5 (B) RESIDENTIAL SUBSTANCE ABUSE
6 TREATMENT.—Such treatment, when provided
7 with respect to a diagnosable substance abuse
8 disorder in a setting that is not a hospital or
9 a psychiatric hospital, is covered only if a
10 health professional designated by the health
11 plan in which the individual receiving such
12 treatment is enrolled determines (based on cri-
13 teria that the plan may choose to employ) that
14 the individual should receive such treatment.

15 (C) LEAST RESTRICTIVE SETTING.—Such
16 treatment is covered only when—

17 (i) provided to an individual in the
18 least restrictive inpatient or residential set-
19 ting that is effective and appropriate for
20 the individual; and

21 (ii) less restrictive intensive nonresi-
22 dential or outpatient treatment would be
23 ineffective or inappropriate.

24 (D) ANNUAL LIMIT.—Prior to January 1,
25 2001, such treatment is subject to an aggregate

1 annual limit of 30 days. A maximum of 30 ad-
2 ditional days of such treatment shall be covered
3 for an individual if a health professional des-
4 ignated by the health plan in which the indi-
5 vidual is enrolled determines in advance that—

6 (i) the individual poses a threat to his
7 or her own life or the life of another indi-
8 vidual; or

9 (ii) the medical condition of the indi-
10 vidual requires inpatient treatment in a
11 hospital or a psychiatric hospital in order
12 to initiate, change, or adjust pharma-
13 cological or somatic therapy.

14 (E) INPATIENT HOSPITAL TREATMENT
15 FOR SUBSTANCE ABUSE.—Such treatment,
16 when provided in a hospital or a psychiatric
17 hospital with respect to a diagnosable substance
18 abuse disorder, is covered under this section
19 only for detoxification requiring the manage-
20 ment of psychiatric conditions associated with
21 withdrawal from alcohol or drugs. The items
22 and services described in this section do not in-
23 clude medical detoxification as required for the
24 management of medical conditions associated

1 with withdrawal from alcohol or drugs (which is
2 covered under section 1111).

3 (d) INTENSIVE NONRESIDENTIAL TREATMENT.—

4 (1) DEFINITION.—For purposes of this subtitle,
5 the term “intensive nonresidential mental illness and
6 substance abuse treatment” means diagnostic or
7 therapeutic items or services provided with respect
8 to a diagnosable mental disorder or a diagnosable
9 substance abuse disorder to an individual—

10 (A) participating in a partial hospitaliza-
11 tion program, a day treatment program, a psy-
12 chiatric rehabilitation program, or an ambula-
13 tory detoxification program; or

14 (B) receiving home-based mental illness
15 services or behavioral aide mental illness serv-
16 ices.

17 The National Health Board shall specify those
18 health professional services described in section 1112
19 that shall be treated as intensive nonresidential men-
20 tal illness and substance abuse treatment when pro-
21 vided to such an individual.

22 (2) LIMITATIONS.—Coverage for intensive non-
23 residential mental illness and substance abuse treat-
24 ment is subject to the following limitations:

1 (A) DISCRETION OF PLAN.—An individual
2 shall receive coverage for such treatment if a
3 health professional designated by the health
4 plan in which the individual is enrolled deter-
5 mines (based on criteria that the plan may
6 choose to employ) that the individual should re-
7 ceive such treatment.

8 (B) TREATMENT PURPOSES.—Such treat-
9 ment is covered only when provided—

10 (i) to avert the need for, or as an al-
11 ternative to, treatment in residential or in-
12 patient settings;

13 (ii) to facilitate the earlier discharge
14 of an individual receiving inpatient or resi-
15 dential care;

16 (iii) to restore the functioning of an
17 individual with a diagnosable mental dis-
18 order or a diagnosable substance abuse
19 disorder; or

20 (iv) to assist such an individual to de-
21 velop the skills and gain access to the sup-
22 port services the individual needs to
23 achieve the maximum level of functioning
24 of the individual within the community.

25 (C) ANNUAL LIMIT.—

1 (i) IN GENERAL.—Prior to January 1,
2 2001, the number of covered days of inpa-
3 tient and residential mental illness and
4 substance abuse treatment that are avail-
5 able to an individual under the 30-day
6 limit described in the first sentence of sub-
7 section (c)(2)(D) shall be reduced by 1 day
8 for each 2 covered days of intensive non-
9 residential mental illness and substance
10 abuse treatment that are provided to the
11 individual, until such number is reduced to
12 zero.

13 (ii) ADDITIONAL DAYS.—After the
14 number of covered days referred to in
15 clause (i) has been reduced to zero with re-
16 spect to an individual, the individual shall
17 receive coverage for a maximum of 60 days
18 of intensive nonresidential mental illness
19 and substance abuse treatment if a health
20 professional designated by the health plan
21 in which the individual is enrolled deter-
22 mines that the individual should receive
23 such treatment.

24 (D) DETOXIFICATION.—Intensive nonresi-
25 dential mental illness and substance abuse

1 treatment consisting of detoxification is covered
2 only if it is provided in the context of a treat-
3 ment program.

4 (E) OUT-OF-POCKET MAXIMUM.—Prior to
5 January 1, 2001, expenses for intensive non-
6 residential mental illness and substance abuse
7 treatment that an individual incurs prior to sat-
8 isfying a deductible applicable to such treat-
9 ment, and copayments and coinsurance paid by
10 or on behalf of the individual for such treat-
11 ment, may not be applied toward any annual
12 out-of-pocket limit on cost sharing under any
13 cost sharing schedule described in part 3 of this
14 subtitle if such treatment is provided—

15 (i) with respect to a diagnosable sub-
16 stance abuse disorder; or

17 (ii) pursuant to subparagraph (C)(ii).

18 (e) OUTPATIENT TREATMENT.—

19 (1) DEFINITION.—For purposes of this subtitle,
20 the term “outpatient mental illness and substance
21 abuse treatment” means the following services pro-
22 vided with respect to a diagnosable mental disorder
23 or a diagnosable substance abuse disorder in an out-
24 patient setting:

25 (A) Screening and assessment.

1 (B) Diagnosis.

2 (C) Medical management.

3 (D) Substance abuse counseling and re-
4 lapse prevention.

5 (E) Crisis services.

6 (F) Somatic treatment services.

7 (G) Psychotherapy.

8 (H) Case management.

9 (I) Collateral services.

10 (2) LIMITATIONS.—Coverage for outpatient
11 mental illness and substance abuse treatment is sub-
12 ject to the following limitations:

13 (A) HEALTH PROFESSIONAL SERVICES.—
14 Such treatment is covered only when it con-
15 stitutes health professional services (as defined
16 in section 1112(c)(2)).

17 (B) DISCRETION OF PLAN.—An individual
18 shall receive coverage for outpatient mental ill-
19 ness and substance abuse treatment consisting
20 of substance abuse counseling and relapse pre-
21 vention if a health professional designated by
22 the health plan in which the individual is en-
23 rolled determines (based on criteria that the
24 plan may choose to employ) that the individual
25 should receive such treatment. This subpara-

graph does not apply to group therapy covered pursuant to subparagraph (C)(ii)(II).

(C) ANNUAL LIMITS.—

(i) PSYCHOTHERAPY AND COLLATERAL SERVICES.—Prior to January 1, 2001, psychotherapy and collateral services are subject to an aggregate annual limit of 30 visits per individual. Additional visits may be covered, at the discretion of the health plan in which the individual receiving treatment is enrolled, to prevent hospitalization or to facilitate earlier hospital release, for which the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits. After such number has been reduced to zero, no additional visits under the preceding sentence may be covered.

(ii) SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION.—

1 (I) IN GENERAL.—Except as pro-
2 vided in subclause (II), the number of
3 covered days of inpatient and residen-
4 tial mental illness and substance
5 abuse treatment that are available to
6 an individual under the 30-day limit
7 described in the first sentence of sub-
8 section (c)(2)(D) shall be reduced by
9 1 day for each 4 visits for substance
10 abuse counseling and relapse preven-
11 tion that are covered for the indi-
12 vidual under subparagraph (B). After
13 such number has been reduced to
14 zero, no visits for substance abuse
15 counseling and relapse prevention may
16 be covered, except as provided in sub-
17 clause (II).

18 (II) GROUP THERAPY.—Prior to
19 January 1, 2001, substance abuse
20 counseling and relapse prevention con-
21 sisting of group therapy is subject to
22 a separate aggregate annual limit of
23 30 visits, if such therapy occurs with-
24 in 12 months after the individual has
25 received, with respect to a diagnosable

1 substance abuse disorder, inpatient
2 and residential mental illness and sub-
3 stance abuse treatment or intensive
4 nonresidential mental illness and sub-
5 stance abuse treatment. The provi-
6 sions of clause (i) and subclause (I)
7 do not apply to therapy that is de-
8 scribed in the preceding sentence.

9 (D) DETOXIFICATION.—Outpatient mental
10 illness and substance abuse treatment con-
11 sisting of detoxification is covered only if it is
12 provided in the context of a treatment program.

13 (E) OUT-OF-POCKET MAXIMUM.—Prior to
14 January 1, 2001, expenses for outpatient men-
15 tal illness and substance abuse treatment that
16 an individual incurs prior to satisfying a de-
17 ductible applicable to such treatment, and co-
18 payments and coinsurance paid by or on behalf
19 of the individual for such treatment, may not be
20 applied toward any annual out-of-pocket limit
21 on cost sharing under any cost sharing schedule
22 described in part 3 of this subtitle.

23 (f) OTHER DEFINITIONS.—For purposes of this sub-
24 title:

1 (1) CASE MANAGEMENT.—The term “case man-
2 agement” means services that assist individuals in
3 gaining access to needed medical, social, educational,
4 and other services.

5 (2) DIAGNOSABLE MENTAL DISORDER AND
6 DIAGNOSABLE SUBSTANCE ABUSE DISORDER.—The
7 terms “diagnosable mental disorder” and
8 “diagnosable substance abuse disorder” mean a dis-
9 order that—

10 (A) is listed in the Diagnostic and Statis-
11 tical Manual of Mental Disorders, Third Edi-
12 tion, Revised or a revised version of such man-
13 ual (except V Codes for Conditions Not Attrib-
14 utable to a Mental Disorder That Are a Focus
15 of Attention or Treatment);

16 (B) is the equivalent of a disorder de-
17 scribed in subparagraph (A), but is listed in the
18 International Classification of Diseases, 9th Re-
19 vision, Clinical Modification, Third Edition or a
20 revised version of such text; or

21 (C) is listed in any authoritative text speci-
22 fying diagnostic criteria for mental disorders or
23 substance abuse disorders that is identified by
24 the National Health Board.

1 (3) PSYCHIATRIC HOSPITAL.—The term “psy-
2 chiatric hospital” has the meaning given such term
3 in section 1861(f) of the Social Security Act, except
4 that such term shall include—

5 (A) in the case of an item or service pro-
6 vided to an individual whose applicable health
7 plan is specified pursuant to section 1004(b)(1),
8 a facility of the uniformed services under title
9 10, United States Code, that is engaged in pro-
10 viding services to inpatients that are equivalent
11 to the services provided by a psychiatric hos-
12 pital;

13 (B) in the case of an item or service pro-
14 vided to an individual whose applicable health
15 plan is specified pursuant to section 1004(b)(2),
16 a facility operated by the Department of Vet-
17 erans Affairs that is engaged in providing serv-
18 ices to inpatients that are equivalent to the
19 services provided by a psychiatric hospital; and

20 (C) in the case of an item or service pro-
21 vided to an individual whose applicable health
22 plan is specified pursuant to section 1004(b)(3),
23 a facility operated by the Indian Health Service
24 that is engaged in providing services to inpa-

1 tients that are equivalent to the services pro-
2 vided by a psychiatric hospital.

3 **SEC. 1116. FAMILY PLANNING SERVICES AND SERVICES**
4 **FOR PREGNANT WOMEN.**

5 The services described in this section are the fol-
6 lowing items and services:

7 (1) Voluntary family planning services.

8 (2) Contraceptive devices that—

9 (A) may only be dispensed upon prescrip-
10 tion; and

11 (B) are subject to approval by the Sec-
12 retary of Health and Human Services under the
13 Federal Food, Drug, and Cosmetic Act.

14 (3) Services for pregnant women.

15 **SEC. 1117. HOSPICE CARE.**

16 The hospice care described in this section is the items
17 and services described in paragraph (1) of section
18 1861(dd) of the Social Security Act, as defined in para-
19 graphs (2), (3), and (4)(A) of such section (with the ex-
20 ception of paragraph (2)(A)(iii)), except that all references
21 to the Secretary of Health and Human Services in such
22 paragraphs shall be treated as references to the National
23 Health Board.

1 **SEC. 1118. HOME HEALTH CARE.**

2 (a) **COVERAGE.**—The home health care described in
3 this section is—

4 (1) the items and services described in section
5 1861(m) of the Social Security Act; and

6 (2) home infusion drug therapy services de-
7 scribed in section 1861(ll) of the Social Security Act
8 (as inserted by section 2005).

9 (b) **LIMITATIONS.**—Coverage for home health care is
10 subject to the following limitations:

11 (1) **INPATIENT TREATMENT ALTERNATIVE.**—
12 Such care is covered only as an alternative to inpa-
13 tient treatment in a hospital, skilled nursing facility,
14 or rehabilitation facility after an illness or injury.

15 (2) **REEVALUATION.**—At the end of each 60-
16 day period of home health care, the need for contin-
17 ued care shall be reevaluated by the person who is
18 primarily responsible for providing the home health
19 care. Additional periods of care are covered only if
20 such person determines that the requirement in
21 paragraph (1) is satisfied.

22 **SEC. 1119. EXTENDED CARE SERVICES.**

23 (a) **COVERAGE.**—The extended care services de-
24 scribed in this section are the items and services described
25 in section 1861(h) of the Social Security Act when pro-

1 vided to an inpatient of a skilled nursing facility or a reha-
2 bilitation facility.

3 (b) LIMITATIONS.—Coverage for extended care serv-
4 ices is subject to the following limitations:

5 (1) HOSPITAL ALTERNATIVE.—Such services
6 are covered only as an alternative to inpatient treat-
7 ment in a hospital after an illness or injury.

8 (2) ANNUAL LIMIT.—Such services are subject
9 to an aggregate annual limit of 100 days.

10 (c) DEFINITIONS.—For purposes of this subtitle:

11 (1) REHABILITATION FACILITY.—The term “re-
12 habilitation facility” means an institution (or a dis-
13 tinct part of an institution) which is established and
14 operated for the purpose of providing diagnostic,
15 therapeutic, and rehabilitation services to individuals
16 for rehabilitation from illness or injury.

17 (2) SKILLED NURSING FACILITY.—The term
18 “skilled nursing facility” means an institution (or a
19 distinct part of an institution) which is primarily en-
20 gaged in providing to residents—

21 (A) skilled nursing care and related serv-
22 ices for residents who require medical or nurs-
23 ing care; or

24 (B) rehabilitation services to residents for
25 rehabilitation from illness or injury.

1 **SEC. 1120. AMBULANCE SERVICES.**

2 (a) **COVERAGE.**—The ambulance services described in
3 this section are the following items and services:

4 (1) Ground transportation by ambulance.

5 (2) Air transportation by an aircraft equipped
6 for transporting an injured or sick individual.

7 (3) Water transportation by a vessel equipped
8 for transporting an injured or sick individual.

9 (b) **LIMITATIONS.**—Coverage for ambulance services
10 is subject to the following limitations:

11 (1) **MEDICAL INDICATION.**—Ambulance services
12 are covered only in cases in which the use of an am-
13 bulance is indicated by the medical condition of the
14 individual concerned.

15 (2) **AIR TRANSPORT.**—Air transportation is cov-
16 ered only in cases in which there is no other method
17 of transportation or where the use of another meth-
18 od of transportation is contra-indicated by the med-
19 ical condition of the individual concerned.

20 (3) **WATER TRANSPORT.**—Water transportation
21 is covered only in cases in which there is no other
22 method of transportation or where the use of an-
23 other method of transportation is contra-indicated
24 by the medical condition of the individual concerned.

1 **SEC. 1121. OUTPATIENT LABORATORY, RADIOLOGY, AND DI-**
2 **AGNOSTIC SERVICES.**

3 The items and services described in this section are
4 laboratory, radiology, and diagnostic services provided
5 upon prescription to individuals who are not inpatients of
6 a hospital, hospice, skilled nursing facility, or rehabilita-
7 tion facility.

8 **SEC. 1122. OUTPATIENT PRESCRIPTION DRUGS AND**
9 **BIOLOGICALS.**

10 (a) **COVERAGE.**—The items described in this section
11 are the following:

12 (1) Covered outpatient drugs described in sec-
13 tion 1861(t) of the Social Security Act (as amended
14 by section 2001(b))—

15 (A) except that, for purposes of this sec-
16 tion, a medically accepted indication with re-
17 spect to the use of a covered outpatient drug in-
18 cludes any use which has been approved by the
19 Food and Drug Administration for the drug,
20 and includes another use of the drug if—

21 (i) the drug has been approved by the
22 Food and Drug Administration; and

23 (ii) such use is supported by one or
24 more citations which are included (or ap-
25 proved for inclusion) in one or more of the
26 following compendia: the American Hos-

1 pital Formulary Service-Drug Information,
2 the American Medical Association Drug
3 Evaluations, the United States Pharma-
4 copoeia-Drug Information, and other au-
5 thoritative compendia as identified by the
6 Secretary, unless the Secretary has deter-
7 mined that the use is not medically appro-
8 priate or the use is identified as not indi-
9 cated in one or more such compendia; or

10 (iii) such use is medically accepted
11 based on supportive clinical evidence in
12 peer reviewed medical literature appearing
13 in publications which have been identified
14 for purposes of this clause by the Sec-
15 retary; and

16 (B) notwithstanding any exclusion from
17 coverage that may be made with respect to such
18 a drug under title XVIII of such Act pursuant
19 to section 1862(a)(18) of such Act.

20 (2) Blood clotting factors when provided on an
21 outpatient basis.

22 (b) REVISION OF COMPENDIA LIST.—The Secretary
23 may revise the list of compendia in subsection (a)(1)(A)(ii)
24 designated as appropriate for identifying medically accept-
25 ed indications for drugs.

1 (c) BLOOD CLOTTING FACTORS.—For purposes of
2 this subtitle, the term “blood clotting factors” has the
3 meaning given such term in section 1861(s)(2)(I) of the
4 Social Security Act.

5 **SEC. 1123. OUTPATIENT REHABILITATION SERVICES.**

6 (a) COVERAGE.—The outpatient rehabilitation serv-
7 ices described in this section are—

- 8 (1) outpatient occupational therapy;
- 9 (2) outpatient physical therapy; and
- 10 (3) outpatient speech pathology services for the
11 purpose of attaining or restoring speech.

12 (b) LIMITATIONS.—Coverage for outpatient rehabili-
13 tation services is subject to the following limitations:

14 (1) RESTORATION OF CAPACITY OR MINIMIZA-
15 TION OF LIMITATIONS.—Such services include only
16 items or services used to restore functional capacity
17 or minimize limitations on physical and cognitive
18 functions as a result of an illness or injury.

19 (2) REEVALUATION.—At the end of each 60-
20 day period of outpatient rehabilitation services, the
21 need for continued services shall be reevaluated by
22 the person who is primarily responsible for providing
23 the services. Additional periods of services are cov-
24 ered only if such person determines that functioning
25 is improving.

1 **SEC. 1124. DURABLE MEDICAL EQUIPMENT AND PROS-**
2 **THETIC AND ORTHOTIC DEVICES.**

3 (a) **COVERAGE.**—The items and services described in
4 this section are—

5 (1) durable medical equipment, including acces-
6 sories and supplies necessary for repair, function,
7 and maintenance of such equipment;

8 (2) prosthetic devices (other than dental de-
9 vices) which replace all or part of the function of an
10 internal body organ (including colostomy bags and
11 supplies directly related to colostomy care), including
12 replacement of such devices;

13 (3) accessories and supplies which are used di-
14 rectly with a prosthetic device to achieve the thera-
15 peutic benefits of the prosthesis or to assure the
16 proper functioning of the device;

17 (4) leg, arm, back, and neck braces;

18 (5) artificial legs, arms, and eyes, including re-
19 placements if required because of a change in the
20 patient's physical condition; and

21 (6) fitting and training for use of the items de-
22 scribed in paragraphs (1) through (5).

23 (b) **LIMITATION.**—An item or service described in
24 this section is covered only if it improves functional ability
25 or prevents further deterioration in function.

1 (c) DURABLE MEDICAL EQUIPMENT.—For purposes
2 of this subtitle, the term “durable medical equipment” has
3 the meaning given such term in section 1861(n) of the
4 Social Security Act.

5 **SEC. 1125. VISION CARE.**

6 (a) COVERAGE.—The vision care described in this
7 section is diagnosis and treatment for defects in vision.

8 (b) LIMITATION.—Eyeglasses and contact lenses are
9 covered only for individuals less than 18 years of age.

10 **SEC. 1126. DENTAL CARE.**

11 (a) COVERAGE.—The dental care described in this
12 section is the following:

13 (1) Emergency dental treatment, including sim-
14 ple extractions, for acute infections, bleeding, and
15 injuries to natural teeth and oral structures for con-
16 ditions requiring immediate attention to prevent
17 risks to life or significant medical complications, as
18 specified by the National Health Board.

19 (2) Prevention and diagnosis of dental disease,
20 including oral dental examinations, radiographs,
21 dental sealants, fluoride application, and dental pro-
22 phylaxis.

23 (3) Treatment of dental disease, including rou-
24 tine fillings, prosthetics for genetic defects, peri-
25 odontal maintenance, and endodontic services.

1 (4) Space maintenance procedures to prevent
2 orthodontic complications.

3 (5) Interceptive orthodontic treatment to pre-
4 vent severe malocclusion.

5 (b) LIMITATIONS.—Coverage for dental care is sub-
6 ject to the following limitations:

7 (1) PREVENTION AND DIAGNOSIS.—Prior to
8 January 1, 2001, the items and services described in
9 subsection (a)(2) are covered only for individuals
10 less than 18 years of age. On or after such date,
11 such items and services are covered for all eligible
12 individuals enrolled under a health plan, except that
13 dental sealants are not covered for individuals 18
14 years of age or older.

15 (2) TREATMENT OF DENTAL DISEASE.—Prior
16 to January 1, 2001, the items and services described
17 in subsection (a)(3) are covered only for individuals
18 less than 18 years of age. On or after such date,
19 such items and services are covered for all eligible
20 individuals enrolled under a health plan, except that
21 endodontic services are not covered for individuals
22 18 years of age or older.

23 (3) SPACE MAINTENANCE.—The items and
24 services described in subsection (a)(4) are covered

1 only for individuals at least 3 years of age, but less
2 than 13 years of age and—

3 (A) are limited to posterior teeth;

4 (B) involve maintenance of a space or
5 spaces for permanent posterior teeth that would
6 otherwise be prevented from normal eruption if
7 the space were not maintained; and

8 (C) do not include a space maintainer that
9 is placed within 6 months of the expected erup-
10 tion of the permanent posterior tooth con-
11 cerned.

12 (4) INTERCEPTIVE ORTHODONTIC TREAT-
13 MENT.—Prior to January 1, 2001, the items and
14 services described in subsection (a)(5) are not cov-
15 ered. On or after such date, such items and services
16 are covered only for individuals at least 6 years of
17 age, but less than 12 years of age.

18 **SEC. 1127. HEALTH EDUCATION CLASSES.**

19 (a) COVERAGE.—Subject to subsection (b), the items
20 and services described in this section are health education
21 and training classes to encourage the reduction of behav-
22 ioral risk factors and to promote healthy activities. Such
23 education and training classes may include smoking ces-
24 sation, nutrition counseling, stress management, support
25 groups, and physical training classes.

1 (b) DISCRETION OF PLAN.—A health plan may offer
2 education and training classes at its discretion.

3 (c) CONSTRUCTION.—This section shall not be con-
4 strued to include or limit education or training that is pro-
5 vided in the course of the delivery of health professional
6 services (as defined in section 1112(c)).

7 **SEC. 1128. INVESTIGATIONAL TREATMENTS.**

8 (a) COVERAGE.—Subject to subsection (b), the items
9 and services described in this subsection are qualifying in-
10 vestigational treatments that are administered for a life-
11 threatening disease, disorder, or other health condition (as
12 defined by the National Health Board).

13 (b) DISCRETION OF PLAN.—A health plan may cover
14 an investigational treatment described in subsection (a) at
15 its discretion.

16 (c) ROUTINE CARE DURING INVESTIGATIONAL
17 TREATMENTS.—The comprehensive benefit package in-
18 cludes an item or service described in any other section
19 of this part, subject to the limitations and cost sharing
20 requirements applicable to the item or service, when the
21 item or service is provided to an individual in the course
22 of an investigational treatment, if—

23 (1) the treatment is a qualifying investigational
24 treatment; and

1 (2) the item or service would have been pro-
2 vided to the individual even if the individual were
3 not receiving the investigational treatment.

4 (d) DEFINITIONS.—For purposes of this subtitle:

5 (1) QUALIFYING INVESTIGATIONAL TREAT-
6 MENT.—The term “qualifying investigational treat-
7 ment” means a treatment—

8 (A) the effectiveness of which has not been
9 determined; and

10 (B) that is under clinical investigation as
11 part of an approved research trial.

12 (2) APPROVED RESEARCH TRIAL.—The term
13 “approved research trial” means—

14 (A) a research trial approved by the Sec-
15 retary of Health and Human Services, the Di-
16 rector of the National Institutes of Health, the
17 Commissioner of the Food and Drug Adminis-
18 tration, the Secretary of Veterans Affairs, the
19 Secretary of Defense, or a qualified nongovern-
20 mental research entity as defined in guidelines
21 of the National Institutes of Health; or

22 (B) a peer-reviewed and approved research
23 program, as defined by the Secretary of Health
24 and Human Services, conducted for the primary
25 purpose of determining whether or not a treat-

1 ment is safe, efficacious, or having any other
2 characteristic of a treatment which must be
3 demonstrated in order for the treatment to be
4 medically necessary or appropriate.

5 **PART 3—COST SHARING**

6 **SEC. 1131. COST SHARING.**

7 (a) IN GENERAL.—Each health plan shall offer to in-
8 dividuals enrolled under the plan one, but not more than
9 one, of the following cost sharing schedules, which sched-
10 ule shall be offered to all such enrollees:

11 (1) Lower cost sharing (described in section
12 1132).

13 (2) Higher cost sharing (described in section
14 1133).

15 (3) Combination cost sharing (described in sec-
16 tion 1134).

17 (b) COST SHARING FOR LOW-INCOME FAMILIES.—
18 For provisions relating to reducing cost sharing for certain
19 low-income families, see section 1371.

20 (c) DEDUCTIBLES, COST SHARING, AND OUT-OF-
21 POCKET LIMITS ON COST SHARING.—

22 (1) APPLICATION ON AN ANNUAL BASIS.—The
23 deductibles and out-of-pocket limits on cost sharing
24 for a year under the schedules referred to in sub-

1 section (a) shall be applied based upon expenses in-
2 curred for items and services furnished in the year.

3 (2) INDIVIDUAL AND FAMILY GENERAL
4 DEDUCTIBLES.—

5 (A) INDIVIDUAL.—Subject to subpara-
6 graph (B), with respect to an individual en-
7 rolled under a health plan (regardless of the
8 class of enrollment), any individual general de-
9 ductible in the cost sharing schedule offered by
10 the plan represents the amount of countable ex-
11 penses (as defined in subparagraph (C)) that
12 the individual may be required to incur in a
13 year before the plan incurs liability for expenses
14 for such items and services furnished to the in-
15 dividual.

16 (B) FAMILY.—In the case of an individual
17 enrolled under a health plan under a family
18 class of enrollment (as defined in section
19 1011(c)(2)(A)), the individual general deduct-
20 ible under subparagraph (A) shall not apply to
21 countable expenses incurred by any member of
22 the individual's family in a year at such time as
23 the family has incurred, in the aggregate,
24 countable expenses in the amount of the family
25 general deductible for the year.

1 (C) COUNTABLE EXPENSE.—In this para-
2 graph, the term “countable expense” means,
3 with respect to an individual for a year, an ex-
4 pense for an item or service covered by the
5 comprehensive benefit package that is subject
6 to the general deductible and for which, but for
7 such deductible and any other cost sharing
8 under this subtitle, a health plan is liable for
9 payment. The amount of countable expenses for
10 an individual for a year under this paragraph
11 shall not exceed the individual general deduct-
12 ible for the year.

13 (3) COINSURANCE AND COPAYMENTS.—After a
14 general or separate deductible that applies to an
15 item or service covered by the comprehensive benefit
16 package has been satisfied for a year, subject to
17 paragraph (4), coinsurance and copayments are
18 amounts (expressed as a percentage of an amount
19 otherwise payable or as a dollar amount, respec-
20 tively) that an individual may be required to pay
21 with respect to the item or service.

22 (4) INDIVIDUAL AND FAMILY LIMITS ON COST
23 SHARING.—

24 (A) INDIVIDUAL.—Subject to subpara-
25 graph (B), with respect to an individual en-

1 rolled under a health plan (regardless of the
2 class of enrollment), the individual out-of-pocket
3 limit on cost sharing in the cost sharing
4 schedule offered by the plan represents the
5 amount of expenses that the individual may be
6 required to incur under the plan in a year be-
7 cause of a general deductible, separate
8 deductibles, copayments, and coinsurance before
9 the plan may no longer impose any cost sharing
10 with respect to items or services covered by the
11 comprehensive benefit package that are pro-
12 vided to the individual, except as provided in
13 subsections (d)(2)(E) and (e)(2)(E) of section
14 1115.

15 (B) FAMILY.—In the case of an individual
16 enrolled under a health plan under a family
17 class of enrollment (as defined in section
18 1011(c)(2)(A)), the family out-of-pocket limit
19 on cost sharing in the cost sharing schedule of-
20 fered by the plan represents the amount of ex-
21 penses that members of the individual's family,
22 in the aggregate, may be required to incur
23 under the plan in a year because of a general
24 deductible, separate deductibles, copayments,
25 and coinsurance before the plan may no longer

1 impose any cost sharing with respect to items
2 or services covered by the comprehensive benefit
3 package that are provided to any member of the
4 individual's family, except as provided in sub-
5 sections (d)(2)(E) and (e)(2)(E) of section
6 1115.

7 **SEC. 1132. LOWER COST SHARING.**

8 (a) IN GENERAL.—The lower cost sharing schedule
9 referred to in section 1131 that is offered by a health
10 plan—

11 (1) may not include a deductible;

12 (2) shall have—

13 (A) an annual individual out-of-pocket
14 limit on cost sharing of \$1500; and

15 (B) an annual family out-of-pocket limit on
16 cost sharing of \$3000;

17 (3) except as provided in paragraph (4)—

18 (A) shall prohibit payment of any coinsur-
19 ance; and

20 (B) subject to section 1152, shall require
21 payment of the copayment for an item or serv-
22 ice (if any) that is specified for the item or
23 service in the table under section 1135; and

24 (4) shall require payment of coinsurance for an
25 out-of-network item or service (as defined in section

1 1402(f)) in an amount that is a percentage (deter-
2 mined under subsection (b)) of the applicable pay-
3 ment rate for the item or service established under
4 section 1322(c), but only if the item or service is
5 subject to coinsurance under the higher cost sharing
6 schedule described in section 1133.

7 (b) OUT-OF-NETWORK COINSURANCE PERCENT-
8 AGE.—

9 (1) IN GENERAL.—The National Health Board
10 shall determine a percentage referred to in sub-
11 section (a)(4). The percentage—

12 (A) may not be less than 20 percent; and

13 (B) shall be the same with respect to all
14 out-of-network items and services that are sub-
15 ject to coinsurance, except as provided in para-
16 graph (2).

17 (2) EXCEPTION.—The National Health Board
18 may provide for a percentage that is greater than a
19 percentage determined under paragraph (1) in the
20 case of an out-of-network item or service for which,
21 under the higher cost sharing schedule described in
22 section 1133, the coinsurance is greater than 20 per-
23 cent of the applicable payment rate.

1 **SEC. 1133. HIGHER COST SHARING.**

2 (a) IN GENERAL.—The higher cost sharing schedule
3 referred to in section 1131 that is offered by a health
4 plan—

5 (1) shall have an annual individual general de-
6 ductible of \$200 and an annual family general de-
7 ductible of \$400 that apply with respect to expenses
8 incurred for all items and services in the comprehen-
9 sive benefit package except—

10 (A) an item or service with respect to
11 which a separate individual deductible applies
12 under paragraph (2), (3), or (4); or

13 (B) an item or service described in para-
14 graph (5), (6), or (7) with respect to which a
15 deductible does not apply;

16 (2) shall require an individual to incur expenses
17 during each episode of inpatient and residential
18 mental illness and substance abuse treatment (de-
19 scribed in section 1115(c)) equal to the cost of one
20 day of such treatment before the plan provides bene-
21 fits for such treatment to the individual;

22 (3) shall require an individual to incur expenses
23 during each episode of intensive nonresidential men-
24 tal illness and substance abuse treatment (described
25 in section 1115(d)) equal to the cost of one day of

1 such treatment before the plan provides benefits for
2 such treatment to the individual;

3 (4) shall require an individual to incur expenses
4 in a year for outpatient prescription drugs and
5 biologicals (described in section 1122) equal to \$250
6 before the plan provides benefits for such items to
7 the individual;

8 (5) shall require an individual to incur expenses
9 in a year for dental care described in section 1126,
10 except the items and services for prevention and di-
11 agnosis of dental disease described in section
12 1126(a)(2), equal to \$50 before the plan provides
13 benefits for such care to the individual;

14 (6) may not require any deductible for clinical
15 preventive services (described in section 1114);

16 (7) may not require any deductible for clinician
17 visits and associated services related to prenatal care
18 or 1 post-partum visit under section 1116;

19 (8) may not require any deductible for the
20 items and services for prevention and diagnosis of
21 dental disease described in section 1126(a)(2);

22 (9) shall have—

23 (A) an annual individual out-of-pocket
24 limit on cost sharing of \$1500; and

1 (B) an annual family out-of-pocket limit on
2 cost sharing of \$3000;

3 (10) shall prohibit payment of any copayment;
4 and

5 (11) subject to section 1152, shall require pay-
6 ment of the coinsurance for an item or service (if
7 any) that is specified for the item or service in the
8 table under section 1135.

9 (b) EPISODES OF TREATMENT.—

10 (1) INPATIENT AND RESIDENTIAL TREAT-
11 MENT.—For purposes of subsection (a)(2), an epi-
12 sode of inpatient and residential mental illness and
13 substance abuse treatment shall be considered to
14 begin on the date an individual is admitted to a fa-
15 cility for such treatment and to end on the date the
16 individual is discharged from the facility.

17 (2) INTENSIVE NONRESIDENTIAL TREAT-
18 MENT.—For purposes of subsection (a)(3), an epi-
19 sode of intensive nonresidential mental illness and
20 substance abuse treatment—

21 (A) shall be considered to begin on the
22 date an individual begins participating in a pro-
23 gram described in section 1115(d)(1)(A) and to
24 end on the date the individual ceases such par-
25 ticipation; or

1 (B) shall be considered to begin on the
2 date an individual begins receiving home-based
3 or behavioral aide services described in section
4 1115(d)(1)(B) and to end on the date the indi-
5 vidual ceases to receive such services.

6 **SEC. 1134. COMBINATION COST SHARING.**

7 (a) IN GENERAL.—The combination cost sharing
8 schedule referred to in section 1131 that is offered by a
9 health plan—

10 (1) shall have—

11 (A) an annual individual out-of-pocket
12 limit on cost sharing of \$1500; and

13 (B) an annual family out-of-pocket limit on
14 cost sharing of \$3000; and

15 (2) otherwise shall require different cost shar-
16 ing for in-network items and services than for out-
17 of-network items and services.

18 (b) IN-NETWORK ITEMS AND SERVICES.—With re-
19 spect to an in-network item or service (as defined in sec-
20 tion 1402(f)(1)), the combination cost sharing schedule
21 that is offered by a health plan—

22 (1) may not apply a deductible;

23 (2) shall prohibit payment of any coinsurance;

24 and

(3) shall require payment of a copayment in accordance with the lower cost sharing schedule described in section 1132.

(c) OUT-OF-NETWORK ITEMS AND SERVICES.—With respect to an out-of-network item or service (as defined in section 1402(f)(2)), the combination cost sharing schedule that is offered by a health plan—

(1) shall require an individual and a family to incur expenses before the plan provides benefits for the item or service in accordance with the deductibles under the higher cost sharing schedule described in section 1133;

(2) shall prohibit payment of any copayment; and

(3) shall require payment of coinsurance in accordance with such schedule.

SEC. 1135. TABLE OF COPAYMENTS AND COINSURANCE.

(a) IN GENERAL.—The following table specifies, for different items and services, the copayments and coinsurance referred to in sections 1132 and 1133:

Copayments and Coinsurance for Items and Services			
Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Inpatient hospital services	1111	No copayment	20 percent of applicable payment rate
Outpatient hospital services ...	1111	\$10 per visit	20 percent of applicable payment rate

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Hospital emergency room services	1111	\$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Services of health professionals	1112	\$10 per visit	20 percent of applicable payment rate
Emergency services other than hospital emergency room services	1113	\$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Ambulatory medical and surgical services	1113	\$10 per visit	20 percent of applicable payment rate
Clinical preventive services	1114	No copayment	No coinsurance
Inpatient and residential mental illness and substance abuse treatment	1115	No copayment	20 percent of applicable payment rate
Intensive nonresidential mental illness and substance abuse treatment (except treatment provided pursuant to section 1115(d)(2)(C)(ii))	1115	No copayment	20 percent of applicable payment rate
Intensive nonresidential mental illness and substance abuse treatment provided pursuant to section 1115(d)(2)(C)(ii)	1115	\$25 per visit	50 percent of applicable payment rate
Outpatient mental illness and substance abuse treatment (except psychotherapy, collateral services, and case management)	1115	\$10 per visit	20 percent of applicable payment rate

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Outpatient psychotherapy and collateral services	1115	\$25 per visit until January 1, 2001, and \$10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter
Case management	1115	No copayment	No coinsurance
Family planning and services for pregnant women (except clinician visits and associated services related to prenatal care and 1 post-partum visit)	1116	\$10 per visit	20 percent of applicable payment rate
Clinician visits and associated services related to prenatal care and 1 post-partum visit	1116	No copayment	No coinsurance
Hospice care	1117	No copayment	20 percent of applicable payment rate
Home health care	1118	No copayment	20 percent of applicable payment rate
Extended care services	1119	No copayment	20 percent of applicable payment rate
Ambulance services	1120	No copayment	20 percent of applicable payment rate
Outpatient laboratory, radiology, and diagnostic services	1121	No copayment	20 percent of applicable payment rate
Outpatient prescription drugs and biologicals	1122	\$5 per prescription	20 percent of applicable payment rate
Outpatient rehabilitation services	1123	\$10 per visit	20 percent of applicable payment rate
Durable medical equipment and prosthetic and orthotic devices	1124	No copayment	20 percent of applicable payment rate
Vision care	1125	\$10 per visit (No additional charge for 1 set of necessary eyeglasses for an individual less than 18 years of age)	20 percent of applicable payment rate

Copayments and Coinsurance for Items and Services—Continued

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Dental care (except space maintenance procedures and interceptive orthodontic treatment)	1126	\$10 per visit	20 percent of applicable payment rate
Space maintenance procedures and interceptive orthodontic treatment	1126	\$20 per visit	40 percent of applicable payment rate
Health education classes	1127	All cost sharing rules determined by plans	All cost sharing rules determined by plans
Investigational treatment for life-threatening condition ...	1128	All cost sharing rules determined by plans	All cost sharing rules determined by plans

1 (b) APPLICABLE PAYMENT RATE.—For purposes of
2 this section, the term “applicable payment rate”, when
3 used with respect to an item or service, means the applica-
4 ble payment rate for the item or service established under
5 section 1322(c).

6 **SEC. 1136. INDEXING DOLLAR AMOUNTS RELATING TO**
7 **COST SHARING.**

8 (a) IN GENERAL.—Any deductible, copayment, out-
9 of-pocket limit on cost sharing, or other amount expressed
10 in dollars in this subtitle for items or services provided
11 in a year after 1994 shall be such amount increased by
12 the percentage specified in subsection (b) for the year.

13 (b) PERCENTAGE.—The percentage specified in this
14 subsection for a year is equal to the product of the factors
15 described in subsection (d) for the year and for each pre-
16 vious year after 1994, minus 1.

1 (c) ROUNDING.—Any increase (or decrease) under
2 subsection (a) shall be rounded, in the case of an amount
3 specified in this subtitle of—

4 (1) \$200 or less, to the nearest multiple of \$1,

5 (2) more than \$200, but less than \$500, to the
6 nearest multiple of \$5, or

7 (3) \$500 or more, to the nearest multiple of
8 \$10.

9 (d) FACTOR.—

10 (1) IN GENERAL.—The factor described in this
11 subsection for a year is 1 plus the general health
12 care inflation factor (as specified in section
13 6001(a)(3) and determined under paragraph (2)) for
14 the year.

15 (2) DETERMINATION.—In computing such fac-
16 tor for a year, the percentage increase in the CPI
17 for a year (referred to in section 6001(b)) shall be
18 determined based upon the percentage increase in
19 the average of the CPI for the 12-month period end-
20 ing with August 31 of the previous year over such
21 average for the preceding 12-month period.

22 **PART 4—EXCLUSIONS**

23 **SEC. 1141. EXCLUSIONS.**

24 (a) MEDICAL NECESSITY.—The comprehensive ben-
25 efit package does not include—

1 (1) an item or service that is not medically nec-
2 essary or appropriate; or

3 (2) an item or service that the National Health
4 Board may determine is not medically necessary or
5 appropriate in a regulation promulgated under sec-
6 tion 1154.

7 (b) **ADDITIONAL EXCLUSIONS.**—The comprehensive
8 benefit package does not include the following items and
9 services:

10 (1) Custodial care, except in the case of hospice
11 care under section 1117.

12 (2) Surgery and other procedures performed
13 solely for cosmetic purposes and hospital or other
14 services incident thereto, unless—

15 (A) required to correct a congenital anom-
16 aly; or

17 (B) required to restore or correct a part of
18 the body that has been altered as a result of—

19 (i) accidental injury;

20 (ii) disease; or

21 (iii) surgery that is otherwise covered
22 under this subtitle.

23 (3) Hearing aids.

24 (4) Eyeglasses and contact lenses for individ-
25 uals at least 18 years of age.

1 (5) In vitro fertilization services.

2 (6) Sex change surgery and related services.

3 (7) Private duty nursing.

4 (8) Personal comfort items, except in the case
5 of hospice care under section 1117.

6 (9) Any dental procedures involving orthodontic
7 care, inlays, gold or platinum fillings, bridges,
8 crowns, pin/post retention, dental implants, surgical
9 periodontal procedures, or the preparation of the
10 mouth for the fitting or continued use of dentures,
11 except as specifically described in section 1126.

12 **PART 5—ROLE OF THE NATIONAL HEALTH**

13 **BOARD**

14 **SEC. 1151. DEFINITION OF BENEFITS.**

15 (a) IN GENERAL.—The National Health Board may
16 promulgate such regulations or establish such guidelines
17 as may be necessary to assure uniformity in the applica-
18 tion of the comprehensive benefit package across all health
19 plans.

20 (b) FLEXIBILITY IN DELIVERY.—The regulations or
21 guidelines under subsection (a) shall permit a health plan
22 to deliver covered items and services to individuals enrolled
23 under the plan using the providers and methods that the
24 plan determines to be appropriate.

1 **SEC. 1152. ACCELERATION OF EXPANDED BENEFITS.**

2 (a) IN GENERAL.—Subject to subsection (b), at any
3 time prior to January 1, 2001, the National Health
4 Board, in its discretion, may by regulation expand the
5 comprehensive benefit package by—

6 (1) adding any item or service that is added to
7 the package as of January 1, 2001; and

8 (2) requiring that a cost sharing schedule de-
9 scribed in part 3 of this subtitle reflect (wholly or
10 in part) any of the cost sharing requirements that
11 apply to the schedule as of January 1, 2001.

12 No such expansion shall be effective except as of January
13 1 of a year.

14 (b) CONDITION.—The Board may not expand the
15 benefit package under subsection (a) which is to become
16 effective with respect to a year, by adding any item or
17 service or altering any cost sharing schedule, unless the
18 Board estimates that the additional increase in per capita
19 health care expenditures resulting from the addition or al-
20 teration, for each regional alliance for the year, will not
21 cause any regional alliance to exceed its per capita target
22 (as determined under section 6003).

1 **SEC. 1153. AUTHORITY WITH RESPECT TO CLINICAL PRE-**
2 **VENTIVE SERVICES.**

3 (a) IN GENERAL.—With respect to clinical preventive
4 services described in section 1114, the National Health
5 Board—

6 (1) shall specify and define specific items and
7 services as clinical preventive services for high risk
8 populations and shall establish and update a perio-
9 dicity schedule for such items and services;

10 (2) shall update the periodicity schedules for
11 the age-appropriate immunizations, tests, and clini-
12 cian visits specified in subsections (b) through (h) of
13 such section;

14 (3) shall establish rules with respect to coverage
15 for an immunization, test, or clinician visit that is
16 not provided to an individual during the age range
17 for such immunization, test, or clinician visit that is
18 specified in one of subsections (b) through (h) of
19 such section; and

20 (4) may otherwise modify the items and services
21 described in such section, taking into account age
22 and other risk factors, but may not modify the cost
23 sharing for any such item or service.

24 (b) CONSULTATION.—In performing the functions de-
25 scribed in subsection (a), the National Health Board shall
26 consult with experts in clinical preventive services.

1 **SEC. 1154. ESTABLISHMENT OF STANDARDS REGARDING**
2 **MEDICAL NECESSITY.**

3 The National Health Board may promulgate such
4 regulations as may be necessary to carry out section
5 1141(a)(2) (relating to the exclusion of certain services
6 that are not medically necessary or appropriate).

7 **PART 6—ADDITIONAL PROVISIONS RELATING TO**
8 **HEALTH CARE PROVIDERS**

9 **SEC. 1161. OVERRIDE OF RESTRICTIVE STATE PRACTICE**
10 **LAWS.**

11 No State may, through licensure or otherwise, re-
12 strict the practice of any class of health professionals be-
13 yond what is justified by the skills and training of such
14 professionals.

15 **SEC. 1162. PROVISION OF ITEMS OR SERVICES CONTRARY**
16 **TO RELIGIOUS BELIEF OR MORAL CONVIC-**
17 **TION.**

18 A health professional or a health facility may not be
19 required to provide an item or service in the comprehen-
20 sive benefit package if the professional or facility objects
21 to doing so on the basis of a religious belief or moral con-
22 viction.

23 **Subtitle C—State Responsibilities**

24 **SEC. 1200. PARTICIPATING STATE.**

25 (a) IN GENERAL.—For purposes of the approval of
26 a State health care system by the Board under section

1 1511, a State is a “participating State” if the State meets
2 the applicable requirements of this subtitle.

3 (b) SUBMISSION OF SYSTEM DOCUMENT.—

4 (1) IN GENERAL.—In order to be approved as
5 a participating State under section 1511, a State
6 shall submit to the National Health Board a docu-
7 ment (in a form and manner specified by the Board)
8 that describes the State health care system that the
9 State is establishing (or has established).

10 (2) DEADLINE.—If a State is not a partici-
11 pating State with a State health care system in op-
12 eration by January 1, 1998, the provisions of sub-
13 part C of part 1 of subtitle F (relating to respon-
14 sibilities in absence of State systems) shall take ef-
15 fect.

16 (3) SUBMISSION OF INFORMATION SUBSEQUENT
17 TO APPROVAL.—A State approved as a participating
18 State under section 1511 shall submit to the Board
19 an annual update to the State health care system
20 not later than February 15 of each year following
21 the first year for which the State is a participating
22 State. The update shall contain—

23 (A) such information as the Board may re-
24 quire to determine that the system shall meet

1 the applicable requirements of this Act for the
2 succeeding year; and

3 (B) such information as the Board may re-
4 quire to determine that the State operated the
5 system during the previous year in accordance
6 with the Board's approval of the system for
7 such previous year.

8 **PART 1—GENERAL STATE RESPONSIBILITIES**

9 **SEC. 1201. GENERAL STATE RESPONSIBILITIES.**

10 The responsibilities for a participating State are as
11 follows:

12 (1) REGIONAL ALLIANCES.—Establishing one
13 or more regional alliances (in accordance with sec-
14 tion 1202).

15 (2) HEALTH PLANS.—Certifying health plans
16 (in accordance with section 1203).

17 (3) FINANCIAL SOLVENCY OF PLANS.—Assur-
18 ing the financial solvency of health plans (in accord-
19 ance with section 1204).

20 (4) ADMINISTRATION.—Designating an agency
21 or official charged with coordinating the State re-
22 sponsibilities under this Act.

23 (5) WORKERS COMPENSATION AND AUTO-
24 MOBILE INSURANCE.—Conforming State laws to
25 meet the requirements of subtitles A and B of title

1 X (relating to medical benefits under workers com-
2 pensation and automobile insurance).

3 (6) OTHER RESPONSIBILITIES.—Carrying out
4 other responsibilities of participating States specified
5 under this Act.

6 **SEC. 1202. STATE RESPONSIBILITIES WITH RESPECT TO AL-**
7 **LIANCES.**

8 (a) ESTABLISHMENT OF ALLIANCES.—

9 (1) IN GENERAL.—A participating State shall—

10 (A) establish and maintain one or more re-
11 gional alliances in accordance with this section
12 and subtitle D, and ensure that such alliances
13 meet the requirements of this Act; and

14 (B) designate alliance areas in accordance
15 with subsection (b).

16 (2) DEADLINE.—A State may not be a partici-
17 pating State for a year unless the State has estab-
18 lished such alliances by March 1 of the previous
19 year.

20 (b) ALLIANCE AREAS.—

21 (1) IN GENERAL.—In accordance with this sub-
22 section, each State shall designate a geographic area
23 assigned to each regional alliance. Each such area is
24 referred to in this Act as an “alliance area”.

25 (2) POPULATION REQUIRED.—

1 (A) IN GENERAL.—Each alliance area shall
2 encompass a population large enough to ensure
3 that the alliance has adequate market share to
4 negotiate effectively with health plans providing
5 the comprehensive benefit package to eligible
6 individuals who reside in the area.

7 (B) TREATMENT OF CONSOLIDATED MET-
8 ROPOLITAN STATISTICAL AREAS.—An alliance
9 area that includes a Consolidated Metropolitan
10 Statistical Area within a State is presumed to
11 meet the requirement of subparagraph (A).

12 (3) SINGLE ALLIANCE IN EACH AREA.—No geo-
13 graphic area may be assigned to more than one re-
14 gional alliance.

15 (4) BOUNDARIES.—In establishing boundaries
16 for alliance areas, the State may not discriminate on
17 the basis of or otherwise take into account race, age,
18 language, religion, national origin, socio-economic
19 status, disability, or perceived health status.

20 (5) TREATMENT OF METROPOLITAN AREAS.—
21 The entire portion of a metropolitan statistical area
22 located in a State shall be included in the same alli-
23 ance area.

24 (6) NO PORTIONS OF STATE PERMITTED TO BE
25 OUTSIDE ALLIANCE AREA.—Each portion of the

1 State shall be assigned to a regional alliance under
2 this subsection.

3 (c) STATE COORDINATION OF REGIONAL ALLI-
4 ANCES.—One or more States may allow or require two or
5 more regional alliances to coordinate their operations,
6 whether such alliances are in the same or different States.
7 Such coordination may include adoption of joint operating
8 rules, contracting with health plans, enforcement activi-
9 ties, and establishment of fee schedules for health pro-
10 viders.

11 (d) ASSISTANCE IN COLLECTION OF AMOUNTS OWED
12 TO ALLIANCES.—Each State shall assure that the
13 amounts owed to regional alliances in the State are col-
14 lected and paid to such alliances.

15 (e) ASSISTANCE IN ELIGIBILITY VERIFICATIONS.—

16 (1) IN GENERAL.—Each State shall assure that
17 the determinations of eligibility for cost sharing as-
18 sistance (and premium discounts and cost sharing
19 reductions for families) are made by regional alli-
20 ances in the State on the basis of the best informa-
21 tion available to the alliances and the State.

22 (2) PROVISION OF INFORMATION.—Each State
23 shall use the information available to the State
24 under section 6103(l)(7)(D)(x) of the Internal Rev-

1 venue Code of 1986 to assist regional alliances in
2 verifying such eligibility status.

3 (f) SPECIAL REQUIREMENTS FOR ALLIANCES WITH
4 SINGLE-PAYER SYSTEM.—If the State operates an alli-
5 ance-specific single-payer system (as described in part 2),
6 the State shall assure that the regional alliance in which
7 the system is operated meets the requirements for such
8 an alliance described in section 1224(b).

9 (g) PAYMENT OF SHORTFALLS FOR CERTAIN ADMIN-
10 ISTRATIVE ERRORS.—Each participating State is finan-
11 cially responsible, under section 9201(c)(2), for adminis-
12 trative errors described in section 9201(e)(2).

13 **SEC. 1203. STATE RESPONSIBILITIES RELATING TO HEALTH**
14 **PLANS.**

15 (a) CRITERIA FOR CERTIFICATION.—

16 (1) IN GENERAL.—For purposes of this section,
17 a participating State shall establish and publish the
18 criteria that are used in the certification of health
19 plans under this section.

20 (2) REQUIREMENTS.—Such criteria shall be es-
21 tablished with respect to—

22 (A) the quality of the plan,

23 (B) the financial stability of the plan,

1 (C) the plan's capacity to deliver the com-
2 prehensive benefit package in the designated
3 service area,

4 (D) other applicable requirements for
5 health plans under parts 1, 3, and 4 of subtitle
6 E, and

7 (E) other requirements imposed by the
8 State consistent with this part.

9 (b) CERTIFICATION OF HEALTH PLANS.—A partici-
10 pating State shall certify each plan as a regional alliance
11 health plan that it determines meets the criteria for cer-
12 tification established and published under subsection (a).

13 (c) MONITORING.—A participating State shall mon-
14 itor the performance of each State-certified regional alli-
15 ance health plan to ensure that it continues to meet the
16 criteria for certification.

17 (d) LIMITATIONS ON AUTHORITY.—A participating
18 State may not—

19 (1) discriminate against a plan based on the
20 domicile of the entity offering of the plan; and

21 (2) regulate premium rates charged by health
22 plans, except as may be required under title VI (re-
23 lating to the enforcement of cost containment rules
24 for plans in the State) or as may be necessary to en-

1 sure that plans meet financial solvency requirements
2 under section 1408.

3 (e) ASSURING ADEQUATE ACCESS TO A CHOICE OF
4 HEALTH PLANS.—

5 (1) GENERAL ACCESS.—

6 (A) IN GENERAL.—Each participating
7 State shall ensure that—

8 (i) each regional alliance eligible fam-
9 ily has adequate access to enroll in a
10 choice of regional alliance health plans pro-
11 viding services in the area in which the in-
12 dividual resides, including (to the max-
13 imum extent practicable) adequate access
14 to a plan whose premium is at or below the
15 weighted average premium for plans in the
16 regional alliance, and

17 (ii) each such family that is eligible
18 for a premium discount under section
19 6104(b) is provided a discount in accord-
20 ance with such section (including an in-
21 crease in such discount described in section
22 6104(b)(2)).

23 (B) AUTHORITY.—In order to carry out its
24 responsibility under subparagraph (A), a par-
25 ticipating State may require, as a condition of

1 entering into a contract with a regional alliance
2 under section 1321, that one or more certified
3 regional alliance health plans cover all (or se-
4 lected portions) of the alliance area.

5 (2) ACCESS TO PLANS USING CENTERS OF EX-
6 CELLENCE.—Each participating State may require,
7 as a condition of entering into a contract with a re-
8 gional alliance under section 1321, that one or more
9 certified health plans provide access (through reim-
10 bursement, contracts, or otherwise) of enrolled indi-
11 viduals to services of centers of excellence (as des-
12 ignated by the State in accordance with rules pro-
13 mulgated by the Secretary).

14 (3) USE OF INCENTIVES TO ENROLL AND
15 SERVE DISADVANTAGED GROUPS.—A State may
16 provide—

17 (A) for an adjustment to the risk-adjust-
18 ment methodology under section 1541(b) and
19 other financial incentives to regional alliance
20 health plans to ensure that such plans enroll in-
21 dividuals who are members of disadvantaged
22 groups, and

23 (B) for appropriate extra services, such as
24 outreach to encourage enrollment and transpor-
25 tation and interpreting services to ensure access

1 to care, for certain population groups that face
2 barriers to access because of geographic loca-
3 tion, income levels, or racial or cultural dif-
4 ferences.

5 (f) COORDINATION OF WORKERS' COMPENSATION
6 SERVICES AND AUTOMOBILE INSURANCE.—Each partici-
7 pating State shall comply with the responsibilities regard-
8 ing workers' compensation and automobile insurance spec-
9 ified in subtitles A and B of title X.

10 (g) IMPLEMENTATION OF MANDATORY REINSUR-
11 ANCE SYSTEM.—If the risk adjustment and reinsurance
12 methodology developed under section 1541 includes a
13 mandatory reinsurance system, each participating State
14 shall establish a reinsurance program consistent with such
15 methodology and any additional standards established by
16 the Board.

17 (h) REQUIREMENTS FOR PLANS OFFERING SUPPLE-
18 MENTAL INSURANCE.—Notwithstanding any other provi-
19 sion of this Act a State may not certify a regional alliance
20 health plan under this section if—

21 (1) the plan (or any entity with which the plan
22 is affiliated under such rules as the Board may es-
23 tablish) offers a supplemental health benefit policy
24 (as defined in section 1421(b)(1)) that fails to meet
25 the applicable requirements for such a policy under

1 part 2 of subtitle E (without regard to the State in
2 which the policy is offered); or

3 (2) the plan offers a cost sharing policy (as de-
4 fined in section 1421(b)(2)) that fails to meet the
5 applicable requirements for such a policy under part
6 2 of subtitle E.

7 **SEC. 1204. FINANCIAL SOLVENCY; FISCAL OVERSIGHT;**
8 **GUARANTY FUND.**

9 (a) CAPITAL STANDARDS.—A participating State
10 shall establish capital standards for health plans that meet
11 minimum Federal requirements established by the Na-
12 tional Health Board under sections 1503(i) and 1551(a).

13 (b) REPORTING AND AUDITING REQUIREMENTS.—
14 Each participating State shall define financial reporting
15 and auditing requirements and requirements for fund re-
16 serves adequate to monitor the financial status of plans.

17 (c) GUARANTY FUND.—

18 (1) ESTABLISHMENT.—Each participating
19 State shall ensure that there is a guaranty fund that
20 meets the requirements established by the Board
21 under sections 1503(i) and 1552, in order to provide
22 financial protection to health care providers and oth-
23 ers in the case of a failure of a regional alliance
24 health plan.

1 (2) ASSESSMENTS TO PROVIDE FUNDS.—In the
2 case of a failure of one or more regional alliance
3 health plans, the State may require each regional al-
4 liance health plan within the State to pay an assess-
5 ment to the State in an amount not to exceed 2 per-
6 cent of the premiums of such plans paid by or on
7 behalf of regional alliance eligible individuals during
8 a year for so long as necessary to generate sufficient
9 revenue to cover any outstanding claims against the
10 failed plan.

11 (d) PROCEDURES IN EVENT OF PLAN FAILURE.—

12 (1) IN GENERAL.—A participating State shall
13 assure that, in the event of the failure of a regional
14 alliance health plan in the State, eligible individuals
15 enrolled in the plan will be assured continuity of cov-
16 erage for the comprehensive benefit package.

17 (2) DESIGNATION OF STATE AGENCY.—A par-
18 ticipating State shall designate an agency of State
19 government that supervises or assumes control of
20 the operation of a regional alliance health plan in
21 the case of the failure of the plan.

22 (3) PROTECTIONS FOR HEALTH CARE PRO-
23 VIDERS AND ENROLLEES.—Each participating State
24 shall assure that in the case of a plan failure—

1 (A) the guaranty fund shall pay health
2 care providers for items and services covered
3 under the comprehensive benefit package for
4 enrollees of the plan for which the plan is other-
5 wise obligated to make payment;

6 (B) after making all payments required to
7 be made to providers under subparagraph (A),
8 the guaranty fund shall make payments for the
9 operational, administrative, and other costs and
10 debts of the plan (in accordance with require-
11 ments imposed by the State based on rules pro-
12 mulgated by the Board);

13 (C) such health care providers have no
14 legal right to seek payment from eligible indi-
15 viduals enrolled in the plan for any such cov-
16 ered items or services (other than the enrollees'
17 obligations under cost sharing arrangements);
18 and

19 (D) health care providers are required to
20 continue caring for such eligible individuals
21 until such individuals are enrolled in a new
22 health plan.

23 (4) PLAN FAILURE.—For purposes of this sec-
24 tion, the failure of a health plan means the current
25 or imminent inability of the plan to pay claims.

1 **SEC. 1205. RESTRICTIONS ON FUNDING OF ADDITIONAL**
2 **BENEFITS.**

3 If a participating State provides benefits (either di-
4 rectly or through regional alliance health plans or other-
5 wise) in addition to those covered under the comprehensive
6 benefit package, the State may not provide for payment
7 for such benefits through funds provided under this Act.

8 **PART 2—REQUIREMENTS FOR STATE SINGLE-**
9 **PAYER SYSTEMS**

10 **SEC. 1221. SINGLE-PAYER SYSTEM DESCRIBED.**

11 The Board shall approve the application of a State
12 to operate a single-payer system if the Board finds that
13 the system—

14 (1) meets the requirements of section 1222;

15 (2)(A) meets the requirements for a Statewide
16 single-payer system under section 1223, in the case
17 of a system offered throughout a State; or

18 (B) meets the requirements for an alliance-spe-
19 cific single-payer system under section 1224, in the
20 case of a system offered in a single alliance of a
21 State.

22 **SEC. 1222. GENERAL REQUIREMENTS FOR SINGLE-PAYER**
23 **SYSTEMS.**

24 Each single-payer system shall meet the following re-
25 quirements:

1 (1) ESTABLISHMENT BY STATE.—The system is
2 established under State law, and State law provides
3 for mechanisms to enforce the requirements of the
4 system.

5 (2) OPERATION BY STATE.—The system is op-
6 erated by the State or a designated agency of the
7 State.

8 (3) ENROLLMENT OF ELIGIBLE INDIVIDUALS.—

9 (A) MANDATORY ENROLLMENT OF ALL
10 REGIONAL ALLIANCE INDIVIDUALS.—The sys-
11 tem provides for the enrollment of all eligible
12 individuals residing in the State (or, in the case
13 of an alliance-specific single-payer system, in
14 the alliance area) for whom the applicable
15 health plan would otherwise be a regional alli-
16 ance health plan.

17 (B) OPTIONAL ENROLLMENT OF MEDI-
18 CARE-ELIGIBLE INDIVIDUALS.—At the option of
19 the State, the system may provide for the en-
20 rollment of medicare-individuals residing in the
21 State (or, in the case of an alliance-specific sin-
22 gle-payer system, in the alliance area) if the
23 Secretary of Health and Human Services has
24 approved an application submitted by the State
25 under section 1893 of the Social Security Act

1 (as added by section 4001(a)) for the integra-
2 tion of medicare beneficiaries into plans of the
3 State. Nothing in this subparagraph shall be
4 construed as requiring that a State have a sin-
5 gle-payer system in order to provide for such in-
6 tegration.

7 (C) OPTIONAL ENROLLMENT OF COR-
8 PORATE ALLIANCE INDIVIDUALS IN STATEWIDE
9 PLANS.—At the option of the State, a Statewide
10 single-payer system may provide for the enroll-
11 ment of individuals residing in the State who
12 are otherwise eligible to enroll in a corporate al-
13 liance health plan under section 1311.

14 (D) OPTIONS INCLUDED IN STATE SYSTEM
15 DOCUMENT.—A State may not exercise any of
16 the options described in subparagraphs (A) or
17 (B) for a year unless the State included a de-
18 scription of the option in the submission of its
19 system document to the Board for the year
20 under section 1200(b).

21 (E) EXCLUSION OF CERTAIN INDIVID-
22 UALS.—A single-payer system may not require
23 the enrollment of electing veterans, active duty
24 military personnel, and electing Indians (as de-
25 fined in 1012(d)).

1 (4) DIRECT PAYMENT TO PROVIDERS.—

2 (A) IN GENERAL.—With respect to pro-
3 viders who furnish items and services included
4 in the comprehensive benefit package to individ-
5 uals enrolled in the system, the State shall
6 make payments directly to such providers and
7 assume (subject to subparagraph (B)) all finan-
8 cial risk associated with making such payments.

9 (B) CAPITATED PAYMENTS PERMITTED.—
10 Nothing in subparagraph (A) shall be construed
11 to prohibit providers furnishing items and serv-
12 ices under the system from receiving payments
13 from the plan on a capitated, at-risk basis
14 based on prospectively determined rates.

15 (5) PROVISION OF COMPREHENSIVE BENEFIT
16 PACKAGE.—

17 (A) IN GENERAL.—The system shall pro-
18 vide for coverage of the comprehensive benefit
19 package, including the cost sharing provided
20 under the package (subject to subparagraph
21 (B)), to all individuals enrolled in the system.

22 (B) IMPOSITION OF REDUCED COST SHAR-
23 ING.—The system may decrease the cost shar-
24 ing otherwise provided in the comprehensive
25 benefit package with respect to any class of in-

1 dividuals enrolled in the system or any class of
2 services included in the package, so long as the
3 system does not increase the cost sharing other-
4 wise imposed with respect to any other class of
5 individuals or services.

6 (6) COST CONTAINMENT.—The system shall
7 provide for mechanisms to ensure, in a manner sat-
8 isfactory to the Board, that—

9 (A) per capita expenditures for items and
10 services in the comprehensive benefit package
11 under the system for a year (beginning with the
12 first year) do not exceed an amount equivalent
13 to the regional alliance per capita premium tar-
14 get that is determined under section 6003
15 (based on the State being a single regional alli-
16 ance) for the year;

17 (B) the per capita expenditures described
18 in subparagraph (A) are computed and effec-
19 tively monitored; and

20 (C) automatic, mandatory, nondis-
21 cretionary reductions in payments to health
22 care providers will be imposed to the extent re-
23 quired to assure that such per capita expendi-
24 tures do not exceed the applicable target re-
25 ferred to in subparagraph (A).

1 (7) REQUIREMENTS GENERALLY APPLICABLE
2 TO HEALTH PLANS.—The system shall meet the re-
3 quirements applicable to a health plan under section
4 1400(a), except that—

5 (A) the system does not have the authority
6 provided to health plans under section
7 1402(a)(2) (relating to permissible limitations
8 on the enrollment of eligible individuals on the
9 basis of limits on the plan’s capacity);

10 (B) the system is not required to meet the
11 requirements of section 1404(a) (relating to re-
12 strictions on the marketing of plan materials);
13 and

14 (C) the system is not required to meet the
15 requirements of section 1408 (relating to plan
16 solvency).

17 **SEC. 1223. SPECIAL RULES FOR STATES OPERATING STATE-**
18 **WIDE SINGLE-PAYER SYSTEM.**

19 (a) IN GENERAL.—In the case of a State operating
20 a Statewide single-payer system—

21 (1) the State shall operate the system through-
22 out the State through a single alliance;

23 (2) except as provided in subsection (b), the
24 State shall meet the requirements for participating
25 States under part 1; and

1 (3) the State shall assume the functions de-
2 scribed in subsection (c) that are otherwise required
3 to be performed by regional alliances in participating
4 States that do not operate a Statewide single-payer
5 system.

6 (b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR
7 PARTICIPATING STATES.—In the case of a State operating
8 a Statewide single-payer system, the State is not required
9 to meet the following requirements otherwise applicable to
10 participating States under part 1:

11 (1) ESTABLISHMENT OF ALLIANCES.—The re-
12 quirements of section 1202 (relating to the estab-
13 lishment of alliances).

14 (2) HEALTH PLANS.—The requirements of sec-
15 tion 1203 (relating to health plans), other than the
16 requirement of subsection (f) of such section (relat-
17 ing to coordination of workers' compensation serv-
18 ices and automobile liability insurance).

19 (3) FINANCIAL SOLVENCY.—The requirements
20 of section 1204 (relating to the financial solvency of
21 health plans in the State).

22 (c) ASSUMPTION BY STATE OF CERTAIN REQUIRE-
23 MENTS APPLICABLE TO REGIONAL ALLIANCES.—A State
24 operating a Statewide single-payer system shall be subject

1 to the following requirements otherwise applicable to re-
2 gional alliances in other participating States:

3 (1) ENROLLMENT; ISSUANCE OF HEALTH SECU-
4 RITY CARDS.—The requirements of subsections (a)
5 and (c) of section 1323 and section 1324 shall apply
6 to the State, eligible individuals residing in the
7 State, and the single-payer system operated by the
8 State in the same manner as such requirements
9 apply to a regional alliance, alliance eligible individ-
10 uals, and regional alliance health plans.

11 (2) REDUCTIONS IN COST SHARING FOR LOW-
12 INCOME INDIVIDUALS.—The requirement of section
13 1371 shall apply to the State in the same manner
14 as such requirement applies to a regional alliance.

15 (3) DATA COLLECTION; QUALITY.—The require-
16 ments of section 1327 shall apply to the State and
17 the single-payer system operated by the State in the
18 same manner as such requirement applies to a re-
19 gional alliance and health plans offered through a
20 regional alliance.

21 (4) ANTI-DISCRIMINATION; COORDINATION.—
22 The requirements of section 1328 shall apply to the
23 State in the same manner as such requirements
24 apply with respect to a regional alliance.

25 (d) FINANCING.—

(1) IN GENERAL.—A State operating a State-wide single-payer system shall provide for the financing of the system using, at least in part, a payroll-based financing system that requires employers to pay at least the amount that the employers would be required to pay if the employers were subject to the requirements of subtitle B of title VI.

8 (2) USE OF FINANCING METHODS.—Such a
9 State may use, consistent with paragraph (1), any
10 other method of financing.

(e) SINGLE-PAYER STATE DEFINED.—In this Act, the term “single-payer State” means a State with a State-wide single-payer system in effect that has been approved by the Board in accordance with this part.

15 SEC. 1224. SPECIAL RULES FOR ALLIANCE-SPECIFIC SIN-
16 GLE-PAYER SYSTEMS.

(a) IN GENERAL.—In the case of a State operating an alliance-specific single-payer system—

19 (1) the State shall meet the requirements for
20 participating States under part 1; and

(2) the regional alliance in which the system is operated shall meet the requirements of subsection (b).

(b) REQUIREMENTS FOR ALLIANCE IN WHICH SYSTEM OPERATES.—A regional alliance in which an alliance-

1 specific single payer system is operated shall meet the re-
2 quirements applicable to regional alliances under subtitle
3 D, except that the alliance is not required to meet the fol-
4 lowing requirements of such subtitle:

5 (1) CONTRACTS WITH HEALTH PLANS.—The re-
6 quirements of section 1321 (relating to contracts
7 with health plans).

8 (2) CHOICE OF HEALTH PLANS OFFERED.—The
9 requirements of subsections (a) or (b) of section
10 1322 (relating to offering a choice of health plans to
11 eligible enrollees).

12 (3) ESTABLISHMENT OF OMBUDSMAN OF-
13 FICE.—The requirements of section 1326(a) (relat-
14 ing to the establishment of an office of ombudsman).

15 (4) ADDRESSING NEEDS OF AREAS WITH INAD-
16 EQUATE HEALTH SERVICES.—The regional alliance
17 does not have any of the authorities described in
18 subsections (a) and (b) of section 1329 (relating to
19 adjusting payments to plans and encouraging the es-
20 tablishment of new plans).

21 **Subtitle D—Health Alliances**

22 **SEC. 1300. HEALTH ALLIANCE DEFINED.**

23 In this Act, the term “health alliance” means a re-
24 gional alliance (as defined in section 1301) and a cor-
25 porate alliance (as defined in section 1311).

1 **PART 1—ESTABLISHMENT OF REGIONAL AND**
2 **CORPORATE ALLIANCES**

3 **Subpart A—Regional Alliances**

4 **SEC. 1301. REGIONAL ALLIANCE DEFINED.**

5 In this Act, the term “regional alliance” means a
6 non-profit organization, an independent state agency, or
7 an agency of the State which—

8 (1) meets the applicable organizational require-
9 ments of this subpart, and

10 (2) is carrying out activities consistent with
11 part 2.

12 **SEC. 1302. BOARD OF DIRECTORS.**

13 (a) IN GENERAL.—A regional alliance must be gov-
14 erned by a Board of Directors appointed consistent with
15 the provisions of this subpart. All powers vested in a re-
16 gional alliance under this Act shall be vested in the Board
17 of Directors.

18 (b) MEMBERSHIP.—

19 (1) IN GENERAL.—Such a Board of Directors
20 shall consist of—

21 (A) members who represent employers
22 whose employees purchase health coverage
23 through the alliance, including self-employed in-
24 dividuals who purchase such coverage; and

1 (B) members who represent individuals
2 who purchase such coverage, including employ-
3 ees who purchase such coverage.

4 (2) EQUAL REPRESENTATION OF EMPLOYERS
5 AND CONSUMERS.—The number of members of the
6 Board described under subparagraph (A) of para-
7 graph (1) shall be the same as the number of mem-
8 bers described in subparagraph (B) of such para-
9 graph.

10 (c) NO CONFLICT OF INTEREST PERMITTED.—An
11 individual may not serve as a member of the Board of
12 Directors if the individual is one of the following (or an
13 immediate family member of one of the following):

14 (1) A health care provider.

15 (2) An individual who is an employee or mem-
16 ber of the Board of Directors of, has a substantial
17 ownership in, or derives substantial income from, a
18 health care provider, health plan, pharmaceutical
19 company, or a supplier of medical equipment, de-
20 vices, or services.

21 (3) A person who derives substantial income
22 from the provision of health care.

23 (4)(A) A member or employee of an association,
24 law firm, or other institution or organization that
25 represents the interests of one or more health care

1 providers, health plans or others involved in the
2 health care field, or (B) an individual who practices
3 as a professional in an area involving health care.

4 **SEC. 1303. PROVIDER ADVISORY BOARDS FOR REGIONAL**
5 **ALLIANCES.**

6 Each regional alliance must establish a provider advi-
7 sory board consisting of representatives of health care pro-
8 viders and professionals who provide covered services
9 through health plans offered by the alliance.

10 **Subpart B—Corporate Alliances**

11 **SEC. 1311. CORPORATE ALLIANCE DEFINED; INDIVIDUALS**
12 **ELIGIBLE FOR COVERAGE THROUGH COR-**
13 **PORATE ALLIANCES; ADDITIONAL DEFINI-**
14 **TIONS.**

15 (a) CORPORATE ALLIANCE DEFINED.—In this Act,
16 the term “corporate alliance” means an eligible sponsor
17 (as defined in subsection (b)) if—

18 (1) the sponsor elects, in a form and manner
19 specified by the Secretary of Labor consistent with
20 this subpart, to be treated as a corporate alliance
21 under this title and such election has not been ter-
22 minated under section 1313; and

23 (2) the sponsor has filed with the Secretary of
24 Labor a document describing how the sponsor shall

1 carry out activities as such an alliance consistent
2 with part 4.

3 (b) ELIGIBLE SPONSORS.—

4 (1) IN GENERAL.—In this subpart, each of the
5 following is an eligible sponsor:

6 (A) LARGE EMPLOYER.—An employer
7 that—

8 (i) is a large employer (as defined in
9 subsection (e)(2)) as of the date of an elec-
10 tion under subsection (a)(1), and

11 (ii) is not an excluded employer de-
12 scribed in paragraph (2).

13 (B) PLAN SPONSOR OF A MULTIEMPLOYER
14 PLAN.—A plan sponsor described in section
15 3(16)(B)(iii) of Employee Retirement Income
16 Security Act of 1974, but only with respect to
17 a group health plan that is a multiemployer
18 plan (as defined in subsection (e)(3)) main-
19 tained by the sponsor and only if—

20 (i) such plan offered health benefits
21 as of September 1, 1993, and

22 (ii) as of both September 1, 1993, and
23 January 1, 1996, such plan has more than
24 5,000 active participants in the United
25 States, or the plan is maintained by one or

1 more affiliates of the same labor organiza-
2 tion, or one or more affiliates of labor or-
3 ganizations representing employees in the
4 same industry, covering more than 5,000
5 employees.

6 (C) RURAL ELECTRIC COOPERATIVE AND
7 RURAL TELEPHONE COOPERATIVE ASSOCIA-
8 TION.—A rural electric cooperative or a rural
9 telephone cooperative association, but only with
10 respect to a group health plan that is main-
11 tained by such cooperative or association (or
12 members of such cooperative or association)
13 and only if such plan—

14 (i) offered health benefits as of Sep-
15 tember 1, 1993, and

16 (ii) as of both September 1, 1993, and
17 January 1, 1996, has more than 5,000
18 full-time employees in the United States
19 entitled to health benefits under the plan.

20 (2) EXCLUDED EMPLOYERS.—For purposes of
21 paragraph (1)(A), any of the following are excluded
22 employers described in this paragraph:

23 (A) An employer whose primary business is
24 employee leasing.

1 (B) The Federal government (other than
2 the United States Postal Service).

3 (C) A State government, a unit of local
4 government, and an agency or instrumentality
5 of government, including any special purpose
6 unit of government.

7 (c) INDIVIDUALS ELIGIBLE TO ENROLL IN COR-
8 PORATE ALLIANCE HEALTH PLANS.—For purposes of
9 part 1 of subtitle A, subject to subsection (d)—

10 (1) FULL-TIME EMPLOYEES OF LARGE EMPLOY-
11 ERS.—Each eligible individual who is a full-time em-
12 ployee (as defined in section 1901(b)(2)(C)) of a
13 large employer that has an election in effect as a
14 corporate alliance is eligible to enroll in a corporate
15 alliance health plan offered by such corporate alli-
16 ance.

17 (2) MULTIEMPLOYER ALLIANCES.—

18 (A) PARTICIPANTS.—Each participant and
19 beneficiary (as defined in subparagraph (B))
20 under a multiemployer plan, with respect to
21 which an eligible sponsor of the plan described
22 in subsection (b)(1)(B) has an election in effect
23 as a corporate alliance, is eligible to enroll in a
24 corporate alliance health plan offered by such
25 corporate alliance.

1 (B) PARTICIPANT AND BENEFICIARY DE-
2 FINED.—In subparagraph (A), the terms “par-
3 ticipant” and “beneficiary” have the meaning
4 given such terms in section 3 of the Employee
5 Retirement Income Security Act of 1974.

6 (3) FULL-TIME EMPLOYEES OF RURAL COOPER-
7 ATIVE ALLIANCES.—Each full-time employee of a
8 member of a rural electric cooperative or rural tele-
9 phone cooperative association which has an election
10 in effect as a corporate alliance (and each full-time
11 employee of such a cooperative or association) is eli-
12 gible to enroll in a corporate alliance health plan of-
13 fered by such corporate alliance.

14 (4) INELIGIBLE TO ENROLL IN REGIONAL ALLI-
15 ANCE HEALTH PLAN.—Except as provided in section
16 1013, a corporate alliance eligible individual is not
17 eligible to enroll under a regional alliance health
18 plan.

19 (d) EXCLUSION OF CERTAIN INDIVIDUALS.—In ac-
20 cordance with rules of the Board, the following individuals
21 shall not be treated as corporate alliance eligible individ-
22 uals:

23 (1) AFDC recipients.

24 (2) SSI recipients.

1 (3) Individuals who are described in section
2 1004(b) (relating to veterans, military personnel,
3 and Indians) and who elect an applicable health plan
4 described in such section.

5 (4) Employees who are seasonal or temporary
6 workers (as defined by the Board), other than such
7 workers who are treated as corporate alliance eligible
8 individuals pursuant to a collective bargaining agree-
9 ment (as defined by the Secretary of Labor).

10 (e) DEFINITIONS RELATING TO CORPORATE ALLI-
11 ANCES.—In this subtitle, except as otherwise provided:

12 (1) GROUP HEALTH PLAN.—The term “group
13 health plan” means an employee welfare benefit plan
14 (as defined in section 3(1) of the Employee Retirement
15 Income Security Act of 1974) providing medical
16 care (as defined in section 213(d) of the Internal
17 Revenue Code of 1986) to participants or bene-
18 ficiaries (as defined in section 3 of the Employee Retirement
19 Income Security Act of 1974) directly or
20 through insurance, reimbursement, or otherwise.

21 (2) LARGE EMPLOYER.—The term “large em-
22 ployer” means an employer that has more than
23 5,000 full-time employees in the United States. Such
24 term includes the United States Postal Service.

1 (3) **MULTIEMPLOYER PLAN.**—The term “multi-
2 employer plan” has the meaning given such term in
3 section 3(37) of the Employee Retirement Income
4 Security Act of 1974, and includes any plan that is
5 treated as such a plan under title I of such Act.

6 (4) **RURAL ELECTRIC COOPERATIVE.**—The term
7 “rural electric cooperative” has the meaning given
8 such term in section 3(40)(A)(iv) of the Employee
9 Retirement Income Security Act of 1974.

10 (5) **RURAL TELEPHONE COOPERATIVE ASSOCIA-**
11 **TIONS.**—The term “rural telephone cooperative asso-
12 ciation” has the meaning given such term in section
13 3(40)(A)(v) of the Employee Retirement Income Se-
14 curity Act of 1974.

15 **SEC. 1312. TIMING OF ELECTIONS.**

16 (a) **FOR LARGE EMPLOYERS.**—

17 (1) **CURRENT LARGE EMPLOYERS.**—

18 (A) **IN GENERAL.**—In the case of an em-
19 ployer that is an eligible sponsor described in
20 section 1311(b)(1)(A) as of the most recent
21 January 1 prior to the general effective date,
22 the sponsor’s election to be a corporate alliance
23 under such section must be made and filed with
24 the Secretary of Labor not later than the date
25 specified in subparagraph (B).

1 (B) DEADLINE FOR NOTICE.—The date
2 specified in this subparagraph is January 1 of
3 the second year preceding the general effective
4 date or, in the case of a State that elects to be-
5 come a participating State before the general
6 effective date, not later than one month later
7 than the date specified for States under section
8 1202(a)(2).

9 (2) NEW LARGE EMPLOYERS.—In the case of
10 an employer that is not an eligible sponsor described
11 in section 1311(b)(1)(A) as of the most recent Janu-
12 ary 1 prior to the general effective date, but first be-
13 comes such a sponsor as of a subsequent date, the
14 election to be a corporate alliance under such section
15 must be made and filed with the Secretary of Labor
16 not later than March 1 of the year following the
17 year in which the employer first becomes such a
18 sponsor.

19 (3) APPLICATION OF OPTION.—The Secretary
20 of Labor shall promulgate rules regarding how the
21 option described in section 1311(c)(1)(B) will be ap-
22 plied to the determination of whether an employer is
23 a large employer before an election is made under
24 section 1311.

1 (b) **FOR MULTIEMPLOYER PLANS AND RURAL CO-**
2 **OPERATIVES.**—In the case of an eligible sponsor described
3 in section 1311(b)(1) (B) or (C), the sponsor’s election
4 to be a corporate alliance under such section must be
5 made and filed with the Secretary of Labor not later than
6 March 1, 1996.

7 (c) **EFFECTIVE DATE OF ELECTION.**—An election
8 made under subsection (a) or (b) shall be effective for cov-
9 erage provided under health plans on and after January
10 1 of the year following the year in which the election is
11 made.

12 (d) **ONE-TIME ELECTION.**—If an eligible sponsor
13 fails to make the election on a timely manner under sub-
14 section (a) or (b), the sponsor may not make such election
15 at any other time.

16 **SEC. 1313. TERMINATION OF ALLIANCE ELECTION.**

17 (a) **TERMINATION FOR INSUFFICIENT NUMBER OF**
18 **FULL-TIME EMPLOYEES OR PARTICIPANTS.**—If a cor-
19 porate alliance reports under section 1387(c), that there
20 were fewer than 4,800 full-time employees (or, active par-
21 ticipants, in the case of one or more plans offered by a
22 corporate alliance which is an eligible sponsor described
23 in section 1311(b)(1)(B)) who are enrolled in a health
24 plan through the alliance, the election under this part with
25 respect to the alliance shall terminate.

1 (b) TERMINATION FOR FAILURE TO MEET REQUIRE-
2 MENTS.—

3 (1) IN GENERAL.—If the Secretary of Labor
4 finds that a corporate alliance has failed substan-
5 tially to meet the applicable requirements of this
6 subtitle, the Secretary shall terminate the election
7 under this part with respect to the alliance

8 (2) EXCESS INCREASE IN PREMIUM EQUIVA-
9 LENT.—If the Secretary of Labor finds that the alli-
10 ance is in violation of the requirements of section
11 6022 (relating to prohibition against excess increase
12 in premium expenditures), the Secretary shall termi-
13 nate the alliance in accordance with such section.

14 (c) ELECTIVE TERMINATION.—A corporate alliance
15 may terminate an election under this part by filing with
16 the National Health Board and the Secretary of Labor
17 a notice of intent to terminate.

18 (d) EFFECTIVE DATE OF TERMINATION.—In the
19 case of a termination of an election under this section,
20 in accordance with rules established by the Secretary of
21 Labor—

22 (1) subject to section 6022(a)(1), the termi-
23 nation shall take effect as of the effective date of en-
24 rollments in regional alliance health plans made dur-

1 ing the next open enrollment period (as provided in
2 section 1323(d)), and

3 (2) the enrollment of eligible individuals in cor-
4 porate alliance health plans of the corporate alliance
5 shall be terminated as of such date and such individ-
6 uals shall be enrolled in other applicable health plans
7 effective on such date.

8 (e) NOTICE TO BOARD.—If an election with respect
9 to a corporate alliance is terminated pursuant to sub-
10 section (a) or subsection (b), the Secretary of Labor shall
11 notify the National Health Board of the termination of
12 the election.

13 **PART 2—GENERAL RESPONSIBILITIES AND**
14 **AUTHORITIES OF REGIONAL ALLIANCES**

15 **SEC. 1321. CONTRACTS WITH HEALTH PLANS.**

16 (a) CONTRACTS WITH PLANS.—

17 (1) IN GENERAL.—In order to assure the avail-
18 ability of the comprehensive benefit package to eligi-
19 ble individuals residing in the alliance area in a cost-
20 effective manner, except as provided in this section,
21 each regional alliance shall negotiate with any will-
22 ing State-certified health plan to enter into a con-
23 tract with the alliance for the enrollment under the
24 plan of eligible individuals in the alliance area. Sub-
25 ject to paragraph (2), a regional alliance shall not

1 enter into any such contract with a health plan that
2 is not a State-certified health plan.

3 (2) TREATMENT OF CERTAIN PLANS.—Each re-
4 gional alliance shall enter into a contract under this
5 section with any veterans health plan of the Depart-
6 ment of Veterans Affairs and with a Uniformed
7 Services Health Plan of the Department of Defense,
8 that offers the comprehensive benefit package to eli-
9 gible individuals residing in the alliance area if the
10 appropriate official requests to enter into such a
11 contract.

12 (b) GENERAL CONDITIONS FOR DENIAL OF CON-
13 TRACT BY A REGIONAL ALLIANCE.—A regional alliance
14 is not required under this section to offer a contract with
15 a health plan if—

16 (1) the alliance finds that the proposed bid ex-
17 ceeds 120 percent of the regional alliance per capita
18 prremium target (as determined under section
19 6003); or

20 (2) the plan has failed to comply with require-
21 ments under prior contracts with the alliance, in-
22 cluding failing to offer coverage for all the services
23 in the comprehensive benefit package in the entire
24 service area of the plan.

1 **SEC. 1322. OFFERING CHOICE OF HEALTH PLANS FOR EN-**
2 **ROLLMENT; ESTABLISHMENT OF FEE-FOR-**
3 **SERVICE SCHEDULE.**

4 (a) IN GENERAL.—Each regional alliance must pro-
5 vide to each eligible enrollee (as defined in section
6 1902(14)) with respect to the alliance a choice of health
7 plans among the plans which have contracts in effect with
8 the alliance under section 1321 (in the case of a regional
9 alliance) or section 1341 (in the case of a corporate alli-
10 ance).

11 (b) OFFERING OF PLANS BY REGIONAL ALLI-
12 ANCES.—

13 (1) IN GENERAL.—Each regional alliance shall
14 include among its health plan offerings at least one
15 fee-for-service plan (as defined in paragraph (2)).

16 (2) FEE-FOR-SERVICE PLAN DEFINED.—

17 (A) IN GENERAL.—For purposes of this
18 Act, the term “fee-for-service plan” means a
19 health plan that—

20 (i) provides coverage for all items and
21 services included in the comprehensive ben-
22 efit package that are furnished by any law-
23 ful health care provider of the enrollee’s
24 choice, subject to reasonable restrictions
25 (described in subparagraph (B)), and

1 (ii) makes payment to such a provider
2 without regard to whether or not there is
3 a contractual arrangement between the
4 plan and the provider.

5 (B) REASONABLE RESTRICTIONS DE-
6 SCRIBED.—The reasonable restrictions on cov-
7 erage permitted under a fee-for-service plan (as
8 specified by the National Health Board) are as
9 follows:

10 (i) Utilization review.

11 (ii) Prior approval for specified serv-
12 ices.

13 (iii) Exclusion of providers on the
14 basis of poor quality of care, based on evi-
15 dence obtainable by the plan.

16 Clause (ii) shall not be construed as permitting
17 a plan to require prior approval for non-pri-
18 mary health care services through a gatekeeper
19 or other process.

20 (c) ESTABLISHMENT OF FEE-FOR-SERVICE SCHED-
21 ULE.—

22 (1) IN GENERAL.—Except in the case of re-
23 gional alliances of a State that has established a
24 Statewide fee schedule under paragraph (3), each re-
25 gional alliance shall establish a fee schedule setting

1 forth the payment rates applicable to services fur-
2 nished during a year to individuals enrolled in fee-
3 for-service plans (or to services furnished under the
4 fee-for-service component of any regional alliance
5 health plan) for use by regional alliance health plans
6 under section 1406(c) and corporate alliance health
7 plans providing services subject to the schedule in
8 the regional alliance area.

9 (2) NEGOTIATION WITH PROVIDERS.—The fee
10 schedule under paragraph (1) shall be established
11 after negotiations with providers, and (subject to
12 paragraphs (5) and (6)) providers may collectively
13 negotiate the fee schedule with the regional alliance.

14 (3) USE OF STATEWIDE SCHEDULE.—At the
15 option of a State, the State may establish its own
16 statewide fee schedule which shall apply to all fee-
17 for-service plans offered by regional alliances and
18 corporate alliances in the State instead of alliance-
19 specific schedules established under paragraph (1).

20 (4) ANNUAL REVISION.—A regional alliance or
21 State (as the case may be) shall annually update the
22 payment rates provided under the fee schedule es-
23 tablished pursuant to paragraph (1) or paragraph
24 (3).

1 (5) ACTIVITIES TREATED AS STATE ACTION OR
2 EFFORTS INTENDED TO INFLUENCE GOVERNMENT
3 ACTION.—The establishment of a fee schedule under
4 this subsection by a regional alliance of a State shall
5 be considered to be pursuant to a clearly articulated
6 and affirmatively expressed State policy to displace
7 competition and to be actively supervised by the
8 State, and conduct by providers respecting the es-
9 tablishment of the fee schedule, including collective
10 negotiations by providers with the regional alliance
11 (or the State) pursuant to paragraph (2), shall be
12 considered as efforts intended to influence govern-
13 mental action.

14 (6) NO BOYCOTT PERMITTED.—Nothing in this
15 subsection shall be construed to permit providers to
16 threaten or engage in any boycott.

17 (7) NEGOTIATIONS DEFINED.—In this sub-
18 section, “negotiations” are the process by which pro-
19 viders collectively and jointly meet, confer, consult,
20 discuss, share information, among and between
21 themselves in order to agree on information to be
22 provided, presentations to be made, and other such
23 activities with respect to regional alliances (or
24 States) relating to the establishment of the fee
25 schedule (but not including any activity that con-

1 stitutes engaging in or threatening to engage in a
2 boycott), as well as any and all collective and joint
3 meetings, discussions, presentations, conferences,
4 and consultations between or among providers and
5 any regional alliance (or State) for the purpose of
6 establishing the fee schedule described in this sub-
7 section.

8 (d) PROSPECTIVE BUDGETING OF FEE-FOR-SERV-
9 ICE.—

10 (1) IN GENERAL.—The fee schedule established
11 by a regional alliance or a State under subsection (c)
12 may be based on prospective budgeting described in
13 paragraph (2).

14 (2) PROSPECTIVE BUDGETING DESCRIBED.—
15 Under prospective budgeting—

16 (A) the regional alliance or State (as the
17 case may be) shall negotiate with health pro-
18 viders annually to develop a budget for the des-
19 ignated fee-for-service plan;

20 (B) the negotiated budget shall establish
21 spending targets for each sector of health ex-
22 penditures made by the plan; and

23 (C) if the regional alliance or State (as the
24 case may be) determines that the utilization of
25 services under the plan is at a level that will re-

1 sult in expenditures under the plan exceeding
2 the negotiated budget, the plan shall reduce the
3 amount of payments otherwise made to pro-
4 viders (through a withhold or delay in payments
5 or adjustments) in such a manner and by such
6 amounts as necessary to assure that expendi-
7 tures will not exceed the budget.

8 (3) USE OF PROSPECTIVE BUDGETING EXCLU-
9 SIVE.—If a regional alliance or State establishes the
10 fee schedule for fee-for-service plans on the basis of
11 prospective budgeting under this subsection, pay-
12 ment for all services provided by fee-for-service plans
13 in the alliance or State shall be determined on such
14 basis.

15 **SEC. 1323. ENROLLMENT RULES AND PROCEDURES.**

16 (a) IN GENERAL.—Each regional alliance shall as-
17 sure that each regional alliance eligible individual who re-
18 sides in the alliance area is enrolled in a regional alliance
19 health plan and shall establish and maintain methods and
20 procedures, consistent with this section, sufficient to as-
21 sure such enrollment. Such methods and procedures shall
22 assure the enrollment of alliance eligible individuals at the
23 time they first become eligible enrollees in the alliance
24 area, including individuals at the time of birth, at the time
25 they move into the alliance area, and at the time of reach-

1 ing the age of individual eligibility as an eligible enrollee
2 (and not merely as a family member). Each regional alli-
3 ance shall establish procedures, consistent with subtitle A,
4 for the selection of a single health plan in which all mem-
5 bers of a family are enrolled.

6 (b) POINT OF SERVICE ENROLLMENT MECHA-
7 NISM.—

8 (1) IN GENERAL.—Each regional alliance shall
9 establish a point-of-service enrollment mechanism
10 (meeting the requirements of this subsection) for en-
11 rolling eligible individuals who are not enrolled in a
12 health plan of the alliance when the individual seeks
13 health services.

14 (2) REQUIREMENTS OF MECHANISM.—Under
15 such a mechanism, if an eligible individual seeks to
16 receive services (included in the comprehensive ben-
17 efit package) from a provider in an alliance area and
18 does not present evidence of enrollment under any
19 applicable health plan, or if the provider has no evi-
20 dence of the individual's enrollment under any such
21 plan, the following rules shall apply:

22 (A) NOTICE TO ALLIANCE.—Consistent
23 with part 2 of subtitle B of title V, the
24 provider—

1 (i) shall provide the regional alliance
2 with information relating to the identity of
3 the eligible individual, and

4 (ii) may request payment from the re-
5 gional alliance for the furnishing of such
6 services.

7 (B) INITIAL DETERMINATION OF ELIGI-
8 BILITY AND ENROLLMENT STATUS.—The re-
9 gional alliance shall determine—

10 (i) if the individual is an alliance eligi-
11 ble individual for the alliance, and

12 (ii) if the individual is enrolled under
13 an applicable health plan (including a cor-
14 porate alliance health plan).

15 (C) TREATMENT OF ALLIANCE ELIGIBLE
16 INDIVIDUALS.—If the regional alliance deter-
17 mines that the individual is an alliance eligible
18 individual with respect to the alliance and—

19 (i) is enrolled under a regional alli-
20 ance health plan of the alliance, the alli-
21 ance shall forward the claim to the health
22 plan involved and shall notify the provider
23 (and the individual) of the fact of such en-
24 rollment and the forwarding of such claim
25 (and the plan shall make payment to the

1 provider for the services furnished to the
2 individual as described in paragraph
3 (3)(C));

4 (ii) is not enrolled under a regional al-
5 liance health plan of the alliance but is re-
6 quired to be so enrolled in a specific health
7 plan as a family member under section
8 1011, the alliance shall record the individ-
9 ual's enrollment under such specific plan,
10 shall forward the claim to such plan, and
11 shall notify the provider (and the indi-
12 vidual) of the fact of such enrollment and
13 the forwarding of such claim (and the plan
14 shall make payment to the provider for the
15 services furnished to the individual as de-
16 scribed in paragraph (3)(C)); or

17 (iii) is not enrolled under such a plan
18 and is not described in clause (ii), the
19 point-of-service enrollment procedures de-
20 scribed in paragraph (3) shall apply.

21 (D) TREATMENT OF INDIVIDUALS EN-
22 ROLLED UNDER HEALTH PLANS OF OTHER AL-
23 LIANCES.—If the regional alliance determines
24 that the individual is not an alliance eligible in-

dividual with respect to the alliance but the individual is enrolled—

(i) under a regional alliance health plan of another alliance, the alliance shall forward the claim to the other regional alliance and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and the plan shall make payment to the provider for the services furnished to the individual as described in paragraph (3)(C)); or

(ii) under a corporate alliance health plan, the alliance shall forward the claim to the corporate alliance involved and shall notify the provider (and the individual) of the fact of such enrollment and the forwarding of such claim (and the plan shall make payment to the provider for the services furnished to the individual as described in section 1383(b)(2)(B)).

(E) TREATMENT OF OTHER ALLIANCE ELIGIBLE INDIVIDUALS NOT ENROLLED IN HEALTH PLAN.—If the regional alliance determines that the individual is not an alliance eligible individual with respect to the alliance and the indi-

vidual is an alliance eligible individual with respect to another health alliance but is not enrolled in a health plan of such alliance, the regional alliance shall forward the claim to the other alliance involved and shall notify the provider (and the individual) of the forwarding of such claim and the requirement for prompt enrollment of the individual under an applicable health plan of such alliance pursuant to the procedures described in paragraph (3) (in the case of a regional alliance) or in section 1383(b) (in the case of a corporate alliance).

(F) TREATMENT OF ALL OTHER INDIVIDUALS.—The National Board shall promulgate rules regarding the responsibilities of regional alliances relating to individuals whose applicable health plan is not an alliance plan and other individuals the alliance is unable to identify as eligible individuals.

(3) POINT-OF-SERVICE ENROLLMENT PROCEDURES DESCRIBED.—The point-of-service enrollment procedures under this paragraph are as follows:

(A) Not later than 10 days after the date an alliance is notified of the receipt of services by an unenrolled eligible individual, the alliance

1 provides the individual with materials describ-
2 ing health plans offered through the alliance.

3 (B) The individual shall be provided a pe-
4 riod of 30 days in which to enroll in a health
5 plan of the individual's choice. If the individual
6 fails to so enroll during such period, the alli-
7 ance shall enroll the individual in a health plan
8 of the alliance selected on a random basis.

9 (C) Using the fee-for-service schedule
10 adopted by the alliance under section 1322(c),
11 the health plan in which the individual is en-
12 rolled under this subparagraph shall reimburse
13 the provider who provided the services referred
14 to in subparagraph (A) to the same extent as
15 if the individual had been enrolled under the
16 plan at the time of provision of the services.

17 (c) ENROLLMENT OF NEW RESIDENTS.—

18 (1) IN GENERAL.—Each regional alliance shall
19 establish procedures for enrolling regional alliance
20 eligible individuals who move into the alliance area.

21 (2) LONG-TERM RESIDENTS.—Such procedures
22 shall assure that regional alliance eligible individuals
23 who intend to reside in the alliance area for longer
24 than 6 months shall register with the regional alli-

1 ance for the area and shall enroll in a regional alli-
2 ance health plan offered by the alliance.

3 (3) SHORT-TERM RESIDENTS.—Such proce-
4 dures shall permit eligible individuals who intend to
5 reside in the alliance area for more than 3 months
6 but less than 6 months to choose among the fol-
7 lowing options:

8 (A) To continue coverage through the
9 health plan in which such individual is pre-
10 viously enrolled, in which case coverage for care
11 in the area of temporary residence may be lim-
12 ited to emergency services and urgent care.

13 (B) To register with the regional alliance
14 and enroll in a regional alliance health plan of-
15 fered by the alliance.

16 (C) To change enrollment in the previous
17 alliance area to enrollment in a health plan of
18 such alliance that provides for coverage on a
19 fee-for-service basis of services provided outside
20 the area of that alliance.

21 (d) CHANGES IN ENROLLMENT.—

22 (1) ANNUAL OPEN ENROLLMENT PERIOD TO
23 CHANGE PLAN ENROLLMENT.—Each regional alli-
24 ance shall hold an annual open enrollment period
25 during which each eligible enrollee in the alliance

1 has the opportunity to choose among health plans
2 offered through the alliance, according to rules to be
3 promulgated by the National Health Board.

4 (2) DISENROLLMENT FOR CAUSE.—In addition
5 to the annual open enrollment period held under
6 paragraph (1), each regional alliance shall establish
7 procedures under which alliance eligible individuals
8 enrolled in a plan may disenroll from the plan for
9 good cause at any time during a year and enroll in
10 another plan of the alliance. Such procedures shall
11 be implemented in a manner that ensures continuity
12 of coverage for the comprehensive benefit package
13 for such individuals during the year.

14 (e) ENROLLMENT OF FAMILY MEMBERS.—Each re-
15 gional alliance shall provide for the enrollment of all family
16 members in the same plan, consistent with part 2 of sub-
17 title A.

18 (f) OVERSUBSCRIPTION OF PLANS.—

19 (1) IN GENERAL.—Each regional alliance shall
20 establish a method for establishing enrollment prior-
21 ities in the case of a health plan that does not have
22 sufficient capacity to enroll all eligible individuals
23 seeking enrollment.

1 (2) PREFERENCE FOR CURRENT MEMBERS.—

2 Such method shall provide that in the case of such
3 an oversubscribed plan—

4 (A) individuals already enrolled in the plan
5 are given priority in continuing enrollment in
6 the plan, and

7 (B) other individuals who seek enrollment
8 during an applicable enrollment period are per-
9 mitted to enroll in accordance with a random
10 selection method, up to the enrollment capacity
11 of the plan.

12 (g) TERMINATION OF ENROLLMENT.—

13 (1) IN GENERAL.—Each regional alliance shall
14 establish special enrollment procedures to permit al-
15 liance eligible individuals to change the plan in
16 which they are enrolled in the case of the termi-
17 nation of coverage under a plan, in a manner that
18 ensures the individuals' continuation of coverage for
19 the comprehensive benefit package.

20 (2) FAILURE OF A CORPORATE ALLIANCE.—

21 Each regional alliance shall establish special enroll-
22 ment procedures to permit individuals, who become
23 alliance eligible individuals as a result of the failure
24 of a corporate alliance, to enroll promptly in regional
25 alliance health plans in a manner that ensures the

1 individuals' continuation of coverage for the com-
2 prehensive benefit package.

3 (h) LIMITATION ON OFFERING OF COVERAGE TO IN-
4 ELIGIBLE INDIVIDUALS.—A regional alliance may not
5 knowingly offer coverage under a regional alliance health
6 plan or other health insurance or health benefits to an
7 individual who is not an eligible individual. Nothing in this
8 section shall be construed as affecting the ability of a re-
9 gional alliance health plan or other health plan to offer
10 coverage to such individuals without any financial pay-
11 ment or participation by a regional alliance.

12 (i) ENFORCEMENT OF ENROLLMENT REQUIRE-
13 MENT.—In the case of a regional alliance eligible indi-
14 vidual who fails to enroll in an applicable health plan as
15 required under section 1002(a)—

16 (1) the applicable regional alliance shall enroll
17 the individual in a regional alliance health plan (se-
18 lected by the alliance consistent with this Act and
19 with any rules established by the Board), and

20 (2) such alliance shall require the payment of
21 twice the amount of the family share of premiums
22 that would have been payable under subtitle B of
23 title VI if the individual had enrolled on a timely
24 basis in the plan, unless the individual has estab-

1 lished to the satisfaction of the alliance good cause
2 for the failure to enroll on a timely basis.

3 **SEC. 1324. ISSUANCE OF HEALTH SECURITY CARDS.**

4 A regional alliance is responsible for the issuance of
5 health security cards to regional alliance eligible individ-
6 uals under section 1001(b).

7 **SEC. 1325. CONSUMER INFORMATION AND MARKETING.**

8 (a) CONSUMER INFORMATION.—

9 (1) IN GENERAL.—Before each open enrollment
10 period, each regional alliance shall make available to
11 eligible enrollees information, in an easily under-
12 stood and useful form, that allows such enrollees
13 (and other alliance eligible individuals) to make valid
14 comparisons among health plans offered by the alli-
15 ance.

16 (2) INFORMATION TO BE INCLUDED.—Such in-
17 formation must include, in the same format for each
18 plan, such information as the National Health
19 Board shall require, including at least the following:

20 (A) The cost of the plan, including pre-
21 miums and average out-of-pocket expenses.

22 (B) The characteristics and availability of
23 health care professionals and institutions par-
24 ticipating in the plan.

1 (C) Any restrictions on access to providers
2 and services under the plan.

3 (D) A summary of the annual quality per-
4 formance report, established pursuant to section
5 5005(c)(1), which contains measures of quality
6 presented in a standard format.

7 (b) **MARKETING.**—Each regional alliance shall, con-
8 sistent with section 1404, review and approve or dis-
9 approve the distribution of any materials used to market
10 health plans offered through the alliance.

11 **SEC. 1326. OMBUDSMAN.**

12 (a) **ESTABLISHMENT.**—Each regional alliance must
13 establish and maintain an office of an ombudsman to as-
14 sist consumers in dealing with problems that arise with
15 health plans and the alliance.

16 (b) **OPTIONAL FINANCING THROUGH VOLUNTARY**
17 **CONTRIBUTION.**—At the option of the State in which a
18 regional alliance is located, the alliance—

19 (1) shall permit alliance eligible individuals to
20 designate that one dollar of the premium paid for
21 enrollment in the individual's regional alliance health
22 plan for the operation of the office of the alliance's
23 ombudsman; and

24 (2) shall apply any such amounts towards the
25 establishment and operation of such office.

1 **SEC. 1327. DATA COLLECTION; QUALITY.**

2 Each regional alliance shall comply with requirements
3 of subtitles A and B of title V (relating to quality, infor-
4 mation systems, and privacy), and shall take appropriate
5 steps to ensure that health plans offered through the alli-
6 ance comply with such requirements.

7 **SEC. 1328. ADDITIONAL DUTIES.**

8 (a) ANTI-DISCRIMINATION.—In carrying out its ac-
9 tivities under this part, a regional alliance may not dis-
10 criminate against health plans on the basis of race, sex,
11 national origin, religion, mix of health professionals, loca-
12 tion of the plan’s headquarters, or (except as specifically
13 provided in this part) organizational arrangement.

14 (b) COORDINATION OF ENROLLMENT ACTIVITIES.—
15 Each regional alliance shall coordinate, in a manner speci-
16 fied by the National Health Board, with other health alli-
17 ances its activities, including enrollment and disenrollment
18 activities, in a manner that ensures continuous, non-
19 duplicative coverage of alliance eligible individuals in
20 health plans and that minimizes administrative procedures
21 and paperwork.

1 **SEC. 1329. ADDITIONAL AUTHORITIES FOR REGIONAL ALLI-**
2 **ANCES TO ADDRESS NEEDS IN AREAS WITH**
3 **INADEQUATE HEALTH SERVICES; PROHIBI-**
4 **TION OF INSURANCE ROLE.**

5 (a) PAYMENT ADJUSTMENT.—In order to ensure
6 that plans are available to all eligible individuals residing
7 in all portions of the alliance area, a regional alliance may
8 adjust payments to plans or use other financial incentives
9 to encourage health plans to expand into areas that have
10 inadequate health services.

11 (b) ENCOURAGING NEW PLANS.—Subject to sub-
12 section (c), in order to encourage the establishment of a
13 new health plan in an area that has inadequate health
14 services, an alliance may—

15 (1) organize health providers to create such a
16 plan in such an area a new health plan targeted at
17 such an area,

18 (2) provide assistance with setting up and ad-
19 ministering such a plan, and

20 (3) arrange favorable financing for such a plan.

21 (c) PROHIBITION OF REGIONAL ALLIANCES BEARING
22 RISK.—A regional alliance may not bear insurance risk.

23 **SEC. 1330. PROHIBITION AGAINST SELF-DEALING AND CON-**
24 **FLICTS OF INTEREST.**

25 (a) PROMULGATION OF STANDARDS.—The Board
26 shall promulgate standards of conduct in accordance with

1 subsection (b) for any administrator, officer, trustee, fidu-
2 ciary, custodian, counsel, agent, or employee of any re-
3 gional alliance.

4 (b) REQUIREMENTS FOR STANDARDS.—The stand-
5 ards of conduct referred to in subsection (a) shall set
6 forth—

7 (1) the types of investment interests, ownership
8 interests, affiliations or other employment that
9 would be improper for an individual described in
10 subsection (a) to hold during the time of the individ-
11 ual's service or employment with an alliance; and

12 (2) the circumstances that will constitute im-
13 permissible conflicts of interest or self-dealing by
14 such employees in performing their official duties
15 and functions for any regional alliance.

16 (c) CIVIL MONETARY PENALTY.—Any individual who
17 engages in an activity that the individual knows or has
18 reason to know is in violation of the regulations and stand-
19 ards promulgated by the Board pursuant to subsections
20 (a) and (b) shall be subject, in addition to any other pen-
21 alties that may be prescribed by law, to a civil money pen-
22 alty of not more than \$10,000 for each such violation. The
23 provisions of section 1128A of the Social Security Act
24 (other than subsections (a) and (b)) shall apply to civil
25 money penalties under this subsection in the same manner

1 as they apply to a penalty or proceeding under section
2 1128A(a) of such Act.

3 **PART 3—AUTHORITIES AND RESPONSIBILITIES**
4 **OF REGIONAL ALLIANCES RELATING TO FI-**
5 **NANCING AND INCOME DETERMINATIONS**

6 **Subpart A—Collection of Funds**

7 **SEC. 1341. INFORMATION AND NEGOTIATION AND ACCEPT-**
8 **ANCE OF BIDS.**

9 (a) INFORMATION PROVIDED TO PLANS BEFORE SO-
10 LICITING BIDS.—

11 (1) IN GENERAL.—Each regional alliance shall
12 make available, by April 1 of each year, to each plan
13 that indicates an interest in submitting a premium
14 bid under section 6004 in the year, information (in-
15 cluding information described in paragraph (2)) that
16 the Board specifies as being necessary to enable a
17 plan to estimate, based upon an accepted bid, the
18 amounts payable to such a plan under section 1351.

19 (2) INFORMATION TO BE INCLUDED.—Such in-
20 formation shall include the following:

21 (A) The demographic and other character-
22 istics of regional alliance eligible individuals for
23 the regional alliance.

1 (B) The uniform per capita conversion fac-
2 tor for the regional alliance (established under
3 subsection (b)).

4 (C) The premium class factors (established
5 by the Board under section 1531).

6 (D) The regional alliance inflation factor
7 (determined under section 6001(a)).

8 (E) The risk-adjustment factors and rein-
9 surance methodology and payment amounts
10 (published under subsection (c)) to be used by
11 the regional alliance in computing blended plan
12 per capita rates (in accordance with section
13 6201).

14 (F) The plan bid proportion, the AFDC
15 proportion, the SSI proportion, the AFDC per
16 capita premium amount, and the SSI per capita
17 premium amount, for the year, as computed
18 under subtitle D of title VI.

19 (G) The alliance administrative allowance
20 percentage, computed under section 1352(b).

21 (b) DETERMINATION OF UNIFORM PER CAPITA CON-
22 VERSION FACTOR.—Each regional alliance shall specify,
23 not later than April 1 of each year (beginning with the
24 year before the first year) a uniform per capita conversion
25 factor to be used under section 6102(a)(2) in converting

1 the accepted bid for each plan for the year into the pre-
2 mium for an individual enrollment for such plan for the
3 year. SSI or AFDC recipients shall not be included for
4 purposes of computing the conversion factor.

5 (c) DETERMINATION OF RISK-ADJUSTMENT FAC-
6 TORS AND REINSURANCE PAYMENT AMOUNTS.—Each re-
7 gional alliance shall compute and publish the risk-adjust-
8 ment factors and reinsurance payment amounts to be used
9 by the regional alliance in computing blended plan per
10 capita rates under section 6201.

11 (d) SOLICITATION OF BIDS.—Each regional alliance
12 shall solicit and negotiate, consistent with section 6004,
13 with each regional alliance health plan a bid for the pay-
14 ment rate on a per capita basis for the comprehensive ben-
15 efit package for all alliance eligible individuals in the alli-
16 ance area.

17 **SEC. 1342. CALCULATION AND PUBLICATION OF GENERAL**
18 **FAMILY SHARE AND GENERAL EMPLOYER**
19 **PREMIUM AMOUNTS.**

20 (a) CALCULATION OF COMPONENTS IN GENERAL
21 FAMILY SHARE AND GENERAL EMPLOYER PREMIUMS.—

22 (1) FAMILY SHARE.—Each regional alliance
23 shall compute the following components of the gen-
24 eral family share of premiums (as defined in sub-
25 section (b)(1)(B)):

1 (A) PLAN PREMIUMS.—For each plan of-
2 ferred, the premium for the plan for each class
3 of family enrollment (including the amount of
4 any family collection shortfall).

5 (B) ALLIANCE CREDIT.—The alliance cred-
6 it amount for each class of family enrollment,
7 under section 6103.

8 (C) EXCESS PREMIUM CREDIT.—The
9 amount of any excess premium credit provided
10 under section 6105 for each class of family en-
11 rollment.

12 (D) CORPORATE ALLIANCE OPT-IN CRED-
13 IT.—The amount of any corporate alliance opt-
14 in credit provided under section 6106 for each
15 class of family enrollment.

16 (2) EMPLOYER PREMIUMS.—Each regional alli-
17 ance shall compute the following components of the
18 general employer premium payment amount (as de-
19 fined in subsection (b)(2)(B)):

20 (A) BASE EMPLOYER MONTHLY PREMIUM
21 PER WORKER.—The base employer monthly
22 premium determined under section 6122 for
23 each class of family enrollment.

1 (B) EMPLOYER COLLECTION SHORTFALL
2 ADD-ON.—The employer collection shortfall
3 add-on computed under section 6125(b).

4 (b) PUBLICATION.—

5 (1) FAMILY SHARE.—

6 (A) IN GENERAL.—Each regional alliance
7 shall publish, before the open enrollment period
8 in each year, the general family share of the
9 premium (as defined in subparagraph (B)) for
10 each class of family enrollment for each re-
11 gional alliance health plan to be offered by the
12 alliance in the following year.

13 (B) GENERAL FAMILY SHARE OF PREMIUM
14 DEFINED.—In this subpart, the term “general
15 family share of premium” means the family
16 share of premium under section 6101 computed
17 without regard to section 6104 and without re-
18 gard to section 6101(b)(2)(C)(v).

19 (2) EMPLOYER PREMIUM.—

20 (A) IN GENERAL.—Each regional alliance
21 shall publish, in December before each year (be-
22 ginning with December before the first year)
23 the general employer premium payment amount
24 (as defined in subparagraph (B)) for each class
25 of family enrollment for the following year.

1 (B) GENERAL EMPLOYER PREMIUM PAY-
2 MENT AMOUNT DEFINED.—In this subpart, the
3 term “general employer premium payment
4 amount” means the employer premium payment
5 under section 6121 computed, as an amount
6 per full-time equivalent worker, without regard
7 to sections 6124 through 6126.

8 **SEC. 1343. DETERMINATION OF FAMILY SHARE FOR FAMI-**
9 **LIES.**

10 (a) AMOUNT OF FAMILY SHARE.—The amount
11 charged by a regional alliance to a family for a class of
12 family enrollment (specified under section 1011(c)) under
13 a regional alliance health plan is equal to the family share
14 of premium established under section 6101(a) for the fam-
15 ily. Based upon the information described in this section,
16 each regional alliance shall determine the amount required
17 to be paid under section 6101 and under section 6111 for
18 each year for families enrolling in regional alliance health
19 plans.

20 (b) FAMILY SHARE AMOUNT.—The amount required
21 to be paid under section 6101, with respect to each family,
22 takes into account—

23 (1) the general family share of premium (as de-
24 fined in section 1342(b)(1)(B)) for the class of en-
25 rollment involved;

1 (2) any income-related discount provided under
2 section 6104(a)(1) for the family; and

3 (3) whether or not the family is an SSI or
4 AFDC family.

5 (c) ALLIANCE CREDIT REPAYMENT AMOUNT.—The
6 amount of the alliance credit repayment amount under
7 section 6111, with respect to each family, takes into ac-
8 count the following:

9 (1) The number of months of enrollment, and
10 class of enrollment, in regional alliance health plans,
11 used in determining the amount of the alliance cred-
12 it under section 6103 for the family.

13 (2) Reductions in liability under section
14 6111(b) based on employer premium payments
15 based on net earnings from self-employment for the
16 family.

17 (3) Reductions in liability under section 6112
18 based on months of employment for the family.

19 (4) Limitations in liability under section 6113
20 on the basis of the adjusted family income for the
21 family.

22 (5) The elimination of liability in the case of
23 certain retirees and qualified spouses and children
24 under section 6114.

1 (6) The elimination of liability in the case of
2 certain working medicare beneficiaries under section
3 6115.

4 (d) ACCESS TO NECESSARY INFORMATION TO MAKE
5 DETERMINATION.—Information required for an alliance
6 to make the determination under subsection (a) shall be
7 based on information obtained or maintained by the alli-
8 ance in the conduct of its business, including the following:

9 (1) Information required for income-related de-
10 terminations shall be obtained under subpart B.

11 (2) Information on SSI and AFDC recipients
12 under subsection (e).

13 (3) Information submitted on a monthly and
14 annual basis by employers under section 1602.

15 (4) Information submitted by self-employed in-
16 dividuals on net earnings from self-employment
17 under section 1602(d).

18 (5) Applications for premium reductions under
19 section 6114.

20 (6) Information concerning medicare-eligible in-
21 dividuals under subsection (f).

22 (7) Any income-related discount provided under
23 section 6104(a)(1) for the family.

24 (8) Whether or not the family is an SSI or
25 AFDC family.

1 (e) INFORMATION CONCERNING CASH ASSISTANCE
2 STATUS.—Each participating State and the Secretary
3 shall make available (in a time and manner specified by
4 the Secretary) to each regional alliance such information
5 as may be necessary to determine and verify whether an
6 individual is an AFDC or SSI recipient for a month in
7 a year.

8 (f) INFORMATION CONCERNING MEDICARE-ELIGIBLE
9 INDIVIDUALS.—

10 (1) INFORMATION TO REGIONAL ALLIANCES.—

11 The Secretary shall make available to regional alli-
12 ances (through regional information centers or oth-
13 erwise) information necessary to determine—

14 (A) whether an individual is a medicare-eli-
15 gible individual,

16 (B) the eligibility of individuals for the
17 special treatment under section 6115,

18 (C) if medicare-eligible individuals are de-
19 scribed in section 1012(a), and

20 (D) the amounts of payments owed the al-
21 liance under section 1894 of the Social Security
22 Act, added by section 4003.

23 (2) INFORMATION TO SECRETARY.—Each re-
24 gional alliance shall make available to the Secretary
25 (through the national information system under sec-

tion 5101 or otherwise) information relating to the enrollment of individuals who would be medicare-eligible individuals but for section 1012(a).

(g) ALLIANCE ACCOUNTING SYSTEM.—

(1) IN GENERAL.—Each regional alliance shall establish an accounting system that meets standards established by the Secretary.

(2) SPECIFICS.—Such system shall collect information, on a timely basis for each individual enrolled (and, to the extent required by the Secretary, identified and required to be enrolled) in a regional alliance health plan regarding—

(A) the applicable premium for such enrollment,

(B) family members covered under such enrollment,

(C) the premium payments made by (or on behalf of) the individual for such enrollment,

(D) employer premium payments made respecting the employment of the individual and other employer contributions made respecting such enrollment, and

(E) any government contributions made with respect to such enrollment (including con-

1 tributions for electing veterans and active duty
2 military personnel).

3 (3) END-OF-YEAR REPORTING.—Such system
4 shall provide for a report, at the end of each year,
5 regarding the total premiums imposed, and total
6 amounts collected, for individuals enrolled under re-
7 gional health alliance plans, in such manner as iden-
8 tifies net amounts that may be owed to the regional
9 alliance.

10 **SEC. 1344. NOTICE OF FAMILY PAYMENTS DUE.**

11 (a) FAMILY STATEMENTS.—

12 (1) NOTICE OF NO AMOUNT OWED.—If the re-
13 gional alliance determines under section 1343 that a
14 family has paid any family share required under sec-
15 tion 6101 and is not required to repay any amount
16 under section 6111 for a year, the alliance shall pro-
17 vide notice of such determination to the family. Such
18 notice shall include a prominent statement that the
19 family is not required to make any additional pay-
20 ment and is not required to file any additional infor-
21 mation with the regional alliance.

22 (2) NOTICE OF AMOUNT OWED.—

23 (A) IN GENERAL.—If the regional alliance
24 determines that a family has not paid the entire
25 family share required under section 6101 or is

1 required to repay an amount under section
2 6111 for a year, the alliance shall provide to
3 the family a notice of such determination.

4 (B) INFORMATION ON AMOUNT DUE.—
5 Such notice shall include detailed information
6 regarding the amount owed, the basis for the
7 computation (including the amount of any re-
8 ductions that have been made in the family's li-
9 ability under subtitle B of title VI), and the
10 date the amount is due and the manner in
11 which such amount is payable.

12 (C) INFORMATION ON DISCOUNTS AND RE-
13 Ductions AVAILABLE.—Such notice shall
14 include—

15 (i) information regarding the dis-
16 counts and reductions available (under sec-
17 tions 6104, 6112, 6113, 6114, and 6115)
18 to reduce or eliminate any liability, and

19 (ii) a worksheet which may be used to
20 calculate reductions in liability based on
21 income under sections 6104 and 6113.

22 (3) INCLUSION OF INCOME RECONCILIATION
23 FORM FOR FAMILIES PROVIDED PREMIUM DIS-
24 COUNTS.—

1 (A) IN GENERAL.—A notice under this
2 subsection shall include, in the case of a family
3 that has been provided a premium discount
4 under section 6104 (or section 6113) for the
5 previous year, an income reconciliation state-
6 ment (for use under section 1375) to be com-
7 pleted and returned to the regional alliance
8 (along with any additional amounts owed) by
9 the deadline specified in subsection (b). Such
10 form shall require the submission of such infor-
11 mation as the Secretary specifies to establish or
12 verify eligibility for such premium discount.

13 (B) OTHER FAMILIES.—Any family which
14 has not been provided such a discount but may
15 be eligible for such a discount may submit such
16 an income reconciliation statement and, if eligi-
17 ble, receive a rebate of the amount of excess
18 family share paid for the previous year.

19 (C) ADDITIONAL INFORMATION.—The alli-
20 ance shall permit a family to provide additional
21 information relating to the amount of such re-
22 ductions or the income of the family (insofar as
23 it may relate to a premium discount or reduc-
24 tion in liability under section 6104 or 6113).

1 (4) TIMING OF NOTICE.—Notices under this
2 subsection shall be mailed to each family at least 45
3 days before the deadline specified in subsection (b).

4 (b) DEADLINE FOR PAYMENT.—The deadline speci-
5 fied in this subsection for amounts owed for a year is such
6 date as the Secretary may specify, taking into account the
7 dates when the information specified in section 1343 be-
8 comes available to compute the amounts owed and to file
9 income reconciliation statements under section 1375.
10 Amounts not paid by such deadline are subject to interest
11 and penalty.

12 (c) CHANGE IN REGIONAL ALLIANCE.—In the case
13 of a family that during a year changes the regional alli-
14 ance through which the family obtains coverage under a
15 regional alliance health plan, the Secretary shall establish
16 rules which provide that the regional alliance in which the
17 family last obtained such coverage in a year—

18 (1) is responsible for recovering amounts due
19 under this subpart for the year (whether or not at-
20 tributable to periods of coverage obtained through
21 that alliance);

22 (2) shall obtain such information, through the
23 health information system implemented under sec-
24 tion 5101, as the alliance may require in order to
25 compute the amount of any liability owed under this

1 subpart (taking into account any reduction in such
2 amount under this section), and

3 (3) shall provide for the payment to other re-
4 gional alliances of such amounts collected as may be
5 attributable to amounts owed for periods of coverage
6 obtained through such alliances.

7 (d) NO LOSS OF COVERAGE.—In no case shall the
8 failure to pay amounts owed under this subsection result
9 in an individual's or family's loss of coverage under this
10 Act.

11 (e) DISPUTE RESOLUTION.—Each regional alliance
12 shall establish a fair hearing mechanism for the resolution
13 of disputes concerning amounts owed the alliance under
14 this subpart.

15 **SEC. 1345. COLLECTIONS.**

16 (a) IN GENERAL.—Each regional alliance is respon-
17 sible for the collection of all amounts owed the alliance
18 (whether by individuals, employers, or others and whether
19 on the basis of premiums owed, incorrect amounts of dis-
20 counts or premium, cost sharing, or other reductions
21 made, or otherwise). No amounts are payable by the Fed-
22 eral Government under this Act (including section 9102)
23 with respect to the failure to collect any such amounts.
24 Each regional alliance shall use credit and collection pro-
25 cedures, including the imposition of interest charges and

1 late fees for failure to make timely payment, as may be
2 necessary to collect amounts owed to the alliance. States
3 assist regional alliances in such collection process under
4 section 1202(d).

5 (b) COLLECTION OF FAMILY SHARE.—

6 (1) WITHHOLDING.—

7 (A) IN GENERAL.—In the case of a family
8 that includes a qualifying employee of an em-
9 ployer, the employer shall deduct from the
10 wages of the qualifying employee (in a manner
11 consistent with any rules of the Secretary of
12 Labor) the amount of the family share of the
13 premium for the plan in which the family is en-
14 rolled.

15 (B) MULTIPLE EMPLOYMENT.—In the case
16 of a family that includes more than one quali-
17 fying employee, the family shall choose the em-
18 ployer to which subparagraph (A) will apply.

19 (C) PAYMENT.—Amounts withheld under
20 this paragraph shall be maintained in a manner
21 consistent with standards established by the
22 Secretary of Labor and paid to the regional alli-
23 ance involved in a manner consistent with the
24 payment of employer premiums under sub-
25 section (c).

1 (D) SATISFACTION OF LIABILITY.—An
2 amount deducted from wages of a qualifying
3 employee by an employer is deemed to have
4 been paid by the employee and to have satisfied
5 the employee's obligation under subsection (a)
6 to the extent of such amount.

7 (2) OTHER METHODS.—In the case of a family
8 that does not include a qualifying employee, the re-
9 gional alliance shall require payment to be made
10 prospectively. Such payment may be required to be
11 made not less frequently than monthly. The Sec-
12 retary may issue regulations in order to assure the
13 timely and accurate collection of the family share
14 due.

15 (c) TIMING AND METHOD OF PAYMENT OF EM-
16 PLOYER PREMIUMS.—

17 (1) FREQUENCY OF PAYMENT.—Payment of
18 employer premiums under section 6121 for a month
19 shall be made not less frequently than monthly (or
20 quarterly in the case of such payments made by vir-
21 tue of section 6126). The Secretary of Labor may
22 establish a method under which employers that pay
23 wages on a weekly or biweekly basis are permitted
24 to make such employer payments on such a weekly
25 or biweekly basis.

1 (2) ELECTRONIC TRANSFER.—A regional alli-
2 ance may require those employers that have the ca-
3 pacity to make payments by electronic transfer to
4 make payments under this subsection by electronic
5 transfer.

6 (d) ASSISTANCE.—

7 (1) EMPLOYER COLLECTIONS.—The Secretary
8 of Labor shall provide regional alliances with such
9 technical and other assistance as may promote the
10 efficient collection of all amounts owed such alli-
11 ances under this Act by employers. Such assistance
12 may include the assessment of civil monetary pen-
13 alties, not to exceed \$5,000 or three times the
14 amount of the liability owed, whichever is greater, in
15 the case of repeated failure to pay (as specified in
16 rules of the Secretary of Labor).

17 (2) FAMILY COLLECTIONS.—Except as provided
18 in paragraph (1), the Secretary shall provide re-
19 gional alliances with such technical and other assist-
20 ance as may promote the efficient collection of other
21 amounts owed such alliances under this Act. Such
22 assistance may include the assessment of civil mone-
23 etary penalties, not to exceed \$5,000 or three times
24 the amount of the liability owed, whichever is great-

1 er, in the case of repeated failure to pay (as speci-
2 fied in rules of the Secretary).

3 (e) RECEIPT OF MISCELLANEOUS AMOUNTS.—For
4 payments to regional alliances by—

5 (1) States, see subtitle A of title IX, and

6 (2) the Federal Government, see subtitle B of
7 such title and section 1894 of the Social Security
8 Act (as added by section 4003).

9 **SEC. 1346. COORDINATION AMONG REGIONAL ALLIANCES.**

10 (a) IN GENERAL.—The regional alliance which offers
11 the regional alliance health plan in which a family is en-
12 rolled in December of each year (in this section referred
13 to as the “final alliance”) is responsible for the collection
14 of any amounts owed by the family under this subpart,
15 without regard to whether the family resided in the alli-
16 ance area during the entire year.

17 (b) PROVISION OF INFORMATION IN THE CASE OF
18 CHANGE OF RESIDENCE.—In the case of a family that
19 moves from one alliance area to another alliance area dur-
20 ing a year, each regional alliance (other than the final alli-
21 ance) is responsible for providing to the final alliance
22 (through the national information system under section
23 5101 or otherwise) such information as the final alliance
24 may require in order to determine the liability (and reduc-

1 tions in liability under section 6112) attributable to alli-
2 ance credits provided by such regional alliance.

3 (c) DISTRIBUTION OF PROCEEDS.—In accordance
4 with rules established by the Secretary, in consultation
5 with the Secretary of Labor, the final alliance shall provide
6 for the distribution of amounts collected under this sub-
7 part with respect to families in a year in an equitable man-
8 ner among the regional alliances that provided health plan
9 coverage to the families in the year.

10 (d) EXPEDITING PROCESS.—In order to reduce pa-
11 perwork and promote efficiency in the collection of
12 amounts owed regional alliances under this subpart, the
13 Secretary may require or permit regional alliances to share
14 such information (through the national information sys-
15 tem under section 5101 or otherwise) as the Secretary de-
16 termines to be cost-effective, subject to such confiden-
17 tiality restrictions as may otherwise apply.

18 (e) STUDENTS.—In the case of a qualifying student
19 who makes an election described in section 1012(e)(1) (re-
20 lating to certain full-time students who are covered under
21 the plan of a parent but enrolled in a health plan offered
22 by a different regional alliance from the one in which the
23 parent is enrolled), the regional alliance that offered the
24 plan to the parent shall provide for transfers of an appro-
25 priate portion of the premium (determined in accordance

1 with procedures specified by the Board) to the other re-
2 gional alliance in order to compensate that alliance for the
3 provision of such coverage.

4 (f) PAYMENTS OF CERTAIN AMOUNTS TO COR-
5 PORATE ALLIANCES.—In the case of a married couple in
6 which one spouse is a qualifying employee of a regional
7 alliance employer and the other spouse is a qualifying em-
8 ployee of a corporate alliance employer, if the couple is
9 enrolled with a corporate alliance health plan the regional
10 alliance (which receives employer premium payments from
11 such regional alliance employer with respect to such em-
12 ployee) shall pay to the corporate alliance the amounts so
13 paid (or would be payable by the employer if section 6123
14 did not apply).

15 **Subpart B—Payments**

16 **SEC. 1351. PAYMENT TO REGIONAL ALLIANCE HEALTH**
17 **PLANS.**

18 (a) COMPUTATION OF BLENDED PLAN PER CAPITA
19 PAYMENT AMOUNT.—For purposes of making payments
20 to plans under this section, each regional alliance shall
21 compute, under section 6201(a), a blended plan per capita
22 payment amount for each regional alliance health plan for
23 enrollment in the alliance for a year.

24 (b) AMOUNT OF PAYMENT TO PLANS.—

1 (1) IN GENERAL.—Subject to subsection (e)
2 and section 6121(b)(5)(B), each regional alliance
3 shall provide for payment to each regional alliance
4 health plan, in which an alliance eligible individual
5 is enrolled, an amount equal to the net blended rate
6 (described in paragraph (2)) adjusted (consistent
7 with subsection (c)) to take into account the relative
8 actuarial risk associated with the coverage with re-
9 spect to the individual.

10 (2) NET BLENDED RATE.—The net blended
11 rate described in this paragraph is the blended plan
12 per capita payment amount (determined under sec-
13 tion 6201(a)), reduced by—

14 (A) such amount multiplied by the sum
15 of—

16 (i) the administrative allowance per-
17 centage for the regional alliance, computed
18 by the alliance under section 1352(b), and

19 (ii) 1.5 percentage points; and

20 (B) any plan payment reduction imposed
21 under section 6011 for the plan for the year.

22 (c) APPLICATION OF RISK ADJUSTMENT AND REIN-
23 SURANCE METHODOLOGY.—Each regional alliance shall
24 use the risk adjustment methodology developed under sec-
25 tion 1541 in making payments to regional alliance health

1 plans under this section, except as provided in section
2 1542.

3 (d) APPLICATION OF PORTION OF SET ASIDE.—
4 Amounts attributable to subsection (b)(2)(A)(ii) are paid
5 to the Federal Government (for academic health centers
6 and graduate medical education) under section 1353.

7 (e) TREATMENT OF VETERANS, MILITARY, AND IN-
8 DIAN HEALTH PLANS AND PROGRAMS.—

9 (1) VETERANS HEALTH PLAN.—In applying
10 this subtitle (and title VI) in the case of a regional
11 alliance health plan that is a veterans health plan of
12 the Department of Veterans Affairs, the following
13 rules apply:

14 (A) For purposes of applying subtitle A of
15 title VI, families enrolled under the plan shall
16 not be taken into account.

17 (B) The provisions of subtitle A of title VI
18 shall not apply to the plan, other than such pro-
19 visions as require the plan to submit a per cap-
20 ita amount for each regional alliance area on a
21 timely basis, which amount shall be treated as
22 the final accepted bid of the plan for the area
23 for purposes of subtitle B of such title and this
24 subtitle. This amount shall not be subject to ne-

1 gotiation and not subject to reduction under
2 section 6011.

3 (C) For purposes of computing the blended
4 plan per capita payment amount under section
5 6201(a), the AFDC and SSI proportions (under
6 section 6202(a)) are deemed to be 0 percent.

7 (2) UNIFORMED SERVICES HEALTH PLAN.—In
8 applying this subtitle (and title VI) in the case of a
9 regional alliance health plan that is a Uniformed
10 Services Health Plan of the Department of Defense,
11 the following rules apply:

12 (A) For purposes of applying subtitle A of
13 title VI, families enrolled under the plan shall
14 not be taken into account.

15 (B) The provisions of subtitle A of title VI
16 shall not apply to the plan, other than such pro-
17 visions as require the plan to submit a per cap-
18 ita amount on a timely basis, which amount
19 shall be treated as the final accepted bid of the
20 plan for the area involved for purposes of sub-
21 title B of such title and this subtitle. This
22 amount shall not be subject to negotiation and
23 not subject to reduction under section 6011.
24 The Board, in consultation with the Secretary

1 of Defense, shall establish rules relating to the
2 area (or areas) in which such a bid shall apply.

3 (C) For purposes of computing the blended
4 plan per capita payment amount under section
5 6201(a), the AFDC and SSI proportions (under
6 section 6202(a)) are deemed to be 0 percent.

7 (3) INDIAN HEALTH PROGRAMS.—In applying
8 this subtitle (and title VI) in the case of a health
9 program of the Indian Health Service, the following
10 rules apply:

11 (A) Except as provided in this paragraph,
12 the plan shall not be considered or treated to be
13 a regional alliance health plan and for purposes
14 of applying title VI, families enrolled under the
15 program shall not be taken into account.

16 (B) In accordance with rules established by
17 the Secretary, regional alliances shall act as
18 agents for the collection of employer premium
19 payments (including payments of corporate alli-
20 ance employers) required under subtitle B of
21 title VI with respect to qualifying employees
22 who are enrolled under a health program of the
23 Indian Health Service. The Secretary shall per-
24 mit such alliances to retain a nominal fee to
25 compensate them for such collection activities.

1 In applying this subparagraph, the family share
2 of premium for such employees is deemed to be
3 zero for electing Indians (as defined in section
4 1012(d)(3)) and for other employees is the
5 amount of the premium established under sec-
6 tion 8306(b)(4)(A), employees are deemed to be
7 residing in the area of residence (or area of em-
8 ployment), as specified under rules of the Sec-
9 retary, and the class of enrollment shall be such
10 class (or classes) as specified under rules of the
11 Secretary.

12 **SEC. 1352. ALLIANCE ADMINISTRATIVE ALLOWANCE PER-**
13 **CENTAGE.**

14 (a) SPECIFICATION BY ALLIANCE.—Before obtaining
15 bids under section 6004 from health plans for a year, each
16 regional alliance shall establish the administrative allow-
17 ance for the operation of the regional alliance in the year.

18 (b) ADMINISTRATIVE ALLOWANCE PERCENTAGE.—
19 Subject to subsection (c), the regional alliance shall com-
20 pute an administrative allowance percentage for each year
21 equal to—

22 (1) the administrative allowance determined
23 under subsection (a) for the year, divided by

24 (2) the total of the amounts payable to regional
25 alliance health plans under subpart A (as estimated

1 by the alliance and determined without regard to
2 section 1345(d)).

3 (c) LIMITATION TO 2½ PERCENT.—In no case shall
4 an administrative allowance percentage exceed 2.5 per-
5 cent.

6 **SEC. 1353. PAYMENTS TO THE FEDERAL GOVERNMENT FOR**
7 **ACADEMIC HEALTH CENTERS AND GRAD-**
8 **UATE MEDICAL EDUCATION.**

9 Each regional alliance shall make payment to the
10 Secretary of an amount equal to the reduction in pay-
11 ments by the alliance to regional alliance health plans at-
12 tributable to section 1351(b)(2)(A)(ii).

13 **Subpart C—Financial Management**

14 **SEC. 1361. MANAGEMENT OF FINANCES AND RECORDS.**

15 (a) IN GENERAL.—Each regional alliance shall com-
16 ply with standards established under section 1571(b) (re-
17 lating to the management of finances, maintenance of
18 records, accounting practices, auditing procedures, and fi-
19 nancial reporting) and under section 1591(d) (relating to
20 employer payments).

21 (b) SPECIFIC PROVISIONS.—In accordance with such
22 standards—

23 (1) FINANCIAL STATEMENTS.—

1 (A) IN GENERAL.—Each regional alliance
2 shall publish periodic audited financial state-
3 ments.

4 (B) ANNUAL FINANCIAL AUDIT.—

5 (i) IN GENERAL.—Each regional alli-
6 ance shall have an annual financial audit
7 conducted by an independent auditor in ac-
8 cordance with generally accepted auditing
9 standards.

10 (ii) PUBLICATION.—A report on each
11 such audit shall be made available to the
12 public at nominal cost.

13 (iii) REQUIRED ACTIONS FOR DEFICI-
14 CIENCIES.—If the report from such an
15 audit does not bear an unqualified opinion,
16 the alliance shall take such steps on a
17 timely basis as may be necessary to correct
18 any material deficiency identified in the re-
19 port.

20 (C) ELIGIBILITY ERROR RATES.—Each re-
21 gional alliance shall make eligibility determina-
22 tions for premium discounts, liability reduc-
23 tions, and cost sharing reductions under sec-
24 tions 6104 and 6123, section 6113, and section
25 1371, respectively, in a manner that maintains

1 the error rates below an applicable maximum
2 permissible error rate specified by the Secretary
3 (or the Secretary of Labor with respect to sec-
4 tion 6123). In specifying such a rate, the Sec-
5 retary shall take into account maximum permis-
6 sible error rates recognized by the Federal Gov-
7 ernment under comparable State-administered
8 programs.

9 (2) SAFEGUARDING OF FUNDS.—Each regional
10 alliance shall safeguard family, employer, State, and
11 Federal government payments to the alliance in ac-
12 cordance with fiduciary standards and shall hold
13 such payments in financial institutions and instru-
14 ments that meet standards recognized or established
15 by the Secretary, in consultation with the Secre-
16 taries of Labor and the Treasury and taking into ac-
17 count current Federal laws and regulations relating
18 to fiduciary responsibilities and financial manage-
19 ment of public funds.

20 (3) CONTINGENCIES.—Each regional alliance
21 shall provide that any surplus of funds resulting
22 from an estimation discrepancy described in section
23 9201(e)(1), up to a reasonable amount specified by
24 the Secretary, shall be held in a contingency fund

1 established by the alliance and used to fund any fu-
2 ture shortfalls resulting from such a discrepancy.

3 (4) AUDITING OF EMPLOYER PAYMENTS.—

4 (A) IN GENERAL.—Each regional alliance
5 is responsible for auditing the records of re-
6 gional alliance employers to assure that em-
7 ployer payments (including the payment of
8 amounts withheld) were made in the appro-
9 priate amount as provided under subpart A of
10 part 2 of subtitle B of title VI.

11 (B) EMPLOYERS WITH EMPLOYEES RESID-
12 ING IN DIFFERENT ALLIANCE AREAS.—In the
13 case of a regional alliance employer which has
14 employees who reside in more than one alliance
15 area, the Secretary of Labor, in consultation
16 with the Secretary, shall establish a process for
17 the coordination of regional alliance auditing
18 activities among the regional alliances involved.

19 (C) APPEAL.—In the case of an audit con-
20 ducted by a regional alliance on an employer
21 under this paragraph, an employer or other re-
22 gional alliance that is aggrieved by the deter-
23 mination in the audit is entitled to review of
24 such audit by the Secretary of Labor in a man-
25 ner to be provided by such Secretary.

**Subpart D—Reductions in Cost Sharing; Income
Determinations**

**SEC. 1371. REDUCTION IN COST SHARING FOR LOW-INCOME
FAMILIES.**

(a) REDUCTION.—

(1) IN GENERAL.—Subject to subsection (b), in the case of a family that is enrolled in a regional alliance health plan and that is either (A) an AFDC or SSI family or (B) is determined under this subpart to have family adjusted income below 150 percent of the applicable poverty level, the family is entitled to a reduction in cost sharing in accordance with this section.

(2) TIMING OF REDUCTION.—The reduction in cost sharing shall only apply to items and services furnished after the date the application for such reduction is approved under section 1372(c) and before the date of termination of the reduction under this subpart, or, in the case of an AFDC or SSI family, during the period in which the family is such a family.

(3) INFORMATION TO PROVIDERS AND PLANS.—Each regional alliance shall provide, through electronic means and otherwise, health care providers and regional alliance health plans with access to such information as may be necessary in

1 order to provide for the cost sharing reductions
2 under this section.

3 (b) LIMITATION.—No reduction in cost sharing under
4 subsection (c)(1) shall be available for families residing
5 in an alliance area if the regional alliance for the area
6 determines that there are sufficient low-cost plans (as de-
7 fined in section 6104(b)(3)) that are lower or combination
8 cost sharing plans available in the alliance area to enroll
9 AFDC and SSI families and families with family adjusted
10 income below 150 percent of the applicable poverty level.

11 (c) AMOUNT OF COST SHARING REDUCTION.—

12 (1) IN GENERAL.—Subject to paragraph (2),
13 the reduction in cost sharing under this section shall
14 be such reduction as will reduce cost sharing to the
15 level of a lower or combination cost sharing plan.

16 (2) SPECIAL TREATMENT OF CERTAIN AFDC
17 AND SSI FAMILIES.—In the case of an AFDC or SSI
18 family enrolled in a lower or combination cost shar-
19 ing plan or receiving a reduction in cost sharing
20 under paragraph (1), the amount of copayment ap-
21 plied with respect to an item or service (other than
22 with respect to hospital emergency room services for
23 which there is no emergency medical condition, as
24 defined in section 1867(e)(1) of the Social Security
25 Act) shall be an amount equal to 20 percent of the

1 copayment amount otherwise applicable under sec-
2 tions 1135 and 1136, rounded to the nearest dollar.

3 (d) ADMINISTRATION.—

4 (1) IN GENERAL.—In the case of an approved
5 family (as defined in section 1372(b)(3)) enrolled in
6 a regional alliance health plan, the regional alliance
7 shall pay the plan for cost sharing reductions (other
8 than cost sharing reductions under subsection
9 (c)(2)) provided under this section and included in
10 payments made by the plan to its providers.

11 (2) ESTIMATED PAYMENTS, SUBJECT TO REC-
12 ONCILIATION.—Such payment shall be made initially
13 on the basis of reasonable estimates of cost sharing
14 reductions incurred by such a plan with respect to
15 approved families and shall be reconciled not less
16 often than quarterly based on actual claims for
17 items and services provided.

18 (e) NO COST SHARING FOR INDIANS AND CERTAIN
19 VETERANS AND MILITARY PERSONNEL.—The provisions
20 of section 6104(a)(3) shall apply to cost sharing reduc-
21 tions under this section in the same manner as such provi-
22 sions apply to premium discounts under section 6104.

23 **SEC. 1372. APPLICATION PROCESS FOR COST SHARING RE-**
24 **DUCTIONS.**

25 (a) APPLICATION.—

1 (1) IN GENERAL.—A regional alliance eligible
2 family may apply for a determination of the family
3 adjusted income of the family, for the purpose of es-
4 tablishing eligibility for cost sharing reductions
5 under section 1371.

6 (2) FORM.—An application under this section
7 shall include such information as may be determined
8 by the regional alliance (consistent with rules devel-
9 oped by the Secretary) and shall include at least in-
10 formation about the family’s employment status and
11 income.

12 (b) TIMING.—

13 (1) IN GENERAL.—An application under this
14 section may be filed at such times as the Secretary
15 may provide, including during any open enrollment
16 period, at the time of a move, or after a change in
17 life circumstances (such as unemployment or di-
18 vorce) affecting class of enrollment or amount of
19 family share or repayment amount.

20 (2) CONSIDERATION.—Each regional alliance
21 shall approve or disapprove an application under this
22 section, and notify the applicant of such decision,
23 within such period (specified by the Secretary) after
24 the date of the filing of the application.

1 (3) APPROVED FAMILY DEFINED.—In this sec-
2 tion and section 1371, the term “approved family”
3 means a family for which an application under this
4 section is approved, until the date of termination of
5 such approval under this section.

6 (c) APPROVAL OF APPLICATION.—

7 (1) IN GENERAL.—A regional alliance shall ap-
8 prove an application of a family under this section
9 filed in a month if the application demonstrates that
10 the family adjusted income of the family (as defined
11 in subsection (d) and determined under paragraph
12 (2)) is (or is expected to be) less than 150 percent
13 of the applicable poverty level.

14 (2) USE OF CURRENT INCOME.—In making the
15 determination under paragraph (1), a regional alli-
16 ance shall take into account the income for the pre-
17 vious 3-month period and current wages from em-
18 ployment (if any), consistent with rules specified by
19 the Secretary.

20 (d) FAMILY ADJUSTED INCOME.—

21 (1) IN GENERAL.—Except as provided in para-
22 graph (4), in this Act the term “family adjusted in-
23 come” means, with respect to a family, the sum of
24 the adjusted incomes (as defined in paragraph (2))

1 for all members of the family (determined without
2 regard to section 1012).

3 (2) ADJUSTED INCOME.—In paragraph (1), the
4 term “adjusted income” means, with respect to an
5 individual, adjusted gross income (as defined in sec-
6 tion 62(a) of the Internal Revenue Code of 1986)—

7 (A) determined without regard to sections
8 135, 162(l), 911, 931, and 933 of such Code,
9 and

10 (B) increased by the amount of interest re-
11 ceived or accrued by the individual which is ex-
12 empt from tax.

13 (3) PRESENCE OF ADDITIONAL DEPEND-
14 ENTS.—At the option of an individual, a family may
15 include (and not be required to separate out) the in-
16 come of other individuals who are claimed as de-
17 pendents of the family for income tax purposes, but
18 such individuals shall not be counted as part of the
19 family for purposes of determining the size of the
20 family.

21 (e) REQUIREMENT FOR PERIODIC CONFIRMATION
22 AND VERIFICATION AND NOTICES.—

23 (1) CONFIRMATION AND VERIFICATION RE-
24 QUIREMENT.—The continued eligibility of a family

1 for cost sharing reductions under this section is con-
2 ditioned upon the family's eligibility being—

3 (A) confirmed periodically by the regional
4 alliance, and

5 (B) verified (through the filing of a new
6 application under this section) by the regional
7 alliance at the time income reconciliation state-
8 ments are required to be filed under section
9 1375.

10 (2) RULES.—The Secretary shall issue rules re-
11 lated to the manner in which alliances confirm and
12 verify eligibility under this section.

13 (3) NOTICES OF CHANGES IN INCOME AND EM-
14 PLOYMENT STATUS.—

15 (A) IN GENERAL.—Each approved family
16 shall promptly notify the regional alliance of
17 any material increase (as defined by the Sec-
18 retary) in the family adjusted income.

19 (B) RESPONSE.—If a regional alliance re-
20 ceives notice under subparagraph (A) (or from
21 an employer under section 1602(b)(3)(A)(i)) or
22 otherwise receives information indicating a po-
23 tential significant change in the family's em-
24 ployment status or increase in adjusted family
25 income, the regional alliance shall promptly

1 take steps necessary to reconfirm the family's
2 eligibility.

3 (f) TERMINATION OF COST SHARING REDUCTION.—

4 The regional alliance shall, after notice to the family, ter-
5 minate the reduction of cost sharing under this subpart
6 for an approved family if the family fails to provide for
7 confirmation or verification or notice required under sub-
8 section (c) on a timely basis or the alliance otherwise de-
9 termines that the family is no longer eligible for such re-
10 duction. The previous sentence shall not prevent the fam-
11 ily from subsequently reapplying for cost sharing reduc-
12 tion under this section.

13 (g) TREATMENT OF AFDC AND SSI RECIPIENTS.—

14 (1) NO APPLICATION REQUIRED.—AFDC and
15 SSI families are not required to make an application
16 under this section.

17 (2) NOTICE REQUIREMENT.—Each State (and
18 the Secretary) shall notify each regional alliance, in
19 a manner specified by the Secretary, of the identity
20 (and period of eligibility under the AFDC or SSI
21 programs) of each AFDC and SSI recipient, unless
22 such a recipient elects (in a manner specified by the
23 Secretary) not to accept the reduction of cost shar-
24 ing under this section.

1 **SEC. 1373. APPLICATION FOR PREMIUM DISCOUNTS AND**
2 **REDUCTION IN LIABILITIES TO ALLIANCES.**

3 (a) IN GENERAL.—Any regional alliance eligible fam-
4 ily may apply for a determination of the family adjusted
5 income of the family, for the purpose of establishing eligi-
6 bility for a premium discount under section 6104 or a re-
7 duction in liability under section 6113.

8 (b) TIMING.—Such an application may be filed at
9 such times as an application for a cost sharing reduction
10 may be filed under section 1372(b) and also may be filed
11 after the end of the year to obtain a rebate for excess pre-
12 mium payments made during a year.

13 (c) APPROVAL OF APPLICATION.—

14 (1) IN GENERAL.—A regional alliance shall ap-
15 prove an application of a family under this section
16 filed in a month—

17 (A) for a premium discount under section
18 6104, if the application demonstrates that fam-
19 ily adjusted income of the family (as deter-
20 mined under paragraph (2)) is (or is expected
21 to be) less than 150 percent of the applicable
22 poverty level, or

23 (B) for a reduction in liability under sec-
24 tion 6113, if the application demonstrates that
25 the wage-adjusted income (as defined in sub-
26 section 6113(d)) of the family (as determined

1 under paragraph (2)) is (or is expected to be)
2 less than 250 percent of the applicable poverty
3 level.

(2) USE OF CURRENT INCOME.—In making the determination under paragraph (1), a regional alliance shall take into account the income for the previous 3-month period and current wages from employment (if any) and the statement of estimated income for the year (filed under section 1374(c)), consistent with rules specified by the Secretary.

(d) REQUIREMENT FOR PERIODIC CONFIRMATION AND VERIFICATION AND NOTICES.—The provisions of subsection (e) of section 1372 shall apply under this section in the same manner as it applies under such section, except that any reference to family adjusted income is deemed a reference to wage-adjusted income.

17 SEC. 1374. GENERAL PROVISIONS RELATING TO APPLICA-
18 TION PROCESS.

(a) DISTRIBUTION OF APPLICATIONS.—Each regional alliance shall distribute applications under this subpart directly to consumers and through employers, banks, and designated public agencies.

(b) TO WHOM APPLICATION MADE.—Applications under this subpart shall be filed, by person or mail, with a regional alliance or an agency designated by the State

1 for this purpose. The application may be submitted with
2 an application to enroll with a health plan under this sub-
3 title or separately.

4 (c) INCOME STATEMENT.—Each application shall in-
5 clude a declaration of estimated annual income for the
6 year involved.

7 (d) FORM AND CONTENTS.—An application for a dis-
8 count or reduction under this subpart shall be in a form
9 and manner specified by the Secretary and shall require
10 the provision of information necessary to make the deter-
11 minations required under this subpart.

12 (e) FREQUENCY OF APPLICATIONS.—

13 (1) IN GENERAL.—An application under this
14 subpart may be filed at any time during the year
15 (including, in the case of section 1373, during the
16 reconciliation process).

17 (2) CORRECTION OF INCOME.—Nothing in
18 paragraph (1) shall be construed as preventing an
19 individual or family from, at any time, submitting an
20 application to reduce the amount of premium dis-
21 count or reduction of liability under this subpart
22 based upon an increase in income from that stated
23 in the previous application.

24 (f) TIMING OF REDUCTIONS AND DISCOUNTS.—

1 (1) IN GENERAL.—Subject to reconciliation
2 under section 1375, premium discounts and cost
3 sharing reductions under this subpart shall be ap-
4 plied to premium payments required (and for ex-
5 penses incurred) after the date of approval of the
6 application under this subpart.

7 (2) AFDC AND SSI RECIPIENTS.—In the case
8 of an AFDC or SSI family, in applying paragraph
9 (1), the date of approval of benefits under the
10 AFDC or SSI program shall be considered the date
11 of approval of an application under this subpart.

12 (g) VERIFICATION.—The Secretary shall provide for
13 verification, on a sample basis or other basis, of the infor-
14 mation supplied in applications under this part. This
15 verification shall be separate from the reconciliation pro-
16 vided under section 1375.

17 (h) HELP IN COMPLETING APPLICATIONS.—Each re-
18 gional alliance shall assist individuals in the filing of appli-
19 cations and income reconciliation statements under this
20 subpart.

21 (i) PENALTIES FOR INACCURATE INFORMATION.—

22 (1) INTEREST FOR UNDERSTATEMENTS.—Each
23 individual who knowingly understates income re-
24 ported in an application to a regional alliance under
25 this subpart or otherwise makes a material misrepre-

1 sentation of information in such an application shall
2 be liable to the alliance for excess payments made
3 based on such understatement or misrepresentation,
4 and for interest on such excess payments at a rate
5 specified by the Secretary.

6 (2) PENALTIES FOR MISREPRESENTATION.—In
7 addition to the liability established under paragraph
8 (1), each individual who knowingly misrepresents
9 material information in an application under this
10 subpart to a regional alliance shall be liable to the
11 State in which the alliance is located for \$2,000 or,
12 if greater, three times the excess payments made
13 based on such misrepresentation. The State shall
14 provide for the transfer of a significant portion of
15 such amount to the regional alliance involved.

16 **SEC. 1375. END-OF-YEAR RECONCILIATION FOR PREMIUM**
17 **DISCOUNT AND REPAYMENT REDUCTION**
18 **WITH ACTUAL INCOME.**

19 (a) IN GENERAL.—In the case of a family whose ap-
20 plication for a premium discount or reduction of liability
21 for a year has been approved before the end of the year
22 under this subpart, the family shall, subject to subsection
23 (c) and by the deadline specified in section 1344(b) file
24 with the regional alliance an income reconciliation state-
25 ment to verify the family's adjusted income or wage-ad-

1 justed income, as the case may be, for the previous year.
2 Such a statement shall contain such information as the
3 Secretary may specify. Each regional alliance shall coordi-
4 nate the submission of such statements with the notice
5 and payment of family payments due under section 1344.

6 (b) RECONCILIATION OF PREMIUM DISCOUNT AND
7 LIABILITY ASSISTANCE BASED ON ACTUAL INCOME.—
8 Based on and using the income reported in the reconcili-
9 ation statement filed under subsection (a) with respect to
10 a family, the regional alliance shall compute the amount
11 of premium discount or reduction in liability that should
12 have been provided under section 6104 or section 6113
13 with respect for the family for the year involved. If the
14 amount of such discount or liability reduction computed
15 is—

16 (1) greater than the amount that has been pro-
17 vided, the family is liable to the regional alliance to
18 pay (directly or through an increase in future family
19 share of premiums or other payments) a total
20 amount equal to the amount of the excess payment,
21 or

22 (2) less than the amount that has been pro-
23 vided, the regional alliance shall pay to the family
24 (directly or through a reduction in future family

1 share of premiums or other payments) a total
2 amount equal to the amount of the deficit.

3 (c) NO RECONCILIATION FOR AFDC AND SSI FAMI-
4 LIES; NO RECONCILIATION FOR COST SHARING REDUC-
5 TIONS.—No reconciliation statement is required under
6 this section—

7 (1) with respect to cost sharing reductions pro-
8 vided under section 1372, or

9 (2) for a family that only claims a premium dis-
10 count or liability reduction under this subpart on the
11 basis of being an AFDC or SSI family.

12 (d) DISQUALIFICATION FOR FAILURE TO FILE.—In
13 the case of any family that is required to file a statement
14 under this section in a year and that fails to file such a
15 statement by the deadline specified, members of the family
16 shall not be eligible for premium reductions under section
17 6104 or reductions in liability under section 6113 until
18 such statement is filed. A regional alliance, using rules es-
19 tablished by the Secretary, shall waive the application of
20 this subsection if the family establishes, to the satisfaction
21 of the alliance under such rules, good cause for the failure
22 to file the statement on a timely basis.

23 (e) PENALTIES FOR FALSE INFORMATION.—Any in-
24 dividual that provides false information in a statement
25 under subsection (a) is subject to the same liabilities as

1 are provided under section 1374(h) for a misrepresenta-
2 tion of material fact described in such section.

3 (f) NOTICE OF REQUIREMENT.—Each regional alli-
4 ance (directly or in coordination with other regional alli-
5 ances) shall provide for written notice, at the end of each
6 year, of the requirement of this section to each family
7 which had received premium discount or reduction in li-
8 ability under this subpart in any month during the pre-
9 ceding year and to which such requirement applies.

10 (g) TRANSMITTAL OF INFORMATION;
11 VERIFICATION.—

12 (1) IN GENERAL.—Each participating State
13 shall transmit annually to the Secretary such infor-
14 mation relating to the income of families for the pre-
15 vious year as the Secretary may require to verify
16 such income under this subpart.

17 (2) VERIFICATION.—Each participating State
18 may use such information as it has available to it to
19 assist regional alliances in verifying income of fami-
20 lies with applications filed under this subpart. The
21 Secretary of the Treasury may, consistent with sec-
22 tion 6103 of the Internal Revenue Code of 1986,
23 permit return information to be disclosed and used
24 by a participating State in verifying such income but
25 only in accordance with such section and only if the

1 information is not directly disclosed to a regional al-
2 liance.

3 (h) CONSTRUCTION.—Nothing in this section shall be
4 construed as authorizing reconciliation of any cost sharing
5 reduction provided under this subpart.

6 **PART 4—RESPONSIBILITIES AND AUTHORITIES**
7 **OF CORPORATE ALLIANCES**

8 **SEC. 1381. CONTRACTS WITH HEALTH PLANS.**

9 (a) CONTRACTS WITH PLANS.—Subject to section
10 1382, each corporate alliance may—

11 (1) offer to individuals eligible to enroll under
12 section 1311(c) coverage under an appropriate self-
13 insured health plan (as defined in section 1400(b)),
14 or

15 (2) negotiate with a State-certified health plan
16 to enter into a contract with the plan for the enroll-
17 ment of such individuals under the plan,
18 or do both.

19 (b) TERMS OF CONTRACTS WITH STATE-CERTIFIED
20 HEALTH PLANS.—Contracts under this section between
21 a corporate alliance and a State-certified health plan may
22 contain such provisions (not inconsistent with the require-
23 ments of this title) as the alliance and plan may provide,
24 except that in no case does such contract remove the obli-
25 gation of the sponsor of the corporate alliance to provide

1 for health benefits to corporate alliance eligible individuals
2 consistent with this part.

3 **SEC. 1382. OFFERING CHOICE OF HEALTH PLANS FOR EN-**
4 **ROLLMENT.**

5 (a) IN GENERAL.—Each corporate alliance must pro-
6 vide to each eligible enrollee with respect to the alliance
7 a choice of health plans among the plans which have con-
8 tracts with the alliance under section 1381.

9 (b) OFFERING OF PLANS BY ALLIANCES.—A cor-
10 porate alliance shall include among its health plan offer-
11 ings for any eligible enrollee at least 3 health plans to en-
12 rollees, of which the alliance must offer—

13 (1) at least one fee-for-service plan (as defined
14 in section 1322(b)(2)); and

15 (2) at least two health plans that are not fee-
16 for-service plans.

17 **SEC. 1383. ENROLLMENT; ISSUANCE OF HEALTH SECURITY**
18 **CARD.**

19 (a) IN GENERAL.—

20 (1) ENROLLMENT OF ALLIANCE ELIGIBLE INDIVIDUALS.—Each corporate alliance shall assure that
21 each alliance eligible individual with respect to the
22 alliance is enrolled in a corporate alliance health
23 plan offered by the alliance, and shall establish and
24 maintain methods and procedures consistent with
25

1 this section sufficient to assure such enrollment.
2 Such methods and procedures shall assure the en-
3 rollment of such individuals at the time they first
4 become alliance eligible individuals with respect to
5 the alliance.

6 (2) ISSUANCE OF HEALTH SECURITY CARDS.—

7 A corporate alliance is responsible for the issuance
8 of health security cards to corporate alliance eligible
9 individuals under section 1001(b).

10 (b) RESPONSE TO POINT-OF-SERVICE NOTICES.—If
11 a corporate alliance is notified under section 1323(b)(2)
12 regarding an individual who has received services and ap-
13 pears to be a corporate alliance eligible individual—

14 (1) the alliance shall promptly ascertain the in-
15 dividual's eligibility as a corporate alliance eligible
16 individual; and

17 (2) if the alliance determines that the individual
18 is a corporate alliance eligible individual—

19 (A) the alliance shall promptly provide for
20 the enrollment of the individual in a health plan
21 offered by the alliance (and notify the Secretary
22 of Labor of such enrollment), and

23 (B) the alliance shall forward the claim for
24 payment for the services to the health plan in
25 which the individual is so enrolled and the plan

1 shall make payment to the provider for such
2 claim (in a manner consistent with require-
3 ments of the Secretary of Labor).

4 (c) ANNUAL OPEN ENROLLMENT; ENROLLMENT OF
5 FAMILY MEMBERS; OVERSUBSCRIPTION OF PLANS.—The
6 provisions of subsections (d) through (f) of section 1323
7 shall apply to a corporate alliance in the same manner
8 as such provisions apply to a regional alliance.

9 (d) TERMINATION.—

10 (1) IN GENERAL.—The provisions of section
11 1323(g)(1) shall apply to a corporate alliance in the
12 same manner as such provisions apply to a regional
13 alliance.

14 (2) FAILURE TO PAY PREMIUMS.—If a cor-
15 porate alliance fails to make premium payments to
16 a health plan, the plan, after reasonable written no-
17 tice to the alliance and the Secretary of Labor, may
18 terminate coverage (and any contract with the alli-
19 ance under this part). If such coverage is terminated
20 the corporate alliance is responsible for the prompt
21 enrollment of alliance eligible individuals whose cov-
22 erage is terminated in another corporate alliance
23 health plan.

24 (e) CORPORATE ALLIANCE TRANSITION.—Each cor-
25 porate alliance must provide coverage—

1 (1) as of the first day of any month in which
2 an individual first becomes a corporate alliance eligi-
3 ble individual, and

4 (2) through the end of the month in the case
5 of a corporate alliance eligible individual who loses
6 such eligibility during the month.

7 **SEC. 1384. COMMUNITY-RATED PREMIUMS WITHIN PRE-**
8 **MIUM AREAS.**

9 (a) APPLICATION OF COMMUNITY-RATED PRE-
10 MIUMS.—The premiums charged by a corporate alliance
11 for enrollment in a corporate alliance health plan (not tak-
12 ing into account any employer premium payment required
13 under section 6131) shall vary only by class of family en-
14 rollment (specified in section 1011(c)) and by premium
15 area.

16 (b) DESIGNATION OF PREMIUM AREAS.—

17 (1) DESIGNATION.—Each corporate alliance
18 shall designate premium areas to be used for the im-
19 position of premiums (and calculation of employer
20 premium payments) under this Act.

21 (2) CONDITIONS.—The boundaries of such
22 areas shall reasonably reflect labor market areas or
23 health care delivery areas and shall be consistent
24 with rules the Secretary of Labor establishes (con-
25 sistent with paragraph (3)) so that within such

1 areas there are not substantial differences in average
2 per capita health care expenditures.

3 (3) ANTI-REDLINING.—The provisions of para-
4 graphs (4) and (5) of section 1202(b) (relating to
5 redlining and metropolitan statistical areas) shall
6 apply to the establishment of premium areas in the
7 same manner as they apply to the establishment of
8 the boundaries of regional alliance areas.

9 (c) APPLICATIONS OF CLASSES OF ENROLLMENT.—

10 (1) IN GENERAL.—The premiums shall be ap-
11 plied under this section based on class of family en-
12 rollment and shall vary based on such class in ac-
13 cordance with factors specified by the corporate alli-
14 ance.

15 (2) BASIS FOR FACTORS.—Such factors shall be
16 the same in each premium area and shall take into
17 account such appropriate considerations (including
18 the considerations the Board takes into account in
19 the establishment of premium class factors under
20 section 1531 and the costs of regional alliance health
21 plans providing the comprehensive benefit package
22 for families enrolled in the different classes) as the
23 alliance considers appropriate, consistent with rules
24 the Secretary of Labor establishes.

1 (d) SPECIAL TREATMENT OF MULTIEMPLOYER ALLI-
2 ANCES.—The Secretary of Labor shall provide for such
3 exceptions to the requirements of this section in the case
4 of a corporate alliance with a sponsor described in section
5 1311(b)(1)(B) as may be appropriate to reflect the unique
6 and historical relationship between the employers and em-
7 ployees under such alliances.

8 **SEC. 1385. ASSISTANCE FOR LOW-WAGE FAMILIES.**

9 Each corporate alliance shall make an additional con-
10 tribution towards the enrollment in health plans of the al-
11 liance by certain low-wage families in accordance with sec-
12 tion 6131(b)(2).

13 **SEC. 1386. CONSUMER INFORMATION AND MARKETING;**
14 **DATA COLLECTION AND QUALITY; ADDI-**
15 **TIONAL DUTIES.**

16 The provisions of sections 1325(a), 1327, and 1328
17 shall apply to a corporate alliance in the same manner
18 as such provisions apply to a regional alliance.

19 **SEC. 1387. PLAN AND INFORMATION REQUIREMENTS.**

20 (a) IN GENERAL.—A corporate alliance shall provide
21 a written submission to the Secretary of Labor (in such
22 form as the Secretary may require) detailing how the cor-
23 porate alliance will carry out its activities under this part.

24 (b) ANNUAL INFORMATION.—A corporate alliance
25 shall provide to the Secretary of Labor each year, in such

1 form and manner as the Secretary may require, such in-
2 formation as the Secretary may require in order to mon-
3 itor the compliance of the alliance with the requirements
4 of this part.

5 (c) ANNUAL NOTICE OF EMPLOYEES OR PARTICI-
6 PANTS.—

7 (1) CORPORATE ALLIANCE.—Each corporate al-
8 liance shall submit to the Secretary of Labor, by not
9 later than March 1 of each year, information on the
10 number of full-time employees or participants ob-
11 taining coverage through the alliance as of January
12 1 of that year.

13 (2) EMPLOYERS THAT BECOME LARGE EMPLOY-
14 ERS.—Each employer that is not a corporate alli-
15 ance but employs 5,000 full-time employees as of
16 January 1 of a year, shall submit to the Secretary
17 of Labor, by not later than March 1 of the year, in-
18 formation on the number of such employees.

19 **SEC. 1388. MANAGEMENT OF FUNDS; RELATIONS WITH EM-**
20 **PLOYEES.**

21 (a) MANAGEMENT OF FUNDS.—The management of
22 funds by a corporate alliance shall be subject to the appli-
23 cable fiduciary requirements of part 4 of subtitle B of title
24 I of the Employee Retirement Income Security Act of

1 1974, together with the applicable enforcement provisions
2 of part 5 of subtitle B of title I of such Act.

3 (b) MANAGEMENT OF FINANCES AND RECORDS; AC-
4 COUNTING SYSTEM.—Each corporate alliance shall comply
5 with standards relating to the management of finances
6 and records and accounting systems as the Secretary of
7 Labor shall specify.

8 **SEC. 1389. COST CONTROL.**

9 Each corporate alliance shall control covered expendi-
10 tures in a manner that meets the requirements of part
11 2 of subtitle A of title VI.

12 **SEC. 1390. PAYMENTS BY CORPORATE ALLIANCE EMPLOY-**
13 **ERS TO CORPORATE ALLIANCES.**

14 (a) LARGE EMPLOYER ALLIANCES.—In the case of
15 a corporate alliance with a sponsor described in section
16 1311(b)(1)(A), the sponsor shall provide for the funding
17 of benefits, through insurance or otherwise, consistent
18 with section 6131, the applicable solvency requirements of
19 sections 1394, 1395, and 1396, and any rules established
20 by the Secretary of Labor.

21 (b) OTHER ALLIANCES.—In the case of a corporate
22 alliance with a sponsor described in subparagraph (B) or
23 (C) of section 1311(b)(1), a corporate alliance employer
24 shall make payment of the employer premiums required
25 under section 6131 under rules established by the cor-

1 corporate alliance, which rules shall be consistent with rules
2 established by the Secretary of Labor.

3 **SEC. 1391. COORDINATION OF PAYMENTS.**

4 (a) PAYMENTS OF CERTAIN AMOUNTS TO REGIONAL
5 ALLIANCES.—In the case of a married couple in which one
6 spouse is a qualifying employee of a regional alliance em-
7 ployer and the other spouse is a qualifying employee of
8 a corporate alliance employer, if the couple is enrolled with
9 a regional alliance health plan, the corporate alliance
10 (which receives employer premium payments from such
11 corporate alliance employer with respect to such employee)
12 shall pay to the regional alliance the amounts so paid.

13 (b) PAYMENTS OF CERTAIN AMOUNTS TO COR-
14 PORATE ALLIANCES.—In the case of a married couple in
15 which one spouse is a qualifying employee of a corporate
16 alliance employer and the other spouse is a qualifying em-
17 ployee of another corporate alliance employer, the cor-
18 porate alliance of the corporate alliance health plan in
19 which the couple is not enrolled shall pay to the corporate
20 alliance of the plan in which the couple is enrolled any
21 employer premium payments received from such corporate
22 alliance employer with respect to such employee.

1 **SEC. 1392. APPLICABILITY OF ERISA ENFORCEMENT MECH-**
2 **ANISMS FOR ENFORCEMENT OF CERTAIN RE-**
3 **QUIREMENTS.**

4 The provisions of sections 502 (relating to civil en-
5 forcement) and 504 (relating to investigative authority) of
6 the Employee Retirement Income Security Act of 1974
7 shall apply to enforcement by the Secretary of Labor of
8 this part in the same manner and to same extent as such
9 provisions apply to enforcement of title I of such Act.

10 **SEC. 1393. APPLICABILITY OF CERTAIN ERISA PROTEC-**
11 **TIONS TO ENROLLED INDIVIDUALS.**

12 The provisions of sections 510 (relating to inter-
13 ference with rights protected under Act) and 511 (relating
14 to coercive interference) of the Employee Retirement In-
15 come Security Act of 1974 shall apply, in relation to the
16 provisions of this Act, with respect to individuals enrolled
17 under corporate alliance health plans in the same manner
18 and to the same extent as such provisions apply, in rela-
19 tion to the provisions of the Employee Retirement Income
20 Security Act of 1974, with respect to participants and
21 beneficiaries under employee welfare benefit plans covered
22 by title I of such Act.

23 **SEC. 1394. DISCLOSURE AND RESERVE REQUIREMENTS.**

24 (a) IN GENERAL.—The Secretary of Labor shall en-
25 sure that each corporate alliance health plan which is a
26 self-insured plan maintains plan assets in trust as pro-

1 vided in section 403 of the Employee Retirement Income
2 Security Act of 1974—

3 (1) without any exemption under section
4 403(b)(4) of such Act, and

5 (2) in amounts which the Secretary determines
6 are sufficient to provide at any time for payment to
7 health care providers of all outstanding balances
8 owed by the plan at such time.

9 The requirements of the preceding sentence may be met
10 through letters of credit, bonds, or other appropriate secu-
11 rity to the extent provided in regulations of the Secretary.

12 (b) DISCLOSURE.—Each self-insured corporate alli-
13 ance health plan shall notify the Secretary at such time
14 as the financial reserve requirements of this section are
15 not being met. The Secretary may assess a civil money
16 penalty of not more than \$100,000 against any corporate
17 alliance for any failure to provide such notification in such
18 form and manner and within such time periods as the Sec-
19 retary may prescribe by regulation.

20 **SEC. 1395. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
21 **VENT CORPORATE ALLIANCE HEALTH PLANS.**

22 (a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
23 INSOLVENT PLANS.—Whenever the Secretary of Labor
24 determines that a corporate alliance health plan which is
25 a self-insured plan will be unable to provide benefits when

1 due or is otherwise in a financially hazardous condition
2 as defined in regulations of the Secretary, the Secretary
3 shall, upon notice to the plan, apply to the appropriate
4 United States district court for appointment of the Sec-
5 retary as trustee to administer the plan for the duration
6 of the insolvency. The plan may appear as a party and
7 other interested persons may intervene in the proceedings
8 at the discretion of the court. The court shall appoint the
9 Secretary trustee if the court determines that the trustee-
10 ship is necessary to protect the interests of the enrolled
11 individuals or health care providers or to avoid any unrea-
12 sonable deterioration of the financial condition of the plan
13 or any unreasonable increase in the liability of the Cor-
14 porate Alliance Health Plan Insolvency Fund. The trustee-
15 ship of the Secretary shall continue until the conditions
16 described in the first sentence of this subsection are rem-
17 edied or the plan is terminated.

18 (b) POWERS AS TRUSTEE.—The Secretary of Labor,
19 upon appointment as trustee under subsection (a), shall
20 have the power—

21 (1) to do any act authorized by the plan, this
22 Act, or other applicable provisions of law to be done
23 by the plan administrator or any trustee of the plan,

1 (2) to require the transfer of all (or any part)
2 of the assets and records of the plan to the Sec-
3 retary as trustee,

4 (3) to invest any assets of the plan which the
5 Secretary holds in accordance with the provisions of
6 the plan, regulations of the Secretary, and applicable
7 provisions of law,

8 (4) to do such other acts as the Secretary
9 deems necessary to continue operation of the plan
10 without increasing the potential liability of the Cor-
11 porate Alliance Health Plan Insolvency Fund, if
12 such acts may be done under the provisions of the
13 plan,

14 (5) to require the corporate alliance, the plan
15 administrator, any contributing employer, and any
16 employee organization representing covered individ-
17 uals to furnish any information with respect to the
18 plan which the Secretary as trustee may reasonably
19 need in order to administer the plan,

20 (6) to collect for the plan any amounts due the
21 plan and to recover reasonable expenses of the trust-
22 eeship,

23 (7) to commence, prosecute, or defend on behalf
24 of the plan any suit or proceeding involving the plan,

1 (8) to issue, publish, or file such notices, state-
2 ments, and reports as may be required under regula-
3 tions of the Secretary or by any order of the court,

4 (9) to terminate the plan and liquidate the plan
5 assets in accordance with applicable provisions of
6 this Act and other provisions of law, to restore the
7 plan to the responsibility of the corporate alliance,
8 or to continue the trusteeship,

9 (10) to provide for the enrollment of individuals
10 covered under the plan in an appropriate regional al-
11 liance health plan, and

12 (11) to do such other acts as may be necessary
13 to comply with this Act or any order of the court
14 and to protect the interests of enrolled individuals
15 and health care providers.

16 (c) NOTICE OF APPOINTMENT.—As soon as prac-
17 ticable after the Secretary's appointment as trustee, the
18 Secretary shall give notice of such appointment to—

19 (1) the plan administrator,

20 (2) each enrolled individual,

21 (3) each employer who may be liable for con-
22 tributions to the plan, and

23 (4) each employee organization which, for pur-
24 poses of collective bargaining, represents enrolled in-
25 dividuals.

1 (d) ADDITIONAL DUTIES.—Except to the extent in-
2 consistent with the provisions of this Act or part 4 of sub-
3 title B of title I of the Employee Retirement Income Secu-
4 rity Act of 1974, or as may be otherwise ordered by the
5 court, the Secretary of Labor, upon appointment as trust-
6 ee under this section, shall be subject to the same duties
7 as those of a trustee under section 704 of title 11, United
8 States Code, and shall have the duties of a fiduciary for
9 purposes of such part 4.

10 (e) OTHER PROCEEDINGS.—An application by the
11 Secretary of Labor under this subsection may be filed not-
12 withstanding the pendency in the same or any other court
13 of any bankruptcy, mortgage foreclosure, or equity receiv-
14 ership proceeding, or any proceeding to reorganize, con-
15 serve, or liquidate such plan or its property, or any pro-
16 ceeding to enforce a lien against property of the plan.

17 (f) JURISDICTION OF COURT.—

18 (1) IN GENERAL.—Upon the filing of an appli-
19 cation for the appointment as trustee or the issuance
20 of a decree under this subsection, the court to which
21 the application is made shall have exclusive jurisdic-
22 tion of the plan involved and its property wherever
23 located with the powers, to the extent consistent
24 with the purposes of this subsection, of a court of
25 the United States having jurisdiction over cases

1 under chapter 11 of title 11, United States Code.
2 Pending an adjudication under this section such
3 court shall stay, and upon appointment by it of the
4 Secretary of Labor as trustee, such court shall con-
5 tinue the stay of, any pending mortgage foreclosure,
6 equity receivership, or other proceeding to reorga-
7 nize, conserve, or liquidate the plan, the sponsoring
8 alliance, or property of such plan or alliance, and
9 any other suit against any receiver, conservator, or
10 trustee of the plan, the sponsoring alliance, or prop-
11 erty of the plan or alliance. Pending such adjudica-
12 tion and upon the appointment by it of the Sec-
13 retary as trustee, the court may stay any proceeding
14 to enforce a lien against property of the plan or the
15 sponsoring alliance or any other suit against the
16 plan or the alliance.

17 (2) VENUE.—An action under this subsection
18 may be brought in the judicial district where the
19 plan administrator resides or does business or where
20 any asset of the plan is situated. A district court in
21 which such action is brought may issue process with
22 respect to such action in any other judicial district.

23 (g) PERSONNEL.—In accordance with regulations of
24 the Secretary of Labor, the Secretary shall appoint, retain,
25 and compensate accountants, actuaries, and other profes-

1 sional service personnel as may be necessary in connection
2 with the Secretary's service as trustee under this section.

3 **SEC. 1396. GUARANTEED BENEFITS UNDER TRUSTEESHIP**
4 **OF THE SECRETARY.**

5 (a) IN GENERAL.—Subject to subsection (b), the Sec-
6 retary of Labor shall guarantee the payment of all benefits
7 under a corporate alliance health plan which is a self-in-
8 sured plan while such plan is under the Secretary's trust-
9 eeship under section 1395.

10 (b) LIMITATIONS.—Any increase in the amount of
11 benefits under the plan resulting from a plan amendment
12 which was made, or became effective, whichever is later,
13 within 180 days (or such other reasonable time as may
14 be prescribed in regulations of the Secretary of Labor) be-
15 fore the date of the Secretary's appointment as trustee
16 of the plan shall be disregarded for purposes of deter-
17 mining the guarantee under this section.

18 (c) CORPORATE ALLIANCE HEALTH PLAN INSOL-
19 VENCY FUND.—

20 (1) ESTABLISHMENT.—The Secretary of Labor
21 shall establish a Corporate Alliance Health Plan In-
22 solvency Fund (hereinafter in this part referred to
23 as the "Fund") from which the Secretary shall au-
24 thorize payment of all guaranteed benefits under
25 this section.

1 (2) RECEIPTS AND DISBURSEMENTS.—

2 (A) RECEIPTS.—The Fund shall be cred-
3 ited with—

4 (i) funds borrowed under paragraph
5 (3),

6 (ii) assessments collected under sec-
7 tion 1397, and

8 (iii) earnings on investment of the
9 Fund.

10 (B) DISBURSEMENTS.—The Fund shall be
11 available—

12 (i) for making such payments as the
13 Secretary of Labor determines are nec-
14 essary to pay benefits guaranteed under
15 this section,

16 (ii) to repay the Secretary of the
17 Treasury such sums as may be borrowed
18 (together with interest thereon) under
19 paragraph (3), and

20 (iii) to pay the operational and admin-
21 istrative expenses of the Fund.

22 (3) BORROWING AUTHORITY.—At the direction
23 of the Secretary of Labor, the Fund may, to the ex-
24 tent necessary to carry out the purposes of para-
25 graph (1), issue to the Secretary of the Treasury

1 notes or other obligations, in such forms and de-
2 nominations, bearing such maturities, and subject to
3 such terms and conditions as may be prescribed by
4 the Secretary of the Treasury. The total balance of
5 the Fund obligations outstanding at any time shall
6 not exceed \$500,000,000. Such notes or other obli-
7 gations shall bear interest at a rate determined by
8 the Secretary of the Treasury, taking into consider-
9 ation the current average market yield on out-
10 standing marketable obligations of the United States
11 of comparable maturities during the month pre-
12 ceding the issuance of such notes or other obliga-
13 tions by the Fund. The Secretary of the Treasury
14 shall purchase any notes or other obligations issued
15 by the Fund under this paragraph, and for that pur-
16 pose the Secretary of the Treasury may use as a
17 public debt transaction the proceeds from the sale of
18 any securities issued under chapter 31 of title 31,
19 United States Code and the purposes for which se-
20 curities may be issued under such chapter are ex-
21 tended to include any purchase of such notes and
22 obligations. The Secretary of the Treasury may at
23 any time sell any of the notes or other obligations
24 acquired by such Secretary under this paragraph.
25 All redemptions, purchases, and sales by the Sec-

1 retary of the Treasury of such notes or other obliga-
2 tions shall be treated as public debt transactions of
3 the United States.

4 (4) INVESTMENT AUTHORITY.—Whenever the
5 Secretary of Labor determines that the moneys of
6 the Fund are in excess of current needs, such Sec-
7 retary may request the investment of such amounts
8 as such Secretary determines advisable by the Sec-
9 retary of the Treasury in obligations issued or guar-
10 anteed by the United States, but, until all bor-
11 rowings under paragraph (3) have been repaid, the
12 obligations in which such excess moneys are invested
13 may not yield a rate of return in excess of the rate
14 of interest payable on such borrowings.

15 **SEC. 1397. IMPOSITION AND COLLECTION OF PERIODIC AS-**
16 **SESSMENTS ON SELF-INSURED CORPORATE**
17 **ALLIANCE PLANS.**

18 (a) IMPOSITION OF ASSESSMENTS.—Upon a deter-
19 mination that additional receipts to the Fund are nec-
20 essary in order to enable the Fund to repay amounts bor-
21 rowed by the Fund under section 1396(c)(3) while main-
22 taining a balance sufficient to ensure the solvency of the
23 Fund, the Secretary of Labor may impose assessments
24 under this section. The Secretary shall prescribe from time
25 to time such schedules of assessment rates and bases for

1 the application of such rates as may be necessary to pro-
2 vide for such repayments.

3 (b) UNIFORMITY OF ASSESSMENTS.—The assess-
4 ment rates so prescribed by the Secretary for any period
5 shall be uniform for all plans, except that the Secretary
6 may vary the amount of such assessments by category,
7 or waive the application of such assessments by category,
8 taking into account differences in the financial solvency
9 of, and financial reserves maintained by, plans in each cat-
10 egory.

11 (c) LIMITATION ON AMOUNT OF ASSESSMENT.—The
12 total amount assessed against a corporate alliance health
13 plan under this section during a year may not exceed 2
14 percent of the total premiums paid to the plan with respect
15 to corporate alliance eligible individuals enrolled with the
16 plan during the year.

17 (d) PAYMENT OF ASSESSMENTS.—

18 (1) OBLIGATION TO PAY.—The designated
19 payor of each plan shall pay the assessments im-
20 posed by the Secretary of Labor under this section
21 with respect to that plan when they are due. Assess-
22 ments under this section are payable at the time,
23 and on an estimated, advance, or other basis, as de-
24 termined by the Secretary. Assessments shall con-
25 tinue to accrue until the plan's assets are distributed

1 pursuant to a termination procedure or the Sec-
2 retary is appointed to serve as trustee of the plan
3 under section 1395.

4 (2) LATE PAYMENT CHARGES AND INTEREST.—

5 (A) LATE PAYMENT CHARGES.—If any as-
6 sessment is not paid when it is due, the Sec-
7 retary of Labor may assess a late payment
8 charge of not more than 100 percent of the as-
9 sessment payment which was not timely paid.

10 (B) WAIVERS.—Subparagraph (A) shall
11 not apply to any assessment payment made
12 within 60 days after the date on which payment
13 is due, if before such date, the designated payor
14 obtains a waiver from the Secretary of Labor
15 based upon a showing of substantial hardship
16 arising from the timely payment of the assess-
17 ment. The Secretary may grant a waiver under
18 this subparagraph upon application made by
19 the designated payor, but the Secretary may
20 not grant a waiver if it appears that the des-
21 ignated payor will be unable to pay the assess-
22 ment within 60 days after the date on which it
23 is due.

24 (C) INTEREST.—If any assessment is not
25 paid by the last date prescribed for a payment,

1 interest on the amount of such assessment at
2 the rate imposed under section 6601(a) of the
3 Internal Revenue Code of 1986 shall be paid
4 for the period from such last date to the date
5 paid.

6 (e) CIVIL ACTION UPON NONPAYMENT.—If any des-
7 ignated payor fails to pay an assessment when due, the
8 Secretary of Labor may bring a civil action in any district
9 court of the United States within the jurisdiction of which
10 the plan assets are located, the plan is administered, or
11 in which a defendant resides or is found, for the recovery
12 of the amount of the unpaid assessment, any late payment
13 charge, and interest, and process may be served in any
14 other district. The district courts of the United States
15 shall have jurisdiction over actions brought under this sub-
16 section by the Secretary without regard to the amount in
17 controversy.

18 (f) GUARANTEE HELD HARMLESS.—The Secretary
19 of Labor shall not cease to guarantee benefits on account
20 of the failure of a designated payor to pay any assessment
21 when due.

22 (g) DESIGNATED PAYOR DEFINED.—

23 (1) IN GENERAL.—For purposes of this section,
24 the term “designated payor” means—

1 (A) the employer or plan administrator in
2 any case in which the eligible sponsor of the
3 corporate alliance health plan is described in
4 subparagraph (A) of section 1311(b)(1); and

5 (B) the contributing employers or the plan
6 administrator in any case in which the eligible
7 sponsor of the corporate alliance is described in
8 subparagraph (B) or (C) of section 1311(b)(1).

9 (2) CONTROLLED GROUPS.—If an employer is a
10 member of a controlled group, each member of such
11 group shall be jointly and severally liable for any as-
12 sessments required to be paid by such employer. For
13 purposes of the preceding sentence, the term “con-
14 trolled group” means any group treated as a single
15 employer under subsection (b), (c), (m), or (o) of
16 section 414 of the Internal Revenue Code of 1986.

17 **SEC. 1398. PAYMENTS TO FEDERAL GOVERNMENT BY MUL-**
18 **TIEMPLOYER CORPORATE ALLIANCES FOR**
19 **ACADEMIC HEALTH CENTERS AND GRAD-**
20 **UATE MEDICAL EDUCATION.**

21 (a) IN GENERAL.—A corporate alliance with an eligi-
22 ble sponsor described in section 1311(b)(1)(B) shall make
23 payment to the Secretary of an amount equivalent to the
24 amount (as estimated based on rules established by the
25 Secretary and based on the annual per capita expenditure

1 equivalent calculated under section 6021) that would have
2 been payable by the alliance under section 1353 if the alli-
3 ance were a regional alliance.

4 (b) REFERENCE TO EXEMPTION FROM ASSESS-
5 MENT.—For provision exempting certain corporate alli-
6 ance employers participating in an alliance described in
7 subsection (a) from an assessment under section 3461 of
8 the Internal Revenue Code of 1986, as added by section
9 7121 of this Act, see section 3461(c)(1) of such Code.

10 **Subtitle E—Health Plans**

11 **SEC. 1400. HEALTH PLAN DEFINED.**

12 (a) IN GENERAL.—In this Act, the term “health
13 plan” means a plan that provides the comprehensive ben-
14 efit package and meets the requirements of parts 1, 3,
15 and 4 applicable to health plans.

16 (b) APPROPRIATE SELF-INSURED HEALTH PLAN.—
17 In this Act, the term “appropriate self-insured health
18 plan” means a group health plan (as defined in section
19 3(42) of the Employee Retirement Income Security Act
20 of 1974) which is a self-insured health plan and with re-
21 spect to which the applicable requirements of title I of the
22 Employee Retirement Income Security Act of 1974 are
23 met.

24 (c) STATE-CERTIFIED HEALTH PLAN.—In this Act,
25 the term “State-certified health plan” means a health plan

1 that has been certified by a State under section 1203(a)
2 (or, in the case in which the Board is exercising certifi-
3 cation authority under section 1522(b), that has been cer-
4 tified by the Board).

5 (d) APPLICABLE REGULATORY AUTHORITY DE-
6 FINED.—In this subtitle, the term “applicable regulatory
7 authority” means—

8 (1) with respect to a self-insured health plan,
9 the Secretary of Labor, or

10 (2) with respect to a State-certified health plan,
11 the State authority responsible for certification of
12 the plan.

13 **PART 1—REQUIREMENTS RELATING TO**
14 **COMPREHENSIVE BENEFIT PACKAGE**

15 **SEC. 1401. APPLICATION OF REQUIREMENTS.**

16 No plan shall be treated under this Act as a health
17 plan—

18 (1) unless the plan is a self-insured plan or a
19 State-certified plan; or

20 (2) on and after the effective date of a finding
21 by the applicable regulatory authority that the plan
22 has failed to comply with such applicable require-
23 ments.

1 **SEC. 1402. REQUIREMENTS RELATING TO ENROLLMENT**
2 **AND COVERAGE.**

3 (a) NO UNDERWRITING.—

4 (1) IN GENERAL.—Subject to paragraph (2),
5 each health plan offered by a regional alliance or a
6 corporate alliance must accept for enrollment every
7 alliance eligible individual who seeks such enroll-
8 ment. No plan may engage in any practice that has
9 the effect of attracting or limiting enrollees on the
10 basis of personal characteristics, such as health sta-
11 tus, anticipated need for health care, age, occupa-
12 tion, or affiliation with any person or entity.

13 (2) CAPACITY LIMITATIONS.—With the approval
14 of the applicable regulatory authority, a health plan
15 may limit enrollment because of the plan's capacity
16 to deliver services or to maintain financial stability.
17 If such a limitation is imposed, the limitation may
18 not be imposed on a basis referred to in paragraph
19 (1).

20 (b) NO LIMITS ON COVERAGE; NO PRE-EXISTING
21 CONDITION LIMITS.—A health plan may not—

22 (1) terminate, restrict, or limit coverage for the
23 comprehensive benefit package in any portion of the
24 plan's service area for any reason, including non-
25 payment of premiums;

1 (2) cancel coverage for any alliance eligible indi-
2 vidual until that individual is enrolled in another ap-
3 plicable health plan;

4 (3) exclude coverage of an alliance eligible indi-
5 vidual because of existing medical conditions;

6 (4) impose waiting periods before coverage be-
7 gins; or

8 (5) impose a rider that serves to exclude cov-
9 erage of particular eligible individuals.

10 (c) ANTIDISCRIMINATION.—

11 (1) IN GENERAL.—No health plan may dis-
12 criminate, or engage (directly or through contractual
13 arrangements) in any activity, including the selection
14 of a service area, that has the effect of discrimi-
15 nating, against an individual on the basis of race,
16 national origin, sex, language, socio-economic status,
17 age, disability, health status, or anticipated need for
18 health services.

19 (2) SELECTION OF PROVIDERS FOR PLAN NET-
20 WORK.—In selecting among providers of health serv-
21 ices for membership in a provider network, or in es-
22 tablishing the terms and conditions of such member-
23 ship, a health plan may not engage in any practice
24 that has the effect of discriminating against a
25 provider—

1 (A) based on the race, national origin, sex,
2 language, age, or disability of the provider; or

3 (B) based on the socio-economic status,
4 disability, health status, or anticipated need for
5 health services of a patient of the provider.

6 (3) BUSINESS NECESSITY.—Except in the case
7 of intentional discrimination, it shall not be a viola-
8 tion of this subsection, or of any regulation issued
9 under this subsection, for any person to take any ac-
10 tion otherwise prohibited under this subsection, if
11 the action is required by business necessity.

12 (4) REGULATIONS.—Not later than 1 year after
13 the date of the enactment of this Act, the Secretary
14 of Health and Human Services shall issue regula-
15 tions to carry out this subsection.

16 (d) REQUIREMENTS FOR PLANS OFFERING LOWER
17 COST SHARING.—Each health plan that offers enrollees
18 the lower cost sharing schedule referred to in section
19 1131—

20 (1) shall apply such schedule to all items and
21 services in the comprehensive benefit package;

22 (2) shall offer enrollees the opportunity to ob-
23 tain coverage for out-of-network items and services
24 (as described in subsection (f)(2)); and

1 (3) notwithstanding section 1403, in the case of
2 an enrollee who obtains coverage for such items and
3 services, may charge an alternative premium to take
4 into account such coverage.

5 (e) TREATMENT OF COST SHARING.—Each health
6 plan, in providing benefits in the comprehensive benefit
7 package—

8 (1) shall include in its payments to providers,
9 such additional reimbursement as may be necessary
10 to reflect cost sharing reductions to which individ-
11 uals are entitled under section 1371, and

12 (2) shall maintain such claims or encounter
13 records as may be necessary to audit the amount of
14 such additional reimbursements and the individuals
15 for which such reimbursement is provided.

16 (f) IN-NETWORK AND OUT-OF-NETWORK ITEMS AND
17 SERVICES DEFINED.—

18 (1) IN-NETWORK ITEMS AND SERVICES.—For
19 purposes of this Act, the term “in-network”, when
20 used with respect to items or services described in
21 this subtitle, means items or services provided to an
22 individual enrolled under a health plan by a health
23 care provider who is a member of a provider network
24 of the plan (as defined in paragraph (3)).

1 (2) OUT-OF-NETWORK ITEMS AND SERVICES.—

2 For purposes of this Act, the term “out-of network”,
3 when used with respect to items or services de-
4 scribed in this subtitle, means items or services pro-
5 vided to an individual enrolled under a health plan
6 by a health care provider who is not a member of
7 a provider network of the plan (as defined in para-
8 graph (3)).

9 (3) PROVIDER NETWORK DEFINED.—A “pro-
10 vider network” means, with respect to a health plan,
11 providers who have entered into an agreement with
12 the plan under which such providers are obligated to
13 provide items and services in the comprehensive ben-
14 efit package to individuals enrolled in the plan, or
15 have an agreement to provide services on a fee-for-
16 service basis.

17 (g) RELATION TO DETENTION.—A health plan is not
18 required to provide any reimbursement to any detention
19 facility for services performed in that facility for detainees
20 in the facility.

21 **SEC. 1403. COMMUNITY RATING.**

22 (a) REGIONAL ALLIANCE HEALTH PLANS.—Each re-
23 gional alliance health plan may not vary the premium im-
24 posed with respect to residents of an alliance area, except
25 as may be required under section 6102(a) with respect to

1 different types of individual and family coverage under the
2 plan.

3 (b) CORPORATE ALLIANCE HEALTH PLANS.—Each
4 corporate alliance health plan may not vary the premium
5 imposed with respect to individuals enrolled in the plan,
6 except as may be required under section 1384 with respect
7 to different types of individual and family coverage under
8 the plan.

9 **SEC. 1404. MARKETING OF HEALTH PLANS; INFORMATION.**

10 (a) REGIONAL ALLIANCE MARKETING RESTRIC-
11 TIONS.—

12 (1) IN GENERAL.—The contract entered into
13 between a regional alliance and a regional alliance
14 health plan shall prohibit the distribution by the
15 health plan of marketing materials within the re-
16 gional alliance that contain false or materially mis-
17 leading information and shall provide for prior ap-
18 proval by the regional alliance of any marketing ma-
19 terials to be distributed by the plan.

20 (2) ENTIRE MARKET.—A health plan offered by
21 a regional alliance may not distribute marketing ma-
22 terials to an area smaller than the entire area served
23 by the plan.

24 (3) PROHIBITION OF TIE-INS.—A regional alli-
25 ance health plan, and any agency of such a plan,

1 may not seek to influence an individual's choice of
2 plans in conjunction with the sale of any other in-
3 surance.

4 (b) INFORMATION AVAILABLE.—

5 (1) IN GENERAL.—Each regional alliance health
6 plan must provide to the regional alliance and make
7 available to alliance eligible individuals and health
8 care professionals complete and timely information
9 concerning the following:

10 (A) Costs.

11 (B) The identity, locations, qualifications,
12 and availability of participating providers.

13 (C) Procedures used to control utilization
14 of services and expenditures.

15 (D) Procedures for assuring and improving
16 the quality of care.

17 (E) Rights and responsibilities of enrollees.

18 (F) Information on the number of plan
19 members who disenroll from the plan.

20 (2) PROHIBITION AGAINST CERTIFICATION OF
21 PLANS PROVIDING INACCURATE INFORMATION.—No
22 regional alliance health plan may be a State-certified
23 health plan under this title if the State determines
24 that the plan submitted materially inaccurate infor-
25 mation under paragraph (1).

1 (c) ADVANCE DIRECTIVES.—Each self-insured health
2 plan and each State-certified health plan shall meet the
3 requirement of section 1866(f) of the Social Security Act
4 (relating to maintaining written policies and procedures
5 respecting advance directives) in the same manner as such
6 requirement relates to organizations with contracts under
7 section 1876 of such Act.

8 **SEC. 1405. GRIEVANCE PROCEDURE.**

9 (a) IN GENERAL.—Each health plan must establish
10 a grievance procedure for enrollees to use in pursuing
11 complaints. Such procedure shall be consistent with sub-
12 title C of title V.

13 (b) ADDITIONAL REMEDIES.—If the grievance proce-
14 dure fails to resolve an enrollee’s complaint—

15 (1) in the case of an enrollee of a regional alli-
16 ance health plan, the enrollee has the option of seek-
17 ing assistance from the office of the ombudsman for
18 the regional alliance established under section
19 1326(a), and

20 (2) the enrollee may pursue additional legal
21 remedies, including those provided under subtitle C
22 of title V.

1 **SEC. 1406. HEALTH PLAN ARRANGEMENTS WITH PRO-**
2 **VIDERS.**

3 (a) **REQUIREMENT.**—Each health plan must enter
4 into such agreements with health care providers or have
5 such other arrangements as may be necessary to assure
6 the provision of all services covered by the comprehensive
7 benefit package to eligible individuals enrolled with the
8 plan.

9 (b) **EMERGENCY AND URGENT CARE SERVICES.**—

10 (1) **IN GENERAL.**—Each health plan must cover
11 emergency and urgent care services provided to en-
12 rollees, without regard to whether or not the pro-
13 vider furnishing such services has a contractual (or
14 other) arrangement with the plan to provide items or
15 services to enrollees of the plan and in the case of
16 emergency services without regard to prior author-
17 ization.

18 (2) **PAYMENT AMOUNTS.**—In the case of emer-
19 gency and urgent care provided to an enrollee out-
20 side of a health plan's service area, the payment
21 amounts of the plan shall be based on the fee for
22 service rate schedule established by the regional alli-
23 ance for the alliance area where the services were
24 provided.

25 (c) **APPLICATION OF FEE SCHEDULE.**—

1 (1) IN GENERAL.—Subject to paragraph (2),
2 each regional alliance health plan or corporate alli-
3 ance health plan that provides for payment for serv-
4 ices on a fee-for-service basis shall make such pay-
5 ment in the amounts provided under the fee sched-
6 ule established by the regional alliance under section
7 1322(c) (or, in the case of a plan offered in a State
8 that has established a Statewide fee schedule under
9 section 1322(c)(3), under such Statewide fee sched-
10 ule).

11 (2) REDUCTION FOR PROVIDERS VOLUNTARILY
12 REDUCING CHARGES.—If a provider under a health
13 plan voluntarily agrees to reduce the amount
14 charged to an individual enrolled under the plan, the
15 plan shall reduce the amount otherwise determined
16 under the fee schedule applicable under paragraph
17 (1) by the proportion of the reduction in such
18 amount charged.

19 (3) REDUCTION FOR NONCOMPLYING PLAN.—
20 Each regional alliance health plan that is a noncom-
21 plying plan shall provide for reductions in payments
22 under the fee schedule to providers that are not par-
23 ticipating providers in accordance with section
24 6012(b).

1 (d) PROHIBITION AGAINST BALANCE BILLING; RE-
2 QUIREMENT OF DIRECT BILLING.—

3 (1) PROHIBITION OF BALANCE BILLING.—A
4 provider may not charge or collect from an enrollee
5 a fee in excess of the applicable payment amount
6 under the applicable fee schedule under subsection
7 (c), and the health plan and its enrollees are not le-
8 gally responsible for payment of any amount in ex-
9 cess of such applicable payment amount for items
10 and services covered under the comprehensive bene-
11 fits package.

12 (2) DIRECT BILLING.—A provider may not
13 charge or collect from an enrollee amounts that are
14 payable by the health plan (including any cost shar-
15 ing reduction assistance payable by the plan) and
16 shall submit charges to such plan in accordance with
17 any applicable requirements of part 1 of subtitle B
18 of title V (relating to health information systems).

19 (3) COVERAGE UNDER AGREEMENTS WITH
20 PLANS.—The agreements or other arrangements en-
21 tered into under subsection (a) between a health
22 plan and the health care providers providing the
23 comprehensive benefit package to individuals en-
24 rolled with the plan shall prohibit a provider from

1 engaging in balance billing described in paragraph
2 (1).

3 (e) IMPOSITION OF PARTICIPATING PROVIDER AS-
4 SESSMENT IN CASE OF A NONCOMPLYING PLAN.—Each
5 regional alliance health plan shall provide that if the plan
6 is a noncomplying plan for a year under section 6012, pay-
7 ments to participating providers shall be reduced by the
8 applicable network reduction percentage under such sec-
9 tion.

10 **SEC. 1407. PREEMPTION OF CERTAIN STATE LAWS RELAT-**
11 **ING TO HEALTH PLANS.**

12 (a) LAWS RESTRICTING PLANS OTHER THAN FEE-
13 FOR-SERVICE PLANS.—Except as may otherwise be pro-
14 vided in this section, no State law shall apply to any serv-
15 ices provided under a health plan that is not a fee-for-
16 service plan (or a fee-for-service component of a plan) if
17 such law has the effect of prohibiting or otherwise restrict-
18 ing plans from—

19 (1) except as provided in section 1203, limiting
20 the number and type of health care providers who
21 participate in the plan;

22 (2) requiring enrollees to obtain health services
23 (other than emergency services) from participating
24 providers or from providers authorized by the plan;

1 (3) requiring enrollees to obtain a referral for
2 treatment by a specialized physician or health insti-
3 tution;

4 (4) establishing different payment rates for par-
5 ticipating providers and providers outside the plan;

6 (5) creating incentives to encourage the use of
7 participating providers; or

8 (6) requiring the use of single-source suppliers
9 for pharmacy, medical equipment, and other health
10 products and services.

11 (b) PREEMPTION OF STATE CORPORATE PRACTICE
12 ACTS.—Any State law related to the corporate practice
13 of medicine and to provider ownership of health plans or
14 other providers shall not apply to arrangements between
15 health plans that are not fee-for-service plans and their
16 participating providers.

17 (c) PARTICIPATING PROVIDER DEFINED.—In this
18 title, a “participating provider” means, with respect to a
19 health plan, a provider of health care services who is a
20 member of a provider network of the plan (as described
21 in section 1402(f)(3)).

22 **SEC. 1408. FINANCIAL SOLVENCY.**

23 Each regional alliance health plan must—

24 (1) meet or exceed minimum capital require-
25 ments established by States under section 1204(a);

1 (2) in the case of a plan operating in a State,
2 must participate in the guaranty fund established by
3 the State under section 1204(c); and

4 (3) meet such other requirements relating to
5 fiscal soundness as the State may establish (subject
6 to the establishment of any alternative standards by
7 the Board).

8 **SEC. 1409. REQUIREMENT FOR OFFERING COST SHARING**
9 **POLICY.**

10 Each regional alliance health plan shall offer a cost
11 sharing policy (as defined in section 1421(b)(2)) to each
12 eligible family enrolled under the plan.

13 **SEC. 1410. QUALITY ASSURANCE.**

14 Each health plan shall comply with such quality as-
15 surance requirements as are imposed under subtitle A of
16 title V with respect to such a plan.

17 **SEC. 1411. PROVIDER VERIFICATION.**

18 Each health plan shall—

19 (1) verify the credentials of practitioners and
20 facilities;

21 (2) ensure that all providers participating in the
22 plan meet applicable State licensing and certification
23 standards;

1 (3) oversee the quality and performance of par-
2 ticipating providers, consistent with section 1410;
3 and

4 (4) investigate and resolve consumer complaints
5 against participating providers.

6 **SEC. 1412. CONSUMER DISCLOSURES OF UTILIZATION MAN-**
7 **AGEMENT PROTOCOLS.**

8 Each health plan shall disclose to enrollees (and pro-
9 spective enrollees) the protocols used by the plan for con-
10 trolling utilization and costs.

11 **SEC. 1413. CONFIDENTIALITY, DATA MANAGEMENT, AND**
12 **REPORTING.**

13 (a) IN GENERAL.—Each health plan shall comply
14 with the confidentiality, data management, and reporting
15 requirements imposed under subtitle B of title V.

16 (b) TREATMENT OF ELECTRONIC INFORMATION.—

17 (1) ACCURACY AND RELIABILITY.—Each health
18 plan shall take such measures as may be necessary
19 to ensure that health care information in electronic
20 form that the plan, or a member of a provider net-
21 work of the plan, collects for or transmits to the
22 Board under subtitle B of title V is accurate and re-
23 liable.

24 (2) PRIVACY AND SECURITY.—Each health plan
25 shall take such measures as may be necessary to en-

1 sure that health care information described in para-
2 graph (1) is not distributed to any individual or en-
3 tity in violation of a standard promulgated by the
4 Board under part 2 of subtitle B of title V.

5 **SEC. 1414. PARTICIPATION IN REINSURANCE SYSTEM.**

6 Each regional alliance health plan of a State that has
7 established a reinsurance system under section 1203(g)
8 shall participate in the system in the manner specified by
9 the State.

10 **PART 2—REQUIREMENTS RELATING TO**
11 **SUPPLEMENTAL INSURANCE**

12 **SEC. 1421. IMPOSITION OF REQUIREMENTS ON SUPPLE-**
13 **MENTAL INSURANCE.**

14 (a) IN GENERAL.—An entity may offer a supple-
15 mental insurance policy but only if—

16 (1) in the case of a supplemental health benefit
17 policy (as defined in subsection (b)(1)), the entity
18 and the policy meet the requirements of section
19 1422; and

20 (2) in the case of a cost sharing policy (as de-
21 fined in subsection (b)(2)), the entity and the policy
22 meet the requirements of section 1423.

23 (b) POLICIES DEFINED.—

24 (1) SUPPLEMENTAL HEALTH BENEFIT POL-
25 ICY.—

1 (A) IN GENERAL.—In this part, the term
2 “supplemental health benefit policy” means a
3 health insurance policy or health benefit plan
4 offered to an alliance eligible individual which
5 provides—

6 (i) coverage for services and items not
7 included in the comprehensive benefit
8 package, or

9 (ii) coverage for items and services in-
10 cluded in such package but not covered be-
11 cause of a limitation in amount, duration,
12 or scope provided under this title,

13 or both.

14 (B) EXCLUSIONS.—Such term does not in-
15 clude the following:

16 (i) A cost sharing policy (as defined in
17 paragraph (2)).

18 (ii) A long-term care insurance policy
19 (as defined in section 2304(10)).

20 (iii) Insurance that limits benefits
21 with respect to specific diseases (or condi-
22 tions).

23 (iv) Hospital or nursing home indem-
24 nity insurance.

1 (v) A medicare supplemental policy
2 (as defined in section 1882(g) of the Social
3 Security Act).

4 (vi) Insurance with respect to acci-
5 dents.

6 (2) COST SHARING POLICY.—In this part, the
7 term “cost sharing policy” means a health insurance
8 policy or health benefit plan offered to an alliance el-
9 igible individual which provides coverage for
10 deductibles, coinsurance, and copayments imposed as
11 part of the comprehensive benefit package under
12 subtitle B, whether imposed under a higher cost
13 sharing plan or with respect to out-of-network pro-
14 viders.

15 **SEC. 1422. STANDARDS FOR SUPPLEMENTAL HEALTH BEN-**
16 **EFIT POLICIES.**

17 (a) PROHIBITING DUPLICATION OF COVERAGE.—

18 (1) IN GENERAL.—No health plan, insurer, or
19 any other person may offer—

20 (A) to any eligible individual a supple-
21 mental health benefit policy that duplicates any
22 coverage provided in the comprehensive benefit
23 package; or

24 (B) to any medicare-eligible individual a
25 supplemental health benefit policy that dupli-

1 cates any coverage provided under the medicare
2 program.

3 (2) EXCEPTION FOR MEDICARE-ELIGIBLE INDIVIDUALS.—For purposes of this subsection, for the
4 period in which an individual is a medicare-eligible
5 individual and also is an alliance eligible individual
6 (and is enrolled under a regional alliance or corporate alliance health plan), paragraph (1)(A) (and
7 not paragraph (1)(B)) shall apply.
8

9 (b) NO LIMITATION ON INDIVIDUALS OFFERED POLICY.—
10

11 (1) IN GENERAL.—Except as provided in paragraph (2), each entity offering a supplemental health
12 benefit policy must accept for enrollment every individual who seeks such enrollment, subject to capacity and financial limits.
13
14
15
16

17 (2) EXCEPTION FOR CERTAIN OFFERORS.—
18 Paragraph (1) shall not apply to any supplemental
19 health benefit policy offered to an individual only on
20 the basis of—

21 (A) the individual's employment (in the
22 case of a policy offered by the individual's employer); or
23

1 (B) the individual's membership or enroll-
2 ment in a fraternal, religious, professional, edu-
3 cational, or other similar organization.

4 (c) RESTRICTIONS ON MARKETING ABUSES.—Not
5 later than January 1, 1996, the Board shall develop (in
6 consultation with the States) minimum standards that
7 prohibit marketing practices by entities offering supple-
8 mental health benefit policies that involve:

9 (1) Providing monetary incentives for or tying
10 or otherwise conditioning the sale of the policy to en-
11 rollment in a regional alliance health plan of the en-
12 tity.

13 (2) Using or disclosing to any party information
14 about the health status or claims experience of par-
15 ticipants in a regional alliance health plan for the
16 purpose of marketing such a policy.

17 (d) CIVIL MONETARY PENALTY.—An entity that
18 knowingly and willfully violates any provision of this sec-
19 tion with respect to the offering of a supplemental health
20 benefit policy to any individual shall be subject to a civil
21 monetary penalty (not to exceed \$10,000) for each such
22 violation. The provisions of section 1128A of the Social
23 Security Act (other than subsections (a) and (b)) shall
24 apply to civil money penalties under this subsection in the

1 same manner as they apply to a penalty or proceeding
2 under section 1128A(a) of such Act.

3 **SEC. 1423. STANDARDS FOR COST SHARING POLICIES.**

4 (a) RULES FOR OFFERING OF POLICIES.—Subject to
5 subsection (f), a cost sharing policy may be offered to an
6 individual only if—

7 (1) the policy is offered by the regional alliance
8 health plan in which the individual is enrolled;

9 (2) the regional alliance health plan offers the
10 policy to all individuals enrolled in the plan;

11 (3) the plan offers each such individual a choice
12 of a policy that provides standard coverage and a
13 policy that provides maximum coverage (in accord-
14 ance with standards established by the Board); and

15 (4) the policy is offered only during the annual
16 open enrollment period for regional alliance health
17 plans (described in section 1323(d)(1)).

18 (b) PROHIBITION OF COVERAGE OF COPAYMENTS.—
19 Each cost sharing policy may not provide any benefits re-
20 lating to any copayments established under the table of
21 copayments and coinsurance under section 1135.

22 (c) EQUIVALENT COVERAGE FOR ALL SERVICES.—
23 Each cost sharing policy must provide coverage for items
24 and services in the comprehensive benefit package to the

1 same extent as the policy provides coverage for all items
2 and services in the package.

3 (d) REQUIREMENTS FOR PRICING.—

4 (1) IN GENERAL.—The price of any cost shar-
5 ing policy shall—

6 (A) be the same for each individual to
7 whom the policy is offered;

8 (B) take into account any expected in-
9 crease in utilization resulting from the purchase
10 of the policy by individuals enrolled in the re-
11 gional alliance health plan; and

12 (C) not result in a loss-ratio of less than
13 90 percent.

14 (2) LOSS-RATIO DEFINED.—In paragraph
15 (1)(C), a “loss-ratio” is the ratio of the premium re-
16 turned to the consumer in payout relative to the
17 total premium collected.

18 (e) LOSS OF STATE CERTIFICATION FOR REGIONAL
19 ALLIANCE HEALTH PLANS FAILING TO MEET STAND-
20 ARDS.—A State may not certify a regional alliance health
21 plan that offers a cost sharing policy unless the plan and
22 the policy meet the standards described in this section.

23 (f) SPECIAL RULES FOR FEHBP SUPPLEMENTAL
24 PLANS.—Subsection (a) shall not apply to an FEHBP

1 supplemental plan described in section 8203(f)(1), but
2 only if the plan meets the following requirements:

3 (1) The plan must be offered to all individuals
4 to whom such a plan is required to be offered under
5 section 8203.

6 (2) The plan must offer each such individual a
7 choice of a policy that provides standard coverage
8 and a policy that provides maximum coverage (in ac-
9 cordance with standards established by the Board
10 under subsection (a)(3)).

11 (3) The plan is offered only during the annual
12 open enrollment period for regional alliance health
13 plans (described in section 1323(d)(1)).

14 (4)(A) The price of the plan shall include an
15 amount, established in accordance with rules estab-
16 lished by the Board in consultation with the Office
17 of Personnel Management, that takes into account
18 any expected increase in utilization of the items and
19 services in the comprehensive benefit package result-
20 ing from the purchase of the plan by individuals en-
21 rolled in a regional alliance health plan.

22 (B) The plan provides for payment, in a man-
23 ner specified by the Board in the case of an indi-
24 vidual enrolled in the plan and in a regional alliance
25 health plan, to the regional alliance health plan of

1 an amount equivalent to the additional amount de-
2 scribed in subparagraph (A).

3 **PART 3—REQUIREMENTS RELATING TO**
4 **ESSENTIAL COMMUNITY PROVIDERS**

5 **SEC. 1431. HEALTH PLAN REQUIREMENT.**

6 (a) IN GENERAL.—Subject to section 1432, each
7 health plan shall, with respect to each electing essential
8 community provider (as defined in subsection (d), other
9 than a provider of school health services) located within
10 the plan’s service area, either—

11 (1) enter into a written provider participation
12 agreement (described in subsection (b)) with the
13 provider, or

14 (2) enter into a written agreement under which
15 the plan shall make payment to the provider in ac-
16 cordance with subsection (c).

17 (b) PARTICIPATION AGREEMENT.—A participation
18 agreement between a health plan and an electing essential
19 community provider under this subsection shall provide
20 that the health plan agrees to treat the provider in accord-
21 ance with terms and conditions at least as favorable as
22 those that are applicable to other providers participating
23 in the health plan with respect to each of the following:

24 (1) The scope of services for which payment is
25 made by the plan to the provider.

1 (2) The rate of payment for covered care and
2 services.

3 (3) The availability of financial incentives to
4 participating providers.

5 (4) Limitations on financial risk provided to
6 other participating providers.

7 (5) Assignment of enrollees to participating
8 providers.

9 (6) Access by the provider's patients to pro-
10 viders in medical specialties or subspecialties partici-
11 pating in the plan.

12 (c) PAYMENTS FOR PROVIDERS WITHOUT PARTICI-
13 PATION AGREEMENTS.—

14 (1) IN GENERAL.—Payment in accordance with
15 this subsection is payment based, as elected by the
16 electing essential community provider, either—

17 (A) on the fee schedule developed by the
18 applicable regional alliance (or the State) under
19 section 1322(c), or

20 (B) on payment methodologies and rates
21 used under the applicable Medicare payment
22 methodology and rates (or the most closely ap-
23 plicable methodology under such program as
24 the Secretary of Health and Human Services
25 specifies in regulations).

1 (2) NO APPLICATION OF GATE-KEEPER LIMITA-
2 TIONS.—Payment in accordance with this subsection
3 may be subject to utilization review, but may not be
4 subject to otherwise applicable gate-keeper require-
5 ments under the plan.

6 (d) ELECTION.—

7 (1) IN GENERAL.—In this part, the term “elect-
8 ing essential community provider” means, with re-
9 spect to a health plan, an essential community pro-
10 vider that elects this subpart to apply to the health
11 plan.

12 (2) FORM OF ELECTION.—An election under
13 this subsection shall be made in a form and manner
14 specified by the Secretary, and shall include notice
15 to the health plan involved. Such an election may be
16 made annually with respect to a health plan, except
17 that the plan and provider may agree to make such
18 an election on a more frequent basis.

19 (e) SPECIAL RULE FOR PROVIDERS OF SCHOOL
20 HEALTH SERVICES.—A health plan shall pay, to each pro-
21 vider of school health services located in the plan’s service
22 area an amount determined by the Secretary for such
23 services furnished to enrollees of the plan.

1 **SEC. 1432. SUNSET OF REQUIREMENT.**

2 (a) IN GENERAL.—Subject to subsection (d), the re-
3 quirement of section 1431 shall only apply to health plans
4 offered by a health alliance during the 5-year period begin-
5 ning with the first year in which any health plan is offered
6 by the alliance.

7 (b) STUDIES.—In order to prepare recommendations
8 under subsection (c), the Secretary shall conduct studies
9 regarding essential community providers, including studies
10 that assess—

11 (1) the definition of essential community pro-
12 vider,

13 (2) the sufficiency of the funding levels for pro-
14 viders, for both covered and uncovered benefits
15 under this Act,

16 (3) the effects of contracting requirements re-
17 lating to such providers on such providers, health
18 plans, and enrollees,

19 (4) the impact of the payment rules for such
20 providers, and

21 (5) the impact of national health reform on
22 such providers.

23 (c) RECOMMENDATIONS TO CONGRESS.—The Sec-
24 retary shall submit to Congress, by not later than March
25 1, 2001, specific recommendations respecting whether,
26 and to what extent, section 1431 should continue to apply

1 to some or all essential community providers. Such rec-
2 ommendations may include a description of the particular
3 types of such providers and circumstances under which
4 such section should continue to apply.

5 (d) CONGRESSIONAL CONSIDERATION.—

6 (1) IN GENERAL.—Recommendations submitted
7 under subsection (c) shall apply under this part (and
8 may supersede the provisions of subsection (a)) un-
9 less a joint resolution (described in paragraph (2))
10 disapproving such recommendations is enacted, in
11 accordance with the provisions of paragraph (3), be-
12 fore the end of the 60-day period beginning on the
13 date on which such recommendations were sub-
14 mitted. For purposes of applying the preceding sen-
15 tence and paragraphs (2) and (3), the days on which
16 either House of Congress is not in session because
17 of an adjournment of more than three days to a day
18 certain shall be excluded in the computation of a pe-
19 riod.

20 (2) JOINT RESOLUTION OF DISAPPROVAL.—A
21 joint resolution described in this paragraph means
22 only a joint resolution which is introduced within the
23 10-day period beginning on the date on which the
24 Secretary submits recommendations under sub-
25 section (c) and—

1 (A) which does not have a preamble;

2 (B) the matter after the resolving clause of
3 which is as follows: “That Congress disapproves
4 the recommendations of the Secretary of Health
5 and Human Services concerning the continued
6 application of certain essential community pro-
7 vider requirements under section 1431 of the
8 Health Security Act, as submitted by the Sec-
9 retary on _____.”, the blank space
10 being filled in with the appropriate date; and

11 (C) the title of which is as follows: “Joint
12 resolution disapproving recommendations of the
13 Secretary of Health and Human Services con-
14 cerning the continued application of certain es-
15 sential community provider requirements under
16 section 1431 of the Health Security Act, as
17 submitted by the Secretary on
18 _____.”, the blank space being filled
19 in with the appropriate date.

20 (3) PROCEDURES FOR CONSIDERATION OF RES-
21 OLUTION OF DISAPPROVAL.—Subject to paragraph
22 (4), the provisions of section 2908 (other than sub-
23 section (a)) of the Defense Base Closure and Re-
24 alignment Act of 1990 shall apply to the consider-
25 ation of a joint resolution described in paragraph (2)

1 in the same manner as such provisions apply to a
2 joint resolution described in section 2908(a) of such
3 Act.

4 (4) SPECIAL RULES.—For purposes of applying
5 paragraph (3) with respect to such provisions—

6 (A) any reference to the Committee on
7 Armed Services of the House of Representatives
8 shall be deemed a reference to an appropriate
9 Committee of the House of Representatives
10 (specified by the Speaker of the House of Rep-
11 resentatives at the time of submission of rec-
12 ommendations under subsection (c)) and any
13 reference to the Committee on Armed Services
14 of the Senate shall be deemed a reference to an
15 appropriate Committee of the Senate (specified
16 by the Majority Leader of the Senate at the
17 time of submission of recommendations under
18 subsection (c)); and

19 (B) any reference to the date on which the
20 President transmits a report shall be deemed a
21 reference to the date on which the Secretary
22 submits recommendations under subsection (c).

1 **PART 4—REQUIREMENTS RELATING TO WORK-**
2 **ERS’ COMPENSATION AND AUTOMOBILE**
3 **MEDICAL LIABILITY COVERAGE**

4 **SEC. 1441. REFERENCE TO REQUIREMENTS RELATING TO**
5 **WORKERS COMPENSATION SERVICES.**

6 Each health plan shall meet the applicable require-
7 ments of part 2 of subtitle A of title X (relating to provi-
8 sion of workers compensation services to enrollees).

9 **SEC. 1442. REFERENCE TO REQUIREMENTS RELATING TO**
10 **AUTOMOBILE MEDICAL LIABILITY SERVICES.**

11 Each health plan shall meet the applicable require-
12 ments of part 2 of subtitle B of title X (relating to provi-
13 sion of automobile medical liability services to enrollees).

14 **Subtitle F—Federal**
15 **Responsibilities**

16 **PART 1—NATIONAL HEALTH BOARD**

17 **Subpart A—Establishment of National Health Board**

18 **SEC. 1501. CREATION OF NATIONAL HEALTH BOARD; MEM-**
19 **BERSHIP.**

20 (a) IN GENERAL.—There is hereby created in the Ex-
21 ecutive Branch a National Health Board.

22 (b) COMPOSITION.—The Board is composed of 7
23 members appointed by the President, by and with the ad-
24 vice and consent of the Senate.

25 (c) CHAIR.—The President shall designate one of the
26 members as chair. The chair serves a term concurrent

1 with that of the President. The chair may serve a max-
2 imum of 3 terms. The chair shall serve as the chief execu-
3 tive officer of the Board.

4 (d) TERMS.—

5 (1) IN GENERAL.—Except as provided in para-
6 graphs (2) and (4), the term of each member of the
7 Board, except the chair, is 4 years and begins when
8 the term of the predecessor of that member ends.

9 (2) INITIAL TERMS.—The initial terms of the
10 members of the Board (other than the chair) first
11 taking office after the date of the enactment of this
12 Act, shall expire as designated by the President, two
13 at the end of one year, two at the end of two years,
14 and two at the end of three years.

15 (3) REAPPOINTMENT.—A member (other than
16 the chair) may be reappointed for one additional
17 term.

18 (4) CONTINUATION IN OFFICE.—Upon the expi-
19 ration of a term of office, a member shall continue
20 to serve until a successor is appointed and qualified.

21 (e) VACANCIES.—

22 (1) IN GENERAL.—Whenever a vacancy shall
23 occur, other than by expiration of term, a successor
24 shall be appointed by the President, by and with the
25 consent of the Senate, to fill such vacancy, and is

1 appointed for the remainder of the term of the pred-
2 ecessor.

3 (2) NO IMPAIRMENT OF FUNCTION.—A vacancy
4 in the membership of the Board does not impair the
5 authority of the remaining members to exercise all
6 of the powers of the Board.

7 (3) ACTING CHAIR.—The Board may designate
8 a Member to act as chair during any period in which
9 there is no chair designated by the President.

10 (f) MEETINGS; QUORUM.—

11 (1) MEETINGS.—At meetings of the Board the
12 chair shall preside, and in the absence of the chair,
13 the Board shall elect a member to act as chair pro
14 tempore.

15 (2) QUORUM.—Four members of the Board
16 shall constitute a quorum thereof.

17 **SEC. 1502. QUALIFICATIONS OF BOARD MEMBERS.**

18 (a) CITIZENSHIP.—Each member of the Board shall
19 be a citizen of the United States.

20 (b) BASIS OF SELECTION.—Board members will be
21 selected on the basis of their experience and expertise in
22 relevant subjects, including the practice of medicine, nurs-
23 ing, or other clinical practices, health care financing and
24 delivery, state health systems, consumer protection, busi-
25 ness, law, and delivery of care to vulnerable populations.

1 (c) EXCLUSIVE EMPLOYMENT.—During the term of
2 appointment, Board members shall serve as employees of
3 the Federal Government and shall hold no other employ-
4 ment.

5 (d) PROHIBITION OF CONFLICT OF INTEREST.—A
6 member of the Board may not have a pecuniary interest
7 in or hold an official relation to any health care plan,
8 health care provider, insurance company, pharmaceutical
9 company, medical equipment company, or other affected
10 industry. Before entering upon the duties as a member
11 of the Board, the member shall certify under oath compli-
12 ance with this requirement.

13 (e) POST-EMPLOYMENT RESTRICTIONS.—After leav-
14 ing the Board, former members are subject to post-em-
15 ployment restrictions applicable to comparable Federal
16 employees.

17 (f) COMPENSATION OF BOARD MEMBERS.—Each
18 member of the Board (other than the chair) shall receive
19 an annual salary at the annual rate payable from time
20 to time for level IV of the Executive Schedule. The chair
21 of the Board, during the period of service as chair, shall
22 receive an annual salary at the annual rate payable from
23 time to time for level III of the Executive Schedule.

24 **SEC. 1503. GENERAL DUTIES AND RESPONSIBILITIES.**

25 (a) COMPREHENSIVE BENEFIT PACKAGE.—

1 (1) INTERPRETATION.—The Board shall inter-
2 pret the comprehensive benefit package, adjust the
3 delivery of preventive services under section 1153,
4 and take such steps as may be necessary to assure
5 that the comprehensive benefit package is available
6 on a uniform national basis to all eligible individuals.

7 (2) RECOMMENDATIONS.—The Board may rec-
8 ommend to the President and the Congress appro-
9 priate revisions to such package. Such recommenda-
10 tions may reflect changes in technology, health care
11 needs, health care costs, and methods of service de-
12 livery.

13 (b) ADMINISTRATION OF COST CONTAINMENT PRO-
14 VISIONS.—The Board shall oversee the cost containment
15 requirements of subtitle A of title VI and certify compli-
16 ance with such requirements.

17 (c) COVERAGE AND FAMILIES.—The Board shall de-
18 velop and implement standards relating to the eligibility
19 of individuals for coverage in applicable health plans under
20 subtitle A of title I and may provide such additional excep-
21 tions and special rules relating to the treatment of family
22 members under section 1012 as the Board finds appro-
23 priate.

24 (d) QUALITY MANAGEMENT AND IMPROVEMENT.—
25 The Board shall establish and have ultimate responsibility

1 for a performance-based system of quality management
2 and improvement as required by section 5001.

3 (e) INFORMATION STANDARDS.—The Board shall de-
4 velop and implement standards to establish national
5 health information system to measure quality as required
6 by section 5101.

7 (f) PARTICIPATING STATE REQUIREMENTS.—Con-
8 sistent with the provisions of subtitle C, the Board shall—

9 (1) establish requirements for participating
10 States,

11 (2) monitor State compliance with those re-
12 quirements,

13 (3) provide technical assistance, and
14 in a manner that ensures access to the comprehensive ben-
15 efit package for all eligible individuals.

16 (g) DEVELOPMENT OF PREMIUM CLASS FACTORS.—
17 The Board shall establish premium class factors under
18 subpart D of this part.

19 (h) DEVELOPMENT OF RISK-ADJUSTMENT METHOD-
20 OLOGY.—The Board shall develop a methodology for the
21 risk-adjustment of premium payments to regional alliance
22 health plans in accordance with subpart E of this part.

23 (i) FINANCIAL REQUIREMENTS.—The Board shall es-
24 tablish minimum capital requirements and requirements
25 for guaranty funds under subpart F of this part.

1 (j) STANDARDS FOR HEALTH PLAN GRIEVANCE
2 PROCEDURES.—The Board shall establish standards for
3 health plan grievance procedures that are used by enroll-
4 ees in pursuing complaints.

5 **SEC. 1504. ANNUAL REPORT.**

6 (a) IN GENERAL.—The Board shall prepare and send
7 to the President and Congress an annual report address-
8 ing the overall implementation of the new health care sys-
9 tem.

10 (b) MATTERS TO BE INCLUDED.—The Board shall
11 include in each annual report under this section the fol-
12 lowing:

13 (1) Information on Federal and State imple-
14 mentation.

15 (2) Data related to quality improvement.

16 (3) Recommendations or changes in the admin-
17 istration, regulation and laws related to health care
18 and coverage.

19 (4) A full account of all actions taken during
20 the previous year.

21 **SEC. 1505. POWERS.**

22 (a) STAFF; CONTRACT AUTHORITY.—The Board
23 shall have authority, subject to the provisions of the civil-
24 service laws and chapter 51 and subchapter III of chapter
25 53 of title 5, United States Code, to appoint such officers

1 and employees as are necessary to carry out its functions.
2 To the extent provided in advance in appropriations Acts,
3 the Board may contract with any person (including an
4 agency of the Federal Government) for studies and anal-
5 ysis as required to execute its functions. Any employee of
6 the Executive Branch may be detailed to the Board to as-
7 sist the Board in carrying out its duties.

8 (b) ESTABLISHMENT OF ADVISORY COMMITTEES.—
9 The Board may establish advisory committees.

10 (c) ACCESS TO INFORMATION.—The Board may se-
11 cure directly from any department or agency of the United
12 States information necessary to enable it to carry out its
13 functions, to the extent such information is otherwise
14 available to a department or agency of the United States.
15 Upon request of the chair, the head of that department
16 or agency shall furnish that information to the Board.

17 (d) DELEGATION OF AUTHORITY.—Except as other-
18 wise provided in this Act, the Board may delegate any
19 function to such officers and employees as the Board may
20 designate and may authorize such successive redelegations
21 of such functions with the Board as the Board deems to
22 be necessary or appropriate. No delegation of functions
23 by the Board shall relieve the Board of responsibility for
24 the administration of such functions.

1 (e) RULEMAKING.—The National Health Board is
2 authorized to establish such rules as may be necessary to
3 carry out this Act.

4 **SEC. 1506. FUNDING.**

5 (a) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to the Board such sums
7 as may be necessary for fiscal years 1994, 1995, 1996,
8 1997, and 1998.

9 (b) SUBMISSION OF BUDGET.—Under the procedures
10 of chapter 11 of title 31, United States Code, the budget
11 for the Board for a fiscal year shall be reviewed by the
12 Director of the Office of Management and Budget and
13 submitted to the Congress as part of the President's sub-
14 mission of the Budget of the United States for the fiscal
15 year.

16 **Subpart B—Responsibilities Relating to Review and**
17 **Approval of State Systems**

18 **SEC. 1511. FEDERAL REVIEW AND ACTION ON STATE SYS-**
19 **TEMS.**

20 (a) APPROVAL OF STATE SYSTEMS BY NATIONAL
21 BOARD.—

22 (1) IN GENERAL.—The National Health Board
23 shall approve a State health care system for which
24 a document is submitted under section 1200(b) un-
25 less the Board finds that the system (as set forth in

1 the document) does not (or will not) provide for the
2 State meeting the responsibilities for participating
3 States under this Act.

4 (2) REGULATIONS.—The Board shall issue reg-
5 ulations, not later than July 1, 1995, prescribing the
6 requirements for State health care systems under
7 parts 2 and 3 of subtitle C, except that in the case
8 of a document submitted under section 1200(b) be-
9 fore the date of issuance of such regulations, the
10 Board shall take action on such document notwith-
11 standing the fact that such regulations have not
12 been issued.

13 (3) NO APPROVAL PERMITTED FOR YEARS
14 PRIOR TO 1996.—The Board may not approve a
15 State health care system under this subpart for any
16 year prior to 1996.

17 (b) REVIEW OF COMPLETENESS OF DOCUMENTS.—

18 (1) IN GENERAL.—If a State submits a docu-
19 ment under subsection (a)(1), the Board shall notify
20 the State, not later than 7 working days after the
21 date of submission, whether or not the document is
22 complete and provides the Board with sufficient in-
23 formation to approve or disapprove the document.

24 (2) ADDITIONAL INFORMATION ON INCOMPLETE
25 DOCUMENT.—If the Board notifies a State that the

1 State's document is not complete, the State shall be
2 provided such additional period (not to exceed 45
3 days) as the Board may by regulation establish in
4 which to submit such additional information as the
5 Board may require. Not later than 7 working days
6 after the State submits the additional information,
7 the Board shall notify the State respecting the com-
8 pleteness of the document.

9 (c) ACTION ON COMPLETED DOCUMENTS.—

10 (1) IN GENERAL.—The Board shall make a de-
11 termination (and notify the State) on whether the
12 State's document provides for implementation of a
13 State system that meets the applicable requirements
14 of subtitle C—

15 (A) in the case of a State that did not re-
16 quire the additional period described in sub-
17 section (b)(2) to file a complete document, not
18 later than 90 days after notifying a State under
19 subsection (b) that the State's document is
20 complete, or

21 (B) in the case of a State that required the
22 additional period described in subsection (b)(2)
23 to file a complete document, not later than 90
24 days after notifying a State under subsection
25 (b) that the State's document is complete.

1 (2) PLANS DEEMED APPROVED.—If the Board
2 does not meet the applicable deadline for making a
3 determination and providing notice under paragraph
4 (1) with respect to a State’s document, the Board
5 shall be deemed to have approved the State’s docu-
6 ment for purposes of this Act.

7 (d) OPPORTUNITY TO RESPOND TO REJECTED DOC-
8 UMENT.—

9 (1) IN GENERAL.—If (within the applicable
10 deadline under subsection (c)(1)) the Board notifies
11 a State that its document does not provide for im-
12 plementation of a State system that meets the appli-
13 cable requirements of subtitle C, the Board shall
14 provide the State with a period of 30 days in which
15 to submit such additional information and assur-
16 ances as the Board may require.

17 (2) DEADLINE FOR RESPONSE.—Not later than
18 30 days after receiving such additional information
19 and assurances, the Board shall make a determina-
20 tion (and notify the State) on whether the State’s
21 document provides for implementation of a State
22 system that meets the applicable requirements of
23 subtitle C.

24 (3) PLAN DEEMED APPROVED.—If the Board
25 does not meet the deadline established under para-

1 graph (2) with respect to a State, the Board shall
2 be deemed to have approved the State's document
3 for purposes of this Act.

4 (e) APPROVAL OF PREVIOUSLY TERMINATED
5 STATES.—If the Board has approved a State system
6 under this part for a year but subsequently terminated
7 the approval of the system under section 1512(b)(2), the
8 Board shall approve the system for a succeeding year if
9 the State—

10 (1) demonstrates to the satisfaction of the
11 Board that the failure that formed the basis for the
12 termination no longer exists, and

13 (2) provides reasonable assurances that the
14 types of actions (or inactions) which formed the
15 basis for such termination will not recur.

16 (f) REVISIONS TO STATE SYSTEM.—

17 (1) SUBMISSION.—A State may revise a system
18 approved for a year under this section, except that
19 such revision shall not take effect unless the State
20 has submitted to the Board a document describing
21 such revision and the Board has approved such revision.
22

23 (2) ACTIONS ON AMENDMENTS.—Not later than
24 60 days after a document is submitted under paragraph (1), the Board shall make a determination
25

1 (and notify the State) on whether the implementa-
2 tion of the State system, as proposed to be revised,
3 meets the applicable requirements of subtitle C. If
4 the Board fails to meet the requirement of the pre-
5 ceding sentence, the Board shall be deemed to have
6 approved the implementation of the State system as
7 proposed to be revised.

8 (3) REJECTION OF AMENDMENTS.—Subsection
9 (d) shall apply to an amendment submitted under
10 this subsection in the same manner as it applies to
11 a completed document submitted under subsection
12 (b).

13 (g) NOTIFICATION OF NON-PARTICIPATING
14 STATES.—If a State fails to submit a document for a
15 State system by the deadline referred to in section 1200,
16 or such a document is not approved under subsection (c),
17 the Board shall immediately notify the Secretary of Health
18 and Human Services of the State’s failure for purposes
19 of applying subpart C in that State.

20 **SEC. 1512. FAILURE OF PARTICIPATING STATES TO MEET**
21 **CONDITIONS FOR COMPLIANCE.**

22 (a) IN GENERAL.—In the case of a participating
23 State, if the Board determines that the operation of the
24 State system under subtitle C fails to meet the applicable

1 requirements of this Act, sanctions shall apply against the
2 State in accordance with subsection (b).

3 (b) TYPE OF SANCTION APPLICABLE.—The sanctions
4 applicable under this part are as follows:

5 (1) If the Board determines that the State's
6 failure does not substantially jeopardize the ability
7 of eligible individuals in the State to obtain coverage
8 for the comprehensive benefit package—

9 (A) the Board may order a regional alli-
10 ance in the State to comply with applicable re-
11 quirements of this Act and take such additional
12 measures to assure compliance with such re-
13 quirements as the Board may impose, if the
14 Board determines that the State's failure re-
15 lates to a requirement applicable to a regional
16 alliance in the State, or

17 (B) if the Board does not take the action
18 described in subparagraph (A) (or if the Board
19 takes the action and determines that the action
20 has not remedied the violation that led to the
21 imposition of the sanction), the Board shall no-
22 tify the Secretary of Health and Human Serv-
23 ices, who shall reduce payments with respect to
24 the State in accordance with section 1513.

1 (2) If the Board determines that the failure
2 substantially jeopardizes the ability of eligible indi-
3 viduals in the State to obtain coverage for the com-
4 prehensive benefit package—

5 (A) the Board shall terminate its approval
6 of the State system; and

7 (B) the Board shall notify the Secretary of
8 Health and Human Services, who shall assume
9 the responsibilities described in section 1522.

10 (c) TERMINATION OF SANCTION.—

11 (1) COMPLIANCE BY STATE.—A State against
12 which a sanction is imposed may submit information
13 at any time to the Board to demonstrate that the
14 failure that led to the imposition of the sanction has
15 been corrected.

16 (2) TERMINATION OF SANCTION.—If the Board
17 determines that the failure that led to the imposition
18 of a sanction has been corrected—

19 (A) in the case of the sanction described in
20 subsection (b)(1)(A), the Board shall notify the
21 regional alliance against which the sanction is
22 imposed; or

23 (B) in the case of any other sanction de-
24 scribed in subsection (b), the Board shall notify
25 the Secretary of Health and Human Services.

1 (d) PROTECTION OF ACCESS TO BENEFITS.—The
2 Board and the Secretary of Health and Human Services
3 shall exercise authority to take actions under this section
4 with respect to a State only in a manner that assures the
5 continuous coverage of eligible individuals under regional
6 alliance health plans.

7 **SEC. 1513. REDUCTION IN PAYMENTS FOR HEALTH PRO-**
8 **GRAMS BY SECRETARY OF HEALTH AND**
9 **HUMAN SERVICES.**

10 (a) IN GENERAL.—Upon receiving notice from the
11 Board under section 1512(b)(1)(B), the Secretary of
12 Health and Human Services shall reduce the amount of
13 any of the payments described in subsection (b) that would
14 otherwise be made to individuals and entities in the State
15 by such amount as the Secretary determines to be appro-
16 priate.

17 (b) PAYMENTS DESCRIBED.—The payments de-
18 scribed in this subsection are as follows:

19 (1) Payments to academic health centers in the
20 State under subtitle B of title III.

21 (2) Payments to individuals and entities in the
22 State for health research activities under section 301
23 and title IV of the Public Health Service Act.

1 (3) Payments to hospitals in the State under
2 part 4 of subtitle E of title III (relating to payments
3 to hospitals serving vulnerable populations)

4 **SEC. 1514. REVIEW OF FEDERAL DETERMINATIONS.**

5 Any State or alliance affected by a determination by
6 the Board under this subpart may appeal such determina-
7 tion in accordance with section 5231.

8 **SEC. 1515. FEDERAL SUPPORT FOR STATE IMPLEMENTA-**
9 **TION.**

10 (a) PLANNING GRANTS.—

11 (1) IN GENERAL.—Not later than 90 days after
12 the date of the enactment of this Act, the Secretary
13 shall make available to each State a planning grant
14 to assist a State in the development of a health care
15 system to become a participating State under sub-
16 title C.

17 (2) FORMULA.—The Secretary shall establish a
18 formula for the distribution of funds made available
19 under this subsection.

20 (3) AUTHORIZATION OF APPROPRIATIONS.—
21 There are authorized to be appropriated
22 \$50,000,000 in each of fiscal years 1995 and 1996
23 for grants under this subsection.

24 (b) GRANTS FOR START-UP SUPPORT.—

(1) IN GENERAL.—The Secretary shall make available to States, upon their enacting enabling legislation to become participating States, grants to assist in the establishment of regional alliances.

(2) FORMULA.—The Secretary shall establish a formula for the distribution of funds made available under this subsection.

(3) STATE MATCHING FUNDS REQUIRED.—

Funds are payable to a State under this subsection only if the State provides assurances, satisfactory to the Secretary, that amounts of State funds (at least equal to the amount made available under this subsection) are expended for the purposes described in paragraph (1).

(4) AUTHORIZATION OF APPROPRIATIONS.—

There are authorized to be appropriated \$313,000,000 for fiscal year 1996, \$625,000,000 for fiscal year 1997, and \$313,000,000 for fiscal year 1998 for grants under this subsection.

20 **Subpart C—Responsibilities in Absence of State**
21 **Systems**

22 SEC. 1521. APPLICATION OF SUBPART.

23 (a) INITIAL APPLICATION.—This subpart shall apply
24 with respect to a State as of January 1, 1998, unless—

1 (1) the State submits a document for a State
2 system under section 1511(a)(1) by July 1, 1997,
3 and

4 (2) the Board determines under section 1511
5 that such system meets the requirements of part 1
6 of subtitle C.

7 (b) TERMINATION OF APPROVAL OF SYSTEM OF PAR-
8 TICIPATING STATE.—In the case of a participating State
9 for which the Board terminates approval of the State sys-
10 tem under section 1512(b)(2), this subpart shall apply
11 with respect to the State as of such date as is appropriate
12 to assure the continuity of coverage for the comprehensive
13 benefit package for eligible individuals in the State.

14 **SEC. 1522. FEDERAL ASSUMPTION OF RESPONSIBILITIES IN**
15 **NON-PARTICIPATING STATES.**

16 (a) NOTICE.—When the Board determines that this
17 subpart will apply to a State for a calendar year, the
18 Board shall notify the Secretary of Health and Human
19 Services.

20 (b) ESTABLISHMENT OF REGIONAL ALLIANCE SYS-
21 TEM.—Upon receiving notice under subsection (a), the
22 Secretary shall take such steps, including the establish-
23 ment of regional alliances, and compliance with other re-
24 quirements applicable to participating States under sub-
25 title C, as are necessary to ensure that the comprehensive

1 benefit package is provided to eligible individuals in the
2 State during the year.

3 (c) REQUIREMENTS FOR ALLIANCES.—Subject to
4 section 1523, any regional alliance established by the Sec-
5 retary pursuant to this section must meet all the require-
6 ments applicable under subtitle D to a regional alliance
7 established and operated by a participating State, and the
8 Secretary shall have the authority to fulfill all the func-
9 tions of such an alliance.

10 (d) ESTABLISHMENT OF GUARANTY FUND.—

11 (1) ESTABLISHMENT.—The Secretary must en-
12 sure that there is a guaranty fund that meets the re-
13 quirements established by the Board under section
14 1552, in order to provide financial protection to
15 health care providers and others in the case of a fail-
16 ure of a regional alliance health plan under a re-
17 gional alliance established and operated by the Sec-
18 retary under this section.

19 (2) ASSESSMENTS TO PROVIDE GUARANTY
20 FUNDS.—In the case of a failure of one or more re-
21 gional alliance health plans under a regional alliance
22 established and operated by the Secretary under this
23 section, the Secretary may require each regional alli-
24 ance health plan under the alliance to pay an assess-
25 ment to the Secretary in an amount not to exceed

1 2 percent of the premiums of such plans paid by or
2 on behalf of regional alliance eligible individuals dur-
3 ing a year for so long as necessary to generate suffi-
4 cient revenue to cover any outstanding claims
5 against the failed plan.

6 **SEC. 1523. IMPOSITION OF SURCHARGE ON PREMIUMS**
7 **UNDER FEDERALLY-OPERATED SYSTEM.**

8 (a) IN GENERAL.—If this subpart applies to a State
9 for a calendar year, the premiums charged under the re-
10 gional alliance established and operated by the Secretary
11 in the State shall be equal to premiums that would other-
12 wise be charged under a regional alliance established and
13 operated by the State, increased by 15 percent. Such 15
14 percent increase shall be used to reimburse the Secretary
15 for any administrative or other expenses incurred as a re-
16 sult of establishing and operating the system.

17 (b) TREATMENT OF SURCHARGE AS PART OF PRE-
18 MIUM.—For purposes of determining the compliance of a
19 State for which this subpart applies in a year with the
20 requirements for budgeting under subtitle A of title VI
21 for the year, the 15 percent increase described in sub-
22 section (a) shall be treated as part of the premium for
23 payment to a regional alliance.

1 **SEC. 1524. RETURN TO STATE OPERATION.**

2 (a) APPLICATION PROCESS.—After the establishment
3 and operation of an alliance system by the Secretary in
4 a State under section 1522, the State may at any time
5 apply to the Board for the approval of a State system in
6 accordance with the procedures described in section 1511.

7 (b) TIMING.—If the Board approves the system of a
8 State for which the Secretary has operated an alliance sys-
9 tem during a year, the Secretary shall terminate the oper-
10 ation of the system, and the State shall establish and oper-
11 ate its approved system, as of January 1 of the first year
12 beginning after the Board approves the State system. The
13 termination of the Secretary’s system and the operation
14 of the State’s system shall be conducted in a manner that
15 assures the continuous coverage of eligible individuals in
16 the State under regional alliance health plans.

17 **Subpart D—Establishment of Class Factors for**
18 **Charging Premiums**

19 **SEC. 1531. PREMIUM CLASS FACTORS.**

20 (a) IN GENERAL.—For each class of family enroll-
21 ment (as specified in section 1011(c)), for purposes of title
22 VI, the Board shall establish a premium class factor that
23 reflects, subject to subsection (b), the relative actuarial
24 value of the comprehensive benefit package of the class
25 of family enrollment compared to such value of such pack-
26 age for individual enrollment.

1 (b) CONDITIONS.—In establishing such factors, the
2 factor for the class of individual enrollment shall be 1 and
3 the factor for the couple-only class of family enrollment
4 shall be 2.

5 **Subpart E—Risk Adjustment and Reinsurance**

6 **Methodology for Payment of Plans**

7 **SEC. 1541. DEVELOPMENT OF A RISK ADJUSTMENT AND RE-**
8 **INSURANCE METHODOLOGY.**

9 (a) DEVELOPMENT.—

10 (1) INITIAL DEVELOPMENT.—Not later than
11 April 1, 1995, the Board shall develop a risk adjust-
12 ment and reinsurance methodology in accordance
13 with this subpart.

14 (2) IMPROVEMENTS.—The Board shall make
15 such improvements in such methodology as may be
16 appropriate to achieve the purposes described in sub-
17 section (b)(1).

18 (b) METHODOLOGY.—

19 (1) PURPOSES.—Such methodology shall pro-
20 vide for the adjustment of payments to regional alli-
21 ance health plans for the purposes of—

22 (A) assuring that payments to such plans
23 reflect the expected relative utilization and ex-
24 penditures for such services by each plan's en-
25 rollees compared to the average utilization and

1 expenditures for regional alliance eligible indi-
2 viduals, and

3 (B) protecting health plans that enroll a
4 disproportionate share of regional alliance eligi-
5 ble individuals with respect to whom expected
6 utilization of health care services (included in
7 the comprehensive benefit package) and ex-
8 pected health care expenditures for such serv-
9 ices are greater than the average level of such
10 utilization and expenditures for regional alliance
11 eligible individuals.

12 (2) FACTORS TO BE CONSIDERED.—In devel-
13 oping such methodology, the Board shall take into
14 account the following factors:

15 (A) Demographic characteristics.

16 (B) Health status.

17 (C) Geographic area of residence.

18 (D) Socio-economic status.

19 (E) Subject to paragraph (5), (i) the pro-
20 portion of enrollees who are SSI recipients and
21 (ii) the proportion of enrollees who are AFDC
22 recipients.

23 (F) Any other factors determined by the
24 Board to be material to the purposes described
25 in paragraph (1).

1 (3) ZERO SUM.—The methodology shall assure
2 that the total payments to health plans by the re-
3 gional alliance after application of the methodology
4 are the same as the amount of payments that would
5 have been made without application of the method-
6 ology.

7 (4) PROSPECTIVE ADJUSTMENT OF PAY-
8 MENTS.—The methodology, to the extent possible
9 and except in the case of a mandatory reinsurance
10 system described in subsection (c), shall be applied
11 in a manner that provides for the prospective adjust-
12 ment of payments to health plans.

13 (5) TREATMENT OF SSI/AFDC ADJUSTMENT.—
14 The Board is not required to apply the factor de-
15 scribed in clause (i) or (ii) of paragraph (2)(E) if
16 the Board determines that the application of the
17 other risk adjustment factors described in paragraph
18 (2) is sufficient to adjust premiums to take into ac-
19 count the enrollment in plans of AFDC recipients
20 and SSI recipients.

21 (6) SPECIAL CONSIDERATION FOR MENTAL ILL-
22 NESS.—In developing the methodology under this
23 section, the Board shall give consideration to the
24 unique problems of adjusting payments to health
25 plans with respect to individuals with mental illness.

1 (7) SPECIAL CONSIDERATION FOR VETERANS,
2 MILITARY, AND INDIAN HEALTH PLANS.—In devel-
3 oping the methodology under this section, the Board
4 shall give consideration to the special enrollment and
5 funding provisions relating to plans described in sec-
6 tion 1004(b).

7 (8) ADJUSTMENT TO ACCOUNT FOR USE OF ES-
8 TIMATES.—Subject to section 1361(b)(3) (relating
9 to establishment of regional alliance reserve funds),
10 if the total payments made by a regional alliance to
11 all regional alliance health plans in a year under sec-
12 tion 1351(b) exceeds, or is less than, the total of
13 such payments estimated by the alliance in the ap-
14 plication of the methodology under this subsection,
15 because of a difference between—

16 (A) the alliance’s estimate of the distribu-
17 tion of enrolled families in different risk cat-
18 egories (assumed in the application of risk fac-
19 tors under this subsection in making payments
20 to regional alliance health plans), and

21 (B) the actual distribution of such enrolled
22 families in such categories,
23 the methodology under this subsection shall provide
24 for an adjustment in the application of such method-
25 ology in the second succeeding year in a manner

1 that would reduce, or increase, respectively, by the
2 amount of such excess (or deficit) the total of such
3 payments made by the alliance to all such plans.

4 (c) MANDATORY REINSURANCE.—

5 (1) IN GENERAL.—The methodology developed
6 under this section may include a system of manda-
7 tory reinsurance, but may not include a system of
8 voluntary reinsurance.

9 (2) REQUIREMENT IN CERTAIN CASES.—If the
10 Board determines that an adequate system of pro-
11 spective adjustment of payments to health plans to
12 account for the health status of individuals enrolled
13 by regional alliance health plans cannot be developed
14 (and ready for implementation) by the date specified
15 in subsection (a)(1), the Board shall include a man-
16 datory reinsurance system as a component of the
17 methodology. The Board may thereafter reduce or
18 eliminate such a system at such time as the Board
19 determines that an adequate prospective payment
20 adjustment for health status has been developed and
21 is ready for implementation.

22 (3) REINSURANCE SYSTEM.—The Board, in de-
23 veloping the methodology for a mandatory reinsur-
24 ance system under this subsection, shall—

1 (A) provide for health plans to make pay-
2 ments to state-established reinsurance programs
3 for the purpose of reinsuring part or all of the
4 health care expenses for items and services in-
5 cluded in the comprehensive benefit package for
6 specified classes of high-cost enrollees or speci-
7 fied high-cost treatments or diagnoses; and

8 (B) specify the manner of creation, struc-
9 ture, and operation of the system in each State,
10 including—

11 (i) the manner (which may be pro-
12 spective or retrospective) in which health
13 plans make payments to the system, and

14 (ii) the type and level of reinsurance
15 coverage provided by the system.

16 (d) CONFIDENTIALITY OF INFORMATION.—The
17 methodology shall be developed in a manner consistent
18 with privacy standards promulgated under section
19 5120(a). In developing such standards, the Board shall
20 take into account any potential need of alliances for cer-
21 tain individually identifiable health information in order
22 to carry out risk-adjustment and reinsurance activities
23 under this Act, but only to the minimum extent necessary
24 to carry out such activities and with protections provided

1 to minimize the identification of the individuals to whom
2 the information relates.

3 **SEC. 1542. INCENTIVES TO ENROLL DISADVANTAGED**
4 **GROUPS.**

5 The Board shall establish standards under which
6 States may provide (under section 1203(e)(3)) for an ad-
7 justment in the risk-adjustment methodology developed
8 under section 1541 in order to provide a financial incen-
9 tive for regional alliance health plans to enroll individuals
10 who are members of disadvantaged groups.

11 **SEC. 1543. ADVISORY COMMITTEE.**

12 (a) IN GENERAL.—The Board shall establish an advi-
13 sory committee to provide technical advice and rec-
14 ommendations regarding the development and modifica-
15 tion of the risk adjustment and reinsurance methodology
16 developed under this subpart.

17 (b) COMPOSITION.—Such advisory committee shall
18 consist of 15 individuals and shall include individuals who
19 are representative of health plans, regional alliances, con-
20 sumers, experts, employers, and health providers.

21 **SEC. 1544. RESEARCH AND DEMONSTRATIONS.**

22 The Secretary shall conduct and support research
23 and demonstration projects to develop and improve, on a
24 continuing basis, the risk adjustment and reinsurance
25 methodology under this subpart.

1 **SEC. 1545. TECHNICAL ASSISTANCE TO STATES AND ALLI-**
2 **ANCES.**

3 The Board shall provide technical assistance to
4 States and regional alliances in implementing the method-
5 ology developed under this subpart.

6 **Subpart F—Responsibilities for Financial**
7 **Requirements**

8 **SEC. 1551. CAPITAL STANDARDS FOR REGIONAL ALLIANCE**
9 **HEALTH PLAN.**

10 (a) IN GENERAL.—The Board shall establish, in con-
11 sultation with the States, minimum capital requirements
12 for regional alliance health plans, for purposes of section
13 1204(a).

14 (b) \$500,000 MINIMUM.—Subject to subsection (c),
15 under such requirements there shall be not less than
16 \$500,000 of capital maintained for each plan offered in
17 each alliance area, regardless of whether or not the same
18 sponsor offered more than one of such plans.

19 (c) ADDITIONAL CAPITAL REQUIREMENTS.—The
20 Board may require additional capital for factors likely to
21 affect the financial stability of health plans, including the
22 following:

23 (1) Projected plan enrollment and number of
24 providers participating in the plan.

25 (2) Market share and strength of competition.

1 (3) Extent and nature of risk-sharing with par-
2 ticipating providers and the financial stability of
3 risk-sharing providers.

4 (4) Prior performance of the plan, risk history,
5 and liquidity of assets.

6 (d) DEVELOPMENT OF STANDARDS BY NAIC.—The
7 Board may request the National Association of Insurance
8 Commissioners to develop model standards for the addi-
9 tional capital requirements described in subsection (c) and
10 to present such standards to the Board not later than July
11 1, 1995. The Board may accept such standards as the
12 standards to be applied under subsection (c) or modify the
13 standards in any manner it finds appropriate.

14 **SEC. 1552. STANDARD FOR GUARANTY FUNDS.**

15 (a) IN GENERAL.—In consultation with the States,
16 the Board shall establish standards for guaranty funds es-
17 tablished by States under section 1204(c).

18 (b) GUARANTY FUND STANDARDS.—The standards
19 established under subsection (a) for a guaranty fund shall
20 include the following:

21 (1) Each fund must have a method to generate
22 sufficient resources to pay health providers and oth-
23 ers in the case of a failure of a health plan (as de-
24 scribed in section 1204(d)(4)) in order to meet obli-
25 gations with respect to—

1 (A) services rendered by the health plan
2 for the comprehensive benefit package, includ-
3 ing any supplemental coverage for cost sharing
4 provided by the health plan, and

5 (B) services rendered prior to health plan
6 insolvency and services to patients after the in-
7 solveny but prior to their enrollment in other
8 health plans.

9 (2) The fund is liable for all claims against the
10 plan by health care providers with respect to their
11 provision of items and services covered under the
12 comprehensive benefit package to enrollees of the
13 failed plan. Such claims, in full, shall take priority
14 over all other claims. The fund also is liable, to the
15 extent and in the manner provided in accordance
16 with rules established by the Board, for other
17 claims, including other claims of such providers and
18 the claims of contractors, employees, governments,
19 or any other claimants.

20 (3) The fund stands as a creditor for any pay-
21 ments owed the plan to the extent of the payments
22 made by the fund for obligations of the plan.

23 (4) The fund has authority to borrow against
24 future assessments (payable under section

1 1204(c)(2)) in order to meet the obligations of failed
2 plans participating in the fund.

3 **PART 2—RESPONSIBILITIES OF DEPARTMENT OF**
4 **HEALTH AND HUMAN SERVICES**

5 **Subpart A—General Responsibilities**

6 **SEC. 1571. GENERAL RESPONSIBILITIES OF SECRETARY OF**
7 **HEALTH AND HUMAN SERVICES.**

8 (a) IN GENERAL.—Except as otherwise specifically
9 provided under this Act (or with respect to administration
10 of provisions in the Internal Revenue Code of 1986 or in
11 the Employee Retirement Income Security Act of 1974),
12 the Secretary of Health and Human Services shall admin-
13 ister and implement all of the provisions of this Act, except
14 those duties delegated to the National Health Board, any
15 other executive agency, or to any State.

16 (b) FINANCIAL MANAGEMENT STANDARDS.—The
17 Secretary, in consultation with the Secretaries of Labor
18 and the Treasury, shall establish, for purposes of section
19 1361, standards relating to the management of finances,
20 maintenance of records, accounting practices, auditing
21 procedures, and financial reporting for health alliances.
22 Such standards shall take into account current Federal
23 laws and regulations relating to fiduciary responsibilities
24 and financial management of funds.

1 (c) AUDITING REGIONAL ALLIANCE PERFORM-
2 ANCE.—The Secretary shall perform periodic financial and
3 other audits of regional alliances to assure that such alli-
4 ances are carrying out their responsibilities under this Act
5 consistent with this Act. Such audits shall include audits
6 of alliance performance in the areas of—

7 (1) assuring enrollment of all regional alliance
8 eligible individuals in health plans,

9 (2) management of premium and cost sharing
10 discounts and reductions provided; and

11 (3) financial management of the alliance, in-
12 cluding allocation of collection shortfalls.

13 **SEC. 1572. ADVISORY COUNCIL ON BREAKTHROUGH**
14 **DRUGS.**

15 (a) IN GENERAL.—The Secretary shall appoint an
16 Advisory Council on Breakthrough Drugs (in this section
17 referred to as the “Council”) that will examine the reason-
18 ableness of launch prices of new drugs that represent a
19 breakthrough or significant advance over existing thera-
20 pies.

21 (b) DUTIES.—(1) At the request of the Secretary, or
22 a member of the Council, the Council shall make a deter-
23 mination regarding the reasonableness of launch prices of
24 a breakthrough drug. Such a determination shall be based
25 on—

1 (A) prices of other drugs in the same thera-
2 peutic class;

3 (B) cost information supplied by the manufac-
4 turer;

5 (C) prices of the drug in countries specified in
6 section 802(b)(4)(A) of the Federal Food, Drug, and
7 Cosmetic Act;

8 (D) projected prescription volume, economies of
9 scale, product stability, special manufacturing re-
10 quirements and research costs;

11 (E) cost effectiveness relative to the cost of al-
12 ternative course of treatment options, including non-
13 pharmacological medical interventions; and

14 (F) improvements in quality of life offered by
15 the new product, including ability to return to work,
16 ability to perform activities of daily living, freedom
17 from attached medical devices, and other appro-
18 priate measurements of quality of life improvements.

19 (2) The Secretary shall review the determinations of
20 the Council and publish the results of such review along
21 with the Council's determination (including minority opin-
22 ions) as a notice in the Federal Register.

23 (c) MEMBERSHIP.—The Council shall consist of a
24 chair and 12 other persons, appointed without regard to
25 the provisions of title 5, United States Code, governing

1 appointments in the competitive service. The Council shall
2 include a representative from the pharmaceutical industry,
3 consumer organizations, physician organizations, the hos-
4 pital industry, and the managed care industry. Other indi-
5 viduals appointed by the Secretary shall be recognized ex-
6 perts in the fields of health care economics, pharmacology,
7 pharmacy, and prescription drug reimbursement. Only one
8 member of the Council may have direct or indirect finan-
9 cial ties to the pharmaceutical industry.

10 (d) TERM OF APPOINTMENTS.—Appointments shall
11 be for a term of 3 years, except that the Secretary may
12 provide initially for such shorter terms as will ensure that
13 the terms of not more than 5 members expire in any one
14 year.

15 (e) COMPENSATION.—Members of the Council shall
16 be entitled to receive reimbursement of expenses and per
17 diem in lieu of subsistence in the same manner as other
18 members of advisory councils appointed by the Secretary
19 are provided such reimbursements under the Social Secu-
20 rity Act.

21 (f) NO TERMINATION.—Notwithstanding the provi-
22 sions of the Federal Advisory Committee Act, the Council
23 shall continue in existence until otherwise specified in law.

1 **Subpart B—Certification of Essential Community**
2 **Providers**

3 **SEC. 1581. CERTIFICATION.**

4 (a) IN GENERAL.—For purposes of this Act, the Sec-
5 retary shall certify as an “essential community provider”
6 any health care provider or organization that—

7 (1) is within any of the categories of providers
8 and organizations specified in section 1582(a), or

9 (2) meets the standards for certification under
10 section 1583(a).

11 (b) TIMELY ESTABLISHMENT OF PROCESS.—The
12 Secretary shall take such actions as may be necessary to
13 permit health care providers and organizations to be cer-
14 tified as essential community providers in a State before
15 the beginning of the first year for the State.

16 **SEC. 1582. CATEGORIES OF PROVIDERS AUTOMATICALLY**
17 **CERTIFIED.**

18 (a) IN GENERAL.—The categories of providers and
19 organizations specified in this subsection are as follows:

20 (1) MIGRANT HEALTH CENTERS.—A recipient
21 or subrecipient of a grant under section 329 of the
22 Public Health Service Act.

23 (2) COMMUNITY HEALTH CENTERS.—A recipi-
24 ent or subrecipient of a grant under section 330 of
25 the Public Health Service Act.

1 (3) HOMELESS PROGRAM PROVIDERS.—A re-
2 recipient or subrecipient of a grant under section 340
3 of the Public Health Service Act.

4 (4) PUBLIC HOUSING PROVIDERS.—A recipient
5 or subrecipient of a grant under section 340A of the
6 Public Health Service Act.

7 (5) FAMILY PLANNING CLINICS.—A recipient or
8 subrecipient of a grant under title X of the Public
9 Health Service Act.

10 (6) INDIAN HEALTH PROGRAMS.—A service unit
11 of the Indian Health Service, a tribal organization,
12 or an urban Indian program, as defined in the In-
13 dian Health Care Improvement Act.

14 (7) AIDS PROVIDERS UNDER RYAN WHITE
15 ACT.—A public or private nonprofit health care pro-
16 vider that is a recipient or subrecipient of a grant
17 under title XXVI of the Public Health Service Act.

18 (8) MATERNAL AND CHILD HEALTH PRO-
19 VIDERS.—A public or private nonprofit entity that
20 provides prenatal care, pediatric care, or ambulatory
21 services to children, including children with special
22 health care needs, and that receives funding for such
23 care or services under title V of the Social Security
24 Act.

1 (9) FEDERALLY QUALIFIED HEALTH CENTER;
2 RURAL HEALTH CLINIC.—A Federally-qualified
3 health center or a rural health clinic (as such terms
4 are defined in section 1861(aa) of the Social Secu-
5 rity Act).

6 (10) PROVIDER OF SCHOOL HEALTH SERV-
7 ICES.—A provider of school health services that re-
8 ceives funding for such services under subtitle G of
9 title III.

10 (11) COMMUNITY PRACTICE NETWORK.—A
11 qualified community practice network receiving de-
12 velopment funds under subtitle E of title III.

13 (b) SUBRECIPIENT DEFINED.—In this subpart, the
14 term “subrecipient” means, with respect to a recipient of
15 a grant under a particular authority, an entity that—

16 (1) is receiving funding from such a grant
17 under a contract with the principal recipient of such
18 a grant, and

19 (2) meets the requirements established to be a
20 recipient of such a grant.

21 (c) HEALTH PROFESSIONAL DEFINED.—In this sub-
22 part, the term “health professional” means a physician,
23 nurse, nurse practitioner, certified nurse midwife, physi-
24 cian assistant, psychologist, dentist, pharmacist, and other
25 health care professional recognized by the Secretary.

1 **SEC. 1583. STANDARDS FOR ADDITIONAL PROVIDERS.**

2 (a) STANDARDS.—The Secretary shall publish stand-
3 ards for the certification of additional categories of health
4 care providers and organizations as essential community
5 providers, including the categories described in subsection
6 (b). Such a health care provider or organization shall not
7 be certified unless the Secretary determines, under such
8 standards, that health plans operating in the area served
9 by the applicant would not otherwise be able to assure ade-
10 quate access to items and services included in the com-
11 prehensive benefit package if such a provider was not so
12 certified.

13 (b) CATEGORIES TO BE INCLUDED.—The categories
14 described in this subsection are as follows:

15 (1) HEALTH PROFESSIONALS.—Health
16 professionals—

17 (A) located in an area designated as a
18 health professional shortage area (under section
19 332 of the Public Health Service Act), or

20 (B) providing a substantial amount of
21 health services (as determined in accordance
22 with standards established by the Secretary) to
23 a medically underserved population (as des-
24 ignated under section 330 of such Act).

25 (2) INSTITUTIONAL PROVIDERS.—Public and
26 private nonprofit hospitals and other institutional

1 health care providers located in such an area or pro-
2 viding health services to such a population.

3 (3) OTHER PROVIDERS.—Other public and pri-
4 vate nonprofit agencies and organizations that—

5 (A) are located in such an area or pro-
6 viding health services to such a population, and

7 (B) provide health care and services essen-
8 tial to residents of such an area or such popu-
9 lations.

10 **SEC. 1584. CERTIFICATION PROCESS; REVIEW; TERMI-**
11 **NATION OF CERTIFICATIONS.**

12 (a) CERTIFICATION PROCESS.—

13 (1) PUBLICATION OF PROCEDURES.—The Sec-
14 retary shall publish, not later than 6 months after
15 the date of the enactment of this Act, the procedures
16 to be used by health care professionals, providers,
17 agencies, and organizations seeking certification
18 under this subpart, including the form and manner
19 in which an application for such certification is to be
20 made.

21 (2) TIMELY DETERMINATION.—The Secretary
22 shall make a determination upon such an application
23 not later than 60 days (or 15 days in the case of
24 a certification for an entity described in section
25 1582) after the date the complete application has

1 been submitted. The determination on an application
2 for certification of an entity described in section
3 1582 shall only involve the verification that the enti-
4 ty is an entity described in such section.

5 (b) REVIEW OF CERTIFICATIONS.—The Secretary
6 shall periodically review whether professionals, providers,
7 agencies, and organizations certified under this subpart
8 continue to meet the requirements for such certification.

9 (c) TERMINATION OR DENIAL OF CERTIFICATION.—

10 (1) PRELIMINARY FINDING.—If the Secretary
11 preliminarily finds that an entity seeking certifi-
12 cation under this section does not meet the require-
13 ments for such certification or such an entity cer-
14 tified under this subpart fails to continue to meet
15 the requirements for such certification, the Secretary
16 shall notify the entity of such preliminary finding
17 and permit the entity an opportunity, under subtitle
18 C of title V, to rebut such findings.

19 (2) FINAL DETERMINATION.—If, after such op-
20 portunity, the Secretary continues to find that such
21 an entity continues to fail to meet such require-
22 ments, the Secretary shall terminate the certification
23 and shall notify the entity, regional alliances, and
24 corporate alliances of such termination and the ef-
25 fective date of the termination.

1 **SEC. 1585. NOTIFICATION OF HEALTH ALLIANCES AND PAR-**
2 **TICIPATING STATES.**

3 (a) IN GENERAL.—Not less often than annually the
4 Secretary shall notify each participating State and each
5 health alliance of essential community providers that have
6 been certified under this subpart.

7 (b) CONTENTS.—Such notice shall include sufficient
8 information to permit each health alliance to notify health
9 plans of the identify of each entity certified as an essential
10 community provider, including—

11 (1) the location of the provider within each
12 plan's service area,

13 (2) the health services furnished by the pro-
14 vider, and

15 (3) other information necessary for health plans
16 to carry out part 3 of subtitle E.

17 **PART 3—SPECIFIC RESPONSIBILITIES OF**
18 **SECRETARY OF LABOR.**

19 **SEC. 1591. RESPONSIBILITIES OF SECRETARY OF LABOR.**

20 (a) IN GENERAL.—The Secretary of Labor is
21 responsible—

22 (1) under subtitle G, for the enforcement of re-
23 quirements applicable to employers under regional
24 alliances (including requirements relating to pay-
25 ment of premiums) and the administration of cor-
26 porate alliances;

1 (2) under subtitle D, with respect to elections
2 by eligible sponsors to become corporate alliances
3 and the termination of such elections;

4 (3) under section 1395, for the temporary as-
5 sumption of the operation of self-insured corporate
6 alliance health plans that are insolvent;

7 (4) under section 1396, for the establishment
8 and administration of Corporate Alliance Health
9 Plan Insolvency Fund;

10 (5) for carrying out any other responsibilities
11 assigned to the Secretary under this Act; and

12 (6) for administering title I of the Employee
13 Retirement Income Security Act of 1974 as it re-
14 lates to group health plans maintained by corporate
15 alliances.

16 (b) AGREEMENTS WITH STATES.—The Secretary of
17 Labor may enter into agreements with States in order to
18 enforce responsibilities of employers and corporate alli-
19 ances, and requirements of corporate alliance health plans,
20 under subtitle B of title I of the Employee Retirement In-
21 come Security Act of 1974.

22 (c) CONSULTATION WITH BOARD.—In carrying out
23 activities under this Act with respect to corporate alli-
24 ances, corporate alliance health plans, and employers, the

1 Secretary of Labor shall consult with the National Health
2 Board.

3 (d) EMPLOYER-RELATED REQUIREMENTS.—

4 (1) IN GENERAL.—The Secretary of Labor, in
5 consultation with the Secretary, shall be responsible
6 for assuring that employers—

7 (A) make payments of any employer pre-
8 miums (and withhold and make payment of the
9 family share of premiums with respect to quali-
10 fying employees) as required under this Act, in-
11 cluding auditing of regional alliance collection
12 activities with respect to such payments,

13 (B) submit timely reports as required
14 under this Act, and

15 (C) otherwise comply with requirements
16 imposed on employers under this Act.

17 (2) AUDIT AND SIMILAR AUTHORITIES.—The
18 Secretary of Labor—

19 (A) may carry out such audits (directly or
20 through contract) and such investigations of
21 employers and health alliances,

22 (B) may exercise such authorities under
23 section 504 of Employee Retirement Income Se-
24 curity Act of 1974 (in relation to activities
25 under this Act),

1 (C) may, with the permission of the Board,
2 provide (through contract or otherwise) for such
3 collection activities (in relation to amounts owed
4 to regional alliances and for the benefit of such
5 alliances), and

6 (D) may impose such civil penalties under
7 section 1345(d)(1),
8 as may be necessary to carry out such Secretary's
9 responsibilities under this section.

10 (e) **AUTHORITY.**—The Secretary of Labor is author-
11 ized to issue such regulations as may be necessary to carry
12 out section 1607 and responsibilities of the Secretary
13 under this Act (including under title XI).

14 **Subtitle G—Employer**
15 **Responsibilities**

16 **SEC. 1601. PAYMENT REQUIREMENT.**

17 (a) **IN GENERAL.**—Each employer shall provide for
18 payments required under section 6121 or 6131 in accord-
19 ance with the applicable provisions of this Act.

20 (b) **EMPLOYERS IN SINGLE-PAYER STATES.**—In the
21 case of an employer with respect to employees who reside
22 in a single-payer State, the responsibilities of such em-
23 ployer under such system shall supersede the obligations
24 of the employer under subsection (a), except as the Board
25 may provide.

1 (c) EMPLOYERS PARTICIPATING IN REGIONAL ALLI-
2 ANCES THROUGH MULTIEMPLOYER PLANS.—In the case
3 of an employer participating in a multiemployer plan,
4 which plan elects to serve as a regional alliance employer
5 on behalf of its participating employers, the employer's
6 payment obligation under section 6121 shall be deemed
7 satisfied if the employer pays to the multiemployer plan
8 at least the premium payment amount specified in section
9 6121(b) and the plan has assumed legal obligations of
10 such an employer under such section.

11 **SEC. 1602. REQUIREMENT FOR INFORMATION REPORTING.**

12 (a) REPORTING OF END-OF-YEAR INFORMATION TO
13 QUALIFYING EMPLOYEES.—

14 (1) IN GENERAL.—Each employer shall provide
15 to each individual who was a qualifying employee of
16 the employer during any month in the previous year
17 information described in paragraph (2) with respect
18 to the employee.

19 (2) INFORMATION TO BE SUPPLIED.—The in-
20 formation described in this paragraph, with respect
21 to a qualifying employee, is the following (as speci-
22 fied by the Secretary):

23 (A) REGIONAL ALLIANCE INFORMATION.—

24 With respect to each regional alliance through
25 which the individual obtained health coverage:

1 (i) The total number of months of
2 full-time equivalent employment (as deter-
3 mined under section 1901(b)(2)) for each
4 class of enrollment.

5 (ii) The amount of wages attributable
6 to qualified employment and the amount of
7 covered wages (as defined in paragraph
8 (4)).

9 (iii) The total amount deducted from
10 wages and paid for the family share of the
11 premium.

12 (iv) Such other information as the
13 Secretary of Labor may specify.

14 (B) CORPORATE ALLIANCE INFORMA-
15 TION.—With respect to a qualifying employee
16 who obtains coverage through a corporate alli-
17 ance health plan:

18 (i) The total number of months of
19 full-time equivalent employees (as deter-
20 mined under section 1901(b)(2)) for each
21 class of enrollment.

22 (ii) Such other information as the
23 Secretary of Labor may specify.

24 (3) ALLIANCE SPECIFIC INFORMATION.—In the
25 case of a qualifying employee with respect to whom

1 an employer made employer premium payments dur-
2 ing the year to more than one regional alliance, the
3 information under this subsection shall be reported
4 separately with respect to each such alliance.

5 (4) COVERED WAGES DEFINED.—In this sec-
6 tion, the term “covered wages” means wages paid an
7 employee of an employer during a month in which
8 the employee was a qualifying employee of the em-
9 ployer.

10 (b) REPORTING OF INFORMATION FOR USE OF RE-
11 GIONAL ALLIANCES.—

12 (1) IN GENERAL.—Each employer (including
13 corporate alliance employers) shall provide under
14 subsection (f) on behalf of each regional alliance in-
15 formation described in paragraph (2) on an annual
16 basis, information described in paragraph (3) on a
17 monthly basis, and information described in para-
18 graph (4) on a one-time basis, with respect to the
19 employment of qualifying employees in each year,
20 month, or other time, respectively.

21 (2) INFORMATION TO BE SUPPLIED ON AN AN-
22 NUAL BASIS.—The information described in this
23 paragraph, with respect to an employer, is the fol-
24 lowing (as specified by the Secretary of Labor):

1 (A) REGIONAL ALLIANCE INFORMATION.—

2 With respect to each regional alliance to which
3 employer premium payments were payable in
4 the year:

5 (i) For each qualifying employee in
6 the year—

7 (I) The total number of months
8 of full-time equivalent employment (as
9 determined under section 1901(b)(2))
10 for the employee for each class of en-
11 rollment.

12 (II) The total amount deducted
13 from wages and paid for the family
14 share of the premium of the quali-
15 fying employee.

16 (ii) The total employer premium pay-
17 ment made under section 6121 for the
18 year with respect to the employment of all
19 qualifying employees residing in the alli-
20 ance area and, in the case of an employer
21 that has obtained (or seeks to obtain) a
22 premium discount under section 6123, the
23 total employer premium payment that
24 would have been owed for such employ-
25 ment for the year but for such section.

1 (iii) The number of full-time equiva-
2 lent employees (determined under section
3 1901(b)(2)) for each class of family enroll-
4 ment in the year (and for each month in
5 the year in the case of an employer that
6 has obtained or is seeking a premium dis-
7 count under section 6123).

8 (iv) In the case of an employer to
9 which section 6124 applies in a year, such
10 additional information as the Secretary of
11 Labor may require for purposes of that
12 section.

13 (v) The amounts paid (and payable)
14 pursuant to section 6125.

15 (vi) The amount of covered wages for
16 each qualifying employee.

17 (3) INFORMATION ON A MONTHLY BASIS.—

18 (A) IN GENERAL.—The information de-
19 scribed in this paragraph for a month for an
20 employer is such information as the Secretary
21 of Labor may specify regarding—

22 (i) the identity of each eligible indi-
23 vidual who changed qualifying employee
24 status with respect to the employer in the
25 month; and

1 (ii) in the case of such an individual
2 described in subparagraph (B)(i)—

3 (I) the regional alliance for the
4 alliance area in which the individual
5 resides, and

6 (II) the individual's class of fam-
7 ily enrollment.

8 (B) CHANGES IN QUALIFYING EMPLOYEE
9 STATUS DESCRIBED.—For purposes of subpara-
10 graph (A), an individual is considered to have
11 changed qualifying employee status in a month
12 if the individual either (i) is a qualifying em-
13 ployee of the employer in the month and was
14 not a qualifying employee of the employer in
15 the previous month, or (ii) is not a qualifying
16 employee of the employer in the month but was
17 a qualifying employee of the employer in the
18 previous month.

19 (4) INITIAL INFORMATION.—Each employer, at
20 such time before the first year in which qualifying
21 employees of the employer are enrolled in regional
22 alliance health plans as the Board may specify, shall
23 provide for the reporting of such information relat-
24 ing to employment of eligible individuals as the
25 Board may specify.

1 (c) RECONCILIATION OF EMPLOYER PREMIUM PAY-
2 MENTS.—

3 (1) PROVISION OF INFORMATION.—Each em-
4 ployer (whether or not the employer claimed (or
5 claims) an employer premium discount under section
6 6123 for a year) that is liable for employer premium
7 payments to a regional alliance for any month in a
8 year shall provide the alliance with such information
9 as the alliance may require (consistent with rules of
10 the Secretary of Labor) to determine the appropriate
11 amount of employer premium payments that should
12 have been made for all months in the year (taking
13 into account any employer premium discount under
14 section 6123 for the employer).

15 (2) DEADLINE.—Such information shall be pro-
16 vided not later than the beginning of February of
17 the following year with the payment to be made for
18 that month.

19 (3) RECONCILIATION.—

20 (A) CONTINUING EMPLOYERS.—Based on
21 such information, the employer shall adjust the
22 amount of employer premium payment made in
23 the month in which the information is provided
24 to reflect the amount by which the payments in
25 the previous year were greater or less than the

1 amount of payments that should have been
2 made.

3 (B) DISCONTINUING EMPLOYERS.—In the
4 case of a person that ceases to be an employer
5 in a year, such adjustment shall be made in the
6 form of a payment to, or from, the alliance in-
7 volved.

8 (4) SPECIAL TREATMENT OF SELF-EMPLOYED
9 INDIVIDUALS.—Except as the Secretary of Labor
10 may provide, individuals who are employers only by
11 virtue of the operation of section 6126 shall have
12 employer premium payments attributable to such
13 section reconciled (in the manner previously de-
14 scribed in this subsection) under the process for the
15 collection of the family share of premiums under sec-
16 tion 1344 rather than under this subsection.

17 (d) SPECIAL RULES FOR SELF-EMPLOYED.—

18 (1) IN GENERAL.—In the case of an individual
19 who is treated as an employer under section 6126,
20 the individual shall provide, under subsection (f) on
21 behalf of each regional alliance, information de-
22 scribed in paragraph (2) with respect to net earn-
23 ings from self-employment income of the individual
24 in each year.

1 (2) INFORMATION TO BE SUPPLIED.—The in-
2 formation described in this paragraph, with respect
3 to an individual, is such information as may be nec-
4 essary to compute the amount payable under section
5 6131 by virtue of section 6126.

6 (e) FORM.—Information shall be provided under this
7 section in such electronic or other form as the Secretary
8 specifies. Such specifications shall be done in a manner
9 that, to the maximum extent practicable, simplifies admin-
10 istration for small employers.

11 (f) INFORMATION CLEARINGHOUSE FUNCTIONS.—

12 (1) DESIGNATION.—The Board shall provide
13 for the use of the regional centers (which are part
14 of the electronic data network under section 5103)
15 to perform information clearinghouse functions
16 under this section with respect to employers and re-
17 gional and corporate alliances.

18 (2) FUNCTIONS.—The functions referred to in
19 paragraph (1) shall include—

20 (A) receipt of information submitted by
21 employers under subsection (b) on an annual
22 (or one-time) basis,

23 (B) from the information received, trans-
24 mittal of information required to regional alli-
25 ances, and

1 (C) such other functions as the Board
2 specifies.

3 (g) DEADLINE.—Information required to be provided
4 by an employer for a year under this section—

5 (1) to a qualifying employee shall be provided
6 not later than the date the employer is required
7 under law to provide for statements under section
8 6051 of the Internal Revenue Code of 1986 for that
9 year, or

10 (2) to a health alliance (through a regional cen-
11 ter) shall be provided not later than the date by
12 which information is required to be filed with the
13 Secretary pursuant to agreements under section 232
14 of the Social Security Act for that year.

15 (h) NOTICE TO CERTAIN INDIVIDUALS WHO ARE
16 NOT EMPLOYEES.—

17 (1) IN GENERAL.—A person that carries on a
18 trade or business shall notify in writing each indi-
19 vidual described in paragraph (2) that the person is
20 not obligated to make any employer health care pre-
21 mium payment (under section 6121) in relation to
22 the services performed by the individual for the per-
23 son.

24 (2) INDIVIDUAL DESCRIBED.—An individual de-
25 scribed in this paragraph, with respect to a person,

1 is an individual who normally performs services for
2 the person in the person's trade or business for more
3 than 40 hours per month but who is not an em-
4 ployee of the person (within the meaning of section
5 1901(a)).

6 (3) TIMING; EFFECTIVE DATE.—Such notice
7 shall be provided within a reasonable time after the
8 individual begins performing services for the person,
9 except that in no event is such a notice required to
10 be provided with respect to services performed before
11 January 1, 1998.

12 (4) EXCEPTIONS.—The Secretary shall issue
13 regulations providing exceptions to the notice re-
14 quirement of paragraph (1) with respect to individ-
15 uals performing services on an irregular, incidental,
16 or casual basis.

17 (5) MODEL NOTICE.—The Secretary shall pub-
18 lish a model notice that is easily understood by the
19 average reader and that persons may use to satisfy
20 the requirements of paragraph (1).

21 **SEC. 1603. REQUIREMENTS RELATING TO NEW EMPLOYEES.**

22 (a) COMPLETION OF ENROLLMENT INFORMATION
23 FORM.—At the time an individual is hired as a qualifying
24 employee of a regional alliance employer, the employer

1 shall obtain from the individual the following information
2 (pursuant to rules established by the Secretary of Labor):

3 (1) The identity of the individual.

4 (2) The individual's alliance area of residence
5 and whether the individual has moved from another
6 alliance area.

7 (3) The class of family enrollment applicable to
8 the individual.

9 (4) The health plan (and health alliance) in
10 which the individual is enrolled at that time.

11 (5) If the individual has moved from another al-
12 liance area, whether the individual intends to enroll
13 in a regional alliance health plan.

14 (b) TRANSMITTAL OF INFORMATION TO ALLIANCE.—

15 (1) IN GENERAL.—Each employer shall trans-
16 mit the information obtained under subsection (a) to
17 the regional alliance for the alliance area in which
18 the qualifying employee resides (or will reside at the
19 time of initial employment).

20 (2) DEADLINE.—Such information shall be
21 transmitted within 30 days of the date of hiring of
22 the employee.

23 (3) FORM.—Information under this section may
24 be forwarded in electronic form to a regional alli-
25 ance.

1 (c) PROVISION OF ENROLLMENT FORM AND INFOR-
2 MATION.—In the case of an individual described in sub-
3 section (a)(5), the employer shall provide the individual,
4 at the time of hiring, with—

5 (1) such information regarding the choice of,
6 and enrollment in, regional alliance health plans,
7 and

8 (2) such enrollment form,
9 as the regional alliance provides to the employer.

10 **SEC. 1604. AUDITING OF RECORDS.**

11 Each regional alliance employer shall maintain such
12 records, and provide the regional alliance for the area in
13 which the employer maintains the principal place of em-
14 ployment (as specified by the Secretary of Labor) with ac-
15 cess to such records, as may be necessary to verify and
16 audit the information reported under this subtitle.

17 **SEC. 1605. PROHIBITION OF CERTAIN EMPLOYER DISCRIMI-**
18 **NATION.**

19 No employer may discriminate with respect to an em-
20 ployee on the basis of the family status of the employee
21 or on the basis of the class of family enrollment selected
22 with respect to the employee.

1 **SEC. 1606. PROHIBITION ON SELF-FUNDING OF COST SHAR-**
2 **ING BENEFITS BY REGIONAL ALLIANCE EM-**
3 **PLOYERS.**

4 (a) PROHIBITION.—A regional alliance employer (and
5 a corporate alliance employer with respect to employees
6 who are regional alliance eligible individuals) may provide
7 benefits to employees that consist of the benefits included
8 in a cost sharing policy (as defined in section 1421(b)(2))
9 only through a contribution toward the purchase of a cost
10 sharing policy which is funded primarily through insur-
11 ance.

12 (b) INDIVIDUAL AND EMPLOYER RESPONSIBIL-
13 ITIES.—In the case of an individual who resides in a sin-
14 gle-payer State and an employer with respect to employees
15 who reside in such a State, the responsibilities of such in-
16 dividual and employer under such system shall supersede
17 the obligations of the individual and employer under this
18 subtitle.

19 **SEC. 1607. EQUAL VOLUNTARY CONTRIBUTION REQUIRE-**
20 **MENT.**

21 (a) IN GENERAL.—

22 (1) EQUAL VOLUNTARY EMPLOYER PREMIUM
23 PAYMENT REQUIREMENT.—

24 (A) REGIONAL ALLIANCE HEALTH
25 PLANS.—If an employer makes available a vol-
26 untary employer premium payment (as defined

1 in subsection (d)) on behalf of a full-time em-
2 ployee (as defined in section 1901(b)(2)(C))
3 who is enrolled in a regional alliance health
4 plan of a regional alliance in a class of family
5 enrollment, the employer shall make available
6 such a voluntary employer premium payment in
7 the same dollar amount to all qualifying em-
8 ployees (as defined in section 1901(b)(1)) of the
9 employer who are enrolled in any regional alli-
10 ance health plan of the same alliance in the
11 same class of family enrollment.

12 (B) CORPORATE ALLIANCE HEALTH
13 PLANS.—If a corporate alliance employer makes
14 available a voluntary employer premium pay-
15 ment on behalf of a full-time employee who is
16 enrolled in a corporate alliance health plan of a
17 corporate alliance in a class of family enroll-
18 ment in a premium area (designated under sec-
19 tion 1384(b)), the employer shall make avail-
20 able such a voluntary employer premium pay-
21 ment in the same dollar amount to all quali-
22 fying employees of the employer enrolled in any
23 corporate alliance health plan of the same alli-
24 ance in the same class of family enrollment in
25 the same premium area.

1 (C) TREATMENT OF PART-TIME EMPLOY-
2 EES.—In applying subparagraphs (A) and (B)
3 in the case of a qualifying employee employed
4 on a part-time basis (within the meaning of sec-
5 tion 1901(b)(2)(A)(ii)), the dollar amount shall
6 be equal to the full-time employment ratio (as
7 defined in section 1901(b)(2)(B)) multiplied by
8 the dollar amount otherwise required.

9 (2) LIMIT ON VOLUNTARY EMPLOYER PREMIUM
10 PAYMENTS.—

11 (A) REGIONAL ALLIANCE HEALTH
12 PLANS.—An employer may not make available a
13 voluntary employer premium payment on behalf
14 of an employee (enrolled in a regional alliance
15 health plan of a regional alliance in a class of
16 family enrollment) in an amount that exceeds
17 the maximum amount that could be payable as
18 the family share of premium (described in sec-
19 tion 6101(b)(2)) for the most expensive regional
20 alliance health plan of the same alliance for the
21 same class of family enrollment.

22 (B) CORPORATE ALLIANCE HEALTH
23 PLANS.—An employer may not make available a
24 voluntary employer premium payment on behalf
25 of an employee (enrolled in a corporate alliance

1 health plan of a corporate alliance in a class of
2 family enrollment in a premium area, des-
3 ignated under section 1384) in an amount that
4 exceeds the maximum amount that could be
5 payable as the family share of premium (de-
6 scribed in section 6101(b)(3)) for the most ex-
7 pensive corporate alliance health plan of the
8 same alliance for the same class of family en-
9 rollment in the same premium area.

10 (C) EXCLUSION OF PLANS WITHOUT MA-
11 TERIAL ENROLLMENT.—Subparagraphs (A)
12 and (B) shall not take into account any health
13 plan that does not have material enrollment (as
14 determined in accordance with regulations of
15 the Secretary of Labor).

16 (3) NONDISCRIMINATION AMONG PLANS SE-
17 LECTED.—An employer may not discriminate in the
18 wages or compensation paid, or other terms or con-
19 ditions of employment, with respect to an employee
20 based on the health plan (or premium of such a
21 plan) in which the employee is enrolled.

22 (b) REBATE REQUIRED IN CERTAIN CASES.—

23 (1) IN GENERAL.—Subject to subsection (c),
24 if—

1 (A) an employer makes available a vol-
2 untary employer premium payment on behalf of
3 an employee, and

4 (B)(i) the sum of the amount of the appli-
5 cable alliance credit (under section 6103) and
6 the voluntary employer premium payment, ex-
7 ceeds (ii) the premium for the plan selected,
8 the employer must rebate to the employee an
9 amount equal to the excess described in subpara-
10 graph (B).

11 (2) REBATES.—

12 (A) IN GENERAL.—Any rebate provided
13 under paragraph (1) shall be treated, for pur-
14 poses of the Internal Revenue Code of 1986, as
15 wages described in section 3121(a) of such Act.

16 (B) TREATMENT OF MULTIPLE FULL-TIME
17 EMPLOYMENT IN A FAMILY.—In the case of—

18 (i) an individual who is an employee
19 of more than one employer, or

20 (ii) a couple for which both spouses
21 are employees,

22 if more than one employer provides for vol-
23 untary employer premium payments, the indi-
24 vidual or couple may elect to have paragraph
25 (1) applied with respect to all employment.

1 (c) EXCEPTION FOR COLLECTIVE BARGAINING
2 AGREEMENT.—Subsections (a) and (b) (other than sub-
3 section (a)(2)) shall not apply with respect to voluntary
4 employer premium payments made pursuant to a bona
5 fide collective bargaining agreement.

6 (d) VOLUNTARY EMPLOYER PREMIUM PAYMENT.—
7 In this section, the term “voluntary employer premium
8 payment” means any payment designed to be used exclu-
9 sively (or primarily) towards the cost of the family share
10 of premiums for a health plan. Such term does not include
11 any employer premiums required to be paid under part
12 3 of subtitle B of title VI.

13 **SEC. 1608. EMPLOYER RETIREE OBLIGATION.**

14 (a) IN GENERAL.—If an employer was providing, as
15 of October 1, 1993, a threshold payment (specified in sub-
16 section (c)) for a person who was a qualifying retired bene-
17 ficiary (as defined in subsection (b)) as of such date, the
18 employer shall pay, to or on behalf of that beneficiary for
19 each month beginning with January 1998, an amount that
20 is not less than the amount specified in subsection (d),
21 but only if and for so long as the person remains a quali-
22 fying retired beneficiary.

23 (b) QUALIFYING RETIRED BENEFICIARY.—In this
24 section, the term “qualifying retired beneficiary” means
25 a person who is an eligible retiree or qualified spouse or

1 child (as such terms are defined in subsections (b) and
2 (c) of section 6114).

3 (c) THRESHOLD PAYMENT.—The term “threshold
4 payment” means, for an employer with respect to a health
5 benefit plan providing coverage to a qualifying retired ben-
6 eficiary, a payment—

7 (1) for coverage of any item or service described
8 in section 1101, and

9 (2) the amount of which is at least 20 percent
10 of the amount of the premium (or premium equiva-
11 lent) for such coverage with respect to the bene-
12 ficiary (and dependents).

13 (d) AMOUNT.—The amount specified in this sub-
14 section is 20 percent of the weighted average premium for
15 the regional alliance in which the beneficiary resides and
16 for the applicable class of family enrollment.

17 (e) NATURE OF OBLIGATION.—The requirement of
18 this section shall be in addition to any other requirement
19 imposed on an employer under this Act or otherwise.

20 (f) PROTECTION OF COLLECTIVE BARGAINING
21 RIGHTS.—Nothing in this Act (including this section)
22 shall be construed as affecting collective bargaining rights
23 or rights under collective bargaining agreements.

1 **SEC. 1609. ENFORCEMENT.**

2 In the case of a person that violates a requirement
3 of this subtitle, the Secretary of Labor may impose a civil
4 money penalty, in an amount not to exceed \$10,000, for
5 each violation with respect to each individual.

6 **Subtitle J—General Definitions;**
7 **Miscellaneous Provisions**

8 **PART 1—GENERAL DEFINITIONS**

9 **SEC. 1901. DEFINITIONS RELATING TO EMPLOYMENT AND**
10 **INCOME.**

11 (a) IN GENERAL.—Except as otherwise specifically
12 provided, in this Act the following definitions and rules
13 apply:

14 (1) EMPLOYER, EMPLOYEE, EMPLOYMENT, AND
15 WAGES DEFINED.—Except as provided in this
16 section—

17 (A) the terms “wages” and “employment”
18 have the meanings given such terms under sec-
19 tion 3121 of the Internal Revenue Code of
20 1986,

21 (B) the term “employee” has the meaning
22 given such term under section 3121 of such
23 Code, subject to the provisions of chapter 25 of
24 such Code, and

1 (C) the term “employer” has the same
2 meaning as the term “employer” as used in
3 such section 3121.

4 (2) EXCEPTIONS.—For purposes of paragraph
5 (1)—

6 (A) EMPLOYMENT.—

7 (i) EMPLOYMENT INCLUDED.—Para-
8 graphs (1), (2), (5), (7) (other than
9 clauses (i) through (iv) of subparagraph
10 (C) and clauses (i) through (v) of subpara-
11 graph (F)), (8), (9), (10), (11), (13), (15),
12 (18), and (19) of section 3121(b) of the
13 Internal Revenue Code of 1986 shall not
14 apply.

15 (ii) EXCLUSION OF INMATES AS EM-
16 PLOYEES.—Employment shall not include
17 services performed in a penal institution by
18 an inmate thereof or in a hospital or other
19 health care institution by a patient thereof.

20 (B) WAGES.—

21 (i) IN GENERAL.—Paragraph (1) of
22 section 3121(a) of the Internal Revenue
23 Code of 1986 shall not apply.

24 (ii) TIPS NOT INCLUDED.—The term
25 “wages” does not include cash tips.

1 (C) EXCLUSION OF EMPLOYEES OUTSIDE
2 THE UNITED STATES.—The term “employee”
3 does not include an individual who does not re-
4 side in the United States.

5 (D) EXCLUSION OF FOREIGN EMPLOY-
6 MENT.—The term “employee” does not include
7 an individual—

8 (i) with respect to service, if the indi-
9 vidual is not a citizen or resident of the
10 United States and the service is performed
11 outside the United States, or

12 (ii) with respect to service, if the indi-
13 vidual is a citizen or resident of the United
14 States and the service is performed outside
15 the United States for an employer other
16 than an American employer (as defined in
17 section 3121(h) of the Internal Revenue
18 Code of 1986).

19 (3) AGGREGATION RULES FOR EMPLOYERS.—
20 For purposes of this Act—

21 (A) all employers treated as a single em-
22 ployer under subsection (a) or (b) of section 52
23 of the Internal Revenue Code of 1986 shall be
24 treated as a single employer, and

1 (B) under regulations of the Secretary of
2 Labor, all employees of organizations which are
3 under common control with one or more organi-
4 zations which are exempt from income tax
5 under subtitle A of the Internal Revenue Code
6 of 1986 shall be treated as employed by a single
7 employer.

8 The regulations prescribed under subparagraph (B)
9 shall be based on principles similar to the principles
10 which apply to taxable organizations under subpara-
11 graph (A).

12 (4) EMPLOYER PREMIUM.—The term “employer
13 premium” refers to the premium established and im-
14 posed under part 2 of subtitle B of title VI.

15 (b) QUALIFYING EMPLOYEE; FULL-TIME EMPLOY-
16 MENT.—

17 (1) QUALIFYING EMPLOYEE.—

18 (A) IN GENERAL.—In this Act, the term
19 “qualifying employee” means, with respect to
20 an employer for a month, an employee (other
21 than a covered child, as defined in subpara-
22 graph (C)) who is employed by the employer for
23 at least 40 hours (as determined under para-
24 graph (3)) in the month.

1 (B) NO SPECIAL TREATMENT OF MEDI-
2 CARE BENEFICIARIES, SSI RECIPIENTS, AFDC
3 RECIPIENTS, AND OTHERS.—Subparagraph (A)
4 shall apply regardless of whether or not the em-
5 ployee is a medicare-eligible individual, an SSI
6 recipient, an AFDC recipient, an individual de-
7 scribed in section 1004(b), an eligible individual
8 or is authorized to be so employed.

9 (C) COVERED CHILD DEFINED.—In sub-
10 paragraph (A), the term “covered child” means
11 an eligible individual who is a child and is en-
12 rolled under a health plan as a family member
13 described in section 1011(b)(2)(B).

14 (2) FULL-TIME EQUIVALENT EMPLOYEES;
15 PART-TIME EMPLOYEES.—

16 (A) IN GENERAL.—For purposes of this
17 Act, a qualifying employee who is employed by
18 an employer—

19 (i) for at least 120 hours in a month,
20 is counted as 1 full-time equivalent em-
21 ployee for the month and shall be deemed
22 to be employed on a full-time basis, or

23 (ii) for at least 40 hours, but less
24 than 120 hours, in a month, is counted as
25 a fraction of a full-time equivalent em-

1 ployee in the month equal to the full-time
2 employment ratio (as defined in subpara-
3 graph (B)) for the employee and shall be
4 deemed to be employed on a part-time
5 basis.

6 (B) FULL-TIME EMPLOYMENT RATIO DE-
7 FINED.—For purposes of this Act, the term
8 “full-time employment ratio” means, with re-
9 spect to a qualifying employee of an employer
10 in a month, the lesser of 1 or the ratio of—

11 (i) the number of hours of employ-
12 ment such employee is employed by such
13 employer for the month (as determined
14 under paragraph (3)), to

15 (ii) 120 hours.

16 (C) FULL-TIME EMPLOYEE.—For purposes
17 of this Act, the term “full-time employee”
18 means, with respect to an employer, an em-
19 ployee who is employed on a full-time basis (as
20 specified in subparagraph (A)) by the employer.

21 (D) CONSIDERATION OF INDUSTRY PRAC-
22 TICE.—As provided under rules established by
23 the Board, an employee who is not described in
24 subparagraph (C) shall be considered to be em-
25 ployed on a full-time basis by an employer (and

1 to be a full-time employee of an employer) for
2 a month (or for all months in a 12-month pe-
3 riod) if the employee is employed by that em-
4 ployer on a continuing basis that, taking into
5 account the structure or nature of the employ-
6 ment in the industry, represents full time em-
7 ployment.

8 (3) HOURS OF EMPLOYMENT.—

9 (A) IN GENERAL.—For purposes of this
10 Act, the Board shall specify the method for
11 computing hours of employment for employees
12 of an employer consistent with this paragraph.
13 The Board shall take into account rules used
14 for purposes of applying the Fair Labor Stand-
15 ards Act.

16 (B) HOURLY WAGE EARNERS.—In the case
17 of an individual who receives compensation (in
18 the form of hourly wages or compensation) for
19 the performance of services, the individual is
20 considered to be “employed” by an employer for
21 an hour if compensation is payable with respect
22 to that hour of employment, without regard to
23 whether or not the employee is actually per-
24 forming services during such hours.

1 (4) TREATMENT OF SALARIED EMPLOYEES AND
2 EMPLOYEES PAID ON CONTINGENT OR BONUS AR-
3 RANGEMENTS.—In the case of an employee who re-
4 ceives compensation on a salaried basis or on the
5 basis of a commission (or other contingent or bonus
6 basis), rather than an hourly wage, the Board shall
7 establish rules for the conversion of the compensa-
8 tion to hours of employment, taking into account the
9 minimum monthly compensation levels for workers
10 employed on a full-time basis under the Fair Labor
11 Standards Act and other factors the Board considers
12 relevant.

13 (c) DEFINITIONS RELATING TO SELF-EMPLOY-
14 MENT.—In this Act:

15 (1) NET EARNINGS FROM SELF-EMPLOY-
16 MENT.—The term “net earnings from self-employ-
17 ment” has the meaning given such term under sec-
18 tion 1402(a) of the Internal Revenue Code of 1986.

19 (2) SELF-EMPLOYED INDIVIDUAL.—The term
20 “self-employed individual” means, for a year, an in-
21 dividual who has net earnings from self-employment
22 for the year.

23 **SEC. 1902. OTHER GENERAL DEFINITIONS.**

24 Except as otherwise specifically provided, in this Act
25 the following definitions apply:

1 (1) ALIEN PERMANENTLY RESIDING IN THE
2 UNITED STATES UNDER COLOR OF LAW.—The term
3 “alien permanently residing in the United States
4 under color of law” means an alien lawfully admitted
5 for permanent residence (within the meaning of sec-
6 tion 101(a)(20) of the Immigration and Nationality
7 Act), and includes any of the following:

8 (A) An alien who is admitted as a refugee
9 under section 207 of the Immigration and Na-
10 tionality Act.

11 (B) An alien who is granted asylum under
12 section 208 of such Act.

13 (C) An alien whose deportation is withheld
14 under section 243(h) of such Act.

15 (D) An alien who is admitted for tem-
16 porary residence under section 210, 210A, or
17 245A of such Act.

18 (E) An alien who has been paroled into the
19 United States under section 212(d)(5) of such
20 Act for an indefinite period or who has been
21 granted extended voluntary departure as a
22 member of a nationality group.

23 (F) An alien who is the spouse or unmar-
24 ried child under 21 years of age of a citizen of
25 the United States, or the parent of such a cit-

1 izen if the citizen is over 21 years of age, and
2 with respect to whom an application for adjust-
3 ment to lawful permanent residence is pending.

4 (G) An alien within such other classifica-
5 tion of permanent resident aliens as the Na-
6 tional Health Board may establish by regula-
7 tion.

8 (2) AFDC FAMILY.—The term “AFDC family”
9 means a family composed entirely of one or more
10 AFDC recipients.

11 (3) AFDC RECIPIENT.—The term “AFDC re-
12 cipient” means, for a month, an individual who is
13 receiving aid or assistance under any plan of the
14 State approved under title I, X, XIV, or XVI, or
15 part A or part E of title IV, of the Social Security
16 Act for the month.

17 (4) ALLIANCE AREA.—The term “alliance area”
18 means the area served by a regional alliance and
19 specified under section 1202(b).

20 (5) ALLIANCE ELIGIBLE INDIVIDUAL.—The
21 term “alliance eligible individual” means, with re-
22 spect to a health alliance, an eligible individual with
23 respect to whom the applicable health plan is a
24 health plan offered by or through such alliance and
25 does not include a prisoner.

1 (6) APPLICABLE HEALTH PLAN.—The term
2 “applicable health plan” means, with respect to an
3 eligible individual, the health plan specified pursuant
4 to section 1004 and part 2 of subtitle A.

5 (7) COMBINATION COST SHARING PLAN.—The
6 term “combination cost sharing plan” means a
7 health plan that provides combination cost sharing
8 schedule (consistent with section 1134).

9 (8) COMPREHENSIVE BENEFIT PACKAGE.—The
10 term “comprehensive benefit package” means the
11 package of health benefits provided under subtitle B.

12 (9) CONSUMER PRICE INDEX; CPI.—The terms
13 “consumer price index” and “CPI” mean the Con-
14 sumer Price Index for all urban consumers (U.S.
15 city average), as published by the Bureau of Labor
16 Statistics.

17 (10) CORPORATE ALLIANCE ELIGIBLE INDIVIDUAL.—The term “corporate alliance eligible individual” means, with respect to a corporate alliance,
18 an eligible individual with respect to whom the cor-
19 porate alliance is the applicable health plan.
20 porate alliance is the applicable health plan.

21 (11) CORPORATE ALLIANCE EMPLOYER.—The
22 term “corporate alliance employer” means, with re-
23 spect to a corporate alliance, an employer of an indi-
24 vidual.

1 vidual who is a participant in a corporate alliance
2 health plan of that alliance.

3 (12) CORPORATE ALLIANCE HEALTH PLAN.—
4 The term “corporate alliance health plan” means a
5 health plan offered by a corporate alliance.

6 (13) DISABLED SSI RECIPIENT.—The term
7 “disabled SSI recipient” means an individual who—

8 (A) is an SSI recipient, and

9 (B) has been determined to be disabled for
10 purposes of the supplemental security income
11 program (under title XVI of the Social Security
12 Act).

13 (14) ELIGIBLE ENROLLEE.—The term “eligible
14 enrollee” means, with respect to a health plan of-
15 fered by a health alliance, an alliance eligible indi-
16 vidual, but does not include such an individual if the
17 individual is enrolled under such a plan as the fam-
18 ily member of another alliance eligible individual.

19 (15) ESSENTIAL COMMUNITY PROVIDER.—The
20 term “essential community provider” means an enti-
21 ty certified as such a provider under subpart B of
22 part 2 of subtitle F.

23 (16) FEE-FOR-SERVICE PLAN.—The term “fee-
24 for-service plan” means a health plan described in
25 section 1322(b)(2)(A).

1 (17) FIRST YEAR.—The term “first year”
2 means, with respect to—

3 (A) a State that is a participating State in
4 a year before 1998, the year in which the State
5 first is a participating State, or

6 (B) any other State, 1998.

7 (18) HIGHER COST SHARING PLAN.—The term
8 “higher cost sharing plan” means a health plan that
9 provides a higher cost sharing schedule (consistent
10 with section 1133).

11 (19) LONG-TERM NONIMMIGRANT.—The term
12 “long-term nonimmigrant” means a nonimmigrant
13 described in subparagraph (E), (H), (I), (J), (K),
14 (L), (M), (N), (O), (Q), or (R) of section 101(a)(15)
15 of the Immigration and Nationality Act or an alien
16 within such other classification of nonimmigrant as
17 the National Health Board may establish by regula-
18 tion.

19 (20) LOWER COST SHARING PLAN.—The term
20 “lower cost sharing plan” means a health plan that
21 provides a lower cost sharing schedule (consistent
22 with section 1132).

23 (21) MEDICARE PROGRAM.—The term “medi-
24 care program” means the health insurance program
25 under title XVIII of the Social Security Act.

1 (22) MEDICARE-ELIGIBLE INDIVIDUAL.—The
2 term “medicare-eligible individual” means, subject to
3 section 1012(a), an individual who is entitled to ben-
4 efits under part A of the medicare program.

5 (23) MOVE.—The term “move” means, respect
6 to an individual, a change of residence of the indi-
7 vidual from one alliance area to another alliance
8 area.

9 (24) NATIONAL HEALTH BOARD; BOARD.—The
10 terms “National Health Board” and “Board” mean
11 the National Health Board created under section
12 1501.

13 (25) POVERTY LEVEL.—

14 (A) IN GENERAL.—The term “applicable
15 poverty level” means, for a family for a year,
16 the official poverty line (as defined by the Of-
17 fice of Management and Budget, and revised
18 annually in accordance with section 673(2) of
19 the Omnibus Budget Reconciliation Act of
20 1981) applicable to a family of the size involved
21 (as determined under subparagraph (B)) for
22 1994 adjusted by the percentage increase or de-
23 crease described in subparagraph (C) for the
24 year involved.

1 (B) FAMILY SIZE.—In applying the appli-
2 cable poverty level to—

3 (i) an individual enrollment, the fam-
4 ily size is deemed to be one person;

5 (ii) a couple-only enrollment, the fam-
6 ily size is deemed to be two persons;

7 (iii) a single parent enrollment, the
8 family size is deemed to be three persons;

9 or

10 (iv) a dual parent enrollment, the
11 family size is deemed to be four persons.

12 (C) PERCENTAGE ADJUSTMENT.—The per-
13 centage increase or decrease described in this
14 subparagraph for a year is the percentage in-
15 crease or decrease by which the average CPI for
16 the 12-month-period ending with August 31 of
17 the preceding year exceeds such average for the
18 12-month period ending with August 31, 1993.

19 (D) ROUNDING.—Any adjustment made
20 under subparagraph (A) for a year shall be
21 rounded to the nearest multiple of \$100.

22 (26) PRISONER.—The term “prisoner” means,
23 as specified by the Board, an eligible individual dur-
24 ing a period of imprisonment under Federal, State,
25 or local authority after conviction as an adult.

1 (27) REGIONAL ALLIANCE ELIGIBLE INDIVIDUAL.—The term “regional alliance eligible individual” means an eligible individual with respect to
2 whom a regional alliance health plan is an applicable
3 health plan.
4

5 (28) REGIONAL ALLIANCE EMPLOYER.—The
6 term “regional alliance employer” means, with re-
7 spect to an employee, an employer that is not a cor-
8 porate alliance employer with respect to such em-
9 ployee.
10

11 (29) REGIONAL ALLIANCE HEALTH PLAN.—The
12 term “regional alliance health plan” means a health
13 plan offered by a regional alliance.

14 (30) RESIDE.—

15 (A) An individual is considered to reside in
16 the location in which the individual maintains a
17 primary residence (as established under rules of
18 the National Health Board).

19 (B) Under such rules and subject to sec-
20 tion 1323(c), in the case of an individual who
21 maintains more than one residence, the primary
22 residence of the individual shall be determined
23 taking into account the proportion of time spent
24 at each residence.

1 (C) In the case of a couple only one spouse
2 of which is a qualifying employee, except as the
3 Board may provide, the residence of the em-
4 ployee shall be the residence of the couple.

5 (31) SECRETARY.—The term “Secretary”
6 means the Secretary of Health and Human Services.

7 (32) SSI FAMILY.—The term “SSI family”
8 means a family composed entirely of one or more
9 SSI recipients.

10 (33) SSI RECIPIENT.—The term “SSI recipi-
11 ent” means, for a month, an individual—

12 (A) with respect to whom supplemental se-
13 curity income benefits are being paid under title
14 XVI of the Social Security Act for the month,

15 (B) who is receiving a supplementary pay-
16 ment under section 1616 of such Act or under
17 section 212 of Public Law 93–66 for the
18 month, or

19 (C) who is receiving monthly benefits
20 under section 1619(a) of the Social Security
21 Act (whether or not pursuant to section
22 1616(c)(3) of such Act) for the month.

23 (34) STATE.—The term “State” includes the
24 District of Columbia, Puerto Rico, the Virgin Is-

1 lands, Guam, American Samoa, and the Northern
2 Mariana Islands.

3 (35) STATE MEDICAID PLAN.—The term “State
4 medicaid plan” means a plan of medical assistance
5 of a State approved under title XIX of the Social
6 Security Act.

7 (36) UNDOCUMENTED ALIEN.—The term “un-
8 documented alien” means an alien who is not a long-
9 term nonimmigrant, a diplomat, or described in sec-
10 tion 1005(c).

11 (37) UNITED STATES.—The term “United
12 States” means the 50 States, the District of Colum-
13 bia, Puerto Rico, the Virgin Islands, Guam, Amer-
14 ican Samoa, and Northern Mariana Islands.

15 **Subtitle B—Miscellaneous** 16 **Provisions**

17 **SEC. 1911. USE OF INTERIM, FINAL REGULATIONS.**

18 In order to permit the timely implementation of the
19 provisions of this Act, the National Health Board, the Sec-
20 retary of Health and Human Services, the Secretary of
21 Labor are each authorized to issue regulations under this
22 Act on an interim basis that become final on the date of
23 publication, subject to change based on subsequent public
24 comment.

1 **SEC. 1912. SOCIAL SECURITY ACT REFERENCES.**

2 Except as may otherwise be provided, any reference
 3 in this title, or in title V or VI, to a provision of the Social
 4 Security Act shall be to that provision of the Social Secu-
 5 rity Act as in effect on the date of the enactment of this
 6 Act.

7 **TITLE II—NEW BENEFITS**

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1 **Subtitle A—Medicare Outpatient**2 **Prescription Drug Benefit**3 **SEC. 2001. COVERAGE OF OUTPATIENT PRESCRIPTION**4 **DRUGS.**

5 (a) COVERED OUTPATIENT DRUGS AS MEDICAL AND

6 OTHER HEALTH SERVICES.—Section 1861(s)(2)(J) of the

1 Social Security Act (42 U.S.C. 1395x(s)(2)(J)) is amend-
2 ed to read as follows:

3 “(J) covered outpatient drugs;”.

4 (b) DEFINITION OF COVERED OUTPATIENT DRUG.—
5 Section 1861(t) of such Act (42 U.S.C. 1395x(t)), as
6 amended by section 13553(b) of the Omnibus Budget Rec-
7 onciliation Act of 1993 (hereafter in this subtitle referred
8 to as “OBRA–1993”), is amended—

9 (1) in the heading, by adding at the end the fol-
10 lowing: “; Covered Outpatient Drugs”;

11 (2) in paragraph (1), by striking “paragraph
12 (2)” and inserting “the succeeding paragraphs of
13 this subsection”; and

14 (3) by striking paragraph (2) and inserting the
15 following:

16 “(2) Except as otherwise provided in paragraph (3),
17 the term ‘covered outpatient drug’ means any of the fol-
18 lowing products used for a medically accepted indication
19 (as described in paragraph (4)):

20 “(A) A drug which may be dispensed only upon
21 prescription and—

22 “(i) which is approved for safety and effec-
23 tiveness as a prescription drug under section
24 505 or 507 of the Federal Food, Drug, and

1 Cosmetic Act or which is approved under sec-
2 tion 505(j) of such Act;

3 “(ii)(I) which was commercially used or
4 sold in the United States before the date of the
5 enactment of the Drug Amendments of 1962 or
6 which is identical, similar, or related (within the
7 meaning of section 310.6(b)(1) of title 21 of the
8 Code of Federal Regulations) to such a drug,
9 and (II) which has not been the subject of a
10 final determination by the Secretary that it is
11 a ‘new drug’ (within the meaning of section
12 201(p) of the Federal Food, Drug, and Cos-
13 metic Act) or an action brought by the Sec-
14 retary under section 301, 302(a), or 304(a) of
15 such Act to enforce section 502(f) or 505(a) of
16 such Act; or

17 “(iii)(I) which is described in section
18 107(c)(3) of the Drug Amendments of 1962
19 and for which the Secretary has determined
20 there is a compelling justification for its med-
21 ical need, or is identical, similar, or related
22 (within the meaning of section 310.6(b)(1) of
23 title 21 of the Code of Federal Regulations) to
24 such a drug, and (II) for which the Secretary
25 has not issued a notice of an opportunity for a

1 hearing under section 505(e) of the Federal
2 Food, Drug, and Cosmetic Act on a proposed
3 order of the Secretary to withdraw approval of
4 an application for such drug under such section
5 because the Secretary has determined that the
6 drug is less than effective for all conditions of
7 use prescribed, recommended, or suggested in
8 the labeling.

9 “(B) A biological product which—

10 “(i) may only be dispensed upon prescrip-
11 tion,

12 “(ii) is licensed under section 351 of the
13 Public Health Service Act, and

14 “(iii) is produced at an establishment li-
15 censed under such section to produce such
16 product.

17 “(C) Insulin certified under section 506 of the
18 Federal Food, Drug, and Cosmetic Act.

19 “(3) The term ‘covered outpatient drug’ does not in-
20 clude any product—

21 “(A) which is administered through infusion in
22 a home setting unless the product is a covered home
23 infusion drug (as defined in paragraph (5));

1 “(B) when furnished as part of, or as incident
2 to, any other item or service for which payment may
3 be made under this title; or

4 “(C) which is listed under paragraph (2) of sec-
5 tion 1927(d) (other than subparagraph (I) or (J) of
6 such subparagraph) as a drug which may be ex-
7 cluded from coverage under a State plan under title
8 XIX and which the Secretary elects to exclude from
9 coverage under part B.

10 “(4) For purposes of paragraph (2), the term ‘medi-
11 cally accepted indication’, with respect to the use of an
12 outpatient drug, includes any use which has been approved
13 by the Food and Drug Administration for the drug, and
14 includes another use of the drug if—

15 “(A) the drug has been approved by the Food
16 and Drug Administration; and

17 “(B)(i) such use is supported by one or more
18 citations which are included (or approved for inclu-
19 sion) in one or more of the following compendia: the
20 American Hospital Formulary Service-Drug Infor-
21 mation, the American Medical Association Drug
22 Evaluations, the United States Pharmacopoeia-Drug
23 Information, and other authoritative compendia as
24 identified by the Secretary, unless the Secretary has
25 determined that the use is not medically appropriate

1 or the use is identified as not indicated in one or
2 more such compendia, or

3 “(ii) the carrier involved determines, based
4 upon guidance provided by the Secretary to carriers
5 for determining accepted uses of drugs, that such
6 use is medically accepted based on supportive clinical
7 evidence in peer reviewed medical literature appear-
8 ing in publications which have been identified for
9 purposes of this clause by the Secretary.

10 The Secretary may revise the list of compendia in sub-
11 paragraph (B)(i) designated as appropriate for identifying
12 medically accepted indications for drugs.

13 “(5)(A) For purposes of paragraph (3), the term
14 ‘covered home infusion drug’ means a covered outpatient
15 drug or an enteral or parenteral nutrient dispensed to an
16 individual that—

17 “(i) is administered intravenously,
18 subcutaneously, epidurally, or through other means
19 determined by the Secretary, using an access device
20 that is inserted in to the body and an infusion device
21 to control the rate of flow of the drug,

22 “(ii) is administered in the individual’s home
23 (including an institution used as the individual’s
24 home, other than a hospital under subsection (e) or

1 a skilled nursing facility that meets the requirements
2 of section 1819(a)), and

3 “(iii)(I) is an antibiotic drug and the Secretary
4 has not determined, for the specific drug or the indi-
5 cation to which the drug is applied, that the drug
6 cannot generally be administered safely and effec-
7 tively in a home setting, or

8 “(II) is not an antibiotic drug and the Sec-
9 retary has determined, for the specific drug or the
10 indication to which the drug is applied, that the
11 drug can generally be administered safely and effec-
12 tively in a home setting.

13 “(B) Not later than January 1, 1996, (and periodi-
14 cally thereafter), the Secretary shall publish a list of the
15 drugs, and indications for such drugs, that are covered
16 home infusion drugs, with respect to which home infusion
17 drug therapy may be provided under this title.”.

18 (c) OTHER CONFORMING AMENDMENTS.—(1) Sec-
19 tion 1861 of such Act (42 U.S.C. 1395x) is amended—

20 (A) in subsection (s)(2), as amended by section
21 13553 of OBRA–1993—

22 (i) by striking subparagraphs (O) and (Q),

23 (ii) by adding “and” at the end of sub-
24 paragraph (N),

1 (iii) by striking “; and” at the end of sub-
 2 paragraph (P) and inserting a period, and

3 (iv) by redesignating subparagraph (P) as
 4 subparagraph (O); and

5 (B) by striking the subsection (jj) added by sec-
 6 tion 4156(a)(2) of the Omnibus Budget Reconcili-
 7 ation Act of 1990.

8 (2) Section 1881(b)(1)(C) of such Act (42 U.S.C.
 9 1395rr(b)(1)(C)), as amended by section 13566(a) of
 10 OBRA–1993, is amended by striking “section
 11 1861(s)(2)(P)” and inserting “section 1861(s)(2)(O)”.

12 **SEC. 2002. PAYMENT RULES AND RELATED REQUIREMENTS**
 13 **FOR COVERED OUTPATIENT DRUGS.**

14 (a) IN GENERAL.—Section 1834 of the Social Secu-
 15 rity Act (42 U.S.C. 1395m) is amended by inserting after
 16 subsection (c) the following new subsection:

17 “(d) PAYMENT FOR AND CERTAIN REQUIREMENTS
 18 CONCERNING COVERED OUTPATIENT DRUGS.—

19 “(1) DEDUCTIBLE.—

20 “(A) IN GENERAL.—Payment shall be
 21 made under paragraph (2) only for expenses in-
 22 curred by an individual for a covered outpatient
 23 drug during a calendar year after the individual
 24 has incurred expenses in the year for such
 25 drugs (during a period in which the individual

1 is entitled to benefits under this part) equal to
2 the deductible amount for that year.

3 “(B) DEDUCTIBLE AMOUNT.—

4 “(i) For purposes of subparagraph
5 (A), the deductible amount is—

6 “(I) for 1996, \$250, and

7 “(II) for any succeeding year, the
8 amount (rounded to the nearest dol-
9 lar) that the Secretary estimates will
10 ensure that the percentage of the av-
11 erage number of individuals covered
12 under this part (other than individ-
13 uals enrolled with an eligible organiza-
14 tion under section 1876 or an organi-
15 zation described in section
16 1833(a)(1)(A)) during the year who
17 will incur expenses for covered out-
18 patient drugs equal to or greater than
19 such amount will be the same as the
20 percentage for the previous year.

21 “(ii) The Secretary shall promulgate
22 the deductible amount for 1997 and each
23 succeeding year during September of the
24 previous year.

1 “(C) SPECIAL RULE FOR DETERMINATION
2 OF EXPENSES INCURRED.—In determining the
3 amount of expenses incurred by an individual
4 for covered outpatient drugs during a year for
5 purposes of subparagraph (A), there shall not
6 be included any expenses incurred with respect
7 to a drug to the extent such expenses exceed
8 the payment basis for such drug under para-
9 graph (3).

10 “(2) PAYMENT AMOUNT.—

11 “(A) IN GENERAL.—Subject to the deduct-
12 ible established under paragraph (1), the
13 amount payable under this part for a covered
14 outpatient drug furnished to an individual dur-
15 ing a calendar year shall be equal to—

16 “(i) 80 percent of the payment basis
17 described in paragraph (3), in the case of
18 an individual who has not incurred ex-
19 penses for covered outpatient drugs during
20 the year (including the deductible imposed
21 under paragraph (1)) in excess of the out-
22 of-pocket limit for the year under subpara-
23 graph (B); and

1 “(ii) 100 percent of the payment basis
2 described in paragraph (3), in the case of
3 any other individual.

4 “(B) OUT-OF-POCKET LIMIT DE-
5 SCRIBED.—

6 “(i) For purposes of subparagraph
7 (A), the out-of-pocket limit for a year is
8 equal to—

9 “(I) for 1996, \$1000, and

10 “(II) for any succeeding year, the
11 amount (rounded to the nearest dol-
12 lar) that the Secretary estimates will
13 ensure that the percentage of the av-
14 erage number of individuals covered
15 under this part (other than individ-
16 uals enrolled with an eligible organiza-
17 tion under section 1876 or an organi-
18 zation described in section
19 1833(a)(1)(A)) during the year who
20 will incur expenses for covered out-
21 patient drugs equal to or greater than
22 such amount will be the same as the
23 percentage for the previous year.

24 “(ii) The Secretary shall promulgate
25 the out-of-pocket limit for 1997 and each

1 succeeding year during September of the
2 previous year.

3 “(C) SPECIAL RULE FOR DETERMINATION
4 OF EXPENSES INCURRED.—In determining the
5 amount of expenses incurred by an individual
6 for covered outpatient drugs during a year for
7 purposes of subparagraph (A), there shall not
8 be included any expenses incurred with respect
9 to a drug to the extent such expenses exceed
10 the payment basis for such drug under para-
11 graph (3).

12 “(3) PAYMENT BASIS.—For purposes of para-
13 graph (2), the payment basis is the lesser of—

14 “(A) the actual charge for a covered out-
15 patient drug, or

16 “(B) the applicable payment limit estab-
17 lished under paragraph (4).

18 “(4) PAYMENT LIMITS.—

19 “(A) PAYMENT LIMIT FOR SINGLE SOURCE
20 DRUGS AND MULTIPLE SOURCE DRUGS WITH
21 RESTRICTIVE PRESCRIPTIONS.—In the case of a
22 covered outpatient drug that is a multiple
23 source drug which has a restrictive prescription,
24 or that is single source drug, the payment limit
25 for a payment calculation period is equal to—

1 “(i) the 90th percentile of the actual
2 charges (computed on the geographic basis
3 specified by the Secretary) for the drug
4 product for the second previous payment
5 calculation period, or

6 “(ii) the amount of the administrative
7 allowance (established under paragraph
8 (5)) plus the product of the number of dos-
9 age units dispensed and the per unit esti-
10 mated acquisition cost for the drug prod-
11 uct (determined under subparagraph (C))
12 for the period,

13 whichever is less.

14 “(B) PAYMENT LIMIT FOR MULTIPLE
15 SOURCE DRUGS WITHOUT RESTRICTIVE PRE-
16 SCRIPTIONS.—In the case of a drug that is a
17 multiple source drug which does not have a re-
18 strictive prescription, the payment limit for a
19 payment calculation period is equal to the
20 amount of the administrative allowance (estab-
21 lished under paragraph (5)) plus the product of
22 the number of dosage units dispensed and the
23 unweighted median of the unit estimated acqui-
24 sition cost (determined under subparagraph
25 (C)) for the drug products for the period.

1 “(C) DETERMINATION OF UNIT PRICE.—

2 “(i) IN GENERAL.—The Secretary
3 shall determine, for the dispensing of a
4 covered outpatient drug product in a pay-
5 ment calculation period, the estimated ac-
6 quisition cost for the drug product. With
7 respect to any covered outpatient drug
8 product, such cost may not exceed 93 per-
9 cent of the published average wholesale
10 price for the drug during the period.

11 “(ii) COMPLIANCE WITH REQUEST
12 FOR INFORMATION.—If a wholesaler or di-
13 rect seller of a covered outpatient drug re-
14 fuses, after being requested by the Sec-
15 retary, to provide price information re-
16 quested to carry out clause (i), or delib-
17 erately provides information that is false,
18 the Secretary may impose a civil money
19 penalty of not to exceed \$10,000 for each
20 such refusal or provision of false informa-
21 tion. The provisions of section 1128A
22 (other than subsections (a) and (b)) shall
23 apply to civil money penalties under the
24 previous sentence in the same manner as
25 they apply to a penalty or proceeding

1 under section 1128A(a). Information gath-
2 ered pursuant to clause (i) shall not be dis-
3 closed except as the Secretary determines
4 to be necessary to carry out the purposes
5 of this part.

6 “(5) ADMINISTRATIVE ALLOWANCE FOR PUR-
7 POSES OF PAYMENT LIMIT.—

8 “(A) IN GENERAL.—Except as provided in
9 subparagraph (B), the administrative allowance
10 established under this paragraph is—

11 “(i) for 1996, \$5, and

12 “(ii) for each succeeding year, the
13 amount for the previous year adjusted by
14 the percentage change in the consumer
15 price index for all urban consumers (U.S.
16 city average) for the 12-month period end-
17 ing with June of that previous year.

18 “(B) REDUCTION FOR MAIL ORDER PHAR-
19 MACIES.—The Secretary may, after consulting
20 with representatives of pharmacists, individuals
21 enrolled under this part, and of private insur-
22 ers, reduce the administrative allowances estab-
23 lished under subparagraph (A) for any covered
24 outpatient drug dispensed by a mail order phar-
25 macy, based on differences between such phar-

1 macies and other pharmacies with respect to
2 operating costs and other economies.

3 “(6) ASSURING APPROPRIATE PRESCRIBING
4 AND DISPENSING PRACTICES.—

5 “(A) IN GENERAL.—The Secretary shall
6 establish a program to identify (and to educate
7 physicians and pharmacists concerning)—

8 “(i) instances or patterns of unneces-
9 sary or inappropriate prescribing or dis-
10 pensing practices for covered outpatient
11 drugs,

12 “(ii) instances or patterns of sub-
13 standard care with respect to such drugs,

14 “(iii) potential adverse reactions, and

15 “(iv) appropriate use of generic prod-
16 ucts.

17 “(B) PRIOR AUTHORIZATION.—The Sec-
18 retary may require advance approval for a cov-
19 ered outpatient drug which the Secretary finds
20 is subject to misuse or inappropriate use, is not
21 cost effective, which is a multiple source drug
22 with a restrictive prescription, or is subject to
23 negotiation under section 1850(c)(3). The Sec-
24 retary may also establish maximum quantities
25 per prescription and limits on the number of

1 prescription refills. The Secretary shall ensure
2 that any advance approval requirements im-
3 posed under this subparagraph do not restrict
4 the access of patients to medically necessary
5 covered outpatient drugs on a timely basis, and
6 assure prompt determinations of approval or
7 disapproval and provide a means for providers
8 and patients to appeal a decision to disapprove
9 a drug.

10 “(C) DRUG USE REVIEW.—The Secretary
11 may provide for a drug use review program
12 with respect to covered outpatient drugs dis-
13 pensed to individuals eligible for benefits under
14 this part. Such program may include such ele-
15 ments as the Secretary determines to be nec-
16 essary to assure that prescriptions (i) are ap-
17 propriate, (ii) are medically necessary, and (iii)
18 are not likely to result in adverse medical re-
19 sults, including any elements of the State drug
20 use review programs required under section
21 1927(g) that the Secretary determines to be ap-
22 propriate.

23 “(7) ADMINISTRATIVE IMPROVEMENTS.—The
24 Secretary shall develop, in consultation with rep-
25 resentatives of pharmacies and of other interested

1 persons, a standard claims form for covered out-
2 patient drugs in accordance with title V of the
3 Health Security Act.

4 “(8) COUNSELING REQUIREMENTS FOR PHAR-
5 MACIES.—A pharmacy may not receive any payment
6 under this part for a covered outpatient drug unless
7 the pharmacy agrees to answer questions of individ-
8 uals enrolled under this part who receive a covered
9 outpatient drug from the pharmacy regarding the
10 appropriate use of the drug, potential interactions
11 between the drug and other drugs dispensed to the
12 individual, and other matters relating to the dis-
13 pensing of such drugs.

14 “(9) DEFINITIONS.—In this subsection:

15 “(A) MULTIPLE AND SINGLE SOURCE
16 DRUGS.—The terms ‘multiple source drug’ and
17 ‘single source drug’ have the meanings of those
18 terms under section 1927(k)(7).

19 “(B) RESTRICTIVE PRESCRIPTION.—A
20 drug has a ‘restrictive prescription’ only if—

21 “(i) in the case of a written prescrip-
22 tion, the prescription for the drug indi-
23 cates, in the handwriting of the physician
24 or other person prescribing the drug and
25 with an appropriate phrase (such as ‘brand

1 medically necessary’) recognized by the
2 Secretary, that a particular drug product
3 must be dispensed, or

4 “(ii) in the case of a prescription
5 issued by telephone—

6 “(I) the physician or other per-
7 son prescribing the drug (through use
8 of such an appropriate phrase) states
9 that a particular drug product must
10 be dispensed, and

11 “(II) the physician or other per-
12 son submits to the pharmacy involved,
13 within 30 days after the date of the
14 telephone prescription, a written con-
15 firmation which is in the handwriting
16 of the physician or other person pre-
17 scribing the drug and which indicates
18 with such appropriate phrase that the
19 particular drug product was required
20 to have been dispensed.

21 “(C) PAYMENT CALCULATION PERIOD.—

22 The term ‘payment calculation period’ means
23 the 6-month period beginning with January of
24 each year and the 6-month period beginning
25 with July of each year.’’.

1 (b) SUBMISSION OF CLAIMS BY PHARMACIES.—Sec-
2 tion 1848(g)(4) of such Act (42 U.S.C. 1395w-4(g)(4))
3 is amended—

4 (1) in the heading—

5 (A) by striking “PHYSICIAN”, and

6 (B) by inserting “BY PHYSICIANS AND
7 SUPPLIERS” after “CLAIMS”,

8 (2) in the matter in subparagraph (A) pre-
9 ceding clause (i)—

10 (A) by striking “For services furnished on
11 or after September 1, 1990, within 1 year” and
12 inserting “Within 1 year (90 days in the case
13 of covered outpatient drugs)”,

14 (B) by striking “a service” and inserting
15 “an item or service”, and

16 (C) by inserting “or of providing a covered
17 outpatient drug,” after “basis,” and

18 (3) in subparagraph (A)(i), by inserting “item
19 or” before “service.

20 (c) SPECIAL RULES FOR CARRIERS.—

21 (1) USE OF REGIONAL CARRIERS.—Section
22 1842(b)(2) of such Act (42 U.S.C. 1395u(b)(2)) is
23 amended by adding at the end the following:

24 “(D) With respect to activities related to covered out-
25 patient drugs, the Secretary may enter into contracts with

1 carriers under this section to perform the activities on a
2 regional basis.”.

3 (2) PAYMENT ON OTHER THAN A COST
4 BASIS.—Section 1842(c)(1)(A) of such Act (42
5 U.S.C. 1395u(c)(1)(A)) is amended—

6 (A) by inserting “(i)” after “(c)(1)(A)”,

7 (B) in the first sentence, by inserting “,
8 except as otherwise provided in clause (ii),”
9 after “under this part, and”, and

10 (C) by adding at the end the following:

11 “(ii) To the extent that a contract under this section
12 provides for activities related to covered outpatient drugs,
13 the Secretary may provide for payment for those activities
14 based on any method of payment determined by the Sec-
15 retary to be appropriate.”.

16 (3) USE OF OTHER ENTITIES FOR COVERED
17 OUTPATIENT DRUGS.—Section 1842(f) of such Act
18 (42 U.S.C. 1395u(f)) is amended—

19 (A) by striking “and” at the end of para-
20 graph (1),

21 (B) by striking the period at the end of
22 paragraph (2) and inserting “; and”, and

23 (C) by adding at the end the following:

24 “(3) with respect to activities related to covered
25 outpatient drugs, any other private entity which the

1 Secretary determines is qualified to conduct such ac-
2 tivities.”.

3 (4) DESIGNATED CARRIERS TO PROCESS
4 CLAIMS OF RAILROAD RETIREES.—Section 1842(g)
5 of such Act (42 U.S.C. 1395u(g)) is amended by in-
6 serting “(other than functions related to covered
7 outpatient drugs)” after “functions”.

8 (d) CONTRACTS FOR AUTOMATIC DATA PROCESSING
9 EQUIPMENT.—Actions taken before 1996 that affect con-
10 tracts related to the processing of claims for covered out-
11 patient drugs (as defined in section 1861(t) of the Social
12 Security Act) shall not be subject to section 111 of the
13 Federal Property and Administrative Services Act of
14 1949, and shall not be subject to administrative or judicial
15 review.

16 (e) CONFORMING AMENDMENTS.—

17 (1)(A) Section 1833(a)(1) of such Act (42
18 U.S.C. 1395l(a)(1)), as amended by section
19 13544(b)(2) of OBRA–1993, is amended—

20 (i) by striking “and” at the end of clause
21 (O), and

22 (ii) by inserting before the semicolon at the
23 end the following: “, and (Q) with respect to
24 covered outpatient drugs, the amounts paid
25 shall be as prescribed by section 1834(d)”.

1 (B) Section 1833(a)(2) of such Act (42 U.S.C.
2 1395l(a)(2)) is amended in the matter preceding
3 subparagraph (A) by inserting “, except for covered
4 outpatient drugs,” after “and (I) of such section”.

5 (2) Section 1833(b)(2) of such Act (42 U.S.C.
6 1395l(b)(2)) is amended by inserting “or with re-
7 spect to covered outpatient drugs” before the
8 comma.

9 (3) The first sentence of section 1842(h)(2) of
10 such Act (42 U.S.C. 1395u(h)(2)) is amended by in-
11 serting “(other than a carrier described in sub-
12 section (f)(3))” after “Each carrier”.

13 (4) The first sentence of section 1866(a)(2)(A)
14 of such Act (42 U.S.C. 1395cc(a)(2)(A)) is
15 amended—

16 (A) in clause (i), by inserting “section
17 1834(d),” after “section 1833(b),” and

18 (B) in clause (ii), by inserting “, other
19 than for covered outpatient drugs,” after “pro-
20 vider)”.

21 **SEC. 2003. MEDICARE REBATES FOR COVERED OUT-**
22 **PATIENT DRUGS.**

23 (a) IN GENERAL.—Part B of title XVIII of the Social
24 Security Act is amended by adding at the end the fol-
25 lowing new section:

1 “REBATES FOR COVERED OUTPATIENT DRUGS

2 “Sec. 1850. (a) REQUIREMENT FOR REBATE AGREE-
3 MENT.—In order for payment to be available under this
4 part for covered outpatient drugs of a manufacturer dis-
5 pensed on or after January 1, 1996, the manufacturer
6 must have entered into and have in effect a rebate agree-
7 ment with the Secretary meeting the requirements of sub-
8 section (b), and an agreement to give equal access to dis-
9 counts in accordance with subsection (e).

10 “(b) TERMS, IMPLEMENTATION, AND ENFORCEMENT
11 OF REBATE AGREEMENT.—

12 “(1) PERIODIC REBATES.—

13 “(A) IN GENERAL.—A rebate agreement
14 under this section shall require the manufac-
15 turer to pay to the Secretary for each calendar
16 quarter, not later than 30 days after the date
17 of receipt of the information described in para-
18 graph (2) for such quarter, a rebate in an
19 amount determined under subsection (c) for all
20 covered outpatient drugs of the manufacturer
21 described in subparagraph (B).

22 “(B) DRUGS INCLUDED IN QUARTERLY
23 REBATE CALCULATION.—Drugs subject to re-
24 bate with respect to a calendar quarter are
25 drugs which are dispensed by a pharmacy dur-

1 ing such quarter to individuals (other than indi-
2 viduals enrolled with an eligible organization
3 with a contract under section 1876) eligible for
4 benefits under this part, as reported by such
5 pharmacies to the Secretary.

6 “(2) INFORMATION FURNISHED TO MANUFAC-
7 TURERS.—

8 “(A) IN GENERAL.—The Secretary shall
9 report to each manufacturer, not later than 60
10 days after the end of each calendar quarter, in-
11 formation on the total number, for each covered
12 outpatient drug, of units of each dosage form,
13 strength, and package size dispensed under the
14 plan during the quarter, on the basis of the
15 data reported to the Secretary described in
16 paragraph (1)(B).

17 “(B) AUDIT.—The Comptroller General
18 may audit the records of the Secretary to the
19 extent necessary to determine the accuracy of
20 reports by the Secretary pursuant to subpara-
21 graph (A). Adjustments to rebates shall be
22 made to the extent determined necessary by the
23 audit to reflect actual units of drugs dispensed.

24 “(3) PROVISION OF PRICE INFORMATION BY
25 MANUFACTURER.—

1 “(A) QUARTERLY PRICING INFORMA-
2 TION.—Each manufacturer with an agreement
3 in effect under this section shall report to the
4 Secretary, not later than 30 days after the last
5 day of each calendar quarter, on the average
6 manufacturer retail price and the average man-
7 ufacturer non-retail price for each dosage form
8 and strength of each covered outpatient drug
9 for the quarter.

10 “(B) BASE QUARTER PRICES.—Each man-
11 ufacturer of a covered outpatient drug with an
12 agreement under this section shall report to the
13 Secretary, by not later than 30 days after the
14 effective date of such agreement (or, if later, 30
15 days after the end of the base quarter), the av-
16 erage manufacturer retail price, for such base
17 quarter, for each dosage form and strength of
18 each such covered drug.

19 “(C) VERIFICATION OF AVERAGE MANU-
20 FACTURER PRICE.—The Secretary may inspect
21 the records of manufacturers, and survey whole-
22 salers, pharmacies, and institutional purchasers
23 of drugs, as necessary to verify prices reported
24 under subparagraph (A).

25 “(D) PENALTIES.—

1 “(i) CIVIL MONEY PENALTIES.—The
2 Secretary may impose a civil money pen-
3 alty on a manufacturer with an agreement
4 under this section—

5 “(I) for failure to provide infor-
6 mation required under subparagraph
7 (A) on a timely basis, in an amount
8 up to \$10,000 per day of delay;

9 “(II) for refusal to provide infor-
10 mation about charges or prices re-
11 quested by the Secretary for purposes
12 of verification pursuant to subpara-
13 graph (C), in an amount up to
14 \$100,000; and

15 “(III) for provision, pursuant to
16 subparagraph (A) or (B), of informa-
17 tion that the manufacturer knows or
18 should know is false, in an amount up
19 to \$100,000 per item of information.

20 Such civil money penalties are in addition
21 to any other penalties prescribed by law.
22 The provisions of section 1128A (other
23 than subsections (a) (with respect to
24 amounts of penalties or additional assess-
25 ments) and (b)) shall apply to a civil

1 money penalty under this subparagraph in
2 the same manner as such provisions apply
3 to a penalty or proceeding under section
4 1128A(a).

5 “(ii) TERMINATION OF AGREE-
6 MENT.—If a manufacturer with an agree-
7 ment under this section has not provided
8 information required under subparagraph
9 (A) or (B) within 90 days of the deadline
10 imposed, the Secretary may suspend the
11 agreement with respect to covered out-
12 patient drugs dispensed after the end of
13 such 90-day period and until the date such
14 information is reported (but in no case
15 shall a suspension be for less than 30
16 days).

17 “(4) LENGTH OF AGREEMENT.—

18 “(A) IN GENERAL.—A rebate agreement
19 shall be effective for an initial period of not less
20 than one year and shall be automatically re-
21 newed for a period of not less than one year un-
22 less terminated under subparagraph (B).

23 “(B) TERMINATION.—

24 “(i) BY THE SECRETARY.—The Sec-
25 retary may provide for termination of a re-

1 bate agreement for violation of the require-
2 ments of the agreement or other good
3 cause shown. Such termination shall not be
4 effective earlier than 60 days after the
5 date of notice of such termination. The
6 Secretary shall afford a manufacturer an
7 opportunity for a hearing concerning such
8 termination, but such hearing shall not
9 delay the effective date of the termination.

10 “(ii) BY A MANUFACTURER.—A man-
11 ufacturer may terminate a rebate agree-
12 ment under this section for any reason.
13 Any such termination shall not be effective
14 until the calendar quarter beginning at
15 least 60 days after the date the manufac-
16 turer provides notice to the Secretary.

17 “(iii) EFFECTIVE DATE OF TERMI-
18 NATION.—Any termination under this sub-
19 paragraph shall not affect rebates due
20 under the agreement before the effective
21 date of its termination.

22 “(iv) NOTICE TO PHARMACIES.—In
23 the case of a termination under this sub-
24 paragraph, the Secretary shall notify phar-
25 macies and physician organizations not less

1 than 30 days before the effective date of
2 such termination.

3 “(c) AMOUNT OF REBATE.—

4 “(1) BASIC REBATE.—Each manufacturer shall
5 remit a basic rebate to the Secretary for each cal-
6 endar quarter in an amount, with respect to each
7 dosage form and strength of a covered drug (except
8 as provided under paragraph (4)), equal to the prod-
9 uct of—

10 “(A) the total number of units subject to
11 rebate for such quarter, as described in sub-
12 section (b)(1)(B); and

13 “(B) the greater of—

14 “(i) the difference between the aver-
15 age manufacturer retail price and the aver-
16 age manufacturer non-retail price,

17 “(ii) 17 percent of the average manu-
18 facturer retail price, or

19 “(iii) the amount determined pursuant
20 to paragraph (3).

21 “(2) ADDITIONAL REBATE.—Each manufac-
22 turer shall remit to the Secretary, for each calendar
23 quarter, an additional rebate for each dosage form
24 and strength of a covered drug (except as provided
25 under paragraph (4)), in an amount equal to—

1 “(A) the total number of units subject to
2 rebate for such quarter, as described in sub-
3 section (b)(1)(B), multiplied by

4 “(B) the amount, if any, by which the av-
5 erage manufacturer retail price for covered
6 drugs of the manufacturer exceeds the average
7 manufacturer retail price for the base quarter,
8 increased by the percentage increase in the
9 Consumer Price Index for all urban consumers
10 (U.S. average) from the end of such base quar-
11 ter to the month before the beginning of such
12 calendar quarter.

13 “(3) NEGOTIATED REBATE AMOUNT FOR NEW
14 DRUGS.—

15 “(A) IN GENERAL.—The Secretary may
16 negotiate with the manufacturer a per-unit re-
17 bate amount, in accordance with this para-
18 graph, for any covered outpatient drug (except
19 as provided under paragraph (4)) first mar-
20 ketted after June 30, 1993—

21 “(i) which is not marketed in any
22 country specified in section 802(b)(4)(A)
23 of the Federal Food, Drug, and Cosmetic
24 Act and for which the Secretary believes

1 the average manufacturer's retail price
2 may be excessive, or

3 “(ii) which is marketed in one or more
4 of such countries, at prices significantly
5 lower than the average manufacturer retail
6 price.

7 “(B) MAXIMUM REBATE AMOUNT FOR
8 DRUGS MARKETING IN CERTAIN COUNTRIES.—
9 The rebate negotiated pursuant to this para-
10 graph for a drug described in subparagraph
11 (A)(ii) may be an amount up to the difference
12 between the average manufacturer retail price
13 and any price at which the drug is available to
14 wholesalers in a country specified in such sec-
15 tion 802(b)(4)(A).

16 “(C) FACTORS TO BE CONSIDERED.—In
17 making determinations with respect to the
18 prices of a covered drug described in subpara-
19 graph (A) and in negotiating a rebate amount
20 pursuant to this paragraph, the Secretary shall
21 take into consideration, as applicable and ap-
22 propriate, the prices of other drugs in the same
23 therapeutic class, cost information requested by
24 the Secretary and supplied by the manufacturer
25 or estimated by the Secretary, prescription vol-

1 umes, economies of scale, product stability, spe-
2 cial manufacturing requirements, prices of the
3 drug in countries specified in subparagraph
4 (A)(i) (in the case of a drug described in such
5 subparagraph), and other relevant factors.

6 “(D) OPTION TO EXCLUDE COVERAGE.—If
7 the Secretary is unable to negotiate with the
8 manufacturer an acceptable rebate amount with
9 respect to a covered outpatient drug pursuant
10 to this paragraph, the Secretary may exclude
11 such drug from coverage under this part.

12 “(E) EFFECTIVE DATE OF EXCLUSION
13 FROM COVERAGE.—An exclusion of a drug from
14 coverage pursuant to subparagraph (D) shall be
15 effective on and after—

16 “(i) the date 6 months after the effec-
17 tive date of marketing approval of such
18 drug by the Food and Drug Administra-
19 tion (but in no event earlier than July 1,
20 1996), or

21 “(ii) the date the manufacturer termi-
22 nates negotiations with the Secretary con-
23 cerning the rebate amount,
24 whichever is earlier.

1 “(4) NO REBATE REQUIRED FOR GENERIC
2 DRUGS.—Paragraphs (1) through (3) shall not apply
3 with respect to a covered outpatient drug that is not
4 a single source drug or an innovator multiple source
5 drug (as such terms are defined in section 1927(k)).

6 “(5) DEPOSIT OF REBATES.—The Secretary
7 shall deposit rebates under this section in the Fed-
8 eral Supplementary Medical Insurance Trust Fund
9 established under section 1841.

10 “(d) CONFIDENTIALITY OF INFORMATION.—Notwith-
11 standing any other provision of law, information disclosed
12 by a manufacturer under this section is confidential and
13 shall not be disclosed by the Secretary, except—

14 “(A) as the Secretary determines to be nec-
15 essary to carry out this section,

16 “(B) to permit the Comptroller General to re-
17 view the information provided, and

18 “(C) to permit the Director of the Congres-
19 sional Budget Office to review the information pro-
20 vided.

21 “(e) AGREEMENT TO GIVE EQUAL ACCESS TO DIS-
22 COUNTS.—An agreement under this subsection by a man-
23 ufacturer of covered outpatient drugs shall guarantee that
24 the manufacturer will offer, to each wholesaler or retailer
25 (or other purchaser representing a group of such whole-

1 salers or retailers) that purchases such drugs on substan-
2 tially the same terms (including such terms as prompt
3 payment, cash payment, volume purchase, single-site de-
4 livery, the use of formularies by purchasers, and any other
5 terms effectively reducing the manufacturer's costs) as
6 any other purchaser (including any institutional pur-
7 chaser) the same price for such drugs as is offered to such
8 other purchaser. In determining a manufacturer's compli-
9 ance with the previous sentence, there shall not be taken
10 into account terms offered to the Department of Veterans
11 Affairs, the Department of Defense, or any public pro-
12 gram.

13 “(f) DEFINITIONS.—For purposes of this section—

14 “(1) AVERAGE MANUFACTURER RETAIL
15 PRICE.—The term ‘average manufacturer retail
16 price’ means, with respect to a covered outpatient
17 drug of a manufacturer for a calendar quarter, the
18 average price (inclusive of discounts for cash pay-
19 ment, prompt payment, volume purchases, and re-
20 bates (other than rebates under this section), but ex-
21 clusive of nominal prices) paid to the manufacturer
22 for the drug in the United States for drugs distrib-
23 uted to the retail pharmacy class of trade.

24 “(2) AVERAGE MANUFACTURER NON-RETAIL
25 PRICE.—The term ‘average manufacturer non-retail

1 price’ means, with respect to a covered outpatient
2 drug of a manufacturer for a calendar quarter, the
3 weighted average price (inclusive of discounts for
4 cash payment, prompt payment, volume purchases,
5 and rebates (other than rebates under this section),
6 but exclusive of nominal prices) paid to the manu-
7 facturer for the drug in the United States by hos-
8 pitals and other institutional purchasers that pur-
9 chase drugs for institutional use and not for resale.

10 “(3) BASE QUARTER.—The term ‘base quarter’
11 means, with respect to a covered outpatient drug of
12 a manufacturer, the calendar quarter beginning
13 April 1, 1993, or (if later) the first full calendar
14 quarter during which the drug was marketed in the
15 United States.

16 “(4) COVERED DRUG.—The term ‘covered drug’
17 includes each innovator multiple source drug and
18 single source drug, as those terms are defined in
19 section 1927(k)(7).

20 “(5) MANUFACTURER.—The term ‘manufac-
21 turer’ means, with respect to a covered outpatient
22 drug—

23 “(A) the entity whose National Drug Code
24 number (as issued pursuant to section 510(e) of

1 the Federal Food, Drug, and Cosmetic Act) ap-
2 pears on the labeling of the drug; or

3 “(B) if the number described in subpara-
4 graph (A) does not appear on the labeling of
5 the drug, the person named as the applicant in
6 a human drug application (in the case of a new
7 drug) or the product license application (in the
8 case of a biological product) for such drug ap-
9 proved by the Food and Drug Administration.”.

10 (b) EXCLUSIONS FROM COVERAGE.—Section
11 1862(a) of such Act (42 U.S.C. 1395y(a)), as amended
12 by sections 4034(b)(4) and 4118(b), is amended—

13 (1) by striking “and” at the end of paragraph
14 (15),

15 (2) by striking the period at the end of para-
16 graph (16) and inserting “; or”, and

17 (3) by inserting after paragraph (16) the fol-
18 lowing new paragraph:

19 “(17) A covered outpatient drug (as described
20 in section 1861(t))—

21 “(A) furnished during a year for which the
22 drug’s manufacturer does not have in effect a
23 rebate agreement with the Secretary that meets
24 the requirements of section 1850 for the year,
25 or

1 “(B) excluded from coverage during the
2 year by the Secretary pursuant to section
3 1850(c)(3)(D) (relating to negotiated rebate
4 amounts for certain new drugs).”.

5 **SEC. 2004. EXTENSION OF 25 PERCENT RULE FOR PORTION**
6 **OF PREMIUM ATTRIBUTABLE TO COVERED**
7 **OUTPATIENT DRUGS.**

8 Section 1839(e) of the Social Security Act (42 U.S.C.
9 1395r(e)) is amended by adding at the end the following:
10 “(3) Notwithstanding the provisions of subsection
11 (a), the portion of the monthly premium for each indi-
12 vidual enrolled under this part for each month after De-
13 cember 1998 that is attributable to covered outpatient
14 drugs shall be an amount equal to 50 percent of the por-
15 tion of the monthly actuarial rate for enrollees age 65 and
16 over, as determined under subsection (a)(1) and applicable
17 to such month, that is attributable to covered outpatient
18 drugs.”.

19 **SEC. 2005. COVERAGE OF HOME INFUSION DRUG THERAPY**
20 **SERVICES.**

21 (a) IN GENERAL.—Section 1832(a)(2)(A) of the So-
22 cial Security Act (42 U.S.C. 1395k(a)(2)(A)) is amended
23 by inserting “and home infusion drug therapy services”
24 before the semicolon.

1 (b) HOME INFUSION DRUG THERAPY SERVICES DE-
2 FINED.—Section 1861 of such Act (42 U.S.C. 1395x) is
3 amended—

4 (1) by redesignating the subsection (jj) inserted
5 by section 4156(a)(2) of the Omnibus Budget Rec-
6 onciliation Act of 1990 as subsection (kk); and

7 (2) by inserting after such subsection the fol-
8 lowing new subsection:

9 “Home Infusion Drug Therapy Services

10 “(ll)(1) The term ‘home infusion drug therapy serv-
11 ices’ means the items and services described in paragraph
12 (2) furnished to an individual who is under the care of
13 a physician—

14 “(A) in a place of residence used as the individ-
15 ual’s home,

16 “(B) by a qualified home infusion drug therapy
17 provider (as defined in paragraph (3)) or by others
18 under arrangements with them made by that pro-
19 vider, and

20 “(C) under a plan established and periodically
21 reviewed by a physician.

22 “(2) The items and services described in this para-
23 graph are such nursing, pharmacy, and related services
24 (including medical supplies, intravenous fluids, delivery,
25 and equipment) as are necessary to conduct safely and ef-

1 fectively a drug regimen through use of a covered home
2 infusion drug (as defined in subsection (t)(5)), but do not
3 include such covered home infusion drugs.

4 “(3) The term ‘qualified home infusion drug therapy
5 provider’ means any entity that the Secretary determines
6 meets the following requirements:

7 “(A) The entity is capable of providing or ar-
8 ranging for the items and services described in para-
9 graph (2) and covered home infusion drugs.

10 “(B) The entity maintains clinical records on
11 all patients.

12 “(C) The entity adheres to written protocols
13 and policies with respect to the provision of items
14 and services.

15 “(D) The entity makes services available (as
16 needed) seven days a week on a 24-hour basis.

17 “(E) The entity coordinates all service with the
18 patient’s physician.

19 “(F) The entity conducts a quality assessment
20 and assurance program, including drug regimen re-
21 view and coordination of patient care.

22 “(G) The entity assures that only trained per-
23 sonnel provide covered home infusion drugs (and any
24 other service for which training is required to pro-
25 vide the service safely).

1 “(H) The entity assumes responsibility for the
2 quality of services provided by others under arrange-
3 ments with the entity.

4 “(I) In the case of an entity in any State in
5 which State or applicable local law provides for the
6 licensing of entities of this nature, the entity (i) is
7 licensed pursuant to such law, or (ii) is approved, by
8 the agency of such State or locality responsible for
9 licensing entities of this nature, as meeting the
10 standards established for such licensing.

11 “(J) The entity meets such other requirements
12 as the Secretary may determine are necessary to as-
13 sure the safe and effective provision of home infu-
14 sion drug therapy services and the efficient adminis-
15 tration of the home infusion drug therapy benefit.”.

16 (c) PAYMENT.—

17 (1) IN GENERAL.—Section 1833 of such Act
18 (42 U.S.C. 1395l) is amended—

19 (A) in subsection (a)(2)(B), by striking “or
20 (E)” and inserting “(E), or (F)”,

21 (B) in subsection (a)(2)(D), by striking
22 “and” at the end,

23 (C) in subsection (a)(2)(E), by striking the
24 semicolon and inserting “; and”,

1 (D) by inserting after subsection (a)(2)(E)
2 the following new subparagraph:

3 “(F) with respect to home infusion drug
4 therapy services, the amounts described in sec-
5 tion 1834(j);”, and

6 (E) in the first sentence of subsection (b),
7 by striking “services, (3)” and inserting “serv-
8 ices and home infusion drug therapy services,
9 (3)”.

10 (2) AMOUNT DESCRIBED.—Section 1834 of
11 such Act, as amended by section 13544(b)(i) of
12 OBRA–1993, is amended by adding at the end the
13 following new subsection:

14 “(j) HOME INFUSION DRUG THERAPY SERVICES.—

15 “(1) IN GENERAL.—With respect to home infu-
16 sion drug therapy services, payment under this part
17 shall be made in an amount equal to the lesser of
18 the actual charges for such services or the fee sched-
19 ule established under paragraph (2).

20 “(2) ESTABLISHMENT OF FEE SCHEDULE.—

21 The Secretary shall establish by regulation before
22 the beginning of 1996 and each succeeding year a
23 fee schedule for home infusion drug therapy services
24 for which payment is made under this part. A fee

1 schedule established under this subsection shall be
2 on a per diem basis.”.

3 (3) PROHIBITION ON CERTAIN REFERRALS.—
4 Section 1877(h)(6) of such Act (42 U.S.C.
5 1395nn(h)(6)), as amended by section 13562(a) of
6 OBRA–1993, is amended by adding at the end the
7 following:

8 “(L) Home infusion drug therapy serv-
9 ices.”.

10 (d) CERTIFICATION.—Section 1835(a)(2) of such Act
11 (42 U.S.C. 1395n(a)(2)) is amended—

12 (1) by striking “and” at the end of subpara-
13 graph (E),

14 (2) by striking the period at the end of sub-
15 paragraph (F) and inserting “; and”, and

16 (3) by inserting after subparagraph (F) the fol-
17 lowing:

18 “(G) in the case of home infusion drug
19 therapy services, (i) such services are or were
20 required because the individual needed such
21 services for the administration of a covered
22 home infusion drug, (ii) a plan for furnishing
23 such services has been established and is re-
24 viewed periodically by a physician, and (iii)
25 such services are or were furnished while the in-

1 dividual is or was under the care of a physi-
2 cian.”.

3 (e) CERTIFICATION OF HOME INFUSION DRUG
4 THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR
5 NONCOMPLIANCE.—

6 (1) TREATMENT AS PROVIDER OF SERVICES.—
7 Section 1861(u) of such Act (42 U.S.C. 1395x(u))
8 is amended by inserting “home infusion drug ther-
9 apy provider,” after “hospice program,”.

10 (2) CONSULTATION WITH STATE AGENCIES AND
11 OTHER ORGANIZATIONS.—Section 1863 of such Act
12 (42 U.S.C. 1395z) is amended by striking “and
13 (dd)(2)” and inserting “(dd)(2), and (ll)(3)”.

14 (3) USE OF STATE AGENCIES IN DETERMINING
15 COMPLIANCE.—Section 1864(a) of such Act (42
16 U.S.C. 1395aa(a)) is amended—

17 (A) in the first sentence, by striking “an
18 agency is a hospice program” and inserting “an
19 agency or entity is a hospice program or a
20 home infusion drug therapy provider,”; and

21 (B) in the second sentence—

22 (i) by striking “institution or agency”
23 and inserting “institution, agency, or enti-
24 ty”, and

1 (ii) by striking “or hospice program”
2 and inserting “hospice program, or home
3 infusion drug therapy provider”.

4 (4) APPLICATION OF INTERMEDIATE SANC-
5 TIONS.—Section 1846 of such Act (42 U.S.C.
6 1395w-2) is amended—

7 (A) in the heading, by adding “AND FOR
8 QUALIFIED HOME INFUSION DRUG THERAPY
9 PROVIDERS” at the end,

10 (B) in subsection (a), by inserting “or that
11 a qualified home infusion drug therapy provider
12 that is certified for participation under this title
13 no longer substantially meets the requirements
14 of section 1861(l)(3)” after “under this part”,
15 and

16 (C) in subsection (b)(2)(A)(iv), by insert-
17 ing “or home infusion drug therapy services”
18 after “clinical diagnostic laboratory tests”.

19 (f) USE OF REGIONAL INTERMEDIARIES IN ADMINIS-
20 TRATION OF BENEFIT.—Section 1816 of such Act (42
21 U.S.C. 1395h) is amended by adding at the end the fol-
22 lowing new subsection:

23 “(k) With respect to carrying out functions relating
24 to payment for home infusion drug therapy services and
25 covered home infusion drugs, the Secretary may enter into

1 contracts with agencies or organizations under this section
2 to perform such functions on a regional basis.”.

3 (g) CONFORMING AMENDMENTS RELATING TO COV-
4 ERAGE OF ENTERAL AND PARENTERAL NUTRIENTS, SUP-
5 PLIES, AND EQUIPMENT.—(1) Section 1834(h)(4)(B) of
6 such Act (42 U.S.C. 1395m(h)(4)(B)) is amended by
7 striking “, except that” and all that follows through
8 “equipment”.

9 (2) Section 1861(s)(8) of such Act (42 U.S.C.
10 1395x(s)(8)) is amended by inserting after “dental” the
11 following: “devices or enteral and parenteral nutrients,
12 supplies, and equipment”.

13 **SEC. 2006. CONFORMING AMENDMENTS TO MEDICAID PRO-**
14 **GRAM.**

15 (a) IN GENERAL.—

16 (1) REQUIRING MEDICARE REBATE AS CONDI-
17 TION OF COVERAGE.—The first sentence of section
18 1927(a)(1) of the Social Security Act (42 U.S.C.
19 1396r–8(a)(1)) is amended—

20 (A) in the first sentence of paragraph (1),
21 by striking “and paragraph (6)” and inserting
22 “, paragraph (6), and (for calendar quarters be-
23 ginning on or after January 1, 1996) para-
24 graph (7)”; and

1 (B) by adding at the end the following new
2 paragraph:

3 “(7) REQUIREMENT RELATING TO REBATE
4 AGREEMENTS FOR COVERED OUTPATIENT DRUGS
5 UNDER MEDICARE PROGRAM.—A manufacturer
6 meets the requirements of this paragraph for quar-
7 ters in a year if the manufacturer has in effect an
8 agreement with the Secretary under section 1850 for
9 providing rebates for covered outpatient drugs fur-
10 nished to individuals under title XVIII during the
11 year.”.

12 (2) NON-DUPLICATION OF REBATES.—Section
13 1927(b)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is
14 amended—

15 (A) by redesignating subparagraph (B) as
16 subparagraph (C), and

17 (B) by inserting after subparagraph (A)
18 the following new subparagraph:

19 “(B) NON-DUPLICATION OF MEDICARE RE-
20 BATE.—Covered drugs furnished to an indi-
21 vidual eligible for benefits under part B of title
22 XVIII and enrolled in a State plan under this
23 title shall not be included in the determination
24 of units of covered outpatient drugs subject to
25 rebate under this section.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to quarters beginning on or
3 after January 1, 1996.

4 **SEC. 2007. EFFECTIVE DATE.**

5 Except as otherwise provided, the amendments made
6 by this subtitle shall apply to items and services furnished
7 on or after January 1, 1996.

8 **Subtitle B—Long-Term Care**

9 **PART 1—STATE PROGRAMS FOR HOME AND COM-**
10 **MUNITY-BASED SERVICES FOR INDIVIDUALS**
11 **WITH DISABILITIES**

12 **SEC. 2101. STATE PROGRAMS FOR HOME AND COMMUNITY-**
13 **BASED SERVICES FOR INDIVIDUALS WITH**
14 **DISABILITIES.**

15 (a) IN GENERAL.—Each State that has a plan for
16 the home and community-based services to individuals
17 with disabilities submitted to and approved by the Sec-
18 retary under section 2102(b) is entitled to payment in ac-
19 cordance with section 2108.

20 (b) NO INDIVIDUAL ENTITLEMENT ESTABLISHED.—
21 Nothing in this part shall be construed to create an enti-
22 tlement for individuals or a requirement that a State with
23 such an approved plan expend the entire amount of funds
24 to which it is entitled in any year.

1 **SEC. 2102. STATE PLANS.**

2 (a) **PLAN REQUIREMENTS.**—In order to be approved
3 under subsection (b), a State plan for home and commu-
4 nity-based services for individuals with disabilities must
5 meet the following requirements:

6 (1) **ELIGIBILITY.**—

7 (A) **IN GENERAL.**—Within the amounts
8 provided by the State (and under section 2108)
9 for such plan, the plan shall provide that serv-
10 ices under the plan will be available to individ-
11 uals with disabilities (as defined in section
12 2103(a)) in the State.

13 (B) **INITIAL SCREENING.**—The plan shall
14 provide a process for the initial screening of in-
15 dividuals who appear to have some reasonable
16 likelihood of being an individual with disabil-
17 ities.

18 (C) **RESTRICTIONS.**—The plan may not
19 limit the eligibility of individuals with disabil-
20 ities based on—

21 (i) income,

22 (ii) age,

23 (iii) geography,

24 (iv) nature, severity, or category of
25 disability,

1 (v) residential setting (other than an
2 institutional setting), or

3 (vi) other grounds specified by the
4 Secretary.

5 (D) MAINTENANCE OF EFFORT.—The plan
6 must provide assurances that, in the case of an
7 individual receiving medical assistance for home
8 and community-based services under the State
9 medicaid plan as of the date of the enactment
10 of this Act, the State will continue to make
11 available (either under this plan, under the
12 State medicaid plan, or otherwise) to such indi-
13 vidual an appropriate level of assistance for
14 home and community-based services, taking
15 into account the level of assistance provided as
16 of such date and the individual's need for home
17 and community-based services.

18 (2) SERVICES.—

19 (A) SPECIFICATION.—Consistent with sec-
20 tion 2104, the plan shall specify—

21 (i) the services made available under
22 the plan,

23 (ii) the extent and manner in which
24 such services are allocated and made avail-
25 able to individuals with disabilities, and

1 (iii) the manner in which services
2 under the plan are coordinated with each
3 other and with health and long-term care
4 services available outside the plan for indi-
5 viduals with disabilities.

6 (B) ALLOCATION.—The State plan—

7 (i) shall specify how it will allocate
8 services under the plan, during and after
9 the 7-fiscal-year phase-in period beginning
10 with fiscal year 1996, among covered indi-
11 viduals with disabilities, and

12 (ii) may not allocate such services
13 based on the income or other financial re-
14 sources of such individuals.

15 (C) LIMITATION ON LICENSURE OR CER-
16 TIFICATION.—The State may not subject con-
17 sumer-directed providers of personal assistance
18 services to licensure, certification, or other re-
19 quirements which the Secretary finds not to be
20 necessary for the health and safety of individ-
21 uals with disabilities.

22 (D) CONSUMER CHOICE.—To the extent
23 possible, the choice of an individual with dis-
24 abilities (and that individual's family) regarding
25 which covered services to receive and the pro-

1 viders who will provide such services shall be
2 followed.

3 (E) REQUIREMENT TO SERVE LOW-INCOME
4 INDIVIDUALS.—The plan shall assure that—

5 (i) the proportion of the population of
6 low-income individuals with disabilities in
7 the State that represents individuals with
8 disabilities who are provided home and
9 community-based services either under the
10 plan, under the State medicaid plan, or
11 under both, is not less than

12 (ii) the proportion of the population of
13 the State that represents individuals who
14 are low-income individuals.

15 (3) COST SHARING.—The plan shall impose cost
16 sharing with respect to covered services only in ac-
17 cordance with section 2105.

18 (4) TYPES OF PROVIDERS AND REQUIREMENTS
19 FOR PARTICIPATION.—The plan shall specify—

20 (A) the types of service providers eligible
21 to participate in the program under the plan,
22 which shall include consumer-directed providers,
23 and

24 (B) any requirements for participation ap-
25 plicable to each type of service provider.

1 (5) BUDGET.—The plan shall specify how the
2 State will manage Federal and State funds available
3 under the plan for each fiscal year during the period
4 beginning with fiscal year 1996 and ending with fis-
5 cal year 2003 and for each 5-fiscal-year periods
6 thereafter to serve all categories of individuals with
7 disabilities and meet the requirements of this sub-
8 section. If the Secretary makes an adjustment under
9 section 2109(a)(5)(C) for a year, each State shall
10 update the specifications under this paragraph to re-
11 flect the impact of such an adjustment.

12 (6) PROVIDER REIMBURSEMENT.—

13 (A) PAYMENT METHODS.—The plan shall
14 specify the payment methods to be used to re-
15 imburse providers for services furnished under
16 the plan. Such methods may include retrospec-
17 tive reimbursement on a fee-for-service basis,
18 prepayment on a capitation basis, payment by
19 cash or vouchers to individuals with disabilities,
20 or any combination of these methods. In the
21 case of the use of cash or vouchers, the plan
22 shall specify how the plan will assure compli-
23 ance with applicable employment tax provisions.

24 (B) PAYMENT RATES.—The plan shall
25 specify the methods and criteria to be used to

1 set payment rates for services furnished under
2 the plan (including rates for cash payments or
3 vouchers to individuals with disabilities).

4 (C) PLAN PAYMENT AS PAYMENT IN
5 FULL.—The plan shall restrict payment under
6 the plan for covered services to those providers
7 that agree to accept the payment under the
8 plan (at the rates established pursuant to sub-
9 paragraph (B)) and any cost sharing permitted
10 or provided for under section 2105 as payment
11 in full for services furnished under the plan.

12 (7) QUALITY ASSURANCE AND SAFEGUARDS.—
13 The State plan shall provide for quality assurance
14 and safeguards for applicants and beneficiaries in
15 accordance with section 2106.

16 (8) ADVISORY GROUP.—The State plan shall—
17 (A) assure the establishment and mainte-
18 nance of an advisory group under section
19 2107(b), and

20 (B) include the documentation prepared by
21 the group under section 2107(b)(4).

22 (9) ADMINISTRATION.—

23 (A) STATE AGENCY.—The plan shall des-
24 ignate a State agency or agencies to administer
25 (or to supervise the administration of) the plan.

1 (B) ADMINISTRATIVE EXPENDITURES.—
2 Effective beginning with fiscal year 2003, the
3 plan shall contain assurances that not more
4 than 10 percent of expenditures under the plan
5 for all quarters in any fiscal year shall be for
6 administrative costs.

7 (C) COORDINATION.—The plan shall speci-
8 fy how the plan—

9 (i) will be integrated with the State
10 medicaid plan, titles V and XX of the So-
11 cial Security Act, programs under the
12 Older Americans Act of 1965, programs
13 under the Developmental Disabilities As-
14 sistance and Bill of Rights Act, the Indi-
15 viduals with Disabilities Education Act,
16 and any other Federal or State programs
17 that provide services or assistance targeted
18 to individuals with disabilities, and

19 (ii) will be coordinated with health
20 plans.

21 (10) REPORTS AND INFORMATION TO SEC-
22 RETARY; AUDITS.—The plan shall provide that the
23 State will furnish to the Secretary—

24 (A) such reports, and will cooperate with
25 such audits, as the Secretary determines are

1 needed concerning the State's administration of
2 its plan under this part, including the proc-
3 essing of claims under the plan, and

4 (B) such data and information as the Sec-
5 retary may require in order to carry out the
6 Secretary's responsibilities.

7 (11) USE OF STATE FUNDS FOR MATCHING.—
8 The plan shall provide assurances that Federal
9 funds will not be used to provide for the State share
10 of expenditures under this part.

11 (12) HEALTH CARE WORKER REDEPLOYMENT
12 REQUIREMENT.—The plan provides for compliance
13 with the requirement of section 3074(a).

14 (b) APPROVAL OF PLANS.—The Secretary shall ap-
15 prove a plan submitted by a State if the Secretary deter-
16 mines that the plan—

17 (1) was developed by the State after consulta-
18 tion with individuals with disabilities and representa-
19 tives of groups of such individuals, and

20 (2) meets the requirements of subsection (a).

21 The approval of such a plan shall take effect as of the
22 first day of the first fiscal year beginning after the date
23 of such approval (except that any approval made before
24 January 1, 1996, shall be effective as of January 1, 1996).

25 In order to budget funds allotted under this part, the Sec-

1 retary may establish a deadline for the submission of such
2 a plan before the beginning of a fiscal year as a condition
3 of its approval effective with that fiscal year.

4 (c) MONITORING.—The Secretary shall monitor the
5 compliance of State plans with the eligibility requirements
6 of section 2103 and may monitor the compliance of such
7 plans with other requirements of this part.

8 (d) REGULATIONS.—The Secretary shall issue such
9 regulations as may be appropriate to carry out this part
10 on a timely basis.

11 **SEC. 2103. INDIVIDUALS WITH DISABILITIES DEFINED.**

12 (a) IN GENERAL.—In this part, the term “individual
13 with disabilities” means any individual within one or more
14 of the following 4 categories of individuals:

15 (1) INDIVIDUALS REQUIRING HELP WITH AC-
16 TIVITIES OF DAILY LIVING.—An individual of any
17 age who—

18 (A) requires hands-on or standby assist-
19 ance, supervision, or cueing (as defined in regu-
20 lations) to perform three or more activities of
21 daily living (as defined in subsection (c)), and

22 (B) is expected to require such assistance,
23 supervision, or cueing over a period of at least
24 100 days.

1 (2) INDIVIDUALS WITH SEVERE COGNITIVE OR
2 MENTAL IMPAIRMENT.—An individual of any age—

3 (A) whose score, on a standard mental sta-
4 tus protocol (or protocols) appropriate for
5 measuring the individual's particular condition
6 specified by the Secretary, indicates either se-
7 vere cognitive impairment or severe mental im-
8 pairment, or both;

9 (B) who—

10 (i) requires hands-on or standby as-
11 sistance, supervision, or cueing with one or
12 more activities of daily living,

13 (ii) requires hands-on or standby as-
14 sistance, supervision, or cueing with at
15 least such instrumental activity (or activi-
16 ties) of daily living related to cognitive or
17 mental impairment as the Secretary speci-
18 fies, or

19 (iii) displays symptoms of one or more
20 serious behavioral problems (that is on a
21 list of such problems specified by the Sec-
22 retary) which create a need for supervision
23 to prevent harm to self or others; and

1 (C) whose is expected to meet the require-
2 ments of subparagraphs (A) and (B) over a pe-
3 riod of at least 100 days.

4 (3) INDIVIDUALS WITH SEVERE OR PROFOUND
5 MENTAL RETARDATION.—An individual of any age
6 who has severe or profound mental retardation (as
7 determined according to a protocol specified by the
8 Secretary).

9 (4) SEVERELY DISABLED CHILDREN.—An indi-
10 vidual under 6 years of age who—

11 (A) has a severe disability or chronic med-
12 ical condition,

13 (B) but for receiving personal assistance
14 services or any of the services described in sec-
15 tion 2104(d)(1), would require institutionaliza-
16 tion in a hospital, nursing facility, or inter-
17 mediate care facility for the mentally retarded,
18 and

19 (C) is expected to have such disability or
20 condition and require such services over a pe-
21 riod of at least 100 days.

22 (b) DETERMINATION.—

23 (1) IN GENERAL.—The determination of wheth-
24 er an individual is an individual with disabilities
25 shall be made, by persons or entities specified under

1 the State plan, using a uniform protocol consisting
2 of an initial screening and assessment specified by
3 the Secretary. A State may collect additional infor-
4 mation, at the time of obtaining information to
5 make such determination, in order to provide for the
6 assessment and plan described in section 2104(b) or
7 for other purposes. The State shall establish a fair
8 hearing process for appeals of such determinations.

9 (2) PERIODIC REASSESSMENT.—The determina-
10 tion that an individual is an individual with disabil-
11 ities shall be considered to be effective under the
12 State plan for a period of not more than 12 months
13 (or for such longer period in such cases as a signifi-
14 cant change in an individual’s condition that may af-
15 fect such determination is unlikely). A reassessment
16 shall be made if there is a significant change in an
17 individual’s condition that may affect such deter-
18 mination.

19 (c) ACTIVITY OF DAILY LIVING DEFINED.—In this
20 part, the term “activity of daily living” means any of the
21 following: eating, toileting, dressing, bathing, and trans-
22 ferring.

23 **SEC. 2104. HOME AND COMMUNITY-BASED SERVICES COV-**
24 **ERED UNDER STATE PLAN.**

25 (a) SPECIFICATION.—

1 (1) IN GENERAL.—Subject to the succeeding
2 provisions of this section, the State plan under this
3 part shall specify—

4 (A) the home and community-based serv-
5 ices available under the plan to individuals with
6 disabilities (or to such categories of such indi-
7 viduals), and

8 (B) any limits with respect to such serv-
9 ices.

10 (2) FLEXIBILITY IN MEETING INDIVIDUAL
11 NEEDS.—The services shall be specified in a manner
12 that permits sufficient flexibility for providers to
13 meet the needs of individuals with disabilities in a
14 cost effective manner. Subject to subsection
15 (e)(1)(B), such services may be delivered in an indi-
16 vidual’s home, a range of community residential ar-
17 rangements, or outside the home.

18 (b) REQUIREMENT FOR NEEDS ASSESSMENT AND
19 PLAN OF CARE.—

20 (1) IN GENERAL.—The State plan shall provide
21 for home and community-based services to an indi-
22 vidual with disabilities only if—

23 (A) a comprehensive assessment of the in-
24 dividual’s need for home and community-based
25 services (regardless of whether all needed serv-

1 ices are available under the plan) has been
2 made,

3 (B) an individualized plan of care based on
4 such assessment is developed, and

5 (C) such services are provided consistent
6 with such plan of care.

7 (2) INVOLVEMENT OF INDIVIDUALS.—The indi-
8 vidualized plan of care under paragraph (1)(B) for
9 an individual with disabilities shall—

10 (A) be developed by qualified individuals
11 (specified under the State plan),

12 (B) be developed and implemented in close
13 consultation with the individual and the individ-
14 ual's family,

15 (C) be approved by the individual (or the
16 individual's representative), and

17 (D) be reviewed and updated not less often
18 than every 6 months.

19 (3) PLAN OF CARE.—The plan of care under
20 paragraph (1)(B) shall—

21 (A) specify which services specified under
22 the individual plan will be provided under the
23 State plan under this part,

24 (B) identify (to the extent possible) how
25 the individual will be provided any services

1 specified under the plan of care and not pro-
2 vided under the State plan, and

3 (C) specify how the provision of services to
4 the individual under the plan will be coordi-
5 nated with the provision of other health care
6 services to the individual.

7 The State shall make reasonable efforts to identify
8 and arrange for services described in subparagraph
9 (B). Nothing in this subsection shall be construed as
10 requiring a State (under the State plan or other-
11 wise) to provide all the services specified in such a
12 plan.

13 (c) MANDATORY COVERAGE OF PERSONAL ASSIST-
14 ANCE SERVICES.—The State plan shall include, in the
15 array of services made available to each category of indi-
16 viduals with disabilities, both agency-administered and
17 consumer-directed personal assistance services (as defined
18 in subsection (g)).

19 (d) ADDITIONAL SERVICES.—

20 (1) TYPES OF SERVICES.—Subject to subsection
21 (e), services available under a State plan under this
22 part shall include any (or all) of the following:

23 (A) Case management.

24 (B) Homemaker and chore assistance.

25 (C) Home modifications.

1 (D) Respite services.

2 (E) Assistive devices.

3 (F) Adult day services.

4 (G) Habilitation and rehabilitation.

5 (H) Supported employment.

6 (I) Home health services.

7 (J) Any other care or assistive services
8 (approved by the Secretary) that the State de-
9 termines will help individuals with disabilities to
10 remain in their homes and communities.

11 (2) CRITERIA FOR SELECTION OF SERVICES.—

12 The State plan shall specify—

13 (A) the methods and standards used to se-
14 lect the types, and the amount, duration, and
15 scope, of services to be covered under the plan
16 and to be available to each category of individ-
17 uals with disabilities, and

18 (B) how the types, and the amount, dura-
19 tion, and scope, of services specified meet the
20 needs of individuals within each of the 4 cat-
21 egories of individuals with disabilities.

22 (e) EXCLUSIONS AND LIMITATIONS.—

23 (1) IN GENERAL.—A State plan may not pro-
24 vide for coverage of—

25 (A) room and board,

1 (B) services furnished in a hospital, nurs-
2 ing facility, intermediate care facility for the
3 mentally retarded, or other institutional setting
4 specified by the Secretary, or

5 (C) items and services to the extent cov-
6 erage is provided for the individual under a
7 health plan or the medicare program.

8 (2) TAKING INTO ACCOUNT INFORMAL CARE.—

9 A State plan may take into account, in determining
10 the amount and array of services made available to
11 covered individuals with disability, the availability of
12 informal care.

13 (f) PAYMENT FOR SERVICES.—A State plan may pro-
14 vide for the use of—

15 (1) vouchers,

16 (2) cash payments directly to individuals with
17 disabilities,

18 (3) capitation payments to health plans, and

19 (4) payment to providers,

20 to pay for covered services.

21 (g) PERSONAL ASSISTANCE SERVICES.—

22 (1) IN GENERAL.—In this section, the term
23 “personal assistance services” means those services
24 specified under the State plan as personal assistance
25 services and shall include at least hands-on and

1 standby assistance, supervision, and cueing with ac-
2 tivities of daily living, whether agency-administered
3 or consumer-directed (as defined in paragraph (2)).

4 (2) CONSUMER-DIRECTED; AGENCY-ADMINIS-
5 TERED.—In this part:

6 (A) The term “consumer-directed” means,
7 with reference to personal assistance services or
8 the provider of such services, services that are
9 provided by an individual who is selected and
10 managed (and, at the individual’s option,
11 trained) by the individual receiving the services.

12 (B) The term “agency-administered”
13 means, with respect to such services, services
14 that are not consumer-directed.

15 **SEC. 2105. COST SHARING.**

16 (a) NO OR NOMINAL COST SHARING FOR POOR-
17 EST.—The State plan may not impose any cost sharing
18 (other than nominal cost sharing) for individuals with in-
19 come (as determined under subsection (c)) less than 150
20 percent of the official poverty line (referred to in section
21 1902(25)(A)) applicable to a family of the size involved
22 (determined without regard to section 1902(25)(B)).

23 (b) SLIDING SCALE FOR REMAINDER.—The State
24 plan shall impose cost sharing in the form of coinsurance

1 (based on the amount paid under the State plan for a serv-
2 ice)—

3 (1) at a rate of 10 percent for individuals with
4 disabilities with income not less than 150 percent,
5 and less than 200 percent, of such official poverty
6 line (as so applied);

7 (2) at a rate of 20 percent for such individuals
8 with income not less than 200 percent, and less than
9 250 percent, of such official poverty line (as so ap-
10 plied); and

11 (3) at a rate of 25 percent for such individuals
12 with income equal to at least 250 percent of such of-
13 ficial poverty line (as so applied).

14 (c) DETERMINATION OF INCOME FOR PURPOSES OF
15 COST SHARING.—The State plan shall specify the process
16 to be used to determine the income of an individual with
17 disabilities for purposes of this section. Such process shall
18 be consistent with standards specified by the Secretary.

19 **SEC. 2106. QUALITY ASSURANCE AND SAFEGUARDS.**

20 (a) QUALITY ASSURANCE.—The State plan shall
21 specify how the State will ensure and monitor the quality
22 of services, including—

23 (1) safeguarding the health and safety of indi-
24 viduals with disabilities,

1 (2) the minimum standards for agency pro-
2 viders and how such standards will be enforced,

3 (3) the minimum competency requirements for
4 agency provider employees who provide direct serv-
5 ices under this part and how the competency of such
6 employees will be enforced,

7 (4) obtaining meaningful consumer input, in-
8 cluding consumer surveys that measure the extent to
9 which participants receive the services described in
10 the plan of care and participant satisfaction with
11 such services,

12 (5) participation in quality assurance activities,
13 and

14 (6) specifying the role of the long-term care om-
15 budsman (under the Older Americans Act of 1965)
16 and the Protection and Advocacy Agency (under the
17 Developmental Disabilities Assistance and Bill of
18 Rights Act) in assuring quality of services and pro-
19 tecting the rights of individuals with disabilities.

20 (b) SAFEGUARDS.—

21 (1) CONFIDENTIALITY.—The State plan shall
22 provide safeguards which restrict the use or disclo-
23 sure of information concerning applicants and bene-
24 ficiaries to purposes directly connected with the ad-

1 ministration of the plan (including performance re-
2 views under section 2602).

3 (2) SAFEGUARDS AGAINST ABUSE.—The State
4 plans shall provide safeguards against physical, emo-
5 tional, or financial abuse or exploitation (specifically
6 including appropriate safeguards in cases where pay-
7 ment for program benefits is made by cash pay-
8 ments or vouchers given directly to individuals with
9 disabilities).

10 **SEC. 2107. ADVISORY GROUPS.**

11 (a) FEDERAL ADVISORY GROUP.—

12 (1) ESTABLISHMENT.—The Secretary shall es-
13 tablish an advisory group, to advise the Secretary
14 and States on all aspects of the program under this
15 part.

16 (2) COMPOSITION.—The group shall be com-
17 posed of individuals with disabilities and their rep-
18 resentatives, providers, Federal and State officials,
19 and local community implementing agencies. A ma-
20 jority of its members shall be individuals with dis-
21 abilities and their representatives.

22 (b) STATE ADVISORY GROUPS.—

23 (1) IN GENERAL.—Each State plan shall pro-
24 vide for the establishment and maintenance of an

1 advisory group to advise the State on all aspects of
2 the State plan under this part.

3 (2) COMPOSITION.—Members of each advisory
4 group shall be appointed by the Governor (or other
5 chief executive officer of the State) and shall include
6 individuals with disabilities and their representa-
7 tives, providers, State officials, and local community
8 implementing agencies. A majority of its members
9 shall be individuals with disabilities and their rep-
10 resentatives.

11 (3) SELECTION OF MEMBERS.—Each State
12 shall establish a process whereby all residents of the
13 State, including individuals with disabilities and
14 their representatives, shall be given the opportunity
15 to nominate members to the advisory group.

16 (4) PARTICULAR CONCERNS.—Each advisory
17 group shall—

18 (A) before the State plan is developed, ad-
19 vise the State on guiding principles and values,
20 policy directions, and specific components of the
21 plan,

22 (B) meet regularly with State officials in-
23 volved in developing the plan, during the devel-
24 opment phase, to review and comment on all as-
25 pects of the plan,

1 (C) participate in the public hearings to
2 help assure that public comments are addressed
3 to the extent practicable,

4 (D) document any differences between the
5 group's recommendations and the plan,

6 (E) document specifically the degree to
7 which the plan is consumer-directed, and

8 (F) meet regularly with officials of the des-
9 ignated State agency (or agencies) to provide
10 advice on all aspects of implementation and
11 evaluation of the plan.

12 **SEC. 2108. PAYMENTS TO STATES.**

13 (a) IN GENERAL.—Subject to section 2102(a)(9)(B)
14 (relating to limitation on payment for administrative
15 costs), the Secretary, in accordance with the Cash Man-
16 agement Improvement Act, shall authorize payment to
17 each State with a plan approved under this part, for each
18 quarter (beginning on or after January 1, 1996), from its
19 allotment under section 2109(b), an amount equal to—

20 (1) the Federal matching percentage (as de-
21 fined in subsection (b)) of amount demonstrated by
22 State claims to have been expended during the quar-
23 ter for home and community-based services under
24 the plan for individuals with disabilities; plus

1 (2) an amount equal to 90 percent of amount
2 expended during the quarter under the plan for ac-
3 tivities (including preliminary screening) relating to
4 determination of eligibility and performance of needs
5 assessment; plus

6 (3) an amount equal to 90 percent (or, begin-
7 ning with quarters in fiscal year 2003, 75 percent)
8 of the amount expended during the quarter for the
9 design, development, and installation of mechanical
10 claims processing systems and for information re-
11 trieval; plus

12 (4) an amount equal to 50 percent of the re-
13 mainder of the amounts expended during the quar-
14 ter as found necessary by the Secretary for the prop-
15 er and efficient administration of the State plan.

16 (b) FEDERAL MATCHING PERCENTAGE.—

17 (1) IN GENERAL.—In subsection (a), the term
18 “Federal matching percentage” means, with respect
19 to a State, the reference percentage specified in
20 paragraph (2) increased by 28 percentage points, ex-
21 cept that the Federal matching percentage shall in
22 no case be less than 78 percent or more than 95
23 percent.

24 (2) REFERENCE PERCENTAGE.—

1 (A) IN GENERAL.—The reference percent-
2 age specified in this paragraph is 100 percent
3 less the State percentage specified in subpara-
4 graph (B), except that—

5 (i) the percentage under this para-
6 graph shall in no case be less than 50 per-
7 cent or more than 83 percent, and

8 (ii) the percentage for Puerto Rico,
9 the Virgin Islands, Guam, the Northern
10 Mariana Islands, and American Samoa
11 shall be 50 percent.

12 (B) STATE PERCENTAGE.—The State per-
13 centage specified in this subparagraph is that
14 percentage which bears the same ratio to 45
15 percent as the square of the per capita income
16 of such State bears to the square of the per
17 capita income of the continental United States
18 (including Alaska) and Hawaii.

19 (c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE
20 ADJUSTMENTS.—The method of computing and making
21 payments under this section shall be as follows:

22 (1) The Secretary shall, prior to the beginning
23 of each quarter, estimate the amount to be paid to
24 the State under subsection (a) for such quarter,
25 based on a report filed by the State containing its

1 estimate of the total sum to be expended in such
2 quarter, and such other information as the Secretary
3 may find necessary.

4 (2) From the allotment available therefore, the
5 Secretary shall provide for payment of the amount
6 so estimated, reduced or increased, as the case may
7 be, by any sum (not previously adjusted under this
8 section) by which the Secretary finds that the esti-
9 mate of the amount to be paid the State for any
10 prior period under this section was greater or less
11 than the amount which should have been paid.

12 (d) APPLICATION OF RULES REGARDING LIMITA-
13 TIONS ON PROVIDER-RELATED DONATIONS AND HEALTH
14 CARE RELATED TAXES.—The provisions of section
15 1903(w) of the Social Security Act shall apply to pay-
16 ments to States under this section in the same manner
17 as they apply to payments to States under section 1903(a)
18 of such Act .

19 **SEC. 2109. TOTAL FEDERAL BUDGET; ALLOTMENTS TO**
20 **STATES.**

21 (a) TOTAL FEDERAL BUDGET.—

22 (1) FISCAL YEARS 1996 THROUGH 2003.—Sub-
23 ject to paragraph (5)(C), for purposes of this part,
24 the total Federal budget for State plans under this

1 part for each of fiscal years 1996 through 2003 is
2 the following:

3 (A) For fiscal year 1996, \$4.5 billion.

4 (B) For fiscal year 1997, \$7.8 billion.

5 (C) For fiscal year 1998, \$11.0 billion.

6 (D) For fiscal year 1999, \$14.7 billion.

7 (E) For fiscal year 2000, \$18.7 billion.

8 (F) For fiscal year 2001, \$26.7 billion.

9 (G) For fiscal year 2002, \$35.5 billion.

10 (H) For fiscal year 2003, \$38.3 billion.

11 (2) SUBSEQUENT FISCAL YEARS.—For pur-
12 poses of this part, the total Federal budget for State
13 plans under this part for each fiscal year after fiscal
14 year 2003 is the total Federal budget under this
15 subsection for the preceding fiscal year multiplied
16 by—

17 (A) a factor (described in paragraph (3))
18 reflecting the change in the CPI for the fiscal
19 year, and

20 (B) a factor (described in paragraph (4))
21 reflecting the change in the number of individ-
22 uals with disabilities for the fiscal year.

23 (3) CPI INCREASE FACTOR.—For purposes of
24 paragraph (2)(A), the factor described in this para-
25 graph for a fiscal year is the ratio of—

1 (A) the annual average index of the con-
2 sumer price index for the preceding fiscal year,
3 to—

4 (B) such index, as so measured, for the
5 second preceding fiscal year.

6 (4) DISABLED POPULATION FACTOR.—For pur-
7 poses of paragraph (2)(B), the factor described in
8 this paragraph for a fiscal year is 100 percent plus
9 (or minus) the percentage increase (or decrease)
10 change in the disabled population of the United
11 States (as determined for purposes of the most re-
12 cent update under subsection (b)(3)(D)).

13 (5) ADDITIONAL FUNDS DUE TO MEDICAID
14 OFFSETS.—

15 (A) IN GENERAL.—Each participating
16 State must provide the Secretary with informa-
17 tion concerning offsets and reductions in the
18 medicaid program resulting from home and
19 community-based services provided disabled in-
20 dividuals under this part, that would have been
21 paid for such individuals under the State med-
22 icaid plan but for the provision of similar serv-
23 ices under the program under this part. At the
24 time a State first submits its plan under this
25 title and before each subsequent fiscal year

1 (through fiscal year 2003), the State also must
2 provide the Secretary with such budgetary in-
3 formation (for each fiscal year through fiscal
4 year 2003), as the Secretary determines to be
5 necessary to carry out this paragraph.

6 (B) REPORTS.—Each State with a pro-
7 gram under this part shall submit such reports
8 to the Secretary as the Secretary may require
9 in order to monitor compliance with subpara-
10 graph (A).

11 (C) ADJUSTMENTS TO FEDERAL BUDG-
12 ET.—

13 (i) IN GENERAL.—For each fiscal year
14 (beginning with fiscal year 1996 and end-
15 ing with fiscal year 2003) and based on a
16 review of information submitted under sub-
17 paragraph (A), the Secretary shall deter-
18 mine the amount by which the total Fed-
19 eral budget under subsection (a) will in-
20 crease. The amount of such increase for a
21 fiscal year shall be limited to the reduction
22 in Federal expenditures of medical assist-
23 ance (as determined by Secretary) that
24 would have been made under title XIX of
25 the Social Security Act for home and com-

1 community based services for disabled individ-
2 uals but for the provision of similar serv-
3 ices under the program under this part.

4 (ii) ANNUAL PUBLICATION.—The Sec-
5 retary shall publish before the beginning of
6 such fiscal year, the revised total Federal
7 budget under this subsection for such fis-
8 cal year (and succeeding fiscal years before
9 fiscal year 2003).

10 (D) NO DUPLICATE PAYMENT.—No pay-
11 ment may be made to a State under this section
12 for any services to the extent that the State re-
13 ceived payment for such services under section
14 1903(a) of the Social Security Act.

15 (E) CONSTRUCTION.—Nothing in this sub-
16 section shall be construed as requiring States to
17 determine eligibility for medical assistance
18 under the State medicaid plan on behalf of indi-
19 viduals receiving assistance under this part.

20 (b) ALLOTMENTS TO STATES.—

21 (1) IN GENERAL.—The Secretary shall allot to
22 each State for each fiscal year an amount that bears
23 the same ratio to the total Federal budget for the
24 fiscal year (specified under paragraph (1) or (2) of
25 subsection (a)) as the State allotment factor (under

1 paragraph (2) for the State for the fiscal year) bears
2 to the sum of such factors for all States for that fis-
3 cal year.

4 (2) STATE ALLOTMENT FACTOR.—

5 (A) IN GENERAL.—For each State for each
6 fiscal year, the Secretary shall compute a State
7 allotment factor equal to the sum of—

8 (i) the base allotment factor (specified
9 in subparagraph (B)), and

10 (ii) the low income allotment factor
11 (specified in subparagraph (C)),
12 for the State for the fiscal year.

13 (B) BASE ALLOTMENT FACTOR.—The base
14 allotment factor, specified in this subparagraph,
15 for a State for a fiscal year is equal to the
16 product of the following:

17 (i) NUMBER OF INDIVIDUALS WITH
18 DISABILITIES.—The number of individuals
19 with disabilities in the State (determined
20 under paragraph (3)) for the fiscal year.

21 (ii) 80 PERCENT OF THE NATIONAL
22 PER CAPITA BUDGET.—80 percent of the
23 national average per capita budget amount
24 (determined under paragraph (4)) for the
25 fiscal year.

1 (iii) WAGE ADJUSTMENT FACTOR.—

2 The wage adjustment factor (determined
3 under paragraph (5)) for the State for the
4 fiscal year.

5 (iv) FEDERAL MATCHING RATE.—The
6 Federal matching rate (determined under
7 section 2108(b)) for the fiscal year.

8 (C) LOW INCOME ALLOTMENT FACTOR.—
9 The low income allotment factor, specified in
10 this subparagraph, for a State for a fiscal year
11 is equal to the product of the following:

12 (i) NUMBER OF INDIVIDUALS WITH
13 DISABILITIES.—The number of individuals
14 with disabilities in the State (determined
15 under paragraph (3)) for the fiscal year.

16 (ii) 10 PERCENT OF THE NATIONAL
17 PER CAPITA BUDGET.—10 percent of the
18 national average per capita budget amount
19 (determined under paragraph (4)) for the
20 fiscal year.

21 (iii) WAGE ADJUSTMENT FACTOR.—
22 The wage adjustment factor (determined
23 under paragraph (5)) for the State for the
24 fiscal year.

1 (iv) FEDERAL MATCHING RATE.—The
2 Federal matching rate (determined under
3 section 2108(b)) for the fiscal year.

4 (v) LOW INCOME INDEX.—The low in-
5 come index (determined under paragraph
6 (6)) for the State for the preceding fiscal
7 year.

8 (3) NUMBER OF INDIVIDUALS WITH DISABIL-
9 ITIES.—The number of individuals with disabilities
10 in a State for a fiscal year shall be determined as
11 follows:

12 (A) BASE.—The Secretary shall determine
13 the number of individuals in the State by age,
14 sex, and income category, based on the 1990
15 decennial census, adjusted (as appropriate) by
16 the March 1994 current population survey.

17 (B) DISABILITY PREVALENCE LEVEL BY
18 POPULATION CATEGORY.—The Secretary shall
19 determine, for each such age, sex, and income
20 category, the national average proportion of the
21 population of such category that represents in-
22 dividuals with disabilities. The Secretary may
23 conduct periodic surveys in order to determine
24 such proportions.

1 (C) BASE DISABLED POPULATION IN A
2 STATE.—The number of individuals with dis-
3 abilities in a State in 1994 is equal to the sum
4 of the products, for such each age, sex, and in-
5 come category, of—

6 (i) the population of individuals in the
7 State in the category (determined under
8 subparagraph (A)), and

9 (ii) the national average proportion
10 for such category (determined under sub-
11 paragraph (B)).

12 (D) UPDATE.—The Secretary shall deter-
13 mine the number of individuals with disabilities
14 in a State in a fiscal year equal to the number
15 determined under subparagraph (C) for the
16 State increased (or decreased) by the percent-
17 age increase (or decrease) in the disabled popu-
18 lation of the State as determined under the cur-
19 rent population survey from 1994 to the year
20 before the fiscal year involved.

21 (4) NATIONAL PER CAPITA BUDGET AMOUNT.—
22 The national average per capita budget amount, for
23 a fiscal year, is—

1 (A) the total Federal budget specified
2 under subsection (a) for the fiscal year; divided
3 by

4 (B) the sum, for the fiscal year, of the
5 numbers of individuals with disabilities (deter-
6 mined under paragraph (3)) for all the States
7 for the fiscal year.

8 (5) WAGE ADJUSTMENT FACTOR.—The wage
9 adjustment factor, for a State for a fiscal year, is
10 equal to the ratio of—

11 (A) the average hourly wages for service
12 workers (other than household or protective
13 services) in the State, to

14 (B) the national average hourly wages for
15 service workers (other than household or protec-
16 tive services).

17 The hourly wages shall be determined under this
18 paragraph based on data from the most recent de-
19 cennial census for which such data are available.

20 (6) LOW INCOME INDEX.—The low income
21 index for each State for a fiscal year is the ratio, de-
22 termined for the preceding fiscal year, of—

23 (A) the percentage of the State's popu-
24 lation that has income below 150 percent of the
25 poverty level, to

1 (B) the percentage of the population of the
2 United States that has income below 150 per-
3 cent of the poverty level.

4 Such percentages shall be based on data from the
5 most recent decennial census for which such data
6 are available, adjusted by data from the most recent
7 current population survey as determined appropriate
8 by the Secretary.

9 (c) STATE ENTITLEMENT.—This part constitutes
10 budget authority in advance of appropriations Acts, and
11 represents the obligation of the Federal Government to
12 provide for the payment to States of amounts described
13 in subsection (a).

14 **PART 2—MEDICAID NURSING HOME**
15 **IMPROVEMENTS**

16 **SEC. 2201. REFERENCE TO AMENDMENTS.**

17 For amendments to the medicaid program under title
18 XIX of the Social Security Act to improve nursing home
19 benefits under such program, see part 2 of subtitle C of
20 title IV.

1 **PART 3—PRIVATE LONG-TERM CARE INSURANCE**

2 **Subpart A—General Provisions**

3 **SEC. 2301. FEDERAL REGULATIONS; PRIOR APPLICATION**

4 **OR CERTAIN REQUIREMENTS.**

5 (a) IN GENERAL.—The Secretary, with the advice
6 and assistance of the Advisory Council, as appropriate,
7 shall promulgate regulations as necessary to implement
8 the provisions of this part, in accordance with the time-
9 table specified in subsection (b).

10 (b) TIMETABLE FOR PUBLICATION OF REGULA-
11 TIONS.—

12 (1) FEDERAL REGISTER NOTICE.—Within 120
13 days after the date a majority of the members are
14 first appointed to the Advisory Council pursuant to
15 section 2302, the Secretary shall publish in the Fed-
16 eral Register a notice setting forth the projected
17 timetable for promulgation of regulations required
18 under this part. Such timetable shall indicate which
19 regulations are proposed to be published by the end
20 of the first, second, and third years after appoint-
21 ment of the Advisory Council.

22 (2) FINAL DEADLINE.—All regulations required
23 under this part shall be published by the end of the
24 third year after appointment of the Advisory Coun-
25 cil.

1 (c) PROVISIONS EFFECTIVE WITHOUT REGARD TO
2 PROMULGATION OF REGULATIONS.—

3 (1) IN GENERAL.—Notwithstanding any other
4 provision of this part, insurers shall be required, not
5 later than 6 months after the enactment of this Act,
6 regardless of whether final implementing regulations
7 have been promulgated by the Secretary, to comply
8 with the following provisions of this part:

9 (A) Section 2321(c) (standard outline of
10 coverage);

11 (B) Section 2321(d) (reporting to State in-
12 surance commissioners);

13 (C) Section 2322(b) (preexisting condition
14 exclusions);

15 (D) Section 2322(c) (limiting conditions on
16 benefits);

17 (E) Section 2322(d) (inflation protection);

18 (F) Section 2324 (sales practices);

19 (G) Section 2325 (continuation, renewal,
20 replacement, conversion, and cancellation of
21 policies); and

22 (H) Section 2326 (payment of benefits).

23 (2) INTERIM REQUIREMENTS.—Before the ef-
24 fective date of applicable regulations promulgated by
25 the Secretary implementing requirements of this

1 part as specified below, such requirements will be
2 considered to be met—

3 (A) in the case of section 2321(c) (requir-
4 ing a standard outline of coverage), if the long-
5 term care insurance policy meets the require-
6 ments of section 6.G.(2) of the NAIC Model
7 Act and of section 24 of the NAIC Model Regu-
8 lation;

9 (B) in the case of section 2321(d) (requir-
10 ing reporting to the State insurance commis-
11 sioner), if the insurer meets the requirements of
12 section 14 of the NAIC Model Regulation;

13 (C) in the case of section 2322(c)(1) (gen-
14 eral requirements concerning limiting conditions
15 on benefits), if such policy meets the require-
16 ments of section 6.D. of the NAIC Model Act;

17 (D) in the case of section 2322(c)(2) (lim-
18 iting conditions on home health care or commu-
19 nity-based services) if such policy meets the re-
20 quirements of section 11 of the NAIC Model
21 Regulations;

22 (E) in the case of section 2322(d) (con-
23 cerning inflation protection), if the insurer
24 meets the requirements of section 12 of the
25 NAIC Model Regulation;

1 (F) in the case of section 2324(b) (con-
2 cerning applications for the purchase of insur-
3 ance), if the insurer meets the requirements of
4 section 10 of the NAIC Model Regulation;

5 (G) in the case of section 2324(d) (con-
6 cerning compensation for the sale of policies), if
7 the insurer meets the requirements of the op-
8 tional regulation entitled “Permitted Compensa-
9 tion Arrangements” included in the NAIC
10 Model Regulation;

11 (H) in the case of section 2324(g) (con-
12 cerning sales through employers or membership
13 organizations), if the insurer and the member-
14 ship organization meet the requirements of sec-
15 tion 21.C. of the NAIC Model Regulation;

16 (I) in the case of section 2324(h) (con-
17 cerning interstate sales of group policies), if the
18 insurer and the policy meet the requirements of
19 section 5 of the NAIC Model Act; and

20 (J) in the case of section 2325(f) (con-
21 cerning continuation, renewal, replacement, and
22 conversion of policies), if the insurer and the
23 policy meet the requirements of section 7 of the
24 NAIC Model Regulation.

1 **SEC. 2302. NATIONAL LONG-TERM CARE INSURANCE ADVI-**
2 **SORY COUNCIL.**

3 (a) APPOINTMENT.—The Secretary shall appoint an
4 advisory board to be known as the National Long-Term
5 Care Insurance Advisory Council.

6 (b) COMPOSITION.—

7 (1) NUMBER AND QUALIFICATIONS OF MEM-
8 BERS.—The Advisory Council shall consist of 5
9 members, each of whom has substantial expertise in
10 matters relating to the provision and regulation of
11 long-term care insurance. At least one member shall
12 have experience as a State insurance commissioner
13 or legislator with expertise in policy development
14 with respect to, and regulation of, long-term care in-
15 surance.

16 (2) TERMS OF OFFICE.—

17 (A) IN GENERAL.—Except as otherwise
18 provided in this subsection, members shall be
19 appointed for terms of office of 5 years.

20 (B) INITIAL MEMBERS.—Of the initial
21 members of the Council, one shall be appointed
22 for a term of 5 years, one for 4 years, one for
23 3 years, one for 2 years, and one for 1 year.

24 (C) TWO-TERM LIMIT.—No member shall
25 be eligible to serve in excess of two consecutive

1 terms, but may continue to serve until such
2 member's successor is appointed.

3 (3) VACANCIES.—Any member appointed to fill
4 a vacancy occurring before the expiration of the
5 term of such member's predecessor shall be ap-
6 pointed for the remainder of such term.

7 (4) REMOVAL.—No member may be removed
8 during the member's term of office except for just
9 and sufficient cause.

10 (c) CHAIRPERSON.—The Secretary shall appoint a
11 Chairperson from among the members.

12 (d) COMPENSATION.—

13 (1) IN GENERAL.—Except as provided in para-
14 graph (3), members of the Advisory Council, while
15 serving on business of the Advisory Council, shall be
16 entitled to receive compensation at a rate not to ex-
17 ceed the daily equivalent of the rate specified for
18 level V of the Executive Schedule under section 5316
19 of title 5, United States Code.

20 (2) TRAVEL.—Except as provided in paragraph
21 (3), members of the Advisory Council, while serving
22 on business of the Advisory Council away from their
23 homes or regular places of business, may be allowed
24 travel expenses (including per diem in lieu of sub-
25 sistence) as authorized by section 5703(b) of title 5,

1 United States Code, for persons in the Government
2 service employed intermittently.

3 (3) RESTRICTION.—A member of the Advisory
4 Council may not be compensated under this section
5 if the member is receiving compensation or travel ex-
6 penses from another source while serving on busi-
7 ness of the Advisory Council.

8 (e) MEETINGS.—The Advisory Council shall meet not
9 less often than 2 times a year at the direction of the Chair-
10 person.

11 (f) STAFF AND SUPPORT.—

12 (1) IN GENERAL.—The Advisory Council shall
13 have a salaried executive director appointed by the
14 Chairperson, and staff appointed by the executive di-
15 rector with the approval of the Chairperson.

16 (2) FEDERAL ENTITIES.—The head of each
17 Federal department and agency shall make available
18 to the Advisory Council such information and other
19 assistance as it may require to carry out its respon-
20 sibilities.

21 (g) GENERAL RESPONSIBILITIES.—The Advisory
22 Council shall—

23 (1) provide advice, recommendations, and as-
24 sistance to the Secretary on matters relating to long-

1 term care insurance as specified in this part and as
2 otherwise required by the Secretary;

3 (2) collect, analyze, and disseminate informa-
4 tion relating to long-term care insurance in order to
5 increase the understanding of insurers, providers,
6 consumers, and regulatory bodies of the issues relat-
7 ing to, and to facilitate improvements in, such insur-
8 ance;

9 (3) develop for the Secretary's consideration
10 proposed models, standards, requirements, and pro-
11 cedures relating to long-term care insurance, as ap-
12 propriate, with respect to the content and format of
13 insurance policies, agent and insurer practices con-
14 cerning the sale and servicing of such policies, and
15 regulatory activities; and

16 (4) monitor the development of the long-term
17 care insurance market (including policies, marketing
18 practices, pricing, eligibility and benefit pre-
19 conditions, and claims payment procedures) and ad-
20 vise the Secretary concerning the need for regulatory
21 changes.

22 (h) SPECIFIC MATTERS FOR CONSIDERATION.—The
23 Advisory Council shall consider, and provide views and
24 recommendations to the Secretary concerning, the fol-
25 lowing matters relating to long-term care insurance:

1 (1) UNIFORM TERMS, DEFINITIONS, AND FOR-
2 MATS.—The Advisory Council shall develop and pro-
3 pose to the Secretary uniform terminology, defini-
4 tions, and formats for use in long-term care insur-
5 ance policies.

6 (2) STANDARD OUTLINE OF COVERAGE.—The
7 Advisory Council shall develop and propose to the
8 Secretary a standard format for use by all insurers
9 offering long-term care policies for the outline of
10 coverage required pursuant to section 2321(c).

11 (3) PREMIUMS.—The Advisory Council shall
12 consider, and make recommendations to the Sec-
13 retary concerning—

14 (A) whether Federal standards should be
15 established governing the amounts of and rates
16 of increase in premiums in long-term care poli-
17 cies, and

18 (B) if so, what factors should be taken into
19 account (and whether such factors should in-
20 clude the age of the insured, actuarial informa-
21 tion, cost of care, lapse rates, financial reserve
22 requirements, insurer solvency, and tax treat-
23 ment of premiums, and benefits.

24 (4) UPGRADES OF COVERAGE.—The Advisory
25 Council shall consider, and make recommendations

1 to the Secretary concerning, whether Federal stand-
2 ards are needed governing the terms and conditions
3 insurers may place on insured individuals' eligibility
4 to obtain improved coverage (including any restric-
5 tions considered advisable with respect to premium
6 increases, agent commissions, medical underwriting,
7 and age rating).

8 (5) THRESHOLD CONDITIONS FOR PAYMENT OF
9 BENEFITS.—The Advisory Council shall—

10 (A) consider, and make recommendations
11 to the Secretary concerning, the advisability of
12 establishing standardized sets of threshold con-
13 ditions (based on degrees of functional or cog-
14 nitive impairment or on other conditions) for
15 payment of covered benefits;

16 (B) to the extent found appropriate, rec-
17 ommend to the Secretary specific sets of thresh-
18 old conditions to be used for such purpose;

19 (C) develop and propose to the Secretary,
20 with respect to assessments of insured individ-
21 uals' levels of need for purposes of receipt of
22 covered benefits—

23 (i) professional qualification standards
24 applicable to individuals making such de-
25 terminations; and

1 (ii) uniform procedures and formats
2 for use in performing and documenting
3 such assessments.

4 (6) DISPUTE RESOLUTION.—The Advisory
5 Council shall consider, and make recommendations
6 to the Secretary concerning, procedures that insur-
7 ers and States should be required to implement to
8 afford insured individuals a reasonable opportunity
9 to dispute denial of benefits under a long-term care
10 insurance policy.

11 (7) SALES AND SERVICING OF POLICIES.—The
12 Advisory Council shall consider, and make rec-
13 ommendations to the Secretary concerning—

14 (A) training and certification to be re-
15 quired of agents involved in selling or servicing
16 long-term care insurance policies;

17 (B) appropriate limits on commissions or
18 other compensation paid to agents for the sale
19 or servicing of such policies;

20 (C) sales practices that should be prohib-
21 ited or limited with respect to such policies (in-
22 cluding any financial limits that should be ap-
23 plied concerning the individuals to whom such
24 policies may be sold); and

1 (D) appropriate standards and require-
2 ments with respect to sales of such policies by
3 or through employers and other entities, to em-
4 ployees, members, or affiliates of such entities.

5 (8) CONTINUING CARE RETIREMENT COMMU-
6 NITIES.—The Advisory Council shall consider, and
7 make recommendations to the Secretary concerning,
8 the extent to which the long-term care insurance as-
9 pects of continuing care retirement community ar-
10 rangements should be subject to regulation under
11 this part (and the Secretary, in consultation with the
12 Secretary of the Treasury, shall consider such rec-
13 ommendations and promulgate appropriate regula-
14 tions).

15 (i) ACTIVITIES.—In order to carry out its responsibil-
16 ities under this part, the Advisory Council is authorized
17 to—

18 (1) consult individuals and public and private
19 entities with experience and expertise in matters re-
20 lating to long-term care insurance (and shall consult
21 the National Association of Insurance Commis-
22 sioners);

23 (2) conduct meetings and hold hearings;

24 (3) conduct research (either directly or under
25 grant or contract);

1 (4) collect, analyze, publish, and disseminate
2 data and information (either directly or under grant
3 or contract); and

4 (5) develop model formats and procedures for
5 insurance policies and marketing materials; and de-
6 velop proposed standards, rules, and procedures for
7 regulatory programs.

8 (j) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated, for activities of the Ad-
10 visory Council, \$1,500,000 for fiscal year 1995, and
11 \$2,000,000 for each succeeding fiscal year.

12 **SEC. 2303. RELATION TO STATE LAW.**

13 Nothing in this part shall be construed as preventing
14 a State from applying standards that provide greater pro-
15 tection to insured individuals under long-term care insur-
16 ance policies than the standards promulgated under this
17 part, except that such State standards may not be incon-
18 sistent with any of the requirements of this part or of reg-
19 ulations hereunder.

20 **SEC. 2304. DEFINITIONS.**

21 For purposes of this part:

22 (1) ACTIVITY OF DAILY LIVING.—The term “ac-
23 tivity of daily living” means any of the following:
24 eating, toileting, dressing, bathing, and transferring.

1 (2) ADULT DAY CARE.—The term “adult day
2 care” means a program providing social and health-
3 related services during the day to six or more adults
4 with disabilities (or such smaller number as the Sec-
5 retary may specify in regulations) in a community
6 group setting outside the home.

7 (3) ADVISORY COUNCIL.—The term “Advisory
8 Council” means the National Long-Term Care In-
9 surance Advisory Council established pursuant to
10 section 2302.

11 (4) CERTIFICATE.—The term “certificate”
12 means a document issued to an individual as evi-
13 dence of such individual’s coverage under a group
14 insurance policy.

15 (5) CONTINUING CARE RETIREMENT COMMU-
16 NITY.—The term “continuing care retirement com-
17 munity” means a residential community operated by
18 a private entity that enters into contractual agree-
19 ments with residents under which such entity guar-
20 antees, in consideration for residents’ purchase of or
21 periodic payment for membership in the community,
22 to provide for such residents’ future long-term care
23 needs.

24 (6) DESIGNATED REPRESENTATIVE.—The term
25 “designated representative” means the person des-

1 ignated by an insured individual (or, if such indi-
2 vidual is incapacitated, pursuant to an appropriate
3 administrative or judicial procedure) to communicate
4 with the insurer on behalf of such individual in the
5 event of such individual's incapacitation.

6 (7) HOME HEALTH CARE.—The term “home
7 health care” means medical and nonmedical services
8 including such services as homemaker services, as-
9 sistance with activities of daily living, and respite
10 care provided to individuals in their residences.

11 (8) INSURED INDIVIDUAL.—The term “insured
12 individual” means, with respect to a long-term care
13 insurance policy, any individual who has coverage of
14 benefits under such policy.

15 (9) INSURER.—The term “insurer” means any
16 person that offers or sells an individual or group
17 long-term care insurance policy under which such
18 person is at risk for all or part of the cost of bene-
19 fits under the policy, and includes any agent of such
20 person.

21 (10) LONG-TERM CARE INSURANCE POLICY.—
22 The term “long-term care insurance policy” has the
23 meaning given that term in section 4 of the NAIC
24 Model Act, except that the last sentence of such sec-
25 tion shall not apply.

1 (11) NAIC MODEL ACT.—The term “NAIC
2 Model Act” means the Long-Term Care Insurance
3 Model Act published by the NAIC, as amended
4 through January 1993.

5 (12) NAIC MODEL REGULATION.—The term
6 “NAIC Model Regulation” means the Long-Term
7 Care Insurance Model Regulation published by the
8 NAIC, as amended through January 1993.

9 (13) NURSING FACILITY.—The term “nursing
10 facility” means a facility licensed by the State to
11 provide to residents—

12 (A) skilled nursing care and related serv-
13 ices for residents who require medical or nurs-
14 ing care;

15 (B) rehabilitation services for the rehabili-
16 tation of injured, disabled, or sick individuals,
17 or

18 (C) on a regular basis, health-related care
19 and services to individuals who because of their
20 mental or physical condition require care and
21 services (above the level of room and board)
22 which can be made available to them only
23 through institutional facilities.

1 (14) POLICYHOLDER.—The term “policyholder”
2 means the entity which is the holder of record of a
3 group long-term care insurance policy.

4 (15) RESIDENTIAL CARE FACILITY.—The term
5 “residential care facility” means a facility (including
6 a nursing facility) that—

7 (A) provides to residents medical or per-
8 sonal care services (including at a minimum as-
9 sistance with activities of daily living) in a set-
10 ting other than an individual or single-family
11 home, and

12 (B) does not provide services of a higher
13 level than can be provided by a nursing facility.

14 (16) RESPITE CARE.—The term “respite care”
15 means the temporary provision of care (including as-
16 sistance with activities of daily living) to an indi-
17 vidual, in the individual’s home or another setting in
18 the community, for the purpose of affording such in-
19 dividual’s unpaid caregiver a respite from the re-
20 sponsibilities of such care.

21 (17) STATE INSURANCE COMMISSIONER.—The
22 term “State insurance commissioner” means the
23 State official bearing such title, or, in the case of a
24 jurisdiction where such title is not used, the State

1 official with primary responsibility for the regulation
2 of insurance.

3 **Subpart B—Federal Standards and Requirements**

4 **SEC. 2321. REQUIREMENTS TO FACILITATE UNDER-**
5 **STANDING AND COMPARISON OF BENEFITS.**

6 (a) IN GENERAL.—The Secretary, after considering
7 (where appropriate) recommendations of the Advisory
8 Council, shall promulgate regulations designed to stand-
9 ardize formats and terminology used in long-term care in-
10 surance policies, to require insurers to provide to cus-
11 tomers and beneficiaries information on the range of pub-
12 lic and private long-term care coverage available, and to
13 establish such other requirements as may be appropriate
14 to promote consumer understanding and facilitate com-
15 parison of benefits, which shall include at a minimum the
16 requirements specified in this section.

17 (b) UNIFORM TERMS, DEFINITIONS, AND FOR-
18 MATS.—Insurers shall be required to use, in long-term
19 care insurance policies, uniform terminology, definitions of
20 terms, and formats, in accordance with regulations pro-
21 mulgated by the Secretary, after considering recommenda-
22 tions of the Advisory Council.

23 (c) STANDARD OUTLINE OF COVERAGE.—

24 (1) IN GENERAL.—Insurers shall be required to
25 develop for each long-term care insurance policy of-

1 ferred or sold, to include as a part of each such pol-
2 icy, and to make available to each potential pur-
3 chaser and furnish to each insured individual and
4 policyholder, an outline of coverage under such pol-
5 icy that—

6 (A) includes the elements specified in para-
7 graph (2),

8 (B) is in a uniform format (as prescribed
9 by Secretary on the basis of recommendations
10 by the Advisory Council),

11 (C) accurately and clearly reflects the con-
12 tents of the policy, and

13 (D) is updated periodically on such time-
14 table as may be required by the Secretary (or
15 more frequently as necessary to reflect signifi-
16 cant changes in outlined information).

17 (2) CONTENTS OF OUTLINE.—The outline of
18 coverage for each long-term care insurance policy
19 shall include at least the following:

20 (A) BENEFITS.—A description of—

21 (i) the principal benefits covered, in-
22 cluding the extent of—

23 (I) benefits for services furnished
24 in residential care facilities, and

25 (II) other benefits,

- 1 (ii) the principal exclusions from and
- 2 limitations on coverage,
- 3 (iii) the terms and conditions, if any,
- 4 upon which the insured individual may ob-
- 5 tain upgraded benefits, and
- 6 (iv) the threshold conditions for enti-
- 7 tlement to receive benefits.

8 (B) CONTINUATION, RENEWAL, AND CON-
 9 VERSION.—A statement of the terms under
 10 which a policy may be—

- 11 (i) returned (and premium refunded)
- 12 during an initial examination period,
- 13 (ii) continued in force or renewed,
- 14 (iii) converted to an individual policy
- 15 (in the case of coverage under a group pol-
- 16 icy),

17 (C) CANCELLATION.—A statement of the
 18 circumstances in which a policy may be termi-
 19 nated, and the refund or nonforfeitures benefits
 20 (if any) applicable in each such circumstance,
 21 including—

- 22 (i) death of the insured individual,
- 23 (ii) nonpayment of premiums,
- 24 (iii) election by the insured individual
- 25 not to renew,

1 (iv) any other circumstance.

2 (D) PREMIUM.—A statement of—

3 (i) the total annual premium, and the
4 portion of such premium attributable to
5 each covered benefit,

6 (ii) any reservation by the insurer of
7 a right to change premiums,

8 (iii) any limit on annual premium in-
9 creases,

10 (iv) any expected premium increases
11 associated with automatic or optional ben-
12 efit increases (including inflation protec-
13 tion), and

14 (v) any circumstances under which
15 payment of premium is waived.

16 (E) DECLARATION CONCERNING SUM-
17 MARY.—A statement, in bold face type on the
18 face of the document in language understand-
19 able to the average individual, that the outline
20 of coverage is a summary only, not a contract
21 of insurance, and that the policy contains the
22 contractual provisions that govern.

23 (F) COST/VALUE COMPARISON.—

24 (i) Information on average costs (and
25 variation in such costs) for nursing facility

1 care (and such other care as the Secretary
2 may specify) and information on the value
3 of benefits relative to such costs.

4 (ii) A comparison of benefits, over a
5 period of at least 20 years, for policies
6 with and without inflation protection.

7 (iii) A declaration as to whether the
8 amount of benefits will increase over time,
9 and, if so, a statement of the type and
10 amount of, any limitations on, and any
11 premium increases for, such benefit in-
12 creases.

13 (G) TAX TREATMENT.—A statement of the
14 Federal income tax treatment of premiums and
15 benefits under the policy, as determined by the
16 Secretary of the Treasury.

17 (H) OTHER.—Such other information as
18 the Secretary may require.

19 (d) REPORTING TO STATE INSURANCE COMMIS-
20 SIONER.—Each insurer shall be required to report at least
21 annually, to the State insurance commissioner of each
22 State in which any long-term care insurance policy of the
23 insurer is sold, such information, in such format, as the
24 Secretary may specify with respect to each such policy,
25 including—

1 (1) the standard outline of coverage required
2 pursuant to subsection (c);

3 (2) lapse rates and replacement rates for such
4 policies;

5 (3) the ratio of premiums collected to benefits
6 paid;

7 (4) reserves;

8 (5) written materials used in sale or promotion
9 of such policy; and

10 (6) any other information the Secretary may re-
11 quire.

12 (e) COMPARISON OF LONG-TERM CARE COVERAGE
13 ALTERNATIVES.—Each insurer shall be required to fur-
14 nish to each individual before a long-term care insurance
15 policy of the insurer is sold to the individual information
16 on the conditions of eligibility for, and benefits under, each
17 of the following:

18 (1) POLICIES OFFERED BY THE INSURER.—The
19 standard outline of coverage, and such other infor-
20 mation as the Secretary may specify, with respect to
21 each long-term care insurance policy offered by the
22 insurer.

23 (2) COMPARISON TO OTHER AVAILABLE PRI-
24 VATE INSURANCE.—Information, in such format as
25 may be required under this part, on—

1 (A) benefits offered under long-term care
2 insurance policies of the insurer (and the
3 threshold conditions for receipt by an insured
4 individual of each such benefit); and

5 (B) additional benefits available under
6 policies offered by other private insurers (to the
7 extent such information is made available by
8 the State insurance commissioner).

9 (3) PUBLIC PROGRAMS; REGIONAL ALLI-
10 ANCES.—Information furnished to the insurer, pur-
11 suant to section 2342(b)(2), by the State in which
12 such individual resides, on conditions of eligibility
13 for, and long-term care benefits (or the lack of such
14 benefits) under—

15 (A) each public long-term care program
16 administered by the State,

17 (B) the Medicare programs under title
18 XVIII of the Social Security Act; and

19 (C) each regional alliance operating in the
20 State.

21 **SEC. 2322. REQUIREMENTS RELATING TO COVERAGE.**

22 (a) IN GENERAL.—The Secretary, after considering
23 (where appropriate) recommendations of the Advisory
24 Council, shall promulgate regulations establishing require-
25 ments with respect to the terms of and benefits under

1 long-term care insurance policies, which shall include at
2 a minimum the requirements specified in this section.

3 (b) LIMITATIONS ON PREEXISTING CONDITION EX-
4 CLUSIONS.—

5 (1) INITIAL POLICIES.—A long-term care insur-
6 ance policy may not exclude or limit coverage for
7 any service or benefit, the need for which is the re-
8 sult of a medical condition or disability because an
9 insured individual received medical treatment for, or
10 was diagnosed as having, such condition before the
11 issuance of the policy, unless—

12 (A) the insurer, prior to issuance of the
13 policy, determines and documents (with evi-
14 dence including written evidence that such con-
15 dition has been treated or diagnosed by a quali-
16 fied health care professional) that the insured
17 individual had such condition during the 6-
18 month period (or such longer period as the Sec-
19 retary may specify) ending on the effective date
20 of the policy; and

21 (B) the need for such service or benefit be-
22 gins within 6 months (or such longer period as
23 the Secretary may specify) following the effec-
24 tive date of the policy.

1 (2) REPLACEMENT POLICIES.—Solely for pur-
2 poses of the requirements of paragraph (1), with re-
3 spect to an insured individual, the effective date of
4 a long-term care insurance policy issued to replace
5 a previous policy, with respect to benefits which are
6 the same as or substantially equivalent to benefits
7 under such previous policy, shall be considered to be
8 the effective date of such previous policy with re-
9 spect to such individual.

10 (c) LIMITING CONDITIONS ON BENEFITS.—

11 (1) IN GENERAL.—A long-term care insurance
12 policy may not—

13 (A) condition eligibility for benefits for a
14 type of service on the need for or receipt of any
15 other type of service (such as prior hospitaliza-
16 tion or institutionalization, or a higher level of
17 care than the care for which benefits are cov-
18 ered);

19 (B) condition eligibility for any benefit
20 (where the need for such benefit has been es-
21 tablished by an independent assessment of im-
22 pairment) on any particular medical diagnosis
23 (including any acute condition) or on one of a
24 group of diagnoses;

1 (C) condition eligibility for benefits fur-
2 nished by licensed or certified providers on com-
3 pliance by such providers with conditions not
4 required under Federal or State law; or

5 (D) condition coverage of any service on
6 provision of such service by a provider, or in a
7 setting, providing a higher level of care than
8 that required by an insured individual.

9 (2) HOME CARE OR COMMUNITY-BASED SERV-
10 ICES.—A long-term care insurance policy that pro-
11 vides benefits for any home care or community-based
12 services provided in a setting other than a residen-
13 tial care facility—

14 (A) may not limit such benefits to services
15 provided by registered nurses or licensed prac-
16 tical nurses;

17 (B) may not limit such benefits to services
18 furnished by persons or entities participating in
19 programs under titles XVIII and XIX of the
20 Social Security Act and in part 1 of this sub-
21 title; and

22 (C) must provide, at a minimum, benefits
23 for personal assistance with activities of daily
24 living, home health care, adult day care, and
25 respite care.

1 (3) NURSING FACILITY SERVICES.—A long-term
2 care insurance policy that provides benefits for any
3 nursing facility services—

4 (A) must provide benefits for such services
5 provided by all types of nursing facilities li-
6 censed by the State, and

7 (B) may provide benefits for care in other
8 residential facilities.

9 (4) PROHIBITION ON DISCRIMINATION BY DIAG-
10 NOSIS.—A long-term care insurance policy may not
11 provide for treatment of—

12 (A) Alzheimer’s disease or any other pro-
13 gressive degenerative dementia of an organic or-
14 igin,

15 (B) any organic or inorganic mental ill-
16 ness,

17 (C) mental retardation or any other cog-
18 nitive or mental impairment, or

19 (D) HIV infection or AIDS,
20 different from the treatment of any other medical
21 condition for purposes of determining whether
22 threshold conditions for the receipt of benefits have
23 been met, or the amount of benefits under the pol-
24 icy.

25 (d) INFLATION PROTECTION.—

1 (1) REQUIREMENT TO OFFER.—An insurer of-
2 fering for sale any long-term care insurance policy
3 shall be required to afford the purchaser the option
4 to obtain coverage under such policy (upon payment
5 of increased premiums) of annual increases in bene-
6 fits at rates in accordance with paragraph (2).

7 (2) RATE INCREASE IN BENEFITS.—For pur-
8 poses of paragraph (1), the benefits under a policy
9 for each year shall be increased by a percentage of
10 the full value of benefits under the policy for the
11 previous year, which shall be not less than 5 percent
12 of such value (or such other rate of increase as may
13 be determined by the Secretary to be adequate to
14 offset increases in the costs of long-term care serv-
15 ices for which coverage is provided under the policy).

16 (3) REQUIREMENT OF WRITTEN REJECTION.—
17 Inflation protection in accordance with paragraph
18 (1) may be excluded from the coverage under a pol-
19 icy only if the insured individual (or, if different, the
20 person responsible for payment of premiums) has re-
21 jected in writing the option to obtain such coverage.

22 **SEC. 2323. REQUIREMENTS RELATING TO PREMIUMS.**

23 (a) IN GENERAL.—The Secretary, after considering
24 (where appropriate) recommendations of the Advisory
25 Council, shall promulgate regulations establishing require-

1 ments applicable to premiums for long-term care insur-
2 ance policies, which shall include at a minimum the re-
3 quirements specified in this section.

4 (b) LIMITATIONS ON RATES AND INCREASES.—The
5 Secretary, after considering recommendations of the Advi-
6 sory Council, may establish by regulation such standards
7 and requirements as may be determined appropriate with
8 respect to—

9 (1) mandatory or optional State procedures for
10 review and approval of premium rates and rate in-
11 creases or decreases;

12 (2) limitations on the amount of initial pre-
13 miums, or on the rate or amount of premium in-
14 creases;

15 (3) the factors to be taken into consideration by
16 an insurer in proposing, and by a State in approving
17 or disapproving, premium rates and increases; and

18 (4) the extent to which consumers should be en-
19 titled to participate or be represented in the rate-set-
20 ting process and to have access to actuarial and
21 other information relied on in setting rates.

22 **SEC. 2324. REQUIREMENTS RELATING TO SALES PRAC-**
23 **TICES.**

24 (a) IN GENERAL.—The Secretary, after considering
25 (where appropriate) recommendations of the Advisory

1 Council, shall promulgate regulations establishing require-
2 ments applicable to the sale or offering for sale of long-
3 term care insurance policies, which shall include at a min-
4 imum the requirements specified in this section.

5 (b) APPLICATIONS.—Any insurer that offers any
6 long-term care insurance policy (including any group pol-
7 icy) shall be required to meet such requirements with re-
8 spect to the content, format, and use of application forms
9 for long-term care insurance as the Secretary may require
10 by regulation.

11 (c) AGENT TRAINING AND CERTIFICATION.—An in-
12 surer may not sell or offer for sale a long-term care insur-
13 ance policy through an agent who does not comply with
14 minimum standards with respect to training and certifi-
15 cation established by the Secretary after consideration of
16 recommendations by the Advisory Council.

17 (d) COMPENSATION FOR SALE OF POLICIES.—Com-
18 pensation by an insurer to an agent or agents for the sale
19 of an original long-term care insurance policy, or for serv-
20 icing or renewing such a policy, may not exceed amounts
21 (or percentage shares of premiums or other reference
22 amounts) specified by the Secretary in regulations, after
23 considering recommendations of the Advisory Council.

24 (e) PROHIBITED SALES PRACTICES.—The following
25 practices by insurers shall be prohibited with respect to

1 the sale or offer for sale of long-term care insurance poli-
2 cies:

3 (1) FALSE AND MISLEADING REPRESENTA-
4 TIONS.—Making any statement or representation—

5 (A) which the insurer knows or should
6 know is false or misleading (including the inac-
7 curate, incomplete, or misleading comparison of
8 long-term care insurance policies or insurers),
9 and

10 (B) which is intended, or would be likely,
11 to induce any person to purchase, retain, termi-
12 nate, forfeit, permit to lapse, pledge, assign,
13 borrow against, convert, or effect a change with
14 respect to, any long-term care insurance policy.

15 (2) INACCURATE COMPLETION OF MEDICAL
16 HISTORY.—Making or causing to be made (by any
17 means including failure to inquire about or to record
18 information relating to preexisting conditions) state-
19 ments or omissions, in records detailing the medical
20 history of an applicant for insurance, which the in-
21 surer knows or should know render such records
22 false, incomplete, or misleading in any way material
23 to such applicant's eligibility for or coverage under
24 a long-term care insurance policy.

1 (3) UNDUE PRESSURE.—Employing force,
2 fright, threat, or other undue pressure, whether ex-
3 plicit or implicit, which is intended, or would be like-
4 ly, to induce the purchase of a long-term care insur-
5 ance policy.

6 (4) COLD LEAD ADVERTISING.—Using, directly
7 or indirectly, any method of contacting consumers
8 (including any method designed to induce consumers
9 to contact the insurer or agent) for the purpose of
10 inducing the purchase of long-term care insurance
11 (regardless of whether such purpose is the sole or
12 primary purpose of the contact) without conspicu-
13 ously disclosing such purpose.

14 (f) PROHIBITION ON SALE OF DUPLICATE BENE-
15 FITS.—An insurer or agent may not sell or issue to an
16 individual a long-term care insurance policy that the in-
17 surer or agent knows or should know provides for coverage
18 that duplicates coverage already provided in another long-
19 term care insurance policy held by such individual (unless
20 the policy is intended to replace such other policy).

21 (g) SALES THROUGH EMPLOYERS OR MEMBERSHIP
22 ORGANIZATIONS.—

23 (1) REQUIREMENTS CONCERNING SUCH AR-
24 RANGEMENTS.—In any case where an employer, or-
25 ganization, association, or other entity (referred to

1 as a “membership entity”) endorses a long-term
2 care insurance policy to, or such policy is marketed
3 or sold through such membership entity to, employ-
4 ees, members, or other individuals affiliated with
5 such membership entity—

6 (A) the insurer offering such policy shall
7 not permit its marketing or sale through such
8 entity unless the requirements of this sub-
9 section are met; and

10 (B) a membership entity that receives any
11 compensation for such sale, marketing, or en-
12 dorsement of such policy shall be considered the
13 agent of the insurer for purposes of this part.

14 (2) DISCLOSURE AND INFORMATION REQUIRE-
15 MENTS.—A membership entity that endorses a long-
16 term care insurance policy, or through which such
17 policy is sold, to individuals affiliated with such enti-
18 ty, shall—

19 (A) disclose prominently, in a form and
20 manner designed to ensure that each such indi-
21 vidual who receives information concerning any
22 such policy through such entity is aware of and
23 understands such disclosure—

24 (i) the manner in which the insurer
25 and policy were selected;

1 (ii) the extent (if any) to which a per-
2 son independent of the insurer with exper-
3 tise in long-term care insurance analyzed
4 the advantages and disadvantages of such
5 policy from the standpoint of such individ-
6 uals (including such matters as the merits
7 of the policy compared to other available
8 benefit packages, and the financial stability
9 of the insurer), and the results of any such
10 analysis;

11 (iii) any organizational or financial
12 ties between the entity (or a related entity)
13 and the insurer (or a related entity); and

14 (iv) the nature of compensation ar-
15 rangements (if any) and the amount of
16 compensation (including all fees, commis-
17 sions, and other forms of financial sup-
18 port) for the endorsement or sale of such
19 policy; and

20 (B) make available to such individuals, ei-
21 ther directly or through referrals, appropriate
22 counseling to assist such individuals to make
23 educated and informed decisions concerning the
24 purchase of such policies.

1 **SEC. 2325. CONTINUATION, RENEWAL, REPLACEMENT, CON-**
2 **VERSION, AND CANCELLATION OF POLICIES.**

3 (a) IN GENERAL.—The Secretary, after considering
4 (where appropriate) recommendations of the Advisory
5 Council, shall promulgate regulations establishing require-
6 ments applicable to the renewal, replacement, conversion,
7 and cancellation of long-term care insurance policies,
8 which shall include at a minimum the requirements speci-
9 fied in this section.

10 (b) INSURED’S RIGHT TO CANCEL DURING EXAM-
11 INATION PERIOD.—Each individual insured (or, if dif-
12 ferent, each individual liable for payment of premiums)
13 under a long-term care insurance policy shall have the un-
14 conditional right to return the policy within 30 days after
15 the date of its issuance and delivery, and to obtain a full
16 refund of any premium paid.

17 (c) INSURER’S RIGHT TO CANCEL (OR DENY BENE-
18 FITS) BASED ON FRAUD OR NONDISCLOSURE.—An in-
19 surer shall have the right to cancel a long-term care insur-
20 ance policy, or to refuse to pay a claim for benefits, based
21 on evidence that the insured falsely represented or failed
22 to disclose information material to the determination of
23 eligibility to purchase such insurance, but only if—

24 (1) the insurer presents written documentation,
25 developed at the time the insured applied for such
26 insurance, of the insurer’s request for the informa-

1 tion thus withheld or misrepresented, and the in-
2 sured individual's response to such request;

3 (2) the insurer presents medical records or
4 other evidence showing that the insured individual
5 knew or should have known that such response was
6 false, incomplete, or misleading;

7 (3) notice of cancellation is furnished to the in-
8 sured individual before the date 3 years after the ef-
9 fective date of the policy (or such earlier date as the
10 Secretary may specify in regulations); and

11 (4) the insured individual is afforded the oppor-
12 tunity to review and refute the evidence presented by
13 the insurer pursuant to paragraphs (1) and (2).

14 (d) INSURER'S RIGHT TO CANCEL FOR NONPAYMENT
15 OF PREMIUMS.—

16 (1) IN GENERAL.—Insurers shall have the right
17 to cancel long-term care insurance policies for non-
18 payment of premiums, subject to the provisions of
19 this subsection and subsection (e) (relating to non-
20 forfeiture).

21 (2) NOTICE AND ACKNOWLEDGEMENT.—

22 (A) IN GENERAL.—The insurer may not
23 cancel coverage of an insured individual until—

24 (i) the insurer, not earlier than the
25 date when such payment is 30 days past

1 due, has given written notice to the insured
2 individual (by registered letter or the
3 equivalent) of such intent, and

4 (ii) 30 days have elapsed since the in-
5 surer obtained written acknowledgment of
6 receipt of such notice from the insured in-
7 dividual (or the designated representative,
8 at the insured individual's option or in the
9 case of an insured individual determined to
10 be incapacitated in accordance with para-
11 graph (4)).

12 (B) ADDITIONAL REQUIREMENT FOR
13 GROUP POLICIES.—In the case of a group long-
14 term care insurance policy, the notice and ac-
15 knowledgement requirements of subparagraph
16 (A) apply with respect to the policyholder and
17 to each insured individual.

18 (3) REINSTATEMENT OF COVERAGE OF INCA-
19 PACITATED INDIVIDUALS.—In any case where the
20 coverage of an individual under a long-term care in-
21 surance policy has been canceled pursuant to para-
22 graph (2), the insurer shall be required to reinstate
23 full coverage of such individual under such policy,
24 retroactive to the effective date of cancellation, if the
25 insurer receives from such individual (or the des-

1 ignated representative of such individual), within 5
2 months after such date—

3 (A) evidence of a determination of such in-
4 dividual’s incapacitation in accordance with
5 paragraph (4) (whether made before or after
6 such date), and

7 (B) payment of all premiums due and past
8 due, and all charges for late payment.

9 (4) DETERMINATION OF INCAPACITATION.—For
10 purposes of this subsection, the term “determination
11 of incapacitation” means a determination by a quali-
12 fied health professional (in accordance with such re-
13 quirements as the Secretary may specify), that an
14 insured individual has suffered a cognitive impair-
15 ment or loss of functional capacity which could rea-
16 sonably be expected to render the individual perma-
17 nently or temporarily unable to deal with business or
18 financial matters. The standard used to make such
19 determination shall not be more stringent than the
20 threshold conditions for the receipt of covered bene-
21 fits.

22 (5) DESIGNATION OF REPRESENTATIVE.—The
23 insurer shall be required—

1 (A) to require the insured individual, at
2 the time of sale or issuance of a long-term care
3 insurance policy—

4 (i) to designate a representative for
5 purposes of communication with the in-
6 surer concerning premium payments in the
7 event the insured individual cannot be lo-
8 cated or is incapacitated, or

9 (ii) to complete a signed and dated
10 statement declining to designate a rep-
11 resentative, and

12 (B) to obtain from the insured individual,
13 at the time of each premium payment (but in
14 no event less often than once in each 12-month
15 period) reconfirmation or revision of such des-
16 ignation or declination.

17 (e) NONFORFEITURE.—

18 (1) IN GENERAL.—The Secretary, after consid-
19 eration of recommendations by the Advisory Council,
20 shall by regulation require appropriate nonforfeiture
21 benefits with respect to each long-term care insur-
22 ance policy that lapses for any reason (including
23 nonpayment of premiums, cancellation, or failure to
24 renew, but excluding lapses due to death) after re-

1 maining in effect beyond a specified minimum pe-
2 riod.

3 (2) NONFORFEITURE BENEFITS.—The stand-
4 ards established under this subsection shall require
5 that the amount or percentage of nonforfeiture bene-
6 fits shall increase proportionally with the amount of
7 premiums paid by a policyholder.

8 (f) CONTINUATION, RENEWAL, REPLACEMENT, AND
9 CONVERSION OF POLICIES.—

10 (1) IN GENERAL.—Insurers shall not be per-
11 mitted to cancel, or refuse to renew (or replace with
12 a substantial equivalent), any long-term care insur-
13 ance policy for any reason other than for fraud or
14 material misrepresentation (as provided in sub-
15 section (c)) or for nonpayment of premium (as pro-
16 vided in subsection (d)).

17 (2) DURATION AND RENEWAL OF POLICIES.—
18 Each long-term care insurance policy shall contain a
19 provision that clearly states—

20 (A) the duration of the policy,

21 (B) the right of the insured individual (or
22 policyholder) to renewal (or to replacement with
23 a substantial equivalent),

1 (C) the date by which, and the manner in
2 which, the option to renew must be exercised,
3 and

4 (D) any applicable restrictions or limita-
5 tions (which may not be inconsistent with the
6 requirements of this part).

7 (3) REPLACEMENT OF POLICIES.—

8 (A) IN GENERAL.—Except as provided in
9 subparagraph (B), an insurer shall not be per-
10 mitted to sell any long-term care insurance pol-
11 icy as a replacement for another such policy un-
12 less coverage under such replacement policy is
13 available to an individual insured for benefits
14 covered under the previous policy to the same
15 extent as under such previous policy (including
16 every individual insured under a group policy)
17 on the date of termination of such previous pol-
18 icy, without exclusions or limitations that did
19 not apply under such previous policy.

20 (B) INSURED'S OPTION TO REDUCE COV-
21 ERAGE.—In any case where an insured indi-
22 vidual covered under a long-term care insurance
23 policy knowingly and voluntarily elects to sub-
24 stitute for such policy a policy that provides less

1 coverage, substitute policy shall be considered a
2 replacement policy for purposes of this part.

3 (3) CONTINUATION AND CONVERSION RIGHTS
4 WITH RESPECT TO GROUP POLICIES.—

5 (A) IN GENERAL.—Insurers shall be re-
6 quired to include in each group long-term care
7 insurance policy, a provision affording to each
8 insured individual, when such policy would oth-
9 erwise terminate, the opportunity (at the insur-
10 er's option, subject to approval of the State in-
11 surance commissioner) either to continue or to
12 convert coverage under such policy in accord-
13 ance with this paragraph.

14 (B) RIGHTS OF RELATED INDIVIDUALS.—
15 In the case of any insured individual whose eli-
16 gibility for coverage under a group policy is
17 based on relationship to another individual, the
18 insurer shall be required to continue such cov-
19 erage upon termination of the relationship due
20 to divorce or death.

21 (C) CONTINUATION OF COVERAGE.—A
22 group policy shall be considered to meet the re-
23 quirements of this paragraph with respect to
24 rights of an insured individual to continuation
25 of coverage if coverage of the same (or substan-

1 tially equivalent) benefits for such individual
2 under such policy is maintained, subject only to
3 timely payment of premiums.

4 (D) CONVERSION OF COVERAGE.—A group
5 policy shall be considered to meet the require-
6 ments of this paragraph with respect to conver-
7 sion if it entitles each individual who has been
8 continuously covered under the policy for at
9 least 6 months before the date of the termi-
10 nation to issuance of a replacement policy pro-
11 viding benefits identical to, substantially equiva-
12 lent to, or in excess of, the benefits under such
13 terminated group policy—

14 (i) without requiring evidence of in-
15 surability with respect to benefits covered
16 under such previous policy, and

17 (ii) at premium rates no higher than
18 would apply if the insured individual had
19 initially obtained coverage under such re-
20 placement policy on the date such insured
21 individual initially obtained coverage under
22 such group policy.

23 (4) TREATMENT OF SUBSTANTIAL EQUIVA-
24 LENCE.—

1 (A) UNDER SECRETARY'S GUIDELINES.—

2 The Secretary, after considering recommenda-
3 tions by the Advisory Council, shall develop
4 guidelines for comparing long-term care insur-
5 ance policies for the purpose of determining
6 whether benefits under such policies are sub-
7 stantially equivalent.

8 (B) BEFORE EFFECTIVE DATE OF SEC-
9 RETARY'S GUIDELINES.—During the period
10 prior to the effective date of guidelines pub-
11 lished by the Secretary under this paragraph,
12 insurers shall comply with standards for deter-
13 minations of substantial equivalence established
14 by State insurance commissioners.

15 (5) ADDITIONAL REQUIREMENTS.—Insurers
16 shall comply with such other requirements relating
17 to continuation, renewal, replacement, and conver-
18 sion of long-term care insurance policies as the Sec-
19 retary may establish.

20 **SEC. 2326. REQUIREMENTS RELATING TO PAYMENT OF**
21 **BENEFITS.**

22 (a) IN GENERAL.—The Secretary, after considering
23 (where appropriate) recommendations of the Advisory
24 Council, shall promulgate regulations establishing require-
25 ments with respect to claims for and payment of benefits

1 under long-term care insurance policies, which shall in-
2 clude at a minimum the requirements specified in this sec-
3 tion.

4 (b) STANDARDS RELATING TO THRESHOLD CONDI-
5 TIONS FOR RECEIPT OF COVERED BENEFITS.—Each
6 long-term care insurance policy shall meet the following
7 requirements with respect to identification of, and deter-
8 mination of whether an insured individual meets, the
9 threshold conditions for receipt of benefits covered under
10 such policy:

11 (1) DECLARATION OF THRESHOLD CONDI-
12 TIONS.—

13 (A) IN GENERAL.—The policy shall specify
14 the level (or levels) of functional or cognitive
15 mental impairment (or combination of impair-
16 ments) required as a threshold condition of en-
17 titlement to receive benefits under the policy
18 (which threshold condition or conditions shall
19 be consistent with any regulations promulgated
20 by the Secretary pursuant to subsection (B)).

21 (B) SECRETARIAL RESPONSIBILITY.—The
22 Secretary (after considering the views of the
23 Advisory Council on current practices of insur-
24 ers concerning, and the appropriateness of
25 standardizing, threshold conditions) may pro-

1 mulgate such regulations as the Secretary finds
2 appropriate establishing standardized thresholds
3 to be used under such policies as preconditions
4 for varying levels of benefits.

5 (2) INDEPENDENT PROFESSIONAL ASSESS-
6 MENT.—The policy shall provide for a procedure for
7 determining whether the threshold conditions speci-
8 fied under paragraph (1) have been met with respect
9 to an insured individual which—

10 (A) applies such uniform assessment
11 standards, procedures, and formats as the Sec-
12 retary may specify, after consideration of rec-
13 ommendations by the Advisory Council;

14 (B) permits an initial evaluation (or, if the
15 initial evaluation was performed by a qualified
16 independent assessor selected by the insurer, a
17 reevaluation) to be made by a qualified inde-
18 pendent assessor selected by the insured indi-
19 vidual (or designated representative) as to
20 whether the threshold conditions for receipt of
21 benefits have been met;

22 (C) permits the insurer the option to ob-
23 tain a reevaluation by a qualified independent
24 assessor selected and reimbursed by the insurer;

1 (D) provides that the insurer will consider
2 that the threshold conditions have been met in
3 any case where—

4 (i) the assessment under subpara-
5 graph (B) concluded that such conditions
6 had been met, and the insurer declined the
7 option under subparagraph (C), or

8 (ii) assessments under both subpara-
9 graphs (B) and (C) concluded that such
10 conditions had been met; and

11 (E) provides for final resolution of the
12 question by a State agency or other impartial
13 third party in any case where assessments
14 under subparagraphs (B) and (C) reach incon-
15 sistent conclusions.

16 (3) QUALIFIED INDEPENDENT ASSESSOR.—For
17 purposes of paragraph (2), the term “qualified inde-
18 pendent assessor” means a licensed or certified pro-
19 fessional, as appropriate, who—

20 (A) meets such standards with respect to
21 professional qualifications as may be established
22 by the Secretary, after consulting with the Sec-
23 retary of the Treasury, and

24 (B) has no significant or controlling finan-
25 cial interest in, is not an employee of, and does

1 not derive more than 5 percent of gross income
2 from, the insurer (or any provider of services
3 for which benefits are available under the policy
4 and in which the insurer has a significant or
5 controlling financial interest).

6 (c) REQUIREMENTS RELATING TO CLAIMS FOR BEN-
7 EFITS.—Insurers shall be required—

8 (1) to promptly pay or deny claims for benefits
9 submitted by (or on behalf of) insured individuals
10 who have been determined pursuant to subsection
11 (b) to meet the threshold conditions for payment of
12 benefits;

13 (2) to provide an explanation in writing of the
14 reasons for payment, partial payment, or denial of
15 each such claim; and

16 (3) to provide an administrative procedure
17 under which an insured individual may appeal the
18 denial of any claim.

19 **Subpart C—Enforcement**

20 **SEC. 2342. STATE PROGRAMS FOR ENFORCEMENT OF**
21 **STANDARDS.**

22 (a) REQUIREMENT FOR STATE PROGRAMS IMPLE-
23 MENTING FEDERAL STANDARDS.—In order for a State to
24 be eligible for grants under this subpart, the State must
25 have in effect a program (including such laws and proce-

1 dures as may be necessary) for the regulation of long-term
2 care insurance which the Secretary has determined—

3 (1) includes the elements required under this
4 subpart, and

5 (2) is designed to ensure the compliance of
6 long-term care insurance policies sold in the State,
7 and insurers offering such policies and their agents,
8 with the requirements established pursuant to sub-
9 part B.

10 (b) ACTIVITIES UNDER STATE PROGRAM.—A State
11 program approved under this subpart shall provide for the
12 following procedures and activities:

13 (1) MONITORING OF INSURERS AND POLI-
14 CIES.—Procedures for ongoing monitoring of the
15 compliance of insurers doing business in the State,
16 and of long-term care insurance policies sold in the
17 State, with requirements under this part, including
18 at least the following:

19 (A) POLICY REVIEW AND CERTIFI-
20 CATION.—A program for review and certifi-
21 cation (and annual recertification) of each such
22 policy sold in the State.

23 (B) REPORTING BY INSURERS.—Require-
24 ments of annual reporting by insurers selling or
25 servicing long-term care insurance policies in

1 the State, in such form and containing such in-
2 formation as the State may require to deter-
3 mine whether the insurer (and policies) are in
4 compliance with requirements under this part.

5 (C) DATA COLLECTION.—Procedures for
6 collection, from insurers, service providers, in-
7 sured individuals, and others, of information re-
8 quired by the State for purposes of carrying out
9 its responsibilities under this part (including
10 authority to compel compliance of insurers with
11 requests for such information).

12 (D) MARKETING OVERSIGHT.—Procedures
13 for monitoring (through sampling or other ap-
14 propriate procedures) the sales practices of in-
15 surers and agents, including review of mar-
16 keting literature.

17 (E) OVERSIGHT OF ADMINISTRATION OF
18 BENEFITS.—Procedures for monitoring
19 (through sampling or other appropriate proce-
20 dures) insurers' administration of benefits, in-
21 cluding monitoring of—

22 (i) determinations of insured individ-
23 uals' eligibility to receive benefits, and

24 (ii) disposition of claims for payment.

1 (2) INFORMATION TO INSURERS.—Procedures
2 for furnishing, to insurers selling or servicing any
3 long-term care insurance policies in the State, infor-
4 mation on conditions of eligibility for, and benefits
5 under, each public long-term care program adminis-
6 tered by the State, in order to enable them to com-
7 ply with the requirement under section 2321(e)(3).

8 (3) CONSUMER COMPLAINTS AND DISPUTE RES-
9 OLUTION.—Administrative procedures for the inves-
10 tigation and resolution of complaints by consumers,
11 and disputes between consumers and insurers, with
12 respect to long-term care insurance, including—

13 (A) procedures for the filing, investigation,
14 and adjudication of consumer complaints with
15 respect to the compliance of insurers and poli-
16 cies with requirements under this part, or other
17 requirements under State law; and

18 (B) procedures for resolution of disputes
19 between insured individuals and insurers con-
20 cerning eligibility for, or the amount of, benefits
21 payable under such policies, and other issues
22 with respect to the rights and responsibilities of
23 insurers and insured individuals under such
24 policies.

1 (4) TECHNICAL ASSISTANCE TO INSURERS.—

2 Provision of technical assistance to insurers to help
3 them to understand and comply with the require-
4 ments of this part, and other State laws, concerning
5 long-term care insurance policies and business prac-
6 tices.

7 (c) STATE ENFORCEMENT AUTHORITIES.—A State
8 program meeting the requirements of this subpart shall
9 ensure that the State insurance commissioner (or other
10 appropriate official or agency) has the following authority
11 with respect to long-term care insurers and policies:

12 (1) PROHIBITION OF SALE.—Authority to pro-
13 hibit the sale, or offering for sale, of any long-term
14 care insurance policy that fails to comply with all
15 applicable requirements under this part.

16 (2) PLANS OF CORRECTION.—Authority, in
17 cases where the business practices of an insurer are
18 determined not to comply with requirements under
19 this part, to require the insurer to develop, submit
20 for State approval, and implement a plan of correc-
21 tion which must be fulfilled within the shortest pe-
22 riod possible (not to exceed a year) as a condition
23 of continuing to do business in the State.

24 (3) CORRECTIVE ACTION ORDERS.—Authority,
25 in cases where an insurer is determined to have

1 failed to comply with requirements of this part, or
2 with the terms of a policy, with respect to a con-
3 sumer or insured individual, to direct the insurer
4 (subject to appropriate due process) to eliminate
5 such noncompliance within 30 days.

6 (4) CIVIL MONEY PENALTIES.—Authority to as-
7 sess civil money penalties, in amounts for each viola-
8 tive act up to the greater of \$10,000 or three times
9 the amount of any commission involved—

10 (A) for violations of subsections (d) (con-
11 cerning compensation or sale of policies), (e)
12 (concerning prohibited sales practices), and (f)
13 (prohibition on sale of duplicate benefits) of
14 section 2324,

15 (B) for such other violative acts as the
16 Secretary may specify in regulations, and

17 (C) in such other cases as the State finds
18 appropriate.

19 (5) OTHER AUTHORITIES.—Such other authori-
20 ties as the State finds necessary or appropriate to
21 enforce requirements under this part.

22 (d) RECORDS, REPORTS, AND AUDITS.—As a condi-
23 tion of approval of its program under this part, a State
24 must agree to maintain such records, make such reports
25 (including expenditure reports), and cooperate with such

1 audits, as the Secretary finds necessary to determine the
2 compliance of such State program (and insurers and poli-
3 cies regulated under such program) with the requirements
4 of this part.

5 (e) SECRETARIAL RESPONSIBILITIES.—

6 (1) APPROVAL OF STATE PROGRAMS.—The Sec-
7 retary shall approve a State program meeting the re-
8 quirements of this part.

9 (2) INFORMATION ON MEDICARE BENEFITS.—
10 The Secretary shall furnish, to the official in each
11 State with chief responsibility for the regulation of
12 long-term care insurance, a description of the Medi-
13 care programs under title XVIII of the Social Secu-
14 rity Act which makes clear the unavailability of long-
15 term benefits under such programs, for distribution
16 by such State official to insurers selling long-term
17 care insurance in the State, in accordance with sub-
18 section (b)(2).

19 **SEC. 2342. AUTHORIZATION OF APPROPRIATIONS FOR**
20 **STATE PROGRAMS.**

21 There are authorized to be appropriated \$10,000,000
22 for fiscal year 1996, \$10,000,000 for fiscal year 1997,
23 \$7,500,000 for fiscal year 1998, and \$5,000,000 for fiscal
24 year 1999 and each succeeding fiscal year, for grants to

1 States with programs meeting the requirements of this
2 part, to remain available until expended.

3 **SEC. 2343. ALLOTMENTS TO STATES.**

4 The allotment for any fiscal year to a State with a
5 program approved under this part shall be an amount de-
6 termined by the Secretary, taking into account the num-
7 bers of long-term care insurance policies sold, and of elder-
8 ly individuals residing, in the State, and such other factors
9 as the Secretary finds appropriate.

10 **SEC. 2344. PAYMENTS TO STATES.**

11 (a) IN GENERAL.—Each State with a program ap-
12 proved under this part shall be entitled to payment under
13 this title for each fiscal year in an amount equal to its
14 allotment for such fiscal year, for expenditure by such
15 State for up to 50 percent of the cost of activities under
16 such program.

17 (b) STATE SHARE OF PROGRAM EXPENDITURES.—
18 No Federal funds from any source may be used as any
19 part of the non-Federal share of expenditures under the
20 State program under this subpart.

21 (c) TRANSFER AND DEPOSIT REQUIREMENTS.—The
22 Secretary shall make payments under this section in ac-
23 cordance with section 6503 of title 31, United States
24 Code.

1 **SEC. 2345. FEDERAL OVERSIGHT OF STATE ENFORCEMENT.**

2 (a) IN GENERAL.—The Secretary shall periodically
3 review State regulatory programs approved under section
4 2341 to determine whether they continue to comply with
5 the requirements of this part.

6 (b) NOTICE OF DETERMINATION OF NONCOMPLI-
7 ANCE.—The Secretary shall promptly notify the State of
8 a determination that a State program fails to comply with
9 this part, specifying the requirement or requirements not
10 met and the elements of the State program requiring cor-
11 rection.

12 (c) OPPORTUNITY FOR CORRECTION.—

13 (1) IN GENERAL.—The Secretary shall afford a
14 State notified of noncompliance pursuant to sub-
15 section (b) a reasonable opportunity to eliminate
16 such noncompliance.

17 (2) CORRECTION PLANS.—In a case where sub-
18 stantial corrections are needed to eliminate non-
19 compliance of a State program, the Secretary may—

20 (A) permit the State a reasonable time
21 after the date of the notice pursuant to sub-
22 section (b) to develop and obtain the Sec-
23 retary's approval of a correction plan, and

24 (B) permit the State a reasonable time
25 after the date of approval of such plan to elimi-
26 nate the noncompliance.

1 (d) WITHDRAWAL OF PROGRAM APPROVAL.—In the
2 case of a State that fails to eliminate noncompliance with
3 requirements under this part by the date specified by the
4 Secretary pursuant to subsection (c), the Secretary shall
5 withdraw the approval of the State program pursuant to
6 section 2341(e).

7 **SEC. 2346. EFFECT OF FAILURE TO HAVE APPROVED STATE**
8 **PROGRAM.**

9 (a) RESTRICTION ON SALE OF LONG-TERM CARE IN-
10 SURANCE.—

11 (1) IN GENERAL.—No insurer may sell or offer
12 for sale any long-term care insurance policy, on or
13 after the date specified in subsection (c), in a State
14 that does not have in effect a regulatory program
15 approved under section 2341(e).

16 (2) APPLICATION OF PROHIBITION.—For pur-
17 poses of paragraph (1), an insurance policy shall not
18 be considered to be sold or offered for sale in a
19 State solely because it is sold or offered to a resident
20 of such State.

21 (b) CIVIL MONEY PENALTY.—

22 (1) IN GENERAL.—An insurer shall be subject
23 to a civil money penalty, in an amount up to the
24 greater of \$10,000 or three times any commission
25 involved, for each incident in which the insurer sells,

1 or offers to sell, an insurance policy to an individual
2 in violation of subsection (a).

3 (2) ENFORCEMENT PROCEDURE.—The Sec-
4 retary shall enforce the provisions of this subsection
5 in accordance with the procedures provided under
6 section 5412 of this Act.

7 (c) EFFECTIVE DATE.—

8 (1) IN GENERAL.—The date specified in this
9 subsection, for purposes of subsection (a), with re-
10 spect to any requirement under this part, is the date
11 one year after the date the Secretary first promul-
12 gates regulations with respect to such requirement.

13 (2) EXCEPTION.—To the extent that a State
14 demonstrates to the Secretary that State legislation
15 is required to meet any such requirement, the State
16 shall not be regarded as failing to have in effect a
17 program in compliance with this part solely on the
18 basis of its failure to comply with such requirement
19 before the first day of the first calendar quarter be-
20 ginning after the close of the first regular session of
21 the State legislature that begins after the promulga-
22 tion of the regulation imposing such requirement.
23 For purposes of the preceding sentence, in the case
24 of a State that has a 2-year legislative session, each

1 year of such session shall be deemed to be a sepa-
2 rate regular session of the State legislature.

3 **Subpart D—Consumer Education Grants**

4 **SEC. 2361. GRANTS FOR CONSUMER EDUCATION.**

5 (a) GRANT PROGRAM AUTHORIZED.—The Secretary
6 is authorized to make grants—

7 (1) to States,

8 (2) to regional alliances (at the option of States
9 within which such Alliances are located), and

10 (3) to national organizations representing insur-
11 ance consumers, long-term care providers, and insur-
12 ers,

13 for the development and implementation of long-term care
14 information, counseling, and other programs.

15 (b) APPLICATIONS.—

16 (1) IN GENERAL.—Each State or organization
17 seeking a grant under this section shall submit to
18 the Secretary an application, in such format and
19 containing such information as the Secretary may
20 require.

21 (2) GOALS.—Programs under this section shall
22 be directed at the goals of increasing consumers' un-
23 derstanding and awareness of options available to
24 them with respect to long-term care insurance (and

1 alternatives, such as public long-term care pro-
2 grams), including—

3 (A) the risk of needing long-term care;

4 (B) the costs associated with long-term
5 care services;

6 (C) the lack of long-term care coverage
7 under the Medicare program, Medicare supple-
8 mental (Medigap) policies, and standard private
9 health insurance;

10 (D) the limitations on (and conditions of
11 eligibility for) long-term care coverage under
12 State programs;

13 (E) the availability, and variations in cov-
14 erage and cost, of private long-term care insur-
15 ance;

16 (F) features common to many private long-
17 term care insurance policies; and

18 (G) pitfalls to avoid when purchasing a
19 long-term care insurance policy.

20 (3) ACTIVITIES.—An application for a grant
21 under this section shall indicate the activities the
22 State or organization would carry out under such
23 grant, which activities may include—

24 (A) coordination of the activities of State
25 agencies and private entities as necessary to

1 carry out the State's program under this sec-
2 tion;

3 (B) collection, analysis, publication, and
4 dissemination of information,

5 (C) conducting or sponsoring of consumer
6 education, outreach, and information programs,

7 (D) providing (directly or through referral)
8 counseling and consultation services to con-
9 sumers to assist them in choosing long-term
10 care insurance coverage appropriate to their cir-
11 cumstances, and

12 (E) other appropriate activities.

13 (4) PRIORITY FOR INNOVATION.—In awarding
14 grants under this section, the Secretary shall give
15 priority to applications proposing to use innovative
16 approaches to providing information, counseling, and
17 other assistance to individuals who might benefit
18 from, or are considering the purchase of, long-term
19 care insurance.

20 (c) PERIOD OF GRANTS.—Grants under this section
21 shall be for not longer than 3 years.

22 (d) EVALUATIONS AND REPORTS.—

23 (1) BY GRANTEES TO THE SECRETARY.—Each
24 recipient of a grant under this section shall annually

1 evaluate the effectiveness of its program under such
2 grant, and report its conclusions to the Secretary.

3 (2) BY THE SECRETARY TO THE CONGRESS.—

4 The Secretary shall annually evaluate, and report to
5 the Congress on, the effectiveness of programs under
6 this section, on the basis of reports received under
7 paragraph (1) and such independent evaluation as
8 the Secretary finds necessary.

9 (e) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated, for grants under this
11 section—

12 (1) \$10,000,000 for each of fiscal years 1995
13 through 1997 for grants to States, and

14 (2) \$1,000,000 for each of fiscal years 1995
15 through 1997,

16 for grants to eligible organizations.

17 **PART 4—TAX TREATMENT OF LONG-TERM CARE**
18 **INSURANCE AND SERVICES**

19 **SEC. 2401. REFERENCE TO TAX PROVISIONS.**

20 For amendments to the Internal Revenue Code of
21 1986 relating to the treatment of long-term care insurance
22 and services, see subtitle G of title VII.

1 **PART 5—TAX INCENTIVES FOR INDIVIDUALS**
2 **WITH DISABILITIES WHO WORK**

3 **SEC. 2501. REFERENCE TO TAX PROVISION.**

4 For amendment to the Internal Revenue Code of
5 1986 providing for a tax credit for cost of personal assist-
6 ance services required by employed individuals, see section
7 7901.

8 **PART 6—DEMONSTRATION AND EVALUATION**

9 **SEC. 2601. DEMONSTRATION ON ACUTE AND LONG-TERM**
10 **CARE INTEGRATION.**

11 (a) PROGRAM AUTHORIZED.—The Secretary of
12 Health and Human Services shall conduct a demonstra-
13 tion program to test the effectiveness of various ap-
14 proaches to financing and providing integrated acute and
15 long-term care services described in subsection (b) for the
16 chronically ill and disabled who meet eligibility criteria
17 under subsection (c).

18 (b) SERVICES AND BENEFITS.—

19 (1) IN GENERAL.—Except as provided in para-
20 graph (2), the following services and benefits shall
21 be provided under each demonstration approved
22 under this section:

23 (A) COMPREHENSIVE BENEFIT PACK-
24 AGE.—All benefits included in the comprehen-
25 sive benefit package under title I of this Act.

1 (B) TRANSITIONAL BENEFITS.—Special-
2 ized benefits relating to the transition from
3 acute to long-term care, including—

- 4 (i) assessment and consultation,
5 (ii) inpatient transitional care,
6 (iii) medical rehabilitation,
7 (iv) home health care and home care,
8 (v) caregiver support, and
9 (vi) self-help technology.

10 (C) LONG-TERM CARE BENEFITS.—Long-
11 term care benefits, including—

- 12 (i) adult day care,
13 (ii) personal assistance services,
14 (iii) homemaker services and chore
15 services;
16 (iv) home-delivered meals;
17 (v) respite services;
18 (vi) nursing facility services in special-
19 ized care units;
20 (vii) services in other residential set-
21 tings including community supported living
22 arrangements and assisted living facilities;
23 and
24 (viii) assistive devices and environ-
25 mental modifications.

1 (D) HABILITATION SERVICES.—Specialized
2 habilitation services for participants with devel-
3 opmental disabilities.

4 (2) VARIATIONS IN MINIMUM BENEFITS.—

5 (A) IN GENERAL.—Subject to the require-
6 ment of subparagraph (B), demonstrations may
7 omit specified services listed under subpara-
8 graphs (C) and (D) of paragraph (1), or pro-
9 vide additional services, as found appropriate by
10 the Secretary in the case of a particular dem-
11 onstration, taking into consideration factors
12 such as—

13 (i) the needs of a specialized group of
14 eligible beneficiaries;

15 (ii) the availability of the omitted ben-
16 efits under other programs in the service
17 area; and

18 (iii) the geographic availability of
19 service providers.

20 (B) BREADTH REQUIREMENT.—In approv-
21 ing variant demonstrations pursuant to sub-
22 paragraph (A), the Secretary shall ensure that
23 demonstrations under this section, taken as a
24 group, adequately test financing and delivery

1 models covering the entire array of services and
2 benefits described in paragraph (1).

3 (c) ELIGIBILITY CRITERIA.—The Secretary shall es-
4 tablish eligibility criteria for individuals who may receive
5 services under demonstrations under this section. Under
6 such criteria, any of the following may be found to be eligi-
7 ble populations for such demonstrations:

8 (1) Individuals with disabilities who are entitled
9 to services and benefits under a State program
10 under part 1 of this subtitle.

11 (2) Individuals who are entitled to benefits
12 under parts A and B of title XVIII of the Social Se-
13 curity Act.

14 (3) Individuals who are entitled to medical as-
15 sistance under a State plan under title XIX of the
16 Social Security Act, and are also—

17 (A) individuals described in paragraph (2),
18 or

19 (B) individuals eligible for supplemental
20 security income under title XVI of that Act.

21 (d) APPLICATION.—

22 (1) IN GENERAL.—Each entity seeking to par-
23 ticipate in a demonstration under this section shall
24 submit an application, in such format and con-
25 taining such information as the Secretary may re-

1 quire, including the information specified in this
2 subsection.

3 (2) SERVICE DELIVERY.—The application shall
4 state the services to be provided under the dem-
5 onstration (either directly by the applicant or under
6 other arrangements approved by the Secretary),
7 which shall include services specified pursuant to
8 subsection (b) and—

9 (A) enrollment services;

10 (B) client assessment and care planning;

11 (C) simplified access to needed services;

12 (D) integrated management of acute and
13 chronic care, including measures to ensure con-
14 tinuity of care across settings and services;

15 (E) quality assurance, grievance, and ap-
16 peals mechanisms; and

17 (F) such other services as the Secretary
18 may require.

19 (3) CONSUMER PROTECTION AND PARTICIPA-
20 TION.—The applicant shall provide evidence of con-
21 sumer participation—

22 (A) in the planning of the demonstration
23 (including a showing of support from commu-
24 nity agencies or consumer interest groups); and

1 (B) in the conduct of the demonstration,
2 including descriptions of methods and proce-
3 dures to be used—

4 (i) to make available to individuals en-
5 rolled in the demonstration information on
6 self-help, health promotion and disability
7 prevention practices, and enrollees' con-
8 tributions to the costs of care;

9 (ii) to ensure participation by such en-
10 rollees (or their designated representatives,
11 where appropriate) in care planning and in
12 decisions concerning treatment;

13 (iii) to handle and resolve client griev-
14 ances and appeals;

15 (iv) to take enrollee views into account
16 in quality assurance and provider con-
17 tracting procedures; and

18 (v) to evaluate enrollee satisfaction
19 with the program.

20 (4) APPLICANT QUALIFICATIONS.—Applicants
21 for grants under this section shall meet eligibility
22 criteria established by the Secretary, including re-
23 quirements relating to—

24 (A) adequate financial controls to monitor
25 administrative and service costs,

1 (B) demonstrated commitment of the
2 Board of Directors or comparable governing
3 body to the goals of demonstration,

4 (C) information systems adequate to pay
5 service providers, to collect required utilization
6 and cost data, and to provide data adequate to
7 permit evaluation of program performance, and

8 (D) compliance with applicable State laws.

9 (e) PAYMENTS TO PARTICIPANTS.—An entity con-
10 ducting a demonstration under this section shall be enti-
11 tled to receive, with respect to each enrollee, for the period
12 during which it is providing to such enrollee services under
13 a demonstration under this section, such amounts as the
14 Secretary shall provide, which amounts—

15 (1) may include risk-based payments and non-
16 risk based payments by governmental programs, by
17 third parties, or by project enrollees, or any com-
18 bination of such payments, and

19 (2) may vary by project and by enrollee.

20 (f) NUMBER AND DURATION OF DEMONSTRATION
21 PROJECTS.—

22 (1) REQUEST FOR APPLICATIONS.—The Sec-
23 retary shall publish a request for applications under
24 this section not later than one year after enactment
25 of this Act.

1 (2) NUMBER AND DURATION.—The Secretary
2 shall authorize not more than 25 demonstrations
3 under this section, each of which shall run for 7
4 years from the date of the award.

5 (g) EVALUATION AND REPORTS.—The Secretary
6 shall evaluate the demonstration projects under this sec-
7 tion, and shall submit to the Congress—

8 (1) an interim report, by three years after en-
9 actment, describing the status of the demonstration
10 and characteristics of the approved projects; and

11 (2) a final report, by one year after completion
12 of such demonstration projects, evaluating their ef-
13 fectiveness (including cost-effectiveness), and dis-
14 cussing the advisability of including some or all of
15 the integrated models tested in the demonstration as
16 a benefit under the comprehensive benefit package
17 under title I of this Act, or under the programs
18 under title XVIII of the Social Security Act.

19 (h) AUTHORIZATION OF APPROPRIATIONS.—

20 (1) FOR SECRETARIAL RESPONSIBILITIES.—

21 (A) IN GENERAL.—There are authorized to
22 be appropriated \$7,000,000 for fiscal year
23 1996, and \$4,500,000 for each of the 6 suc-
24 ceeding fiscal years, for payment of costs of the
25 Secretary in carrying out this section (including

costs for technical assistance to potential service providers, and research and evaluation), which amounts shall remain available until expended.

(B) SET-ASIDE FOR FEASIBILITY STUDIES.—Of the total amount authorized to be appropriated under subparagraph (A), not less than \$1,000,000 shall be available for studies of the feasibility of systems to provide integrated care for nonaged populations (including physically disabled children and adults, the chronically mentally ill, and individuals with disabilities, and combinations of these groups).

(2) FOR COVERED BENEFITS.—There are authorized to be appropriated \$50,000,000 for the first fiscal year for which grants are awarded under this section, and for each of the four succeeding fiscal years, for payment of costs of benefits for which no public or private program or entity is legally obligated to pay.

SEC. 2602. PERFORMANCE REVIEW OF THE LONG-TERM CARE PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall prepare and submit to the Congress—

1 (1) an interim report, not later than the end of
2 the seventh full calendar year beginning after the
3 date of the enactment of this Act, and

4 (2) a final report, not later than two years after
5 the date of the interim report,

6 evaluating the effectiveness of the programs established
7 and amendments made by this subtitle (and including at
8 a minimum the elements specified in subsection (b)).

9 (b) ELEMENTS OF ASSESSMENT.—The evaluations to
10 be made, and included in the reports required pursuant
11 to subsection (a), include at least the following:

12 (1) STATE SERVICE DELIVERY PROGRAMS.—An
13 evaluation of States' effectiveness in meeting the
14 needs for home and community-based services (in-
15 cluding personal assistance services) of individuals
16 with disabilities (including individuals who do, and
17 who do not, meet the eligibility criteria for the serv-
18 ice program under part 1, individuals of different
19 ages, type and degree of disability, and income lev-
20 els, members of minority groups, and individuals re-
21 siding in rural areas).

22 (2) SERVICE ACCESS.—An evaluation of the de-
23 gree of (and obstacles to) access of individuals with
24 disabilities to needed home and community-based
25 services and to inpatient services.

1 (3) QUALITY.—An evaluation of the quality of
2 long-term care services available.

3 (4) PRIVATE INSURANCE.—An evaluation of the
4 performance of the private sector in offering afford-
5 able long-term care insurance that provides adequate
6 protection against the costs of long-term care, and
7 of the effectiveness of Federal standards and State
8 enforcement, pursuant to part 3, in adequately pro-
9 tecting long-term care insurance consumers.

10 (5) COST ISSUES.—An evaluation of the effec-
11 tiveness of amendments made by this subtitle in con-
12 taining the costs of long-term care, and in limiting
13 the share of such costs borne by individuals with
14 lower incomes.

15 (6) SERVICE COORDINATION AND INTEGRA-
16 TION.—An evaluation of the effectiveness of the pro-
17 grams established or amended under this subtitle in
18 achieving coordination and integration of long-term
19 care services, and of such services with acute care
20 services and social services, and in ensuring provi-
21 sion of services in the least restrictive setting pos-
22 sible.

23 **TITLE III—PUBLIC HEALTH**
24 **INITIATIVES**

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1 **Subtitle A—Workforce Priorities**

2 **Under Federal Payments**

3 **PART 1—INSTITUTIONAL COSTS OF GRADUATE**

4 **MEDICAL EDUCATION; WORKFORCE PRIORITIES**

5 **Subpart A—National Council**

6 **Regarding Workforce Priorities**

7 **SEC. 3001. NATIONAL COUNCIL ON GRADUATE MEDICAL**

8 **EDUCATION.**

9 (a) IN GENERAL.—There is established within the

10 Department of Health and Human Services a council to

11 be known as the National Council on Graduate Medical

12 Education.

13 (b) DUTIES.—The Secretary shall carry out subpart

14 B acting through the National Council.

15 (c) COMPOSITION.—

1 (1) IN GENERAL.—The membership of the Na-
2 tional Council shall include individuals who are ap-
3 pointed to the Council from among individuals who
4 are not officers or employees of the United States.
5 Such individuals shall be appointed by the Secretary,
6 and shall include individuals from each of the fol-
7 lowing categories:

8 (A) Consumers of health care services.

9 (B) Physicians who are faculty members of
10 medical schools.

11 (C) Physicians in private practice who are
12 not physicians described in subparagraph (B).

13 (D) Officers or employees of regional and
14 corporate health alliances.

15 (E) Officers or employees of health care
16 plans that participate in such alliances.

17 (F) Such other individuals as the Secretary
18 determines to be appropriate.

19 (2) EX OFFICIO MEMBERS; OTHER FEDERAL
20 OFFICERS OR EMPLOYEES.—The membership of the
21 National Council shall include individuals designated
22 by the Secretary to serve as members of the Council
23 from among Federal officers or employees who are
24 appointed by the President, or by the Secretary or

1 other Federal officers who are appointed by the
2 President with the advice and consent of the Senate.

3 (d) CHAIR.—The Secretary shall, from among mem-
4 bers of the National Council appointed under subsection
5 (c)(1), designate an individual to serve as the Chair of
6 the Council.

7 (e) DEFINITIONS.—For purposes of this subtitle:

8 (1) The term “medical school” means a school
9 of medicine (as defined in section 799 of the Public
10 Health Service Act) or a school of osteopathic medi-
11 cine (as defined in such section).

12 (2) The term “National Council” means the
13 council established in subsection (a).

14 **Subpart B—Authorized Positions**

15 **in Specialty Training**

16 **SEC. 3011. COOPERATION REGARDING APPROVED PHYSI-**
17 **CIAN TRAINING PROGRAMS.**

18 (a) IN GENERAL.—With respect to an approved phy-
19 sician training program in a medical specialty, a funding
20 agreement for payments under section 3031 for a calendar
21 year is that the program will ensure that the number of
22 individuals enrolled in the program in the subsequent aca-
23 demic year is in accordance with this subpart.

24 (b) DEFINITIONS.—

1 (1) APPROVED PROGRAM.—For purposes of this
2 subtitle:

3 (A) The term “approved physician training
4 program”, with respect to the medical speciality
5 involved, means a residency or other post-
6 graduate program that trains physicians and
7 meets the following conditions:

8 (i) Participation in the program may
9 be counted toward certification in the med-
10 ical specialty.

11 (ii) The program is accredited by the
12 Accreditation Council on Graduate Medical
13 Education, or approved by the Council on
14 Postgraduate Training of the American
15 Osteopathic Association.

16 (B) The term “approved physician training
17 program” includes any postgraduate program
18 described in subparagraph (A) that provides
19 health services in an ambulatory setting, with-
20 out regard to whether the program provides in-
21 patient hospital services.

22 (C) The term “approved physician training
23 program” includes any postgraduate program
24 described in subparagraph (A), whether oper-
25 ated by academic health centers, teaching hos-

1 pitals, multispecialty group practices, ambula-
2 tory care providers, prepaid health plans, or
3 other entities.

4 (2) ELIGIBLE PROGRAM; SUBPART DEFINI-
5 TION.—For purposes of this subpart, the term “eli-
6 gible program”, with respect to an academic year,
7 means an approved physician training program that
8 receives payments under subpart C for the calendar
9 year in which the academic year begins.

10 (3) OTHER DEFINITIONS.—For purposes of this
11 subtitle:

12 (A)(i) The term “academic year” means
13 the 1-year period beginning on July 1. The aca-
14 demic year beginning July 1, 1993, is academic
15 year 1993–94.

16 (ii) With respect to the funding agreement
17 described in subsection (a), the term “subse-
18 quent academic year” means the academic year
19 beginning July 1 of the calendar year for which
20 payments are to be made under the agreement.

21 (B) The term “funding agreement”, with
22 respect to payments under section 3031 to an
23 eligible program, means that the Secretary may
24 make the payments only if the program makes
25 the agreement involved.

1 (C) The term “medical specialty” includes
2 all medical, surgical, and other physician spe-
3 cialties and subspecialties.

4 **SEC. 3012. ANNUAL AUTHORIZATION OF NUMBER OF SPE-**
5 **CIALTY POSITIONS; REQUIREMENTS REGARD-**
6 **ING PRIMARY HEALTH CARE.**

7 (a) ANNUAL AUTHORIZATION OF NUMBER OF POSI-
8 TIONS.—In the case of each medical specialty, the Na-
9 tional Council shall, pursuant to section 3011, designate
10 for each academic year the number of individuals nation-
11 wide who are authorized to be enrolled in eligible pro-
12 grams. The preceding sentence is subject to subsection
13 (c)(2).

14 (b) PRIMARY HEALTH CARE.—

15 (1) IN GENERAL.—Subject to paragraph (2), in
16 carrying out subsection (a) for an academic year, the
17 National Council shall ensure that, of the class of
18 training participants entering eligible programs for
19 academic year 1998–99 or any subsequent academic
20 year, the percentage of such class that completes eli-
21 gible programs in primary health care is not less
22 than 55 percent (without regard to the academic
23 year in which the members of the class complete the
24 programs).

1 (2) RULE OF CONSTRUCTION.—The require-
2 ment of paragraph (1) regarding a percentage ap-
3 plies in the aggregate to training participants enter-
4 ing eligible programs for the academic year involved,
5 and not individually to any eligible program.

6 (c) DESIGNATIONS REGARDING 3-YEAR PERIODS.—

7 (1) DESIGNATION PERIODS.—For each medical
8 specialty, the National Council shall make the an-
9 nual designations under subsection (a) for periods of
10 3 academic years.

11 (2) INITIAL PERIOD.—The first designation pe-
12 riod established by the National Council after the
13 date of the enactment of this Act shall be the aca-
14 demic years 1998–99 through 2000–01.

15 (d) CERTAIN CONSIDERATIONS IN DESIGNATING AN-
16 NUAL NUMBERS.—

17 (1) IN GENERAL.—Factors considered by the
18 National Council in designating the annual number
19 of specialty positions for an academic year for a
20 medical specialty shall include the extent to which
21 there is a need for additional practitioners in the
22 specialty, as indicated by the following:

23 (A) The incidence and prevalence (in the
24 general population and in various other popu-
25 lations) of the diseases, disorders, or other

1 health conditions with which the specialty is
2 concerned.

3 (B) The number of physicians who will be
4 practicing in the specialty in the academic year.

5 (C) The number of physicians who will be
6 practicing in the specialty at the end of the 5-
7 year period beginning on the first day of the
8 academic year.

9 (2) RECOMMENDATIONS OF PRIVATE ORGANIZA-
10 TIONS.—In designating the annual number of spe-
11 cialty positions for an academic year for a medical
12 specialty, the National Council shall consider the
13 recommendations of organizations representing phy-
14 sicians in the specialty and the recommendations of
15 organizations representing consumers of the services
16 of such physicians.

17 (3) TOTAL OF RESPECTIVE ANNUAL NUM-
18 BERS.—

19 (A) Subject to subparagraph (B), for aca-
20 demic year 1998-99 and subsequent academic
21 years, the National Council shall ensure that
22 the total of the respective annual numbers des-
23 ignated under subsection (a) for an academic
24 year is a total that—

1 (i) bears a relationship to the number
2 of individuals who graduated from medical
3 schools in the United States in the pre-
4 ceding academic year; and

5 (ii) is consistent with the purposes of
6 this subpart.

7 (B) For each of the academic years 1998-
8 99 through 2002-03, the total determined
9 under subparagraph (A) shall be reduced by a
10 percentage determined by the National Council.

11 (e) DEFINITIONS.—For purposes of this subtitle:

12 (1) The term “annual number of specialty posi-
13 tions”, with respect to a medical specialty, means
14 the number designated by the National Council
15 under subsection (a) for eligible programs for the
16 academic year involved.

17 (2) The term “designation period” means a 3-
18 year period under subsection (c)(1) for which des-
19 ignations under subsection (a) are made by the Na-
20 tional Council.

21 (3) The term “primary health care” means the
22 following medical specialties: Family medicine, gen-
23 eral internal medicine, general pediatrics, and ob-
24 stetrics and gynecology.

1 (4) The term “specialty position” means a posi-
2 tion as a training participant.

3 (5) The term “training participant” means an
4 individual who is enrolled in an approved physician
5 training program.

6 **SEC. 3013. ALLOCATIONS AMONG SPECIALTIES AND PRO-**
7 **GRAMS.**

8 (a) IN GENERAL.—For each academic year, the Na-
9 tional Council shall for each medical specialty make alloca-
10 tions among eligible programs of the annual number of
11 specialty positions that the Council has designated for
12 such year. The preceding sentence is subject to subsection
13 (b)(3).

14 (b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

15 (1) IN GENERAL.—For each medical specialty,
16 the National Council shall make the annual alloca-
17 tions under subsection (a) for periods of 3 academic
18 years.

19 (2) ADVANCE NOTICE TO PROGRAMS.—With re-
20 spect to the first academic year of an allocation pe-
21 riod established by the National Council, the Na-
22 tional Council shall, not later than July 1 of the pre-
23 ceding academic year, notify each eligible program of
24 the allocations made for the program for each of the
25 academic years of the period.

1 (3) INITIAL PERIOD.—The first allocation pe-
2 riod established by the National Council after the
3 date of the enactment of this Act shall be the aca-
4 demic years 1998–99 through 2000–01.

5 (c) CERTAIN CONSIDERATIONS.—

6 (1) GEOGRAPHIC AREAS; QUALITY OF PRO-
7 GRAMS.—In making allocations under subsection (a)
8 for eligible programs of the various geographic
9 areas, the National Council shall include among the
10 factors considered the historical distribution among
11 the areas of approved physician training programs,
12 and the quality of such programs.

13 (2) UNDERREPRESENTATION OF MINORITY
14 GROUPS.—In making an allocation under subsection
15 (a) for an eligible program, the National Council
16 shall include among the factors considered the fol-
17 lowing:

18 (A) The extent to which the population of
19 training participants in the program includes
20 training participants who are members of racial
21 or ethnic minority groups.

22 (B) With respect to a racial or ethnic
23 group represented among the training partici-
24 pants, the extent to which the group is under-

1 represented in the field of medicine generally
2 and in the various medical specialties.

3 (3) RECOMMENDATIONS OF PRIVATE ORGANIZA-
4 TIONS.—In making allocations under subsection (a)
5 for eligible programs, the National Council shall con-
6 sider the recommendations of organizations rep-
7 resenting physicians in the medical specialties and
8 the recommendations of organizations representing
9 consumers of the services of such physicians.

10 (d) DEFINITIONS.—For purposes of this subtitle, the
11 term “allocation period” means a 3-year period under sub-
12 section (b)(1) for which allocations under subsection (a)
13 are made by the National Council.

14 **Subpart C—Institutional Costs of**

15 **Graduate Medical Education**

16 **SEC. 3031. FEDERAL FORMULA PAYMENTS TO APPROVED**
17 **PHYSICIAN TRAINING PROGRAMS.**

18 (a) IN GENERAL.—In the case of an approved physi-
19 cian training program that in accordance with section
20 3032 submits to the Secretary an application for calendar
21 year 1996 or any subsequent calendar year, the Secretary
22 shall make payments for such year to the program for the
23 purpose specified in subsection (b). The Secretary shall
24 make the payments in an amount determined in accord-

1 ance with section 3033, and may administer the payments
2 as a contract, grant, or cooperative agreement.

3 (b) PAYMENTS FOR OPERATION OF APPROVED PHY-
4 SICIAN TRAINING PROGRAMS.—The purpose of payments
5 under subsection (a) is to assist an eligible program with
6 the costs of operation. A funding agreement for such pay-
7 ments is that the approved physician training program in-
8 volved will expend the payments only for such purpose.

9 (c) ELIGIBLE PROGRAM; SUBPART DEFINITION.—
10 For purposes of this subpart, the term “eligible program”,
11 with respect to the calendar year involved, means an ap-
12 proved physician training program that submits to the
13 Secretary an application for such year in accordance with
14 section 3032.

15 **SEC. 3032. APPLICATION FOR PAYMENTS.**

16 (a) IN GENERAL.—For purposes of section 3031(a),
17 an application for payments under such section for a cal-
18 endar year is in accordance with this section if—

19 (1) the approved physician training program in-
20 volved submits the application not later than the
21 date specified by the Secretary;

22 (2) the application demonstrates that the condi-
23 tion described in subsection (b) is met with respect
24 to the program;

1 (3) the application contains each funding agree-
2 ment described in this part and the application pro-
3 vides such assurances of compliance with the agree-
4 ments as the Secretary may require; and

5 (4) the application is in such form, is made in
6 such manner, and contains such agreements, assur-
7 ances, and information as the Secretary determines
8 to be necessary to carry out this part.

9 (b) CERTAIN CONDITIONS.—An approved physician
10 training program meets the condition described in this
11 subsection for receiving payments under section 3031 for
12 a calendar year if the institution within which the program
13 operates agrees that such payments will be made by the
14 Secretary directly to the program (and such agreement is
15 included in the application under subsection (a)), and the
16 Secretary shall ensure that such institution is permitted
17 to participate as a provider in a regional or corporate alli-
18 ance health plan during such year only if each of the ap-
19 proved physician training programs of the institution
20 meets the requirements for receiving payments under such
21 section for such year.

22 **SEC. 3033. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**
23 **NUAL AMOUNT OF PAYMENTS.**

24 (a) ANNUAL HEALTH PROFESSIONS WORKFORCE
25 ACCOUNT.—

1 (1) IN GENERAL.—Subject to paragraph (2)
2 and section 3034, the amount available for a cal-
3 endar year for making payments under sections
4 3031 and 3051 (constituting an account to be
5 known as the annual health professions workforce
6 account) is the following, as applicable to the cal-
7 endar year:

8 (A) In the case of calendar year 1996,
9 \$3,200,000,000.

10 (B) In the case of calendar year 1997,
11 \$3,550,000,000.

12 (C) In the case of calendar year 1998,
13 \$4,800,000,000.

14 (D) In the case of each of the calendar
15 years 1999 and 2000, \$5,800,000,000.

16 (E) In the case of each subsequent cal-
17 endar year, the amount specified in subpara-
18 graph (D) increased by the product of such
19 amount and the general health care inflation
20 factor for such year (as defined in subsection
21 (d)).

22 (2) TRANSITIONAL PROVISION.—

23 (A) With respect to making payments
24 under sections 3031 and 3051 for calendar year
25 1996 or 1997, the Secretary shall first make

1 payments under section 3031 to eligible pro-
2 grams described in subparagraph (B) in the
3 amount determined for the programs under
4 subsection (b) for such year, and then, from
5 such amounts as remain available in the annual
6 health professions workforce account for such
7 year, shall make payments under section 3031
8 to other eligible programs and shall make pay-
9 ments under section 3051.

10 (B) An eligible program described in this
11 subparagraph is such a program that is oper-
12 ated in a State that is a participating State
13 under title I.

14 (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-
15 BLE PROGRAMS.—

16 (1) IN GENERAL.—Subject to the annual health
17 professions workforce account available for a cal-
18 endar year, the amount of payments required in sec-
19 tion 3031 to be made to an eligible program for the
20 calendar year is an amount equal to the product
21 of—

22 (A) the number of full-time equivalent
23 training participants in the program; and

24 (B) the national average of the costs of
25 such programs in training such a participant,

1 as determined by consideration of the following
2 factors (and as adjusted under paragraph (2)):

3 (i) The national average salary of
4 training participants.

5 (ii) The national average costs of such
6 programs in providing for faculty super-
7 vision of training participants and for re-
8 lated activities.

9 (2) ADDITIONAL PROVISIONS REGARDING NA-
10 TIONAL AVERAGE COST.—

11 (A) The Secretary shall in accordance with
12 paragraph (1)(B) determine, for academic year
13 1992–93, an amount equal to the national aver-
14 age described in such paragraph with respect to
15 training a participant in an approved physician
16 training program in the medical specialty in-
17 volved. The national average applicable under
18 such paragraph for a calendar year for such
19 programs is, subject to subparagraph (B), the
20 amount determined under the preceding sen-
21 tence increased by the amount necessary to off-
22 set the effects of inflation occurring since aca-
23 demic year 1992–93, as determined through use
24 of the consumer price index.

1 (B) The national average determined
2 under subparagraph (A) and applicable to a cal-
3 endar year shall, in the case of the eligible pro-
4 gram involved, be adjusted by a factor to reflect
5 regional differences in the applicable wage and
6 wage-related costs.

7 (c) LIMITATION.—If, subject to subsection (a)(2), the
8 annual health professions workforce account available for
9 a calendar year is insufficient for providing each eligible
10 program with the amount of payments determined under
11 subsection (b) for the program for such year, the Sec-
12 retary shall make such pro rata reductions in the amounts
13 so determined as may be necessary to ensure that the total
14 of payments made under section 3031 for such year equals
15 the total of such account.

16 (d) DEFINITIONS.—For purposes of this subtitle:

17 (1) The term “annual health professions work-
18 force account” means the account established pursu-
19 ant to subsection (a)(1).

20 (2) The term “consumer price index” has the
21 meaning given such term in section 1902.

22 (3) The term “general health care inflation fac-
23 tor”, with respect to a year, has the meaning given
24 such term in section 6001(a)(3) for such year.

1 **SEC. 3034. ADDITIONAL FUNDING PROVISIONS.**

2 (a) SOURCES OF FUNDS FOR ANNUAL HEALTH PRO-
3 FESSIONS WORKFORCE ACCOUNT.—The amount specified
4 in section 3033(a)(1) for the annual health professions
5 workforce account for a calendar year shall be derived
6 from the sources specified in subsection (b).

7 (b) CONTRIBUTIONS FROM MEDICARE TRUST
8 FUNDS, REGIONAL ALLIANCES, AND CORPORATE ALLI-
9 ANCES.—For purposes of subsection (a), the sources spec-
10 ified in this subsection for a calendar year are the fol-
11 lowing:

12 (1) Transfers made by the Secretary under sec-
13 tion 4051.

14 (2) Payments made by regional alliances under
15 section 1353 and—

16 (A) in the case of each of the calendar
17 years 1996 and 1997, transferred in an amount
18 equal to 50 percent of such payments made for
19 the calendar year involved; and

20 (B) in the case of calendar year 1998 and
21 each subsequent calendar year, transferred in
22 an amount equal to the aggregate regional alli-
23 ance portion determined under subsection
24 (c)(2)(A).

25 (3) The transfer made under subsection (d)(1).

1 (c) CONTRIBUTIONS FROM REGIONAL AND COR-
2 PORATE ALLIANCES.—

3 (1) DETERMINATION OF AGGREGATE REGIONAL
4 AND CORPORATE ALLIANCE AMOUNT.—For purposes
5 regarding the provision of funds for the annual
6 health professions workforce account for a calendar
7 year (other than calendar year 1996 or 1997), the
8 Secretary shall determine an aggregate regional and
9 corporate alliance amount, which amount is to be
10 paid by such alliances pursuant to paragraphs
11 (2)(B) and (3) of subsection (b), respectively, and
12 which amount shall be equal to the difference
13 between—

14 (A) the amount specified in section
15 3033(a)(1) for the annual health professions
16 workforce account for such year; and

17 (B) the amount transferred under section
18 4051 for the year.

19 (2) ALLOCATION OF AMOUNT AMONG REGIONAL
20 AND CORPORATE ALLIANCES.—With respect to the
21 aggregate regional and corporate alliance amount
22 determined under paragraph (1) for a calendar year
23 (other than calendar year 1996 or 1997)—

24 (A) the aggregate regional alliance portion
25 of such amount is the product of such amount

1 and the percentage constituted by the ratio of
2 the total plan payments of regional alliances to
3 the combined total plan payments of regional
4 alliances and corporate alliances; and

5 (B) the aggregate corporate alliance por-
6 tion of such amount is the product of such
7 amount and the percentage constituted by the
8 ratio of the total plan payments of corporate al-
9 liances to such combined total plan payments.

10 (d) COMPLIANCE REGARDING CORPORATE ALLI-
11 ANCES.—

12 (1) IN GENERAL.—Effective January 15 of cal-
13 endar year 1996 and each subsequent calendar year,
14 there is hereby transferred to the Secretary, out of
15 any money in the Treasury not otherwise
16 appropriated—

17 (A) in the case of each of the calendar
18 years 1996 and 1997, an amount equal to the
19 difference between—

20 (i) the amount specified in section
21 3033(a)(1) for the annual health profes-
22 sions workforce account for the calendar
23 year involved; and

24 (ii) the sum of the amount transferred
25 under section 4051 for such year and the

1 amount transferred under subsection
2 (b)(2)(A) for such year; and
3 (B) in the case of calendar year 1998 and
4 each subsequent calendar year, an amount
5 equal to the aggregate corporate alliance por-
6 tion determined under subsection (c)(2)(B) for
7 the calendar year involved.

8 (2) MANNER OF COMPLIANCE.—The payment
9 by corporate alliances of the tax imposed under sec-
10 tion 3461 of the Internal Revenue Code of 1986 (as
11 added by section 7121 of this Act), together with the
12 transfer made in paragraph (1)(B) for the calendar
13 year involved, is deemed to be the payment required
14 pursuant to subsection (c)(1) for corporate alliances
15 for such year.

16 (3) GRADUATE NURSE EDUCATION.—Effective
17 January 15 of calendar year 1996 and each subse-
18 quent calendar year, there is hereby transferred to
19 the Secretary, out of any money in the Treasury not
20 otherwise appropriated, 50 percent of the amount
21 specified in section 3063(b) with respect to the an-
22 nual graduate nurse training account.

23 (e) DEFINITIONS.—For purposes of this subtitle, the
24 term “plan payments” with respect to a regional or cor-

1 porate alliance, means the amount paid to health plans
2 by the alliance.

3 **Subpart D—General Provisions**

4 **SEC. 3041. DEFINITIONS.**

5 For purposes of this subtitle:

6 (1) The term “academic year” has the meaning
7 given such term in section 3011(b).

8 (2) The term “allocation period” has the mean-
9 ing given such term in section 3013(d).

10 (3) The term “annual health professions work-
11 force account” has the meaning given such term in
12 section 3033(d).

13 (4) The term “annual number of specialty posi-
14 tions” has the meaning given such term in section
15 3012(e).

16 (5) The term “approved physician training pro-
17 gram” has the meaning given such term in section
18 3011(b).

19 (6) The term “consumer price index” has the
20 meaning given such term in section 3033(d).

21 (7) The term “designation period” has the
22 meaning given such term in section 3012(e).

23 (8) The term “eligible program” has the mean-
24 ing given such term in section 3011(b), in the case

1 of subpart B; and has the meaning given such term
2 in section 3031(c), in the case of subpart C.

3 (9) The term “funding agreement” has the
4 meaning given such term in section 3011(b).

5 (10) The term “general health care inflation
6 factor” has the meaning given such term in section
7 3033(d).

8 (11) The term “medical school” has the mean-
9 ing given such term in section 3001(e).

10 (12) The term “medical specialty” has the
11 meaning given such term in section 3011(b).

12 (13) The term “National Council” has the
13 meaning given such term in section 3001(e).

14 (14) The term “plan payments” has the mean-
15 ing given such term in section 3034(e).

16 (15) The term “primary health care” has the
17 meaning given such term in section 3012(e).

18 (16) The term “specialty position” has the
19 meaning given such term in section 3012(e).

20 (17) The term “training participant” has the
21 meaning given such term in section 3012(e).

22 **Subpart E—Transitional Provisions**

23 **SEC. 3051. TRANSITIONAL PAYMENTS TO INSTITUTIONS.**

24 (a) PAYMENTS REGARDING EFFECTS OF SUBPART B
25 ALLOCATIONS.—For each of the four calendar years speci-

1 fied in subsection (b)(2), in the case of an institution that
2 submits to the Secretary an application for such year in
3 accordance with subsection (d), the Secretary shall make
4 payments for the year to the institution for the purpose
5 specified in subsection (c). The Secretary shall make the
6 payments in an amount determined in accordance with
7 subsection (e), and may administer the payments as a con-
8 tract, grant, or cooperative agreement.

9 (b) INSTITUTIONS LOSING SPECIALTY POSITIONS;
10 RELEVANT YEARS REGARDING PAYMENTS.—

11 (1) INSTITUTIONS LOSING SPECIALTY POSI-
12 TIONS.—The Secretary may make payments under
13 subsection (a) to an institution only if, with respect
14 to the calendar year involved, the institution meets
15 the following conditions:

16 (A) The institution operates one or more
17 programs that—

18 (i) are approved physician training
19 programs; and

20 (ii) are receiving payments under sec-
21 tion 3031 for such year.

22 (B) The aggregate number of speciality po-
23 sitions in such programs (in the medical speci-
24 alities with respect to which such payments are
25 made) is below the aggregate number of such

1 positions at the institution for academic year
2 1993–94 as a result of allocations under sub-
3 part B.

4 (2) RELEVANT YEARS.—The Secretary may
5 make payments under subsection (a) to an institu-
6 tion only for the first four calendar years after cal-
7 endar 1997 for which the institution meets the con-
8 ditions described in paragraph (1).

9 (3) ELIGIBLE INSTITUTION.—For purposes of
10 this section, the term “eligible institution” means an
11 institution that submits to the Secretary an applica-
12 tion in accordance with subsection (d).

13 (c) PURPOSE OF PAYMENTS.—The purpose of pay-
14 ments under subsection (a) is to assist an eligible institu-
15 tion with the costs of operation. A funding agreement for
16 such payments is that the institution involved will expend
17 the payments only for such purpose.

18 (d) APPLICATION FOR PAYMENTS.—For purposes of
19 subsection (a), an application for payments under such
20 subsection is in accordance with this subsection if the in-
21 stitution involved submits the application not later than
22 the date specified by the Secretary; the application dem-
23 onstrates that the institution meets the conditions de-
24 scribed in subsection (b)(1) and that the institution has
25 cooperated with the approved physician training programs

1 of the institution in meeting the condition described in sec-
2 tion 3032(b); the application contains each funding agree-
3 ment described in this subpart and the application pro-
4 vides such assurances of compliance with the agreements
5 as the Secretary may require; and the application is in
6 such form, is made in such manner, and contains such
7 agreements, assurances, and information as the Secretary
8 determines to be necessary to carry out this subpart.

9 (e) AMOUNT OF PAYMENTS.—

10 (1) IN GENERAL.—Subject to the annual health
11 professions workforce account available for the cal-
12 endar year involved, the amount of payments re-
13 quired in subsection (a) to be made to an eligible in-
14 stitution for such year is the product of the amount
15 determined under paragraph (2) and the applicable
16 percentage specified in paragraph (3).

17 (2) NUMBER OF SPECIALTY POSITIONS LOST;
18 NATIONAL AVERAGE SALARY.—For purposes of
19 paragraph (1), the amount determined under this
20 paragraph for an eligible institution for the calendar
21 year involved is the product of—

22 (A) an amount equal to the aggregate
23 number of full-time equivalent specialty posi-
24 tions lost; and

1 (B) the national average salary of training
2 participants.

3 (3) APPLICABLE PERCENTAGE.—For purposes
4 of paragraph (1), the applicable percentage for a cal-
5 endar year is the following, as applicable to such
6 year:

7 (A) For the first calendar year after cal-
8 endar 1997 for which the eligible institution in-
9 volved meets the conditions described in sub-
10 section (b)(1), 100 percent.

11 (B) For the second such year, 75 percent.

12 (C) For the third such year, 50 percent.

13 (D) For the fourth such year, 25 percent.

14 (4) DETERMINATION OF SPECIALTY POSITIONS
15 LOST.—

16 (A) For purposes of this subsection, the
17 aggregate number of specialty positions lost,
18 with respect to a calendar year, is the difference
19 between—

20 (i) the aggregate number of specialty
21 positions described in subparagraph (B)
22 that are estimated for the eligible institu-
23 tion involved for the academic year begin-
24 ning in such calendar year; and

1 (ii) the aggregate number of such spe-
2 cialty positions at the institution for aca-
3 demic year 1993-94.

4 (B) For purposes of subparagraph (A), the
5 specialty positions described in this subpara-
6 graph are specialty positions in the medical spe-
7 cialties with respect to which payments under
8 section 3031 are made to the approved physi-
9 cian training programs of the eligible institution
10 involved.

11 (5) ADDITIONAL PROVISION REGARDING NA-
12 TIONAL AVERAGE SALARY.—

13 (A) The Secretary shall determine, for aca-
14 demic year 1992-93, an amount equal to the
15 national average described in paragraph (2)(B).
16 The national average applicable under such
17 paragraph for a calendar year is, subject to
18 subparagraph (B), the amount determined
19 under the preceding sentence increased by an
20 amount necessary to offset the effects of infla-
21 tion occurring since academic year 1992-93, as
22 determined through use of the consumer price
23 index.

24 (B) The national average determined
25 under subparagraph (A) and applicable to a cal-

1 endar year shall, in the case of the eligible insti-
2 tution involved, be adjusted by a factor to re-
3 flect regional differences in the applicable wage
4 and wage-related costs.

5 **PART 2—INSTITUTIONAL COSTS**

6 **OF GRADUATE NURSING EDU-**
7 **CATION; WORKFORCE PRIOR-**
8 **ITIES**

9 **SEC. 3061. NATIONAL COUNCIL; AUTHORIZED GRADUATE**
10 **NURSE TRAINING POSITIONS; INSTITU-**
11 **TIONAL COSTS.**

12 (a) PROGRAM REGARDING GRADUATE NURSE TRAIN-
13 ING PROGRAMS.—The Secretary shall, in accordance with
14 this part, carry out a program with respect to graduate
15 nurse training programs that is equivalent to the program
16 carried out under part 1 with respect to approved physi-
17 cian training programs.

18 (b) DEFINITIONS.—For purposes of this part:

19 (1) The term “graduate nurse training pro-
20 grams” means programs for advanced nurse edu-
21 cation, programs for education as nurse practi-
22 tioners, programs for education as nurse midwives,
23 programs for education as nurse anesthetists, and
24 such other programs for training in clinical nurse

1 specialties as are determined by the Secretary to re-
2 quire advanced education.

3 (2) The term “graduate nurse training posi-
4 tion” means a position as an individual who is en-
5 rolled in a graduate nurse training program.

6 (3) The term “programs for advanced nurse
7 education” means programs meeting the conditions
8 to be programs for which awards of grants and con-
9 tracts may be made under section 821 of the Public
10 Health Service Act.

11 (4) The term “programs for education as nurse
12 practitioners” means programs meeting the condi-
13 tions to be programs for which awards of grants and
14 contracts may be made under section 822 of the
15 Public Health Service Act for education as a nurse
16 practitioners.

17 (5) The term “programs for education as nurse
18 midwives” means programs meeting the conditions
19 to be programs for which awards of grants and con-
20 tracts may be made under section 822 of the Public
21 Health Service Act for education as nurse midwives.

22 (6) The term “programs for education as nurse
23 anesthetists” means programs meeting the condi-
24 tions to be programs for which awards of grants

1 may be made under section 831 of the Public Health
2 Service Act for education as nurse anesthetists.

3 **SEC. 3062. APPLICABILITY OF PART 1 PROVISIONS.**

4 (a) IN GENERAL.—The provisions of part 1 apply to
5 the program carried out under section 3061 to the same
6 extent and in the same manner as such provisions apply
7 to the program carried out under part 1, subject to the
8 subsequent provisions of this section. Section 3051 does
9 not apply for purposes of the preceding sentence.

10 (b) NATIONAL COUNCIL.—With respect to section
11 3001 as applied to this part, the council shall be known
12 as the National Council on Graduate Nurse Education (in
13 this part referred to as the “National Council”). The pro-
14 visions of section 851 of the Public Health Service Act
15 regarding the composition of the council under such sec-
16 tion apply to the composition of the National Council to
17 the same extent and in the same manner as such provi-
18 sions apply to the council under such section 851.

19 (c) ALLOCATION OF GRADUATE NURSE TRAINING
20 POSITIONS; FORMULA PAYMENTS FOR OPERATING
21 COSTS.—With respect to subparts B and C of part 1 as
22 applied to this part—

23 (1) the funding agreement described in section
24 3011 is to be made by graduate nurse training pro-
25 grams;

1 (2) designations under section 3012 and alloca-
2 tions under section 3013 apply to graduate nurse
3 training positions; and

4 (3) payments under section 3031 are to be
5 made to graduate nurse training programs, subject
6 to the requirements for such payments.

7 **SEC. 3063. FUNDING.**

8 (a) IN GENERAL.—With respect to sections 3033 and
9 3034 as applied to this part, the provisions of this section
10 apply.

11 (b) ANNUAL GRADUATE NURSE TRAINING AC-
12 COUNT.—Subject to subsection (c), the amount available
13 for each calendar year for making payments pursuant to
14 section 3062(c)(3) to graduate nurse training programs
15 (constituting an account to be known as the annual grad-
16 uate nurse training account) is \$200,000,000.

17 (c) SOURCES OF FUNDS FOR ACCOUNT.—The
18 amount specified in subsection (b) for the annual graduate
19 nurse training account for a calendar year shall be derived
20 from the following sources:

21 (1) The transfer under section 3034(d)(3).

22 (2) The transfer under section 3104(d)(3).

1 **PART 3—RELATED PROGRAMS**

2 **SEC. 3071. PROGRAMS OF THE SECRETARY OF HEALTH AND**
3 **HUMAN SERVICES.**

4 (a) IN GENERAL.—

5 (1) FUNDING.—For purposes of carrying out
6 the programs described in this section, there is au-
7 thorized to be appropriated \$400,000,000 for fiscal
8 year 1994 and each subsequent fiscal year (in addi-
9 tion to amounts that may otherwise be authorized to
10 be appropriated for carrying out the programs).

11 (2) ADMINISTRATION.—The programs described
12 in this section and carried out with amounts made
13 available under subsection (a) shall be carried out by
14 the Secretary of Health and Human Services.

15 (b) PRIMARY CARE PHYSICIAN AND PHYSICIAN AS-
16 SISTANT TRAINING.—For purposes of subsection (a), the
17 programs described in this section include programs to
18 support projects to train additional numbers of primary
19 care physicians and physician assistants, including
20 projects to enhance community-based generalist training
21 for medical students, residents, and practicing physicians;
22 to retrain mid-career physicians previously certified in a
23 nonprimary care medical specialty; to expand the supply
24 of physicians with special training to serve in rural and
25 inner-city medically underserved areas; to support expan-

1 sion of service-linked educational networks that train a
2 range of primary care providers in community settings;
3 to provide for training in managed care, cost-effective
4 practice management, and continuous quality improve-
5 ment; and to develop additional information on primary
6 care workforce issues as required to meet future needs in
7 health care.

8 (c) TRAINING OF UNDERREPRESENTED MINORITIES
9 AND DISADVANTAGED PERSONS.—For purposes of sub-
10 section (a), the programs described in this section include
11 a program to support projects to increase the number of
12 underrepresented minority and disadvantaged persons in
13 medicine, osteopathy, dentistry, nursing, public health,
14 and other health professions, including projects to provide
15 continuing financial assistance for such persons entering
16 health professions training programs; to increase support
17 for recruitment and retention of such persons in the health
18 professions; to maintain efforts to foster interest in health
19 careers among such persons at the preprofessional level;
20 and to increase the number of minority health professions
21 faculty.

22 (d) NURSE TRAINING.—For purposes of subsection
23 (a), the programs described in this section include a pro-
24 gram to support projects to support midlevel provider
25 training and address priority nursing workforce needs, in-

cluding projects to train additional nurse practitioners and nurse midwives; to support baccalaureate-level nurse training programs providing preparation for careers in teaching, community health service, and specialized clinical care; to train additional nurse clinicians and nurse anesthetists; to support interdisciplinary school-based community nursing programs; and to promote research on nursing workforce issues.

(e) INAPPROPRIATE PRACTICE BARRIERS; FULL UTILIZATION OF SKILLS.—For purposes of subsection (a), the programs described in this section include a program—

(1) to develop and encourage the adoption of model professional practice statutes for advanced practice nurses and physician assistants, and to otherwise support efforts to remove inappropriate barriers to practice by such nurses and such physician assistants; and

(2) to promote the full utilization of the professional education and clinical skills of advanced practice nurses and physician assistants.

(f) OTHER PROGRAMS.—For purposes of subsection (a), the programs described in this section include a program to train health professionals and administrators in managed care, cost-effective practice management, contin-

1 uous quality improvement practices, and provision of cul-
2 turally sensitive care.

3 (g) RELATIONSHIP TO EXISTING PROGRAMS.—This
4 section may be carried out through programs established
5 in title VII or VIII of the Public Health Service Act, as
6 appropriate and as consistent with the purposes of such
7 programs.

8 **SEC. 3072. PROGRAMS OF THE SECRETARY OF LABOR.**

9 (a) IN GENERAL.—

10 (1) FUNDING.—For purposes of carrying out
11 the programs described in this section, and for car-
12 rying out section 3073, there is authorized to be ap-
13 propriated \$200,000,000 for fiscal year 1994 and
14 each subsequent fiscal year (in addition to amounts
15 that may otherwise be authorized to be appropriated
16 for carrying out the programs).

17 (2) ADMINISTRATION.—The programs described
18 in this section and carried out with amounts made
19 available under subsection (a) shall be carried out by
20 the Secretary of Labor (in this section referred to as
21 the “Secretary”).

22 (b) RETRAINING PROGRAMS; ADVANCED CAREER
23 POSITIONS; WORKFORCE ADJUSTMENT PROGRAMS.—

1 (1) IN GENERAL.—For purposes of subsection
2 (a), the programs described in this section are the
3 following:

4 (A) A program for skills upgrading and oc-
5 cupational retraining (including retraining
6 health care workers for more advanced positions
7 as technicians, nurses, and physician assist-
8 ants), and for quality and workforce improve-
9 ment.

10 (B) A demonstration program to assist
11 workers in health care institutions in obtaining
12 advanced career positions.

13 (C) A program to develop and operate
14 health-worker job banks in local employment
15 services agencies, subject to the following:

16 (i) Such job banks shall be available
17 to all health care providers in the commu-
18 nity involved.

19 (ii) Such job banks shall begin oper-
20 ation not later than 90 days after the date
21 of the enactment of this Act.

22 (D) A program to provide for joint labor-
23 management decision-making in the health care
24 sector on workplace matters related to the re-

1 structuring of the health care delivery system
2 provided for in this Act.

3 (E) A program to facilitate the comprehen-
4 sive workforce adjustment initiative.

5 (2) USE OF FUNDS.—Amounts made available
6 under subsection (a) for carrying out this section
7 may be expended for program support, faculty devel-
8 opment, trainee support, workforce analysis, and dis-
9 semination of information, as necessary to produce
10 required performance outcomes.

11 (c) CERTAIN REQUIREMENTS FOR PROGRAMS.—In
12 carrying out the programs described in subsection (b), the
13 Secretary shall, with respect to the organizations and em-
14 ployment positions involved, provide for the following:

15 (1) Explicit, clearly defined skill requirements
16 developed for all the positions and projections of the
17 number of openings for each position.

18 (2) Opportunities for internal career movement.

19 (3) Opportunities to work while training or
20 completing an educational program.

21 (4) Evaluation and dissemination.

22 (5) Training opportunities in several forms, as
23 appropriate.

24 (d) ADMINISTRATIVE REQUIREMENTS.—In carrying
25 out the programs described in subsection (b), the Sec-

1 retary shall, with respect to the organizations and employ-
2 ment positions involved, provide for the following:

3 (1) Joint labor-management implementation
4 and administration.

5 (2) Discussion with employees as to training
6 needs for career advancement.

7 (3) Commitment to a policy of internal hirings
8 and promotion.

9 (4) Provision of support services.

10 (5) Consultations with employers and with or-
11 ganized labor.

12 **SEC. 3073. NATIONAL INSTITUTE FOR HEALTH CARE WORK-**
13 **FORCE DEVELOPMENT.**

14 (a) ESTABLISHMENT OF INSTITUTE.—The Secretary
15 of Health and Human Services and the Secretary of Labor
16 shall jointly establish an office to be known as the Na-
17 tional Institute for Health Care Workforce Development.

18 (b) DIRECTOR.—The Institute shall be headed by a
19 director, who shall be appointed jointly by the Secretaries.

20 (c) DUTIES.—

21 (1) IN GENERAL.—The Director of the Institute
22 shall make recommendations to the Secretaries
23 regarding—

24 (A) the supply of health care workers
25 needed for proper staffing of the health care de-

1 livery system serving the regional and corporate
2 alliance health plans established under title I;

3 (B) the impact of this Act, and of related
4 changes regarding health care, on health care
5 workers and the needs of such workers with re-
6 spect to such matters, including needs regard-
7 ing education, training, and other matters relat-
8 ing to career development; and

9 (C) the development and implementation of
10 high-performance, high-quality health care de-
11 livery systems, including employee participation
12 committee systems and employee team systems,
13 that will contribute to the development of bet-
14 ter, more effective health care by increasing the
15 role, the responsibilities and the area of inde-
16 pendent decision-making authority of health
17 care workers.

18 (2) ADMINISTRATION OF PROGRAMS REGARD-
19 ING RETRAINING, ADVANCED CAREER POSITIONS,
20 JOB BANKS, AND HIGH-PERFORMANCE WORK-
21 PLACES.—The Secretary of Labor is authorized to—

22 (A) carry out section 3073 acting through
23 the Director of the Institute; and

1 (B) implement the recommendations of the
2 Director regarding employee participation com-
3 mittees and other high-performance systems.

4 (d) ADVISORY BOARD.—

5 (1) IN GENERAL.—The Secretaries shall estab-
6 lish an advisory board to assist in the develop of rec-
7 ommendations under subsection (c).

8 (2) COMPOSITION.—The Advisory Board shall
9 be composed of—

10 (A) the Secretary of Labor;

11 (B) the Secretary of Health and Human
12 Services;

13 (C) representatives of health care workers
14 in organized labor;

15 (D) representatives of health care institu-
16 tions;

17 (E) representatives of health care edu-
18 cation organizations;

19 (F) representatives of consumer organiza-
20 tions; and

21 (G) such other individuals as the Secre-
22 taries determine to be appropriate.

23 (e) STAFF, QUARTERS, AND OTHER ASSISTANCE.—
24 The Secretaries shall provide the Institute and the Advi-
25 sory Board with such staff, quarters, and other adminis-

1 trative assistance as may be necessary for the Institute
2 and the Advisory Board to carry out this section.

3 (f) DEFINITIONS.—For purposes of this section:

4 (1) The term “Advisory Board” means the ad-
5 visory board established under subsection (d).

6 (2) The term “employee participation commit-
7 tees” means committees of workers independently
8 drawn from a facility’s workforce, or selected by
9 unions where collective bargaining agreements are in
10 effect, and which operate without employer inter-
11 ference and consult with management on issues of
12 costs and efficiency, workplace reorganizations, pro-
13 ductivity, and quality of care.

14 (3) The term “Institute” means the Institute
15 established under subsection (a).

16 (4) The term “Secretaries” means the Sec-
17 retary of Health and Human Services and the Sec-
18 retary of Labor.

19 (g) SUNSET.—Effective upon the end of calendar
20 year 2000, this section is repealed.

21 **SEC. 3074. REQUIREMENT FOR CERTAIN PROGRAMS RE-**
22 **GARDING REDEPLOYMENT OF HEALTH CARE**
23 **WORKERS.**

24 (a) STATE PROGRAMS FOR HOME AND COMMUNITY-
25 BASED SERVICES FOR INDIVIDUALS WITH DISABIL-

1 ITIES.—With respect to the plan required in section
2 2102(a) (for State programs for home and community-
3 based services for individuals with disabilities under part
4 1 of subtitle B of title II), the plan shall, in addition to
5 requirements under such part, provide for the following:

6 (1) Before initiating the process of imple-
7 menting the State program under such plan, nego-
8 tiations will be commenced with labor unions rep-
9 resenting the employees of the affected hospitals or
10 other facilities.

11 (2) Negotiations under paragraph (1) will ad-
12 dress the following:

13 (A) The impact of the implementation of
14 the program upon the workforce.

15 (B) Methods to redeploy workers to posi-
16 tions in the proposed system, in the case of
17 workers affected by the program.

18 (3) The plan will provide evidence that there
19 has been compliance with paragraphs (1) and (2),
20 including a description of the results of the negotia-
21 tions.

22 (b) PLAN FOR INTEGRATION OF MENTAL HEALTH
23 SYSTEMS.—With respect to the plan required in section
24 3511(a) (relating to the integration of the mental health
25 and substance abuse services of a State and its political

1 subdivisions with the mental health and substance abuse
2 services included in the comprehensive benefit package
3 under title I), the plan shall, in addition to requirements
4 under such section, provide for the following:

5 (1) Before initiating the process of imple-
6 menting the integration of such services, negotia-
7 tions will be commenced with labor unions rep-
8 resenting the employees of the affected hospitals or
9 other facilities.

10 (2) Negotiations under paragraph (1) will ad-
11 dress the following:

12 (A) The impact of the proposed changes
13 upon the workforce.

14 (B) Methods to redeploy workers to posi-
15 tions in the proposed system, in the case of
16 workers affected by the proposed changes.

17 (3) The plan will provide evidence that there
18 has been compliance with paragraphs (1) and (2),
19 including a description of the results of the negotia-
20 tions.

1 **Subtitle B—Academic Health**
2 **Centers**

3 **PART 1—FORMULA PAYMENTS**

4 **SEC. 3101. FEDERAL FORMULA PAYMENTS TO ACADEMIC**
5 **HEALTH CENTERS.**

6 (a) IN GENERAL.—In the case of a qualified aca-
7 demic health center or qualified teaching hospital that in
8 accordance with section 3102 submits to the Secretary a
9 written request for calendar year 1996 or any subsequent
10 calendar year, the Secretary shall make payments for such
11 year to the center or hospital for the purpose specified
12 in subsection (b). The Secretary shall make the payments
13 in an amount determined in accordance with section 3103,
14 and may administer the payments as a contract, grant,
15 or cooperative agreement.

16 (b) PAYMENTS FOR COSTS ATTRIBUTABLE TO ACA-
17 DEMIC NATURE OF INSTITUTIONS.—The purpose of pay-
18 ments under subsection (a) is to assist eligible institutions
19 with costs that are not routinely incurred by other entities
20 in providing health services, but are incurred by such insti-
21 tutions in providing health services by virtue of the aca-
22 demic nature of such institutions. Such costs include—

23 (1) with respect to productivity in the provision
24 of health services, costs resulting from the reduced

1 rate of productivity of faculty due to teaching re-
2 sponsibilities;

3 (2) the uncompensated costs of clinical re-
4 search; and

5 (3) exceptional costs associated with the treat-
6 ment of health conditions with respect to which an
7 eligible institution has specialized expertise (includ-
8 ing treatment of rare diseases, treatment of unusu-
9 ally severe conditions, and providing other special-
10 ized health care).

11 (c) DEFINITIONS.—

12 (1) ACADEMIC HEALTH CENTER.—For purposes
13 of this subtitle, the term “academic health center”
14 means an entity that—

15 (A) operates a school of medicine or osteo-
16 pathic medicine, as defined in section 799 of
17 the Public Health Service Act;

18 (B) operates, or is affiliated with, one or
19 more other types of schools or programs de-
20 scribed in such section, or with one or more
21 schools of nursing (as defined in section 853 of
22 such Act); and

23 (C) operates, or is affiliated with, one or
24 more teaching hospitals.

1 (2) TEACHING HOSPITAL.—For purposes of this
2 subtitle, the term “teaching hospital” means a hos-
3 pital that operates an approved physician training
4 program (as defined in section 3011(b)).

5 (3) QUALIFIED CENTER OR HOSPITAL.—For
6 purposes of this subtitle:

7 (A) The term “qualified academic health
8 center” means an academic health center that
9 operates a teaching hospital.

10 (B) The term “qualified teaching hospital”
11 means any teaching hospital other than a teach-
12 ing hospital that is operated by an academic
13 health center.

14 (4) ELIGIBLE INSTITUTION.—For purposes of
15 this subtitle, the term “eligible institution”, with re-
16 spect to a calendar year, means a qualified academic
17 health center, or a qualified teaching hospital, that
18 submits to the Secretary a written request in accord-
19 ance with section 3102.

20 **SEC. 3102. REQUEST FOR PAYMENTS.**

21 (a) IN GENERAL.—For purposes of section 3101, a
22 written request for payments under such section is in ac-
23 cordance with this section if the qualified academic health
24 center or qualified teaching hospital involved submits the
25 request not later than the date specified by the Secretary;

1 the request is accompanied by each funding agreement de-
2 scribed in this part; and the request is in such form, is
3 made in such manner, and contains such agreements, as-
4 surances, and information as the Secretary determines to
5 be necessary to carry out this part.

6 (b) CONTINUED STATUS AS ACADEMIC HEALTH
7 CENTER.—A funding agreement for payments under sec-
8 tion 3101 is that the qualified academic health center or
9 qualified teaching hospital involved will maintain status as
10 such a center or hospital, respectively. For purposes of
11 this subtitle, the term “funding agreement”, with respect
12 to payments under section 3101 to such a center or hos-
13 pital, means that the Secretary may make the payments
14 only if the center or hospital makes the agreement in-
15 volved.

16 **SEC. 3103. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**
17 **NUAL AMOUNT OF PAYMENTS.**

18 (a) ANNUAL ACADEMIC HEALTH CENTER AC-
19 COUNT.—Subject to section 3104, the amount available
20 for a calendar year for making payments under section
21 3101 (constituting an account to be known as the annual
22 academic health center account) is the following, as appli-
23 cable to the calendar year:

24 (1) In the case of calendar year 1996,
25 \$3,100,000,000.

1 (2) In the case of each of the calendar years
2 1997 and 1998, \$3,200,000,000.

3 (3) In the case of calendar year 1999,
4 \$3,700,000,000.

5 (4) In the case of calendar year 2000,
6 \$3,800,000,000.

7 (5) In the case of each subsequent calendar
8 year, the amount specified in paragraph (4) in-
9 creased by the product of such amount and the gen-
10 eral health care inflation factor (as defined in sub-
11 section (d)).

12 (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-
13 BLE INSTITUTIONS.—The amount of payments required
14 in section 3101 to be made to an eligible institution for
15 a calendar year is an amount equal to the product of—

16 (1) the annual academic health center account
17 available for the calendar year; and

18 (2) the percentage constituted by the ratio of—

19 (A) an amount equal to the product of—

20 (i) the portion of the gross receipts of
21 the institution for the preceding calendar
22 year that was derived from providing serv-
23 ices to patients (both inpatients and out-
24 patients); and

1 (ii) the indirect teaching adjustment
2 factor determined under section
3 1886(d)(5)(B)(ii) of the Social Security
4 Act (as in effect before January 1, 1998)
5 and—

6 (I) applicable to patients dis-
7 charged from the institution (or hos-
8 pitals of the institution, as the case
9 may be) in such preceding year; or

10 (II) in the case of patients dis-
11 charged on or after January 1, 1998,
12 applicable to patients discharged in
13 calendar year 1997; to

14 (B) the sum of the respective amounts de-
15 termined under subparagraph (A) for eligible
16 institutions.

17 (c) REPORT REGARDING MODIFICATIONS IN FOR-
18 MULA.—Not later than July 1, 1996, the Secretary shall
19 submit to the Congress a report containing any rec-
20 ommendations of the Secretary regarding policies for allo-
21 cating amounts under subsection (a) among eligible insti-
22 tutions. In making such recommendations, the Secretary
23 shall consider the costs described in section 3101(b) that
24 are incurred by such institutions.

25 (d) DEFINITION.—For purposes of this subtitle:

1 (1) The term “annual academic health center
2 account” means the account established pursuant to
3 subsection (a).

4 (2) The term “general health care inflation fac-
5 tor”, with respect to a year, has the meaning given
6 such term in section 6001(a)(3) for such year.

7 **SEC. 3104. ADDITIONAL FUNDING PROVISIONS.**

8 (a) SOURCES OF FUNDS FOR ANNUAL ACADEMIC
9 HEALTH CENTER ACCOUNT.—The amount specified in
10 section 3103(a) for the annual academic health center ac-
11 count for a calendar year shall be derived from the sources
12 specified in subsection (b).

13 (b) CONTRIBUTIONS FROM MEDICARE TRUST
14 FUNDS, REGIONAL ALLIANCES, AND CORPORATE ALLI-
15 ANCES.—For purposes of subsection (a), the sources spec-
16 ified in this subsection for a calendar year are the fol-
17 lowing:

18 (1) Transfers made by the Secretary under sec-
19 tion 4052.

20 (2) Payments made by regional alliances under
21 section 1353 and—

22 (A) in the case of each of the calendar
23 years 1996 and 1997, transferred in an amount
24 equal to 50 percent of such payments made for
25 the calendar year involved; and

1 (B) in the case of calendar year 1998 and
2 each subsequent calendar year, transferred in
3 an amount equal to the aggregate regional alli-
4 ance portion determined under subsection
5 (c)(2)(A).

6 (3) The transfer made under subsection (d)(1).

7 (c) CONTRIBUTIONS FROM REGIONAL AND COR-
8 PORATE ALLIANCES.—

9 (1) DETERMINATION OF AGGREGATE REGIONAL
10 AND CORPORATE ALLIANCE AMOUNT.—For purposes
11 regarding the provision of funds for the annual aca-
12 demic health center account for a calendar year
13 (other than calendar year 1996 or 1997), the Sec-
14 retary shall determine an aggregate regional and
15 corporate alliance amount, which amount is to be
16 paid by such alliances pursuant to paragraphs
17 (2)(B) and (3) of subsection (b), respectively, and
18 which amount shall be equal to the difference
19 between—

20 (A) the amount specified in section
21 3103(a) for the annual academic health center
22 account for such year; and

23 (B) the amount transferred under section
24 4052 for the year.

1 (2) ALLOCATION OF AMOUNT AMONG REGIONAL
2 AND CORPORATE ALLIANCES.—With respect to the
3 aggregate regional and corporate alliance amount
4 determined under paragraph (1) for a calendar year
5 (other than calendar year 1996 or 1997)—

6 (A) the aggregate regional alliance portion
7 of such amount is the product of such amount
8 and the percentage constituted by the ratio of
9 the total plan payments of regional alliances to
10 the combined total plan payments of regional
11 alliances and corporate alliances; and

12 (B) the aggregate corporate alliance por-
13 tion of such amount is the product of such
14 amount and the percentage constituted by the
15 ratio of the total plan payments of corporate al-
16 liances to such combined total plan payments.

17 (d) COMPLIANCE REGARDING CORPORATE ALLI-
18 ANCES.—

19 (1) IN GENERAL.—Effective January 15 of cal-
20 endar year 1996 and each subsequent calendar year,
21 there is hereby transferred to the Secretary, out of
22 any money in the Treasury not otherwise
23 appropriated—

1 (A) in the case of each of the calendar
2 years 1996 and 1997, an amount equal to the
3 difference between—

4 (i) the amount specified in section
5 3103(a) for the annual academic health
6 center account for the calendar year in-
7 volved; and

8 (ii) the sum of the amount transferred
9 under section 4052 for such year and the
10 amount transferred under subsection
11 (b)(2)(A) for such year; and

12 (B) in the case of calendar year 1998 and
13 each subsequent calendar year, an amount
14 equal to the aggregate corporate alliance por-
15 tion determined under subsection (c)(2)(B) for
16 the calendar year involved.

17 (2) MANNER OF COMPLIANCE.—The payment
18 by corporate alliances of the tax imposed under sec-
19 tion 3461 of the Internal Revenue Code of 1986 (as
20 added by section 7121 of this Act), together with the
21 transfer made in paragraph (1)(B) for the calendar
22 year involved, is deemed to be the payment required
23 pursuant to subsection (c)(1) for corporate alliances
24 for such year.

1 (3) GRADUATE NURSE EDUCATION.—Effective
2 January 15 of calendar year 1996 and each subse-
3 quent calendar year, there is hereby transferred to
4 the Secretary, out of any money in the Treasury not
5 otherwise appropriated, 50 percent of the amount
6 specified in section 3063(b) with respect to the an-
7 nual graduate nurse training account.

8 (e) DEFINITIONS.—For purposes of this subtitle, the
9 term “plan payments” with respect to a regional or cor-
10 porate alliance, means the amount paid to health plans
11 by the alliance.

12 **PART 2—ACCESS OF PATIENTS TO ACADEMIC**
13 **HEALTH CENTERS**

14 **SEC. 3131. CONTRACTS FOR ENSURING ACCESS TO CEN-**
15 **TERS.**

16 (a) CONTRACTS WITH HEALTH PLANS.—Regional
17 and corporate health alliances under this Act shall ensure
18 that, in accordance with subsection (b), the health plans
19 of the alliances enter into sufficient contracts with eligible
20 centers to ensure that enrollees in regional or corporate
21 alliance health plans, as appropriate, receive the special-
22 ized treatment expertise of such centers, subject to such
23 exceptions as the Secretary may provide.

24 (b) UTILIZATION OF SPECIALIZED TREATMENT EX-
25 PERTISE OF CENTERS.—Contracts under subsection (a)

1 between eligible centers and health plans are in accordance
2 with this subsection if the contracts provide that, with re-
3 spect to health conditions within the specialized treatment
4 expertise of the centers, health plans will refer medical
5 cases involving such conditions to the centers.

6 (c) SPECIALIZED TREATMENT EXPERTISE.—For
7 purposes of this subtitle, the term “specialized treatment
8 expertise”, with respect to treatment of a health condition
9 by an academic health center, means expertise in treating
10 rare diseases, treating unusually severe conditions, and
11 providing other specialized health care.

12 **SEC. 3132. DISCRETIONARY GRANTS REGARDING ACCESS**
13 **TO CENTERS.**

14 (a) RURAL INFORMATION AND REFERRAL SYS-
15 TEMS.—The Secretary may make grants to eligible centers
16 for the establishment and operation of information and re-
17 ferral systems to provide the services of such centers to
18 rural regional and corporate health alliance health plans.

19 (b) OTHER PURPOSES REGARDING URBAN AND
20 RURAL AREAS.—The Secretary may make grants to eligi-
21 ble centers to carry out activities (other than activities car-
22 ried out under subsection (a)) for the purpose of providing
23 the services of eligible centers to residents of rural or
24 urban communities who otherwise would not have ade-
25 quate access to such services.

Subtitle C—Health Research Initiatives

PART 1—PROGRAMS FOR CERTAIN AGENCIES

SEC. 3201. BIOMEDICAL AND BEHAVIORAL RESEARCH ON HEALTH PROMOTION AND DISEASE PREVEN- TION.

Section 402(f) of the Public Health Service Act (42 U.S.C. 282(f)), as amended by section 201 of Public Law 103–43 (107 Stat. 144), is amended—

(1) in paragraph (3), by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(2) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C);

(3) by inserting “(1)” after “(f)”; and

(4) by adding at the end the following paragraph:

“(2)(A) The Director of NIH, in collaboration with the Associate Director for Prevention and with the heads of the agencies of the National Institutes of Health, shall ensure that such Institutes conduct and support biomedical and behavioral research on promoting health and preventing diseases, disorders, and other health conditions (including Alzheimer’s disease, breast cancer, heart disease, and stroke).

1 “(B) In carrying out subparagraph (A), the Director
2 of NIH shall give priority to conducting and supporting
3 research on child and adolescent health (including birth
4 defects), chronic and recurrent health conditions, repro-
5 ductive health, mental health, elderly health, substance
6 abuse, infectious diseases, health and wellness promotion,
7 and environmental health, and to resource development re-
8 lated to such research.”.

9 **SEC. 3202. HEALTH SERVICES RESEARCH.**

10 Section 902 of the Public Health Service Act (42
11 U.S.C. 299a), as amended by section 2(b) of Public Law
12 102–410 (106 Stat. 2094), is amended by adding at the
13 end the following subsection:

14 “(f) RESEARCH ON HEALTH CARE REFORM.—

15 “(1) IN GENERAL.—In carrying out section
16 901(b), the Administrator shall conduct and support
17 research on the reform of the health care system of
18 the United States, as directed by the National
19 Board.

20 “(2) PRIORITIES.—In carrying out paragraph
21 (1), the Administrator shall give priority to the fol-
22 lowing:

23 “(A) Conducting and supporting research
24 on the appropriateness and effectiveness of al-
25 ternative clinical strategies; the quality and out-

1 comes of care; and administrative simplifica-
2 tion.

3 “(B) Conducting and supporting research
4 on consumer choice and information resources;
5 the effects of health care reform on health de-
6 livery systems; workplace injury and illness pre-
7 vention; methods for risk adjustment; factors
8 influencing access to health care for under-
9 served populations; and primary care.

10 “(C) The development of clinical practice
11 guidelines consistent with section 913, the dis-
12 semination of such guidelines consistent with
13 section 903, and the assessment of the effec-
14 tiveness of such guidelines.”.

15 **PART 2—FUNDING FOR PROGRAMS**

16 **SEC. 3211. AUTHORIZATIONS OF APPROPRIATIONS.**

17 (a) BIOMEDICAL AND BEHAVIORAL RESEARCH ON
18 HEALTH PROMOTION AND DISEASE PREVENTION.—For
19 the purpose of carrying out activities pursuant to the
20 amendments made by section 3201, there are authorized
21 to be appropriated \$400,000,000 for fiscal year 1995, and
22 \$500,000,000 for each of the fiscal years 1996 through
23 2000.

24 (b) HEALTH SERVICES RESEARCH.—For the purpose
25 of carrying out activities pursuant to the amendments

1 made by section 3202, there are authorized to be appro-
2 priated \$150,000,000 for fiscal year 1995, \$400,000,000
3 for fiscal year 1996, \$500,000,000 for fiscal year 1997,
4 and \$600,000,000 for each of the fiscal years 1998
5 through 2000.

6 (c) RELATION TO OTHER FUNDS.—The authoriza-
7 tions of appropriations established in subsections (a) and
8 (b) are in addition to any other authorizations of appro-
9 priations that are available for the purposes described in
10 such subsections.

11 **Subtitle D—Core Functions of Pub-**
12 **lic Health Programs; National**
13 **Initiatives Regarding Preven-**
14 **tive Health**

15 **PART 1—FUNDING**

16 **SEC. 3301. AUTHORIZATIONS OF APPROPRIATIONS.**

17 (a) CORE FUNCTIONS OF PUBLIC HEALTH PRO-
18 GRAMS.—For the purpose of carrying out part 2, there
19 are authorized to be appropriated \$12,000,000 for fiscal
20 year 1995, \$325,000,000 for fiscal year 1996,
21 \$450,000,000 for fiscal year 1997, \$550,000,000 for fis-
22 cal year 1998, \$650,000,000 for fiscal year 1999, and
23 \$750,000,000 for fiscal year 2000.

24 (b) NATIONAL INITIATIVES REGARDING HEALTH
25 PROMOTION AND DISEASE PREVENTION.—For the pur-

1 pose of carrying out part 3, there are authorized to be
2 appropriated \$175,000,000 for fiscal year 1996, and
3 \$200,000,000 for each of the fiscal years 1997 through
4 2000.

5 (c) RELATION TO OTHER FUNDS.—The authoriza-
6 tions of appropriations established in subsections (a) and
7 (b) are in addition to any other authorizations of appro-
8 priations that are available for the purposes described in
9 such subsections.

10 **PART 2—CORE FUNCTIONS OF PUBLIC HEALTH**
11 **PROGRAMS**

12 **SEC. 3311. PURPOSES.**

13 Subject to the subsequent provisions of this subtitle,
14 the purposes of this part are to strengthen the capacity
15 of State and local public health agencies to carry out the
16 following functions:

17 (1) To monitor and protect the health of com-
18 munities against communicable diseases and expo-
19 sure to toxic environmental pollutants, occupational
20 hazards, harmful products, and poor quality health
21 care.

22 (2) To identify and control outbreaks of infec-
23 tious disease and patterns of chronic disease and in-
24 jury.

1 (3) To inform and educate health care con-
2 sumers and providers about their roles in preventing
3 and controlling disease and the appropriate use of
4 medical services.

5 (4) To develop and test new prevention and
6 public health control interventions.

7 **SEC. 3312. GRANTS TO STATES FOR CORE HEALTH FUNC-**
8 **TIONS.**

9 (a) IN GENERAL.—The Secretary may make grants
10 to States for the purpose of carrying out one or more of
11 the functions described in subsection (b).

12 (b) CORE FUNCTIONS OF PUBLIC HEALTH PRO-
13 GRAMS.—For purposes of subsection (a), the functions de-
14 scribed in this subsection are, subject to subsection to sub-
15 section (c), as follows:

16 (1) Data collection, activities related to popu-
17 lation health measurement and outcomes monitoring,
18 including the regular collection and analysis of pub-
19 lic health data, vital statistics, and personal health
20 services data and analysis for planning and needs
21 assessment purposes of data collected from health
22 plans through the information system under title V
23 of this Act.

1 (2) Activities to protect the environment and to
2 assure the safety of housing, workplaces, food and
3 water, including the following activities:

4 (A) Monitoring the overall public health
5 quality and safety of communities.

6 (B) Assessing exposure to high lead levels
7 and water contamination.

8 (C) Monitoring sewage and solid waste dis-
9 posal, radiation exposure, radon exposure, and
10 noise levels.

11 (D) Abatement of lead-related hazards.

12 (E) Assuring recreation and worker safety.

13 (F) Enforcing public health safety and
14 sanitary codes.

15 (G) Other activities relating to promoting
16 the public health of communities.

17 (3) Investigation and control of adverse health
18 conditions, including improvements in emergency
19 treatment preparedness, cooperative activities to re-
20 duce violence levels in communities, activities to con-
21 trol the outbreak of disease, exposure related condi-
22 tions and other threats to the health status of indi-
23 viduals.

24 (4) Public information and education programs
25 to reduce risks to health such as use of tobacco, al-

1 cohol and other drugs, sexual activities that increase
2 the risk to HIV transmission and sexually trans-
3 mitted diseases, poor diet, physical inactivity, and
4 low childhood immunization levels.

5 (5) Accountability and quality assurance activi-
6 ties, including monitoring the quality of personal
7 health services furnished by health plans and pro-
8 viders of medical and health services in a manner
9 consistent with the overall quality of care monitoring
10 activities undertaken under title V, and monitoring
11 communities' overall access to health services.

12 (6) Provision of public health laboratory serv-
13 ices to complement private clinical laboratory serv-
14 ices and that screen for diseases and conditions such
15 as metabolic diseases in newborns, provide toxicology
16 assessments of blood lead levels and other environ-
17 mental toxins, diagnose sexually transmitted dis-
18 eases, tuberculosis and other diseases requiring part-
19 ner notification, test for infectious and food-borne
20 diseases, and monitor the safety of water and food
21 supplies.

22 (7) Training and education to assure provision
23 of care by all health professionals, with special em-
24 phasis placed on the training of public health profes-
25 sions including epidemiologists, biostatisticians,

1 health educators, public health administrators,
2 sanitarians and laboratory technicians.

3 (8) Leadership, policy development and admin-
4 istration activities, including needs assessment, the
5 setting of public health standards, the development
6 of community public health policies, and the develop-
7 ment of community public health coalitions.

8 (c) RESTRICTIONS ON USE OF GRANT.—

9 (1) IN GENERAL.—A funding agreement for a
10 grant under subsection (a) for a State is that the
11 grant will not be expended—

12 (A) to provide inpatient services;

13 (B) to make cash payments to intended re-
14 cipients of health services;

15 (C) to purchase or improve land, purchase,
16 construct, or permanently improve (other than
17 minor remodeling) any building or other facil-
18 ity, or purchase major medical equipment;

19 (D) to satisfy any requirement for the ex-
20 penditure of non-Federal funds as a condition
21 for the receipt of Federal funds; or

22 (E) to provide financial assistance to any
23 entity other than a public or nonprofit private
24 entity.

1 (2) LIMITATION ON ADMINISTRATIVE EX-
2 PENSES.—A funding agreement for a grant under
3 subsection (a) is that the State involved will not ex-
4 pend more than 10 percent of the grant for adminis-
5 trative expenses with respect to the grant.

6 (d) MAINTENANCE OF EFFORT.—A funding agree-
7 ment for a grant under subsection (a) is that the State
8 involved will maintain expenditures of non-Federal
9 amounts for core health functions at a level that is not
10 less than the level of such expenditures maintained by the
11 State for the fiscal year preceding the first fiscal year for
12 which the State receives such a grant.

13 **SEC. 3313. SUBMISSION OF INFORMATION.**

14 The Secretary may make a grant under section 3312
15 only if the State involved submits to the Secretary the fol-
16 lowing information:

17 (1) A description of existing deficiencies in the
18 State's public health system (at the State level and
19 the local level), using standards of sufficiency devel-
20 oped by the Secretary.

21 (2) A description of health status measures to
22 be improved within the State (at the State level and
23 the local level) through expanded public health func-
24 tions.

1 (3) Measurable outcomes and process objectives
2 for improving health status and core health func-
3 tions for which the grant is to be expended.

4 (4) Information regarding each such function,
5 which—

6 (A) identifies the amount of State and
7 local funding expended on each such function
8 for the fiscal year preceding the fiscal year for
9 which the grant is sought; and

10 (B) provides a detailed description of how
11 additional Federal funding will improve each
12 such function by both the State and local public
13 health agencies.

14 (5) A description of the core health functions to
15 be carried out at the local level, and a specification
16 for each such function of—

17 (A) the communities in which the function
18 will be carried out; and

19 (B) the amount of the grant to be ex-
20 pended for the function in each community so
21 specified.

22 **SEC. 3314. REPORTS.**

23 A funding agreement for a grant under section 3312
24 is that the States involved will, not later than the date

1 specified by the Secretary, submit to the Secretary a re-
2 port describing—

3 (1) the purposes for which the grant was ex-
4 pended; and

5 (2) describing the extent of progress made by
6 the State in achieving measurable outcomes and
7 process objectives described in section 3313(3).

8 **SEC. 3315. APPLICATION FOR GRANT.**

9 The Secretary may make a grant under section 3312
10 only if an application for the grant is submitted to the
11 Secretary, the application contains each agreement de-
12 scribed in this part, the application contains the informa-
13 tion required in section 3314, and the application is in
14 such form, is made in such manner, and contains such
15 agreements, assurances, and information as the Secretary
16 determines to be necessary to carry out this part.

17 **SEC. 3316. GENERAL PROVISIONS.**

18 (a) **UNIFORM DATA SETS.**—The Secretary, in con-
19 sultation with the States, shall develop uniform sets of
20 data for the purpose of monitoring the core health func-
21 tions carried out with grants under section 3312.

22 (b) **DURATION OF GRANT.**—The period during which
23 payments are made to a State from a grant under section
24 3312 may not exceed 5 years. The provision of such pay-
25 ments shall be subject to annual approval by the Secretary

1 of the payments. This subsection may not be construed
2 as establishing a limitation on the number of grants under
3 such section that may be made to the State.

4 **SEC. 3317. ALLOCATIONS FOR CERTAIN ACTIVITIES.**

5 Of the amounts made available under section 3301
6 for a fiscal year for carrying out this part, the Secretary
7 may reserve not more than 5 percent for carrying out the
8 following activities:

9 (1) Technical assistance with respect to plan-
10 ning, development, and operation of core health
11 functions carried out under section 3312, including
12 provision of biostatistical and epidemiological exper-
13 tise and provision of laboratory expertise.

14 (2) Development and operation of a national in-
15 formation network among State and local health
16 agencies.

17 (3) Program monitoring and evaluation of core
18 health functions carried out under section 3312.

19 (4) Development of a unified electronic report-
20 ing mechanism to improve the efficiency of adminis-
21 trative management requirements regarding the pro-
22 vision of Federal grants to State public health agen-
23 cies.

24 **SEC. 3318. DEFINITIONS.**

25 For purposes of this part:

1 (1) The term “funding agreement”, with re-
2 spect to a grant under section 3312 to a State,
3 means that the Secretary may make the grant only
4 if the State makes the agreement involved.

5 (2) The term “core health functions”, with re-
6 spect to a State, means the functions described in
7 section 3312(b).

8 **PART 3—NATIONAL INITIATIVES REGARDING**
9 **HEALTH PROMOTION AND DISEASE PREVENTION**
10 **SEC. 3331. GRANTS FOR NATIONAL PREVENTION INITIA-**
11 **TIVES.**

12 (a) IN GENERAL.—The Secretary may make grants
13 to entities described in subsection (b) for the purpose of
14 carrying out projects to develop and implement innovative
15 community-based strategies to provide for health pro-
16 motion and disease prevention activities for which there
17 is a significant need, as identified under section 1701 of
18 the Public Health Service Act.

19 (b) ELIGIBLE ENTITIES.—The entities referred to in
20 subsection (a) are agencies of State or local government,
21 private nonprofit organizations (including research institu-
22 tions), and coalitions that link two or more of these
23 groups.

24 (c) CERTAIN ACTIVITIES.—The Secretary shall en-
25 sure that projects carried out under subsection (a)—

1 (1) reflect approaches that take into account
2 the special needs and concerns of the affected popu-
3 lations;

4 (2) are targeted to the most needy and vulner-
5 able population groups and geographic areas of the
6 Nation;

7 (3) examine links between various high priority
8 preventable health problems and the potential com-
9 munity-based remedial actions; and

10 (4) establish or strengthen the links between
11 the activities of agencies engaged in public health
12 activities with those of health alliances, health care
13 providers, and other entities involved in the personal
14 health care delivery system described in title I.

15 **SEC. 3332. PRIORITIES.**

16 (a) ESTABLISHMENT.—

17 (1) ANNUAL STATEMENT.—The Secretary shall
18 for each fiscal year develop a statement of proposed
19 priorities for grants under section 3331 for the fiscal
20 year.

21 (2) ALLOCATIONS AMONG PRIORITIES.—With
22 respect to the amounts available under section
23 3301(b) for the fiscal year for carrying out this part,
24 each statement under paragraph (1) for a fiscal year
25 shall include a specification of the percentage of the

1 amount to be devoted to projects addressing each of
2 the proposed priorities established in the statement.

3 (3) PROCESS FOR ESTABLISHING PRIORITIES.—

4 Not later than January 1 of each fiscal year, the
5 Secretary shall publish a statement under paragraph
6 (1) in the Federal Register. A period of 60 days
7 shall be allowed for the submission of public com-
8 ments and suggestions concerning the proposed pri-
9 orities. After analyzing and considering comments
10 on the proposed priorities, the Secretary shall pub-
11 lish in the Federal Register final priorities (and as-
12 sociated reservations of funds) for approval of
13 projects for the following fiscal year.

14 (b) APPLICABILITY TO MAKING OF GRANTS.—

15 (1) IN GENERAL.—The Secretary may make
16 grants under section 3331 for projects that the Sec-
17 retary determines—

18 (A) are consistent with the applicable final
19 statement of priorities and otherwise meets the
20 objectives described in subsection (a); and

21 (B) will assist in meeting a health need or
22 concern of a population served by a health plan
23 or health alliance established under title I.

24 (2) SPECIAL CONSIDERATION FOR CERTAIN
25 PROJECTS.—In making grants under section 3331,

1 the Secretary shall give special consideration to ap-
2 plicants that will carry out projects that, in addition
3 to being consistent with the applicable published pri-
4 orities under subsection (a) and otherwise meeting
5 the requirements of this part, have the potential for
6 replication in other communities.

7 **SEC. 3333. SUBMISSION OF INFORMATION.**

8 The Secretary may make a grant under section 3331
9 only if the applicant involved submits to the Secretary the
10 following information:

11 (1) A description of the activities to be con-
12 ducted, and the manner in which the activities are
13 expected to contribute to meeting one or more of the
14 priority health needs specified under section 3332
15 for the fiscal year for which the grant is initially
16 sought.

17 (2) A description of the total amount of Federal
18 funding requested, the geographic area and popu-
19 lations to be served, and the evaluation procedures
20 to be followed.

21 (3) Such other information as the Secretary de-
22 termines to be appropriate.

23 **SEC. 3334. APPLICATION FOR GRANT.**

24 The Secretary may make a grant under section 3331
25 only if an application for the grant is submitted to the

1 Secretary, the application contains each agreement de-
2 scribed in this part, the application contains the informa-
3 tion required in section 3333, and the application is in
4 such form, is made in such manner, and contains such
5 agreements, assurances, and information as the Secretary
6 determines to be necessary to carry out this part.

7 **Subtitle E—Health Services for**
8 **Medically Underserved Popu-**
9 **lations**

10 **PART 1—COMMUNITY AND MIGRANT HEALTH**
11 **CENTERS**

12 **SEC. 3401. AUTHORIZATIONS OF APPROPRIATIONS.**

13 (a) GRANTS TO COMMUNITY AND MIGRANT HEALTH
14 CENTERS.—The Secretary shall make grants in accord-
15 ance with this part to migrant health centers and commu-
16 nity health centers.

17 (b) AUTHORIZATION OF APPROPRIATIONS.—For the
18 purpose of carrying out subsection (a), there are author-
19 ized to be appropriated \$100,000,000 for each of the fiscal
20 years 1995 through 2000.

21 (c) RELATION TO OTHER FUNDS.—The authoriza-
22 tions of appropriations established in subsection (b) for
23 the purpose described in such subsection are in addition
24 to any other authorizations of appropriations that are
25 available for such purpose.

1 (d) DEFINITIONS.—For purposes of this subtitle, the
2 terms “migrant health center” and “community health
3 center” have the meanings given such terms in sections
4 329(a)(1) and 330(a) of the Public Health Service Act,
5 respectively.

6 **SEC. 3402. USE OF FUNDS.**

7 (a) DEVELOPMENT, OPERATION, AND OTHER PUR-
8 POSES REGARDING CENTERS.—Subject to subsection (b),
9 grants under section 3401 to migrant health centers and
10 community health centers may be made only in accordance
11 with the conditions upon which grants are made under
12 sections 329 and 330 of the Public Health Service Act,
13 respectively.

14 (b) REQUIRED FINANCIAL RESERVES.—The Sec-
15 retary may authorize migrant health centers and commu-
16 nity health centers to expend a grant under section 3401
17 to establish and maintain the financial reserves required
18 under title I for providers of health services.

19 **PART 2—INITIATIVES FOR ACCESS TO HEALTH**
20 **CARE**

21 **Subpart A—Purposes; Funding**

22 **SEC. 3411. PURPOSES.**

23 Subject to the provisions of subparts B through D,
24 the purposes of this part are as follows:

1 (1) To improve access to health services for
2 urban and rural medically-underserved populations
3 through a program of flexible grants, contracts, and
4 loans.

5 (2) To facilitate transition to a system in which
6 medically-underserved populations have an adequate
7 choice of community-oriented providers and health
8 plans.

9 (3) To promote the development of community
10 practice networks and community health plans that
11 integrate health professionals and health care orga-
12 nizations supported through public funding with
13 other providers in medically underserved areas.

14 (4) To support linkages between providers of
15 health care for medically-underserved populations
16 and regional and corporate alliance health plans.

17 (5) To expand the capacity of community prae-
18 tice networks and community health plans in under-
19 served areas by increasing the number of practice
20 sites and by renovating and converting substandard
21 inpatient and outpatient facilities.

22 (6) To link providers in underserved areas with
23 each other and with regional health care institutions
24 and academic health centers through information
25 systems and telecommunications.

1 (7) To support activities that enable medically
2 underserved populations to gain access to the health
3 care system and use it effectively.

4 **SEC. 3412. AUTHORIZATIONS OF APPROPRIATIONS.**

5 (a) DEVELOPMENT OF QUALIFIED COMMUNITY
6 HEALTH PLANS AND PRACTICE GROUPS.—For the pur-
7 pose of carrying out subparts B and C, there are author-
8 ized to be appropriated \$200,000,000 for fiscal year 1995,
9 \$500,000,000 for fiscal year 1996, \$600,000,000 for fis-
10 cal year 1997, \$700,000,000 for fiscal year 1998,
11 \$500,000,000 for fiscal year 1999, and \$200,000,000 for
12 fiscal year 2000.

13 (b) RELATION TO OTHER FUNDS.—The authoriza-
14 tions of appropriations established in subsection (a) are
15 in addition to any other authorizations of appropriations
16 that are available for the purpose described in such sub-
17 section.

18 (c) RELATIONSHIP TO PROGRAM REGARDING
19 SCHOOL-RELATED HEALTH SERVICES.—This section is
20 subject to section 3692.

1 **Subpart B—Development of Qualified Community**

2 **Health Plans and Practice Networks**

3 **SEC. 3421. GRANTS AND CONTRACTS FOR DEVELOPMENT**

4 **OF PLANS AND NETWORKS.**

5 (a) IN GENERAL.—The Secretary may make grants
6 to and enter into contracts with consortia of public or pri-
7 vate health care providers for the development of qualified
8 community health plans and qualified community practice
9 networks. For purposes of this subtitle, the term “quali-
10 fied community health group” means such a health plan
11 or such a practice network.

12 (b) QUALIFIED COMMUNITY HEALTH PLANS.—For
13 purposes of this subtitle, the term “qualified community
14 health plan” means a health plan that meets the following
15 conditions:

16 (1) The health plan is a public or nonprofit pri-
17 vate entity whose principal purpose is, with respect
18 to the items and services included in the comprehen-
19 sive benefit package under title I, to provide each of
20 such items and services in one or more health pro-
21 fessional shortage areas or to provide such items and
22 services to a significant number of individuals who
23 are members of a medically underserved population.

24 (2) The health plan is a participant in one or
25 more health alliances.

1 (3) Two or more of the categories specified in
2 subsection (d) are represented among the entities
3 providing health services through the health plan.

4 (c) QUALIFIED COMMUNITY PRACTICE NET-
5 WORKS.—For purposes of this subtitle, the term “quali-
6 fied community practice network” means a consortium of
7 health care providers meeting the following conditions:

8 (1) The consortium is a public or nonprofit pri-
9 vate entity whose principal purpose is the purpose
10 described in subsection (b)(1).

11 (2) The consortium has an agreement with one
12 or more health plans that are participating in one or
13 more health alliances.

14 (3) The participation of health care providers in
15 the consortium is governed by a written agreement
16 to which each of the participating providers is a
17 party.

18 (4) Two or more of the categories described in
19 subsection (d) are represented among the entities
20 participating in the consortium.

21 (d) RELEVANT CATEGORIES OF ENTITIES.—For pur-
22 poses of subsections (b)(3) and (c)(4), the categories de-
23 scribed in this subsection are the following categories of
24 entities:

1 (1) Physicians, other health professionals, or
2 health care institutions that provide health services
3 in one or more health professional shortage areas or
4 provide such services to a significant number of indi-
5 viduals who are members of a medically underserved
6 population, and that do not provide health services
7 under any of the programs specified in paragraphs
8 (2) through (7) or as employees of public entities.

9 (2) Entities providing health services under
10 grants under sections 329 and 330 of the Public
11 Health Service Act.

12 (3) Entities providing health services under
13 grants under sections 340 and 340A of such Act.

14 (4) Entities providing health services under
15 grants under section 1001 or title XXVI of such
16 Act.

17 (5) Entities providing health services under title
18 V of the Social Security Act.

19 (6) Entities providing health services through
20 rural health clinics and other federally qualified
21 health centers.

22 (7) Entities providing health services in urban
23 areas through programs under title V of the Indian
24 Health Care Improvement Act, and entities pro-

1 viding outpatient health services through programs
2 under the Indian Self-Determination Act.

3 (8) Programs providing personal health services
4 and operating through State or local public health
5 agencies.

6 (e) RULE OF CONSTRUCTION.—The consortia to
7 which the Secretary may make an award of financial as-
8 sistance under subsection (a) for the development of quali-
9 fied community practice networks include any health plan
10 that participates in one or more health alliances, without
11 regard to whether the health plan is a qualified community
12 health plan.

13 (f) SERVICE AREA.—In making an award of financial
14 assistance under subsection (a), the Secretary shall des-
15 ignate the geographic area with respect to which the quali-
16 fied community health group involved is to provide health
17 services. A funding agreement for such an award is that
18 the qualified community health group involved will provide
19 such services in the area so designated.

20 (g) DEFINITIONS.—For purposes of this subtitle:

21 (1) The term “health professional shortage
22 areas” means health professional shortage areas des-
23 ignated under section 332 of the Public Health Serv-
24 ice Act.

1 (2) The term “medically underserved popu-
2 lation” means a medically underserved population
3 designated under section 330 of the Public Health
4 Service Act.

5 (3) The term “rural health clinic” has the
6 meaning given such term in section 1861(aa)(2) of
7 the Social Security Act.

8 (4) The term “federally qualified health cen-
9 ters” has the meaning given such term in section
10 1861(aa)(4) of the Social Security Act.

11 (5) The term “service area”, with respect to a
12 qualified community health group, means the geo-
13 graphic area designated under subsection (f).

14 (6) The term “funding agreement”, with re-
15 spect to an award of financial assistance under this
16 section, means that the Secretary may make the
17 award only if the applicant for the award makes the
18 agreement involved.

19 (7) The term “financial assistance”, with re-
20 spect to awards under subsection (a), means a grant
21 or contract.

1 **SEC. 3422. PREFERENCES IN MAKING AWARDS OF ASSIST-**
2 **ANCE.**

3 In making awards of financial assistance under sec-
4 tion 3421, the Secretary shall give preference to applicants
5 in accordance with the following:

6 (1) The Secretary shall give preference if 3 or
7 more of the categories described in subsection (d) of
8 such section will be represented in the qualified com-
9 munity health group involved (pursuant to sub-
10 section (b)(3) or (c)(4) of such section, as the case
11 may be).

12 (2) Of applicants receiving preference under
13 paragraph (1), the Secretary shall give a greater de-
14 gree of preference according to the extent to which
15 a greater number of categories are represented.

16 (3) Of applicants receiving preference under
17 paragraph (1), the Secretary shall give a greater de-
18 gree of preference if one of the categories rep-
19 resented is the category described in subsection
20 (d)(1) of such section.

21 **SEC. 3423. CERTAIN USES OF AWARDS.**

22 (a) IN GENERAL.—Subject to subsection (b), the pur-
23 poses for which an award of financial assistance under sec-
24 tion 3421 may be expended in developing a qualified com-
25 munity health group include the following:

1 (1) Planning such group, including entering
2 into contracts between the recipient of the award
3 and health care providers who are to participate in
4 the group.

5 (2) Recruitment, compensation, and training of
6 health professionals and administrative staff.

7 (3) Acquisition, expansion, modernization, and
8 conversion of facilities, including for purposes of
9 providing for sites at which health services are to be
10 provided through such group.

11 (4) Acquisition and development of information
12 systems (exclusive of systems that the Secretary de-
13 termines are information highways).

14 (5) Such other expenditures as the Secretary
15 determines to be appropriate.

16 (b) TWENTY-YEAR OBLIGATION REGARDING SIGNIFI-
17 CANT CAPITAL EXPENDITURES; RIGHT OF RECOVERY.—

18 (1) IN GENERAL.—With respect to a facility for
19 which substantial capital costs are to paid from an
20 award of financial assistance under section 3421,
21 the Secretary may make the award only if the appli-
22 cant involved agrees that the applicant will be liable
23 to the United States for the amount of the award
24 expended for such costs, together with an amount
25 representing interest, if at any time during the 20-

1 year period beginning on the date of completion of
2 the activities involved, the facility—

3 (A) ceases to be a facility utilized by a
4 qualified community health group, or by an-
5 other public or nonprofit private entity that
6 provides health services in one or more health
7 professional shortage areas or that provides
8 such services to a significant number of individ-
9 uals who are members of a medically under-
10 served population; or

11 (B) is sold or transferred to any entity
12 other than an entity that is—

13 (i) a qualified community health
14 group or other entity described in subpara-
15 graph (A); and

16 (ii) approved by the Secretary as a
17 purchaser or transferee regarding the facil-
18 ity.

19 (2) SUBORDINATION; WAIVERS.—The Secretary
20 may subordinate or waive the right of recovery
21 under paragraph (1), and any other Federal interest
22 that may be derived by virtue of an award of finan-
23 cial assistance under section 3421 from which sub-
24 stantial capital costs are to paid, if the Secretary de-

1 termines that subordination or waiver will further
2 the objectives of this part.

3 **SEC. 3424. ACCESSIBILITY OF SERVICES.**

4 (a) SERVICES FOR CERTAIN INDIVIDUALS.—A fund-
5 ing agreement for an award of financial assistance under
6 section 3421 is that the qualified community health group
7 involved will ensure that the services of the group will be
8 accessible directly or through formal contractual arrange-
9 ments with its participating providers regardless of wheth-
10 er individuals who seek care from the applicant are eligible
11 persons under title I.

12 (b) USE OF THIRD-PARTY PAYORS.—A funding
13 agreement for an award of financial assistance under sec-
14 tion 3421 is that the qualified community health group
15 involved will ensure that the health care providers of the
16 group are all approved by the Secretary as providers under
17 title XVIII of the Social Security Act and by the appro-
18 priate State agency as providers under title XIX of the
19 Social Security Act, and the applicant has made or will
20 make every reasonable effort to collect appropriate reim-
21 bursement for its costs in providing health services to indi-
22 viduals who are entitled to health benefits under title I
23 of this Act, insurance benefits under title XVIII of the
24 Social Security Act, medical assistance under a State plan
25 approved under title XIX of the Social Security Act, or

1 to assistance for medical expenses under any other public
2 assistance program or private health insurance program.

3 (c) SCHEDULE OF FEES.—A funding agreement for
4 an award of financial assistance under section 3421 is that
5 the qualified community health group involved will—

6 (1) prepare a schedule of fees or payments for
7 the provision of health services not covered by title
8 I that is consistent with locally prevailing rates or
9 charges and designed to cover its reasonable costs of
10 operation and has prepared a corresponding sched-
11 ule of discounts to be applied to the payment of such
12 fees or payments (or payments of cost sharing
13 amounts owed in the case of covered benefits) which
14 discounts are applied on the basis of the patient's
15 ability to pay; and

16 (2) make every reasonable effort to secure from
17 patients payment in accordance with such schedules,
18 and to collect reimbursement for services to persons
19 entitled to public or private insurance benefits or
20 other medical assistance on the basis of full fees
21 without application of discounts, except that the ap-
22 plicant will ensure that no person is denied service
23 based on the person's inability to pay therefor.

24 (d) BARRIERS WITHIN SERVICE AREA.—A funding
25 agreement for an award of financial assistance under sec-

tion 3421 is that the qualified community health group involved will ensure that the following conditions are met:

(1) In the service area of the group, the group will ensure that—

(A) the services of the group are accessible to all residents; and

(B) to the maximum extent possible, barriers to access to the services of the group are eliminated, including barriers resulting from the area's physical characteristics, its residential patterns, its economic, social and cultural groupings, and available transportation.

(2) The group will periodically conduct reviews within the service area of the group to determine whether the conditions described in paragraph (1) are being met.

(e) LIMITED ABILITY TO SPEAK ENGLISH LANGUAGE.—A funding agreement for an award of financial assistance under section 3421 is that, if the service area of the qualified community health group involved includes a substantial number of individuals who have a limited ability to speak the English language, the applicant will—

(1) maintain arrangements responsive to the needs of such individuals for providing services to

1 the extent practicable in the language and cultural
2 context most appropriate to such individuals; and

3 (2) maintain a sufficient number of staff mem-
4 bers who are fluent in both English and the lan-
5 guages spoken by such individuals, and will ensure
6 that the responsibilities of the employees include
7 providing guidance and assistance to such individ-
8 uals and to other staff members of the group.

9 **SEC. 3425. ADDITIONAL AGREEMENTS.**

10 (a) **REQUIRED SERVICES.**—A funding agreement for
11 an award of financial assistance under section 3421 is that
12 the qualified community health group involved will provide
13 enabling services (as defined in section 3461(g)) and all
14 of the items and services identified by the Secretary in
15 rules regarding qualified community health plans and
16 practice networks.

17 (b) **QUALITY CONTROL SYSTEM.**—A funding agree-
18 ment for an award of financial assistance under section
19 3421 is that the qualified community health group in-
20 volved will maintain a community-oriented, patient respon-
21 sive, quality control system under which the group, in ac-
22 cordance with regulations prescribed by the Secretary—

23 (1) conducts an ongoing quality assurance pro-
24 gram for the health services delivered by partici-
25 pating provider entities;

1 (2) maintains a continuous community health
2 status improvement process; and

3 (3) maintains a system for development, com-
4 pilation, evaluation and reporting of information to
5 the public regarding the costs of operation, service
6 utilization patterns, availability, accessibility and ac-
7 ceptability of services, developments in the health
8 status of the populations served, uniform health and
9 clinical performance measures and financial per-
10 formance of the network or plan.

11 (c) USE OF EXISTING RESOURCES.—A funding
12 agreement for an award of financial assistance under sec-
13 tion 3421 is that the applicant will, in developing the
14 qualified community health group involved, utilize existing
15 resources to the maximum extent practicable.

16 **SEC. 3426. SUBMISSION OF CERTAIN INFORMATION.**

17 (a) ASSESSMENT OF NEED.—The Secretary may
18 make an award of financial assistance under section 3421
19 only if the applicant involved submits to the Secretary an
20 assessment of the need that the medically underserved
21 population or populations proposed to be served by the ap-
22 plicant have for health services and for enabling services
23 (as defined in section 3461(g)).

24 (b) DESCRIPTION OF INTENDED EXPENDITURES;
25 RELATED INFORMATION.—The Secretary may make an

1 award of financial assistance under section 3421 only if
2 the applicant involved submits to the Secretary the fol-
3 lowing information:

4 (1) A description of how the applicant will de-
5 sign the proposed quality community health plan or
6 practice network (including the service sites in-
7 volved) for such populations based on the assess-
8 ment of need.

9 (2) A description of efforts to secure, within the
10 proposed service area of such health plan or practice
11 network (including the service sites involved), finan-
12 cial and professional assistance and support for the
13 project.

14 (3) Evidence of significant community involve-
15 ment in the initiation, development and ongoing op-
16 eration of the project.

17 **SEC. 3427. REPORTS; AUDITS.**

18 A funding agreement for an award of financial assist-
19 ance under section 3421 is that the applicant involved
20 will—

21 (1) provide such reports and information on ac-
22 tivities carried out under this section in a manner
23 and form required by the Secretary; and

24 (2) provide an annual organization-wide audit
25 that meets applicable standards of the Secretary.

1 **SEC. 3428. APPLICATION FOR ASSISTANCE.**

2 The Secretary may make an award of financial assist-
3 ance under section 3421 only if an application for the
4 award is submitted to the Secretary, the application con-
5 tains each funding agreement described in this subpart,
6 the application contains the information required in sec-
7 tion 3426, and the application is in such form, is made
8 in such manner, and contains such agreements, assur-
9 ances, and information as the Secretary determines to be
10 necessary to carry out this subpart.

11 **SEC. 3429. GENERAL PROVISIONS.**

12 (a) **LIMITATION ON NUMBER OF AWARDS.**—The Sec-
13 retary may not make more than two awards of financial
14 assistance under section 3421 for the same project.

15 (b) **AMOUNT.**—The amount of any award of financial
16 assistance under section 3421 for any project shall be de-
17 termined by the Secretary.

18 **Subpart C—Capital Cost of Development of Qualified**
19 **Community Health Plans and Practice Networks**

20 **SEC. 3441. LOANS AND LOAN GUARANTEES REGARDING**
21 **PLANS AND NETWORKS.**

22 (a) **IN GENERAL.**—The Secretary may make loans to,
23 and guarantee the payment of principal and interest to
24 Federal and non-Federal lenders on behalf of, public and
25 private entities for the capital costs of developing qualified
26 community health groups (as defined in section 3421(a)).

1 (b) PREFERENCES; ACCESSIBILITY OF SERVICES;
2 CERTAIN OTHER PROVISIONS.—The provisions of subpart
3 B apply to loans and loan guarantees under subsection
4 (a) to the same extent and in the same manner as such
5 provisions apply to awards of grants and contracts under
6 section 3421.

7 (c) USE OF ASSISTANCE.—

8 (1) IN GENERAL.—With respect to the develop-
9 ment of qualified community health groups, the cap-
10 ital costs for which loans made pursuant to sub-
11 section (a) may be expended are, subject to para-
12 graphs (2) and (3), the following:

13 (A) The acquisition, modernization, expan-
14 sion or construction of facilities, or the conver-
15 sion of unneeded hospital facilities to facilities
16 that will assure or enhance the provision and
17 accessibility of health care and enabling services
18 to medically underserved populations.

19 (B) The purchase of major equipment, in-
20 cluding equipment necessary for the support of
21 external and internal information systems.

22 (C) The establishment of reserves required
23 for furnishing services on a prepaid basis.

1 (D) Such other capital costs as the Sec-
2 retary may determine are necessary to achieve
3 the objectives of this section.

4 (2) PRIORITIES REGARDING USE OF FUNDS.—
5 In providing loans or loan guarantees under sub-
6 section (a) for an entity, the Secretary shall give pri-
7 ority to authorizing the use of amounts for projects
8 for the renovation and modernization of medical fa-
9 cilities necessary to prevent or eliminate safety haz-
10 ards, avoid noncompliance with licensure or accredi-
11 tation standards, or projects to replace obsolete fa-
12 cilities.

13 (3) LIMITATION.—The Secretary may authorize
14 the use of amounts under subsection (a) for the con-
15 struction of new buildings only if the Secretary de-
16 termines that appropriate facilities are not available
17 through acquiring, modernizing, expanding or con-
18 verting existing buildings, or that construction new
19 buildings will cost less.

20 (d) AMOUNT OF ASSISTANCE.—The principal amount
21 of loans or loan guarantees under subsection (a) may,
22 when added to any other assistance under this section,
23 cover up to 100 percent of the costs involved.

24 **SEC. 3442. CERTAIN REQUIREMENTS.**

25 (a) LOANS.—

1 (1) IN GENERAL.—The Secretary may approve
2 a loan under section 3441 only if—

3 (A) the Secretary is reasonably satisfied
4 that the applicant for the project for which the
5 loan would be made will be able to make pay-
6 ments of principal and interest thereon when
7 due; and

8 (B) the applicant provides the Secretary
9 with reasonable assurances that there will be
10 available to it such additional funds as may be
11 necessary to complete the project or under-
12 taking with respect to which such loan is re-
13 quested.

14 (2) TERMS AND CONDITIONS.—Any loan made
15 under section 3441 shall, subject to the Federal
16 Credit Reform Act of 1990, meet such terms and
17 conditions (including provisions for recovery in case
18 of default) as the Secretary, in consultation with the
19 Secretary of the Treasury, determines to be nec-
20 essary to carry out the purposes of such section
21 while adequately protecting the financial interests of
22 the United States. Terms and conditions for such
23 loans shall include provisions regarding the fol-
24 lowing:

25 (A) Security.

1 (B) Maturity date.

2 (C) Amount and frequency of installments.

3 (D) Rate of interest, which shall be at a
4 rate comparable to the rate of interest pre-
5 vailing on the date the loan is made.

6 (b) LOAN GUARANTEES.—The Secretary may not ap-
7 prove a loan guarantee under section 3441 unless the Sec-
8 retary determines that the terms, conditions, security (if
9 any), schedule and amount of repayments with respect to
10 the loan are sufficient to protect the financial interests
11 of the United States and are otherwise reasonable. Such
12 loan guarantees shall be subject to such further terms and
13 conditions as the Secretary determines, in consultation
14 with the Secretary of the Treasury, and subject to the
15 Federal Credit Reform Act of 1990, to be necessary to
16 ensure that the purposes of this section will be achieved.

17 (c) USE OF EXISTING RESOURCES.—The Secretary
18 may provide a loan or loan guarantee under section 3441
19 only if the applicant involved agrees that, in developing
20 the qualified community health group involved, the appli-
21 cant will utilize existing resources to the maximum extent
22 practicable.

23 **SEC. 3443. DEFAULTS; RIGHT OF RECOVERY.**

24 (a) DEFAULTS.—

1 (1) IN GENERAL.—The Secretary may take
2 such action as may be necessary to prevent a default
3 on loans or loan guarantees under section 3441, in-
4 cluding the waiver of regulatory conditions, deferral
5 of loan payments, renegotiation of loans, and the ex-
6 penditure of funds for technical and consultative as-
7 sistance, for the temporary payment of the interest
8 and principal on such a loan, and for other pur-
9 poses.

10 (2) FORECLOSURE.—The Secretary may take
11 such action, consistent with State law respecting
12 foreclosure procedures, as the Secretary deems ap-
13 propriate to protect the interest of the United States
14 in the event of a default on a loan made pursuant
15 to section 3441, including selling real property
16 pledged as security for such a loan or loan guarantee
17 and for a reasonable period of time taking posses-
18 sion of, holding, and using real property pledged as
19 security for such a loan or loan guarantee.

20 (3) WAIVERS.—The Secretary may, for good
21 cause, but with due regard to the financial interests
22 of the United States, waive any right of recovery
23 which the Secretary has by reasons of the failure of
24 a borrower to make payments of principal of and in-
25 terest on a loan made pursuant to section 3441, ex-

1 cept that if such loan is sold and guaranteed, any
2 such waiver shall have no effect upon the Secretary's
3 guarantee of timely payment of principal and inter-
4 est.

5 (b) TWENTY-YEAR OBLIGATION; RIGHT OF RECOV-
6 ERY.—

7 (1) IN GENERAL.—With respect to a facility for
8 which a loan is to be made pursuant to section
9 3441, the Secretary may provide the loan or loan
10 guarantee only if the applicant involved agrees that
11 the applicant will be liable to the United States for
12 the amount of the loan or loan guarantee, together
13 with an amount representing interest, if at any time
14 during the 20-period beginning on the date of com-
15 pletion of the activities involved, the facility—

16 (A) ceases to be a facility utilized by a
17 qualified community health group, or by an-
18 other public or nonprofit private entity that
19 provides health services in one or more health
20 professional shortage areas or that provides
21 such services to a significant number of individ-
22 uals who are members of a medically under-
23 served population; or

24 (B) is sold or transferred to any entity
25 other than an entity that is—

1 (i) a qualified community health
2 group or other entity described in subpara-
3 graph (A); and

4 (ii) approved by the Secretary as a
5 purchaser or transferee regarding the facil-
6 ity.

7 (2) SUBORDINATION; WAIVERS.—The Secretary
8 may subordinate or waive the right of recovery
9 under paragraph (1), and any other Federal interest
10 that may be derived by virtue of a loan or loan guar-
11 antee under subsection (a), if the Secretary deter-
12 mines that subordination or waiver will further the
13 objectives of this part.

14 **SEC. 3444. PROVISIONS REGARDING CONSTRUCTION OR EX-**
15 **PANSION OF FACILITIES.**

16 (a) SUBMISSION OF INFORMATION.—In the case of
17 a project for construction, conversion, expansion or mod-
18 ernization of a facility, the Secretary may provide loans
19 or loan guarantees under section 3441 only if the appli-
20 cant submits to the Secretary the following:

21 (1) A description of the site.

22 (2) Plans and specifications which meet require-
23 ments prescribed by the Secretary.

24 (3) Information reasonably demonstrating that
25 title to such site is vested in one or more of the enti-

1 ties filing the application (unless the agreement de-
2 scribed in subsection (b)(1) is made).

3 (4) A specification of the type of assistance
4 being requested under section 3441.

5 (b) AGREEMENTS.—In the case of a project for con-
6 struction, conversion, expansion or modernization of a fa-
7 cility, the Secretary may provide loans or loan guarantees
8 under section 3441 only if the applicant makes the fol-
9 lowing agreements:

10 (1) Title to such site will be vested in one or
11 more of the entities filing the application (unless the
12 assurance described in subsection (a)(3) has been
13 submitted under such subsection).

14 (2) Adequate financial support will be available
15 for completion of the project and for its maintenance
16 and operation when completed.

17 (3) All laborers and mechanics employed by
18 contractors or subcontractors in the performance of
19 work on a project will be paid wages at rates not
20 less than those prevailing on similar construction in
21 the locality as determined by the Secretary of Labor
22 in accordance with the Act of March 3, 1931 (40
23 U.S.C. 276a et seq; commonly known as the Davis-
24 Bacon Act), and the Secretary of Labor shall have
25 with respect to such labor standards the authority

1 and functions set forth in Reorganization Plan
2 Numbered 14 of 1950 (15 FR 3176; 5 U.S.C. Ap-
3 pendix) and section 276c of title 40.

4 (4) The facility will be made available to all
5 persons seeking service regardless of their ability to
6 pay.

7 **SEC. 3445. APPLICATION FOR ASSISTANCE.**

8 The Secretary may provide loans or loan guarantees
9 under section 3441 only if an application for such assist-
10 ance is submitted to the Secretary, the application con-
11 tains each agreement described in this subpart, the appli-
12 cation contains the information required in section
13 3444(a), and the application is in such form, is made in
14 such manner, and contains such agreements, assurances,
15 and information as the Secretary determines to be nec-
16 essary to carry out this subpart.

17 **SEC. 3446. ADMINISTRATION OF PROGRAMS.**

18 This subpart, and any other program of the Secretary
19 that provides loans or loan guarantees, shall be carried
20 out by a centralized loan unit established within the De-
21 partment of Health and Human Services.

22 **Subpart D—Enabling Services**

23 **SEC. 3461. GRANTS AND CONTRACTS FOR ENABLING SERV-**
24 **ICES.**

25 (a) IN GENERAL.—

1 (1) GRANTS AND CONTRACTS.—The Secretary
2 may make grants to and enter into contracts with
3 entities described in paragraph (2) to assist such en-
4 tities in providing the services described in sub-
5 section (b) for the purpose of increasing the capacity
6 of individuals to utilize the items and services in-
7 cluded in the comprehensive benefits package under
8 title I.

9 (2) RELEVANT ENTITIES.—For purposes of
10 paragraph (1), the entities described in this para-
11 graph are qualified community health groups (as de-
12 fined in section 3421(a)), and other public or non-
13 profit private entities, that—

14 (A) provide health services in one or more
15 health professional shortage areas or that pro-
16 vide such services to a significant number of in-
17 dividuals who are members of a medically un-
18 derserved population; and

19 (B) are experienced in providing services to
20 increase the capacity of individuals to utilize
21 health services.

22 (b) ENABLING SERVICES.—The services referred to
23 in subsection (a)(1) are transportation, community and
24 patient outreach, patient education, translation services,
25 and such other services as the Secretary determines to be

1 appropriate in carrying out the purpose described in such
2 subsection.

3 (c) CERTAIN REQUIREMENTS REGARDING PROJECT
4 AREA.—The Secretary may make an award of a grant or
5 contract under subsection (a) only if the applicant
6 involved—

7 (1) submits to the Secretary—

8 (A) information demonstrating that the
9 medically underserved populations in the com-
10 munity to be served under the award have a
11 need for enabling services; and

12 (B) a proposed budget for providing such
13 services; and

14 (2) the applicant for the award agrees that the
15 residents of the community will be significantly in-
16 volved in the project carried out with the award.

17 (d) IMPOSITION OF FEES.—The Secretary may make
18 an award of a grant or contract under subsection (a) only
19 if the applicant involved agrees that, in the project carried
20 out under such subsection, enabling services will be pro-
21 vided without charge to the recipients of the services.

22 (e) USE OF EXISTING RESOURCES.—The Secretary
23 may make an award of a grant or contract under sub-
24 section (a) only if the applicant involved agrees that, in
25 carrying out the project under such subsection, the appli-

1 cant will utilize existing resources to the maximum extent
2 practicable.

3 (f) APPLICATION FOR AWARDS OF ASSISTANCE.—

4 The Secretary may make an award of a grant or contract
5 under subsection (a) only if an application for the award
6 is submitted to the Secretary, the application contains
7 each agreement described in this subpart, the application
8 contains the information required in subsection (d)(1),
9 and the application is in such form, is made in such man-
10 ner, and contains such agreements, assurances, and infor-
11 mation as the Secretary determines to be necessary to
12 carry out this subpart.

13 (g) DEFINITION.—For purposes of this section, the
14 term “enabling services” means services described in sub-
15 section (b) that are provided for the purpose described in
16 subsection (a)(1).

17 **SEC. 3462. AUTHORIZATIONS OF APPROPRIATIONS.**

18 (a) ENABLING SERVICES.—For the purpose of car-
19 rying out section 3461, there are authorized to be appro-
20 priated \$200,000,000 for fiscal year 1996, \$300,000,000
21 for each of the fiscal years 1997 through 1999, and
22 \$100,000,000 for fiscal year 2000.

23 (b) RELATION TO OTHER FUNDS.—The authoriza-
24 tions of appropriations established in subsection (a) are
25 in addition to any other authorizations of appropriations

1 that are available for the purpose described in such sub-
2 section.

3 **PART 3—NATIONAL HEALTH SERVICE CORPS**

4 **SEC. 3471. AUTHORIZATIONS OF APPROPRIATIONS.**

5 (a) ADDITIONAL FUNDING; GENERAL CORPS PRO-
6 GRAM; ALLOCATIONS REGARDING NURSES.—For the pur-
7 pose of carrying out subpart II of part D of title III of
8 the Public Health Service Act, and for the purpose of car-
9 rying out section 3472, there are authorized to be appro-
10 priated \$50,000,000 for fiscal year 1995, \$100,000,000
11 for fiscal year 1996, and \$200,000,000 for each of the
12 fiscal years 1997 through 2000.

13 (b) RELATION TO OTHER FUNDS.—The authoriza-
14 tions of appropriations established in subsection (a) are
15 in addition to any other authorizations of appropriations
16 that are available for the purpose described in such sub-
17 section.

18 (c) AVAILABILITY OF FUNDS.—An appropriation
19 under this section for any fiscal year may be made at any
20 time before that fiscal year and may be included in an
21 Act making an appropriation under an authorization
22 under subsection (a) for another fiscal year; but no funds
23 may be made available from any appropriation under this
24 section for obligation under sections 331 through 335, sec-
25 tion 336A, and section 337 before the fiscal year involved.

1 **SEC. 3472. ALLOCATION FOR PARTICIPATION OF NURSES**
2 **IN SCHOLARSHIP AND LOAN REPAYMENT**
3 **PROGRAMS.**

4 Of the amounts appropriated under section 3471, the
5 Secretary shall reserve such amounts as may be necessary
6 to ensure that, of the aggregate number of individuals who
7 are participants in the Scholarship Program under section
8 338A of the Public Health Service Act, or in the Loan
9 Repayment Program under section 338B of such Act, the
10 total number who are being educated as nurses or are
11 serving as nurses, respectively, is increased to 20 percent.

12 **PART 4—PAYMENTS TO HOSPITALS SERVING**
13 **VULNERABLE POPULATIONS**

14 **SEC. 3481. PAYMENTS TO HOSPITALS.**

15 (a) **ENTITLEMENT STATUS.**—The Secretary shall
16 make payments in accordance with this part to eligible
17 hospitals described in section 3482. The preceding
18 sentence—

19 (1) is an entitlement in the Secretary on behalf
20 of such eligible hospitals (but is not an entitlement
21 in the State in which any such hospital is located or
22 in any individual receiving services from any such
23 hospital); and

24 (2) constitutes budget authority in advance of
25 appropriations Acts and represents the obligation of
26 the Federal Government to provide funding for such

1 payments in the amounts, and for the fiscal years,
2 specified in subsection (b).

3 (b) AMOUNT OF ENTITLEMENT.—

4 (1) IN GENERAL.—For purposes of subsection
5 (a)(2), the amounts and fiscal years specified in this
6 subsection are (in the aggregate for all eligible hos-
7 pitals) \$800,000,000 for the fiscal year in which the
8 general effective date occurs and for each subse-
9 quent fiscal year.

10 (2) SPECIAL RULE FOR YEARS BEFORE GEN-
11 ERAL EFFECTIVE DATE.—

12 (A) IN GENERAL.—For any fiscal year
13 that begins prior to the general effective date,
14 the amount specified in this subsection for pur-
15 poses of subsection (a)(2) shall be equal to the
16 aggregate DSH percentage of the amount oth-
17 erwise determined under paragraph (1).

18 (B) AGGREGATE DSH PERCENTAGE DE-
19 FINED.—In subparagraph (A), the “aggregate
20 DSH percentage” for a year is the amount (ex-
21 pressed as a percentage) equal to—

22 (i) the total amount of payment made
23 by the Secretary under section 1903(a) of
24 the Social Security Act during the base
25 year with respect to payment adjustments

1 made under section 1923(c) of such Act
2 for hospitals in the States in which eligible
3 hospitals for the year are located; divided
4 by

5 (ii) the total amount of payment made
6 by the Secretary under section 1903(a) of
7 such Act during the base year with respect
8 to payment adjustments made under sec-
9 tion 1923(c) of such Act for hospitals in
10 all States.

11 (c) PERIOD OF PAYMENT.—An eligible hospital shall
12 receive a payment under this section for a period of 5
13 years, without regard to the year for which the hospital
14 first receives a payment.

15 (d) PAYMENTS MADE ON QUARTERLY BASIS.—Pay-
16 ments to an eligible hospital under this section for a year
17 shall be made on a quarterly basis during the year.

18 **SEC. 3482. IDENTIFICATION OF ELIGIBLE HOSPITALS.**

19 (a) HOSPITALS IN PARTICIPATING STATES.—In
20 order to be an eligible hospital under this part, a hospital
21 must be located in a State that is a participating State
22 under this Act, except that an eligible hospital remains
23 eligible to receive a payment under this part notwith-
24 standing that, during the 5-year period for which the pay-
25 ment is to be made, the State in which it is located no

1 longer meets the requirements for participating States
2 under this Act.

3 (b) STATE IDENTIFICATION.—In accordance with the
4 criteria described in subsection (c) and such procedures
5 as the Secretary may require, each State shall identify the
6 hospitals in the State that meet such criteria and provide
7 the Secretary with a list of such hospitals.

8 (c) CRITERIA FOR ELIGIBILITY.—A hospital meets
9 the criteria described in this subsection if the hospital's
10 low-income utilization rate for the base year under section
11 1923(b)(3) of the Social Security Act (as such section is
12 in effect on the day before the date of the enactment of
13 this Act) is not less than 25 percent.

14 **SEC. 3483. AMOUNT OF PAYMENTS.**

15 (a) DISTRIBUTION OF ALLOCATION FOR LOW-IN-
16 COME ASSISTANCE.—

17 (1) ALLOCATION FROM TOTAL AMOUNT.—Of
18 the total amount available for payments under this
19 section in a year, 75 percent shall be allocated to
20 hospitals for low-income assistance in accordance
21 with this subsection.

22 (2) DETERMINATION OF HOSPITAL PAYMENT
23 AMOUNT.—The amount of payment to an eligible
24 hospital from the allocation made under paragraph

1 (1) during a year shall be the equal to the hospital's
2 low-income percentage of the allocation for the year.

3 (b) DISTRIBUTION OF ALLOCATION FOR ASSISTANCE
4 FOR UNCOVERED SERVICES.—

5 (1) ALLOCATION FROM TOTAL AMOUNT; DETER-
6 MINATION OF STATE-SPECIFIC PORTION OF ALLOCA-
7 TION.—Of the total amount available for payments
8 under this section in a year, 25 percent shall be allo-
9 cated to hospitals for assistance in furnishing inpa-
10 tient hospital services that are not covered services
11 under title I (in accordance with regulations of the
12 Secretary) in accordance with this subsection. The
13 amount available for payments to eligible hospitals
14 in a State shall be equal to an amount determined
15 in accordance with a methodology specified by the
16 Secretary.

17 (2) DETERMINATION OF HOSPITAL PAYMENT
18 AMOUNT.—The amount of payment to an eligible
19 hospital in a State from the amount available for
20 payments to eligible hospitals in the State under
21 paragraph (1) during a year shall be the equal to
22 the hospital's low-income percentage of such amount
23 for the year.

24 (c) LOW-INCOME PERCENTAGE DEFINED.—

1 (1) IN GENERAL.—In this subsection, an eligi-
2 ble hospital’s “low-income percentage” for a year is
3 equal to the amount (expressed as a percentage) of
4 the total low-income days for all eligible hospitals for
5 the year that are attributable to the hospital.

6 (2) LOW-INCOME DAYS DESCRIBED.—For pur-
7 poses of paragraph (1), an eligible hospital’s low-in-
8 come days for a year shall be equal to the product
9 of—

10 (A) the total number of inpatient days for
11 the hospital for the year (as reported to the
12 Secretary by the State in which the hospital is
13 located, in accordance with a reporting schedule
14 and procedures established by the Secretary);
15 and

16 (B) the hospital’s low-income utilization
17 rate for the base year under section 1923(b)(3)
18 of the Social Security Act (as such section is in
19 effect on the day before the date of the enact-
20 ment of this Act).

21 **SEC. 3484. BASE YEAR.**

22 In this part, the “base year” is, with respect to a
23 State and hospitals in a State, the year immediately prior
24 to the year in which the general effective date occurs.

**Subtitle F—Mental Health;
Substance Abuse**

PART 1—FINANCIAL ASSISTANCE

SEC. 3501. AUTHORIZATIONS OF APPROPRIATIONS.

(a) IN GENERAL.—For the purpose of carrying out this part, there are authorized to be appropriated \$100,000,000 for fiscal year 1995, \$150,000,000 for fiscal year 1996, and \$250,000,000 for each of the fiscal years 1997 through 2000.

(b) ALLOCATION AMONG PROGRAMS.—Of the amounts made available under subsection (a) for a fiscal year—

(1) the Secretary may reserve for carrying out section 3503 such amounts as the Secretary determines to be appropriate; and

(2) the Secretary shall, of the remaining amounts, reserve 50 percent for carrying out subsection (a) of section 3502 and 50 percent for carrying out subsection (b) of such section.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

1 **SEC. 3502. SUPPLEMENTAL FORMULA GRANTS FOR STATES**
2 **REGARDING ACTIVITIES UNDER PART B OF**
3 **TITLE XIX OF PUBLIC HEALTH SERVICE ACT.**

4 (a) MENTAL HEALTH.—

5 (1) IN GENERAL.—In the case of any State that
6 submits to the Secretary an application in accord-
7 ance with subsection (e) for a fiscal year with re-
8 spect to mental health, the Secretary shall make a
9 grant to the State for the purposes authorized in
10 subsection (c) with respect to mental health. The
11 grant shall consist of the allotment determined
12 under paragraph (2) for the State for such year.

13 (2) DETERMINATION OF ALLOTMENT.—For
14 purposes of paragraph (1), the allotment under this
15 paragraph for a State for a fiscal year shall be de-
16 termined as follows: With respect to the amount re-
17 served under section 3501(b)(2) for carrying out
18 this subsection, section 1918 of the Public Health
19 Service Act shall be applied to such amount to the
20 same extent and in the same manner as such section
21 1918 is applied to the amount determined under sec-
22 tion 1918(a)(2) of such Act.

23 (b) SUBSTANCE ABUSE.—

24 (1) IN GENERAL.—In the case of any State that
25 submits to the Secretary an application in accord-
26 ance with subsection (e) for a fiscal year with re-

1 spect to substance abuse, the Secretary shall make
2 a grant to the State for the purposes authorized in
3 subsection (c) with respect to substance abuse. The
4 grant shall consist of the allotment determined
5 under paragraph (2) for the State for such year.

6 (2) DETERMINATION OF ALLOTMENT.—For
7 purposes of paragraph (1), the allotment under this
8 paragraph for a State for a fiscal year shall be de-
9 termined as follows: With respect to the amount re-
10 served under section 3501(b)(2) for carrying out
11 this subsection, section 1933 of the Public Health
12 Service Act shall be applied to such amount to the
13 same extent and in the same manner as such section
14 1933 is applied to the amount determined pursuant
15 to sections 1933(a)(1)(B)(i) and 1918(a)(2)(A) of
16 such Act.

17 (c) USE OF GRANTS.—

18 (1) IN GENERAL.—With respect to the expendi-
19 ture of a grant to a State under subsection (a) or
20 (b), the Secretary—

21 (A) shall designate as authorized expendi-
22 tures such of the activities described in para-
23 graph (2) with respect to mental health and
24 substance abuse, respectively, as the Secretary
25 determines to be appropriate; and

1 (B) may make the grant only if the State
2 agrees to expend the grant in accordance with
3 the activities so designated.

4 (2) DESCRIPTION OF ACTIVITIES.—The activi-
5 ties referred to in paragraph (1) are (as applicable
6 to the grant involved) the following:

7 (A) For the purpose of increasing the ac-
8 cess of individuals to services relating to mental
9 health and substance abuse, the following serv-
10 ices: Transportation, community and patient
11 outreach, patient education, translation serv-
12 ices, and such other services as the Secretary
13 determines to be appropriate regarding such
14 purpose.

15 (B) Improving the capacity of State and
16 local service systems to coordinate and monitor
17 mental health and substance abuse services, in-
18 cluding improvement of management informa-
19 tion systems, and establishment of linkages be-
20 tween providers of mental health and substance
21 abuse services and primary care providers and
22 health plans.

23 (C) Providing incentives to integrate public
24 and private systems for the treatment of mental
25 health and substance abuse disorders.

1 (D) Any activity for which a grant under
2 section 1911 or section 1921 of the Public
3 Health Service Act is authorized to be ex-
4 pended.

5 (d) MAINTENANCE OF EFFORT.—

6 (1) IN GENERAL.—With respect to the activities
7 for which a grant under subsection (a) or (b) is to
8 be made, the Secretary may make the grant only if
9 the State involved agrees to maintain expenditures
10 of non-Federal amounts for such activities at a level
11 that is not less than the level of such expenditures
12 maintained by the State for the fiscal year preceding
13 the first fiscal year for which the State receives such
14 a grant.

15 (2) WAIVER.—The Secretary may waive all or
16 part of the requirement established for a State
17 under paragraph (1) if—

18 (A) the State agrees that the amounts that
19 otherwise would have been subject to such re-
20 quirement will be expended for the purpose of
21 developing community-based systems of care to
22 promote the eventual integration of the public
23 and private systems for treatment of mental
24 health, or substance abuse, as applicable to the
25 grant;

1 (B) the State submits to the Secretary a
2 request for the waiver and a description of the
3 manner in which the State will carry out such
4 purpose; and

5 (C) the Secretary approves the waiver.

6 (e) APPLICATION FOR GRANT.—For purposes of sub-
7 section (a)(1) and (b)(1), an application for a grant under
8 this section regarding mental health or substance abuse,
9 respectively, is in accordance with this subsection if the
10 State involved submits the application not later than the
11 date specified by the Secretary, the application contains
12 each applicable agreement described in this section, and
13 the application otherwise is in such form, is made in such
14 manner, and contains such agreements, assurances, and
15 information as the Secretary determines to be necessary
16 to carry out the purpose involved.

17 **SEC. 3503. CAPITAL COSTS OF DEVELOPMENT OF CERTAIN**
18 **CENTERS AND CLINICS.**

19 (a) IN GENERAL.—The Secretary may make loans to,
20 and guarantee the payment of principal and interest to
21 Federal and non-Federal lenders on behalf of, public and
22 private entities for the capital costs to be incurred by the
23 entities in the development of non-acute, residential treat-
24 ment centers and community-based ambulatory clinics.

1 (b) PRIORITIES REGARDING USE OF FUNDS.—In
2 providing loans or loan guarantees under subsection (a),
3 the Secretary shall give priority to authorizing the use of
4 amounts for projects in health professional shortage areas
5 or in geographic area in which there resides a significant
6 number of individuals who are members of a medically un-
7 derserved population.

8 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
9 Secretary may provide loans or loan guarantees under
10 subsection (a) only if the applicant involved agrees that,
11 except to the extent inconsistent with the purpose de-
12 scribed in subsection (a), subpart C of part 2 of subtitle
13 E applies to such assistance to the same extent and in
14 the same manner as such subpart applies to loans and
15 loan guarantees under section 3441.

16 **PART 2—AUTHORITIES REGARDING**
17 **PARTICIPATING STATES**

18 **Subpart A—Report**

19 **SEC. 3511. REPORT ON INTEGRATION OF MENTAL HEALTH**
20 **SYSTEMS.**

21 (a) IN GENERAL.—As a condition of being a partici-
22 pating State under title I, each State shall, not later than
23 October 1, 1998, submit to the Secretary a report on (in-
24 cluding a plan for) the measures to be implemented by
25 the State to achieve the integration of the mental illness

1 and substance abuse services of the State and its political
2 subdivisions with the mental illness and substance abuse
3 services that are included in the comprehensive benefit
4 package under title I. The plan required in the preceding
5 sentence shall meet the conditions described in section
6 3074(b).

7 (b) REQUIRED CONTENTS.—With respect to the pro-
8 vision of items and services relating to mental illness and
9 substance abuse, the report of a State under subsection
10 (a) shall, at a minimum, contain the following information:

11 (1) Information on the number of individuals
12 served by or through mental illness and substance
13 abuse programs administered by State and local
14 agencies and the proportion who are eligible persons
15 under title I.

16 (2) The following information on services fur-
17 nished to eligible persons:

18 (A) Each type of benefit furnished.

19 (B) The mental illness diagnoses for which
20 each type of benefit is covered, the amount, du-
21 ration and scope of coverage for each covered
22 benefit, and any applicable limits on benefits.

23 (C) Cost sharing rules that apply.

24 (3) Information on the extent to which each
25 health provider furnishing mental illness and sub-

1 stance abuse services under a State program partici-
2 pates in one or more regional or corporate alliance
3 health plans, and, in the case of providers that do
4 not so participate, the reasons for the lack of par-
5 ticipation.

6 (4) The amount of revenues from health plans
7 received by mental illness and substance abuse pro-
8 viders that are participating in such health plans
9 and are funded under one or more State programs.

10 (5) With respect to the two years preceding the
11 year in which the State becomes a participating
12 State under title I—

13 (A) the amount of funds expended by the
14 State and its political subdivisions for each of
15 such years for items and services that are in-
16 cluded in the comprehensive benefit package
17 under such title;

18 (B) the amount of funds expended for
19 medically necessary and appropriate items and
20 services not included in such benefit package,
21 including medical care, other health care, and
22 supportive services related to the provision of
23 health care.

24 (6) An estimate of the amount that the State
25 will expend to furnish items and services not in-

1 cluded in such package once the expansion of cov-
2 erage for mental illness and substance abuse services
3 is implemented in the year 2001.

4 (7) A description of how the State will assure
5 that all individuals served by mental illness and sub-
6 stance abuse programs funded by the State will be
7 enrolled in a health plan and how mental illness and
8 substance abuse services not covered under the ben-
9 efit package will continue to be furnished to such en-
10 rollees.

11 (8) A description of the conditions under which
12 the integration of mental illness and substance abuse
13 providers into regional and corporate alliances can
14 be achieved, and an identification of changes in par-
15 ticipation and certification requirements that are
16 needed to achieve the integration of such programs
17 and providers into health plans.

18 (9) If the integration of mental illness and sub-
19 stance abuse programs operated by the State into
20 one or more health plans is not medically appro-
21 priate or feasible for one or more groups of individ-
22 uals treated under State programs, a description of
23 the reasons that integration is not feasible or appro-
24 priate and a plan for assuring the coordination for
25 such individuals of the care and services covered

1 under the comprehensive benefit package with the
2 additional items and services furnished by such pro-
3 grams.

4 (c) GENERAL PROVISIONS.—Reports under sub-
5 section (a) shall be provided at the time and in the manner
6 prescribed by the Secretary.

7 **Subpart B—Pilot Program**

8 **SEC. 3521. PILOT PROGRAM.**

9 (a) IN GENERAL.—The Secretary shall establish a
10 pilot program to demonstrate model methods of achieving
11 the integration of the mental illness and substance abuse
12 services of the States with the mental illness and sub-
13 stance abuse services that are included in the comprehen-
14 sive benefit package under title I.

15 (b) CERTAIN CONSIDERATIONS.—With respect to the
16 provision of items and services relating to mental illness
17 and substance abuse, the Secretary, in carrying out sub-
18 section (a), shall consider the following:

19 (1) The types of items and services needed in
20 addition to the items and services included in the
21 comprehensive benefits package under title I.

22 (2) The optimal methods of treatment for indi-
23 viduals with long-term conditions.

24 (3) The capacity of alliance health plans to fur-
25 nish such treatment.

1 (4) The modifications that should be made in
2 the items and services furnished by such health
3 plans.

4 (5) The role of publicly-funded health providers
5 in the integration of acute and long-term treatment.

6 **Subtitle G—Comprehensive School**
7 **Health Education; School-Re-**
8 **lated Health Services**

9 **PART 1—GENERAL PROVISIONS**

10 **SEC. 3601. PURPOSES.**

11 Subject to the subsequent provisions of this subtitle,
12 the purposes of this subtitle are as follows:

13 (1) To support the provision in kindergarten
14 through grade 12 of sequential, age-appropriate,
15 comprehensive health education programs that ad-
16 dress locally relevant priorities.

17 (2) To establish a national framework within
18 which States can create comprehensive school health
19 education programs that—

20 (A) target the health risk behaviors ac-
21 counting for the majority of the morbidity and
22 mortality among youth and adults, including
23 the following: Tobacco use; alcohol and other
24 drug abuse; sexual behaviors resulting in infec-
25 tion with the human immunodeficiency virus, in

1 other sexually transmitted diseases or in unin-
2 tended pregnancy; behaviors resulting in inten-
3 tional and unintentional injuries; dietary pat-
4 terns resulting in disease; and sedentary life-
5 styles; and

6 (B) are integrated with plans and pro-
7 grams in the State, if any, under title III of the
8 Goals 2000: Educate America Act and those
9 targeting health promotion and disease preven-
10 tion goals related to the national health objec-
11 tives set forth in Healthy People 2000.

12 (3) To pay the initial costs of planning and es-
13 tablishing Statewide comprehensive school health
14 education programs that will be implemented and
15 maintained with local, State, and other Federal re-
16 sources.

17 (4) To support Federal activities such as re-
18 search and demonstrations, evaluations, and training
19 and technical assistance regarding comprehensive
20 school health education.

21 (5) To motivate youth, especially low-achieving
22 youth, to stay in school, avoid teen pregnancy, and
23 strive for success by providing intensive, high-quality
24 health education programs that include peer-teach-
25 ing, family, and community involvement.

1 (6) To improve the knowledge and skills of chil-
2 dren and youth by integrating academic and experi-
3 ential learning in health education with other ele-
4 ments of a comprehensive school health program.

5 (7) To further the National Education Goals
6 set forth in title I of the Goals 2000: Educate Amer-
7 ica Act and the national health objectives set forth
8 in Healthy People 2000.

9 **SEC. 3602. DEFINITIONS.**

10 (a) COMPREHENSIVE SCHOOL HEALTH EDUCATION
11 PROGRAM.—For purposes of this subtitle, the term “com-
12 prehensive school health education program” means a pro-
13 gram that addresses locally relevant priorities and meets
14 the following conditions:

15 (1) The program is sequential, and age and de-
16 velopmentally appropriate.

17 (2) The program is provided, in the area served
18 by the program, every year for all students from kin-
19 dergarten through grade 12.

20 (3) The program provides comprehensive health
21 education, including the following components:

22 (A) Community health.

23 (B) Environmental health.

24 (C) Personal health.

25 (D) Family life.

1 (E) Growth and development.

2 (F) Nutritional health.

3 (G) Prevention and control of disease and
4 disorders.

5 (H) Safety and prevention of injuries.

6 (I) Substance abuse, including tobacco and
7 alcohol use.

8 (J) Consumer health, including education
9 to ensure that students understand the benefits
10 and appropriate use of medical services, includ-
11 ing immunizations and other clinical preventive
12 services.

13 (4) The program promotes personal responsi-
14 bility for a healthy lifestyle and provides the knowl-
15 edge and skills necessary to adopt a healthy lifestyle,
16 including teaching the legal, social, and health con-
17 sequences of behaviors that pose health risks.

18 (5) The program is sensitive to cultural and
19 ethnic issues in the content of instructional mate-
20 rials and approaches.

21 (6) The program includes activities that sup-
22 port instruction.

23 (7) The program includes activities to promote
24 involvement by parents, families, community organi-
25 zations, and other appropriate entities.

1 (8) The program is coordinated with other Fed-
2 eral, State, and local health education and preven-
3 tion programs and with other Federal, State and
4 local education programs, including those carried out
5 under title I of the Elementary and Secondary Edu-
6 cation Act of 1965.

7 (9) The program focuses on the particular
8 health concerns of the students in the State, school
9 district, or school, as the case may be.

10 (b) OTHER DEFINITIONS.—For purposes of this sub-
11 title:

12 (1) The term “local educational agency” has
13 the meaning given such term in section 1471(12) of
14 the Elementary and Secondary Education Act of
15 1965.

16 (2) The term “State educational agency” has
17 the meaning given such term in section 1471(23) of
18 the Elementary and Secondary Education Act of
19 1965.

20 **PART 2—SCHOOL HEALTH EDUCATION; GENERAL**
21 **PROVISIONS**

22 **SEC. 3611. AUTHORIZATIONS OF APPROPRIATIONS.**

23 (a) FUNDING FOR SCHOOL HEALTH EDUCATION.—
24 For the purpose of carrying out parts 3 and 4, there are

1 authorized to be appropriated \$50,000,000 for each of the
2 fiscal year 1995 through 2000.

3 (b) ALLOCATIONS.—Of the amounts appropriated
4 under subsection (a) for a fiscal year—

5 (1) the Secretary may reserve not more than
6 \$13,000,000 for carrying out part 4;

7 (2) the Secretary may reserve not more than
8 \$5,000,000 to support national leadership activities,
9 such as research and demonstration, evaluation, and
10 training and technical assistance in comprehensive
11 school health education; and

12 (3) the Secretary may reserve not more than 5
13 percent for administrative expenses regarding parts
14 3 and 4.

15 (c) RELATION TO OTHER FUNDS.—The authoriza-
16 tions of appropriations established in subsection (a) are
17 in addition to any other authorizations of appropriations
18 that are available for the purpose described in such sub-
19 section.

20 **SEC. 3612. WAIVERS OF STATUTORY AND REGULATORY RE-**
21 **QUIREMENTS.**

22 (a) IN GENERAL.—

23 (1) WAIVERS.—Except as provided in sub-
24 section (c), upon the request of an entity receiving
25 funds under part 3 or part 4 and under a program

1 specified in paragraph (2), the Secretary of Health
2 and Human Services or the Secretary of Education
3 (as the case may be, according to which Secretary
4 administers the program so specified) may grant to
5 the entity a waiver of any requirement of such pro-
6 gram regarding the use of funds, or of the regula-
7 tions issued for the program by the Secretary in-
8 volved, if the following conditions are met with re-
9 spect to such program:

10 (A) The Secretary involved determines that
11 the requirement of such program impedes the
12 ability of the State educational agency or other
13 recipient to achieve more effectively the pur-
14 poses of part 3 or 4.

15 (B) The Secretary involved determines
16 that, with respect to the use of funds under
17 such program, the requested use of the funds
18 by the entity would be consistent with the pur-
19 poses of part 3 or 4.

20 (C) In the case of a request for a waiver
21 submitted by a State educational agency, the
22 State educational agency—

23 (i) provides all interested local edu-
24 cational agencies in the State with notice

1 and an opportunity to comment on the
2 proposal; and

3 (ii) submits the comments to the Sec-
4 retary involved.

5 (D) In the case of a request for a waiver
6 submitted by a local educational agency or
7 other agency, institution, or organization that
8 receives funds under part 3 from the State edu-
9 cational agency, such request has been reviewed
10 by the State educational agency and is accom-
11 panied by the comments, if any, of such agency.

12 (2) RELEVANT PROGRAMS.—For purposes of
13 paragraph (1), the programs specified in this para-
14 graph are as follows:

15 (A) In the case of programs administered
16 by the Secretary of Health and Human Serv-
17 ices, the following:

18 (i) The program known as the Preven-
19 tion, Treatment, and Rehabilitation Model
20 Projects for High Risk Youth, carried out
21 under section 517 of the Public Health
22 Service Act.

23 (ii) The program known as the State
24 and Local Comprehensive School Health
25 Programs to Prevent Important Health

1 Problems and Improve Educational Out-
2 comes, carried out under such Act.

3 (B) In the case of programs administered
4 by the Secretary of Education, any program
5 carried out under part B of the Drug-Free
6 Schools and Communities Act of 1986.

7 (b) WAIVER PERIOD.—

8 (1) IN GENERAL.—A waiver under this section
9 shall be for a period not to exceed three years.

10 (2) EXTENSIONS.—The Secretary involved
11 under subsection (a) may extend such period if the
12 Secretary determines that—

13 (A) the waiver has been effective in ena-
14 bling the State or affected recipients to carry
15 out the activities for which it was requested and
16 has contributed to improved performance; and

17 (B) such extension is in the public interest.

18 (c) WAIVERS NOT AUTHORIZED.—The Secretary in-
19 volved under subsection (a) may not waive, under this sec-
20 tion, any statutory or regulatory requirement relating to—

21 (1) comparability of services;

22 (2) maintenance of effort;

23 (3) the equitable participation of students at-
24 tending private schools;

25 (4) parental participation and involvement;

1 (5) the distribution of funds to States or to
2 local educational agencies or other recipients of
3 funds under the programs specified in subsection
4 (a)(2);

5 (6) maintenance of records;

6 (7) applicable civil rights requirements; or

7 (8) the requirements of sections 438 and 439 of
8 the General Education Provisions Act.

9 (d) **TERMINATION OF WAIVER.**—The Secretary in-
10 volved under subsection (a) shall terminate a waiver under
11 this section if the Secretary determines that the perform-
12 ance of the State or other recipient affected by the waiver
13 has been inadequate to justify a continuation of the waiver
14 or if it is no longer necessary to achieve its original pur-
15 poses.

16 **PART 3—SCHOOL HEALTH EDUCATION; GRANTS**
17 **TO STATE EDUCATION AGENCIES**

18 **Subpart A—Planning Grants for State Education**
19 **Agencies**

20 **SEC. 3621. APPLICATION FOR GRANT.**

21 (a) **IN GENERAL.**—Any State educational agency
22 that wishes to receive a planning grant under this subpart
23 shall submit an application to the Secretary of Health and
24 Human Services, at such time and in such manner as the
25 Secretary may require.

1 (b) APPLICATION; JOINT DEVELOPMENT; CON-
2 TENTS.—An application under subsection (a) shall be
3 jointly developed by the State educational agency and the
4 State health agencies of the State involved, and shall con-
5 tain the following:

6 (1) An assessment of the State’s need for com-
7 prehensive school health education, using goals es-
8 tablished by the Department of Health and Human
9 Services and the Department of Education and the
10 State’s school improvement plan, if any, under title
11 III of Goals 2000: Educate America Act.

12 (2) A description of how the State educational
13 agency will collaborate with the State health agency
14 in the planning and development of a comprehensive
15 school health education program in the State, in-
16 cluding coordination of existing health education
17 programs and resources.

18 (3) A plan to build capacity at the State and
19 local levels to provide staff development and tech-
20 nical assistance to local educational agency and local
21 health agency personnel involved with comprehensive
22 school health education.

23 (4) A preliminary plan for evaluating com-
24 prehensive school health education activities.

1 (5) Information demonstrating that the State
2 has established a State-level advisory council whose
3 membership includes representatives of the State
4 agencies with principal responsibilities for programs
5 regarding health, education, and mental health.

6 (6) A timetable and proposed budget for the
7 planning process.

8 (7) Such other information and assurances as
9 the Secretary may require.

10 (c) NUMBER OF GRANTS.—States may receive one
11 planning grant annually and no more than two planning
12 grants may be awarded to any one State.

13 **SEC. 3622. APPROVAL OF SECRETARY.**

14 The Secretary may approve the application of a State
15 under section 3621 if the Secretary determines that—

16 (1) the application meets the requirements of
17 this subpart; and

18 (2) there is a substantial likelihood that the
19 State will be able to develop and implement a com-
20 prehensive school health education plan that com-
21 plies with the requirements of subpart B.

22 **SEC. 3623. AMOUNT OF GRANT.**

23 For any fiscal year, the minimum grant to any State
24 under this subpart is an amount determined by the Sec-
25 retary to be necessary to enable the State to conduct the

1 planning process, and the maximum such grant is
2 \$500,000.

3 **SEC. 3624. AUTHORIZED ACTIVITIES.**

4 A State may use funds received under this subpart
5 only for the following:

6 (1) To establish and carry out the State plan-
7 ning process.

8 (2) To conduct Statewide or sub-State regional
9 coordination and collaboration activities for local
10 educational agencies, local health agencies, and other
11 agencies and organizations, as appropriate.

12 (3) To conduct activities to build capacity to
13 provide staff development and technical assistance
14 services to local educational agency and local health
15 agency personnel involved with comprehensive school
16 health education.

17 (4) To develop student learning objectives and
18 assessment instruments.

19 (5) To work with State and local health agen-
20 cies and State and local educational agencies to re-
21 duce barriers to the implementation of comprehen-
22 sive school health education programs in schools.

23 (6) To prepare the plan required to receive an
24 implementation grant under subpart B.

1 (7) To adopt, validate, and disseminate cur-
2 riculum models and program strategies, if the Sec-
3 retary determines that such activities are necessary
4 to achieving the objectives of the State's program.

5 **Subpart B—Implementation Grants for State**
6 **Education Agencies**

7 **SEC. 3631. APPLICATION FOR GRANT.**

8 (a) IN GENERAL.—Any State that wishes to receive
9 an implementation grant under this subpart shall submit
10 an application to the Secretary of Health and Human
11 Services, at such time, in such manner, and containing
12 such information and assurances as the Secretary may re-
13 quire.

14 (b) APPLICATION AND STATE PLAN; JOINT DEVEL-
15 OPMENT; CONTENTS.—An application under subsection
16 (a) shall be jointly developed by the State educational
17 agency and the State health agencies of the State involved,
18 and shall include a State plan for comprehensive school
19 health education programs (as defined in section 3602)
20 that describes the following:

21 (1) The State's goals and objectives for those
22 programs.

23 (2) How the State will allocate funds to local
24 educational agencies in accordance with section
25 3634.

1 (3) How the State will coordinate programs
2 under this subpart with other local, State and Fed-
3 eral health education programs.

4 (4) How comprehensive school health education
5 programs will be coordinated with other local, State
6 and Federal education programs, such as programs
7 under title I of the Elementary and Secondary Edu-
8 cation Act of 1965, with the State's school improve-
9 ment plan, if any, under title III of the Goals 2000:
10 Educate America Act, and with any similar pro-
11 grams.

12 (5) How the State has worked with State and
13 local education agencies and with State and local
14 health agencies to reduce barriers to implementing
15 comprehensive school health education programs.

16 (6) How the State will monitor the implementa-
17 tion of such programs by local educational agencies.

18 (7) How the State will build capacity for profes-
19 sional development of health educators.

20 (8) How the State will provide staff develop-
21 ment and technical assistance to local educational
22 agencies.

23 (9) The respective roles of the State educational
24 agency, local educational agencies, the State health
25 agency, and the local health agencies in developing

1 and implementing such school health education pro-
2 grams.

3 (10) How such school health education pro-
4 grams will be tailored to the extent practicable to be
5 culturally and linguistically sensitive and responsive
6 to the various needs of the students served, includ-
7 ing individuals with disabilities, and individuals from
8 disadvantaged backgrounds (including racial and
9 ethnic minorities).

10 (11) How the State will evaluate and report on
11 the State's progress toward attaining the goals and
12 objectives described in paragraph (1).

13 **SEC. 3632. SELECTION OF GRANTEES.**

14 (a) SELECTION OF GRANTEES.—The Secretary shall
15 establish criteria for the competitive selection of grantees
16 under this subpart.

17 (b) OPPORTUNITY FOR PLANNING GRANT.—If the
18 Secretary does not approve a State's application under
19 this subpart and determines that the State could benefit
20 from a planning grant under subpart A, the Secretary
21 shall inform the State of any planning grant funds that
22 may be available to it under subpart A, subject to section
23 3621(c).

1 **SEC. 3633. AMOUNT OF GRANT.**

2 (a) IN GENERAL.—For any fiscal year, the minimum
3 grant to any State under this subpart is an amount deter-
4 mined by the Secretary to be necessary to enable the State
5 to conduct the implementation process.

6 (b) CRITERIA.—In determining the amount of any
7 such grant, the Secretary may consider such factors as
8 the number of children enrolled in schools in the State,
9 the number of school-aged children living in poverty in the
10 State, and the scope and quality of the State’s plan.

11 **SEC. 3634. AUTHORIZED ACTIVITIES; LIMITATION ON AD-**
12 **MINISTRATIVE COSTS.**

13 (a) SUBGRANTS TO LOCAL EDUCATIONAL AGEN-
14 CIES.—Each State that receives funds under this subpart
15 for any fiscal year shall retain not more than 75 percent
16 of those funds in the first year, 50 percent of those funds
17 in the second and third years, and 25 percent of those
18 funds in each succeeding year. Those funds not retained
19 by the State shall be used to make grants to local edu-
20 cational agencies in accordance with section 3635.

21 (b) STATE-LEVEL ACTIVITIES.—Each State shall use
22 retained funds for any fiscal year for the following pur-
23 poses:

24 (1) To conduct Statewide or sub-State regional
25 coordination and collaboration activities.

1 (2) To adapt, validate, or disseminate program
2 models or strategies for comprehensive school health
3 education.

4 (3) To build capacity to deliver staff develop-
5 ment and technical assistance services to local edu-
6 cational agencies, and State and local health agen-
7 cies.

8 (4) To promote program activities involving
9 families and coordinating program activities with
10 community groups and agencies.

11 (5) To evaluate and report to the Secretary on
12 the progress made toward attaining the goals and
13 objectives described in section 3621(b)(1).

14 (6) To conduct such other activities to achieve
15 the objectives of this subpart as the Secretary may
16 by regulation authorize.

17 (c) STATE ADMINISTRATION.—Of the amounts re-
18 ceived by a State for a fiscal year under this subpart and
19 remaining after any grants to local educational agencies
20 made from such amounts, the State may use up to 10
21 percent for the costs of administering such amounts, in-
22 cluding the activities of the State advisory council and
23 monitoring the performance of local educational agencies.

1 **SEC. 3635. SUBGRANTS TO LOCAL EDUCATIONAL AGEN-**
2 **CIES.**

3 (a) APPLICATION FOR GRANT.—Any local edu-
4 cational agency that wishes to receive a grant under this
5 subpart shall submit an application to the State, con-
6 taining such information and assurances as the State may
7 require, including a description of the following:

8 (1) The local educational agency's goals and ob-
9 jectives for comprehensive school health education
10 programs.

11 (2) How the local educational agency will con-
12 centrate funds in high-need schools and provide suf-
13 ficient funds to targeted schools to ensure the imple-
14 mentation of comprehensive programs.

15 (3) How the local educational agency will mon-
16 itor the implementation of these programs.

17 (4) How the local educational agency will en-
18 sure that school health education programs are tai-
19 lored to the extent practicable to be culturally and
20 linguistically sensitive and responsive to the various
21 needs of the students served, including individuals
22 with disabilities, and individuals from disadvantaged
23 backgrounds (including racial and ethnic minorities).

24 (5) How the local educational agency, in con-
25 sultation with the local health agency, will evaluate

1 and report on its progress toward attaining the goals
2 and objectives described in paragraph (1).

3 (b) SELECTION OF SUBGRANTEES.—Each State shall
4 give priority to applications from local educational agen-
5 cies serving areas with high needs, as indicated by criteria
6 developed by the State, which shall include, but need not
7 be limited to, high rates of any of the following:

8 (1) Poverty among school-aged youth.

9 (2) Births to adolescents.

10 (3) Sexually transmitted diseases among school-
11 aged youth.

12 (4) Drug and alcohol use among school-aged
13 youth.

14 (5) Violence among school-aged youth.

15 (c) AUTHORIZED ACTIVITIES.—Each local edu-
16 cational agency that receives a grant under this subpart
17 shall use the grant funds to implement comprehensive
18 school health education programs, as defined in section
19 3602.

20 **Subpart C—State and Local Reports**

21 **SEC. 3641. STATE AND LOCAL REPORTS.**

22 (a) STATE REPORTS.—Each State that receives a
23 grant under this part shall collect and submit to the Sec-
24 retary such data and other information on State and local
25 programs as the Secretary may require.

1 (b) IN GENERAL.— Each local educational agency
2 that receives a grant under subpart B shall collect and
3 report to the State such data and other information as
4 the Secretary may require.

5 **PART 4—SCHOOL HEALTH EDUCATION; GRANTS**
6 **TO CERTAIN LOCAL EDUCATIONAL AGENCIES**

7 **Subpart A—Eligibility**

8 **SEC. 3651. SUBSTANTIAL NEED OF AREA SERVED BY**
9 **AGENCY.**

10 Any local educational agency is eligible for a grant
11 under this part for any fiscal year if—

12 (1) the agency enrolls at least 25,000 students;

13 and

14 (2) the geographic area served by the agency
15 has a substantial need for such a grant, relative to
16 other geographic areas in the United States.

17 **Subpart B—Planning Grants for Local Education**
18 **Agencies**

19 **SEC. 3661. APPLICATION FOR GRANT.**

20 (a) IN GENERAL.—Any local educational agency that
21 wishes to receive a planning grant under this subpart shall
22 submit an application to the Secretary of Health and
23 Human Services at such time and in such manner as the
24 Secretary may require.

1 (b) STATE EDUCATIONAL AGENCY REVIEW.—Each
2 such local educational agency, before submitting its appli-
3 cation to the Secretary, shall submit the application to the
4 State educational agency for comment by such agency and
5 by the State health agencies of the State.

6 (c) CONTENTS OF APPLICATIONS.—Each such appli-
7 cation shall contain the following:

8 (1) An assessment of the local educational
9 agency's need for comprehensive school health edu-
10 cation, using goals established by the Department of
11 Health and Human Services and the Department of
12 Education, as well as local health and education
13 strategies, such as State school improvement plans,
14 if any, under title III of the Goals 2000: Educate
15 America Act.

16 (2) Information demonstrating that the local
17 educational agency has established or selected a
18 community-level advisory council, which shall include
19 representatives of relevant community agencies such
20 as those that administer education, child nutrition,
21 health, and mental health programs.

22 (3) A description of how the local educational
23 agency will collaborate with the State educational
24 agency, the State health agency, and the local health
25 agency in the planning and development of a com-

1 prehensive school health education program in the
2 local educational agency, including coordination of
3 existing health education programs and resources.

4 (4) A plan to build capacity at the local edu-
5 cational agency to provide staff development and
6 technical assistance to local educational agency and
7 local health agency personnel involved with com-
8 prehensive school health education.

9 (5) A preliminary plan for evaluating com-
10 prehensive school health education activities.

11 (6) A timetable and proposed budget for the
12 planning process.

13 (7) Such other information and assurances as
14 the Secretary may require.

15 (d) NUMBER OF GRANTS.—Local educational agen-
16 cies may receive at a maximum two annual planning
17 grants.

18 **SEC. 3662. SELECTION OF GRANTEES.**

19 (a) SELECTION CRITERIA.—The Secretary shall es-
20 tablish criteria for the competitive selection of grantees
21 under this part.

22 (b) LIMITATION.—The Secretary shall not approve
23 an application from a local educational agency in a State
24 that has an approved plan under subpart A or B of part
25 3 of this subtitle unless the Secretary determines, after

1 consultation with the State that the local application is
2 consistent with the State plan, if one exists.

3 **SEC. 3663. AMOUNT OF GRANT.**

4 For any fiscal year, the minimum grant to any local
5 educational agency under this subpart is an amount deter-
6 mined by the Secretary to be necessary to enable the local
7 educational agency to conduct the planning process, and
8 the maximum such grant is \$500,000.

9 **SEC. 3664. AUTHORIZED ACTIVITIES.**

10 A local educational agency may use funds received
11 under this subpart only for the following:

12 (1) To establish and carry out the local edu-
13 cational agency planning process.

14 (2) To undertake joint training, staffing, ad-
15 ministration, and other coordination and collabora-
16 tion activities for local educational agencies, local
17 health agencies, and other agencies and organiza-
18 tions, as appropriate.

19 (3) To conduct activities to build capacity to
20 provide staff development and technical assistance
21 services to local educational agency and local health
22 agency personnel involved with comprehensive school
23 health education.

24 (4) To develop student learning objectives and
25 assessment instruments.

1 (5) To work with State and local health agen-
2 cies and State educational agencies to reduce bar-
3 riers to the implementation of comprehensive school
4 health education programs in schools, by, for exam-
5 ple, ensuring that adequate time is available dur-
6 ing the school day for such programs.

7 (6) To prepare the plan required to receive an
8 implementation grant under subpart C.

9 **Subpart C—Implementation Grants for Local**
10 **Educational Agencies**

11 **SEC. 3671. APPLICATION FOR GRANT.**

12 (a) IN GENERAL.—Any local educational agency that
13 wishes to receive an implementation grant under this sub-
14 part shall submit an application to the Secretary of Health
15 and Human Services, at such time, in such manner, and
16 containing such information and assurances as the Sec-
17 retary may require.

18 (b) STATE EDUCATIONAL AGENCY REVIEW.—Each
19 such local educational agency shall submit its application
20 to the State educational agency for comment before sub-
21 mitting it to the Secretary.

22 (c) LOCAL EDUCATIONAL AGENCY PLAN.—Each
23 such application shall include a local educational agency
24 plan for comprehensive school health education programs
25 (as defined in section 3602) that describes the following:

1 (1) The local educational agency's goals and ob-
2 jectives for those programs.

3 (2) How the local educational agency will co-
4 ordinate programs under this subpart with other
5 local, State and Federal health education programs.

6 (3) How comprehensive school health education
7 programs will be coordinated with other local, State
8 and Federal education programs, such as programs
9 under title I of the Elementary and Secondary Edu-
10 cation Act of 1965, and with State's school improve-
11 ment plan, if any, under title III of the Goals 2000:
12 Educate America Act.

13 (4) How the local educational agency has
14 worked with State educational agencies and with
15 State and local health agencies to reduce barriers to
16 implementing comprehensive school health education
17 programs.

18 (5) How local educational agencies will monitor
19 the implementation of such programs.

20 (6) How the local educational agency, in con-
21 sultation with the State educational agency and
22 State and local health agencies and in conjunction
23 with other local professional development activities,
24 will build capacity for professional development of
25 health educators.

1 (7) How the local educational agency, in con-
2 sultation with the State educational agency and
3 State and local health agencies, will provide staff de-
4 velopment and technical assistance.

5 (8) The respective roles of the State educational
6 agency, local educational agencies, the State health
7 agency, and the local health agencies in developing
8 and implementing such school health education pro-
9 grams.

10 (9) How such school health education programs
11 will be tailored to the extent practicable to be cul-
12 turally and linguistically sensitive and responsive to
13 the various needs of the students served, including
14 individuals with disabilities, and individuals from
15 disadvantaged backgrounds (including racial and
16 ethnic minorities).

17 (10) How the local educational agency, in con-
18 sultation with the local health agency, will evaluate
19 and report on the local educational agency's progress
20 toward attaining the goals and objectives described
21 in paragraph (1).

22 **SEC. 3672. SELECTION OF GRANTEES.**

23 (a) SELECTION OF GRANTEES.—The Secretary shall
24 establish criteria for the competitive selection of grantees
25 under this subpart.

1 (b) LIMITATION.—The Secretary shall not approve
2 an application from a local educational agency in a State
3 that has an approved plan under subpart A or B of part
4 3 unless the Secretary determines, after consultation with
5 the State that the local application is consistent with such
6 State plan.

7 (c) OPPORTUNITY FOR PLANNING GRANT.—If the
8 Secretary does not approve a local educational agency’s
9 application under this subpart and determines that the
10 local educational agency could benefit from a planning
11 grant under subpart B, the Secretary shall inform the
12 local educational agency of any planning grant funds that
13 may be available to it under subpart B, subject to section
14 3661(d).

15 **SEC. 3673. AMOUNT OF GRANT.**

16 (a) IN GENERAL.—For any fiscal year, the minimum
17 grant to any local educational agency under this subpart
18 is an amount determined by the Secretary to be necessary
19 to enable the local educational agency to conduct the im-
20 plementation process.

21 (b) CRITERIA.—In determining the amount of any
22 such grant, the Secretary may consider such factors as
23 the number of children enrolled in schools in the local edu-
24 cational agency, the number of school-aged children living

1 in poverty in the local educational agency, and the scope
2 and quality of the local educational agency's plan.

3 **SEC. 3674. AUTHORIZED ACTIVITIES.**

4 Each local educational agency that receives a grant
5 under this subpart shall use the grant funds as follows:

6 (1) To implement comprehensive school health
7 education programs, as defined in section 3602.

8 (2) To conduct local or regional coordination
9 and collaboration activities.

10 (3) To provide staff development and technical
11 assistance to schools, local health agencies, and
12 other community agencies involved in providing com-
13 prehensive school health education programs.

14 (4) To administer the program and monitor
15 program implementation at the local level.

16 (5) To evaluate and report to the Secretary on
17 the local educational agency's progress toward at-
18 taining the goals and objectives described in section
19 3671(c)(1).

20 (6) To conduct such other activities as the Sec-
21 retary may by regulation authorize.

22 **SEC. 3675. REPORTS.**

23 Each local educational agency that receives a grant
24 under this subpart shall collect and report to the Secretary

1 and the State such data and other information as the Sec-
2 retary may require.

3 **PART 5—SCHOOL-RELATED HEALTH SERVICES**

4 **Subpart A—Development and Operation of Projects**

5 **SEC. 3681. AUTHORIZATIONS OF APPROPRIATIONS.**

6 (a) FUNDING FOR SCHOOL-RELATED HEALTH SERV-
7 ICES.—For the purpose of carrying out this subpart, there
8 are authorized to be appropriated \$100,000,000 for fiscal
9 year 1996, \$275,000,000 for fiscal year 1997,
10 \$350,000,000 for fiscal year 1998, and \$400,000,000 for
11 each of the fiscal years 1999 and 2000.

12 (b) RELATION TO OTHER FUNDS.—The authoriza-
13 tions of appropriations established in subsection (a) are
14 in addition to any other authorizations of appropriations
15 that are available for the purpose described in such sub-
16 section.

17 **SEC. 3682. ELIGIBILITY FOR DEVELOPMENT AND OPER-**
18 **ATION GRANTS.**

19 (a) IN GENERAL.—Entities eligible to apply for and
20 receive grants under section 3484 or 3485 are the fol-
21 lowing:

22 (1) State health agencies that apply on behalf
23 of local community partnerships and other commu-
24 nities in need of adolescent health services within the
25 State.

1 (2) Local community partnerships in States in
2 which health agencies have not applied.

3 (b) LOCAL COMMUNITY PARTNERSHIPS.—

4 (1) IN GENERAL.—A local community partner-
5 ship under subsection (a)(2) is an entity that, at a
6 minimum, includes—

7 (A) a local health care provider with expe-
8 rience in delivering services to adolescents;

9 (B) one or more local public schools; and

10 (C) at least one community based organi-
11 zation located in the community to be served
12 that has a history of providing services to at-
13 risk youth in the community.

14 (2) PARTICIPATION.—A partnership described
15 in paragraph (1) shall, to the maximum extent fea-
16 sible, involve broad based community participation
17 from parents and youth to be served, health and so-
18 cial service providers (including regional alliance
19 health plans and corporate alliance health plans in
20 which families in the community are enrolled),
21 teachers and other public school and school board
22 personnel, the regional health alliance in which the
23 schools participating in the partnership are located,
24 youth development and service organizations, and in-
25 terested business leaders. Such participation may be

1 evidenced through an expanded partnership, or an
2 advisory board to such partnership.

3 **SEC. 3683. PREFERENCES.**

4 (a) IN GENERAL.—In making grants under sections
5 3484 and 3485, the Secretary shall give preference to ap-
6 plicants whose communities to be served show the most
7 substantial level of need for such services among individ-
8 uals who are between the ages of 10 and 19 (inclusive),
9 as measured by indicators of community health including
10 the following:

11 (1) High levels of poverty.

12 (2) The presence of a medically underserved
13 area or population (as defined under section 330(a)
14 of the Public Health Service Act).

15 (3) A health professional shortage area, as des-
16 ignated under section 332 of the Public Health Serv-
17 ice Act.

18 (4) High rates of indicators of health risk
19 among children and youth, including a high propor-
20 tion of children receiving services through the Indi-
21 viduals with Disabilities Education Act, adolescent
22 pregnancy, sexually transmitted disease (including
23 infection with the human immunodeficiency virus),
24 preventable disease, communicable disease, inten-
25 tional and unintentional injuries among children and

1 youth, community and gang violence, youth unem-
2 ployment, juvenile justice involvement, and high
3 rates of drug and alcohol exposure.

4 (b) LINKAGE TO QUALIFIED COMMUNITY HEALTH
5 GROUPS.—In making grants under sections 3484 and
6 3485, the Secretary shall give preference to applicants
7 that demonstrate a linkage to qualified community health
8 groups (as defined in section 3421(a)).

9 **SEC. 3684. GRANTS FOR DEVELOPMENT OF PROJECTS.**

10 (a) IN GENERAL.—The Secretary may make grants
11 to State health agencies or to local community partner-
12 ships to develop school health service sites.

13 (b) USE OF FUNDS.—A project for which a grant
14 may be made under subsection (a) may include but not
15 be limited to the cost of the following:

16 (1) Planning for the provision of school health
17 services.

18 (2) Recruitment, compensation, and training of
19 health and administrative staff.

20 (3) The development of agreements with re-
21 gional and corporate alliance health plans and the
22 acquisition and development of equipment and infor-
23 mation services necessary to support information ex-
24 change between school health service sites and

1 health plans, health providers, and other entities au-
2 thorized to collect information under this Act.

3 (4) In the case of communities described in
4 subsection (d)(2)(B), funds to aid in the establish-
5 ment of local community partnerships.

6 (5) Other activities necessary to assume oper-
7 ational status.

8 (c) APPLICATION FOR GRANT.—

9 (1) IN GENERAL.—Applicants shall submit ap-
10 plications in a form and manner prescribed by the
11 Secretary.

12 (2) APPLICATIONS BY STATE HEALTH AGEN-
13 CIES.—

14 (A) In the case of applicants that are State
15 health agencies, the application shall contain
16 assurances that the State health agency is ap-
17 plying for funds—

18 (i) on behalf of at least one local com-
19 munity partnership; and

20 (ii) on behalf of at least one other
21 community identified by the State as in
22 need of the services funded under this part
23 but without a local community partnership.

24 (B) In the case of communities identified
25 in applications submitted by State health agen-

1 cies that do not yet have local community part-
2 nerships, the State shall describe the steps that
3 will be taken to aid the community in devel-
4 oping a local community partnership.

5 (C) A State applying on behalf of local
6 community partnerships and other communities
7 may retain not more than 10 percent of grants
8 awarded under this subpart for administrative
9 costs.

10 (d) CONTENTS OF APPLICATION.—In order to receive
11 a grant under this section, an applicant must include in
12 the application the following information:

13 (1) An assessment of the need for school health
14 services in the communities to be served, using the
15 latest available health data and health goals and ob-
16 jectives established by the Secretary.

17 (2) A description of how the applicant will de-
18 sign the proposed school health services to reach the
19 maximum number of school-aged children and youth
20 at risk for poor health outcome.

21 (3) An explanation of how the applicant will in-
22 tegrate its services with those of other health and
23 social service programs within the community.

24 (4) An explanation of how the applicant will
25 link its activities to the regional and corporate alli-

1 ance health plans serving the communities in which
2 the applicant's program is to be located.

3 (5) A description of linkages with regional and
4 corporate health alliances in whose areas the appli-
5 cant's program is to be located.

6 (6) A description of a quality assurance pro-
7 gram which complies with standards that the Sec-
8 retary may prescribe.

9 (e) NUMBER OF GRANTS.—Not more than one plan-
10 ning grant may be made to a single applicant. A planning
11 grant may not exceed two years in duration.

12 **SEC. 3685. GRANTS FOR OPERATION OF PROJECTS.**

13 (a) IN GENERAL.—The Secretary may make grants
14 to State health agencies or to local community partner-
15 ships for the cost of operating school health service sites.

16 (b) USE OF GRANT.—The costs for which a grant
17 may be made under this section include but are not limited
18 to the following:

19 (1) The cost of furnishing health services that
20 are not covered under title I of this Act or by any
21 other public or private insurer.

22 (2) The cost of furnishing enabling services, as
23 defined in section 3461(g).

24 (3) Training, recruitment and compensation of
25 health professionals and other staff.

1 (4) Outreach services to at-risk youth and to
2 parents.

3 (5) Linkage of individuals to health plans, com-
4 munity health services and social services.

5 (6) Other activities deemed necessary by the
6 Secretary.

7 (c) APPLICATION FOR GRANT.—Applicants shall sub-
8 mit applications in a form and manner prescribed by the
9 Secretary. In order to receive a grant under this section,
10 an applicant must include in the application the following
11 information:

12 (1) A description of the services to be furnished
13 by the applicant.

14 (2) The amounts and sources of funding that
15 the applicant will expend, including estimates of the
16 amount of payments the applicant will received from
17 alliance health plans and from other sources.

18 (3) Such other information as the Secretary de-
19 termines to be appropriate.

20 (d) ADDITIONAL CONTENTS OF APPLICATION.—In
21 order to receive a grant under this section, an applicant
22 must meet the following conditions:

23 (1) The applicant furnishes the following serv-
24 ices:

1 (A) Diagnosis and treatment of simple ill-
2 nesses and minor injuries.

3 (B) Preventive health services, including
4 health screenings.

5 (C) Enabling services, as defined in section
6 3461(g).

7 (D) Referrals and followups in situations
8 involving illness or injury.

9 (E) Health and social services, counseling
10 services, and necessary referrals, including re-
11 ferrals regarding mental health and substance
12 abuse.

13 (F) Such other services as the Secretary
14 determines to be appropriate.

15 (2) The applicant maintains agreements with
16 all regional and corporate alliance health plans offer-
17 ing services in the applicant's service area.

18 (3) The applicant is a participating provider in
19 the State's program for medical assistance under
20 title XIX of the Social Security Act.

21 (4) The applicant does not impose charges on
22 students or their families for services (including col-
23 lection of any cost-sharing for services under the
24 comprehensive benefit package that otherwise would
25 be required).

1 (5) The applicant has reviewed and will periodi-
2 cally review the needs of the population served by
3 the applicant in order to ensure that its services are
4 accessible to the maximum number of school age
5 children and youth in the area, and that, to the
6 maximum extent possible, barriers to access to serv-
7 ices of the applicant are removed (including barriers
8 resulting from the area's physical characteristics, its
9 economic, social and cultural grouping, the health
10 care utilization patterns of children and youth, and
11 available transportation).

12 (6) In the case of an applicant which serves a
13 population that includes a substantial proportion of
14 individuals of limited English speaking ability, the
15 applicant has developed a plan to meet the needs of
16 such population to the extent practicable in the lan-
17 guage and cultural context most appropriate to such
18 individuals.

19 (7) The applicant will provide non-Federal con-
20 tributions toward the cost of the project in an
21 amount determined by the Secretary.

22 (8) The applicant will operate a quality assur-
23 ance program consistent with section 3684(e)(6).

24 (e) DURATION OF GRANT.—A grant under this sec-
25 tion shall be for a period determined by the Secretary.

1 (f) REPORTS.—A recipient of funding under this sec-
2 tion shall provide such reports and information as are re-
3 quired in regulations of the Secretary.

4 **SEC. 3686. FEDERAL ADMINISTRATIVE COSTS.**

5 Of the amounts made available under section 3681,
6 the Secretary may reserve not more than 5 percent for
7 administrative expenses regarding this subpart.

8 **Subpart B—Capital Costs of Developing Projects**

9 **SEC. 3691. LOANS AND LOAN GUARANTEES REGARDING**
10 **PROJECTS.**

11 (a) IN GENERAL.—The Secretary may make loans to,
12 and guarantee the payment of principal and interest to
13 Federal and non-Federal lenders on behalf of, State health
14 agencies and local community partnerships for the capital
15 costs of developing projects in accordance with subpart A.

16 (b) APPLICABILITY OF CERTAIN PROVISIONS.—The
17 provisions of subpart A apply to loans and loan guarantees
18 under subsection (a) to the same extent and in the same
19 manner as such provisions apply to grants under subpart
20 A. Except for any provision inconsistent with the purpose
21 described in subsection (a), the provisions of subpart C
22 of part 2 of subtitle E apply to loans and loan guarantees
23 under subsection (a) to the same extent and in the same
24 manner as such provisions apply to loans and loan guaran-
25 tees under section 3441.

1 **SEC. 3692. FUNDING.**

2 Amounts available to the Secretary under section
3 3412 for the purpose of carrying out subparts B and C
4 of part 2 of subtitle E are, in addition to such purpose,
5 available to the Secretary for the purpose of carrying out
6 this subpart.

7 **Subtitle H—Public Health Service**
8 **Initiative**

9 **SEC. 3701. PUBLIC HEALTH SERVICE INITIATIVE.**

10 (a) IN GENERAL.—There is established pursuant to
11 this title a Public Health Service Initiative consisting of
12 the total amounts authorized and described in subsection
13 (b). The Initiative includes the programs of subtitles C
14 through G of this title and the programs of subtitle D
15 of title VIII.

16 (b) TOTAL OF THE AMOUNTS AUTHORIZED TO BE
17 APPROPRIATED.—The following is the total of the
18 amounts authorized to be appropriated for the Initiative
19 under the previous subtitles of this title:

20 (1) For fiscal year 1995, \$1,125,000,000.

21 (2) For fiscal year 1996, \$2,984,000,000.

22 (3) For fiscal year 1997, \$3,830,000,000.

23 (4) For fiscal year 1998, \$4,205,000,000.

24 (5) For fiscal year 1999, \$4,055,000,000.

25 (6) For fiscal year 2000, \$3,666,000,000.

26 (c) USE OF AMOUNTS; AVAILABILITY.—

1 (1) USE; ANNUAL APPROPRIATIONS.—Amounts
2 appropriated to carry out the Initiative, including
3 subtitles A through F of this title, are available to
4 carry out the specific programs for which the
5 amounts are appropriated.

6 (2) AVAILABILITY OF APPROPRIATED
7 AMOUNTS.—Amounts appropriated for programs in
8 the Initiative are available until expended.

9 **Subtitle I—Coordination With**
10 **COBRA Continuation Coverage**

11 **SEC. 3801. PUBLIC HEALTH SERVICE ACT; COORDINATION**
12 **WITH COBRA CONTINUATION COVERAGE.**

13 (a) PERIOD OF COVERAGE.—Subparagraph (D) of
14 section 2202(2) of the Public Health Service Act (42
15 U.S.C. 300bb–2(2)) is amended—

16 (1) by striking “or” at the end of clause (i), by
17 striking the period at the end of clause (ii) and in-
18 serting “, or”, and by adding at the end the fol-
19 lowing new clause:

20 “(iii) eligible for comprehensive health
21 coverage described in section 1101 of the
22 Health Security Act.”, and

23 (2) by striking “OR MEDICARE ENTITLEMENT”
24 in the heading and inserting “, MEDICARE ENTITLE-
25 MENT, OR HEALTH SECURITY ACT ELIGIBILITY”.

1 (b) QUALIFIED BENEFICIARY.—Section 2208(3) of
2 such Act (42 U.S.C. 300bb–8(3)) is amended by adding
3 at the end the following new subparagraph:

4 “(C) SPECIAL RULE FOR INDIVIDUALS
5 COVERED BY HEALTH SECURITY ACT.—The
6 term ‘qualified beneficiary’ shall not include any
7 individual who, upon termination of coverage
8 under a group health plan, is eligible for com-
9 prehensive health coverage described in section
10 1101 of the Health Security Act.”.

11 (c) REPEAL UPON IMPLEMENTATION OF HEALTH
12 SECURITY ACT.—

13 (1) IN GENERAL.—Title XXII of such Act (42
14 U.S.C. 300bb–1 et seq.) is hereby repealed.

15 (2) CONFORMING AMENDMENT.—The table of
16 contents of such Act is amended by striking the item
17 relating to title XXII.

18 (3) EFFECTIVE DATE.—The amendments made
19 by this subsection shall take effect on the earlier
20 of—

21 (A) January 1, 1998, or

22 (B) the first day of the first calendar year
23 following the calendar year in which all States
24 have in effect plans under which individuals are

1 eligible for comprehensive health coverage de-
2 scribed in section 1101 of this Act.

TITLE IV—MEDICARE AND MEDICAID

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1 **TITLE IV—MEDICARE AND**
2 **MEDICAID**

3 **SEC. 4000. REFERENCES IN TITLE.**

4 (a) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-
5 cept as otherwise specifically provided, whenever in this
6 title an amendment is expressed in terms of an amend-
7 ment to or repeal of a section or other provision, the ref-
8 erence shall be considered to be made to that section or
9 other provision of the Social Security Act.

10 (b) REFERENCES TO OBRA.—In this title, the terms
11 “OBRA–1986”, “OBRA–1987”, “OBRA–1989”,
12 “OBRA–1990”, and “OBRA–1993” refer to the Omnibus
13 Budget Reconciliation Act of 1986 (Public Law 99–509),
14 the Omnibus Budget Reconciliation Act of 1987 (Public
15 Law 100–203), the Omnibus Budget Reconciliation Act
16 of 1989 (Public Law 101–239), the Omnibus Budget Rec-
17 onciliation Act of 1990 (Public Law 101–508), and the
18 Omnibus Budget Reconciliation Act of 1993 (Public Law
19 103–66), respectively.

**Subtitle A—Medicare and the
Alliance System**

PART 1—ENROLLMENT OF MEDICARE

BENEFICIARIES IN REGIONAL ALLIANCE PLANS

SEC. 4001. OPTIONAL STATE INTEGRATION OF MEDICARE

**BENEFICIARIES INTO REGIONAL ALLIANCE
PLANS.**

Title XVIII is amended by adding at the end the following:

**“INTEGRATION OF MEDICARE INTO STATE HEALTH
SECURITY PROGRAMS**

“SEC. 1893. (a) PAYMENT TO STATES.—The Secretary shall pay a participating State that has submitted an application, as specified by subsection (b) which the Secretary has approved under subsection (c), the amount specified by subsection (d) for the period specified by subsection (e) for covered medicare beneficiaries. This section shall apply without regard to whether or not a State is a single-payer State.

“(b) APPLICATION BY STATE.—An application submitted by a participating State shall contain the following assurances:

**“(1) COVERAGE OF ALL MEDICARE-ELIGIBLE
INDIVIDUALS.—**The State’s application shall assure that the provisions of the succeeding paragraphs of

1 this subsection shall apply to all medicare-eligible in-
2 dividuals who are residents of the State.”.

3 “(2) ENROLLMENT IN AND SELECTION OF
4 HEALTH PLANS.—

5 “(A) ENROLLMENT.—Each medicare-elig-
6 ble individual (within a class of medicare bene-
7 ficiaries covered under the application) who is a
8 resident of the State will be enrolled in a re-
9 gional alliance health plan serving the area in
10 which the individual resides (or, in the case of
11 an individual who is a resident of a single-payer
12 State, in the Statewide single-payer system op-
13 erated under part 2 of subtitle C of title I of
14 the Health Security Act).

15 “(B) SELECTION.—Each such individual
16 will have the same choice among applicable
17 health plans as other individuals in the State
18 who are eligible individuals under the Health
19 Security Act.

20 “(C) OFFER OF FEE-FOR-SERVICE PLAN.—
21 Each such individual shall be offered enrollment
22 in at least one health plan that is a fee-for-serv-
23 ice plan (or, in the case of an individual who is
24 a resident of a single-payer State, the Statewide
25 single-payer system under part 2 of subtitle C

1 of title I of the Health Security Act) that meets
2 the following requirements:

3 “(i) The plan’s premium rate, and the
4 actuarial value of the plan’s deductibles,
5 coinsurance, and copayments, charged to
6 the individual do not exceed the actuarial
7 value of the coinsurance and deductibles
8 that would be applicable on the average if
9 this section did not apply to those individ-
10 uals.

11 “(ii) The plan’s payment rates for
12 covered items and services are accepted as
13 payment in full for such items and serv-
14 ices.

15 “(3) COVERAGE OF FULL MEDICARE BENE-
16 FITS.—For each health plan providing coverage
17 under this section—

18 “(A) the plan shall cover at least the items
19 and services for which payment would otherwise
20 be made under this title (including payments
21 under section 1862(b)(4)), and

22 “(B) coverage determinations under the
23 plan are made under rules that are no more re-
24 strictive than otherwise applicable under this
25 title.

1 “(4) PREMIUM.—During the period for which
2 payments are made to a State under this section,
3 the requirements of the Health Security Act relating
4 to premiums that are otherwise applicable with re-
5 spect to individuals enrolled in health plans in a
6 State shall not apply with respect to medicare-eli-
7 gible individuals in the State who are covered under
8 the State’s application under this section. Nothing in
9 the previous sentence shall operate to permit a State
10 or health plans in a State to charge different pre-
11 miums among medicare-eligible individuals within
12 the same premium class under the Health Security
13 Act.

14 “(5) QUALITY ASSURANCE.—For each health
15 plan providing coverage under this section there are
16 quality assurance mechanisms for covered medicare
17 individuals that equal, or exceed, such mechanisms
18 otherwise applicable under this title.

19 “(6) REVIEW RIGHTS.—Covered medicare indi-
20 viduals have review, reconsideration, and appeal
21 rights (including appeals to courts of the State) that
22 equal or exceed such rights otherwise applicable
23 under this title.

24 “(7) DATA REPORTING AND ACCESS TO DOCU-
25 MENTS.—The State will—

1 “(A) provide such utilization and statistical
2 data as the Secretary determines are needed for
3 purposes of the programs established under this
4 title, and

5 “(B) the State will ensure access by the
6 Secretary or the Comptroller General to rel-
7 evant documents.

8 “(8) USE OF PAYMENTS.—Payments made to
9 the State under subsection (a) will be used only to
10 carry out the purposes of this section.

11 “(c) APPROVAL BY SECRETARY.—The Secretary shall
12 approve an application under subsection (b) if the Sec-
13 retary finds—

14 “(1) that the individuals covered under the
15 State’s application shall receive at least the benefits
16 provided under this title (including cost sharing);

17 “(2) that the amount of expenditures that will
18 be made under this title will not exceed the amount
19 of expenditures that will be made if the State’s ap-
20 plication is not accepted; and

21 “(3) that the State is able and willing to carry
22 out the assurances provided in its application.

23 “(d) AMOUNT AND SOURCE OF PAYMENT.—

24 “(1) AMOUNT OF PAYMENT.—For purposes of
25 subsection (a), the amount of payments to a State—

1 “(A) for the first year for which payments
2 are made to the State under this section shall
3 be determined by the applicable rate specified
4 in section 1876(a)(1)(C) (but at 100 percent,
5 rather than 95 percent, of the applicable
6 amount) for each medicare-eligible individual
7 who is a resident of the State (but without re-
8 gard to any reduction based on payments to be
9 made under section 1876(a)(1)(G)), and

10 “(B) for each succeeding year, shall be de-
11 termined by the applicable rate determined
12 under subparagraph (A) or this subparagraph
13 for the preceding year for each such individual,
14 adjusted by the regional alliance inflation factor
15 applicable to regional alliances in the State (as
16 determined in accordance with section 6001(a)
17 of the Health Security Act) for the year.

18 “(2) SOURCE OF PAYMENT.—Payment shall be
19 made from the Federal Hospital Insurance Trust
20 Fund and the Federal Supplementary Medical In-
21 surance Trust Fund as provided under paragraph
22 (5) of section 1876(a) (other than as provided under
23 subparagraph (B) of that paragraph).

1 “(e) PERIOD FOR WHICH PAYMENT MADE.—The pe-
2 riod for which payment may be made under subsection (a)
3 to a State—

4 “(1) begins with January 1 of the first calendar
5 year for which the Secretary approves under sub-
6 section (c) the application of the State; and

7 “(2) ends—

8 “(A) on December 31 of the year in which
9 the State notifies the Secretary (before April of
10 that year) that the State no longer intends to
11 receive payments under this section, or

12 “(B) if the Secretary finds that the State
13 is no longer in substantial compliance with the
14 requirements under paragraphs (2) or (3) of
15 subsection (c), at the time specified by the Sec-
16 retary.

17 No termination is effective under paragraph (2) unless no-
18 tice has been provided to medicare covered individuals,
19 health providers, and health plans affected by the termi-
20 nation.

21 “(f) PAYMENTS UNDER THIS SECTION AS SOLE
22 MEDICARE BENEFITS.—Payments to a State under sub-
23 section (a) shall be instead of the amounts that would oth-
24 erwise be payable, pursuant to sections 1814(b) and

1 1833(a), for services furnished to medicare-eligible resi-
2 dents of the State covered under the application.

3 “(g) EVALUATION.—The Secretary shall evaluate on
4 an ongoing basis the compliance of a State with the re-
5 quirements of this section.

6 “(h) DEFINITIONS.—In this section the terms ‘appli-
7 cable health plan’, ‘fee-for-service plan’, ‘health plan’,
8 ‘medicare-eligible individual’, ‘participating State’, ‘single-
9 payer State’, and ‘Statewide single-payer system’ have the
10 meanings of those terms in the Health Security Act.”.

11 **SEC. 4002. INDIVIDUAL ELECTION TO REMAIN IN CERTAIN**
12 **HEALTH PLANS.**

13 (a) IN GENERAL.—Section 1876 (42 U.S.C.
14 1395mm) is amended by adding at the end the following
15 new subsection:

16 “(k)(1) Notwithstanding any other provision of this
17 section, each eligible organization with a risk-sharing con-
18 tract (or which is eligible to enter into such a contract,
19 as determined by the Secretary) that is the sponsor of a
20 health plan under subtitle E of title I of the Health Secu-
21 rity Act shall provide each individual who meets the re-
22 quirements of paragraph (2) with the opportunity to elect
23 (by submitting an application at such time and in such
24 manner as specified by the Secretary) to continue enroll-
25 ment in such plan (for the same benefits as alliance-eli-

1 ble individuals) and to have payments made by the Sec-
2 retary to the plan on the individual's behalf in accordance
3 with paragraph (3). The premium imposed with respect
4 to such an individual by the plan shall be in an amount
5 (determined in accordance with rules of the Secretary and
6 notwithstanding other provisions of such Act) which re-
7 flects the difference between the premium otherwise estab-
8 lished (adjusted by a factor to reflect the actuarial dif-
9 ference between medicare beneficiaries and other plan en-
10 rollees) and the amount payable under paragraph (3).

11 “(2) An individual meets the requirements of this
12 paragraph if the individual is—

13 “(A) enrolled in the health plan of an eligible
14 organization in a month in which the individual is
15 either not entitled to benefits under part A, or is an
16 eligible employee (as defined in the Health Security
17 Act) or the spouse or dependent of an eligible em-
18 ployee,

19 “(B) entitled to benefits under part A and en-
20 rolled under part B in the succeeding month,

21 “(C) an eligible individual under the Health Se-
22 curity Act in that succeeding month, and

23 “(D) not an eligible employee (as defined in the
24 Health Security Act) or the spouse or dependent of
25 an eligible employee in that succeeding month.

1 “(3) The Secretary shall make a payment to an eligi-
2 ble organization on behalf of each individual enrolled with
3 the organization for whom an election is in effect under
4 this subsection in an amount determined by the rate speci-
5 fied by subsection (a)(1)(C) (notwithstanding the second
6 sentence of paragraph (1)). Such payment shall be made
7 from the Federal Hospital Insurance Trust Fund and the
8 Federal Supplementary Medical Insurance Trust Fund as
9 provided under subsection (a)(5) (other than as provided
10 under subparagraph (B) of that paragraph).

11 “(4) The period for which payment may be made
12 under paragraph (3)—

13 “(A) begins with the first month for which the
14 individual meets the requirements of paragraph (2)
15 (or a later month, in the case of a late application,
16 as may be specified by the Secretary); and

17 “(B) ends with the earliest of—

18 “(i) the month following the month—

19 “(I) in which the individual notifies
20 the Secretary that the individual no longer
21 wishes to be enrolled in the health plan of
22 the eligible organization and to have pay-
23 ment made on the individual’s behalf under
24 this subsection; and

1 “(II) which is a month specified by
2 the Secretary as a uniform open enroll-
3 ment period under subsection (c)(3)(A)(i),
4 or

5 “(ii) the month in which the individual
6 ceases to meet the requirements of paragraph
7 (2).

8 “(5) Notwithstanding any other provision of this title,
9 payments to an eligible organization under this subsection
10 on behalf of an individual shall be the sole payments made
11 with respect to items and services furnished to the indi-
12 vidual during the period for which the individual’s election
13 under this subsection is in effect.”.

14 (b) CONFORMING AMENDMENT.—Section 1838(b)
15 (42 U.S.C. 1395q(b)) is amended by inserting after “sec-
16 tion 1843(e)” the following: “, 1876(c)(3)(B),
17 1876(k)(4)(B), or 1890(j)(1)(B)(iv)”.

18 **SEC. 4003. PAYMENTS TO REGIONAL ALLIANCES ON BE-**
19 **HALF OF CERTAIN MEDICARE-ELIGIBLE INDI-**
20 **VIDUALS.**

21 Title XVIII, as amended by section 4001, is further
22 amended by adding at the end the following new section:

1 “PAYMENTS TO REGIONAL ALLIANCES ON BEHALF OF
2 CERTAIN MEDICARE-ELIGIBLE INDIVIDUALS UNDER
3 HEALTH SECURITY ACT

4 “SEC. 1894. The Secretary shall provide for a trans-
5 fer from the Federal Hospital Insurance Trust Fund and
6 the Federal Supplementary Medical Insurance Trust
7 Fund, in appropriate proportions, to each regional alliance
8 in each year of the amount of the reductions in liability
9 owed to the alliance in the year resulting from the applica-
10 tion of section 6115 of the Health Security Act. In the
11 case of an individual to whom such section applies, unless
12 all the members of the family would be medicare-eligible
13 individuals (but for section 1012(a) of such Act), the re-
14 ductions in liability under section 6115 of such Act shall
15 be based upon the alliance credit amount for an individual
16 class of enrollment (as defined in section 1011(c)(1)(A)
17 of such Act).”.

18 **SEC. 4004. PROHIBITING EMPLOYERS FROM TAKING INTO**
19 **ACCOUNT STATUS AS MEDICARE BENE-**
20 **FICIARY ON ANY GROUNDS.**

21 (a) EXTENSION OF PROTECTIONS FOR WORKING
22 AGED TO GROUP HEALTH PLANS OF ALL EMPLOYERS.—
23 Section 1862(b)(1)(A) (42 U.S.C. 1395y(b)(1)(A)) is
24 amended by striking clauses (ii) and (iii).

1 (b) EXTENSION OF PROTECTIONS FOR DISABLED IN-
2 DIVIDUALS TO ALL GROUP HEALTH PLANS.—

3 (1) IN GENERAL.—Section 1862(b)(1)(B) (42
4 U.S.C. 1395y(b)(1)(B)), as amended by section
5 13561(e) of OBRA–1993, is amended—

6 (A) in clause (i), by striking “large group
7 health plans (as defined in clause (iv))” and in-
8 serting “group health plan (as defined in sub-
9 paragraph (A)(v), taking into account the ex-
10 ceptions described in clauses (ii) and (iii) of
11 subparagraph (A))”; and

12 (B) by striking clause (iv).

13 (2) CONFORMING AMENDMENT.—Section
14 1862(b)(1)(A)(v) (42 U.S.C. 1395y(b)(1)(A)(v)) is
15 amended by striking “this subparagraph, and sub-
16 paragraph (C)” and inserting “this paragraph”.

17 (c) REPEAL OF LIMITATION ON PERIOD OF PROTEC-
18 TION FOR INDIVIDUALS WITH END STAGE RENAL DIS-
19 EASE.—

20 (1) IN GENERAL.—Section 1862(b)(1)(C) (42
21 U.S.C. 1395y(b)(1)(C)), as amended by section
22 13561(c) of OBRA–1993, is amended—

23 (A) in clause (i), by striking “an individual
24 is entitled” and all that follows through “such
25 benefits” and inserting “an individual (or a

1 member of the individual's family) who is cov-
2 ered under the plan by virtue of the individual's
3 current employment status with an employer is
4 entitled to benefits under this title under sec-
5 tion 226A”;

6 (B) in clause (ii), by striking the semicolon
7 at the end and inserting a period; and

8 (C) by striking the matter following clause
9 (ii).

10 (2) CONFORMING AMENDMENT.—Section
11 1862(b)(1) is amended—

12 (A) in subparagraph (A), by striking
13 clause (iv); and

14 (B) in subparagraph (B), by striking
15 clause (ii).

16 (d) NO PRIMARY PAYMENT FOR SERVICES UNDER
17 A HEALTH PLAN.—Section 1862(b)(2)(A) (42 U.S.C.
18 1395y(b)(2)(A)(i)) is amended—

19 (1) by striking “or” at the end of clause (i);

20 (2) by striking the period at the end of clause
21 (ii) and inserting “, or”;

22 (3) by inserting after clause (ii) the following
23 new clause:

24 “(iii) payment has been made, or can
25 reasonably be expected to be made, with

1 respect to the item or service under any
2 health plan under the Health Security
3 Act.”; and

4 (4) in the second sentence—

5 (A) by striking “and” after “applies”, and

6 (B) by inserting before the period at the
7 end the following: “, and a health plan under
8 the Health Security Act to the extent that
9 clause (iii) applies”.

10 (e) SIMPLIFICATION OF COORDINATION OF BENE-
11 FITS.—Section 1862(b)(4) (42 U.S.C. 1395y(b)(4)) is
12 amended by adding after and below subparagraph (B) the
13 following:

14 “Notwithstanding the previous sentence, where pay-
15 ment is made for an item or service by a primary
16 plan that is a health plan (within the meaning of
17 section 1400 of the Health Security Act) and for
18 which payment would be made under this title but
19 for this subsection, payment may be made under
20 this title (without regard to deductibles and coinsur-
21 ance) in the amount of the cost sharing imposed
22 under such primary plan (consistent with such
23 Act).”.

24 (f) EFFECTIVE DATE.—The amendments made by
25 this section shall apply with respect to medicare-eligible

1 individuals residing in a participating State as of January
2 1 of the first year for which the State is a participating
3 State.

4 **PART 2—ENCOURAGING MAN-**
5 **AGED CARE UNDER MEDI-**
6 **CARE PROGRAM; COORDINA-**
7 **TION WITH MEDIGAP PLANS**

8 **SEC. 4011. ENROLLMENT AND TERMINATION OF ENROLL-**
9 **MENT.**

10 (a) UNIFORM OPEN ENROLLMENT PERIODS.—

11 (1) FOR CAPITATED PLANS.—The first sentence
12 of section 1876(c)(3)(A)(i) (42 U.S.C.
13 1395mm(c)(3)(A)(i)) is amended by inserting
14 “(which may be specified by the Secretary)” after
15 “open enrollment period”.

16 (2) FOR MEDIGAP PLANS.—Section 1882(s) (42
17 U.S.C. 1395ss(s)) is amended—

18 (A) in paragraph (3), by striking “para-
19 graphs (1) and (2)” and inserting “paragraph
20 (1), (2), or (3)”,

21 (B) by redesignating paragraph (3) as
22 paragraph (4), and

23 (C) by inserting after paragraph (2) the
24 following new paragraph:

1 “(3) Each issuer of a medicare supplemental policy
2 shall have an open enrollment period (which shall be the
3 period specified by the Secretary under section
4 1876(c)(3)(A)(i)), of at least 30 days duration every year,
5 during which the issuer may not deny or condition the
6 issuance or effectiveness of a medicare supplemental pol-
7 icy, or discriminate in the pricing of the policy, because
8 of age, health status, claims experience, receipt of health
9 care, or medical condition. The policy may not provide any
10 time period applicable to pre-existing conditions, waiting
11 periods, elimination periods, and probationary periods (ex-
12 cept as provided by paragraph (2)(B)). The Secretary may
13 require enrollment through a third party designated under
14 section 1876(c)(3)(B).”.

15 (b) ENROLLMENTS FOR NEW MEDICARE BENE-
16 FICIARIES AND THOSE WHO MOVE.—Section
17 1876(c)(3)(A) (42 U.S.C. 1395mm(c)(3)(A)) is
18 amended—

19 (1) in clause (i), by striking “clause (ii)” and
20 inserting “clauses (ii) through (iv)”, and

21 (2) by adding at the end the following:

22 “(iii) Each eligible organization shall have an open
23 enrollment period for each individual eligible to enroll
24 under subsection (d) during any enrollment period speci-
25 fied by section 1837 that applies to that individual. Enroll-

1 ment under this clause shall be effective as specified by
2 section 1838.

3 “(iv) Each eligible organization shall have an open
4 enrollment period for each individual eligible to enroll
5 under subsection (d) who has previously resided outside
6 the geographic area which the organization serves. The en-
7 rollment period shall begin with the beginning of the
8 month that precedes the month in which the individual
9 becomes a resident of that geographic area and shall end
10 at the end of the following month. Enrollment under this
11 clause shall be effective as of the first of the month fol-
12 lowing the month in which the individual enrolls.”.

13 (c) ENROLLMENT THROUGH THIRD PARTY; UNI-
14 FORM TERMINATION OF ENROLLMENT.—The first sen-
15 tence of section 1876(c)(3)(B) (42 U.S.C.
16 1395mm(c)(3)(B)) is amended—

17 (1) by inserting “(including enrollment through
18 a third party)” after “regulations”, and

19 (2) by striking everything after “with the eligi-
20 ble organization” and inserting “during an annual
21 period as prescribed by the Secretary, and as speci-
22 fied by the Secretary in the case of financial insol-
23 vency of the organization, if the individual moves
24 from the geographic area served by the organization,

1 or in other special circumstances that the Secretary
2 may prescribe.”.

3 (d) EFFECTIVE DATE.—The amendments made by
4 the previous subsections apply to enrollments and termi-
5 nations of enrollments occurring after 1995 (but only after
6 the Secretary of Health and Human Services has pre-
7 scribed the relevant annual period), except that the
8 amendments made by subsection (a)(2) apply to enroll-
9 ments for a medicare supplemental policy made after
10 1995.

11 **SEC. 4012. UNIFORM INFORMATIONAL MATERIALS.**

12 (a) FOR CAPITATED PLANS.—Section 1876(c)(3)(C)
13 (42 U.S.C. 1395mm(c)(3)(C)) is amended by adding at
14 the end the following: “In addition, the Secretary shall de-
15 velop and distribute comparative materials about all eligi-
16 ble organizations. Each eligible organization shall reim-
17 burse the Secretary for its pro rata share (as determined
18 by the Secretary) of the costs incurred by the Secretary
19 in carrying out the requirements of the preceding sentence
20 and other enrollment activities.”.

21 (b) FOR MEDIGAP PLANS.—Paragraph (1) of section
22 1882(f) (42 U.S.C. 1395ss(f)) is amended to read as fol-
23 lows:

24 “(f)(1) The Secretary shall develop and distribute
25 comparative materials about all medicare supplemental

1 policies issued in a State. Each issuer of such a policy
2 shall reimburse the Secretary for its pro rata share (as
3 determined by the Secretary for purposes of section
4 1876(c)(3)(C)) of the costs incurred by the Secretary in
5 carrying out the requirements of the preceding sentence
6 and other enrollment activities, or the issuer shall no
7 longer be considered as meeting the requirements of this
8 section.”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply with respect to materials for enroll-
11 ment in years after 1995.

12 **SEC. 4013. OUTLIER PAYMENTS.**

13 (a) GENERAL RULE.—Section 1876(a)(1) (42 U.S.C.
14 1395mm(a)(1)) is amended by adding at the end the fol-
15 lowing:

16 “(G)(i) In the case of an eligible organization with
17 a risk-sharing contract, the Secretary may make addi-
18 tional payments to the organization equal to not more
19 than 50 percent of the imputed reasonable cost (or, if so
20 requested by the organization, the reasonable cost) above
21 the threshold amount of services covered under parts A
22 and B and provided (or paid for) in a year by the organi-
23 zation to any individual enrolled with the organization
24 under this section.

1 “(ii) For purposes of clause (i), the ‘imputed reason-
2 able cost’ is an amount determined by the Secretary on
3 a national, regional, or other basis that is related to the
4 reasonable cost of services.

5 “(iii) For purposes of clause (i), the ‘threshold
6 amount’ is an amount determined by the Secretary from
7 time to time, adjusted by the geographic factor utilized
8 in determining payments to the organization under sub-
9 paragraph (C) and rounded to the nearest multiple of
10 \$100, such that the total amount to be paid under this
11 subparagraph for a year is estimated to be 5 percent or
12 less of the total amount to be paid under risk-sharing con-
13 tracts for services furnished for that year.

14 “(iv) An eligible organization shall submit a claim for
15 additional payments under subsection (i) within such time
16 as the Secretary may specify.

17 “(v) To the extent that total payments under clause
18 (i) in a year—

19 “(I) exceed the payment set aside as a result of
20 the reduction under subparagraph (C) for the year,
21 the Secretary shall increase the percentage reduction
22 under such subparagraph for the following year by
23 such percentage as will result in an increase in the
24 reduction equal to such excess in previous payments,
25 or

1 “(II) are less than the payment set aside as a
2 result of the reduction under subparagraph (C) for
3 the year, the amount of such difference shall remain
4 available in the succeeding years for additional pay-
5 ments under this subparagraph and the Secretary
6 may take such difference into account in establishing
7 the percentage reduction under subparagraph (C)
8 for the following year.”.

9 (b) CONFORMING AMENDMENT.—Section
10 1876(a)(1)(C)(i) (42 U.S.C. 1395mm(a)(1)(C)(i)), as
11 amended by section 4132(a), is further amended by insert-
12 ing “, and reduced by a uniform percentage (determined
13 by the Secretary for a year, subject to adjustment under
14 subparagraph (G)(v)) so that the total reduction is esti-
15 mated to equal the amount to be paid under subparagraph
16 (G)” before the period.

17 (c) EFFECTIVE DATE.—The amendments made by
18 the preceding subsections apply to services furnished after
19 1994.

20 **SEC. 4014. POINT OF SERVICE OPTION.**

21 (a) POINT OF SERVICE CONTRACTS.—Part C of title
22 XVIII is amended by inserting after section 1889 the fol-
23 lowing:

24 “POINT OF SERVICE OPTION

25 “SEC. 1890. (a) ESTABLISHMENT OF PROGRAM.—
26 Not later than July 1, 1995, the Secretary shall promul-

1 gate regulations establishing a point-of-service program
2 under which individuals entitled to benefits under this title
3 (other than individuals enrolled with an eligible organiza-
4 tion with a risk-sharing contract under section 1876(g))
5 may obtain such benefits through providers and suppliers
6 who are members of a point-of-service network established
7 by the Secretary in accordance with the criteria described
8 in subsection (b).

9 “(b) CRITERIA FOR NETWORKS.—In establishing cri-
10 teria for point-of-service networks under the program
11 under this section, the Secretary shall—

12 “(1) designate an appropriate geographic serv-
13 ice area for each such network to ensure that each
14 network has a sufficient number of participating
15 members to provide items and services under this
16 title to beneficiaries, except that no such service area
17 may be served by more than one such network;

18 “(2) establish requirements for participating
19 members;

20 “(3) establish a schedule of payments for serv-
21 ices furnished by networks, including a schedule of
22 bundled payment arrangements for selected medical
23 and surgical procedures;

24 “(4) delineate permissible incentives to encour-
25 age physicians and other suppliers to join the net-

1 work, and to encourage individuals to receive serv-
2 ices under this title through the network;

3 “(5) specify the rules under which carriers
4 under section 1842 may administer the program;

5 “(6) establish procedures to used for the provi-
6 sion of case management services and criteria for
7 determining whether (and under which cir-
8 cumstances) services which would otherwise not be
9 covered under this title would be covered by the net-
10 work under such case management;

11 “(7) establish standards for the processing and
12 payment of claims for payment for services fur-
13 nished by the network, including standards for the
14 apportionment of payments among the Trust Funds
15 established under this title;

16 “(8) establish standards for the selection of
17 physicians for the network based on practice pat-
18 terns and a demonstration of effective quality assur-
19 ance;

20 “(9) develop standards to ensure that the point-
21 of-service option does not result in a net financial
22 loss to the medicare program under this title after
23 the implementation of the option in an area, taking
24 into account administrative costs, the costs of serv-
25 ices (which would otherwise not be covered under

1 this title) provided to beneficiaries under case man-
2 agement, and the costs of incentives for physicians,
3 other providers, and beneficiaries; and

4 “(10) apply such other criteria as the Secretary
5 considers appropriate.

6 “(c) BONUS PAYMENTS PERMITTED.—

7 “(1) IN GENERAL.—Notwithstanding any other
8 provision of this title, the Secretary may increase the
9 amount of payment otherwise provided under this
10 title for items and services furnished by individuals
11 who are members of a point-of-service network
12 under this section by a bonus payment (in such
13 amount as the Secretary may determine).

14 “(2) CRITERIA FOR RECEIVING PAYMENT.—The
15 Secretary may make a bonus payment under this
16 subsection to members of a point-of-service network
17 if the Secretary determines that the members of the
18 network have reduced the costs to the medicare pro-
19 gram of the items and services furnished by the net-
20 work without adversely affecting the quality of care
21 provided to beneficiaries.”.

22 (b) CONFORMING AMENDMENTS.—

23 (1) Section 1812(a) (42 U.S.C. 1395d(a)) is
24 amended—

1 (A) by striking “and” at the end of para-
2 graph (3),

3 (B) by substituting “; and” for the period
4 at the end of paragraph (4), and

5 (C) by adding at the end the following:

6 “(5) such additional items and services fur-
7 nished by a provider of services to an individual sub-
8 ject to case management as may be specified under
9 a point-of-service network arrangement under sec-
10 tion 1890.”.

11 (2)(A) Section 1814(b) (42 U.S.C. 1395f(b)) is
12 amended—

13 (i) in paragraph (1), by inserting “or (4)”
14 after “paragraph (3)”,

15 (ii) by striking “or” at the end of para-
16 graph (2),

17 (iii) by substituting “; and” for the period
18 at the end of paragraph (3), and

19 (iv) by inserting after paragraph (3) the
20 following:

21 “(4) in the case of items and services furnished
22 through a point of service network (as described in
23 section 1890), the payment basis specified under the
24 arrangement established for such network, plus any

1 bonus payments as determined under subsection (c)
2 of that section.”.

3 (B) The matter in section 1886(d)(1)(A) (42
4 U.S.C. 1395ww(d)(1)(A)) preceding clause (i) is
5 amended by inserting “(other than paragraph (4))”
6 after “1814(b)”.

7 (3) Section 1832(a)(2) (42 U.S.C. 1395k(a)(2))
8 is amended—

9 (A) by striking “and” at the end of sub-
10 paragraph (I),

11 (B) by substituting “; and” for the period
12 at the end of subparagraph (J), and

13 (C) by adding at the end the following:

14 “(K) such additional items and services
15 (other than inpatient services furnished by pro-
16 viders of services) as may be specified under a
17 point-of-service network arrangement under sec-
18 tion 1890.”.

19 (4) Section 1833 (42 U.S.C. 1395l), as amend-
20 ed by section 4032, is amended by adding at the end
21 the following new subsection:

22 “(u) In the case of items and services furnished
23 through a point of service network (as described in section
24 1890), there shall be paid (subject to subsection (b))
25 amounts equal to 80 percent of the payment basis speci-

1 fied in an agreement entered into pursuant to that section,
2 plus any bonus payments as determined under subsection
3 (c) of that section.”.

4 (5) Section 1862(a) (42 U.S.C. 1395y(a)), as
5 amended by sections 4034(b)(4), 4118(b), and
6 2003(b), is further amended—

7 (A) in paragraph (7), by striking “or
8 under paragraph (1)(F)” and inserting “, under
9 paragraph (1)(F), or under a contract under
10 section 1890”,

11 (B) by striking “or” at the end of para-
12 graph (16),

13 (C) by striking the period at the end of
14 paragraph (17) and inserting “; or”, and

15 (D) by inserting after paragraph (17) the
16 following new paragraph:

17 “(18) which are furnished to an individual and
18 related to a health condition with respect to which
19 the individual is subject to case management
20 through a point-of-service network under section
21 1890 but which are not included in the plan of care
22 developed for such individual and agreed to by the
23 individual and the case manager.”.

24 (c) EFFECTIVE DATE.—The amendments made by
25 this subsection shall take effect January 1, 1996.

1 **PART 3—MEDICARE COVERAGE**

2 **EXPANSIONS**

3 **SEC. 4021. REFERENCE TO COVERAGE OF OUTPATIENT**
4 **PRESCRIPTION DRUGS.**

5 For provisions adding a new outpatient prescription
6 drug benefit to the medicare program, see subtitle A of
7 title II.

8 **SEC. 4022. EXPANDED COVERAGE FOR PHYSICIAN ASSIST-**
9 **ANTS, NURSE PRACTITIONERS, AND CLIN-**
10 **ICAL NURSE SPECIALISTS.**

11 (a) PHYSICIAN ASSISTANTS.—Section
12 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is amend-
13 ed by striking “(I) in a hospital” and all that follows
14 through “shortage area”.

15 (b) NURSE PRACTITIONERS AND CLINICAL NURSE
16 SPECIALISTS.—Section 1861(s)(2)(K)(iii) (42 U.S.C.
17 1395x(s)(2)(K)(iii)) is amended—

18 (1) by inserting “(I)” before “in a rural area”,
19 and

20 (2) by inserting “, (II) in any other area, in the
21 case of services furnished by nurse practitioners
22 other than services furnished to an inpatient of a
23 hospital, or (III) in any other area, in the case of
24 services furnished by clinical nurse specialists other
25 than services furnished to an inpatient of a hospital,

1 skilled nursing facility or nursing facility (as defined
2 in section 1919(a)), and” after “section
3 1886(d)(2)(D))”.

4 (c) CONFORMING AMENDMENTS.—(1) Section
5 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is
6 amended by striking “provided in a rural area (as defined
7 in section 1886(d)(2)(D))” and inserting “described in
8 section 1861(s)(2)(K)(iii)”.

9 (2) Section 1833(a)(1)(O) (42 U.S.C.
10 1395l(a)(1)(O)) is amended by striking “provided in a
11 rural area”.

12 (3) Section 1833(r)(1) (42 U.S.C. 1395l(r)(1)) is
13 amended by striking “provided in a rural area”.

14 (d) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to services furnished on or after
16 January 1, 1996.

17 **PART 4—COORDINATION WITH**
18 **ADMINISTRATIVE SIM-**
19 **PLIFICATION AND QUALITY**
20 **MANAGEMENT INITIATIVES**

21 **SEC. 4031. REPEAL OF SEPARATE MEDICARE PEER REVIEW**
22 **PROGRAM.**

23 Part B of title XI of the Social Security Act (42
24 U.S.C. 1301 et seq.) is amended by adding at the end
25 the following new section:

1 “TERMINATION

2 “SEC. 1165. The provisions of this part shall termi-
3 nate effective upon the adoption of the National Quality
4 Management Program under subtitle A of title V of the
5 Health Security Act. Any reference to this part or any
6 section in this part shall not be effective after such date.”.

7 **SEC. 4032. MANDATORY ASSIGNMENT FOR ALL PART B**
8 **SERVICES.**

9 Section 1833 (42 U.S.C. 1395l) is amended—

10 (1) by redesignating the subsection (r) added by
11 section 4206(b)(2) of OBRA–1990 as subsection (s);
12 and

13 (2) by adding at the end the following new sub-
14 section:

15 “(t)(1) Notwithstanding any other provision of this
16 part, payment under this part for any item or service fur-
17 nished on or after January 1, 1996, may only be made
18 on an assignment-related basis.

19 “(2) Except for deductible, coinsurance, or copay-
20 ment amounts applicable under this part, no physician,
21 supplier, or other person may bill or collect any amount
22 from an individual enrolled under this part or other person
23 for an item or service for which payment may be made
24 under this part. No such individual or person is liable for

1 payment of any amounts billed in violation of the previous
2 sentence.

3 “(3) If a physician, supplier, or other person know-
4 ingly and willfully bills or collects an amount in violation
5 of paragraph (2), the Secretary may apply sanctions
6 against such physician, supplier, or other person in ac-
7 cordance with section 1842(j)(2). Paragraph (4) of section
8 1842(j) shall apply in this paragraph in the same manner
9 as such paragraph applies to such section.”.

10 **SEC. 4033. ELIMINATION OF COMPLEXITIES CAUSED BY**
11 **DUAL FUNDING SOURCES AND RULES FOR**
12 **PAYMENT OF CLAIMS.**

13 (a) IN GENERAL.—The Secretary of Health and
14 Human Services shall take such steps as may be necessary
15 to consolidate the administration (including processing
16 systems) of parts A and B of the medicare program (under
17 title XVIII of the Social Security Act).

18 (b) COMBINATION OF INTERMEDIARY AND CARRIER
19 FUNCTIONS.—In taking such steps, the Secretary shall
20 contract with a single entity that combines the fiscal inter-
21 mediary and carrier functions in each area except where
22 the Secretary finds that special regional or national con-
23 tracts are appropriate.

24 (c) SUPERSEDING CONFLICTING REQUIREMENTS.—
25 The provisions of sections 1816 and 1842 of the Social

1 Security Act (including provider nominating provisions in
2 such section 1816) are superseded to the extent required
3 to carry out this section.

4 **SEC. 4034. REPEAL OF PRO PRECERTIFICATION REQUIRE-**
5 **MENT FOR CERTAIN SURGICAL PROCE-**
6 **DURES.**

7 (a) IN GENERAL.—Section 1164 (42 U.S.C. 1320c–
8 13) is repealed.

9 (b) CONFORMING AMENDMENTS.—

10 (1) Section 1154 (42 U.S.C. 1320c–3) is
11 amended—

12 (A) in subsection (a), by striking para-
13 graph (12), and

14 (B) in subsection (d), by striking “(and ex-
15 cept as provided in section 1164)”.

16 (2) Section 1833 (42 U.S.C. 1395l) is
17 amended—

18 (A) in subsection (a)(1)(D)(i), by striking
19 “, or for tests furnished in connection with ob-
20 taining a second opinion required under section
21 1164(c)(2) (or a third opinion, if the second
22 opinion was in disagreement with the first opin-
23 ion)”;

24 (B) in subsection (a)(1), by striking clause
25 (G);

1 (C) in subsection (a)(2)(A), by striking “,
2 to items and services (other than clinical diag-
3 nostic laboratory tests) furnished in connection
4 with obtaining a second opinion required under
5 section 1164(c)(2) (or a third opinion, if the
6 second opinion was in disagreement with the
7 first opinion),”;

8 (D) in subsection (a)(2)(D)(i)—

9 (i) by striking “basis,” and inserting
10 “basis or”, and

11 (ii) by striking “, or for tests fur-
12 nished in connection with obtaining a sec-
13 ond opinion required under section
14 1164(c)(2) (or a third opinion, if the sec-
15 ond opinion was in disagreement with the
16 first opinion)”;

17 (E) in subsection (a)(3), by striking “and
18 for items and services furnished in connection
19 with obtaining a second opinion required under
20 section 1164(c)(2), or a third opinion, if the
21 second opinion was in disagreement with the
22 first opinion)”;

23 (F) in the first sentence of subsection (b),
24 by striking “(4)” and all that follows through
25 “and (5)” and inserting and “(4)”.

1 (3) Section 1834(g)(1)(B) (42 U.S.C.
2 1395m(g)(1)(B)) is amended by striking “and for
3 items and services furnished in connection with ob-
4 taining a second opinion required under section
5 1164(c)(2), or a third opinion, if the second opinion
6 was in disagreement with the first opinion)”.

7 (4) Section 1862(a) (42 U.S.C. 1395y(a)) is
8 amended—

9 (A) by adding “or” at the end of para-
10 graph (14),

11 (B) by striking “; or” at the end of para-
12 graph (15) and inserting a period, and

13 (C) by striking paragraph (16).

14 (5) The third sentence of section 1866(a)(2)(A)
15 (42 U.S.C. 1395w(a)(2)(A)) is amended by striking
16 “, with respect to items and services furnished in
17 connection with obtaining a second opinion required
18 under section 1164(c)(2) (or a third opinion, if the
19 second opinion was in disagreement with the first
20 opinion),”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to services provided on or after
23 the date of the enactment of this Act.

1 **SEC. 4035. REQUIREMENTS FOR CHANGES IN BILLING PRO-**
2 **CEDURES.**

3 (a) LIMITATION ON FREQUENCY OF SYSTEM
4 CHANGES.—The Secretary of Health and Human Services
5 may not implement any change in the system used for the
6 billing and processing of claims for payment for items and
7 services furnished under title XVIII of the Social Security
8 Act within 6 months of implementing any previous change
9 in such system.

10 (b) ADVANCE NOTIFICATION TO PROVIDERS AS RE-
11 QUIREMENT FOR CARRIERS AND FISCAL INTER-
12 MEDIARIES.—

13 (1) FISCAL INTERMEDIARIES.—Section 1816(c)
14 (42 U.S.C. 1395h(c)) is amended by adding at the
15 end the following new paragraph:

16 “(4) Each agreement with an agency or organization
17 under this section shall provide that the agency or organi-
18 zation shall notify providers of services of any major
19 change in the procedures for billing for services furnished
20 under this part at least 120 days before such change is
21 to take effect.”.

22 (2) CARRIERS.—Section 1842(b)(3) (42 U.S.C.
23 1395u(b)(3)) is amended—

24 (A) by striking “and” at the end of sub-
25 paragraph (G) and the end of subparagraph
26 (H); and

1 (B) by inserting after subparagraph (H)
2 the following new subparagraph:

3 “(I) will notify individuals and entities fur-
4 nishing items and services for which payment may
5 be made under this part of any major change in the
6 procedures for billing for such items and services at
7 least 120 days before such change is to take effect;
8 and”.

9 (3) EFFECTIVE DATE.—The amendments made
10 by paragraphs (1) and (2) shall apply to agreements
11 with fiscal intermediaries under section 1816 of the
12 Social Security Act and to contracts with carriers
13 under section 1842 of such Act for years beginning
14 after the expiration of the 9-month period beginning
15 on the date of the enactment of this Act.

16 **PART 5—AMENDMENTS TO ANTI-**
17 **FRAUD AND ABUSE PROVISIONS**

18 **SEC. 4041. ANTI-KICKBACK PROVISIONS.**

19 (a) REVISION TO PENALTIES.—

20 (1) PERMITTING SECRETARY TO IMPOSE CIVIL
21 MONETARY PENALTY.—Section 1128A(a) (42 U.S.C.
22 1320a–7a(a)) is amended—

23 (A) by striking “or” at the end of para-
24 graphs (1) and (2);

1 (B) by striking the semicolon at the end of
2 paragraph (3) and inserting “; or”; and

3 (C) by inserting after paragraph (3) the
4 following new paragraph:

5 “(4) carries out any activity in violation of
6 paragraph (1) or (2) of section 1128B(b);”.

7 (2) DESCRIPTION OF CIVIL MONETARY PEN-
8 ALTY APPLICABLE.—Section 1128A(a) (42 U.S.C.
9 1320a–7a(a)) is amended—

10 (A) by striking “given).” at the end of the
11 first sentence and inserting the following:
12 “given or, in cases under paragraph (4),
13 \$50,000 for each such violation).”; and

14 (B) by striking “claim.” at the end of the
15 second sentence and inserting the following:
16 “claim (or, in cases under paragraph (4), dam-
17 ages of not more than three times the total
18 amount of remuneration offered, paid, solicited,
19 or received, without regard to whether a portion
20 of such remuneration was offered, paid, solie-
21 ited, or received for a lawful purpose).”.

22 (3) INCREASE IN CRIMINAL PENALTY.—Para-
23 graphs (1) and (2) of section 1128B(b) (42 U.S.C.
24 1320a–7b(b)) are each amended—

1 (A) by striking “\$25,000” and inserting
2 “\$50,000”; and

3 (B) by striking the period at the end and
4 inserting the following: “, and shall be subject
5 to damages of not more than three times the
6 total remuneration offered, paid, solicited, or
7 received, without regard to whether a portion of
8 such remuneration was offered, paid, solicited,
9 or received for a lawful purpose.”.

10 (b) REVISIONS TO EXCEPTIONS.—

11 (1) EXCEPTION FOR DISCOUNTS.—Section
12 1128B(b)(3)(A) (42 U.S.C. 1320a–7b(b)(3)(A)) is
13 amended by striking “program;” and inserting “pro-
14 gram and is not—

15 “(i) for the furnishing of one item or serv-
16 ice without charge or at a reduced charge in ex-
17 change for any agreement to buy a different
18 item or service;

19 “(ii) applicable to one payor but not to
20 providers of services or other entities under title
21 XVIII or a State health care program; or

22 “(iii) in the form of a cash payment;”.

23 (2) EXCEPTION FOR PAYMENTS TO EMPLOY-
24 EES.—Section 1128B(b)(3)(B) (42 U.S.C. 1320a–
25 7b(b)(3)(B)) is amended by inserting at the end “if

1 the amount of remuneration under the arrangement
2 is consistent with the fair market value of the serv-
3 ices and is not determined in a manner that takes
4 into account (directly or indirectly) the volume or
5 value of any referrals, except that such employee can
6 be paid remuneration in the form of a productivity
7 bonus based on services personally performed by the
8 employee.”.

9 (3) EXCEPTION FOR WAIVER OF COINSURANCE
10 BY CERTAIN PROVIDERS.—Section 1128B(b)(3)(D)
11 (42 U.S.C. 1320a–7b(b)(3)(D)) is amended to read
12 as follows:

13 “(D) a waiver or reduction of any coinsurance
14 or other copayment if the waiver or reduction is
15 made pursuant to a public schedule of discounts
16 which the person is obligated as a matter of law to
17 apply to certain individuals.”.

18 (4) NEW EXCEPTION FOR CERTAIN PRO-
19 VIDERS.—Section 1128B(b)(3) (42 U.S.C. 1320a–
20 7b(b)(3)) is amended—

21 (A) by striking “and” at the end of sub-
22 paragraph (D);

23 (B) by striking the period at the end of
24 subparagraph (E) and inserting “; and”; and

1 (C) by adding at the end the following new
2 subparagraph:

3 “(F) any remuneration obtained by or given to
4 an individual or entity who receives assistance under
5 a grant or cooperative agreement for the provision of
6 health care services under title V, title XX, or the
7 Public Health Service Act, or is obligated as a mat-
8 ter of law to provide services according to a schedule
9 which provides for discounts based on the ability of
10 the individual services to pay, if—

11 “(i) in the case of an individual or entity
12 who receives assistance under a grant or coop-
13 erative agreement for the provision of health
14 care services under title V, title XX, or the
15 Public Health Service Act, the remuneration is
16 directly and primarily related to the activity
17 supported by the grant or cooperative agree-
18 ment; and

19 “(ii) the remuneration is pursuant to a
20 written arrangement for the use or procurement
21 of space, equipment, goods, or services for the
22 referral of patients that—

23 “(I) does not result in private
24 inurement to any current employee, officer,
25 member of the Board of Directors, or

1 agent of the recipient or any other person
2 involved in recommending or negotiating
3 the arrangement; and

4 “(II) does not preclude the referral of
5 patients to other providers of service of the
6 patient’s own choosing and does not inter-
7 fere with the ability of health professionals
8 to refer patients to providers of services
9 they believe are the most appropriate, ex-
10 cept to the extent such choices or referrals
11 are limited by the terms of a health plan
12 in which the patient has enrolled or the
13 terms of a grant or cooperative agreement
14 described in clause (i).”.

15 (5) NEW EXCEPTION FOR CAPITATED PAY-
16 MENTS.—Section 1128B(b)(3) (42 U.S.C. 1320a-
17 7b(b)(3)), as amended by paragraph (4), is further
18 amended—

19 (A) by striking “and” at the end of sub-
20 paragraph (E);

21 (B) by striking the period at the end of
22 subparagraph (F) and inserting “; and”; and

23 (C) by adding at the end the following new
24 subparagraph—

1 “(G) any reduction in cost sharing or increased
2 benefits given to an individual, any amounts paid to
3 a provider of services for items or services furnished
4 to an individual, or any discount or reduction in
5 price given by the provider for such items or serv-
6 ices, if the individual is enrolled with and such items
7 and services are covered under any of the following:

8 “(i) A health plan which is furnishing
9 items or services under title XVIII or a State
10 health care program to individuals on an at-
11 risk, prepaid, capitated basis pursuant to a
12 written agreement with the Secretary or a State
13 health care program.

14 “(ii) An organization receiving payments
15 on a prepaid basis, under a demonstration
16 project under section 402(a) of the Social Secu-
17 rity Amendments of 1967 or under section
18 222(a) of the Social Security Amendments of
19 1972.

20 “(iii) Any other plan or insurer under
21 which each participating provider is paid wholly
22 on an at-risk, prepaid, capitated basis for such
23 items or services pursuant to a written arrange-
24 ment between the plan and the provider.”.

1 (c) CLARIFICATION OF COVERAGE OF EMPLOYERS
2 AND EMPLOYEES.—Section 1128B(b) (42 U.S.C. 1320a–
3 7b(b)), as amended by subsection (a)(4), is further amend-
4 ed by adding at the end the following new paragraph:

5 “(5) In this subsection, the term ‘referral’ includes
6 the referral by an employee to his or her employer of any
7 item or service for which payment may be made in whole
8 or in part under title XVIII or a State health care pro-
9 gram.”

10 (d) AUTHORIZATION FOR THE SECRETARY TO ISSUE
11 REGULATIONS.—Section 1128B(b) (42 U.S.C. 1320a–
12 7b(b)), as amended by subsections (a)(4) and (c), is fur-
13 ther amended by adding at the end the following new para-
14 graph:

15 “(6) The Secretary is authorized to impose by regula-
16 tion such other requirements as needed to protect against
17 program or patient abuse with respect to any of the excep-
18 tions described in paragraph (3).”.

19 (e) CLARIFICATION OF OTHER ELEMENTS OF OF-
20 FENSE.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is
21 amended—

22 (1) in paragraph (1) in the matter preceding
23 subparagraph (A), by striking “kind—” and insert-
24 ing “kind with intent to be influenced—”;

1 (2) in paragraph (1)(A), by striking “in return
2 for referring” and inserting “to refer”;

3 (3) in paragraph (1)(B), by striking “in return
4 for purchasing, leasing, ordering, or arranging for or
5 recommending” and inserting “to purchase, lease,
6 order, or arrange for or recommend”;

7 (4) in paragraph (2) in the matter preceding
8 subparagraph (A), by striking “to induce such per-
9 son” and inserting “with intent to influence such
10 person”; and

11 (5) by adding at the end of paragraphs (1) and
12 (2) the following sentence: “A violation exists under
13 this paragraph if one or more purposes of the remu-
14 neration is unlawful under this paragraph.”.

15 **SEC. 4042. REVISIONS TO LIMITATIONS ON PHYSICIAN**
16 **SELF-REFERRAL.**

17 (a) CLARIFICATION OF PAYMENT BAN.—Section
18 1877(a)(1)(B) (42 U.S.C. 1395nn(a)(1)(B)) is amended
19 to read as follows:

20 “(B) no physician or entity may present or
21 cause to be presented a claim under this title or bill
22 to any third party payor or other entity for des-
23 ignated health services furnished pursuant to a re-
24 ferral prohibited under subparagraph (A).”.

1 (b) CLARIFICATION OF COVERAGE OF HOLDING
2 COMPANY TYPE ARRANGEMENTS AND LOANS.—The last
3 sentence of section 1877(a)(2) (42 U.S.C. 1395nn(a)(2))
4 is amended by striking “an interest in an entity that holds
5 an ownership or investment interest in any entity pro-
6 viding the designated health service” and inserting the fol-
7 lowing: “a loan from the entity, and an interest held indi-
8 rectly through means such as (but not limited to) having
9 a family member hold such investment interest or holding
10 a legal or beneficial interest in another entity (such as a
11 trust or holding company) that holds such investment in-
12 terest”.

13 (c) REVISIONS TO GENERAL EXCEPTIONS TO BOTH
14 OWNERSHIP AND COMPENSATION ARRANGEMENT PROHI-
15 BITIONS.—

16 (1) REPEAL OF EXCEPTION FOR PHYSICIANS’
17 SERVICES.—Section 1877(b) (42 U.S.C. 1395nn(b))
18 is amended—

19 (A) by striking paragraph (1); and

20 (B) by redesignating paragraphs (2) and
21 (3) as paragraphs (1) and (2).

22 (2) REVISION TO IN-OFFICE ANCILLARY SERV-
23 ICES EXCEPTION.—Section 1877(b)(1) (42 U.S.C.
24 1395nn(b)(1)), as redesignated by paragraph (1), is
25 amended—

1 (A) in the matter preceding subparagraph
2 (A), by striking “services (other than durable
3 medical equipment (excluding infusion pumps)
4 and parenteral and enteral nutrients, equip-
5 ment, and supplies)” and inserting “clinical lab-
6 oratory services, x-ray and ultrasound services
7 that are provided at low-cost (as determined in
8 accordance with regulations of the Secretary)”;
9 and

10 (B) in subparagraph (A)—

11 (i) in clause (ii)(I), by striking “(or
12 another physician who is a member of the
13 same group practice)”,

14 (ii) in clause (ii)(II) by inserting “the
15 same or” before “another building”, and

16 (iii) in clause (ii)(II)(bb), by inserting
17 “all of” after “centralized provision of”.

18 (3) REVISION TO PREPAID PLAN EXCEPTION.—

19 Section 1877(b)(2), (42 U.S.C. 1395nn(b)(2)), as
20 redesignated by paragraph (1), is amended to read
21 as follows:

22 “(2) PREPAID PLANS.—In the case of des-
23 ignated health services furnished by an
24 organization—

1 “(A) with a risk sharing contract under
2 section 1876(g) to an individual enrolled with
3 the organization,

4 “(B) receiving payments on a prepaid
5 basis, under a demonstration project under sec-
6 tion 402(a) of the Social Security Amendments
7 of 1967 or under section 222(a) of the Social
8 Security Amendments of 1972, to an individual
9 enrolled with the organization, or

10 “(C) that is a qualified health maintenance
11 organization (within the meaning of section
12 1310(d) of the Public Health Service Act) to an
13 individual enrolled with the organization.”.

14 (4) NEW EXCEPTION FOR CAPITATED PAY-
15 MENTS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as
16 amended by paragraph (1), is amended by inserting
17 after paragraph (2) the following new paragraph:

18 “(3) OTHER CAPITATED PAYMENTS.—In the
19 case of a designated health service, if the designated
20 health service is included in the services for which a
21 physician or physician group is paid wholly on an at-
22 risk, prepaid, capitated basis by a health plan or in-
23 surer pursuant to a written arrangement between
24 the plan or insurer and the physician or physician
25 group.”.

1 (d) REVISION TO PUBLICLY TRADED SECURITIES
2 EXCEPTION.—Section 1877(c)(1) (42 U.S.C.
3 1395nn(c)(1)) is amended by inserting “at the time ac-
4 quired by the physician” after “which may be purchased
5 on terms generally available to the public”.

6 (e) REVISION TO RURAL PROVIDER EXCEPTION.—
7 Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended
8 by striking “substantially all” and inserting “not less than
9 85 percent (as determined in accordance with regulations
10 of the Secretary)”.

11 (f) REVISIONS TO EXCEPTIONS RELATING TO OTHER
12 COMPENSATION ARRANGEMENTS.—

13 (1) EXCEPTION FOR PERSONAL SERVICES AR-
14 RANGEMENTS.—(A) Section 1877(e)(3)(B)(i)(II) (42
15 U.S.C. 1395nn(e)(3)(B)(i)(II)) is amended to read
16 as follows:

17 “(II) If the plan places a physi-
18 cian or physician group at substantial
19 financial risk (as determined by the
20 Secretary pursuant to section
21 1876(i)(8)(A)(ii)), for services not
22 provided by the physician, the entity
23 complies with the provisions of sub-
24 clauses (I) and (II) of section
25 1876(i)(8)(A)(ii).”;

1 (B) Section 1877(e)(3)(B)(ii), 42 U.S.C.
2 1395nn(e)(3)(B)(ii) is amended by striking “may di-
3 rectly or indirectly have the effect of” and inserting
4 “has the purpose of”.

5 (2) REPEAL OF EXCEPTION FOR REMUNERA-
6 TION UNRELATED TO THE PROVISION OF DES-
7 IGNATED HEALTH SERVICES.—Section 1877(e) (42
8 U.S.C. 1395nn(e)) is amended—

9 (A) by striking paragraph (4); and

10 (B) by redesignating paragraphs (5), (6),
11 (7), and (8) as paragraphs (4), (5), (6), and
12 (7).

13 (3) EXCEPTION FOR CERTAIN PHYSICIAN RE-
14 CRUITMENT.—Section 1877(e)(4) (42 U.S.C.
15 1395nn(e)(4)), as redesignated by paragraph (2), is
16 amended to read as follows:

17 “(4) PHYSICIAN RECRUITMENT.—In the case of
18 remuneration which is provided by an entity located
19 in a rural area (as defined in section 1886(d)(2)(D))
20 or a health professional shortage areas (designated
21 under section 332 of the Public Health Service Act),
22 or an entity for which 85 percent of the patients are
23 members of a medically underserved population des-
24 ignated under section 330 of the Public Health Serv-
25 ice Act (as determined in accordance with regula-

1 tions of the Secretary), in order to induce a physi-
2 cian who has been practicing within the physician's
3 current specialty for less than one year to establish
4 staff privileges at the entity, or to induce any other
5 physician to relocate his or her primary place of
6 practice to the geographic area served by the entity,
7 if the following standards are met:

8 “(A) The arrangement is set forth in a
9 written agreement that specifies the benefits
10 provided by the entity to the physician, the
11 terms under which the benefits are to be pro-
12 vided, and the obligations of each party.

13 “(B) If a physician is leaving an estab-
14 lished practice, the physical location of the new
15 primary place of practice must be not less than
16 100 miles from the location of the established
17 primary place of practice and at least 85 per-
18 cent of the revenues of the physician's new
19 practice must be generated from new patients
20 for whom the physician did not previously pro-
21 vide services at the former practice.

22 “(C) The benefits are provided by the enti-
23 ty for a period not in excess of 3 years, and the
24 terms of the agreement are not renegotiated
25 during this 3-year period in any substantial as-

1 pect, unless the physician’s new primary place
2 of practice is designated as a health profes-
3 sional shortage area (pursuant to section 332 of
4 the Public Health Service Act) for the physi-
5 cian’s specialty category during the entire dura-
6 tion of the relationship between the physician
7 and the entity.

8 “(D) There is no requirement that the
9 physician make referrals to, be in a position to
10 make or influence referrals to, or otherwise gen-
11 erate business for the entity as a condition for
12 receiving the benefits.

13 “(E) The physician is not restricted from
14 establishing staff privileges at, referring any
15 service to, or otherwise generating any business
16 for any other entity of the physician’s choosing.

17 “(F) The amount or value of the benefits
18 provided by the entity may not vary (or be ad-
19 justed or renegotiated) in any manner based on
20 the volume or value of any expected referrals to
21 or business otherwise generated for the entity
22 by the physician for which payment may be
23 made in whole or in part under this title or a
24 State health care program (as defined in section
25 1128(h)).

1 “(G) The physician agrees to treat patients
2 entitled to benefits under this title or enrolled
3 in a State plan for medical assistance under
4 title XIX.”.

5 (4) EXCEPTION FOR ISOLATED TRANS-
6 ACTIONS.—Section 1877(e)(5) (42 U.S.C.
7 1395nn(e)(6)), as redesignated by paragraph (2), is
8 amended—

9 (A) by redesignating subparagraph (B) as
10 subparagraph (C);

11 (B) by striking “and” at the end of sub-
12 paragraph (A); and

13 (C) by inserting after subparagraph (A)
14 the following new subparagraph:

15 “(B) there is no financing of the sale be-
16 tween the parties, and”.

17 (5) EXCEPTION FOR PAYMENTS BY A PHYSI-
18 CIAN.—Section 1877(e)(7) (42 U.S.C.
19 1395nn(e)(7)), as redesignated by paragraph (2), is
20 amended to read as follows:

21 “(7) PAYMENTS BY A PHYSICIAN FOR ITEMS
22 AND SERVICES.—Payments made by a physician to
23 an individual or entity as compensation for items or
24 services if the items or services are furnished at a
25 price that is consistent with fair market value.”.

1 (6) ADDITIONAL EXCEPTION FOR DISCOUNTS
2 OR OTHER REDUCTIONS IN PRICE.—Section 1877(e)
3 (42 U.S.C. 1395nn(e)), as amended by paragraph
4 (2), is amended by adding at the end the following
5 new paragraph:

6 “(8) DISCOUNTS OR OTHER REDUCTIONS IN
7 PRICE.—Discounts or other reductions in price be-
8 tween a physician and an entity for items or services
9 for which payment may be made under this title so
10 long as the discount or other reduction in price is
11 properly disclosed and appropriately reflected in the
12 costs claimed or charges made by the physician or
13 entity under this title and is not—

14 “(A) for the furnishing of one item or serv-
15 ice without charge or at a reduced charge in ex-
16 change for any agreement to buy a different
17 item or service,

18 “(B) applicable to one or more payers but
19 not to all individuals and entities providing
20 services for which payment may be made under
21 this title, or

22 “(C) in the form of a cash payment.”.

23 (g) CLARIFICATION OF SANCTION AUTHORITY.—Sec-
24 tion 1877(g)(4) (42 U.S.C. 1395nn(g)(4)) is amended by
25 striking “Any physician” and all that follows through “to

1 such entity,” and inserting the following: “Any physician
2 or other entity that enters into an arrangement or scheme
3 (such as a cross-referral arrangement or an arrangement
4 with multiple leases overlapping in time for the same or
5 similar rental space or equipment) which the physician or
6 entity knows or should know has a principal purpose of
7 inducing referrals to another entity, which referrals, if
8 made directly by the physician or entity to such other enti-
9 ty,”.

10 (h) CLARIFICATION OF DEFINITION OF REMUNERA-
11 TION.—Section 1877(h)(1)(B) (42 U.S.C.
12 1395nn(h)(1)(B)) is amended to read as follows:

13 “(B) The term ‘remuneration’ includes any pay-
14 ment, discount or other reduction in price, forgive-
15 ness of debt or other benefit made directly or indi-
16 rectly, overtly or covertly, in cash or in kind.”.

17 (i) REVISION TO DEFINITION OF GROUP PRAC-
18 TICE.—Section 1877(h)(4) (42 U.S.C. 1395nn(h)(4)) is
19 amended—

20 (1) in subparagraph (A)(vi), by striking the pe-
21 riod at the end and inserting the following: “, in-
22 cluding a requirement for the physical grouping of
23 physician practices as may be reasonably required to
24 prevent the abuse of any exceptions provided to
25 group practices under this section.”; and

1 (2) in subparagraph (B)(i), by striking “or
2 services incident to such personally performed serv-
3 ices”.

4 (j) EXPANSION TO COVER ADDITIONAL ITEMS AND
5 SERVICES.—Section 1877(h)(6) (42 U.S.C.
6 1395nn(h)(6)), as amended by section 2005(c)(3), is
7 amended—

8 (1) in subparagraph (D), by striking “or
9 other”; and

10 (2) by adding at the end the following new sub-
11 paragraphs:

12 “(M) Diagnostic services.

13 “(N) Any other item or service not ren-
14 dered by the physician personally or by a per-
15 son under the physician’s direct supervision.”.

16 (k) AUTHORIZATION FOR THE SECRETARY TO ISSUE
17 REGULATIONS.—Section 1877 (42 U.S.C. 1395nn) is
18 amended by adding the following new subsection:

19 “(i) ADDITIONAL REQUIREMENTS.—The Secretary is
20 authorized to impose by regulation such other require-
21 ments as needed to protect against program or patient
22 abuse with respect to any of the exceptions under this sec-
23 tion.”.

24 (l) INCORPORATION OF AMENDMENTS MADE UNDER
25 OBRA–1993.—In this section, any reference to section

1 1877 of the Social Security Act shall be considered a ref-
2 erence to such section as amended by section 13562(a)
3 of OBRA–1993.

4 **SEC. 4043. CIVIL MONETARY PENALTIES.**

5 (a) PROHIBITION AGAINST OFFERING INDUCEMENTS
6 TO INDIVIDUALS ENROLLED UNDER PLANS.—

7 (1) OFFER OF REMUNERATION.—Section
8 1128A(a) (42 U.S.C. 1320a–7a(a)) (as amended by
9 section 4041(a)(1)) is amended—

10 (A) by striking “; or” at the end of para-
11 graph (3) and inserting a semicolon;

12 (B) by striking the semicolon at the end of
13 paragraph (4) and inserting “; or”; and

14 (C) by inserting after paragraph (4) the
15 following new paragraph:

16 “(5) offers, pays, or transfers remuneration to
17 any individual eligible for benefits under title XVIII
18 of this Act, or under a State health care program
19 (as defined in section 1128(h)) that such person
20 knows or should know is likely to influence such in-
21 dividual to order or receive from a particular pro-
22 vider, practitioner, or supplier any item or service
23 for which payment may be made, in whole or in
24 part, under title XVIII, or a State health care pro-
25 gram;”.

1 (2) REMUNERATION DEFINED.—Section
2 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by
3 adding at the end the following new paragraph:

4 “(6) The term ‘remuneration’ includes the waiv-
5 er of coinsurance and deductible amounts (or any
6 part thereof), and transfers of items or services for
7 free or for other than fair market value, except that
8 such term does not include the waiver of coinsurance
9 or deductible amounts by a person or entity, if—

10 “(A) the waiver is not offered as part of
11 any advertisement or solicitation;

12 “(B) the person does not routinely waive
13 coinsurance or deductible amounts; and

14 “(C) the person—

15 “(i) waives the coinsurance and de-
16 ductible amounts after determining in good
17 faith that the individual is indigent;

18 “(ii) fails to collect coinsurance or de-
19 ductible amounts after making reasonable
20 collection efforts; or

21 “(iii) provides for any permissible
22 waiver as specified in section 1128B(b)(3)
23 or in regulations issued by the Secretary.”.

24 (b) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-
25 RECT CODING OR MEDICALLY UNNECESSARY SERV-

1 ICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1))
2 is amended—

3 (1) in subparagraph (A), by striking “claimed,”
4 and inserting the following: “claimed, including any
5 person who presents or causes to be presented a
6 claim for an item or service which includes a proce-
7 dure or diagnosis code that the person knows or
8 should know will result in a greater payment to the
9 person than the code applicable to the item or serv-
10 ice actually provided or actual patient medical condi-
11 tion,”;

12 (2) in subparagraph (C), by striking “or” at
13 the end;

14 (3) in subparagraph (D), by striking “; or” and
15 inserting “, or”; and

16 (4) by inserting after subparagraph (D) the fol-
17 lowing new subparagraph:

18 “(E) is for a medical or other item or serv-
19 ice that a person knows or should know is not
20 medically necessary; or”.

21 (c) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP
22 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—
23 Section 1128A(a) of such Act, as amended by section
24 4041(a)(1) and subsection (a)(1), is further amended—

1 (1) by striking “or” at the end of paragraph
2 (4);

3 (2) by striking the semicolon at the end of
4 paragraph (5) and inserting “; or”; and

5 (3) by inserting after paragraph (5) the fol-
6 lowing new paragraph:

7 “(6) in the case of a person who is not an orga-
8 nization, agency, or other entity, who is excluded
9 from participating in a program under title XVIII or
10 a State health care program in accordance with this
11 section, section 1128, or section 1156 and who, dur-
12 ing the period of exclusion, retains either a direct or
13 indirect ownership or control interest of 5 percent or
14 more in, or an ownership or control interest (as de-
15 fined in section 1124(a)(3)) in, or who is an officer,
16 director, agent, or managing employee (as defined in
17 section 1126(b)) of, an entity that is participating in
18 a program under title XVIII or a State health care
19 program;”.

20 (d) ADDITIONAL OFFENSES RELATING TO ALLIANCE
21 SYSTEM.—Section 1128A(a) of such Act, as amended by
22 section 4041(a)(1) and subsections (a)(1) and (c), is fur-
23 ther amended—

24 (1) by striking “or” at the end of paragraph
25 (5);

1 (2) by striking the semicolon at the end of
2 paragraph (6) and inserting “; or”; and

3 (3) by inserting after paragraph (6) the fol-
4 lowing new paragraphs:

5 “(7) engages in a practice that circumvents a
6 payment methodology intended to reimburse for two
7 or more discreet medical items or services at a single
8 or fixed amount, including but not limited to, mul-
9 tiple admissions or readmission to hospitals and
10 other institutions reimbursed on a diagnosis reim-
11 bursement grouping basis;

12 “(8) engages in a practice which has the effect
13 of limiting or discouraging (as compared to other
14 plan enrollees) the utilization of health care services
15 covered by law or under the service contract by title
16 XIX or other publicly subsidized patients, including
17 but not limited to differential standards for the loca-
18 tion and hours of service offered by providers par-
19 ticipating in the plan;

20 “(9) substantially fails to cooperate with a qual-
21 ity assurance program or a utilization review activ-
22 ity;

23 “(10) fails substantially to provide or authorize
24 medically necessary items and services that are re-
25 quired to be provided to an individual covered under

1 a health plan under the Health Security Act or pub-
2 lic program for the delivery of or payment for health
3 care items or services, if the failure has adversely af-
4 fected (or had a substantial likelihood of adversely
5 affecting) the individual;

6 “(11) employs or contracts with any individual
7 or entity who is excluded from participating in a
8 program under title XVIII or a State health care
9 program in accordance with this section, section
10 1128, or section 1156, for the provision of any serv-
11 ices (including but not limited to health care, utiliza-
12 tion review, medical social work, or administrative),
13 or employs or contracts with any entity for the di-
14 rect or indirect provision of such services, through
15 such an excluded individual or entity; or

16 “(12) submits false or fraudulent statements,
17 data or information or claims to the National Health
18 Board established under part 1 of subtitle F of title
19 I of the Health Security Act, any other Federal
20 agency, a State health care agency, a health alliance
21 (under subtitle D of title I of such Act), or any
22 other Federal, State or local agency charged with
23 implementation or oversight of a health plan under
24 such Act or a public program that the person knows
25 or should know is fraudulent;”.

1 (e) MODIFICATIONS OF AMOUNTS OF PENALTIES
2 AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C.
3 1320a–7a(a)), as amended by section 4041(a), subsection
4 (a)(1), subsection (c), and subsection (d), is amended in
5 the matter following paragraph (12)—

6 (1) by striking “\$2,000” and inserting
7 “\$10,000”;

8 (2) by inserting after “under paragraph (4),
9 \$50,000 for each such violation” the following: “; in
10 cases under paragraph (5), \$10,000 for each such
11 offer, payment, or transfer; in cases under para-
12 graph (6), \$10,000 for each day the prohibited rela-
13 tionship occurs; in cases under paragraphs (7)
14 through (12), an amount not to exceed \$50,000 for
15 each such determination by the Secretary”; and

16 (3) by striking “twice the amount” and insert-
17 ing “three times the amount”.

18 (f) INTEREST ON PENALTIES.—Section 1128A(f) (42
19 U.S.C. 1320a–7a(f)) is amended by adding after the first
20 sentence the following: “Interest shall accrue on the pen-
21 alties and assessments imposed by a final determination
22 of the Secretary in accordance with an annual rate estab-
23 lished by the Secretary under the Federal Claims Collec-
24 tion Act. The rate of interest charged shall be the rate
25 in effect on the date the determination becomes final and

1 shall remain fixed at that rate until the entire amount due
2 is paid. In addition, the Secretary is authorized to recover
3 the costs of collection in any case where the penalties and
4 assessments are not paid within 30 days after the deter-
5 mination becomes final, or in the case of a compromised
6 amount, where payments are more than 90 days past due.
7 In lieu of actual costs, the Secretary is authorized to im-
8 pose a charge of up to 10 percent of the amount of pen-
9 alties and assessments owed to cover the costs of collec-
10 tion.”.

11 (g) AUTHORIZATION TO ACT.—

12 (1) IN GENERAL.—The first sentence of section
13 1128A(c)(1) (42 U.S.C. 1320a–7a(c)(1)) is amended
14 by striking all that follows “(b)” and inserting the
15 following: “unless, within one year after the date the
16 Secretary presents a case to the Attorney General
17 for consideration, the Attorney General brings an ac-
18 tion in a district court of the United States.”.

19 (2) EFFECTIVE DATE.—The amendment made
20 by this paragraph (1) shall apply to cases presented
21 by the Secretary of Health and Human Services for
22 consideration on or after the date of the enactment
23 of this Act.

24 (h) DEPOSIT OF PENALTIES COLLECTED INTO ALL-
25 PAYER ACCOUNT.—Section 1128A(f)(3) (42 U.S.C.

1 1320a–7a(f)(3)) is amended by striking “as miscellaneous
2 receipts of the Treasury of the United States” and insert-
3 ing “in the All-Payer Health Care Fraud and Abuse Con-
4 trol Account established under section 5402 of the Health
5 Security Act”.

6 (i) CLARIFICATION OF PENALTY IMPOSED ON EX-
7 CLUDED PROVIDER FURNISHING SERVICES.—Section
8 1128A(a)(1)(D) (42 U.S.C. 1320a–7a(a)(1)(D)) is
9 amended by inserting “who furnished the service” after
10 “in which the person”.

11 **SEC. 4044. EXCLUSIONS FROM PROGRAM PARTICIPATION.**

12 (a) MANDATORY EXCLUSION FOR INDIVIDUAL CON-
13 VICTED OF CRIMINAL OFFENSE RELATED TO HEALTH
14 CARE FRAUD.—Section 1128 (42 U.S.C. 1320a–7) is
15 amended—

16 (1) by amending paragraph (1) of subsection
17 (a) to read as follows:

18 “(1) CONVICTIONS OF PROGRAM-RELATED
19 CRIMES AND HEALTH CARE FRAUD.—

20 “(A) Any individual or entity that has been
21 convicted of a criminal offense related to the
22 delivery of an item or service under title XVIII
23 or under any State health care program; or

24 “(B) Any individual or entity that has
25 been convicted, under Federal or State law, in

1 connection with the delivery of a health care
2 item or service of a criminal offense relating to
3 fraud, theft, embezzlement, breach of fiduciary
4 responsibility, or other financial misconduct.”;
5 and

6 (2) in subsection (b)(1), by striking “in connec-
7 tion with the delivery of a health care item or service
8 or”.

9 (b) ESTABLISHMENT OF MINIMUM PERIOD OF EX-
10 CLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUB-
11 JECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND
12 STATE HEALTH CARE PROGRAMS.—Section 1128(c)(3)
13 (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the
14 end the following new subparagraphs:

15 “(D) In the case of an exclusion of an individual or
16 entity under paragraphs (1), (2), or (3) of subsection (b),
17 the period of exclusion shall be a minimum of 3 years,
18 unless the Secretary determines that a longer period is
19 appropriate because of aggravating circumstances.

20 “(E) In the case of an exclusion of an individual or
21 entity under paragraph (4) or (5) of subsection (b), the
22 period of the exclusion shall not be less than the period
23 during which the individual’s or entity’s license to provide
24 health care is revoked, suspended, or surrendered, or the

1 individual or the entity is excluded or suspended from a
2 Federal or State health care program.

3 “(F) In the case of an exclusion of an individual or
4 entity under subsection (b)(6)(B), the period of the exclu-
5 sion shall be not less than 1 year.”.

6 (c) REVISION TO EXCLUSION FOR DEFAULT ON
7 HEALTH EDUCATION LOAN OR SCHOLARSHIP OBLIGA-
8 TIONS.—Section 1128(b)(14) (42 U.S.C. 1320a–7(b)(14))
9 is amended by striking “all reasonable steps” and insert-
10 ing “reasonable steps”.

11 (d) PERMISSIVE EXCLUSION OF INDIVIDUALS WITH
12 OWNERSHIP OR CONTROL INTEREST IN SANCTIONED EN-
13 TITIES.—Section 1128(b) (42 U.S.C. 1320a–7(b)) is
14 amended by adding at the end the following new para-
15 graph:

16 “(15) INDIVIDUALS CONTROLLING A SANC-
17 TIONED ENTITY.—Any individual who has a direct
18 or indirect ownership or control interest of 5 percent
19 or more, or an ownership or control interest (as de-
20 fined in section 1124(a)(3)) in, or who is an officer,
21 director, agent, or managing employee (as defined in
22 section 1126(b)) of, an entity—

23 “(A) that has been convicted of any of-
24 fense described in subsection (a) or in para-
25 graph (1), (2), or (3) of this subsection;

1 “(B) against which a civil monetary pen-
2 alty has been assessed under section 1128A; or

3 “(C) that has been excluded from partici-
4 pation under a program under title XVIII or
5 under a State health care program.”.

6 (e) EXCLUSIONS BASED ON ACTIONS UNDER ALLI-
7 ANCE SYSTEM.—Section 1128 (42 U.S.C. 1320a–7), as
8 amended by subsections (a) and (d), is amended—

9 (1) in subsection (a)(1)(A), by striking “XVIII
10 or under a State health care program” and inserting
11 “XVIII, a State health care program, or under an
12 applicable health plan (as defined in section 1902(6)
13 of the Health Security Act)”;

14 (2) in subsection (b)(5)—

15 (A) by striking “or” at the end of subpara-
16 graph (A),

17 (B) by adding “or” at the end of subpara-
18 graph (B), and

19 (C) by inserting after subparagraph (B)
20 the following new subparagraph:

21 “(C) an applicable health plan (as defined
22 in section 1902(6) of the Health Security Act)
23 under section 5411 or 5412(b)(3) of such
24 Act,”;

1 (3) in subsection (b)(6)(B), by striking “XVIII
2 or under a State health care program” and inserting
3 “XVIII, a State health care program, or an applica-
4 ble health plan (as defined in section 1902(6) of the
5 Health Security Act)”;

6 (4) in subsection (b)(7), by striking the period
7 at the end and inserting “, or in section 5412 of the
8 Health Security Act.”;

9 (5) in subsection (b)(8)(B)—

10 (A) in clause (ii), by striking “1128A” and
11 inserting “1128A or under section 5412 of the
12 Health Security Act”, and

13 (B) in clause (iii), by striking “XVIII or
14 under a State health care program” and insert-
15 ing “XVIII, a State health care program, or
16 under an applicable health plan (as defined in
17 section 1902(6) of the Health Security Act)”;

18 (6) in subsection (b)(9), by striking the period
19 at the end and inserting “, or provide any informa-
20 tion requested by the Inspector General of the De-
21 partment of Health and Human Services to carry
22 out the All-Payer Health Care Fraud and Abuse
23 Control Program established under section 5401 of
24 the Health Security Act.”;

25 (7) in subsection (b)(11)—

1 (A) by striking “title XVIII or a State
2 health care program” and inserting “title
3 XVIII, a State health care program, or an ap-
4 plicable health plan (as defined in section
5 1902(6) of the Health Security Act)”;

6 (B) by striking “Secretary or the appro-
7 priate State agency” and inserting “Secretary,
8 the appropriate State agency, or plan sponsor”,
9 and

10 (C) by striking “Secretary or that agency”
11 and inserting “Secretary, that agency, or that
12 sponsor”;

13 (8) in subsection (b)(12), by adding at the end
14 the following new subparagraph:

15 “(E) Any entity authorized by law to (i)
16 conduct on-site health, safety or patient care re-
17 views and surveys or (ii) to investigate whether
18 any violations of law have occurred, including
19 violations under this section, section 1128A,
20 section 1128B, or part 2 of subtitle E of title
21 V of the Health Security Act.”;

22 (9) in subsection (b)(14), by striking “XVIII or
23 XIX” and inserting “XVIII, a State health care pro-
24 gram, or an applicable health plan (as defined in
25 section 1902(6) of the Health Security Act)”;

1 (10) in subsection (b)(15)—

2 (A) in subparagraph (B), by striking
3 “1128A” and inserting “1128A or section 5412
4 of the Health Security Act”, and

5 (B) in subparagraph (C), by striking “title
6 XVIII or under a State health care program”
7 and inserting “title XVIII, a State health care
8 program, or an applicable health plan (as de-
9 fined in section 1902(6) of the Health Security
10 Act”.

11 (f) APPEAL OF EXCLUSIONS TO COURT OF AP-
12 PEALS.—Section 1128(f)(1) (42 U.S.C. 1320a–7(f)(1)) is
13 amended by striking the period at the end and inserting
14 the following: “, except that any action brought to appeal
15 such decision shall be brought in the United States Court
16 of Appeals for the judicial circuit in which the individual
17 or entity resides or has a principal place of business (or,
18 if the individual or entity does not reside or have a prin-
19 cipal place of business within any such judicial circuit, in
20 the United States Court of Appeals for the District of Co-
21 lumbia Circuit).”.

1 **SEC. 4045. SANCTIONS AGAINST PRACTITIONERS AND PER-**
2 **SONS FOR FAILURE TO COMPLY WITH STATU-**
3 **TORY OBLIGATIONS RELATING TO QUALITY**
4 **OF CARE.**

5 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-
6 TIONERS AND PERSONS FAILING TO MEET STATUTORY
7 OBLIGATIONS.—

8 (1) IN GENERAL.—The second sentence of sec-
9 tion 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is
10 amended by striking “may prescribe)” and inserting
11 “may prescribe, except that such period may not be
12 less than one year)”.

13 (2) CONFORMING AMENDMENT.—Section
14 1156(b)(2) (42 U.S.C. 1320c-5(b)(2)) is amended by
15 striking “shall remain” and inserting “shall (subject
16 to the minimum period specified in the second sen-
17 tence of paragraph (1)) remain”.

18 (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-
19 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)
20 (42 U.S.C. 1320c-5(b)(1)) is amended—

21 (1) in the second sentence, by striking “and de-
22 termines” and all that follows through “such obliga-
23 tions,” and

24 (2) by striking the third sentence.

25 (c) AMOUNT OF CIVIL MONEY PENALTY.—Section
26 1156(b)(3) (42 U.S.C. 1320c-5(b)(3)) is amended by

1 striking “the actual or estimated cost” and inserting the
2 following: “\$50,000 for each instance”.

3 **SEC. 4046. EFFECTIVE DATE.**

4 The amendments made by this part shall take effect
5 January 1, 1995.

6 **PART 6—FUNDING OF GRADUATE MEDICAL**

7 **EDUCATION AND ACADEMIC HEALTH CENTERS**

8 **SEC. 4051. TRANSFERS FROM MEDICARE TRUST FUNDS**
9 **FOR GRADUATE MEDICAL EDUCATION.**

10 (a) IN GENERAL.—For purposes of complying with
11 section 3034(a), there shall be transferred to the Sec-
12 retary from the Federal Hospital Insurance Trust Fund
13 (established under section 1817 of the Social Security Act)
14 and the Federal Supplementary Medical Insurance Trust
15 Fund (established under section 1841 of such Act) the fol-
16 lowing amount (in the aggregate), as applicable to a fiscal
17 year:

18 (1) In the case of fiscal year 1996,
19 \$1,500,000,000.

20 (2) In the case of each of the fiscal years 1997
21 and 1998, \$1,600,000,000.

22 (3) In the case of each subsequent fiscal year,
23 the amount specified in paragraph (2) increased by
24 the Secretary’s estimate of the percentage increase
25 in the consumer price index for all urban consumers

1 (U.S. city average) for the 12-month period ending
2 with the midpoint of the previous fiscal year.

3 (b) ALLOCATION OF AMOUNT AMONG FUNDS.—With
4 respect to the amount required under subsection (a) to
5 be transferred for a year from the Federal Hospital Insur-
6 ance Trust Fund and the Federal Supplementary Medical
7 Insurance Trust Fund, the Secretary shall determine an
8 equitable allocation of such amount among the funds.

9 (c) TERMINATION OF GRADUATE MEDICAL EDU-
10 CATION PAYMENTS UNDER MEDICARE.—

11 (1) IN GENERAL.— Section 1886(h) (42 U.S.C.
12 1395ww(h)) is amended by adding at the end the
13 following new paragraph:

14 “(6) TERMINATION OF PAYMENTS ATTRIB-
15 UTABLE TO COSTS OF TRAINING PHYSICIANS.—Not-
16 withstanding any other provision of this section or
17 section 1861(v), no payment may be made under
18 this title for direct graduate medical education costs
19 attributable to an approved medical residency train-
20 ing program for any cost reporting period (or por-
21 tion thereof) beginning on or after October 1,
22 1995.”.

23 (2) PROHIBITION AGAINST RECOGNITION OF
24 COSTS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1))

1 is amended by adding at the end the following new
2 subparagraph:

3 “(T) Such regulations shall not include any provision
4 for specific recognition of the costs of graduate medical
5 education for hospitals for any cost reporting period (or
6 portion thereof) beginning on or after October 1, 1995.
7 Nothing in the previous sentence shall be construed to af-
8 fect in any way payments to hospitals for the costs of any
9 approved educational activities that are not described in
10 such sentence.”.

11 **SEC. 4052. TRANSFERS FROM HOSPITAL INSURANCE TRUST**
12 **FUND FOR ACADEMIC HEALTH CENTERS.**

13 (a) IN GENERAL.—For purposes of complying with
14 section 3104(a), there shall be transferred to the Sec-
15 retary from the Federal Hospital Insurance Trust Fund
16 (established under section 1817 of the Social Security Act)
17 the following amount (in the aggregate), as applicable to
18 a fiscal year:

19 (1) In the case of fiscal year 1996,
20 \$2,100,000,000.

21 (2) In the case of each of the fiscal years 1997
22 and 1998, \$2,000,000,000.

23 (3) In the case of each subsequent fiscal year,
24 the amount specified in paragraph (2) increased by
25 the Secretary’s estimate of the percentage increase

1 in the consumer price index for all urban consumers
2 (U.S. city average) for the 12-month period ending
3 with the midpoint of the previous fiscal year.

4 (b) TERMINATION OF PAYMENTS UNDER MEDI-
5 CARE.—

6 (1) IN GENERAL.—Section 1886(d)(5)(B) (42
7 U.S.C. 1395ww(d)(5)(B)) is amended in the matter
8 preceding clause (i) by striking “The Secretary” and
9 inserting “For discharges occurring before October
10 1, 1995, the Secretary”.

11 (2) ADJUSTMENT TO STANDARDIZED
12 AMOUNTS.—Section 1886(d)(2)(C)(i) (42 U.S.C.
13 1395ww(d)(2)(C)(i)) is amended by striking “exclud-
14 ing” and inserting “for discharges occurring before
15 October 1, 1995, excluding”.

16 **PART 7—COVERAGE OF SERVICES PROVIDED BY**
17 **FACILITIES AND PLANS OF DEPARTMENTS**
18 **OF DEFENSE AND VETERANS AFFAIRS**

19 **SEC. 4061. TREATMENT OF UNIFORMED SERVICES HEALTH**
20 **PLAN AS ELIGIBLE ORGANIZATION UNDER**
21 **MEDICARE.**

22 (a) IN GENERAL.—Section 1876 (42 U.S.C.
23 1395mm), as amended by section 4002(a), is further
24 amended by adding at the end the following new sub-
25 section:

1 “(l) Notwithstanding any other provision of this sec-
2 tion, a Uniformed Services Health Plan of the Department
3 of Defense under chapter 55 of title 10, United States
4 Code, shall be considered an eligible organization under
5 this section, and the Secretary shall make payments to
6 such Plan during a year on behalf of any individuals enti-
7 tled to benefits under this title who are enrolled with such
8 a Plan during the year in the same amounts and under
9 the same terms and conditions under which the Secretary
10 makes payments to eligible organizations with risk-sharing
11 contracts under section 1876.”.

12 (b) EFFECTIVE DATE.—The amendment made by
13 subsection (a) shall apply to items and services furnished
14 under title XVIII of the Social Security Act on or after
15 October 1, 1995.

16 **SEC. 4062. COVERAGE OF SERVICES PROVIDED TO MEDI-**
17 **CARE BENEFICIARIES BY PLANS AND FACILI-**
18 **TIES OF DEPARTMENT OF VETERANS AF-**
19 **FAIRS.**

20 (a) IN GENERAL.—Title XVIII, as amended by sec-
21 tions 4001 and 4003, is further amended by adding at
22 the end the following new section:

23 “TREATMENT OF PLANS AND FACILITIES OF
24 DEPARTMENT OF VETERANS AFFAIRS AS PROVIDERS

25 “SEC. 1895. (a) IN GENERAL.—Notwithstanding any
26 other provision of this title—

1 “(1) a VA health plan (as defined in section
2 1801(2) of title 38, United States Code) shall be
3 considered an eligible organization for purposes of
4 section 1876; and

5 “(2) a health care facility of the Department of
6 Veterans Affairs shall be considered a provider of
7 services under section 1861(u).

8 “(b) ELIGIBILITY FOR PAYMENTS.—

9 “(1) VA HEALTH PLANS.—The Secretary shall
10 make payments to a VA health plan during a year
11 on behalf of any veteran, other than a veteran de-
12 scribed in section 1831(b) during the year (other
13 than any individuals described in section 1831(b) of
14 title 38, United States Code) in the same amounts
15 and under the same terms and conditions under
16 which the Secretary makes payments to eligible or-
17 ganizations with a risk-sharing contract under sec-
18 tion 1876.

19 “(2) HEALTH CARE FACILITIES.—The Sec-
20 retary shall make payments to a health care facility
21 of the Department of Veterans Affairs for services
22 provided to an individual entitled to benefits under
23 this title in the same amounts and under the same
24 terms and conditions under which the Secretary

1 makes payments to provider of services under this
2 title.”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to items and services furnished
5 under title XVIII of the Social Security Act on or after
6 January 1, 1998.

7 **SEC. 4063. CONFORMING AMENDMENTS.**

8 (a) PART A.—Section 1814 (42 U.S.C. 1395f) is
9 amended by striking subsection (c).

10 (b) PART B.—Section 1835 (42 U.S.C. 1395n) is
11 amended by striking subsection (d).

12 (c) ADDITIONAL CONFORMING AMENDMENT.—Sec-
13 tion 1880(a) (42 U.S.C. 1395qq(a)) is amended by strik-
14 ing “, notwithstanding sections 1814(c) and 1835(d),”.

15 (d) EFFECTIVE DATE.—The amendments made by
16 this section shall take effect January 1, 1998.

17 **Subtitle B—Savings in Medicare**
18 **Program**

19 **PART 1—SAVINGS RELATING TO PART A**

20 **SEC. 4101. REDUCTION IN UPDATE FOR INPATIENT HOS-**
21 **PITAL SERVICES.**

22 Section 1886(b)(3)(B)(i) (42 U.S.C.
23 1395ww(b)(3)(B)(i)), as amended by section 13501(a)(1)
24 of OBRA–1993, is amended—

25 (1) in subclause (XII)—

1 (A) by striking “fiscal year 1997” and in-
2 serting “for each of the fiscal years 1997
3 through 2000”, and

4 (B) by striking “0.5 percentage point” and
5 inserting “2.0 percentage points”; and

6 (2) in subclause (XIII), by striking “fiscal year
7 1998” and inserting “fiscal year 2003”.

8 **SEC. 4102. REDUCTION IN ADJUSTMENT FOR INDIRECT**
9 **MEDICAL EDUCATION.**

10 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42
11 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as fol-
12 lows:

13 “(ii) For purposes of clause (i)(II), the indirect
14 teaching adjustment factor is equal to $c * (((1+r)$
15 $\text{to the } n\text{th power}) - 1)$, where ‘r’ is the ratio of the
16 hospital’s full-time equivalent interns and residents
17 to beds and ‘n’ equals .405. For discharges occur-
18 ring on or after—

19 “(I) May 1, 1986, and before October 1,
20 1995, ‘c’ is equal to 1.89, and

21 “(II) October 1, 1995, ‘c’ is equal to
22 0.74.”.

23 (b) NO RESTANDARDIZATION OF PAYMENT
24 AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42
25 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking “of

1 1985” and inserting “of 1985, but not taking into account
2 the amendments made by section 4102(a) of the Health
3 Security Act”.

4 **SEC. 4103. REDUCTION IN PAYMENTS FOR CAPITAL-RE-**
5 **LATED COSTS FOR INPATIENT HOSPITAL**
6 **SERVICES.**

7 (a) PPS HOSPITALS.—

8 (1) REDUCTION IN BASE PAYMENT RATES.—

9 Section 1886(g)(1)(A) (42 U.S.C.
10 1395ww(g)(1)(A)), as amended by section
11 13501(a)(3) of OBRA–1993, is amended by adding
12 at the end the following new sentence: “In addition
13 to the reduction described in the preceding sentence,
14 for discharges occurring after September 30, 1995,
15 the Secretary shall reduce by 7.31 percent the
16 unadjusted standard Federal capital payment rate
17 (as described in 42 CFR 412.308(c), as in effect on
18 the date of the enactment of the Health Security
19 Act) and shall reduce by 10.41 percent the
20 unadjusted hospital-specific rate (as described in 42
21 CFR 412.328(e)(1), as in effect on the date of the
22 enactment of the Health Security Act).”.

23 (2) REDUCTION IN UPDATE.—Section
24 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

25 (A) in subparagraph (B)(i)—

1 (i) by striking “and (II)” and insert-
2 ing “(II)”, and

3 (ii) by striking the semicolon at the
4 end and inserting the following: “, and
5 (III) an annual update factor established
6 for the prospective payment rates applica-
7 ble to discharges in a fiscal year which
8 (subject to reduction under subparagraph
9 (C)) will be based upon such factor as the
10 Secretary determines appropriate to take
11 into account amounts necessary for the ef-
12 ficient and effective delivery of medically
13 appropriate and necessary care of high
14 quality;”;

15 (B) by redesignating subparagraph (C) as
16 subparagraph (D); and

17 (C) by inserting after subparagraph (B)
18 the following new subparagraph:

19 “(C)(i) With respect to payments attributable
20 to portions of cost reporting periods or discharges
21 occurring during each of the fiscal years 1996
22 through 2003, the Secretary shall include a reduc-
23 tion in the annual update factor established under
24 subparagraph (B)(i)(III) for discharges in the year
25 equal to the applicable update reduction described in

1 clause (ii) to adjust for excessive increases in capital
2 costs per discharge for fiscal years prior to fiscal
3 year 1992 (but in no event may such reduction re-
4 sult in an annual update factor less than zero).

5 “(ii) In clause (i), the term ‘applicable update
6 reduction’ means, with respect to the update factor
7 for a fiscal year—

8 “(I) 4.9 percentage points; or

9 “(II) if the annual update factor for the
10 previous fiscal year was less than the applicable
11 update reduction for the previous year, the sum
12 of 4.9 percentage points and the difference be-
13 tween the annual update factor for the previous
14 year and the applicable update reduction for the
15 previous year.”.

16 (b) PPS-EXEMPT HOSPITALS.—Section 1861(v)(1)
17 (42 U.S.C. 1395x(v)(1)), as amended by section
18 4051(c)(2), is further amended by adding at the end the
19 following new subparagraph:

20 “(U) Such regulations shall provide that, in deter-
21 mining the amount of the payments that may be made
22 under this title with respect to the capital-related costs
23 of inpatient hospital services furnished by a hospital that
24 is not a subsection (d) hospital (as defined in section
25 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital

1 (as defined in section 1886(d)(9)(A)), the Secretary shall
2 reduce the amounts of such payments otherwise estab-
3 lished under this title by 15 percent for payments attrib-
4 utable to portions of cost reporting periods occurring dur-
5 ing each of the fiscal years 1996 through 2003.”.

6 **SEC. 4104. REVISIONS TO PAYMENT ADJUSTMENTS FOR**
7 **DISPROPORTIONATE SHARE HOSPITALS IN**
8 **PARTICIPATING STATES.**

9 (a) APPLICATION OF ALTERNATIVE ADJUST-
10 MENTS.—Section 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is
11 amended—

12 (1) by redesignating subparagraphs (H) and (I)
13 as subparagraphs (I) and (J); and

14 (2) by inserting after subparagraph (G) the fol-
15 lowing new subparagraph:

16 “(H)(i) In accordance with this subparagraph, the
17 Secretary shall provide for an additional payment for each
18 subsection (d) hospital that is located in a participating
19 State under the Health Security Act during a cost report-
20 ing period and that meets the eligibility requirements de-
21 scribed in clause (iii).

22 “(ii) The amount of the additional payment made
23 under clause (i) for each discharge shall be determined
24 by multiplying—

1 “(I) the sum of the amount determined under
2 paragraph (1)(A)(ii)(II) (or, if applicable, the
3 amount determined under paragraph (1)(A)(iii)) and
4 the amount paid to the hospital under subparagraph
5 (A) for the discharge, by

6 “(II) the SSI adjustment percentage for the
7 cost reporting period in which the discharge occurs
8 (as defined in clause (iv)).

9 “(iii) A hospital meets the eligibility requirements de-
10 scribed in this clause with respect to a cost reporting pe-
11 riod if—

12 “(I) in the case of a hospital that is located in
13 an urban area and that has more than 100 beds, the
14 hospital’s SSI patient percentage (as defined in
15 clause (v)) for the cost reporting period is not less
16 than 5.5 percent;

17 “(II) in the case of a hospital that is located in
18 an urban area and that has less than 100 beds, the
19 hospital’s SSI patient percentage is not less than 17
20 percent;

21 “(III) in the case of a hospital that is classified
22 as a rural referral center under subparagraph (C) or
23 a sole community hospital under subparagraph (D),
24 the hospital’s SSI patient percentage for the cost re-
25 porting period is not less than 23 percent; and

1 “(IV) in the case of any other hospital, the hos-
2 pital’s SSI patient percentage is not less than 23
3 percent.

4 “(iv) For purposes of clause (ii), the ‘SSI adjustment
5 percentage’ applicable to a hospital for a cost reporting
6 period is equal to—

7 “(I) in the case of a hospital described in clause
8 (iii)(I), the percentage determined in accordance
9 with the following formula: e to the n th power $- 1$,
10 where ‘ e ’ is the natural antilog of 1 and where ‘ n ’
11 is equal to $(.5642 * (\text{the hospital's SSI patient per-}$
12 centage for the cost reporting period $- .055))$;

13 “(II) in the case of a hospital described in
14 clause (iii)(II) or clause (iii)(IV), 2 percent; and

15 “(III) in the case of a hospital described in
16 clause (iii)(III), the sum of 2 percent and .30 per-
17 cent of the difference between the hospital’s SSI pa-
18 tient percentage for the cost reporting period and 23
19 percent.

20 “(v) In this subparagraph, a hospital’s ‘SSI patient
21 percentage’ with respect to a cost reporting period is equal
22 to the fraction (expressed as a percentage)—

23 “(I) the numerator of which is the number of
24 the hospital’s patient days for such period which
25 were made up of patients who (for such days) were

1 entitled to benefits under part A and were entitled
2 to supplementary security income benefits (excluding
3 State supplementation) under title XVI; and

4 “(II) the denominator of which is the number
5 of the hospital’s patient days for such period which
6 were made up of patients who (for such days) were
7 entitled to benefits under part A.”.

8 (b) NO STANDARDIZATION RESULTING FROM RE-
9 Duction.—Section 1886(d)(2)(C)(iv) (42 U.S.C.
10 1395ww(d)(2)(C)(iv)) is amended—

11 (1) by striking “exclude additional payments”
12 and inserting “adjust such estimate for changes in
13 payments”;

14 (2) by striking “1989 or” and inserting
15 “1989,”; and

16 (3) by striking the period at the end and insert-
17 ing the following: “, or the enactment of section
18 4104 of the Health Security Act.”.

19 (c) CONFORMING AMENDMENT.—Section
20 1886(d)(5)(F)(i) (42 U.S.C. 1395ww(d)(5)(F)(i)) is
21 amended in the matter preceding subclause (I) by insert-
22 ing after “hospital” the following: “that is not located in
23 a State that is a participating State under the Health Se-
24 curity Act”.

1 **SEC. 4105. MORATORIUM ON DESIGNATION OF ADDITIONAL**
2 **LONG-TERM CARE HOSPITALS.**

3 Notwithstanding clause (iv) of section 1886(d)(1)(B)
4 of the Social Security Act, a hospital which has an average
5 inpatient length of stay (as determined by the Secretary
6 of Health and Human Services) of greater than 25 days
7 shall not be treated as a hospital described in such clause
8 for purposes of title XVIII of such Act unless the hospital
9 was treated as a hospital described in such clause for pur-
10 poses of such title as of the date of the enactment of this
11 Act.

12 **SEC. 4106. EXTENSION OF FREEZE ON UPDATES TO ROU-**
13 **TINE SERVICE COSTS OF SKILLED NURSING**
14 **FACILITIES.**

15 (a) PAYMENTS BASED ON COST LIMITS.—Section
16 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking
17 “112 percent” each place it appears and inserting “100
18 percent (adjusted by such amount as the Secretary deter-
19 mines to be necessary to preserve the savings resulting
20 from the enactment of section 13503(a)(1) of the Omni-
21 bus Budget Reconciliation Act of 1993)”.

22 (b) PAYMENTS DETERMINED ON PROSPECTIVE
23 BASIS.—Section 1888(d)(2)(B) (42 U.S.C.
24 1395yy(d)(2)(B)) is amended by striking “105 percent”
25 and inserting “100 percent (adjusted by such amount as
26 the Secretary determines to be necessary to preserve the

1 savings resulting from the enactment of section 13503(b)
2 of the Omnibus Budget Reconciliation Act of 1993”).

3 (c) EFFECTIVE DATE.—The amendments made by
4 subsections (a) and (b) shall apply to cost reporting peri-
5 ods beginning on or after October 1, 1995.

6 **PART 2—SAVINGS RELATING TO PART B**

7 **SEC. 4111. ESTABLISHMENT OF CUMULATIVE EXPENDI-**
8 **TURE GOALS FOR PHYSICIAN SERVICES.**

9 (a) USE OF CUMULATIVE PERFORMANCE STAND-
10 ARD.—Section 1848(f)(2) (42 U.S.C. 1395w-4(f)(2)) is
11 amended—

12 (1) in subparagraph (A)—

13 (A) in the heading, by striking “IN GEN-
14 ERAL” and inserting “FISCAL YEARS 1991
15 THROUGH 1994.—”,

16 (B) in the matter preceding clause (i), by
17 striking “a fiscal year (beginning with fiscal
18 year 1991)” and inserting “fiscal years 1991,
19 1992, 1993, and 1994”, and

20 (C) in the matter following clause (iv), by
21 striking “subparagraph (B)” and inserting
22 “subparagraph (C)”;

23 (2) in subparagraph (B), by striking “subpara-
24 graph (A)” and inserting “subparagraphs (A) and
25 (B)”;

1 (3) by redesignating subparagraphs (B) and
2 (C) as subparagraphs (C) and (D); and

3 (4) by inserting after subparagraph (A) the fol-
4 lowing new subparagraph:

5 “(B) FISCAL YEARS BEGINNING WITH FIS-
6 CAL YEAR 1995.—Unless Congress otherwise
7 provides, the performance standard rate of in-
8 crease, for all physicians’ services and for each
9 category of physicians’ services, for a fiscal year
10 beginning with fiscal year 1995 shall be equal
11 to the performance standard rate of increase
12 determined under this paragraph for the pre-
13 vious fiscal year, increased by the product of—

14 “(i) 1 plus the Secretary’s estimate of
15 the weighted average percentage increase
16 (divided by 100) in the fees for all physi-
17 cians’ services or for the category of physi-
18 cians’ services, respectively, under this part
19 for portions of calendar years included in
20 the fiscal year involved,

21 “(ii) 1 plus the Secretary’s estimate of
22 the percentage increase or decrease (di-
23 vided by 100) in the average number of in-
24 dividuals enrolled under this part (other

1 than HMO enrollees) from the previous fis-
2 cal year to the fiscal year involved,

3 “(iii) 1 plus the Secretary’s estimate
4 of the average annual percentage growth
5 (divided by 100) in volume and intensity of
6 all physicians’ services or of the category
7 of physicians’ services, respectively, under
8 this part for the 5-fiscal-year period ending
9 with the preceding fiscal year (based upon
10 information contained in the most recent
11 annual report made pursuant to section
12 1841(b)(2)), and

13 “(iv) 1 plus the Secretary’s estimate
14 of the percentage increase or decrease (di-
15 vided by 100) in expenditures for all physi-
16 cians’ services or of the category of physi-
17 cians’ services, respectively, in the fiscal
18 year (compared with the previous fiscal
19 year) which are estimated to result from
20 changes in law or regulations affecting the
21 percentage increase described in clause (i)
22 and which is not taken into account in the
23 percentage increase described in clause (i),

1 minus 1, multiplied by 100, and reduced by the
2 performance standard factor (specified in sub-
3 paragraph (C)).”.

4 (b) TREATMENT OF DEFAULT UPDATE.—

5 (1) IN GENERAL.—Section 1848(d)(3)(B) (42
6 U.S.C. 1395w-4(d)(3)(B)) is amended—

7 (A) in clause (i)—

8 (i) in the heading, by striking “IN
9 GENERAL” and inserting “1992 THROUGH
10 1996”, and

11 (ii) by striking “for a year” and in-
12 serting “for 1992, 1993, 1994, 1995, and
13 1996”; and

14 (B) by adding after clause (ii) the fol-
15 lowing new clause:

16 “(iii) YEARS BEGINNING WITH 1997.—

17 “(I) IN GENERAL.—The update
18 for a category of physicians’ services
19 for a year beginning with 1997 pro-
20 vided under subparagraph (A) shall be
21 increased or decreased by the same
22 percentage by which the cumulative
23 percentage increase in actual expendi-
24 tures for such category of physicians’
25 services for such year was less or

1 greater, respectively, than the per-
2 formance standard rate of increase
3 (established under subsection (f)) for
4 such category of services for such
5 year.

6 “(II) CUMULATIVE PERCENTAGE
7 INCREASE DEFINED.—In subclause
8 (I), the ‘cumulative percentage in-
9 crease in actual expenditures’ for a
10 year shall be equal to the product of
11 the adjusted increases for each year
12 beginning with 1995 up to and includ-
13 ing the year involved, minus 1 and
14 multiplied by 100. In the previous
15 sentence, the ‘adjusted increase’ for a
16 year is equal to 1 plus the percentage
17 increase in actual expenditures for the
18 year.”.

19 (2) CONFORMING AMENDMENT.—Section
20 1848(d)(3)(A)(i) (42 U.S.C. 1395w-4(d)(3)(A)(i)) is
21 amended by striking “subparagraph (B)” and insert-
22 ing “subparagraphs (B) and (C)”.

1 **SEC. 4112. USE OF REAL GDP TO ADJUST FOR VOLUME AND**
2 **INTENSITY; REPEAL OF RESTRICTION ON**
3 **MAXIMUM REDUCTION PERMITTED IN DE-**
4 **FAULT UPDATE.**

5 (a) USE OF REAL GDP TO ADJUST FOR VOLUME
6 AND INTENSITY.—Section 1848(f)(2)(B)(iii) (42 U.S.C.
7 1395w–4(f)(2)(B)(iii)), as added by section 4111(a), is
8 amended to read as follows:

9 “(iii) 1 plus the average per capita
10 growth in the real gross domestic product
11 (divided by 100) for the 5-fiscal-year pe-
12 riod ending with the previous fiscal year
13 (increased by 1.5 percentage points for the
14 category of services consisting of primary
15 care services), and”.

16 (b) REPEAL OF RESTRICTION ON MAXIMUM REDUC-
17 TION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w–
18 4(d)(3)(B)(ii)), as amended by section 13512(b) of
19 OBRA–1993, is amended—

20 (1) in the heading, by inserting “IN CERTAIN
21 YEARS” after “ADJUSTMENT”;

22 (2) in the matter preceding subclause (I), by
23 striking “for a year”;

24 (3) in subclause (I), by adding “and” at the
25 end;

1 (4) in subclause (II), by striking “, and” and
2 inserting a period; and

3 (5) by striking subclause (III).

4 (c) REPEAL OF PERFORMANCE STANDARD FAC-
5 TOR.—

6 (1) IN GENERAL.—Section 1842(f)(2), as
7 amended by section 4111(a)(3), is amended by strik-
8 ing subparagraph (C) and redesignating subpara-
9 graph (D) as subparagraph (C).

10 (2) CONFORMING AMENDMENT.—Section
11 1842(f)(2)(B), as added by section 4111(a), is
12 amended in the matter following clause (iv) by strik-
13 ing “1, multiplied by 100” and all that follows
14 through “subparagraph (C))” and inserting “1 and
15 multiplied by 100”.

16 **SEC. 4113. REDUCTION IN CONVERSION FACTOR FOR PHY-**
17 **SICIAN FEE SCHEDULE FOR 1995.**

18 Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)) is
19 amended—

20 (1) in subparagraph (A), by inserting after
21 “subparagraph (B)” the following: “, and, in the
22 case of 1995, specified in subparagraph (C)”;

23 (2) by redesignating subparagraph (C) as sub-
24 paragraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

“(C) SPECIAL PROVISION FOR 1995.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph for 1995 is—

“(i) in the case of physicians’ services included in the category of primary care services (as defined in subsection (j)(1)), the conversion factor established under this subsection for 1994 adjusted by the update established under paragraph (3) for 1995; and

“(ii) in the case of any other physicians’ services, the conversion factor established under this subsection for 1994 reduced by 3 percent and adjusted by the update established under paragraph (3) for 1995.”.

SEC. 4114. LIMITATIONS ON PAYMENT FOR PHYSICIANS’ SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS.

(a) IN GENERAL.—

(1) LIMITATIONS DESCRIBED.—Part B of title XVIII, as amended by section 2003(a), is amended

1 by inserting after section 1848 the following new
2 section:

3 “LIMITATIONS ON PAYMENT FOR PHYSICIANS’ SERVICES
4 FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS

5 “SEC. 1849. (a) SERVICES SUBJECT TO REDUC-
6 TION.—

7 “(1) DETERMINATION OF HOSPITAL-SPECIFIC
8 PER ADMISSION RELATIVE VALUE.—Not later than
9 October 1 of each year (beginning with 1997), the
10 Secretary shall determine for each hospital—

11 “(A) the hospital-specific per admission
12 relative value under subsection (b)(2) for the
13 following year; and

14 “(B) whether such hospital-specific relative
15 value is projected to exceed the allowable aver-
16 age per admission relative value applicable to
17 the hospital for the following year under sub-
18 section (b)(1).

19 “(2) REDUCTION FOR SERVICES AT HOSPITALS
20 EXCEEDING ALLOWABLE AVERAGE PER ADMISSION
21 RELATIVE VALUE.—If the Secretary determines
22 (under paragraph (1)) that a medical staff’s hos-
23 pital-specific per admission relative value for a year
24 (beginning with 1998) is projected to exceed the al-
25 lowable average per admission relative value applica-
26 ble to the medical staff for the year, the Secretary

1 shall reduce (in accordance with subsection (c)) the
2 amount of payment otherwise determined under this
3 part for each physician's service furnished during
4 the year to an inpatient of the hospital by an indi-
5 vidual who is a member of the hospital's medical
6 staff.

7 “(3) TIMING OF DETERMINATION; NOTICE TO
8 HOSPITALS AND CARRIERS.—Not later than October
9 1 of each year (beginning with 1997), the Secretary
10 shall notify the medical executive committee of each
11 hospital (as set forth in the Standards of the Joint
12 Commission on the Accreditation of Health Organi-
13 zations) of the determinations made with respect to
14 the medical staff under paragraph (1).

15 “(b) DETERMINATION OF ALLOWABLE AVERAGE
16 PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPE-
17 CIFIC PER ADMISSION RELATIVE VALUES.—

18 “(1) ALLOWABLE AVERAGE PER ADMISSION
19 RELATIVE VALUE.—

20 “(A) URBAN HOSPITALS.—In the case of a
21 hospital located in an urban area, the allowable
22 average per admission relative value established
23 under this subsection for a year is equal to 125
24 percent (or 120 percent for years after 1999) of
25 the median of 1996 hospital-specific per admis-

1 sion relative values determined under paragraph
2 (2) for all hospital medical staffs.

3 “(B) RURAL HOSPITALS.—In the case of a
4 hospital located in a rural area, the allowable
5 average per admission relative value established
6 under this subsection for 1998 and each suc-
7 ceeding year, is equal to 140 percent of the me-
8 dian of the 1996 hospital-specific per admission
9 relative values determined under paragraph (2)
10 for all hospital medical staffs.

11 “(2) HOSPITAL-SPECIFIC PER ADMISSION REL-
12 ATIVE VALUE.—

13 “(A) IN GENERAL.—The hospital-specific
14 per admission relative value projected for a hos-
15 pital (other than a teaching hospital) for a cal-
16 endar year, shall be equal to the average per
17 admission relative value (as determined under
18 section 1848(c)(2)) for physicians’ services fur-
19 nished to inpatients of the hospital by the hos-
20 pital’s medical staff (excluding interns and resi-
21 dents) during the second year preceding such
22 calendar year, adjusted for variations in case-
23 mix and disproportionate share status among
24 hospitals (as determined by the Secretary under
25 subparagraph (C)).

1 “(B) SPECIAL RULE FOR TEACHING HOS-
2 PITALS.—The hospital-specific relative value
3 projected for a teaching hospital in a calendar
4 year shall be equal to the sum of—

5 “(i) the average per admission relative
6 value (as determined under section
7 1848(c)(2)) for physicians’ services fur-
8 nished to inpatients of the hospital by the
9 hospital’s medical staff (excluding interns
10 and residents) during the second year pre-
11 ceding such calendar year; and

12 “(ii) the equivalent per admission rel-
13 ative value (as determined under section
14 1848(c)(2)) for physicians’ services fur-
15 nished to inpatients of the hospital by in-
16 terns and residents of the hospital during
17 the second year preceding such calendar
18 year, adjusted for variations in case-mix,
19 disproportionate share status, and teaching
20 status among hospitals (as determined by
21 the Secretary under subparagraph (C)).
22 The Secretary shall determine such equiva-
23 lent relative value unit per admission for
24 interns and residents based on the best
25 available data for teaching hospitals and

1 may make such adjustment in the aggre-
2 gate.

3 “(C) ADJUSTMENT FOR TEACHING AND
4 DISPROPORTIONATE SHARE HOSPITALS.—The
5 Secretary shall adjust the allowable per admis-
6 sion relative values otherwise determined under
7 this paragraph to take into account the needs
8 of teaching hospitals and hospitals receiving ad-
9 ditional payments under subparagraphs (F) and
10 (G) of section 1886(d)(5). The adjustment for
11 teaching status or disproportionate share shall
12 not be less than zero.

13 “(c) AMOUNT OF REDUCTION.—The amount of pay-
14 ment otherwise made under this part for a physician’s
15 service that is subject to a reduction under subsection (a)
16 during a year shall be reduced 15 percent, in the case of
17 a service furnished by a member of the medical staff of
18 the hospital for which the Secretary determines under sub-
19 section (a)(1) that the hospital medical staff’s projected
20 relative value per admission exceeds the allowable average
21 per admission relative value.

22 “(d) RECONCILIATION OF REDUCTIONS BASED ON
23 HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION
24 WITH ACTUAL RELATIVE VALUES.—

1 “(1) DETERMINATION OF ACTUAL AVERAGE
2 PER ADMISSION RELATIVE VALUE.—Not later than
3 October 1 of each year (beginning with 1999), the
4 Secretary shall determine the actual average per ad-
5 mission relative value (as determined pursuant to
6 section 1848(c)(2)) for the physicians’ services fur-
7 nished by members of a hospital’s medical staff to
8 inpatients of the hospital during the previous year,
9 on the basis of claims for payment for such services
10 that are submitted to the Secretary not later than
11 90 days after the last day of such previous year. The
12 actual average per admission shall be adjusted by
13 the appropriate case-mix, disproportionate share fac-
14 tor, and teaching factor for the hospital medical
15 staff (as determined by the Secretary under sub-
16 section (b)(2)(C)). Notwithstanding any other provi-
17 sion of this title, no payment may be made under
18 this part for any physician’s service furnished by a
19 member of a hospital’s medical staff to an inpatient
20 of the hospital during a year unless the hospital sub-
21 mits a claim to the Secretary for payment for such
22 service not later than 90 days after the last day of
23 the year.

24 “(2) RECONCILIATION WITH REDUCTIONS
25 TAKEN.—In the case of a hospital for which the pay-

1 ment amounts for physicians' services furnished by
2 members of the hospital's medical staff to inpatients
3 of the hospital were reduced under this section for
4 a year—

5 “(A) if the actual average per admission
6 relative value for such hospital's medical staff
7 during the year (as determined by the Secretary
8 under paragraph (1)) did not exceed the allow-
9 able average per admission relative value appli-
10 cable to the hospital's medical staff under sub-
11 section (b)(1) for the year, the Secretary shall
12 reimburse the fiduciary agent for the medical
13 staff by the amount by which payments for
14 such services were reduced for the year under
15 subsection (c), including interest at an appro-
16 priate rate determined by the Secretary;

17 “(B) if the actual average per admission
18 relative value for such hospital's medical staff
19 during the year is less than 15 percentage
20 points above the allowable average per admis-
21 sion relative value applicable to the hospital's
22 medical staff under subsection (b)(1) for the
23 year, the Secretary shall reimburse the fidu-
24 ciary agent for the medical staff, as a percent
25 of the total allowed charges for physicians' serv-

1 ices performed in such hospital (prior to the
2 withhold), the difference between 15 percentage
3 points and the actual number of percentage
4 points that the staff exceeds the limit allowable
5 average per admission relative value, including
6 interest at an appropriate rate determined by
7 the Secretary; and

8 “(C) if the actual average per admission
9 relative value for such hospital’s medical staff
10 during the year exceeded the allowable average
11 per admission relative value applicable to the
12 hospital’s medical staff by 15 percentage points
13 or more, none of the withhold is paid to the fi-
14 duciary agent for the medical staff.

15 “(3) MEDICAL EXECUTIVE COMMITTEE OF A
16 HOSPITAL.—Each medical executive committee of a
17 hospital whose medical staff is projected to exceed
18 the allowable relative value per admission for a year,
19 shall have one year from the date of notification that
20 such medical staff is projected to exceed the allow-
21 able relative value per admission to designate a fidu-
22 ciary agent for the medical staff to receive and dis-
23 burse any appropriate withhold amount made by the
24 carrier.

1 “(4) ALTERNATIVE REIMBURSEMENT TO MEM-
2 BERS OF STAFF.—At the request of a fiduciary
3 agent for the medical staff, if the fiduciary agent for
4 the medical staff is owed the reimbursement de-
5 scribed in paragraph (2)(B) for excess reductions in
6 payments during a year, the Secretary shall make
7 such reimbursement to the members of the hospital’s
8 medical staff, on a pro-rata basis according to the
9 proportion of physicians’ services furnished to inpa-
10 tients of the hospital during the year that were fur-
11 nished by each member of the medical staff.

12 “(e) DEFINITIONS.—In this section, the following
13 definitions apply:

14 “(1) MEDICAL STAFF.—An individual fur-
15 nishing a physician’s service is considered to be on
16 the medical staff of a hospital—

17 “(A) if (in accordance with requirements
18 for hospitals established by the Joint Commis-
19 sion on Accreditation of Health Organiza-
20 tions)—

21 “(i) the individual is subject to by-
22 laws, rules, and regulations established by
23 the hospital to provide a framework for the
24 self-governance of medical staff activities;

1 “(ii) subject to such bylaws, rules, and
2 regulations, the individual has clinical
3 privileges granted by the hospital’s gov-
4 erning body; and

5 “(iii) under such clinical privileges,
6 the individual may provide physicians’
7 services independently within the scope of
8 the individual’s clinical privileges, or

9 “(B) if such physician provides at least one
10 service to a medicare beneficiary in such hos-
11 pital.

12 “(2) RURAL AREA; URBAN AREA.—The terms
13 ‘rural area’ and ‘urban area’ have the meaning given
14 such terms under section 1886(d)(2)(D).

15 “(3) TEACHING HOSPITAL.—The term ‘teaching
16 hospital’ means a hospital which has a teaching pro-
17 gram approved as specified in section 1861(b)(6).”.

18 (2) CONFORMING AMENDMENTS.—(A) Section
19 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is
20 amended by inserting “(subject to reduction under
21 section 1849)” after “1848(a)(1)”.

22 (B) Section 1848(a)(1)(B) (42 U.S.C. 1395w-
23 4(a)(1)(B)) is amended by striking “this sub-
24 section,” and inserting “this subsection and section
25 1849,”.

1 (b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL
2 AT WHICH SERVICE FURNISHED.—Section
3 1848(g)(4)(A)(i) (42 U.S.C. 1395w-4(g)(4)(A)(i)) is
4 amended by striking “beneficiary,” and inserting “bene-
5 ficiary (and, in the case of a service furnished to an inpa-
6 tient of a hospital, report the hospital identification num-
7 ber on such claim form),”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to services furnished on or after
10 January 1, 1998.

11 **SEC. 4115. MEDICARE INCENTIVES FOR PHYSICIANS TO**
12 **PROVIDE PRIMARY CARE.**

13 (a) RESOURCE-BASED PRACTICE EXPENSE REL-
14 ATIVE VALUE UNITS.—

15 (1) INCREASE IN PRACTICE EXPENSE RELATIVE
16 VALUE UNITS FOR CERTAIN SERVICES.—Section
17 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)), as amended
18 by sections 13513 and 13514 of OBRA-93, is
19 amended by adding at the end the following new
20 subparagraph:

21 “(G) INCREASE IN PRACTICE EXPENSE
22 RELATIVE VALUE UNITS FOR CERTAIN SERV-
23 ICES.—The Secretary shall increase the practice
24 expense relative value units applied in primary

1 care services, as defined in section 1842(i)(4),
2 by 10 percent, beginning with 1996.”.

3 (2) ASSURING BUDGET NEUTRALITY.—Section
4 1842(c)(2)(F) (42 U.S.C. 1395u(c)(2)(F)), as added
5 by section 13513 and amended by section 13514 of
6 OBRA–93, is amended by adding at the end the fol-
7 lowing new clause:

8 “(iii) shall reduce the relative values
9 for all services (other than anesthesia serv-
10 ices and primary care services, as defined
11 in section 1842(i)(4)) established under
12 this paragraph (and, in the case of anes-
13 thesia services, the conversion factor estab-
14 lished by the Secretary for such services)
15 by such percentage as the Secretary deter-
16 mines to be necessary so that, beginning in
17 1996, the amendment made by section
18 4115(a)(1) of the Health Security Act
19 would not result in expenditures under this
20 section that exceed the amount of such ex-
21 penditures that would have been made if
22 such amendment had not been made.”.

23 (3) STUDY.—The Secretary of Health and
24 Human Services shall—

1 (A) develop a methodology for imple-
2 menting in 1997 a resource-based system for
3 determining practice expense relative values
4 unit for each physician's service, and

5 (B) transmit a report by June 30, 1996,
6 on the methodology developed under paragraph
7 (1) to the Committees on Ways and Means and
8 Energy and Commerce of the House of Rep-
9 resentatives and the Committee on Finance of
10 the Senate. The reported shall include a presen-
11 tation of the data utilized in developing the
12 methodology and an explanation of the method-
13 ology.

14 (b) OFFICE VISIT PRE- AND POST-TIME.—

15 (1) INCREASE IN WORK RELATIVE VALUE UNITS
16 FOR OFFICE VISITS.—Section 1848(c)(2) (42 U.S.C.
17 1395w-4(c)(2)), as amended by subsection (a)(1), is
18 amended by adding at the end the following new
19 subparagraph:

20 “(H) INCREASE IN WORK RELATIVE VALUE
21 UNITS FOR CERTAIN SERVICES.—The Secretary
22 shall increase the work relative value units ap-
23 plied to office visits by 10 percent, beginning
24 with 1996.”.

1 (2) ASSURING BUDGET NEUTRALITY.—Section
2 1842(c)(2)(F)(iii) (42 U.S.C. 1395u(c)(2)(F)(iii)),
3 as added by subsection (a)(2), is amended by strik-
4 ing “section 4115(a)(1)” and substituting “sections
5 4115(a)(1) and (b)(1)”.

6 (c) OFFICE CONSULTATIONS.—Section 1848(c)(2)
7 (42 U.S.C. 1395w–4(c)(2)), as amended by subsections
8 (a)(1) and (b)(1), is amended by adding at the end the
9 following new subparagraph:

10 “(I) AMENDMENT IN RELATIVE VALUES
11 FOR OFFICE CONSULTATIONS.—The Secretary
12 shall reduce the work, practice expense and
13 malpractice relative value components of office
14 consultations to be equal to the work, practice
15 expense and malpractice relative value compo-
16 nents for comparable office visits beginning
17 with 1996. In making such adjustment, the
18 Secretary shall apply the savings from such re-
19 duction to increase each of the relative value
20 components for office visits in a manner that
21 would not result in expenditures under this sec-
22 tion that exceed the amount of such expendi-
23 tures that would have been made if such
24 amendment had not been made.”.

1 (d) OUTLIER INTENSITY RELATIVE VALUE ADJUST-
2 MENTS.—

3 (1) ADJUSTMENT OF OUTLIER INTENSITY OF
4 RELATIVE VALUES.—Section 1848(c)(2) (42 U.S.C.
5 1395w-4(c)(2)), as amended by subsections (a)(1),
6 (b)(1), and (c), is amended by adding at the end the
7 following new subparagraph:

8 “(J) ADJUSTMENT OF OUTLIER INTENSITY
9 OF RELATIVE VALUES.—Beginning with 1996,
10 the Secretary shall reduce the work relative
11 value components of procedures, or classes of
12 procedures, where the intensity exceeds thresh-
13 olds established by the Secretary. In the pre-
14 vious sentence, intensity shall mean the work
15 relative value units for the procedure divided by
16 the time for the procedure. The Secretary shall
17 apply the savings from such reductions to in-
18 crease the work relative value components of
19 primary care services, as defined in section
20 1842(i)(4), such that the changes made by this
21 subsection would not result in expenditures
22 under this section that exceed the amount of
23 such expenditures that would have been made if
24 such amendment had not been made.”.

1 (e) CHANGES IN UNDERSERVED AREA BONUS PAY-
2 MENTS.—

3 (1) IN GENERAL.—Section 1833(m) (42 U.S.C.
4 1395l(m)) is amended—

5 (A) by striking “10 percent” and inserting
6 “a percent”,

7 (B) by striking “service” the last place it
8 appears and inserting “services”, and

9 (C) by adding the following new sentence:
10 “The percent referred to in the previous sen-
11 tence is 20 percent in the case of primary care
12 services, as defined in section 1842(i)(4), and
13 10 percent for services other than primary care
14 services furnished in health professional short-
15 age areas located in rural areas as defined in
16 section 1886(d)(2)(D).”.

17 (2) The amendments made by paragraph (1)
18 are effective for services furnished on or after Janu-
19 ary 1, 1996.

20 **SEC. 4116. ELIMINATION OF FORMULA-DRIVEN OVERPAY-**
21 **MENTS FOR CERTAIN OUTPATIENT HOSPITAL**
22 **SERVICES.**

23 (a) AMBULATORY SURGICAL CENTER PROCE-
24 DURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C.
25 1395l(i)(3)(B)(i)(II)) is amended—

1 (1) by striking “of 80 percent”; and

2 (2) by striking the period at the end and insert-
3 ing the following: “, less the amount a provider may
4 charge as described in clause (ii) of section
5 1866(a)(2)(A).”.

6 (b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCE-
7 DURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C.
8 1395l(n)(1)(B)(i)(II)) is amended—

9 (1) by striking “of 80 percent”; and

10 (2) by striking the period at the end and insert-
11 ing the following: “, less the amount a provider may
12 charge as described in clause (ii) of section
13 1866(a)(2)(A).”.

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to services furnished during por-
16 tions of cost reporting periods occurring on or after July
17 1, 1994.

18 **SEC. 4117. IMPOSITION OF COINSURANCE ON LABORATORY**
19 **SERVICES.**

20 (a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of
21 section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

22 (1) by striking “(or 100 percent” and all that
23 follows through “the first opinion))”; and

1 (2) by striking “100 percent of such negotiated
2 rate” and inserting “80 percent of such negotiated
3 rate”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 subsection (a) shall apply to tests furnished on or after
6 January 1, 1995.

7 **SEC. 4118. APPLICATION OF COMPETITIVE ACQUISITION**
8 **PROCESS FOR PART B ITEMS AND SERVICES.**

9 (a) GENERAL RULE.—Part B of title XVIII of the
10 Social Security Act is amended by inserting after section
11 1846 the following:

12 “COMPETITION ACQUISITION FOR ITEMS AND SERVICES

13 “SEC. 1847. (a) ESTABLISHMENT OF BIDDING
14 AREAS.—

15 “(1) IN GENERAL.—The Secretary shall estab-
16 lish competitive acquisition areas for the purpose of
17 awarding a contract or contracts for the furnishing
18 under this part of the items and services described
19 in subsection (c) on or after January 1, 1995. The
20 Secretary may establish different competitive acqui-
21 sition areas under this subsection for different class-
22 es of items and services under this part.

23 “(2) CRITERIA FOR ESTABLISHMENT.—The
24 competitive acquisition areas established under para-
25 graph (1) shall—

1 “(A) initially be, or be within, metropolitan
2 statistical areas; and

3 “(B) be chosen based on the availability
4 and accessibility of suppliers and the probable
5 savings to be realized by the use of competitive
6 bidding in the furnishing of items and services
7 in the area.

8 “(b) AWARDING OF CONTRACTS IN AREAS.—

9 “(1) IN GENERAL.—The Secretary shall con-
10 duct a competition among individuals and entities
11 supplying items and services under this part for
12 each competitive acquisition area established under
13 subsection (a) for each class of items and services.

14 “(2) CONDITIONS FOR AWARDING CONTRACT.—
15 The Secretary may not award a contract to any indi-
16 vidual or entity under the competition conducted
17 pursuant to paragraph (1) to furnish an item or
18 service under this part unless the Secretary finds
19 that the individual or entity—

20 “(A) meets quality standards specified by
21 the Secretary for the furnishing of such item or
22 service; and

23 “(B) offers to furnish a total quantity of
24 such item or service that is sufficient to meet

1 the expected need within the competitive acqui-
2 sition area.

3 “(3) CONTENTS OF CONTRACT.—A contract en-
4 tered into with an individual or entity under the
5 competition conducted pursuant to paragraph (1)
6 shall specify (for all of the items and services within
7 a class)—

8 “(A) the quantity of items and services the
9 entity shall provide; and

10 “(B) such other terms and conditions as
11 the Secretary may require.

12 “(c) SERVICES DESCRIBED.—The items and services
13 to which the provisions of this section shall apply are as
14 follows:

15 “(1) Magnetic resonance imaging tests and
16 computerized axial tomography scans, including a
17 physician’s interpretation of the results of such tests
18 and scans.

19 “(2) Oxygen and oxygen equipment.

20 “(3) Such other items and services for which
21 the Secretary determines that the use of competitive
22 acquisition under this section will be appropriate and
23 cost-effective.”.

24 (b) ITEMS AND SERVICES TO BE FURNISHED ONLY
25 THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)

1 (42 U.S.C. 1395y(a)), as amended by section 4034(b)(4),
2 is amended—

3 (1) by striking “or” at the end of paragraph
4 (14);

5 (2) by striking the period at the end of para-
6 graph (15) and inserting “; or”; and

7 (3) by inserting after paragraph (15) the fol-
8 lowing new paragraph:

9 “(16) where such expenses are for an item or
10 service furnished in a competitive acquisition area
11 (as established by the Secretary under section
12 1847(a)) by an individual or entity other than the
13 supplier with whom the Secretary has entered into
14 a contract under section 1847(b) for the furnishing
15 of such item or service in that area, unless the Sec-
16 retary finds that such expenses were incurred in a
17 case of urgent need.”.

18 (c) REDUCTION IN PAYMENT AMOUNTS IF COMPETI-
19 TIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUC-
20 TION IN PAYMENTS.—Notwithstanding any other provi-
21 sion of title XVIII of the Social Security Act, if the estab-
22 lishment of competitive acquisition areas under section
23 1847 of such Act (as added by subsection (a)) and the
24 limitation of coverage for items and services under part
25 B of such title to items and services furnished by providers

1 with competitive acquisition contracts under such section
2 does not result in a reduction of at least 10 percent in
3 the projected payment amount that would have applied to
4 the item or service under part B if the item or service
5 had not been furnished through competitive acquisition
6 under such section, the Secretary shall reduce the pay-
7 ment amount by such percentage as the Secretary deter-
8 mines necessary to result in such a reduction.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to items and services furnished
11 under part B of title XVIII of the Social Security Act on
12 or after January 1, 1995.

13 **SEC. 4119. APPLICATION OF COMPETITIVE ACQUISITION**
14 **PROCEDURES FOR LABORATORY SERVICES.**

15 (a) IN GENERAL.—Section 1847(c), as added by sec-
16 tion 4118, is amended—

17 (1) by redesignating paragraph (4) as para-
18 graph (5); and

19 (2) by inserting after paragraph (3) the fol-
20 lowing new paragraph:

21 “(4) Clinical diagnostic laboratory tests.”.

22 (b) REDUCTION IN FEE SCHEDULE AMOUNTS IF
23 COMPETITIVE ACQUISITION FAILS TO ACHIEVE SAV-
24 INGS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended
25 by adding at the end the following new paragraph:

1 “(7) Notwithstanding any other provision of this sub-
2 section, if the Secretary applies the authority provided
3 under section 1847 to establish competitive acquisition
4 areas for the furnishing of clinical diagnostic laboratory
5 tests in a year and the application of such authority does
6 not result in a reduction of at least 10 percent in the pro-
7 jected payment amount that would have applied to such
8 tests under this section if the tests had not been furnished
9 through competitive acquisition under section 1847, the
10 Secretary shall reduce each payment amount otherwise de-
11 termined under the fee schedules and negotiated rates es-
12 tablished under this subsection by such percentage as the
13 Secretary determines necessary to result in such a reduc-
14 tion.”.

15 **PART 3—SAVINGS RELATING TO PARTS A AND B**

16 **SEC. 4131. MEDICARE SECONDARY PAYER CHANGES.**

17 (a) EXTENSION OF DATA MATCH.—

18 (1) Section 1862(b)(5)(C) (42 U.S.C.
19 1395y(b)(5)(C)) is amended by striking clause (iii).

20 (2) Section 6103(l)(12) of the Internal Revenue
21 Code of 1986 is amended by striking subparagraph
22 (F).

23 (b) REPEAL OF SUNSET ON APPLICATION TO DIS-
24 ABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN
25 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C.

1 1395y(b)(1)(B)(iii)), as amended by section 13561(b) of
2 OBRA–1993, is amended—

3 (1) in the heading, by striking “SUNSET” and
4 inserting “EFFECTIVE DATE”; and

5 (2) by striking “, and before October 1, 1998”.

6 (c) EXTENSION OF PERIOD FOR END STAGE RENAL
7 DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) (42
8 U.S.C. 1395y(b)(1)(C)), as amended by section 13561(c)
9 of OBRA–1993, is amended in the second sentence by
10 striking “and on or before October 1, 1998,”.

11 **SEC. 4132. PAYMENT LIMITS FOR HMOS AND CMPS WITH**
12 **RISK-SHARING CONTRACTS.**

13 (a) IN GENERAL.—Section 1876(a)(1)(C) (42 U.S.C.
14 1395mm(a)(1)(C)) is amended—

15 (1) by inserting “, subject to adjustment to
16 take into account the provisions of the succeeding
17 clauses” before the period,

18 (2) by striking “(C)” and inserting “(C)(i)”,
19 and

20 (3) by adding at the end the following new
21 clauses:

22 “(ii) The portion of the annual per capita rate of pay-
23 ment for each such class attributable to payments made
24 from the Federal Supplementary Medical Insurance Trust
25 Fund may not exceed 95 percent of the following amount

1 (unless the portion of the annual per capita rate of pay-
2 ment for each such class attributable to payments made
3 from the Federal Hospital Insurance Trust Fund is less
4 than 95 percent of the weighted national average of all
5 adjusted average per capita costs determined under para-
6 graph (4) for that class that are attributable to payments
7 made from the Federal Hospital Insurance Trust Fund):

8 “(I) For 1995, 150 percent of the weighted na-
9 tional average of all adjusted average per capita
10 costs determined under paragraph (4) for that class
11 that are attributable to payments made from such
12 Trust Fund, plus 80 percent of the amount by which
13 (if any) the adjusted average per capita cost for that
14 class exceeds 150 percent of that weighted national
15 average.

16 “(II) For 1996, 150 percent of the weighted
17 national average of all adjusted average per capita
18 costs determined under paragraph (4) for that class
19 that are attributable to payments made from such
20 Trust Fund, plus 60 percent of the amount by which
21 (if any) the adjusted average per capita cost for that
22 class exceeds 150 percent of that weighted national
23 average.

24 “(III) For 1997, 150 percent of the weighted
25 national average of all adjusted average per capita

1 costs determined under paragraph (4) for that class
2 that are attributable to payments made from such
3 Trust Fund, plus 40 percent of the amount by which
4 (if any) the adjusted average per capita cost for that
5 class exceeds 150 percent of that weighted national
6 average.

7 “(IV) For 1998, 150 percent of the weighted
8 national average of all adjusted average per capita
9 costs determined under paragraph (4) for that class
10 that are attributable to payments made from such
11 Trust Fund, plus 20 percent of the amount by which
12 (if any) the adjusted average per capita cost for that
13 class exceeds 150 percent of that weighted national
14 average.

15 “(V) For 1999 and each succeeding year (sub-
16 ject to the establishment by the Secretary of alter-
17 native limits under clause (vi)), 150 percent of the
18 weighted national average of all adjusted average
19 per capita costs determined under paragraph (4) for
20 that class that are attributable to payments made
21 from such Trust Fund.

22 “(iii) The portion of the annual per capita rate of
23 payment for each such class attributable to payments
24 made from the Federal Hospital Insurance Trust Fund
25 may not exceed 95 percent of the following amount (unless

1 the portion of the annual per capita rate of payment for
2 each such class attributable to payments made from the
3 Federal Supplementary Medical Insurance Trust Fund is
4 less than 95 percent of the weighted national average of
5 all adjusted average per capita costs determined under
6 paragraph (4) for that class that are attributable to pay-
7 ments made from the Federal Supplementary Medical In-
8 surance Trust Fund):

9 “(I) For 1995, 170 percent of the weighted na-
10 tional average of all adjusted average per capita
11 costs determined under paragraph (4) for that class
12 that are attributable to payments made from such
13 Trust Fund, plus 80 percent of the amount by which
14 (if any) the adjusted average per capita cost for that
15 class exceeds 170 percent of that weighted national
16 average.

17 “(II) For 1996, 170 percent of the weighted
18 national average of all adjusted average per capita
19 costs determined under paragraph (4) for that class
20 that are attributable to payments made from such
21 Trust Fund, plus 60 percent of the amount by which
22 (if any) the adjusted average per capita cost for that
23 class exceeds 170 percent of that weighted national
24 average.

1 “(III) For 1997, 170 percent of the weighted
2 national average of all adjusted average per capita
3 costs determined under paragraph (4) for that class
4 that are attributable to payments made from such
5 Trust Fund, plus 40 percent of the amount by which
6 (if any) the adjusted average per capita cost for that
7 class exceeds 170 percent of that weighted national
8 average.

9 “(IV) For 1998, 170 percent of the weighted
10 national average of all adjusted average per capita
11 costs determined under paragraph (4) for that class
12 that are attributable to payments made from such
13 Trust Fund, plus 20 percent of the amount by which
14 (if any) the adjusted average per capita cost for that
15 class exceeds 170 percent of that weighted national
16 average.

17 “(V) For 1999 and each succeeding year (sub-
18 ject to the establishment by the Secretary of alter-
19 native limits under clause (vi)), 170 percent of the
20 weighted national average of all adjusted average
21 per capita costs determined under paragraph (4) for
22 that class that are attributable to payments made
23 from such Trust Fund.

24 “(iv) For 1995 and succeeding years, the portion of
25 the annual per capita rate of payment for each such class

1 attributable to payments made from the Federal Supple-
2 mentary Medical Insurance Trust Fund may not be less
3 than 80 percent of 95 percent of the weighted national
4 average of all adjusted average per capita costs deter-
5 mined under paragraph (4) for that class that are attrib-
6 utable to payments made from such Trust Fund, unless
7 the portion of the annual per capita rate of payment for
8 each such class attributable to payments made from the
9 Federal Hospital Insurance Trust Fund is greater than
10 95 percent of the weighted national average of all adjusted
11 average per capita costs determined under paragraph (4)
12 for that class that are attributable to payments made from
13 the Federal Hospital Insurance Trust Fund.

14 “(v) For 1995 and succeeding years, the portion of
15 the annual per capita rate of payment for each such class
16 attributable to payments made from the Federal Hospital
17 Insurance Trust Fund may not be less than 80 percent
18 of 95 percent of the weighted national average of all ad-
19 justed average per capita costs determined under para-
20 graph (4) for that class that are attributable to payments
21 made from such Trust Fund, unless the portion of the
22 annual per capita rate of payment for each such class at-
23 tributable to payments made from the Federal Supple-
24 mentary Medical Insurance Trust Fund is greater than
25 95 percent of the weighted national average of all adjusted

1 average per capita costs determined under paragraph (4)
2 for that class that are attributable to payments made from
3 the Federal Supplementary Medical Insurance Trust
4 Fund.

5 “(vi) For 2000 and succeeding years, the Secretary
6 may revise any of the percentages otherwise applicable
7 during a year under the preceding clauses (other than
8 clause (i)), but only if the aggregate payments made under
9 this title to eligible organizations under risk-sharing con-
10 tracts during the year is not greater than the aggregate
11 payments that would have been made under this title to
12 such organizations during the year if the Secretary had
13 not revised the percentages.

14 “(vii) For purposes of clauses (ii) through (v), in de-
15 termining the weighed average of all adjusted average per
16 capita costs determined under paragraph (4) for a class,
17 the Secretary shall not take into account any costs associ-
18 ated with individuals entitled to benefits under this title
19 under section 226A.”.

20 (b) CONFORMING AMENDMENT.—Section
21 1876(a)(5)(A) (42 U.S.C. 1395mm(a)(5)(A)) is amended
22 by inserting “, adjusted to take into account the limita-
23 tions imposed by clauses (ii) through (vi) of paragraph
24 (1)(C)” before the period.

1 **SEC. 4133. REDUCTION IN ROUTINE COST LIMITS FOR**
2 **HOME HEALTH SERVICES.**

3 (a) REDUCTION IN UPDATE TO MAINTAIN FREEZE
4 IN 1996.—Section 1861(v)(1)(L)(i) (42 U.S.C.
5 1395x(v)(1)(L)(i)) is amended—

6 (1) in subclause (II), by striking “or” at the
7 end;

8 (2) in subclause (III), by striking “112 per-
9 cent,” and inserting “and before July 1, 1996, 112
10 percent, or”; and

11 (3) by inserting after subclause (III) the fol-
12 lowing new subclause:

13 “(IV) July 1, 1996, 100 percent (adjusted by
14 such amount as the Secretary determines to be nec-
15 essary to preserve the savings resulting from the en-
16 actment of section 13564(a)(1) of the Omnibus
17 Budget Reconciliation Act of 1993),”.

18 (b) BASING LIMITS IN SUBSEQUENT YEARS ON ME-
19 DIAN OF COSTS.—

20 (1) IN GENERAL.—Section 1861(v)(1)(L)(i)
21 (U.S.C. 1395x(v)(1)(L)(i)), as amended by sub-
22 section (a), is amended in the matter following sub-
23 clause (IV) by striking “the mean” and inserting
24 “the median”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall apply to cost reporting peri-
3 ods beginning on or after July 1, 1997.

4 **SEC. 4134. IMPOSITION OF COPAYMENT FOR CERTAIN**
5 **HOME HEALTH VISITS.**

6 (a) IN GENERAL.—

7 (1) PART A.—Section 1813(a) (42 U.S.C.
8 1395e(a)) is amended by adding at the end the fol-
9 lowing new paragraph:

10 “(5) The amount payable for home health services
11 furnished to an individual under this part shall be reduced
12 by a copayment amount equal to 10 percent of the average
13 of all per visit costs for home health services furnished
14 under this title determined under section 1861(v)(1)(L)
15 (as determined by the Secretary on a prospective basis for
16 services furnished during a calendar year), unless such
17 services were furnished to the individual during the 30-
18 day period that begins on the date the individual is dis-
19 charged as an inpatient from a hospital.”.

20 (2) PART B.—Section 1833(a)(2) (42 U.S.C.
21 1395l(a)(2)) is amended—

22 (A) in subparagraph (A), by striking “to
23 home health services,” and by striking the
24 comma after “opinion”;

1 (B) in subparagraph (D), by striking
2 “and” at the end;

3 (C) in subparagraph (E), by striking the
4 semicolon at the end and inserting “; and”; and

5 (D) by adding at the end the following new
6 subparagraph:

7 “(F) with respect to home health
8 services—

9 “(i) the lesser of —

10 “(I) the reasonable cost of such
11 services, as determined under section
12 1861(v), or

13 “(II) the customary charges with
14 respect to such services,

15 less the amount a provider may charge as
16 described in clause (ii) of section
17 1866(a)(2)(A),

18 “(ii) if such services are furnished by
19 a public provider of services, or by another
20 provider which demonstrates to the satis-
21 faction of the Secretary that a significant
22 portion of its patients are low-income (and
23 requests that payment be made under this
24 clause), free of charge or at nominal
25 charges to the public, the amount deter-

1 mined in accordance with section
2 1814(b)(2), or

3 “(iii) if (and for so long as) the condi-
4 tions described in section 1814(b)(3) are
5 met, the amounts determined under the re-
6 imbursement system described in such sec-
7 tion,

8 less a copayment amount equal to 10 percent of
9 the average of all per visit costs for home
10 health services furnished under this title deter-
11 mined under section 1861(v)(1)(L) (as deter-
12 mined by the Secretary on a prospective basis
13 for services furnished during a calendar year),
14 unless such services were furnished to the indi-
15 vidual during the 30-day period that begins on
16 the date the individual is discharged as an inpa-
17 tient from a hospital;”.

18 (3) PROVIDER CHARGES.—Section
19 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is
20 amended—

21 (A) by striking “deduction or coinsurance”
22 and inserting “deduction, coinsurance, or co-
23 payment”; and

24 (B) by striking “or (a)(4)” and inserting
25 “(a)(4), or (a)(5)”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to home health services fur-
3 nished on or after July 1, 1995.

4 **SEC. 4135. EXPANSION OF CENTERS OF EXCELLENCE.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services shall use a competitive process to con-
7 tract with centers of excellence for cataract surgery, coro-
8 nary artery by-pass surgery, and such other services as
9 the Secretary determines to be appropriate. Payment
10 under title XVIII of the Social Security Act will be made
11 for services subject to such contracts on the basis of nego-
12 tiated or all-inclusive rates as follows:

13 (1) The center shall cover services provided in
14 an urban area (as defined in section 1886(d)(2)(D)
15 of the Social Security Act) for years beginning with
16 fiscal year 1995.

17 (2) The amount of payment made by the Sec-
18 retary to the center under title XVIII of the Social
19 Security Act for services covered under the project
20 shall be less than the aggregate amount of the pay-
21 ments that the Secretary would have made to the
22 center for such services had the project not been in
23 effect.

24 (3) The Secretary shall make payments to the
25 center on such a basis for the following services fur-

1 nished to individuals entitled to benefits under such
2 title:

3 (A) Facility, professional, and related serv-
4 ices relating to cataract surgery.

5 (B) Coronary artery bypass surgery and
6 related services.

7 (C) Such other services as the Secretary
8 and the center may agree to cover under the
9 agreement.

10 (b) REBATE OF PORTION OF SAVINGS.—In the case
11 of any services provided under a demonstration project
12 conducted under subsection (a), the Secretary shall make
13 a payment to each individual to whom such services are
14 furnished (at such time and in such manner as the Sec-
15 retary may provide) in an amount equal to 10 percent of
16 the amount by which—

17 (1) the amount of payment that would have
18 been made by the Secretary under title XVIII of the
19 Social Security Act to the center for such services if
20 the services had not been provided under the project,
21 exceeds

22 (2) the amount of payment made by the Sec-
23 retary under such title to the center for such serv-
24 ices.

1 **PART 4—PART B PREMIUM**

2 **SEC. 4141. GENERAL PART B PREMIUM.**

3 Section 1839(e) (42 U.S.C. 1395r(e)), as amended
4 by section 13571 of OBRA–1993, is amended—

5 (1) in paragraph (1)(A), by striking “and prior
6 to January 1999”; and

7 (2) in paragraph (2), by striking “prior to Jan-
8 uary 1998”.

9 **PART 5—REPORT ON MEDICARE SAVINGS FOR**
10 **FISCAL YEARS 2000 THROUGH 2003**

11 **SEC. 4151. REPORT ON SAVINGS.**

12 (a) IN GENERAL.—The Secretary shall submit to
13 Congress, by January 30, 1999, a report that contains—

14 (1) a determination of whether the average, an-
15 nual rate of growth in spending under the medicare
16 program (taking into account savings under this
17 subtitle) in the 4-fiscal-year period beginning with
18 fiscal year 2000 will exceed the rate of growth de-
19 scribed in subsection (b); and

20 (2) if so, recommendations as to how to achieve
21 the rate of growth specified in subsection (b).

22 (b) RATE OF GROWTH DESCRIBED.—The rate of
23 growth described in this subsection is the sum of the fol-
24 lowing:

25 (1) CPI.—The average annual percentage
26 change in the CPI.

1 (2) MEDICARE POPULATION.—The average, an-
2 nual percentage change in the number of medicare-
3 eligible individuals.

4 (3) REAL GDP PER CAPITA.—The average, an-
5 nual percentage change in the real, per capita gross
6 domestic product of the United States, and

7 (4) 1 PERCENT.—1 percentage point.

8 **Subtitle C—Medicaid**

9 **PART 1—COMPREHENSIVE BENEFIT PACKAGE**

10 **SEC. 4201. LIMITING COVERAGE UNDER MEDICAID OF** 11 **ITEMS AND SERVICES COVERED UNDER COM-** 12 **PREHENSIVE BENEFIT PACKAGE.**

13 (a) REMOVAL OF COMPREHENSIVE BENEFITS PACK-
14 AGE FROM STATE PLAN.—Title XIX is amended by redes-
15 ignating section 1931 as section 1932 and by inserting
16 after section 1930 the following new section:

17 “TREATMENT OF COMPREHENSIVE BENEFIT PACKAGE
18 UNDER HEALTH SECURITY ACT

19 “SEC. 1931. (a) ITEMS AND SERVICES COVERED
20 UNDER COMPREHENSIVE BENEFIT PACKAGE.—If a State
21 plan for medical assistance under this title provides for
22 payment in accordance with section 1902(a)(63) for a
23 year, notwithstanding any other provision of this title, the
24 State plan under this title is not required to provide med-
25 ical assistance consisting of payment for items and serv-
26 ices in the comprehensive benefit package under subtitle

1 B of title I of the Health Security Act for alliance eligible
2 individuals (as defined in section 1902(5) of such Act).

3 “(b) CONSTRUCTION.—(1) Payment under section
4 1902(a)(63) shall not constitute medical assistance for
5 purposes of section 1903(a).

6 “(2) This section shall not be construed as affecting
7 the provision of medical assistance under this title for
8 items and services included in the comprehensive benefit
9 package for—

10 “(A) medicare-eligible individuals, or

11 “(B) certain emergency services to certain
12 aliens under section 1903(v)(2).”.

13 (b) SUBSTITUTE REQUIREMENT OF STATE PAY-
14 MENT.—Section 1902(a) (42 U.S.C. 1396a(a)), as amend-
15 ed by section 13631(a)(3) of OBRA–1993, is amended—

16 (1) by striking “and” at the end of paragraph
17 (61),

18 (2) by striking the period at the end of para-
19 graph (62) and inserting “; and”, and

20 (3) by inserting after paragraph (62) the fol-
21 lowing new paragraph:

22 “(63) provide for payment to regional alliances
23 of the amounts required under subtitle A of title IX
24 of the Health Security Act.”.

1 (c) NO FEDERAL FINANCIAL PARTICIPATION.—Sec-
2 tion 1903(i) (42 U.S.C. 1396b(i)), as amended by section
3 13631(h)(1)(C) of OBRA–1993, is amended—

4 (1) by striking “or” at the end of paragraph
5 (14),

6 (2) by striking the period at the end of para-
7 graph (15) and inserting “; or”, and

8 (3) by inserting after paragraph (15) the fol-
9 lowing new paragraph:

10 “(16) with respect to items and services covered
11 under the comprehensive benefit package under sub-
12 title B of title I of the Health Security Act for alli-
13 ance eligible individuals (as defined in section
14 1902(5) of such Act).”.

15 (d) EFFECTIVE DATE.—The amendments made by
16 this section shall apply with respect to items or services
17 furnished in a State on or after January 1 of the first
18 year (as defined in section 1902(17)) for the State.

19 **PART 2—EXPANDING ELIGIBILITY FOR NURSING**
20 **FACILITY SERVICES; LONG-TERM CARE INTE-**
21 **GRATION OPTION**

22 **SEC. 4211. SPENDDOWN ELIGIBILITY FOR NURSING FACIL-**
23 **ITY RESIDENTS.**

24 (a) IN GENERAL.—Section 1902(a)(10)(A)(i) (42
25 U.S.C. 1396a(a)(10)(A)(i)) is amended—

1 (1) by striking “or” at the end of subclause
2 (VI);

3 (2) by striking the semicolon at the end of sub-
4 clause (VII) and inserting “, or”; and

5 (3) by inserting after subclause (VII) the fol-
6 lowing new subclause:

7 “(VIII) who are individuals who
8 would meet the income and resource
9 requirements of the appropriate State
10 plan described in subclause (I) or the
11 supplemental security income program
12 (as the case may be), if incurred ex-
13 penses for medical care as recognized
14 under State law were deducted from
15 income;”.

16 (b) LIMITATION TO BENEFITS FOR NURSING FACIL-
17 ITY SERVICES.—Section 1902(a)(10) of such Act (42
18 U.S.C. 1396a(a)(10)), as amended by section 13603(c)(1)
19 of OBRA–1993, is amended in the matter following sub-
20 paragraph (F)—

21 (1) by striking “and (XIII)” and inserting
22 “(XIII)”; and

23 (2) by inserting before the semicolon at the end
24 the following: “, and (XIV) the medical assistance
25 made available to an individual described in sub-

1 paragraph (A)(i)(VIII) shall be limited to medical
2 assistance for nursing facility services, except to the
3 extent that assistance is provided in accordance with
4 the election described in section 1932 in the case of
5 a State making such election”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 subsections (a) and (b) shall apply with respect to a State
8 as of January 1, 1996.

9 **SEC. 4212. INCREASED INCOME AND RESOURCE DIS-**
10 **REGARDS FOR NURSING FACILITY RESI-**
11 **DENTS.**

12 (a) INCREASED DISREGARDS FOR PERSONAL NEEDS
13 ALLOWANCE; RESOURCES.—Section 1902(a)(10) (42
14 U.S.C. 1396a(a)(1)) is amended—

15 (1) by striking “and” at the end of paragraph
16 (F); and

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

19 “(G) that, in determining the eligibility of
20 any individual who is an inpatient in a nursing
21 facility or intermediate care facility for the
22 mentally retarded—

23 “(i) the first \$50 of income for each
24 month shall be disregarded; and

1 “(ii) in the case of an unmarried indi-
2 vidual, the first \$12,000 of resources may,
3 at the option of the State, be dis-
4 regarded;”.

5 (b) CONFORMING SSI PERSONAL NEEDS ALLOW-
6 ANCE.—For provision increasing SSI personal needs al-
7 lowance, see section 4301.

8 (c) FEDERAL REIMBURSEMENT FOR REDUCTIONS IN
9 STATE FUNDS ATTRIBUTABLE TO INCREASED DIS-
10 REGARD.—Section 1903(a) (42 U.S.C. 1396b(a)) is
11 amended—

12 (1) by striking “plus” at the end of paragraph
13 (6);

14 (2) by striking the period at the end of para-
15 graph (7) and inserting “; plus”; and

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

18 “(8) an amount equal to 100 percent of the dif-
19 ference between the amount of expenditures made by
20 the State for nursing facility services and services in
21 an intermediate care facility for the mentally re-
22 tarded during the quarter and the amount of ex-
23 penditures that would have been made by the State
24 for such services during the quarter based on the

1 personal needs allowance in effect in the State as of
2 September 30, 1993.”.

3 (d) EFFECTIVE DATE.—The amendments made by
4 subsection (a) shall apply with respect to months begin-
5 ning with January 1996.

6 **SEC. 4213. INFORMING NURSING HOME RESIDENTS ABOUT**
7 **AVAILABILITY OF ASSISTANCE FOR HOME**
8 **AND COMMUNITY-BASED SERVICES.**

9 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.
10 1396a(a)), as amended by section 4201(b), is amended—

11 (1) by striking “and” at the end of paragraph
12 (62),

13 (2) by striking the period at the end of para-
14 graph (63) and inserting “; and”, and

15 (3) by inserting after paragraph (63) the fol-
16 lowing new paragraph:

17 “(64) provide, in the case of an individual who
18 is a resident (or who is applying to become a resi-
19 dent) of a nursing facility or intermediate care facil-
20 ity for the mentally retarded, at the time of applica-
21 tion for medical assistance and periodically there-
22 after, the individual (or a designated representative)
23 with information on the range of home and commu-
24 nity-based services for which assistance is available
25 in the State either under the plan under this title,

1 under the program under part 1 of subtitle B of title
2 II of the Health Security Act, or any other public
3 program.”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to quarters beginning on or after
6 January 1, 1996.

7 **PART 3—OTHER BENEFITS**

8 **SEC. 4221. TREATMENT OF ITEMS AND SERVICES NOT COV-**
9 **ERED UNDER THE COMPREHENSIVE BENEFIT**
10 **PACKAGE.**

11 (a) CONTINUATION OF ELIGIBILITY FOR ASSISTANCE
12 FOR AFDC AND SSI RECIPIENTS.—With respect to an
13 individual who is described in section 1933(b) of the Social
14 Security Act (as added by subsection (b)(1)), nothing in
15 this Act shall be construed as—

16 (1) changing the eligibility of the individual for
17 medical assistance under title XIX of the Social Se-
18 curity Act for items and services not covered under
19 the comprehensive benefit package, or

20 (2) subject to the amendments made by this
21 subtitle, changing the amount, duration, or scope of
22 medical assistance required (or permitted) to be pro-
23 vided to the individual under such title.

24 (b) LIMITATION ON SCOPE OF ASSISTANCE FOR
25 OTHER MEDICAID BENEFICIARIES.—

1 (1) IN GENERAL.—Title XIX, as amended by
2 sections 4201(a) and 4213, is amended by redesignig-
3 nating section 1933 as section 1934 and by inserting
4 after section 1932 the following new section:

5 “LIMITATION ON SCOPE OF ASSISTANCE FOR MOST NON-
6 CASH BENEFICIARIES

7 “SEC 1933. (a) LIMITATION.—Notwithstanding any
8 other provision of this title, the medical assistance made
9 available under section 1902(a) to an individual not de-
10 scribed in subsection (b) shall be limited to medical assist-
11 ance for—

12 “(1) long-term care services (as defined in sub-
13 section (c)); and

14 “(2) medicare cost-sharing (as defined in sec-
15 tion 1905(p)(3)), in accordance with the require-
16 ments of section 1902(a)(10)(E).

17 “(b) INDIVIDUALS EXEMPT FROM LIMITATION.—The
18 individuals described in this subsection are the following:

19 “(1) AFDC recipients (as defined in section
20 1902(3) of the Health Security Act).

21 “(2) SSI recipients (as defined in section
22 1902(33) of the Health Security Act).

23 “(3) Individuals entitled to benefits under title
24 XVIII.

25 “(4) Children under 18 years of age (or, at the
26 option of the State, under age 19, 20, or 21).

1 “(c) LONG-TERM CARE SERVICES DEFINED.—In
2 subsection (a), the term ‘long-term care services’ means
3 the following items and services, but only to the extent
4 they are not included as an item or service under the com-
5 prehensive benefit package under the Health Security Act:

6 “(1) Nursing facility services and intermediate
7 care facility services for the mentally retarded (in-
8 cluding items and services that may be included in
9 such services pursuant to regulations in effect as of
10 October 26, 1993).

11 “(2) Personal care services.

12 “(3) Home or community-based services pro-
13 vided under a waiver granted under subsection (c),
14 (d), or (e) of section 1915.

15 “(4) Home and community care provided to
16 functionally disabled elderly individuals under sec-
17 tion 1929.

18 “(5) Community supported living arrangements
19 services provided under section 1930.

20 “(6) Case-management services (as described in
21 section 1915(g)(2)).

22 “(7) Home health care services, clinic services,
23 and rehabilitation services that are furnished to an
24 individual who has a condition or disability that

1 qualifies the individual to receive any of the services
2 described in paragraphs (1) through (6).”.

3 (2) CONFORMING AMENDMENT.—Section
4 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)),
5 as amended by section 13603(c)(1) of OBRA–1993
6 and section 4211(b), is amended in the matter fol-
7 lowing subparagraph (G) (as inserted by section
8 4212(a))—

9 (A) by striking “and (XIV)” and inserting
10 “(XIV)”; and

11 (B) by inserting before the semicolon at
12 the end the following: “, and (XV) the medical
13 assistance made available to an individual who
14 is not described in section 1933(b) shall be lim-
15 ited in accordance with section 1933”.

16 (c) CONFORMING AMENDMENTS RELATING TO SEC-
17 ONDARY PAYER.—(1) Section 1902(a)(25)(A) (42 U.S.C.
18 1396a(a)(25)(A)), as amended by section 13622(a) of
19 OBRA–1993, is amended by inserting “health plans (as
20 defined in section 1400 of the Health Security Act),” after
21 “of 1974),”.

22 (2) Section 1903(o) (42 U.S.C. 1396b(o)), as so
23 amended, is amended by inserting “and a health plan (as
24 defined in section 1400 of the Health Security Act)” after
25 “of 1974)”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to items and services furnished in
3 a State on or after January 1 of the first year for which
4 the State is a participating State under the Health Security Act.
5

6 **SEC. 4222. ESTABLISHMENT OF PROGRAM FOR POVERTY-**
7 **LEVEL CHILDREN WITH SPECIAL NEEDS.**

8 (a) ESTABLISHMENT OF PROGRAM.—Title XIX, as
9 amended by sections 4201, 4213, and 4221(b), is amended
10 by redesignating section 1934 as section 1935 and by inserting after section 1933 the following new section:

12 “SERVICES FOR POVERTY-LEVEL CHILDREN WITH
13 SPECIAL NEEDS

14 “SEC 1934. (a) ESTABLISHMENT OF PROGRAM.—
15 There is hereby established a program under which the
16 Secretary shall provide for payment on behalf of each
17 qualified child (as defined in subsection (b)) during a year
18 for all medically necessary or appropriate items and services described in section 1905(a) (including items and
19 services described in section 1905(r) but excluding long-term care services described in section 1933(c)) that are
20 not included in the comprehensive benefit package under
21 subtitle B of title I of the Health Security Act.

24 “(b) QUALIFIED CHILD DEFINED.—

1 “(1) IN GENERAL.—In this section, a ‘qualified
2 child’ is an eligible individual (as defined in section
3 1001(c) of the Health Security Act) who—

4 “(A) for years prior to 1998, is a resident
5 of a participating State under the Health Secu-
6 rity Act;

7 “(B) is under the age of 19; and

8 “(C) meets the requirements relating to fi-
9 nancial eligibility described in paragraph (2).

10 “(2) REQUIREMENTS RELATING TO FINANCIAL
11 ELIGIBILITY.—An individual meets the requirements
12 of this paragraph if—

13 “(A) the individual is an AFDC recipient
14 or an SSI recipient (as such terms are defined
15 in section 1902 of the Health Security Act);

16 “(B) the individual is eligible to receive
17 medical assistance under the State plan under
18 section 1902(a)(10)(C); or

19 “(C) the individual is—

20 “(i) under one year of age and has
21 adjusted family income at or below 133
22 percent of the income official poverty line
23 (as defined by the Office of Management
24 and Budget, and revised annually in ac-
25 cordance with section 673(2) of the Omni-

1 bus Budget Reconciliation Act of 1981, ap-
2 plicable to a family of the size involved)
3 (or, in the case of a State that established
4 an income level greater than 133 percent
5 for individuals under 1 year of age for pur-
6 poses of section 1902(l)(2)(A) as of Octo-
7 ber 1, 1993, an income level which is a
8 percentage of such level not greater than
9 185 percent),

10 “(ii) the individual has attained 1
11 year of age but is under 6 years of age and
12 has adjusted family income at or below
13 133 percent of such income official poverty
14 line, or

15 “(iii) the individual was born after
16 September 30, 1983, has attained 6 years
17 of age, and has adjusted family income at
18 or below 100 percent of such income offi-
19 cial poverty line.

20 “(3) ENROLLMENT PROCEDURES.—

21 “(A) IN GENERAL.—Not later than July 1,
22 1995, the Secretary shall establish procedures
23 for the enrollment of qualified children in the
24 program under this section under which—

1 “(i) essential community providers
2 certified by the Secretary under subpart B
3 of part 2 of subtitle F of title I of the
4 Health Security Act serve as enrollment
5 sites for the program; and

6 “(ii) any forms used for enrollment
7 purposes are designed to make the enroll-
8 ment as simple as practicable.

9 “(B) INDIVIDUALS UNDER ALLIANCE
10 PLANS AUTOMATICALLY ENROLLED.—The Sec-
11 retary shall establish a process under which an
12 individual who is a qualified child under para-
13 graph (1) and is enrolled in a health plan (as
14 defined in section 1400(a) of the Health Secu-
15 rity Act) shall automatically be deemed to have
16 met any enrollment requirements established
17 under paragraph (1).

18 “(c) ADDITIONAL RESPONSIBILITIES OF SEC-
19 RETARY.—Not later than July 1, 1995, the Secretary shall
20 promulgate such regulations as are necessary to establish
21 and operate the program under this section, including reg-
22 ulations with respect to the following:

23 “(1) The benefits to be provided and the cir-
24 cumstances under which such benefits shall be con-
25 sidered medically necessary.

1 “(2) Procedures for the periodic redetermina-
2 tion of an individual’s eligibility for benefits.

3 “(3) Qualification criteria for providers partici-
4 pating in the program.

5 “(4) Payment amounts for services provided
6 under the program, the methodology used to deter-
7 mine such payment amounts, and the procedures for
8 making payments to providers.

9 “(5) Standards to ensure the quality of services
10 and the coordination of services under the program
11 with services under the comprehensive benefit pack-
12 age, as well as services under parts B and H of the
13 Individuals With Disabilities Education Act, title V,
14 and any other program providing health care, reme-
15 dial, educational, and social services to qualified chil-
16 dren as the Secretary may identify.

17 “(6) Hearing and appeals for individuals ad-
18 versely affected by any determination by the Sec-
19 retary under the program.

20 “(7) Such other requirements as the Secretary
21 determines to be necessary for the proper and effi-
22 cient administration of the program.

23 “(d) FEDERAL PAYMENT FOR PROGRAM.—

24 “(1) IN GENERAL.—Subject to paragraph (2),
25 the Secretary shall pay 100 percent of the costs of

1 providing benefits under this program in a year, in-
2 cluding all administrative expenses.

3 “(2) ANNUAL LIMIT ON EXPENDITURES.—The
4 total amount of Federal expenditures that may be
5 made under this section in a year may not exceed—

6 “(A) for a year prior to 1998, an amount
7 equal to total expenditures for medical assist-
8 ance under State plans under this title during
9 fiscal year 1993 for services described in sub-
10 section (a) furnished to qualified children that
11 are attributable to States in which the program
12 is in operation during the year (adjusted to
13 take into account the operation of the program
14 under this section on a calendar year basis)—

15 “(i) adjusted to take into account any
16 increases or decreases in the number of
17 qualified children under the most recent
18 decennial census, as adjusted by the most
19 recent current population survey for the
20 year in question, and

21 “(ii) adjusted by the applicable per-
22 centage applied to the State non-cash, non-
23 DSH baseline amount for the year under
24 section 9003(a) of the Health Security Act;

1 “(B) for 1998, the total expenditures for
2 medical assistance under State plans under this
3 title during 1993 for services described in sub-
4 section (a) furnished to qualified children (ad-
5 justed to take into account the operation of the
6 program under this section on a calendar year
7 basis)—

8 “(i) adjusted to take into account any
9 increases or decreases in the number of
10 qualified children under the most recent
11 decennial census, as adjusted by the most
12 recent current population survey for the
13 year in question, and

14 “(ii) adjusted by the update applied to
15 the State non-cash, non-DSH baseline
16 amount for the year under section 9003(b)
17 of the Health Security Act; and

18 “(C) for each succeeding year, the limit es-
19 tablished under this paragraph for the previous
20 year (adjusted to take into account the oper-
21 ation of the program under this section on a
22 calendar year basis), adjusted by the update ap-
23 plied to the State non-cash baseline amount for
24 the year under section 9003(b) of the Health
25 Security Act.”.

1 (b) REPEAL OF ALTERNATIVE ELIGIBILITY STAND-
2 ARDS FOR CHILDREN IN PARTICIPATING STATES.—Sec-
3 tion 1902(r)(2) (42 U.S.C. 1396a(r)(2)) is amended by
4 adding at the end the following new subparagraph:

5 “(C) Subparagraph (A) shall not apply with respect
6 to the determination of income and resources for children
7 under age 18 under the State plan of a State (other than
8 under the State plan of a State that utilized an alternative
9 methodology pursuant to such subparagraph as of October
10 1, 1993)—

11 “(i) in the case of a State that is a partici-
12 pating State under the Health Security Act for a
13 year prior to 1998, for quarters beginning on or
14 after January 1 of the first year for which the State
15 is such a participating State; and

16 “(ii) in the case of any State not described in
17 clause (i), for quarters beginning on or after Janu-
18 ary 1, 1998.”.

19 **PART 4—DISCONTINUATION OF CERTAIN**
20 **PAYMENT POLICIES**

21 **SEC. 4231. DISCONTINUATION OF MEDICAID DSH PAY-**
22 **MENTS.**

23 (a) ELIMINATION OF SPECIFIC OBLIGATION.—Sec-
24 tion 1923(a) (42 U.S.C. 1396r–4(a)) is amended by add-
25 ing at the end the following new paragraph:

1 “(5) Notwithstanding any other provision of
2 this title, the requirement of this subsection shall
3 not apply—

4 “(A) with respect to a State for any por-
5 tion of a fiscal year during which the State is
6 a participating State under the Health Security
7 Act; or

8 “(B) with respect to any State for any
9 months beginning on or after January 1,
10 1998.”.

11 (b) ELIMINATION OF STATE PLAN REQUIREMENT.—
12 Section 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)) is
13 amended by inserting after “special needs” the following:
14 “(but only with respect to any quarters during which the
15 State is not a participating State under the Health Secu-
16 rity Act or with respect to any quarters ending on or be-
17 fore December 31, 1997)”.

18 (c) ELIMINATION OF STATE DSH ALLOTMENTS AND
19 FEDERAL FINANCIAL PARTICIPATION.—Section 1923(f)
20 (42 U.S.C. 1396r–4(f)) is amended—

21 (1) in paragraph (2), by inserting “and para-
22 graph (5)” after “subparagraph (B)”, and

23 (2) by adding at the end the following new
24 paragraph:

1 “(5) ELIMINATION OF ALLOTMENTS FOR PAR-
2 TICIPATING STATES AND SUNSET FOR ALL
3 STATES.—

4 “(A) IN GENERAL.—Notwithstanding any
5 other provision of this section, the State DSH
6 allotment shall be zero with respect to—

7 “(i) any participating State under the
8 Health Security Act; and

9 “(ii) any State for any portion of a
10 fiscal year that occurs on or after January
11 1, 1998.

12 “(B) NO REDISTRIBUTION OF REDUC-
13 TIONS.—In the computation of State supple-
14 mental amounts under paragraph (3), the State
15 DSH allotments shall be determined under sub-
16 paragraph (A)(ii) of such paragraph as if this
17 paragraph did not apply.”.

18 **SEC. 4232. DISCONTINUATION OF REIMBURSEMENT STAND-**
19 **ARDS FOR INPATIENT HOSPITAL SERVICES.**

20 Section 1902(a)(13)(A) (42 U.S.C.
21 1396a(a)(13)(A)), as amended by section 4231(b), is
22 amended by inserting “(in the case of services other than
23 hospital services in a State that is a participating State
24 under the Health Security Act)” before “are reasonable
25 and adequate”.

1 **PART 5—COORDINATION WITH ADMINISTRATIVE**
2 **SIMPLIFICATION AND QUALITY MANAGE-**
3 **MENT INITIATIVES**

4 **SEC. 4241. REQUIREMENTS FOR CHANGES IN BILLING PRO-**
5 **CEDURES.**

6 (a) LIMITATION ON FREQUENCY OF SYSTEM
7 CHANGES; ADVANCE NOTIFICATION TO PROVIDERS.—

8 Section 1902(a) (42 U.S.C. 1396a(a)), as amended by sec-
9 tions 4201(b) and 4214(a), is amended—

10 (1) by striking “and” at the end of paragraph
11 (63),

12 (2) by striking the period at the end of para-
13 graph (64) and inserting “; and”, and

14 (3) by inserting after paragraph (64) the fol-
15 lowing new paragraph:

16 “(65) provide that the State—

17 “(A) will not implement any change in the
18 system used for the billing and processing of
19 claims for payment for items and services fur-
20 nished under the State plan within 6 months of
21 implementing any previous change in such sys-
22 tem; and

23 “(B) shall notify individuals and entities
24 providing medical assistance under the State
25 plan of any major change in the procedures for
26 billing for services furnished under the plan at

1 least 120 days before such change is to take ef-
2 fect.”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 subsection (a) shall apply to a State as of January 1 of
5 the first year for which the State is a participating State.

6 **PART 6—MEDICAID COMMISSION**

7 **SEC. 4251. MEDICAID COMMISSION.**

8 (a) ESTABLISHMENT.—There is established a com-
9 mission to be known as the “Medicaid Commission” (in
10 this section referred to as the “Commission”).

11 (b) MEMBERSHIP.—(1) The Commission shall be
12 composed of 15 members appointed by the Secretary for
13 the life of the Commission.

14 (2) Members shall include representatives of the Fed-
15 eral Government and State Governments.

16 (3) The Administrator of the Health Care Financing
17 Administration shall be an ex officio member of the Com-
18 mission.

19 (4) Individuals, while serving as members of the
20 Commission, shall not be entitled to compensation, other
21 than travel expenses, including per diem in lieu of subsist-
22 ence, in accordance with sections 5702 and 5703 of title
23 5, United States Code.

24 (c) STUDY.—The Commission shall study options
25 with respect to each of the following in relation to the

1 medicaid program under title XIX of the Social Security
2 Act:

3 (1) USE OF BLOCK GRANT.—Whether, and (if
4 so) how, to convert payments for services not cov-
5 ered in the comprehensive benefit package (for all
6 recipients, including AFDC and SSI recipients de-
7 fined in section 1902) into new financing mecha-
8 nisms that give the States greater flexibility in tar-
9 geting and delivering needed services.

10 (2) INTEGRATION OF ACUTE AND LONG-TERM
11 CARE SERVICES FOR HEALTH PLANS.—Whether, and
12 (if so) how, to integrate long-term care services and
13 the home and community-based services program
14 under part 1 of subtitle B of title II with the serv-
15 ices covered under the comprehensive benefit pack-
16 age offered by health plans.

17 (3) CONSOLIDATING INSTITUTIONAL AND HOME
18 AND COMMUNITY-BASED LONG-TERM CARE.—Wheth-
19 er, and (if so) how, to offer States an option to com-
20 bine together expenditures under the home and com-
21 munity-based services program (under part 1 of sub-
22 title B of title II) with continuing home and commu-
23 nity-based services and institutional care under the
24 medicaid program into a global budget for long-term

1 care services, and how such a combined program
2 could be implemented.

3 (d) REPORT AND RECOMMENDATIONS.—The Com-
4 mission shall submit to the Secretary and the National
5 Health Board, not later than 1 year after the date of the
6 enactment of this Act, a report on its study under sub-
7 section (c). The Commission shall include in such report
8 such recommendations for changes in the medicaid pro-
9 gram, and the programs under this Act, as it deems ap-
10 propriate.

11 (e) OPERATIONS.—(1) The Commission shall appoint
12 a chair from among its members.

13 (2) Upon request of the Chair of the Commission,
14 the head of any Federal department or agency may detail,
15 on a reimbursable basis, any of the personnel of that de-
16 partment or agency to the Commission to assist it in car-
17 rying out its duties under this section.

18 (3) The Commission may secure directly from any de-
19 partment or agency of the United States information nec-
20 essary to enable it to carry out this section. Upon request
21 of the Chair of the Commission, the head of that depart-
22 ment or agency shall furnish that information to the Com-
23 mission.

24 (4) Upon the request of the Commission, the Admin-
25 istrator of General Services shall provide to the Commis-

1 sion, on a reimbursable basis, the administrative support
2 services necessary for the Commission to carry out its re-
3 sponsibilities under this section.

4 (f) TERMINATION.—The Commission shall terminate
5 90 days after the date of submission of its report under
6 subsection (d).

7 (g) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated such sums as may be
9 necessary to carry out this section.

10 **Subtitle D—Increase in SSI** 11 **Personal Needs Allowance**

12 **SEC. 4301. INCREASE IN SSI PERSONAL NEEDS ALLOW-** 13 **ANCE.**

14 (a) IN GENERAL.—Section 1611(e)(1)(B) (42 U.S.C.
15 1382(e)(1)(B)) is amended—

16 (1) in clauses (i) and (ii)(I), by striking “\$360”
17 and inserting “\$600”; and

18 (2) in clause (iii), by striking “\$720” and in-
19 serting “\$1,200”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 subsection (a) shall apply with respect to months begin-
22 ning with January 1996.

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1 **Subtitle A—Quality Management** 2 **and Improvement**

3 **SEC. 5001. NATIONAL QUALITY MANAGEMENT PROGRAM.**

4 Not later than 1 year after the date of the enactment
5 of this Act, the National Health Board shall establish and
6 oversee a performance-based program of quality manage-
7 ment and improvement designed to enhance the quality,
8 appropriateness, and effectiveness of health care services
9 and access to such services. The program shall be known
10 as the National Quality Management Program and shall

1 be administered by the National Quality Management
2 Council established under section 5002.

3 **SEC. 5002. NATIONAL QUALITY MANAGEMENT COUNCIL.**

4 (a) ESTABLISHMENT.—There is established a council
5 to be known as the National Quality Management Council.

6 (b) DUTIES.—The Council shall—

7 (1) administer the National Quality Manage-
8 ment Program;

9 (2) perform any other duty specified as a duty
10 of the Council in this subtitle; and

11 (3) advise the National Health Board with re-
12 spect its duties under this subtitle.

13 (c) NUMBER AND APPOINTMENT.—The Council shall
14 be composed of 15 members appointed by the President.
15 The Council shall consist of members who are broadly rep-
16 resentative of the population of the United States and
17 shall include—

18 (1) individuals representing the interests of gov-
19 ernmental and corporate purchasers of health care;

20 (2) individuals representing the interests of
21 health plans;

22 (3) individuals representing the interests of
23 States;

1 (4) individuals representing the interests of
2 health care providers and academic health centers
3 (as defined in section 3101(c)); and

4 (5) individuals distinguished in the fields of
5 public health, health care quality, and related fields
6 of health services research.

7 (d) TERMS.—

8 (1) IN GENERAL.—Except as provided in para-
9 graph (2), members of the Council shall serve for a
10 term of 3 years.

11 (2) STAGGERED ROTATION.—Of the members
12 first appointed to the Council under subsection (c),
13 the President shall appoint 5 members to serve for
14 a term of 3 years, 5 members to serve for a term
15 of 2 years, and 5 members to serve for a term of
16 1 year.

17 (3) SERVICE BEYOND TERM.—A member of the
18 Council may continue to serve after the expiration of
19 the term of the member until a successor is ap-
20 pointed.

21 (e) VACANCIES.—If a member of the Council does not
22 serve the full term applicable under subsection (d), the in-
23 dividual appointed to fill the resulting vacancy shall be ap-
24 pointed for the remainder of the term of the predecessor
25 of the individual.

1 (f) CHAIR.—The President shall designate an indi-
2 vidual to serve as the chair of the Council.

3 (g) MEETINGS.—The Council shall meet not less than
4 once during each 4-month period and shall otherwise meet
5 at the call of the President or the chair.

6 (h) COMPENSATION AND REIMBURSEMENT OF EX-
7 PENSES.—Members of the Council shall receive compensa-
8 tion for each day (including travel time) engaged in car-
9 rying out the duties of the Council. Such compensation
10 may not be in an amount in excess of the maximum rate
11 of basic pay payable for level IV of the Executive Schedule
12 under section 5315 of title 5, United States Code.

13 (i) STAFF.—The National Health Board shall provide
14 to the Council such staff, information, and other assist-
15 ance as may be necessary to carry out the duties of the
16 Council.

17 (j) HEALTH CARE PROVIDER.—For purposes of this
18 subtitle, the term “health care provider” means an indi-
19 vidual who, or entity that, provides an item or service to
20 an individual that is covered under the health plan (as
21 defined in section 1400) in which the individual is en-
22 rolled.

1 **SEC. 5003. NATIONAL MEASURES OF QUALITY PERFORM-**
2 **ANCE.**

3 (a) IN GENERAL.—The National Quality Manage-
4 ment Council shall develop a set of national measures of
5 quality performance, which shall be used to assess the pro-
6 vision of health care services and access to such services.

7 (b) SUBJECT OF MEASURES.—National measures of
8 quality performance shall be selected in a manner that
9 provides information on the following subjects:

10 (1) Access to health care services by consumers.

11 (2) Appropriateness of health care services pro-
12 vided to consumers.

13 (3) Outcomes of health care services and proce-
14 dures.

15 (4) Health promotion.

16 (5) Prevention of diseases, disorders, and other
17 health conditions.

18 (6) Consumer satisfaction with care.

19 (c) SELECTION OF MEASURES.—

20 (1) CONSULTATION.—In developing and select-
21 ing the national measures of quality performance,
22 the National Quality Management Council shall con-
23 sult with appropriate interested parties, including—

24 (A) States;

25 (B) health plans;

1 (C) employers and individuals purchasing
2 health care through regional and corporate alli-
3 ances;

4 (D) health care providers;

5 (E) the National Quality Consortium es-
6 tablished under section 5009;

7 (F) individuals distinguished in the fields
8 of law, medicine, economics, public health, and
9 health services research;

10 (G) the Administrator for Health Care
11 Policy and Research;

12 (H) the Director of the National Institutes
13 of Health; and

14 (I) the Administrator of the Health Care
15 Financing Administration.

16 (2) CRITERIA.—The following criteria shall be
17 used in developing and selecting national measures
18 of quality performance:

19 (A) SIGNIFICANCE.—When a measure re-
20 lates to a specific disease, disorder, or other
21 health condition, the disease, disorder, or condi-
22 tion shall be of significance in terms of preva-
23 lence, morbidity, mortality, or the costs associ-
24 ated with the prevention, diagnosis, treatment,

1 or clinical management of the disease, disorder,
2 or condition.

3 (B) RANGE OF SERVICES.—The set of
4 measures, taken as a whole, shall be representa-
5 tive of the range of services provided to con-
6 sumers of health care.

7 (C) RELIABILITY AND VALIDITY.—The
8 measures shall be reliable and valid.

9 (D) UNDUE BURDEN.—The data needed to
10 calculate the measures shall be obtained with-
11 out undue burden on the entity or individual
12 providing the data.

13 (E) VARIATION.—Performance with re-
14 spect to a measure shall be expected to vary
15 widely among the individuals and entities whose
16 performance is assessed using the measure.

17 (F) LINKAGE TO HEALTH OUTCOME.—
18 When a measure is a rate of a process of care,
19 the process shall be linked to a health outcome
20 based upon the best available scientific evi-
21 dence.

22 (G) PROVIDER CONTROL AND RISK AD-
23 JUSTMENT.—When a measure is an outcome of
24 the provision of care, the outcome shall be with-
25 in the control of the provider and one with re-

1 spect to which an adequate risk adjustment can
2 be made.

3 (H) PUBLIC HEALTH.—The measures may
4 incorporate standards identified by the Sec-
5 retary of Health and Human Services for meet-
6 ing public health objectives.

7 (d) UPDATING.—The National Quality Management
8 Council shall review and update the set of national meas-
9 ures of quality performance annually to reflect changing
10 goals for quality improvement. The Council shall establish
11 and maintain a priority list of performance measures that
12 within a 5-year period it intends to consider for inclusion
13 within the set through the updating process.

14 **SEC. 5004. CONSUMER SURVEYS.**

15 (a) IN GENERAL.—The National Quality Manage-
16 ment Council shall conduct periodic surveys of health care
17 consumers to gather information concerning access to
18 care, use of health services, health outcomes, and patient
19 satisfaction. The surveys shall monitor consumer reaction
20 to the implementation of this Act and be designed to as-
21 sess the impact of this Act on the general population of
22 the United States and potentially vulnerable populations.

23 (b) SURVEY ADMINISTRATION.—The National Qual-
24 ity Management Council shall develop and approve a
25 standard design for the surveys, which shall be adminis-

tered by the Administrator for Health Care Policy and Research on a plan-by-plan and State-by-State basis. A State may add survey questions on quality measures of local interest to surveys conducted in the State.

(c) **SAMPLING STRATEGIES.**—The National Quality Management Council shall develop sampling strategies that ensure that survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care and may be difficult to reach through consumer-sampling methods, including individuals who—

- (1) fail to enroll in a health plan;
- (2) resign from a plan; or
- (3) are members of a vulnerable population.

SEC. 5005. EVALUATION AND REPORTING OF QUALITY PERFORMANCE.

(a) **NATIONAL GOALS.**—In subject matter areas with respect to which the National Quality Management Council determines that sufficient information and consensus exist, the Council shall recommend to the Board that the Board establish goals for performance by health plans and health care providers on a subset of the set of national measures of quality performance.

(b) **IMPACT OF REFORM.**—The National Quality Management Council shall evaluate the impact of the implementation of this Act on the quality of health care serv-

1 ices in the United States and the access of consumers to
2 such services.

3 (c) PERFORMANCE REPORTS.—

4 (1) ALLIANCE AND HEALTH PLAN REPORTS.—

5 Each health alliance annually shall publish and
6 make available to the public a performance report
7 outlining in a standard format the performance of
8 each health plan offered in the alliance on the set of
9 national measures of quality performance. The re-
10 port shall include the results of a smaller number of
11 such measures for health care providers who are
12 members of provider networks of such plans (as de-
13 fined in section 1402(f)), if the available information
14 is statistically meaningful. The report also shall in-
15 clude the results of consumer surveys described in
16 section 5004 that were conducted in the alliance
17 area during the year that is the subject of the re-
18 port.

19 (2) NATIONAL QUALITY REPORTS.—The Na-
20 tional Quality Management Council annually shall
21 provide to the Congress and to each health alliance
22 a report that—

23 (A) outlines in a standard format the per-
24 formance of each regional alliance, corporate al-
25 liance, and health plan;

1 (B) discusses State-level and national
2 trends relating to health care quality; and

3 (C) presents data for each health alliance
4 from consumer surveys described in section
5 5004 that were conducted during the year that
6 is the subject of the report.

7 (d) PUBLIC AVAILABILITY OF INFORMATION IN NA-
8 TIONAL PRACTITIONER DATA BANK ON DEFENDANTS,
9 AWARDS, AND SETTLEMENTS.—

10 (1) IN GENERAL.—Section 427(a) of the Health
11 Care Quality Improvement Act (42 U.S.C.
12 11137(a)) is amended by adding at the end the fol-
13 lowing new sentence: “Not later than January 1,
14 1996, the Secretary shall promulgate regulations
15 under which individuals seeking to enroll in health
16 plans under the Health Security Act may obtain in-
17 formation reported under this part with respect to
18 physicians and other licensed health practitioners
19 participating in such plans for whom information
20 has been reported under this part on repeated occa-
21 sions.”.

22 (2) ACCESS TO DATA BANK FOR POINT-OF-
23 SERVICE CONTRACTORS UNDER MEDICARE.—Section
24 427(a) of such Act (42 U.S.C. 11137(a)) is
25 amended—

1 (A) by inserting “to sponsors of point-of-
2 service networks under section 1890 of the So-
3 cial Security Act,” after “State licensing
4 boards,” and

5 (B) in the heading, by inserting “RE-
6 LATED” after “CARE”.

7 **SEC. 5006. DEVELOPMENT AND DISSEMINATION OF PRAC-**
8 **TICE GUIDELINES.**

9 (a) DEVELOPMENT OF GUIDELINES.—

10 (1) IN GENERAL.—The National Quality Man-
11 agement Council shall direct the Administrator for
12 Health Care Policy and Research to develop and pe-
13 riodically review and update clinically relevant guide-
14 lines that may be used by health care providers to
15 assist in determining how diseases, disorders, and
16 other health conditions can most effectively and ap-
17 propriately be prevented, diagnosed, treated, and
18 managed clinically.

19 (2) CERTAIN REQUIREMENTS.—Guidelines
20 under paragraph (1) shall—

21 (A) be based on the best available research
22 and professional judgment regarding the effec-
23 tiveness and appropriateness of health care
24 services and procedures;

1 (B) be presented in formats appropriate
2 for use by health care providers, medical edu-
3 cators, medical review organizations, and con-
4 sumers of health care;

5 (C) include treatment-specific or condition-
6 specific practice guidelines for clinical treat-
7 ments and conditions in forms appropriate for
8 use in clinical practice, for use in educational
9 programs, and for use in reviewing quality and
10 appropriateness of medical care;

11 (D) include information on risks and bene-
12 fits of alternative strategies for prevention, di-
13 agnosis, treatment, and management of a given
14 disease, disorder, or other health condition;

15 (E) include information on the costs of al-
16 ternative strategies for the prevention, diag-
17 nosis, treatment, and management of a given
18 disease, disorder, or other health condition,
19 where cost information is available and reliable;
20 and

21 (F) be developed in accordance with prior-
22 ities that shall be established by the National
23 Quality Management Council based on the re-
24 search priorities that are established under sec-
25 tion 5007(b) and the 5-year priority list of per-

1 formance measures described in section
2 5003(d).

3 (3) HEALTH SERVICE UTILIZATION PROTO-
4 COLS.—The National Quality Management Council
5 shall establish standards and procedures for evalu-
6 ating the clinical appropriateness of protocols used
7 to manage health service utilization.

8 (4) USE IN MEDICAL MALPRACTICE LIABILITY
9 PILOT PROGRAM.—Guidelines developed under this
10 subsection may be used by the Secretary of Health
11 and Human Services in the pilot program applying
12 practice guidelines to medical malpractice liability
13 under section 5312.

14 (b) EVALUATION AND CERTIFICATION OF OTHER
15 GUIDELINES.—

16 (1) METHODOLOGY.—The National Quality
17 Management Council shall direct the Administrator
18 for Health Care Policy and Research to develop and
19 publish standards relating to methodologies for de-
20 veloping the types of guidelines described in sub-
21 section (a)(1).

22 (2) EVALUATION AND CERTIFICATION.—The
23 National Quality Management Council shall direct
24 the Administrator for Health Care Policy and Re-
25 search to establish a procedure by which individuals

1 and entities may submit guidelines of the type de-
2 scribed in subsection (a)(1) to the Council for eval-
3 uation and certification by the Council using the
4 standards developed under paragraph (1).

5 (3) USE IN MEDICAL MALPRACTICE LIABILITY
6 PILOT PROGRAM.—Guidelines certified under para-
7 graph (2) may be used by the Secretary of Health
8 and Human Services in the pilot program applying
9 practice guidelines to medical malpractice liability
10 under section 5312.

11 (c) GUIDELINE CLEARINGHOUSE.—The National
12 Quality Management Council shall direct the Adminis-
13 trator for Health Care Policy and Research to establish
14 and oversee a clearinghouse and dissemination program
15 for practice guidelines that are developed or certified
16 under this section.

17 (d) DISSEMINATION OF INFORMATION ON INEFFECTIVE
18 TREATMENTS.—The National Quality Management
19 Council shall collect and disseminate information docu-
20 menting clinically ineffective treatments and procedures.

21 **SEC. 5007. RESEARCH ON HEALTH CARE QUALITY.**

22 (a) RESEARCH SUPPORT.—The National Quality
23 Management Council shall direct the Administrator for
24 Health Care Policy and Research to support research di-
25 rectly related to the 5-year priority list of performance

1 measures described in section 5003(d), including research
2 with respect to—

3 (1) outcomes of health care services and proce-
4 dures;

5 (2) effective and efficient dissemination of in-
6 formation, standards, and guidelines;

7 (3) methods of measuring quality and shared
8 decisionmaking; and

9 (4) design and organization of quality of care
10 components of automated health information sys-
11 tems.

12 (b) RESEARCH PRIORITIES.—The National Quality
13 Management Council shall establish priorities for research
14 with respect to the quality, appropriateness, and effective-
15 ness of health care and make recommendations concerning
16 research projects. In establishing the priorities, the Na-
17 tional Quality Management Council shall emphasize re-
18 search involving diseases, disorders, and health conditions
19 as to which—

20 (1) there is the highest level of uncertainty con-
21 cerning treatment;

22 (2) there is the widest variation in practice pat-
23 terns;

1 (3) the costs associated with prevention, diag-
2 nosis, treatment, or clinical management are signifi-
3 cant; and

4 (4) the rate of incidence or prevalence is high
5 for the population as a whole or for particular sub-
6 populations.

7 **SEC. 5008. REGIONAL PROFESSIONAL FOUNDATIONS.**

8 (a) ESTABLISHMENT.—The National Health Board
9 shall establish and oversee regional professional founda-
10 tions to perform the duties specified in subsection (c).

11 (b) STRUCTURE AND MEMBERSHIP.—

12 (1) IN GENERAL.—The National Quality Con-
13 sortium established under section 5009 shall oversee
14 the establishment of regional professional founda-
15 tions, the membership requirements for each founda-
16 tion, and any other requirement for the internal op-
17 eration of each foundation.

18 (2) ENTITIES ELIGIBLE FOR MEMBERSHIP.—
19 Each regional professional foundation shall include
20 at least one academic health center (as defined in
21 section 3101(c)). The following entities also shall be
22 eligible to serve as members of the regional profes-
23 sional foundation for the region in which the entity
24 is located:

1 (A) Schools of public health (as defined in
2 section 799 of the Public Health Service Act).

3 (B) Other schools and programs defined in
4 such section.

5 (C) Health plans.

6 (D) Regional alliances.

7 (E) Corporate alliances.

8 (F) Health care providers.

9 (c) DUTIES.—A regional professional foundation
10 shall carry out the following duties for the region in which
11 the foundation is located (such region to be demarcated
12 by the National Health Board with the advice of the Na-
13 tional Quality Consortium established under section
14 5009):

15 (1) Developing programs in lifetime learning for
16 health professionals (as defined in section
17 1112(c)(1)) to ensure the delivery of quality health
18 care.

19 (2) Fostering collaboration among health plans
20 and health care providers to improve the quality of
21 primary and specialized health care.

22 (3) Disseminating information about successful
23 quality improvement programs, practice guidelines,
24 and research findings.

1 (4) Disseminating information on innovative
2 uses of health professionals.

3 (5) Developing innovative patient education sys-
4 tems that enhance patient involvement in decisions
5 relating their health care.

6 (6) Applying for and conducting research de-
7 scribed in section 5007.

8 (d) PROGRAMS IN LIFETIME LEARNING.—The pro-
9 grams described in subsection (c)(1) shall ensure that
10 health professionals remain abreast of new knowledge, ac-
11 quire new skills, and adopt new roles as technology and
12 societal demands change.

13 **SEC. 5009. NATIONAL QUALITY CONSORTIUM.**

14 (a) ESTABLISHMENT.—The National Health Board
15 shall establish a consortium to be known as the National
16 Quality Consortium.

17 (b) DUTIES.—The Consortium shall—

18 (1) establish programs for continuing education
19 for health professionals;

20 (2) advise the National Quality Management
21 Council and the Administrator for Health Care Pol-
22 icy and Research on research priorities;

23 (3) oversee the development of the regional pro-
24 fessional foundations established under section 5008;

1 (4) advise the National Quality Management
2 Council with respect to the funding of proposals to
3 establish such foundations;

4 (5) consult with the National Quality Manage-
5 ment Council regarding the selection of national
6 measures of quality performance under section
7 5003(c); and

8 (6) advise the National Health Board and the
9 National Quality Management Council with respect
10 to any other duty of the Board or the Council under
11 this subtitle.

12 (c) MEMBERSHIP.—The Consortium shall be com-
13 posed of 11 members appointed by the National Health
14 Board. The members of the Consortium shall include—

15 (1) 5 individuals representing the interests of
16 academic health centers; and

17 (2) 6 other individuals representing the inter-
18 ests of one of the following persons:

19 (A) Schools of public health.

20 (B) Other schools and programs defined in
21 section 799 of the Public Health Service Act
22 (including medical schools, nursing schools, and
23 allied health professional schools).

24 (d) TERMS.—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (2), members of the Consortium shall serve
3 for a term of 3 years.

4 (2) STAGGERED ROTATION.—Of the members
5 first appointed to the Consortium under subsection
6 (c), the National Health Board shall appoint 4 mem-
7 bers to serve for a term of 3 years, 3 members to
8 serve for a term of 2 years, and 4 members to serve
9 for a term of 1 year.

10 (e) CHAIR.—The National Health Board shall des-
11 ignate an individual to serve as the chair of the Consor-
12 tium.

13 **SEC. 5010. ELIMINATING CLIA REQUIREMENT FOR CERTIFI-**
14 **CATE OF WAIVER FOR SIMPLE LABORATORY**
15 **EXAMINATIONS AND PROCEDURES.**

16 (a) IN GENERAL.—Section 353 of the Public Health
17 Service Act (42 U.S.C. 263a) is amended—

18 (1) in subsection (b), by inserting before the pe-
19 riod at the end the following: “or unless the labora-
20 tory is exempt from the certificate requirement
21 under subsection (d)(2)”;

22 (2) by amending paragraph (2) of subsection
23 (d) to read as follows:

24 “(2) EXEMPTION FROM CERTIFICATE REQUIRE-
25 MENT FOR LABORATORIES PERFORMING ONLY SIM-

1 PLE EXAMINATIONS AND PROCEDURES.—A labora-
2 tory which performs only laboratory examinations
3 and procedures described in paragraph (3) is not re-
4 quired to have in effect a certificate under this sec-
5 tion.”;

6 (3) by striking paragraph (4) of subsection (d);
7 and

8 (4) in subsection (m)(1), by striking “, except
9 that the Secretary” and all that follows and insert-
10 ing a period.

11 (b) EFFECTIVE DATE.—The amendments made by
12 this section shall take effect on the first day of the first
13 month beginning after the date of the enactment of this
14 Act.

15 **SEC. 5011. UNIFORM STANDARDS FOR HEALTH CARE INSTI-**
16 **TUTIONS.**

17 (a) DEVELOPMENT OF STANDARDS.—Not later than
18 3 years after the date of the enactment of this Act, the
19 National Health Board shall develop demonstration stand-
20 ards for the licensing of health care institutions that ad-
21 dress essential performance requirements related to pa-
22 tient care. The standards shall be developed in a manner
23 that permits them to be applied uniformly to all such insti-
24 tutions, except in the areas of fire safety, sanitation, and

1 patient rights, and so as not to undermine ongoing nurs-
2 ing home reforms.

3 (b) DEMONSTRATION PROJECTS.—By January 1,
4 1996, the National Quality Management Council shall
5 complete demonstration projects for the standards devel-
6 oped under subsection (a) and shall revise the standards
7 according to the findings of such projects. The demonstra-
8 tion projects shall evaluate the impact of these standards
9 in ensuring quality of care, reducing cost, and reducing
10 burdens on health care providers.

11 (c) PREEMPTIVE EFFECT OF FULLY IMPLEMENTED
12 STANDARD.—After a standard developed under this sec-
13 tion is tested, evaluated, revised, and fully implemented,
14 it shall replace existing standards, except in cases in which
15 statutory changes are necessary to implement such stand-
16 ards. In such cases, the National Quality Management
17 Council shall recommend to the President and the Con-
18 gress revisions in Federal statutes to conform the statutes
19 to the standards.

20 (d) CONSOLIDATED AUDIT AND INSPECTION.—The
21 National Quality Management Council shall undertake re-
22 search efforts designed to develop a system for carrying
23 out through grant or contract a single, consolidated an-
24 nual audit and inspection of each health care institution
25 and health care provider for the combined purposes of

1 Federal, State, local, and private licensure, accreditation,
2 and certification.

3 **SEC. 5012. ROLE OF ALLIANCES IN QUALITY ASSURANCE.**

4 Each regional alliance and each corporate alliance
5 shall—

6 (1) disseminate to consumers information re-
7 lated to quality and access to aid in their selection
8 of plans in accordance with section 1325;

9 (2) disseminate information on the quality of
10 health plans and health care providers contained in
11 reports of the National Quality Management Council
12 section 5005(c)(2);

13 (3) ensure through negotiations with health
14 plans that performance and quality standards are
15 continually improved; and

16 (4) conduct educational programs in coopera-
17 tion with regional professional foundations to assist
18 consumers in using quality and other information in
19 choosing health plans.

20 **SEC. 5013. ROLE OF HEALTH PLANS IN QUALITY MANAGE-**
21 **MENT.**

22 Each health plan shall—

23 (1) measure and disclose performance on qual-
24 ity measures used by—

1 (A) participating States in which the plan
2 does business;

3 (B) regional alliances and corporate alli-
4 ances that offer the plan; and

5 (C) the National Quality Management
6 Council;

7 (2) furnish information required under subtitle
8 B of this title and provide such other reports and in-
9 formation on the quality of care delivered by health
10 care providers who are members of a provider net-
11 work of the plan (as defined in section 1402(f)) as
12 may be required under this Act; and

13 (3) maintain quality management systems
14 that—

15 (A) use the national measures of quality
16 performance developed by the National Quality
17 Management Council under section 5003; and

18 (B) measure the quality of health care fur-
19 nished to enrollees under the plan by all health
20 care providers who are members of a provider
21 network of the plan.

1 **Subtitle B—Information Systems,**
2 **Privacy, and Administrative**
3 **Simplification**

4 **PART 1—HEALTH INFORMATION SYSTEMS**

5 **SEC. 5101. ESTABLISHMENT OF HEALTH INFORMATION SYS-**
6 **TEM.**

7 (a) IN GENERAL.—Not later than 2 years after the
8 date of the enactment of this Act, the National Health
9 Board shall develop and implement a health information
10 system by which the Board shall collect, report, and regu-
11 late the collection and dissemination of the health care in-
12 formation described in subsection (e) pursuant to stand-
13 ards promulgated by the Board and (if applicable) con-
14 sistent with policies established as part of the National
15 Information Infrastructure Act of 1993.

16 (b) PRIVACY.—The health information system shall
17 be developed and implemented in a manner that is con-
18 sistent with the privacy and security standards established
19 under section 5120.

20 (c) REDUCTION IN ADMINISTRATIVE COSTS.—The
21 health information system shall be developed and imple-
22 mented in a manner that is consistent with the objectives
23 of reducing wherever practicable and appropriate—

24 (1) the costs of providing and paying for health
25 care;

1 (2) the time, effort, and financial resources ex-
2 pended by persons to provide information to States,
3 the Federal Government, health alliances, and health
4 plans.

5 (d) USES OF INFORMATION.—The health care infor-
6 mation described in subsection (e) shall be collected and
7 reported in a manner that facilitates its use for the fol-
8 lowing purposes:

9 (1) Health care planning, policy development,
10 policy evaluation, and research by Federal, State,
11 and local governments and regional and corporate
12 alliances.

13 (2) Establishing and monitoring payments for
14 health services by the Federal Government, States,
15 regional alliances, and corporate alliances.

16 (3) Assessing and improving the quality of
17 health care.

18 (4) Measuring and optimizing access to health
19 care.

20 (5) Evaluating the cost of specific clinical or
21 administrative functions.

22 (6) Supporting public health functions and ob-
23 jectives.

1 (7) Improving the ability of health plans, health
2 care providers, and consumers to coordinate, im-
3 prove, and make choices about health care.

4 (8) Managing and containing costs at the alli-
5 ance and plan levels.

6 (e) HEALTH CARE INFORMATION.—The health care
7 information referred to in subsection (a) shall include data
8 on—

9 (1) enrollment and disenrollment in health
10 plans;

11 (2) clinical encounters and other items and
12 services provided by health care providers;

13 (3) administrative and financial transactions
14 and activities of participating States, regional alli-
15 ances, corporate alliances, health plans, health care
16 providers, employers, and individuals that are nec-
17 essary to determine compliance with this Act or an
18 Act amended by this Act;

19 (4) the characteristics of regional alliances, in-
20 cluding the number, and demographic characteristics
21 of eligible individuals residing in each alliance area;

22 (5) the characteristics of corporate alliances, in-
23 cluding the number, and demographic characteristics
24 of individuals who are eligible to be enrolled in each
25 corporate alliance health plan and individuals with

1 respect to whom a large employer has exercised an
2 option under section 1311 to make ineligible for
3 such enrollment;

4 (6) terms of agreement between health plans
5 and the health care providers who are members of
6 provider networks of the plans (as defined in section
7 1402(f));

8 (7) payment of benefits in cases in which bene-
9 fits may be payable under a health plan and any
10 other insurance policy or health program;

11 (8) utilization management by health plans and
12 health care providers;

13 (9) the information collected and reported by
14 the Board or disseminated by other individuals or
15 entities as part of the National Quality Management
16 Program under subtitle A;

17 (10) grievances filed against regional alliances,
18 corporate alliances, and health plans and the resolu-
19 tions of such grievances; and

20 (11) any other fact that may be necessary to
21 determine whether a health plan or a health care
22 provider has complied with a Federal statute per-
23 taining to fraud or misrepresentation in the provi-
24 sion or purchasing of health care or in the submis-

1 sion of a claim for benefits or payment under a
2 health plan.

3 **SEC. 5102. ADDITIONAL REQUIREMENTS FOR HEALTH IN-**
4 **FORMATION SYSTEM.**

5 (a) CONSULTATION.—The health information system
6 shall be developed in consultation with—

7 (1) Federal agencies that—

8 (A) collect health care information;

9 (B) oversee the collection of information or
10 records management by other Federal agencies;

11 (C) directly provide health care services;

12 (D) provide for payments for health care
13 services; or

14 (E) enforce a provision of this Act or any
15 Act amended by this Act;

16 (2) the National Quality Management Council
17 established under section 5002;

18 (3) participating States;

19 (4) regional alliances and corporate alliances;

20 (5) health plans;

21 (6) representatives of health care providers;

22 (7) representatives of employers;

23 (8) representatives of consumers of health care;

24 (9) experts in public health and health care in-
25 formation and technology; and

1 (10) representatives of organizations furnishing
2 health care supplies, services, and equipment.

3 (b) COLLECTION AND TRANSMISSION REQUIRE-
4 MENTS.—In establishing standards under section 5101,
5 the National Health Board shall specify the form and
6 manner in which individuals and entities are required to
7 collect or transmit health care information for or to the
8 Board. The Board also shall specify the frequency with
9 which individuals and entities are required to transmit
10 such information to the Board. Such specifications shall
11 include, to the extent practicable—

12 (1) requirements for use of uniform paper
13 forms containing standard data elements, defini-
14 tions, and instructions for completion in cases where
15 the collection or transmission of data in electronic
16 form is not specified by the Board;

17 (2) requirements for use of uniform health data
18 sets with common definitions to standardize the col-
19 lection and transmission of data in electronic form;

20 (3) uniform presentation requirements for data
21 in electronic form; and

22 (4) electronic data interchange requirements for
23 the exchange of data among automated health infor-
24 mation systems.

1 (c) PREEMPTION OF STATE “PEN & QUILL” LAWS.—
2 A standard established by the National Health Board re-
3 lating to the form in which medical or health plan records
4 are required to be maintained shall supercede any contrary
5 provision of State law, except where the Board determines
6 that the provision is necessary to prevent fraud and abuse,
7 with respect to controlled substances, or for other pur-
8 poses.

9 **SEC. 5103. ELECTRONIC DATA NETWORK.**

10 (a) IN GENERAL.—As part of the health information
11 system, the National Health Board shall oversee the estab-
12 lishment of an electronic data network consisting of re-
13 gional centers that collect, compile, and transmit informa-
14 tion.

15 (b) CONSULTATION.—The electronic data network
16 shall be developed in consultation with—

- 17 (1) Federal agencies that—
- 18 (A) collect health care information;
- 19 (B) oversee the collection of information or
- 20 records management by other Federal agencies;
- 21 (C) directly provide health care services;
- 22 (D) provide for payments for health care
- 23 services; or
- 24 (E) enforce a provision of this Act or any
- 25 Act amended by this Act;

1 (2) the National Quality Management Council
2 established under section 5002;

3 (3) participating States;

4 (4) regional alliances and corporate alliances;

5 (5) health plans;

6 (6) representatives of health care providers;

7 (7) representatives of employers;

8 (8) representatives of consumers of health care;

9 (9) experts in public health and health care in-
10 formation and technology; and

11 (10) representatives of organizations furnishing
12 health care supplies, services, and equipment.

13 (c) DEMONSTRATION PROJECTS.—The electronic
14 data network shall be tested prior to full implementation
15 through the establishment of demonstration projects.

16 (d) DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE
17 INFORMATION.—The electronic data network may be used
18 to disclose individually identifiable health information (as
19 defined in section 5123(3)) to any individual or entity only
20 in accordance with the health information system privacy
21 standards promulgated by the National Health Board
22 under section 5120.

1 **SEC. 5104. UNIQUE IDENTIFIER NUMBERS.**

2 (a) IN GENERAL.—As part of the health information
3 system, the Board shall establish a system to provide for
4 a unique identifier number for each—

- 5 (1) eligible individual;
6 (2) employer;
7 (3) health plan; and
8 (4) health care provider.

9 (b) IMPERMISSIBLE DATA LINKS.—In establishing
10 the system under subsection (a), the National Health
11 Board shall ensure that a unique identifier number may
12 not be used to connect individually identifiable health in-
13 formation (as defined in section 5123(3)) that is collected
14 as part of the health information system or that otherwise
15 may be accessed through the number with individually
16 identifiable information from any other source, except in
17 cases where the National Health Board determines that
18 such connection is necessary to carry out a duty imposed
19 on any individual or entity under this Act.

20 (c) PERMISSIBLE USES OF IDENTIFIER.—The Na-
21 tional Health Board shall by regulation establish the pur-
22 poses for which a unique identifier number provided pur-
23 suant to this section may be used.

24 **SEC. 5105. HEALTH SECURITY CARDS.**

25 (a) PERMISSIBLE USES OF CARD.—A health security
26 card that is issued to an eligible individual under section

1 1001(b) may be used by an individual or entity, in accord-
2 ance with regulations promulgated by the Board, only for
3 the purpose of providing or assisting the eligible individual
4 in obtaining an item or service that is covered under—

5 (1) the applicable health plan in which the indi-
6 vidual is enrolled (as defined in section 1902);

7 (2) a policy consisting of a supplemental health
8 benefit policy (described in part 2 of subtitle E of
9 title I), a cost sharing policy (described in such
10 part), or both;

11 (3) a FEHBP supplemental plan (described in
12 subtitle C of title VIII);

13 (4) a FEHBP medicare supplemental plan (de-
14 scribed in such subtitle); or

15 (5) such other programs as the Board may
16 specify.

17 (b) FORM OF CARD AND ENCODED INFORMATION.—

18 The National Health Board shall establish standards re-
19 specting the form of health security cards and the infor-
20 mation to be encoded in electronic form on the cards. Such
21 information shall include—

22 (1) the identity of the individual to whom the
23 card is issued;

24 (2) the applicable health plan in which the indi-
25 vidual is enrolled;

1 (3) any policy described in paragraph (2), (3),
2 or (4) of subsection (a) in which the individual is en-
3 rolled; and

4 (4) any other information that the National
5 Health Board determines to be necessary in order
6 for the card to serve the purpose described in sub-
7 section (a).

8 (c) UNIQUE IDENTIFIER NUMBERS.—The unique
9 identifier number system developed by the National
10 Health Board under section 5104 shall be used in encod-
11 ing the information described in subsection (b).

12 (d) REGISTRATION OF CARD.—The Board shall take
13 appropriate steps to register the card, the name of the
14 card, and other indicia relating to the card as a trademark
15 or service mark (as appropriate) under the Trademark Act
16 of 1946. For purposes of this subsection, the “Trademark
17 Act of 1946” refers to the Act entitled “An Act to provide
18 for the registration and protection of trademarks used in
19 commerce, to carry out the provisions of international con-
20 ventions, and for other purposes”, approved July 5, 1946
21 (15 U.S.C. et seq.).

22 (e) REFERENCE TO CRIME.—For a provision relating
23 to criminal penalties for misuse of a health security card
24 or a unique identifier number, see section 5438.

1 **SEC. 5106. TECHNICAL ASSISTANCE IN THE ESTABLISH-**
2 **MENT OF HEALTH INFORMATION SYSTEMS.**

3 The National Health Board shall provide information
4 and technical assistance to participating States, regional
5 alliances, corporate alliances, health plans, and health care
6 providers with respect to the establishment and operation
7 of automated health information systems. Such assistance
8 shall focus on—

9 (1) the promotion of community-based health
10 information systems; and

11 (2) the promotion of patient care information
12 systems that collect data at the point of care or as
13 a by-product of the delivery of care.

14 **PART 2—PRIVACY OF INFORMATION**

15 **SEC. 5120. HEALTH INFORMATION SYSTEM PRIVACY**
16 **STANDARDS.**

17 (a) HEALTH INFORMATION SYSTEM STANDARDS.—

18 Not later than 2 years after the date of the enactment
19 of this Act, the National Health Board shall promulgate
20 standards respecting the privacy of individually identifi-
21 able health information that is in the health information
22 system described in part 1 of this subtitle. Such standards
23 shall include standards concerning safeguards for the se-
24 curity of such information. The Board shall develop and
25 periodically revise the standards in consultation with—

26 (1) Federal agencies that—

- 1 (A) collect health care information;
- 2 (B) oversee the collection of information or
- 3 records management by other Federal agencies;
- 4 (C) directly provide health care services;
- 5 (D) provide for payments for health care
- 6 services; or
- 7 (E) enforce a provision of this Act or any
- 8 Act amended by this Act;
- 9 (2) the National Quality Management Council
- 10 established under section 5002;
- 11 (3) participating States;
- 12 (4) regional alliances and corporate alliances;
- 13 (5) health plans; and
- 14 (6) representatives of consumers of health care.

15 (b) INFORMATION COVERED.—The standards estab-
16 lished under subsection (a) shall apply to individually iden-
17 tifiable health information collected for or by, reported to
18 or by, or the dissemination of which is regulated by, the
19 National Health Board under section 5101.

20 (c) PRINCIPLES.—The standards established under
21 subsection (a) shall incorporate the following principles:

- 22 (1) UNAUTHORIZED DISCLOSURE.—All disclo-
23 sures of individually identifiable health information
24 by an individual or entity shall be unauthorized
25 unless—

1 (A) the disclosure is by the enrollee identi-
2 fied in the information or whose identity can be
3 associated with the information;

4 (B) the disclosure is authorized by such
5 enrollee in writing in a manner prescribed by
6 the Board;

7 (C) the disclosure is to Federal, State, or
8 local law enforcement agencies for the purpose
9 of enforcing this Act or an Act amended by this
10 Act; or

11 (D) the disclosure otherwise is consistent
12 with this Act and specific criteria governing dis-
13 closure established by the Board.

14 (2) MINIMAL DISCLOSURE.—All disclosures of
15 individually identifiable health information shall be
16 restricted to the minimum amount of information
17 necessary to accomplish the purpose for which the
18 information is being disclosed.

19 (3) RISK ADJUSTMENT.—No individually identi-
20 fiable health information may be provided by a
21 health plan to a regional alliance or a corporate alli-
22 ance for the purpose of setting premiums based on
23 risk adjustment factors.

24 (4) REQUIRED SAFEGUARDS.—Any individual
25 or entity who maintains, uses, or disseminates indi-

vidually identifiable health information shall implement administrative, technical, and physical safeguards for the security of such information.

(5) RIGHT TO KNOW.—An enrollee (or an enrollee representative of the enrollee) has the right to know—

(A) whether any individual or entity uses or maintains individually identifiable health information concerning the enrollee; and

(B) for what purposes the information may be used or maintained.

(6) RIGHT TO ACCESS.—Subject to appropriate procedures, an enrollee (or an enrollee representative of the enrollee) has the right, with respect to individually identifiable health information concerning the enrollee that is recorded in any form or medium—

(A) to see such information;

(B) to copy such information; and

(C) to have a notation made with or in such information of any amendment or correction of such information requested by the enrollee or enrollee representative.

(7) RIGHT TO NOTICE.—An enrollee and an enrollee representative have the right to receive a written statement concerning—

1 (A) the purposes for which individually
2 identifiable health information provided to a
3 health care provider, a health plan, a regional
4 alliance, a corporate alliance, or the National
5 Health Board may be used or disclosed by, or
6 disclosed to, any individual or entity; and

7 (B) the right of access described in para-
8 graph (6).

9 (8) USE OF UNIQUE IDENTIFIER.—When indi-
10 vidually identifiable health information concerning
11 an enrollee is required to accomplish the purpose for
12 which information is being transmitted between or
13 among the National Health Board, regional and cor-
14 porate alliances, health plans, and health care pro-
15 viders, the transmissions shall use the unique identi-
16 fier number provided to the enrollee pursuant to sec-
17 tion 5104 in lieu of the name of the enrollee.

18 (9) USE FOR EMPLOYMENT DECISIONS.—Indi-
19 vidually identifiable health care information may not
20 be used in making employment decisions.

21 **SEC. 5121. OTHER DUTIES WITH RESPECT TO PRIVACY.**

22 (a) RESEARCH AND TECHNICAL SUPPORT.—The Na-
23 tional Health Board may sponsor—

24 (1) research relating to the privacy and security
25 of individually identifiable health information;

1 (2) the development of consent forms governing
2 disclosure of such information; and

3 (3) the development of technology to implement
4 standards regarding such information.

5 (c) EDUCATION.—The National Health Board shall
6 establish education and awareness programs—

7 (1) to foster adequate security practices by
8 States, regional alliances, corporate alliances, health
9 plans, and health care providers;

10 (2) to train personnel of public and private en-
11 tities who have access to individually identifiable
12 health information respecting the duties of such per-
13 sonnel with respect to such information; and

14 (3) to inform individuals and employers who
15 purchase health care respecting their rights with re-
16 spect to such information.

17 **SEC. 5122. COMPREHENSIVE HEALTH INFORMATION PRI-**
18 **VACY PROTECTION ACT.**

19 (a) IN GENERAL.—Not later than 3 years after the
20 date of the enactment of this Act, the National Health
21 Board shall submit to the President and the Congress a
22 detailed proposal for legislation to provide a comprehen-
23 sive scheme of Federal privacy protection for individually
24 identifiable health information.

1 (b) CODE OF FAIR INFORMATION PRACTICES.—The
2 proposal shall include a Code of Fair Information Prac-
3 tices to be used to advise enrollees to whom individually
4 identifiable health information pertains of their rights with
5 respect to such information in an easily understood and
6 useful form.

7 (c) ENFORCEMENT.—The proposal shall include pro-
8 visions to enforce effectively the rights and duties that
9 would be created by the legislation.

10 **SEC. 5123. DEFINITIONS.**

11 For purposes of this part:

12 (1) ENROLLEE.—The term “enrollee” means
13 an individual who enrolls or has enrolled under a
14 health plan. The term includes a deceased individual
15 who was enrolled under a health plan.

16 (2) ENROLLEE REPRESENTATIVE.—The term
17 “enrollee representative” means any individual le-
18 gally empowered to make decisions concerning the
19 provision of health care to an enrollee or the admin-
20 istrator or executor of the estate of a deceased en-
21 rollee.

22 (3) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
23 FORMATION.—The term “individually identifiable
24 health information” means any information, whether
25 oral or recorded in any form or medium, that—

1 (A) identifies or can readily be associated
2 with the identity of an enrollee; and

3 (B) relates to—

4 (i) the past, present, or future phys-
5 ical or mental health of the enrollee;

6 (ii) the provision of health care to the
7 enrollee; or

8 (iii) payment for the provision of
9 health care to the enrollee.

10 **PART 3—INTERIM REQUIREMENTS FOR**
11 **ADMINISTRATIVE SIMPLIFICATION**

12 **SEC. 5130. STANDARD BENEFIT FORMS.**

13 (a) DEVELOPMENT.—Not later than 1 year after the
14 date of the enactment of this Act, the National Health
15 Board shall develop, promulgate, and publish in the Fed-
16 eral Register the following standard health care benefit
17 forms:

18 (1) An enrollment and disenrollment form to be
19 used to record enrollment and disenrollment in a
20 health benefit plan.

21 (2) A clinical encounter record to be used by
22 health benefit plans and health service providers.

23 (3) A claim form to be used in the submission
24 of claims for benefits or payment under a health
25 benefit plan.

1 (b) INSTRUCTIONS, DEFINITIONS, AND CODES.—

2 Each standard form developed under subsection (a) shall
3 include instructions for completing the form that—

4 (1) specifically define, to the extent practicable,
5 the data elements contained in the form; and

6 (2) standardize any codes or data sets to be
7 used in completing the form.

8 (c) REQUIREMENTS FOR ADOPTION OF FORMS.—

9 (1) HEALTH SERVICE PROVIDERS.—On or after
10 the date that is 270 days after the publication of the
11 standard forms developed under subsection (a), a
12 health service provider that furnishes items or serv-
13 ices in the United States for which payment may be
14 made under a health benefit plan may not—

15 (A) maintain records of clinical encounters
16 involving such items or services that are re-
17 quired to be maintained by the National Health
18 Board in a paper form that is not the clinical
19 encounter record promulgated by the Board; or

20 (B) submit any claim for benefits or pay-
21 ment for such services to such plan in a paper
22 form that is not the claim form promulgated by
23 the National Health Board.

24 (2) HEALTH BENEFIT PLANS.—On or after the
25 date that is 270 days after the publication of the

1 standard forms developed under subsection (a), a
2 health benefit plan may not—

3 (A) record enrollment and disenrollment in
4 a paper form that is not the enrollment and
5 disenrollment form promulgated by the Na-
6 tional Health Board;

7 (B) maintain records of clinical encounters
8 that are required to be maintained by the Na-
9 tional Health Board in a paper form that is not
10 the clinical encounter record promulgated by
11 the Board; or

12 (C) reject a claim for benefits or payment
13 under the plan on the basis of the form or me-
14 dium in which the claim is submitted if—

15 (i) the claim is submitted on the claim
16 form promulgated by the National Health
17 Board; and

18 (ii) the plan accepts claims submitted
19 in paper form.

20 (d) DEFINITIONS.—For purposes of this subtitle:

21 (1) HEALTH BENEFIT PLAN.—

22 (A) IN GENERAL.—The term “health ben-
23 efit plan” means, except as provided in sub-
24 paragraphs (B) through (D), any public or pri-

1 vate entity or program that provides for pay-
2 ments for health care services, including—

3 (i) a group health plan (as defined in
4 section 5000(b)(1) of the Internal Revenue
5 Code of 1986); and

6 (ii) any other health insurance ar-
7 rangement, including any arrangement
8 consisting of a hospital or medical expense
9 incurred policy or certificate, hospital or
10 medical service plan contract, or health
11 maintenance organization subscriber con-
12 tract.

13 (B) PLANS EXCLUDED.—Such term does
14 not include—

15 (i) accident-only, credit, or disability
16 income insurance;

17 (ii) coverage issued as a supplement
18 to liability insurance;

19 (iii) an individual making payment on
20 the individual's own behalf (or on behalf of
21 a relative or other individual) for
22 deductibles, coinsurance, or services not
23 covered under a health benefit plan; and

24 (iv) such other plans as the National
25 Health Board may determine, because of

1 the limitation of benefits to a single type
2 or kind of health care, such as dental serv-
3 ices or hospital indemnity plans, or other
4 reasons should not be subject to the re-
5 quirements of this section.

6 (C) PLANS INCLUDED.—Such term
7 includes—

8 (i) workers compensation or similar
9 insurance insofar as it relates to workers
10 compensation medical benefits (as defined
11 in section 10000(3)) provided by or
12 through health plans; and

13 (ii) automobile medical insurance in-
14 sofar as it relates to automobile insurance
15 medical benefits (as defined in section
16 10100(2)) provided by or through health
17 plans.

18 (D) TREATMENT OF DIRECT PROVISION OF
19 SERVICES.—Such term does not include a Fed-
20 eral or State program that provides directly for
21 the provision of health services to beneficiaries.

22 (2) HEALTH SERVICE PROVIDER.—The term
23 “health service provider” includes a provider of serv-
24 ices (as defined in section 1861(u) of the Social Se-
25 curity Act), physician, supplier, and other person

1 furnishing health care services. Such term includes
2 a Federal or State program that provides directly
3 for the provision of health services to beneficiaries.

4 (e) INTERIM NATURE OF REQUIREMENTS.—The Na-
5 tional Health Board may modify, update, or supercede any
6 standard form or requirement developed, promulgated, or
7 imposed under this section through the establishment of
8 a standard under section 5101.

9 **PART 4—GENERAL PROVISIONS**

10 **SEC. 5140. NATIONAL PRIVACY AND HEALTH DATA ADVI-**
11 **SORY COUNCIL.**

12 (a) ESTABLISHMENT.—There is established an advi-
13 sory council to be known as the National Privacy and
14 Health Data Advisory Council.

15 (b) DUTIES.—The Council shall advise the National
16 Health Board with respect to its duties under this subtitle.

17 (c) NUMBER AND APPOINTMENT.—The Council shall
18 be composed of 15 members appointed by the National
19 Health Board. The members of the Council shall include—

20 (1) individuals representing the interests of con-
21 sumers, employers, and other purchasers of health
22 care;

23 (2) individuals representing the interests of
24 health plans, health care providers, corporate alli-

1 ances, regional alliances, public health agencies, and
2 participating States; and

3 (3) individuals distinguished in the fields of
4 data collection, data protection and privacy, law,
5 ethics, medical and health services research, public
6 health, and civil liberties and patient advocacy.

7 (d) TERMS.—

8 (1) IN GENERAL.—Except as provided in para-
9 graph (2), members of the Council shall serve for a
10 term of 3 years.

11 (2) STAGGERED ROTATION.—Of the members
12 first appointed to the Council under subsection (c),
13 the National Health Board shall appoint 5 members
14 to serve for a term of 3 years, 5 members to serve
15 for a term of 2 years, and 5 members to serve for
16 a term of 1 year.

17 (3) SERVICE BEYOND TERM.—A member of the
18 Council may continue to serve after the expiration of
19 the term of the member until a successor is ap-
20 pointed.

21 (e) VACANCIES.—If a member of the Council does not
22 serve the full term applicable under subsection (d), the in-
23 dividual appointed to fill the resulting vacancy shall be ap-
24 pointed for the remainder of the term of the predecessor
25 of the individual.

1 (f) CHAIR.—The National Health Board shall des-
2 ignate an individual to serve as the chair of the Council.

3 (g) MEETINGS.—The Council shall meet not less than
4 once during each 4-month period and shall otherwise meet
5 at the call of the National Health Board or the chair.

6 (h) COMPENSATION AND REIMBURSEMENT OF EX-
7 PENSES.—Members of the Council shall receive compensa-
8 tion for each day (including travel time) engaged in car-
9 rying out the duties of the Council. Such compensation
10 may not be in an amount in excess of the maximum rate
11 of basic pay payable for level IV of the Executive Schedule
12 under section 5315 of title 5, United States Code.

13 (i) STAFF.—The National Health Board shall provide
14 to the Council such staff, information, and other assist-
15 ance as may be necessary to carry out the duties of the
16 Council.

17 (j) DURATION.—Notwithstanding section 14(a) of the
18 Federal Advisory Committee Act, the Council shall con-
19 tinue in existence until otherwise provided by law.

20 **SEC. 5141. CIVIL MONEY PENALTIES.**

21 (a) VIOLATION OF HEALTH INFORMATION SYSTEM
22 STANDARDS.—Any person who the Secretary of Health
23 and Human Services determines—

1 (1) is required, but has substantially failed, to
2 comply with a standard established by the National
3 Health Board under section 5101 or 5120;

4 (2) has required the display of, has required the
5 use of, or has used a health security card for any
6 purpose other than a purpose described in section
7 5105(a); or

8 (3) has required the disclosure of, has required
9 the use of, or has used a unique identifier number
10 provided pursuant to section 5104 for any purpose
11 that is not authorized by the National Health Board
12 pursuant to such section

13 shall be subject, in addition to any other penalties that
14 may be prescribed by law, to a civil money penalty of not
15 more than \$10,000 for each such violation.

16 (b) STANDARD BENEFIT FORMS.—Any health service
17 provider or health benefit plan that the Secretary of
18 Health and Human Services determines is required, but
19 has substantially failed, to comply with section 5130(c)
20 shall be subject, in addition to any other penalties that
21 may be prescribed by law, to a civil money penalty of not
22 more than \$10,000 for each such violation.

23 (c) PROCESS.—The process for the imposition of a
24 civil money penalty under the All-Payer Health Care
25 Fraud and Abuse Control Program under part 1 of sub-

1 title E of this title shall apply to a civil money penalty
2 under this section in the same manner as such process
3 applies to a penalty or proceeding under such program.

4 **SEC. 5142. RELATIONSHIP TO OTHER LAWS.**

5 (a) COURT ORDERS.—Nothing in this title shall be
6 construed to invalidate or limit the power or authority of
7 any court of competent jurisdiction with respect to health
8 care information.

9 (b) PUBLIC HEALTH REPORTING.—Nothing in this
10 title shall be construed to invalidate or limit the authori-
11 ties, powers, or procedures established under any law that
12 provides for the reporting of disease, child abuse, birth,
13 or death.

14 **Subtitle C—Remedies and**
15 **Enforcement**

16 **PART 1—REVIEW OF BENEFIT DETERMINATIONS**
17 **FOR ENROLLED INDIVIDUALS**

18 **Subpart A—General Rules**

19 **SEC. 5201. HEALTH PLAN CLAIMS PROCEDURE.**

20 (a) DEFINITIONS.—For purposes of this section—

21 (1) CLAIM.—The term “claim” means a claim
22 for payment or provision of benefits under a health
23 plan or a request for preauthorization of items or
24 services which is submitted to a health plan prior to
25 receipt of the items or services.

1 (2) INDIVIDUAL CLAIMANT.—The term “indi-
2 vidual claimant” with respect to a claim means any
3 individual who submits the claim to a health plan in
4 connection with the individual’s enrollment under
5 the plan, or on whose behalf the claim is submitted
6 to the plan by a provider.

7 (3) PROVIDER CLAIMANT.—The term “provider
8 claimant” with respect to a claim means any pro-
9 vider who submits the claim to a health plan with
10 respect to items or services provided to an individual
11 enrolled under the plan.

12 (b) GENERAL RULES GOVERNING TREATMENT OF
13 CLAIMS.—

14 (1) ADEQUATE NOTICE OF DISPOSITION OF
15 CLAIM.—In any case in which a claim is submitted
16 in complete form to a health plan, the plan shall
17 provide to the individual claimant and any provider
18 claimant with respect to the claim a written notice
19 of the plan’s approval or denial of the claim within
20 30 days after the date of the submission of the
21 claim. The notice to the individual claimant shall be
22 written in language calculated to be understood by
23 the typical individual enrolled under the plan and in
24 a form which takes into account accessibility to the
25 information by individuals whose primary language

1 is not English. In the case of a denial of the claim,
2 the notice shall be provided within 5 days after the
3 date of the determination to deny the claim, and
4 shall set forth the specific reasons for the denial.
5 The notice of a denial shall include notice of the
6 right to appeal the denial under paragraph (2). Fail-
7 ure by any plan to comply with the requirements of
8 this paragraph with respect to any claim submitted
9 to the plan shall be treated as approval by the plan
10 of the claim.

11 (2) PLAN'S DUTY TO REVIEW DENIALS UPON
12 TIMELY REQUEST.—The plan shall review its denial
13 of the claim if an individual claimant or provider
14 claimant with respect to the claim submits to the
15 plan a written request for reconsideration of the
16 claim after receipt of written notice from the plan of
17 the denial. The plan shall allow any such claimant
18 not less than 60 days, after receipt of written notice
19 from the plan of the denial, to submit the claimant's
20 request for reconsideration of the claim.

21 (3) TIME LIMIT FOR REVIEW.—The plan shall
22 complete any review required under paragraph (2),
23 and shall provide the individual claimant and any
24 provider claimant with respect to the claim written
25 notice of the plan's decision on the claim after re-

1 consideration pursuant to the review, within 30 days
2 after the date of the receipt of the request for recon-
3 sideration.

4 (4) DE NOVO REVIEWS.—Any review required
5 under paragraph (2)—

6 (A) shall be de novo,

7 (B) shall be conducted by an individual
8 who did not make the initial decision denying
9 the claim and who is authorized to approve the
10 claim, and

11 (C) shall include review by a qualified phy-
12 sician if the resolution of any issues involved re-
13 quires medical expertise.

14 (c) TREATMENT OF URGENT REQUESTS TO PLANS
15 FOR PREAUTHORIZATION.—

16 (1) IN GENERAL.—This subsection applies in
17 the case of any claim submitted by an individual
18 claimant or a provider claimant consisting of a re-
19 quest for preauthorization of items or services (other
20 than emergency services which under section
21 1406(b) may not be subject to preauthorization)
22 which is accompanied by an attestation that—

23 (A) failure to immediately provide the
24 items or services could reasonably be expected
25 to result in—

1 (i) placing the health of the individual
2 claimant (or, with respect to an individual
3 claimant who is a pregnant woman, the
4 health of the woman or her unborn child)
5 in serious jeopardy,

6 (ii) serious impairment to bodily func-
7 tions, or

8 (iii) serious dysfunction of any bodily
9 organ or part,

10 or

11 (B) immediate provision of the items or
12 services is necessary because the individual
13 claimant has made or is at serious risk of mak-
14 ing an attempt to harm such individual claim-
15 ant or another individual.

16 (2) SHORTENED TIME LIMIT FOR CONSIDER-
17 ATION OF REQUESTS FOR PREAUTHORIZATION.—

18 Notwithstanding subsection (b)(1), a health plan
19 shall approve or deny any claim described in para-
20 graph (1) within 24 hours after submission of the
21 claim to the plan. Failure by the plan to comply with
22 the requirements of this paragraph with respect to
23 the claim shall be treated as approval by the plan of
24 the claim.

1 (3) EXPEDITED EXHAUSTION OF PLAN REM-
2 EDIES.—Any claim described in paragraph (1) which
3 is denied by the plan shall be treated as a claim with
4 respect to which all remedies under the plan pro-
5 vided pursuant to this section are exhausted, irre-
6 spective of any review provided under subsection
7 (b)(2).

8 (4) DENIAL OF PREVIOUSLY AUTHORIZED
9 CLAIMS NOT PERMITTED.—In any case in which a
10 health plan approves a claim described in paragraph
11 (1)—

12 (A) the plan may not subsequently deny
13 payment or provision of benefits pursuant to
14 the claim, unless the plan makes a showing of
15 an intentional misrepresentation of a material
16 fact by the individual claimant, and

17 (B) in the case of a violation of subpara-
18 graph (A) in connection with the claim, all rem-
19 edies under the plan provided pursuant to this
20 section with respect to the claim shall be treat-
21 ed as exhausted.

22 (d) TIME LIMIT FOR DETERMINATION OF INCOM-
23 PLETENESS OF CLAIM.—For purposes of this section—

24 (1) any claim submitted by an individual claim-
25 ant and accepted by a provider serving under con-

1 tract with a health plan and any claim described in
2 subsection (b)(1) shall be treated with respect to the
3 individual claimant as submitted in complete form,
4 and

5 (2) any other claim for benefits under the plan
6 shall be treated as filed in complete form as of 10
7 days after the date of the submission of the claim,
8 unless the plan provides to the individual claimant
9 and any provider claimant, within such period, a
10 written notice of any required matter remaining to
11 be filed in order to complete the claim.

12 Any filing by the individual claimant or the provider claim-
13 ant of additional matter requested by the plan pursuant
14 to paragraph (2) shall be treated for purposes of this sec-
15 tion as an initial filing of the claim.

16 (e) **ADDITIONAL NOTICE AND DISCLOSURE RE-**
17 **QUIREMENTS FOR HEALTH PLANS.**—In the case of a de-
18 nial of a claim for benefits under a health plan, the plan
19 shall include, together with the specific reasons provided
20 to the individual claimant and any provider claimant
21 under subsection (b)(1)—

22 (1) if the denial is based in whole or in part on
23 a determination that the claim is for an item or
24 service which is not covered by the comprehensive
25 benefit package or exceeds payment rates under the

1 applicable alliance or State fee schedule, the factual
2 basis for the determination,

3 (2) if the denial is based in whole or in part on
4 exclusion of coverage with respect to services be-
5 cause the services are determined to comprise an ex-
6 perimental treatment or investigatory procedure, the
7 medical basis for the determination and a descrip-
8 tion of the process used in making the determina-
9 tion, and

10 (3) if the denial is based in whole or in part on
11 a determination that the treatment is not medically
12 necessary or appropriate or is inconsistent with the
13 plan's practice guidelines, the medical basis for the
14 determination, the guidelines used in making the de-
15 termination, and a description of the process used in
16 making the determination.

17 (f) WAIVER OF RIGHTS PROHIBITED.—A health plan
18 may not require any party to waive any right under the
19 plan or this Act as a condition for approval of any claim
20 under the plan, except to the extent otherwise specified
21 in a formal settlement agreement.

22 **SEC. 5202. REVIEW IN REGIONAL ALLIANCE COMPLAINT**
23 **REVIEW OFFICES OF GRIEVANCES BASED ON**
24 **ACTS OR PRACTICES BY HEALTH PLANS.**

25 (a) COMPLAINT REVIEW OFFICES.—

1 (1) IN GENERAL.—In accordance with rules
2 which shall be prescribed by the Secretary of Labor,
3 each State shall establish and maintain a complaint
4 review office for each regional alliance established by
5 such State. According to designations which shall be
6 made by each State under regulations of the Sec-
7 retary of Labor, the complaint review office for a re-
8 gional alliance established by such State shall also
9 serve as the complaint review office for corporate al-
10 liances operating in the State with respect to indi-
11 viduals who are enrolled under plans described in
12 subsection (b) maintained by such corporate alli-
13 ances and who reside within the area of the regional
14 alliance.

15 (2) REGIONAL ALLIANCES NOT ESTABLISHED
16 BY STATES.—In the case of any regional alliance es-
17 tablished in any State by the Secretary of Health
18 and Human Services, the Secretary of Health and
19 Human Services shall assume all duties and obliga-
20 tions of such State under this part in accordance
21 with the applicable regulations of the Secretary of
22 Labor under this part.

23 (b) FILINGS OF COMPLAINTS BY AGGRIEVED PER-
24 SONS.—In the case of any person who is aggrieved by—

1 (1) any act or practice engaged in by any
2 health plan which consists of or results in denial of
3 payment or provision of benefits under the plan or
4 delay in the payment or provision of benefits, or

5 (2) any act or practice engaged in by any other
6 plan maintained by a regional alliance or a corporate
7 alliance which consists of or results in denial of pay-
8 ment or provision of benefits under a supplemental
9 benefit policy described in section 1421(b)(1) or a
10 cost sharing policy described in section 1421(b)(2)
11 or delay in the payment or provision of the benefits,
12 if the denial or delay consists of a failure to comply with
13 the terms of the plan (including the provision of benefits
14 in full when due in accordance with the terms of the plan),
15 or with the applicable requirements of this Act, such per-
16 son may file a complaint with the appropriate complaint
17 review office.

18 (c) EXHAUSTION OF PLAN REMEDIES.—Any com-
19 plaint including a claim to which section 5201 applies may
20 not be filed until the complainant has exhausted all rem-
21 edies provided under the plan with respect to the claim
22 in accordance with such section.

23 (d) EXCLUSIVE MEANS OF REVIEW FOR PLANS
24 MAINTAINED BY CORPORATE ALLIANCES.—Notwith-
25 standing part 2, proceedings under sections 5203 and

1 5204 pursuant to complaints filed under subsection (b),
2 and review under section 5205 of determinations made
3 under section 5204, shall be the exclusive means of review
4 of acts or practices described in subsection (b) which are
5 engaged in by a corporate alliance health plan or by any
6 plan maintained by a corporate alliance with respect to
7 benefits under a supplemental benefit policy described in
8 section 1421(b)(1) or a cost sharing policy described in
9 section 1421(b)(2).

10 (e) FORM OF COMPLAINT.—The complaint shall be
11 in writing under oath or affirmation, shall set forth the
12 complaint in a manner calculated to give notice of the na-
13 ture of the complaint, and shall contain such information
14 as may be prescribed in regulations of the Secretary of
15 Labor.

16 (f) NOTICE OF FILING.—The complaint review office
17 shall serve by certified mail a notice of the complaint (in-
18 cluding the date, place, and circumstances of the alleged
19 violation) on the person or persons alleged in the com-
20 plaint to have committed the violation within 10 days after
21 the filing of the complaint.

22 (g) TIME LIMITATION.—Complaints may not be
23 brought under this section with respect to any violation
24 later than one year after the date on which the violation

1 occurs. This subsection shall not prevent the subsequent
2 amending of a complaint.

3 **SEC. 5203. INITIAL PROCEEDINGS IN COMPLAINT REVIEW**
4 **OFFICES.**

5 (a) ELECTIONS.—Whenever a complaint is brought
6 to the complaint review office under section 5202(b), the
7 complaint review office shall provide the complainant with
8 an opportunity, in such form and manner as shall be pre-
9 scribed in regulations of the Secretary of Labor, to elect
10 one of the following:

11 (1) to forego further proceedings in the com-
12 plaint review office and rely on remedies available in
13 a court of competent jurisdiction, with respect to
14 any matter in the complaint with respect to which
15 proceedings under this section and section 5204, and
16 review under section 5205, are not under section
17 5202(d) the exclusive means of review,

18 (2) to submit the complaint as a dispute under
19 the Early Resolution Program established under
20 subpart B and thereby suspend further review pro-
21 ceedings under this section pending termination of
22 proceedings under the Program, or

23 (3) in any case in which an election under para-
24 graph (2) is not made, or such an election was made
25 but resolution of all matters in the complaint was

1 not obtained upon termination of proceedings pursu-
2 ant to the election by settlement agreement or other-
3 wise, to proceed with the complaint to a hearing in
4 the complaint review office under section 5204 re-
5 garding the unresolved matters.

6 (b) EFFECT OF PARTICIPATION IN EARLY RESOLU-
7 TION PROGRAM.—Any matter in a complaint brought to
8 the complaint review office which is included in a dispute
9 which is timely submitted to the Early Resolution Pro-
10 gram established under subpart B shall not be assigned
11 to a hearing under section 5204 unless the proceedings
12 under the Program with respect to the dispute are termi-
13 nated without settlement or resolution of the dispute with
14 respect to such matter. Upon termination of any pro-
15 ceedings regarding a dispute submitted to the Program,
16 the applicability of this section to any matter in a com-
17 plaint which was included in the dispute shall not be af-
18 fected by participation in the proceedings, except to the
19 extent otherwise required under the terms of any settle-
20 ment agreement or other formal resolution obtained in the
21 proceedings.

22 **SEC. 5204. HEARINGS BEFORE HEARING OFFICERS IN COM-**
23 **PLAINT REVIEW OFFICES.**

24 (a) HEARING PROCESS.—

1 (1) ASSIGNMENT OF COMPLAINTS TO HEARING
2 OFFICERS AND NOTICE TO PARTIES.—

3 (A) IN GENERAL.—In the case of an elec-
4 tion under section 5203(a)(3)—

5 (i) the complaint review office shall
6 assign the complaint, and each motion in
7 connection with the complaint, to a hearing
8 officer employed by the State in the office;
9 and

10 (ii) the hearing officer shall have the
11 power to issue and cause to be served upon
12 the plan named in the complaint a copy of
13 the complaint and a notice of hearing be-
14 fore the hearing officer at a place fixed in
15 the notice, not less than 5 days after the
16 serving of the complaint.

17 (B) QUALIFICATIONS FOR HEARING OFFI-
18 CERS.—No individual may serve in a complaint
19 review office as a hearing officer unless the in-
20 dividual meets standards which shall be pre-
21 scribed by the Secretary of Labor. Such stand-
22 ards shall include experience, training, affili-
23 ations, diligence, actual or potential conflicts of
24 interest, and other qualifications deemed rel-
25 evant by the Secretary of Labor. At no time

1 shall a hearing officer have any official, finan-
2 cial, or personal conflict of interest with respect
3 to issues in controversy before the hearing offi-
4 cer.

5 (2) AMENDMENT OF COMPLAINTS.—Any such
6 complaint may be amended by the hearing officer
7 conducting the hearing, upon the motion of the com-
8 plainant, in the hearing officer's discretion at any
9 time prior to the issuance of an order based thereon.

10 (3) ANSWERS.—The party against whom the
11 complaint is filed shall have the right to file an an-
12 swer to the original or amended complaint and to
13 appear in person or otherwise and give testimony at
14 the place and time fixed in the complaint.

15 (b) ADDITIONAL PARTIES.—In the discretion of the
16 hearing officer conducting the hearing, any other person
17 may be allowed to intervene in the proceeding and to
18 present testimony.

19 (c) HEARINGS.—

20 (1) DE NOVO HEARING.—Each hearing officer
21 shall hear complaints and motions de novo.

22 (2) TESTIMONY.—The testimony taken by the
23 hearing officer shall be reduced to writing. There-
24 after, the hearing officer, in his or her discretion,

1 upon notice may provide for the taking of further
2 testimony or hear argument.

3 (3) AUTHORITY OF HEARING OFFICERS.—The
4 hearing officer may compel by subpoena the attend-
5 ance of witnesses and the production of evidence at
6 any designated place or hearing. In case of contu-
7 macy or refusal to obey a subpoena lawfully issued
8 under this paragraph and upon application of the
9 hearing officer, an appropriate district court of the
10 United States may issue an order requiring compli-
11 ance with the subpoena and any failure to obey the
12 order may be punished by the court as a contempt
13 thereof. The hearing officer may also seek enforce-
14 ment of the subpoena in a State court of competent
15 jurisdiction.

16 (4) EXPEDITED HEARINGS.—Notwithstanding
17 section 5203 and the preceding provisions of this
18 section, upon receipt of a complaint containing a
19 claim described in section 5201(c)(1), the complaint
20 review office shall promptly provide the complainant
21 with the opportunity to make an election under sec-
22 tion 5203(a)(3) and assignment to a hearing on the
23 complaint before a hearing officer. The complaint re-
24 view office shall ensure that such a hearing com-

1 mences not later than 24 hours after receipt of the
2 complaint by the complaint hearing office.

3 (d) DECISION OF HEARING OFFICER.—

4 (1) IN GENERAL.—The hearing officer shall de-
5 cide upon the preponderance of the evidence whether
6 to decide in favor of the complainant with respect to
7 each alleged act or practice. Each such decision—

8 (A) shall include the hearing officer's find-
9 ings of fact, and

10 (B) shall constitute the hearing officer's
11 final disposition of the proceedings.

12 (2) DECISIONS FINDING IN FAVOR OF COM-
13 PLAINANT.—If the hearing officer's decision includes
14 a determination that any party named in the com-
15 plaint has engaged in or is engaged in an act or
16 practice described in section 5202(b), the hearing of-
17 ficer shall issue and cause to be served on such
18 party an order which requires such party—

19 (A) to cease and desist from such act or
20 practice,

21 (B) to provide the benefits due under the
22 terms of the plan and to otherwise comply with
23 the terms of the plan and the applicable re-
24 quirements of this Act,

1 (C) to pay to the complainant prejudgment
2 interest on the actual costs incurred in obtain-
3 ing the items and services at issue in the com-
4 plaint, and

5 (D) to pay to the prevailing complainant a
6 reasonable attorney's fee, reasonable expert wit-
7 ness fees, and other reasonable costs relating to
8 the hearing on the charges on which the com-
9 plainant prevails.

10 (3) DECISIONS NOT IN FAVOR OF COMPLAIN-
11 ANT.—If the hearing officer's decision includes a de-
12 termination that the party named in the complaint
13 has not engaged in or is not engaged in an act or
14 practice referred to in section 5202(b), the hearing
15 officer—

16 (A) shall include in the decision a dismissal
17 of the charge in the complaint relating to the
18 act or practice, and

19 (B) upon a finding that such charge is
20 frivolous, shall issue and cause to be served on
21 the complainant an order which requires the
22 complainant to pay to such party a reasonable
23 attorney's fee, reasonable expert witness fees,
24 and other reasonable costs relating to the pro-
25 ceedings on such charge.

1 (4) SUBMISSION AND SERVICE OF DECISIONS.—

2 The hearing officer shall submit each decision to the
3 complaint review office at the conclusion of the pro-
4 ceedings and the office shall cause a copy of the de-
5 cision to be served on the parties to the proceedings.

6 (e) REVIEW.—

7 (1) IN GENERAL.—The decision of the hearing
8 officer shall be final and binding upon all parties.
9 Except as provided in paragraph (2), any party to
10 the complaint may, within 30 days after service of
11 the decision by the complaint review office, file an
12 appeal of the decision with the Federal Health Plan
13 Review Board under section 5205 in such form and
14 manner as may be prescribed by such Board.

15 (2) EXCEPTION.—The decision in the case of
16 an expedited hearing under subsection (c)(4) shall
17 not be subject to review.

18 (f) COURT ENFORCEMENT OF ORDERS.—

19 (1) IN GENERAL.—If a decision of the hearing
20 officer in favor of the complainant is not appealed
21 under section 5205, the complainant may petition
22 any court of competent jurisdiction for enforcement
23 of the order. In any such proceeding, the order of
24 the hearing officer shall not be subject to review.

1 (2) AWARDING OF COSTS.—In any action for
2 court enforcement under this subsection, a prevailing
3 complainant shall be entitled to a reasonable attor-
4 ney’s fee, reasonable expert witness fees, and other
5 reasonable costs relating to such action.

6 **SEC. 5205. REVIEW BY FEDERAL HEALTH PLAN REVIEW**
7 **BOARD.**

8 (a) ESTABLISHMENT AND MEMBERSHIP.—The Sec-
9 retary of Labor shall establish by regulation a Federal
10 Health Plan Review Board (hereinafter in this subtitle re-
11 ferred to as the “Review Board”). The Review Board shall
12 be composed of 5 members appointed by the Secretary of
13 Labor from among persons who by reason of training,
14 education, or experience are qualified to carry out the
15 functions of the Review Board under this subtitle. The
16 Secretary of Labor shall prescribe such rules as are nec-
17 essary for the orderly transaction of proceedings by the
18 Review Board. Every official act of the Review Board shall
19 be entered of record, and its hearings and records shall
20 be open to the public.

21 (b) REVIEW PROCESS.—The Review Board shall en-
22 sure, in accordance with rules prescribed by the Secretary
23 of Labor, that reasonable notice is provided for each ap-
24 peal before the Review Board of a hearing officer’s deci-
25 sion under section 5304, and shall provide for the orderly

1 consideration of arguments by any party to the hearing
2 upon which the hearing officer's decision is based. In the
3 discretion of the Review Board, any other person may be
4 allowed to intervene in the proceeding and to present writ-
5 ten argument. The National Health Board may intervene
6 in the proceeding as a matter of right.

7 (c) SCOPE OF REVIEW.—The Review Board shall re-
8 view the decision of the hearing officer from which the
9 appeal is made, except that the review shall be only for
10 the purposes of determining—

11 (1) whether the determination is supported by
12 substantial evidence on the record considered as a
13 whole,

14 (2) in the case of any interpretation by the
15 hearing officer of contractual terms (irrespective of
16 the extent to which extrinsic evidence was consid-
17 ered), whether the determination is supported by a
18 preponderance of the evidence,

19 (3) whether the determination is in excess of
20 statutory jurisdiction, authority, or limitations, or in
21 violation of a statutory right, or

22 (4) whether the determination is without ob-
23 servance of procedure required by law.

24 (d) DECISION OF REVIEW BOARD.—The decision of
25 the hearing officer as affirmed or modified by the Review

1 Board (or any reversal by the Review Board of the hearing
2 officer's final disposition of the proceedings) shall become
3 the final order of the Review Board and binding on all
4 parties, subject to review under subsection (e). The Review
5 Board shall cause a copy of its decision to be served on
6 the parties to the proceedings not later than 5 days after
7 the date of the decision.

8 (e) REVIEW OF FINAL ORDERS.—

9 (1) IN GENERAL.—Not later than 60 days after
10 the entry of the final order, any person aggrieved by
11 any such final order under which the amount or
12 value in controversy exceeds \$10,000 may seek a re-
13 view of the order in the United States court of ap-
14 peals for the circuit in which the violation is alleged
15 to have occurred or in which the complainant re-
16 sides.

17 (2) FURTHER REVIEW.—Upon the filing of the
18 record with the court, the jurisdiction of the court
19 shall be exclusive and its judgment shall be final, ex-
20 cept that the judgment shall be subject to review by
21 the Supreme Court of the United States upon writ
22 of certiorari or certification as provided in section
23 1254 of title 28 of the United States Code.

24 (3) ENFORCEMENT DECREE IN ORIGINAL RE-
25 VIEW.—If, upon appeal of an order under paragraph

1 (1), the United States court of appeals does not re-
2 verse the order, the court shall have the jurisdiction
3 to make and enter a decree enforcing the order of
4 the Review Board.

5 (f) AWARDING OF ATTORNEYS' FEES AND OTHER
6 COSTS AND EXPENSES.—In any proceeding before the Re-
7 view Board under this section or any judicial proceeding
8 under subsection (e), the Review Board or the court (as
9 the case may be) shall award to a prevailing complainant
10 reasonable costs and expenses (including a reasonable at-
11 torney's fee) on the causes on which the complainant pre-
12 vails.

13 **SEC. 5206. RULES GOVERNING BENEFIT CLAIMS DETER-**
14 **MINATIONS.**

15 (a) IN GENERAL.—Determinations made under this
16 part or by any State court in connection with a complaint
17 based on an act or practice described in section 5202(b)
18 shall be in accordance with the provisions of this Act, the
19 comprehensive benefit package as provided by this Act, the
20 rules and regulations of the National Health Board pre-
21 scribed under this Act, and decisions of the National
22 Health Board under this Act.

23 (b) RIGHTS AND REMEDIES UNDER STATE LAW.—
24 Subject to subsection (a), the rights and remedies avail-
25 able in State court against a health plan providing services

1 through a regional alliance in connection with a complaint
2 based on an act or practice described in section 5202(b)
3 shall be governed by State law.

4 **SEC. 5207. CIVIL MONEY PENALTIES.**

5 (a) DENIAL OR DELAY IN PAYMENT OR PROVISION
6 OF BENEFITS.—

7 (1) IN GENERAL.—The Secretary of Labor may
8 assess a civil penalty against any health plan, or
9 against any other plan in connection with benefits
10 provided thereunder under a supplemental benefit
11 policy described in section 1421(b)(1) or a cost shar-
12 ing policy described in section 1421(b)(2), for unrea-
13 sonable denial or delay in the payment or provision
14 of benefits thereunder, in an amount not to exceed—

15 (A) \$25,000 per violation, or \$75,000 per
16 violation in the case of a finding of bad faith
17 on the part of the plan, and

18 (B) in the case of a finding of a pattern
19 or practice of such violations engaged in by the
20 plan, \$1,000,000 in addition to the total
21 amount of penalties assessed under subpara-
22 graph (A) with respect to such violations.

23 For purposes of subparagraph (A), each violation
24 with respect to any single individual shall be treated
25 as a separate violation.

1 (2) CIVIL ACTION TO ENFORCE CIVIL PEN-
2 ALTY.—The Secretary of Labor may commence a
3 civil action in any court of competent jurisdiction to
4 enforce a civil penalty assessed under paragraph (1).

5 (b) CIVIL PENALTIES FOR CERTAIN OTHER AC-
6 TIONS.—The Secretary of Labor may assess a civil penalty
7 described in section 5412(b)(1) against any corporate alli-
8 ance health plan, or against any other plan sponsored by
9 a corporate alliance in connection with benefits provided
10 thereunder under a cost sharing policy described in section
11 1421(b)(2), for any action described in section 5412(a).
12 The Secretary of Labor may initiate proceedings to impose
13 such penalty in the same manner as the Secretary of
14 Health and Human Services may initiate proceedings
15 under section 5412 with respect to actions described in
16 section 5412(a).

17 **Subpart B—Early Resolution Programs**

18 **SEC. 5211. ESTABLISHMENT OF EARLY RESOLUTION PRO-**
19 **GRAMS IN COMPLAINT REVIEW OFFICES.**

20 (a) ESTABLISHMENT OF PROGRAMS.—Each State
21 shall establish and maintain an Early Resolution Program
22 in each complaint review office in such State. The Pro-
23 gram shall include—

1 (1) the establishment and maintenance of fo-
2 rums for mediation of disputes in accordance with
3 this subpart, and

4 (2) the establishment and maintenance of such
5 forums for other forms of alternative dispute resolu-
6 tion (including binding arbitration) as may be pre-
7 scribed in regulations of the Secretary of Labor.

8 Each State shall ensure that the standards applied in
9 Early Resolution Programs administered in such State
10 which apply to any form of alternative dispute resolution
11 described in paragraph (2) and which relate to time re-
12 quirements, qualifications of facilitators, arbitrators, or
13 other mediators, and confidentiality are at least equivalent
14 to the standards which apply to mediation proceedings
15 under this subpart.

16 (b) DUTIES OF COMPLAINT REVIEW OFFICES.—
17 Each complaint review office in a State—

18 (1) shall administer its Early Resolution Pro-
19 gram in accordance with regulations of the Secretary
20 of Labor,

21 (2) shall, pursuant to subsection (a)(1)—

22 (A) recruit and train individuals to serve
23 as facilitators for mediation proceedings under
24 the Early Resolution Program from attorneys
25 who have the requisite expertise for such serv-

1 ice, which shall be specified in regulations of
2 the Secretary of Labor,

3 (B) provide meeting sites, maintain
4 records, and provide facilitators with adminis-
5 trative support staff, and

6 (C) establish and maintain attorney refer-
7 ral panels,

8 (3) shall ensure that, upon the filing of a com-
9 plaint with the office, the complainant is adequately
10 apprised of the complainant's options for review
11 under this part, and

12 (4) shall monitor and evaluate the Program on
13 an ongoing basis.

14 **SEC. 5212. INITIATION OF PARTICIPATION IN MEDIATION**
15 **PROCEEDINGS.**

16 (a) **ELIGIBILITY OF CASES FOR SUBMISSION TO**
17 **EARLY RESOLUTION PROGRAM.**—A dispute may be sub-
18 mitted to the Early Resolution Program only if the fol-
19 lowing requirements are met with respect to the dispute:

20 (1) **NATURE OF DISPUTE.**—The dispute con-
21 sists of an assertion by an individual enrolled under
22 a health plan of one or more claims against the
23 health plan for payment or provision of benefits, or
24 against any other plan maintained by the regional
25 alliance or corporate alliance sponsoring the health

1 plan with respect to benefits provided under a sup-
2 plemental benefit policy described in section
3 1421(b)(1) or a cost sharing policy described in sec-
4 tion 1421(b)(2), based on alleged coverage under the
5 plan, and a denial of the claims, or a denial of ap-
6 propriate reimbursement based on the claims, by the
7 plan.

8 (2) NATURE OF DISPUTED CLAIM.—Each claim
9 consists of—

10 (A) a claim for payment or provision of
11 benefits under the plan; or

12 (B) a request for information or docu-
13 ments the disclosure of which is required under
14 this Act (including claims of entitlement to dis-
15 closure based on colorable claims to rights to
16 benefits under the plan).

17 (b) FILING OF ELECTION.—A complainant with a
18 dispute which is eligible for submission to the Early Reso-
19 lution Program may make the election under section
20 5203(a)(2) to submit the dispute to mediation proceedings
21 under the Program not later than 15 days after the date
22 the complaint is filed with the complaint review office
23 under section 5202(b).

24 (c) AGREEMENT TO PARTICIPATE.—

1 (1) ELECTION BY CLAIMANT.—A complainant
2 may elect participation in the mediation proceedings
3 only by entering into a written participation agree-
4 ment (including an agreement to comply with the
5 rules of the Program and consent for the complaint
6 review office to contact the health plan regarding the
7 agreement), and by releasing plan records to the
8 Program for the exclusive use of the facilitator as-
9 signed to the dispute.

10 (2) PARTICIPATION BY PLANS OR HEALTH BEN-
11 EFITS CONTRACTORS.—Each party whose participa-
12 tion in the mediation proceedings has been elected
13 by a claimant pursuant to paragraph (1) shall par-
14 ticipate in, and cooperate fully with, the proceedings.
15 The claims review office shall provide such party
16 with a copy of the participation agreement described
17 in paragraph (1), together with a written description
18 of the Program. Such party shall submit the copy of
19 the agreement, together with its authorized signa-
20 ture signifying receipt of notice of the agreement, to
21 the claims review office, and shall include in the sub-
22 mission to the claims review office a copy of the
23 written record of the plan claims procedure com-
24 pleted pursuant to section 5201 with respect to the
25 dispute and all relevant plan documents. The rel-

1 evant documents shall include all documents under
2 which the plan is or was administered or operated,
3 including copies of any insurance contracts under
4 which benefits are or were provided and any fee or
5 reimbursement schedules for health care providers.

6 **SEC. 5213. MEDIATION PROCEEDINGS.**

7 (a) **ROLE OF FACILITATOR.**—In the course of medi-
8 ation proceedings under the Early Resolution Program,
9 the facilitator assigned to the dispute shall prepare the
10 parties for a conference regarding the dispute and serve
11 as a neutral mediator at such conference, with the goal
12 of achieving settlement of the dispute.

13 (b) **PREPARATIONS FOR CONFERENCE.**—In advance
14 of convening the conference, after identifying the nec-
15 essary parties and confirming that the case is eligible for
16 the Program, the facilitator shall analyze the record of the
17 claims procedure conducted pursuant to section 5201 and
18 any position papers submitted by the parties to determine
19 if further case development is needed to clarify the legal
20 and factual issues in dispute, and whether there is any
21 need for additional information and documents.

22 (c) **CONFERENCE.**—Upon convening the conference,
23 the facilitator shall assist the parties in identifying undis-
24 puted issues and exploring settlement. If settlement is
25 reached, the facilitator shall assist in the preparation of

1 a written settlement agreement. If no settlement is
2 reached, the facilitator shall present the facilitator's eval-
3 uation, including an assessment of the parties' positions,
4 the likely outcome of further administrative action or liti-
5 gation, and suggestions for narrowing the issues in dis-
6 pute.

7 (d) TIME LIMIT.—The facilitator shall ensure that
8 mediation proceedings with respect to any dispute under
9 the Early Resolution Program shall be completed within
10 120 days after the election to participate. The parties may
11 agree to one extension of the proceedings by not more than
12 30 days if the proceedings are suspended to obtain an
13 agency ruling or to reconvene the conference in a subse-
14 quent session.

15 (e) INAPPLICABILITY OF FORMAL RULES.—Formal
16 rules of evidence shall not apply to mediation proceedings
17 under the Early Resolution Program. All statements made
18 and evidence presented in the proceedings shall be admis-
19 sible in the proceedings. The facilitator shall be the sole
20 judge of the proper weight to be afforded to each submis-
21 sion. The parties to mediation proceedings under the Pro-
22 gram shall not be required to make statements or present
23 evidence under oath.

1 (f) REPRESENTATION.—Parties may participate pro
2 se or be represented by attorneys throughout the pro-
3 ceedings of the Early Resolution Program.

4 (g) CONFIDENTIALITY.—

5 (1) IN GENERAL.—Under regulations of the
6 Secretary of Labor, rules similar to the rules under
7 section 574 of title 5, United States Code (relating
8 to confidentiality in dispute resolution proceedings)
9 shall apply to the mediation proceedings under the
10 Early Resolution Program.

11 (2) CIVIL REMEDIES.—The Secretary of Labor
12 may assess a civil penalty against any person who
13 discloses information in violation of the regulations
14 prescribed pursuant to paragraph (1) in the amount
15 of three times the amount of the claim involved. The
16 Secretary of Labor may bring a civil action to en-
17 force such civil penalty in any court of competent ju-
18 risdiction.

19 **SEC. 5214. LEGAL EFFECT OF PARTICIPATION IN MEDI-**
20 **ATION PROCEEDINGS.**

21 (a) PROCESS NONBINDING.—Findings and conclu-
22 sions made in the mediation proceedings of the Early Res-
23 olution Program shall be treated as advisory in nature and
24 nonbinding. Except as provided in subsection (b), the

1 rights of the parties under subpart A shall not be affected
2 by participation in the Program.

3 (b) RESOLUTION THROUGH SETTLEMENT AGREE-
4 MENT.—If a case is settled through participation in medi-
5 ation proceedings under the Program, the facilitator shall
6 assist the parties in drawing up an agreement which shall
7 constitute, upon signature of the parties, a binding con-
8 tract between the parties, which shall be enforceable under
9 section 5215.

10 (c) PRESERVATION OF RIGHTS OF NON-PARTIES.—
11 The settlement agreement shall not have the effect of
12 waiving or otherwise affecting any rights to review under
13 subpart A, or any other right under this Act or the plan,
14 with respect to any person who is not a party to the settle-
15 ment agreement.

16 **SEC. 5215. ENFORCEMENT OF SETTLEMENT AGREEMENTS.**

17 (a) ENFORCEMENT.—Any party to a settlement
18 agreement entered pursuant to mediation proceedings
19 under this subpart may petition any court of competent
20 jurisdiction for the enforcement of the agreement, by filing
21 in the court a written petition praying that the agreement
22 be enforced. In such a proceeding, the order of the hearing
23 officer shall not be subject to review.

24 (b) COURT REVIEW.—It shall be the duty of the court
25 to advance on the docket and to expedite to the greatest

1 possible extent the disposition of any petition filed under
2 this section, with due deference to the role of settlement
3 agreements under this part in achieving prompt resolution
4 of disputes involving health plans.

5 (c) AWARDING OF ATTORNEY'S FEES AND OTHER
6 COSTS AND EXPENSES.—In any action by an individual
7 enrolled under a health plan for court enforcement under
8 this section, a prevailing plaintiff shall be entitled to rea-
9 sonable costs and expenses (including a reasonable attor-
10 ney's fee and reasonable expert witness fees) on the
11 charges on which the plaintiff prevails.

12 **PART 2—ADDITIONAL REMEDIES AND**
13 **ENFORCEMENT PROVISIONS**

14 **SEC. 5231. JUDICIAL REVIEW OF FEDERAL ACTION ON**
15 **STATE SYSTEMS.**

16 (a) IN GENERAL.—Any State or alliance that is ag-
17 grieved by a determination by the National Health Board
18 under subpart B of part 1 of subtitle F of title I shall
19 be entitled to judicial review of such determination in ac-
20 cordance with this section.

21 (b) JUDICIAL REVIEW.—

22 (1) JURISDICTION.—The courts of appeals of
23 the United States (other than the United States
24 Court of Appeals for the Federal Circuit) shall have
25 jurisdiction to review a determination described in

1 subsection (a), to affirm the determination, or to set
2 it aside, in whole or in part. A judgment of a court
3 of appeals in such an action shall be subject to re-
4 view by the Supreme Court of the United States
5 upon certiorari or certification as provided in section
6 1254 of title 28, United States Code.

7 (2) PETITION FOR REVIEW.—A State or an alli-
8 ance that desires judicial review of a determination
9 described in subsection (a) shall, within 30 days
10 after it has been notified of such determination, file
11 with the United States court of appeals for the cir-
12 cuit in which the State or alliance is located a peti-
13 tion for review of such determination. A copy of the
14 petition shall be transmitted by the clerk of the
15 court to the National Health Board, and the Board
16 shall file in the court the record of the proceedings
17 on which the determination or action was based, as
18 provided in section 2112 of title 28, United States
19 Code.

20 (3) SCOPE OF REVIEW.—The findings of fact of
21 the National Health Board, if supported by substan-
22 tial evidence, shall be conclusive; but the court, for
23 good cause shown, may remand the case to the
24 Board to take further evidence, and the Board may
25 make new or modified findings of fact and may mod-

1 ify its previous action, and shall certify to the court
2 the record of the further proceedings. Such new or
3 modified findings of fact shall likewise be conclusive
4 if supported by substantial evidence.

5 **SEC. 5232. ADMINISTRATIVE AND JUDICIAL REVIEW RELAT-**
6 **ING TO COST CONTAINMENT.**

7 There shall be no administrative or judicial review of
8 any determination by the National Health Board respect-
9 ing any matter under subtitle A of title VI.

10 **SEC. 5233. CIVIL ENFORCEMENT.**

11 Unless otherwise provided in this Act, the district
12 courts of the United States shall have jurisdiction of civil
13 actions brought by—

14 (1) the Secretary of Labor to enforce any final
15 order of such Secretary or to collect any civil mone-
16 tary penalty assessed by such Secretary under this
17 Act; and

18 (2) the Secretary of Health and Human Serv-
19 ices to enforce any final order of such Secretary or
20 to collect any civil monetary penalty assessed by
21 such Secretary under this Act.

22 **SEC. 5234. PRIORITY OF CERTAIN BANKRUPTCY CLAIMS.**

23 Section 507(a)(8) of title 11, United States Code, is
24 amended to read as follows:

25 “(8) Eighth, allowed unsecured claims—

“(A) based upon any commitment by the debtor to the Federal Deposit Insurance Corporation, the Resolution Trust Corporation, the Director of the Office of Thrift Supervision, the Comptroller of the Currency, or the Board of Governors of the Federal Reserve System, or their predecessors or successors, to maintain the capital of an insured depository institution;

“(B) for payments under subtitle B of title IV of the Health Security Act owed to a regional alliance (as defined in section 1301 of such Act);

“(C) for payments owed to a corporate alliance health plan under trusteeship of the Secretary of Labor under section 1395 of the Health Security Act; or

“(D) for assessments and related amounts owed to the Secretary of Labor under section 1397 of the Health Security Act.”.

SEC. 5235. PRIVATE RIGHT TO ENFORCE STATE RESPONSIBILITIES.

The failure of a participating State to carry out a responsibility applicable to participating States under this Act constitutes a deprivation of rights secured by this Act for the purposes of section 1977 of the Revised Statutes

1 of the United States (42 U.S.C. 1983). In an action
2 brought under such section, the court shall exercise juris-
3 diction without regard to whether the aggrieved person
4 has exhausted any administrative or other remedies that
5 may be provided by law.

6 **SEC. 5236. PRIVATE RIGHT TO ENFORCE FEDERAL RESPON-**
7 **SIBILITIES IN OPERATING A SYSTEM IN A**
8 **STATE.**

9 (a) IN GENERAL.—The failure of the Secretary of
10 Health and Human Services to carry out a responsibility
11 under section 1522 (relating to operation of an alliance
12 system in a State) confers an enforceable right of action
13 on any person who is aggrieved by such failure. Such a
14 person may commence a civil action against the Secretary
15 in an appropriate State court or district court of the
16 United States.

17 (b) EXHAUSTION OF REMEDIES.—In an action under
18 subsection (a), the court shall exercise jurisdiction without
19 regard to whether the aggrieved person has exhausted any
20 administrative or other remedies that may be provided by
21 law.

22 (c) RELIEF.—In an action under subsection (a), if
23 the court finds that a failure described in such subsection
24 has occurred, the aggrieved person may recover compen-

1 satory and punitive damages and the court may order any
2 other appropriate relief.

3 (d) ATTORNEY'S FEES.—In an action under sub-
4 section (a), the court, in its discretion, may allow the pre-
5 vailing party, other than the United States, a reasonable
6 attorney's fee (including expert fees) as part of the costs,
7 and the United States shall be liable for costs the same
8 as a private person.

9 **SEC. 5237. PRIVATE RIGHT TO ENFORCE RESPONSIBILITIES**
10 **OF ALLIANCES.**

11 (a) IN GENERAL.—The failure of a regional alliance
12 or a corporate alliance to carry out a responsibility appli-
13 cable to the alliance under this Act confers an enforceable
14 right of action on any person who is aggrieved by such
15 failure. Such a person may commence a civil action
16 against the alliance in an appropriate State court or dis-
17 trict court of the United States.

18 (b) EXHAUSTION OF REMEDIES.—

19 (1) IN GENERAL.—Except as provided in para-
20 graph (2), in an action under subsection (a) the
21 court may not exercise jurisdiction until the ag-
22 grieved person has exhausted any administrative
23 remedies that may be provided by law.

24 (2) NO EXHAUSTION REQUIRED.—In an action
25 under subsection (a), the court shall exercise juris-

1 diction without regard to whether the aggrieved per-
2 son has exhausted any administrative or other rem-
3 edies that may be provided by law if the action re-
4 lates to—

5 (A) whether the person is an eligible indi-
6 vidual within the meaning of section 1001(c);

7 (B) whether the person is eligible for a
8 premium discount under subpart A of part 1 of
9 subtitle B of title VI;

10 (C) whether the person is eligible for a re-
11 duction in cost sharing under subpart D of part
12 3 of subtitle D of title I; or

13 (D) enrollment or disenrollment in a health
14 plan.

15 (c) RELIEF.—In an action under subsection (a), if
16 the court finds that a failure described in such subsection
17 has occurred, the aggrieved person may recover compen-
18 satory and punitive damages and the court may order any
19 other appropriate relief.

20 (d) ATTORNEY'S FEES.—In any action under sub-
21 section (a), the court, in its discretion, may allow the pre-
22 vailing party, other than the United States, a reasonable
23 attorney's fee (including expert fees) as part of the costs,
24 and the United States shall be liable for costs the same
25 as a private person.

1 **SEC. 5238. DISCRIMINATION CLAIMS.**

2 (a) CIVIL ACTION BY AGGRIEVED PERSON.—

3 (1) IN GENERAL.—Any person who is aggrieved
4 by the failure of a health plan to comply with section
5 1402(c) may commence a civil action against the
6 plan in an appropriate State court or district court
7 of the United States.

8 (2) STANDARDS.—The standards used to deter-
9 mine whether a violation has occurred in a complaint
10 alleging discrimination on the basis of age or dis-
11 ability under section 1402(c) shall be the standards
12 applied under the Age Discrimination Act of 1975
13 (42 U.S.C. 6101 et seq.) and the Americans with
14 Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

15 (3) RELIEF.—In an action under paragraph
16 (1), if the court finds that the health plan has failed
17 to comply with section 1402(c), the aggrieved person
18 may recover compensatory and punitive damages
19 and the court may order any other appropriate re-
20 lief.

21 (4) ATTORNEY'S FEES.—In any action under
22 paragraph (1), the court, in its discretion, may allow
23 the prevailing party, other than the United States,
24 a reasonable attorney's fee (including expert fees) as
25 part of the costs, and the United States shall be lia-
26 ble for costs the same as a private person.

1 (b) ACTION BY SECRETARY.—Whenever the Sec-
2 retary of Health and Human Services finds that a health
3 plan has failed to comply with section 1402(c), or with
4 an applicable regulation issued under such section, the
5 Secretary shall notify the plan. If within a reasonable pe-
6 riod of time the health plan fails or refuses to comply,
7 the Secretary may—

8 (1) refer the matter to the Attorney General
9 with a recommendation that an appropriate civil ac-
10 tion be instituted;

11 (2) terminate the participation of the health
12 plan in an alliance; or

13 (3) take such other action as may be provided
14 by law.

15 (c) ACTION BY ATTORNEY GENERAL.—When a mat-
16 ter is referred to the Attorney General under subsection
17 (b)(1), the Attorney General may bring a civil action in
18 a district court of the United States for such relief as may
19 be appropriate, including injunctive relief. In a civil action
20 under this section, the court—

21 (1) may grant any equitable relief that the
22 court considers to be appropriate;

23 (2) may award such other relief as the court
24 considers to be appropriate, including compensatory
25 and punitive damages; and

1 (3) may, to vindicate the public interest when
2 requested by the Attorney General, assess a civil
3 money penalty against the health plan in an
4 amount—

5 (A) not exceeding \$50,000 for a first viola-
6 tion; and

7 (B) not exceeding \$100,000 for any subse-
8 quent violation.

9 **SEC. 5239. NONDISCRIMINATION IN FEDERALLY ASSISTED**
10 **PROGRAMS.**

11 Federal payments to regional alliances under part 2
12 of subtitle C of title VI shall be treated as Federal finan-
13 cial assistance for purposes of section 504 of the Rehabili-
14 tation Act of 1973 (29 U.S.C. 794), section 303 of the
15 Age Discrimination Act of 1975 (42 U.S.C. 6102), and
16 section 601 of the Civil Rights Act of 1964 (42 U.S.C.
17 2000d).

18 **SEC. 5240. CIVIL ACTION BY ESSENTIAL COMMUNITY PRO-**
19 **VIDER.**

20 (a) IN GENERAL.—An electing essential community
21 provider (as defined in section 1431(d)) who is aggrieved
22 by the failure of a health plan to fulfill a duty imposed
23 on the plan by section 1431 may commence a civil action
24 against the plan in an appropriate State court or district
25 court of the United States.

1 (b) RELIEF.—In an action under subsection (a), if
2 the court finds that the health plan has failed to fulfill
3 a duty imposed on the plan by section 1431, the electing
4 essential community provider may recover compensatory
5 damages and the court may order any other appropriate
6 relief.

7 (c) ATTORNEY’S FEES.—In any action under sub-
8 section (a), the court, in its discretion, may allow the pre-
9 vailing party, other than the United States, a reasonable
10 attorney’s fee (including expert fees) as part of the costs,
11 and the United States shall be liable for costs the same
12 as a private person.

13 **SEC. 5241. FACIAL CONSTITUTIONAL CHALLENGES.**

14 (a) JURISDICTION.—The United States District
15 Court for the District of Columbia shall have original and
16 exclusive jurisdiction of any civil action brought to invali-
17 date this Act or a provision of this Act on the ground of
18 its being repugnant to the Constitution of the United
19 States on its face and for every purpose. In any action
20 described in this subsection, the district court may not
21 grant any temporary order or preliminary injunction re-
22 straining the enforcement, operation, or execution of this
23 Act or any provision of this Act.

1 (b) STATUTE OF LIMITATIONS.—An action described
2 in subsection (a) shall be commenced not later than 1 year
3 after the date of the enactment of this Act.

4 (c) CONVENING OF THREE-JUDGE COURT.—An ac-
5 tion described in subsection (a) shall be heard and deter-
6 mined by a district court of three judges in accordance
7 with section 2284 of title 28, United States Code.

8 (d) CONSOLIDATION.—When actions described in
9 subsection (a) involving a common question of law or fact
10 are pending before a district court, the court shall order
11 all the actions consolidated.

12 (e) DIRECT APPEAL TO SUPREME COURT.—In any
13 action described in subsection (a), an appeal may be taken
14 directly to the Supreme Court of the United States from
15 any final judgment, decree, or order in which the district
16 court—

17 (1) holds this Act or any provision of this Act
18 invalid; and

19 (2) makes a determination that its holding will
20 materially undermine the application of the Act as
21 whole.

22 (f) CONSTRUCTION.—This section does not limit—

23 (1) the right of any person—

24 (A) to a litigation concerning the Act or
25 any portion of the Act; or

1 (B) to petition the Supreme Court for re-
2 view of any holding of a district court by writ
3 of certiorari at any time before the rendition of
4 judgment in a court of appeals; or

5 (2) the authority of the Supreme Court to grant
6 a writ of certiorari for the review described in para-
7 graph (1)(B).

8 **SEC. 5242. TREATMENT OF PLANS AS PARTIES IN CIVIL AC-**
9 **TIONS.**

10 (a) IN GENERAL.—A health plan may sue or be sued
11 under this Act as an entity. Service of summons, sub-
12 poena, or other legal process of a court or hearing officer
13 upon a trustee or an administrator of any such plan in
14 his capacity as such shall constitute service upon the plan.
15 In a case where a plan has not designated in applicable
16 plan documents an individual as agent for the service of
17 legal process, service upon the Secretary of Health and
18 Human Services (in the case of a regional alliance health
19 plan) or the Secretary of Labor (in the case of a corporate
20 alliance health plan) shall constitute such service. The
21 Secretary, not later than 15 days after receipt of service
22 under the preceding sentence, shall notify the adminis-
23 trator or any trustee of the plan of receipt of such service.

24 (b) OTHER PARTIES.—Any money judgment under
25 this Act against a plan referred to in subsection (a) shall

1 be enforceable only against the plan as an entity and shall
2 not be enforceable against any other person unless liability
3 against such person is established in his individual capac-
4 ity under this Act.

5 **SEC. 5243. GENERAL NONPREEMPTION OF EXISTING**
6 **RIGHTS AND REMEDIES.**

7 Nothing in this title shall be construed to deny, im-
8 pair, or otherwise adversely affect a right or remedy avail-
9 able under law to any person on the date of the enactment
10 of this Act or thereafter, except to the extent the right
11 or remedy is inconsistent with this title.

12 **Subtitle D—Medical Malpractice**

13 **PART 1—LIABILITY REFORM**

14 **SEC. 5301. FEDERAL TORT REFORM.**

15 (a) APPLICABILITY.—

16 (1) IN GENERAL.—Except as provided in sec-
17 tion 5302, this part shall apply with respect to any
18 medical malpractice liability action brought in any
19 State or Federal court, except that this part shall
20 not apply to a claim or action for damages arising
21 from a vaccine-related injury or death to the extent
22 that title XXI of the Public Health Service Act ap-
23 plies to the claim or action.

24 (2) PREEMPTION.—The provisions of this part
25 shall preempt any State law to the extent such law

1 is inconsistent with the limitations contained in such
2 provisions. The provisions of this part shall not pre-
3 empt any State law that provides for defenses or
4 places limitations on a person's liability in addition
5 to those contained in this subtitle, places greater
6 limitations on the amount of attorneys' fees that can
7 be collected, or otherwise imposes greater restric-
8 tions than those provided in this part.

9 (3) EFFECT ON SOVEREIGN IMMUNITY AND
10 CHOICE OF LAW OR VENUE.—Nothing in this part
11 shall be construed to—

12 (A) waive or affect any defense of sov-
13 ereign immunity asserted by any State under
14 any provision of law;

15 (B) waive or affect any defense of sov-
16 ereign immunity asserted by the United States;

17 (C) affect the applicability of any provision
18 of the Foreign Sovereign Immunities Act of
19 1976;

20 (D) preempt State choice-of-law rules with
21 respect to claims brought by a foreign nation or
22 a citizen of a foreign nation; or

23 (E) affect the right of any court to trans-
24 fer venue or to apply the law of a foreign nation
25 or to dismiss a claim of a foreign nation or of

1 a citizen of a foreign nation on the ground of
2 inconvenient forum.

3 (4) FEDERAL COURT JURISDICTION NOT ES-
4 TABLISHED ON FEDERAL QUESTION GROUNDS.—
5 Nothing in this part shall be construed to establish
6 any jurisdiction in the district courts of the United
7 States over medical malpractice liability actions on
8 the basis of section 1331 or 1337 of title 28, United
9 States Code.

10 (b) DEFINITIONS.—In this subtitle, the following
11 definitions apply:

12 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
13 TEM; ADR.—The term “alternative dispute resolu-
14 tion system” or “ADR” means a system that pro-
15 vides for the resolution of medical malpractice claims
16 in a manner other than through medical malpractice
17 liability actions.

18 (2) CLAIMANT.—The term “claimant” means
19 any person who alleges a medical malpractice claim,
20 and any person on whose behalf such a claim is al-
21 leged, including the decedent in the case of an action
22 brought through or on behalf of an estate.

23 (3) HEALTH CARE PROFESSIONAL.—The term
24 “health care professional” means any individual who
25 provides health care services in a State and who is

1 required by the laws or regulations of the State to
2 be licensed or certified by the State to provide such
3 services in the State.

4 (4) HEALTH CARE PROVIDER.—The term
5 “health care provider” means any organization or
6 institution that is engaged in the delivery of health
7 care services in a State and that is required by the
8 laws or regulations of the State to be licensed or cer-
9 tified by the State to engage in the delivery of such
10 services in the State.

11 (5) INJURY.—The term “injury” means any ill-
12 ness, disease, or other harm that is the subject of
13 a medical malpractice liability action or a medical
14 malpractice claim.

15 (6) MEDICAL MALPRACTICE LIABILITY AC-
16 TION.—The term “medical malpractice liability ac-
17 tion” means a civil action brought in a State or Fed-
18 eral court against a health care provider or health
19 care professional (regardless of the theory of liability
20 on which the claim is based) in which the plaintiff
21 alleges a medical malpractice claim.

22 (7) MEDICAL MALPRACTICE CLAIM.—The term
23 “medical malpractice claim” means a claim brought
24 against a health care provider or health care profes-
25 sional in which a claimant alleges that injury was

1 caused by the provision of (or the failure to provide)
2 health care services, except that such term does not
3 include—

4 (A) any claim based on an allegation of an
5 intentional tort; or

6 (B) any claim based on an allegation that
7 a product is defective that is brought against
8 any individual or entity that is not a health
9 care professional or health care provider.

10 **SEC. 5302. PLAN-BASED ALTERNATIVE DISPUTE RESOLU-**
11 **TION MECHANISMS.**

12 (a) APPLICATION TO MALPRACTICE CLAIMS UNDER
13 PLANS.—In the case of any medical malpractice claim
14 arising from the provision of (or failure to provide) health
15 care services to an individual enrolled in a regional alliance
16 health plan or a corporate alliance health plan, no medical
17 malpractice liability action may be brought with respect
18 to such claim until the final resolution of the claim under
19 the alternative dispute resolution system adopted by the
20 plan under subsection (b).

21 (b) ADOPTION OF MECHANISM BY PLANS.—Each re-
22 gional alliance health plan and corporate alliance health
23 plan shall—

24 (1) adopt at least one of the alternative dispute
25 resolution methods specified under subsection (c) for

1 the resolution of medical malpractice claims arising
2 from the provision of (or failure to provide) health
3 care services to individuals enrolled in the plan; and
4 (2) disclose to enrollees (and potential enroll-
5 ees), in a manner specified by the regional alliance
6 or the corporate alliance, the availability and proce-
7 dures for consumer grievances under the plan, in-
8 cluding the alternative dispute resolution method or
9 methods adopted under this subsection.

10 (c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE
11 DISPUTE RESOLUTION METHODS.—

12 (1) IN GENERAL.—The Board shall, by regula-
13 tion, develop alternative dispute resolution methods
14 for the use by regional alliance and corporate alli-
15 ance health plans in resolving medical malpractice
16 claims under subsection (a). Such methods shall in-
17 clude at least the following:

18 (A) ARBITRATION.—The use of arbitra-
19 tion.

20 (B) MEDIATION.—The use of required me-
21 diation.

22 (C) EARLY OFFERS OF SETTLEMENT.—
23 The use of a process under which parties are
24 required to make early offers of settlement.

1 (2) STANDARDS FOR ESTABLISHING METH-
2 ODS.—In developing alternative dispute resolution
3 methods under paragraph (1), the Board shall as-
4 sure that the methods promote the resolution of
5 medical malpractice claims in a manner that—

6 (A) is affordable for the parties involved;

7 (B) provides for timely resolution of
8 claims;

9 (C) provides for the consistent and fair
10 resolution of claims; and

11 (D) provides for reasonably convenient ac-
12 cess to dispute resolution for individuals en-
13 rolled in plans.

14 (d) FURTHER REDRESS.—A plan enrollee dissatisfied
15 with the determination reached as a result of an alter-
16 native dispute resolution method applied under this sec-
17 tion may, after the final resolution of the enrollee's claim
18 under the method, bring a cause of action to seek damages
19 or other redress with respect to the claim to the extent
20 otherwise permitted under State law.

21 **SEC. 5303. REQUIREMENT FOR CERTIFICATE OF MERIT.**

22 (a) REQUIRING SUBMISSION WITH COMPLAINT.—No
23 medical malpractice liability action may be brought by any
24 individual unless, at the time the individual brings the ac-

1 tion (except as provided in subsection (b)(1)), the indi-
2 vidual submits an affidavit—

3 (1) declaring that the individual (or the individ-
4 ual's attorney) has consulted and reviewed the facts
5 of the action with a qualified specialist (as defined
6 in subsection (c));

7 (2) including a written report by a qualified
8 specialist that clearly identifies the individual and
9 that includes the specialist's determination that,
10 after a review of the medical record and other rel-
11 evant material, there is a reasonable and meritorious
12 cause for the filing of the action against the defend-
13 ant; and

14 (3) on the basis of the qualified specialist's re-
15 view and consultation, that the individual (or the in-
16 dividual's attorney) has concluded that there is a
17 reasonable and meritorious cause for the filing of the
18 action.

19 (b) EXTENSION IN CERTAIN INSTANCES.—

20 (1) IN GENERAL.—Subject to paragraph (2),
21 subsection (a) shall not apply with respect to an in-
22 dividual who brings a medical malpractice liability
23 action without submitting an affidavit described in
24 such subsection if—

1 (A) the individual is unable to obtain the
2 affidavit before the expiration of the applicable
3 statute of limitations; or

4 (B) at the time the individual brings the
5 action, the individual has been unable to obtain
6 medical records or other information necessary
7 to prepare the affidavit requested pursuant to
8 any applicable law.

9 (2) DEADLINE FOR SUBMISSION WHERE EX-
10 TENSION APPLIES.—In the case of an individual who
11 brings an action for which paragraph (1) applies,
12 the action shall be dismissed unless the individual
13 submits the affidavit described in subsection (a) not
14 later than—

15 (A) in the case of an action for which sub-
16 paragraph (A) of paragraph (1) applies, 90
17 days after bringing the action; or

18 (B) in the case of an action for which sub-
19 paragraph (B) of paragraph (1) applies, 90
20 days after obtaining the information described
21 in such subparagraph.

22 (c) QUALIFIED SPECIALIST DEFINED.—In sub-
23 section (a), a “qualified specialist” means, with respect
24 to a medical malpractice liability action, a health care pro-
25 fessional who—

1 (1) is knowledgeable of, and has expertise in,
2 the same specialty area of practice that is the sub-
3 ject of the action; and

4 (2) is reasonably believed by the individual
5 bringing the action (or the individual's attorney)—

6 (A) to be knowledgeable in the relevant
7 issues involved in the particular action,

8 (B) to practice (or to have practiced within
9 the preceding 6 years) or to teach (or to have
10 taught within the preceding 6 years) in the
11 same area of health care or medicine that is at
12 issue in the action, and

13 (C) to be qualified by experience or dem-
14 onstrated competence in the subject matter of
15 the case.

16 (d) SANCTIONS FOR SUBMITTING FALSE ALLEGA-
17 TIONS.—Upon the motion of any party or its own initia-
18 tive, the court in a medical malpractice liability action may
19 impose a sanction on a party or the party's attorney (or
20 both), including a requirement that the party reimburse
21 the other party to the action for costs and reasonable at-
22 torney's fees, if any information contained in an affidavit
23 described in subsection (a) is submitted without reason-
24 able cause and is found to be untrue.

1 **SEC. 5304. LIMITATION ON AMOUNT OF ATTORNEY'S CON-**
2 **TINGENCY FEES.**

3 (a) IN GENERAL.—An attorney who represents, on
4 a contingency fee basis, a plaintiff in a medical mal-
5 practice liability action may not charge, demand, receive,
6 or collect for services rendered in connection with such ac-
7 tion (including the resolution of the claim that is the sub-
8 ject of the action under any alternative dispute resolution
9 system) in excess of 33⅓ percent of the total amount re-
10 covered by judgment or settlement in such action.

11 (b) CALCULATION OF PERIODIC PAYMENTS.—In the
12 event that a judgment or settlement includes periodic or
13 future payments of damages, the amount recovered for
14 purposes of computing the limitation on the contingency
15 fee under subsection (a) shall be based on the cost of the
16 annuity or trust established to make the payments. In any
17 case in which an annuity or trust is not established to
18 make such payments, such amount shall be based on the
19 present value of the payments.

20 (c) CONTINGENCY FEE DEFINED.—As used in this
21 section, the term “contingency fee” means any fee for pro-
22 fessional legal services which is, in whole or in part, con-
23 tingent upon the recovery of any amount of damages,
24 whether through judgment or settlement.

1 **SEC. 5305. REDUCTION OF AWARDS FOR RECOVERY FROM**
2 **COLLATERAL SOURCES.**

3 The total amount of damages recovered by a plaintiff
4 in a medical malpractice liability action shall be reduced
5 by the amount of any past or future payment which the
6 plaintiff has received or for which the plaintiff is eligible
7 on account of the same injury for which the damages are
8 awarded, including payment under—

- 9 (1) Federal or State disability or sickness pro-
10 grams;
11 (2) Federal, State, or private health insurance
12 programs;
13 (3) private disability insurance programs;
14 (4) employer wage continuation programs; and
15 (5) any other program, if the payment is in-
16 tended to compensate the plaintiff for the same in-
17 jury for which damages are awarded.

18 **SEC. 5306. PERIODIC PAYMENT OF AWARDS.**

19 At the request of any party to a medical malpractice
20 liability action, the defendant shall not be required to pay
21 damages in a single, lump-sum payment, but shall be per-
22 mitted to make such payments periodically based on such
23 schedule as the court considers appropriate, taking into
24 account the periods for which the injured party will need
25 medical and other services.

1 **PART 2—OTHER PROVISIONS RELATING TO**
2 **MEDICAL MALPRACTICE LIABILITY**
3 **SEC. 5311. ENTERPRISE LIABILITY DEMONSTRATION**
4 **PROJECT.**

5 (a) **ESTABLISHMENT.**—Not later than January 1,
6 1996, the Secretary shall establish a demonstration
7 project under which the Secretary shall provide funds (in
8 such amount as the Secretary considers appropriate) to
9 one or more eligible States to demonstrate whether sub-
10 stituting liability for medical malpractice on the part of
11 the health plan in which a physician participates for the
12 personal liability of the physician will result in improve-
13 ments in the quality of care provided under the plan, re-
14 ductions in defensive medical practices, and better risk
15 management.

16 (b) **ELIGIBILITY OF STATE.**—A State is eligible to
17 participate in the demonstration project established under
18 subsection (a) if the State submits an application to the
19 Secretary (at such time and in such form as the Secretary
20 may require) containing such information and assurances
21 as the Secretary may require, including assurances that
22 the State—

23 (1) has entered into an agreement with a health
24 plan (other than a fee-for-service plan) operating in
25 the State under which the plan assumes legal liabil-
26 ity with respect to any medical malpractice claim

1 arising from the provision of (or failure to provide)
2 services under the plan by any physician partici-
3 pating in the plan;

4 (2) has provided that, under the law of the
5 State, a physician participating in a plan that has
6 entered into an agreement with the State under
7 paragraph (1) may not be liable in damages or oth-
8 erwise for such a claim and the plan may not require
9 such physician to indemnify the plan for any such li-
10 ability; and

11 (3) will provide the Secretary with such reports
12 on the operation of the project as the Secretary may
13 require.

14 (c) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated such sums as may be
16 necessary to carry out demonstration projects under this
17 section.

18 **SEC. 5312. PILOT PROGRAM APPLYING PRACTICE GUIDE-**
19 **LINES TO MEDICAL MALPRACTICE LIABILITY**
20 **ACTIONS.**

21 (a) ESTABLISHMENT.—Not later than 1 year after
22 the Secretary determines that appropriate practice guide-
23 lines are available, the Secretary shall establish a pilot
24 program under which the Secretary shall provide funds (in
25 such amount as the Secretary considers appropriate) to

1 one or more eligible States to determine the effect of ap-
2 plying practice guidelines in the resolution of medical mal-
3 practice liability actions.

4 (b) ELIGIBILITY OF STATE.—A State is eligible to
5 participate in the pilot program established under sub-
6 section (a) if the State submits an application to the Sec-
7 retary (at such time and in such form as the Secretary
8 may require) containing—

9 (1) assurances that, under the law of the State,
10 in the resolution of any medical malpractice liability
11 action, it shall be a complete defense to any allega-
12 tion that a party against whom the action is filed
13 was negligent that, in the provision of (or the failure
14 to provide) the services that are the subject of the
15 action, the party followed the appropriate practice
16 guideline established by the National Quality Man-
17 agement Program under subtitle A; and

18 (2) such other information and assurances as
19 the Secretary may require.

20 (c) REPORTS TO CONGRESS.—Not later than 3
21 months after the last day of each year for which the pilot
22 program established under subsection (a) is in effect, the
23 Secretary shall submit a report to Congress describing the
24 operation of the program during the previous year and
25 containing such recommendations as the Secretary con-

1 siders appropriate, including recommendations relating to
2 revisions to the laws governing medical malpractice liabil-
3 ity.

4 **Subtitle E—Fraud and Abuse**

5 **PART 1—ESTABLISHMENT OF ALL-PAYER** 6 **HEALTH CARE FRAUD AND ABUSE CONTROL** 7 **PROGRAM**

8 **SEC. 5401. ALL-PAYER HEALTH CARE FRAUD AND ABUSE** 9 **CONTROL PROGRAM.**

10 (a) IN GENERAL.—Not later than January 1, 1996,
11 the Secretary (acting through the Inspector General of the
12 Department of Health and Human Services) and the At-
13 torney General shall establish a program—

14 (1) to coordinate the functions of the Attorney
15 General, the Secretary, and other organizations with
16 respect to the prevention, detection, and control of
17 health care fraud and abuse,

18 (2) to conduct investigations, audits, evalua-
19 tions, and inspections relating to the delivery of and
20 payment for health care in the United States, and

21 (3) to facilitate the enforcement of this subtitle
22 and other statutes applicable to health care fraud
23 and abuse.

24 (b) COORDINATION WITH LAW ENFORCEMENT
25 AGENCIES.—In carrying out the program under sub-

1 section (a), the Secretary and Attorney General shall con-
2 sult with, and arrange for the sharing of data and re-
3 sources with Federal, State and local law enforcement
4 agencies, State Medicaid Fraud Control Units, and State
5 agencies responsible for the licensing and certification of
6 health care providers.

7 (c) COORDINATION WITH HEALTH ALLIANCES AND
8 HEALTH PLANS.—In carrying out the program under
9 subsection (a), the Secretary and Attorney General shall
10 consult with, and arrange for the sharing of data with rep-
11 resentatives of health alliances and health plans.

12 (d) AUTHORITIES OF ATTORNEY GENERAL AND IN-
13 SPECTOR GENERAL.—In carrying out duties under sub-
14 section (a), the Attorney General and the Inspector Gen-
15 eral are authorized—

16 (1) to conduct, supervise, and coordinate audits,
17 civil and criminal investigations, inspections, and
18 evaluations relating to the program established
19 under such subsection; and

20 (2) to have access (including on-line access as
21 requested and available) to all records available to
22 health alliances and health plans relating to the ac-
23 tivities described in paragraph (1) (subject to re-
24 strictions based on the confidentiality of certain in-
25 formation under part 2 of subtitle B).

1 (e) QUALIFIED IMMUNITY FOR PROVIDING INFORMA-
2 TION.—The provisions of section 1157(a) of the Social Se-
3 curity Act (relating to limitation on liability) shall apply
4 to a person providing information or communications to
5 the Secretary or Attorney General in conjunction with
6 their performance of duties under this section, in the same
7 manner as such section applies to information provided
8 to organizations with a contract under part B of title XI
9 of such Act.

10 (f) AUTHORIZATIONS OF APPROPRIATIONS FOR IN-
11 VESTIGATORS AND OTHER PERSONNEL.—In addition to
12 any other amounts authorized to be appropriated to the
13 Secretary and the Attorney General for health care anti-
14 fraud and abuse activities for a fiscal year, there are au-
15 thorized to be appropriated such additional amounts as
16 may be necessary to enable the Secretary and the Attorney
17 General to conduct investigations, audits, evaluations, and
18 inspections of allegations of health care fraud and abuse
19 and otherwise carry out the program established under
20 subsection (a) in a fiscal year.

21 (g) USE OF POWERS UNDER INSPECTOR GENERAL
22 ACT OF 1978.—In carrying out duties and responsibilities
23 under the program established under subsection (a), the
24 Inspector General is authorized to exercise all powers

1 granted under the Inspector General Act of 1978 to the
2 same manner and extent as provided in that Act.

3 (h) DEFINITION.—In this part and part 2, the term
4 “Inspector General” means the Inspector General of the
5 Department of Health and Human Services.

6 **SEC. 5402. ESTABLISHMENT OF ALL-PAYER HEALTH CARE**
7 **FRAUD AND ABUSE CONTROL ACCOUNT.**

8 (a) ESTABLISHMENT.—

9 (1) IN GENERAL.—There is hereby created on
10 the books of the Treasury of the United States an
11 account to be known as the “All-Payer Health Care
12 Fraud and Abuse Control Account” (in this section
13 referred to as the “Anti-Fraud Account”). The Anti-
14 Fraud Account shall consist of such gifts and be-
15 quests as may be made as provided in paragraph (2)
16 and such amounts as may be deposited in such Anti-
17 Fraud Account as provided in section 5412(d)(2)
18 and title XI of the Social Security Act. It shall also
19 include the following:

20 (A) All criminal fines imposed in cases in-
21 volving a Federal health care offense (as de-
22 fined in subsection (d)).

23 (B) Penalties and damages imposed under
24 the False Claims Act (31 U.S.C. 3729 et seq.),
25 in cases involving claims related to the provision

1 of health care items and services (other than
2 funds awarded to a relator or for restitution).

3 (C) Administrative penalties and assess-
4 ments imposed under titles XI, XVIII, and XIX
5 of the Social Security Act and section 5412 (ex-
6 cept as otherwise provided by law).

7 (D) Amounts resulting from the forfeiture
8 of property by reason of a Federal health care
9 offense.

10 Any such funds received on or after the date of the
11 enactment of this Act shall be deposited in the Anti-
12 Fraud Account.

13 (2) AUTHORIZATION TO ACCEPT GIFTS.—The
14 Anti-Fraud Account is authorized to accept on be-
15 half of the United States money gifts and bequests
16 made unconditionally to the Anti-Fraud Account, for
17 the benefit of the Anti-Fraud Account or any activ-
18 ity financed through the Anti-Fraud Account.

19 (b) USE OF FUNDS.—

20 (1) IN GENERAL.—Amounts in the Anti-Fraud
21 Account shall be available without appropriation and
22 until expended as determined jointly by the Sec-
23 retary and Attorney General in carrying out the All-
24 Payer Health Care Fraud and Abuse Control Pro-
25 gram established under section 5401 (including the

1 administration of the Program), and may be used to
2 cover costs incurred in operating the Program,
3 including—

4 (A) costs of prosecuting health care mat-
5 ters (through criminal, civil and administrative
6 proceedings);

7 (B) costs of investigations (including
8 equipment, salaries, administratively uncontrol-
9 lable work, travel, and training of law enforce-
10 ment personnel);

11 (C) costs of financial and performance au-
12 dits of health care programs and operations;
13 and

14 (D) costs of inspections and other evalua-
15 tions.

16 (2) FUNDS USED TO SUPPLEMENT AGENCY AP-
17 PROPRIATIONS.—It is intended that disbursements
18 made from the Anti-Fraud Account to any Federal
19 agency be used to increase and not supplant the re-
20 cipient agency's appropriated operating budget.

21 (c) ANNUAL REPORT.—The Secretary and the Attor-
22 ney General shall submit an annual report to Congress
23 on the amount of revenue which is generated and dis-
24 bursed by the Anti-Fraud Account in each fiscal year.

1 (d) FEDERAL HEALTH CARE OFFENSE DEFINED.—

2 The term “Federal health care offense” means a violation
3 of, or a criminal conspiracy to violate—

4 (1) sections 226, 668, 1033, or 1347 of title
5 18, United States Code;

6 (2) section 1128B of the Social Security Act;

7 (3) sections 287, 371, 664, 666, 1001, 1027,
8 1341, 1343, or 1954 of title 18, United States Code,
9 if the violation or conspiracy relates to health care
10 fraud;

11 (4) sections 501 or 511 of the Employee Retirement
12 Income Security Act of 1974, if the violation
13 or conspiracy relates to health care fraud; or

14 (5) sections 301, 303(a)(2), or 303 (b) or (e)
15 of the Federal Food Drug and Cosmetic Act, if the
16 violation or conspiracy relates to health care fraud.

17 **SEC. 5403. USE OF FUNDS BY INSPECTOR GENERAL.**

18 (a) REIMBURSEMENTS FOR INVESTIGATIONS.—

19 (1) IN GENERAL.—The Inspector General is au-
20 thorized to receive and retain for current use reim-
21 bursement for the costs of conducting investigations,
22 when such restitution is ordered by a court, volun-
23 tarily agreed to by the payor, or otherwise.

24 (2) CREDITING.—Funds received by the Inspec-
25 tor General as reimbursement for costs of con-

ducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of their deposit.

(3) EXCEPTION FOR FORFEITURES.—This subsection does not apply to investigative costs paid to the Inspector General from the Department of Justice Asset Forfeiture Fund, which monies shall be deposited and expended in accordance with subsection (b).

(b) HHS OFFICE OF INSPECTOR GENERAL ASSET FORFEITURE PROCEEDS FUND.—

(1) IN GENERAL.—There is established in the Treasury of the United States the “HHS Office of Inspector General Asset Forfeiture Proceeds Fund,” to be administered by the Inspector General, which shall be available to the Inspector General without fiscal year limitation for expenses relating to the investigation of matters within the jurisdiction of the Inspector General.

(2) DEPOSITS.—There shall be deposited in the Fund all proceeds from forfeitures that have been transferred to the Inspector General from the De-

1 partment of Justice Asset Forfeiture Fund under
2 section 524 of title 28, United States Code.

3 **PART 2—APPLICATION OF FRAUD AND ABUSE**
4 **AUTHORITIES UNDER THE SOCIAL SECURITY**
5 **ACT TO ALL PAYERS**

6 **SEC. 5411. EXCLUSION FROM PARTICIPATION.**

7 (a) **MANDATORY EXCLUSION.**—The Secretary shall
8 exclude an individual or entity from participation in any
9 applicable health plan if the individual or entity is ex-
10 cluded from participation in a public program under, or
11 is otherwise described in, section 1128(a) of the Social Se-
12 curity Act (relating to individuals and entities convicted
13 of health care-related crimes or patient abuse).

14 (b) **PERMISSIVE EXCLUSION.**—The Secretary may
15 exclude an individual or entity from participation in any
16 applicable health plan if the individual or entity is ex-
17 cluded from participation in a public program under, or
18 is otherwise described in, section 1128(b) of the Social Se-
19 curity Act (other than paragraphs (6)(A), (6)(C), (6)(D),
20 (10), or (13) of such section).

21 (c) **NOTICE, EFFECTIVE DATE, AND PERIOD OF EX-**
22 **CLUSION.**—(1) An exclusion under this section or section
23 5412(b)(3) shall be effective at such time and upon such
24 reasonable notice to the public and to the individual or

1 entity excluded as may be specified in regulations con-
2 sistent with paragraph (2).

3 (2) Such an exclusion shall be effective with respect
4 to services furnished to an individual on or after the effec-
5 tive date of the exclusion.

6 (3)(A) The Secretary shall specify, in the notice of
7 exclusion under paragraph (1) and the notice under sec-
8 tion 5412(e), the minimum period (or, in the case of an
9 exclusion of an individual excluded from participation in
10 a public program under, or is otherwise described in, sec-
11 tion 1128(b)(12) of the Social Security Act, the period)
12 of the exclusion.

13 (B) In the case of a mandatory exclusion under sub-
14 section (a), the minimum period of exclusion shall be not
15 less than 5 years.

16 (C) In the case of an exclusion of an individual ex-
17 cluded from participation in a public program under, or
18 is otherwise described in, paragraph (1), (2), or (3) of sec-
19 tion 1128(b) of the Social Security Act, the period of ex-
20 clusion shall be a minimum of 3 years, unless the Sec-
21 retary determines that a longer period is necessary be-
22 cause of aggravating circumstances.

23 (D) In the case of an exclusion of an individual or
24 entity excluded from participation in a public program
25 under, or is otherwise described in, paragraph (4), (5)(A),

1 or (5)(B) of section 1128(b) of the Social Security Act,
2 the period of the exclusion shall not be less than the period
3 during which the individual's or entity's license to provide
4 health care is revoked, suspended or surrendered, or the
5 individual or the entity is excluded or suspended from a
6 Federal or State health care program.

7 (E) In the case of an exclusion of an individual or
8 entity described in paragraph (6)(B) of section 1128(b)
9 of the Social Security Act, the period of the exclusion shall
10 be not less than 1 year.

11 (F) In the case of an exclusion of an individual de-
12 scribed in paragraph (12) of section 1128(b) of the Social
13 Security Act, the period of the exclusion shall be equal
14 to the sum of—

15 (i) the length of the period in which the indi-
16 vidual failed to grant the immediate access described
17 in that paragraph, and

18 (ii) an additional period, not to exceed 90 days,
19 set by the Secretary.

20 (d) NOTICE TO ENTITIES ADMINISTERING PUBLIC
21 PROGRAMS FOR THE DELIVERY OF OR PAYMENT FOR
22 HEALTH CARE ITEMS OR SERVICES.—(1) The Secretary
23 shall exercise the authority under this section in a manner
24 that results in an individual's or entity's exclusion from

1 all applicable health plans for the delivery of or payment
2 for health care items or services.

3 (2) The Secretary shall promptly notify each sponsor
4 of an applicable health plan and each entity that admin-
5 isters a State health care program described in section
6 1128(h) of the Social Security Act of the fact and cir-
7 cumstances of each exclusion (together with the period
8 thereof) effected against an individual or entity under this
9 section or under section 5412(b)(3).

10 (e) NOTICE TO STATE LICENSING AGENCIES.—The
11 provisions of section 1128(e) of the Social Security Act
12 shall apply to this section in the same manner as such
13 provisions apply to sections 1128 and 1128A of such Act.

14 (f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1)
15 Subject to paragraph (2), any individual or entity that is
16 excluded (or directed to be excluded) from participation
17 under this section is entitled to reasonable notice and op-
18 portunity for a hearing thereon by the Secretary to the
19 same extent as is provided in section 205(b) of the Social
20 Security Act, and to judicial review of the Secretary's final
21 decision after such hearing as is provided in section 205(g)
22 of such Act, except that such action shall be brought in
23 the Court of Appeals of the United States for the judicial
24 circuit in which the individual or entity resides, or has a
25 principal place of business, or, if the individual or entity

1 does not reside or have a principal place of business within
2 any such judicial circuit, in the United States Court of
3 Appeals for the District of Columbia Circuit.

4 (2) Unless the Secretary determines that the health
5 or safety of individuals receiving services warrants the ex-
6 clusion taking effect earlier, any individual or entity that
7 is the subject of an adverse determination based on para-
8 graphs (6)(B), (7), (8), (9), (11), (12), (14), or (15) of
9 section 1128(b) of the Social Security Act, shall be enti-
10 tled to a hearing by an administrative law judge (as pro-
11 vided under section 205(b) of the Social Security Act) on
12 the determination before any exclusion based upon the de-
13 termination takes effect. If a hearing is requested, the ex-
14 clusion shall be effective upon the issuance of an order
15 by the administrative law judge upholding the determina-
16 tion of the Secretary to exclude.

17 (3) The provisions of section 205(h) of the Social Se-
18 curity Act shall apply with respect to this section or sec-
19 tion 5412(b)(3) to the same extent as such provisions
20 apply with respect to title II of such Act.

21 (g) APPLICATION FOR TERMINATION OF EXCLU-
22 SION.—(1) An individual or entity excluded (or directed
23 to be excluded) from participation under this section or
24 section 5412(b)(3) may apply to the Secretary, in a man-
25 ner specified by the Secretary in regulations and at the

1 end of the minimum period of exclusion (or, in the case
2 of an individual or entity described in section 1128(b)(12),
3 the period of exclusion) provided under this section or sec-
4 tion 5412(b)(3) and at such other times as the Secretary
5 may provide, for termination of the exclusion.

6 (2) The Secretary may terminate the exclusion if the
7 Secretary determines, on the basis of the conduct of the
8 applicant which occurred after the date of the notice of
9 exclusion or which was unknown to the Secretary at the
10 time of the exclusion, that—

11 (A) there is no basis under this section or sec-
12 tion 5412(b)(3) for a continuation of the exclusion,
13 and

14 (B) there are reasonable assurances that the
15 types of actions which formed the basis for the origi-
16 nal exclusion have not recurred and will not recur.

17 (3) The Secretary shall promptly notify each sponsor
18 of an applicable health plan and each entity that admin-
19 isters a State health care program described in section
20 1128(h) of the Social Security Act of each termination of
21 exclusion made under this subsection.

22 (h) CONVICTED DEFINED.—In this section, the term
23 “convicted” has the meaning given such term in section
24 1128(i) of the Social Security Act.

1 (i) REQUEST FOR EXCLUSION.—The sponsor of any
2 applicable health plan (including a State in the case of
3 a regional alliance health plan and the Secretary of Labor
4 in the case of a corporate alliance health plan) may re-
5 quest that the Secretary of Health and Human Services
6 exclude an individual or entity with respect to actions
7 under such a plan in accordance with this section.

8 (j) EFFECT OF EXCLUSION.—Notwithstanding any
9 other provision of this Act, no payment may be made
10 under a health plan for the delivery of or payment for any
11 item or service (other than an emergency item or service,
12 not including items or services furnished in an emergency
13 room of a hospital) furnished—

14 (1) by an individual or entity during the period
15 when such individual or entity is excluded pursuant
16 to this section or section 5412(b)(3) from participa-
17 tion in a health plan; or

18 (2) at the medical direction or on the prescrip-
19 tion of a physician during the period when the physi-
20 cian is excluded pursuant to this section or section
21 5412(b)(3) from participation in a health plan and
22 the person furnishing the item or service knew or
23 had reason to know of the exclusion (after a reason-
24 able time period after reasonable notice has been
25 furnished to the person).

1 (k) DELEGATION.—The Secretary may delegate au-
2 thority granted under this section to the Inspector Gen-
3 eral.

4 **SEC. 5412. CIVIL MONETARY PENALTIES.**

5 (a) ACTIONS SUBJECT TO PENALTY.—Any person
6 who is determined by the Secretary to have committed any
7 of the following actions with respect to an applicable
8 health plan shall be subject to a penalty in accordance
9 with subsection (b):

10 (1) ACTIONS SUBJECT TO PENALTY UNDER
11 MEDICARE, MEDICAID, AND OTHER SOCIAL SECURITY
12 HEALTH PROGRAMS.—Any action that would subject
13 the person to a penalty under paragraphs (1)
14 through (12) of section 1128A(a) of the Social Secu-
15 rity Act if the action was taken with respect to title
16 V, XVIII, XIX, or XX of such Act.

17 (2) TERMINATION OF ENROLLMENT.—The ter-
18 mination of an individual's enrollment (including the
19 refusal to re-enroll an individual) in violation of sub-
20 title E of title I or State law.

21 (3) DISCRIMINATING ON BASIS OF MEDICAL
22 CONDITION.—The engagement in any practice that
23 would reasonably be expected to have the effect of
24 denying or discouraging the initial or continued en-
25 rollment in a health plan by individuals whose med-

1 ical condition or history indicates a need for sub-
2 stantial future medical services.

3 (4) INDUCING ENROLLMENT ON FALSE PRE-
4 TENSES.—The engagement in any practice to induce
5 enrollment in an applicable health plan through rep-
6 resentations to individuals which the person knows
7 or should know are false or fraudulent.

8 (5) PROVIDING INCENTIVES TO ENROLL.—The
9 offer or payment of remuneration to any individual
10 that such person knows or should know is likely to
11 influence such individual to enroll in a particular
12 plan, or to cause such individual to induce others to
13 enroll in a particular plan.

14 (b) PENALTIES DESCRIBED.—

15 (1) GENERAL RULE.—Any person who the Sec-
16 retary determines has committed an action described
17 in paragraphs (2) through (5) of subsection (a) shall
18 be subject to a civil monetary penalty in an amount
19 not to exceed \$50,000 for each such determination.

20 (2) ACTIONS SUBJECT TO PENALTIES UNDER
21 SOCIAL SECURITY ACT.—In the case of a person who
22 the Secretary determines has committed an action
23 described in paragraph (1) of subsection (a), the
24 person shall be subject to the civil monetary penalty
25 (together with any additional assessment) to which

1 the person would be subject under section 1128A of
2 the Social Security Act if the action on which the
3 determination is based had been committed with re-
4 spect to title V, XVIII, XIX, or XX of such Act.

5 (3) DETERMINATIONS TO EXCLUDE PER-
6 MITTED.—In addition to any civil monetary penalty
7 or assessment imposed under this subsection, the
8 Secretary may make a determination in the same
9 proceeding to exclude the person from participation
10 in all applicable health plans for the delivery of or
11 payment for health care items or services (in accord-
12 ance with section 5411(c)).

13 (c) PROCEDURES FOR IMPOSITION OF PENALTIES.—

14 (1) APPLICABILITY OF PROCEDURES UNDER SO-
15 CIAL SECURITY ACT.—Except as otherwise provided
16 in paragraph (2), the provisions of section 1128A of
17 the Social Security Act (other than subsections (a)
18 and (b) and the second sentence of subsection (f))
19 shall apply to the imposition of a civil monetary pen-
20 alty, assessment, or exclusion under this section in
21 the same manner as such provisions apply with re-
22 spect to the imposition of a penalty, assessment, or
23 exclusion under section 1128A of such Act.

1 (2) AUTHORITY OF SECRETARY OF LABOR AND
2 STATES TO IMPOSE PENALTIES, ASSESSMENTS, AND
3 EXCLUSIONS.—

4 (A) IN GENERAL.—The Secretary of Labor
5 or a State may initiate an action to impose a
6 civil monetary penalty, assessment, or exclusion
7 under this section with respect to actions relat-
8 ing to a corporate alliance health plan or a re-
9 gional alliance health plan, respectively, if au-
10 thorized by the Attorney General and the Sec-
11 retary pursuant to regulations promulgated by
12 the Secretary in consultation with the Attorney
13 General.

14 (B) REQUIREMENTS DESCRIBED.—Under
15 the regulations promulgated under subpara-
16 graph (A), the Attorney General and the Sec-
17 retary shall review an action proposed by the
18 Secretary of Labor or a State, and not later
19 than 120 days after receiving notice of the pro-
20 posed action from the Secretary of Labor or the
21 State, shall—

22 (i) approve the proposed action to be
23 taken by the Secretary of Labor or the
24 State;

25 (ii) disapprove the proposed action; or

1 (iii) assume responsibility for initi-
2 ating a criminal, civil, or administrative ac-
3 tion based on the information provided in
4 the notice.

5 (C) ACTION DEEMED APPROVED IF DEAD-
6 LINE MISSED.—If the Attorney General and the
7 Secretary fail to respond to a proposed action
8 by the Secretary of Labor or a State within the
9 period described in subparagraph (B), the At-
10 torney General and the Secretary shall be
11 deemed to have approved the proposed action to
12 be taken by the Secretary of Labor or the
13 State.

14 (d) TREATMENT OF AMOUNTS RECOVERED.—Any
15 amounts recovered under this section shall be paid to the
16 Secretary and disposed of as follows:

17 (1) Such portions of the amounts recovered as
18 is determined to have been improperly paid from an
19 applicable health plan for the delivery of or payment
20 for health care items or services shall be repaid to
21 such plan.

22 (2) The remainder of the amounts recovered
23 shall be deposited in the All-Payer Health Care
24 Fraud and Abuse Control Account established under
25 section 5402.

1 (e) NOTIFICATION OF LICENSING AUTHORITIES.—

2 Whenever the Secretary's determination to impose a pen-
3 alty, assessment, or exclusion under this section becomes
4 final, the Secretary shall notify the appropriate State or
5 local licensing agency or organization (including the agen-
6 cy specified in section 1864(a) and 1902(a)(33) of the So-
7 cial Security Act) that such a penalty, assessment, or ex-
8 clusion has become final and the reasons therefor.

9 **SEC. 5413. LIMITATIONS ON PHYSICIAN SELF-REFERRAL.**

10 The provisions of section 1877 of the Social Security
11 Act shall apply—

12 (1) to items and services (and payments and
13 claims for payment for such items and services) fur-
14 nished under any applicable health plan in the same
15 manner as such provisions apply to designated
16 health services (and payments and claims for pay-
17 ment for such services) under title XVIII of the So-
18 cial Security Act; and

19 (2) to a State (with respect to an item or serv-
20 ice furnished or payment made under a regional alli-
21 ance health plan) and to the Secretary of Labor
22 (with respect to an item or service furnished or pay-
23 ment made under a corporate alliance health plan)
24 in the same manner as such provisions apply to the
25 Secretary.

1 **SEC. 5414. CONSTRUCTION OF SOCIAL SECURITY ACT REF-**
2 **ERENCES.**

3 (a) INCORPORATION OF OTHER AMENDMENTS.—Any
4 reference in this part to a provision of the Social Security
5 Act shall be considered a reference to the provision as
6 amended under title IV.

7 (b) EFFECT OF SUBSEQUENT AMENDMENTS.—Ex-
8 cept as provided in subsection (a), any reference to a pro-
9 vision of the Social Security Act in this part shall be
10 deemed to be a reference to such provision as in effect
11 on the date of the enactment of this Act, and (except as
12 Congress may otherwise provide) any amendments made
13 to such provisions after such date shall not be taken into
14 account in determining the applicability of such provisions
15 to individuals and entities under this Act.

16 **PART 3—AMENDMENTS TO ANTI-FRAUD AND**
17 **ABUSE PROVISIONS UNDER THE SOCIAL SE-**
18 **CURITY ACT**

19 **SEC. 5421. REFERENCE TO AMENDMENTS.**

20 For provisions amending the anti-fraud and abuse
21 provisions existing under the Social Security Act, see part
22 5 of subtitle A of title IV.

1 **PART 4—AMENDMENTS TO CRIMINAL LAW**

2 **SEC. 5431. HEALTH CARE FRAUD.**

3 (a) IN GENERAL.—Chapter 63 of title 18, United
4 States Code, is amended by adding at the end the fol-
5 lowing:

6 **“§ 1347. Health care fraud**

7 “(a) Whoever knowingly executes, or attempts to exe-
8 cute, a scheme or artifice—

9 “(1) to defraud any health alliance, health plan,
10 or other person, in connection with the delivery of or
11 payment for health care benefits, items, or services;

12 “(2) to obtain, by means of false or fraudulent
13 pretenses, representations, or promises, any of the
14 money or property owned by, or under the custody
15 or control of, any health alliance, health plan, or
16 person in connection with the delivery of or payment
17 for health care benefits, items, or services;

18 shall be fined under this title or imprisoned not more than
19 10 years, or both. If the violation results in serious bodily
20 injury (as defined in section 1365 of this title) such person
21 shall be imprisoned for life or any term of years.

22 “(b) As used in this section, the terms ‘health alli-
23 ance’ and ‘health plan’ have the meanings given those
24 terms in title I of the Health Security Act.”.

1 (b) CLERICAL AMENDMENT.—The table of sections
2 at the beginning of chapter 63 of title 18, United States
3 Code, is amended by adding at the end the following:

“1347. Health care fraud.”.

4 **SEC. 5432. FORFEITURES FOR VIOLATIONS OF FRAUD STAT-**
5 **UTES.**

6 (a) IN GENERAL.—Section 982(a) of title 18, United
7 States Code, is amended by inserting after paragraph (5)
8 the following:

9 “(6) If the court determines that a Federal health
10 care offense (as defined in section 5402(d) of the Health
11 Security Act) is of a type that poses a serious threat to
12 the health of any person or has a significant detrimental
13 impact on the health care system, the court, in imposing
14 sentence on a person convicted of that offense, shall order
15 that person to forfeit property, real or personal, that—

16 “(A)(i) is used in the commission of the offense;
17 or

18 “(ii) constitutes or is derived from proceeds
19 traceable to the commission of the offense; and

20 “(B) is of a value proportionate to the serious-
21 ness of the offense.”.

22 (b) PROCEEDS OF HEALTH CARE FRAUD FORFEIT-
23 URES.—Section 524(c)(4)(A) of title 28, United States
24 Code, is amended by inserting “all proceeds of forfeitures
25 relating to Federal health care offenses (as defined in sec-

tion 5402(d) of the Health Security Act), and” after “except”.

SEC. 5433. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

“§ 1033. False statements relating to health care matters

“(a) Whoever, in any matter involving a health alliance or health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

“(b) As used in this section the terms ‘health alliance’ and ‘health plan’ have the meanings given those terms in title I of the Health Security Act.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following:

“1033. False statements relating to health care matters.”.

1 **SEC. 5434. BRIBERY AND GRAFT.**

2 (a) IN GENERAL.—Chapter 11 of title 18, United
3 States Code, is amended by adding at the end the fol-
4 lowing:

5 **“§ 226. Bribery and graft in connection with health**
6 **care**

7 “(a) Whoever—

8 “(1) directly or indirectly, corruptly gives, of-
9 fers, or promises anything of value to a health care
10 official, or offers or promises a health care official
11 to give anything of value to any other person, with
12 intent—

13 “(A) to influence any of the health care of-
14 ficial’s actions, decisions, or duties relating to a
15 health alliance or health plan;

16 “(B) to influence such an official to com-
17 mit or aid in the committing, or collude in or
18 allow, any fraud, or make opportunity for the
19 commission of any fraud, on a health alliance or
20 health plan; or

21 “(C) to induce such an official to engage
22 in any conduct in violation of the lawful duty of
23 such official; or

24 “(2) being a health care official, directly or in-
25 directly, corruptly demands, seeks, receives, accepts,
26 or agrees to accept anything of value personally or

1 for any other person or entity, the giving of which
2 violates paragraph (1) of this subsection;
3 shall be fined under this title or imprisoned not more than
4 15 years, or both.

5 “(b) Whoever, otherwise than as provided by law for
6 the proper discharge of any duty, directly or indirectly
7 gives, offers, or promises anything of value to a health
8 care official, for or because of any of the health care offi-
9 cial’s actions, decisions, or duties relating to a health care
10 alliance or health plan, shall be fined under this title or
11 imprisoned not more than two years, or both.

12 “(c) As used in this section—

13 “(1) the term ‘health care official’ means—

14 “(A) an administrator, officer, trustee, fi-
15 duciary, custodian, counsel, agent, or employee
16 of any health care alliance or health plan;

17 “(B) an officer, counsel, agent, or em-
18 ployee, of an organization that provides services
19 under contract to any health alliance or health
20 plan;

21 “(C) an official or employee of a State
22 agency having regulatory authority over any
23 health alliance or health plan;

24 “(D) an officer, counsel, agent, or em-
25 ployee of a health care sponsor; and

1 “(2) the term ‘health care sponsor’ means any
2 individual or entity serving as the sponsor of a
3 health alliance or health plan for purposes of the
4 Health Security Act, and includes the joint board of
5 trustees or other similar body used by two or more
6 employers to administer a health alliance or health
7 plan for purposes of such Act.”.

8 (b) CLERICAL AMENDMENT.—The table of chapters
9 at the beginning of chapter 11 of title 18, United States
10 Code, is amended by adding at the end the following:

 “226. Bribery and graft in connection with health care.”.

11 **SEC. 5435. INJUNCTIVE RELIEF RELATING TO HEALTH**
12 **CARE OFFENSES.**

13 Section 1345(a)(1) of title 18, United States Code,
14 is amended—

15 (1) by striking “or” at the end of subparagraph
16 (A);

17 (2) by inserting “or” at the end of subpara-
18 graph (B); and

19 (3) by adding at the end the following:

20 “(C) committing or about to commit a Federal
21 health care offense (as defined in section 5402(d) of
22 the Health Security Act);”.

23 **SEC. 5436. GRAND JURY DISCLOSURE.**

24 Section 3322 of title 18, United States Code, is
25 amended—

1 (1) by redesignating subsections (c) and (d) as
2 subsections (d) and (e), respectively; and

3 (2) by inserting after subsection (b) the fol-
4 lowing:

5 “(c) A person who is privy to grand jury information
6 concerning a health law violation—

7 “(1) received in the course of duty as an attor-
8 ney for the Government; or

9 “(2) disclosed under rule 6(e)(3)(A)(ii) of the
10 Federal Rules of Criminal Procedure;

11 may disclose that information to an attorney for the Gov-
12 ernment to use in any civil proceeding related to a Federal
13 health care offense (as defined in section 5402(d) of the
14 Health Security Act).”.

15 **SEC. 5437. THEFT OR EMBEZZLEMENT.**

16 (a) IN GENERAL.—Chapter 31 of title 18, United
17 States Code, is amended by adding at the end the fol-
18 lowing:

19 **“§ 668. Theft or embezzlement in connection with**
20 **health care**

21 “(a) Whoever embezzles, steals, willfully and unlaw-
22 fully converts to the use of any person other than the
23 rightful owner, or intentionally misapplies any of the mon-
24 eys, securities, premiums, credits, property, or other assets
25 of a health alliance, health plan, or of any fund connected

1 with such an alliance or plan, shall be fined under this
2 title or imprisoned not more than 10 years, or both.

3 “(b) As used in this section, the terms ‘health alli-
4 ance’ and ‘health plan’ have the meanings given those
5 terms under title I of the Health Security Act.”.

6 (b) CLERICAL AMENDMENT.—The table of sections
7 at the beginning of chapter 31 of title 18, United States
8 Code, is amended by adding at the end the following:

“668. Theft or embezzlement in connection with health care.”.

9 **SEC. 5438. MISUSE OF HEALTH SECURITY CARD OR UNIQUE**
10 **IDENTIFIER.**

11 (a) IN GENERAL.—Chapter 33 of title 18, United
12 States Code, is amended by adding at the end the fol-
13 lowing:

14 **“§ 716. Misuse of health security card or unique iden-**
15 **tifier**

16 “Whoever—

17 “(1) requires the display of, requires the use of,
18 or uses a health security card that is issued under
19 section 1001(b) of the Health Security Act for any
20 purpose other than a purpose described in section
21 5105(a) of such Act; or

22 “(2) requires the disclosure of, requires the use
23 of, or uses a unique identifier number provided pur-
24 suant to section 5104 of such Act for any purpose

1 that is not authorized by the National Health Board
 2 pursuant to such section;
 3 shall be fined under this title or imprisoned not more than
 4 2 years, or both.”.

5 (b) AMENDMENT TO CHAPTER HEADING.—The
 6 heading for chapter 33 of title 18, United States Code,
 7 is amended to read as follows:

8 **“CHAPTER 33—EMBLEMS, INSIGNIA,**
 9 **IDENTIFIERS, AND NAMES”.**

10 (c) CLERICAL AMENDMENT TO TABLE OF SEC-
 11 TIONS.—The table of sections at the beginning of chapter
 12 33, United States Code, is amended by adding at the end
 13 the following new item:

“716. Misuse of health security card or unique identifier.”.

14 (d) CLERICAL AMENDMENT TO TABLE OF CHAP-
 15 TERS.—The item relating to chapter 33 in the table of
 16 chapters at the beginning of part 1 of title 18, United
 17 States Code, is amended to read as follows:

“33. Emblems, insignia, identifiers, and names 701”.

18 **PART 5—AMENDMENTS TO CIVIL FALSE CLAIMS**
 19 **ACT**

20 **SEC. 5441. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.**

21 Section 3729 of title 31, United States Code, is
 22 amended—

23 (1) in subsection (a)(7), by inserting “or to a
 24 health plan” after “property to the Government”;

1 (2) in the matter following subsection (a)(7), by
2 inserting “or health plan” before “sustains because
3 of the act of that person,”;

4 (3) at the end of the first sentence of sub-
5 section (a), by inserting “or health plan” before
6 “sustains because of the act of the person.”;

7 (4) in subsection (c)—

8 (A) by inserting “the term” after “sec-
9 tion,”; and

10 (B) by adding at the end the following:

11 “The term also includes any request or demand,
12 whether under contract or otherwise, for money
13 or property which is made or presented to a
14 health plan.”; and

15 (5) by adding at the end the following:

16 “(f) HEALTH PLAN DEFINED.—For purposes of this
17 section, the term ‘health plan’ has the meaning given such
18 term under section 1400 of the Health Security Act.”.

19 **Subtitle F—McCarran-Ferguson**
20 **Reform**

21 **SEC. 5501. REPEAL OF EXEMPTION FOR HEALTH INSUR-**
22 **ANCE.**

23 (a) IN GENERAL.—Section 3 of the Act of March 9,
24 1945 (15 U.S.C. 1013), known as the McCarran-Ferguson
25 Act, is amended by adding at the end the following:

1 “(c) Notwithstanding that the business of insurance
 2 is regulated by State law, nothing in this Act shall limit
 3 the applicability of the following Acts to the business of
 4 insurance to the extent that such business relates to the
 5 provision of health benefits:

6 “(1) The Sherman Act (15 U.S.C. 1 et seq.).

7 “(2) The Clayton Act (15 U.S.C. 12 et seq.).

8 “(3) Federal Trade Commission Act (15 U.S.C.
 9 41 et seq.).

10 “(4) The Act of June 19, 1936 (49 Stat. 1526;
 11 15 U.S.C. 21a et seq.), known as the Robinson-Pat-
 12 man Antidiscrimination Act.”.

13 (b) EFFECTIVE DATE.—The amendment made by
 14 subsection (a) shall take effect on the first day of the sixth
 15 month beginning after the date of the enactment of this
 16 Act.

17 **TITLE VI—PREMIUM CAPS; PRE-**
 18 **MIUM-BASED FINANCING;**
 19 **AND PLAN PAYMENTS**

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1 SEC. 6000. GENERAL DEFINITIONS.

2 (a) DEFINITIONS RELATING TO BIDS.—In this title:

3 (1) ACCEPTED BID.—The term “accepted bid”
4 means the bid which is agreed to between a regional
5 alliance health plan and a regional alliance for cov-
6 erage of the comprehensive benefit package in the
7 alliance area under subpart A of part 1.

8 (2) FINAL ACCEPTED BID.—The term “final ac-
9 cepted bid” means the accepted bid, taking into ac-
10 count any voluntary reduction in such bid made
11 under section 6004(e).

12 (3) WEIGHTED AVERAGE ACCEPTED BID.—The
13 term “weighted average accepted bid” means, for a
14 regional alliance for a year, the average of the ac-
15 cepted bids for all regional alliance health plans of-
16 fered by such alliance, weighted to reflect the rel-
17 ative enrollment of regional alliance eligible individ-
18 uals among such plans.

1 (4) REDUCED WEIGHTED AVERAGE ACCEPTED
2 BID.—The term “reduced weighted average accepted
3 bid”, for a health plan offered by a regional alliance
4 for a year, is the lesser of—

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

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

11 (b) WEIGHTED AVERAGE PREMIUM.—In this title,
12 the term “weighted average premium” means, for a class
13 of family enrollment and with respect to a regional alliance
14 for a year, the product of—

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

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

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

22 (c) INCORPORATION OF OTHER DEFINITIONS.—Ex-
23 cept as otherwise provided in this title, the definitions of
24 terms in subtitle J of title I of this Act shall apply to
25 this title.

Subtitle A—Premium Caps

PART 1—REGIONAL ALLIANCE HEALTH

EXPENDITURES

Subpart A—Computation of Targets and Accepted Bids

SEC. 6001. COMPUTATION OF REGIONAL ALLIANCE INFLA- TION FACTORS.

(a) COMPUTATION.—

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

(2) REGIONAL ALLIANCE INFLATION FACTOR.—

In this part, the term “regional alliance inflation factor” means, for a year for a regional alliance—

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

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

1 (C) decreased by the percentage adjust-
2 ment (if any) provided with respect to the re-
3 gional alliance under subsection (d) (relating to
4 adjustment for previous excess expenditures);
5 and

6 (D) in the case of the year 2001, increased
7 by a factor that the Board determines to reflect
8 the ratio of (i) the actuarial value of the in-
9 crease in benefits provided in that year under
10 the comprehensive benefit package to (ii) the
11 actuarial value of the benefits that would have
12 been in such package in the year without regard
13 to the increase.

14 For purposes of subparagraph (D)(i), the actuarial
15 value of the increase with respect to mental illness
16 and substance abuse services (included within the
17 comprehensive benefit package) shall not exceed an
18 actuarial value based on the amount of the total ex-
19 penditures that would have been made in 2001 by
20 States and subdivisions of States for mental illness
21 and substance abuse services (included in such pack-
22 age as of 2001) if this Act had not been enacted.

23 (3) GENERAL HEALTH CARE INFLATION FAC-
24 TOR.—

1 (A) 1996 THROUGH 2000.—In this part,
2 the term “general health care inflation factor”,
3 for a year, means the percentage increase in the
4 CPI (as specified under subsection (b)) for the
5 year plus the following:

6 (i) For 1996, 1.5 percentage points.

7 (ii) For 1997, 1.0 percentage points.

8 (iii) For 1998, 0.5 percentage points.

9 (iv) For 1999 and for 2000, 0 per-
10 centage points.

11 (B) YEARS AFTER 2000.—

12 (i) RECOMMENDATION TO CON-
13 GRESS.—In 1999, the Board shall submit
14 to Congress recommendations on what the
15 general health care inflation factor should
16 be for years beginning with 2001.

17 (ii) FAILURE OF CONGRESS TO ACT.—
18 If the Congress fails to enact a law speci-
19 fying the general health care inflation fac-
20 tor for a year after 2000, the Board, in
21 January of the year before the year in-
22 volved, shall compute such factor for the
23 year involved. Such factor shall be the
24 product of the factors described in sub-

1 paragraph (C) for that fiscal year, minus
2 1.

3 (C) FACTORS.—The factors described in
4 this subparagraph for a year are the following:

5 (i) CPI.—1 plus the percentage
6 change in the CPI for the year, determined
7 based upon the percentage change in the
8 average of the CPI for the 12-month pe-
9 riod ending with August 31 of the previous
10 fiscal year over such average for the pre-
11 ceding 12-month period.

12 (ii) REAL GDP PER CAPITA.—1 plus
13 the average annual percentage change in
14 the real, per capita gross domestic product
15 of the United States during the 3-year pe-
16 riod ending in the preceding calendar year,
17 determined by the Board based on data
18 supplied by the Department of Commerce.

19 (b) PROJECTION OF INCREASE IN CPI.—

20 (1) IN GENERAL.—For purposes of this section,
21 the Board shall specify, as of the time of publica-
22 tion, the annual percentage increase in the CPI (as
23 defined in section 1902(9)) for the following year.

24 (2) DATA TO BE USED.—Such increase shall be
25 the projection of the CPI contained in the budget of

1 the United States transmitted by the President to
2 the Congress in the year.

3 (c) SPECIAL ADJUSTMENT FOR MATERIAL CHANGES
4 IN DEMOGRAPHIC CHARACTERISTICS OF POPULATION.—

5 (1) ADJUSTMENT FOR CORPORATE ALLIANCE
6 OPT-IN.—

7 (A) IN GENERAL.—The Board shall de-
8 velop a method for adjusting the regional alli-
9 ance inflation factor for each regional alliance
10 in order to reflect material changes in the de-
11 mographic characteristics of regional alliance el-
12 igible individuals residing in the alliance area
13 (in comparison with such characteristics for the
14 previous year) as a result of one or more cor-
15 porate alliances terminating an election under
16 section 1313.

17 (B) BASIS FOR ADJUSTMENTS.—Adjust-
18 ments under this paragraph (whether an in-
19 crease or decrease) shall be based on the char-
20 acteristics and factors used for making adjust-
21 ments in payments under section 6124.

22 (2) ADJUSTMENT FOR REGIONAL TREND COM-
23 PARED TO NATIONAL TREND.—

24 (A) IN GENERAL.—The Board shall de-
25 velop a method for adjusting the regional alli-

1 ance inflator factor for each regional alliance in
2 order to reflect material changes in the demo-
3 graphic characteristics (including at least age,
4 gender, and socio-economic status) and health
5 status of regional alliance eligible individuals re-
6 siding in the alliance area in comparison with
7 the average change in such characteristics for
8 such individuals residing in the United States.
9 The adjustment under this paragraph shall be
10 for changes not taken into account in the ad-
11 justment under paragraph (1).

12 (B) NEUTRAL ADJUSTMENT.—Such meth-
13 od (and any annual adjustment under this
14 paragraph) shall be designed to result in the
15 adjustment effected under this paragraph for a
16 year not changing the weighted average of the
17 regional alliance inflation factors.

18 (3) APPLICATION.—The Board shall provide, on
19 an annual basis, for an adjustment of regional alli-
20 ance inflation factors under this subsection using
21 such methods.

22 (d) CONSULTATION PROCESS.—The Board shall have
23 a process for consulting with representatives of States and
24 regional alliances before establishing the regional alliance
25 inflation factors for each year under this section.

1 **SEC. 6002. BOARD DETERMINATION OF NATIONAL PER CAP-**
2 **ITA BASELINE PREMIUM TARGET.**

3 (a) IN GENERAL.—Not later than January 1, 1995,
4 the Board shall determine a national per capita baseline
5 premium target. Such target is equal to—

6 (1) the national average per capita current cov-
7 erage health expenditures (determined under sub-
8 section (b)),

9 (2) updated under subsection (c).

10 (b) DETERMINATION OF NATIONAL AVERAGE PER
11 CAPITA CURRENT COVERAGE HEALTH EXPENDITURES.—

12 (1) IN GENERAL.—The Board shall determine
13 the national average per capita current coverage
14 health expenditures equal to—

15 (A) total covered current health care ex-
16 penditures (described in paragraph (2)), divided
17 by

18 (B) the estimated population in the United
19 States of regional alliance eligible individuals
20 (as determined by the Board as of 1993 under
21 paragraph (4)) for whom such expenditures
22 were determined.

23 The population under subparagraph (B) shall not in-
24 clude SSI recipients or AFDC recipients.

25 (2) CURRENT HEALTH CARE EXPENDITURES.—

26 For purposes of paragraph (1)(A), the Board shall

1 determine current health care expenditures as fol-
2 lows:

3 (A) DETERMINATION OF TOTAL EXPENDI-
4 TURES.—The Board shall first determine the
5 amount of total payments made for items and
6 services included in the comprehensive benefit
7 package (determined without regard to cost
8 sharing) in the United States in 1993.

9 (B) REMOVAL OF CERTAIN EXPENDITURES
10 NOT TO BE COVERED THROUGH REGIONAL AL-
11 LIANCES.—The amount so determined shall be
12 decreased by the proportion of such amount
13 that is attributable to any of the following:

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

17 (ii) AFDC recipients or SSI recipi-
18 ents.

19 (iii) Expenditures which are paid for
20 through workers' compensation or auto-
21 mobile or other liability insurance.

22 (iv) Expenditures by parties (includ-
23 ing the Federal Government) that the
24 Board determines will not be payable by
25 regional alliance health plans for coverage

1 of the comprehensive benefit package
2 under this Act.

3 (C) ADDITION OF PROJECTED EXPENDI-
4 TURES FOR UNINSURED AND UNDERINSURED
5 INDIVIDUALS.—The amount so determined and
6 adjusted shall be increased to take into account
7 increased utilization of, and expenditures for,
8 items and services covered under the com-
9 prehensive benefit package likely to occur, as a
10 result of coverage under a regional alliance
11 health plan of individuals who, as of 1993 were
12 uninsured or underinsured with respect to the
13 comprehensive benefit package. In making such
14 determination, such expenditures shall be based
15 on the estimated average cost for such services
16 in 1993 (and not on private payment rates es-
17 tablished for such services). In making such de-
18 termination, the estimated amount of uncom-
19 pensated care in 1993 shall be removed and will
20 not include adjustments to offset payments
21 below costs by public programs.

22 (D) ADDITION OF HEALTH PLAN AND AL-
23 LIANCE COSTS OF ADMINISTRATION.—The
24 amount so determined and adjusted shall be in-
25 creased by an estimated percentage (determined

1 by the Board, but no more than 15 percent)
2 that reflects the proportion of premiums that
3 are required for health plan and regional alli-
4 ance administration (including regional alliance
5 costs for administration of income-related pre-
6 mium discounts and cost sharing reductions)
7 and for State premium taxes (which taxes shall
8 be limited to such amounts in 1993 as are at-
9 tributable to the health benefits to be included
10 in the comprehensive benefit package).

11 (E) DECREASE FOR COST SHARING.—The
12 amount so determined and adjusted shall be de-
13 creased by a percentage that reflects (i) the es-
14 timated average percentage of total amounts
15 payable for items and services covered under
16 the comprehensive benefit package that will be
17 payments in the form of cost sharing under a
18 higher cost sharing plan, and (ii) the percent-
19 age reduction in utilization estimated to result
20 from the application of high cost sharing.

21 (3) SPECIAL RULES.—

22 (A) BENEFITS USED.—The determinations
23 under this section shall be based on the com-
24 prehensive benefit package as in effect in 1996.

1 (B) ASSUMING NO CHANGE IN EXPENDI-
2 TURE PATTERN.—The determination under
3 paragraph (2) shall be made without regard to
4 any change in the pattern of expenditures that
5 may result from the enrollment of AFDC recipi-
6 ents and SSI recipients in regional alliance
7 health plans.

8 (4) ELIGIBLE INDIVIDUALS.—In this sub-
9 section, the determination of who are regional alli-
10 ance eligible individuals under this subsection shall
11 be made as though this Act was fully in effect in
12 each State as of 1993.

13 (c) UPDATING.—

14 (1) IN GENERAL.—Subject to paragraph (3),
15 the Board shall update the amount determined
16 under subsection (b)(1) for each of 1994 and 1995
17 by the appropriate update factor described in para-
18 graph (2) for the year.

19 (2) APPROPRIATE UPDATE FACTOR.—In para-
20 graph (1), the appropriate update factor for a year
21 is 1 plus the annual percentage increase for the year
22 (as determined by the Secretary, based on actual or
23 projected information) in private sector health care
24 spending for items and services included in the com-
25 prehensive benefit package (as of 1996).

1 (3) LIMIT.—The total, cumulative update under
2 this subsection shall not exceed 15 percent.

3 **SEC. 6003. DETERMINATION OF ALLIANCE PER CAPITA**
4 **PREMIUM TARGETS.**

5 (a) INITIAL DETERMINATION.—Not later than Janu-
6 ary 1, 1995, the Board shall determine, for each regional
7 alliance for 1996, a regional alliance per capita premium
8 target. Such target shall equal—

9 (1) the national per capita baseline premium
10 target (determined by the Board under section
11 6002),

12 (2) updated by the regional alliance inflation
13 factor (as determined under section 6001(a)(2)) for
14 1996, and

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

17 (b) SUBSEQUENT DETERMINATIONS.—

18 (1) DETERMINATION.—Not later than March 1
19 of each year (beginning with 1996) the Board shall
20 determine, for each regional alliance for the suc-
21 ceeding year a regional alliance per capita premium
22 target.

23 (2) GENERAL RULE.—Subject to subsection (e),
24 such target shall equal—

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

5 (B) updated by the regional alliance infla-
6 tion factor (as determined in section 6001(a))
7 for the year.

8 (3) ADJUSTMENT FOR PREVIOUS EXCESS RATE
9 OF INCREASE IN EXPENDITURES.—Such target for a
10 year is subject to a decrease under section 6001(d).

11 (c) ADJUSTMENT FACTORS FOR REGIONAL ALLI-
12 ANCES FOR INITIAL DETERMINATION.—

13 (1) IN GENERAL.—The Board shall establish an
14 adjustment factor for each regional alliance in a
15 manner consistent with this subsection.

16 (2) CONSIDERATIONS.—In establishing the fac-
17 tor for each regional alliance, the Board shall con-
18 sider, using information of the type described in
19 paragraph (3), the difference between the national
20 average of the factors taken into account in deter-
21 mining the national per capita baseline premium tar-
22 get and such factors for the regional alliance, includ-
23 ing variations in health care expenditures and in
24 rates of uninsurance and underinsurance in the dif-
25 ferent alliance areas and including variations in the

1 proportion of expenditures for services provided by
2 academic health centers in the different alliance
3 areas.

4 (3) TYPE OF INFORMATION.—The type of infor-
5 mation described in this paragraph is—

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

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

12 (C) information on variations across States
13 in per capita spending under the medicare pro-
14 gram and in such spending among alliance
15 areas within a State under such program; and

16 (D) area rating factors commonly used by
17 actuaries.

18 (4) APPLICATION OF FACTORS IN NEUTRAL
19 MANNER.—The application of the adjustment factors
20 under this subsection for 1996 shall be done in a
21 manner so that the weighted average of the regional
22 alliance per capita premium targets for 1996 is
23 equal to the national per capita baseline premium
24 target determined under section 6002. Such weight-
25 ed average shall be based on the Board's estimate of

1 the expected distribution of alliance eligible individ-
2 uals (taken into account under section 6002) among
3 the regional alliances.

4 (5) CONSULTATION PROCESS.—The Board shall
5 have a process for consulting with representatives of
6 States and regional alliances before establishing the
7 adjustment for regional alliances under this sub-
8 section.

9 (d) TREATMENT OF CERTAIN STATES.—

10 (1) NON-ALLIANCE STATES.—In the case of a
11 State that is not a participating State or otherwise
12 has not established regional alliances, the entire
13 State shall be treated under the provisions of this
14 part as composing a single regional alliance.

15 (2) CHANGES IN ALLIANCE BOUNDARIES.—In
16 the case of a State that changes the boundaries of
17 its regional alliances (including the establishment of
18 such alliances after 1996), the Board shall provide
19 a method for computing a regional alliance per cap-
20 ita premium target for each regional alliance af-
21 fected by such change in a manner that—

22 (A) reflects the factors taken into account
23 in establishing the adjustment factors for re-
24 gional alliances under subsection (c), and

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1 (B) results in the weighted average of the
2 newly computed regional targets for the re-
3 gional alliances affected by the change equal to
4 the weighted average of the regional targets for
5 the regional alliances as previously established.

6 (e) ADJUSTMENT FOR PREVIOUS EXCESS RATE OF
7 INCREASE IN EXPENDITURES.—

8 (1) IN GENERAL.—If the actual weighted aver-
9 age accepted bid for a regional alliance for a year
10 (as determined by the Board based on actual enroll-
11 ment in the first month of the year) exceeds the re-
12 gional alliance per capita premium target (deter-
13 mined under this section) for the year, then the re-
14 gional alliance per capita premium target shall be
15 reduced, by $\frac{1}{2}$ of the excess percentage (described in
16 paragraph (2)) for the year, for each of the 2 suc-
17 ceeding years.

18 (2) EXCESS PERCENTAGE.—The excess percent-
19 age described in this paragraph for a year is the per-
20 centage by which—

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

1 (B) the regional alliance per capita pre-
2 mium target (determined under this section) for
3 the year.

4 **SEC. 6004. ALLIANCE INITIAL BIDDING AND NEGOTIATION**
5 **PROCESS.**

6 (a) BIDDING PROCESS.—

7 (1) OBTAINING BIDS.—

8 (A) IN GENERAL.—Not later than July 1
9 before the first year, and not later than August
10 1 of each succeeding year, the regional alliance
11 shall have obtained premium bids from each
12 plan seeking to participate as a regional alli-
13 ance health plan with respect to the alliance in
14 the following year.

15 (B) DISCLOSURE.—In obtaining such bids,
16 a regional alliance may determine to disclose
17 (or not to disclose) the regional alliance per
18 capita premium target for the regional alliance
19 (determined under section 6003) for the year
20 involved.

21 (C) CONDITION.—Each bid submitted by a
22 plan under this subsection shall be conditioned
23 upon the plan's agreement to accept any pay-
24 ment reduction that may be imposed under sec-
25 tion 6011.

1 (2) NEGOTIATION PROCESS.—Following the
2 bidding process under paragraph (1), a State may
3 provide for negotiations with health plans relating to
4 the premiums to be charged by such plans. Such ne-
5 gotiations may result in the resubmission of bids,
6 but in no case shall a health plan resubmit a bid
7 that exceeds its prior bid.

8 (3) LEGALLY BINDING BIDS.—All bids sub-
9 mitted under this subsection must be legally binding
10 with respect to the plans involved.

11 (4) ACCEPTANCE.—The final bid submitted by
12 a plan under this subsection shall be considered to
13 be the final accepted bid, except as provided in sub-
14 section (e).

15 (5) ASSISTANCE.—The Board shall provide re-
16 gional alliances with such information and technical
17 assistance as may assist such alliances in the bid-
18 ding process under this subsection.

19 (b) SUBMISSION OF INFORMATION TO BOARD.—By
20 not later than September 1 of each year for which bids
21 are obtained under subsection (a), each regional alliance
22 shall submit to the Board a report that discloses—

23 (1) information regarding the final bids ob-
24 tained under subsection (a) by the different plans;

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

6 (B) for a succeeding year, the actual distribu-
7 tion of enrollment of alliance eligible individuals in
8 regional alliance health plans in the year in which
9 the report is transmitted; and

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

12 (c) COMPUTATION OF WEIGHTED AVERAGE ACCEPT-
13 ED BID.—

14 (1) IN GENERAL.—For each regional alliance
15 the Board shall determine a weighted average ac-
16 cepted bid for each year for which bids are obtained
17 under subsection (a). Such determination shall be
18 based on information on accepted bids for the year,
19 submitted under subsection (b)(1), and shall take
20 into account, subject to paragraph (2), the informa-
21 tion on enrollment distribution submitted under sub-
22 section (b)(2).

23 (2) ENROLLMENT DISTRIBUTION RULES.—In
24 making the determination under paragraph (1) for a
25 regional alliance, the Board shall establish rules re-

1 specting the treatment of enrollment in plans that
2 are discontinued or are newly offered.

3 (d) NOTICE TO CERTAIN ALLIANCES.—

4 (1) IN GENERAL.—By not later than October 1
5 of each year for which bids are obtained, the Board
6 shall notify a regional alliance—

7 (A) if the weighted average accepted bid
8 (determined under subsection (c)) for the alli-
9 ance is greater than the regional alliance per
10 capita premium target for the alliance (deter-
11 mined under section 6003) for the year, and

12 (B) of the reduced weighted average ac-
13 cepted bid for the alliance.

14 (2) NOTICE OF PREMIUM REDUCTIONS.—If no-
15 tice is provided to a regional alliance under para-
16 graph (1), the Board shall notify the regional alli-
17 ance and each noncomplying plan of any plan pay-
18 ment reduction computed under section 6011 for
19 such a plan and the opportunity to voluntarily re-
20 duce the accepted bid under subsection (e) in order
21 to avoid such a reduction.

22 (e) VOLUNTARY REDUCTION OF ACCEPTED BID
23 (FINAL ACCEPTED BID).—After the Board has deter-
24 mined under subsection (c) the weighted average accepted
25 bid for a regional alliance and the Board has determined

1 plan payment reductions, before such date as the Board
2 may specify (in order to provide for an open enrollment
3 period), a noncomplying plan has the opportunity to volun-
4 tarily reduce its accepted bid by the amount of the plan
5 payment reduction that would otherwise apply to the plan.
6 Such reduction shall not affect the amount of the plan
7 payment reduction for any other plan for that year.

8 **SEC. 6005. STATE FINANCIAL INCENTIVES.**

9 (a) **ELECTION.**—Any participating State may elect to
10 assume responsibility for containment of health care ex-
11 penditures in the State consistent with this part. Such re-
12 sponsibility shall include submitting annual reports to the
13 Board on any activities undertaken by the State to contain
14 such expenditures. A participating State may regulate the
15 rates charged by providers furnishing health care items
16 and services to all private payers. Such regulation of rates
17 may not cause a corporate alliance health plan to be
18 charged, directly or indirectly, rates different from those
19 charged other health plans for the same items and services
20 or otherwise discriminate against corporate alliance health
21 plans.

22 (b) **FINANCIAL INCENTIVE.**—In the case of a State
23 that has made an election under subsection (a), if the
24 Board determines for a particular year (beginning with
25 the first year) that the statewide weighted average of the

1 reduced weighted average accepted bids (based on actual
2 average enrollment for the year), for regional alliances in
3 the State, is less than the statewide weighted average of
4 the regional alliance per capita premium targets (based
5 upon such enrollment) for such alliances for the year, then
6 the amount of the State maintenance-of-effort payment
7 under section 9001(b), for the following year, shall be re-
8 duced by $\frac{1}{2}$ of the product of—

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

13 (2) the total of the amount of the Federal pay-
14 ments made in that particular year to regional alli-
15 ances in the State under subtitle B of title IX.

16 **SEC. 6006. RECOMMENDATIONS TO ELIMINATE REGIONAL**
17 **VARIATIONS IN ALLIANCE TARGETS DUE TO**
18 **VARIATION IN PRACTICE PATTERNS; CON-**
19 **GRESSIONAL CONSIDERATION.**

20 (a) ESTABLISHMENT OF ADVISORY COMMISSION ON
21 REGIONAL VARIATIONS IN HEALTH EXPENDITURES.—
22 The chair of the Board shall establish, by not later than
23 60 days after the date of appointment of the first chair,
24 an advisory commission on regional variations in health
25 expenditures.

1 (b) COMPOSITION.—The advisory commission shall
2 be composed of consumers, employers, providers, rep-
3 resentatives of health plans, States, regional alliances, in-
4 dividuals with expertise in the financing of health care,
5 individuals with expertise in the economics of health care,
6 and representatives of diverse geographic areas.

7 (c) ELIMINATION OF REGIONAL VARIATION IN PRE-
8 MIUMS DUE TO PRACTICE PATTERN.—

9 (1) COMMISSION STUDY.—The advisory com-
10 mission shall examine methods of eliminating vari-
11 ation in regional alliance per capita premium targets
12 due to variation in practice patterns, not due to
13 other factors (such as health care input prices and
14 demographic factors), by 2002.

15 (2) COMMISSION REPORT.—The advisory com-
16 mission shall submit to the Board a report that
17 specifies one or more methods for eliminating the
18 variation described in paragraph (1).

19 (3) BOARD RECOMMENDATIONS.—The Board
20 shall submit to Congress, by not later July 1, 1995,
21 detailed recommendations respecting the specific
22 method to be used to eliminate the variation de-
23 scribed in paragraph (1) by 2002. Such rec-
24 ommendations may take into account regional vari-
25 ations in demographic or health status and in health

1 care input prices, based on the availability of accu-
2 rate proxies for measuring price variation. In taking
3 into account health care input prices, the Board
4 shall explain what percentage of variation found
5 should be adjusted and what percentage of the pre-
6 mium should be adjusted.

7 (d) CONGRESSIONAL CONSIDERATION.—

8 (1) IN GENERAL.—Detailed recommendations
9 submitted under subsection (c)(3) shall apply under
10 this subtitle unless a joint resolution (described in
11 paragraph (2)) disapproving such recommendations
12 is enacted, in accordance with the provisions of
13 paragraph (3), before the end of the 60-day period
14 beginning on the date on which such recommenda-
15 tions were submitted. For purposes of applying the
16 preceding sentence and paragraphs (2) and (3), the
17 days on which either House of Congress is not in
18 session because of an adjournment of more than
19 three days to a day certain shall be excluded in the
20 computation of a period.

21 (2) JOINT RESOLUTION OF DISAPPROVAL.—A
22 joint resolution described in this paragraph means
23 only a joint resolution which is introduced within the
24 10-day period beginning on the date on which the

1 Board submits recommendations under subsection
2 (e)(3) and—

3 (A) which does not have a preamble;

4 (B) the matter after the resolving clause of
5 which is as follows: “That Congress disapproves
6 the recommendations of the National Health
7 Board concerning elimination of regional vari-
8 ation in regional alliance premiums, as sub-
9 mitted by the Board on _____.”, the
10 blank space being filled in with the appropriate
11 date; and

12 (C) the title of which is as follows: “Joint
13 resolution disapproving recommendations of the
14 National Health Board concerning elimination
15 of regional variation in regional alliance pre-
16 miums, as submitted by the Board on
17 _____.”, the blank space being filled
18 in with the appropriate date.

19 (3) PROCEDURES FOR CONSIDERATION OF RES-
20 OLUTION OF DISAPPROVAL.—Subject to paragraph
21 (4), the provisions of section 2908 (other than sub-
22 section (a)) of the Defense Base Closure and Re-
23 alignment Act of 1990 shall apply to the consider-
24 ation of a joint resolution described in paragraph (2)
25 in the same manner as such provisions apply to a

1 joint resolution described in section 2908(a) of such
2 Act.

3 (4) SPECIAL RULES.—For purposes of applying
4 paragraph (3) with respect to such provisions—

5 (A) any reference to the Committee on
6 Armed Services of the House of Representatives
7 shall be deemed a reference to an appropriate
8 Committee of the House of Representatives
9 (specified by the Speaker of the House of Rep-
10 resentatives at the time of submission of rec-
11 ommendations under subsection (c)(3)) and any
12 reference to the Committee on Armed Services
13 of the Senate shall be deemed a reference to an
14 appropriate Committee of the Senate (specified
15 by the Majority Leader of the Senate at the
16 time of submission of recommendations under
17 subsection (c)(3)); and

18 (B) any reference to the date on which the
19 President transmits a report shall be deemed a
20 reference to the date on which the Board sub-
21 mits a recommendation under subsection (c)(3).

22 (e) ELIMINATION OF REGIONAL VARIATION STATE
23 PAYMENT AMOUNTS.—

24 (1) COMMISSION STUDY.—The advisory com-
25 mission shall examine methods of reducing variation

1 among States in the level of payments required
2 under subtitle A of title IX by 2002. The commis-
3 sion shall examine methods of reducing variation due
4 to practice patterns, historical differences in the
5 rates of reimbursement to providers, and in the
6 amount, duration, and scope of benefits covered
7 under State medicaid plans.

8 (2) COMMISSION REPORT.—The advisory com-
9 mission shall submit to the Board a report that
10 specifies one or more methods for reducing the vari-
11 ation described in paragraph (1).

12 (3) BOARD RECOMMENDATIONS.—The Board
13 shall submit to Congress, by not later than July 1,
14 1995, detailed recommendations respecting the spe-
15 cific method to be used to reduce the variation de-
16 scribed in paragraph (1) by 2002 in a budget neu-
17 tral manner with respect to total government pay-
18 ments and payments by the Federal Government. In
19 submitting recommendations under this paragraph,
20 the Board shall consider the fiscal capacity of the
21 States.

22 (4) CONGRESSIONAL CONSIDERATION.—

23 (A) IN GENERAL.—Subject to the suc-
24 ceeding provisions of this paragraph, the provi-
25 sions of subsection (d) shall apply to rec-

ommendations under paragraph (3) in the same manner as they apply to recommendations under subsection (c)(3).

(B) SPECIAL RULES.—In applying subparagraph (A)—

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

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

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

1 **SEC. 6007. REFERENCE TO LIMITATION ON ADMINISTRA-**
2 **TIVE AND JUDICIAL REVIEW OF CERTAIN DE-**
3 **TERMINATIONS.**

4 For limitation on administrative and judicial review
5 of certain determinations under this part, see section
6 5232.

7 **Subpart B—Plan and Provider Payment Reductions**
8 **to Maintain Expenditures within Targets**

9 **SEC. 6011. PLAN PAYMENT REDUCTION.**

10 (a) PLAN PAYMENT REDUCTION.—In order to assure
11 that payments to regional alliance health plans by a re-
12 gional alliance are consistent with the applicable regional
13 alliance per capita target for the alliance (computed under
14 this subtitle), each noncomplying plan (as defined in sub-
15 section (b)(2)) for a year is subject to a reduction in plan
16 payment (under section 1351) by the amount equal to
17 plan payment reduction specified in subsection (c) for the
18 year.

19 (b) NONCOMPLYING ALLIANCE AND NONCOMPLYING
20 PLAN DEFINED.—In this part:

21 (1) NONCOMPLYING ALLIANCE.—The term
22 “noncomplying alliance” means, for a year, a re-
23 gional alliance for which the weighted average ac-
24 cepted bid (computed under section 6004(c)) exceeds
25 the regional alliance per capita premium target for
26 the year.

1 (2) NONCOMPLYING PLAN.—The term “non-
2 complying plan” means, for a year, a regional alli-
3 ance health plan offered through a noncomplying al-
4 liance if the final accepted bid for the year exceeds
5 the maximum complying bid (as defined in sub-
6 section (d)) for the year. No plan shall be a noncom-
7 plying plan for a year before the first year in which
8 the plan is offered by a regional alliance.

9 (c) AMOUNT OF PLAN PAYMENT REDUCTION.—

10 (1) IN GENERAL.—The amount of the plan pay-
11 ment reduction, for a noncomplying plan offered by
12 an alliance, is the alliance-wide reduction percentage
13 (as defined in paragraph (2)) of the excess bid
14 amount (as defined in paragraph (3)) for the plan.

15 (2) ALLIANCE-WIDE REDUCTION PERCENT-
16 AGE.—

17 (A) IN GENERAL.—In paragraph (1), the
18 term “alliance-wide reduction percentage”
19 means, for a noncomplying plan offered by an
20 alliance for a year—

21 (i) the amount by which (I) the
22 weighted average accepted bid (computed
23 under section 6004(c)(1)) for the alliance
24 for the year, exceeds (II) the regional alli-

1 ance per capita target for the alliance for
2 the year; divided by

3 (ii) the sum, for noncomplying plans
4 offered by the alliance, of the plan propor-
5 tions of alliance excess bid amounts (de-
6 scribed in subparagraph (B)(i)) for the
7 year.

8 (B) PLAN PROPORTION OF ALLIANCE EX-
9 CESS BID AMOUNT DESCRIBED.—

10 (i) IN GENERAL.—The “plan propor-
11 tion of alliance excess bid amount” de-
12 scribed in this clause, for a noncomplying
13 plan, is the product of—

14 (I) the excess bid amount (as de-
15 fined in paragraph (3)) for the plan,
16 and

17 (II) the plan enrollment propor-
18 tion (as defined in clause (i)) for the
19 plan.

20 (ii) PLAN ENROLLMENT PROPOR-
21 TION.—In clause (i)(II), the term “plan
22 enrollment proportion” means, with respect
23 to a health plan offered by a regional alli-
24 ance, the total enrollment of alliance eligi-
25 ble individuals enrolled in such plan ex-

1 pressed as a percentage of the total enroll-
2 ment of alliance eligible individuals in all
3 regional alliance plans offered by the alli-
4 ance. Such proportion shall be computed
5 based on the information used in com-
6 puting the weighted average accepted bid
7 for the alliance under section 6004(c)(1).

8 (3) EXCESS BID AMOUNT.—In this subsection,
9 the “excess bid amount”, with respect to a noncom-
10 plying plan for a year, is the amount by which—

11 (A) the accepted bid for the year (not tak-
12 ing into account any voluntary reduction under
13 section 6004(e)), exceeds

14 (B) the maximum complying bid (as de-
15 fined in subsection (d)) for the plan for the
16 year.

17 (d) MAXIMUM COMPLYING BID.—

18 (1) FIRST YEAR.—In this part for the first
19 year, the “maximum complying bid” for each plan
20 offered by a regional alliance, is the regional alliance
21 per capita premium target for the alliance (deter-
22 mined under section 6003) for the year.

23 (2) SUBSEQUENT YEARS.—In this part, subject
24 to paragraph (3), for a subsequent year, the “max-

1 imum complying bid”, for a plan offered by an alli-
2 ance for a year, is the sum of the following:

3 (A) NET PREVIOUS YEAR ACCEPTED BID
4 FOR PLAN.—The accepted bid for the previous
5 year (not taking into account any voluntary re-
6 duction under section 6004(e)), minus the
7 amount of any plan payment reduction for the
8 plan for that year.

9 (B) ALLIANCE-WIDE INFLATION ALLOW-
10 ANCE.—The amount by which—

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

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

17 (3) SPECIAL RULES FOR NEW PLANS.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (B), in the case of a plan that is first of-
20 fered by a regional alliance in a year after the
21 first year the maximum complying bid shall be
22 the regional alliance per capita premium target
23 for the year.

24 (B) AUTHORITY.—The Board or a State
25 may establish rules to modify the application of

1 subparagraph (A) for regional alliance health
2 plans in the State in order—

3 (i) to prevent abusive premium prac-
4 tices by entities previously offering plans,
5 or

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

9 **SEC. 6012. PROVIDER PAYMENT REDUCTION.**

10 (a) PARTICIPATING PROVIDERS.—

11 (1) IN GENERAL.—Each regional alliance health
12 plan, as part of its contract under section 1406(e)
13 with any participating provider (as defined in section
14 1407(c), or group of participating providers) shall—

15 (A) include a provision that provides that
16 if the plan is a noncomplying plan for a year,
17 payments to the provider (or group) shall be re-
18 duced by the applicable network reduction per-
19 centage (described in paragraph (2)) for the
20 year, and

21 (B) not include any provision which the
22 State determines otherwise varies the payments
23 to such providers (or group) because of, or in
24 relation to, a plan payment reduction under sec-

1 tion 6011 or otherwise is intended to nullify the
2 effect of subparagraph (A).

3 The Board may issue regulations relating to the re-
4 quirements of this paragraph.

5 (2) APPLICABLE NETWORK REDUCTION PER-
6 CENTAGE.—

7 (A) IN GENERAL.—Subject to subpara-
8 graph (B), the “applicable network reduction
9 percentage”, with respect to participating pro-
10 viders of a noncomplying plan for a year is—

11 (i) the plan payment reduction
12 amount for the plan for the year (as deter-
13 mined under section 6011(c)), divided by

14 (ii) the final accepted bid for the plan
15 for the year,

16 adjusted under subparagraph (B).

17 (B) INDUCED VOLUME OFFSET.—The
18 Board shall provide for an appropriate increase
19 of the percentage reduction computed under
20 subparagraph (A) to take into account any esti-
21 mated increase in volume of services provided
22 that may reasonably be anticipated as a con-
23 sequence of applying a reduction in payment
24 under this subsection. The Board may compute
25 and apply such increase differently for different

1 classes of providers or services or different
2 types of health plans (as the Board may de-
3 fine).

4 (b) OTHER PROVIDERS.—

5 (1) IN GENERAL.—Each regional alliance health
6 plan that is a noncomplying plan in a year shall pro-
7 vide for a reduction in the amount of payments to
8 providers (or groups of providers) that are not par-
9 ticipating providers under the applicable alliance fee
10 schedule under section 1406(c)(3) by the applicable
11 nonnetwork reduction percentage (described in para-
12 graph (2)) for the year.

13 (2) APPLICABLE NONNETWORK REDUCTION
14 PERCENTAGE.—

15 (A) IN GENERAL.—Subject to subpara-
16 graph (B), the “applicable nonnetwork reduc-
17 tion percentage”, with respect to nonpartici-
18 pating providers of a noncomplying plan for a
19 year is—

20 (i) the plan payment reduction
21 amount for the plan for the year (as deter-
22 mined under section 6011(c)), divided by

23 (ii) the final accepted bid for the plan
24 for the year,

25 adjusted under subparagraph (B).

1 (B) INDUCED VOLUME OFFSET.—The
2 Board shall provide for an appropriate increase
3 of the percentage reduction computed under
4 subparagraph (A) to take into account any esti-
5 mated increase in volume of services provided
6 that may reasonably be anticipated as a con-
7 sequence of applying a reduction in payment
8 under this subsection. The Board may compute
9 and apply such increase differently for different
10 classes of providers or services or different
11 types of health plans (as the Board may de-
12 fine).

13 (c) APPLICATION TO COST SHARING AND TO BAL-
14 ANCE BILLING RESTRICTIONS.—For purposes of applying
15 section 1406(d) (relating to balance billing limitations)
16 and part 3 of subtitle B of title I (relating to computation
17 of cost sharing), the payment basis otherwise used for
18 computing any limitation on billing or cost sharing shall
19 be such payment basis as adjusted by any reductions ef-
20 fected under this section.

21 **PART 2—CORPORATE ALLIANCES HEALTH**
22 **EXPENDITURES**

23 **SEC. 6021. CALCULATION OF PREMIUM EQUIVALENTS.**

24 (a) IN GENERAL.—By January 1, 1998, the Board
25 shall develop a methodology for calculating an annual per

1 capita expenditure equivalent for amounts paid for cov-
2 erage for the comprehensive benefit package within a cor-
3 porate alliance.

4 (b) ADJUSTMENT PERMITTED.—Such methodology
5 shall permit a corporate alliance to petition the Secretary
6 of Labor for an adjustment of the inflation adjustment
7 that would otherwise apply to compensate for material
8 changes in the demographic characteristics of the eligible
9 individuals receiving coverage through the alliance.

10 (c) REPORTING.—In 2001 and each subsequent year,
11 each corporate alliance shall report to the Secretary of
12 Labor, in a form and manner specified by the Secretary,
13 the average of the annual per capita expenditure equiva-
14 lent for the previous 3-year period.

15 **SEC. 6022. TERMINATION OF CORPORATE ALLIANCE FOR**
16 **EXCESS INCREASE IN EXPENDITURES.**

17 (a) TERMINATION.—

18 (1) IN GENERAL.—If a corporate alliance has
19 two excess years (as defined in subsection (b)) in a
20 3-year-period, then, effective beginning with the sec-
21 ond year following the second excess year in such
22 period—

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

1 (B) employers that were corporate alliance
2 employers with respect to such corporate alli-
3 ance shall become regional alliance employers
4 (unless, in the case of a corporate alliance with
5 a plan sponsor described in subparagraph (B)
6 or (C) of section 1311(b)(1), the employers be-
7 come corporate alliance employers of another
8 such corporate alliance).

9 (2) INITIAL 3-YEAR-PERIOD.—Paragraph (1)
10 shall first apply to the 3-year-period beginning with
11 1998.

12 (3) SPECIAL SUBSEQUENT TREATMENT FOR
13 LARGE EMPLOYERS.—In the case of corporate alli-
14 ance employers described in paragraph (1)(B) that
15 are large employers, the employer premium pay-
16 ments under section 6121 are subject to adjustment
17 under section 6124.

18 (4) NO FURTHER ELECTION.—If a corporate al-
19 liance of a large employer is terminated under this
20 subsection, no employer that is a corporate alliance
21 employer for that alliance is eligible to be a sponsor
22 of a corporate alliance.

23 (b) EXCESS YEAR.—

1 (1) IN GENERAL.—In subsection (a), the term
2 “excess year” means, for a corporate alliance, a year
3 (after 2000) for which—

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

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

9 (2) RATE OF INCREASE FOR CORPORATE ALLI-
10 ANCE.—The rate of increase for a corporate alliance
11 for a year, specified in this paragraph, is the per-
12 centage by which—

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

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

21 (3) NATIONAL CORPORATE INFLATION FAC-
22 TOR.—The national corporate inflation factor for a
23 year, specified in this paragraph, is the average of
24 the general health care inflation factors (as defined

1 in section 6001(a)(3)) for each of the 3 years ending
2 with such year.

3 **PART 3—TREATMENT OF SINGLE-PAYER STATES**

4 **SEC. 6031. SPECIAL RULES FOR SINGLE-PAYER STATES.**

5 In the case of a Statewide single-payer State, for pur-
6 poses of section 1222(6), the Board shall compute a State-
7 wide per capita premium target for each year in the same
8 manner as a regional alliance per capita premium target
9 is determined under section 6003.

10 **PART 4—TRANSITION PROVISIONS**

11 **SEC. 6041. MONITORING PRICES AND EXPENDITURES.**

12 (a) IN GENERAL.—The Secretary shall establish a
13 program to monitor prices and expenditures in the health
14 care system in the United States.

15 (b) REPORTS.—The Secretary shall periodically re-
16 port to the President on—

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

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

22 (c) ACCESS TO INFORMATION.—

23 (1) IN GENERAL.—The Secretary may obtain,
24 through surveys or otherwise, information on prices
25 and expenditures for health care services. The Sec-

1 retary may compel health care providers and third
2 party payers to disclose such information as is nec-
3 essary to carry out the program under this section.

4 (2) CONFIDENTIALITY.—Non-public informa-
5 tion obtained under this subsection with respect to
6 individual patients is confidential.

7 (d) PERIODIC REPORTS.—The Secretary shall peri-
8 odically issue public reports on the matters described in
9 subsection (b).

10 **Subtitle B—Premium-Related** 11 **Financings**

12 **PART 1—FAMILY PREMIUM PAYMENTS**

13 **Subpart A—Family Share**

14 **SEC. 6101. FAMILY SHARE OF PREMIUM.**

15 (a) REQUIREMENT.—Each family enrolled in a re-
16 gional alliance health plan or in a corporate alliance health
17 plan in a class of family enrollment is responsible for pay-
18 ment of the family share of premium payable respecting
19 such enrollment. Such premium may be paid by an em-
20 ployer or other person on behalf of such a family.

21 (b) FAMILY SHARE OF PREMIUM DEFINED.—

22 (1) IN GENERAL.—In this subtitle, the term
23 “family share of premium” means, with respect to
24 enrollment of a family—

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

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

6 (2) REGIONAL ALLIANCE.—

7 (A) IN GENERAL.—The amount specified
8 in this paragraph for a health plan based on a
9 class of family enrollment is the sum of the
10 base amounts described in subparagraph (B)
11 reduced (but not below zero) by the sum of the
12 amounts described in subparagraph (C).

13 (B) BASE.—The base amounts described
14 in this subparagraph (for a plan for a class of
15 enrollment) are as follows:

16 (i) REGIONAL ALLIANCE PREMIUM.—
17 The premium specified in section 6102(a)
18 with respect to such class of enrollment.

19 (ii) FAMILY COLLECTION SHORT-
20 FALL.—20 percent of the family collection
21 shortfall add-on (computed under section
22 6107 for such class).

23 (C) CREDITS AND DISCOUNTS.—The
24 amounts described in this subparagraph (for a
25 plan for a class of enrollment) are as follows:

1 (i) ALLIANCE CREDIT.—The amount
2 of the alliance credit under section
3 6103(a).

4 (ii) INCOME RELATED DISCOUNT.—
5 The amount of any income-related discount
6 provided under section 6104(a)(1).

7 (iii) EXCESS PREMIUM CREDIT.—The
8 amount of any excess premium credit pro-
9 vided under section 6105.

10 (iv) CORPORATE ALLIANCE OPT-IN
11 CREDIT.—The amount of any corporate al-
12 liance opt-in credit provided under section
13 6106.

14 (v) ADDITIONAL CREDIT FOR SSI AND
15 AFDC RECIPIENTS.—In the case of an SSI
16 or AFDC family or for whom the amount
17 described in clause (ii) is equal to the
18 amount described in section 6104(b)(1)(A),
19 the amount described in subparagraph
20 (B)(ii).

21 (D) LIMIT ON MISCELLANEOUS CRED-
22 ITS.—In no case shall the family share, due to
23 credits under subparagraph (C), be less than
24 zero.

25 (3) CORPORATE ALLIANCE.—

1 (A) IN GENERAL.—The amount specified
2 in this paragraph for a health plan based on a
3 class of family enrollment is the premium de-
4 scribed in subparagraph (B) reduced (but not
5 below zero) by the sum of the amounts de-
6 scribed in subparagraph (C).

7 (B) PREMIUM.—The premium described in
8 this subparagraph (for a plan for a class of en-
9 rollment) is premium specified under section
10 1384 with respect to the plan and class of en-
11 rollment involved.

12 (C) CREDITS AND DISCOUNTS.—The
13 amounts described in this subparagraph (for a
14 plan for a class of enrollment) are as follows:

15 (i) ALLIANCE CREDIT.—The amount
16 of the alliance credit under section
17 6103(b).

18 (ii) INCOME RELATED DISCOUNT.—
19 The amount of any income-related discount
20 provided under section 6104(a)(2).

21 **SEC. 6102. AMOUNT OF PREMIUM.**

22 (a) REGIONAL ALLIANCE.—The amount of the pre-
23 mium charged by a regional alliance for all families in a
24 class of family enrollment under a regional alliance health
25 plan offered by the alliance is equal to the product of—

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

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

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

8 (b) REFERENCE TO CORPORATE ALLIANCE PREMIUM
9 PROVISIONS.—The amount of the premium charged by a
10 corporate alliance for all families in a class of family en-
11 rollment under a corporate alliance health plan offered by
12 the alliance is specified under section 1384.

13 (c) SPECIAL RULES FOR DIVIDED FAMILIES.—In the
14 case of an individual who is a qualifying employee of an
15 employer, if the individual has a spouse or child who is
16 not treated as part of the individual's family because of
17 section 1012—

18 (1) the combined premium for both families
19 under this section shall be computed as though such
20 section had not applied if such combined premium is
21 less than the total of the premiums otherwise appli-
22 cable (without regard to this subsection),

23 (2) the regional alliance shall divide such com-
24 bined premium between the families proportionally
25 (consistent with rules established by the Board), and

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

4 **SEC. 6103. ALLIANCE CREDIT.**

5 (a) REGIONAL ALLIANCES.—The credit provided
6 under this section for a family enrolled in a regional alli-
7 ance health plan through a regional alliance for a class
8 of family enrollment is equal to 80 percent of the weighted
9 average premium (as defined in section 6000(b)) for
10 health plans offered by the alliance for the class.

11 (b) CORPORATE ALLIANCES.—The credit provided
12 under this section for a family enrolled in a corporate alli-
13 ance health plan for a class of family enrollment is equal
14 to the minimum employer premium payment required
15 under section 6131 with respect to the family.

16 **SEC. 6104. PREMIUM DISCOUNT BASED ON INCOME.**

17 (a) IN GENERAL.—

18 (1) ENROLLEES IN REGIONAL ALLIANCE
19 HEALTH PLANS.—Each family enrolled with a re-
20 gional alliance health plan is entitled to a premium
21 discount under this section, in the amount specified
22 in subsection (b), if the family—

23 (A) is an AFDC or SSI family,

24 (B) is determined, under subpart D of part
25 3 of subtitle D of title I, to have family ad-

1 justed income below 150 percent of the applica-
2 ble poverty level, or

3 (C) is a family described in subsection
4 (c)(3) for which the family obligation amount
5 under subsection (c) for the year would other-
6 wise exceed a specified percent of family ad-
7 justed income described in such subsection.

8 (2) ENROLLEES IN CORPORATE ALLIANCE
9 HEALTH PLANS.—

10 (A) IN GENERAL.—Subject to subpara-
11 graph (B), each family enrolled with a cor-
12 porate alliance health plan in a class of family
13 enrollment by virtue of the full-time employ-
14 ment of a low-wage employee (as defined in
15 subparagraph (B)) is entitled to a premium dis-
16 count under this section in the amount (if any)
17 by which—

18 (i) 95 percent of the premium (speci-
19 fied in section 1384) for the least expen-
20 sive corporate alliance health plan that is
21 offered to the employee and that is a lower
22 or combination cost sharing plan (as de-
23 fined in paragraphs (7) and (20) of section
24 1902 for that class and premium area), ex-
25 ceeds

1 (ii) the alliance credit under section
2 6103(b) for that class.

3 (B) LOW-WAGE EMPLOYEE DEFINED.—

4 (i) IN GENERAL.—In this paragraph,
5 the term “low-wage employee” means, with
6 respect to an employer, an employee who is
7 employed on a full-time basis and who is
8 receiving wages (as defined in section
9 1901(a)(1)(A)) for employment for the em-
10 ployer, at an annual rate of less than
11 \$15,000 (as adjusted under clause (ii)).

12 (ii) INDEXING.—For a year after
13 1994, the dollar amount specified in clause
14 (i) shall be increased or decreased by the
15 same percentage as the percentage increase
16 or decrease by which the average CPI (de-
17 scribed in section 1902(9)) for the 12-
18 month-period ending with August 31 of the
19 preceding year exceeds such average for
20 the 12-month period ending with August
21 31, 1993.

22 (C) TIMING OF DETERMINATION.—

23 (i) IN GENERAL.—The determination
24 of whether or not an employee is a low-
25 wage employee shall be made, in accord-

1 ance with rules of the Secretary of Labor,
2 at the time of initial enrollment and shall
3 also be made at the time of each subse-
4 quent open enrollment period, on the basis
5 of the wages payable by the employer at
6 that time.

7 (ii) EFFECTIVE DATE.—Such deter-
8 mination shall apply as of the effective
9 date of the initial enrollment, or, in the
10 case of an open enrollment period, as of
11 the effective date of changes in enrollment
12 during such period.

13 (3) NO LIABILITY FOR INDIANS AND CERTAIN
14 VETERANS AND MILITARY PERSONNEL.—

15 (A) IN GENERAL.—In the case of an indi-
16 vidual described in subparagraph (B), because
17 the applicable health plan does not impose any
18 premium for such an individual, the individual
19 is not eligible for any premium discount under
20 this section.

21 (B) INDIVIDUALS DESCRIBED.—An indi-
22 vidual described in this subparagraph is—

23 (i) an electing veteran (as defined in
24 section 1012(d)(1)) who is enrolled under
25 a health plan of the Department of Vet-

erans Affairs and who, under the laws and rules as in effect as of December 31, 1994, has a service-connected disability or who is unable to defray the expenses of necessary care as determined under section 1722(a) of title 38, United States Code,

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

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

(4) MONTHLY APPLICATION TO AFDC AND SSI FAMILIES.—Paragraph (1)(A) (and the family obligation amount under subsection (c) insofar as it relates to an AFDC or SSI family) shall be applied to the premium or family obligation amount only for months in which the family is such an AFDC or SSI family.

(b) AMOUNT OF PREMIUM DISCOUNT FOR REGIONAL ALLIANCE HEALTH PLANS.—

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

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

7 (B) the sum of—

8 (i) the family obligation amount de-
9 scribed in subsection (c), and

10 (ii) the amount of any employer pay-
11 ment (not required under part 2) towards
12 the family share of premiums for covered
13 members of the family.

14 (2) INCREASE TO ASSURE ENROLLMENT IN AT-
15 OR-BELOW-AVERAGE-COST PLAN.—If a regional alli-
16 ance determines that a family eligible for a discount
17 under this section is unable to enroll in a at-or-
18 below-average-cost plan (as defined in paragraph
19 (3)) that serves the area in which the family resides,
20 the amount of the premium discount under this sub-
21 section is increased but only to such amount as will
22 permit the family to enroll in a regional alliance
23 health plan without the need to pay a family share
24 of premium under this part in excess of the sum de-
25 scribed in paragraph (1)(B).

1 (3) AT-OR-BELOW-AVERAGE-COST PLAN DE-
2 FINED.—In this section, the term “at-or-below-aver-
3 age-cost plan” means a regional alliance health plan
4 the premium for which does not exceed, for the class
5 of family enrollment involved, the weighted average
6 premium for the regional alliance.

7 (c) FAMILY OBLIGATION AMOUNT.—

8 (1) DETERMINATION.—Subject to paragraphs
9 (2) and (3), the family obligation amount under this
10 subsection is determined as follows:

11 (A) NO OBLIGATION IF INCOME BELOW IN-
12 COME THRESHOLD AMOUNT OR IF AFDC OR SSI
13 FAMILY.—If the family adjusted income (as de-
14 fined in section 1372(d)) of the family is less
15 than the income threshold amount (specified in
16 paragraph (4)) or if the family is an AFDC or
17 SSI family, the family obligation amount is
18 zero.

19 (B) INCOME ABOVE INCOME THRESHOLD
20 AMOUNT.—If such income is at least such in-
21 come threshold amount and the family is not an
22 AFDC or SSI family, the family obligation
23 amount is the sum of the following:

24 (i) FOR INCOME (ABOVE INCOME
25 THRESHOLD AMOUNT) UP TO THE POV-

1 ERTY LEVEL.—The product of the initial
2 marginal rate (specified in paragraph (2))
3 and the amount by which—

4 (I) the family adjusted income
5 (not including any portion that ex-
6 ceeds the applicable poverty level for
7 the class of family involved), exceeds

8 (II) such income threshold
9 amount.

10 (ii) GRADUATED PHASE OUT OF DIS-
11 COUNT UP TO 150 PERCENT OF POVERTY
12 LEVEL.—The product of the final marginal
13 rate (specified in paragraph (2)) and the
14 amount by which the family adjusted in-
15 come exceeds 100 percent (but is less than
16 150 percent) of the applicable poverty
17 level.

18 (2) MARGINAL RATES.—In paragraph (1)—

19 (A) INDIVIDUAL MARGINAL RATES.—For a
20 year for an individual class of enrollment—

21 (i) INITIAL MARGINAL RATE.—The
22 initial marginal rate is the ratio of—

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

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

4 (ii) FINAL MARGINAL RATE.—The
5 final marginal rate is the ratio of—

6 (I) the amount by which the gen-
7 eral family share (as defined in sub-
8 paragraph (C)) for an individual class
9 of enrollment exceeds 3 percent of the
10 applicable poverty level (for an indi-
11 vidual class of enrollment for the
12 year); to

13 (II) 50 percent of such poverty
14 level.

15 (B) FAMILY MARGINAL RATES.—For a
16 year for a family class of enrollment (as defined
17 in section 1011(c)(2)(A))—

18 (i) INITIAL MARGINAL RATE.—The
19 initial marginal rate is the ratio of—

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

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

1 (ii) FINAL MARGINAL RATE.—The
2 final marginal rate is the ratio of—

3 (I) the amount by which the gen-
4 eral family share (as defined in sub-
5 paragraph (C)) for a dual parent class
6 of enrollment exceeds 3 percent of the
7 applicable poverty level (for such a
8 class for the year); to

9 (II) 50 percent of such poverty
10 level.

11 (C) GENERAL FAMILY SHARE.—In sub-
12 paragraphs (A) and (B), the term “general
13 family share” means, for a class, the weighted
14 average premium for the class minus the alli-
15 ance credit (determined without regard to this
16 section).

17 (3) LIMITATION TO 3.9 PERCENT FOR ALL FAM-
18 ILIES.—

19 (A) IN GENERAL.—

20 (i) FAMILIES WITH INCOME BELOW
21 150 PERCENT OF POVERTY.—In the case of
22 a family with family adjusted income of
23 less than 150 percent of the applicable
24 poverty level, in no case shall the family
25 obligation amount under this subsection

1 for the year exceed 3.9 percent (adjusted
2 under subparagraph (C)) of the amount of
3 such adjusted income.

4 (ii) OTHER FAMILIES WITH INCOME
5 BELOW \$40,000.—In the case of a family
6 with family adjusted income of at least 150
7 percent of the applicable poverty level but
8 less than \$40,000 (adjusted under sub-
9 paragraph (B)) for a year, the family obli-
10 gation amount under this subsection for
11 the year is equal to 3.9 percent (adjusted
12 under subparagraph (C)) of the amount of
13 such adjusted income.

14 (B) INDEXING OF DOLLAR AMOUNTS.—

15 (i) IN GENERAL.—For a year after
16 1994, the dollar amounts specified in sub-
17 paragraph (A)(i) and in section
18 6113(d)(1)(B) shall be increased or de-
19 creased by the same percentage as the per-
20 centage increase or decrease by which the
21 average CPI (described in section 1902(9))
22 for the 12-month-period ending with Au-
23 gust 31 of the preceding year exceeds such
24 average for the 12-month period ending
25 with August 31, 1993.

1 (ii) ROUNDING.—The dollar amounts
2 adjusted under this subparagraph shall be
3 rounded each year to the nearest multiple
4 of \$100.

5 (C) INDEXING OF PERCENTAGE.—

6 (i) IN GENERAL.—The percentage
7 specified in subparagraph (A) shall be ad-
8 justed for any year after 1994 so that the
9 percentage for the year bears the same
10 ratio to the percentage so specified as the
11 ratio of—

12 (I) 1 plus the general health care
13 inflation factor (as defined in section
14 6001(a)(3)) for the year, bears to

15 (II) 1 plus the percentage speci-
16 fied in section 1136(b) (relating to in-
17 dexing of dollar amounts related to
18 cost sharing) for the year.

19 (ii) ROUNDING.—Any adjustment
20 under clause (i) for a year shall be round-
21 ed to the nearest multiple of $\frac{1}{10}$ of 1 per-
22 centage point.

23 (4) INCOME THRESHOLD AMOUNT.—

24 (A) IN GENERAL.—For purposes of this
25 subtitle, the income threshold amount specified

1 in this paragraph is \$1,000 (adjusted under
2 subparagraph (B)) .

3 (B) INDEXING.—For a year after 1994,
4 the income threshold amount specified in sub-
5 paragraph (A) shall be increased or decreased
6 by the same percentage as the percentage in-
7 crease or decrease by which the average CPI
8 (described in section 1902(9)) for the 12-
9 month-period ending with August 31 of the pre-
10 ceeding year exceeds such average for the 12-
11 month period ending with August 31, 1993.

12 (C) ROUNDING.—Any increase or decrease
13 under subparagraph (B) for a year shall be
14 rounded to the nearest multiple of \$10.

15 **SEC. 6105. EXCESS PREMIUM CREDIT.**

16 (a) IN GENERAL.—If plan payment reductions are
17 made for one or more regional alliance health plans offered
18 by a regional alliance for plan payments in a year under
19 section 6021, the alliance shall provide for a credit under
20 this section, in the amount described in subsection (b),
21 in the case of each family enrolled in a regional alliance
22 health plan offered by the alliance for premiums in the
23 year.

24 (b) AMOUNT OF CREDIT.—

1 (1) IN GENERAL.—Subject to paragraph (2),
2 the amount of the credit under this subsection, for
3 a family enrolled in a class of family enrollment for
4 a regional alliance for a year, is the amount that
5 would be the weighted average premium for such al-
6 liance, class, and year, if the per capita excess pre-
7 mium amount (determined under subsection (c)) for
8 the alliance for the year were substituted for the re-
9 duced weighted average accepted bid for the regional
10 alliance for the year.

11 (2) ADJUSTMENT TO ACCOUNT FOR USE OF ES-
12 TIMATES.—Subject to section 1361(b)(3), if the
13 total payments made by a regional alliance to all re-
14 gional alliance health plans in a year under section
15 1351(b) exceeds (or is less than) the total of such
16 payments estimated by the alliance (based on the re-
17 duced weighted average accepted bid under sub-
18 section (c)(1)), because of a difference between—

19 (A) the alliance’s estimate of the distribu-
20 tion of enrolled families between excess pre-
21 mium plans and other plans, and

22 (B) the actual distribution of such enrolled
23 families among such plans,

24 the amount of the credit under this section in the
25 second succeeding year shall be reduced (or in-

1 creased, respectively) by the amount of such excess
2 (or deficit) in the total of such payments made by
3 the alliance to all such plans.

4 (c) PER CAPITA EXCESS PREMIUM AMOUNT.—The
5 per capita excess premium amount, for a regional alliance
6 for a year, is the amount by which—

7 (1) the reduced weighted average accepted bid
8 (as defined in section 6000(a)(1)) for the alliance
9 for the year, exceeds

10 (2) the regional alliance per capita premium
11 target for the alliance for the year.

12 **SEC. 6106. CORPORATE ALLIANCE OPT-IN CREDIT.**

13 (a) IN GENERAL.—If a regional alliance is owed a
14 payment adjustment under section 6124 for a year, then
15 the alliance shall provide for a credit under this section
16 equal to 20 percent of the amount described in subsection
17 (b), in the case of each family enrolled in a regional alli-
18 ance plan offered by the alliance.

19 (b) AMOUNT OF CREDIT.—The amount described in
20 this subsection, for a family enrolled in a class of family
21 enrollment for a regional alliance for a year, is the amount
22 that would be the weighted average premium for such alli-
23 ance, class, and year, if the per capita corporate alliance
24 opt-in amount (determined under subsection (c)) for the
25 alliance for the year were substituted for the reduced

1 weighted average accepted bid for the regional alliance for
2 the year.

3 (c) PER CAPITA CORPORATE ALLIANCE OPT-IN
4 AMOUNT.—The per capita corporate alliance opt-in
5 amount, for a regional alliance for a year, is—

6 (1) the total amount of the payment adjust-
7 ments owed for the year under section 6124, divided
8 by

9 (2) the estimated average number of regional
10 alliance eligible individuals in the regional alliance
11 during the year (reduced by the average number of
12 such individuals whose family share of premiums,
13 determined without regard to this section and sec-
14 tion 6107, is zero).

15 **SEC. 6107. FAMILY COLLECTION SHORTFALL ADD-ON.**

16 (a) IN GENERAL.—The family collection shortfall
17 add-on, for a regional alliance for a class of enrollment
18 for a year, is the amount that would be the weighted aver-
19 age premium for such alliance, class, and year, if the per
20 capita collection shortfall amount (determined under sub-
21 section (b)) for the alliance for the year were substituted
22 for the reduced weighted average accepted bid for the re-
23 gional alliance for the year.

24 (b) COMPUTATION OF PER CAPITA ADJUSTMENT
25 FOR COLLECTION SHORTFALLS.—

1 (1) PER CAPITA COLLECTION SHORTFALL
2 AMOUNT.—The per capita collection shortfall
3 amount, for a regional alliance for a year, under this
4 subsection is equal to—

5 (A) the amount estimated under paragraph
6 (2)(A) for the year, divided by

7 (B) the estimated average number of re-
8 gional alliance eligible individuals in the re-
9 gional alliance during the year (reduced by the
10 average number of such individuals whose fam-
11 ily share of premiums, determined without re-
12 gard to this section and section 6106, is zero).

13 (2) AGGREGATE COLLECTION SHORTFALL.—

14 (A) IN GENERAL.—Each regional alliance
15 shall estimate, for each year (beginning with
16 the first year) the total amount of payments
17 which the alliance can reasonably identify as
18 owed to the alliance under this Act (taking into
19 account any premium reduction or discount
20 under this subtitle and including amounts owed
21 under subpart B and not taking into account
22 any penalties) for the year and not likely to be
23 collected (after making collection efforts de-
24 scribed in section 1345) during a period speci-

1 fied by the Secretary beginning on the first day
2 of the year.

3 (B) EXCLUSION OF GOVERNMENT
4 DEBTS.—The amount under subparagraph (A)
5 shall not include any payments owed to a re-
6 gional alliance by the Federal, State, or local
7 governments.

8 (C) ADJUSTMENT FOR PREVIOUS SHORT-
9 FALL ESTIMATION DISCREPANCY.—Subject to
10 section 1361(b)(3), the amount estimated under
11 this paragraph for a year shall be adjusted to
12 reflect over (or under) estimations in the
13 amounts so computed under this paragraph for
14 previous years (based on actual collections),
15 taking into account interest payable based upon
16 borrowings (or savings) attributable to such
17 over or under estimations.

18 **Subpart B—Repayment of Alliance Credit by Certain**
19 **Families**

20 **SEC. 6111. REPAYMENT OF ALLIANCE CREDIT BY CERTAIN**
21 **FAMILIES.**

22 (a) IN GENERAL.—Subject to the succeeding provi-
23 sions of this subpart, each family which is provided an
24 alliance credit under section 6103(a) for a class of enroll-
25 ment is liable to the regional alliance for repayment of

1 an amount equal to the base employment monthly pre-
2 mium (applicable to such class) for the month under sec-
3 tion 6122.

4 (b) REDUCTION FOR SELF-EMPLOYMENT PAY-
5 MENTS.—The liability of a family under this section for
6 a year shall be reduced (but not below zero) by the amount
7 of any employer payments made in the year under section
8 6126 based on the net earnings from self-employment of
9 a family member.

10 **SEC. 6112. NO LIABILITY FOR FAMILIES EMPLOYED FULL-**
11 **TIME; REDUCTION IN LIABILITY FOR PART-**
12 **TIME EMPLOYMENT.**

13 (a) IN GENERAL.—The amount of any liability under
14 section 6111 shall be reduced, in accordance with rules
15 established by the National Health Board consistent with
16 this section, based on employer premiums payable under
17 section 6121 with respect to the employment of a family
18 member who is a qualifying employee or with respect to
19 a family member. In no case shall the reduction under this
20 section result in any payment owing to a family.

21 (b) CREDIT FOR FULL-TIME AND PART-TIME EM-
22 PLOYMENT.—

23 (1) IN GENERAL.—Under rules of the Board, in
24 the case of a family enrolled under a class of family
25 enrollment, if a family member is a qualifying em-

1 ployee for a month and (except in the case described
2 in section 6114(a)) the employer is liable for pay-
3 ment under section 6121 based on such
4 employment—

5 (A) FULL-TIME EMPLOYMENT CREDIT.—If
6 the employment is on a full-time basis (as de-
7 fined in section 1901(b)(2)(A)) the liability
8 under section 6111 shall be reduced by the
9 credit amount described in subparagraph (C).

10 (B) PART-TIME EMPLOYMENT CREDIT.—If
11 the employment is on a part-time basis (as de-
12 fined in section 1901(b)(2)(A)) the liability
13 under section 6111 shall be reduced by the em-
14 ployment ratio (as defined in section
15 1901(b)(2)(B)) of the credit amount described
16 in subparagraph (C).

17 (C) FULL-TIME MONTHLY CREDIT.—The
18 amount of the credit under this subparagraph,
19 with respect to employment by an employer in
20 a month, is $\frac{1}{12}$ (or, if applicable, the fraction
21 described in paragraph (2)) of the amount owed
22 under section 6111, based on the class of en-
23 rollment, for the year.

24 (2) COVERAGE DURING ONLY PART OF A
25 YEAR.—In the case of a family that is not enrolled

1 in a regional alliance health plan for all the months
2 in a year, the fraction described in this paragraph
3 is 1 divided by the number of months in the year in
4 which the family was enrolled in such a plan.

5 (3) AGGREGATION OF CREDITS.—For purposes
6 of paragraph (1)—

7 (A) INDIVIDUALS.—In the case of an indi-
8 vidual who is a qualifying employee of more
9 than one employer in a month, the credit for
10 the month shall equal the sum of the credits
11 earned with respect to employment by each em-
12 ployer. Such sum may exceed the credit amount
13 described in paragraph (1)(C).

14 (B) COUPLES.—In the case of a couple
15 each spouse of which is a qualifying employee
16 in a month, the credit for the month shall equal
17 the sum of the credits earned with respect to
18 employment by each spouse. Such sum may ex-
19 ceed the credit amount described in paragraph
20 (1)(C).

21 (c) TREATMENT OF CHANGE OF ENROLLMENT STA-
22 TUS.—In the case of a family for which the class of family
23 enrollment changes during a year, the Board shall estab-
24 lish rules for appropriate conversion and allocation of the
25 credit amounts under the previous provisions of this sec-

tion in a manner that reflects the relative values of the base employment monthly premiums (as determined under section 6122) among the different classes of family enrollment.

SEC. 6113. LIMITATION OF LIABILITY BASED ON INCOME.

(a) IN GENERAL.—In the case of an eligible family described in subsection (b), the repayment amount required under this subpart (after taking into account any work credit earned under section 6112) with respect to a year shall not exceed the amount of liability described in subsection (c) for the year.

(b) ELIGIBLE FAMILY DESCRIBED.—An eligible family described in this subsection is a family which is determined, under subpart B of part 3 of subtitle D of title I by the regional alliance for the alliance area in which the family resides, to have wage-adjusted income (as defined in subsection (d)) below 250 percent of the applicable poverty level.

(c) AMOUNT OF LIABILITY.—

(1) DETERMINATION.—Subject to subsection (f), in the case of a family enrolled in a class of enrollment with wage-adjusted income (as defined in subsection (d)), the amount of liability under this subsection is determined as follows:

1 (A) NO OBLIGATION IF INCOME BELOW IN-
2 COME THRESHOLD AMOUNT OR IF AFDC OR SSI
3 FAMILY.—If such income is less than the in-
4 come threshold amount (specified in section
5 6104(c)(4)) or if the family is an AFDC or SSI
6 family, the amount of liability is zero.

7 (B) INCOME ABOVE INCOME THRESHOLD
8 AMOUNT.—If such income is at least such in-
9 come threshold amount and the family is not an
10 AFDC or SSI family, the amount of liability is
11 the sum of the following:

12 (i) 5.5 PERCENT OF INCOME (ABOVE
13 INCOME THRESHOLD AMOUNT) UP TO THE
14 POVERTY LEVEL.—The initial marginal
15 rate (specified in paragraph (2)(A)) of the
16 amount by which—

17 (I) the wage-adjusted income
18 (not including any portion that ex-
19 ceeds the applicable poverty level for
20 the class of family involved), exceeds

21 (II) such income threshold
22 amount.

23 (ii) GRADUATED PHASE OUT OF DIS-
24 COUNT UP TO 250 PERCENT OF POVERTY
25 LEVEL.—The final marginal rate (specified

1 in paragraph (2)(B)) of the amount by
2 which the wage-adjusted income exceeds
3 100 percent of the applicable poverty level.

4 (2) MARGINAL RATES.—In paragraph (1)—

5 (A) INITIAL MARGINAL RATE.—The initial
6 marginal rate, for a year for a class of enroll-
7 ment, is the ratio of—

8 (i) 5.5 percent of the applicable pov-
9 erty level for the class of enrollment for
10 the year, to

11 (ii) the amount by which such poverty
12 level exceeds such income threshold
13 amount.

14 (B) FINAL MARGINAL RATE.—The final
15 marginal rate, for a year for a class of enroll-
16 ment, is the ratio of—

17 (i) the amount by which (I) the
18 amount of the repayment amount de-
19 scribed in section 6111(a) exceeds (II) 5.5
20 percent of the applicable poverty level (for
21 the class and year); to

22 (ii) 150 percent of such poverty level.

23 (3) MONTHLY APPLICATION TO AFDC AND SSI
24 FAMILIES.—Paragraph (1) insofar as it relates to an
25 AFDC or SSI family shall be applied so as to reduce

1 to zero the liability amount only for months in which
2 the family is such an AFDC or SSI family.

3 (d) WAGE-ADJUSTED INCOME DEFINED.—In this
4 subtitle, the term “wage-adjusted income” means, for a
5 family, family adjusted income of the family (as defined
6 in section 1372(d)(1)), reduced by the sum of the fol-
7 lowing:

8 (1)(A) Subject to subparagraph (B), the
9 amount of any wages included in such family’s in-
10 come that is received for employment which is taken
11 into account in the computation of the amount of
12 employer premiums under section 6121 (without
13 consideration of section 6126).

14 (B) The reduction under subparagraph (A)
15 shall not exceed for a year \$5,000 (adjusted under
16 section 6104(c)(3)(B)) multiplied by the number of
17 months (including portions of months) of employ-
18 ment with respect to which employer premiums were
19 payable under section 6121 (determined in a manner
20 consistent with section 1901(b)(3)).

21 (2) The amount of net earnings from self em-
22 ployment of the family taken into account under sec-
23 tion 6126.

1 (3) The amount of unemployment compensation
2 included in income under section 85 of the Internal
3 Revenue Code of 1986.

4 (e) DETERMINATIONS.—A family’s wage-adjusted in-
5 come and the amount of liability under subsection (c) shall
6 be determined by the applicable regional alliance upon ap-
7 plication by a family under subpart B of part 3 of
8 subtitle D of title I.

9 (f) NO LIABILITY FOR INDIANS AND CERTAIN VET-
10 ERANS AND MILITARY PERSONNEL.—The provisions of
11 paragraph (3) of section 6104(a) shall apply to the reduc-
12 tion in liability under this section in the same manner as
13 such paragraph applies to the premium discount under
14 section 6104.

15 **SEC. 6114. SPECIAL TREATMENT OF CERTAIN RETIREES**
16 **AND QUALIFIED SPOUSES AND CHILDREN.**

17 (a) TREATMENT AS FULL-TIME EMPLOYEE.—Sub-
18 ject to subsection (d), an individual who is an eligible re-
19 tiree (as defined in subsection (b)) or a qualified spouse
20 or child (as defined in subsection (c)) for a month in a
21 year (beginning with 1998) is considered, for purposes of
22 section 6112, to be a full-time employee described in such
23 section in such month.

24 (b) ELIGIBLE RETIREE DEFINED.—In this section,
25 the term “eligible retiree” means, for a month, an indi-

1 vidual who establishes to the satisfaction of the regional
2 alliance (for the alliance area in which the individual re-
3 sides), pursuant to rules of the Secretary, that the indi-
4 vidual, as of the first day of the month—

5 (1) is at least 55, but less than 65, years of
6 age,

7 (2) is not employed on a full-time basis (as de-
8 fined in section 1901(b)(2)(A)),

9 (3) would be eligible (under section 226(a) of
10 the Social Security Act) for hospital insurance bene-
11 fits under part A of title XVIII of such Act if the
12 individual were 65 years of age based only on the
13 employment of the individual, and

14 (4) is not a medicare-eligible individual.

15 (c) QUALIFIED SPOUSE OR CHILD DEFINED.—In
16 subsection (a), the term “qualified spouse or child” means,
17 in relation to an eligible retiree for a month, an individual
18 who establishes to the satisfaction of the regional alliance
19 (for the alliance area in which the individual resides)
20 under rules of the Secretary that the requirements in one
21 of the following paragraphs is met with respect to the indi-
22 vidual:

23 (1) The individual (A) is under 65 years of age
24 and is (and has been for a period of at least one

1 year) married to an eligible retiree or (B) is a child
2 of the eligible retiree.

3 (2) In the case of a person who was an eligible
4 retiree at the time of the person's death—

5 (A) the individual was (and had for a pe-
6 riod of at least one year been) married to the
7 retiree at the time of the person's death,

8 (B) the individual is under 65 years of age,

9 (C) the individual is not employed on a
10 full-time basis (as defined in section
11 1901(b)(2)(A)),

12 (D) the individual is not remarried, and

13 (E) the deceased spouse would still be an
14 eligible retiree in the month if such spouse had
15 not died.

16 (3) The individual is a child of an individual de-
17 scribed in paragraph (2).

18 (d) APPLICATION.—An individual may not be deter-
19 mined to be an eligible retiree or qualified spouse or child
20 unless an application has been filed with the regional alli-
21 ance. Such application shall contain such information as
22 the Secretary may require to establish such status and
23 verify information in the application. Any material mis-
24 representation in the application is subject to a penalty

1 in the same manner as a misrepresentation described in
2 section 1374(i)(2).

3 **SEC. 6115. SPECIAL TREATMENT OF CERTAIN MEDICARE**
4 **BENEFICIARIES.**

5 In the case of an individual who would be a medicare-
6 eligible individual in a month but for the application of
7 section 1012(a) on the basis of employment (in the month
8 or a previous month) of the individual or the individual's
9 spouse or parent, the individual (or spouse or parent, as
10 the case may be) so employed is considered, for purposes
11 of section 6112, to be a full-time employee described in
12 such section in such month.

13 **PART 2—EMPLOYER PREMIUM PAYMENTS**

14 **Subpart A—Regional Alliance Employers**

15 **SEC. 6121. EMPLOYER PREMIUM PAYMENT REQUIRED.**

16 (a) REQUIREMENT.—

17 (1) IN GENERAL.—Each regional alliance em-
18 ployer described in paragraph (2) for a month shall
19 pay to the regional alliance that provides health cov-
20 erage to a qualifying employee of the employer an
21 employer premium in a amount at least equal to the
22 amount specified in subsection (b). Such payments
23 shall be made in accordance with section 1345(c).

24 (2) EMPLOYER DESCRIBED.—An employer de-
25 scribed in this paragraph for a month is an employer

1 that in the month employs one or more qualifying
2 employees (as defined in section 1901(b)(1)).

3 (3) TREATMENT OF CERTAIN EMPLOYMENT BY
4 CORPORATE ALLIANCE EMPLOYERS.—A corporate al-
5 liance employer shall be deemed, for purposes of this
6 subpart, to be a regional alliance employer with re-
7 spect to qualifying employees who are not corporate
8 alliance eligible individuals.

9 (b) PREMIUM PAYMENT AMOUNT.—

10 (1) IN GENERAL.—Except as provided in sec-
11 tion 6123 (relating to a discount for certain employ-
12 ers), section 6124 (relating to large employers elect-
13 ing coverage in a regional alliance), and section
14 6125 (relating to the employer collection shortfall
15 add-on), the amount of the employer premium pay-
16 ment, for a month for qualifying employees of the
17 employer who reside in an alliance area, is the sum
18 of the payment amounts computed under paragraph
19 (2) for each class of family enrollment with respect
20 to such employees in such area.

21 (2) PAYMENT AMOUNT FOR ALL EMPLOYEES IN
22 A CLASS OF FAMILY ENROLLMENT.—Subject to
23 paragraph (3), the payment amount under this para-
24 graph, for an employer for a class of family enroll-

1 ment for a month for qualifying employees residing
2 in an alliance area, is the product of—

3 (A) the base employment monthly premium
4 determined under section 6122 for the class of
5 family enrollment for the previous month for
6 the regional alliance, and

7 (B) the number of full-time equivalent em-
8 ployees (determined under section 1901(b)(2))
9 enrolled in that class of family enrollment for
10 the previous month and residing in the alliance
11 area.

12 (3) TREATMENT OF CERTAIN EMPLOYEES.—In
13 applying this subpart in the case of a qualifying em-
14 ployee (other than a medicare-eligible individual)
15 who is not enrolled in any alliance health plan—

16 (A) the employee is deemed enrolled in a
17 regional alliance health plan (for the alliance
18 area in which the individual resides) in the dual
19 parent class of enrollment, and

20 (B) if the employee's residence is not
21 known, the employee is deemed to reside in the
22 alliance area in which the employee principally
23 is employed for the employer.

24 (4) TRANSITIONAL RULES FOR FIRST MONTH IN
25 FIRST YEAR FOR A STATE.—In the case of an em-

1 ployer for a State in the first month of the State’s
2 first year—

3 (A) the premium amount for such month
4 shall be computed by substituting “month” for
5 “previous month” in paragraph (2);

6 (B) payment for such month shall be made
7 on the first of the month based on an estimate
8 of the payment for such month;

9 (C) an adjustment shall be made to the
10 payment in the following month to reflect the
11 difference between the payment in the first
12 month and the payment in the following month
13 (calculated without regard to the adjustment
14 under this subparagraph); and

15 (D) the reconciliation of premiums for
16 such first month under section 1602(c) shall be
17 included in the reconciliation of premiums for
18 the following 12 months.

19 (5) SPECIAL RULES FOR DIVIDED FAMILIES.—
20 In the case of an individual who is a qualifying em-
21 ployee of an employer, if the individual has a spouse
22 or child who is not treated as part of the individual’s
23 family because of section 1012—

1 (A) the employer premium payment under
2 this section shall be computed as though such
3 section had not applied, and

4 (B) the regional alliance shall make pro-
5 portional payments (consistent with rules estab-
6 lished by the Secretary) to the health plans (if
7 different) of the qualifying employee and of the
8 employee's spouse and children.

9 (c) APPLICATION DURING TRANSITION PERIOD.—

10 (1) IN GENERAL.—For purposes of applying
11 this subpart in the case of an employer described in
12 paragraph (3), there shall only be taken into account
13 qualifying employees (and wages of such employees)
14 who reside in a participating State.

15 (2) EXCEPTION.—Paragraph (1) shall not
16 apply in determining the average number of full-time
17 equivalent employees or whether an employer is a
18 small employer.

19 (3) EMPLOYER DESCRIBED.—An employer de-
20 scribed in this paragraph is an employer that em-
21 ploys one or more qualifying employees in a partici-
22 pating State and one or more qualifying employees
23 in a State that is not a participating State.

1 **SEC. 6122. COMPUTATION OF BASE EMPLOYMENT MONTH-**
2 **LY PREMIUM.**

3 (a) IN GENERAL.—Each regional alliance shall pro-
4 vide for the computation for each year (beginning with the
5 first year) of a base employment monthly premium for
6 each class of family enrollment as follows:

7 (1) INDIVIDUAL ENROLLMENT.—The base em-
8 ployment monthly premium for the individual class
9 of enrollment is equal to $\frac{1}{12}$ of 80 percent of the
10 credit-adjusted weighted average premium (as de-
11 fined in paragraph (4)) for such regional alliance for
12 the individual class of enrollment.

13 (2) COUPLE-ONLY ENROLLMENT.—

14 (A) IN GENERAL.—The base employment
15 monthly premium for the couple-only class of
16 enrollment is equal to $\frac{1}{12}$ of 80 percent of the
17 product described in subparagraph (B), divided
18 by the sum described in subparagraph (C).

19 (B) TOTAL PREMIUMS FOR COUPLE-ONLY
20 ENROLLMENTS.—The product described in this
21 subparagraph is—

22 (i) the credit-adjusted weighted aver-
23 age premium for such regional alliance for
24 the couple-only class of enrollment, multi-
25 plied by

1 (ii) the sum, for all the months in the
2 year, of the number of covered families re-
3 ceiving coverage through regional alliance
4 health plans of the regional alliance within
5 such class of enrollment in each such
6 month.

7 (C) NUMBER OF WORKERS AND EXTRA
8 WORKERS.—The sum described in this subpara-
9 graph is—

10 (i) the sum specified in subparagraph
11 (B)(ii), plus

12 (ii) the number of additional workers
13 (determined under subsection (b)(1)), for
14 families receiving coverage within such
15 class from regional alliance health plans of-
16 fered by the regional alliance.

17 (3) SINGLE AND DUAL PARENT ENROLL-
18 MENTS.—

19 (A) IN GENERAL.—The base employment
20 monthly premium for the single parent and
21 dual parent classes of enrollment is equal to $\frac{1}{12}$
22 of 80 percent of the sum described in subpara-
23 graph (B), divided by the sum described in sub-
24 paragraph (C).

1 (B) TOTAL PREMIUMS FOR SINGLE AND
2 DUAL PARENT ENROLLMENTS.—The sum de-
3 scribed in this subparagraph is the sum of the
4 products described in the following clauses:

5 (i) TOTAL PREMIUMS FOR SINGLE
6 PARENT ENROLLMENT.—The product of—

7 (I) the credit-adjusted weighted
8 average premium for such regional al-
9 liance for the single parent class of
10 enrollment, multiplied by

11 (II) the sum, for all the months
12 in the year, of the number of covered
13 families receiving coverage through re-
14 gional alliance health plans of the re-
15 gional alliance within such class of en-
16 rollment in each such month.

17 (ii) TOTAL PREMIUMS FOR DUAL PAR-
18 ENT ENROLLMENT.—The product of—

19 (I) the credit-adjusted weighted
20 average premium for such regional al-
21 liance for the dual parent class of en-
22 rollment, multiplied by

23 (II) the sum, for all the months
24 in the year, of the number of covered
25 families receiving coverage through re-

1 regional alliance health plans of the re-
2 gional alliance within such class of en-
3 rollment in each such month.

4 (C) NUMBER OF WORKERS AND EXTRA
5 WORKERS.—The sum described in this subpara-
6 graph is—

7 (i) the sum specified in subparagraph
8 (B)(i)(II); plus

9 (ii) the sum specified in subparagraph
10 (B)(ii)(II); plus

11 (iii) the number of additional workers
12 (determined under subsection (b)(1)), for
13 families receiving coverage within the dual
14 parent class of enrollment from regional al-
15 liance health plans offered by the regional
16 alliance.

17 (4) CREDIT-ADJUSTED WEIGHTED AVERAGE
18 PREMIUM DEFINED.—In this subsection, the term
19 “credit-adjusted weighted average premium” means,
20 for a class of enrollment and a regional alliance, the
21 weighted average premium for the class and alliance,
22 reduced by the amount described in section 6106(b)
23 for such class and alliance.

24 (b) DETERMINATION OF ADDITIONAL WORKERS FOR
25 COUPLE-ONLY AND DUAL PARENT CLASS.—

1 (1) IN GENERAL.—Subject to paragraph (4),
2 the regional alliance shall determine, for each couple
3 class of family enrollment and in a manner specified
4 by the Board, an estimated total number of addi-
5 tional workers equal to—

6 (A) 12 times the alliance-wide monthly av-
7 erage number of premium payments (as deter-
8 mined under paragraph (2)) for covered fami-
9 lies (as defined in paragraph (3)) within such
10 class of enrollment, minus

11 (B) the sum described in subsection
12 (a)(2)(B)(ii) or (a)(3)(B)(ii)(II) for the couple-
13 only and dual parent classes, respectively.

14 (2) COMPUTATION OF ALLIANCE-WIDE MONTH-
15 LY AVERAGE NUMBER.—

16 (A) IN GENERAL.—In determining the alli-
17 ance-wide monthly average number of premium
18 payments under paragraph (1)(A), a covered
19 family shall count for a month as 1, or, if
20 greater, the number computed under subpara-
21 graph (B) (but in no case greater than 2).

22 (B) COUNTING OF FAMILIES IN WHICH
23 BOTH SPOUSES ARE QUALIFYING EMPLOY-
24 EES.—The number computed under this sub-
25 paragraph over all families within a couple-only

1 or dual parent class of enrollment in which both
2 spouses are qualifying employees is determined
3 on an alliance-wide basis based on the fol-
4 lowing:

5 (i) For such a spouse, determine,
6 using the rules under section
7 1902(b)(1)(A), how many full-time equiva-
8 lent employees the spouse is counted as,
9 but not to exceed 1 for either spouse.

10 (ii) Add the 2 numbers determined
11 under clause (i) for spouses in such fami-
12 lies.

13 (3) COVERED FAMILY DEFINED.—In this sub-
14 section, the term “covered family” means a family
15 other than—

16 (A) an SSI family or AFDC family,

17 (B) a family in which a spouse is a medi-
18 care-eligible individual, or

19 (C) a family that is enrolled in a health
20 plan other than a regional alliance health plan.

21 (4) ADJUSTMENT TO ACCOUNT FOR USE OF ES-
22 TIMATES.—Subject to section 1361(b)(3), if the
23 total receipts of a regional alliance to all regional al-
24 liance health plans in a year under this subpart ex-
25 ceeds, or is less than, the total of such receipts esti-

1 mated by the alliance (based on the base employ-
2 ment monthly premium under subsection (a)), be-
3 cause of a difference between—

4 (A) the alliance's estimate of the estimated
5 total number of additional workers for the alli-
6 ance and the estimate of the number of covered
7 families, and

8 (B) the actual total number of additional
9 workers and the actual number of covered fami-
10 lies,

11 the estimated total number of additional workers to
12 be applied under this section in the second suc-
13 ceeding year shall be reduced, or increased, respec-
14 tively, in a manner that results in total receipts of
15 the alliance under this subpart in such succeeding
16 year being increased or decreased by the amount of
17 such excess (or deficit).

18 (c) BASIS FOR DETERMINATIONS.—

19 (1) PREMIUMS.—The determinations of pre-
20 miums and families under plans under this section
21 shall be made in a manner determined by the Board
22 and based on the premiums and families used by the
23 Board in carrying out subtitle A and shall be based
24 on estimates on an annualized basis.

1 (2) EMPLOYMENT.—The determinations of em-
2 ployment under this section for the first year for a
3 State shall be based on estimates of employment es-
4 tablished by the regional alliance in accordance with
5 standards promulgated by the Secretary of Labor in
6 consultation with the National Health Board.

7 (3) REPORTS.—In accordance with rules estab-
8 lished by the Secretary of Labor in consultation with
9 the National Health Board, a regional alliance may
10 require regional alliance employers to submit such
11 periodic information on employment as may be nec-
12 essary to monitor the determinations made under
13 this section, including months and extent of employ-
14 ment.

15 (d) TIMING OF DETERMINATION.—Determinations
16 under this section for a year shall be made by not later
17 than December 1, or such other date as the Board may
18 specify, before the beginning of the year.

19 **SEC. 6123. PREMIUM DISCOUNT FOR CERTAIN EMPLOYERS.**

20 (a) EMPLOYER DISCOUNT.—

21 (1) IN GENERAL.—Subject to section 6124(c)
22 (relating to phase in for certain large corporate alli-
23 ance employers) and section 6125 (relating to the
24 employer collection shortfall add-on), the amount of
25 the employer premium payment required under this

1 subpart for a regional alliance employer for any year
2 shall not exceed the limiting percentage (as defined
3 in subsection (b)) of the employer's wages for that
4 year.

5 (2) EXCLUSION OF GOVERNMENTAL EMPLOY-
6 ERS AND CERTAIN CORPORATE ALLIANCE EMPLOY-
7 ERS.—Paragraph (1) shall not apply to—

8 (A) the Federal Government, a State gov-
9 ernment, or a unit of local government, or a
10 unit or instrumentality of such government, be-
11 fore 2002; and

12 (B) a corporate alliance employer which is
13 treated as a regional alliance employer under
14 section 6131(a)(2).

15 (b) LIMITING PERCENTAGE DEFINED.—In sub-
16 section (a)—

17 (1) ANY EMPLOYER.—For an employer that is
18 not a small employer (as defined in subsection (c)),
19 the limiting percentage is 7.9 percent.

20 (2) SMALL EMPLOYERS.—For an employer that
21 is a small employer and that has an average number
22 of full-time equivalent employees and average annual
23 wages per full-time equivalent employee (as deter-
24 mined under subsection (d)), the limiting percentage

1 is the applicable percentage determined based on fol-
2 lowing table:
3

Average number of full-time equivalent employees	Limiting Percentage				
	Employer's average annual wages per full-time equivalent employee are:				
	\$0– \$12,000	\$12,001– \$15,000	\$15,001– \$18,000	\$18,001– \$21,000	\$21,001– \$24,000
Fewer than 25	3.5%	4.4%	5.3%	6.2%	7.1%
25 but fewer than 50	4.4%	5.3%	6.2%	7.1%	7.9%
50 but not over 75	5.3%	6.2%	7.1%	7.9%	7.9%

4 (c) SMALL EMPLOYER DEFINED.—

5 (1) IN GENERAL.—In this section—

6 (A) the term “small employer” means an
7 employer that does not employ, on average,
8 more than 75 full-time equivalent employees;
9 and

10 (B) the average number of full-time equiv-
11 alent employees shall be determined by aver-
12 aging the number of full-time equivalent em-
13 ployees employed by the employer in each
14 countable month during the year.

15 (2) COUNTABLE MONTH.—In paragraph (1),
16 the term “countable month” means, for an em-
17 ployer, a month in which the employer employs any
18 qualifying employee.

1 (3) DETERMINATIONS.—The number of full-
2 time equivalent employees shall be determined using
3 the rules under section 1901(b)(2).

4 (d) AVERAGE ANNUAL WAGES PER FULL-TIME
5 EQUIVALENT EMPLOYEE DEFINED.—

6 (1) IN GENERAL.—In this section, the term
7 “average annual wages per full-time equivalent em-
8 ployee” means, for an employer for a year—

9 (A) the total wages paid in the year to in-
10 dividuals who, at the time of payment of the
11 wages, are qualifying employees of the em-
12 ployer; divided by

13 (B) the number of full-time equivalent em-
14 ployees of the employer in the year.

15 (2) DETERMINATION.—The Board may estab-
16 lish rules relating to the computation of the average
17 annual wages for employers.

18 (e) DETERMINATIONS.—For purposes of this section,
19 the number of employees and average wages shall be de-
20 termined on an annual basis.

21 (f) TREATMENT OF CERTAIN SELF-EMPLOYED INDIV-
22 VIDUALS.—In the case of an individual who is a partner
23 in a partnership, is a 2-percent shareholder in an S cor-
24 poration (within the meaning of section 1372 of the Inter-
25 nal Revenue Code of 1986), or is any other individual who

1 carries on a trade or business as a sole proprietorship,
2 for purposes of this section—

3 (1) the individual is deemed to be an employee
4 of the partnership, S corporation, or proprietorship,
5 and

6 (2) the individual's net earnings from self em-
7 ployment attributable to the partnership, S corpora-
8 tion, or sole proprietorship are deemed to be wages
9 from the partnership, S corporation, or proprietor-
10 ship.

11 (g) APPLICATION TO EMPLOYERS.—An employer
12 that claims that this section applies—

13 (1) shall provide notice to the regional alliance
14 involved of the claim at the time of making pay-
15 ments under this subpart; and

16 (2) shall make available such information (and
17 provide access to such information) as the regional
18 alliance may require (in accordance with regulations
19 of the Secretary of Labor) to audit the determina-
20 tion of—

21 (A) whether the employer is a small em-
22 ployer, and, if so, the average number of full-
23 time equivalent employees and average annual
24 wages of the employer; and

1 (B) the total wages paid by the employer
2 for qualifying employees.

3 (h) TREATMENT OF MULTI-ALLIANCE EMPLOY-
4 ERS.—In the case in which this section is applied to an
5 employer that makes employer premium payments to more
6 than one regional alliance, the reduction under this section
7 shall be applied in a pro-rated manner to the premium
8 payments made to all such alliances.

9 **SEC. 6124. PAYMENT ADJUSTMENT FOR LARGE EMPLOYERS**
10 **ELECTING COVERAGE IN A REGIONAL ALLI-**
11 **ANCE.**

12 (a) APPLICATION OF SECTION.—

13 (1) IN GENERAL.—Except as otherwise pro-
14 vided in this subsection, this section shall apply to
15 the employer premium payments for full-time em-
16 ployees in a State of an employer if—

17 (A)(i) the employer is an eligible sponsor
18 described in section 1311(b)(1)(A), (ii) the em-
19 ployer elected to be a corporate alliance under
20 section 1312(a)(1), and (iii) the election is ter-
21 minated under section 1313;

22 (B)(i) the employer is such an eligible
23 sponsor as of the first day of the first year of
24 the State, and (ii) the employer did not provide
25 the notice required under section 1312(a)(1)

1 (with respect to an election to become a cor-
2 porate alliance); or

3 (C)(i) the employer is such an eligible
4 sponsor, (ii) the employer subsequently became
5 a large employer and elected to be a corporate
6 alliance under section 1312(a)(2), and (iii) the
7 election was terminated under section 1313.

8 (2) EFFECTIVE DATE.—In the case of an em-
9 ployer described in—

10 (A) paragraph (1)(A) or (1)(C), this sec-
11 tion shall first apply on the effective date of the
12 termination of the election under section 1313,
13 or

14 (B) paragraph (1)(B), this section shall
15 first apply as of January 1, 1996 (or, if later
16 with respect to a State, the first day of the first
17 year for the State).

18 (3) TREATMENT OF EMPLOYEES IN SMALL ES-
19 TABLISHMENTS.—This section shall not apply to the
20 payment of premiums for full-time employees of an
21 employer described in paragraph (1)(A) or (1)(C), if
22 the employees are employed at an establishment with
23 respect to which the option described in section
24 1311(c)(1)(B) was exercised.

1 (4) SUNSET.—This section shall cease applying
2 to an employer with respect to employment in a
3 State after the 7th year in which this section applies
4 to the employer in the State.

5 (5) LARGE EMPLOYER DEFINED.—In this sec-
6 tion, the term “large employer” has the meaning
7 given such term in section 1311(e)(3).

8 (b) ADDITIONAL AMOUNT.—

9 (1) IN GENERAL.—If an employer subject to
10 this section for a year has an excess risk proportion
11 (specified in paragraph (3)) of greater than zero
12 with respect to an alliance area, then the employer
13 shall provide, on a monthly basis, for payment to the
14 regional alliance for such area of an amount equal
15 to $\frac{1}{12}$ of the excess risk amount described in para-
16 graph (2) for the year.

17 (2) EXCESS RISK AMOUNT.—The excess risk
18 amount described in this paragraph, for an employer
19 for a year with respect to an alliance area, is equal
20 to the product of the following:

21 (A) The reduced weighted average accept-
22 ed bid for the regional alliance for the area for
23 the year.

24 (B) The total average number of alliance
25 eligible individuals who—

1 (i) were full-time employees (or family
2 members of such employees) of the em-
3 ployer, and

4 (ii) residing in the regional alliance
5 area,

6 in the year before the first year in which this
7 section applies to the employer.

8 (C) The excess risk proportion (specified in
9 paragraph (3)) for the employer for such area.

10 (D) The phase-down percentage (specified
11 in paragraph (4)) for the year.

12 (3) EXCESS RISK PROPORTION.—

13 (A) IN GENERAL.—The “excess risk pro-
14 portion”, specified in this paragraph, with re-
15 spect to an employer and an alliance area, is a
16 percentage that reflects, for the year before the
17 first year in which this section applies to the
18 employer, the amount by which—

19 (i) the average demographic risk for
20 employees (and family members) described
21 in paragraph (2)(B) residing in the alli-
22 ance area, exceeds

23 (ii) the average demographic risk for
24 all regional alliance eligible individuals re-
25 siding in the area.

1 (B) MEASUREMENT OF DEMOGRAPHIC
2 RISK.—

3 (i) IN GENERAL.—Demographic risk
4 under subparagraph (A) shall be meas-
5 ured, in a manner specified by the Board,
6 based on the demographic characteristics
7 described in section 6001(c)(1)(A), that re-
8 late to the actuarial value of the com-
9 prehensive benefit package.

10 (ii) PROVISION OF INFORMATION.—
11 Each employer to which this section ap-
12 plies shall submit, to each regional alliance
13 for which an additional payment may be
14 required under this section, such informa-
15 tion (and at such time) as the Board may
16 require in order to determine the demo-
17 graphic risk referred to in subparagraph
18 (A)(i).

19 (4) PHASE-DOWN PERCENTAGE.—The phase
20 down percentage, specified in this paragraph for an
21 employer for—

22 (A) each of the first 4 years to which this
23 section applies to the employer, is 100 percent,

24 (B) the fifth such year, is 75 percent,

25 (C) the sixth such year, is 50 percent, and

1 (D) the seventh such year, is 25 percent.

2 (c) PHASE IN OF EMPLOYER PREMIUM DISCOUNT.—

3 For—

4 (1) each of the first 4 years in which this sec-
5 tion applies to such employer, section 6123 shall not
6 apply to the employer;

7 (2) the fifth such year, section 6123 shall apply
8 to the employer but the reduction in premium pay-
9 ment effected by such section shall be 25 percent of
10 the reduction that would otherwise apply (but for
11 this subsection);

12 (3) the sixth such year, section 6123 shall apply
13 to the employer but the reduction in premium pay-
14 ment effected by such section shall be 50 percent of
15 the reduction that would otherwise apply (but for
16 this subsection);

17 (4) the seventh such year, section 6123 shall
18 apply to the employer but the reduction in premium
19 payment effected by such section shall be 75 percent
20 of the reduction that would otherwise apply (but for
21 this subsection); or

22 (5) a subsequent year, section 6123 shall apply
23 to the employer without any reduction under this
24 subsection.

1 **SEC. 6125. EMPLOYER COLLECTION SHORTFALL ADD-ON.**

2 (a) IN GENERAL.—The amount payable by an em-
3 ployer under this subpart shall be increased by the amount
4 computed under subsection (b).

5 (b) AMOUNT.—The amount under this subsection for
6 an employer is equal to the premium payment amount that
7 would be computed under section 6121(b)(2) if the per
8 capita collection shortfall amount (computed under section
9 6107(b)(1)) for the year were substituted for the reduced
10 weighted average accepted bid for the year. The reduced
11 weighted average accepted bid is used under section
12 6000(b)(1) in computing the weighted average premium,
13 which in turn is used under section 6122(a)(1) in com-
14 puting the base employment monthly premium, which in
15 turn is used under section 6121(b)(2)(A) in computing the
16 employer premium amount.

17 (c) DISCOUNT NOT APPLICABLE.—Section 6123
18 shall not apply to the increase in the amount payable by
19 virtue of this section.

20 **SEC. 6126. APPLICATION TO SELF-EMPLOYED INDIVIDUALS.**

21 (a) IN GENERAL.—A self-employed individual (as de-
22 fined in section 1901(c)(2)) shall be considered, for pur-
23 poses of this subpart to be an employer of himself or her-
24 self and to pay wages to himself or herself equal to the
25 amount of net earnings from self-employment (as defined
26 in section 1901(c)(1)).

1 (b) CREDIT FOR EMPLOYER PREMIUMS.—

2 (1) IN GENERAL.—In the case of a self-em-
3 ployed individual, the amount of any employer pre-
4 mium payable by virtue of subsection (a) in a year
5 shall be reduced (but not below zero) by the sum of
6 the following:

7 (A) Subject to paragraph (2), the amount
8 of any employer premiums payable under this
9 subpart (determined not taking into account
10 any adjustment in the premium amounts under
11 section 6123 or 6124) with respect to the em-
12 ployment of that individual in the year.

13 (B) The product of (i) the number of
14 months in the year the individual was employed
15 on a full-time basis by a corporate alliance em-
16 ployer, and (ii) the employer premium that
17 would have been payable for such months under
18 this subpart (determined not taking into ac-
19 count any adjustment in the premium amounts
20 under section 6123 or 6124) for the class of en-
21 rollment if such employer had been a regional
22 alliance employer.

23 (2) SPECIAL RULE FOR CERTAIN CLOSELY-
24 HELD BUSINESSES.—

1 (A) IN GENERAL.—In the case of an indi-
2 vidual who—

3 (i) has wage-adjusted income (as de-
4 fined in section 6113(d), determined with-
5 out regard to paragraphs (1)(B) and (2)
6 thereof) that exceeds 250 percent (or such
7 higher percentage as the Board may estab-
8 lish) of the applicable poverty level, and

9 (ii) is both a substantial owner and an
10 employee of a closely held business,
11 the amount of any reduction under paragraph
12 (1)(A) that is attributable to the individual's
13 employment by that business shall be appro-
14 priately reduced in accordance with rules pre-
15 scribed by the Board, in order to prevent indi-
16 viduals from avoiding payment of the full
17 amount owed through fraudulent or secondary
18 employment arrangements.

19 (B) CLOSELY HELD BUSINESS.—For pur-
20 poses of subparagraph (A), a business is “close-
21 ly held” if it is an employer that meets the re-
22 quirements of section 542(a)(2) of the Internal
23 Revenue Code of 1986 or similar requirements
24 as appropriate in the case of a partnership or
25 other entity.

1 **Subpart B—Corporate Alliance Employers**

2 **SEC. 6131. EMPLOYER PREMIUM PAYMENT REQUIRED.**

3 (a) PER EMPLOYEE PREMIUM PAYMENT.—Subject
4 to section 6124, each corporate alliance employer of a cor-
5 porate alliance that in a month in a year employs a quali-
6 fying employee who is—

7 (1) enrolled in a corporate alliance health plan
8 offered by the alliance, shall provide for a payment
9 toward the premium for the plan in an amount at
10 least equal to the corporate employer premium speci-
11 fied in subsection (b); or

12 (2) is not so enrolled, shall make employer pre-
13 mium payments with respect to such employment
14 under subpart A in the same manner as if the em-
15 ployer were a regional alliance employer (except as
16 otherwise provided in such subpart).

17 (b) CORPORATE EMPLOYER PREMIUM.—

18 (1) AMOUNT.—

19 (A) IN GENERAL.—Except as provided in
20 paragraph (2), the amount of the corporate em-
21 ployer premium for a month in a year for a
22 class of family enrollment for a family residing
23 in a premium area (established under section
24 1384(b)) is 80 percent of the weighted average
25 monthly premium of the corporate alliance
26 health plans offered by the corporate alliance

1 for that class of enrollment for families residing
2 in that area.

3 (B) APPLICATION TO SELF-INSURED
4 PLANS.—In applying this paragraph in the case
5 of one or more corporate alliance health plans
6 that are self-insured plans—

7 (i) the “premium” for the plan is the
8 actuarial equivalent of such premium,
9 based upon the methodology (or such other
10 consistent methodology) used under section
11 6021(a) (relating to application of pre-
12 mium caps to corporate alliance health
13 plans), and

14 (ii) the premium amount, for different
15 classes and, if applicable, for different pre-
16 mium areas, shall be computed in a man-
17 ner based on such factors as may bear a
18 reasonable relationship to costs for the
19 provision of the comprehensive benefit
20 package to the different classes in such
21 areas.

22 The Secretary of Labor shall establish rules to
23 carry out this subparagraph.

24 (2) LOW-WAGE EMPLOYEES.—In the case of a
25 low-wage employee entitled to a premium discount

1 under section 6104(a)(2), the amount of the em-
2 ployer premium payment for a month in a year for
3 a class of family enrollment shall be increased by the
4 amount of such premium discount.

5 (c) DETERMINATIONS.—

6 (1) BASIS.—Determinations under this section
7 shall be made based on such information as the Sec-
8 retary of Labor shall specify.

9 (2) TIMING.—Determinations of the monthly
10 premiums under this section for months in a year
11 shall be made not later than December 1 of the pre-
12 vious year.

13 **Subtitle C—Payments to Regional** 14 **Alliance Health Plans**

15 **SEC. 6201. COMPUTATION OF BLENDED PLAN PER CAPITA** 16 **PAYMENT AMOUNT.**

17 (a) IN GENERAL.—For purposes of section 1351, the
18 blended plan per capita payment amount for a regional
19 alliance health plan for enrollments in an alliance for a
20 year is equal to the sum of the 3 components described
21 in subsection (b), multiplied by any adjustment factor ap-
22 plied for the year under section 6202(d).

23 (b) SUM OF PRODUCTS.—The 3 components de-
24 scribed in this subsection are:

1 (1) PLAN BID COMPONENT FOR THAT PLAN.—

2 The product of—

3 (A) the final accepted bid for plan (as
4 defined in section 6000(a)(2)) for the year,
5 and

6 (B) the plan bid proportion deter-
7 mined under section 6202(a)(1) for the
8 year.

9 (2) AFDC COMPONENT FOR ALLIANCE.—The
10 product of—

11 (A) the AFDC per capita premium
12 amount for the regional alliance for the
13 year (determined under section 9012), and

14 (B) the AFDC proportion determined
15 under section 6202(a)(2) for the year.

16 (3) SSI COMPONENT FOR ALLIANCE.—The
17 product of—

18 (A) the SSI per capita premium
19 amount for the regional alliance for the
20 year (determined under section 9013) for
21 the year, and

22 (B) the SSI proportion determined
23 under section 6202(a)(3) for the year.

1 **SEC. 6202. COMPUTATION OF PLAN BID, AFDC, AND SSI**
2 **PROPORTIONS.**

3 (a) IN GENERAL.—For purposes of this subtitle:

4 (1) PLAN BID PROPORTION.—The “plan bid
5 proportion” is, for a class of enrollment, 1 minus the
6 sum of (A) the AFDC proportion, and (B) the SSI
7 proportion.

8 (2) AFDC PROPORTION.—The “AFDC propor-
9 tion” is, for a class of family enrollment for a year,
10 the ratio of—

11 (A) the average of the number of AFDC
12 recipients (as determined under subsection (c))
13 enrolled in regional alliance health plans in that
14 class of enrollment for the year, to

15 (B) the average of the total number of in-
16 dividuals enrolled in regional alliance health
17 plans in that class of enrollment for the year.

18 (3) SSI PROPORTION.—The “SSI proportion”
19 is, for a class of family enrollment for a year, the
20 ratio of—

21 (A) the average of the number of SSI re-
22 cipients (as determined under subsection (c))
23 enrolled in regional alliance health plans in that
24 class of enrollment for the year, to

25 (B) the average described in paragraph
26 (2)(B).

1 (b) COMPUTATION.—

2 (1) PROJECTIONS.—The proportions described
3 in subsection (a) shall be determined and applied by
4 the State, based upon the best available data, at
5 least 1 month before the date bids are submitted
6 under section 6004 before the beginning of the cal-
7 endar year involved.

8 (2) ACTUAL.—For purposes of making adjust-
9 ments under subsection (d), the regional alliance
10 shall determine, after the end of each year, the ac-
11 tual proportions described in subsection (a).

12 (c) COUNTING OF AFDC AND SSI RECIPIENTS.—
13 For purposes of subsections (a)(2)(A) and (a)(3)(A), the
14 terms “SSI recipient” and “AFDC recipient” do not in-
15 clude a medicare-eligible individual.

16 (d) ADJUSTMENTS FOR DISCREPANCIES IN ESTI-
17 MATIONS.—

18 (1) IN GENERAL.—If the actual AFDC propor-
19 tion or SSI proportion (as determined under sub-
20 section (a)) for a year (in this subsection referred to
21 as the “reference year”), determined after the end
22 of the year based upon actual number of AFDC re-
23 cipients and SSI recipients in the year, is different
24 from the projected AFDC and SSI proportions (as
25 determined under subsection (b)(1)) used in com-

1 puting the blended plan payment amount for the
2 year, then, subject to section 1361(b)(3), the re-
3 gional alliance shall adjust the blended plan payment
4 amount in the second succeeding year (in this sub-
5 section referred to as the “applicable year”) in the
6 manner described in paragraph (2). By regulation
7 the Secretary may apply the adjustment, based on
8 estimated amounts, in the year before the applicable
9 year, with final adjustment in the applicable year.

10 (2) ADJUSTMENT DESCRIBED.—

11 (A) POSITIVE CASH FLOW.—If the cash
12 flow difference (as defined in paragraph (3)(A))
13 for the reference year is positive, then in the
14 applicable year the blended plan payment
15 amount shall be increased by the adjustment
16 percentage described in paragraph (4).

17 (B) NEGATIVE CASH FLOW.—If the cash
18 flow difference (as defined in paragraph (3)(A))
19 for the reference year is negative, then in the
20 applicable year the blended plan payment
21 amount shall be reduced by the adjustment per-
22 centage described in paragraph (4).

23 (3) CASH FLOW DIFFERENCE DEFINED.—In
24 this subsection:

1 (A) IN GENERAL.—The term “cash flow
2 difference” means, for a regional alliance for a
3 reference year—

4 (i) the actual cash flow (as defined in
5 subparagraph (B)) for the alliance for the
6 year, minus

7 (ii) the reconciled cash flow (as de-
8 fined in subparagraph (C)) for the alliance
9 for the year.

10 (B) ACTUAL CASH FLOW.—The term “ac-
11 tual cash flow” means, for a regional alliance
12 for a reference year, the total amount paid by
13 the regional alliance to the regional alliance
14 health plans in the year based on the blended
15 plan payment amount (computed on the basis
16 of projected AFDC and SSI proportions deter-
17 mined under subsection (b)(1)).

18 (C) RECONCILED CASH FLOW.—The term
19 “reconciled cash flow” means, for a regional al-
20 liance for a reference year, the total amount
21 that would have been paid to regional alliance
22 health plans in the year if such payments had
23 been made based on the blended plan payment
24 amount computed on the basis of the actual
25 AFDC and SSI proportions for the year (deter-

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1 mined under subsection (b)(2), rather than
 2 based on such payment amount computed on
 3 the basis of the projected AFDC and SSI pro-
 4 portions for the year (determined under sub-
 5 section (b)(1)).

6 (4) PERCENTAGE ADJUSTMENT.—The percent-
 7 age adjustment described in this paragraph for a re-
 8 gional alliance for an applicable year is the ratio (ex-
 9 pressed as a percentage) of—

10 (A) the cash flow difference for the ref-
 11 erence year, to

12 (B) the total payments estimated by the
 13 regional alliance to be paid to regional alliance
 14 health plans under this subtitle in the applica-
 15 ble year (determined without regard to any ad-
 16 justment under this subsection).

17 **TITLE VII—REVENUE**

18 **PROVISIONS**

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1 **SEC. 7001. AMENDMENT OF 1986 CODE.**

2 Except as otherwise expressly provided, whenever in
3 this title an amendment or repeal is expressed in terms
4 of an amendment to, or repeal of, a section or other provi-
5 sion, the reference shall be considered to be made to a
6 section or other provision of the Internal Revenue Code
7 of 1986.

8 **Subtitle A—Financing Provisions**9 **PART 1—INCREASE IN TAX ON TOBACCO**10 **PRODUCTS**11 **SEC. 7111. INCREASE IN EXCISE TAXES ON TOBACCO**12 **PRODUCTS.**

13 (a) CIGARETTES.—Subsection (b) of section 5701 is
14 amended—

15 (1) by striking “\$12 per thousand (\$10 per
16 thousand on cigarettes removed during 1991 or
17 1992)” in paragraph (1) and inserting “\$49.50 per
18 thousand”, and

1 (2) by striking “\$25.20 per thousand (\$21 per
2 thousand on cigarettes removed during 1991 or
3 1992)” in paragraph (2) and inserting “\$103.95 per
4 thousand”.

5 (b) CIGARS.—Subsection (a) of section 5701 is
6 amended—

7 (1) by striking “\$1.125 cents per thousand
8 (93.75 cents per thousand on cigars removed during
9 1991 or 1992)” in paragraph (1) and inserting
10 “\$38.62½ per thousand”, and

11 (2) by striking “equal to” and all that follows
12 in paragraph (2) and inserting “equal to 52.594 per-
13 cent of the price for which sold but not more than
14 \$123.75 per thousand.”

15 (c) CIGARETTE PAPERS.—Subsection (c) of section
16 5701 is amended by striking “0.75 cent (0.625 cent on
17 cigarette papers removed during 1991 or 1992)” and in-
18 serting “3.09 cents”.

19 (d) CIGARETTE TUBES.—Subsection (d) of section
20 5701 is amended by striking “1.5 cents (1.25 cents on
21 cigarette tubes removed during 1991 or 1992)” and in-
22 serting “6.19 cents”.

23 (e) SMOKELESS TOBACCO.—Subsection (e) of section
24 5701 is amended—

1 (1) by striking “36 cents (30 cents on snuff re-
2 moved during 1991 or 1992)” in paragraph (1) and
3 inserting “\$12.86”, and

4 (2) by striking “12 cents (10 cents on chewing
5 tobacco removed during 1991 or 1992)” in para-
6 graph (2) and inserting “\$12.62”.

7 (f) PIPE TOBACCO.—Subsection (f) of section 5701
8 is amended by striking “67.5 cents (56.25 cents on pipe
9 tobacco removed during 1991 or 1992)” and inserting
10 “\$13.17½”.

11 (g) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to articles removed (as defined in
13 section 5702(k) of the Internal Revenue Code of 1986,
14 as amended by this Act) after September 30, 1994.

15 (h) FLOOR STOCKS TAXES.—

16 (1) IMPOSITION OF TAX.—On tobacco products
17 and cigarette papers and tubes manufactured in or
18 imported into the United States which are removed
19 before October 1, 1994, and held on such date for
20 sale by any person, there is hereby imposed a tax in
21 an amount equal to the excess of—

22 (A) the tax which would be imposed under
23 section 5701 of the Internal Revenue Code of
24 1986 on the article if the article had been re-
25 moved on such date, over

1 (B) the prior tax (if any) imposed under
2 section 5701 or 7652 of such Code on such ar-
3 ticle.

4 (2) AUTHORITY TO EXEMPT CIGARETTES HELD
5 IN VENDING MACHINES.—To the extent provided in
6 regulations prescribed by the Secretary, no tax shall
7 be imposed by paragraph (1) on cigarettes held for
8 retail sale on October 1, 1994, by any person in any
9 vending machine. If the Secretary provides such a
10 benefit with respect to any person, the Secretary
11 may reduce the \$500 amount in paragraph (3) with
12 respect to such person.

13 (3) CREDIT AGAINST TAX.—Each person shall
14 be allowed as a credit against the taxes imposed by
15 paragraph (1) an amount equal to \$500. Such credit
16 shall not exceed the amount of taxes imposed by
17 paragraph (1) for which such person is liable.

18 (4) LIABILITY FOR TAX AND METHOD OF PAY-
19 MENT.—

20 (A) LIABILITY FOR TAX.—A person hold-
21 ing cigarettes on October 1, 1994, to which any
22 tax imposed by paragraph (1) applies shall be
23 liable for such tax.

24 (B) METHOD OF PAYMENT.—The tax im-
25 posed by paragraph (1) shall be paid in such

1 manner as the Secretary shall prescribe by reg-
2 ulations.

3 (C) TIME FOR PAYMENT.—The tax im-
4 posed by paragraph (1) shall be paid on or be-
5 fore December 31, 1994.

6 (5) ARTICLES IN FOREIGN TRADE ZONES.—
7 Notwithstanding the Act of June 18, 1934 (48 Stat.
8 998, 19 U.S.C. 81a) and any other provision of law,
9 any article which is located in a foreign trade zone
10 on October 1, 1994, shall be subject to the tax im-
11 posed by paragraph (1) if—

12 (A) internal revenue taxes have been deter-
13 mined, or customs duties liquidated, with re-
14 spect to such article before such date pursuant
15 to a request made under the 1st proviso of sec-
16 tion 3(a) of such Act, or

17 (B) such article is held on such date under
18 the supervision of a customs officer pursuant to
19 the 2d proviso of such section 3(a).

20 (6) DEFINITIONS.—For purposes of this
21 subsection—

22 (A) IN GENERAL.—Terms used in this sub-
23 section which are also used in section 5702 of
24 the Internal Revenue Code of 1986 shall have
25 the respective meanings such terms have in

1 such section, and such term shall include arti-
2 cles first subject to the tax imposed by section
3 5701 of such Code by reason of the amend-
4 ments made by this Act.

5 (B) SECRETARY.—The term “Secretary”
6 means the Secretary of the Treasury or his del-
7 egate.

8 (7) CONTROLLED GROUPS.—Rules similar to
9 the rules of section 5061(e)(3) of such Code shall
10 apply for purposes of this subsection.

11 (8) OTHER LAWS APPLICABLE.—All provisions
12 of law, including penalties, applicable with respect to
13 the taxes imposed by section 5701 of such Code
14 shall, insofar as applicable and not inconsistent with
15 the provisions of this subsection, apply to the floor
16 stocks taxes imposed by paragraph (1), to the same
17 extent as if such taxes were imposed by such section
18 5701. The Secretary may treat any person who bore
19 the ultimate burden of the tax imposed by para-
20 graph (1) as the person to whom a credit or refund
21 under such provisions may be allowed or made.

1 **SEC. 7112. MODIFICATIONS OF CERTAIN TOBACCO TAX**
2 **PROVISIONS.**

3 (a) EXEMPTION FOR EXPORTED TOBACCO PROD-
4 UCTS AND CIGARETTE PAPERS AND TUBES TO APPLY
5 ONLY TO ARTICLES MARKED FOR EXPORT.—

6 (1) Subsection (b) of section 5704 is amended
7 by adding at the end thereof the following new sen-
8 tence: “Tobacco products and cigarette papers and
9 tubes may not be transferred or removed under this
10 subsection unless such products or papers and tubes
11 bear such marks, labels, or notices as the Secretary
12 shall by regulations prescribe.”

13 (2) Section 5761 is amended by redesignating
14 subsections (c) and (d) as subsections (d) and (e),
15 respectively, and by inserting after subsection (b)
16 the following new subsection:

17 “(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE
18 PAPERS AND TUBES FOR EXPORT.—Except as provided
19 in subsections (b) and (d) of section 5704—

20 “(1) every person who sells, relands, or receives
21 within the jurisdiction of the United States any to-
22 bacco products or cigarette papers or tubes which
23 have been labeled or shipped for exportation under
24 this chapter,

1 “(2) every person who sells or receives such re-
2 landed tobacco products or cigarette papers or tubes,
3 and

4 “(3) every person who aids or abets in such
5 selling, relanding, or receiving,

6 shall, in addition to the tax and any other penalty provided
7 in this title, be liable for a penalty equal to the greater
8 of \$1,000 or 5 times the amount of the tax imposed by
9 this chapter. All tobacco products and cigarette papers
10 and tubes relanded within the jurisdiction of the United
11 States, and all vessels, vehicles, and aircraft used in such
12 relanding or in removing such products, papers, and tubes
13 from the place where relanded, shall be forfeited to the
14 United States.”

15 (3) Subsection (a) of section 5761 is amended
16 by striking “subsection (b)” and inserting “sub-
17 section (b) or (c)”.

18 (4) Subsection (d) of section 5761, as redesign-
19 nated by paragraph (2), is amended by striking
20 “The penalty imposed by subsection (b)” and insert-
21 ing “The penalties imposed by subsections (b) and
22 (c)”.

23 (5)(A) Subpart F of chapter 52 is amended by
24 adding at the end thereof the following new section:

1 **“SEC. 5754. RESTRICTION ON IMPORTATION OF PRE-**
2 **VIOUSLY EXPORTED TOBACCO PRODUCTS.**

3 “(a) IN GENERAL.—Tobacco products and cigarette
4 papers and tubes previously exported from the United
5 States may be imported or brought into the United States
6 only as provided in section 5704(d).

7 “(b) CROSS REFERENCE.—

**“For penalty for the sale of cigarettes in the
United States which are labeled for export, see sec-
tion 5761(d).”**

8 (B) The table of sections for subpart F of chap-
9 ter 52 is amended by adding at the end thereof the
10 following new item:

“Sec. 5754. Restriction on importation of previously exported to-
bacco products.”

11 (b) IMPORTERS REQUIRED TO BE QUALIFIED.—

12 (1) Sections 5712, 5713(a), 5721, 5722,
13 5762(a)(1), and 5763(b) and (c) are each amended
14 by inserting “or importer” after “manufacturer”.

15 (2) The heading of subsection (b) of section
16 5763 is amended by inserting “QUALIFIED IMPORT-
17 ERS,” after “MANUFACTURERS,”.

18 (3) The heading for subchapter B of chapter 52
19 is amended by inserting “and Importers” after
20 **“Manufacturers”**.

21 (4) The item relating to subchapter B in the
22 table of subchapters for chapter 52 is amended by
23 inserting “and importers” after “manufacturers”.

1 (c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES
2 OF CIGARETTE MANUFACTURERS.—

3 (1) Subsection (a) of section 5704 is
4 amended—

5 (A) by striking “EMPLOYEE USE OR” in
6 the heading, and

7 (B) by striking “for use or consumption by
8 employees or” in the text.

9 (2) Subsection (e) of section 5723 is amended
10 by striking “for use or consumption by their employ-
11 ees, or for experimental purposes” and inserting
12 “for experimental purposes”.

13 (d) REPEAL OF TAX-EXEMPT SALES TO UNITED
14 STATES.—Subsection (b) of section 5704 is amended by
15 striking “and manufacturers may similarly remove such
16 articles for use of the United States;”.

17 (e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS
18 SUBJECT TO TAX.—Subsection (c) of section 5701 is
19 amended by striking “On each book or set of cigarette
20 papers containing more than 25 papers,” and inserting
21 “On cigarette papers,”.

22 (f) STORAGE OF TOBACCO PRODUCTS.—Subsection
23 (k) of section 5702 is amended by inserting “under section
24 5704” after “internal revenue bond”.

1 (g) AUTHORITY TO PRESCRIBE MINIMUM MANUFAC-
2 TURING ACTIVITY REQUIREMENTS.—Section 5712 is
3 amended by striking “or” at the end of paragraph (1),
4 by redesignating paragraph (2) as paragraph (3), and by
5 inserting after paragraph (1) the following new paragraph:

6 “(2) the activity proposed to be carried out at
7 such premises does not meet such minimum capacity
8 or activity requirements as the Secretary may pre-
9 scribe, or”.

10 (h) LIMITATION ON COVER OVER OF TAX ON TO-
11 BACCO PRODUCTS.—Section 7652 is amended by adding
12 at the end thereof the following new subsection:

13 “(h) LIMITATION ON COVER OVER OF TAX ON TO-
14 BACCO PRODUCTS.—For purposes of this section, with re-
15 spect to taxes imposed under section 5701 or this section
16 on any tobacco product or cigarette paper or tube, the
17 amount covered into the treasuries of Puerto Rico and the
18 Virgin Islands shall not exceed the rate of tax under sec-
19 tion 5701 in effect on the article on the day before the
20 date of the enactment of the Health Security Act.”

21 (i) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to articles removed (as defined in
23 section 5702(k) of the Internal Revenue Code of 1986,
24 as amended by this Act) after September 30, 1994.

1 **SEC. 7113. IMPOSITION OF EXCISE TAX ON MANUFACTURE**
2 **OR IMPORTATION OF ROLL-YOUR-OWN TO-**
3 **BACCO.**

4 (a) IN GENERAL.—Section 5701 (relating to rate of
5 tax) is amended by redesignating subsection (g) as sub-
6 section (h) and by inserting after subsection (f) the fol-
7 lowing new subsection:

8 “(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own
9 tobacco, manufactured in or imported into the United
10 States, there shall be imposed a tax of \$12.50 per pound
11 (and a proportionate tax at the like rate on all fractional
12 parts of a pound).”

13 (b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (re-
14 lating to definitions) is amended by adding at the end
15 thereof the following new subsection :

16 “(p) ROLL-YOUR-OWN TOBACCO.—The term ‘roll-
17 your-own tobacco’ means any tobacco which, because of
18 its appearance, type, packaging, or labeling, is suitable for
19 use and likely to be offered to, or purchased by, consumers
20 as tobacco for making cigarettes.”

21 (c) TECHNICAL AMENDMENTS.—

22 (1) Subsection (c) of section 5702 is amended
23 by striking “and pipe tobacco” and inserting “pipe
24 tobacco, and roll-your-own tobacco”.

25 (2) Subsection (d) of section 5702 is
26 amended—

1 (A) in the material preceding paragraph
2 (1), by striking “or pipe tobacco” and inserting
3 “pipe tobacco, or roll-your-own tobacco”, and

4 (B) by striking paragraph (1) and insert-
5 ing the following new paragraph:

6 “(1) a person who produces cigars, cigarettes,
7 smokeless tobacco, pipe tobacco, or roll-your-own to-
8 bacco solely for his own personal consumption or
9 use, and”.

10 (3) The chapter heading for chapter 52 is
11 amended to read as follows:

12 **“CHAPTER 52—TOBACCO PRODUCTS AND**
13 **CIGARETTE PAPERS AND TUBES”.**

14 (4) The table of chapters for subtitle E is
15 amended by striking the item relating to chapter 52
16 and inserting the following new item:

“Chapter 52. Tobacco products and cigarette papers and tubes.”

17 (d) EFFECTIVE DATE.—

18 (1) IN GENERAL.—The amendments made by
19 this section shall apply to roll-your-own tobacco re-
20 moved (as defined in section 5702(k) of the Internal
21 Revenue Code of 1986, as amended by this Act)
22 after September 30, 1994.

23 (2) TRANSITIONAL RULE.—Any person who—

24 (A) on the date of the enactment of this
25 Act is engaged in business as a manufacturer of

1 roll-your-own tobacco or as an importer of to-
2 bacco products or cigarette papers and tubes,
3 and

4 (B) before October 1, 1994, submits an
5 application under subchapter B of chapter 52
6 of such Code to engage in such business,
7 may, notwithstanding such subchapter B, continue
8 to engage in such business pending final action on
9 such application. Pending such final action, all pro-
10 visions of such chapter 52 shall apply to such appli-
11 cant in the same manner and to the same extent as
12 if such applicant were a holder of a permit under
13 such chapter 52 to engage in such business.

14 **PART 2—HEALTH RELATED ASSESSMENTS**

15 **SEC. 7121. HEALTH RELATED ASSESSMENTS.**

16 (a) IN GENERAL.—Subtitle C (relating to employ-
17 ment taxes) is amended by inserting after chapter 24 the
18 following new chapter:

19 **“CHAPTER 24A—HEALTH RELATED**
20 **ASSESSMENTS**

“Subchapter A. Assessment on corporate alliance employers.

“Subchapter B. Temporary assessment on employers with retiree
health benefit costs.

“Subchapter C. Definitions and administrative provisions.

21 **“Subchapter A—Assessment on Corporate**
22 **Alliance Employers**

“Sec. 3461. Assessment on corporate alliance employers.

1 **“SEC. 3461. ASSESSMENT ON CORPORATE ALLIANCE EM-**
2 **PLOYERS.**

3 “(a) IMPOSITION OF ASSESSMENT.—Every corporate
4 alliance employer shall pay (in addition to any other
5 amount imposed by this subtitle) for each calendar year
6 an assessment equal to 1 percent of the payroll of such
7 employer.

8 “(b) DEFINITIONS.—For purposes of this section—

9 “(1) CORPORATE ALLIANCE EMPLOYER.—The
10 term ‘corporate alliance employer’ means any em-
11 ployer if any individual, by reason of being an em-
12 ployee of such employer, is provided with health cov-
13 erage through any corporate alliance described in
14 section 1311 of the Health Security Act.

15 “(2) PAYROLL.—The term ‘payroll’ means the
16 sum of—

17 “(A) the wages (as defined in section
18 3121(a) without regard to paragraph (1) there-
19 of) paid by the employer during the calendar
20 year, plus

21 “(B)(i) in the case of a sole proprietorship,
22 the net earnings from self-employment of the
23 proprietor from such trade or business for the
24 taxable year ending with or within the calendar
25 year,

1 “(ii) in the case of a partnership, the ag-
2 gregate of the net earnings from self-employ-
3 ment of each partner which is attributable to
4 such partnership for the taxable year of such
5 partnership ending with or within the calendar
6 year, and

7 “(iii) in the case of an S corporation, the
8 aggregate of the net earnings from self-employ-
9 ment of each shareholder which is attributable
10 to such corporation for the taxable year of such
11 corporation ending with or within the calendar
12 year.

13 “(3) NET EARNINGS FROM SELF-EMPLOY-
14 MENT.—The term ‘net earnings from self-employ-
15 ment’ has the meaning given such term by section
16 1402; except that the amount thereof—

17 “(A) may never be less than zero, and

18 “(B) shall be determined without regard to
19 any deduction for an assessment under this sec-
20 tion to the extent attributable to payroll de-
21 scribed in paragraph (2)(B).

22 “(c) SPECIAL RULES.—For purposes of this
23 section—

24 “(1) TREATMENT OF CERTAIN EMPLOYERS IN
25 MULTIEMPLOYER CORPORATE ALLIANCES.—An em-

1 ployer who is a corporate alliance employer solely by
2 reason of employees who are provided with health
3 coverage through a corporate alliance the eligible
4 sponsor of which is a multiemployer plan described
5 in section 1311(b)(1)(B) of the Health Security Act
6 is not subject to the assessment under this section.
7 In the case of an employer who is a corporate alli-
8 ance employer in part (but not solely) by reason of
9 such employees, the payroll of such employer shall
10 be determined without taking into account such em-
11 ployees.

12 “(2) CONTROLLED GROUP RULES.—All persons
13 treated as a single employer under section 1901 of
14 the Health Security Act (relating to employer pre-
15 miums for comprehensive health care) shall be treat-
16 ed as a single employer.

17 “(3) APPLICATION OF ASSESSMENT BEGINNING
18 IN 1996.—

19 “(A) IN GENERAL.—Every employer eligi-
20 ble to elect to be an eligible sponsor under sec-
21 tion 1311 of the Health Security Act shall be
22 treated as a corporate alliance employer as of
23 January 1, 1996, unless the employer waives
24 such employer’s rights ever to be treated as

1 such a sponsor. The waiver under this subpara-
2 graph shall be irrevocable.

3 “(B) EXCEPTION.—Subparagraph (A)
4 shall not apply to any employer referred to in
5 the first sentence of paragraph (1).

6 **“SEC. 3462. TEMPORARY ASSESSMENT ON EMPLOYERS**
7 **WITH RETIREE HEALTH BENEFIT COSTS.**

8 “(a) IMPOSITION OF ASSESSMENT.—Every employer
9 with base period retiree health costs shall pay (in addition
10 to any other amount imposed by this subtitle) for each
11 calendar year to which this section applies an assessment
12 equal to the amount determined under subsection (b).

13 “(b) AMOUNT OF ASSESSMENT.—For purposes of
14 subsection (a), the amount determined under this sub-
15 section with respect to any employer for any calendar year
16 is 50 percent of the greater of—

17 “(1) the adjusted base period retiree health
18 costs of such employer for such calendar year, or

19 “(2) the amount (determined in the manner
20 prescribed by the Secretary) by which such employ-
21 er’s applicable retiree health costs for such calendar
22 year were reduced by reason of the enactment of the
23 Health Security Act.

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

1 “(1) BASE PERIOD RETIREE HEALTH COSTS.—

2 The term ‘base period retiree health costs’ means
3 the average of the applicable retiree health costs of
4 the employer for calendar years 1991, 1992, and
5 1993.

6 “(2) ADJUSTED BASE PERIOD RETIREE
7 HEALTH COSTS.—

8 “(A) IN GENERAL.—The term ‘adjusted
9 base period retiree health costs’ means, with re-
10 spect to any employer for any calendar year,
11 the base period retiree health costs of the em-
12 ployer adjusted in the manner prescribed by the
13 Secretary to reflect increases in the medical
14 care component of the Consumer Price Index
15 during the period after 1992 and before such
16 calendar year.

17 “(B) ADJUSTMENTS FOR ACQUISITIONS
18 AND DISPOSITIONS.—Rules similar to the rules
19 of subparagraphs (A) and (B) of section
20 41(f)(3) shall apply to acquisitions and disposi-
21 tions after December 31, 1993.

22 “(3) APPLICABLE RETIREE HEALTH COSTS.—

23 “(A) IN GENERAL.—The term ‘applicable
24 retiree health costs’ means, with respect to any
25 employer for any calendar year, the aggregate

1 cost (including administrative costs) of the
2 health benefits or coverage provided during
3 such calendar year (whether directly by the em-
4 ployer or through a plan described in section
5 401(h) or a welfare benefit fund as defined in
6 section 419(e)) to individuals who are entitled
7 to receive such benefits or coverage by reason
8 of being retired employees of such employer (or
9 by reason of being a spouse or other beneficiary
10 of such an employee).

11 “(B) ONLY BENEFITS AND COVERAGE
12 AFTER AGE 55 AND BEFORE AGE 65 TAKEN
13 INTO ACCOUNT.—In applying subparagraph
14 (A), there shall be taken into account only
15 health benefits and coverage provided after the
16 date the retired employee attained age 55 and
17 before the date such employee attained (or, but
18 for the death of such employee, would have at-
19 tained) age 65.

20 “(d) YEARS TO WHICH ASSESSMENT APPLIES.—This
21 section shall apply to calendar years 1998, 1999, and
22 2000.

1 **“Subchapter C—Definitions and**
2 **Administrative Provisions**

3 **“SEC. 3463. DEFINITIONS AND ADMINISTRATIVE PROVI-**
4 **SIONS**

5 “(a) EMPLOYER.—For purposes of this chapter—

6 “(1) IN GENERAL.—The term ‘employer’ means
7 any person or governmental entity for whom an indi-
8 vidual performs services, of whatever nature, as an
9 employee (as defined in section 3401(c)).

10 “(2) SPECIAL RULES.—

11 “(A) An individual who owns the entire in-
12 terest in an unincorporated trade or business
13 shall be treated as his own employer.

14 “(B) A partnership shall be treated as the
15 employer of each partner who is an employee
16 within the meaning of section 401(c)(1).

17 “(C) An S corporation shall be treated as
18 the employer of each shareholder who is an em-
19 ployee within the meaning of section 401(c)(1).

20 “(b) ASSESSMENTS TO APPLY TO GOVERNMENTAL
21 AND OTHER TAX-EXEMPT ENTITIES.—Notwithstanding
22 any other provision of law or rule of law, none of the fol-
23 lowing shall be exempt from the assessments imposed by
24 this chapter:

1 “(1) The United States, any State or political
2 subdivision thereof, the District of Columbia, and
3 any agency or instrumentality of any of the fore-
4 going.

5 “(2) Any other entity otherwise exempt from
6 tax under chapter 1.

7 “(c) ADMINISTRATIVE PROVISIONS.—

8 “(1) PAYMENT.—

9 “(A) SECTION 3461.—Any assessment
10 under section 3461 shall be paid at the same
11 time and in the same manner as the tax im-
12 posed by chapter 21.

13 “(B) SECTION 3462.—Any assessment
14 under section 3462 for any calendar year shall
15 be paid on or before March 15 of the following
16 calendar year; except that the Secretary may
17 require quarterly estimated payments of such
18 assessment in a manner similar to the require-
19 ments of section 6655.

20 “(2) COLLECTION, ETC.—For purposes of sub-
21 title F, any assessment under this subchapter shall
22 be treated as if it were a tax imposed by this sub-
23 title.”

1 (b) CLERICAL AMENDMENT.—The table of chapters
2 for subtitle C is amended by inserting after the item relat-
3 ing to chapter 24 the following new item:

“Chapter 24A. Health-related assessments.”

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall take effect on January 1, 1996.

6 **PART 3—RECAPTURE OF CERTAIN HEALTH CARE**
7 **SUBSIDIES**

8 **SEC. 7131. RECAPTURE OF CERTAIN HEALTH CARE SUB-**
9 **SIDIES RECEIVED BY HIGH-INCOME INDIVID-**
10 **UALS.**

11 (a) IN GENERAL.—Subchapter A of chapter 1 is
12 amended by adding at the end thereof the following new
13 part:

14 **“PART VIII—CERTAIN HEALTH CARE SUBSIDIES**
15 **RECEIVED BY HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Recapture of certain health care subsidies.

16 **“SEC. 59B. RECAPTURE OF CERTAIN HEALTH CARE SUB-**
17 **SIDIES.**

18 “(a) IMPOSITION OF RECAPTURE AMOUNT.—In the
19 case of an individual, if the modified adjusted gross in-
20 come of the taxpayer for the taxable year exceeds the
21 threshold amount, such taxpayer shall pay (in addition to
22 any other amount imposed by this subtitle) a recapture
23 amount for such taxable year equal to the sum of—

1 “(1) the aggregate of the Medicare part B re-
2 capture amounts (if any) for months during such
3 year that a premium is paid under part B of title
4 XVIII of the Social Security Act for the coverage of
5 the individual under such part, and

6 “(2) the aggregate reductions (if any) in the in-
7 dividual’s liability for periods after December 31,
8 1997, under section 6111 of the Health Security Act
9 (relating to repayment of alliance credit by certain
10 families) pursuant to section 6114 of such Act (re-
11 lating to special treatment of certain retirees and
12 qualified spouses and children) for months during
13 such year.

14 “(b) MEDICARE PART B PREMIUM RECAPTURE
15 AMOUNT FOR MONTH.—For purposes of this section, the
16 Medicare part B premium recapture amount for any
17 month is the amount equal to the excess of—

18 “(1) 150 percent of the monthly actuarial rate
19 for enrollees age 65 and over determined for that
20 calendar year under section 1839(b) of the Social
21 Security Act, over

22 “(2) the total monthly premium under section
23 1839 of the Social Security Act (determined without
24 regard to subsections (b) and (f) of section 1839 of
25 such Act).

1 “(c) PHASEIN OF RECAPTURE AMOUNT.—

2 “(1) IN GENERAL.—If the modified adjusted
3 gross income of the taxpayer for any taxable year
4 exceeds the threshold amount by less than \$15,000,
5 the recapture amount imposed by this section for
6 such taxable year shall be an amount which bears
7 the same ratio to the recapture amount which would
8 (but for this subsection) be imposed by this section
9 for such taxable year as such excess bears to
10 \$15,000.

11 “(2) JOINT RETURNS.—If a recapture amount
12 is determined separately for each spouse filing a
13 joint return, paragraph (1) shall be applied by sub-
14 stituting ‘\$30,000’ for ‘\$15,000’ each place it ap-
15 pears.

16 “(d) OTHER DEFINITIONS AND SPECIAL RULES.—
17 For purposes of this section—

18 “(1) THRESHOLD AMOUNT.—The term ‘thresh-
19 old amount’ means—

20 “(A) except as otherwise provided in this
21 paragraph, \$90,000,

22 “(B) \$115,000 in the case of a joint re-
23 turn, and

24 “(C) zero in the case of a taxpayer who—

1 “(i) is married (as determined under
2 section 7703) but does not file a joint re-
3 turn for such year, and

4 “(ii) does not live apart from his
5 spouse at all times during the taxable year.

6 “(2) MODIFIED ADJUSTED GROSS INCOME.—
7 The term ‘modified adjusted gross income’ means
8 adjusted gross income—

9 “(A) determined without regard to sections
10 135, 911, 931, and 933, and

11 “(B) increased by the amount of interest
12 received or accrued by the taxpayer during the
13 taxable year which is exempt from tax.

14 “(3) JOINT RETURNS.—In the case of a joint
15 return—

16 “(A) the recapture amount under sub-
17 section (a) shall be the sum of the recapture
18 amounts determined separately for each spouse,
19 and

20 “(B) subsections (a) and (c) shall be ap-
21 plied by taking into account the combined modi-
22 fied adjusted gross income of the spouses.

23 “(4) COORDINATION WITH OTHER PROVI-
24 SIONS.—

1 “(A) TREATED AS TAX FOR SUBTITLE F.—

2 For purposes of subtitle F, the recapture
3 amount imposed by this section shall be treated
4 as if it were a tax imposed by section 1.

5 “(B) NOT TREATED AS TAX FOR CERTAIN
6 PURPOSES.—The recapture amount imposed by
7 this section shall not be treated as a tax im-
8 posed by this chapter for purposes of
9 determining—

10 “(i) the amount of any credit allow-
11 able under this chapter, or

12 “(ii) the amount of the minimum tax
13 under section 55.

14 “(C) TREATED AS PAYMENT FOR MEDICAL
15 INSURANCE.—The recapture amount imposed
16 by this section shall be treated as an amount
17 paid for insurance covering medical care, within
18 the meaning of section 213(d).”

19 (b) TRANSFERS TO SUPPLEMENTAL MEDICAL IN-
20 SURANCE TRUST FUND.—

21 (1) IN GENERAL.—There are hereby appro-
22 priated to the Supplemental Medical Insurance
23 Trust Fund amounts equivalent to the aggregate in-
24 crease in liabilities under chapter 1 of the Internal
25 Revenue Code of 1986 which is attributable to the

1 application of section 59B(a)(1) of such Code, as
2 added by this section.

3 (2) TRANSFERS.—The amounts appropriated
4 by paragraph (1) to the Supplemental Medical In-
5 surance Trust Fund shall be transferred from time
6 to time (but not less frequently than quarterly) from
7 the general fund of the Treasury on the basis of es-
8 timates made by the Secretary of the Treasury of
9 the amounts referred to in paragraph (1). Any quar-
10 terly payment shall be made on the first day of such
11 quarter and shall take into account the recapture
12 amounts referred to in such section 59B(a)(1) for
13 such quarter. Proper adjustments shall be made in
14 the amounts subsequently transferred to the extent
15 prior estimates were in excess of or less than the
16 amounts required to be transferred.

17 (c) REPORTING REQUIREMENTS.—

18 (1)(A) Paragraph (1) of section 6050F(a) (re-
19 lating to returns relating to social security benefits)
20 is amended by striking “and” at the end of subpara-
21 graph (B) and by inserting after subparagraph (C)
22 the following new subparagraph:

23 “(D) the number of months during the cal-
24 endar year for which a premium was paid under
25 part B of title XVIII of the Social Security Act

1 for the coverage of such individual under such
2 part, and”.

3 (B) Paragraph (2) of section 6050F(b) is
4 amended to read as follows:

5 “(2) the information required to be shown on
6 such return with respect to such individual.”

7 (C) Subparagraph (A) of section 6050F(c)(1) is
8 amended by inserting before the comma “and in the
9 case of the information specified in subsection
10 (a)(1)(D)”.

11 (D) The heading for section 6050F is amended
12 by inserting “**AND MEDICARE PART B COV-**
13 **ERAGE**” before the period.

14 (E) The item relating to section 6050F in the
15 table of sections for subpart B of part III of sub-
16 chapter A of chapter 61 is amended by inserting
17 “and Medicare part B coverage” before the period.

18 (2)(A) Subpart B of part III of subchapter A
19 of chapter 61 (relating to information concerning
20 transactions with other persons) is amended by add-
21 ing at the end thereof the following new section:

22 **“SEC. 6050Q. RETURNS RELATING TO CERTAIN RETIREE**
23 **HEALTH CARE SUBSIDIES.**

24 “(a) IN GENERAL.—Every alliance (as defined in sec-
25 tion 1301 of the Health Security Act) that reduces an in-

1 individual's liability under section 6111 of such Act (relating
2 to repayment of alliance credit by certain families) pursu-
3 ant to section 6114 of such Act (relating to special treat-
4 ment of certain retirees and qualified spouses and chil-
5 dren) shall make a return (according to the forms and
6 regulations prescribed by the Secretary) setting forth—

7 “(1) the aggregate amount of such reductions
8 by such alliance with respect to any individual dur-
9 ing such calendar year, and

10 “(2) the name and address of such individual.

11 “(b) STATEMENTS TO BE FURNISHED TO INDIVID-
12 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
13 QUIRED TO BE REPORTED.—Every alliance required to
14 make a return under subsection (a) shall furnish to each
15 individual whose name is required to be set forth in such
16 return a written statement showing—

17 “(1) the name and address of such alliance, and

18 “(2) the information required to be shown on
19 the return with respect to such individual.

20 “(c) DUE DATE FOR RETURNS AND STATEMENTS.—

21 The written return required under subsection (a) shall be
22 made, and the statement required under subsection (b)
23 shall be furnished to the individual, on or before January
24 31 of the second year following the calendar year for which
25 the return under subsection (a) is required to be made.”

1 (B) Subparagraph (B) of section 6724(d)(1) is
2 amended by inserting after clause (viii) the following
3 new clause (and by redesignating the following
4 clauses accordingly):

5 “(ix) section 6050Q(a) (relating to re-
6 turns relating to certain retiree health care
7 subsidies),”.

8 (C) Paragraph (2) of section 6724(d) is amend-
9 ed by redesignating subparagraphs (Q) through (T)
10 as subparagraphs (R) through (U), respectively, and
11 by inserting after subparagraph (P) the following
12 new subparagraph:

13 “(Q) section 6050Q(b) (relating to state-
14 ments relating to certain retiree health care
15 subsidies),”.

16 (D) The table of sections for subpart B of part
17 III of subchapter A of chapter 61 is amended by
18 adding at the end thereof the following new item:

 “Sec. 6050Q. Returns relating to certain retiree health care sub-
 sidies.”

19 (d) WAIVER OF CERTAIN ESTIMATED TAX PEN-
20 ALTIES.—No addition to tax shall be imposed under sec-
21 tion 6654 of the Internal Revenue Code of 1986 (relating
22 to failure to pay estimated income tax) for any period
23 before—

1 (1) April 16, 1997, with respect to any under-
 2 payment to the extent that such underpayment re-
 3 sulted from section 59B(a)(1) of the Internal Rev-
 4 enue Code of 1986, as added by this section, and

5 (2) April 16, 1999, with respect to any under-
 6 payment to the extent that such underpayment re-
 7 sulted from section 59B(a)(2) of such Code, as
 8 added by this section.

9 (e) CLERICAL AMENDMENT.—The table of parts for
 10 subchapter A of chapter 1 is amended by adding at the
 11 end thereof the following new item:

“Part VIII. Certain health care subsidies received by high-income
 individuals.”

12 (f) EFFECTIVE DATE.—The amendments made by
 13 this section shall apply to periods after December 31,
 14 1995, in taxable years ending after such date.

15 **PART 4—OTHER PROVISIONS**

16 **SEC. 7141. MODIFICATION TO SELF-EMPLOYMENT TAX**

17 **TREATMENT OF CERTAIN S CORPORATION**

18 **SHAREHOLDERS AND PARTNERS.**

19 (a) TREATMENT OF CERTAIN S CORPORATION
 20 SHAREHOLDERS.—

21 (1) AMENDMENT TO INTERNAL REVENUE
 22 CODE.—Section 1402 (relating to definitions) is
 23 amended by adding at the end thereof the following
 24 new subsection:

1 “(k) TREATMENT OF CERTAIN S CORPORATION
2 SHAREHOLDERS.—

3 “(1) IN GENERAL.—In the case of any
4 individual—

5 “(A) who is a 2-percent shareholder (as
6 defined in section 1372(b)) of an S corporation
7 for any taxable year of such corporation, and

8 “(B) who materially participates in the ac-
9 tivities of such S corporation during such tax-
10 able year,

11 such shareholder’s net earnings from self-employ-
12 ment for such shareholder’s taxable year in which
13 the taxable year of the S corporation ends shall in-
14 clude such shareholder’s pro rata share (as deter-
15 mined under section 1366(a)) of the taxable income
16 or loss of such corporation from service-related busi-
17 nesses carried on by such corporation.

18 “(2) CERTAIN EXCEPTIONS TO APPLY.—In de-
19 termining the amount to be taken into account
20 under paragraph (1), the exceptions provided in sub-
21 section (a) shall apply, except that, in the case of
22 the exceptions provided in subsection (a)(5), the
23 rules of subparagraph (B) thereof shall apply to
24 shareholders in S corporations.

1 “(3) SERVICE-RELATED BUSINESS.—For pur-
2 poses of this subsection, the term ‘service-related
3 business’ means any trade or business described in
4 subparagraph (A) of section 1202(e)(3).”

5 (2) AMENDMENT TO SOCIAL SECURITY ACT.—
6 Section 211 of the Social Security Act is amended
7 by adding at the end the following new subsection:
8 “Treatment of Certain S Corporation Shareholders

9 “(k)(1) In the case of any individual—
10 “(A) who is a 2-percent shareholder (as defined
11 in section 1372(b) of the Internal Revenue Code of
12 1986) of an S corporation for any taxable year of
13 such corporation, and

14 “(B) who materially participates in the activi-
15 ties of such S corporation during such taxable year,
16 such shareholder’s net earnings from self-employment for
17 such shareholder’s taxable year in which the taxable year
18 of the S corporation ends shall include such shareholder’s
19 pro rata share (as determined under section 1366(a) of
20 such Code) of the taxable income or loss of such corpora-
21 tion from service-related businesses (as defined in section
22 1402(k)(3) of such Code) carried on by such corporation.

23 “(2) In determining the amount to be taken into ac-
24 count under paragraph (1), the exceptions provided in
25 subsection (a) shall apply, except that, in the case of the

1 exceptions provided in subsection (a)(5), the rules of sub-
2 paragraph (B) thereof shall apply to shareholders in S cor-
3 porations.”.

4 (b) TREATMENT OF CERTAIN LIMITED PARTNERS.—

5 (1) AMENDMENT OF INTERNAL REVENUE
6 CODE.—Paragraph (13) of section 1402(a) is
7 amended by striking “limited partner, as such” and
8 inserting “limited partner who does not materially
9 participate in the activities of the partnership”.

10 (2) AMENDMENT OF SOCIAL SECURITY ACT.—

11 Paragraph (12) of section 211(a) of the Social Secu-
12 rity Act is amended by striking “limited partner, as
13 such” and inserting “limited partner who does not
14 materially participate in the activities of the partner-
15 ship”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years of individuals be-
18 ginning after December 31, 1995, and to taxable years
19 of S corporations and partnerships ending with or within
20 such taxable years of individuals.

21 **SEC. 7142. EXTENDING MEDICARE COVERAGE OF, AND AP-**
22 **PLICATION OF HOSPITAL INSURANCE TAX**
23 **TO, ALL STATE AND LOCAL GOVERNMENT**
24 **EMPLOYEES.**

25 (a) IN GENERAL.—

1 (1) APPLICATION OF HOSPITAL INSURANCE
2 TAX.—Section 3121(u)(2) is amended by striking
3 subparagraphs (C) and (D).

4 (2) COVERAGE UNDER MEDICARE.—Section
5 210(p) of the Social Security Act (42 U.S.C. 410(p))
6 is amended by striking paragraphs (3) and (4).

7 (3) EFFECTIVE DATE.—The amendments made
8 by this subsection shall apply to services performed
9 after September 30, 1995.

10 (b) TRANSITION IN BENEFITS FOR STATE AND
11 LOCAL GOVERNMENT EMPLOYEES AND FORMER EM-
12 PLOYEES.—

13 (1) IN GENERAL.—

14 (A) EMPLOYEES NEWLY SUBJECT TO
15 TAX.—For purposes of sections 226, 226A, and
16 1811 of the Social Security Act, in the case of
17 any individual who performs services during the
18 calendar quarter beginning October 1, 1995,
19 the wages for which are subject to the tax im-
20 posed by section 3101(b) of the Internal Rev-
21 enue Code of 1986 only because of the amend-
22 ment made by subsection (a), the individual's
23 medicare qualified State or local government
24 employment (as defined in subparagraph (B))
25 performed before October 1, 1995, shall be con-

1 sidered to be “employment” (as defined for pur-
2 poses of title II of such Act), but only for pur-
3 poses of providing the individual (or another
4 person) with entitlement to hospital insurance
5 benefits under part A of title XVIII of such Act
6 for months beginning with October 1995.

7 (B) MEDICARE QUALIFIED STATE OR
8 LOCAL GOVERNMENT EMPLOYMENT DE-
9 FINED.—In this paragraph, the term “medicare
10 qualified State or local government employ-
11 ment” means medicare qualified government
12 employment described in section 210(p)(1)(B)
13 of the Social Security Act (determined without
14 regard to section 210(p)(3) of such Act, as in
15 effect before its repeal under subsection (a)(2)).

16 (2) AUTHORIZATION OF APPROPRIATIONS.—

17 There are authorized to be appropriated to the Fed-
18 eral Hospital Insurance Trust Fund from time to
19 time such sums as the Secretary of Health and
20 Human Services deems necessary for any fiscal year
21 on account of—

22 (A) payments made or to be made during
23 such fiscal year from such Trust Fund with re-
24 spect to individuals who are entitled to benefits

1 under title XVIII of the Social Security Act
2 solely by reason of paragraph (1),

3 (B) the additional administrative expenses
4 resulting or expected to result therefrom, and

5 (C) any loss in interest to such Trust
6 Fund resulting from the payment of those
7 amounts, in order to place such Trust Fund in
8 the same position at the end of such fiscal year
9 as it would have been in if this subsection had
10 not been enacted.

11 (3) INFORMATION TO INDIVIDUALS WHO ARE
12 PROSPECTIVE MEDICARE BENEFICIARIES BASED ON
13 STATE AND LOCAL GOVERNMENT EMPLOYMENT.—
14 Section 226(g) of the Social Security Act (42 U.S.C.
15 426(g)) is amended—

16 (A) by redesignating paragraphs (1)
17 through (3) as subparagraphs (A) through (C),
18 respectively,

19 (B) by inserting “(1)” after “(g)”, and

20 (C) by adding at the end the following new
21 paragraph:

22 “(2) The Secretary, in consultation with State
23 and local governments, shall provide procedures de-
24 signed to assure that individuals who perform medi-
25 care qualified government employment by virtue of

1 service described in section 210(a)(7) are fully in-
2 formed with respect to (A) their eligibility or poten-
3 tial eligibility for hospital insurance benefits (based
4 on such employment) under part A of title XVIII,
5 (B) the requirements for, and conditions of, such eli-
6 gibility, and (C) the necessity of timely application
7 as a condition of becoming entitled under subsection
8 (b)(2)(C), giving particular attention to individuals
9 who apply for an annuity or retirement benefit and
10 whose eligibility for such annuity or retirement ben-
11 efit is based on a disability.”

12 (c) TECHNICAL AMENDMENTS.—

13 (1) Subparagraph (A) of section 3121(u)(2) is
14 amended by striking “subparagraphs (B) and (C),”
15 and inserting “subparagraph (B),”.

16 (2) Subparagraph (B) of section 210(p)(1) of
17 the Social Security Act (42 U.S.C. 410(p)(1)) is
18 amended by striking “paragraphs (2) and (3).” and
19 inserting “paragraph (2).”

20 (3) Section 218 of the Social Security Act (42
21 U.S.C. 418) is amended by striking subsection (n).

22 (4) The amendments made by this subsection
23 shall apply after September 30, 1995.

1 **Subtitle B—Tax Treatment of**
2 **Employer-Provided Health Care**

3 **SEC. 7201. LIMITATION ON EXCLUSION FOR EMPLOYER-**
4 **PROVIDED HEALTH BENEFITS.**

5 (a) GENERAL RULE.—Section 106 (relating to con-
6 tributions by employer to accident and health plans) is
7 amended to read as follows:

8 **“SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT**
9 **AND HEALTH PLANS.**

10 “(a) GENERAL RULE.—Except as otherwise provided
11 in this section, gross income of an employee does not in-
12 clude employer-provided coverage under an accident or
13 health plan.

14 “(b) INCLUSION OF CERTAIN BENEFITS NOT PART
15 OF COMPREHENSIVE BENEFIT PACKAGE.—

16 “(1) IN GENERAL.—Effective on and after Jan-
17 uary 1, 2004, gross income of an employee shall in-
18 clude employer-provided coverage under any accident
19 or health plan except to the extent that—

20 “(A) such coverage consists of comprehen-
21 sive health coverage described in section 1101
22 of the Health Security Act,

23 “(B) such coverage consists of coverage of
24 cost sharing amounts under the comprehensive
25 benefit package described in such section (in-

1 including such coverage under a cost sharing pol-
2 icy under section 1421(b)(2) of such Act), or

3 “(C) such coverage consists of permitted
4 coverage.

5 “(2) PERMITTED COVERAGE.—For purposes of
6 this subsection, the term ‘permitted coverage’
7 means—

8 “(A) any coverage providing wages or pay-
9 ments in lieu of wages for any period during
10 which the employee is absent from work on ac-
11 count of sickness or injury,

12 “(B) any coverage providing for payments
13 referred to in section 105(c),

14 “(C) any coverage provided to an employee
15 or former employee after such employee has at-
16 tained age 65, unless such coverage is provided
17 by reason of the current employment of the in-
18 dividual (within the meaning of section
19 1862(b)(1)(A)(i)(I) of the Social Security Act)
20 with the employer providing the coverage,

21 “(D) any coverage under a qualified long-
22 term care insurance policy (as defined in sec-
23 tion 7702B),

1 “(E) any coverage provided under Federal
2 law to any individual (or spouse or dependent
3 thereof) by reason of such individual being—

4 “(i) a member of the Armed Forces of
5 the United States, or

6 “(ii) a veteran, and

7 “(F) any other coverage to the extent that
8 the Secretary determines that the continuation
9 of an exclusion for such coverage is not incon-
10 sistent with the purposes of this subsection.

11 “(3) SPECIAL RULES FOR FLEXIBLE SPENDING
12 ARRANGEMENTS.—

13 “(A) IN GENERAL.—To the extent that
14 any employer-provided coverage is provided
15 through a flexible spending or similar arrange-
16 ment, paragraph (1) shall be applied by sub-
17 stituting ‘January 1, 1997,’ for ‘January 1,
18 2004’.

19 “(B) FLEXIBLE SPENDING ARRANGE-
20 MENT.—For purposes of this paragraph, a
21 flexible spending arrangement is a benefit pro-
22 gram which provides employees with coverage
23 under which—

24 “(i) specified incurred expenses may
25 be reimbursed (subject to reimbursement

1 maximums and other reasonable condi-
2 tions), and

3 “(ii) the maximum amount of reim-
4 bursement which is reasonably available to
5 a participant for such coverage is less than
6 200 percent of the value of such coverage.

7 In the case of an insured plan, the maximum
8 amount reasonably available shall be deter-
9 mined on the basis of the underlying coverage.

10 “(c) SPECIAL RULES FOR DETERMINING AMOUNT OF
11 INCLUSION.—

12 “(1) IN GENERAL.—For purposes of this sec-
13 tion, the value of any coverage shall be determined
14 on the basis of the average cost of providing such
15 coverage to the beneficiaries receiving such coverage.

16 “(2) SPECIAL RULE.—To the extent provided
17 by the Secretary, cost determinations under para-
18 graph (1) may be made on the basis of reasonable
19 estimates.

20 “(d) POTENTIAL CASH PAYMENT NOT TO AFFECT
21 EXCLUSION.—No amount shall be included in the gross
22 income of an employee solely because the employee may
23 select coverage under an accident or health plan which re-
24 sults in a cash payment referred to in section 1607 of the
25 Health Security Act.”

1 (b) EMPLOYMENT TAX TREATMENT.—

2 (1) SOCIAL SECURITY TAX.—

3 (A) Subsection (a) of section 3121 is
4 amended by inserting after paragraph (21) the
5 following new sentence:

6 “Nothing in paragraph (2) shall exclude from the term
7 ‘wages’ any amount which is required to be included in
8 gross income under section 106(b).”

9 (B) Subsection (a) of section 209 of the
10 Social Security Act is amended by inserting
11 after paragraph (21) the following new sen-
12 tence:

13 “Nothing in paragraph (2) shall exclude from the term
14 ‘wages’ any amount which is required to be included in
15 gross income under section 106(b) of the Internal Revenue
16 Code of 1986.”

17 (2) RAILROAD RETIREMENT TAX.—Paragraph
18 (1) of section 3231(e) is amended by adding at the
19 end thereof the following new sentence: “Nothing in
20 clause (i) of the second sentence of this paragraph
21 shall exclude from the term ‘compensation’ any
22 amount which is required to be included in gross in-
23 come under section 106(b).”

1 (3) UNEMPLOYMENT TAX.—Subsection (b) of
2 section 3306 is amended by inserting after para-
3 graph (16) the following new sentence:

4 “Nothing in paragraph (2) shall exclude from the term
5 ‘wages’ any amount which is required to be included in
6 gross income under section 106(b).”

7 (4) WAGE WITHHOLDING.—Subsection (a) of
8 section 3401 is amended by adding at the end there-
9 of the following new sentence:

10 “Nothing in the preceding provisions of this subsection
11 shall exclude from the term ‘wages’ any amount which is
12 required to be included in gross income under section
13 106(b).”

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall take effect on January 1, 1997.

16 **SEC. 7202. HEALTH BENEFITS MAY NOT BE PROVIDED**
17 **UNDER CAFETERIA PLANS.**

18 (a) GENERAL RULE.—Subsection (f) of section 125
19 (defining qualified benefits) is amended by adding at the
20 end thereof the following new sentence: “Such term shall
21 not include any benefits or coverage (other than coverage
22 described in section 106(b)(2)(A)) under an accident or
23 health plan.”

24 (b) CONFORMING AMENDMENT.—Subsection (g) of
25 section 125 is amended by striking paragraph (2) and re-

1 designating paragraphs (3) and (4) as paragraphs (2) and
2 (3), respectively.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall take effect on January 1, 1997.

5 **SEC. 7203. INCREASE IN DEDUCTION FOR HEALTH INSUR-**
6 **ANCE COSTS OF SELF-EMPLOYED INDIVID-**
7 **UALS.**

8 (a) PROVISION MADE PERMANENT.—

9 (1) IN GENERAL.—Subsection (l) of section 162
10 (relating to special rules for health insurance costs
11 of self-employed individuals) is amended by striking
12 paragraph (6).

13 (2) EFFECTIVE DATE.—The amendment made
14 by paragraph (1) shall apply to taxable years begin-
15 ning after December 31, 1993.

16 (b) DEDUCTION LIMITED TO BASIC COVERAGE PUR-
17 CHASED FROM HEALTH ALLIANCE.—

18 (1) IN GENERAL.—Paragraphs (1) and (2) of
19 section 162(l) are amended to read as follows:

20 “(1) IN GENERAL.—In the case of an individual
21 who is an employee within the meaning of section
22 401(c), there shall be allowed as a deduction under
23 this section an amount equal to 100 percent of the
24 amount paid during the taxable year for insurance
25 which constitutes medical care for the taxpayer, his

1 spouse, and dependents; but only to the extent such
2 insurance is comprehensive health coverage de-
3 scribed in section 1101 of the Health Security Act
4 purchased from a qualified alliance described in sec-
5 tion 1311 of such Act.

6 “(2) LIMITATIONS.—

7 “(A) LOWER PERCENTAGE IN CERTAIN
8 CASES.—If—

9 “(i) the taxpayer has 1 or more em-
10 ployees in a trade or business with respect
11 to which such taxpayer is treated as an
12 employee within the meaning of section
13 401(c), and

14 “(ii) the taxpayer does not pay at
15 least 100 percent of the weighted average
16 premium applicable under the Health Se-
17 curity Act for each of such employees,
18 paragraph (1) shall be applied by substituting
19 for ‘100 percent’ the lowest percentage of such
20 weighted average premium paid by the taxpayer
21 for any of such employees.

22 “(B) DEDUCTION LIMITED TO EARNED IN-
23 COME.—No deduction shall be allowed under
24 paragraph (1) to the extent that the amount of

1 such deduction exceeds the taxpayer's earned
2 income (within the meaning of section 401(c)).

3 “(C) OTHER COVERAGE.—Paragraph (1)
4 shall not apply to amounts paid for coverage for
5 any individual for any calendar month if such
6 individual is employed on a full-time basis
7 (within the meaning of section 1901 of the
8 Health Security Act) by an employer during
9 such month.”

10 (2) CONFORMING AMENDMENT.—Subparagraph
11 (A) of section 162(l)(5) is amended by striking
12 “shall be treated as such individual's earned in-
13 come” and inserting “shall be included in such indi-
14 vidual's earned income”.

15 (3) EFFECTIVE DATE.—The amendments made
16 by this subsection shall take effect on the earlier
17 of—

18 (A) January 1, 1997, or

19 (B) the first day on which the taxpayer
20 could purchase comprehensive health coverage
21 from a qualified alliance.

1 **SEC. 7204. LIMITATION ON PREPAYMENT OF MEDICAL IN-**
2 **SURANCE PREMIUMS.**

3 (a) GENERAL RULE.—Subsection (d) of section 213
4 is amended by adding at the end thereof the following new
5 paragraph:

6 “(10) LIMITATION ON PREPAYMENTS.—If the
7 taxpayer pays a premium or other amount which
8 constitutes medical care under paragraph (1), to the
9 extent such premium or other amount is properly al-
10 locable to insurance coverage or care to be provided
11 during periods more than 12 months after the
12 month in which such payment is made, such pre-
13 mium shall be treated as paid ratably over the pe-
14 riod during which such insurance coverage or care is
15 to be provided. The preceding sentence shall not
16 apply to any premium to which paragraph (7) ap-
17 plies nor to any premium paid under a qualified
18 long-term care insurance policy.”

19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) shall apply to amounts paid after December
21 31, 1996.

1 **Subtitle C—Employment Status**
2 **Provisions**

3 **SEC. 7301. ANTI-ABUSE REGULATIONS RELATING TO EM-**
4 **PLOYMENT STATUS.**

5 (a) GENERAL RULE.—In order to prevent
6 misclassification of workers so as to minimize payments
7 under this Act, chapter 25 (relating to general provisions
8 applicable to employment taxes) is amended by adding at
9 the end thereof the following new section:

10 **“SEC. 3510. DEFINITION OF EMPLOYEE.**

11 “(a) REGULATIONS.—The Secretary shall prescribe
12 regulations setting forth rules for determining whether an
13 individual is an employee for purposes of—

14 “(1) the employment taxes imposed under this
15 subtitle, and

16 “(2) to the extent provided in such regulations,
17 subtitle A.

18 “(b) SCOPE OF REGULATIONS.—Such regulations
19 may modify the rules otherwise applicable for the deter-
20 minations referred to in paragraphs (1) and (2) of sub-
21 section (a); except that—

22 “(1) such regulations shall give significant
23 weight to the common law applicable in determining
24 the employer-employee relationship, and

1 “(2) nothing in such regulations shall modify
2 the provisions of paragraph (1), (3), or (4) of sec-
3 tion 3121(d), section 3506, section 3508, or section
4 3511.”

5 (b) CLERICAL AMENDMENT.—The table of sections
6 for chapter 25 is amended by adding at the end thereof
7 the following new item:

 “Sec. 3510. Definition of employee.”

8 (c) EFFECTIVE DATE.—The regulations described in
9 section 3510 of the Internal Revenue Code of 1986 (as
10 added by this section) shall be effective for periods begin-
11 ning no earlier than the date which is 6 months after the
12 date such regulations are promulgated as final regula-
13 tions.

14 (d) REPORT TO CONGRESS.—Upon issuance of the
15 regulations described in section 3510 of the Internal Rev-
16 enue Code of 1986 (as added by this section) as final regu-
17 lations, the Secretary of the Treasury shall submit a re-
18 port to Congress relating to such regulations, including
19 an explanation of their purposes and the issues they are
20 designed to address.

21 **SEC. 7302. INCREASE IN SERVICES REPORTING PENALTIES.**

22 (a) INCREASE IN PENALTY.—Section 6721(a) (relat-
23 ing to imposition of penalty) is amended by adding at the
24 end the following new paragraph:

1 “(3) INCREASED PENALTY FOR RETURNS IN-
2 VOLVING PAYMENTS FOR SERVICES.—

3 “(A) IN GENERAL.—Subject to the overall
4 limitation of paragraph (1), the amount of the
5 penalty under paragraph (1) for any failure
6 with respect to any applicable return shall be
7 equal to the greater of \$50 or 5 percent of the
8 amount required to be reported correctly but
9 not so reported.

10 “(B) EXCEPTION WHERE SUBSTANTIAL
11 COMPLIANCE.—Subparagraph (A) shall not
12 apply to failures with respect to applicable re-
13 turns required to be filed by a person during
14 any calendar year if the aggregate amount
15 which is timely and correctly reported on appli-
16 cable returns filed by the person for the cal-
17 endar year is at least 97 percent of the aggre-
18 gate amount which is required to be reported
19 on applicable returns by the person for the cal-
20 endar year.

21 “(C) APPLICABLE RETURN.—For purposes
22 of this paragraph, the term ‘applicable return’
23 means any information return required to be
24 filed under—

1 “(i) section 6041(a) which relates to
2 payments to any person for services per-
3 formed by such person (other than as an
4 employee), or

5 “(ii) section 6041A(a).”

6 (b) CONFORMING AMENDMENT.—Section 6721(a)(1)
7 is amended by striking “In” and inserting “Except as pro-
8 vided in paragraph (3), in”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to returns the due date for which
11 (without regard to extensions) is more than 30 days after
12 the date of the enactment of this Act.

13 **SEC. 7303. REVISION OF SECTION 530 SAFE HARBOR RULES.**

14 (a) GENERAL RULE.—Chapter 25 (relating to gen-
15 eral provisions applicable to employment taxes) is amend-
16 ed by adding at the end thereof the following new section:

17 **“SEC. 3511. PROTECTION AGAINST RETROACTIVE EMPLOY-
18 MENT TAX RECLASSIFICATIONS.**

19 “(a) GENERAL RULE.—If—

20 “(1) for purposes of employment taxes, the tax-
21 payer treats an individual as not being an employee
22 for any period,

23 “(2) for such period, the taxpayer meets—

24 “(A) the consistency requirements of sub-
25 section (b),

1 “(B) the return filing requirements of sub-
2 section (c), and

3 “(C) the safe harbor requirement of sub-
4 section (d), and

5 “(3) the Secretary has not notified the taxpayer
6 in writing before the beginning of such period that
7 the Secretary has determined that the taxpayer
8 should treat such individual (or any individual hold-
9 ing a substantially similar position) as an employee,
10 then, for purposes of applying this subtitle for such period,
11 the individual shall be deemed not to be an employee of
12 the taxpayer.

13 “(b) CONSISTENCY REQUIREMENTS.—A taxpayer
14 meets the consistency requirements of this subsection with
15 respect to any individual for any period if the taxpayer
16 treats such individual (and all other individuals holding
17 substantially similar positions) as not being an employee
18 for purposes of the employment taxes for such period and
19 all prior periods.

20 “(c) RETURN FILING REQUIREMENTS.—

21 “(1) IN GENERAL.—The taxpayer meets the re-
22 turn filing requirements of this subsection with re-
23 spect to any individual for any period if all Federal
24 tax returns (including information returns) required
25 to be filed by the taxpayer for such period with re-

1 spect to such individual (and all other individuals
2 holding substantially similar positions) are timely
3 filed on a basis consistent with the taxpayer's treat-
4 ment of such individuals as not being employees.

5 “(2) SPECIAL RULES.—For purposes of para-
6 graph (1)—

7 “(A) any return filed for which the penalty
8 under section 6721(a) is reduced or waived pur-
9 suant to subsection (b) or (c) of section 6721
10 shall be considered timely filed, and

11 “(B) a taxpayer shall not be considered as
12 failing to meet the requirements of paragraph
13 (1) solely because the taxpayer failed to timely
14 file accurate information returns in respect of
15 payments to individuals holding substantially
16 similar positions if the taxpayer satisfies the re-
17 quirements of section 6721(a)(3)(B) for such
18 period.

19 “(d) SAFE HARBORS.—

20 “(1) IN GENERAL.—The taxpayer meets the
21 safe harbor requirement of this subsection with re-
22 spect to any individual for any period if the tax-
23 payer's treatment of such individual as not being an
24 employee for such period was—

1 “(A) in reasonable reliance on a written
2 determination (as defined in section
3 6110(b)(1)) issued to or in respect of the tax-
4 payer that addressed the employment status of
5 the individual or an individual holding a sub-
6 stantially similar position;

7 “(B) in reasonable reliance on a concluded
8 Internal Revenue Service audit of the
9 taxpayer—

10 “(i) which was for a period in which
11 the rules for determining employment sta-
12 tus were the same as for the period in
13 question, and

14 “(ii) in which the employment status
15 of the individual or any individual holding
16 a substantially similar position was exam-
17 ined without change to any such individ-
18 ual’s status;

19 “(C) in reasonable reliance on a long-
20 standing recognized practice of a significant
21 segment of the industry in which the individual
22 is engaged; or

23 “(D) supported by substantial authority.

24 For purposes of subparagraph (D), the term ‘sub-
25 stantial authority’ has the same meaning as when

1 used in section 6662(d)(2)(B)(i); except that such
2 term shall not include any private letter ruling
3 issued to a person other than the taxpayer.

4 “(2) SPECIAL RULES.—

5 “(A) SUBSEQUENT AUTHORITY.—The tax-
6 payer shall not be considered to meet the safe
7 harbor requirement of paragraph (1)(B) with
8 respect to any individual for any period if the
9 treatment of such individual as not being an
10 employee is inconsistent with any regulation,
11 Revenue Ruling, Revenue Procedure, or other
12 authority published by the Secretary before the
13 beginning of such period and after the conclu-
14 sion of the audit referred to in paragraph
15 (1)(B).

16 “(B) TERMINATION OF INDUSTRY PRAC-
17 TICE SAFE HARBOR.—The taxpayer shall not be
18 considered to meet the safe harbor requirement
19 of paragraph (1)(C) with respect to any indi-
20 vidual for—

21 “(i) any period beginning after the
22 date on which the Secretary prescribes reg-
23 ulations pursuant to section 3510, or

24 “(ii) any period if the treatment of
25 such individual as not being an employee is

1 inconsistent with any regulation, Revenue
2 Ruling, Revenue Procedure, or other au-
3 thority published by the Secretary before
4 the beginning of such period.

5 “(e) DEFINITIONS AND SPECIAL RULES.—For pur-
6 poses of this section—

7 “(1) EMPLOYMENT TAX.—The term ‘employ-
8 ment tax’ means any tax imposed by this subtitle.

9 “(2) TAXPAYER.—The term ‘taxpayer’ includes
10 any person or entity (including a governmen-
11 tal entity) which is (or would be but for this section) liable
12 for any employment tax. Such term includes any
13 predecessor or successor to the taxpayer.

14 “(f) REGULATIONS.—The Secretary shall prescribe
15 such regulations as may be appropriate to carry out the
16 purposes of this section.”

17 (b) RULES TO APPLY FOR INCOME TAX PUR-
18 POSES.—Part I of subchapter B of chapter 1 is amended
19 by adding at the end thereof the following new section:

20 **“SEC. 69. DETERMINATION OF EMPLOYMENT STATUS.**

21 “For purposes of this subtitle, an individual shall be
22 treated as a self-employed individual with respect to any
23 services performed by such individual for another person
24 if, under the rules of section 3511, such individual is treat-

1 ed as not being an employee of such other person with
2 respect to such services.”

3 (c) CONFORMING AMENDMENT.—Section 530 of the
4 Revenue Act of 1978 is hereby repealed.

5 (d) CLERICAL AMENDMENTS.—

6 (1) The table of sections for chapter 25 is
7 amended by adding at the end thereof the following
8 new item:

“Sec. 3511. Protection against retroactive employment tax reclas-
sifications.”

9 (2) The table of sections for part I of sub-
10 chapter B of chapter 1 is amended by adding at the
11 end thereof the following new item:

“Sec. 69. Determination of employment status.”

12 (e) EFFECTIVE DATE.—

13 (1) IN GENERAL.—Except as provided in para-
14 graph (2), the amendments made by this section
15 shall apply to all periods beginning after December
16 31, 1995.

17 (2) REPEAL OF LIMITATIONS ON REGULATIONS
18 AND RULINGS.—The repeal made by subsection (c),
19 insofar as it relates to section 530(b) of the Revenue
20 Act of 1978, shall take effect on the date of the en-
21 actment of this Act.

1 **Subtitle D—Tax Treatment of**
2 **Funding of Retiree Health Benefits**

3 **SEC. 7401. POST-RETIREMENT MEDICAL AND LIFE INSUR-**
4 **ANCE RESERVES.**

5 (a) MINIMUM PERIOD FOR WORKING LIVES.—Sec-
6 tion 419A(c)(2) (relating to additional reserves for post-
7 retirement medical and life insurance benefits) is amended
8 by inserting “(but not less than 10 years)” after “working
9 lives of the covered employees”.

10 (b) SEPARATE ACCOUNTING.—

11 (1) REQUIREMENT.—Section 419A(c)(2) is
12 amended by adding at the end the following new
13 flush sentence:

14 “Such reserve shall be maintained as a separate account.”

15 (2) USE OF RESERVE FOR OTHER PURPOSES.—

16 Paragraph (1) of section 4976(b) (defining disquali-
17 fied benefit) is amended by striking “and” at the
18 end of subparagraph (B), by striking the period at
19 the end of subparagraph (C) and inserting “, and”,
20 and by adding after subparagraph (C) the following
21 new subparagraph:

22 “(D) any payment to which subparagraph

23 (C) does not apply which is out of an account

24 described in section 419A(c)(2) and which is

1 not used to provide a post-retirement medical
2 benefit or life insurance benefit.”

3 (c) SPECIAL LIMITATIONS.—Section 419A(e) (relat-
4 ing to special limitations on reserves) is amended by add-
5 ing at the end the following new paragraph:

6 “(3) BENEFITS MUST BE EXCLUDABLE.—Post-
7 retirement medical benefits and life insurance bene-
8 fits shall not be taken into account under subsection
9 (c)(2) to the extent it may be reasonably anticipated
10 that such benefits will be required to be included in
11 gross income when provided.”

12 (d) EFFECTIVE DATES.—

13 (1) IN GENERAL.—Except as provided in para-
14 graph (2), the amendments made by this section
15 shall apply to contributions paid or accrued after
16 December 31, 1994, in taxable years ending after
17 such date.

18 (2) SEPARATE ACCOUNTING.—The amendments
19 made by subsection (b) shall apply to contributions
20 paid or accrued after the date of the enactment of
21 this Act, in taxable years ending after such date.

22 **SEC. 7402. HEALTH BENEFITS ACCOUNTS MAINTAINED BY**
23 **PENSION PLANS.**

24 (a) TERMINATION OF ACCOUNTS.—

1 (1) IN GENERAL.—Section 401(h) (relating to
2 medical, etc., benefits for retired employees and
3 their spouses and dependents) is amended by adding
4 at the end the following new paragraph:

5 “(2) TERMINATION.—

6 “(A) IN GENERAL.—In the case of a pen-
7 sion or annuity plan to which paragraph (1)
8 applies—

9 “(i) no contributions may be made to
10 the separate account described in para-
11 graph (1)(C) other than allowable con-
12 tributions, and

13 “(ii) such plan may pay benefits de-
14 scribed in paragraph (1) only from funds
15 attributable to allowable contributions and
16 earnings allocable to such contributions.

17 “(B) ALLOWABLE CONTRIBUTION.—For
18 purposes of subparagraph (A), the term ‘allow-
19 able contribution’ means—

20 “(i) any contribution made before
21 January 1, 1995,

22 “(ii) in the case of a plan maintained
23 pursuant to 1 or more collective bargaining
24 agreements between employee representa-
25 tives and 1 or more employees ratified on

1 or before October 29, 1993, any contribu-
2 tion under such plan made before the ear-
3 lier of—

4 “(I) the date on which the last of
5 such agreements terminates (deter-
6 mined without regard to any extension
7 after October 29, 1993), or, if later,
8 January 1, 1995, or

9 “(II) January 1, 1998, or

10 “(iii) any qualified transfer under sec-
11 tion 420.”

12 (2) CONFORMING AMENDMENTS.—Section
13 401(h) is amended—

14 (A) by striking “Under” and inserting:

15 “(1) IN GENERAL.—Under”,

16 (B) by redesignating paragraphs (1)
17 through (6) as subparagraphs (A) through (F),
18 respectively,

19 (C) by striking “paragraph (6)” and in-
20 serting “subparagraph (F)”, and

21 (D) by striking “paragraph (1)” and in-
22 serting “subparagraph (A)”.

23 (b) MINIMUM COST REQUIREMENTS OF EM-
24 PLOYER.—Paragraph (3) of section 420(c) (relating to

1 minimum cost requirements) is amended by adding at the
2 end the following new subparagraph:

3 “(E) ADJUSTMENT FOR COST SAVINGS
4 UNDER HEALTH SECURITY ACT.—To the extent
5 provided by the Secretary, a plan shall not be
6 treated as failing to meet the requirements of
7 this section to the extent such failure is attrib-
8 utable to a reduction in qualified current retiree
9 health liabilities by reason of the enactment of
10 the Health Security Act.”

11 **Subtitle E—Coordination With**
12 **COBRA Continuing Care Provi-**
13 **sions**

14 **SEC. 7501. COORDINATION WITH COBRA CONTINUING CARE**
15 **PROVISIONS.**

16 (a) PERIOD OF COVERAGE.—Clause (iv) of section
17 4980B(f)(2)(B) (defining period of coverage) is
18 amended—

19 (1) by striking “or” at the end of subclause (I),
20 by striking the period at the end of subclause (II)
21 and inserting “, or”, and by adding at the end the
22 following new subclause:

23 “(III) eligible for comprehensive health cov-
24 erage described in section 1101 of the Health Secu-
25 rity Act.”, and

1 (2) by striking “OR MEDICARE ENTITLEMENT”
2 in the heading and inserting “, MEDICARE ENTITLE-
3 MENT, OR HEALTH SECURITY ACT ELIGIBILITY”.

4 (b) QUALIFIED BENEFICIARY.—Section 4980B(g)(1)
5 (defining qualified beneficiary) is amended by adding at
6 the end the following new subparagraph:

7 “(E) SPECIAL RULE FOR INDIVIDUALS
8 COVERED BY HEALTH SECURITY ACT.—The
9 term ‘qualified beneficiary’ shall not include any
10 individual who, upon termination of coverage
11 under a group health plan, is eligible for com-
12 prehensive health coverage described in section
13 1101 of the Health Security Act.”

14 (c) REPEAL UPON IMPLEMENTATION OF HEALTH
15 SECURITY ACT.—

16 (1) IN GENERAL.—Section 4980B (relating to
17 failure to satisfy continuation coverage requirements
18 of group health care plans) is hereby repealed.

19 (2) CONFORMING AMENDMENTS.—

20 (A) Section 414(n)(3)(C) is amended by
21 striking “505, and 4980B” and inserting “and
22 505”.

23 (B) Section 414(t)(2) is amended by strik-
24 ing “505, or 4980B” and inserting “or 505”.

1 (C) The table of sections for chapter 43 is
2 amended by striking the item relating to section
3 4980B.

4 (3) EFFECTIVE DATE.—The amendments made
5 by this subsection shall take effect on the earlier
6 of—

7 (A) January 1, 1998, or

8 (B) the first day of the first calendar year
9 following the calendar year in which all States
10 have in effect plans under which individuals are
11 eligible for comprehensive health coverage de-
12 scribed in section 1101 of this Act.

13 Such amendments shall not apply in determining the
14 amount of any tax under section 4980B of the Inter-
15 nal Revenue Code of 1986 with respect to any fail-
16 ure occurring before the date determined under the
17 preceding sentence.

18 **Subtitle F—Tax Treatment of Orga-**
19 **nizations Providing Health Care**
20 **Services and Related Organiza-**
21 **tions**

22 **SEC. 7601. TREATMENT OF NONPROFIT HEALTH CARE OR-**
23 **GANIZATIONS.**

24 (a) TREATMENT OF HOSPITALS AND OTHER ENTI-
25 TIES PROVIDING HEALTH CARE SERVICES.—Section 501

1 (relating to exemption from tax on corporations, certain
2 trusts, etc.) is amended by redesignating subsection (n)
3 as subsection (o) and by inserting after subsection (m) the
4 following new subsection:

5 “(n) QUALIFICATION OF ORGANIZATIONS PROVIDING
6 HEALTH CARE SERVICES AS CHARITABLE ORGANIZA-
7 TIONS.—For purposes of subsection (c)(3), the provision
8 of health care services shall not be treated as an activity
9 that accomplishes a charitable purpose unless the organi-
10 zation providing such services, on a periodic basis (no less
11 frequently than annually), and with the participation of
12 community representatives—

13 “(1) assesses the health care needs of its com-
14 munity, and

15 “(2) develops a plan to meet those needs.

16 In the case of a health maintenance organization, the pro-
17 vision of health care services shall not be treated as an
18 activity that accomplishes a charitable purpose for pur-
19 poses of subsection (c)(3) unless, in addition to meeting
20 the requirement of the preceding sentence, such services
21 are provided as described in subsection (m)(6)(B)(i).”

22 (b) TREATMENT OF HEALTH MAINTENANCE ORGA-
23 NIZATIONS.—Section 501(m) is amended by adding at the
24 end thereof the following new paragraph:

1 “(6) INSURANCE PROVIDED BY HEALTH MAIN-
2 TENANCE ORGANIZATIONS.—

3 “(A) CERTAIN INSURANCE TREATED AS
4 COMMERCIAL-TYPE INSURANCE.—Health insur-
5 ance provided by a health maintenance organi-
6 zation shall be treated as commercial-type in-
7 surance if such insurance relates to care pro-
8 vided other than pursuant to a pre-existing ar-
9 rangement with such organization. In applying
10 the preceding sentence, care described in sub-
11 paragraph (B)(iv) shall not be taken into ac-
12 count.

13 “(B) CERTAIN INSURANCE NOT TREATED
14 AS COMMERCIAL-TYPE INSURANCE.—Health in-
15 surance provided by a health maintenance orga-
16 nization shall not be treated as commercial-type
17 insurance if it relates to—

18 “(i) care provided by such organiza-
19 tion to its members at its own facilities
20 through health care professionals who do
21 not provide substantial health care services
22 other than on behalf of such organization,

23 “(ii) primary care provided by a
24 health care professional to a member of
25 such organization on a basis under which

1 the amount paid to such professional does
2 not vary with the amount of care provided
3 to such member,

4 “(iii) services other than primary care
5 provided pursuant to a pre-existing ar-
6 rangement with such organization, or

7 “(iv) emergency care provided to a
8 member of such organization at a location
9 outside such member’s area of residence.”

10 (c) TREATMENT OF PARENT ORGANIZATIONS OF
11 HEALTH CARE PROVIDERS.—Section 509(a) (defining
12 private foundation) is amended by striking “and” at the
13 end of paragraph (3), by redesignating paragraph (4) as
14 paragraph (5), and by inserting after paragraph (3) the
15 following new paragraph:

16 “(4) an organization which is organized and op-
17 erated for the benefit of, and which directly or indi-
18 rectly controls, an organization described in section
19 170(b)(1)(A)(iii), and”.

20 (d) EFFECTIVE DATES.—

21 (1) IN GENERAL.—Except as provided in para-
22 graph (2), the amendments made by this section
23 shall take effect on January 1, 1995.

1 (2) SUBSECTIONS (b) AND (c).—The amend-
2 ments made by subsections (b) and (c) shall take ef-
3 fect on the date of the enactment of this Act.

4 **SEC. 7602. TAX TREATMENT OF TAXABLE ORGANIZATIONS**
5 **PROVIDING HEALTH INSURANCE AND OTHER**
6 **PREPAID HEALTH CARE SERVICES.**

7 (a) GENERAL RULE.—Section 833 is amended to
8 read as follows:

9 **“SEC. 833. TREATMENT OF ORGANIZATIONS PROVIDING**
10 **HEALTH INSURANCE AND OTHER PREPAID**
11 **HEALTH CARE SERVICES.**

12 “(a) GENERAL RULE.—Any organization to which
13 this section applies shall be taxable under this part in the
14 same manner as if it were an insurance company other
15 than a life insurance company.

16 “(b) ORGANIZATIONS TO WHICH SECTION AP-
17 PLIES.—This section shall apply to any organization—

18 “(1) which is not exempt from taxation under
19 this subtitle,

20 “(2) which is not taxable as a life insurance
21 company under part I of this subchapter, and

22 “(3) the primary and predominant business ac-
23 tivity of which during the taxable year consists of 1
24 or more of the following:

1 “(A) Issuing accident and health insurance
2 contracts or the reinsuring of risks undertaken
3 by other insurance companies under such con-
4 tracts.

5 “(B) Operating as a health maintenance
6 organization.

7 “(C) Entering into arrangements under
8 which—

9 “(i) fixed payments or premiums are
10 received as consideration for the organiza-
11 tion’s agreement to provide or arrange for
12 the provision of health care services, re-
13 gardless of how the health care services are
14 provided or arranged to be provided, and

15 “(ii) such fixed payments or pre-
16 miums do not vary depending on the
17 amount of health care services provided.

18 In the case of an organization which has as a material
19 business activity the issuing of accident and health insur-
20 ance contracts or the reinsuring of risks undertaken by
21 other insurance companies under such contracts, the ad-
22 ministering of accident and health insurance contracts by
23 such organization shall be treated as part of such business
24 activity for purposes of paragraph (3)(A).”

25 (b) CONFORMING AMENDMENTS.—

1 (1) Subsection (c) of section 56 is amended by
2 striking paragraph (3).

3 (2) The table of sections for part II of sub-
4 chapter L of chapter 1 is amended by striking the
5 item relating to section 833 and inserting the fol-
6 lowing:

 “Sec. 833. Treatment of organizations providing health insurance
 and other prepaid health care services.”

7 (c) EFFECTIVE DATES.—

8 (1) IN GENERAL.—Except as otherwise pro-
9 vided in this subsection, the amendments made by
10 this section shall apply to taxable years beginning
11 after December 31, 1996.

12 (2) TRANSITION RULES FOR BLUE CROSS AND
13 BLUE SHIELD ORGANIZATIONS.—

14 (A) PRIOR FRESH START PRESERVED.—

15 The adjusted basis of any asset determined
16 under section 1012(c)(3)(A)(ii) of the Tax Re-
17 form Act of 1986 shall not be affected by the
18 amendments made by this section nor by reason
19 of any failure to qualify in taxable years begin-
20 ning after December 31, 1996, as an existing
21 Blue Cross or Blue Shield organization (as de-
22 fined in section 833(c)(2) of the Internal Rev-
23 enue Code of 1986, as in effect on the day be-
24 fore the date of the enactment of this Act).

1 (B) RECOUPMENT OF PRIOR RESERVE
2 BENEFIT.—In the case of any organization enti-
3 tled to the benefits of section 833(a)(3) of the
4 Internal Revenue Code of 1986 (as in effect on
5 the day before the date of the enactment of this
6 Act) for such organization's last taxable year
7 beginning before January 1, 1997, the amount
8 determined under paragraph (4) of section
9 832(b) of such Code for each of such organiza-
10 tion's first 6 taxable years beginning after De-
11 cember 31, 1996, shall be increased by an
12 amount equal to 3 $\frac{1}{3}$ percent of its unearned
13 premiums on outstanding business as of the
14 close of such organization's last taxable year be-
15 ginning before January 1, 1997.

16 (C) PHASE-OUT OF SPECIAL DEDUCTION
17 FOR CERTAIN ORGANIZATIONS.—

18 (i) IN GENERAL.—In the case of an
19 organization which meets the requirements
20 of clause (ii)—

21 (I) such organization shall con-
22 tinue to be entitled to the deduction
23 provided under section 833(b) of the
24 Internal Revenue Code of 1986 (as in
25 effect on the day before the date of

1 the enactment of this Act) for its first
2 taxable years beginning after De-
3 cember 31, 1996, except that

4 (II) the amount of such deduc-
5 tion for such organization's taxable
6 year beginning in 1997 shall be 67
7 percent of the amount which would
8 have been determined under such sec-
9 tion 833(b) as so in effect, and the
10 amount of such deduction for organi-
11 zation's taxable year beginning in
12 1998 shall be 33 percent of the
13 amount which would have been so de-
14 termined.

15 Notwithstanding the amendment made by
16 subsection (b)(1), any deduction under the
17 preceding sentence shall not be allowable
18 in computing alternative minimum taxable
19 income.

20 (ii) REQUIREMENTS.—An organiza-
21 tion meets the requirements of this clause
22 if, for each of its taxable years beginning
23 in 1995 and 1996, such organization—

1 (I) was an organization to which
2 section 833 of such Code (as so in ef-
3 fect) applied, and

4 (II) met the requirements of sub-
5 paragraph (A) of section 833(c)(3) of
6 such Code (as so in effect).

7 (3) TRANSITIONAL RULES FOR OTHER COMPA-
8 NIES.—

9 (A) ORGANIZATIONS TO WHICH PARA-
10 GRAPH APPLIES.—This paragraph shall apply
11 to any organization to which section 833 of the
12 Internal Revenue Code of 1986 (as amended by
13 subsection (a)) applies for such organization's
14 first taxable year beginning after December 31,
15 1996; except that this paragraph shall not
16 apply if such organization treated itself as an
17 insurance company taxable under part II of
18 subchapter L of chapter 1 of such Code on its
19 original Federal income tax return for its tax-
20 able year beginning in 1992 and for all of its
21 taxable years thereafter beginning before Janu-
22 ary 1, 1997.

23 (B) TREATMENT OF CURRENTLY TAXABLE
24 COMPANIES.—Except as provided in subpara-

graph (C), in the case of any organization to which this paragraph applies—

(i) the amendments made by this section shall be treated as a change in the method of accounting, and

(ii) all adjustments required to be taken into account under section 481 of the Internal Revenue Code of 1986, shall be taken into account for such company's first taxable year beginning after December 31, 1996.

(C) TREATMENT OF CURRENTLY TAX EXEMPT COMPANIES.—In the case of any organization to which this paragraph applies and which was exempt from tax under chapter 1 of the Internal Revenue Code of 1986 for such organization's last taxable year beginning before January 1, 1997—

(i) no adjustment shall be made under section 481 (or any other provision) of such Code on account of a change in its method of accounting required by this section for its first taxable year beginning after December 31, 1996, and

1 (ii) for purposes of determining gain
2 or loss, the adjusted basis of any asset
3 held by such organization on the first day
4 of such taxable year shall be treated as
5 equal to its fair market value as of such
6 day.

7 **SEC. 7603. EXEMPTION FROM INCOME TAX FOR REGIONAL**
8 **ALLIANCES.**

9 (a) IN GENERAL.—Subsection (c) of section 501 (re-
10 lating to exemption from tax on corporations, certain
11 trusts, etc.) is amended by adding at the end thereof the
12 following new paragraph:

13 “(26) Any regional alliance described in section
14 1301 of the Health Security Act. Such an alliance
15 shall be treated as not described in any other para-
16 graph of this subsection.”

17 (b) EFFECTIVE DATE.—The amendment made by
18 subsection (a) shall apply to taxable years beginning after
19 the date of the enactment of this Act.

1 **Subtitle G—Tax Treatment of**
2 **Long-term Care Insurance and**
3 **Services**

4 **SEC. 7701. QUALIFIED LONG-TERM CARE SERVICES TREAT-**
5 **ED AS MEDICAL CARE.**

6 (a) GENERAL RULE.—Paragraph (1) of section
7 213(d) (defining medical care) is amended by striking
8 “or” at the end of subparagraph (B), by redesignating
9 subparagraph (C) as subparagraph (D), and by inserting
10 after subparagraph (B) the following new subparagraph:

11 “(C) for qualified long-term care services
12 (as defined in subsection (g)), or”.

13 (b) QUALIFIED LONG-TERM CARE SERVICES DE-
14 FINED.—Section 213 (relating to the deduction for med-
15 ical, dental, etc., expenses) is amended by adding at the
16 end thereof the following new subsection:

17 “(g) QUALIFIED LONG-TERM CARE SERVICES.—For
18 purposes of this section—

19 “(1) IN GENERAL.—The term ‘qualified long-
20 term care services’ means necessary diagnostic, cur-
21 ing, mitigating, treating, preventive, therapeutic, and
22 rehabilitative services, and maintenance and per-
23 sonal care services (whether performed in a residen-
24 tial or nonresidential setting) which—

1 “(A) are required by an individual during
2 any period the individual is an incapacitated in-
3 dividual (as defined in paragraph (2)),

4 “(B) have as their primary purpose—

5 “(i) the provision of needed assistance
6 with 1 or more activities of daily living (as
7 defined in paragraph (3)), or

8 “(ii) protection from threats to health
9 and safety due to severe cognitive impair-
10 ment, and

11 “(C) are provided pursuant to a continuing
12 plan of care prescribed by a licensed profes-
13 sional (as defined in paragraph (4)).

14 “(2) INCAPACITATED INDIVIDUAL.—The term
15 ‘incapacitated individual’ means any individual
16 who—

17 “(A) is unable to perform, without sub-
18 stantial assistance from another individual (in-
19 cluding assistance involving cueing or substan-
20 tial supervision), at least 2 activities of daily
21 living as defined in paragraph (3), or

22 “(B) has severe cognitive impairment as
23 defined by the Secretary in consultation with
24 the Secretary of Health and Human Services.

1 Such term shall not include any individual otherwise
2 meeting the requirements of the preceding sentence
3 unless a licensed professional within the preceding
4 12-month period has certified that such individual
5 meets such requirements.

6 “(3) ACTIVITIES OF DAILY LIVING.—Each of
7 the following is an activity of daily living:

8 “(A) Eating.

9 “(B) Toileting.

10 “(C) Transferring.

11 “(D) Bathing.

12 “(E) Dressing.

13 “(4) LICENSED PROFESSIONAL.—The term ‘li-
14 censed professional’ means—

15 “(A) a physician or registered professional
16 nurse, or

17 “(B) any other individual who meets such
18 requirements as may be prescribed by the Sec-
19 retary after consultation with the Secretary of
20 Health and Human Services.

21 “(5) CERTAIN SERVICES NOT INCLUDED.—The
22 term ‘qualified long-term care services’ shall not in-
23 clude any services provided to an individual—

24 “(A) by a relative (directly or through a
25 partnership, corporation, or other entity) unless

1 the relative is a licensed professional with re-
2 spect to such services, or

3 “(B) by a corporation or partnership which
4 is related (within the meaning of section 267(b)
5 or 707(b)) to the individual.

6 For purposes of this paragraph, the term ‘relative’
7 means an individual bearing a relationship to the in-
8 dividual which is described in paragraphs (1)
9 through (8) of section 152(a).”

10 (c) TECHNICAL AMENDMENTS.—

11 (1) Subparagraph (D) of section 213(d)(1) (as
12 redesignated by subsection (a)) is amended to read
13 as follows:

14 “(D) for insurance (including amounts
15 paid as premiums under part B of title XVIII
16 of the Social Security Act, relating to supple-
17 mentary medical insurance for the aged) cov-
18 ering medical care referred to in—

19 “(i) subparagraphs (A) and (B), or

20 “(ii) subparagraph (C), but only if
21 such insurance is provided under a quali-
22 fied long-term care insurance policy (as de-
23 fined in section 7702B(b)) and the amount
24 paid for such insurance is not disallowed
25 under section 7702B(d)(4).”

1 (2) Paragraph (6) of section 213(d) is
2 amended—

3 (A) by striking “subparagraphs (A) and
4 (B)” and inserting “subparagraph (A), (B),
5 and (C)”, and

6 (B) by striking “paragraph (1)(C)” in sub-
7 paragraph (A) and inserting “paragraph
8 (1)(D)”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years beginning after
11 December 31, 1995.

12 **SEC. 7702. TREATMENT OF LONG-TERM CARE INSURANCE.**

13 (a) GENERAL RULE.—Chapter 79 (relating to defini-
14 tions) is amended by inserting after section 7702A the fol-
15 lowing new section:

16 **“SEC. 7702B. TREATMENT OF LONG-TERM CARE INSUR-**
17 **ANCE.**

18 “(a) IN GENERAL.—For purposes of this title—

19 “(1) a qualified long-term care insurance policy
20 (as defined in subsection (b)) shall be treated as an
21 accident and health insurance contract,

22 “(2) amounts (other than policyholder dividends
23 (as defined in section 808) or premium refunds) re-
24 ceived under a qualified long-term care insurance
25 policy shall be treated as amounts received for per-

1 sonal injuries and sickness and shall be treated as
2 reimbursement for expenses actually incurred for
3 medical care (as defined in section 213(d)),

4 “(3) any plan of an employer providing cov-
5 erage under a qualified long-term care insurance pol-
6 icy shall be treated as an accident and health plan
7 with respect to such coverage,

8 “(4) amounts paid for a qualified long-term
9 care insurance policy providing the benefits de-
10 scribed in subsection (b)(6)(B) shall be treated as
11 payments made for insurance for purposes of section
12 213(d)(1)(D), and

13 “(5) a qualified long-term care insurance policy
14 shall be treated as a guaranteed renewable contract
15 subject to the rules of section 816(e).

16 “(b) QUALIFIED LONG-TERM CARE INSURANCE POL-
17 ICY.—For purposes of this title—

18 “(1) IN GENERAL.—The term ‘qualified long-
19 term care insurance policy’ means any long-term
20 care insurance policy (as defined in section 2304 of
21 the Health Security Act) that—

22 “(A) satisfies the requirements of subpart
23 B of part 3 of subtitle B of title II of the
24 Health Security Act,

1 “(B) limits benefits under such policy to
2 individuals who are certified by a licensed pro-
3 fessional (as defined in section 213(g)(4)) with-
4 in the preceding 12-month period as being un-
5 able to perform, without substantial assistance
6 from another individual (including assistance
7 involving cueing or substantial supervision), 2
8 or more activities of daily living (as defined in
9 section 213(g)(3)), or who have a severe cog-
10 nitive impairment (as defined in section
11 213(g)(2)(B)), and

12 “(C) satisfies the requirements of para-
13 graphs (2), (3), (4), (5), and (6).

14 “(2) PREMIUM REQUIREMENTS.—The require-
15 ments of this paragraph are met with respect to a
16 policy if such policy provides that premium pay-
17 ments may not be made earlier than the date such
18 payments would have been made if the contract pro-
19 vided for level annual payments over the life expect-
20 ancy of the insured or 20 years, whichever is short-
21 er. A policy shall not be treated as failing to meet
22 the requirements of the preceding sentence solely by
23 reason of a provision in the policy providing for a
24 waiver of premiums if the insured becomes an indi-
25 vidual certified in accordance with paragraph (1)(B).

1 “(3) PROHIBITION OF CASH VALUE.—The re-
2 quirements of this paragraph are met if the policy
3 does not provide for a cash value or other money
4 that can be paid, assigned, pledged as collateral for
5 a loan, or borrowed, other than as provided in para-
6 graph (4).

7 “(4) REFUNDS OF PREMIUMS AND DIVI-
8 DENDS.—The requirements of this paragraph are
9 met with respect to a policy if such policy provides
10 that—

11 “(A) policyholder dividends are required to
12 be applied as a reduction in future premiums
13 or, to the extent permitted under paragraph
14 (6), to increase benefits described in subsection
15 (a)(2), and

16 “(B) refunds of premiums upon a partial
17 surrender or a partial cancellation are required
18 to be applied as a reduction in future pre-
19 miums, and

20 “(C) any refund on the death of the in-
21 sured, or on a complete surrender or cancella-
22 tion of the policy, cannot exceed the aggregate
23 premiums paid under the contract.

24 Any refund on a complete surrender or cancellation
25 of the policy shall be includible in gross income to

1 the extent that any deduction or exclusion was allow-
2 able with respect to the premiums.

3 “(5) COORDINATION WITH OTHER ENTITLE-
4 MENTS.—The requirements of this paragraph are
5 met with respect to a policy if such policy does not
6 cover expenses incurred to the extent that such ex-
7 penses are also covered under title XVIII of the So-
8 cial Security Act or are covered under comprehensive
9 health coverage described in section 1101 of the
10 Health Security Act.

11 “(6) MAXIMUM BENEFIT.—

12 “(A) IN GENERAL.—The requirements of
13 this paragraph are met if the benefits payable
14 under the policy for any period (whether on a
15 periodic basis or otherwise) shall not exceed the
16 dollar amount in effect for such period.

17 “(B) NONREIMBURSEMENT PAYMENTS
18 PERMITTED.—Benefits shall include all pay-
19 ments described in subsection (a)(2) to or on
20 behalf of an insured individual without regard
21 to the expenses incurred during the period to
22 which the payments relate. For purposes of sec-
23 tion 213(a), such payments shall be treated as
24 compensation for expenses paid for medical
25 care.

1 “(C) DOLLAR AMOUNT.—The dollar
2 amount in effect under this paragraph shall be
3 \$150 per day (or the equivalent amount within
4 the calendar year in the case of payments on
5 other than a per diem basis).

6 “(D) ADJUSTMENTS FOR INCREASED
7 COSTS.—

8 “(i) IN GENERAL.—In the case of any
9 calendar year after 1996, the dollar
10 amount in effect under subparagraph (C)
11 for any period or portion thereof occurring
12 during such calendar year shall be equal to
13 the sum of—

14 “(I) the amount in effect under
15 subparagraph (C) for the preceding
16 calendar year (after application of this
17 subparagraph), plus

18 “(II) the product of the amount
19 referred to in subclause (I) multiplied
20 by the cost-of-living adjustment for
21 the calendar year of the amount
22 under subclause (I).

23 “(ii) COST-OF-LIVING ADJUSTMENT.—
24 For purposes of clause (i), the cost-of-liv-
25 ing adjustment for any calendar year is the

1 percentage (if any) by which the cost index
2 under clause (iii) for the preceding cal-
3 endar year exceeds such index for the sec-
4 ond preceding calendar year.

5 “(iii) COST INDEX.—The Secretary, in
6 consultation with the Secretary of Health
7 and Human Services, shall before January
8 1, 1997, establish a cost index to measure
9 increases in costs of nursing home and
10 similar facilities. The Secretary may from
11 time to time revise such index to the extent
12 necessary to accurately measure increases
13 or decreases in such costs.

14 “(iv) SPECIAL RULE FOR CALENDAR
15 YEAR 1997.—Notwithstanding clause (ii),
16 for purposes of clause (i), the cost-of-living
17 adjustment for calendar year 1997 is the
18 sum of 1 ½ percent plus the percentage by
19 which the CPI for calendar year 1996 (as
20 defined in section 1(f)(4)) exceeds the CPI
21 for calendar year 1995 (as so defined).

22 “(E) PERIOD.—For purposes of this para-
23 graph, a period begins on the date that an indi-
24 vidual has a condition which would qualify for

1 certification under subsection (b)(1)(B) and
2 ends on the earlier of the date upon which—

3 “(i) such individual has not been so
4 certified within the preceding 12-months,
5 or

6 “(ii) the individual’s condition ceases
7 to be such as to qualify for certification
8 under subsection (b)(1)(B).

9 “(F) AGGREGATION RULE.—For purposes
10 of this paragraph, all policies issued with re-
11 spect to the same insured shall be treated as
12 one policy.

13 “(c) TREATMENT OF LONG-TERM CARE INSURANCE
14 POLICIES.—For purposes of this title, any amount re-
15 ceived or coverage provided under a long-term care insur-
16 ance policy that is not a qualified long-term care insurance
17 policy shall not be treated as an amount received for per-
18 sonal injuries or sickness or provided under an accident
19 and health plan and shall not be treated as excludible from
20 gross income under any provision of this title.

21 “(d) TREATMENT OF COVERAGE PROVIDED AS PART
22 OF A LIFE INSURANCE CONTRACT.—Except as otherwise
23 provided in regulations prescribed by the Secretary, in the
24 case of any long-term care insurance coverage (whether

1 or not qualified) provided by rider on a life insurance
2 contract—

3 “(1) IN GENERAL.—This section shall apply as
4 if the portion of the contract providing such cov-
5 erage is a separate contract or policy.

6 “(2) PREMIUMS AND CHARGES FOR LONG-TERM
7 CARE COVERAGE.—Premium payments for coverage
8 under a long-term care insurance policy and charges
9 against the life insurance contract’s cash surrender
10 value (within the meaning of section 7702(f)(2)(A))
11 for such coverage shall be treated as premiums for
12 purposes of subsection (b)(2).

13 “(3) APPLICATION OF 7702.—Section
14 7702(c)(2) (relating to the guideline premium limi-
15 tation) shall be applied by increasing the guideline
16 premium limitation with respect to a life insurance
17 contract, as of any date—

18 “(A) by the sum of any charges (but not
19 premium payments) described in paragraph (2)
20 made to that date under the contract, less

21 “(B) any such charges the imposition of
22 which reduces the premiums paid for the con-
23 tract (within the meaning of section
24 7702(f)(1)).

1 “(4) APPLICATION OF SECTION 213.—No deduc-
2 tion shall be allowed under section 213(a) for
3 charges against the life insurance contract’s cash
4 surrender value described in paragraph (2), unless
5 such charges are includible in income as a result of
6 the application of section 72(e)(10) and the coverage
7 provided by the rider is a qualified long-term care
8 insurance policy under subsection (b).

9 For purposes of this subsection, the term ‘portion’ means
10 only the terms and benefits under a life insurance contract
11 that are in addition to the terms and benefits under the
12 contract without regard to the coverage under a long-term
13 care insurance policy.

14 “(e) PROHIBITION OF DISCRIMINATION.—

15 “(1) IN GENERAL.—Notwithstanding subsection
16 (a)(3), any plan of an employer providing coverage
17 under a qualified long-term care insurance policy
18 shall qualify as an accident and health plan with re-
19 spect to such coverage only if—

20 “(A) the plan allows all employees, except
21 as provided in paragraph (2), to participate,
22 and

23 “(B) the benefits provided under the plan
24 are identical for all employees that choose to
25 participate.

1 “(2) EXCLUSION OF CERTAIN EMPLOYEES.—

2 For purposes of paragraph (1), there may be ex-
3 cluded from consideration—

4 “(A) employees who have not completed 3
5 years of service;

6 “(B) employees who have not attained age
7 25;

8 “(C) part-time or seasonal employees; and

9 “(D) employees who are nonresident aliens
10 and who receive no earned income (within the
11 meaning of section 911(d)(2)) from the em-
12 ployer which constitutes income from sources
13 within the United States (within the meaning of
14 section 861(a)(3)).

15 “(f) REGULATIONS.—The Secretary shall prescribe
16 such regulations as may be necessary to carry out the re-
17 quirements of this section, including regulations to prevent
18 the avoidance of this section by providing long-term care
19 insurance coverage under a life insurance contract and to
20 provide for the proper allocation of amounts between the
21 long-term care and life insurance portions of a contract.”.

22 (b) CLERICAL AMENDMENT.—The table of sections
23 for chapter 79 is amended by inserting after the item re-
24 lating to section 7702A the following new item:

 “Sec. 7702B. Treatment of long-term care insurance.”.

25 (c) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The amendments made by
2 this section shall apply to policies issued after De-
3 cember 31, 1995. Solely for purposes of the pre-
4 ceding sentence, a policy issued prior to January 1,
5 1996, that satisfies the requirements of a qualified
6 long-term care insurance policy as set forth in sec-
7 tion 7702B(b) shall, on and after January 1, 1996,
8 be treated as being issued after December 31, 1995.

9 (2) TRANSITION RULE.—If, after the date of
10 enactment of this Act and before January 1, 1996,
11 a policy providing for long-term care insurance cov-
12 erage is exchanged solely for a qualified long-term
13 care insurance policy (as defined in section
14 7702B(b)), no gain or loss shall be recognized on
15 the exchange. If, in addition to a qualified long-term
16 care insurance policy, money or other property is re-
17 ceived in the exchange, then any gain shall be recog-
18 nized to the extent of the sum of the money and the
19 fair market value of the other property received. For
20 purposes of this paragraph, the cancellation of a pol-
21 icy providing for long-term care insurance coverage
22 and reinvestment of the cancellation proceeds in a
23 qualified long-term care insurance policy within 60
24 days thereafter shall be treated as an exchange.

1 (3) ISSUANCE OF CERTAIN RIDERS PER-
2 MITTED.—For purposes of determining whether sec-
3 tion 7702 or 7702A of the Internal Revenue Code
4 of 1986 applies to any contract, the issuance, wheth-
5 er before, on, or after December 31, 1995, of a rider
6 on a life insurance contract providing long-term care
7 insurance coverage shall not be treated as a modi-
8 fication or material change of such contract.

9 **SEC. 7703. TAX TREATMENT OF ACCELERATED DEATH BEN-**
10 **EFITS UNDER LIFE INSURANCE CONTRACTS.**

11 (a) GENERAL RULE.—Section 101 (relating to cer-
12 tain death benefits) is amended by adding at the end
13 thereof the following new subsection:

14 “(g) TREATMENT OF CERTAIN ACCELERATED
15 DEATH BENEFITS.—

16 “(1) IN GENERAL.—For purposes of this sec-
17 tion, any amount distributed to an individual under
18 a life insurance contract on the life of an insured
19 who is a terminally ill individual (as defined in para-
20 graph (3)) shall be treated as an amount paid by
21 reason of the death of such insured.

22 “(2) NECESSARY CONDITIONS.—

23 “(A) Paragraph (1) shall not apply to any
24 distribution unless—

1 “(i) the distribution is not less than
2 the present value (determined under sub-
3 paragraph (B)) of the reduction in the
4 death benefit otherwise payable in the
5 event of the death of the insured, and

6 “(ii) the percentage derived from di-
7 viding the cash surrender value of the con-
8 tract, if any, immediately after the dis-
9 tribution by the cash surrender value of
10 the contract immediately before the dis-
11 tribution is equal to or greater than the
12 percentage derived by dividing the death
13 benefit immediately after the distribution
14 by the death benefit immediately before the
15 distribution.

16 “(B) The present value of the reduction in
17 the death benefit occurring on the distribution
18 must be determined by—

19 “(i) using as the discount rate a rate
20 not to exceed the highest rate set forth in
21 subparagraph (C), and

22 “(ii) assuming that the death benefit
23 (or the portion thereof) would have been
24 paid at the end of a period that is no more
25 than the insured’s life expectancy from the

1 date of the distribution or 12 months,
2 whichever is shorter.

3 “(C) RATES.—The rates set forth in this
4 subparagraph are the following:

5 “(i) the 90-day Treasury bill yield,

6 “(ii) the rate described as Moody’s
7 Corporate Bond Yield Average-Monthly
8 Average Corporates as published by
9 Moody’s Investors Service, Inc., or any
10 successor thereto for the calendar month
11 ending 2 months before the date on which
12 the rate is determined,

13 “(iii) the rate used to compute the
14 cash surrender values under the contract
15 during the applicable period plus 1 percent
16 per annum, and

17 “(iv) the maximum permissible inter-
18 est rate applicable to policy loans under
19 the contract.

20 “(3) TERMINALLY ILL INDIVIDUAL.—For pur-
21 poses of this subsection, the term ‘terminally ill indi-
22 vidual’ means an individual who the insurer has de-
23 termined, after receipt of an acceptable certification
24 by a licensed physician, has an illness or physical
25 condition which can reasonably be expected to result

1 in death within 12 months of the date of certifi-
2 cation.

3 “(4) APPLICATION OF SECTION 72(E)(10).—For
4 purposes of section 72(e)(10) (relating to the treat-
5 ment of modified endowment contracts), section
6 72(e)(4)(A)(i) shall not apply to distributions de-
7 scribed in paragraph (1).”

8 (b) EFFECTIVE DATE.—The amendment made by
9 subsection (a) shall apply to taxable years beginning after
10 December 31, 1993.

11 **SEC. 7704. TAX TREATMENT OF COMPANIES ISSUING**
12 **QUALIFIED ACCELERATED DEATH BENEFIT**
13 **RIDERS.**

14 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-
15 ERS TREATED AS LIFE INSURANCE.—Section 818 (relat-
16 ing to other definitions and special rules) is amended by
17 adding at the end thereof the following new subsection:

18 “(g) QUALIFIED ACCELERATED DEATH BENEFIT
19 RIDERS TREATED AS LIFE INSURANCE.—For purposes of
20 this part—

21 “(1) IN GENERAL.—Any reference to a life in-
22 surance contract shall be treated as including a ref-
23 erence to a qualified accelerated death benefit rider
24 on such contract.

1 “(2) QUALIFIED ACCELERATED DEATH BEN-
2 EFIT RIDERS.—For purposes of this subsection, the
3 term ‘qualified accelerated death benefit rider’
4 means any rider on a life insurance contract which
5 provides for a distribution to an individual upon the
6 insured becoming a terminally ill individual (as de-
7 fined in section 101(g)(3)).

8 (b) DEFINITIONS OF LIFE INSURANCE AND MODI-
9 FIED ENDOWMENT CONTRACTS.—Paragraph (5)(A) of
10 section 7702(f) is amended by striking “or” at the end
11 of clause (iv), by redesignating clause (v) as clause (vi),
12 and by inserting after clause (iv) the following new clause:

13 “(v) any qualified accelerated death
14 benefit rider (as defined in section 818(g)),
15 or”.

16 (c) EFFECTIVE DATE.—

17 (1) IN GENERAL.—The amendments made by
18 this section shall apply to contracts issued after De-
19 cember 31, 1993.

20 (2) TRANSITIONAL RULE.—For purposes of de-
21 termining whether section 7702 or 7702A of the In-
22 ternal Revenue Code of 1986 applies to any con-
23 tract, the issuance, whether before, on, or after De-
24 cember 31, 1993, of a rider on a life insurance con-
25 tract permitting the acceleration of death benefits

1 (as described in section 101(g) of such Code) shall
 2 not be treated as a modification or material change
 3 of such contract.

4 **Subtitle H—Tax Incentives for**
 5 **Health Services Providers**

6 **SEC. 7801. NONREFUNDABLE CREDIT FOR CERTAIN PRI-**
 7 **MARY HEALTH SERVICES PROVIDERS.**

8 (a) IN GENERAL.—Subpart A of part IV of sub-
 9 chapter A of chapter 1 (relating to nonrefundable personal
 10 credits) is amended by inserting after section 22 the fol-
 11 lowing new section:

12 **“SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.**

13 “(a) ALLOWANCE OF CREDIT.—There shall be al-
 14 lowed as a credit against the tax imposed by this chapter
 15 for the taxable year an amount equal to the product of—

16 “(1) the number of months during such taxable
 17 year—

18 “(A) during which the taxpayer is a quali-
 19 fied primary health services provider, and

20 “(B) which are within the taxpayer’s man-
 21 datory service period, and

22 “(2) \$1,000 (\$500 in the case of a qualified
 23 practitioner who is not a physician).

24 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-
 25 VIDER.—For purposes of this section, the term ‘qualified

1 primary health services provider’ means, with respect to
2 any month, any qualified practitioner who—

3 “(1) has in effect a certification by the Bureau
4 as a provider of primary health services and such
5 certification is, when issued, for a health profes-
6 sional shortage area in which the qualified practi-
7 tioner is commencing the providing of primary
8 health services,

9 “(2) is providing primary health services full
10 time in the health professional shortage area identi-
11 fied in such certification, and

12 “(3) has not received a scholarship under the
13 National Health Service Corps Scholarship Program
14 or any loan repayments under the National Health
15 Service Corps Loan Repayment Program.

16 For purposes of paragraph (2), a provider shall be treated
17 as providing services in a health professional shortage area
18 when such area ceases to be such an area if it was such
19 an area when the provider commenced providing services
20 in the area.

21 “(c) MANDATORY SERVICE PERIOD.—For purposes
22 of this section, the term ‘mandatory service period’ means
23 the period of 60 consecutive calendar months beginning
24 with the first month the taxpayer is a qualified primary

1 health services provider. A taxpayer shall not have more
2 than 1 mandatory service period.

3 “(d) DEFINITIONS AND SPECIAL RULES.—For pur-
4 poses of this section—

5 “(1) BUREAU.—The term ‘Bureau’ means the
6 Bureau of Primary Health Care, Health Resources
7 and Services Administration of the United States
8 Public Health Service.

9 “(2) QUALIFIED PRACTITIONER.—The term
10 ‘qualified practitioner’ means a physician, a physi-
11 cian assistant, a nurse practitioner, or a certified
12 nurse-midwife.

13 “(3) PHYSICIAN.—The term ‘physician’ has the
14 meaning given to such term by section 1861(r) of
15 the Social Security Act.

16 “(4) PHYSICIAN ASSISTANT; NURSE PRACTI-
17 TIONER.—The terms ‘physician assistant’ and ‘nurse
18 practitioner’ have the meanings given to such terms
19 by section 1861(aa)(5) of the Social Security Act.

20 “(5) CERTIFIED NURSE-MIDWIFE.—The term
21 ‘certified nurse-midwife’ has the meaning given to
22 such term by section 1861(gg)(2) of the Social Secu-
23 rity Act.

24 “(6) PRIMARY HEALTH SERVICES.—The term
25 ‘primary health services’ has the meaning given such

1 term by section 330(b)(1) of the Public Health Serv-
 2 ice Act.

3 “(7) HEALTH PROFESSIONAL SHORTAGE
 4 AREA.—The term ‘health professional shortage area’
 5 has the meaning given such term by section
 6 332(a)(1)(A) of the Public Health Service Act.

7 “(e) RECAPTURE OF CREDIT.—

8 “(1) IN GENERAL.—If there is a recapture
 9 event during any taxable year, then—

10 “(A) no credit shall be allowed under sub-
 11 section (a) for such taxable year and any suc-
 12 ceeding taxable year, and

13 “(B) the tax of the taxpayer under this
 14 chapter for such taxable year shall be increased
 15 by an amount equal to the product of—

16 “(i) the applicable percentage, and

17 “(ii) the aggregate unrecaptured cred-
 18 its allowed to such taxpayer under this sec-
 19 tion for all prior taxable years.

20 “(2) APPLICABLE RECAPTURE PERCENTAGE.—

21 “(A) IN GENERAL.—For purposes of this
 22 subsection, the applicable recapture percentage
 23 shall be determined from the following table:

“If the recapture event occurs during:	The applicable recap- ture percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50

Months 49–60	25
Months 61 and thereafter	0.

1 “(B) TIMING.—For purposes of subpara-
 2 graph (A), month 1 shall begin on the first day
 3 of the mandatory service period.

4 “(3) RECAPTURE EVENT DEFINED.—

5 “(A) IN GENERAL.—For purposes of this
 6 subsection, the term ‘recapture event’ means
 7 the failure of the taxpayer to be a qualified pri-
 8 mary health services provider for any month
 9 during the taxpayer’s mandatory service period.

10 “(B) CESSATION OF DESIGNATION.—The
 11 cessation of the designation of any area as a
 12 health professional shortage area after the be-
 13 ginning of the mandatory service period for any
 14 taxpayer shall not constitute a recapture event.

15 “(C) SECRETARIAL WAIVER.—The Sec-
 16 retary, in consultation with the Secretary of
 17 Health and Human Services, may waive any re-
 18 capture event caused by extraordinary cir-
 19 cumstances.

20 “(4) NO CREDITS AGAINST TAX; MINIMUM
 21 TAX.—Any increase in tax under this subsection
 22 shall not be treated as a tax imposed by this chapter
 23 for purposes of determining the amount of any cred-

1 it under subpart A, B, or D of this part or for pur-
2 poses of section 55.”

3 (b) CLERICAL AMENDMENT.—The table of sections
4 for subpart A of part IV of subchapter A of chapter 1
5 is amended by inserting after the item relating to section
6 22 the following new item:

“Sec. 23. Primary health services providers.”

7 (c) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to taxable years beginning after
9 December 31, 1994.

10 **SEC. 7802. EXPENSING OF MEDICAL EQUIPMENT.**

11 (a) IN GENERAL.—Paragraph (1) of section 179(b)
12 (relating to dollar limitation on expensing of certain depre-
13 ciable business assets) is amended to read as follows:

14 “(1) DOLLAR LIMITATION.—

15 “(A) GENERAL RULE.—The aggregate cost
16 which may be taken into account under sub-
17 section (a) for any taxable year shall not exceed
18 \$17,500.

19 “(B) HEALTH CARE PROPERTY.—The ag-
20 gregate cost which may be taken into account
21 under subsection (a) shall be increased by the
22 lesser of—

23 “(i) the cost of section 179 property
24 which is health care property placed in
25 service during the taxable year, or

1 “(ii) \$10,000.”

2 (b) DEFINITION.—Section 179(d) (relating to defini-
3 tions) is amended by adding at the end the following new
4 paragraph:

5 “(11) HEALTH CARE PROPERTY.—For purposes
6 of this section, the term ‘health care property’
7 means section 179 property—

8 “(A) which is medical equipment used in
9 the screening, monitoring, observation, diag-
10 nosis, or treatment of patients in a laboratory,
11 medical, or hospital environment,

12 “(B) which is owned (directly or indirectly)
13 and used by a physician (as defined in section
14 1861(r) of the Social Security Act) in the active
15 conduct of such physician’s full-time trade or
16 business of providing primary health services
17 (as defined in section 330(b)(1) of the Public
18 Health Service Act) in a health professional
19 shortage area (as defined in section
20 332(a)(1)(A) of the Public Health Service Act),
21 and

22 “(C) substantially all the use of which is in
23 such area.”

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to property placed in service after
3 December 31, 1994.

4 **Subtitle I—Miscellaneous**
5 **Provisions**

6 **SEC. 7901. CREDIT FOR COST OF PERSONAL ASSISTANCE**
7 **SERVICES REQUIRED BY EMPLOYED INDIVID-**
8 **UALS.**

9 (a) IN GENERAL.—Subpart A of part IV of sub-
10 chapter A of chapter 1 (relating to nonrefundable personal
11 credits) is amended by inserting after section 23 the fol-
12 lowing new section:

13 **“SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES RE-**
14 **QUIRED BY EMPLOYED INDIVIDUALS.**

15 “(a) ALLOWANCE OF CREDIT.—

16 “(1) IN GENERAL.—In the case of an eligible
17 individual, there shall be allowed as a credit against
18 the tax imposed by this chapter for the taxable year
19 an amount equal to the applicable percentage of the
20 personal assistance expenses paid or incurred by the
21 taxpayer during such taxable year.

22 “(2) APPLICABLE PERCENTAGE.—For purposes
23 of paragraph (1), the term ‘applicable percentage’
24 means 50 percent reduced (but not below zero) by
25 10 percentage points for each \$5,000 by which the

1 modified adjusted gross income (as defined in sec-
2 tion 59B(d)(2)) of the taxpayer for the taxable year
3 exceeds \$45,000. In the case of a married individual
4 filing a separate return, the preceding sentence shall
5 be applied by substituting ‘\$2,500’ for ‘\$5,000’ and
6 ‘\$22,500’ for ‘\$45,000’.

7 “(b) LIMITATION.—The amount of personal assist-
8 ance expenses incurred for the benefit of an individual
9 which may be taken into account under subsection (a) for
10 the taxable year shall not exceed the lesser of—

11 “(1) \$15,000, or

12 “(2) such individual’s earned income (as de-
13 fined in section 32(c)(2)) for the taxable year.

14 In the case of a joint return, the amount under the pre-
15 ceding sentence shall be determined separately for each
16 spouse.

17 “(c) ELIGIBLE INDIVIDUAL.—For purposes of this
18 section, the term ‘eligible individual’ means any individual
19 (other than a nonresident alien) who, by reason of any
20 medically determinable physical impairment which can be
21 expected to result in death or which has lasted or can be
22 expected to last for a continuous period of not less than
23 12 months, is unable to engage in any substantial gainful
24 activity without personal assistance services appropriate to
25 carry out activities of daily living. An individual shall not

1 be treated as an eligible individual unless such individual
2 furnishes such proof thereof (in such form and manner,
3 and at such times) as the Secretary may require.

4 “(d) OTHER DEFINITIONS.—For purposes of this
5 section—

6 “(1) PERSONAL ASSISTANCE EXPENSES.—The
7 term ‘personal assistance expenses’ means expenses
8 for—

9 “(A) personal assistance services appro-
10 priate to carry out activities of daily living in or
11 outside the home,

12 “(B) homemaker/chore services incidental
13 to the provision of such personal assistance
14 services,

15 “(C) in the case of an individual with a
16 cognitive impairment, assistance with life skills,

17 “(D) communication services,

18 “(E) work-related support services,

19 “(F) coordination of services described in
20 this paragraph,

21 “(G) assistive technology and devises, in-
22 cluding assessment of the need for particular
23 technology and devices and training of family
24 members, and

1 “(H) modifications to the principal place of
2 abode of the individual to the extent the ex-
3 penses for such modifications would (but for
4 subsection (e)(2)) be expenses for medical care
5 (as defined by section 213) of such individual.

6 “(2) ACTIVITIES OF DAILY LIVING.—The term
7 ‘activities of daily living’ means the activities re-
8 ferred to in section 213(g)(3).

9 “(e) SPECIAL RULES.—

10 “(1) PAYMENTS TO RELATED PERSONS.—No
11 credit shall be allowed under this section for any
12 amount paid by the taxpayer to any person who is
13 related (within the meaning of section 267 or
14 707(b)) to the taxpayer.

15 “(2) COORDINATION WITH MEDICAL EXPENSE
16 DEDUCTION.—Any amount taken into account in de-
17 termining the credit under this section shall not be
18 taken into account in determining the amount of the
19 deduction under section 213.

20 “(3) BASIS REDUCTION.—For purposes of this
21 subtitle, if a credit is allowed under this section for
22 any expense with respect to any property, the in-
23 crease in the basis of such property which would
24 (but for this paragraph) result from such expense

1 shall be reduced by the amount of the credit so al-
2 lowed.

3 “(f) COST-OF-LIVING ADJUSTMENT.—In the case of
4 any taxable year beginning after 1996, the \$45,000 and
5 \$22,500 amounts in subsection (a)(2) and the \$15,000
6 amount in subsection (b) shall be increased by an amount
7 equal to—

8 “(1) such dollar amount, multiplied by

9 “(2) the cost-of-living adjustment determined
10 under section 1(f)(3) for the calendar year in which
11 the taxable year begins by substituting ‘calendar
12 year 1995’ for ‘calendar year 1992’ in subparagraph
13 (B) thereof.

14 If any increase determined under the preceding sentence
15 is not a multiple of \$1,000, such increase shall be rounded
16 to the nearest multiple of \$1,000.”

17 (b) TECHNICAL AMENDMENT.—Subsection (a) of
18 section 1016 is amended by striking “and” at the end of
19 paragraph (24), by striking the period at the end of para-
20 graph (25) and inserting “, and”, and by adding at the
21 end thereof the following new paragraph:

22 “(26) in the case of any property with respect
23 to which a credit has been allowed under section 23,
24 to the extent provided in section 23(e)(3).”

1 (c) CLERICAL AMENDMENT.—The table of sections
2 for subpart A of part IV of subchapter A of chapter 1
3 is amended by inserting after the item relating to section
4 22 the following new item:

“Sec. 23. Cost of personal assistance services required by employed individuals.”

5 (d) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to taxable years beginning after
7 December 31, 1995.

8 **SEC. 7902. DENIAL OF TAX-EXEMPT STATUS FOR BOR-**
9 **ROWINGS OF HEALTH CARE-RELATED ENTI-**
10 **TIES.**

11 (a) IN GENERAL.—Paragraph (6) of section 141(b)
12 (relating to private business use) is amended by adding
13 at the end thereof the following new subparagraph:

14 “(C) CERTAIN HEALTH CARE-RELATED
15 ENTITIES.—Use by—

16 “(i) any regional alliance described in
17 section 1301 of the Health Security Act,

18 “(ii) any corporate alliance described
19 in section 1311 of such Act, and

20 “(iii) any guaranty fund described in
21 section 1204 of such Act,

22 shall be treated as private business use by an
23 organization that is not a 501(c)(3) organiza-
24 tion.”

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to obligations issued after the
3 date of the enactment of this Act.

4 **SEC. 7903. DISCLOSURE OF RETURN INFORMATION FOR AD-**
5 **MINISTRATION OF CERTAIN PROGRAMS**
6 **UNDER THE HEALTH SECURITY ACT.**

7 (a) IN GENERAL.—Subparagraph (D) of section
8 6103(l)(7) (relating to disclosure of return information to
9 Federal, State, and local agencies administering certain
10 programs) is amended by striking “and” at the end of
11 clause (viii), by striking the period at the end of clause
12 (ix) and inserting “; and”, and by inserting after clause
13 (ix) the following new clause:

14 “(x) assistance provided under the
15 Health Security Act.”

16 (b) INFORMATION NOT AVAILABLE TO LOCAL AGEN-
17 CIES.—Subparagraph (D) of section 6103(l)(7) is amend-
18 ed by adding at the end thereof the following new sen-
19 tence: “Subparagraphs (A) and (B) shall be applied with-
20 out regard to any reference to any local agency with re-
21 spect to the program referred to in clause (x).”

1 **TITLE VIII—HEALTH AND**
2 **HEALTH-RELATED PRO-**
3 **GRAMS OF THE FEDERAL**
4 **GOVERNMENT**

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1 Subtitle A—Military Health Care
2 Reform

3 SEC. 8001. UNIFORMED SERVICES HEALTH PLANS.

4 (a) ESTABLISHMENT OF PLANS.—(1) Chapter 55 of
5 title 10, United States Code, is amended by inserting after
6 section 1073 the following new section:

7 “§ 1073a. Uniformed Services Health Plans: establish-
8 ment and coordination with national
9 health care reform

10 “(a) ESTABLISHMENT AUTHORIZED.—(1) The Sec-
11 retary of Defense, in consultation with the other admin-
12 istering Secretaries, may establish one or more Uniformed
13 Services Health Plans pursuant to this section in order
14 to provide health care services to members of the uni-
15 formed services on active duty for a period of more than
16 30 days and persons described in subsection (e)(2).

17 “(2) The establishment and operation of a Uniformed
18 Services Health Plan shall be carried out in accordance

1 with regulations prescribed by the Secretary of Defense,
2 in consultation with the other administering Secretaries.
3 The Secretary shall assure that such regulations conform,
4 to the maximum extent practicable, to the requirements
5 for health plans set forth in the Health Security Act.

6 “(b) USE OF UNIFORMED SERVICES FACILITIES AND
7 OTHER HEALTH CARE PROVIDERS.—(1) A Uniformed
8 Services Health Plan may rely upon the use of facilities
9 of the uniformed services for the provision of health care
10 services to persons enrolled in the plan, supplemented by
11 the use of civilian health care providers or health plans
12 under agreements entered into by the Secretary of De-
13 fense.

14 “(2) An agreement with a civilian health care pro-
15 vider or a health plan under paragraph (1) may be entered
16 into without regard to provisions of law requiring the use
17 of competitive procedures. An agreement with a health
18 plan may provide for the sharing of resources with the
19 health plan that is a party to the agreement.

20 “(c) HEALTH CARE SERVICES UNDER A PLAN.—(1)
21 Subject to paragraph (2), a Uniformed Services Health
22 Plan shall provide to persons enrolled in the plan at least
23 the items and services in the comprehensive benefit pack-
24 age under the Health Security Act.

1 “(2)(A) In addition, a Uniformed Services Health
2 Plan shall guarantee to each person described in subpara-
3 graph (B) who is enrolled in the plan those health care
4 services that the person would be entitled to receive under
5 this chapter in the absence of this section. In the case
6 of a person described in subparagraph (B) who is a cov-
7 ered beneficiary, such health care services shall consist of
8 the types of health care services described in section
9 1079(a) of this title.

10 “(B) A person referred to in subparagraph (A) is a
11 member of the uniformed services on active duty for a pe-
12 riod of more than 30 days as of December 31, 1994, or
13 any person who is a covered beneficiary as of that date,
14 who is (or afterwards becomes) enrolled in a Uniformed
15 Services Health Plan.

16 “(d) PREEMPTION OF CONFLICTING STATE RE-
17 QUIREMENTS.—In carrying out responsibilities under the
18 Health Security Act, a State (or State-established enti-
19 ty)—

20 “(1) may not impose any standard or require-
21 ment on a Uniformed Services Health Plan that is
22 inconsistent with this section or any regulation pre-
23 scribed under this section or other Federal law re-
24 garding the operation of this section; and

1 “(2) may not deny certification of a Uniformed
2 Services Health Plan as a health plan under the
3 Health Security Act on the basis of a conflict be-
4 tween a rule of a State or health alliance and this
5 section or any regulation prescribed under this sec-
6 tion or other Federal law regarding the operation of
7 this section.

8 “(e) ENROLLMENT.—(1) Except as authorized by the
9 administering Secretary concerned, each member of a uni-
10 formed service on active duty for a period of more than
11 30 days shall be required to enroll in a Uniformed Services
12 Health Plan available to the member.

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

18 “(A) Spouses and children of members of the
19 uniformed services who are on active duty for a pe-
20 riod of more than 30 days.

21 “(B) Persons described in subsection (c) of sec-
22 tion 1086 of this title. The administering Secretary
23 concerned may disregard the exclusion set forth in
24 subsection (d)(1) of such section in the case of a
25 person described in subsection (c) of such section

1 who is enrolled in the supplementary medical insur-
2 ance program under part B of title XVIII of the So-
3 cial Security Act (42 U.S.C. 1395j et seq.).

4 “(3) With respect to a member described in para-
5 graph (1) or a covered beneficiary described in paragraph
6 (2) who enrolls in a Uniformed Services Health Plan, par-
7 ticipation in such a plan shall be the exclusive source of
8 health care services available to the member or person
9 under this chapter.

10 “(f) EFFECT OF FAILURE TO ENROLL.—(1) Except
11 as provided in paragraph (2), if a person described in sub-
12 section (e)(2) declines the opportunity offered by the ad-
13 ministering Secretaries to enroll in a Uniformed Services
14 Health Plan, the person shall not be entitled or eligible
15 for health care services in facilities of the uniformed serv-
16 ices or pursuant to a contract entered into under this
17 chapter. However, nothing in this paragraph shall be con-
18 strued to effect the right of a person to a premium pay-
19 ment by the Secretary of Defense if the person is enrolled
20 in another health plan under the Health Security Act and
21 is otherwise entitled to such a payment under subsection
22 (h).

23 “(2) A person described in subsection (e)(2) who is
24 enrolled with a health plan that is not a Uniformed Serv-
25 ices Health Plan may receive the items and services in

1 the comprehensive benefit package in a facility of the uni-
2 formed services only if—

3 “(A) the Secretary of Defense authorizes the
4 provision of a particular item or service in the pack-
5 age to the person;

6 “(B) the Secretary determines that the provi-
7 sion of the item or service involved will not interfere
8 with the provision of health care services to members
9 of the uniformed services or persons enrolled in a
10 Uniformed Services Health Plan; and

11 “(C) the health plan in which the person is en-
12 rolled agrees to pay the actual and full cost of the
13 items and services in the package actually provided
14 to the person.

15 “(3) The administering Secretaries shall assure that
16 all rights and entitlements under this chapter of any per-
17 son described in subsection (e)(2) are fully preserved if
18 the person—

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

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

24 “(g) SPECIAL RULE FOR OTHER PAYERS.—(1)(A) In
25 the case of a person who is enrolled in the supplementary

1 medical insurance program under part B of title XVIII
2 of the Social Security Act (42 U.S.C. 1395j et seq.) and
3 who is also enrolled in a Uniformed Services Health Plan,
4 Medicare shall be responsible for making a premium pay-
5 ment on behalf of the person. The payment responsibilities
6 of Medicare under this paragraph shall be in the same
7 amounts and under the same terms and conditions under
8 which the Secretary of Health and Human Services makes
9 payments to eligible organizations with a risk-sharing con-
10 tract under section 1876 of the Social Security Act. A pre-
11 mium payment by Medicare under this paragraph shall be
12 the person's exclusive benefit under Medicare.

13 “(B) In this paragraph, the term ‘Medicare’ means
14 any program administered under title XVIII of the Social
15 Security Act (42 U.S.C. 1395c et seq.).

16 “(2) Nothing in this section shall affect the payment
17 of the retiree discount under the Health Security Act on
18 behalf of a person who is enrolled in a Uniformed Services
19 Health Plan if the person is otherwise eligible for the re-
20 tiree discount.

21 “(h) PAYMENT RESPONSIBILITIES OF THE SEC-
22 RETARY.—(1) In the case of a person described in sub-
23 section (e)(2) who is not enrolled in a Uniformed Services
24 Health Plan, the Secretary may make a premium payment
25 for the person's enrollment through a health alliance in

1 another health plan. In determining the amount of the
2 payment, the Secretary shall consider the amount of any
3 retiree discount payable under the Health Security Act on
4 behalf of the person and the amount of any premium cred-
5 its attributable to employer payments with respect to em-
6 ployment of the person.

7 “(2) The Secretary shall not make a payment pursu-
8 ant to this subsection in connection with any person en-
9 rolled in a health plan of the Department of Veterans Af-
10 fairs or a health program of the Indian Health Service.

11 “(i) PAYMENT RESPONSIBILITIES OF PERSONS EN-
12 ROLLED IN A UNIFORMED SERVICES HEALTH PLAN.—(1)
13 In the case of an active duty member who is enrolled in
14 a Uniformed Services Health Plan, the administering Sec-
15 retaries may not impose or collect from the member a cost-
16 share charge of any kind (whether a premium, copayment,
17 deductible, coinsurance charge, or other charge) other
18 than subsistence charges authorized under section 1075
19 of this title.

20 “(2) Subject to paragraph (3), persons described in
21 subsection (e)(2) who are enrolled in a Uniformed Services
22 Health Plan shall have such payment responsibilities as
23 the Secretary establishes, but not to exceed payment of
24 a family share under section 1343 of a premium and cost
25 sharing. Payment obligations established under this para-

1 graph may not exceed those obligations otherwise required
2 under the national standards for health plans established
3 pursuant to the Health Security Act.

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

10 “(i) the out-of-pocket costs in effect for such
11 beneficiaries under section 1075, 1078, 1079(b), or
12 1086(b) of this title (whichever applies) on Decem-
13 ber 31, 1994; and

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

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

1 “(C) The limitation on out-of-pocket costs established
2 pursuant to subparagraph (A) may be adjusted for years
3 after 1995 by an appropriate economic index, as deter-
4 mined by the Secretary of Defense.

5 “(4) The Secretary of Defense shall establish the pay-
6 ment requirements under paragraph (2), and enforce the
7 limitations on such requirements specified in paragraph
8 (3), in regulations prescribed pursuant to subsection (a).

9 “(j) FINANCIAL ACCOUNT.—There is hereby estab-
10 lished in the Department of Defense a financial account
11 to which shall be credited all premium payments and other
12 receipts from other payers and beneficiaries made in con-
13 nection with any person enrolled in a Uniformed Services
14 Health Plan. The account shall be administered by the
15 Secretary of Defense, and funds in the account may be
16 used by the Secretary for any purpose directly related to
17 the delivery and financing of health care services under
18 this chapter, including operations, maintenance, per-
19 sonnel, procurement, contributions toward construction
20 projects, and related costs. Funds in the account shall re-
21 main available until expended.”.

22 (2) The table of sections at the beginning of such
23 chapter is amended by inserting after the item relating
24 to section 1073 the following new item:

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

1 (b) DEFINITION.—Section 1072 of such title is
2 amended by adding at the end the following new para-
3 graph:

4 “(6) The term ‘Uniformed Services Health
5 Plan’ means a plan established by the Secretary of
6 Defense under section 1073a(a) of this title in order
7 to provide health care services to members of the
8 uniformed services on active duty and other covered
9 beneficiaries under this chapter.”.

10 (c) REPORT ON ESTABLISHMENT.—If the Secretary
11 of Defense determines to establish any Uniformed Services
12 Health Plan under section 1073a of title 10, United States
13 Code, as added by subsection (a), the Secretary shall sub-
14 mit to Congress a report describing the Plans proposed
15 to be initially offered under such section. The report re-
16 quired by this subsection shall be submitted not later than
17 30 days before the date on which the Secretary first issues
18 proposed rules under subsection (a) of such section to es-
19 tablish any such Plan.

1 **Subtitle B—Department of**
2 **Veterans Affairs**

3 **SEC. 8101. BENEFITS AND ELIGIBILITY THROUGH DEPART-**
4 **MENT OF VETERANS AFFAIRS MEDICAL SYS-**
5 **TEM.**

6 (a) DVA AS A PARTICIPANT IN HEALTH CARE RE-
7 FORM.—

8 (1) IN GENERAL.—Title 38, United States
9 Code, is amended by inserting after chapter 17 the
10 following new chapter:

11 **“CHAPTER 18—ELIGIBILITY AND BENEFITS**
12 **UNDER HEALTH SECURITY ACT**

 “SUBCHAPTER I—GENERAL

“1801. Definitions.

 “SUBCHAPTER II—ENROLLMENT

“1811. Enrollment: veterans.

“1812. Enrollment: CHAMPVA eligibles.

“1813. Enrollment: family members.

 “SUBCHAPTER III—BENEFITS

“1821. Benefits for VA enrollees.

“1822. Chapter 17 benefits.

“1823. Supplemental benefits packages and policies.

“1824. Limitation regarding veterans enrolled with health plans outside Depart-
 ment.

 “SUBCHAPTER IV—FINANCIAL MATTERS

“1831. Premiums, copayments, etc.

“1832. Medicare coverage and reimbursement.

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

“1834. Health Plan Funds.

1 “SUBCHAPTER I—GENERAL

2 **“§ 1801. Definitions**

3 “For purposes of this chapter:

4 “(1) The term ‘health plan’ means an entity
5 that has been certified under the Health Security
6 Act as a health plan.7 “(2) The term ‘VA health plan’ means a health
8 plan that is operated by the Secretary under section
9 7341 of this title.10 “(3) The term ‘VA enrollee’ means an indi-
11 vidual enrolled under the Health Security Act in a
12 VA health plan.

13 “SUBCHAPTER II—ENROLLMENT

14 **“§ 1811. Enrollment: veterans**15 “Each veteran who is an eligible individual within the
16 meaning of section 1001 of the Health Security Act may
17 enroll with a VA health plan. A veteran who wants to re-
18 ceive the comprehensive benefit package through the De-
19 partment shall enroll with a VA health plan.20 **“§ 1812. Enrollment: CHAMPVA eligibles**21 “An individual who is eligible for benefits under sec-
22 tion 1713 of this title and who is eligible to enroll in a
23 health plan pursuant to section 1001 of the Health Secu-
24 rity Act may enroll under that Act with a VA health plan
25 in the same manner as a veteran.

1 **“§ 1813. Enrollment: family members**

2 “(a) The Secretary may authorize a VA health plan
3 to enroll members of the family of an enrollee under sec-
4 tion 1811 or 1812 of this title, subject to payment of pre-
5 miums, deductibles, copayments, and coinsurance as re-
6 quired under the Health Security Act.

7 “(b) For purposes of subsection (a), an enrollee’s
8 family is those individuals (other than the enrollee) in-
9 cluded within the term ‘family’ as defined in section
10 1011(b) of the Health Security Act.

11 “SUBCHAPTER III—BENEFITS

12 **“§ 1821. Benefits for VA enrollees**

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

17 **“§ 1822. Chapter 17 benefits**

18 “The Secretary shall provide to veterans the care and
19 services that are authorized to be provided under chapter
20 17 of this title in accordance with the terms and conditions
21 applicable to that veteran and that care under such chap-
22 ter, notwithstanding that such care and services are not
23 included in the comprehensive benefit package.

24 **“§ 1823. Supplemental benefits packages and policies**

25 “A VA health plan may offer supplemental health
26 benefits policies for health care services not provided

1 under chapter 17 of this title and cost sharing policies con-
2 sistent with the requirements of part 2 of subtitle E of
3 title I of the Health Security Act.

4 **“§ 1824. Limitation regarding veterans enrolled with**
5 **health plans outside Department**

6 “A veteran who is residing in a regional alliance area
7 in which the Department operates a health plan and who
8 is enrolled in a health plan that is not operated by the
9 Department may be provided the items and services in the
10 comprehensive benefit package by a VA health plan only
11 if the plan is reimbursed for the actual and full cost of
12 the care provided.

13 “SUBCHAPTER IV—FINANCIAL MATTERS

14 **“§ 1831. Premiums, copayments, etc.**

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

22 “(b) The veterans referred to in subsection (a) are
23 the following:

24 “(1) Any veteran with a service-connected dis-
25 ability.

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

5 “(3) Any veteran who is in receipt of, or who,
6 but for a suspension pursuant to section 1151 of
7 this title (or both such a suspension and the receipt
8 of retired pay), would be entitled to disability com-
9 pensation, but only to the extent that such a vet-
10 eran’s continuing eligibility for such care is provided
11 for in the judgment or settlement provided for in
12 such section.

13 “(4) Any veteran who is a former prisoner of
14 war.

15 “(5) Any veteran of the Mexican border period
16 or World War I.

17 “(6) Any veteran who is unable to defray the
18 expenses of necessary care as determined under sec-
19 tion 1722(a) of this title.

20 “(c) In the case of a VA enrollee who is not described
21 in subsection (b), the Secretary shall charge premiums
22 and establish copayments, deductibles, and coinsurance
23 amounts. The premium rate, and the rates for deductibles
24 and copayments, for each VA health plan shall be estab-

1 lished by that health plan based on rules established by
2 the health alliance under which it is operating.

3 “(d) In the case of a veteran with a service-connected
4 disability who is enrolled in a VA health plan and who
5 has net earnings from self-employment, the Secretary
6 shall, under regulations prescribed by the Secretary, pro-
7 vide for a reduction in any premium payment (or alliance
8 credit repayment) owed by the veteran under section 6126
9 or 6111 of the Health Security Act by virtue of the vet-
10 eran’s net earnings from self-employment.

11 **“§ 1832. Medicare coverage and reimbursement**

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

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

18 “(2) For purposes of this section, the term ‘Medicare
19 HMO’ means an eligible organization under section 1876
20 of the Social Security Act.

21 “(c) In the case of care provided to a veteran other
22 than a veteran described in section 1831(b) of this title
23 who is eligible for benefits under the Medicare program
24 under title XVIII of the Social Security Act, the Secretary
25 of Health and Human Services shall reimburse a VA

1 health plan or Department health-care facility providing
2 services as a Medicare provider or Medicare HMO in the
3 same amounts and under the same terms and conditions
4 as that Secretary reimburses other Medicare providers or
5 Medicare HMOs, respectively. The Secretary of Health
6 and Human Services shall include with each such reim-
7 bursement a Medicare explanation of benefits.

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

13 **“§ 1833. Recovery of cost of certain care and services**

14 “(a) In the case of an individual provided care or
15 services through a VA health plan who has coverage under
16 a supplemental health insurance policy pursuant to part
17 2 of subtitle E of title I of the Health Security Act or
18 under any other provision of law, or who has coverage
19 under a Medicare supplemental health insurance plan (as
20 defined in the Health Security Act) or under any other
21 provision of law, the Secretary has the right to recover
22 or collect charges for care or services (as determined by
23 the Secretary, but not including care or services for a serv-
24 ice-connected disability) from the party providing that cov-
25 erage to the extent that the individual (or the provider

1 of the care or services) would be eligible to receive pay-
2 ment for such care or services from such party if the care
3 or services had not been furnished by a department or
4 agency of the United States.

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

10 **“§ 1834. Health Plan Fund**

11 “(a) There is hereby established in the Treasury a
12 revolving fund to be known as the ‘Department of Vet-
13 erans Affairs Health Plan Fund’.

14 “(b) Any amount received by the Department by rea-
15 son of the furnishing of health care by a VA health plan
16 or the enrollment of an individual with a VA health plan
17 (including amounts received as premiums, premium dis-
18 count payments, copayments or coinsurance, and
19 deductibles, amounts received as third-party reimburse-
20 ments, and amounts received as reimbursements from an-
21 other health plan for care furnished to one of its enrollees)
22 shall be credited to the revolving fund.

23 “(c) Notwithstanding subsection (b), the Department
24 may not retain amounts received for care furnished to a
25 VA enrollee in a case in which the costs of such care have

1 been covered by appropriations. Such amounts shall be de-
 2 posited in the General Fund of the Treasury.

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

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

“18. Benefits and Eligibility Under Health Security Act 1801.”.

12 (b) PRESERVATION OF EXISTING BENEFITS FOR FA-
 13 CILITIES NOT OPERATING AS HEALTH PLANS.—(1)
 14 Chapter 17 of title 38, United States Code, is amended
 15 by inserting after section 1704 the following new section:
 16 **“§ 1705. Facilities not operating within health plans;**
 17 **veterans not eligible to enroll in health**
 18 **plans**

19 “The provisions of this chapter shall apply with re-
 20 spect to the furnishing of care and services—

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

24 “(2) by any facility of the Department (whether
 25 or not operating as or within a health plan certified

1 as a health plan under the Health Security Act) in
2 the case of a veteran who is not an eligible indi-
3 vidual with the meaning of section 1001 of the
4 Health Security Act.”.

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

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

8 **SEC. 8102. ORGANIZATION OF DEPARTMENT OF VETERANS**
9 **AFFAIRS FACILITIES AS HEALTH PLANS.**

10 (a) IN GENERAL.—Chapter 73 of title 38, United
11 States Code, is amended—

12 (1) by redesignating subchapter IV as sub-
13 chapter V; and

14 (2) by inserting after subchapter III the fol-
15 lowing new subchapter:

16 **“SUBCHAPTER IV—PARTICIPATION AS PART OF**
17 **NATIONAL HEALTH CARE REFORM**

18 **“§ 7341. Organization of health care facilities as**
19 **health plans**

20 “(a) The Secretary shall organize health plans and
21 operate Department facilities as or within health plans
22 under the Health Security Act. The Secretary shall pre-
23 scribe regulations establishing standards for the operation
24 of Department health care facilities as or within health

1 plans under that Act. In prescribing those standards, the
2 Secretary shall assure that they conform, to the maximum
3 extent practicable, to the requirements for health plans
4 generally set forth in part 1 of subtitle E of title I of the
5 Health Security Act.

6 “(b) Within a geographic area or region, health care
7 facilities of the Department located within that area or
8 region may be organized to operate as a single health plan
9 encompassing all Department facilities within that area or
10 region or may be organized to operate as several health
11 plans.

12 “(c) In carrying out responsibilities under the Health
13 Security Act, a State (or a State-established entity)—

14 “(1) may not impose any standard or require-
15 ment on a VA health plan that is inconsistent with
16 this section or any regulation prescribed under this
17 section or other Federal laws regarding the oper-
18 ation of this section; and

19 “(2) may not deny certification of a VA health
20 plan under the Health Security Act on the basis of
21 a conflict between a rule of a State or health alliance
22 and this section or regulations prescribed under this
23 section or other Federal laws regarding the oper-
24 ation of this section.

1 **“§ 7342. Contract authority for facilities operating as**
2 **or within health plans**

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

11 **“§ 7343. Resource sharing authority: facilities oper-**
12 **ating as or within health plans**

13 “The Secretary may enter into agreements under sec-
14 tion 8153 of this title with other health care plans, with
15 health care providers, and with other health industry orga-
16 nizations, and with individuals, for the sharing of re-
17 sources of the Department through facilities of the De-
18 partment operating as or within health plans.

19 **“§ 7344. Administrative and personnel flexibility**

20 “(a) In order to carry out this subchapter, the Sec-
21 retary may—

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

1 “(2) enter into contracts for the performance of
2 services previously performed by employees of the
3 Department without regard to section 8110(c) of
4 this title.

5 “(b) The Secretary may establish alternative per-
6 sonnel systems or procedures for personnel at facilities op-
7 erating as or with health plans under the Health Security
8 Act whenever the Secretary considers such action nec-
9 essary in order to carry out the terms of that Act, except
10 that the Secretary shall provide for preference eligibles (as
11 defined in section 2108 of title 5, United States Code)
12 in a manner comparable to the preference for such eligi-
13 bles under subchapter I of chapter 33, and subchapter I
14 of chapter 35, of such title.

15 “(c) Subject to the provisions of section 1404 of the
16 Health Security Act, the Secretary may carry out appro-
17 priate promotional, advertising, and marketing activities
18 to inform individuals of the availability of facilities of the
19 Department operating as or within health plans. Such ac-
20 tivities may only be carried out using nonappropriated
21 funds.

22 **“§ 7345. Veterans Health Care Investment Fund**

23 “(a) There is hereby authorized to be appropriated
24 to the Department, in addition to amounts otherwise au-
25 thorized to be appropriated to the Department for VA

1 health plans, such amounts as are necessary for the Sec-
2 retary of the Treasury to fulfill the requirement of sub-
3 section (b).

4 “(b) For each of fiscal years 1995, 1996, and 1997,
5 the Secretary of the Treasury shall, subject to subsection
6 (a), credit to a special fund (in this section referred to
7 as the ‘Fund’) of the Treasury an amount equal to—

8 “(1) \$1,000,000,000 for fiscal year 1995;

9 “(2) \$600,000,000 for fiscal year 1996; and

10 “(3) \$1,700,000,000 for fiscal year 1997.

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

14 “(2) For fiscal year 1995, 1996, or 1997, the amount
15 credited to the Fund for the fiscal year shall be available
16 for use by the Secretary under paragraph (1) only if ap-
17 propriations Acts for that fiscal year, without addition of
18 amounts provided under subsection (a) for the Fund, pro-
19 vide new budget authority for the Department of Veterans
20 Affairs Medical Care account, for that fiscal year, of no
21 less than the amount for that account proposed in the
22 budget of the President for that fiscal year under section
23 1105 of title 31.

24 “(d) The Secretary shall submit to Congress, no later
25 than March 1, 1997, a report concerning the operation

1 of the Department of Veterans Affairs health care system
2 in preparing for, and operating under, national health care
3 reform under the Health Security Act during fiscal years
4 1995 and 1996. The report shall include a discussion of—

5 “(1) the adequacy of amounts in the Fund for
6 the operation of VA health plans;

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

8 “(3) the ability of such plans to attract pa-
9 tients; and

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

12 **“§ 7346. Funding provisions: grants and other sources**
13 **of assistance**

14 “The Secretary may apply for and accept, if awarded,
15 any grant or other source of funding that is intended to
16 meet the needs of special populations and that but for this
17 section is unavailable to facilities of the Department or
18 to health plans operated by the Government if funds ob-
19 tained through the grant or other source of funding will
20 be used through a facility of the Department operating
21 as or within a health plan.”.

22 (b) CLERICAL AMENDMENT.—The table of sections
23 at the beginning of chapter 73 is amended by striking out
24 the item relating to the heading for subchapter IV and
25 inserting in lieu thereof the following:

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“SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE
REFORM

- “7341. Organization of health care facilities as health plans.
- “7342. Contract authority for facilities operating as or within health plans.
- “7343. Resource sharing authority: facilities operating as or within health plans.
- “7344. Administrative and personnel flexibility.
- “7345. Veterans Health Care Investment Fund.
- “7346. Funding provisions: grants and other sources of assistance.

“SUBCHAPTER V—RESEARCH CORPORATIONS”.

1 (c) TRANSITION PROVISION.—The limitation in the
2 second sentence of section 7344(c) of title 38, United
3 States Code, as added by subsection (a), shall not apply
4 during fiscal year 1994.

5 **Subtitle C—Federal Employees**
6 **Health Benefits Program**

7 **SEC. 8201. DEFINITIONS.**

8 Except as otherwise specifically provided, in this sub-
9 title:

10 (1) ABROAD.—The term “abroad” means out-
11 side the United States.

12 (2) ANNUITANT, ETC.—The terms “annuitant”,
13 “employee”, and “Government”, have the same re-
14 spective meanings as are given such terms by section
15 8901 of title 5, United States Code (as last in ef-
16 fect).

17 (3) EMPLOYEES HEALTH BENEFITS FUND.—
18 The term “Employees Health Benefits Fund” means

1 the fund under section 8909 of title 5, United States
2 Code (as last in effect).

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

6 (5) FEHBP PLAN.—The term “FEHBP plan”
7 has the same meaning as is given the term “health
8 benefits plan” by section 8901(6) of title 5, United
9 States Code (as last in effect).

10 (6) FEHBP TERMINATION DATE.—The term
11 “FEHBP termination date” means the date (speci-
12 fied in section 8202) after which FEHBP ceases to
13 be in effect.

14 (7) RETIRED EMPLOYEES HEALTH BENEFITS
15 FUND.—The term “Retired Employees Health Bene-
16 fits Fund” means the fund under section 8 of the
17 Retired Federal Employees Health Benefits Act
18 (Public Law 86-724; 74 Stat. 851), as last in effect.

19 (8) RFEHBP.—The term “RFEHBP” means
20 the health insurance program under the Retired
21 Federal Employees Health Benefits Act.

22 **SEC. 8202. FEHBP TERMINATION.**

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

1 **SEC. 8203. TREATMENT OF FEDERAL EMPLOYEES, ANNU-**
2 **ITANTS, AND OTHER INDIVIDUALS (WHO**
3 **WOULD OTHERWISE HAVE BEEN ELIGIBLE**
4 **FOR FEHBP) UNDER HEALTH PLANS.**

5 (a) APPLICABILITY.—This section sets forth rules ap-
6 plicable, after the FEHBP termination date, with respect
7 to individuals who—

8 (1) are eligible individuals under section 1001;
9 and

10 (2) but for this subtitle, would be eligible to en-
11 roll in an FEHBP plan.

12 (b) FEDERAL EMPLOYEES.—

13 (1) SAME TREATMENT AS NON-FEDERAL EM-
14 PLOYEES.—A Federal employee shall be treated in
15 the same way, for purposes of provisions of this Act
16 outside of this subtitle, as if that individual were a
17 non-Federal employee, including for purposes of any
18 requirements relating to enrollment, family premium
19 payments, and employer premium payments.

20 (2) EMPLOYER PREMIUM PAYMENTS.—Any em-
21 ployer premium payment required with respect to
22 the employment of a Federal employee shall be pay-
23 able from the appropriation or fund from which any
24 Government contribution on behalf of such employee
25 would have been payable under FEHBP.

1 (3) OFFER OF FEHBP SUPPLEMENTAL
2 PLANS.—The Federal Government shall offer to
3 Federal employees one or more FEHBP supple-
4 mental plans developed under subsection (f)(1).

5 (4) DEFINITIONS.—In this subsection:

6 (A) FEDERAL EMPLOYEE.—The term
7 “Federal employee” means an “employee” as
8 defined by section 8201.

9 (B) NON-FEDERAL EMPLOYEE.—The term
10 “non-Federal employee” means an “employee”
11 as defined by section 1901.

12 (c) ANNUITANTS.—

13 (1) HEALTH PLAN.—

14 (A) AUTHORITY TO MAKE CERTAIN
15 WITHHOLDINGS FROM ANNUITIES.—

16 (i) IN GENERAL.—The Office of Per-
17 sonnel Management may, on the request of
18 an annuitant enrolled in a health plan,
19 withhold from the annuity of such annu-
20 itant any premiums required for such en-
21 rollment. The Office shall forward any
22 amounts so withheld to the appropriate
23 fund or as otherwise indicated in the re-
24 quest. A request under this subparagraph
25 shall contain such information, and other-

1 wise be made in such form and manner, as
2 the Office shall by regulation prescribe.

3 (ii) REFERENCES.—Any reference in
4 clause (i) to the Office of Personnel Man-
5 agement shall, for purposes of any annuity
6 (including monthly compensation under
7 subchapter I of chapter 81 of title 5,
8 United States Code) payable under provi-
9 sions of law which are administered by a
10 Government entity other than the Office,
11 be considered to be a reference to such
12 other Government entity.

13 (B) PAYMENT OF ALLIANCE CREDIT LI-
14 ABILITY FOR ANNUITANTS BELOW AGE 55.—In
15 the case of an annuitant who does not satisfy
16 the eligibility requirements under section 6114,
17 a Government contribution shall be made equal
18 to such amount as is necessary to reduce the
19 employee's liability under section 6111 to zero.

20 (2) FEHBP SUPPLEMENTAL PLAN.—

21 (A) CURRENT ANNUITANTS.—

22 (i) IN GENERAL.—Each current
23 annuitant—

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

4 (II) shall be eligible for the Gov-
5 ernment contribution amount de-
6 scribed in clause (ii) toward the pre-
7 mium for such a plan.

8 (ii) GOVERNMENT CONTRIBUTION
9 AMOUNT.—The Office of Personnel Man-
10 agement shall specify a level of Govern-
11 ment contribution under this subparagraph
12 for an FEHBP supplemental plan. Such
13 level—

14 (I) shall reasonably reflect the
15 portion of the Government contribu-
16 tions (last provided under FEHBP)
17 attributable to the portion of FEHBP
18 benefits which the plan is designed to
19 replace; and

20 (II) shall be applied toward pre-
21 miums for such a plan.

22 (B) FUTURE ANNUITANTS.—In the case of
23 a future annuitant, the Federal Government
24 shall offer to such an annuitant one or more

1 FEHBP supplemental plans developed under
2 subsection (f)(1).

3 (C) DEFINITIONS.—In this paragraph:

4 (i) CURRENT ANNUITANT.—The term
5 “current annuitant” means an individual
6 who is residing in a State on January 1,
7 1998, and, on the day before such date,
8 was—

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

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

16 (ii) FUTURE ANNUITANT.—The term
17 “future annuitant” means an annuitant
18 who is not a current annuitant.

19 (d) INDIVIDUALS WHO WOULD NOT BE ELIGIBLE
20 FOR A GOVERNMENT CONTRIBUTION UNDER FEHBP.—

21 (1) IN GENERAL.—In the case of an individual
22 described in paragraph (2)—

23 (A) the Federal Government may, but is
24 not required to, offer one or more FEHBP sup-

1 plemental plans developed under subsection
2 (f)(1); and

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

6 (2) APPLICABILITY.—This subsection shall
7 apply with respect to any individual who (but for
8 this subtitle) would be eligible to enroll in an
9 FEHBP plan, but would not be eligible for a Gov-
10 ernment contribution toward any such plan.

11 (e) MEDICARE-ELIGIBLE INDIVIDUALS.—

12 (1) CURRENT MEDICARE-ELIGIBLE INDIVID-
13 UALS.—

14 (A) IN GENERAL.—Each current medicare-
15 eligible individual—

16 (i) shall be eligible to enroll in medi-
17 care supplemental plans developed under
18 subsection (f)(2); and

19 (ii) if such individual would (but for
20 this subtitle) have been eligible for a Gov-
21 ernment contribution under FEHBP (as-
22 suming such individual were then enrolled
23 thereunder), shall be eligible for the Gov-
24 ernment medicare contribution amount de-
25 scribed in subparagraph (B) toward the

1 premium for such a plan or toward the
2 premium for enrollment with an eligible or-
3 ganization under a risk-sharing contract
4 under section 1876 of the Social Security
5 Act).

6 (B) MEDICARE CONTRIBUTION AMOUNT.—

7 The Office of Personnel Management shall
8 specify a level of Government contribution
9 under this paragraph for an FEHBP medicare
10 supplemental plan. Such level—

11 (i) shall reasonably reflect the portion
12 of the Government contributions (last pro-
13 vided under FEHBP) attributable to the
14 portion of FEHBP benefits which the plan
15 is designed to replace; and

16 (ii) except as otherwise provided in
17 paragraph (3), shall be applied toward pre-
18 miums for such a plan.

19 (2) FUTURE MEDICARE-ELIGIBLE INDIVID-
20 UALS.—In the case of a future medicare-eligible in-
21 dividual, the Federal Government may, but is not re-
22 quired to—

23 (A) offer to such a medicare-eligible indi-
24 vidual one or more FEHBP medicare supple-

1 mental plans developed under subsection (f)(2);
2 and

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

5 (3) APPLICATION OF CONTRIBUTION TOWARD
6 MEDICARE HMO OPTION.—

7 (A) ELECTION.—A medicare-eligible indi-
8 vidual may elect to have the amount of the Gov-
9 ernment contribution described in paragraph
10 (1)(B) or referred to in paragraph (2)(B) ap-
11 plied toward premiums for enrollment with an
12 eligible organization under a risk-sharing con-
13 tract under section 1876 of the Social Security
14 Act.

15 (B) LEVEL CONTRIBUTION RULE.—The
16 level of such Government contribution on behalf
17 of an individual shall be determined without
18 taking into account any election under subpara-
19 graph (A).

20 (4) DEFINITIONS.—In this subsection:

21 (A) CURRENT MEDICARE-ELIGIBLE INDIV-
22 IDUAL.—The term “current medicare-eligible
23 individual” means an individual who is residing
24 in a State on January 1, 1998, and, on the day

1 before such date, was a medicare-eligible indi-
2 vidual.

3 (B) FUTURE MEDICARE-ELIGIBLE INDI-
4 VIDUAL.—The term “future medicare-eligible
5 individual” means a medicare-eligible individual
6 who is not a current medicare-eligible indi-
7 vidual.

8 (5) INAPPLICABILITY.—Subsections (b) through
9 (d) shall not apply with respect to a medicare-eli-
10 ble individual.

11 (f) DEVELOPMENT OF SUPPLEMENTAL PLANS.—

12 (1) FEHBP SUPPLEMENTAL PLANS.—The Of-
13 fice of Personnel Management shall develop one or
14 more FEHBP supplemental plans which are supple-
15 mental health benefit policies or cost sharing policies
16 (as defined in section 1421(b)). Each such plan
17 shall—

18 (A) be consistent with the applicable re-
19 quirements of part 2 of subtitle E of title I (in-
20 cluding the requirements under section
21 1423(f)); and

22 (B) reflect (taking into consideration the
23 benefits in the comprehensive benefit package)
24 the overall level of benefits last generally af-
25 forded under FEHBP.

1 (2) FEHBP MEDICARE SUPPLEMENTAL
2 PLANS.—The Office of Personnel Management shall
3 develop one or more medicare supplemental plans.
4 Each such plan shall—

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

9 (B) reflect (taking into consideration the
10 benefits provided under the medicare program)
11 the overall level of benefits last generally af-
12 forded under FEHBP.

13 (g) AUTHORIZATION OF APPROPRIATIONS.—The Gov-
14 ernment contributions authorized by this section on behalf
15 of an annuitant (including an annuitant who is a medi-
16 care-eligible individual) shall be paid from annual appro-
17 priations which are authorized to be made for that purpose
18 and which may be made available until expended.

19 (h) FUND.—

20 (1) ESTABLISHMENT.—There shall be estab-
21 lished in the Treasury of the United States a fund
22 into which shall be paid all contributions relating to
23 any—

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

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

3 (C) health insurance program established
4 under section 8204.

5 (2) ADMINISTRATION AND USE.—The fund
6 shall be administered by the Office of Personnel
7 Management, and any monies in the fund shall be
8 available for purposes of the plan or program (re-
9 ferred to in paragraph (1)) to which they are attrib-
10 utable.

11 **SEC. 8204. TREATMENT OF INDIVIDUALS RESIDING**
12 **ABROAD.**

13 (a) IN GENERAL.—After the FEHBP termination
14 date, individuals residing abroad who (but for this sub-
15 title) would be eligible to enroll in an FEHBP plan shall
16 be eligible for health insurance under a program which
17 the Office of Personnel Management shall by regulation
18 establish.

19 (b) REQUIREMENT.—To the extent practicable, cov-
20 erage and benefits provided to individuals under such pro-
21 gram shall be equal to the coverage and benefits which
22 would be available to them if they were residing in the
23 United States.

24 (c) GOVERNMENT CONTRIBUTIONS.—Any Govern-
25 ment contribution payable under such program shall be

1 made from the appropriation or fund from which any Gov-
2 ernment contribution would have been payable under
3 FEHBP (if any) on behalf of the individual involved, ex-
4 cept that, in the case of an annuitant, any such contribu-
5 tion shall be payable from amounts appropriated pursuant
6 to section 8203(g).

7 **SEC. 8205. TRANSITION AND SAVINGS PROVISIONS.**

8 (a) EMPLOYEES HEALTH BENEFITS FUND.—

9 (1) TEMPORARY CONTINUED AVAILABILITY.—

10 Notwithstanding section 8202, the Employees
11 Health Benefits Fund shall be maintained, and
12 amounts in such Fund shall remain available, after
13 the FEHBP termination date, for such period of
14 time as the Office of Personnel Management con-
15 sidered necessary in order to satisfy any outstanding
16 claims.

17 (2) FINAL DISBURSEMENT.—After the end of
18 the period referred to in paragraph (1), any
19 amounts remaining in the Fund shall be disbursed
20 (between the Government and former participants in
21 FEHBP) in accordance with a plan which the Office
22 shall prepare, consistent with the cost-sharing ratio
23 between the Government and plan enrollees during
24 the final contract term. The details of any such plan
25 shall be submitted to the President and the Con-

1 gress at least 1 year before the date of its proposed
2 implementation.

3 (b) PROCEEDINGS.—After the FEHBP termination
4 date, chapter 89 of title 5, United States Code (as last
5 in effect) shall be considered to have remained in effect
6 for purposes of any suit, action, or other proceeding with
7 respect to any liability incurred or violation which oc-
8 curred on or before such date.

9 (c) RFEHBA.—

10 (1) REPEAL.—The Retired Federal Employees
11 Health Benefits Act (Public Law 86–724; 74 Stat.
12 849) is repealed effective as of the FEHBP termi-
13 nation date.

14 (2) RELATED PROVISIONS.—After the FEHBP
15 termination date—

16 (A) the Retired Employees Health Benefits
17 Fund shall temporarily remain available, and
18 amounts in that fund shall subsequently be dis-
19 bursed, in a manner comparable to that pro-
20 vided for under subsection (a); and

21 (B) retired employees who (but for this
22 subtitle) would be eligible for coverage under
23 the Retired Federal Employees Health Benefits
24 Act shall be treated, for purposes of this sub-
25 title, as if they were annuitants (subject to any

1 differences in the overall level of coverage or
2 benefits last generally afforded to annuitants
3 under FEHBP and to retired employees under
4 RFEHBP, respectively).

5 (3) REGULATIONS.—Regulations prescribed
6 under section 8206 to carry out this subsection shall
7 include any necessary provisions relating to individ-
8 uals residing abroad.

9 **SEC. 8206. REGULATIONS.**

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

13 **SEC. 8207. TECHNICAL AND CONFORMING AMENDMENTS.**

14 (a) OPM'S ANNUAL REPORT ON FEHBP.—Sub-
15 section (c) of section 1308 of title 5, United States Code,
16 is repealed.

17 (b) OTHER REFERENCES TO FEHBP.—Any ref-
18 erence in any provision of law to the health insurance pro-
19 gram under chapter 89 of title 5, United States Code (or
20 any aspect of such program) shall be considered to be a
21 reference to the health insurance program under this sub-
22 title (or corresponding aspect), subject to such clarifica-
23 tion as may be provided, or except as may otherwise be
24 provided, in regulations prescribed by the agency or other

1 authority responsible for the administration of such provi-
2 sion.

3 (c) OMNIBUS BUDGET RECONCILIATION ACT OF
4 1993.—Effective as of the date of the enactment of this
5 Act, section 11101(b)(3) of the Omnibus Budget Rec-
6 onciliation Act of 1993 (Public Law 103–66; 107 Stat.
7 413) is amended by striking “September 30, 1998” and
8 inserting “December 31, 1997”.

9 (d) EFFECTIVE DATE.—Except as provided in sub-
10 section (c), this section and the amendments made by this
11 section shall take effect on the day after the FEHBP ter-
12 mination date.

13 **Subtitle D—Indian Health Service**

14 **SEC. 8301. DEFINITIONS.**

15 For the purposes of this subtitle—

16 (1) the term “health program of the Indian
17 Health Service” means a program which provides
18 health services under this Act through a facility of
19 the Indian Health Service, a tribal organization
20 under the authority of the Indian Self-Determination
21 Act or a self-governance compact, or an urban In-
22 dian program;

23 (2) the term “reservation” means the reserva-
24 tion of any federally recognized Indian tribe, former
25 Indian reservations in Oklahoma, and lands held by

1 incorporated Native groups, regional corporations,
2 and village corporations under the provisions of the
3 Alaska Native Claims Settlement Act (43 U.S.C.
4 1601 et seq.);

5 (3) the term “urban Indian program” means
6 any program operated pursuant to title V of the In-
7 dian Health Care Improvement Act; and

8 (4) the terms “Indian”, “Indian tribe”, “tribal
9 organization”, “urban Indian”, “urban Indian orga-
10 nization”, and “service unit” have the same meaning
11 as when used in the Indian Health Care Improve-
12 ment Act (25 U.S.C. 1601 et seq.).

13 **SEC. 8302. ELIGIBILITY AND HEALTH SERVICE COVERAGE**
14 **OF INDIANS.**

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

18 (1) an Indian, or a descendent of a member of
19 an Indian tribe who belongs to and is regarded as
20 an Indian by the Indian community in which the in-
21 dividual lives, who resides on or near an Indian res-
22 ervation or in a geographical area designated by
23 statute as meeting the requirements of being on or
24 near an Indian reservation notwithstanding the lack
25 of an Indian reservation;

1 (2) an urban Indian; or

2 (3) an Indian described in section 809(b) of the
3 Indian Health Care Improvement Act (25 U.S.C.
4 1679(b)).

5 (b) ELECTION.—An individual described in sub-
6 section (a) may elect a health program of the Indian
7 Health Service instead of a health plan.

8 (c) ENROLLMENT FOR BENEFITS.—An individual
9 who elects a health program of the Indian Health Service
10 under subsection (b) shall enroll in such program through
11 a service unit, tribal organization, or urban Indian pro-
12 gram. An individual who enrolls in such program is not
13 subject to any charge for health insurance premiums,
14 deductibles, copayments, coinsurance, or any other cost
15 for health services provided under such program.

16 (d) PAYMENTS BY INDIVIDUALS WHO DO NOT EN-
17 ROLL.—If an individual described in subsection (a) does
18 not enroll in a health program of the Indian Health Serv-
19 ice, no payment shall be made by the Indian Health Serv-
20 ice to the individual (or on behalf of the individual) with
21 respect to premiums charged for enrollment in an applica-
22 ble health plan or any other cost of health services under
23 the applicable health plan which the individual is required
24 to pay.

1 **SEC. 8303. SUPPLEMENTAL INDIAN HEALTH CARE BENE-**
2 **FITS.**

3 (a) IN GENERAL.—All individuals described in sec-
4 tions 8302(a) remain eligible for such benefits under the
5 laws administered by the Indian Health Service as supple-
6 ment the comprehensive benefit package. The individual
7 shall not be subject to any charge or any other cost for
8 such benefits.

9 (b) AUTHORIZATION OF APPROPRIATIONS.—In addi-
10 tion to amounts otherwise authorized to be appropriated,
11 there is authorized to be appropriated to carry out this
12 section \$180,000,000 for fiscal year 1995, \$200,000,000
13 for each of the fiscal years 1996 through 1999, and such
14 sums as may be necessary for fiscal year 2000 and each
15 fiscal year thereafter.

16 **SEC. 8304. HEALTH PLAN AND HEALTH ALLIANCE RE-**
17 **QUIREMENTS.**

18 (a) COMPREHENSIVE BENEFIT PACKAGE.—The Sec-
19 retary shall ensure that the comprehensive benefit package
20 is provided by all health programs of the Indian Health
21 Service effective January 1, 1999, notwithstanding section
22 1001(a).

23 (b) APPLICABLE REQUIREMENTS OF HEALTH
24 PLANS.—In addition to subsection (a), the Secretary shall
25 determine which other requirements relating to health

1 plans apply to health programs of the Indian Health Serv-
2 ice.

3 (c) CERTIFICATION.—Effective January 1, 1999, all
4 health programs of the Indian Health Service must meet
5 the certification requirements for health plans, as required
6 by the Secretary under this section, as certified from time
7 to time by the Secretary. Before January 1, 1999, all such
8 health programs shall, to the extent practicable, meet such
9 certification requirements.

10 (d) HEALTH ALLIANCE REQUIREMENTS.—The Sec-
11 retary shall determine which requirements relating to
12 health alliances apply to the Indian Health Service.

13 **SEC. 8305. EXEMPTION OF TRIBAL GOVERNMENTS AND**
14 **TRIBAL ORGANIZATIONS FROM EMPLOYER**
15 **PAYMENTS.**

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

21 **SEC. 8306. PROVISION OF HEALTH SERVICES TO NON-EN-**
22 **ROLLEES AND NON-INDIANS.**

23 (a) CONTRACTS WITH HEALTH PLANS.—

24 (1) IN GENERAL.—A health program of the In-
25 dian Health Service, a service unit, a tribal organi-

1 zation, or an urban Indian organization operating
2 within a health program may enter into a contract
3 with a health plan for the provision of health care
4 services to individuals enrolled in such health plan if
5 the program, unit, or organization determines that
6 the provision of such health services will not result
7 in a denial or diminution of health services to any
8 individual described in section 8302(a) who is en-
9 rolled for health services provided by such program,
10 unit, or organization.

11 (2) REIMBURSEMENT.—Any contract entered
12 into pursuant to paragraph (1) shall provide for re-
13 imbursement to such program, unit, or organization
14 in accordance with the essential community provider
15 provisions of section 1431(c), as determined by the
16 Secretary.

17 (b) FAMILY TREATMENT.—

18 (1) DETERMINATION TO OPEN ENROLLMENT.—
19 A health program of the Indian Health Service may
20 open enrollment to family members of individuals
21 described in section 8302(a).

22 (2) ELECTION.—If a health program of the In-
23 dian Health Service opens enrollment to family
24 members of individuals described in section 8302(a),
25 an individual described in that section may elect

1 family enrollment in the health program instead of
2 in a health plan.

3 (3) ENROLLMENT.—

4 (A) IN GENERAL.—An individual who
5 elects family enrollment under paragraph (2) in
6 a health program of the Indian Health Service
7 shall enroll in such program.

8 (B) APPLICABLE INDIVIDUAL CHARGES.—

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

19 (C) APPLICABLE EMPLOYER CHARGES.—

20 Employers, other than tribal governments and
21 tribal organizations exempt under section 8305,
22 are liable for making employer premium pay-
23 ments as an employer under section 6121 in the
24 case of any family member enrolled under this
25 subsection who is not eligible for a health pro-

1 gram of the Indian Health Service under sec-
2 tion 8302(a).

3 (4) PREMIUM.—

4 (A) ESTABLISHMENT AND COLLECTION.—

5 The Secretary shall establish premiums for all
6 family members enrolled in a health program of
7 the Indian Health Service under this paragraph
8 who are not eligible for a health program of the
9 Indian Health Service under section 8302(a).
10 The Secretary shall collect each premium pay-
11 ment owed under this paragraph.

12 (B) REDUCTION.—The Secretary shall pro-
13 vide for a process for premium reduction which
14 is the same as the process, and uses the same
15 standards, used by regional alliances for the
16 areas in which individuals described in subpara-
17 graph (A) reside, except that in computing the
18 family share of the premiums the Secretary
19 shall use the lower of the premium quoted or
20 the reduced weighted average accepted bid for
21 the reference regional alliance.

22 (C) PAYMENT BY SECRETARY.—The Sec-
23 retary shall provide for payment to each health
24 program of the Indian Health Service, in the
25 same manner as payments under section 6201,

1 amounts equivalent to the amount of payments
2 that would have been made to a regional alli-
3 ance if the individuals described in subpara-
4 graph (A) were enrolled in a regional alliance
5 health plan (with a final accepted bid equal to
6 the reduced weighted average accepted bid pre-
7 mium for the regional alliance).

8 (c) ESSENTIAL COMMUNITY PROVIDER.—

9 (1) HEALTH SERVICES.—If a health program of
10 the Indian Health Service, a service unit, a tribal or-
11 ganization, or an urban Indian organization oper-
12 ating within a health program elects to be an essen-
13 tial community provider under section 1431, an indi-
14 vidual described in paragraph (2) enrolled in a
15 health plan other than a health program of the In-
16 dian Health Service may receive health services from
17 that essential community provider.

18 (2) INDIVIDUAL COVERED.—An individual re-
19 ferred to in paragraph (1) is an individual who—

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

21 (B) is a family member described in sub-
22 section (b) who does not enroll in a health pro-
23 gram of the Indian Health Service.

1 **SEC. 8307. PAYMENT BY OTHER PAYERS.**

2 (a) PAYMENT FOR SERVICES PROVIDED BY INDIAN
3 HEALTH SERVICE PROGRAMS.—Nothing in this subtitle
4 shall be construed as amending section 206, 401, or 402
5 of the Indian Health Care Improvement Act (relating to
6 payments on behalf of Indians for health services from
7 other Federal programs or from other third party payers).

8 (b) PAYMENT FOR SERVICES PROVIDED BY CON-
9 TRACTORS.—Nothing in this subtitle shall be construed as
10 affecting any other provision of law, regulation, or judicial
11 or administrative interpretation of law or policy con-
12 cerning the status of the Indian Health Service as the
13 payer of last resort for Indians eligible for contract health
14 services under a health program of the Indian Health
15 Service.

16 **SEC. 8308. CONTRACTING AUTHORITY.**

17 Section 601(d)(1)(B) of the Indian Health Care Im-
18 provement Act (25 U.S.C. 1661(d)(1)(B)) is amended by
19 inserting “(including personal services for the provision of
20 direct health care services)” after “goods and services”.

21 **SEC. 8309. CONSULTATION.**

22 The Secretary shall consult with representatives of
23 Indian tribes, tribal organizations, and urban Indian orga-
24 nizations annually concerning health care reform initia-
25 tives that affect Indian communities.

1 **SEC. 8310. INFRASTRUCTURE.**

2 (a) FACILITIES.—The Secretary, acting through the
3 Indian Health Service, may expend amounts appropriated
4 pursuant to section 8313 for the construction and renova-
5 tion of hospitals, health centers, health stations, and other
6 facilities for the purpose of improving and expanding such
7 facilities to enable the delivery of the full array of items
8 and services guaranteed in the comprehensive benefit
9 package.

10 (b) CAPITAL FINANCING.—There is established in the
11 Indian Health Service a revolving loan program. Under
12 the program, the Secretary, acting through the Indian
13 Health Service, shall provide guaranteed loans under such
14 terms and conditions as the Secretary may prescribe to
15 providers within the Indian Health Service system to im-
16 prove and expand health care facilities to enable the deliv-
17 ery of the full array of items and services guaranteed in
18 the comprehensive benefit package.

19 **SEC. 8311. FINANCING.**

20 (a) ESTABLISHMENT OF FUND.—Each health pro-
21 gram of the Indian Health Service shall establish a com-
22 prehensive benefit package fund (hereafter in this section
23 referred to as the “fund”).

24 (b) DEPOSITS.—There shall be deposited into the
25 fund the following:

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

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

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

10 (4) Any other amount received with respect to
11 health services for the comprehensive benefit pack-
12 age.

13 (c) ADMINISTRATION AND EXPENDITURES.—

14 (1) MANAGEMENT.—The fund shall be man-
15 aged by the health program of the Indian Health
16 Service.

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

22 (3) AVAILABILITY OF FUNDS.—Amounts in the
23 fund established by a service unit of the Indian
24 Health Service under this section shall be available
25 without further appropriation and shall remain

1 available until expended for payments for the deliv-
2 ery of the items and services in the comprehensive
3 benefit package.

4 **SEC. 8312. RULE OF CONSTRUCTION.**

5 Unless otherwise provided by this Act, no part of this
6 Act shall be construed to rescind or otherwise modify any
7 obligations, findings, or purposes contained in the Indian
8 Health Care Improvement Act (25 U.S.C. 1601 et seq.)
9 and in the Indian Self-Determination and Education As-
10 sistance Act.

11 **SEC. 8313. AUTHORIZATIONS OF APPROPRIATIONS.**

12 (a) AUTHORIZATION OF APPROPRIATIONS.—For the
13 purpose of carrying out this subtitle, there are authorized
14 to be appropriated \$40,000,000 for fiscal year 1995,
15 \$180,000,000 for fiscal year 1996, and \$200,000,000 for
16 each of the fiscal years 1997 through 2000.

17 (b) RELATION TO OTHER FUNDS.—The authoriza-
18 tions of appropriations established in subsection (a) are
19 in addition to any other authorizations of appropriations
20 that are available for the purposes of carrying out this
21 subtitle.

22 **SEC. 8314. PAYMENT OF PREMIUM DISCOUNT EQUIVALENT**
23 **AMOUNTS FOR UNEMPLOYED INDIANS.**

24 (a) DETERMINATION.—The Secretary shall deter-
25 mine (and certify to the Secretary of the Treasury) for

1 each fiscal year (beginning with fiscal year 1998) an
2 amount equivalent to the aggregate amount of the pre-
3 mium discounts (established in section 6104) that would
4 have been paid to individuals described in subsection (c)
5 if such individuals had been enrolled in regional alliance
6 health plans.

7 (b) PAYMENT.—For each fiscal year for which an
8 amount is certified to the Secretary of the Treasury under
9 subsection (a), from the funds available under section
10 9102, such Secretary shall pay the amount so certified to
11 the Indian Health Service for the purpose of providing the
12 comprehensive benefit package.

13 (c) INDIVIDUAL DESCRIBED.—For purposes of this
14 section, an individual described in this subsection is an
15 individual described in section 8302(a) who is not a quali-
16 fying employee or a family member of such an employee.

17 **Subtitle E—Amendments to the**
18 **Employee Retirement Income**
19 **Security Act of 1974**

20 **SEC. 8401. GROUP HEALTH PLAN DEFINED.**

21 Section 3 of the Employee Retirement Income Secu-
22 rity Act of 1974 (29 U.S.C. 1002) is amended by adding
23 at the end the following new paragraph:

24 “(42) The term ‘group health plan’ means an em-
25 ployee welfare benefit plan which provides medical care (as

1 defined in section 213(d) of the Internal Revenue Code
2 of 1986) to participants or beneficiaries directly or
3 through insurance, reimbursement, or otherwise.”.

4 **SEC. 8402. LIMITATION ON COVERAGE OF GROUP HEALTH**
5 **PLANS UNDER TITLE I OF ERISA.**

6 (a) IN GENERAL.—Section 4 of the Employee Retire-
7 ment Income Security Act of 1974 (29 U.S.C. 1003) is
8 amended—

9 (1) in subsection (a), by striking “subsection
10 (b)” and inserting “subsections (b) and (c)”;

11 (2) in subsection (b), by striking “The provi-
12 sions” and inserting “Except as provided in sub-
13 section (c), the provisions”; and

14 (3) by adding at the end the following new sub-
15 section:

16 “(c) COVERAGE OF GROUP HEALTH PLANS.—

17 “(1) LIMITED INCLUSION.—This title shall
18 apply to a group health plan only to the extent pro-
19 vided in this subsection.

20 “(2) COVERAGE UNDER CERTAIN PROVISIONS
21 WITH RESPECT TO CERTAIN PLANS.—

22 “(A) IN GENERAL.—Except as provided in
23 subparagraph (B), parts 1, 4, and 6 of subtitle
24 B shall apply to—

1 “(i) a group health plan which is
2 maintained by—

3 “(I) a corporate alliance (as de-
4 fined in section 1311(a) of the Health
5 Security Act), or

6 “(II) a member of a corporate al-
7 liance (as so defined) whose eligible
8 sponsor is described in section
9 1311(b)(1)(C) (relating to rural elec-
10 tric cooperatives and rural telephone
11 cooperative associations), and

12 “(ii) a group health plan not de-
13 scribed in clause (i) which provides bene-
14 fits which are permitted under paragraph
15 (4) of section 1003 of the Health Security
16 Act.

17 “(B) INAPPLICABILITY WITH RESPECT TO
18 STATE-CERTIFIED HEALTH PLANS.—Subpara-
19 graph (A) shall not apply with respect to any
20 plan or portion thereof which consists of a
21 State-certified health plan (as defined in section
22 1400(c) of the Health Security Act). The Sec-
23 retary shall provide by regulation for treatment
24 as a separate group health plan of any arrange-
25 ment which would otherwise be treated under

1 this title as part of a group health plan to the
2 extent necessary to carry out the purposes of
3 this title.

4 “(3) CIVIL ACTIONS BY CORPORATE ALLIANCE
5 PARTICIPANTS, BENEFICIARIES, AND FIDUCIARIES
6 AND BY THE SECRETARY.—

7 “(A) IN GENERAL.—Except as provided in
8 subparagraph (B), in the case of a group health
9 plan to which parts 1, 4, and 6 of subtitle B
10 apply under paragraph (2), section 502 shall
11 apply with respect to a civil action described in
12 such section brought—

13 “(i) by a participant, beneficiary, or
14 fiduciary under such plan, or

15 “(ii) by the Secretary.

16 “(B) EXCEPTION WHERE REVIEW IS OTH-
17 ERWISE AVAILABLE UNDER HEALTH SECURITY
18 ACT.—Subparagraph (A) shall not apply with
19 respect to any cause of action for which, under
20 section 5202(d) of the Health Security Act,
21 proceedings under sections 5203 and 5204 of
22 such Act pursuant to complaints filed under
23 section 5202(b) of such Act, and review under
24 section 5205 of such Act of determinations

1 made under such section 5204, are the exclu-
2 sive means of review.

3 “(4) DEFINITIONS AND ENFORCEMENT PROVI-
4 SIONS.—Sections 3, 501, 502, 503, 504, 505, 506,
5 507, 508, 509, 510, and 511 and the preceding sub-
6 sections of this section shall apply to a group health
7 plan to the extent necessary to effectively carry out,
8 and enforce the requirements under, the provisions
9 of this title as they apply pursuant to this sub-
10 section.

11 “(5) APPLICABILITY OF PREEMPTION RULES.—
12 Section 514 shall apply in the case of any group
13 health plan to which parts 1, 4, and 6 of subtitle B
14 apply under paragraph (2).”.

15 (b) REPORTING AND DISCLOSURE REQUIREMENTS
16 APPLICABLE TO GROUP HEALTH PLANS.—

17 (1) IN GENERAL.—Part 1 of subtitle B of title
18 I of such Act is amended—

19 (A) in the heading for section 110 (29
20 U.S.C. 1030), by adding “BY PENSION PLANS”
21 at the end;

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

24 (C) by inserting after section 110 the fol-
25 lowing new section:

1 “SPECIAL RULES FOR GROUP HEALTH PLANS

2 “SEC. 111. (a) IN GENERAL.—The Secretary may by
3 regulation provide special rules for the application of this
4 part to group health plans which are consistent with the
5 purposes of this title and the Health Security Act and
6 which take into account the special needs of participants,
7 beneficiaries, and health care providers under such plans.

8 “(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—
9 Such special rules may include rules providing for—

10 “(1) reductions in the periods of time referred
11 to in this part,

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

14 “(3) such other changes in the provisions of
15 this part as may result in more expeditious reporting
16 and disclosure of plan terms and changes in such
17 terms to the Secretary and to plan participants and
18 beneficiaries,

19 to the extent that the Secretary determines that the rules
20 described in this subsection are necessary to ensure timely
21 reporting and disclosure of information consistent with the
22 purposes of this part and the Health Security Act as they
23 relate to group health plans.

24 “(c) ADDITIONAL REQUIREMENTS.—Such special
25 rules may include rules providing for reporting and disclo-

1 sure to the Secretary and to participants and beneficiaries
2 of additional information or at additional times with re-
3 spect to group health plans to which this part applies
4 under section 4(c)(2), if such reporting and disclosure
5 would be comparable to and consistent with similar re-
6 quirements applicable under the Health Security Act with
7 respect to plans maintained by regional alliances (as de-
8 fined in such section 1301 of such Act) and applicable reg-
9 ulations of the Secretary of Health and Human Services
10 prescribed thereunder.”.

11 (2) CLERICAL AMENDMENT.—The table of con-
12 tents in section 1 of such Act is amended by striking
13 the items relating to sections 110 and 111 and in-
14 serting the following new items:

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

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

“Sec. 112. Repeal and effective date.”.

15 (d) EXCLUSION OF PLANS MAINTAINED BY RE-
16 GIONAL ALLIANCES FROM TREATMENT AS MULTIPLE EM-
17 PLOYER WELFARE ARRANGEMENTS.—Section 3(40)(A) of
18 such Act (29 U.S.C. 1002(40)(A)) is amended—

19 (1) in clause (ii), by striking “or”;

20 (2) in clause (iii), by striking the period and in-
21 serting “, or”; and

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

1 “(iv) by a regional alliance (as defined in sec-
2 tion 1301 of the Health Security Act).”.

3 **SEC. 8403. AMENDMENTS RELATING TO CONTINUATION**
4 **COVERAGE.**

5 (a) PERIOD OF COVERAGE.—Subparagraph (D) of
6 section 602(2) of the Employee Retirement Income Secu-
7 rity Act of 1974 (29 U.S.C. 1162(1)) is amended—

8 (1) by striking “or” at the end of clause (i), by
9 striking the period at the end of clause (ii) and in-
10 serting “, or”, and by adding at the end the fol-
11 lowing new clause:

12 “(iii) eligible for coverage under a
13 comprehensive benefit package described in
14 section 1101 of the Health Security Act.”,
15 and

16 (2) by striking “OR MEDICARE ENTITLEMENT”
17 in the heading and inserting “, MEDICARE ENTITLE-
18 MENT, OR HEALTH SECURITY ACT ELIGIBILITY”.

19 (b) QUALIFIED BENEFICIARY.—Section 607(3) of
20 such Act (29 U.S.C. 1167(3)) is amended by adding at
21 the end the following new subparagraph:

22 “(D) SPECIAL RULE FOR INDIVIDUALS
23 COVERED BY HEALTH SECURITY ACT.—The
24 term ‘qualified beneficiary’ shall not include any
25 individual who, upon termination of coverage

1 under a group health plan, is eligible for cov-
2 erage under a comprehensive benefit package
3 described in section 1101 of the Health Secu-
4 rity Act.”

5 (c) REPEAL UPON IMPLEMENTATION OF HEALTH
6 SECURITY ACT.—

7 (1) IN GENERAL.—Part 6 of subtitle B of title
8 I of such Act (29 U.S.C. 601 et seq.) is amended
9 by striking sections 601 through 608 and by redesign-
10 nating section 609 as section 601.

11 (2) CONFORMING AMENDMENTS.—

12 (A) Section 502(a)(7) of such Act (29
13 U.S.C. 1132(a)(7)) is amended by striking
14 “609(a)(2)(A)” and inserting “601(a)(2)(A)”.

15 (B) Section 502(c)(1) is amended by strik-
16 ing “paragraph (1) or (4) of section 606 or”.

17 (C) Section 514 of such Act (29 U.S.C.
18 1144) is amended by striking “609” each place
19 it appears in subsections (b)(7) and (b)(8) and
20 inserting “601”.

21 (D) The table of contents in section 1 of
22 such Act is amended by striking the items relat-
23 ing to sections 601 through 609 and inserting
24 the following new item:

“Sec. 601. Additional standards for group health plans.”

25 (d) EFFECTIVE DATE.—

1 (1) SUBSECTIONS (a) AND (b).—The amend-
2 ments made by subsections (a) and (b) shall take ef-
3 fect on the date of the enactment of this Act.

4 (2) SUBSECTION (c).—The amendments made
5 by subsection (c) shall take effect on the earlier of—

6 (A) January 1, 1998, or

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

13 **SEC. 8404. ADDITIONAL AMENDMENTS RELATING TO**
14 **GROUP HEALTH PLANS.**

15 (a) REGULATIONS OF THE NATIONAL HEALTH
16 BOARD REGARDING CASES OF ADOPTION.—Section
17 601(c) of the Employee Retirement Income Security Act
18 of 1974 (as redesignated by section 8403) is amended by
19 adding at the end the following new paragraph:

20 “(4) REGULATIONS BY NATIONAL HEALTH
21 BOARD.—The preceding provisions of this subsection
22 shall apply except to the extent otherwise provided
23 in regulations of the National Health Board under
24 the Health Security Act.”.

1 (b) COVERAGE OF PEDIATRIC VACCINES.—Section
2 601(d) of such Act (as redesignated by section 8403) is
3 amended by adding at the end the following new sentence:
4 “The preceding sentence shall cease to apply to a group
5 health plan upon becoming a corporate alliance health
6 plan pursuant to an effective election of the plan sponsor
7 to be a corporate alliance under section 1311 of the Health
8 Security Act.”.

9 (c) TECHNICAL CORRECTIONS.—Effective as if in-
10 cluded in the enactment of the Omnibus Budget Reconcili-
11 ation Act of 1993—

12 (1) Subsection (a)(2)(B)(ii) of section 609 of
13 the Employee Retirement Income Security Act of
14 1974 is amended by striking “section 13822” and
15 inserting “section 13623”.

16 (2) Subsection (a)(4) of such section 609 is
17 amended by striking “section 13822” and inserting
18 “section 13623”.

19 (3) Subsection (d) of such section 609 is
20 amended by striking “section 13830” and inserting
21 “section 13631”.

22 **SEC. 8405. PLAN CLAIMS PROCEDURES.**

23 Section 503 of the Employee Retirement Income Se-
24 curity Act of 1974 (29 U.S.C. 1133) is amended—

1 (1) by inserting “(a) IN GENERAL.—” after
2 “SEC. 503.”; and

3 (2) by adding at the end the following new sub-
4 section:

5 “(b) GROUP HEALTH PLANS.—In addition to the re-
6 quirements of subsection (a), a group health plan to which
7 parts 1 and 4 apply under section 4(c)(2) shall comply
8 with the requirements of section 5201 of the Health Secu-
9 rity Act (relating to health plan claims procedure).”.

10 **SEC. 8406. EFFECTIVE DATES.**

11 Except as otherwise provided in this subtitle, the
12 amendments made by this subtitle shall take effect on the
13 earlier of—

14 (1) January 1, 1998, or

15 (2) such date or dates as may be prescribed in
16 regulations of the National Health Board in connec-
17 tion with plans whose participants or beneficiaries
18 reside in any State which becomes a participating
19 State under section 1200 of this Act before January
20 1, 1998.

1 **Subtitle F—Special Fund for WIC**
2 **Program**

3 **SEC. 8501. ADDITIONAL FUNDING FOR SPECIAL SUPPLE-**
4 **MENTAL FOOD PROGRAM FOR WOMEN, IN-**
5 **FANTS, AND CHILDREN (WIC).**

6 (a) AUTHORIZATION OF ADDITIONAL APPROPRIA-
7 TIONS.—There is hereby authorized to be appropriated for
8 the special supplemental food program for women, infants,
9 and children (WIC) under section 17 of the Child Nutri-
10 tion Act of 1966, in addition to amounts otherwise author-
11 ized to be appropriated for such program, such amounts
12 as are necessary for the Secretary of the Treasury to fulfill
13 the requirements of subsection (b).

14 (b) WIC FUND.—

15 (1) CREDIT.—For each of fiscal years 1996
16 through 2000, the Secretary of the Treasury shall
17 credit to a special fund of the Treasury an amount
18 equal to—

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

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

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

22 (D) \$398,000,000 for fiscal year 1999,

23 and

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

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1 (2) AVAILABILITY.—Subject to paragraph (3),
2 amounts in such fund—

3 (A) shall be available only for the program
4 authorized under section 17 of the Child Nutri-
5 tion Act of 1966, exclusive of activities author-
6 ized under section 17(m) of such Act, and

7 (B) shall be paid to the Secretary of Agri-
8 culture for such purposes.

9 (3) LIMITATION.—For a fiscal year specified in
10 paragraph (1), the amount credited to such fund for
11 the fiscal year shall be available for use in such pro-
12 gram only if appropriations Acts for the fiscal year,
13 without the addition of amounts provided under sub-
14 section (a) for the fund, provide new budget author-
15 ity for the program of no less than—

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

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

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

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

20 and

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

22 **TITLE IX—AGGREGATE**
23 **GOVERNMENT PAYMENTS**

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1 **Subtitle A—Aggregate State**
2 **Payments**

3 **PART 1—STATE MAINTENANCE OF EFFORT**
4 **PAYMENT**

5 **SEC. 9001. STATE MAINTENANCE-OF-EFFORT PAYMENT RE-**
6 **LATING TO NON-CASH ASSISTANCE RECIPI-**
7 **ENTS.**

8 (a) PAYMENT.—Each participating State shall pro-
9 vide for each year (beginning with State’s first year) for
10 payment to regional alliances in the State in the amounts
11 specified in subsection (b).

12 (b) AMOUNT.—Subject to sections 6005, 9023, and
13 9201(c)(2), the total amount of such payment for a year
14 shall be equal to the following:

15 (1) FIRST YEAR.—In the case of the first year
16 for a State, the sum of—

17 (A) the State non-cash, non-DSH baseline
18 amount for the State, determined under section
19 9002(a)(1) and updated under section
20 9003(a)(1), and

21 (B) the State non-cash, DSH baseline
22 amount for the State, determined under section
23 9002(a)(2) and updated under section
24 9003(a)(2).

1 (2) SUBSEQUENT YEAR.—In the case of any
2 succeeding year, the sum computed under paragraph
3 (1) for the first year updated to the year involved
4 under section 9003(b) .

5 (c) DIVISION AMONG REGIONAL ALLIANCES.—In the
6 case of a State with more than one regional alliance, the
7 payment required to be made under this section shall be
8 distributed among the regional alliances in an equitable
9 manner (determined by the State) that takes into account,
10 for each regional alliance, the proportion of the non-cash
11 baseline amount (described in section 9002) that is attrib-
12 utable to individuals who resided in the alliance area of
13 the regional alliance.

14 **SEC. 9002. NON-CASH BASELINE AMOUNTS.**

15 (a) BASELINE AMOUNTS.—

16 (1) NON-DSH AMOUNT.—The Secretary shall
17 determine for each State a non-cash, non-DSH base-
18 line amount which is equal to the sum of the fol-
19 lowing:

20 (A) EXPENDITURES FOR COMPREHENSIVE
21 BENEFIT PACKAGE FOR NON-CASH ASSISTANCE
22 CHILDREN.—The aggregate State medicaid ex-
23 penditures in fiscal year 1993 (as defined in
24 subsection (b)(1)) for the comprehensive benefit

1 package for non-cash assistance children (as de-
2 fined in section 9004(a)).

3 (B) EXPENDITURES FOR COMPREHENSIVE
4 BENEFIT PACKAGE FOR NON-CASH ASSISTANCE
5 ADULTS.—The aggregate State medicaid ex-
6 penditures in fiscal year 1993 for the com-
7 prehensive benefit package for non-cash assist-
8 ance adults (as defined in section 9004(b)).

9 (C) EXPENDITURES FOR ADDITIONAL BEN-
10 EFITS FOR CERTAIN CHILDREN RECEIVING
11 AFDC OR SSI.—The aggregate medicaid expend-
12 itures in fiscal year 1993 for all medically nec-
13 essary items and services described in section
14 1905(a) of the Social Security Act (including
15 items and services described in section 1905(r)
16 of such Act but excluding long-term care serv-
17 ices described in section 1933(c) of such Act)
18 for qualified children described in section
19 1934(b)(1) of such Act who are AFDC or SSI
20 recipients.

21 (2) DSH AMOUNT.—The Secretary shall deter-
22 mine for each State a non-cash, DSH baseline
23 amount which is equal to the DSH expenditures in
24 fiscal year 1993 (as defined in subsection (b)(2)).

1 (b) STATE MEDICAID EXPENDITURES AND DSH EX-
2 PENDITURES DEFINED.—

3 (1) AGGREGATE STATE MEDICAID EXPENDI-
4 TURES.—

5 (A) IN GENERAL.—In this section, the
6 term “aggregate State medicaid expenditures”
7 means, with respect to specified individuals and
8 a State in fiscal year 1993, the amount of pay-
9 ments under the State medicaid plan with re-
10 spect to medical assistance furnished for such
11 individuals for calendar quarters in fiscal year
12 1993, less the amount of Federal financial par-
13 ticipation paid to the State with respect to such
14 assistance, and not including any DSH expendi-
15 tures.

16 (B) LIMITED TO PAYMENTS FOR SERV-
17 ICES.—In applying subparagraph (A), payments
18 under the State medicaid plan shall not be in-
19 cluded unless Federal financial participation is
20 provided with respect to such payments under
21 section 1903(a)(1) of the Social Security Act
22 and such payments shall not include payments
23 for medicare cost-sharing (as defined in section
24 1905(p)(3) of the Social Security Act).

1 (2) DSH EXPENDITURES.—In this section, the
2 term “DSH expenditures” means, with respect to
3 fiscal year 1993, payments made under section 1923
4 of the Social Security Act in fiscal year 1993 multi-
5 plied by proportion of payments for medical assist-
6 ance for hospital services (including psychiatric hos-
7 pital services) under the State medicaid plan in fis-
8 cal year 1993 that is attributable to non-cash assist-
9 ance adults and non-cash assistance children.

10 (3) ADJUSTMENT AUTHORIZED TO TAKE INTO
11 ACCOUNT CASH FLOW VARIATIONS.—If the Secretary
12 finds that a State took an action that had the effect
13 of shifting the timing of medical assistance pay-
14 ments under the State medicaid plan between quar-
15 ters or fiscal years in a manner so that the pay-
16 ments made in fiscal year 1993 do not accurately re-
17 flect the value of the medical assistance provided
18 with respect to items and services furnished in that
19 fiscal year, the Secretary may provide for such ad-
20 justment in the amounts computed under this sub-
21 section as may be necessary so that the non-cash
22 baseline amounts determined under this section ac-
23 curately reflects such value.

24 (4) TREATMENT OF DISALLOWANCES.—The
25 amounts determined under this subsection shall take

1 into account amounts (or an estimate of amounts)
2 disallowed.

3 (c) APPLICATION TO PARTICULAR ITEMS AND SERV-
4 ICES IN COMPREHENSIVE BENEFIT PACKAGE.—For pur-
5 poses of subsection (a)(1), in determining the aggregate
6 State medicaid expenditures for a category of items and
7 services (within the comprehensive benefit package) fur-
8 nished in a State, there shall be counted only that propor-
9 tion of such expenditures that were attributable to items
10 and services included in the comprehensive benefit pack-
11 age (taking into account any limitation on amount, dura-
12 tion, or scope of items and services included in such pack-
13 age).

14 **SEC. 9003. UPDATING OF BASELINE AMOUNTS.**

15 (a) INITIAL UPDATE THROUGH THE FIRST YEAR.—

16 (1) NON-CASH, NON-DSH BASELINE AMOUNT.—

17 The Secretary shall update the non-cash, non-DSH
18 baseline amount determined under section
19 9002(a)(1) for each State from fiscal year 1993
20 through the first year, by the following percentage:

21 (A) If such first year is 1996, the applica-
22 ble percentage is 56.6 percent.

23 (B) If such first year is 1997, the applica-
24 ble percentage is 78.1 percent.

1 (C) If such first year is 1998, the applica-
2 ble percentage is 102.2 percent.

3 (2) NON-CASH, DSH BASELINE AMOUNT.—The
4 Secretary shall update the non-cash, DSH baseline
5 amount determined under section 9002(a)(2) for
6 each State from fiscal year 1993 through the first
7 year, by the following percentage:

8 (A) If such first year is 1996, the applica-
9 ble percentage is 45.9 percent.

10 (B) If such first year is 1997, the applica-
11 ble percentage is 61.8 percent.

12 (C) If such first year is 1998, the applica-
13 ble percentage is 79.0 percent.

14 (3) ADJUSTMENT AUTHORIZED TO TAKE INTO
15 ACCOUNT CASH FLOW VARIATIONS.—In determining
16 the updates under paragraphs (1) and (2), the Sec-
17 retary may provide for an adjustment in a manner
18 similar to the adjustment permitted under section
19 9002(b)(3).

20 (b) UPDATE FOR SUBSEQUENT YEARS.—For each
21 State for each year after the first year, the Board shall
22 update the non-cash baseline amount (as previously up-
23 dated under this subsection) by the product of—

1 (1) 1 plus the general health care inflation fac-
2 tor (as defined in section 6001(a)(3)) for the year,
3 and

4 (2) 1 plus the annual percentage increase in the
5 population of the United States of individuals who
6 are under 65 years of age (as estimated by the
7 Board based on projections made by the Bureau of
8 Labor Statistics of the Department of Labor) for
9 the year.

10 **SEC. 9004. NON-CASH ASSISTANCE CHILD AND ADULT DE-**
11 **FINED.**

12 (a) NON-CASH ASSISTANCE CHILD.—In this part,
13 the term “non-cash assistance child” means a child de-
14 scribed in section 1934(b)(1) of the Social Security Act
15 (as inserted by section 4222(a)) who is not a medicare-
16 eligible individual.

17 (b) NON-CASH ASSISTANCE ADULT.—In this part,
18 the term “non-cash assistance adult” means an individual
19 who is—

20 (1) over 21 years,

21 (2) is a citizen or national of the United States
22 or an alien who is lawfully admitted for permanent
23 residence or otherwise permanently residing in the
24 United States under color of law, and

1 (3) is not an AFDC or SSI recipient or a medi-
2 care-eligible individual.

3 **PART 2—STATE PREMIUM PAYMENTS**

4 **SEC. 9011. STATE PREMIUM PAYMENT RELATING TO CASH**
5 **ASSISTANCE RECIPIENTS.**

6 (a) IN GENERAL.—Subject to subsection (c), each
7 participating State shall provide in each year (beginning
8 with the State's first year) for payment to each regional
9 alliance in the State of an amount equal to the State med-
10 ical assistance percentage (as defined in subsection (b))
11 of 95 percent of the sum of the following products:

12 (1) AFDC PORTION.—The product of—

13 (A) the AFDC per capita premium amount
14 for the regional alliance for the year (deter-
15 mined under section 9012(a)), and

16 (B) the number of AFDC recipients resid-
17 ing in the alliance area in the year (as deter-
18 mined under section 9014(b)(1)).

19 (2) SSI PORTION.—The product of—

20 (A) the SSI per capita premium amount
21 for the regional alliance for the year (deter-
22 mined under section 9013), and

23 (B) the number of SSI recipients residing
24 in the alliance area in the year (as determined
25 under section 9014(b)(1)).

1 (b) STATE MEDICAL ASSISTANCE PERCENTAGE DE-
2 FINED.—In subsection (a), the term “State medical assist-
3 ance percentage” means, for a State for a quarter in a
4 fiscal year, 100 percent minus the Federal medical assist-
5 ance percentage (as defined in section 1905(b) of the So-
6 cial Security Act) for the State for the fiscal year.

7 (c) ADDITIONAL AMOUNT.—The amount of payment
8 under subsection (a) for a State for a year shall be in-
9 creased by the State medical assistance percentage multi-
10 plied by the sum of the following:

11 (1) AMOUNT OF SPECIAL INCREASE IN PRE-
12 MIUM DISCOUNT.—The aggregate increase in the
13 premium discounts under section 6104 for AFDC
14 and SSI families enrolled in regional alliance health
15 plans in the State that is attributable to subsection
16 (b)(2) of such section, and

17 (2) AMOUNT OF BASIC COST SHARING REDUC-
18 TION.—The amount of any cost sharing reduction
19 under section 1371(c)(1) for such families.

20 **SEC. 9012. DETERMINATION OF AFDC PER CAPITA PRE-**
21 **MIUM AMOUNT FOR REGIONAL ALLIANCES.**

22 (a) IN GENERAL.—For each regional alliance in a
23 State for each year, the Secretary shall determine an
24 AFDC per capita premium amount in accordance with
25 this section. Such amount is equal to—

1 (1) the per capita State medicaid expenditures
2 for the comprehensive benefit package for AFDC re-
3 cipients for the State for the year (as determined
4 under subsection (b)), multiplied by

5 (2) the regional alliance adjustment factor (de-
6 termined under section 9015) for the year for the
7 regional alliance.

8 (b) PER CAPITA STATE MEDICAID EXPENDITURES
9 DEFINED.—The “per capita State medicaid expenditures
10 for the comprehensive benefit package for AFDC recipi-
11 ents” for a State for a year is equal to the base per capita
12 expenditures (described in subsection (c)), updated to the
13 year involved under subsection (d)).

14 (c) BASE PER CAPITA EXPENDITURES.—The “base
15 per capita expenditures” described in this subsection, for
16 a State for a year, is—

17 (1) the baseline medicaid expenditures (as de-
18 fined in subsection (e)) for the State, divided by

19 (2) the number of AFDC recipients enrolled in
20 the State medicaid plan in fiscal year 1993, as de-
21 termined under section 9014(a).

22 (d) UPDATING.—

23 (1) INITIAL UPDATE THROUGH YEAR BEFORE
24 FIRST YEAR.—

1 (A) IN GENERAL.—The Secretary shall up-
2 date the base per capita expenditures described
3 in subsection (c) for each State from fiscal year
4 1993 through the year before first year, by the
5 applicable percentage specified in subparagraph
6 (B), or, if less, the increase percentage specified
7 in subparagraph (C).

8 (B) APPLICABLE PERCENTAGE.—For pur-
9 poses of subparagraph (A), the applicable per-
10 centage specified in this subparagraph, in the
11 case of a State in which the first year is—

12 (i) 1996 is 32.2 percent,

13 (ii) 1997 is 46.6 percent, or

14 (iii) 1998 is 62.1 percent.

15 (C) INCREASE PERCENTAGE.—

16 (i) IN GENERAL.—The increase per-
17 centage for a State specified in this sub-
18 paragraph is the Secretary's estimate of
19 the percentage increase in the per capita
20 expenditures specified in clause (ii) from
21 fiscal year 1993 through the year before
22 the first year, adjusted so as to eliminate
23 any change in medicaid expenditures that
24 is attributable to a reduction in the scope
25 of services, an arbitrary reduction in pay-

1 ment rates, or a reduction in access to
2 high quality services under the State med-
3 icaid plan.

4 (ii) PER CAPITA EXPENDITURES.—

5 The per capita expenditures specified in
6 this clause for a year is the quotient of the
7 baseline medicaid expenditures for the
8 State for the year, divided by the number
9 of AFDC recipients enrolled in the State
10 medicaid plan for the year.

11 (D) ADJUSTMENT AUTHORIZED TO TAKE

12 INTO ACCOUNT CASH FLOW VARIATIONS.—In
13 determining the update under paragraph (1),
14 the Secretary may provide for an adjustment in
15 a manner similar to the adjustment permitted
16 under section 9002(b)(3).

17 (2) UPDATE FOR SUBSEQUENT YEARS.—For

18 each State for the first year and for each year after
19 the first year, the Board shall update the base per
20 capita expenditures described in subsection (c) (as
21 previously updated under this subsection) by a fac-
22 tor equal to 1 plus the general health care inflation
23 factor (as defined in section 6001(a)(3)) for the
24 year.

1 (e) DETERMINATION OF BASELINE MEDICAID EX-
2 PENDITURES.—

3 (1) IN GENERAL.—For purposes of subsection
4 (c)(1), the “baseline medicaid expenditures” for a
5 State is the gross amount of payments under the
6 State medicaid plan with respect to medical assist-
7 ance furnished, for items and services included in
8 the comprehensive benefit package, for AFDC recipi-
9 ents for calendar quarters in fiscal year 1993, but
10 does not include such expenditures for which no
11 Federal financial participation is provided under
12 such plan.

13 (2) DISPROPORTIONATE SHARE PAYMENTS NOT
14 INCLUDED.—In applying paragraph (1), payments
15 made under section 1923 of the Social Security Act
16 shall not be counted in the gross amount of pay-
17 ments.

18 (3) TREATMENT OF DISALLOWANCES.—The
19 amount determined under this subsection shall take
20 into account amounts (or an estimate of amounts)
21 disallowed.

22 (f) APPLICATION TO PARTICULAR ITEMS AND SERV-
23 ICES IN COMPREHENSIVE BENEFIT PACKAGE.—For pur-
24 poses of this section, in determining the per capita State
25 medicaid expenditures for a category of items and services

1 (within the comprehensive benefit package) furnished in
2 a State, there shall be counted only that proportion of
3 such expenditures (determined only with respect to med-
4 ical assistance furnished to AFDC recipients) that were
5 attributable to items and services included in the com-
6 prehensive benefit package (taking into account any limi-
7 tation on amount, duration, or scope of items and services
8 included in such package).

9 **SEC. 9013. DETERMINATION OF SSI PER CAPITA PREMIUM**
10 **AMOUNT FOR REGIONAL ALLIANCES.**

11 For each regional alliance in a State for each year,
12 the Secretary shall determine an SSI per capita premium
13 amount in accordance with this section. Such amount shall
14 be determined in the same manner as the AFDC per cap-
15 ita premium amount for the regional alliance is deter-
16 mined under section 9012 except that, for purposes of this
17 section—

18 (1) any reference in such section (or in sections
19 referred to in such section) to an “AFDC recipient”
20 is deemed a reference to an “SSI recipient”, and

21 (2) the following percents shall be substituted
22 for the percents specified in section 9012(d)(1)(B):

23 (A) For 1996, 29.4 percent.

24 (B) For 1997, 43.7 percent.

25 (C) For 1998, 58.8 percent.

1 **SEC. 9014. DETERMINATION OF NUMBER OF AFDC AND SSI**
2 **RECIPIENTS.**

3 (a) BASELINE.—For purposes of section 9012 and
4 section 9013, the number of AFDC recipients and SSI
5 recipients for a State for fiscal year 1993 shall be deter-
6 mined based on actual reports submitted by the State to
7 the Secretary. In the case of individuals who were not re-
8 cipients for the entire fiscal year, the number shall take
9 into account only the portion of the year in which they
10 were such recipients. The Secretary may audit such re-
11 ports.

12 (b) SUBSEQUENT YEARS.—

13 (1) PAYMENTS.—For purposes of section
14 9011(a), the number of AFDC and SSI recipients
15 enrolled in regional alliance health plans for a re-
16 gional alliance shall be determined on a monthly
17 basis based on actual enrollment.

18 (2) COMPUTATION OF REGIONAL ADJUSTMENT
19 FACTORS AND BLENDED PLAN PAYMENT RATES.—
20 For purposes of computing regional alliance adjust-
21 ment factors under section 9015 and the AFDC and
22 SSI proportions under section 6202, the number of
23 AFDC and SSI recipients for a regional alliance in
24 a State for a year (beginning with 1997) shall be de-
25 termined by the State before the date the State is
26 required to compute AFDC and SSI proportions

1 under section 6202 based on the best available esti-
2 mate of such proportion in the previous year.

3 **SEC. 9015. REGIONAL ALLIANCE ADJUSTMENT FACTORS.**

4 (a) IN GENERAL.—If a State—

5 (1) has more than one regional alliance oper-
6 ating in the State for a year, the State shall com-
7 pute under this section a regional alliance adjust-
8 ment factor for each such regional alliance for the
9 year in accordance with subsection (b), or

10 (2) has only one regional alliance for a year, the
11 regional alliance adjustment factor under this sec-
12 tion is 1.

13 (b) RULES.—The adjustment factors under sub-
14 section (a)(1) for a year shall be computed in a manner
15 so that—

16 (1) such factors for the different regional alli-
17 ances reflect—

18 (A) the variation in regional alliance per
19 capita premium targets (determined under sec-
20 tion 6003), and

21 (B) the variation in base per capita ex-
22 penditures for medicaid across regional alli-
23 ances; and

24 (2) the weighted average of such factors is 1.

1 (c) USE OF SAME DATA.—The weighted average
2 under subsection (b)(2) shall be determined based on the
3 number of AFDC recipients or SSI recipients (as the case
4 may be) enrolled in each regional alliance in a State (as
5 determined for each regional alliance under section
6 9014(b)(2)).

7 (d) CLARIFICATION OF SEPARATE COMPUTATIONS.—
8 Determinations of adjustment factors under this section
9 shall be made separately for AFDC recipients and for SSI
10 recipients.

11 **PART 3—GENERAL AND MISCELLANEOUS**
12 **PROVISIONS**

13 **SEC. 9021. TIMING AND MANNER OF PAYMENTS.**

14 The provisions of paragraphs (1) and (2) of section
15 9101(b) apply to payments by a State under this subtitle
16 in the same manner as they apply to payments by the Sec-
17 retary under section 9101, and any reference in such pro-
18 visions to the Secretary is deemed a reference to the State.

19 **SEC. 9022. REVIEW OF PAYMENT LEVEL.**

20 (a) IN GENERAL.—The National Health Board shall
21 review from time to time the appropriateness of the levels
22 of payments required of States under this subtitle.

23 (b) REPORT.—The Board may report to the Congress
24 on such adjustments as should be made to assure an equi-

1 table distribution of State payments under this Act, taking
2 into account the revenue base in each of the States.

3 (c) LIMIT ON AUTHORITY.—Nothing in this subtitle
4 shall be construed as permitting the Board to change the
5 amount of the payments required by States under the pre-
6 vious sections in this subtitle.

7 **SEC. 9023. SPECIAL RULES FOR PUERTO RICO AND OTHER**
8 **TERRITORIES.**

9 (a) WAIVER AUTHORITY.—Notwithstanding any
10 other requirement of this title or title VI, the Secretary
11 may waive or modify any requirement of this title or title
12 VI (other than financial contribution and subsidy require-
13 ments) with respect to Puerto Rico, the Virgin Islands,
14 Guam, American Samoa, and the Northern Mariana Is-
15 lands, consistent with this section, to accommodate their
16 unique geographic and social conditions and features of
17 their health care systems.

18 (b) TERRITORIAL MAINTENANCE OF EFFORT AND
19 DIVISION OF FINANCIAL RESPONSIBILITY.—

20 (1) IN GENERAL.—In the case of such a Com-
21 monwealth or territory, the Secretary shall deter-
22 mine the State payments under part 1 taking into
23 account—

1 (A) payments that qualify for Federal fi-
2 nancial participation under the medicaid pro-
3 gram,

4 (B) payments that would qualify for such
5 participation in the absence of section 1108(c)
6 of the Social Security Act, and

7 (C) other factors that the Secretary may
8 consider.

9 (2) CASH ASSISTANCE RECIPIENTS.—With re-
10 spect to such Commonwealths and territories not
11 covered under the supplementary security income
12 program, in this Act, the term “SSI recipient” in-
13 cludes an individual receiving aid under a territorial
14 program for the aged, blind, or disabled under the
15 Social Security Act.

16 **Subtitle B—Aggregate Federal**
17 **Alliance Payments**

18 **SEC. 9101. FEDERAL PREMIUM PAYMENTS FOR CASH AS-**
19 **SISTANCE RECIPIENTS.**

20 (a) AMOUNT.—

21 (1) IN GENERAL.—The Secretary shall provide
22 each year (beginning with a State’s first year) for
23 payment to each regional alliance of an amount
24 equal to the Federal medical assistance percentage
25 (as defined in section 1905(b) of the Social Security

1 Act) of (A) 95 percent of the sum of the products
2 described in section 9011(a) for that State for that
3 fiscal year, plus (B) the sum described in section
4 9011(c).

5 (2) SPECIAL RULES FOR SINGLE-PAYER
6 STATES.—In determining the products referred to in
7 paragraph (1) in the case of a single-payer State,
8 the State is deemed to be a single regional alliance
9 and the regional alliance adjustment factor (under
10 section 9015) is deemed to be 1.

11 (b) TIMING AND MANNER OF PAYMENT.—

12 (1) IN GENERAL.—Amounts required to be paid
13 under this section shall be paid on a periodic basis
14 that reflects the cash flow requirements of regional
15 alliances for payments under this section in order to
16 meet obligations established under this Act and, in
17 consultation with the Secretary of the Treasury, the
18 cash management interests of the Federal Govern-
19 ment.

20 (2) PERIODIC PROVISION OF INFORMATION.—
21 Each regional alliance shall periodically transmit to
22 the Secretary such information as the Secretary may
23 require to make such payments.

24 (3) RECONCILIATION.—

1 (A) PRELIMINARY.—At such time after the
2 end of each year as the Secretary shall specify,
3 the State shall submit to the Secretary such in-
4 formation as the Secretary may require to do a
5 preliminary reconciliation of the amounts paid
6 under this section and the amounts due.

7 (B) FINAL.—No later than June 30 of
8 each year, the Secretary shall provide for a
9 final reconciliation for such payments for quar-
10 ters in the previous year. Amounts subsequently
11 payable are subject to adjustment to reflect the
12 results of such reconciliation.

13 (C) AUDIT.—Payments under this section
14 are subject to audits by the Secretary in accord-
15 ance with rules established by the Secretary.

16 **SEC. 9102. CAPPED FEDERAL ALLIANCE PAYMENTS.**

17 (a) CAPPED ENTITLEMENT.—

18 (1) PAYMENT.—The Secretary shall provide for
19 each calendar quarter (beginning on or after Janu-
20 ary 1, 1996) for payment to each regional alliance
21 of an amount equal to the capped Federal alliance
22 payment amount (as defined in subsection (b)(1))
23 for the regional alliance for the quarter.

24 (2) ENTITLEMENT.—This section constitutes
25 budget authority in advance of appropriations Acts,

1 and represents the obligation of the Federal Govern-
2 ment to provide for the payment to regional alliances
3 of the capped Federal alliance payment amount
4 under this section.

5 (b) CAPPED FEDERAL ALLIANCE PAYMENT
6 AMOUNT.—

7 (1) IN GENERAL.—In this section, the term
8 “capped Federal alliance payment amount” means,
9 for a regional alliance for a calendar quarter in a
10 year and subject to subsection (e), the amount by
11 which—

12 (A) $\frac{1}{4}$ of the total payment obligation (de-
13 scribed in paragraph (2)) for the alliance for
14 the year, exceeds

15 (B) $\frac{1}{4}$ of the total amounts receivable (de-
16 scribed in paragraph (3)) by the alliance for the
17 year.

18 (2) TOTAL PAYMENT OBLIGATION.—The total
19 payment obligation described in this paragraph for
20 an alliance for a year is the total amount payable by
21 the alliance for the following:

22 (A) PLAN PAYMENTS (AND CERTAIN COST
23 SHARING REDUCTIONS).—Payments to regional
24 alliance health plans under section 1351 (in-
25 cluding amounts attributable to cost sharing re-

1 ductions under section 1371, not including a re-
2 duction under subsection (c)(2) thereof).

3 (B) ALLIANCE ADMINISTRATIVE EX-
4 PENSES.—Payments retained by the regional
5 alliance for administration (in accordance with
6 section 1352).

7 (3) TOTAL AMOUNTS RECEIVABLE.—The total
8 amounts receivable by a regional alliance for a year
9 is the sum of the following:

10 (A) PREMIUMS.—The amount payable to
11 the regional alliance for the family share of pre-
12 miums, employer premiums, and liabilities owed
13 the alliance under subtitle B of title VI, not
14 taking into account any failure to make or col-
15 lect such payments.

16 (B) OTHER GOVERNMENT PAYMENTS.—
17 The amounts payable to the regional alliance
18 under sections 9001, 9011, and 9101, and pay-
19 able under section 1894 of the Social Security
20 Act (as added by section 4003) during the year.

21 (4) NO PAYMENT FOR CERTAIN AMOUNTS.—

22 (A) UNCOLLECTED ALLIANCE PRE-
23 MIUMS.—Each regional alliance is responsible,
24 under section 1345(a), for the collection of all
25 amounts owed the alliance (whether by individ-

1 uals, employers, or others and whether on the
2 basis of premiums owed, incorrect amounts of
3 discounts or premium, cost sharing, or other re-
4 ductions made, or otherwise), and no amounts
5 are payable by the Federal Government under
6 this section with respect to the failure to collect
7 any such amounts.

8 (B) ADMINISTRATIVE ERRORS.—

9 (i) IN GENERAL.—Each participating
10 State is responsible, under section 1202(g),
11 for the payment to regional alliances in the
12 State of amounts attributable to adminis-
13 trative errors (described in clause (ii)).

14 (ii) ADMINISTRATIVE ERRORS DE-
15 SCRIBED.—The administrative errors de-
16 scribed in this clause include the following:

17 (I) An eligibility error rate for
18 premium discounts, liability reduc-
19 tions, and cost sharing reductions
20 under sections 6104 and 6123, section
21 6113, and section 1371, respectively,
22 to the extent the applicable error rate
23 exceeds the maximum permissible
24 error rate, specified by the applicable
25 Secretary under section

1303

1 1361(b)(1)(C), with respect to the
2 section involved.

3 (II) Misappropriations or other
4 regional alliance expenditures that the
5 Secretary finds are attributable to
6 malfeasance or misfeasance by the re-
7 gional alliance or the State.

8 (5) SPECIAL RULES FOR SINGLE-PAYER
9 STATES.—In applying this subsection in the case of
10 a single-payer State, the Secretary shall develop and
11 apply a methodology for computing an amount of
12 payment (with respect to each calendar quarter) that
13 is equivalent to the amount of payment that would
14 have been made to all regional alliances in the State
15 for the quarter if the State were not a single-payer
16 State.

17 (c) DETERMINATION OF CAPPED FEDERAL ALLI-
18 ANCE PAYMENT AMOUNTS.—

19 (1) REPORTS.—At such time as the Secretary
20 may require before the beginning of each fiscal year,
21 each regional alliance shall submit to the Secretary
22 such information as the Secretary may require to es-
23 timate the capped Federal alliance payment amount
24 under this section for the succeeding calendar year

1 (and the portion of such year that falls in such fiscal
2 year).

3 (2) ESTIMATION.—Before the beginning of each
4 year, the Secretary shall estimate for each regional
5 alliance the capped Federal alliance payment amount
6 for calendar quarters in such year. Such estimate
7 shall be based on factors including prior financial ex-
8 perience in the alliance, future estimates of income,
9 wages, and employment, and other characteristics of
10 the area found relevant by the Secretary. The Sec-
11 retary shall transmit to Congress, on a timely basis
12 consistent with the timely appropriation of funds
13 under this section, a report that specifies an esti-
14 mate of the total capped Federal alliance payment
15 amounts owed to regional alliances under this sec-
16 tion for the fiscal and calendar year involved.

17 (d) PAYMENTS TO REGIONAL ALLIANCES.—Subject
18 to subsection (e), the provisions of section 9101(b) apply
19 to payments under this section in the same manner as
20 they apply to payments under section 9101.

21 (e) CAP ON PAYMENTS.—

22 (1) IN GENERAL.—The total amount of the
23 capped Federal alliance payments made under this
24 section for quarters in a fiscal year may not exceed

1 the cap specified under paragraph (2) for the fiscal
2 year.

3 (2) CAP.—Subject to paragraphs (3) and (6)—

4 (A) FISCAL YEARS 1996 THROUGH 2000.—

5 The cap under this paragraph—

6 (i) for fiscal year 1996, is \$10.3 bil-
7 lion,

8 (ii) for fiscal year 1997, is \$28.3 bil-
9 lion,

10 (iii) for fiscal year 1998, is \$75.6 bil-
11 lion,

12 (iv) for fiscal year 1999, is \$78.9 bil-
13 lion, and

14 (v) for fiscal year 2000, is \$81.0 bil-
15 lion.

16 (B) SUBSEQUENT FISCAL YEAR.—The cap
17 under this paragraph for a fiscal year after fis-
18 cal year 2000 is the cap under this paragraph
19 for the previous fiscal year (not taking into ac-
20 count paragraph (3)) multiplied by the product
21 of the factors described in subparagraph (C) for
22 that fiscal year and for each previous year after
23 fiscal year 2000.

1 (C) FACTOR.—The factor described in this
2 subparagraph for a fiscal year is 1 plus the fol-
3 lowing:

4 (i) CPI.—The percentage change in
5 the CPI for the fiscal year, determined
6 based upon the percentage change in the
7 average of the CPI for the 12-month pe-
8 riod ending with May 31 of the previous
9 fiscal year over such average for the pre-
10 ceding 12-month period.

11 (ii) POPULATION.—The average an-
12 nual percentage change in the population
13 of the United States during the 3-year pe-
14 riod ending in the preceding calendar year,
15 determined by the Board based on data
16 supplied by the Bureau of the Census.

17 (iii) REAL GDP PER CAPITA.—The av-
18 erage annual percentage change in the
19 real, per capita gross domestic product of
20 the United States during the 3-year period
21 ending in the preceding calendar year, de-
22 termined by the Board based on data sup-
23 plied by the Department of Commerce.

24 (3) CARRYFORWARD.—If the total of the
25 capped Federal alliance payment amounts for all re-

1 regional alliances for all calendar quarters in a fiscal
2 year is less than the cap specified in paragraph (2)
3 for the fiscal year, then the amount of such surplus
4 shall be accumulated and will be available in the
5 case of a year in which the cap would otherwise be
6 breached.

7 (4) NOTIFICATION.—

8 (A) IN GENERAL.—If the Secretary antici-
9 pates that the amount of the cap, plus any
10 carryforward from a previous year accumulated
11 under paragraph (3), will not be sufficient for
12 a fiscal year, the Secretary shall notify the
13 President, the Congress, and each regional alli-
14 ance. Such notification shall include informa-
15 tion about the anticipated amount of the short-
16 fall and the anticipated time when the shortfall
17 will first occur.

18 (B) REQUIRED ACTION.—Within 30 days
19 after receiving such a notice, the President shall
20 submit to Congress a report containing specific
21 legislative recommendations for actions which
22 would eliminate the shortfall.

23 (5) CONGRESSIONAL CONSIDERATION.—

24 (A) EXPEDITED CONSIDERATION.—If a
25 joint resolution the substance of which approves

1 the specific recommendations submitted under
2 paragraph (4)(B) is introduced, subject to sub-
3 paragraph (B), the provisions of section 2908
4 (other than subsection (a)) of the Defense Base
5 Closure and Realignment Act of 1990 shall
6 apply to the consideration of the joint resolution
7 in the same manner as such provisions apply to
8 a joint resolution described in section 2908(a)
9 of such Act.

10 (B) SPECIAL RULES.—For purposes of ap-
11 plying subparagraph (A) with respect to such
12 provisions, any reference to the Committee on
13 Armed Services of the House of Representatives
14 shall be deemed a reference to an appropriate
15 Committee of the House of Representatives
16 (specified by the Speaker of the House of Rep-
17 resentatives at the time of submission of rec-
18 ommendations under paragraph (4)) and any
19 reference to the Committee on Armed Services
20 of the Senate shall be deemed a reference to an
21 appropriate Committee of the Senate (specified
22 by the Majority Leader of the Senate at the
23 time of submission of such recommendations).

24 (6) METHOD FOR ADJUSTING THE CAP FOR
25 CHANGES IN INFLATION.—If the inflation rate, as

1 measured by the percentage increase in the CPI, is
2 projected to be significantly different from the infla-
3 tion rate projected by the Council of Economic Advi-
4 sors to the President as of October 1993, the Sec-
5 retary may adjust the caps under paragraph (2) so
6 as to reflect such deviation from the projection.

7 **Subtitle C—Borrowing Authority to**
8 **Cover Cash-flow Shortfalls**

9 **SEC. 9201. BORROWING AUTHORITY TO COVER CASH-FLOW**
10 **SHORTFALLS.**

11 (a) IN GENERAL.—The Secretary shall make avail-
12 able loans to regional alliances in order to cover any period
13 of temporary cash-flow shortfall attributable to any of the
14 following:

15 (1) Any estimation discrepancy (including those
16 described in subsection (e)(1)).

17 (2) A period of temporary cash-flow shortfall
18 attributable to an administrative error (described in
19 subsection (e)(2)).

20 (3) A period of temporary cash-flow shortfall
21 relating to the relative timing during the year in
22 which amounts are received and payments are re-
23 quired to be made.

24 (b) TERMS AND CONDITIONS.—

1 (1) IN GENERAL.—Loans shall be made under
2 this section under terms and conditions, consistent
3 with this subsection, specified by the Secretary, in
4 consultation with the Secretary of the Treasury and
5 taking into account Treasury cash management
6 rules.

7 (2) PERIOD.—Loans under this section shall be
8 repayable with interest over a period of not to exceed
9 2 years.

10 (3) INTEREST RATE.—The rate of interest on
11 such loans shall be at a rate determined by the Sec-
12 retary of the Treasury taking into consideration the
13 current average rate on outstanding marketable obli-
14 gations of the United States.

15 (4) APPROPRIATE PAYMENT ADJUSTMENTS.—
16 As a condition of providing a loan under subsection
17 (a)(1), the Secretary shall require the regional alli-
18 ance to make such adjustments under the appro-
19 priate estimation adjustment provision (described in
20 subsection (f)) in order to assure the repayment of
21 the amount so borrowed.

22 (5) LIMITATION ON LOAN BALANCE OUT-
23 STANDING TO A REGIONAL ALLIANCE.—The total
24 balance of loans outstanding at any time to a re-
25 gional alliance shall not exceed—

1 (A) for the first year, 25 percent of the es-
2 timated total premiums for the alliance for such
3 year, or

4 (B) for a subsequent year, 25 percent of
5 the actual total premiums for the alliance for
6 the previous year.

7 (c) REPAYMENT.—

8 (1) ESTIMATION DISCREPANCIES AND TIM-
9 ING.—Loans made under paragraphs (1) and (3) of
10 subsection (a) shall be repaid through a reduction in
11 the payment amounts otherwise required to be made
12 under section 9102 to the regional alliance.

13 (2) ADMINISTRATIVE ERROR.—Loans made
14 under subsection (a)(2) shall be repaid through a
15 temporary increase in the amount of the State main-
16 tenance-of-effort payment required under section
17 9001.

18 (d) REPORTS.—The Secretary shall annually report
19 to Congress on the loans made (and loan amounts repaid)
20 under this section.

21 (e) SOURCES OF DISCREPANCY DESCRIBED.—

22 (1) ESTIMATION DISCREPANCIES.—The esti-
23 mation discrepancies described in this paragraph are
24 discrepancies in estimating the following:

1 (A) The average premium payments per
2 family under section 6122(b).

3 (B) The AFDC and SSI proportions under
4 section 6202.

5 (C) The distribution of enrolled families in
6 different risk categories for purposes of section
7 1351(c).

8 (D) The distribution of enrollment in ex-
9 cess premium plans (for purposes of calculating
10 and applying the reduced weighted average ac-
11 cepted bid under section 6105(c)(1)).

12 (E) The collection shortfalls (used in com-
13 puting the family collection shortfall add-on
14 under section 6107).

15 (2) ADMINISTRATIVE ERRORS.—The adminis-
16 trative errors described in this paragraph are errors
17 described in section 9201(b)(4)(B)(ii).

18 (f) ESTIMATION ADJUSTMENT PROVISIONS DE-
19 SCRIBED.—The estimation adjustment provisions, referred
20 to in subsection (b)(4)) are the following adjustments (cor-
21 responding to the respective estimation discrepancies spec-
22 ified in subsection (d)(1)):

23 (1) Adjustments for average premium payments
24 per family under section 6122(b)(4).

1 (2) Adjustments in the AFDC and SSI propor-
2 tions under section 6202(d).

3 (3) Adjustments pursuant to the methodology
4 described in section 1541(b)(8).

5 (4) Adjustments in excess premium credit pur-
6 suant to section 6105(b)(2).

7 (5) Adjustment in the collection shortfall add-
8 on under section 6107(b)(2)(C)).

9 (g) ADVANCES; LIMITATIONS ON ADVANCES.—

10 (1) IN GENERAL.—Subject to paragraph (2),
11 the Secretary of the Treasury is authorized to ad-
12 vance to the Secretary, under terms and conditions
13 determined by the Secretary of the Treasury,
14 amounts sufficient to cover the loans made to re-
15 gional alliances by the Secretary under this section.

16 (2) LIMITATION.—The total balance of Treas-
17 ury advances outstanding at any time to the Sec-
18 retary under paragraph (1) shall not exceed
19 \$3,500,000,000.

20 **TITLE X—COORDINATION OF**
21 **MEDICAL PORTION OF WORK-**
22 **ERS COMPENSATION AND**
23 **AUTOMOBILE INSURANCE**

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1 **Subtitle A—Workers Compensation**

2 **Insurance**

3 **SEC. 10000. DEFINITIONS.**

4 In this subtitle:

5 (1) **INJURED WORKER.**—The term “injured
6 worker” means, with respect to a health plan, an in-
7 dividual enrolled under the plan who has a work-re-
8 lated injury or illness for which workers compensa-
9 tion medical benefits are available under State law.

10 (2) **SPECIALIZED WORKERS COMPENSATION**
11 **PROVIDER.**—The term “specialized workers com-
12 pensation provider” means a health care provider
13 that specializes in the provision of treatment relating
14 to work-related injuries or illness, and includes spe-
15 cialists in industrial medicine, specialists in occupa-
16 tional therapy, and centers of excellence in industrial
17 medicine and occupational therapy.

18 (3) **WORKERS COMPENSATION MEDICAL BENE-**
19 **FITS.**—The term “workers compensation medical
20 benefits” means, with respect to an enrollee who is
21 an employee subject to the workers compensation

1 laws of a State, the comprehensive medical benefits
2 for work-related injuries and illnesses provided for
3 under such laws with respect to such an employee.

4 (4) WORKERS COMPENSATION CARRIER.—The
5 term “workers compensation carrier” means an in-
6 surance company that underwrites workers com-
7 pensation medical benefits with respect to one or
8 more employers and includes an employer or fund
9 that is financially at risk for the provision of work-
10 ers compensation medical benefits.

11 (5) WORKERS COMPENSATION SERVICES.—The
12 term “workers compensation services” means items
13 and services included in workers compensation med-
14 ical benefits and includes items and services (includ-
15 ing rehabilitation services and long-term care serv-
16 ices) commonly used for treatment of work-related
17 injuries and illnesses.

18 **PART 1—HEALTH PLAN REQUIREMENTS**

19 **RELATING TO WORKERS COMPENSATION**

20 **SEC. 10001. PROVISION OF WORKERS COMPENSATION**
21 **SERVICES.**

22 (a) PROVISION OF BENEFITS.—Subject to subsection

23 (b)—

24 (1) REQUIREMENT FOR CERTAIN HEALTH
25 PLANS.—

1 (A) IN GENERAL.—Each health plan that
2 provides services to enrollees through partici-
3 pating providers shall enter into such contracts
4 and arrangements as are necessary (in accord-
5 ance with subparagraph (B)) to provide or ar-
6 range for the provision of workers compensation
7 services to such enrollees, in return for payment
8 from the workers compensation carrier under
9 section 10002.

10 (B) PROVISION OF SERVICES.—For pur-
11 poses of this paragraph, a health plan provides
12 (or arranges for the provision of) workers com-
13 pensation services with respect to an enrollee if
14 the services are provided by—

15 (i) a participating provider in the
16 plan,

17 (ii) any other provider with whom the
18 plan has entered into an agreement for the
19 provision of such services, or

20 (iii) a specialized workers compensa-
21 tion provider (designated by the State
22 under 10011(b)), whether or not the pro-
23 vider is a provider described in clause (i)
24 or (ii).

1 (2) INDIVIDUAL REQUIREMENT.—An individual
2 entitled to workers compensation medical benefits
3 and enrolled in a health plan (whether or not the
4 plan is described in paragraph (1)(A)) shall receive
5 workers compensation services through the provision
6 (or arrangement for the provision) of such services
7 by the health plan.

8 (3) EXCEPTIONS.—

9 (A) EMERGENCY SERVICES.—Paragraphs
10 (1) and (2) shall not apply in the case of emer-
11 gency services.

12 (B) ELECTING VETERANS, MILITARY PER-
13 SONNEL AND INDIANS.—Paragraphs (1) and
14 (2) shall not apply in the case of an individual
15 described in section 1004(b) and making an
16 election described in such section.

17 (4) USE OF SPECIALIZED WORKERS COMPENSA-
18 TION PROVIDERS.—If a participating State has des-
19 ignated under section 10011(b) specialized workers
20 compensation providers with respect to one or more
21 types of injuries or illnesses for a geographic area,
22 either a health plan or an injured worker who has
23 an injury or illness of such type may elect to provide
24 or receive the benefits under this subsection through
25 such a provider.

1 (b) ALTERNATIVE PERMITTED.—Subsection (a) shall
2 not be construed as preventing an injured worker and a
3 workers compensation carrier from agreeing that workers
4 compensation services shall be provided other than by or
5 through the health plan in which the worker is enrolled.

6 (c) COORDINATION.—

7 (1) DESIGNATION OF CASE MANAGER.—Each
8 health plan shall employ or contract with one or
9 more individuals, such as occupational nurses, with
10 experience in the treatment of occupational illness
11 and injury to provide case management services with
12 respect to workers compensation services provided
13 through the plan under this section.

14 (2) FUNCTIONS OF CASE MANAGER.—The
15 health plan (through the case manager described in
16 paragraph (1)) is responsible for ensuring that—

17 (A) there is plan of treatment (when ap-
18 propriate) for each enrollee who is an injured
19 worker designed to assure appropriate treat-
20 ment and facilitate return to work;

21 (B) the plan of treatment is coordinated
22 with the workers compensation carrier, the em-
23 ployer, or both;

1 (C) the health plan (and its providers)
2 comply with legal duties and requirements
3 under State workers compensation law; and

4 (D) if the health plan is unable to provide
5 a workers compensation service needed to treat
6 a work-related injury or illness, the injured
7 worker is referred (in consultation with the
8 workers compensation carrier) to an appro-
9 priate provider.

10 (c) ADMINISTRATION.—The Secretary of Labor shall
11 administer this part and, for such purposes, the Secretary
12 is authorized to prescribe such rules and regulations as
13 may be necessary and appropriate.

14 **SEC. 10002. PAYMENT BY WORKERS COMPENSATION CAR-**
15 **RIER.**

16 (a) PAYMENT.—

17 (1) IN GENERAL.—Each workers compensation
18 carrier that is liable for payment for workers com-
19 pensation services furnished by or through a health
20 plan, regardless of whether or not the services are
21 included in the comprehensive benefit package, shall
22 make payment for such services.

23 (2) USE OF REGIONAL ALLIANCE FEE SCHED-
24 ULE.—Except as provided in subsection (b), such
25 payment shall be made in accordance with the appli-

1 cable fee schedule established under section 1322(c)
2 or section 10013.

3 (b) ALTERNATIVE PAYMENT METHODOLOGIES.—
4 Subsection (a)(2) shall not apply—

5 (1) in the case of a regional alliance or partici-
6 pating State that establishes an alternative payment
7 methodology (such as payment on a negotiated fee
8 for each case) for payment for workers compensation
9 services; or

10 (2) in the case in which a workers compensa-
11 tion carrier and the health plan negotiate alternative
12 payment arrangements.

13 (c) LIMITATION OF LIABILITY OF INJURED WORK-
14 ER.—Nothing in this part shall be construed as requiring
15 an injured worker to make any payment (including pay-
16 ment of any cost sharing or any amount in excess of the
17 applicable fee schedule) to any health plan or health care
18 provider for the receipt of workers compensation services.

19 **PART 2—REQUIREMENTS OF**

20 **PARTICIPATING STATES**

21 **SEC. 10011. COORDINATION OF SPECIALIZED WORKERS**

22 **COMPENSATION PROVIDERS.**

23 (a) IN GENERAL.—Each participating State shall co-
24 ordinate access to services provided by specialized workers
25 compensation providers on behalf of health plans, pro-

1 viding coverage to individuals residing in the State, under
2 part 1.

3 (b) OPTIONAL DESIGNATION OF SPECIALIZED
4 WORKERS COMPENSATION PROVIDERS.—A participating
5 State may designate such specialized workers compensa-
6 tion providers, with respect to one or more types of ill-
7 nesses or injuries in a geographic area as the State deter-
8 mines to be appropriate, to provide under part 1 workers
9 compensation services that—

10 (1) are not included in the comprehensive ben-
11 efit package, or

12 (2) are so included but are specialized services
13 that are typically provided (as determined by the
14 State) by specialists in occupational or rehabilitative
15 medicine.

16 Injured workers and health plans may elect to use such
17 providers under section 10001(a)(4).

18 **SEC. 10012. PREEMPTION OF STATE LAWS RESTRICTING**
19 **DELIVERY OF WORKERS COMPENSATION**
20 **MEDICAL BENEFITS.**

21 (a) IN GENERAL.—Subject to section 10011(b), no
22 State law shall have any effect that restricts the choice,
23 or payment, of providers that may provide workers com-
24 pensation services for individuals enrolled in a health plan.

1 (b) DISPUTE RESOLUTION.—A State law may pro-
2 vide for a method for resolving disputes among parties re-
3 lated to—

4 (1) an individual’s entitlement to workers com-
5 pensation medical benefits under State law,

6 (2) the necessity and appropriateness of work-
7 ers compensation services provided to an injured
8 worker, and

9 (3) subject to section 10002, the reasonableness
10 of charges or fees charged for workers compensation
11 services.

12 **SEC. 10013. DEVELOPMENT OF SUPPLEMENTAL SCHEDULE.**

13 Each participating State shall develop a fee schedule
14 applicable to payment for workers compensation services
15 for which a fee is not included in the applicable fee sched-
16 ule established under section 1322(c).

17 **SEC. 10014. CONSTRUCTION.**

18 (a) IN GENERAL.—Nothing in this subtitle shall be
19 construed as altering—

20 (1) the effect of a State workers compensation
21 law as the exclusive remedy for work-related injuries
22 or illnesses,

23 (2) the determination of whether or not a per-
24 son is an injured worker and entitled to workers
25 compensation medical benefits under State law,

1 (3) the scope of items and services available to
2 injured workers entitled to workers compensation
3 medical benefits under State law, or

4 (4) the eligibility of any individual or class of
5 individuals for workers compensation medical bene-
6 fits under State law.

7 (b) EARLY INTEGRATION.—Nothing in this subtitle
8 shall prevent a State from integrating or otherwise coordi-
9 nating the payment for workers compensation medical
10 benefits with payment for benefits under health insurance
11 or health benefit plans before the date the Commission
12 submits its report under section 10201(e).

13 **PART 3—APPLICATION OF IN-**

14 **FORMATION REQUIREMENTS;**

15 **REPORT ON PREMIUM RE-**

16 **DUCTIONS**

17 **SEC. 10021. APPLICATION OF INFORMATION REQUIRE-**
18 **MENTS.**

19 (a) IN GENERAL.—The provisions of—

20 (1) part 3 of subtitle B of title V (relating to
21 use of standard forms), and

22 (2) section 5101(e)(9) (relating to provision of
23 data on quality),

24 apply to the provision of workers compensation services
25 in the same manner as such provisions apply with respect

1 to the provision of services included in the comprehensive
2 benefit package.

3 (b) RULES.—The Secretary of Labor shall promul-
4 gate rules to clarify the responsibilities of health plans and
5 workers compensation carriers in carrying out the provi-
6 sions referred to in subsection (a).

7 **SEC. 10022. REPORT ON REDUCTION IN WORKERS COM-**
8 **PENSATION PREMIUMS.**

9 (a) STUDY AND REPORT.—

10 (1) STUDY.—The Secretary of Labor shall pro-
11 vide for a study of the impact of the provisions of
12 this subtitle on the premium rates charged to em-
13 ployers for workers compensation insurance. Such
14 study shall use information supplied by States relat-
15 ing to workers compensation premiums and such
16 other information as such Secretary finds appro-
17 priate.

18 (2) REPORT.—Such Secretary shall submit to
19 the Congress, by not later than 2 years after the
20 date that this subtitle applies in all States, a report
21 on the findings of the study.

22 (b) WORKERS COMPENSATION CARRIER FILINGS.—

23 (1) IN GENERAL.—Within six months after the
24 date this subtitle is effective in a participating State,
25 each workers compensation carrier (other than a

1 self-funded employer) providing workers compensa-
2 tion insurance in the State shall make a filing with
3 an agency designated by the State. Such filing shall
4 describe the manner in which such carrier has modi-
5 fied (or intends to modify) its premium rates for
6 workers compensation insurance provided in the
7 State to reflect the changes brought about by the
8 provisions in this subtitle. The filing shall include
9 such actuarial projections and assumptions as nec-
10 essary to support the modifications of such rates.

11 (2) REPORT TO SECRETARY.—Each partici-
12 pating State shall provide to the Secretary of Labor
13 such information on filings made under paragraph
14 (1) as such Secretary may specify.

15 **PART 4—DEMONSTRATION PROJECTS**

16 **SEC. 10031. AUTHORIZATION.**

17 The Secretary of Health and Human Services and the
18 Secretary of Labor are authorized to conduct demonstra-
19 tion projects under this part in one or more States with
20 respect to treatment of work-related injuries and illnesses.

21 **SEC. 10032. DEVELOPMENT OF WORK-RELATED PROTO-**
22 **COLS.**

23 (a) IN GENERAL.—Under this part, the Secretaries,
24 in consultation with States and such experts on work-re-
25 lated injuries and illnesses as the Secretaries find appro-

1 priate, shall develop protocols for the appropriate treat-
2 ment of work-related conditions.

3 (b) TESTING OF PROTOCOLS.—The Secretaries shall
4 enter into contracts with one or more health alliances to
5 test the validity of the protocols developed under sub-
6 section (a).

7 **SEC. 10033. DEVELOPMENT OF CAPITATION PAYMENT MOD-**
8 **ELS.**

9 Under this part, the Secretaries shall develop, using
10 protocols developed under section 10032 if possible, meth-
11 ods of providing for payment by workers compensation
12 carriers to health plans on a per case, capitated payment
13 for the treatment of specified work-related injuries and ill-
14 nesses.

15 **Subtitle B—Automobile Insurance**

16 **SEC. 10100. DEFINITIONS.**

17 In this subtitle:

18 (1) INJURED INDIVIDUAL.—The term “injured
19 individual” means, with respect to a health plan, an
20 individual enrolled under the plan who has an injury
21 or illness sustained in an automobile accident for
22 which automobile insurance medical benefits are
23 available.

24 (2) AUTOMOBILE INSURANCE MEDICAL BENE-
25 FITS.—The term “automobile insurance medical

1 benefits” means, with respect to an enrollee, the
2 comprehensive medical benefits for injuries or ill-
3 nesses sustained in automobile accidents.

4 (3) AUTOMOBILE INSURANCE CARRIER.—The
5 term “automobile insurance carrier” means an in-
6 surance company that underwrites automobile insur-
7 ance medical benefits and includes an employer or
8 fund that is financially at risk for the provision of
9 automobile insurance medical benefits.

10 (4) AUTOMOBILE INSURANCE MEDICAL SERV-
11 ICES.—The term “automobile insurance medical
12 services” means items and services included in auto-
13 mobile insurance medical benefits and includes items
14 and services (such as rehabilitation services and
15 long-term care services) commonly used for treat-
16 ment of injuries and illnesses sustained in auto-
17 mobile accidents.

18 **PART 1—HEALTH PLAN REQUIREMENTS**

19 **RELATING TO AUTOMOBILE INSURANCE**

20 **SEC. 10101. PROVISION OF AUTOMOBILE INSURANCE MED-**
21 **ICAL BENEFITS THROUGH HEALTH PLANS.**

22 (a) IN GENERAL.—An individual entitled to auto-
23 mobile insurance medical benefits and enrolled in a health
24 plan shall receive automobile insurance medical services

1 through the provision (or arrangement for the provision)
2 of such services by the health plan.

3 (b) REFERRAL FOR SPECIALIZED SERVICES.—Each
4 health plan shall provide for such referral for automobile
5 insurance medical services as may be necessary to assure
6 appropriate treatment of injured individuals.

7 (c) EXCEPTIONS.—Subsections (a) and (b) shall not
8 apply in the case of an individual described in section
9 1004(b) and making an election described in such section.

10 (d) ALTERNATIVE PERMITTED.—Subsection (a) shall
11 not be construed as preventing an injured individual and
12 an automobile insurance carrier from agreeing that auto-
13 mobile insurance medical services shall be provided other
14 than by or through the health plan in which the individual
15 is enrolled.

16 **SEC. 10102. PAYMENT BY AUTOMOBILE INSURANCE CAR-**
17 **RIER.**

18 (a) PAYMENT.—

19 (1) IN GENERAL.—Except as provided in sub-
20 section (b), each automobile insurance carrier that is
21 liable for payment for automobile insurance medical
22 services furnished by or through a health plan, re-
23 gardless of whether or not the services are included
24 in the comprehensive benefit package, shall make
25 payment for such services.

1 (2) USE OF REGIONAL ALLIANCE FEE SCHED-
2 ULE.—Such payment shall be made in accordance
3 with the applicable fee schedule established under
4 section 1322(c) or section 10111.

5 (b) ALTERNATIVE PAYMENT METHODOLOGIES.—
6 Subsection (a) shall not apply—

7 (1) in the case of a regional alliance or partici-
8 pating State that establishes an alternative payment
9 methodology (such as payment on a negotiated fee
10 for each case) for payment for automobile insurance
11 medical services; or

12 (2) in the case in which a automobile insurance
13 carrier and the health plan negotiate alternative pay-
14 ment arrangements.

15 (c) LIMITATION OF LIABILITY OF INJURED INDIV-
16 IDUAL.—Nothing in this part shall be construed as re-
17 quiring an injured individual to make any payment (in-
18 cluding payment of any cost sharing or any amount in
19 excess of the applicable fee schedule) to any health plan
20 or health care provider for the receipt of automobile insur-
21 ance medical services.

1 **PART 2—REQUIREMENT OF PARTICIPATING**
2 **STATES**

3 SEC. 10111. DEVELOPMENT OF SUPPLEMENTAL SCHEDULE.

4 Each participating State shall develop a fee schedule
5 applicable to payment for automobile insurance medical
6 services for which a fee is not included in the applicable
7 fee schedule established under section 1322(c).

8 SEC. 10112. CONSTRUCTION.

9 Nothing in this subtitle shall be construed as
10 altering—

11 (1) the determination of whether or not a per-
12 son is an injured individual and entitled to auto-
13 mobile insurance medical benefits under State law,
14 or

(2) the scope of items and services available to injured individuals entitled to automobile insurance medical benefits under State law.

18 **PART 3—APPLICATION OF INFORMATION**
19 **REQUIREMENTS.**

20 SEC. 10121. APPLICATION OF INFORMATION REQUIRE-
21 MENTS.

22 (a) IN GENERAL.—The provisions of—

(1) part 3 of subtitle B of title V (relating to
use of standard forms), and

25 (2) section 5101(e)(9) (relating to provision of
26 data on quality),

1 apply to the provision of automobile insurance medical
2 services in the same manner as such provisions apply with
3 respect to the provision of services included in the com-
4 prehensive benefit package.

5 (b) RULES.—The Secretary of Labor shall promul-
6 gate rules to clarify the responsibilities of health plans and
7 automobile insurance carriers in carrying out the provi-
8 sions referred to in subsection (a).

9 **Subtitle C—COMMISSION ON IN-**
10 **TEGRATION OF HEALTH BEN-**
11 **EFITS**

12 **SEC. 10201. COMMISSION.**

13 (a) ESTABLISHMENT.—There is hereby created a
14 Commission on Integration of Health Benefits (in this sec-
15 tion referred to as the “Commission”).

16 (b) COMPOSITION.—

17 (1) IN GENERAL.—The Commission shall con-
18 sist of 15 members appointed jointly by the Sec-
19 retary of Health and Human Services and the Sec-
20 retary of Labor.

21 (2) NO COMPENSATION EXCEPT TRAVEL EX-
22 PENSES.—Members of the Commission shall serve
23 without compensation, but the Secretaries shall pro-
24 vide that each member shall receive travel expenses,
25 including per diem in lieu of subsistence, in accord-

1 ance with sections 5702 and 5703 of title 5, United
2 States Code.

3 (c) DUTIES.—The Commission shall study the feasi-
4 bility and appropriateness of transferring financial respon-
5 sibility for all medical benefits (including those currently
6 covered under workers compensation and automobile in-
7 surance) to health plans.

8 (d) STAFF SUPPORT.—The Secretaries shall provide
9 staff support for the Commission.

10 (e) REPORT.—The Commission shall submit a report
11 on its work to the President by not later than July 1,
12 1995. If such report recommends the integration of finan-
13 cial responsibility for all medical benefits in health plans,
14 such report shall provide for a detailed plan as to how
15 (and when) such an integration should be effected under
16 this Act.

17 (f) TERMINATION.—The Commission shall terminate
18 90 days after the date of submission of its report under
19 subsection (e).

20 (g) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated such sums as may be
22 necessary to carry out this section.

1 **Subtitle D—Federal Employees’**
2 **Compensation Act**

3 **SEC. 10301. APPLICATION OF POLICY.**

4 (a) IN GENERAL.—Chapter 81 of title 5, United
5 States Code, known as the Federal Employees’ Compensa-
6 tion Act shall be interpreted and administered consistent
7 with the provisions of subtitle A.

8 (b) CONSTRUCTION.—In applying subsection (a),
9 subtitle A shall be applied as if the following modifications
10 had been made in subtitle A:

11 (1) Any reference in section 10000, section
12 10001(c)(2)(C), section 10012(b), or section 10014
13 to a State law is deemed to include a reference to
14 chapter 81 of title 5, United States Code.

15 (2) The term “workers compensation carrier”
16 includes the Employees Compensation Fund (estab-
17 lished under section 8147 of title 5, United States
18 Code).

19 **Subtitle E—Davis-Bacon Act and**
20 **Service Contract Act**

21 **SEC. 10401. COVERAGE OF BENEFITS UNDER HEALTH SE-**
22 **CURITY ACT.**

23 (a) DAVIS-BACON ACT.—Subsection (b)(2) of the
24 first section of the Davis Bacon Act (40 U.S.C.
25 276a(b)(2)) is amended in the matter following subpara-

1 graph (B) by inserting after “local law” the following:
2 “(other than benefits provided pursuant to the Health Se-
3 curity Act)”.

4 (b) SERVICE CONTRACT ACT OF 1965.—The second
5 sentence of section 2(a)(2) of the Service Contract Act of
6 1965 (41 U.S.C. 351(a)(2)) is amended by inserting after
7 “local law” the following: “(other than benefits provided
8 pursuant to the Health Security Act)”.

9 **Subtitle F—Effective Dates**

10 **SEC. 10501. REGIONAL ALLIANCES.**

11 The provisions of subtitles A and B of this title apply
12 to regional alliances, and regional alliance health plans,
13 in a State 2 years after the State’s first year (as defined
14 in section 1902(17)).

15 **SEC. 10502. CORPORATE ALLIANCES.**

16 The provisions of subtitles A and B of this title apply
17 to corporate alliances, and corporate alliance health plans,
18 on the date under section 10501 that such subtitles apply
19 to regional alliances, and regional alliance health plans,
20 in the State.

21 **SEC. 10503. FEDERAL REQUIREMENTS.**

22 The provisions of subtitle D of this title shall take
23 effect on January 1, 1998.

1 **TITLE XI—TRANSITIONAL**

2 **INSURANCE REFORM**

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3 **SEC. 11001. IMPOSITION OF REQUIREMENTS.**

4 (a) IN GENERAL.—The Secretary and the Secretary
5 of Labor shall apply the provisions of this title to assure,
6 to the extent possible, the maintenance of current health
7 care coverage and benefits during the period between the
8 enactment of this Act and the dates its provisions are im-
9 plemented in the various States.

10 (b) ENFORCEMENT.—

11 (1) HEALTH INSURANCE PLANS.—The Sec-
12 retary shall enforce the requirements of this title
13 with respect to health insurance plans. The Sec-
14 retary shall promulgate regulations to carry out the
15 requirements under this title with respect to health
16 insurance plans. The Secretary shall promulgate reg-
17 ulations with respect to section 11004 within 90
18 days after the date of the enactment of this Act.

1 (2) SELF-INSURED PLANS.—The Secretary of
2 Labor shall enforce the requirements of this title
3 with respect to self-insured plans. Such Secretary
4 shall promulgate regulations to carry out the re-
5 quirements under this title as they relate to self-
6 funded plans.

7 (3) ARRANGEMENTS WITH STATES.—The Sec-
8 retary and the Secretary of Labor may enter into ar-
9 rangements with a State to enforce the requirements
10 of this title with respect to health insurance plans
11 and self-insured plans issued or sold, or established
12 and maintained, in the State.

13 (c) PREEMPTION.—The requirements of this title do
14 not preempt any State law unless State law directly con-
15 flicts with such requirements. The provision of additional
16 protections under State law shall not be considered to di-
17 rectly conflict with such requirements. The Secretary (or,
18 in the case of a self-insured plan, the Secretary of Labor)
19 may issue letter determinations with respect to whether
20 this Act preempts a provision of State law.

21 (d) INTERIM FINAL REGULATIONS.—Section 1911
22 shall apply to regulations issued to carry out this title.
23 The Secretary may consult with States and the National
24 Association of Insurance Commissioners in issuing regula-
25 tions and guidelines under this title.

1 (e) CONSTRUCTION.—The provisions of this title shall
2 be construed in a manner that assures, to the greatest
3 extent practicable, continuity of health benefits under
4 health benefit plans in effect on the effective date of this
5 Act.

6 (f) SPECIAL RULES FOR ACQUISITIONS AND TRANS-
7 FERS.—The Secretary may issue regulations regarding the
8 application of this title in the case of health insurance
9 plans (or groups of such plans) which are transferred from
10 one insurer to another insurer through assumption, acqui-
11 sition, or otherwise.

12 **SEC. 11002. ENFORCEMENT.**

13 (a) IN GENERAL.—Any health insurer or health ben-
14 efit plan sponsor that violates a requirement of this title
15 shall be subject to a civil money penalty of not more than
16 \$25,000 for each such violation. The provisions of section
17 1128A of the Social Security Act (other than subsections
18 (a) and (b)) shall apply to civil money penalties under this
19 subsection in the same manner as they apply to a penalty
20 or proceeding under section 1128A(a) of such Act.

21 (b) EQUITABLE REMEDIES.—

22 (1) IN GENERAL.—A civil action may be
23 brought by the applicable Secretary—

24 (A) to enjoin any act or practice which vio-
25 lates any provision of this title, or

1 (B) to obtain other appropriate equitable
2 relief (i) to redress such violations, or (ii) to en-
3 force any provision of this title, including, in
4 the case of a wrongful termination of (or re-
5 fusal to renew) coverage, reinstating coverage
6 effective as of the date of the violation.

7 **SEC. 11003. REQUIREMENTS RELATING TO PRESERVING**
8 **CURRENT COVERAGE.**

9 (a) PROHIBITION OF TERMINATION.—

10 (1) GROUP HEALTH INSURANCE PLANS.—Each
11 health insurer that provides a group health insur-
12 ance plan may not terminate (or fail to renew) cov-
13 erage for any covered employee if the employer of
14 the employee continues the plan, except in the case
15 of—

16 (A) nonpayment of required premiums,

17 (B) fraud, or

18 (C) misrepresentation of a material fact re-
19 lating to an application for coverage or claim
20 for benefits.

21 (2) INDIVIDUAL HEALTH INSURANCE PLANS.—

22 Each health insurer that provides coverage to a cov-
23 ered individual under an individual health insurance
24 plan may not terminate (or fail to renew) coverage

1 for such individual (or a covered dependent), except
2 in the case of—

3 (A) nonpayment of required premiums,

4 (B) fraud, or

5 (C) misrepresentation of a material fact re-
6 lating to an application for coverage or claim
7 for benefits.

8 (2) EFFECTIVE DATE OF TITLE.—

9 (A) IN GENERAL.—This subsection shall
10 take effect on the effective date of this title and
11 shall apply to coverage on or after such date.

12 (B) DEFINITION.—Except as otherwise
13 provided, in this title the term “effective date of
14 this title” means the date of the enactment of
15 this Act.

16 (b) ACCEPTANCE OF NEW MEMBERS IN A GROUP
17 HEALTH INSURANCE PLAN.—

18 (1) IN GENERAL.—In the case of a health in-
19 surer that provides a group health insurance plan
20 that is in effect on the effective date of this title, the
21 insurer is required—

22 (A) to accept all individuals, and their eli-
23 gible dependents, who become full-time employ-
24 ees (as defined in section 1901(b)(2)(C)) of an
25 employer covered after such effective date;

1 (B) to establish and apply premium rates
2 that are consistent with section 11004(b); and
3 (C) to limit the application of pre-existing
4 condition restrictions in accordance with section
5 11005.

6 (2) CONSISTENT APPLICATION OF RULES RE-
7 LATING TO DEPENDENTS AND WAITING PERIODS.—
8 In this subsection, the term “eligible dependent”,
9 with respect to a group health insurance plan, has
10 the meaning provided under the plan as of October
11 27, 1993, or, in the case of a plan not established
12 as of such date, as of the date of establishment of
13 the plan.

14 **SEC. 11004. RESTRICTIONS ON PREMIUM INCREASES DUR-**
15 **ING TRANSITION.**

16 (a) DIVISION OF HEALTH INSURANCE PLANS BY
17 SECTOR.—For purposes of this section, each health in-
18 surer shall divide its health insurance business into the
19 following 3 sectors:

- 20 (1) Health insurance for groups with at least
21 100 covered lives (in this section referred to as the
22 “large group sector”)
- 23 (2) Health insurance for groups with fewer
24 than 100 covered lives (in this section referred as
25 the “small group sector”).

1 (3) Health insurance for individuals, and not
2 for groups (in this section referred to as the “indi-
3 vidual sector”).

4 (b) PREMIUM CHANGES TO REFLECT CHANGES IN
5 GROUP OR INDIVIDUAL CHARACTERISTICS OR TERMS OF
6 COVERAGE.—

7 (1) APPLICATION.—The provisions of this sub-
8 section shall apply to changes in premiums that
9 reflect—

10 (A) changes in the number of individuals
11 covered under a plan;

12 (B) changes in the group or individual
13 characteristics (including age, gender, family
14 composition or geographic area but not includ-
15 ing health status, claims experience or duration
16 of coverage under the plan) of individuals cov-
17 ered under a plan;

18 (C) changes in the level of benefits (includ-
19 ing changes in cost-sharing) under the plan;
20 and

21 (D) changes in any material terms and
22 conditions of the health insurance plan (other
23 than factors related to health status, claims ex-
24 perience, and duration of coverage under the
25 plan).

1 (2) SPECIFICATION OF REFERENCE RATE FOR
2 EACH SECTOR.—Each health insurer shall calculate
3 a reference rate for each such sector. The reference
4 rate for a sector shall be calculated so that, if it
5 were applied using the rate factors specified under
6 paragraph (3), the average premium rate for individ-
7 uals and groups in that sector would approximate
8 the average premium rate charged individuals and
9 groups in the sector as of the effective date of this
10 title.

11 (3) SINGLE SET OF RATE FACTORS WITHIN
12 EACH SECTOR.—

13 (A) IN GENERAL.—Each health insurer
14 shall develop for each sector a single set of rate
15 factors which will be used to calculate any
16 changes in premium that relate to the reasons
17 described in subparagraphs (B) through (D) of
18 paragraph (1).

19 (B) STANDARDS.—Such rate factors—

20 (i) shall relate to reasonable and ob-
21 jective differences in demographic charac-
22 teristics, in the design and in levels of cov-
23 erage, and in other terms and conditions of
24 a contract,

1 (ii) shall not relate to expected health
2 status, claims experience, or duration of
3 coverage of the one or more groups or indi-
4 viduals, and

5 (iii) shall comply with regulations es-
6 tablished under subsection (f).

7 (4) COMPUTATION OF PREMIUM CHANGES.—

8 (A) IN GENERAL.—Changes in premium
9 rates that relate to the reasons described in
10 paragraph (1) shall be calculated using the rate
11 factors developed pursuant to paragraph (3).

12 (B) APPLICATION TO CHANGES IN NUMBER
13 OF COVERED INDIVIDUALS.—In the case of a
14 change in premium rates related to the reason
15 described in paragraph (1)(A), the change in
16 premium rates shall be calculated to reflect,
17 with respect to the enrollees who enroll or
18 disenroll in a health insurance plan, the sum of
19 the products, for such individuals, of the ref-
20 erence rate (determined under paragraph (2))
21 and the rate factors (specified under paragraph
22 (3)) applicable to such enrollees.

23 (C) APPLICATION OF OTHER FACTORS.—

24 (i) IN GENERAL.—In the case of a
25 change in premium rates related to a rea-

son described in subparagraph (B), (C), or (D) of paragraph (1), the change in premium rates with respect to each health insurance plan in each sector shall reflect the rate factors specified under paragraph (3) applicable to the reason as applied to the current premium charged for the health insurance plan. Such rate factors shall be applied in a manner so that the resulting adjustment, to the extent possible, reflects the premium that would have been charged under the plan if the reason for the change in premium had existed at the time that the current premium rate was calculated.

(ii) NO REFLECTION OF CHANGE IN HEALTH STATUS.—In applying the rate factors under this subparagraph, the adjustment shall not reflect any change in the health status, claims experience or duration of coverage with respect to any employer or individual covered under the plan.

(5) LIMITATION ON APPLICATION.—This subsection shall only apply—

1 (A) to changes in premiums occurring on
2 or after the date of the enactment of this Act
3 to groups and individuals covered as of such
4 date, and

5 (B) with respect to groups and individuals
6 subsequently covered, to changes in premiums
7 subsequent to such coverage.

8 (6) APPLICATION TO COMMUNITY-RATED
9 PLANS.—Nothing in this subsection shall require the
10 application of rate factors related to individual or
11 group characteristics with respect to community-
12 rated plans.

13 (c) LIMITATIONS ON CHANGES IN PREMIUMS RE-
14 LATED TO INCREASES IN HEALTH CARE COSTS AND UTI-
15 LIZATION.—

16 (1) APPLICATION.—The provisions of this sub-
17 section shall apply to changes in premiums that re-
18 flect increases in health care costs and utilization.

19 (2) EQUAL INCREASE FOR ALL PLANS IN ALL
20 SECTORS.—

21 (A) IN GENERAL.—Subject to subpara-
22 graph (B), the annual percentage increase in
23 premiums by a health insurer for health insur-
24 ance plans in the individual sector, small group
25 sector, and large group sector, to the extent

1 such increase reflect increases in health care
2 costs and utilization, shall be the same for all
3 such plans in those sectors.

4 (B) SPECIAL RULE FOR LARGE GROUP
5 SECTOR.—The annual percentage increase in
6 premiums by a health insurer for health insur-
7 ance plans in the large group sector may vary
8 among such plans based on the claims experi-
9 ence of an employer (to the extent the experi-
10 ence is credible), so long as the weighted aver-
11 age of such increases for all such plans in the
12 sector complies with the requirement of sub-
13 paragraph (A).

14 (C) GEOGRAPHIC APPLICATION.—Subpara-
15 graphs (A) and (B)—

16 (i) may be applied on a national level,
17 or

18 (ii) may vary based on geographic
19 area, but only if (I) such areas are suffi-
20 ciently large to provide credible data on
21 which to calculate the variation and (II)
22 the variation is due to reasonable factors
23 related to the objective differences among
24 such areas in costs and utilization of
25 health services.

1 (D) EXCEPTIONS TO ACCOMMODATE STATE
2 RATE REFORM EFFORTS.—Subparagraphs (A)
3 and (B) shall not apply, in accordance with
4 guidelines of the Secretary, to the extent nec-
5 essary to permit a State to narrow the vari-
6 ations in premiums among health insurance
7 plans offered by health insurers to similarly sit-
8 uated groups or individuals within a sector.

9 (E) EXCEPTION FOR RATES SUBJECT TO
10 PRIOR APPROVAL.—Subparagraphs (A) and (B)
11 shall not apply to premiums that are subject to
12 prior approval by a State insurance commis-
13 sioner (or similar official) and are approved by
14 such official.

15 (F) OTHER REASONS SPECIFIED BY THE
16 SECRETARY.—The Secretary may specify
17 through regulations such other exceptions to
18 the provisions of this subsection as the Sec-
19 retary determines are required to enhance sta-
20 bility of the health insurance market and con-
21 tinued availability of coverage.

22 (3) EVEN APPLICATION THROUGHOUT A
23 YEAR.—In applying the provisions of this subsection
24 to health insurance plans that are renewed in dif-
25 ferent months of a year, the annual percentage in-

1 crease shall be applied in a consistent, even manner
2 so that any variations in the rate of increase applied
3 in consecutive months are even and continuous dur-
4 ing the year.

5 (4) PETITION FOR EXCEPTION.—A health in-
6 surer may petition the Secretary (or a State acting
7 under a contract with the Secretary under section
8 11001(b)(3)) for an exception from the application
9 of the provisions of this subsection. The Secretary
10 may approve such an exception if—

11 (A) the health insurer demonstrates that
12 the application of this subsection would threat-
13 en the financial viability of the insurer, and

14 (B) the health insurer offers an alternative
15 method for increasing premiums that is not
16 substantially discriminatory to any sector or to
17 any group or individual covered by a health in-
18 surance plan offered by the insurer.

19 (d) PRIOR APPROVAL FOR CERTAIN RATE IN-
20 CREASES.—

21 (1) IN GENERAL.—If the percentage increase in
22 the premium rate for the individual and small group
23 sector exceeds a percentage specified by the Sec-
24 retary under paragraph (2), annualized over any 12-
25 month period, the increase shall not take effect un-

1 less the Secretary (or a State acting under a con-
2 tract with the Secretary under section 11001(b)(3))
3 has approved the increase.

4 (2) PERCENTAGE.—The Secretary shall specify,
5 for each 12-month period beginning after the date of
6 the enactment of this Act, a percentage that will
7 apply under paragraph (1). Such percentage shall be
8 determined taking into consideration the rate of in-
9 crease in health care costs and utilization, previous
10 trends in health insurance premiums, and the condi-
11 tions in the health insurance market. Within 30 days
12 after the date of the enactment of this Act, the Sec-
13 retary shall first specify a percentage under this
14 paragraph.

15 (e) DOCUMENTATION OF COMPLIANCE.—

16 (1) PERIOD FOR CONFORMANCE.—Effective 1
17 year after the date of the enactment of this Act, the
18 premium for each health insurance plan shall be
19 conformed in a manner that complies with the provi-
20 sions of this section.

21 (2) METHODOLOGY.—Each health insurer shall
22 document the methodology used in applying sub-
23 sections (b) and (c) with respect to each sector (and
24 each applicable health plan). Such documentation
25 shall be sufficient to permit the auditing of the ap-

1 plication of such methodology to determine if such
2 application was consistent with such subsections.

3 (3) CERTIFICATION.—For each 6-month period
4 in which this section is effective, each health insurer
5 shall file a certification with the Secretary (or with
6 a State with which the Secretary has entered into an
7 arrangement under section 11001(b)(3)) that the in-
8 surer is in compliance with such requirements.

9 (f) REGULATIONS.—The Secretary shall establish
10 regulations to carry out this section. Such regulations may
11 include guidelines relating to the permissible variation
12 that results from the use of demographic or other charac-
13 teristics in the development of rate factors. Such guide-
14 lines may be based on the guidelines currently used by
15 States in applying rate limitations under State insurance
16 regulations.

17 (g) EFFECTIVE PERIOD.—This section shall apply to
18 premium increases occurring during the period beginning
19 on the date of the enactment of this Act and ending, for
20 a health insurance plan provided in a State, on the first
21 day of the State's first year.

22 **SEC. 11005. REQUIREMENTS RELATING TO PORTABILITY.**

23 (a) TREATMENT OF PREEXISTING CONDITION EX-
24 CLUSIONS.—

1 (1) IN GENERAL.—Subject to the succeeding
2 provisions of this subsection, a group health benefit
3 plan may exclude coverage with respect to services
4 related to treatment of a preexisting condition, but
5 the period of such exclusion may not exceed 6
6 months. The exclusion of coverage shall not apply to
7 services furnished to newborns or in the case of a
8 plan that did not apply such exclusions as of the ef-
9 fective date of this title.

10 (2) CREDITING OF PREVIOUS COVERAGE.—

11 (A) IN GENERAL.—A group health benefit
12 plan shall provide that if an individual covered
13 under such plan is in a period of continuous
14 coverage (as defined in subparagraph (B)(i))
15 with respect to particular services as of the date
16 of initial coverage under such plan, any period
17 of exclusion of coverage with respect to a pre-
18 existing condition for such services or type of
19 services shall be reduced by 1 month for each
20 month in the period of continuous coverage.

21 (B) DEFINITIONS.—As used in this para-
22 graph:

23 (i) PERIOD OF CONTINUOUS COV-
24 ERAGE.—The term “period of continuous
25 coverage” means, with respect to par-

1 ticular services, the period beginning on
2 the date an individual is enrolled under a
3 group or individual health benefit plan,
4 self-insured plan, the medicare program, a
5 State medicaid plan, or other health ben-
6 efit arrangement which provides benefits
7 with respect to such services and ends on
8 the date the individual is not so enrolled
9 for a continuous period of more than 3
10 months.

11 (ii) PREEXISTING CONDITION.—The
12 term “preexisting condition” means, with
13 respect to coverage under a health benefits
14 plan, a condition which has been diagnosed
15 or treated during the 6-month period end-
16 ing on the day before the first date of such
17 coverage (without regard to any waiting
18 period).

19 (b) WAITING PERIODS.—A self-insured plan, and an
20 employer with respect to a group health insurance plan,
21 may not discriminate among employees in the establish-
22 ment of a waiting period before making health insurance
23 coverage available based on the health status, claims expe-
24 rience, receipt of health care, medical history, or lack of

1 evidence of insurability, of the employee or the employee's
2 dependents.

3 **SEC. 11006. REQUIREMENTS LIMITING REDUCTION OF BEN-**
4 **EFITS.**

5 (a) IN GENERAL.—A self-insured sponsor may not
6 make a modification of benefits described in subsection
7 (b).

8 (b) MODIFICATION OF BENEFITS DESCRIBED.—

9 (1) IN GENERAL.—A modification of benefits
10 described in this subsection is any reduction or limi-
11 tation in coverage, effected on or after the effective
12 date of this title, with respect to any medical condi-
13 tion or course of treatment for which the anticipated
14 cost is likely to exceed \$5,000 in any 12-month pe-
15 riod.

16 (2) TREATMENT OF TERMINATION.—A modi-
17 fication of benefits includes the termination of a
18 plan if the sponsor, within a period (specified by the
19 Secretary of Labor) establishes a substitute plan
20 that reflects the reduction or limitation described in
21 paragraph (1).

22 (c) REMEDY.—Any modification made in violation of
23 this section shall not be effective and the self-insured
24 sponsor shall continue to provide benefits as though the

1 modification (described in subsection (b)) had not oc-
2 curred.

3 **SEC. 11007. NATIONAL TRANSITIONAL HEALTH INSURANCE**
4 **RISK POOL.**

5 (a) ESTABLISHMENT.—In order to assure access to
6 health insurance during the transition, the Secretary is
7 authorized to establish a National Transitional Health In-
8 surance Risk Pool (in this section referred to as the “na-
9 tional risk pool”) in accordance with this section.

10 (b) ADMINISTRATION.—

11 (1) IN GENERAL.—The Secretary may admin-
12 ister the national risk pool through contracts with—

13 (A) one or more existing State health in-
14 surance risk pools,

15 (B) one or more private health insurers, or

16 (C) such other contracts as the Secretary
17 deems appropriate.

18 (2) COORDINATION WITH STATE RISK POOLS.—

19 The Secretary may enter into such arrangements
20 with existing State health insurance risk pools to co-
21 ordinate the coverage under such pools with the cov-
22 erage under the national risk pool. Such coordina-
23 tion may address eligibility and funding of coverage
24 for individuals currently covered under State risk
25 pools.

1 (c) ELIGIBILITY FOR COVERAGE.—The national risk
2 pool shall provide health insurance coverage to individuals
3 who are unable to secure health insurance coverage from
4 private health insurers because of their health status or
5 condition (as determined in accordance with rules and pro-
6 cedures specified by the Secretary).

7 (d) BENEFITS.—

8 (1) IN GENERAL.—Benefits and terms of cov-
9 erage provided through the national risk pool shall
10 include items and services, conditions of coverage,
11 and cost sharing (subject to out-of-pocket limits on
12 cost sharing) comparable to the benefits and terms
13 of coverage available in State health insurance risk
14 pools.

15 (2) PAYMENT RATES.—Payments under the na-
16 tional risk pool for covered items and services shall
17 be made at rates (specified by the Secretary) based
18 on payment rates for comparable items and services
19 under the medicare program. Providers who accept
20 payment from the national risk pool shall accept
21 such payment as payment in full for the service,
22 other than for cost sharing provided under the na-
23 tional risk pool.

24 (e) PREMIUMS.—

1 (1) IN GENERAL.—Premiums for coverage in
2 the national risk pool shall be set in a manner speci-
3 fied by the Secretary.

4 (2) VARIATION.—Such premiums shall vary
5 based upon age, place of residence, and other tradi-
6 tional underwriting factors other than on the basis
7 of health status or claims experience.

8 (3) LIMITATION.—The premiums charged indi-
9 viduals shall be set at a level that is no less than
10 150 percent of the premiums that the Secretary esti-
11 mates would be charged to a population of average
12 risk for the covered benefits.

13 (f) TREATMENT OF SHORTFALLS.—

14 (1) ESTIMATES.—The Secretary shall estimate
15 each year the extent to which the total premiums
16 collected under subsection (e) in the year are insuffi-
17 cient to cover the expenses of the national risk pool
18 with respect to the year.

19 (2) TEMPORARY BORROWING AUTHORITY.—The
20 Secretary of the Treasury is authorized to advance
21 to the Secretary amounts sufficient to cover the
22 amount estimated under paragraph (1) during the
23 year before assessments are collected under para-
24 graph (3), except that the total balance of such
25 Treasury advances at any time shall not exceed

1 \$1,500,000,000. The Secretary shall repay such
2 amounts, with interest at a rate specified by the Sec-
3 retary of the Treasury, from the assessments under
4 paragraph (3).

5 (3) ASSESSMENTS.—

6 (A) IN GENERAL.—Each health benefit
7 plan sponsor shall be liable for an assessment
8 in the amount specified in subparagraph (C).

9 (B) AMOUNT.—For each year for which
10 amounts are advanced under paragraph (2), the
11 Secretary shall—

12 (i) estimate the total amount of pre-
13 miums (and premium equivalents) for
14 health benefits under health benefit plans
15 for the succeeding year, and

16 (ii) calculate a percentage equal to (I)
17 the total amounts repayable by the Sec-
18 retary to the Secretary of the Treasury
19 under paragraph (2) for the year, divided
20 by the amount determined under clause (i).

21 (C) ASSESSMENT AMOUNT.—The amount
22 of an assessment for a sponsor of a health ben-
23 efit plan for a year shall be equal to the per-
24 centage calculated under subparagraph (B)(ii)
25 (or, if less, $\frac{1}{2}$ of 1 percent) of the total amount

1 of premiums (and premium equivalents) for
2 health benefits under the plan for the previous
3 year.

4 (D) SELF-INSURED PLANS.—The amount
5 of premiums (and premium equivalents) under
6 this paragraph shall be estimated—

7 (i) by the Secretary for health insur-
8 ance plans, and

9 (ii) by the Secretary of Labor for self-
10 insured plans.

11 Such estimates may be based on a methodology
12 that requires plans liable for assessment to file
13 information with the applicable Secretary.

14 **SEC. 11008. DEFINITIONS.**

15 In this title:

16 (1) APPLICABLE SECRETARY.—The term “ap-
17 plicable Secretary” means—

18 (A) the Secretary with respect to health in-
19 surance plans and insurers, or

20 (B) the Secretary of Labor with respect to
21 self-insured plans and self-insured plan spon-
22 sors.

23 (2) COVERED EMPLOYEE.—The term “covered
24 employee” means an employee (or dependent of such

1 an employee) covered under a group health benefits
2 plan.

3 (3) COVERED INDIVIDUAL.—The “covered indi-
4 vidual” means, with respect to a health benefit plan,
5 an individual insured, enrolled, eligible for benefits,
6 or otherwise covered under the plan.

7 (4) GROUP HEALTH BENEFITS PLAN.—The
8 term “group health benefits plan” means a group
9 health insurance plan and a self-insured plan.

10 (5) GROUP HEALTH INSURANCE PLAN.—

11 (A) IN GENERAL.—The term “group
12 health insurance plan” means a health insur-
13 ance plan offered primarily to employers for the
14 purpose of providing health insurance to the
15 employees (and dependents) of the employer.

16 (B) INCLUSION OF ASSOCIATION PLANS
17 AND MEWAS.—Such term includes—

18 (i) any arrangement in which coverage
19 for health benefits is offered to employers
20 through an association, trust, or other ar-
21 rangement, and

22 (ii) a multiple employer welfare ar-
23 rangement (as defined in section 3(40) of
24 the Employee Retirement Income Security

1 Act of 1974), whether funded through in-
2 surance or otherwise.

3 (6) HEALTH BENEFITS PLAN.—The term
4 “health benefits plan” means health insurance plan
5 and a self-insured health benefit plan.

6 (7) HEALTH BENEFIT PLAN SPONSOR.—The
7 term “health benefit plan sponsor” means, with re-
8 spect to a health insurance plan or self-insured plan,
9 the insurer offering the plan or the self-insured
10 sponsor for the plan, respectively.

11 (8) HEALTH INSURANCE PLAN.—

12 (A) IN GENERAL.—Except as provided in
13 subparagraph (B), the term “health insurance
14 plan” means any contract of health insurance,
15 including any hospital or medical service policy
16 or certificate, any major medical policy or cer-
17 tificate, any hospital or medical service plan
18 contract, or health maintenance organization
19 subscriber contract offered by an insurer.

20 (B) EXCEPTION.—Such term does not in-
21 clude any of the following—

22 (i) coverage only for accident, dental,
23 vision, disability income, or long-term care
24 insurance, or any combination thereof,

- 1 (ii) medicare supplemental health in-
2 surance,
3 (iii) coverage issued as a supplement
4 to liability insurance,
5 (iv) worker's compensation or similar
6 insurance, or
7 (v) automobile medical payment insur-
8 ance,
9 or any combination thereof.

10 (C) STOP LOSS INSURANCE NOT COV-
11 ERED.—Such term does not include any aggre-
12 gate or specific stop-loss insurance or similar
13 coverage applicable to a self-insured plan. The
14 Secretary may develop rules determining the
15 applicability of this subparagraph with respect
16 to minimum premium plans or other partially
17 insured plans.

18 (9) HEALTH INSURER.—The term “health in-
19 surer” means a licensed insurance company, a pre-
20 paid hospital or medical service plan, a health main-
21 tenance organization, or other entity providing a
22 plan of health insurance or health benefits with re-
23 spect to which the State insurance laws are not pre-
24 empted under section 514 of the Employee Retirement
25 Income Security Act of 1974.

1 (10) INDIVIDUAL HEALTH INSURANCE PLAN.—

2 (A) IN GENERAL.—The term “individual
3 health insurance plan” means any health insur-
4 ance plan directly purchased by an individual or
5 offered primarily to individuals (including fami-
6 lies) for the purpose of permitting individuals
7 (without regard to an employer contribution) to
8 purchase health insurance coverage.

9 (B) INCLUSION OF ASSOCIATION PLANS.—
10 Such term includes any arrangement in which
11 coverage for health benefits is offered to indi-
12 viduals through an association, trust, list-billing
13 arrangement, or other arrangement in which
14 the individual purchaser is primarily responsible
15 for the payment of any premium associated
16 with the contract.

17 (C) TREATMENT OF CERTAIN ASSOCIATION
18 PLANS.—In the case of a health insurance plan
19 sponsored by an association, trust, or other ar-
20 rangement that provides health insurance cov-
21 erage both to employers and to individuals, the
22 plan shall be treated as—

23 (i) a group health insurance plan with
24 respect to such employers, and

1 (ii) an individual health insurance
2 plan with respect to such individuals.

3 (11) SELF-INSURED PLAN.—The term “self-in-
4 sured plan” means an employee welfare benefit plan
5 or other arrangement insofar as the plan or arrange-
6 ment provides benefits with respect to some or all of
7 the items and services included in the comprehensive
8 benefit package (as in effect as of January 1, 1996)
9 that is funded in a manner other than through the
10 purchase of one or more health insurance plans.
11 Such term shall not include a group health insur-
12 ance plan described in paragraph (5)(B)(ii).

13 (12) SELF-INSURED SPONSOR.—The term “self-
14 insured sponsor” includes, with respect to a self-in-
15 sured plan, any entity which establishes or main-
16 tains the plan.

17 (13) STATE COMMISSIONER OF INSURANCE.—
18 The term “State commissioner of insurance” in-
19 cludes a State superintendent of insurance.

20 **SEC. 11009. TERMINATION.**

21 (a) HEALTH INSURANCE PLANS.—The provisions of
22 this title shall not apply to a health insurance plan pro-
23 vided in a State on and after the first day of the first
24 year for the State.

1 (b) SELF-INSURED PLANS.—The provisions of this
2 title shall not apply to a self-insured plan that—

3 (1) is sponsored by a sponsor that is an eligible
4 sponsor of a corporate alliance (described in section
5 1311(b)(1)), as of the effective date of the election
6 under section 1312(c); and

7 (2) is sponsored by a sponsor that is not such
8 an eligible sponsor, with respect to individuals or
9 groups in a State on and after the first day of the
10 first year for the State.

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