

103^D CONGRESS
2^D SESSION

H. R. 3698

To provide Americans with secure, portable health insurance benefits and greater choice of health insurance plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 22, 1993

Mr. STEARNS (for himself, Mr. ARMEY, Mr. HASTERT, Mr. BAKER of California, Mr. CUNNINGHAM, Mr. DELAY, Mr. GINGRICH, Mr. RAMSTAD, Mr. GRAMS, Mr. HANCOCK, Mr. HYDE, Mr. TALENT, Mrs. VUCANOVICH, Mr. HUTCHINSON, Mr. DORNAN, Mr. HUNTER, Mr. GEKAS, and Mr. DUNCAN) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, the Judiciary, and Rules

MARCH 1, 1994

Additional sponsors: Mr. GOSS, Mr. CRAMER, Mr. CRANE, Mr. SMITH of Michigan, and Mr. LINDER

A BILL

To provide Americans with secure, portable health insurance benefits and greater choice of health insurance plans, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Consumer Choice Health Security Act of 1993”.

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

- Sec. 1. Short title and table of contents.
- Sec. 2. Purposes.

TITLE I—TAX AND INSURANCE PROVISIONS

Subtitle A—Tax Treatment of Health Care Expenses

- Sec. 101. Refundable health care expenses tax credit.
- Sec. 102. Medical savings accounts.
- Sec. 103. Other tax provisions.

Subtitle B—Insurance Provisions

PART I—FEDERALLY QUALIFIED HEALTH INSURANCE PLAN

- Sec. 111. Federally qualified health insurance plan.
- Sec. 112. Family security benefits package.
- Sec. 113. Rating practices.
- Sec. 114. Guaranteed issue.
- Sec. 115. Guaranteed renewability.

PART II—CERTIFICATION OF FEDERALLY QUALIFIED HEALTH INSURANCE
PLANS

- Sec. 117. Establishment of regulatory program for certification of plans.
- Sec. 118. Standards for regulatory programs.

Subtitle C—Employer Provisions

- Sec. 121. General provisions relating to employers.
- Sec. 122. Conversion of non-self-insured plans.
- Sec. 123. Provisions relating to existing self-insured plans.
- Sec. 124. Continuation of employer-provided health coverage required until effective date of new coverage under this Act.
- Sec. 125. Requirements with respect to cashing out employer-sponsored plans.
- Sec. 126. Enforcement.

Subtitle D—State Plan Requirements

- Sec. 131. State plan requirements.

Subtitle E—Federal Preemption

- Sec. 141. Federal preemption of certain State laws.

TITLE II—MEDICARE AND MEDICAID REFORMS

Subtitle A—Medicare

- Sec. 201. Study of medicare private health insurance program.
- Sec. 202. Elimination of medicare hospital disproportionate share adjustment payments.
- Sec. 203. Reduction in adjustment for indirect medical education.
- Sec. 204. Imposition of copayment for skilled nursing facility services.

- Sec. 205. Shift payment updates to January for all payment rates under hospital insurance program.
- Sec. 206. Acceleration of transition to prospective rates for facility costs in hospital outpatient departments.

Subtitle B—Medicaid

- Sec. 211. Cap on Federal payments made for acute medical services under the medicaid program.
- Sec. 212. Waivers for the furnishing of acute medical services under the medicaid program.
- Sec. 213. Termination of disproportionate share payments.
- Sec. 214. Grants for health insurance coverage, acute medical services, preventive care, and disease prevention.

TITLE III—HEALTH CARE LIABILITY REFORM

- Sec. 301. Short title.
- Sec. 302. Definitions.
- Sec. 303. Health care malpractice.
- Sec. 304. Health care product liability of manufacturer or seller.
- Sec. 305. General provisions relating to health care liability.
- Sec. 306. Punitive damages.
- Sec. 307. Exceptions.
- Sec. 308. Rules of construction.

TITLE IV—ADMINISTRATIVE COST SAVINGS

Subtitle A—Standardization of Claims Processing

- Sec. 401. Adoption of data elements, uniform claims, and uniform electronic transmission standards.
- Sec. 402. Application of standards.
- Sec. 403. Periodic review and revision of standards.
- Sec. 404. Health insurance plan defined.

Subtitle B—Electronic Medical Data Standards

- Sec. 411. Medical data standards for hospitals and other providers.
- Sec. 412. Application of electronic data standards to certain hospitals.
- Sec. 413. Electronic transmission to Federal agencies.
- Sec. 414. Limitation on data requirements where standards in effect.
- Sec. 415. Advisory commission.

Subtitle C—Development and Distribution of Comparative Value Information

- Sec. 421. State comparative value information programs for health care purchasing.
- Sec. 422. Federal implementation.
- Sec. 423. Comparative value information concerning Federal programs.

Subtitle D—Preemption of State Quill Pen Laws

- Sec. 431. Preemption of State quill pen laws.

TITLE V—ANTI-FRAUD

Subtitle A—Criminal Prosecution of Health Care Fraud

- Sec. 501. Penalties for health care fraud.
 Sec. 502. Rewards for information leading to prosecution and conviction.

Subtitle B—Coordination of Health Care Anti-Fraud and Abuse Activities

- Sec. 511. Application of Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health insurance plan.

TITLE VI—ANTITRUST PROVISIONS

- Sec. 601. Exemption from antitrust laws for certain competitive and collaborative activities.
 Sec. 602. Safe harbors.
 Sec. 603. Designation of additional safe harbors.
 Sec. 604. Certificates of review.
 Sec. 605. Notifications providing reduction in certain penalties under antitrust law for health care cooperative ventures.
 Sec. 606. Review and reports on safe harbors and certificates of review.
 Sec. 607. Rules, regulations, and guidelines.
 Sec. 608. Definitions.

TITLE VII—LONG-TERM CARE

- Sec. 701. Exclusion from gross income for amounts withdrawn from individual retirement plans or 401(k) plans for long-term care insurance.
 Sec. 702. Certain exchanges of life insurance contracts for long-term care insurance contracts not taxable.
 Sec. 703. Tax treatment of accelerated death benefits under life insurance contracts.
 Sec. 704. Effective date.

TITLE VIII—WELFARE RESTRICTIONS FOR ALIENS

- Sec. 801. Ineligibility of aliens for public welfare assistance.
 Sec. 802. State AFDC agencies required to provide information on illegal aliens to the Immigration and Naturalization Service.

TITLE IX—INCREASE IN ASSISTANCE TO COMMUNITY AND
 MIGRANT HEALTH CENTERS FROM RESIDUAL SAVINGS

- Sec. 901. Grant program to promote primary health care services for underserved populations.

1 **SEC. 2. PURPOSES.**

2 The purposes of this Act are to—

3 (1) provide Americans with secure, portable
 4 health insurance benefits and greater choice of
 5 health insurance plans,

6 (2) make the American health care system re-
 7 sponsive to consumer needs and encourage the provi-

1 sion of quality medical care at reasonable prices
2 through enhanced competition,

3 (3) provide more equitable tax treatment of
4 health insurance and medical care expenses, and

5 (4) assist low-income and uninsured Americans
6 in purchasing health insurance and receiving pri-
7 mary medical care.

8 **TITLE I—TAX AND INSURANCE**
9 **PROVISIONS**

10 **Subtitle A—Tax Treatment of**
11 **Health Care Expenses**

12 **SEC. 101. REFUNDABLE HEALTH CARE EXPENSES TAX**
13 **CREDIT.**

14 (a) IN GENERAL.—Subpart C of part IV of sub-
15 chapter A of chapter 1 of the Internal Revenue Code of
16 1986 (relating to refundable personal credits) is amended
17 by inserting after section 34 the following new section:

18 **“SEC. 34A. HEALTH CARE EXPENSES.**

19 “(a) ALLOWANCE OF CREDIT.—In the case of a
20 qualified individual, there shall be allowed as a credit
21 against the tax imposed by this subtitle for the taxable
22 year an amount equal to the applicable percentage of the
23 sum of—

24 “(1) 25 percent of the sum of the qualified
25 health insurance premiums and the unreimbursed

1 expenses for medical care paid by such individual
2 during the taxable year which does not exceed 10
3 percent of the adjusted gross income of such individ-
4 ual for such year, plus

5 “(2) 50 percent of the sum of such premiums
6 and such unreimbursed expenses so paid which ex-
7 ceeds 10 percent but does not exceed 20 percent of
8 such adjusted gross income, plus

9 “(3) 75 percent of the sum of such premiums
10 and such unreimbursed expenses so paid which ex-
11 ceeds 20 percent of such adjusted gross income.

12 “(b) QUALIFIED INDIVIDUALS.—For purposes of this
13 section—

14 “(1) IN GENERAL.—The term ‘qualified individ-
15 ual’ means the taxpayer, the spouse of the taxpayer,
16 and each dependent of the taxpayer (as defined in
17 section 152) who is enrolled in a federally qualified
18 health insurance plan.

19 “(2) FEDERALLY COVERED INDIVIDUALS.—The
20 term ‘qualified individual’ does not include any indi-
21 vidual whose medical care is covered under—

22 “(A) title XVIII or XIX of the Social Se-
23 curity Act,

24 “(B) chapter 55 of title 10, United States
25 Code,

1 “(C) chapter 17 of title 38, United States
2 Code, or

3 “(D) the Indian Health Care Improvement
4 Act.

5 “(3) SPECIAL RULE IN THE CASE OF CHILD OF
6 DIVORCED PARENTS, ETC.—Any child to whom sec-
7 tion 152(e) applies shall be treated as a dependent
8 of both parents.

9 “(4) MARRIAGE RULES.—The determination of
10 whether an individual is married at any time during
11 the taxable year shall be made in accordance with
12 the provisions of section 6013(d) (relating to deter-
13 mination of status as husband and wife).

14 “(c) APPLICABLE PERCENTAGE.—For purposes of
15 subsection (a), the applicable percentage for any taxable
16 year is determined by the number of whole months in such
17 year in which the taxpayer is a qualified individual.

18 “(d) QUALIFIED HEALTH INSURANCE PREMIUMS.—
19 For purposes of this section, the term ‘qualified health in-
20 surance premiums’ means premiums for—

21 “(1) a federally qualified health insurance plan,
22 and

23 “(2) any other benefits or plans supplementary
24 to such a federally qualified health insurance plan.

1 “(e) FEDERALLY QUALIFIED HEALTH INSURANCE
2 PLAN.—For purposes of this section, the term ‘federally
3 qualified health insurance plan’ means a health insurance
4 plan which is described in section 111 of the Consumer
5 Choice Health Security Act of 1993.

6 “(f) MEDICAL CARE.—For purposes of this section—

7 “(1) IN GENERAL.—The term ‘medical care’
8 means amounts paid—

9 “(A) for the diagnosis, cure, mitigation,
10 treatment, or prevention of disease, or for the
11 purpose of affecting any structure or function
12 of the body, and

13 “(B) for transportation primarily for and
14 essential to medical care referred to in subpara-
15 graph (A).

16 “(2) AMOUNTS PAID FOR CERTAIN LODGING
17 AWAY FROM HOME TREATED AS PAID FOR MEDICAL
18 CARE.—Amounts paid for lodging (not lavish or ex-
19 travagant under the circumstances) while away from
20 home primarily for and essential to medical care re-
21 ferred to in paragraph (1)(A) shall be treated as
22 amounts paid for medical care if—

23 “(A) the medical care referred to in para-
24 graph (1)(A) is provided by a physician in a li-
25 censed hospital (or in a medical care facility

1 which is related to, or the equivalent of, a li-
2 censed hospital), and

3 “(B) there is no significant element of per-
4 sonal pleasure, recreation, or vacation in the
5 travel away from home.

6 The amount taken into account under the preceding
7 sentence shall not exceed \$50 for each night for each
8 individual.

9 “(3) COSMETIC SURGERY.—

10 “(A) IN GENERAL.—The term ‘medical
11 care’ does not include cosmetic surgery or other
12 similar procedures, unless the surgery or proce-
13 dure is necessary to ameliorate a deformity
14 arising from, or directly related to, a congenital
15 abnormality, a personal injury resulting from
16 an accident or trauma, or disfiguring disease.

17 “(B) COSMETIC SURGERY DEFINED.—For
18 purposes of this paragraph, the term ‘cosmetic
19 surgery’ means any procedure which is directed
20 at improving the patient’s appearance and does
21 not meaningfully promote the proper function
22 of the body or prevent or treat illness or dis-
23 ease.

1 “(4) PHYSICIAN.—The term ‘physician’ has the
2 meaning given to such term by section 1861(r) of
3 the Social Security Act (42 U.S.C. 1395x(r)).

4 “(g) SPECIAL RULES.—For purposes of this sec-
5 tion—

6 “(1) LIMITATION WITH RESPECT TO MEDICINE
7 AND DRUGS.—

8 “(A) IN GENERAL.—An amount paid dur-
9 ing the taxable year for medicine or a drug
10 shall be taken into account under subsection (a)
11 only if such medicine or drug is a prescribed
12 drug or is insulin.

13 “(B) PRESCRIBED DRUG.—The term ‘pre-
14 scribed drug’ means a drug or biological which
15 requires a prescription of a physician for its use
16 by an individual.

17 “(2) SPECIAL RULE FOR DECEDENTS.—

18 “(A) TREATMENT OF EXPENSES PAID
19 AFTER DEATH.—Expenses for the medical care
20 of the taxpayer which are paid out of the tax-
21 payer’s estate during the 1-year period begin-
22 ning with the day after the date of the tax-
23 payer’s death shall be treated as paid by the
24 taxpayer at the time incurred.

1 “(B) LIMITATION.—Subparagraph (A)
2 shall not apply if the amount paid is allowable
3 under section 2053 as a deduction in computing
4 the taxable estate of the decedent, but this sub-
5 paragraph shall not apply if (within the time
6 and in the manner and form prescribed by the
7 Secretary) there is filed—

8 “(i) a statement that such amount
9 has not been allowed as a deduction under
10 section 2053, and

11 “(ii) a waiver of the right to have
12 such amount allowed at any time as a de-
13 duction under section 2053.

14 “(3) FORM OF INSURANCE CONTRACT.—In the
15 case of an insurance contract under which amounts
16 are payable for other than medical care—

17 “(A) no amount shall be treated as paid
18 for insurance to which subsection (a) applies
19 unless the charge for such insurance is either
20 separately stated in the contract, or furnished
21 to the policyholder by the insurance company in
22 a separate statement,

23 “(B) the amount taken into account as the
24 amount paid for such insurance shall not exceed
25 such charge, and

1 “(C) no amount shall be treated as paid
2 for such insurance if the amount specified in
3 the contract (or furnished to the policyholder by
4 the insurance company in a separate statement)
5 as the charge for such insurance is unreason-
6 ably large in relation to the total charges under
7 the contract.

8 “(4) EXCLUSION OF AMOUNTS ALLOWED FOR
9 CARE OF CERTAIN DEPENDENTS.—Any expense al-
10 lowed as a credit under section 21 shall not be treat-
11 ed as an expense paid for medical care.

12 “(5) COORDINATION WITH ADVANCE PAYMENT
13 AND MINIMUM TAX.—Rules similar to the rules of
14 subsections (g) and (h) of section 32 shall apply to
15 any credit to which this section applies.

16 “(6) SUBSIDIZED EXPENSES.—No expense shall
17 be taken into account under subsection (a), if—

18 “(A) such expense is paid, reimbursed, or
19 subsidized (whether by being disregarded for
20 purposes of another program or otherwise) by
21 the Federal Government, a State or local gov-
22 ernment, or any agency or instrumentality
23 thereof, and

1 “(B) the payment, reimbursement, or sub-
2 sidy of such expense is not includable in the
3 gross income of the recipient.

4 “(7) COORDINATION WITH MEDICAL SAVINGS
5 ACCOUNTS.—The amount otherwise taken into ac-
6 count under subsection (a) shall be reduced by the
7 amount (if any) of the distributions from any medi-
8 cal savings account of the taxpayer during the tax-
9 able year which is not includible in gross income by
10 reason of being used for qualified medical expenses
11 (as defined in section 25A(c)(2)).

12 “(h) REGULATIONS.—The Secretary shall prescribe
13 such regulations as may be necessary to carry out the pur-
14 poses of this section.”.

15 (b) ADVANCE PAYMENT OF CREDIT.—Chapter 25 of
16 the Internal Revenue Code of 1986 (relating to general
17 provisions relating to employment taxes) is amended by
18 inserting after section 3507 the following new section:

19 “**SEC. 3507A. ADVANCE PAYMENT OF HEALTH EXPENSES**
20 **CREDIT.**

21 “(a) GENERAL RULE.—Except as otherwise provided
22 in this section, every employer making payment of wages
23 with respect to whom a health care expenses eligibility cer-
24 tificate is in effect shall, at the time of paying such wages,

1 make an additional payment equal to such employee's
2 health care expenses advance amount.

3 “(b) HEALTH CARE EXPENSES ELIGIBILITY CER-
4 TIFICATE.—For purposes of this title, a health care ex-
5 penses eligibility certificate is a statement furnished by an
6 employee to the employer which—

7 “(1) certifies that the employee will be eligible
8 to receive the credit provided by section 34A for the
9 taxable year,

10 “(2) certifies that the employee does not have
11 a health care expenses eligibility certificate in effect
12 for the calendar year with respect to the payment of
13 wages by another employer,

14 “(3) states whether or not the employee's
15 spouse has a health care expenses eligibility certifi-
16 cate in effect, and

17 “(4) estimates the amount of premiums for a
18 federally qualified health insurance plan and unreim-
19 bursed expenses for medical care (as defined in sec-
20 tion 34A) for the calendar year.

21 For purposes of this section, a certificate shall be treated
22 as being in effect with respect to a spouse if such a certifi-
23 cate will be in effect on the first status determination date
24 following the date on which the employee furnishes the
25 statement in question.

1 “(c) HEALTH CARE EXPENSES ADVANCE
2 AMOUNT.—

3 “(1) IN GENERAL.—For purposes of this title,
4 the term ‘health expenses advance amount’ means,
5 with respect to any payroll period, the amount deter-
6 mined—

7 “(A) on the basis of the employee’s wages
8 from the employer for such period,

9 “(B) on the basis of the employee’s esti-
10 mated premiums for a federally qualified health
11 insurance plan and unreimbursed expenses for
12 medical care included in the health care ex-
13 penses eligibility certificate, and

14 “(C) in accordance with tables provided by
15 the Secretary.

16 “(2) ADVANCE AMOUNT TABLES.—The tables
17 referred to in paragraph (1)(C) shall be similar in
18 form to the tables prescribed under section 3402
19 and, to the maximum extent feasible, shall be coordi-
20 nated with such tables and the tables prescribed
21 under section 3507(c).

22 “(d) OTHER RULES.—For purposes of this section,
23 rules similar to the rules of subsections (d) and (e) of sec-
24 tion 3507 shall apply.

1 “(e) REGULATIONS.—The Secretary shall prescribe
2 such regulations as may be necessary to carry out the pur-
3 poses of this section.”.

4 (c) CLERICAL AMENDMENTS.—

5 (1) The table of sections for subpart A of part
6 IV of subchapter A of chapter 1 of the Internal Rev-
7 enue Code of 1986 is amended by inserting after the
8 item relating to section 34 the following new item:

 “Sec. 34A. Health care expenses.”.

9 (2) The table of sections for chapter 25 of such
10 Code is amended by adding after the item relating
11 to section 3507 the following new item:

 “Sec. 3507A. Advance payment of health care expenses credit.”.

12 (d) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to taxable years beginning after
14 December 31, 1996.

15 **SEC. 102. MEDICAL SAVINGS ACCOUNTS.**

16 (a) IN GENERAL.—Subpart A of part IV of sub-
17 chapter A of chapter 1 of the Internal Revenue Code of
18 1986 (relating to nonrefundable personal credits) is
19 amended by inserting after section 25 the following new
20 section:

21 **“SEC. 25A. MEDICAL SAVINGS ACCOUNTS.**

22 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
23 dividual, there shall be allowed as a credit against the tax
24 imposed by this subtitle for the taxable year an amount

1 equal to 25 percent of the amount paid in cash during
2 such year by or on behalf of such individual to a medical
3 savings account.

4 “(b) LIMITATIONS.—For purposes of this section—

5 “(1) ONLY 1 ACCOUNT PER FAMILY.—No credit
6 shall be allowed under subsection (a) for amounts
7 paid to any medical savings account for the benefit
8 of an individual, such individual’s spouse, or any de-
9 pendent (as defined in section 152) of such individ-
10 ual if such individual, spouse, or dependent is a ben-
11 efiiciary of any other medical savings account.

12 “(2) DOLLAR LIMITATION.—The aggregate
13 amount of contributions which may be taken into ac-
14 count under subsection (a) with respect to any indi-
15 vidual for any taxable year shall not exceed the sum
16 of—

17 “(A) \$3,000, plus

18 “(B) \$500 for each individual who is a de-
19 pendent (as so defined) of the individual for
20 whose benefit the account is established.

21 “(c) DEFINITIONS AND SPECIAL RULES.—For pur-
22 poses of this section—

23 “(1) MEDICAL SAVINGS ACCOUNT.—

24 “(A) IN GENERAL.—The term ‘medical
25 savings account’ means a trust created or orga-

1 nized in the United States exclusively for the
2 purpose of paying the qualified medical ex-
3 penses of the individual for whose benefit the
4 trust is established, but only if the written gov-
5 erning instrument creating the trust meets the
6 following requirements:

7 “(i) No contribution will be accepted
8 unless it is in cash and contributions will
9 not be accepted for any taxable year in ex-
10 cess of the amount determined under sub-
11 section (b)(1).

12 “(ii) The trustee is a bank (as defined
13 in section 408(n)) or another person who
14 demonstrates to the satisfaction of the Sec-
15 retary that the manner in which such per-
16 son will administer the trust will be con-
17 sistent with the requirements of this sec-
18 tion.

19 “(iii) No part of the trust assets will
20 be invested in life insurance contracts.

21 “(iv) The assets of the trust will not
22 be commingled with other property except
23 in a common trust fund or common invest-
24 ment fund.

1 “(v) The interest of an individual in
2 the balance in such individual’s account is
3 nonforfeitable.

4 “(vi) Under regulations prescribed by
5 the Secretary, rules similar to the rules of
6 section 401(a)(9) shall apply to the dis-
7 tribution of the entire interest of bene-
8 ficiaries of such trust.

9 “(B) TREATMENT OF COMPARABLE AC-
10 COUNTS HELD BY INSURANCE COMPANIES.—An
11 account held by an insurance company in the
12 United States shall be treated as a medical sav-
13 ings account (and such company shall be treat-
14 ed as a bank) if—

15 “(i) such account is part of a federally
16 qualified health insurance plan (as defined
17 in section 34A(e)),

18 “(ii) such account is exclusively for
19 the purpose of paying the medical expenses
20 of the beneficiaries of such account who
21 are covered under such health insurance
22 plan, and

23 “(iii) the written instrument govern-
24 ing the account meets the requirements of

1 clauses (i), (v), and (vi) of subparagraph
2 (A).

3 “(2) QUALIFIED MEDICAL EXPENSES.—The
4 term ‘qualified medical expenses’ means amounts
5 paid by the individual for whose benefit the account
6 was established for premiums for a federally quali-
7 fied health insurance plan (as so defined) and the
8 unreimbursed expenses for medical care (as deter-
9 mined under section 34A) of such individual, the
10 spouse of such individual, and any dependent (as so
11 defined) of such individual.

12 “(3) TIME WHEN CONTRIBUTIONS DEEMED
13 MADE.—A contribution shall be deemed to be made
14 on the last day of the preceding taxable year if the
15 contribution is made on account of such taxable year
16 and is made not later than the time prescribed by
17 law for filing the return for such taxable year (not
18 including extensions thereof).

19 “(d) TAX TREATMENT OF DISTRIBUTIONS.—

20 “(1) IN GENERAL.—Except as otherwise pro-
21 vided in this subsection, any amount paid or distrib-
22 uted out of a medical savings account shall be in-
23 cluded in the gross income of the individual for
24 whose benefit such account was established unless

1 such amount is used exclusively to pay the qualified
2 medical expenses of such individual.

3 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
4 FORE DUE DATE OF RETURN.—Paragraph (1) shall
5 not apply to the distribution of any contribution paid
6 during a taxable year to a medical savings account
7 to the extent that such contribution exceeds the
8 amount allowable under subsection (b) if—

9 “(A) such distribution is received on or be-
10 fore the day prescribed by law (including exten-
11 sions of time) for filing such individual’s return
12 for such taxable year,

13 “(B) no credit is allowed under subsection
14 (a) with respect to such excess contribution,
15 and

16 “(C) such distribution is accompanied by
17 the amount of net income attributable to such
18 excess contribution.

19 Any net income described in subparagraph (C) shall
20 be included in the gross income of the individual for
21 the taxable year in which it is received.

22 “(3) PENALTY FOR DISTRIBUTIONS NOT USED
23 FOR MEDICAL EXPENSES.—The tax imposed by this
24 chapter for any taxable year in which there is a pay-
25 ment or distribution from a medical savings account

1 which is not used to pay the medical expenses of the
2 individual for whose benefit the account was estab-
3 lished, shall be increased by 10 percent of the
4 amount of such payment or distribution which is in-
5 cludible in gross income under paragraph (1).

6 “(4) ROLLOVERS.—Paragraph (1) shall not
7 apply to any amount paid or distributed out of a
8 medical savings account to the individual for whose
9 benefit the account is maintained, if the entire
10 amount received (including money and any other
11 property) is paid into another medical savings ac-
12 count for the benefit of such individual not later
13 than the 60th day after the day on which the indi-
14 vidual received the payment or distribution.

15 “(e) TAX TREATMENT OF ACCOUNTS.—

16 “(1) EXEMPTION FROM TAX.—Any medical sav-
17 ings account is exempt from taxation under this sub-
18 title unless such account has ceased to be a medical
19 savings account by reason of paragraph (2) or (3).
20 Notwithstanding the preceding sentence, any such
21 account shall be subject to the taxes imposed by sec-
22 tion 511 (relating to imposition of tax on unrelated
23 business income of charitable, etc. organizations).

1 “(2) LOSS OF EXEMPTION OF ACCOUNT WHERE
2 INDIVIDUAL ENGAGES IN PROHIBITED TRANS-
3 ACTION.—

4 “(A) IN GENERAL.—If, during any taxable
5 year of the individual for whose benefit the
6 medical savings account was established, such
7 individual engages in any transaction prohibited
8 by section 4975 with respect to the account, the
9 account ceases to be a medical savings account
10 as of the first day of that taxable year.

11 “(B) ACCOUNT TREATED AS DISTRIBUTING
12 ALL ITS ASSETS.—In any case in which any ac-
13 count ceases to be a medical savings account by
14 reason of subparagraph (A) on the first day of
15 any taxable year, paragraph (1) of subsection
16 (d) applies as if there were a distribution on
17 such first day in an amount equal to the fair
18 market value (on such first day) of all assets in
19 the account (on such first day) and no portion
20 of such distribution were used to pay qualified
21 medical expenses.

22 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
23 RITY.—If, during any taxable year, the individual for
24 whose benefit a medical savings account was estab-
25 lished uses the account or any portion thereof as se-

1 curity for a loan, the portion so used is treated as
2 distributed to that individual and not used to pay
3 qualified medical expenses.

4 “(f) CUSTODIAL ACCOUNTS.—For purposes of this
5 section, a custodial account shall be treated as a trust if—

6 “(1) the assets of such account are held by a
7 bank (as defined in section 408(n)) or another per-
8 son who demonstrates to the satisfaction of the Sec-
9 retary that the manner in which he will administer
10 the account will be consistent with the requirements
11 of this section, and

12 “(2) the custodial account would, except for the
13 fact that it is not a trust, constitute a medical sav-
14 ings account described in subsection (c).

15 For purposes of this title, in the case of a custodial ac-
16 count treated as a trust by reason of the preceding sen-
17 tence, the custodian of such account shall be treated as
18 the trustee thereof.

19 “(g) INFLATION ADJUSTMENT.—

20 “(1) IN GENERAL.—In the case of any taxable
21 year beginning in a calendar year after 1997, each
22 applicable dollar amount shall be increased by an
23 amount equal to—

24 “(A) such dollar amount, multiplied by

1 “(B) the cost-of-living adjustment for the
2 calendar year in which the taxable year begins.

3 “(2) COST-OF-LIVING ADJUSTMENT.—For pur-
4 poses of paragraph (1), the cost-of-living adjustment
5 for any calendar year is the percentage (if any) by
6 which—

7 “(A) the deemed average total wages (as
8 defined in section 209(k) of the Social Security
9 Act) for the preceding calendar year, exceeds

10 “(B) the deemed average total wages (as
11 so defined) for calendar year 1996.

12 “(3) APPLICABLE DOLLAR AMOUNT.—For pur-
13 poses of paragraph (1), the term ‘applicable dollar
14 amount’ means the \$3,000 and \$500 amounts in
15 subsection (b)(2).

16 “(4) ROUNDING.—If any amount as adjusted
17 under paragraph (1) is not a multiple of \$10, such
18 amount shall be rounded to the nearest multiple of
19 \$10 (or, if such amount is a multiple of \$5 and not
20 of \$10, such amount shall be rounded to the next
21 highest multiple of \$10).

22 “(h) REPORTS.—The trustee of a medical savings ac-
23 count shall make such reports regarding such account to
24 the Secretary and to the individual for whose benefit the
25 account is maintained with respect to contributions, dis-

1 tributions, and such other matters as the Secretary may
2 require under regulations. The reports required by this
3 subsection shall be filed at such time and in such manner
4 and furnished to such individuals at such time and in such
5 manner as may be required by those regulations.”.

6 (b) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
7 of the Internal Revenue Code of 1986 (relating to tax on
8 excess contributions to individual retirement accounts, cer-
9 tain section 403(b) contracts, and certain individual re-
10 tirement annuities) is amended—

11 (1) by inserting “**MEDICAL SAVINGS AC-**
12 **COUNTS,**” after “**ACCOUNTS,**” in the heading of
13 such section,

14 (2) by redesignating paragraph (2) of sub-
15 section (a) as paragraph (3) and by inserting after
16 paragraph (1) the following:

17 “(2) a medical savings account (within the
18 meaning of section 25A(c)(1)),”,

19 (3) by striking “or” at the end of paragraph
20 (1) of subsection (a), and

21 (4) by adding at the end thereof the following
22 new subsection:

23 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS
24 ACCOUNTS.—For purposes of this section, in the case of
25 a medical savings account (within the meaning of section

1 25A(c)(1)), the term ‘excess contributions’ means the
2 amount by which the amount contributed for the taxable
3 year to the account exceeds the amount allowable under
4 section 25A(b)(2) for such taxable year. For purposes of
5 this subsection, any contribution which is distributed out
6 of the medical savings account and a distribution to which
7 section 25A(d)(2) applies shall be treated as an amount
8 not contributed.”.

9 (c) TAX ON PROHIBITED TRANSACTIONS.—Section
10 4975 of the Internal Revenue Code of 1986 (relating to
11 prohibited transactions) is amended—

12 (1) by adding at the end of subsection (c) the
13 following new paragraph:

14 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
15 COUNTS.—An individual for whose benefit a medical
16 savings account (within the meaning of section
17 25A(c)(1)) is established shall be exempt from the
18 tax imposed by this section with respect to any
19 transaction concerning such account (which would
20 otherwise be taxable under this section) if, with re-
21 spect to such transaction, the account ceases to be
22 a medical savings account by reason of the applica-
23 tion of section 25A(e)(2)(A) to such account.”, and

1 (2) by inserting “or a medical savings account
2 described in section 25A(c)(1)” in subsection (e)(1)
3 after “described in section 408(a)”.

4 (d) FAILURE TO PROVIDE REPORTS ON MEDICAL
5 SAVINGS ACCOUNTS.—Section 6693 of the Internal Reve-
6 nue Code of 1986 (relating to failure to provide reports
7 on individual retirement account or annuities) is amend-
8 ed—

9 (1) by inserting “**OR ON MEDICAL SAVINGS**
10 **ACCOUNTS**” after “**ANNUITIES**” in the heading of
11 such section, and

12 (2) by adding at the end of subsection (a) the
13 following: “The person required by section 25A(h) to
14 file a report regarding a medical savings account at
15 the time and in the manner required by such section
16 shall pay a penalty of \$50 for each failure unless it
17 is shown that such failure is due to reasonable
18 cause.”.

19 (e) CLERICAL AMENDMENTS.—

20 (1) The table of sections for subpart A of part
21 IV of subchapter A of chapter 1 of the Internal Rev-
22 enue Code of 1986 is amended by inserting after the
23 item relating to section 25 the following:

“Sec. 25A. Medical savings accounts.”.

1 (2) The table of sections for chapter 43 of such
2 Code is amended by striking the item relating to sec-
3 tion 4973 and inserting the following:

 “Sec. 4973. Tax on excess contributions to individual retirement
 accounts, medical savings accounts, certain 403(b)
 contracts, and certain individual retirement annu-
 ities.”.

4 (3) The table of sections for subchapter B of
5 chapter 68 of such Code is amended by inserting “or
6 on medical savings accounts” after “annuities” in
7 the item relating to section 6693.

8 (g) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 1996.

11 **SEC. 103. OTHER TAX PROVISIONS.**

12 (a) EXEMPTION AMOUNT DISALLOWED FOR UNIN-
13 SURED INDIVIDUALS.—

14 (1) IN GENERAL.—Subsection (d) of section
15 151 of the Internal Revenue Code of 1986 (relating
16 to allowance of deductions for personal exemptions)
17 is amended by adding at the end thereof the follow-
18 ing new paragraph:

19 “(5) EXEMPTION AMOUNT DISALLOWED FOR
20 UNINSURED INDIVIDUALS.—The exemption amount
21 for any individual for such individual’s taxable year
22 shall be zero, unless the individual includes the pol-
23 icy number of the federally qualified health insur-

1 ance plan or an enrollment code regarding a State
2 program described in section 131(b) of the
3 Consumer Choice Health Security Act of 1993 for
4 such individual in the return claiming such exemp-
5 tion amount for such individual.”.

6 (2) EMPLOYER ROLE.—Section 3402 of the In-
7 ternal Revenue Code of 1986 (relating to income tax
8 collected at source) is amended—

9 (A) by striking “section 151(d)(2)” in sub-
10 section (f)(1)(A) and inserting “paragraph (2)
11 or (5) of section 151(d)”, and

12 (B) by adding at the end the following new
13 subsection:

14 “(t) DETERMINATION OF STANDARD DEDUCTION
15 STATUS.—For purposes of applying the tables in sub-
16 sections (a) and (c) to a payment of wages, the employer
17 shall treat the employee as having an exemption amount
18 of zero unless there is in effect with respect to such pay-
19 ment of wages a withholding exemption certificate fur-
20 nished to the employer by the employee by April 1, indicat-
21 ing the policy number of the federally qualified health in-
22 surance plan or an enrollment code regarding a State pro-
23 gram described in section 131(b) of the Consumer Choice
24 Health Security Act of 1993 for such individual.”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1996.

4 (b) TERMINATION OF MEDICAL EXPENSE DEDUC-
5 TION.—Section 213 of the Internal Revenue Code of 1986
6 (relating to medical, dental, etc., expenses) is amended by
7 adding at the end thereof the following new subsection:
8 “(g) TERMINATION.—No amount paid after Decem-
9 ber 31, 1996, shall be treated as an expense paid for medi-
10 cal care.”.

11 (c) TERMINATION OF DEDUCTION FOR HEALTH IN-
12 SURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

13 (1) IN GENERAL.—Section 162(l) of the Inter-
14 nal Revenue Code of 1986 (relating to special rules
15 for health insurance costs of self-employed individ-
16 uals) is amended by striking paragraph (6).

17 (2) EFFECTIVE DATE.—The amendment made
18 by paragraph (1) shall apply to taxable years begin-
19 ning after December 31, 1996.

20 (d) TERMINATION OF EXCLUSION FOR EMPLOYER-
21 PROVIDED HEALTH INSURANCE.—Section 106 of the In-
22 ternal Revenue Code of 1986 (relating to contributions by
23 employer to accident and health plans) is amended by add-
24 ing at the end the following new sentence: “The preceding

1 sentence shall not apply to any amount paid after Decem-
2 ber 31, 1996.”.

3 **Subtitle B—Insurance Provisions**

4 **PART I—FEDERALLY QUALIFIED HEALTH** 5 **INSURANCE PLAN**

6 **SEC. 111. FEDERALLY QUALIFIED HEALTH INSURANCE** 7 **PLAN.**

8 (a) **IN GENERAL.**—A federally qualified health insur-
9 ance plan is a health insurance plan offered, issued, or
10 renewed on or after January 1, 1997, which is certified
11 by the applicable regulatory authority as meeting, at a
12 minimum, the requirements of sections 112, 113, 114, and
13 115, and the regulatory program described in section 117.

14 (b) **GENERAL DEFINITIONS.**—As used in this Act—

15 (1) **HEALTH INSURANCE PLAN.**—The term
16 “health insurance plan” means any hospital or medi-
17 cal service policy or certificate, hospital or medical
18 service plan contract, or health maintenance organi-
19 zation group contract and, in States which have dis-
20 tinct licensure requirements, a multiple employer
21 welfare arrangement, but does not include any of the
22 following offered by an insurer:

23 (A) Accident only, dental only, disability
24 only, or long-term care only insurance.

1 (B) Coverage issued as a supplement to li-
2 ability insurance.

3 (C) Workers' compensation or similar in-
4 surance.

5 (D) Automobile medical-payment insur-
6 ance.

7 (2) APPLICABLE REGULATORY AUTHORITY.—

8 The term 'applicable regulatory authority' means—

9 (A) in the case of a State with a program
10 described in section 117, the State commis-
11 sioner or superintendent of insurance or other
12 State authority responsible for regulation of
13 health insurance; or

14 (B) if the State has not established such a
15 program or such program has been decertified
16 under section 117(b), the Secretary.

17 (3) SECRETARY.—The term "Secretary" means
18 the Secretary of Health and Human Services.

19 (4) STATE.—The term "State" means each of
20 the several States of the United States, the District
21 of Columbia, the Commonwealth of Puerto Rico, the
22 United States Virgin Islands, Guam, America
23 Samoa, and the Commonwealth of the Northern
24 Mariana Islands.

1 **SEC. 112. FAMILY SECURITY BENEFITS PACKAGE.**

2 (a) IN GENERAL.—The requirements of this section
3 are met, if the health insurance plan—

4 (1) provides coverage for all medically necessary
5 acute medical care described in subsection (b),

6 (2) does not exclude coverage for selected ill-
7 nesses or selected treatments if consistent with
8 medically accepted practices, and

9 (3) meets the patient cost sharing requirements
10 of subsection (c).

11 (b) ACUTE MEDICAL CARE.—Coverage for all medi-
12 cally necessary acute medical care is described in this sub-
13 section if such coverage includes—

14 (1) physician services,

15 (2) inpatient, outpatient, and emergency hos-
16 pital services and appropriate alternatives to hos-
17 pitalization, and

18 (3) inpatient and outpatient prescription drugs.

19 Nothing in this subsection may be construed to require
20 the inclusion of abortion services.

21 (c) COST SHARING REQUIREMENTS.—The require-
22 ments of this subsection are as follows:

23 (1) LIMITATION ON DEDUCTIBLES.—A health
24 insurance plan shall not provide a deductible amount
25 for benefits provided in any plan year that exceeds—

1 (A) with respect to benefits payable for
2 items and services furnished to a single individ-
3 ual enrolled under the plan, for a plan year be-
4 ginning in—

5 (i) a calendar year prior to 1998,
6 \$1,000; or

7 (ii) for a subsequent calendar year,
8 the limitation specified in this subpara-
9 graph for the previous calendar year in-
10 creased by the percentage increase in the
11 consumer price index for all urban consum-
12 ers (United States city average, as pub-
13 lished by the Bureau of Labor Statistics)
14 for the 12-month period ending on Septem-
15 ber 30 of the preceding calendar year; and

16 (B) with respect to benefits payable for
17 items and services furnished to a family en-
18 rolled under the plan, for a plan year beginning
19 in—

20 (i) a calendar year prior to 1998,
21 \$2,000 per family; or

22 (ii) for a subsequent calendar year,
23 the limitation specified in this subpara-
24 graph for the previous calendar year in-
25 creased by such percentage increase.

1 If the limitation computed under subparagraph
2 (A)(ii) or (B)(ii) is not a multiple of \$10, it shall be
3 rounded to the next highest multiple of \$10.

4 (2) LIMITATION ON COPAYMENTS AND COIN-
5 SURANCE.—

6 (A) IN GENERAL.—A health insurance
7 plan may not require the payment of any
8 copayment or coinsurance for an item or service
9 for which coverage is required under this sec-
10 tion after an individual or a family covered
11 under the plan has incurred out-of-pocket ex-
12 penses under the plan that are equal to the out-
13 of-pocket limit for a plan year.

14 (B) LIMIT ON OUT-OF-POCKET EX-
15 PENSES.—As used in this paragraph—

16 (i) OUT-OF-POCKET EXPENSES DE-
17 FINED.—The term “out-of-pocket ex-
18 penses” means, with respect to an individ-
19 ual or a family in a plan year, amounts
20 payable under the plan as deductibles and
21 coinsurance with respect to items and serv-
22 ices provided under the plan and furnished
23 in the plan year on behalf of the individual
24 or the family covered under the plan.

1 (ii) OUT-OF-POCKET LIMIT DE-
2 FINED.—The term “out-of-pocket limit”
3 means for a plan year beginning in—

4 (I) a calendar year prior to 1998,
5 \$5,000; or

6 (II) for a subsequent calendar
7 year, the limit specified in this clause
8 for the previous calendar year in-
9 creased by the percentage increase in
10 the consumer price index for all urban
11 consumers (United States city aver-
12 age, as published by the Bureau of
13 Labor Statistics) for the 12-month pe-
14 riod ending on September 30 of the
15 preceding calendar year.

16 If the limit computed under subclause (II)
17 is not a multiple of \$10, it shall be round-
18 ed to the next highest multiple of \$10.

19 **SEC. 113. RATING PRACTICES.**

20 (a) IN GENERAL.—The requirements of this section
21 are met, if, except as provided in subsection (b), the health
22 insurance plan provides for—

23 (1) a variation in premium rates only on the
24 basis of age, sex, and geography, and

1 (2) a charge of the same premium rates to new
2 applicants and existing policyholders with the same
3 age, sex, and geographic characteristics.

4 (b) INCENTIVE DISCOUNTS.—A plan may discount
5 an individual’s premium rate as an incentive for partici-
6 pating in a program, approved by the applicable regulatory
7 authority to be offered in conjunction with the coverage,
8 which has as its objective, 1 or more of the following:

9 (1) To promote healthy behavior.

10 (2) To prevent or delay the onset of illness.

11 (3) To provide for screening or early detection
12 of illness.

13 **SEC. 114. GUARANTEED ISSUE.**

14 (a) IN GENERAL.—Except as provided in paragraph
15 (2), in the case of applications made on and after January
16 1, 1998, the following rules apply:

17 (1) IN GENERAL.—The requirements of this
18 section are met, if, except as provided in paragraph
19 (2), the health insurance plan—

20 (A) provides guaranteed issue at standard
21 rates to all applicants, and

22 (B) does not exclude from coverage, or
23 limit coverage for, any preexisting medical con-
24 dition of any applicant who, on the date the ap-
25 plication is made, has been continuously insured

1 for a period of at least 1 year prior to the date
2 of the application under 1 or more of the fol-
3 lowing health insurance plans or programs:

4 (i) Another federally qualified health
5 insurance plan.

6 (ii) An employer-sponsored group
7 health insurance plan in effect before the
8 date of the enactment of this Act.

9 (iii) An individual health insurance
10 plan in effect before such date.

11 (iv) A program described in—

12 (I) title XVIII or XIX of the So-
13 cial Security Act,

14 (II) chapter 55 of title 10, Unit-
15 ed States Code,

16 (III) chapter 17 of title 38, Unit-
17 ed States Code,

18 (IV) chapter 89 of title 5, United
19 States Code, or

20 (V) the Indian Health Care Im-
21 provement Act.

22 (2) BREAK IN COVERAGE.—In the case of an
23 applicant who has not been continuously insured for
24 a period of 1 year prior to the date the application
25 is made, the health insurance plan may exclude from

1 coverage, or limit coverage for, any preexisting medi-
2 cal condition for a period no greater than the lesser
3 of—

4 (A) the number of months immediately
5 prior to the date of the application during
6 which the individual was not insured since the
7 illness or condition in question was first diag-
8 nosed, or

9 (B) 1 year.

10 (b) TRANSITION RULE.—In the case of applications
11 made in 1997, the requirements of this section are met,
12 if the health insurance plan—

13 (1) provides guaranteed issue at standard rates
14 to all applicants, and

15 (2) does not exclude from coverage, or limit
16 coverage for, any preexisting medical condition of
17 any applicant.

18 **SEC. 115. GUARANTEED RENEWABILITY.**

19 The requirements of this section are met, if the
20 health insurance plan provides the policyholder with a con-
21 tractual right to renew the coverage which stipulates that
22 the insurer cannot cancel or refuse to renew the coverage
23 except for cases of—

24 (1) nonpayment of premiums by the policy-
25 holder, or

1 (2) fraud or misrepresentation by the policy-
2 holder.

3 **PART II—CERTIFICATION OF FEDERALLY**
4 **QUALIFIED HEALTH INSURANCE PLANS**

5 **SEC. 117. ESTABLISHMENT OF REGULATORY PROGRAM**
6 **FOR CERTIFICATION OF PLANS.**

7 (a) IN GENERAL.—Each State shall establish no later
8 than January 1, 1997, a regulatory program which meets
9 the standards referred to in section 118.

10 (b) PERIODIC SECRETARIAL REVIEW OF STATE REG-
11 ULATORY PROGRAM.—The Secretary periodically shall re-
12 view each State regulatory program to determine if such
13 program continues to meet and enforce the standards re-
14 ferred to in section 118. If the Secretary initially deter-
15 mines that a State regulatory program no longer meets
16 and enforces such standards, the Secretary shall provide
17 the State an opportunity to adopt a plan of correction that
18 would bring such program into compliance with such
19 standards. If the Secretary makes a final determination
20 that the State regulatory program fails to meet and en-
21 force such standards after such an opportunity, the Sec-
22 retary shall decertify such program and assume respon-
23 sibility with respect to health insurance plans in the State.

1 **SEC. 118. STANDARDS FOR REGULATORY PROGRAMS.**

2 (a) IN GENERAL.—The Secretary, in consultation
3 with the National Association of Insurance Commissioners
4 (hereafter in this section referred to as “NAIC”) shall de-
5 velop by not later than 1 year after the date of the enact-
6 ment of this Act, in the form of model Acts and model
7 regulations, State regulatory program standards which in-
8 clude—

9 (1) procedures for certifying that the require-
10 ments of part I of this subtitle have been met by a
11 health insurance plan applying for certification as a
12 federally qualified health insurance plan,

13 (2) the requirements described in subsections
14 (b), (c), and (d),

15 (3) requirements with respect to solvency stand-
16 ards and guaranty funds for carriers of federally
17 qualified health insurance plans, and

18 (4) reporting requirements under which carriers
19 report to the Internal Revenue Service regarding the
20 acquisition and termination by individuals of cov-
21 erage under federally qualified health insurance
22 plans.

23 (b) PASSBACK OF CLAIMS AND PREMIUMS.—The re-
24 quirements of this subsection are met, if, in the case of
25 an applicant who has been continuously insured, as de-
26 scribed in section 114(b)(1)(B), and is at the time of the

1 application receiving treatment for a preexisting medical
2 condition—

3 (1) the federally qualified health insurance plan
4 is allowed to pass back to the applicant's previous
5 plan any claims relating to such condition, together
6 with a portion of the premium, and

7 (2) such previous plan is required to pay such
8 claims and premium incurred during the lesser of—

9 (A) the duration of the course of the treat-
10 ment or spell of illness, or

11 (B) 2 years from the date at which cov-
12 erage commenced under the federally qualified
13 health insurance plan.

14 (c) **MARKETING PRACTICES.**—The requirements of
15 this subsection are met, if the carrier offering the federally
16 qualified health insurance plan retains the right to select
17 agents with whom such plan contracts and to determine
18 the amount and form of compensation to such agents, ex-
19 cept that—

20 (1) if the carrier chooses to contract with an
21 agent, the carrier may not terminate or refuse to
22 renew the agency contract for any reason related to
23 the age, sex, health status, claims experience, occu-
24 pation, or geographic location of the insureds placed
25 by the agent with such plan, and

1 (2) the carrier may not, directly or indirectly,
2 enter into any contract, agreement, or arrangement
3 with an agent that provides for, or results in, any
4 consideration provided to such agent for the issu-
5 ance or renewal of such a plan to vary on account
6 of the age, sex, health status, claims experience, oc-
7 cupation, or geographic location of the insureds
8 placed by the agent with such plan.

9 (d) RISK ADJUSTMENT OR REINSURANCE PRO-
10 GRAMS.—The requirements of this subsection are met, if
11 the carrier offering the federally qualified health insurance
12 plan participates in a State-administered risk adjustment
13 program (or, at the option of the State, a reinsurance pro-
14 gram) designed to compensate for the potential occurrence
15 of grossly disproportionate distributions of above-standard
16 or below-standard insured risks among federally qualified
17 health insurance plans.

18 (e) NONBINDING STANDARDS.—The Secretary, in
19 consultation with NAIC, shall also develop within the 1-
20 year period described in subsection (a), nonbinding stand-
21 ards for premium rating practices and guaranteed renew-
22 ability of coverage which, if the insurer so elects, is more
23 generous (additional benefits or lower cost sharing or
24 both) than the requirements under part I of this subtitle
25 for federally qualified health insurance plans.

1 **Subtitle C—Employer Provisions**

2 **SEC. 121. GENERAL PROVISIONS RELATING TO EMPLOY-**
3 **ERS.**

4 (a) **PREMIUMS WITHHELD.**—Each employer shall—

5 (1) withhold from each employee’s wages the
6 amount of the employee’s health insurance premium
7 and remit, directly or indirectly, such premium to
8 the insurance plan of the employee’s choice accord-
9 ing to an agreed upon schedule, and

10 (2) within the first 30 days of any calendar
11 year or the date of the hire of an employee, notify
12 each employee of the employee’s right to claim an
13 advance refundable tax credit for such premium
14 under section 34A of the Internal Revenue Code of
15 1986.

16 (b) **EFFECTIVE DATE.**—The requirements under
17 subsection (a) shall apply with respect to calendar year
18 1997 and thereafter.

19 **SEC. 122. CONVERSION OF NON-SELF-INSURED PLANS.**

20 In the case of an employer-sponsored health insur-
21 ance plan in force on the date of the enactment of this
22 Act, and which is not a self-insured plan, the insurer from
23 whom the plan was purchased (or, in the event such in-
24 surer refuses, any new subsidiary, corporation, insurer,

1 union, cooperative, or association willing to become the
2 new sponsor of the plan) shall—

3 (1) notify, not later than October 1, 1996, all
4 of the primary insured beneficiaries of the employer-
5 sponsored plan of their rights to convert their insur-
6 ance coverage to a federally qualified health insur-
7 ance plan (as defined in section 111) offered by the
8 insurer with benefits identical to, or actuarially
9 equivalent to, those of the employer-sponsored plan
10 and the rates of that coverage, and provide such
11 beneficiaries 60 additional days to decline or accept
12 the new coverage, and

13 (2) offer such coverage beginning January 1,
14 1997, at premium rates which vary only by age, sex,
15 and geography, except that the combined total of the
16 new rates charged separately to the various bene-
17 ficiaries may not exceed the total group rate paid by
18 the employer or employees or both under the em-
19 ployer-sponsored plan on the last day it is, or was,
20 in force.

21 **SEC. 123. PROVISIONS RELATING TO EXISTING SELF-IN-**
22 **SURED PLANS.**

23 (a) **IN GENERAL.**—In the case of an employer-spon-
24 sored health insurance plan in force on the date of the
25 enactment of this Act, and which is a self-insured plan,

1 the employer sponsoring the plan may, at anytime follow-
2 ing such date sell, transfer, or assign the plan to any exist-
3 ing or new, subsidiary, corporation, insurer, union, cooper-
4 ative or association, willing to become the new sponsor of
5 the plan, except that—

6 (1) such sale, transfer, or assignment may not
7 take effect unless first approved by a two-thirds ma-
8 jority vote of all the primary-insured beneficiaries of
9 the plan, and

10 (2) the terms or conditions and benefits or cov-
11 erage of the plan, and the eligibility criteria for par-
12 ticipation in the plan, may not be altered before
13 such date.

14 (b) PROVISIONS GOVERNING PLAN.—As of the date
15 of the enactment of this Act, the sponsor of the plan de-
16 scribed in subsection (a) becomes subject to all laws gov-
17 erning the operation of a corporation selling health insur-
18 ance in the applicable State or States and to the provisions
19 of section 122.

20 **SEC. 124. CONTINUATION OF EMPLOYER-PROVIDED**
21 **HEALTH COVERAGE REQUIRED UNTIL EF-**
22 **FECTIVE DATE OF NEW COVERAGE UNDER**
23 **THIS ACT.**

24 (a) IN GENERAL.—Clause (i) of section
25 4980B(f)(2)(B) of the Internal Revenue Code of 1986 (re-

1 lating to period of coverage) is amended by inserting after
2 subclause (V) the following new subclause:

3 “(VI) QUALIFYING EVENT IN-
4 VOLVING END OF PLAN.—In the case
5 of an event described in paragraph
6 (3)(G), December 31, 1996.”.

7 (b) QUALIFYING EVENT INVOLVING END OF
8 PLAN.—Paragraph (3) of section 4980B(f) of the Internal
9 Revenue Code of 1986 (defining qualifying event) is
10 amended by inserting after subparagraph (F) the follow-
11 ing new subparagraph:

12 “(G) The termination by the employer of
13 the group health plan after the date of the en-
14 actment of the Consumer Choice Health Secu-
15 rity Act of 1993.”.

16 (c) CONFORMING AMENDMENT.—Clause (ii) of sec-
17 tion 4980B(f)(2)(B) of the Internal Revenue Code of 1986
18 is amended by striking “The date” and inserting “Except
19 in the case of a qualifying event described in paragraph
20 (3)(G), the date”.

21 (d) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to qualifying events occurring after
23 the date of the enactment of this Act.

1 **SEC. 125. REQUIREMENTS WITH RESPECT TO CASHING OUT**
2 **EMPLOYER-SPONSORED PLANS.**

3 (a) NON-FEDERAL EMPLOYERS.—

4 (1) IN GENERAL.—Each employer contributing
5 in whole or in part to an employer-sponsored health
6 insurance plan on December 1, 1996, shall, within
7 30 days after such date—

8 (A) notify each employee participating in
9 the plan of the amount spent by the employer
10 on the employee's health insurance, as deter-
11 mined under paragraph (2),

12 (B) add such amount to the cash wages of
13 the employee commencing with pay periods be-
14 ginning on and after January 1, 1997, and

15 (C) hold each employee harmless for the
16 employer's share of any payroll taxes due under
17 chapter 31 of the Internal Revenue Code of
18 1986 on such amount.

19 (2) AMOUNT OF INCLUSION.—The amount de-
20 scribed in paragraph (1)(A) shall equal the actuarial
21 value of the employer's contribution for group health
22 issuance coverage apportioned to the plan's bene-
23 ficiaries according to the new premiums for individ-
24 ual and family coverage determined by the insurer.

25 (3) PRIOR TERMINATION.—Any beneficiary of
26 an employer-sponsored health insurance plan who

1 voluntarily terminates coverage under such a plan
2 before December 1, 1996, forfeits the right to re-
3 ceive the value of the beneficiary's coverage in cash.

4 (b) COMMISSION ON CASHING OUT FEHBP BENE-
5 FITS.—

6 (1) ESTABLISHMENT.—

7 (A) IN GENERAL.—There is established an
8 independent board to be known as the “Bene-
9 fits Cash Out Commission” (in this subtitle, re-
10 ferred to as the “Commission”).

11 (B) DUTIES.—The Commission shall study
12 and propose a procedure under which individ-
13 uals may cash out health benefits under chapter
14 89 of title 5, United States Code, and pay
15 scales and retirement benefits would be ad-
16 justed accordingly. The Commission shall report
17 to Congress regarding such study and proposal
18 not later than 1 year after the date of the en-
19 actment of this Act.

20 (C) MEMBERSHIP.—

21 (i) IN GENERAL.—The Commission
22 shall be composed of 13 members ap-
23 pointed by the President by and with the
24 advice and consent of the Senate.

1 (ii) CONSULTATION.—In selecting in-
2 dividuals for nominations for appointments
3 for the Commission, the President should
4 consult with—

5 (I) the Speaker of the House of
6 Representatives concerning the ap-
7 pointment of 3 members;

8 (II) the Majority Leader of the
9 Senate concerning the appointment of
10 3 members;

11 (III) the Minority Leader of the
12 House of Representatives concerning
13 the appointment of 3 members; and

14 (IV) the Minority Leader of the
15 Senate concerning the appointment of
16 3 members.

17 (iii) CHAIR.—The President shall des-
18 ignate 1 individual described in clause (ii)
19 who shall serve as Chair of the Commis-
20 sion.

21 (iv) COMPOSITION OF COMMISSION.—
22 The membership of the Commission shall
23 include individuals with national recogni-
24 tion for expertise in the valuation of health

1 insurance benefits and of Federal civilian
2 pay and retirement benefits.

3 (D) ADMINISTRATIVE PROVISIONS.—

4 (i) MEETINGS.—Each meeting of the
5 Commission shall be open to the public.

6 (ii) PAY AND TRAVEL EXPENSES.—

7 (I) IN GENERAL.—Each member,
8 other than the Chair, shall be paid at
9 a rate equal to the daily equivalent of
10 the minimum annual rate of basic pay
11 payable for level IV of the Executive
12 Schedule under section 5315 of title
13 5, United States Code, for each day
14 (including travel time) during which
15 the member is engaged in the actual
16 performance of duties vested in the
17 Commission.

18 (II) CHAIR.—The Chair shall be
19 paid for each day referred to in
20 subclause (I) at a rate equal to the
21 daily equivalent of the minimum an-
22 nual rate of basic pay payable for
23 level III of the Executive Schedule
24 under section 5314 of title 5, United
25 States Code.

1 (III) TRAVEL EXPENSES.—Mem-
2 bers shall receive travel expenses, in-
3 cluding per diem in lieu of subsist-
4 ence, in accordance with sections
5 5702 and 5703 of title 5, United
6 States Code.

7 (iii) STAFF.—

8 (I) IN GENERAL.—Subject to
9 subclauses (II) and (III), the Chair,
10 with the approval of the Commission,
11 may appoint and fix the pay of addi-
12 tional personnel.

13 (II) PAY.—The Chair may make
14 such appointments without regard to
15 the provisions of title 5, United States
16 Code, governing appointments in the
17 competitive service, and any personnel
18 so appointed may be paid without re-
19 gard to the provisions of chapter 51
20 and subchapter III of chapter 53 of
21 such title, relating to classification
22 and General Schedule pay rates, ex-
23 cept that an individual so appointed
24 may not receive pay in excess of 120
25 percent of the annual rate of basic

1 pay payable for GS-15 of the General
2 Schedule.

3 (III) DETAILED PERSONNEL.—

4 Upon request of the Chair, the head
5 of any Federal department or agency
6 may detail any of the personnel of
7 that department or agency to the
8 Commission to assist the Commission
9 in carrying out its duties under this
10 Act.

11 (iv) OTHER AUTHORITY.—

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

19 (II) LEASES, ETC.—The Com-
20 mission may lease space and acquire
21 personal property to the extent funds
22 are available.

23 (2) CONSIDERATION.—

24 (A) IN GENERAL.—The proposal described
25 in paragraph (1)(B) shall be considered by the

1 Congress under the procedures for consider-
2 ation of an “approval resolution” as described
3 in subparagraph (D).

4 (B) EFFECTIVE DATE OF IMPLEMENTA-
5 TION.—The provisions of the proposal shall be-
6 come effective on January 1, 1997.

7 (C) PERIOD FOR RESUBMISSION OF PRO-
8 POSAL IN CASE OF NONAPPROVAL.—If the pro-
9 posal of the Commission described in subpara-
10 graph (A) is not approved by Congress, the
11 Commission shall by not later than January 1,
12 1996, submit a new proposal to Congress.

13 (D) RULES GOVERNING CONGRESSIONAL
14 CONSIDERATION.—

15 (i) RULES OF HOUSE OF REPRESENT-
16 ATIVES AND SENATE.—This subparagraph
17 is enacted by the Congress—

18 (I) as an exercise of the rule-
19 making power of the House of Rep-
20 resentatives and the Senate, respec-
21 tively, and as such is deemed a part
22 of the rules of each House, respec-
23 tively, but applicable only with respect
24 to the procedure to be followed in that
25 House in the case of approval resolu-

1 tions described in clause (ii), and su-
2 persedes other rules only to the extent
3 that such rules are inconsistent there-
4 with; and

5 (II) with full recognition of the
6 constitutional right of either House to
7 change the rules (so far as relating to
8 the procedure of that House) at any
9 time, in the same manner and to the
10 same extent as in the case of any
11 other rule of that House.

12 (ii) TERMS OF THE RESOLUTION.—

13 For purposes of subparagraph (A), the
14 term “approval resolution” means only a
15 joint resolution of the 2 Houses of the
16 Congress, providing in—

17 (I) the matter after the resolving
18 clause of which is as follows: “That
19 the Congress approves the rec-
20 ommendations of the Benefits Cash
21 Out Commission as submitted by the
22 Commission on _____”, the
23 blank space being filled in with the
24 appropriate date; and

1 (II) the title of which is as fol-
2 lows: “Joint Resolution approving the
3 recommendation of the Benefits Cash
4 Out Commission”.

5 (iii) INTRODUCTION AND REFER-
6 RAL.—On the day on which the rec-
7 ommendation of the Commission is trans-
8 mitted to the House of Representatives
9 and the Senate, an approval resolution
10 with respect to such recommendation shall
11 be introduced (by request) in the House of
12 Representatives by the Majority Leader of
13 the House, for himself or herself and the
14 Minority Leader of the House, or by Mem-
15 bers of the House designated by the Ma-
16 jority Leader and Minority Leader of the
17 House; and shall be introduced (by re-
18 quest) in the Senate by the Majority Lead-
19 er of the Senate, for himself or herself and
20 the Minority Leader of the Senate, or by
21 Members of the Senate designated by the
22 Majority Leader and Minority Leader of
23 the Senate. If either House is not in ses-
24 sion on the day on which such rec-
25 ommendation is transmitted, the approval

1 resolution with respect to such rec-
2 ommendation shall be introduced in the
3 House, as provided in the preceding sen-
4 tence, on the first day thereafter on which
5 the House is in session. The approval reso-
6 lution introduced in the House of Rep-
7 resentatives and the Senate shall be re-
8 ferred to the appropriate committees of
9 each House.

10 (iv) AMENDMENTS PROHIBITED.—No
11 amendment to an approval resolution shall
12 be in order in either the House of Rep-
13 resentatives or the Senate; and no motion
14 to suspend the application of this clause
15 shall be in order in either House, nor shall
16 it be in order in either House for the Pre-
17 siding Officer to entertain a request to sus-
18 pend the application of this clause by
19 unanimous consent.

20 (v) PERIOD FOR COMMITTEE AND
21 FLOOR CONSIDERATION.—

22 (I) IN GENERAL.—Except as pro-
23 vided in subclause (II), if the commit-
24 tee or committees of either House to
25 which an approval resolution has been

1 referred have not reported it at the
2 close of the 30th day after its intro-
3 duction, such committee or commit-
4 tees shall be automatically discharged
5 from further consideration of the ap-
6 proval resolution and it shall be
7 placed on the appropriation calendar.
8 A vote on final passage of the ap-
9 proval resolution shall be taken in
10 each House on or before the close of
11 the 30th day after the approval reso-
12 lution is reported by the committees
13 or committee of that House to which
14 it was referred, or after such commit-
15 tee or committees have been dis-
16 charged from further consideration of
17 the approval resolution. If prior to the
18 passage by 1 House of an approval
19 resolution of that House, that House
20 receives the same approval resolution
21 from the other House then the proce-
22 dure in that House shall be the same
23 as if no approval resolution had been
24 received from the other House, but
25 the vote on final passage shall be on

1 the approval resolution of the other
2 House.

3 (II) COMPUTATION OF DAYS.—
4 For purposes of subclause (I), in com-
5 puting a number of days in either
6 House, there shall be excluded any
7 day on which the House is not in ses-
8 sion.

9 (vi) FLOOR CONSIDERATION IN THE
10 HOUSE OF REPRESENTATIVES.—

11 (I) MOTION TO PROCEED.—A
12 motion in the House of Representa-
13 tives to proceed to the consideration
14 of an approval resolution shall be
15 highly privileged and not debatable.
16 An amendment to the motion shall
17 not be in order, nor shall it be in
18 order to move to reconsider the vote
19 by which the motion is agreed to or
20 disagreed to.

21 (II) DEBATE.—Debate in the
22 House of Representatives on an ap-
23 proval resolution shall be limited to
24 not more than 20 hours, which shall
25 be divided equally between those fa-

1 voring and those opposing the bill or
2 resolution. A motion further to limit
3 debate shall not be debatable. It shall
4 not be in order to move to recommit
5 an approval resolution or to move to
6 reconsider the vote by which an ap-
7 proval resolution is agreed to or dis-
8 agreed to.

9 (III) MOTION TO POSTPONE.—

10 Motions to postpone, made in the
11 House of Representatives with respect
12 to the consideration of an approval
13 resolution, and motions to proceed to
14 the consideration of other business,
15 shall be decided without debate.

16 (IV) APPEALS.—All appeals from

17 the decisions of the Chair relating to
18 the application of the Rules of the
19 House of Representatives to the pro-
20 cedure relating to an approval resolu-
21 tion shall be decided without debate.

22 (V) GENERAL RULES APPLY.—

23 Except to the extent specifically pro-
24 vided in the preceding provisions of
25 this clause, consideration of an ap-

1 proval resolution shall be governed by
2 the Rules of the House of Representa-
3 tives applicable to other bills and reso-
4 lutions in similar circumstances.

5 (vii) FLOOR CONSIDERATION IN THE
6 SENATE.—

7 (I) MOTION TO PROCEED.—A
8 motion in the Senate to proceed to the
9 consideration of an approval resolu-
10 tion shall be privileged and not debat-
11 able. An amendment to the motion
12 shall not be in order, nor shall it be
13 in order to move to reconsider the
14 vote by which the motion is agreed to
15 or disagreed to.

16 (II) GENERAL DEBATE.—Debate
17 in the Senate on an approval resolu-
18 tion, and all debatable motions and
19 appeals in connection therewith, shall
20 be limited to not more than 20 hours.
21 The time shall be equally divided be-
22 tween, and controlled by, the Majority
23 Leader and the Minority Leader or
24 their designees.

1 (III) DEBATE OF MOTIONS AND
2 APPEALS.—Debate in the Senate on
3 any debatable motion or appeal in
4 connection with an approval resolution
5 shall be limited to not more than 1
6 hour, to be equally divided between,
7 and controlled by, the mover and the
8 manager of the approval resolution,
9 except that in the event the manager
10 of the approval resolution is in favor
11 of any such motion or appeal, the
12 time in opposition thereto, shall be
13 controlled by the Minority Leader or
14 his designee. Such leaders, or either of
15 them, may, from time under their
16 control on the passage of an approval
17 resolution, allot additional time to any
18 Senator during the consideration of
19 any debatable motion or appeal.

20 (IV) OTHER MOTIONS.—A mo-
21 tion in the Senate to further limit de-
22 bate is not debatable. A motion to re-
23 commit an approval resolution is not
24 in order.

1 **SEC. 126. ENFORCEMENT.**

2 (a) IN GENERAL.—Chapter 47 of the Internal Reve-
3 nue Code of 1986 (relating to excise taxes on qualified
4 pension, etc. plans) is amended by inserting after section
5 5000 the following new sections:

6 **“SEC. 5000A. FAILURE OF EMPLOYERS WITH RESPECT TO**
7 **HEALTH INSURANCE.**

8 “(a) GENERAL RULE.—There is hereby imposed a
9 tax on the failure of any person to comply with the re-
10 quirements of sections 121 and 125(a) of the Consumer
11 Choice Health Security Act of 1993 with respect to any
12 employee of the person.

13 “(b) AMOUNT OF TAX.—

14 “(1) IN GENERAL.—The amount of the tax im-
15 posed by subsection (a) on any failure with respect
16 to an employee shall be \$50 for each day in the non-
17 compliance period with respect to such failure.

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

21 “(A) beginning on the date such failure
22 first occurs, and

23 “(B) ending on the date such failure is
24 corrected.

25 “(3) CORRECTION.—A failure of a person to
26 comply with the requirements of section 121 or

1 125(a) of the Consumer Choice Health Security Act
2 of 1993 with respect to any employee of the person
3 shall be treated as corrected if—

4 “(A) such failure is retroactively undone to
5 the extent possible, and

6 “(B) the employee is placed in a financial
7 position which is as good as such employee
8 would have been in had such failure not oc-
9 curred.

10 “(c) LIMITATIONS ON AMOUNT OF TAX.—

11 “(1) TAX NOT TO APPLY WHERE FAILURE NOT
12 DISCOVERED EXERCISING REASONABLE DILI-
13 GENCE.—No tax shall be imposed by subsection (a)
14 on any failure during any period for which it is es-
15 tablished to the satisfaction of the Secretary that
16 none of the persons referred to in subsection (d)
17 knew, or exercising reasonable diligence would have
18 known, that such failure existed.

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

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

24 “(B) such failure is corrected during the
25 30-day period beginning on the first date any of

1 the persons referred to in subsection (d) knew,
2 or exercising reasonable diligence would have
3 known, that such failure existed.

4 “(3) WAIVER BY SECRETARY.—In the case of a
5 failure which is due to reasonable cause and not to
6 willful neglect, the Secretary may waive part or all
7 of the tax imposed by subsection (a) to the extent
8 that the payment of such tax would be excessive rel-
9 ative to the failure involved.

10 “(d) LIABILITY FOR TAX.—

11 “(1) IN GENERAL.—Except as otherwise pro-
12 vided in this subsection, the following shall be liable
13 for the tax imposed by subsection (a) on a failure:

14 “(A) In the case of a health insurance plan
15 other than a multiemployer plan, the employer.

16 “(B) In the case of a multiemployer plan,
17 the plan.

18 “(C) Each person who is responsible (other
19 than in a capacity as an employee) for admin-
20 istering or providing benefits under the health
21 insurance plan and whose act or failure to act
22 caused (in whole or in part) the failure.

23 “(2) SPECIAL RULES FOR PERSONS DESCRIBED
24 IN PARAGRAPH (1)(C).—A person described in sub-
25 paragraph (C) (and not in subparagraphs (A) and

1 (B)) of paragraph (1) shall be liable for the tax im-
2 posed by subsection (a) on any failure only if such
3 person assumed (under a legally enforceable written
4 agreement) responsibility for the performance of the
5 act to which the failure relates.

6 **“SEC. 5000B. FAILURE OF CARRIERS WITH RESPECT TO**
7 **HEALTH INSURANCE.**

8 “(a) GENERAL RULE.—There is hereby imposed a
9 tax on the failure of any carrier offering any health insur-
10 ance plan to comply with the requirements of sections 122
11 and 123 of the Consumer Choice Health Security Act of
12 1993.

13 “(b) AMOUNT OF TAX.—

14 “(1) IN GENERAL.—The amount of tax imposed
15 by subsection (a) by reason of 1 or more failures
16 during a taxable year shall be equal to 50 percent
17 of the gross premiums received during such taxable
18 year with respect to all health insurance plans issued
19 by the carrier on whom such tax is imposed.

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

24 “(3) CONTROLLED GROUPS.—For purposes of
25 paragraph (1)—

1 “(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of
2 the same controlled group of corporations shall
3 be treated as 1 carrier. For purposes of the pre-
4 ceding sentence, the term ‘controlled group of
5 corporations’ has the meaning given to such
6 term by section 1563(a), except that—
7

8 “(i) ‘more than 50 percent’ shall be
9 substituted for ‘at least 80 percent’ each
10 place it appears in section 1563(a)(1), and

11 “(ii) the determination shall be made
12 without regard to subsections (a)(4) and
13 (e)(3)(C) of section 1563.

14 “(B) PARTNERSHIPS, PROPRIETORSHIPS,
15 ETC., WHICH ARE UNDER COMMON CONTROL.—
16 Under regulations prescribed by the Secretary,
17 all trades or business (whether or not incor-
18 porated) which are under common control shall
19 be treated as 1 carrier. The regulations pre-
20 scribed under this subparagraph shall be based
21 on principles similar to the principles which
22 apply in the case of subparagraph (A).

23 “(c) LIMITATION ON TAX.—

24 “(1) TAX NOT TO APPLY WHERE FAILURE NOT
25 DISCOVERED EXERCISING REASONABLE DILI-

1 GENCE.—No tax shall be imposed by subsection (a)
2 with respect to any failure for which it is established
3 to the satisfaction of the Secretary that the carrier
4 on whom the tax is imposed did not know, and exer-
5 cising reasonable diligence would not have known,
6 that such failure existed.

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

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

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

18 “(3) WAIVER BY SECRETARY.—In the case of a
19 failure which is due to reasonable cause and not to
20 willful neglect, the Secretary may waive part or all
21 of the tax imposed by subsection (a) to the extent
22 that the payment of such tax would be excessive rel-
23 ative to the failure involved.”.

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

“Sec. 5000A. Failure of employers with respect to health insur-
ance.

“Sec. 5000B. Failure of carriers with respect to health insur-
ance.”.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall take effect on January 1, 1997.

6 **Subtitle D—State Plan** 7 **Requirements**

8 **SEC. 131. STATE PLAN REQUIREMENTS.**

9 (a) IN GENERAL.—As a condition of receiving Fed-
10 eral funds for health care programs after December 31,
11 1996, each State shall meet the requirements of the fol-
12 lowing subsections.

13 (b) HEALTH PLANS FOR UNINSURED.—The require-
14 ment of this subsection is met, if the State establishes a
15 program to provide health insurance coverage at least
16 equal to that of the federally qualified health insurance
17 plans (as defined in section 111) to any resident (other
18 than a federally covered individual (within the meaning
19 on section 34A(b)(2) of the Internal Revenue Code of
20 1986) who refuses to voluntarily purchase such insurance
21 coverage privately. Such coverage may be through—

22 (1) the State’s program under title XIX of the
23 Social Security Act,

1 (2) an existing or new State health care pro-
2 gram, including a State program established under
3 section 1933 of the Social Security Act,

4 (3) any private insurer the State contracts with
5 for this purpose, or

6 (4) any health insurance plan available to the
7 resident.

8 (c) ENROLLMENT IN PLAN.—The requirement of this
9 subsection is met, if—

10 (1) in the case of any uninsured individual de-
11 scribed in subsection (b) who is eligible for assist-
12 ance under a State program established under sec-
13 tion 1933 of the Social Security Act, such individual
14 is identified by the State and provided with assist-
15 ance through such a program, and

16 (2) in the case of any uninsured individual de-
17 scribed in subsection (b) who is not eligible for such
18 assistance, such individual is identified by the State
19 and automatically enrolled in the program described
20 in subsection (b), except that—

21 (A) the State may charge such individual
22 a premium for coverage under the program
23 which the State deems appropriate given the
24 cost of coverage and the individual's ability to
25 pay, and

1 (B) such individual may, upon submitting
2 proof of having purchased a federally qualified
3 health insurance plan (as so defined), terminate
4 coverage under the State program without pen-
5 alty.

6 (d) MONITORING.—The requirement of this sub-
7 section is met, if the State designates or creates an office
8 of the State government to monitor the health insurance
9 coverage status of workers and their dependents residing
10 in the State for the purposes of determining eligibility for
11 State health care assistance programs.

12 **Subtitle E—Federal Preemption**

13 **SEC. 141. FEDERAL PREEMPTION OF CERTAIN STATE LAWS.**

14 All State laws in existence on January 1, 1997, in
15 the following areas are preempted:

16 (1) MANDATED INSURANCE BENEFIT LAWS.—
17 Laws requiring health insurance policies to cover
18 specific diseases, services, or providers.

19 (2) ANTI-MANAGED CARE LAWS.—Laws re-
20 stricting the ability of managed care plans to selec-
21 tively contract with providers of their choice.

22 (3) MANDATED COST-SHARING LAWS.—Laws
23 restricting the extent to which insurers may require
24 enrollee cost sharing as part of their plans, or re-
25 stricting the extent to which managed care plans

1 may impose different levels of cost sharing on en-
2 rollee claims for treatment by providers not partici-
3 pating in the plan.

4 **TITLE II—MEDICARE AND**
5 **MEDICAID REFORMS**
6 **Subtitle A—Medicare**

7 **SEC. 201. STUDY OF MEDICARE PRIVATE HEALTH INSUR-**
8 **ANCE PROGRAM.**

9 (a) STUDY.—The Secretary shall conduct a study of
10 the feasibility of permitting future medicare beneficiaries
11 to elect, upon attaining medicare eligibility, to retain pri-
12 vate health insurance coverage and receive, in lieu of the
13 medicare benefits such beneficiaries would otherwise be
14 entitled to, certificates for use in purchasing private health
15 insurance coverage. The study shall recommend—

16 (1) certificate amounts which—

17 (A) provide the maximum assistance pos-
18 sible to eligible individuals,

19 (B) are adjusted for different classes of
20 beneficiaries on the basis of age, sex, and geog-
21 raphy to reflect actuarial differences in the cost
22 of insurance, and

23 (C) will not further jeopardize the future
24 solvency of the medicare program, as projected

1 by the trustees of the medicare trust funds as
2 of the date of the report of the study,

3 (2) a mechanism for annually adjusting such
4 amounts, and

5 (3) legislative, regulatory, and administrative
6 reforms necessary or desirable for establishing such
7 a program.

8 (b) REPORT.—The Secretary shall submit a report
9 regarding the study described in subsection (a) to the Con-
10 gress no later than January 1, 1996.

11 **SEC. 202. ELIMINATION OF MEDICARE HOSPITAL DIS-**
12 **PROPORTIONATE SHARE ADJUSTMENT PAY-**
13 **MENTS.**

14 Section 1886(d)(5)(F)(i) of the Social Security Act
15 (42 U.S.C. 1395ww(d)(5)(F)(i)) is amended by inserting
16 “and before September 30, 1994,” after “1986,”.

17 **SEC. 203. REDUCTION IN ADJUSTMENT FOR INDIRECT MED-**
18 **ICAL EDUCATION.**

19 Section 1886(d)(5)(B)(ii) of the Social Security Act
20 (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as
21 follows:

22 “(ii) For purposes of clause (i)(II), the indirect
23 teaching adjustment factor is equal to $c * (((1+r)$
24 $\text{to the } n\text{th power}) - 1)$, where ‘r’ is the ratio of the
25 hospital’s full-time equivalent interns and residents

1 to beds and 'n' equals .405. For discharges occur-
2 ring on or after—

3 “(I) May 1, 1986, and before October 1,
4 1994, 'c' is equal to 1.89,

5 “(II) October 1, 1994, and before October
6 1, 1995, 'c' is equal to 1.395, and

7 “(III) October 1, 1995, 'c' is equal to
8 0.74.”.

9 **SEC. 204. IMPOSITION OF COPAYMENT FOR SKILLED NURS-**
10 **ING FACILITY SERVICES.**

11 (a) IN GENERAL.—Paragraph (3) of section 1813(b)
12 of the Social Security Act (42 U.S.C. 1395e(b)) is amend-
13 ed to read as follows:

14 “(3) The amount payable for post-hospital extended
15 care services furnished an individual during any spell of
16 illness shall be reduced by a copayment amount equal to
17 20 percent of the average of all per day costs for such
18 services furnished under this title (as determined by the
19 Secretary on a prospective basis for services furnished
20 during a calendar year).”.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall apply to post-hospital extended care
23 services furnished on or after October 1, 1994.

1 **SEC. 205. SHIFT PAYMENT UPDATES TO JANUARY FOR ALL**
2 **PAYMENT RATES UNDER HOSPITAL INSUR-**
3 **ANCE PROGRAM.**

4 (a) PPS HOSPITALS.—

5 (1) IN GENERAL.—Section 1886(b)(3)(B)(i) of
6 the Social Security Act (42 U.S.C.
7 1395ww(b)(3)(B)(i)) is amended—

8 (A) in the matter preceding subclause (I),
9 by striking “fiscal year” and inserting “particu-
10 lar time period”,

11 (B) in subclause (IX), by striking “fiscal
12 year 1994”, and inserting “the 15-month pe-
13 riod beginning on October 1, 1993”,

14 (C) in subclauses (X), (XI), and (XII), by
15 striking “fiscal year”, and

16 (D) in subclause (XIII), by striking “fiscal
17 year 1998 and each subsequent fiscal year” and
18 inserting “1998 and each subsequent calendar
19 year”.

20 (2) OTHER HOSPITALS.—

21 (A) IN GENERAL.—Section
22 1886(b)(3)(B)(ii) of such Act (42 U.S.C.
23 1395ww(b)(3)(B)(ii)) is amended—

24 (A) in subclause (V)—

25 (i) by striking “fiscal years 1994
26 through 1997” and inserting “the 15-

1 month period beginning on October 1,
2 1993,” and

3 (ii) by striking “and” at the end, and
4 (B) by striking subclause (VI) and insert
5 the following:

6 “(VI) 1995 through 1997, is the market basket
7 percentage increase minus the applicable reduction
8 (as defined in clause (vi)(II)), or in the case of a
9 hospital for a calendar year for which the hospital’s
10 update adjustment percentage (as defined in clause
11 (vi)(I)) is at least 10 percent, the market basket per-
12 centage increase, and

13 “(VII) subsequent calendar years is the market
14 basket percentage increase.”.

15 (B) CONFORMING AMENDMENT.—Section
16 1886(b)(3)(B) of such Act (42 U.S.C.
17 1395ww(b)(3)(B)) is amended by adding at the
18 end the following new clause:

19 “(vi) For purposes of clause (ii)(VI)—

20 “(I) a hospital’s ‘update adjustment percentage’
21 for a calendar year is the percentage by which the
22 hospital’s allowable operating cost of inpatient hos-
23 pital services recognized under this title for the cost
24 reporting period beginning in fiscal year 1990 ex-
25 ceeds the hospital’s target amount (as determined

1 under subparagraph (A)) for such cost reporting pe-
2 riod, increased for each calendar year (beginning
3 with 1995) by the sum of any of the hospital's appli-
4 cable reductions under subclause (VI) for previous
5 years; and

6 “(II) the ‘applicable reduction’ with respect to
7 a hospital for a calendar year is the lesser of 1 per-
8 centage point or the percentage point difference be-
9 tween 10 percent and the hospital’s update adjust-
10 ment percentage for the calendar year.”.

11 (3) SOLE COMMUNITY AND MEDICARE-DEPEND-
12 ENT, SMALL RURAL HOSPITALS.—

13 (A) IN GENERAL.—Section
14 1886(b)(3)(B)(iv) of such Act (42 U.S.C.
15 1395ww(b)(3)(B)(iv)) is amended—

16 (i) in subclause (II), by striking “fis-
17 cal year 1994” and inserting “the 15-
18 month period beginning on October 1,
19 1993”,

20 (ii) in subclause (III), by striking “fis-
21 cal year”, and

22 (iii) in subclause (IV), by striking
23 “fiscal year 1996 and each subsequent fis-
24 cal year” and inserting “1996 and each
25 subsequent calendar year”.

1 (B) TARGET AMOUNT ADJUSTMENT.—Sec-
2 tion 1886(b)(3)(C) of such Act (42 U.S.C.
3 1395ww(b)(3)(C)) is amended—

4 (i) in clause (iii), by inserting “or por-
5 tion of a cost reporting period occurring
6 before December 31, 1994,” before “the
7 target amount”, and

8 (ii) in clause (iv), by striking “fiscal
9 year 1995 and each subsequent fiscal
10 year” and inserting “1995 and each subse-
11 quent year”.

12 (C) EXTENSION OF REGIONAL FLOOR.—
13 Section 1886(d)(1)(A)(iii)(II) of such Act (42
14 U.S.C. 1395ww(d)(1)(A)(iii)(II)) is amended—

15 (i) by striking “for discharges occur-
16 ring during a fiscal year ending on or be-
17 fore September 30, 1996” and inserting
18 “for discharges occurring during the 15-
19 month period beginning on October 1,
20 1993, and during any calendar year ending
21 on or before December 31, 1996”, and

22 (ii) by striking “such fiscal year” and
23 inserting “such 15-month period or such
24 calendar year, as the case may be”.

25 (4) CONFORMING AMENDMENTS.—

1 (A) Section 1886(b)(3)(B)(iii) of such Act
2 (42 U.S.C. 1395ww(b)(3)(B)(iii)) is amended—

3 (i) by inserting “beginning in” after
4 “cost reporting periods”,

5 (ii) by striking “fiscal year” the first
6 place it appears and inserting “particular
7 time period”,

8 (iii) by striking “or fiscal year” the
9 first and second place it appears, and

10 (iv) by striking “cost reporting period
11 or fiscal year” and inserting “period”.

12 (B) Section 1886(d)(1)(A) of such Act (42
13 U.S.C. 1395ww(d)(1)(A)) is amended in the
14 matter preceding clause (i) by inserting “or cal-
15 endar” after “fiscal”.

16 (C) Section 1886(d)(2)(D) of such Act (42
17 U.S.C. 1395ww(d)(2)(D)) is amended by insert-
18 ing “or calendar” after “fiscal” each place it
19 appears.

20 (D) Section 1886(d)(3) of such Act (42
21 U.S.C. 1395ww(d)(3)) is amended in the first
22 sentence by inserting “or calendar” after “fis-
23 cal” the first place it appears and by inserting
24 “for each fiscal year through 1994” after “in
25 the United States, and”.

1 (E) Section 1886(d)(3)(A)(ii) of such Act
2 (42 U.S.C. 1395ww(d)(3)(A)(ii)) is amended—

3 (i) by striking “1994,” and inserting
4 “1993, and occurring in the 15-month pe-
5 riod beginning on October 1, 1993,”, and

6 (ii) by striking “fiscal year” the sec-
7 ond and last place it appears and inserting
8 “time period”.

9 (F) Section 1886(d)(3)(A)(iii) of such Act
10 (42 U.S.C. 1395ww(d)(3)(A)(iii)) is amended
11 by striking “the fiscal year beginning on Octo-
12 ber 1, 1994” and inserting “1995”.

13 (G) Section 1886(d)(3)(A)(iv) of such Act
14 (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

15 (i) by striking “fiscal year beginning
16 on or after October 1, 1995” and inserting
17 “year beginning on or after January 1,
18 1996”,

19 (ii) by striking “and within each re-
20 gion”, and

21 (iii) by striking “fiscal” each place it
22 appears.

23 (H) Section 1886(d)(3)(D) of such Act (42
24 U.S.C. 1395ww(d)(3)(D)) is amended—

1 (i) by inserting “or calendar” after
2 “fiscal” each place it appears, and

3 (ii) by inserting “for each fiscal year
4 through 1994” after “and shall establish”.

5 (I) Section 1886(d)(3)(E) of such Act (42
6 U.S.C. 1395ww(d)(3)(E)) is amended—

7 (i) in the second sentence, by striking
8 “at least every 12 months thereafter” and
9 inserting “beginning January 1, 1995, at
10 least every 12 months thereafter”, and

11 (ii) in the last sentence, by inserting
12 “or calendar” after “fiscal” the first and
13 last place it appears.

14 (J)(i) Section 1886(d)(4)(C)(iii) of such
15 Act (42 U.S.C. 1395ww(d)(4)(C)(iii)) is amend-
16 ed—

17 (I) by inserting “or calendar” after
18 “fiscal” the first place it appears, and

19 (II) by deleting “fiscal” the last place
20 it appears.

21 (ii) The requirements of paragraphs (3)(E)
22 and (4)(C)(iii) of section 1886(d) of the Social
23 Security Act (42 U.S.C. 1395ww(d)(4)(C)(iii))
24 shall be applied on a 15-month basis for the pe-

1 riod beginning on October 1, 1993, and ending
2 on December 31, 1994.

3 (K)(i) Section 1886(d)(5)(A) of such Act
4 (42 U.S.C. 1395ww(d)(5)(A)) is amended—

5 (I) in clause (i), by striking “fiscal
6 years ending on or before September 30,
7 1997” and inserting “calendar years end-
8 ing on or before December 31, 1997”,

9 (II) in clause (ii), by striking “fiscal
10 years beginning on or after October 1,
11 1994” and inserting “calendar years begin-
12 ning on or after January 1, 1995”,

13 (III) in clause (iv), by inserting “or
14 calendar” after “fiscal”,

15 (IV) in clause (v), by striking “fiscal
16 year” each place it appears, and

17 (V) in clause (vi), by striking “fiscal”
18 and inserting “calendar”.

19 (ii) The requirement of section
20 1886(d)(5)(A)(iv) of the Social Security Act
21 (42 U.S.C. 1395ww(d)(5)(A)(iv)) shall be ap-
22 plied on a 15-month basis for the period begin-
23 ning on October 1, 1993, and ending on De-
24 cember 31, 1994.

1 (L) Section 1886(d)(5)(E)(ii) of such Act
2 (42 U.S.C. 1395ww(d)(5)(E)(ii)) is amended by
3 inserting “or calendar” after “fiscal”.

4 (M) Section 1886(d)(6) of such Act (42
5 U.S.C. 1395ww(d)(6)) is amended by inserting
6 “or December 1 of each calendar year (begin-
7 ning with calendar year 1995)” after “1984”.

8 (N) Section 1886(d)(9)(A) of such Act (42
9 U.S.C. 1395ww(d)(9)(A)) is amended in the
10 matter preceding clause (i) by striking “fiscal
11 year” and inserting “particular time period”.

12 (O) Section 1886(d)(9)(C)(i) of such Act
13 (42 U.S.C. 1395ww(d)(9)(C)(i)) is amended—

14 (i) by striking “fiscal year” the first
15 place it appears and inserting “time pe-
16 riod”,

17 (ii) by striking “for fiscal year 1989”,
18 and

19 (iii) by striking “fiscal years” and in-
20 serting “time periods”.

21 (P) Section 1886(d)(10)(C) of such Act
22 (42 U.S.C. 1395ww(d)(10)(C)) is amended—

23 (i) in clause (i), by striking “fiscal
24 year” and inserting “particular time pe-
25 riod”, and

1 (ii) in clause (ii), by inserting “or cal-
2 endar” after “fiscal” the first place it ap-
3 pears and striking “fiscal” the last place it
4 appears.

5 (Q) Section 1886(e)(2) of such Act (42
6 U.S.C. 1395ww(e)(2)) is amended—

7 (i) in subparagraph (A), by striking
8 “fiscal years” and inserting “particular
9 time periods”, and

10 (ii) in subparagraph (B), by striking
11 “fiscal year” each place it appears and in-
12 sserting “particular time period”.

13 (R) Section 1886(e)(3) of such Act (42
14 U.S.C. 1395ww(e)(3)) is amended—

15 (i) in subparagraph (A)—

16 (I) by striking “before the begin-
17 ning of each fiscal year (beginning
18 with fiscal year 1986)”, and

19 (II) by striking “that fiscal year”
20 and inserting “the succeeding year”,
21 and

22 (ii) in subparagraph (B)—

23 (I) by striking “before the begin-
24 ning of each fiscal year (beginning
25 with fiscal year 1989)”, and

1 (II) by striking “that fiscal year”
2 and inserting “the succeeding year”.

3 (S) Section 1886(e)(4)(A) of such Act (42
4 U.S.C. 1395ww(e)(4)(A)) is amended in the
5 first sentence by striking “fiscal” the first and
6 last place it appears and by striking “(begin-
7 ning with fiscal year 1988)”.

8 (T) Section 1886(e)(4)(B) of such Act (42
9 U.S.C. 1395ww(e)(4)(B)) is amended by strik-
10 ing “fiscal” the first place it appears and by
11 striking “(beginning with fiscal year 1992)”.

12 (U) Section 1886(e)(5) of such Act (42
13 U.S.C. 1395ww(e)(5)) is amended—

14 (i) in subparagraph (A), by striking
15 “the May 1 before each fiscal year (begin-
16 ning with fiscal year 1986) and inserting
17 “May 1” and by striking “that fiscal year”
18 and inserting “the succeeding year”, and

19 (ii) in subparagraph (B), by striking
20 “fiscal”.

21 (V) The second and third sentences of sec-
22 tion 1886(e)(5) of such Act (42 U.S.C.
23 1395ww(e)(5)) are each amended by striking
24 “fiscal” each place it appears.

1 (W) Section 1886(g)(1)(A) of such Act (42
2 U.S.C. 1395ww(g)(1)(A)) is amended—

3 (i) by striking “fiscal years 1992,
4 through 1995” and inserting “fiscal years
5 1992 and 1993, the 15-month period be-
6 ginning on October 1, 1993, and calendar
7 year 1995”, and

8 (ii) by striking “such fiscal year” and
9 inserting “such period”.

10 (5) CLERICAL AMENDMENTS CONCERNING
11 TRANSITIONAL PAYMENTS FOR A RECLASSIFIED
12 HOSPITAL.—

13 (A) Section 1886(d)(8)(A) of such Act (42
14 U.S.C. 1395ww(d)(8)(A)) is amended in the
15 matter preceding clause (i), by striking “cost
16 reporting periods” and inserting “years”.

17 (B) Section 1886(d)(8)(A)(i) of such Act
18 (42 U.S.C. 1395ww(d)(8)(A)(i)) is amended—

19 (i) in the matter preceding subclause
20 (I), by striking “cost reporting period” and
21 inserting “year” and by striking “reporting
22 period” and inserting “year”,

23 (ii) in subclause (I), by striking “re-
24 porting period” and inserting “year”, and

1 (iii) in subclause (II), by striking “re-
2 reporting period” and inserting “year”.

3 (C) Section 1886(d)(8)(A)(ii) of such Act
4 (42 U.S.C. 1395ww(d)(8)(A)(ii)) is amended—

5 (i) in the matter preceding subclause
6 (I), by striking “cost reporting period” and
7 inserting “year” and by striking “reporting
8 period” and inserting “year”,

9 (ii) in subclause (I), by striking “re-
10 reporting period” and inserting “year”, and

11 (iii) in subclause (II), by striking “re-
12 reporting period” and inserting “year”.

13 (b) HOME HEALTH AGENCIES.—Clause (iii) of sec-
14 tion 1861(v)(1)(L) of such Act (42 U.S.C.
15 1395x(v)(1)(L)) is amended by striking “July 1, 1991,
16 and annually thereafter (but not for cost reporting periods
17 beginning on and after July 1, 1994, and before July 1,
18 1996)” and inserting “July 1 of 1991, 1992, and 1993
19 (but not for cost reporting periods beginning on and after
20 July 1, 1994, and before January 1, 1997), and annually
21 thereafter”.

22 (c) HOSPICE CARE.—

23 (1) IN GENERAL.—Clause (ii) of section
24 1814(i)(1)(C) of such Act (42 U.S.C.
25 1395f(i)(1)(C)) is amended—

1 (A) in subclause (II), by striking “fiscal
2 year 1994” and inserting “the 15-month period
3 beginning on October 1, 1993”, and

4 (B) in subclauses (III), (IV), (V), and
5 (VI), by striking “fiscal year” each place it ap-
6 pears and inserting “calendar year”.

7 (2) CONFORMING AMENDMENT.—Section
8 1814(i)(2) of such Act (42 U.S.C. 1395f(i)(2)) is
9 amended by adding at the end the following new
10 subparagraph:

11 “(D) For purposes of subparagraph (A), the term
12 ‘accounting year’ means—

13 “(i) fiscal years 1985 through 1993,

14 “(ii) the 15-month period beginning on October
15 1, 1993, and

16 “(iii) calendar years beginning on or after Jan-
17 uary 1, 1995.”.

18 (d) SKILLED NURSING FACILITY SERVICES.—

19 (1) IN GENERAL.—The last sentence of section
20 1888(a) of such Act (42 U.S.C. 1395yy(b)) is
21 amended by striking “October 1, 1995” and insert-
22 ing “January 1, 1996”.

23 (2) CONFORMING AMENDMENTS.—

1 (A) Section 1888(d)(4) of such Act (42
2 U.S.C. 1395yy(d)(4)) is amended by striking
3 “fiscal” each place it appears.

4 (B) Subsections (a)(1) and (b) of section
5 13503 of the Omnibus Budget Reconciliation
6 Act of 1993 are amended by striking “fiscal
7 years 1994 and 1995” each place it appears
8 and inserting “the 15-month period beginning
9 on October 1, 1993, and calendar year 1995”.

10 **SEC. 206. ACCELERATION OF TRANSITION TO PROSPEC-**
11 **TIVE RATES FOR FACILITY COSTS IN HOS-**
12 **PITAL OUTPATIENT DEPARTMENTS.**

13 (a) OUTPATIENT SURGERY.—Section
14 1833(i)(3)(B)(ii) of the Social Security Act (42 U.S.C.
15 1395l(i)(3)(B)(ii)) is amended—

16 (1) in subclause (I)—

17 (A) by striking “and 42 percent” and in-
18 serting “42 percent”, and

19 (B) by striking “1991” and inserting
20 “1991, and beginning on or before September
21 30, 1994, 25 percent for portions of cost re-
22 porting periods beginning in fiscal year 1995,
23 and 0 percent for portions of cost reporting pe-
24 riods beginning on or after October 1, 1995”,
25 and

1 (2) in subclause (II)—

2 (A) by striking “and 58 percent” and in-
3 serting “58 percent”, and

4 (B) by striking “1991” and inserting
5 “1991, and beginning on or before September
6 30, 1994, 75 percent for portions of cost re-
7 porting periods beginning in fiscal year 1995,
8 and 100 percent for portions of cost reporting
9 periods beginning on or after October 1, 1995”.

10 (b) OUTPATIENT RADIOLOGY AND DIAGNOSTIC
11 SERVICES.—Section 1833(n)(1)(B)(ii)(I) of the Social Se-
12 curity Act (42 U.S.C. 1395l(n)(1)(B)(ii)(I)) is amended
13 by striking “January 1, 1991.” and inserting “January
14 1, 1991, and beginning on or before September 30, 1994.
15 The term means 25 percent for portions of cost reporting
16 periods beginning in fiscal year 1995 and 0 percent for
17 portions of cost reporting periods beginning on or after
18 October 1, 1995.”.

19 **Subtitle B—Medicaid**

20 **SEC. 211. CAP ON FEDERAL PAYMENTS MADE FOR ACUTE** 21 **MEDICAL SERVICES UNDER THE MEDICAID** 22 **PROGRAM.**

23 (a) IN GENERAL.—Title XIX of the Social Security
24 Act (42 U.S.C. 1396 et seq.) is amended by redesignating

1 section 1931 as section 1932 and by inserting after section
2 1930 the following new section:

3 “CAP ON FEDERAL PAYMENT MADE FOR ACUTE MEDICAL
4 SERVICES FURNISHED UNDER THE MEDICAID PROGRAM

5 “SEC. 1931. (a) ANNUAL FEDERAL CAP.—For pur-
6 poses of furnishing acute medical services to eligible indi-
7 viduals, the Secretary shall pay to a State for a fiscal year
8 under section 1903 an amount that does not exceed the
9 State’s total funding amount for such fiscal year deter-
10 mined under subsection (b).

11 “(b) STATE TOTAL FUNDING AMOUNT.—

12 “(1) IN GENERAL.—A State’s total funding
13 amount for a fiscal year is an amount equal to the
14 lesser of—

15 “(A) the sum of—

16 “(i) the product of—

17 “(I) the per-adult funding
18 amount for the State for such fiscal
19 year, and

20 “(II) the total number of eligible
21 individuals who are at least 21 years
22 of age who will receive acute medical
23 services in the State during the fiscal
24 year; and

25 “(ii) the product of—

1 “(I) the per-child funding
2 amount for the State for such fiscal
3 year, and

4 “(II) the total number of eligible
5 individuals who are under 21 years of
6 age who will receive acute medical
7 services in the State during the fiscal
8 year; or

9 “(B) the maximum Federal amount for
10 such State (as determined under paragraph
11 (3)).

12 “(2) PER-ADULT AND PER-CHILD FUNDING
13 AMOUNTS.—The Secretary shall calculate for each
14 State a per-adult funding amount and a per-child
15 funding amount for each fiscal year as follows:

16 “(A) IN GENERAL.—

17 “(i) FISCAL YEAR 1995.—For fiscal
18 year 1995—

19 “(I) the per-adult funding
20 amount for a State shall be an
21 amount equal to the base per-adult
22 funding amount determined under
23 subparagraph (B) increased by 20
24 percent of such amount; and

1 “(II) the per-child funding
2 amount for the State shall be an
3 amount equal to the base per-child
4 funding amount for the State deter-
5 mined under subparagraph (C) in-
6 creased by 20 percent of such amount.

7 “(ii) SUBSEQUENT FISCAL YEARS.—
8 For fiscal year 1996 and subsequent fiscal
9 years, the per-adult funding amount for a
10 State and the per-child funding amount for
11 a State, respectively, shall be an amount
12 equal to the amount determined under this
13 subparagraph for the previous fiscal year
14 updated, through the midpoint of the pe-
15 riod, by the estimated percentage change
16 in the Consumer Price Index during the
17 12-month period ending at that midpoint,
18 with appropriate adjustments to reflect
19 previous underestimations or overesti-
20 mations under this clause in the projected
21 percentage change in the Consumer Price
22 Index, plus 1 percentage point.

23 “(B) BASE PER-ADULT FUNDING
24 AMOUNT.—The base per-adult funding amount
25 for a State is an amount equal to—

1 “(i) the total amount of Federal funds
2 paid to such State under section 1903(a)
3 for fiscal year 1993 for providing acute
4 medical services to eligible individuals who
5 were at least 21 years of age; divided by

6 “(ii) the total number of eligible indi-
7 viduals who were at least 21 years of age
8 who received acute medical services in such
9 State during fiscal year 1993.

10 “(C) BASE PER-CHILD FUNDING
11 AMOUNT.—The base per-child funding amount
12 for a State is an amount equal to—

13 “(i) the total amount of Federal funds
14 paid to such State under section 1903(a)
15 for fiscal year 1993 for providing acute
16 medical services to eligible individuals who
17 were under 21 years of age; divided by

18 “(ii) the total number of eligible indi-
19 viduals who were under 21 years of age
20 who received acute medical services in such
21 State during fiscal year 1993.

22 “(3) MAXIMUM FEDERAL AMOUNT.—The Sec-
23 retary shall calculate for each State a maximum
24 Federal amount for each fiscal year as follows:

25 “(A) IN GENERAL.—

1 “(i) FISCAL YEAR 1995.—For fiscal
2 year 1995, the maximum Federal amount
3 for a State shall be an amount equal to the
4 base maximum Federal amount determined
5 under subparagraph (C) increased by 20
6 percent of such amount.

7 “(ii) SUBSEQUENT FISCAL YEARS.—
8 For fiscal year 1996 and subsequent fiscal
9 years, the maximum Federal amount for a
10 State shall be an amount equal to the
11 amount determined under this subpara-
12 graph for the previous fiscal year updated,
13 through the midpoint of the period, by the
14 estimated percentage change in the
15 Consumer Price Index during the 12-
16 month period ending at that midpoint,
17 with appropriate adjustments to reflect
18 previous underestimations or overesti-
19 mations under this clause in the projected
20 percentage change in the Consumer Price
21 Index, plus 2.5 percentage points.

22 “(B) BASE MAXIMUM FEDERAL
23 AMOUNT.—

24 “(i) IN GENERAL.—The base maxi-
25 mum Federal amount for a State is an

1 amount equal to the State's applicable per-
2 centage (as determined under clause (ii))
3 of the State's total maximum amount (as
4 determined under clause (iii)).

5 “(ii) STATE'S APPLICABLE PERCENT-
6 AGE.—A State's applicable percentage de-
7 termined under this clause is a percentage
8 equal to the quotient of—

9 “(I) the amount of Federal funds
10 paid to the State for the furnishing of
11 acute medical services to eligible indi-
12 viduals and the provision of adminis-
13 trative services to such individuals in
14 fiscal year 1993, divided by

15 “(II) the amount of Federal
16 funds paid to all States for the fur-
17 nishing of acute medical services to el-
18 igible individuals and the provision of
19 administrative services to such indi-
20 viduals in fiscal year 1993.

21 “(iii) STATE'S TOTAL MAXIMUM
22 AMOUNT.—A State's total maximum
23 amount determined under this clause is an
24 amount equal to the applicable percentage
25 of the total amount of Federal funds paid

1 to all States for the furnishing of acute
2 medical services to eligible individuals and
3 the provision of administrative services to
4 such individuals in fiscal year 1993.

5 “(c) MINIMUM EXPENDITURE BY STATES.—

6 “(1) IN GENERAL.—For the purpose of furnish-
7 ing acute medical services to eligible individuals and
8 providing administrative services to such individuals
9 in a fiscal year, a State shall incur expenditures
10 which are at least equal to the product of—

11 “(A) the State’s updated per capita
12 amount, and

13 “(B) the total number of eligible individ-
14 ual’s receiving acute medical services in the
15 State during such fiscal year.

16 “(2) UPDATED PER CAPITA AMOUNT.—For pur-
17 poses of paragraph (1)(A)—

18 “(A) IN GENERAL.—The updated per cap-
19 ita amount for a State shall be—

20 “(i) for fiscal year 1995, an amount
21 equal to the State’s base per capita
22 amount, and

23 “(ii) for fiscal year 1996 and each
24 succeeding fiscal year, an amount equal to
25 the amount determined under this sub-

1 paragraph for the first preceding fiscal
2 year updated by the percentage change in
3 the consumer price index between such
4 first preceding fiscal year and the second
5 preceding fiscal year (as determined by the
6 Secretary of Commerce).

7 “(B) BASE PER CAPITA AMOUNT.—The
8 base per capita amount for a State shall be an
9 amount equal to the quotient of—

10 “(i) the total amount of State expend-
11 itures in fiscal year 1993 for the furnish-
12 ing of acute medical services to eligible in-
13 dividuals and the provision of administra-
14 tive services to such individuals, divided by

15 “(ii) the total number of eligible indi-
16 viduals receiving acute medical services
17 during fiscal year 1993.

18 “(d) DEFINITIONS.—For purposes of this section—

19 “(1) ACUTE MEDICAL SERVICES.—The term
20 ‘acute medical services’ means all of the care and
21 services furnished to individuals eligible under a
22 State plan under this title except the following:

23 “(A) Nursing facility services (as defined
24 in section 1905(f)).

1 “(B) Intermediate care facility for the
2 mentally retarded services (as defined in section
3 1905(d)).

4 “(C) Personal care services (as described
5 in section 1905(a)(24)).

6 “(D) Private duty nursing services (as re-
7 ferred to in section 1905(a)(8)).

8 “(E) Home or community-based services
9 furnished under a waiver granted under sub-
10 section (c), (d), or (e) of section 1915.

11 “(F) Home and community care furnished
12 to functionally disabled elderly individuals
13 under section 1929.

14 “(G) Community supported living arrange-
15 ments services under section 1930.

16 “(H) Case-management services (as de-
17 scribed in section 1915(g)(2)).

18 “(I) Home health care services (as referred
19 to in section 1905(a)(7)).

20 “(J) Hospice care (as defined in section
21 1905(o)).

22 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
23 individual’ means an individual who is eligible to re-
24 ceive medical assistance under the State plan under
25 this title.

1 “(3) FEDERAL FUNDS.—The term ‘Federal
2 funds’ means funds paid to a State under section
3 1903, excluding funds paid under such section with
4 respect to expenditures by such State in the form of
5 payment adjustments made by such State in order
6 to comply with the requirement under section
7 1902(a)(13)(A) (as in effect on the date of the en-
8 actment of this section) that payments to hospitals
9 to take into account the situation of hospitals which
10 serve a disproportionate number of low income pa-
11 tients with special needs.

12 “(4) STATE EXPENDITURES.—The term ‘State
13 expenditures’ means expenditures by a State under
14 its plan under this title, excluding expenditures in
15 the form of payment adjustments made by such
16 State in order to comply with the requirement under
17 section 1902(a)(13)(A) (as in effect on the date of
18 the enactment of this section) that payments made
19 by the State to hospitals take into account the situa-
20 tion of hospitals which serve a disproportionate
21 number of low income patients with special needs.”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall be effective with respect to fiscal years
24 beginning after September 30, 1994.

1 **SEC. 212. WAIVERS FOR THE FURNISHING OF ACUTE MEDI-**
2 **CAL SERVICES UNDER THE MEDICAID PRO-**
3 **GRAM.**

4 (a) IN GENERAL.—Title XIX of the Social Security
5 Act (42 U.S.C. 1396 et seq.) is amended by redesignating
6 section 1932 as section 1933 and by inserting after section
7 1931 the following new section:

8 “WAIVERS FOR THE FURNISHING OF ACUTE MEDICAL
9 SERVICES UNDER THE MEDICAID PROGRAM

10 “SEC. 1932. (a) IN GENERAL.—The Secretary shall
11 establish a process under which a State with a State plan
12 approved under this title may apply for waivers of any
13 of the requirements under this title in order to establish
14 innovative and cost effective programs for furnishing acute
15 medical services (as defined in section 1931(d)(1)) to eligi-
16 ble individuals (as defined in section 1931(d)(2)).

17 “(b) APPLICATION FOR WAIVERS.—

18 “(1) IN GENERAL.—In order to receive a waiver
19 under subsection (a), a State shall submit an appli-
20 cation to the Secretary at such time and containing
21 such information as the Secretary determines appro-
22 priate.

23 “(2) APPROVAL OF APPLICATION.—

24 “(A) INITIAL REVIEW.—Within 60 days
25 after an application is submitted by the State
26 under this subsection, the Secretary shall review

1 and approve such application or provide the
2 State with a list of the modifications that are
3 necessary for such application to be approved.

4 “(B) ADDITIONAL REVIEW.—Within 60
5 days after a State resubmits any application
6 under this subsection, the Secretary shall review
7 and approve such application or provide the
8 State with a summary of which items included
9 on the list provided to the State under subpara-
10 graph (A) remain unsatisfied. A State may re-
11 submit an application under this subparagraph
12 as many times as necessary to gain approval.

13 “(c) DURATION OF WAIVERS.—Except as provided in
14 subsection (d), any waiver under this section shall be
15 granted for a period of 5 years, and renewed for subse-
16 quent 5-year periods, unless the Secretary determines that
17 the State has failed to furnish acute medical services in
18 accordance with the terms of the waiver and any provi-
19 sions of this title with respect to which the Secretary has
20 not granted a waiver.

21 “(d) TERMINATION OF WAIVERS.—The Secretary
22 may terminate a waiver granted under this section at any
23 time if the Secretary determines that the State has failed
24 to furnish acute medical services in accordance with the

1 terms of the waiver and any provisions of this title with
2 respect to which the Secretary has not granted a waiver.

3 “(e) REPORTS.—

4 “(1) IN GENERAL.—The State shall, through
5 an independent entity, evaluate the programs oper-
6 ated under a waiver granted under this section and
7 submit interim and final reports to the Secretary at
8 such times and containing such information as the
9 Secretary shall require.

10 “(2) REPORT TO CONGRESS.—Not later than
11 60 days after the receipt of a final report by the
12 State regarding a waiver granted under this section,
13 the Secretary shall submit a report to Congress.”.

14 (b) EFFECTIVE DATE.—The amendment made by
15 subsection (a) shall be effective with respect to fiscal years
16 beginning after September 30, 1994.

17 **SEC. 213. TERMINATION OF DISPROPORTIONATE SHARE**
18 **PAYMENTS.**

19 (a) IN GENERAL.—

20 (1) ELIMINATION OF STATE PLAN REQUIRE-
21 MENT.—Section 1902(a)(13) of the Social Security
22 Act (42 U.S.C. 1396a(a)(13)) is amended by strik-
23 ing “which, in the case of hospitals, take into ac-
24 count the situation of hospitals which serve a dis-

1 proportionate number of low income patients with
2 special needs and”.

3 (2) CONFORMING AMENDMENTS.—(A) Section
4 1923 of such Act (42 U.S.C. 1396r-4) is repealed.

5 (B) Section 1902(a)(55) of such Act (42 U.S.C.
6 1396a(a)(55)) is amended by striking “facilities de-
7 fined as disproportionate share hospitals under sec-
8 tion 1923(a)(1)(A) and”.

9 (C) Section 1902(s) of such Act (42 U.S.C.
10 1396a(s)) is amended by striking “, and to children
11 who have not attained the age of 6 years and who
12 receive such services in a disproportionate share hos-
13 pital described in section 1923(b)(1),”.

14 (D) Section 1903(a)(1) of such Act (42 U.S.C.
15 1396b(a)(1)) is amended by striking “and sub-
16 section 1923(f)”.

17 (E) Section 1903(d)(6) of such Act (42 U.S.C.
18 1396b(d)(6)) is amended—

19 (i) by striking “(6)(A)” and inserting
20 “(6)”,

21 (ii) by striking “(i)” and “(ii)” and insert-
22 ing “(A)” and “(B)”, respectively, and

23 (iii) by striking subparagraph (B).

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall be effective on and after October 1,
3 1996.

4 **SEC. 214. GRANTS FOR HEALTH INSURANCE COVERAGE,**
5 **ACUTE MEDICAL SERVICES, PREVENTIVE**
6 **CARE, AND DISEASE PREVENTION.**

7 (a) IN GENERAL.—Title XIX of the Social Security
8 Act (42 U.S.C. 1396 et seq.) is amended by redesignating
9 section 1933 as section 1934 and by inserting after section
10 1932 the following new section:

11 “GRANTS FOR HEALTH INSURANCE COVERAGE, ACUTE
12 MEDICAL SERVICES, PREVENTIVE CARE, AND DIS-
13 EASE PREVENTION

14 “SEC. 1933. (a) IN GENERAL.—The Secretary shall
15 provide grants to States for the purpose of conducting
16 State programs under which individuals with incomes
17 below 150 percent of the income official poverty line are
18 provided health insurance coverage, acute medical serv-
19 ices, preventive care, and disease prevention services. A
20 State receiving a grant under this section shall conduct
21 a program described in this section in consultation with
22 the Secretary and in any manner determined appropriate
23 by the State which is in accordance with subsection (b).

24 “(b) REQUIREMENTS ON PROGRAMS.—

1 “(1) PRIORITY OF BENEFITS.—A State pro-
2 gram conducted under this section shall give priority
3 to individuals who—

4 “(A) are ineligible for benefits under a
5 State plan under title XIX of the Social Secu-
6 rity Act,

7 “(B) are eligible for the tax credit estab-
8 lished under section 34A of the Internal Reve-
9 nue Code of 1986, and

10 “(C) has unreimbursed expenses for health
11 insurance coverage and medical care—

12 “(i) exceeding 5 percent of the indi-
13 vidual’s adjusted gross income, and

14 “(ii) not otherwise taken into account
15 in determining the credit under section
16 34A of the Internal Revenue Code of 1986
17 for such individual.

18 “(2) SERVICES.—

19 “(A) MANDATORY.—A State program con-
20 ducted under this section shall provide financial
21 assistance as determined by the State for pur-
22 chasing health insurance coverage and paying
23 medical bills to individuals described in para-
24 graph (1).

1 “(B) OPTIONAL.—A State program con-
2 ducted under this section may provide—

3 “(i) medical services directly to eligi-
4 ble individuals,

5 “(ii) primary and preventive care serv-
6 ices to underserved populations,

7 “(iii) funding for community and mi-
8 grant health centers,

9 “(iv) delivery of outpatient primary
10 and preventive health services,

11 “(v) improvements to the availability
12 and quality of emergency medical services
13 and trauma care,

14 “(vi) transportation of victims of med-
15 ical emergencies, including air transpor-
16 tation for victims of medical emergencies
17 in rural areas, and

18 “(vii) telecommunications systems be-
19 tween rural medical facilities and other
20 medical facilities which have expertise in
21 certain areas or equipment that can be uti-
22 lized by rural facilities through such sys-
23 tems.

24 “(c) FEDERAL FUNDS AVAILABLE FOR GRANTS.—

1 “(1) IN GENERAL.—The total amount of Fed-
2 eral funds available under this title for grants to
3 States under this section shall be—

4 “(A) \$14,200,000,000 for fiscal year 1997,

5 “(B) \$15,800,000,000 for fiscal year 1998,

6 “(C) \$17,400,000,000 for fiscal year 1999,

7 “(D) \$20,000,000,000 for fiscal year
8 2000, and

9 “(E) for each fiscal year thereafter, the
10 amount for the preceding fiscal year increased
11 by 7.5 percent of such amount.

12 “(2) FORMULA FOR DISTRIBUTION OF
13 GRANTS.—

14 “(A) IN GENERAL.—The Secretary shall
15 pay to each State conducting a program under
16 this section for a fiscal year an amount equal
17 to the State’s percentage (as determined under
18 subparagraph (B)) of the total amount available
19 for grants under this section as provided in
20 paragraph (1).

21 “(B) STATE PERCENTAGE.—

22 “(i) IN GENERAL.—A State’s percent-
23 age determined under this subparagraph
24 for a fiscal year is a percentage equal to
25 the quotient of—

1 “(I) the number of individuals in
2 the State’s needy population (as de-
3 fined in clause (ii)) for such fiscal
4 year, divided by

5 “(II) the total number of individ-
6 uals in the needy populations of all
7 States for the fiscal year.

8 “(ii) STATE NEEDY POPULATION.—
9 The term “State’s needy population”
10 means, with respect to a fiscal year, the
11 number of individuals equal to the product
12 of—

13 “(I) the average number of indi-
14 viduals in the State with incomes
15 below the income official poverty line
16 during the 3 preceding fiscal years (as
17 determined by the Secretary), and

18 (II) the State’s Federal percent-
19 age (as determined under clause (iii)).

20 “(iii) STATE FEDERAL PERCENT-
21 AGE.—

22 “(I) IN GENERAL.—A State’s
23 Federal percentage for a fiscal year is
24 the greater of—

1 “(aa) 1 minus the percent-
2 age determined under subclause
3 (II), or

4 “(bb) 40 percent.

5 “(II) PERCENTAGE DETER-
6 MINED.—The percentage determined
7 under this subclause is the product
8 of—

9 “(aa) .40, and

10 “(bb) the product of the
11 amount determined under
12 subclause (III) multiplied by it-
13 self.

14 “(III) AMOUNT DETERMINED.—
15 The amount determined under this
16 subclause is the quotient of—

17 “(aa) the State’s share of
18 total taxable resources, divided
19 by

20 “(bb) the State’s share of
21 need.

22 “(d) STATE EXPENDITURES.—

23 “(1) IN GENERAL.—For a fiscal year, a State
24 shall expend for purposes of conducting the State

1 program described in subsection (a) an amount at
2 least equal to—

3 “(A) for fiscal year 1997, the base year
4 DSH payment for the State (as defined in
5 paragraph (2)) updated by the percentage
6 change in the consumer price index between fis-
7 cal year 1996 and fiscal year 1995 (as deter-
8 mined by the Secretary of Commerce), and

9 “(B) for fiscal year 1998 and each suc-
10 ceeding fiscal year, an amount equal to the
11 amount determined under this clause for the
12 first preceding fiscal year updated by the per-
13 centage change in the consumer price index be-
14 tween such first preceding fiscal year and the
15 second preceding fiscal year (as determined by
16 the Secretary of Commerce).

17 “(2) BASE YEAR DSH PAYMENT.—For purposes
18 of paragraph (1), the term ‘base year DSH pay-
19 ment’ means the amount of expenditures made by
20 the State in fiscal year 1996 in the form of payment
21 adjustments in order to comply with the requirement
22 under section 1902(a)(13)(A) (as in effect on the
23 date of the enactment of this section) that payments
24 made by the State to hospitals take into account the

1 situation of hospitals which serve a disproportionate
2 number of low income patients with special needs.

3 “(e) OTHER DEFINITIONS.—

4 “(1) INCOME OFFICIAL POVERTY LINE.—For
5 purposes of this section, the term ‘income official
6 poverty line’ means the income official poverty line
7 (as defined by the Office of Management and Budget,
8 and revised annually in accordance with section
9 673(2) of the Omnibus Budget Reconciliation Act of
10 1981).

11 “(2) STATE’S SHARE OF TOTAL TAXABLE RE-
12 SOURCES.—

13 “(A) IN GENERAL.—Except as provided in
14 subparagraph (B), the term ‘State share of
15 total taxable resources’ for a fiscal year means
16 an amount equal to the quotient of—

17 “(i) the average of total taxable re-
18 sources for the State (as determined by the
19 Secretary of the Treasury based on data
20 available for the 3 most recent calendar
21 years), divided by

22 “(ii) the average of the total taxable
23 resources for all States (as determined by
24 the Secretary of the Treasury based on

1 data available for the 3 most recent cal-
2 endar years).

3 “(B) SPECIAL RULE FOR THE DISTRICT OF
4 COLUMBIA.—Notwithstanding subparagraph
5 (A), with respect to the District of Columbia,
6 the term ‘State share of total taxable resources’
7 for a fiscal year means an amount equal to the
8 quotient of—

9 “(i) the average of the total personal
10 income in such District for the 3 preceding
11 calendar years (as determined by the Sec-
12 retary of Commerce), divided by

13 “(ii) the average of the total personal
14 income for all States for the 3 preceding
15 calendar years (as determined by the Sec-
16 retary of Commerce).

17 “(3) STATE’S SHARE OF NEED.—The term
18 ‘State’s share of need’ for a fiscal year means the
19 quotient of—

20 “(A) the average number of individuals in
21 the State with incomes below the income official
22 poverty line for the 3 preceding fiscal years (as
23 determined by the Secretary), divided by

24 “(B) the average number of individuals in
25 all States with incomes below the income offi-

1 cial poverty line for the 3 preceding fiscal years
2 (as determined by the Secretary).”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall be effective with respect to fiscal years
5 beginning after September 30, 1996.

6 **TITLE III—HEALTH CARE**
7 **LIABILITY REFORM**

8 **SEC. 301. SHORT TITLE.**

9 This title may be cited as the “Health Care Liability
10 Reform Act of 1993”.

11 **SEC. 302. DEFINITIONS.**

12 For purposes of this title the term—

13 (1) “approved by the Food and Drug Adminis-
14 tration” means, with respect to a health care prod-
15 uct, that the health care product—

16 (A) was subject to premarket approval by
17 the Food and Drug Administration with respect
18 to the safety of the formulation or performance
19 of the aspect of such drug or device which
20 caused the claimant’s harm or the adequacy of
21 the packaging or labeling of such drug or de-
22 vice, and such drug or device was approved by
23 the Food and Drug Administration; or

24 (B) is generally recognized as safe and ef-
25 fective under conditions established by the Food

1 and Drug Administration and applicable regula-
2 tions, including packaging and labeling regula-
3 tions;

4 (2) “arbitration” means a dispute resolution
5 process in which the parties submit the dispute out-
6 side of a Federal or State civil justice system for
7 resolution by a person or panel of persons;

8 (3) “economic losses” means losses for hospital
9 and medical expenses, lost wages, lost employment,
10 and other pecuniary losses;

11 (4) “health care malpractice action” means a
12 civil action alleging a health care malpractice claim
13 against a health care provider or health care profes-
14 sional;

15 (5) “health care malpractice claim” means any
16 claim relating to the provision of (or the failure to
17 provide) health care services based on negligence or
18 gross negligence, breach of express or implied war-
19 ranty or contract, or failure to discharge a duty to
20 warn or instruct to obtain consent;

21 (6) “health care product” means a drug, as de-
22 fined under section 201(g)(1) of the Federal Food,
23 Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a
24 medical device, as defined under section 201(h) of

1 the Federal Food, Drug, and Cosmetic Act (21
2 U.S.C. 321(h)), or any combination thereof;

3 (7) “health care product liability action” means
4 a civil action alleging a health care product liability
5 claim against a manufacturer or seller of a health
6 care product or against a health care provider or
7 health care professional;

8 (8) “health care product liability claim” means
9 any claim relating to harm alleged to have been
10 caused by a health care product;

11 (9) “health care professional” means any indi-
12 vidual who provides health care services in a State
13 and who is required by State law or regulation to be
14 licensed or certified by the State to provide such
15 services in the State, including a physician, nurse,
16 chiropractor, nurse midwife, physical therapist, so-
17 cial worker, or physician assistant;

18 (10) “health care provider” means any organi-
19 zation or institution that is engaged in the delivery
20 of health care services in a State and that is re-
21 quired by State law or regulation to be licensed or
22 certified by the State to engage in the delivery of
23 such services in the State;

1 (11) “injury” means any injury, illness, disease,
2 or other harm that is the subject of a health care
3 malpractice claim; and

4 (12) “noneconomic losses” means losses for
5 physical and emotional pain, suffering, inconven-
6 ience, physical impairment, mental anguish, dis-
7 figurement, loss of enjoyment of life, and other
8 nonpecuniary losses.

9 **SEC. 303. HEALTH CARE MALPRACTICE.**

10 (a) APPLICATION.—The provisions of this section
11 shall apply to any health care malpractice action filed in
12 any Federal or State court and any health care mal-
13 practice claim resolved through arbitration.

14 (b) PAYMENTS.—No person may be required to pay
15 more than \$100,000 in a single payment in damages for
16 expenses to be incurred in the future, but such person
17 shall be permitted to make such payments on a periodic
18 basis. The periods for such payments shall be determined
19 by the court, based on projections of when expenses are
20 likely to be incurred.

21 (c) DAMAGES.—(1) The total amount of damages re-
22 ceived by an individual shall be reduced, in accordance
23 with paragraph (2), by any other payment which has been
24 made or which will be made to such individual to com-

1 pensate such individual for an injury, including payments
2 under—

3 (A) Federal or State disability or sickness pro-
4 grams;

5 (B) Federal, State, or private health insurance
6 programs;

7 (C) private disability insurance programs;

8 (D) employer wage continuation programs; and

9 (E) any other source of payment intended to
10 compensate such individual for such injury.

11 (2) The amount by which an award of damages to
12 an individual for an injury shall be reduced under para-
13 graph (1) shall be—

14 (A) the total amount of any payments (other
15 than such award) which have been made or which
16 will be made to such individual to compensate such
17 individual for such injury; minus

18 (B) the amount paid by such individual (or by
19 the spouse, parent, or legal guardian of such individ-
20 ual) to secure the payments described under sub-
21 paragraph (A).

22 (d) STATUTE OF LIMITATIONS.—(1) Except as pro-
23 vided under paragraph (2), no health care malpractice
24 claim may be initiated after the expiration of the 2-year
25 period that begins on the date the alleged injury should

1 reasonably have been discovered, or the expiration of the
2 4-year period that begins on the date the alleged injury
3 occurred, whichever is later.

4 (2) In the case of an alleged injury suffered by a
5 minor who has not attained 6 years of age, no health care
6 malpractice claim may be initiated after the expiration of
7 the 2-year period that begins on the date the alleged injury
8 should reasonably have been discovered, or the date on
9 which the minor attains 10 years of age, whichever is
10 later.

11 (e) ATTORNEYS' FEES.—With respect to any health
12 care malpractice action or any health care malpractice
13 claim, attorneys' fees may not exceed

14 (1) 40 percent of the first \$50,000 of any
15 award or settlement under such action or claim;

16 (2) 33 $\frac{1}{3}$ percent of the next \$50,000 of any
17 award or settlement under such action or claim;

18 (3) 25 percent of the next \$500,000 of any
19 award or settlement under such action or claim; and

20 (4) 15 percent of any additional amounts.

21 **SEC. 304. HEALTH CARE PRODUCT LIABILITY OF MANUFAC-**
22 **TURER OR SELLER.**

23 (a) NONAPPLICATION OF STRICT LIABILITY.—A
24 manufacturer or seller of a health care product approved

1 by the Food and Drug Administration shall not be strictly
2 liable for any injury alleged to have resulted from—

3 (1) a defect in the design of the health care
4 product; or

5 (2) a failure to warn or instruct regarding a
6 risk posed by the health care product that was nei-
7 ther known nor reasonably knowable at the time the
8 health care product left the control of the manufac-
9 turer or seller.

10 (b) DUTY TO WARN.—(1) A manufacturer or seller
11 of a health care product that is to be prescribed by, or
12 used at the direction of, a health care professional shall
13 not be liable for harm allegedly caused by a failure to warn
14 or instruct the ultimate user or recipient of the product
15 about a risk if the manufacturer or seller provided ade-
16 quate warning or instruction to the user's or recipient's
17 health care professional.

18 (2) This subsection shall not apply to any health care
19 product to which the Food and Drug Administration spe-
20 cifically provides that a warning or instruction regarding
21 such product shall be given by the manufacturer or seller
22 directly to the ultimate user or recipient.

1 **SEC. 305. GENERAL PROVISIONS RELATING TO HEALTH**
2 **CARE LIABILITY.**

3 (a) LIMITATION ON NONECONOMIC DAMAGES.—(1)
4 Except as provided under paragraph (2), the total amount
5 of damages which may be awarded to an individual and
6 the family members of such individual for noneconomic
7 losses resulting from an injury which is the subject of a
8 health care malpractice claim or a health care product li-
9 ability claim may not exceed \$250,000, regardless of the
10 number of defendants against whom the claim is brought,
11 the number of claims brought with respect to the injury,
12 or the number of actions brought with respect to the in-
13 jury.

14 (2)(A) In any jury trial, the jury shall not be in-
15 formed of the limitation established under paragraph (1).
16 If the jury awards an amount for noneconomic damages
17 that exceeds \$250,000, the court shall reduce the award
18 to \$250,000 unless the court finds that special cir-
19 cumstances (such as egregious injury) would make such
20 reduction unjust.

21 (B) In any case in which the court finds a reduction
22 under subparagraph (A) would be unjust, the court may—

23 (i) decline to reduce such award; or

24 (ii) reduce such award by a lesser amount than
25 provided for under subparagraph (A).

1 (b) SEVERAL LIABILITY FOR NONECONOMIC LOSS.—

2 (1) In any health care malpractice action or health care
3 product liability action the liability of each defendant for
4 noneconomic loss and for punitive damages shall be sev-
5 eral only and shall not be joint. Each defendant shall be
6 liable only for the amount of noneconomic loss and puni-
7 tive damages allocated to such defendant in direct propor-
8 tion to such defendant's percentage of responsibility as de-
9 termined under paragraph (2). A separate judgment shall
10 be rendered against such defendant for that amount.

11 (2) For purposes of this subsection, the trier of fact
12 shall determine the proportion of responsibility of each
13 party for the claimant's harm.

14 **SEC. 306. PUNITIVE DAMAGES.**

15 (a) IN GENERAL.—Punitive damages may, if other-
16 wise permitted by applicable law, be awarded against a
17 defendant in a health care malpractice action or a health
18 care product liability action only if the claimant estab-
19 lishes by clear and convincing evidence that the harm suf-
20 fered by the claimant was the result of conduct manifest-
21 ing conscious, flagrant indifference to the health of the
22 claimant or to the health of those persons who might be
23 harmed by the health care product.

24 (b) DETERMINATION OF AMOUNT.—The amount of
25 any punitive damages award shall be determined (subject

1 to appellate review as permitted by applicable law) by the
2 trial judge.

3 (c) LIMITATION CONCERNING CERTAIN HEALTH
4 CARE PRODUCTS.—Punitive damages shall not be award-
5 ed against a manufacturer or seller of a health care prod-
6 uct approved by the Food and Drug Administration where
7 that health care product caused the claimant’s harm.

8 **SEC. 307. EXCEPTIONS.**

9 The provisions of sections 304(a) and 306(c) shall
10 not apply in any case in which—

11 (1) the defendant, before or after premarket ap-
12 proval of a drug or device, withheld from or mis-
13 represented to the Food and Drug Administration or
14 any other agency or official of the Federal Govern-
15 ment required information that is material and rel-
16 evant to the performance of such drug or device and
17 is causally related to the harm which the claimant
18 allegedly suffered; or

19 (2) the defendant made an illegal payment to
20 an official of the Food and Drug Administration for
21 the purpose of either securing or maintaining ap-
22 proval of such drug or device.

23 **SEC. 308. RULES OF CONSTRUCTION.**

24 Nothing in this title shall be construed to—

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

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

6 (3) affect the applicability of any provision of
7 the Foreign Sovereign Immunities Act of 1976;

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

11 (5) affect the right of any court to transfer
12 venue or to apply the law of a foreign nation or to
13 dismiss a claim of a foreign nation or of a citizen
14 of a foreign nation on the grounds of inconvenient
15 forum;

16 (6) restrict or limit the preemptive effect of any
17 other Federal law; or

18 (7) create any cause of action under Federal
19 law.

1 **TITLE IV—ADMINISTRATIVE**
2 **COST SAVINGS**
3 **Subtitle A—Standardization of**
4 **Claims Processing**

5 **SEC. 401. ADOPTION OF DATA ELEMENTS, UNIFORM**
6 **CLAIMS, AND UNIFORM ELECTRONIC TRANS-**
7 **MISSION STANDARDS.**

8 (a) IN GENERAL.—The Secretary shall adopt stand-
9 ards relating to each of the following:

10 (1) Data elements for use in paper and elec-
11 tronic claims processing under health insurance
12 plans, as well as for use in utilization review and
13 management of care (including data fields, formats,
14 and medical nomenclature, and including plan bene-
15 fit and insurance information).

16 (2) Uniform claims forms (including uniform
17 procedure and billing codes for uses with such forms
18 and including information on other health insurance
19 plans that may be liable for benefits).

20 (3) Uniform electronic transmission of the data
21 elements (for purposes of billing and utilization re-
22 view).

23 Standards under paragraph (3) relating to electronic
24 transmission of data elements for claims for services shall
25 supersede (to the extent specified in such standards) the

1 standards adopted under paragraph (2) relating to the
2 submission of paper claims for such services. Standards
3 under paragraph (3) shall include protections to assure
4 the confidentiality of patient-specific information and to
5 protect against the unauthorized use and disclosure of in-
6 formation.

7 (b) USE OF TASK FORCES.—In adopting standards
8 under this section—

9 (1) the Secretary shall take into account the
10 recommendations of current task forces, including at
11 least the Workgroup on Electronic Data Inter-
12 change, National Uniform Billing Committee, the
13 Uniform Claim Task Force, and the Computer-based
14 Patient Record Institute;

15 (2) the Secretary shall consult with the Na-
16 tional Association of Insurance Commissioners (and,
17 with respect to standards under subsection (a)(3),
18 the American National Standards Institute); and

19 (3) the Secretary shall, to the maximum extent
20 practicable, seek to make the standards consistent
21 with any uniform clinical data sets which have been
22 adopted and are widely recognized.

23 (c) DEADLINES FOR PROMULGATION.—The Sec-
24 retary shall promulgate the standards under—

1 (1) subsection (a)(1) relating to claims process-
2 ing data, by not later than 12 months after the date
3 of the enactment of this Act;

4 (2) subsection (a)(2) (relating to uniform
5 claims forms) by not later than 12 months after the
6 date of the enactment of this Act; and

7 (3)(A) subsection (a)(3) relating to trans-
8 mission of information concerning hospital and phy-
9 sicians services, by not later than 24 months after
10 the date of the enactment of this Act, and

11 (B) subsection (a)(3) relating to transmission
12 of information on other services, by such later date
13 as the Secretary may determine it to be feasible.

14 (d) REPORT TO CONGRESS.—Not later than 3 years
15 after the date of the enactment of this Act, the Secretary
16 shall report to Congress recommendations regarding re-
17 structuring the medicare peer review quality assurance
18 program given the availability of hospital data in elec-
19 tronic form.

20 **SEC. 402. APPLICATION OF STANDARDS.**

21 (a) IN GENERAL.—If the Secretary determines, at
22 the end of the 2-year period beginning on the date that
23 standards are adopted under section 401 with respect to
24 classes of services, that a significant number of claims for
25 benefits for such services under health insurance plans are

1 not being submitted in accordance with such standards,
2 the Secretary may require, after notice in the Federal
3 Register of not less than 6 months, that all providers of
4 such services must submit claims to health insurance plans
5 in accordance with such standards. The Secretary may
6 waive the application of such a requirement in such cases
7 as the Secretary finds that the imposition of the require-
8 ment would not be economically practicable.

9 (b) SIGNIFICANT NUMBER.—The Secretary shall
10 make an affirmative determination described in subsection
11 (a) for a class of services only if the Secretary finds that
12 there would be a significant, measurable additional gain
13 in efficiencies in the health care system that would be ob-
14 tained by imposing the requirement described in such
15 paragraph with respect to such services.

16 (c) APPLICATION OF REQUIREMENT.—

17 (1) IN GENERAL.—If the Secretary imposes the
18 requirement under subsection (a)—

19 (A) in the case of a requirement that im-
20 poses the standards relating to electronic trans-
21 mission of claims for a class of services, each
22 health care provider that furnishes such services
23 for which benefits are payable under a health
24 insurance plan shall transmit electronically and
25 directly to the plan on behalf of the beneficiary

1 involved a claim for such services in accordance
2 with such standards;

3 (B) any health insurance plan may reject
4 any claim subject to the standards adopted
5 under section 401 but which is not submitted in
6 accordance with such standards;

7 (C) it is unlawful for a health insurance
8 plan (i) to reject any such claim on the basis
9 of the form in which it is submitted if it is sub-
10 mitted in accordance with such standards or (ii)
11 to require, for the purpose of utilization review
12 or as a condition of providing benefits under
13 the plan, a provider to transmit medical data
14 elements that are inconsistent with the stand-
15 ards established under section 401(a)(1); and

16 (D) the Secretary may impose a civil
17 money penalty on any provider that knowingly
18 and repeatedly submits claims in violation of
19 such standards or on any health insurance plan
20 (other than a health insurance plan described in
21 paragraph (2)) that knowingly and repeatedly
22 rejects claims in violation of subparagraph (B),
23 in an amount not to exceed \$100 for each such
24 claim.

1 The provisions of section 1128A of the Social Secu-
2 rity Act (other than the first sentence of subsection
3 (a) and other than subsection (b)) shall apply to a
4 civil money penalty under subparagraph (D) in the
5 same manner as such provisions apply to a penalty
6 or proceeding under section 1128A(a) of such Act.

7 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
8 ULATION.—A plan described in this paragraph is a
9 health insurance plan—

10 (A) that is subject to regulation by a
11 State, and

12 (B) with respect to which the Secretary
13 finds that—

14 (i) the State provides for application
15 of the standards established under section
16 401, and

17 (ii) the State regulatory program pro-
18 vides for the appropriate and effective en-
19 forcement of such standards.

20 (d) TREATMENT OF REJECTIONS.—If a plan rejects
21 a claim pursuant to subsection (c)(1), the plan shall per-
22 mit the person submitting the claim a reasonable oppor-
23 tunity to resubmit the claim on a form or in an electronic
24 manner that meets the requirements for acceptance of the
25 claim under such subsection.

1 **SEC. 403. PERIODIC REVIEW AND REVISION OF STAND-**
2 **ARDS.**

3 (a) IN GENERAL.—The Secretary shall—

4 (1) provide for the ongoing receipt and review
5 of comments and suggestions for changes in the
6 standards adopted and promulgated under section
7 401;

8 (2) establish a schedule for the periodic review
9 of such standards; and

10 (3) based upon such comments, suggestions,
11 and review, revise such standards and promulgate
12 such revisions.

13 (b) APPLICATION OF REVISED STANDARDS.—If the
14 Secretary under subsection (a) revises the standards de-
15 scribed in 401, then, in the case of any claim for benefits
16 submitted under a health insurance plan more than the
17 minimum period (of not less than 6 months specified by
18 the Secretary) after the date the revision is promulgated
19 under subsection (a)(3), such standards shall apply under
20 section 402 instead of the standards previously promul-
21 gated.

22 **SEC. 404. HEALTH INSURANCE PLAN DEFINED.**

23 In this title, the term “health insurance plan” has
24 the meaning given such term in section 111(b) and in-
25 cludes—

1 (1) the medicare program (under title XVIII of
2 the Social Security Act) and medicare supplemental
3 health insurance, and

4 (2) a State medicaid plan (approved under title
5 XIX of such Act).

6 **Subtitle B—Electronic Medical**
7 **Data Standards**

8 **SEC. 411. MEDICAL DATA STANDARDS FOR HOSPITALS AND**
9 **OTHER PROVIDERS.**

10 (a) PROMULGATION OF HOSPITAL DATA STAND-
11 ARDS.—

12 (1) IN GENERAL.—Between July 1, 1995, and
13 January 1, 1996, the Secretary shall promulgate
14 standards described in subsection (b) for hospitals
15 concerning electronic medical data.

16 (2) REVISION.—The Secretary may from time
17 to time revise the standards promulgated under this
18 subsection.

19 (b) CONTENTS OF DATA STANDARDS.—The stand-
20 ards promulgated under subsection (a) shall include at
21 least the following:

22 (1) A definition of a standard set of data ele-
23 ments for use by utilization and quality control peer
24 review organizations.

1 (2) A definition of the set of comprehensive
2 data elements, which set shall include for hospitals
3 the standard set of data elements defined under
4 paragraph (1).

5 (3) Standards for an electronic patient care in-
6 formation system with data obtained at the point of
7 care, including standards to protect against the un-
8 authorized use and disclosure of information.

9 (4) A specification of, and manner of presen-
10 tation of, the individual data elements of the sets
11 and system under this subsection.

12 (5) Standards concerning the transmission of
13 electronic medical data.

14 (6) Standards relating to confidentiality of pa-
15 tient-specific information.

16 The standards under this section shall be consistent with
17 standards for data elements established under section 401.

18 (c) OPTIONAL DATA STANDARDS FOR OTHER PRO-
19 VIDERS.—

20 (1) IN GENERAL.—The Secretary may promul-
21 gate standards described in paragraph (2) concern-
22 ing electronic medical data for providers that are not
23 hospitals. The Secretary may from time to time re-
24 vise the standards promulgated under this sub-
25 section.

1 (2) CONTENTS OF DATA STANDARDS.—The
2 standards promulgated under paragraph (1) for non-
3 hospital providers may include standards comparable
4 to the standards described in paragraphs (2), (4),
5 and (5) of subsection (b) for hospitals.

6 (d) CONSULTATION.—In promulgating and revising
7 standards under this section, the Secretary shall—

8 (1) consult with the American National Stand-
9 ards Institute, hospitals, with the advisory commis-
10 sion established under section 415, and with other
11 affected providers, health insurance plans, and other
12 interested parties, and

13 (2) take into consideration, in developing stand-
14 ards under subsection (b)(1), the data set used by
15 the utilization and quality control peer review pro-
16 gram under part B of title XI of the Social Security
17 Act.

18 **SEC. 412. APPLICATION OF ELECTRONIC DATA STANDARDS**

19 **TO CERTAIN HOSPITALS.**

20 (a) MEDICARE REQUIREMENT FOR SHARING OF
21 HOSPITAL INFORMATION.—As of January 1, 1996, sub-
22 ject to paragraph (2), each hospital, as a requirement of
23 each participation agreement under section 1866 of the
24 Social Security Act, shall—

1 (1) maintain clinical data included in the set of
2 comprehensive data elements under section
3 411(b)(2) in electronic form on all inpatients,

4 (2) upon request of the Secretary or of a utili-
5 zation and quality control peer review organization
6 (with which the Secretary has entered into a con-
7 tract under part B of title XI of such Act), transmit
8 electronically the data set, and

9 (3) upon request of the Secretary, or of a fiscal
10 intermediary or carrier, transmit electronically any
11 data (with respect to a claim) from such data set,
12 in accordance with the standards promulgated under sec-
13 tion 411(a).

14 (b) WAIVER AUTHORITY.—Until January 1, 2000:

15 (1) The Secretary may waive the application of
16 the requirements of subsection (a) for a hospital
17 that is a small rural hospital, for such period as the
18 hospital demonstrates compliance with such require-
19 ments would constitute an undue financial hardship.

20 (2) The Secretary may waive the application of
21 the requirements of subsection (a) for a hospital
22 that is in the process of developing a system to pro-
23 vide the required data set and executes agreements
24 with its fiscal intermediary and its utilization and
25 quality control peer review organization that the hos-

1 pital will meet the requirements of subsection (a) by
2 a specified date (not later than January 1, 2000).

3 (3) The Secretary may waive the application of
4 the requirement of subsection (a)(1) for a hospital
5 that agrees to obtain from its records the data ele-
6 ments that are needed to meet the requirements of
7 paragraphs (2) and (3) of subsection (a) and agrees
8 to subject its data transfer process to a quality as-
9 surance program specified by the Secretary.

10 (c) APPLICATION TO HOSPITALS OF THE DEPART-
11 MENT OF VETERANS AFFAIRS.—

12 (1) IN GENERAL.—The Secretary of Veterans
13 Affairs shall provide that each hospital of the De-
14 partment of Veterans Affairs shall comply with the
15 requirements of subsection (a) in the same manner
16 as such requirements would apply to the hospital if
17 it were participating in the Medicare program.

18 (2) WAIVER.—The Secretary of Veterans Af-
19 fairs may waive the application of such requirements
20 to a hospital in the same manner as the Secretary
21 of Health and Human Services may waive under
22 subsection (b) the application of the requirements of
23 subsection (a).

1 **SEC. 413. ELECTRONIC TRANSMISSION TO FEDERAL AGEN-**
2 **CIES.**

3 (a) IN GENERAL.—Effective January 1, 2000, if a
4 provider is required under a Federal program to transmit
5 a data element that is subject to a presentation or trans-
6 mission standard (as defined in subsection (b)), the head
7 of the Federal agency responsible for such program (if not
8 otherwise authorized) is authorized to require the provider
9 to present and transmit the data element electronically in
10 accordance with such a standard.

11 (b) PRESENTATION OR TRANSMISSION STANDARD
12 DEFINED.—In subsection (a), the term “presentation or
13 transmission standard” means a standard, promulgated
14 under subsection (b) or (c) of section 411, described in
15 paragraph (4) or (5) of section 411(b).

16 **SEC. 414. LIMITATION ON DATA REQUIREMENTS WHERE**
17 **STANDARDS IN EFFECT.**

18 (a) IN GENERAL.—If standards with respect to data
19 elements are promulgated under section 411 with respect
20 to a class of provider, a health insurance plan may not
21 require, for the purpose of utilization review or as a condi-
22 tion of providing benefits under the plan, that a provider
23 in the class—

24 (1) provide any data element not in the set of
25 comprehensive data elements specified under such
26 standards, or

1 (2) transmit or present any such data element
2 in a manner inconsistent with the applicable stand-
3 ards for such transmission or presentation.

4 (b) COMPLIANCE.—

5 (1) IN GENERAL.—The Secretary may impose a
6 civil money penalty on any health insurance plan
7 (other than a health insurance plan described in
8 paragraph (2)) that fails to comply with subsection
9 (a) in an amount not to exceed \$100 for each such
10 failure. The provisions of section 1128A of the So-
11 cial Security Act (other than the first sentence of
12 subsection (a) and other than subsection (b)) shall
13 apply to a civil money penalty under this paragraph
14 in the same manner as such provisions apply to a
15 penalty or proceeding under section 1128A(a) of
16 such Act.

17 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
18 ULATION.—A plan described in this paragraph is a
19 health insurance plan that is subject to regulation by
20 a State, if the Secretary finds that—

21 (A) the State provides for application of
22 the requirement of subsection (a), and

23 (B) the State regulatory program provides
24 for the appropriate and effective enforcement of
25 such requirement with respect to such plans.

1 **SEC. 415. ADVISORY COMMISSION.**

2 (a) IN GENERAL.—The Secretary shall establish an
3 advisory commission including hospital executives, hospital
4 data base managers, physicians, health services research-
5 ers, and technical experts in collection and use of data
6 and operation of data systems. Such commission shall in-
7 clude, as ex officio members, a representative of the Direc-
8 tor of the National Institutes of Health, the Administrator
9 for Health Care Policy and Research, the Secretary of
10 Veterans Affairs, and the Director of the Centers for Dis-
11 ease Control.

12 (b) FUNCTIONS.—The advisory commission shall
13 monitor and advise the Secretary concerning—

14 (1) the standards established under this sub-
15 title, and

16 (2) operational concerns about the implementa-
17 tion of such standards under this subtitle.

18 (c) STAFF.—From the amounts appropriated under
19 subsection (d), the Secretary shall provide sufficient staff
20 to assist the advisory commission in its activities under
21 this section.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated \$2,000,000 for each of
24 fiscal years 1995 through 2000 to carry out this section.

1 **Subtitle C—Development and Dis-**
2 **tribution of Comparative Value**
3 **Information**

4 **SEC. 421. STATE COMPARATIVE VALUE INFORMATION PRO-**
5 **GRAMS FOR HEALTH CARE PURCHASING.**

6 (a) PURPOSE.—In order to assure the availability of
7 comparative value information to purchasers of health
8 care in each State, the Secretary shall determine whether
9 each State is developing and implementing a health care
10 value information program that meets the criteria and
11 schedule set forth in subsection (b).

12 (b) CRITERIA AND SCHEDULE FOR STATE PRO-
13 GRAMS.—The criteria and schedule for a State health care
14 value information program in this subsection shall be spec-
15 ified by the Secretary as follows:

16 (1) The State begins promptly after enactment
17 of this Act to develop (directly or through contrac-
18 tual or other arrangements with 1 or more States,
19 coalitions of health insurance purchasers, other enti-
20 ties, or any combination of such arrangements) in-
21 formation systems regarding comparative health val-
22 ues.

23 (2) The information contained in such systems
24 covers at least the average prices of common health
25 care services (as defined in subsection (d)) and

1 health insurance plans, and, where available, meas-
2 ures of the variability of these prices within a State
3 or other market areas.

4 (3) The information described in paragraph (2)
5 is made available within the State beginning not
6 later than 1 year after the date of the enactment of
7 this Act, and is revised as frequently as reasonably
8 necessary, but at intervals of no greater than 1 year.

9 (4) Not later than 6 years after the date of the
10 enactment of this Act the State has developed infor-
11 mation systems that provide comparative costs, qual-
12 ity, and outcomes data with respect to health insur-
13 ance plans and hospitals and made the information
14 broadly available within the relevant market areas.

15 Nothing in this section shall preclude a State from provid-
16 ing additional information, such as information on prices
17 and benefits of different health insurance plans, available.

18 (c) GRANTS TO STATES FOR THE DEVELOPMENT OF
19 STATE PROGRAMS.—

20 (1) GRANT AUTHORITY.—The Secretary may
21 make grants to each State to enable such State to
22 plan the development of its health care value infor-
23 mation program and, if necessary, to initiate the im-
24 plementation of such program. Each State seeking
25 such a grant shall submit an application therefor,

1 containing such information as the Secretary finds
2 necessary to assure that the State is likely to de-
3 velop and implement a program in accordance with
4 the criteria and schedule in subsection (b).

5 (2) OFFSET AUTHORITY.—If, at any time with-
6 in the 3-year period following the receipt by a State
7 of a grant under this subsection, the Secretary is re-
8 quired by section 422 to implement a health care in-
9 formation program in the State, the Secretary may
10 recover the amount of the grant under this sub-
11 section by offset against any other amount payable
12 to the State under the Social Security Act. The
13 amount of the offset shall be made available (from
14 the appropriation account with respect to which the
15 offset was taken) to the Secretary to carry out such
16 section.

17 (3) AUTHORIZATION OF APPROPRIATIONS.—
18 There are authorized to be appropriated such sums
19 as are necessary to make grants under this sub-
20 section, to remain available until expended.

21 (d) COMMON HEALTH CARE SERVICES DEFINED.—
22 In this section, the term “common health care services”
23 includes such procedures as the Secretary may specify and
24 any additional health care services which a State may wish
25 to include in its comparative value information program.

1 (e) STATE DEFINED.—In this title, the term “State”
2 includes the District of Columbia, Puerto Rico, the Virgin
3 Islands, Guam, and American Samoa.

4 **SEC. 422. FEDERAL IMPLEMENTATION.**

5 (a) IN GENERAL.—If the Secretary finds, at any
6 time, that a State has failed to develop or to continue to
7 implement a health care value information program in ac-
8 cordance with the criteria and schedule in section 421(b),
9 the Secretary shall take the actions necessary, directly or
10 through grants or contract, to implement a comparable
11 program in the State.

12 (b) FEES.—Fees may be charged by the Secretary
13 for the information materials provided pursuant to a pro-
14 gram under this section. Any amounts so collected shall
15 be deposited in the appropriation account from which the
16 Secretary’s costs of providing such materials were met,
17 and shall remain available for such purposes until ex-
18 pended.

19 **SEC. 423. COMPARATIVE VALUE INFORMATION CONCERN-**
20 **ING FEDERAL PROGRAMS.**

21 (a) DEVELOPMENT.—The head of each Federal agen-
22 cy with responsibility for the provision of health insurance
23 or of health care services to individuals shall promptly de-
24 velop health care value information relating to each pro-
25 gram that such head administers and covering the same

1 types of data that a State program meeting the criteria
2 of section 421(b) would provide.

3 (b) DISSEMINATION OF INFORMATION.—Such infor-
4 mation shall be made generally available to States and to
5 providers and consumers of health care services.

6 **Subtitle D—Preemption of State**
7 **Quill Pen Laws**

8 **SEC. 431. PREEMPTION OF STATE QUILL PEN LAWS.**

9 (a) IN GENERAL.—Effective January 1, 1996, no ef-
10 fect shall be given to any provision of State law that re-
11 quires medical or health insurance records (including bill-
12 ing information) to be maintained in written, rather than
13 electronic form.

14 (b) SECRETARIAL AUTHORITY.—The Secretary may
15 issue regulations to carry out subsection (a). Such regula-
16 tions may provide for such exceptions to subsection (a)
17 as the Secretary determines to be necessary to prevent
18 fraud and abuse, with respect to controlled substances,
19 and in such other cases as the Secretary deems appro-
20 priate.

1 **TITLE V—ANTI-FRAUD**
2 **Subtitle A—Criminal Prosecution**
3 **of Health Care Fraud**

4 **SEC. 501. PENALTIES FOR HEALTH CARE FRAUD.**

5 (a) IN GENERAL.—Chapter 63 of title 18, United
6 States Code, is amended by adding at the end the follow-
7 ing:

8 **“§ 1347. Health care fraud**

9 “(a) OFFENSE.—Whoever, being a health care pro-
10 vider, knowingly engages in any scheme or artifice to de-
11 fraud any person in connection with the provision of
12 health care shall be fined under this title or imprisoned
13 not more than 5 years, or both.

14 “(b) DEFINITION.—In this section, the term ‘health
15 care provider’ means—

16 “(1) a physician, nurse, dentist, therapist, phar-
17 macist, or other professional provider of health care;
18 and

19 “(2) a hospital, health maintenance organiza-
20 tion, pharmacy, laboratory, clinic, or other health
21 care facility or a provider of medical services, medi-
22 cal devices, medical equipment, or other medical sup-
23 plies.

24 (b) CLERICAL AMENDMENT.—The table of sections
25 at the beginning of chapter 63 of title 18, United States

1 Code, is amended by adding at the end the following new
2 item:

“1347. Health care fraud.”.

3 **SEC. 502. REWARDS FOR INFORMATION LEADING TO PROS-**
4 **ECUTION AND CONVICTION.**

5 Section 3059 of title 18, United States Code, is
6 amended by adding at the end the following new sub-
7 section:

8 “(c)(1) In special circumstances and in the Attorney
9 General’s sole discretion, the Attorney General may make
10 a payment of up to \$10,000 to a person who furnishes
11 information unknown to the Government relating to a pos-
12 sible prosecution under section 1101.

13 “(2) A person is not eligible for a payment under
14 paragraph (1) if—

15 “(A) the person is a current or former officer
16 or employee of a Federal or State government agen-
17 cy or instrumentality who furnishes information dis-
18 covered or gathered in the course of government em-
19 ployment;

20 “(B) the person knowingly participated in the
21 offense;

22 “(C) the information furnished by the person
23 consists of allegations or transactions that have been
24 disclosed to the public—

1 “(i) in a criminal, civil, or administrative
2 proceeding;

3 “(ii) in a congressional, administrative or
4 General Accounting Office report, hearing,
5 audit, or investigation; or

6 “(iii) by the news media, unless the person
7 is the original source of the information; or

8 “(D) when, in the judgment of the Attorney
9 General, it appears that a person whose illegal ac-
10 tivities are being prosecuted or investigated could
11 benefit from the award.

12 “(3) For the purposes of paragraph (2)(C)(iii), the
13 term ‘original source’ means a person who has direct and
14 independent knowledge of the information that is fur-
15 nished and has voluntarily provided the information to the
16 Government prior to disclosure by the news media.

17 “(4) Neither the failure of the Attorney General to
18 authorize a payment under paragraph (1) nor the amount
19 authorized shall be subject to judicial review.”.

1 **Subtitle B—Coordination of Health**
2 **Care Anti-Fraud and Abuse Ac-**
3 **tivities**

4 **SEC. 511. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD**
5 **AND ABUSE SANCTIONS TO ALL FRAUD AND**
6 **ABUSE AGAINST ANY HEALTH INSURANCE**
7 **PLAN.**

8 (a) CIVIL MONETARY PENALTIES.—Section 1128A
9 of the Social Security Act (42 U.S.C. 1320a–7a) is amend-
10 ed as follows:

11 (1) In subsection (a)(1), in the matter before
12 subparagraph (A), by inserting “or of any health in-
13 surance plan,” after “subsection (i)(1),”.

14 (2) In subsection (b)(1)(A), by inserting “or
15 under a health insurance plan” after “title XIX”.

16 (3) In subsection (f)—

17 (A) by redesignating paragraph (3) as
18 paragraph (4); and

19 (B) by inserting after paragraph (2) the
20 following new paragraph:

21 “(3) With respect to amounts recovered arising
22 out of a claim under a health insurance plan, the
23 portion of such amounts as is determined to have
24 been paid by the plan shall be repaid to the plan.”.

25 (4) In subsection (i)—

1 (A) in paragraph (2), by inserting “or
2 under a health insurance plan” before the pe-
3 riod at the end, and

4 (B) in paragraph (5), by inserting “or
5 under a health insurance plan” after “or XX”.

6 (b) CRIMES.—

7 (1) SOCIAL SECURITY ACT.—Section 1128B of
8 such Act (42 U.S.C. 1320a-7b) is amended as fol-
9 lows:

10 (A) In the heading, by adding at the end
11 the following: “OR HEALTH INSURANCE PLANS”.

12 (B) In subsection (a)(1)—

13 (i) by striking “title XVIII or” and
14 inserting “title XVIII,” and

15 (ii) by adding at the end the follow-
16 ing: “or a health insurance plan (as de-
17 fined in section 1128(i))”.

18 (C) In subsection (a)(5), by striking “title
19 XVIII or a State health care program” and in-
20 serting “title XVIII, a State health care pro-
21 gram, or a health insurance plan”.

22 (D) In the second sentence of subsection
23 (a)—

1 (i) by inserting after “title XIX” the
2 following: “or a health insurance plan”,
3 and

4 (ii) by inserting after “the State” the
5 following: “or the plan”.

6 (E) In subsection (b)(1), by striking “title
7 XVIII or a State health care program” each
8 place it appears and inserting “title XVIII, a
9 State health care program, or a health insur-
10 ance plan”.

11 (F) In subsection (b)(2), by striking “title
12 XVIII or a State health care program” each
13 place it appears and inserting “title XVIII, a
14 State health care program, or a health insur-
15 ance plan”.

16 (G) In subsection (b)(3), by striking “title
17 XVIII or a State health care program” each
18 place it appears in subparagraphs (A) and (C)
19 and inserting “title XVIII, a State health care
20 program, or a health insurance plan”.

21 (H) In subsection (d)(2)—

22 (i) by striking “title XIX,” and insert-
23 ing “title XIX or under a health insurance
24 plan,”, and

1 (ii) by striking “State plan,” and in-
2 serting “State plan or the health insurance
3 plan,”.

4 (2) TREBLE DAMAGES FOR CRIMINAL SANC-
5 TIONS.—Section 1128B of such Act (42 U.S.C.
6 1320a–7b) is amended by adding at the end the fol-
7 lowing new subsection:

8 “(f) In addition to the fines that may be imposed
9 under subsection (a), (b), or (c), any individual found to
10 have violated the provisions of any of such subsections
11 may be subject to treble damages.”.

12 (3) IDENTIFICATION OF COMMUNITY SERVICE
13 OPPORTUNITIES.—Section 1128B of such Act (42
14 U.S.C. 1320a–7b) is further amended by adding at
15 the end the following new subsection:

16 “(g) The Secretary shall—

17 “(1) in consultation with State and local health
18 care officials, identify opportunities for the satisfac-
19 tion of community service obligations that a court
20 may impose upon the conviction of an offense under
21 this section, and

22 “(2) make information concerning such oppor-
23 tunities available to Federal and State law enforce-
24 ment officers and State and local health care offi-
25 cials.”.

1 (c) HEALTH INSURANCE PLAN DEFINED.—Section
 2 1128 of such Act (42 U.S.C. 1320a-7) is amended by re-
 3 designating subsection (i) as subsection (j) and by insert-
 4 ing after subsection (h) the following new subsection:

5 “(i) HEALTH INSURANCE PLAN DEFINED.—For pur-
 6 poses of sections 1128A and 1128B, the term ‘health in-
 7 surance plan’ means a health insurance program other
 8 than the medicare program, the medicaid program, or a
 9 State health care program.”.

10 (d) CONFORMING AMENDMENT.—Section
 11 1128(b)(8)(B)(ii) of such Act (42 U.S.C. 1320a-
 12 7(b)(8)(B)(ii)) is amended by striking “1128A” and in-
 13 serting “1128A (other than a penalty arising from a
 14 health insurance plan, as defined in subsection (i))”.

15 (e) EFFECTIVE DATE.—The amendments made by
 16 this section shall take effect January 1, 1995.

17 **TITLE VI—ANTITRUST**
 18 **PROVISIONS**

19 **SEC. 601. EXEMPTION FROM ANTITRUST LAWS FOR CER-**
 20 **TAIN COMPETITIVE AND COLLABORATIVE**
 21 **ACTIVITIES.**

22 (a) EXEMPTION DESCRIBED.—An activity relating to
 23 the provision of health care services shall be exempt from
 24 the antitrust laws if—

1 (1) the activity is within one of the categories
2 of safe harbors described in section 602;

3 (2) the activity is within an additional safe har-
4 bor designated by the Attorney General under sec-
5 tion 603; or

6 (3) the activity is specified in and in compliance
7 with the terms of a certificate of review issued by
8 the Attorney General under section 604 and the ac-
9 tivity occurs—

10 (A) while the certificate is in effect, or

11 (B) in the case of a certificate issued dur-
12 ing the 2-year period beginning on the date of
13 the enactment of this Act, at any time on or
14 after the first day of the 2-year period that
15 ends on the date the certificate takes effect.

16 (b) AWARD OF ATTORNEY'S FEES AND COSTS OF
17 SUIT.—

18 (1) IN GENERAL.—If any person brings an ac-
19 tion alleging a claim under the antitrust laws and
20 the activity on which the claim is based is found by
21 the court to be exempt from such laws under sub-
22 section (a), the court shall, at the conclusion of the
23 action—

1 (A) award to a substantially prevailing
2 claimant the cost of suit attributable to such
3 claim, including a reasonable attorney's fee, or

4 (B) award to a substantially prevailing
5 party defending against such claim the cost of
6 such suit attributable to such claim, including
7 reasonable attorney's fee, if the claim, or the
8 claimant's conduct during litigation of the
9 claim, was frivolous, unreasonable, without
10 foundation, or in bad faith.

11 (2) OFFSET IN CASES OF BAD FAITH.—The
12 court may reduce an award made pursuant to para-
13 graph (1) in whole or in part by an award in favor
14 of another party for any part of the cost of suit (in-
15 cluding a reasonable attorney's fee) attributable to
16 conduct during the litigation by any prevailing party
17 that the court finds to be frivolous, unreasonable,
18 without foundation, or in bad faith.

19 **SEC. 602. SAFE HARBORS.**

20 The following activities are safe harbors for purposes
21 of section 601(a)(1):

22 (1) COMBINATIONS WITH MARKET SHARE
23 BELOW THRESHOLD.—Activities relating to health
24 care services of any combination of health care pro-
25 viders if the number of each type or specialty of pro-

1 vider in question does not exceed 20 percent of the
2 total number of such type or specialty of provider in
3 the relevant market area.

4 (2) ACTIVITIES OF MEDICAL SELF-REGULATORY
5 ENTITIES.—

6 (A) IN GENERAL.—Subject to subpara-
7 graph (B), any activity of a medical self-regu-
8 latory entity relating to standard setting or
9 standard enforcement activities that are de-
10 signed to promote the quality of health care
11 provided to patients.

12 (B) EXCEPTION.—No activity of a medical
13 self-regulatory entity may be deemed to fall
14 under the safe harbor established under this
15 paragraph if the activity is conducted for pur-
16 poses of financial gain.

17 (3) PARTICIPATION IN SURVEYS.—The partici-
18 pation of a provider of health care services in a writ-
19 ten survey of the prices of services, reimbursement
20 levels, or the compensation and benefits of employ-
21 ees and personnel, but only if—

22 (A) the survey is conducted by a third
23 party, such as a purchaser of health care serv-
24 ices, governmental entity, institution of higher
25 education, or trade association;

1 (B) the information provided by partici-
2 pants in the survey is based on prices charged,
3 reimbursements received, or compensation and
4 benefits paid prior to the third month preceding
5 the month in which the information is provided;
6 and

7 (C) if the results of the survey are dissemi-
8 nated, the results are aggregated in a manner
9 that ensures that no recipient of the results
10 may identify the prices charged, reimbursement
11 received, or compensation and benefits paid by
12 any particular provider.

13 (4) JOINT VENTURES FOR HIGH TECHNOLOGY
14 AND COSTLY EQUIPMENT AND SERVICES.—Any ac-
15 tivity of a health care cooperative venture relating to
16 the purchase, operation, or marketing of high tech-
17 nology or other expensive medical equipment, or the
18 provision of high cost or complex services, but only
19 if the number of participants in the venture does not
20 exceed the lowest number needed to support the ven-
21 ture. Other providers may be included in the ven-
22 ture, but only if such other providers could not pur-
23 chase, operate, or market such equipment or provide
24 a competing service either alone or through the for-
25 mation of a competing venture.

1 (5) HOSPITAL MERGERS.—Activities relating to
2 a merger of 2 hospitals if, during the 3-year period
3 preceding the merger, one of the hospitals had an
4 average of 150 or fewer operational beds and an av-
5 erage daily inpatient census of less than 50 percent
6 of such beds.

7 (6) JOINT PURCHASING ARRANGEMENTS.—Any
8 joint purchasing arrangement among health care
9 providers if—

10 (A) the purchases under the arrangement
11 represent less than 35 percent of the total sales
12 of the product or service purchased in the rel-
13 evant market; and

14 (B) the cost of the products and services
15 purchased jointly accounts for less than 20 per-
16 cent of the total revenues from all products or
17 services sold by each participant in the joint
18 purchasing arrangement.

19 (7) NEGOTIATIONS.—Activities consisting of
20 good faith negotiations to carry out any activity—

21 (A) described in this section,

22 (B) within an additional safe harbor des-
23 ignated by the Attorney General under section
24 603,

1 (C) that is the subject of an application for
2 a certificate of review under section 604, or

3 (D) that is deemed a submission of a noti-
4 fication under section 605(a)(2)(B),
5 without regard to whether such an activity is carried
6 out.

7 **SEC. 603. DESIGNATION OF ADDITIONAL SAFE HARBORS.**

8 (a) IN GENERAL.—

9 (1) SOLICITATION OF PROPOSALS.—Not later
10 than 30 days after the date of the enactment of this
11 Act, the Attorney General shall publish a notice in
12 the Federal Register soliciting proposals for addi-
13 tional safe harbors.

14 (2) REVIEW AND REPORT ON PROPOSED SAFE
15 HARBORS.—Not later than 180 days after the date
16 of the enactment of this Act, the Attorney General
17 (in consultation with the Secretary of Health and
18 Human Services and the Chair of the Federal Trade
19 Commission) shall—

20 (A) review the proposed safe harbors sub-
21 mitted under paragraph (1); and

22 (B) submit a report to Congress describing
23 the proposals to be included in the publication
24 of additional safe harbors described in para-

1 graph (3) and the proposals that are not to be
2 so included, together with explanations therefor.

3 (3) PUBLICATION OF ADDITIONAL SAFE HAR-
4 BORS.—Not later than 180 days after the date of
5 the enactment of this Act, the Attorney General (in
6 consultation with the Secretary of Health and
7 Human Services and the Chair of the Federal Trade
8 Commission) shall publish in the Federal Register
9 proposed additional safe harbors for purposes of sec-
10 tion 601(a)(2) for providers of health care services.
11 Not later than 180 days after publishing such pro-
12 posed safe harbors in the Federal Register, the At-
13 torney General shall issue final rules establishing
14 such safe harbors.

15 (b) CRITERIA FOR SAFE HARBORS.—In establishing
16 safe harbors under subsection (a), the Attorney General
17 shall take into account the following:

18 (1) The extent to which a competitive or col-
19 laborative activity will accomplish any of the follow-
20 ing:

21 (A) An increase in access to health care
22 services.

23 (B) The enhancement of the quality of
24 health care services.

1 (C) The establishment of cost efficiencies
2 that will be passed on to consumers, including
3 economies of scale and reduced transaction and
4 administrative costs.

5 (D) An increase in the ability of health
6 care facilities to provide services in medically
7 underserved areas or to medically underserved
8 populations.

9 (E) An improvement in the utilization of
10 health care resources or the reduction in the in-
11 efficient duplication of the use of such re-
12 sources.

13 (2) Whether the designation of an activity as a
14 safe harbor under subsection (a) will result in the
15 following outcomes:

16 (A) Health plans and other health care in-
17 surers, consumers of health care services, and
18 health care providers will be better able to ne-
19 gotiate payment and service arrangements
20 which will reduce costs to consumers.

21 (B) Taking into consideration the charac-
22 teristics of the particular purchasers and pro-
23 viders involved, competition will not be unduly
24 restricted.

1 (C) Equally efficient and less restrictive al-
2 ternatives do not exist to meet the criteria de-
3 scribed in paragraph (1).

4 (D) The activity will not unreasonably
5 foreclose competition by denying competitors a
6 necessary element of competition.

7 **SEC. 604. CERTIFICATES OF REVIEW.**

8 (a) ESTABLISHMENT OF PROGRAM.—In consultation
9 with the Secretary and the Chair, the Attorney General
10 shall (not later than 180 days after the date of the enact-
11 ment of this Act) issue certificates of review in accordance
12 with this section for providers of health care services and
13 advise and assist any person with respect to applying for
14 such a certificate of review.

15 (b) PROCEDURES FOR APPLICATION FOR CERTIFI-
16 CATE.—

17 (1) FORM; CONTENT.—To apply for a certifi-
18 cate of review, a person shall submit to the Attorney
19 General a written application which—

20 (A) specifies the activities relating to the
21 provision of health care services which satisfy
22 the criteria described in section 603(b) and
23 which will be included in the certificate; and

24 (B) is in a form and contains any informa-
25 tion, including information pertaining to the

1 overall market in which the applicant operates,
2 required by rule or regulation promulgated
3 under section 607.

4 (2) PUBLICATION OF NOTICE IN FEDERAL REG-
5 ISTER.—Within 10 days after an application submit-
6 ted under paragraph (1) is received by the Attorney
7 General, the Attorney General shall publish in the
8 Federal Register a notice that announces that an
9 application for a certificate of review has been sub-
10 mitted, identifies each person submitting the appli-
11 cation, and describes the conduct for which the ap-
12 plication is submitted.

13 (3) ESTABLISHMENT OF PROCEDURES FOR IS-
14 SUANCE OF CERTIFICATE.—In consultation with the
15 Chair and the Secretary, the Attorney General shall
16 establish procedures to be used in applying for and
17 in determining whether to approve an application for
18 a certificate of review under this title. Under such
19 procedures the Attorney General shall approve an
20 application if the Attorney General determines that
21 the activities to be covered under the certificate will
22 satisfy the criteria described in section 603(b) for
23 additional safe harbors designated under such sec-
24 tion and that the benefits of the issuance of the cer-

1 tificate will outweigh any disadvantages that may re-
2 sult from reduced competition.

3 (4) TIMING FOR DECISION ON APPLICATION.—

4 (A) IN GENERAL.—Within 90 days after
5 the Attorney General receives an application for
6 a certificate of review, the Attorney General
7 shall determine whether the applicant’s health
8 care market activities are in accordance with
9 the procedures described in paragraph (3). If
10 the Attorney General, with the concurrence of
11 the Secretary, determines that such procedures
12 are met, the Attorney General shall issue to the
13 applicant a certificate of review. The certificate
14 of review shall specify—

15 (i) the health care market activities to
16 which the certificate applies,

17 (ii) the person to whom the certificate
18 of review is issued, and

19 (iii) any terms and conditions the At-
20 torney General or the Secretary deems nec-
21 essary to assure compliance with the appli-
22 cable procedures described in paragraph
23 (3).

24 (B) APPLICATIONS DEEMED APPROVED.—

25 If the Attorney General does not reject an ap-

1 plication before the expiration of the 90-period
2 beginning on the date the Attorney General re-
3 ceives the application, the Attorney General
4 shall be deemed to have approved the applica-
5 tion and to have issued a certificate of review
6 relating to the applicant's health care market
7 activities covered under the application.

8 (5) EXPEDITED ACTION.—If the applicant indi-
9 cates a special need for prompt disposition, the At-
10 torney General and the Secretary may expedite ac-
11 tion on the application, except that no certificate of
12 review may be issued within 30 days of publication
13 of notice in the Federal Register under subsection
14 (b)(2).

15 (6) ACTIONS UPON DENIAL.—

16 (A) NOTIFICATION.—If the Attorney Gen-
17 eral denies in whole or in part an application
18 for a certificate, the Attorney General shall no-
19 tify the applicant of the Attorney General's de-
20 termination and the reasons for it.

21 (B) REQUEST FOR RECONSIDERATION.—
22 An applicant may, within 30 days of receipt of
23 notification that the application has been denied
24 in whole or in part, request the Attorney Gen-
25 eral to reconsider the determination. The Attor-

1 ney General, with the concurrence of the Sec-
2 retary, shall notify the applicant of the deter-
3 mination upon reconsideration within 30 days
4 of receipt of the request.

5 (C) RETURN OF DOCUMENTS.—If the At-
6 torney General denies an application for the is-
7 suanance of a certificate of review and thereafter
8 receives from the applicant a request for the re-
9 turn of documents submitted by the applicant
10 in connection with the application for the cer-
11 tificate, the Attorney General and the Secretary
12 shall return to the applicant, not later than 30
13 days after receipt of the request, the documents
14 and all copies of the documents available to the
15 Attorney General and the Secretary, except to
16 the extent that the information has been made
17 public under an exception to the rule against
18 public disclosure described in subsection
19 (g)(2)(B).

20 (7) FRAUDULENT PROCUREMENT.—A certifi-
21 cate of review shall be void ab initio with respect to
22 any health care market activities for which the cer-
23 tificate was procured by fraud.

24 (c) AMENDMENT AND REVOCATION OF CERTIFI-
25 CATES.—

1 (1) NOTIFICATION OF CHANGES.—Any appli-
2 cant who receives a certificate of review—

3 (A) shall promptly report to the Attorney
4 General any change relevant to the matters
5 specified in the certificate; and

6 (B) may submit to the Attorney General
7 an application to amend the certificate to re-
8 flect the effect of the change on the conduct
9 specified in the certificate.

10 (2) AMENDMENT TO CERTIFICATE.—An appli-
11 cation for an amendment to a certificate of review
12 shall be treated as an application for the issuance of
13 a certificate. The effective date of an amendment
14 shall be the date on which the application for the
15 amendment is submitted to the Attorney General.

16 (3) REVOCATION.—

17 (A) GROUNDS FOR REVOCATION.—In ac-
18 cordance with this paragraph, the Attorney
19 General may revoke in whole or in part a cer-
20 tificate of review issued under this section. The
21 following shall be considered grounds for the
22 revocation of a certificate:

23 (i) After the expiration of the 2-year
24 period beginning on the date a person's
25 certificate is issued, the activities of the

1 person have not substantially accomplished
2 the purposes for the issuance of the certifi-
3 cate.

4 (ii) The person has failed to comply
5 with any of the terms or conditions im-
6 posed under the certificate by the Attorney
7 General or the Secretary under subsection
8 (b)(4).

9 (iii) The activities covered under the
10 certificate no longer satisfy the criteria set
11 forth in section 603(b).

12 (B) REQUEST FOR COMPLIANCE INFORMA-
13 TION.—If the Attorney General or Secretary
14 has reason to believe that any of the grounds
15 for revocation of a certificate of review de-
16 scribed in subparagraph (A) may apply to a
17 person holding the certificate, the Attorney
18 General shall request such information from
19 such person as the Attorney General or the Sec-
20 retary deems necessary to resolve the matter of
21 compliance. Failure to comply with such request
22 shall be grounds for revocation of the certificate
23 under this paragraph.

24 (C) PROCEDURES FOR REVOCATION.—If
25 the Attorney General or the Secretary deter-

1 mines that any of the grounds for revocation of
2 a certificate of review described in subpara-
3 graph (A) apply to a person holding the certifi-
4 cate, or that such person has failed to comply
5 with a request made under subparagraph (B),
6 the Attorney General shall give written notice of
7 the determination to such person. The notice
8 shall include a statement of the circumstances
9 underlying, and the reasons in support of, the
10 determination. In the 60-day period beginning
11 30 days after the notice is given, the Attorney
12 General shall revoke the certificate or modify it
13 as the Attorney General or the Secretary deems
14 necessary to cause the certificate to apply only
15 to activities that meet the procedures for the is-
16 suance of certificates described in subsection
17 (b)(2).

18 (D) INVESTIGATION AUTHORITY.—For
19 purposes of carrying out this paragraph, the
20 Attorney General may conduct investigations in
21 the same manner as the Attorney General con-
22 ducts investigations under section 3 of the Anti-
23 trust Civil Process Act, except that no civil in-
24 vestigative demand may be issued to a person

1 to whom a certificate of review is issued if such
2 person is the target of such investigation.

3 (d) REVIEW OF DETERMINATIONS.—

4 (1) AVAILABILITY OF REVIEW FOR CERTAIN AC-
5 TIONS.—If the Attorney General denies, in whole or
6 in part, an application for a certificate of review or
7 for an amendment to a certificate, or revokes or
8 modifies a certificate pursuant to paragraph (3), the
9 applicant or certificate holder (as the case may be)
10 may, within 30 days of the denial or revocation,
11 bring an action in any appropriate district court of
12 the United States to set aside the determination on
13 the ground that such determination is erroneous
14 based on the preponderance of the evidence.

15 (2) NO OTHER REVIEW PERMITTED.—Except
16 as provided in paragraph (1), no action by the At-
17 torney General or the Secretary pursuant to this
18 title shall be subject to judicial review.

19 (3) EFFECT OF REJECTED APPLICATION.—If
20 the Attorney General denies, in whole or in part, an
21 application for a certificate of review or for an
22 amendment to a certificate, or revokes or amends a
23 certificate, neither the negative determination nor
24 the statement of reasons therefore shall be admissi-
25 ble in evidence, in any administrative or judicial pro-

1 ceeding, concerning any claim under the antitrust
2 laws.

3 (e) PUBLICATION OF DECISIONS.—The Attorney
4 General shall publish a notice in the Federal Register on
5 a timely basis of each decision made with respect to an
6 application for a certificate of review under this section
7 or the amendment or revocation of such a certificate, in
8 a manner that protects the confidentiality of any propri-
9 etary information relating to the application.

10 (f) ANNUAL REPORTS.—Every person to whom a cer-
11 tificate of review is issued shall submit to the Attorney
12 General an annual report, in such form and at such time
13 as the Attorney General may require, that contains any
14 necessary updates to the information required under sub-
15 section (b) and a description of the activities of the holder
16 under the certificate during the preceding year.

17 (g) RESTRICTIONS ON DISCLOSURE OF INFORMA-
18 TION.—

19 (1) WAIVER OF DISCLOSURE REQUIREMENTS
20 UNDER ADMINISTRATIVE PROCEDURE ACT.—Infor-
21 mation submitted by any person in connection with
22 the issuance, amendment, or revocation of a certifi-
23 cate of review shall be exempt from disclosure under
24 section 552 of title 5, United States Code.

1 (2) RESTRICTIONS ON DISCLOSURE OF COM-
2 MERCIAL OR FINANCIAL INFORMATION.—

3 (A) IN GENERAL.—Except as provided in
4 subparagraph (B), no officer or employee of the
5 United States shall disclose commercial or fi-
6 nancial information submitted in connection
7 with the issuance, amendment, or revocation of
8 a certificate of review if the information is priv-
9 ileged or confidential and if disclosure of the in-
10 formation would cause harm to the person who
11 submitted the information.

12 (B) EXCEPTIONS.—Subparagraph (A)
13 shall not apply with respect to information dis-
14 closed—

15 (i) upon a request made by the Con-
16 gress or any committee of the Congress,

17 (ii) in a judicial or administrative pro-
18 ceeding, subject to appropriate protective
19 orders,

20 (iii) with the consent of the person
21 who submitted the information,

22 (iv) in the course of making a deter-
23 mination with respect to the issuance,
24 amendment, or revocation of a certificate
25 of review, if the Attorney General deems

1 disclosure of the information to be nec-
2 essary in connection with making the de-
3 termination,

4 (v) in accordance with any require-
5 ment imposed by a statute of the United
6 States, or

7 (vi) in accordance with any rule or
8 regulation promulgated under subsection
9 (i) permitting the disclosure of the infor-
10 mation to an agency of the United States
11 or of a State on the condition that the
12 agency will disclose the information only
13 under the circumstances specified in
14 clauses (i) through (v).

15 (3) PROHIBITION AGAINST USE OF INFORMA-
16 TION TO SUPPORT OR ANSWER CLAIMS UNDER ANTI-
17 TRUST LAWS.—Any information disclosed in an ap-
18 plication for a certificate of review under this section
19 shall only be admissible into evidence in a judicial or
20 administrative proceeding for the sole purpose of es-
21 tablishing that a person is entitled to the protections
22 provided by such a certificate.

1 **SEC. 605. NOTIFICATIONS PROVIDING REDUCTION IN CER-**
2 **TAIN PENALTIES UNDER ANTITRUST LAW**
3 **FOR HEALTH CARE COOPERATIVE VEN-**
4 **TURES.**

5 (a) NOTIFICATIONS DESCRIBED.—

6 (1) SUBMISSION OF NOTIFICATION BY VEN-
7 TURE.—Any party to a health care cooperative ven-
8 ture, acting on such venture's behalf, may, not later
9 than 90 days after entering into a written agreement
10 to form such venture or not later than 90 days after
11 the date of the enactment of this Act, whichever is
12 later, file with the Attorney General a written notifi-
13 cation disclosing—

14 (A) the identities of the parties to such
15 venture,

16 (B) the nature and objectives of such ven-
17 ture, and

18 (C) such additional information as the At-
19 torney General may require by regulation.

20 (2) ACTIVITIES DEEMED SUBMISSION OF NOTI-
21 FICATION.—The following health care cooperative
22 ventures shall be deemed to have filed a written noti-
23 fication with respect to the venture under paragraph
24 (1):

25 (A) SUBMISSION OF APPLICATION FOR
26 CERTIFICATE OF REVIEW.—Any health care co-

1 operative venture for which an application for a
2 certificate of review is filed with the Attorney
3 General under section 603.

4 (B) CERTAIN VENTURES.—Any health care
5 cooperative venture meeting the following re-
6 quirements:

7 (i) The venture consists of a network
8 of non-institutional providers not greater
9 than—

10 (I) in the case of a nonexclusive
11 network in which the participating
12 members are permitted to create or
13 join other competing networks, 50
14 percent of the providers of health care
15 services in the relevant geographic
16 area and 50 percent of the members
17 of the provider specialty group in the
18 relevant market; or

19 (II) in the case of an exclusive
20 network in which the participating
21 members are not permitted to create
22 or join other competing networks, 35
23 percent of the providers of health care
24 services in the relevant geographic
25 area and 35 percent of the members

1 of the provider specialty group in the
2 relevant market.

3 (ii) Each member of the venture as-
4 sumes substantial financial risk for the op-
5 eration of the venture through risk-sharing
6 arrangements, including (but not limited
7 to)—

8 (I) the acceptance of capitation
9 contracts;

10 (II) the acceptance of contracts
11 with fee withholding mechanisms re-
12 lating to the ability to meet estab-
13 lished goals for utilization review and
14 management; and

15 (III) the holding by members of
16 significant ownership or equity inter-
17 ests in the venture, where the capital
18 contributed by the members is used to
19 fund the operational costs of the ven-
20 ture such as administration, market-
21 ing, and computer-operated medical
22 information, if the venture develops
23 and operates comprehensive programs
24 for utilization management and qual-
25 ity assurance that include controls

1 over the use of institutional, special-
2 ized, and ancillary medical services.

3 (3) SUBMISSION OF ADDITIONAL INFORMA-
4 TION.—

5 (A) REQUEST OF ATTORNEY GENERAL.—

6 At any time after receiving a notification filed
7 under paragraph (1), the Attorney General may
8 require the submission of additional information
9 or documentary material relevant to the pro-
10 posed health care cooperative venture.

11 (B) PARTIES TO VENTURE.—Any party to
12 a health care cooperative venture may submit
13 such additional information on the venture's be-
14 half as may be appropriate to ensure that the
15 venture will receive the protections provided
16 under subsection (b).

17 (C) REQUIRED SUBMISSION OF INFORMA-
18 TION ON CHANGES TO VENTURE.—A health
19 care cooperative venture for which a notification
20 is in effect under this section shall submit infor-
21 mation on any change in the membership of the
22 venture not later than 90 days after such
23 change occurs.

24 (4) PUBLICATION OF NOTIFICATION.—

1 (A) INFORMATION MADE PUBLICLY AVAIL-
2 ABLE.—Not later than 30 days after receiving
3 a notification with respect to a venture under
4 paragraph (1), the Attorney General shall pub-
5 lish in the Federal Register a notice with re-
6 spect to the venture that identifies the parties
7 to the venture and generally describes the pur-
8 pose and planned activity of the venture. Prior
9 to its publication, the contents of the notice
10 shall be made available to the parties to the
11 venture.

12 (B) RESTRICTION ON DISCLOSURE OF
13 OTHER INFORMATION.—All information and
14 documentary material submitted pursuant to
15 this section and all information obtained by the
16 Attorney General in the course of any investiga-
17 tion or case with respect to a potential violation
18 of the antitrust laws by the health care coopera-
19 tive venture (other than information and mate-
20 rial described in subparagraph (A)) shall be ex-
21 empt from disclosure under section 552 of title
22 5, United States Code, and shall not be made
23 publicly available by any agency of the United
24 States to which such section applies except in

1 a judicial proceeding in which such information
2 and material is subject to any protective order.

3 (5) WITHDRAWAL OF NOTIFICATION.—Any per-
4 son who files a notification pursuant to this section
5 may withdraw such notification before a publication
6 by the Attorney General pursuant to paragraph (4).
7 Any person who is deemed to have filed a notifica-
8 tion under paragraph (2)(A) shall be deemed to have
9 withdrawn the notification if the certificate of review
10 in question is revoked or withdrawn under section
11 604.

12 (6) NO JUDICIAL REVIEW PERMITTED.—Any
13 action taken or not taken by the Attorney General
14 with respect to notifications filed pursuant to this
15 subsection shall not be subject to judicial review.

16 (b) PROTECTIONS FOR VENTURES SUBJECT TO NO-
17 TIFICATION.—

18 (1) IN GENERAL.—

19 (A) PROTECTIONS DESCRIBED.—The pro-
20 visions of paragraphs (2), (3), (4), and (5) shall
21 apply with respect to any action under the anti-
22 trust laws challenging conduct within the scope
23 of a notification which is in effect pursuant to
24 subsection (a)(1).

1 (B) TIMING OF PROTECTIONS.—The pro-
2 tections described in this subsection shall apply
3 to the venture that is the subject of a notifica-
4 tion under subsection (a)(1) as of the earlier
5 of—

6 (i) the date of the publication in the
7 Federal Register of the notice published
8 with respect to the notification; or

9 (ii) if such notice is not published dur-
10 ing the period required under subsection
11 (a)(4), the expiration of the 30-day period
12 that begins on the date the Attorney Gen-
13 eral receives any necessary information re-
14 quired to be submitted under subsection
15 (a)(1) or any additional information re-
16 quired by the Attorney General under sub-
17 section (a)(3)(A).

18 (2) APPLICABILITY OF RULE OF REASON
19 STANDARD.—In any action under the antitrust laws,
20 the conduct of any person which is within the scope
21 of a notification filed under subsection (a) shall not
22 be deemed illegal per se, but shall be judged on the
23 basis of its reasonableness, taking into account all
24 relevant factors affecting competition, including, but

1 not limited to, effects on competition in relevant
2 markets.

3 (3) LIMITATION ON RECOVERY TO ACTUAL
4 DAMAGES AND INTEREST.—Notwithstanding section
5 4 of the Clayton Act, any person who is entitled to
6 recovery under the antitrust laws for conduct that is
7 within the scope of a notification filed under sub-
8 section (a) shall recover the actual damages sus-
9 tained by such person and interest calculated at the
10 rate specified in section 1961 of title 28, United
11 States Code, for the period beginning on the earliest
12 date for which injury can be established and ending
13 on the date of judgment, unless the court finds that
14 the award of all or part of such interest is unjust
15 under the circumstances.

16 (4) AWARD OF ATTORNEY'S FEES AND COSTS
17 OF SUIT.—

18 (A) IN GENERAL.—In any action under the
19 antitrust laws brought against a health care co-
20 operative venture for conduct that is within the
21 scope of a notification filed under subsection
22 (a), the court shall, at the conclusion of the ac-
23 tion—

24 (i) award to a substantially prevailing
25 claimant the cost of suit attributable to

1 such claim, including a reasonable attorney's fee, or
2

3 (ii) award to a substantially prevailing
4 party defending against such claim the
5 cost of such suit attributable to such claim,
6 including reasonable attorney's fee, if the
7 claim, or the claimant's conduct during
8 litigation of the claim, was frivolous, un-
9 reasonable, without foundation, or in bad
10 faith.

11 (B) OFFSET IN CASES OF BAD FAITH.—

12 The court may reduce an award made pursuant
13 to subparagraph (A) in whole or in part by an
14 award in favor of another party for any part of
15 the cost of suit (including a reasonable attorney's
16 fee) attributable to conduct during the
17 litigation by any prevailing party that the court
18 finds to be frivolous, unreasonable, without
19 foundation, or in bad faith.

20 (5) RESTRICTIONS ON ADMISSIBILITY OF INFORMATION.—
21

22 (A) IN GENERAL.—Any information disclosed
23 in a notification submitted under subsection
24 (a)(1) and the fact of the publication of
25 a notification by the Attorney General under

1 subsection (a)(4) shall only be admissible into
2 evidence in a judicial or administrative proceed-
3 ing for the sole purpose of establishing that a
4 party to a health care cooperative venture is en-
5 titled to the protections described in this sub-
6 section.

7 (B) ACTIONS OF ATTORNEY GENERAL.—
8 No action taken by the Attorney General pursu-
9 ant to this section shall be admissible into evi-
10 dence in any judicial or administrative proceed-
11 ing for the purpose of supporting or answering
12 any claim under the antitrust laws.

13 **SEC. 606. REVIEW AND REPORTS ON SAFE HARBORS AND**
14 **CERTIFICATES OF REVIEW.**

15 (a) IN GENERAL.—The Attorney General (in con-
16 sultation with the Secretary and the Chair) shall periodi-
17 cally review the safe harbors described in section 602, the
18 additional safe harbors designated under section 603, and
19 the certificates of review issued under section 604, and—

20 (1) with respect to the safe harbors described in
21 section 602, submit such recommendations to Con-
22 gress as the Attorney General considers appropriate
23 for modifications of such safe harbors;

24 (2) with respect to the additional safe harbors
25 under designated under section 603, issue proposed

1 revisions to such activities and publish the revisions
2 in the Federal Register; and

3 (3) with respect to the certificates of review,
4 submit a report to Congress on the issuance of such
5 certificates, and shall include in the report a descrip-
6 tion of the effect of such certificates on increasing
7 access to high quality health care services at reduced
8 costs.

9 (b) RECOMMENDATIONS FOR LEGISLATION.—The
10 Attorney General shall include in the reports submitted
11 under subsection (a)(3) any recommendations of the At-
12 torney General for legislation to improve the program for
13 the issuance of certificates of review established under this
14 title.

15 **SEC. 607. RULES, REGULATIONS, AND GUIDELINES.**

16 (a) SAFE HARBORS, CERTIFICATES, AND NOTIFICA-
17 TIONS.—The Attorney General, with the concurrence of
18 the Secretary, shall promulgate such rules, regulations,
19 and guidelines as are necessary to carry out sections 602,
20 603, 604, and 605, including guidelines defining or relat-
21 ing to relevant geographic and product markets for health
22 care services and providers of health care services.

23 (b) GUIDANCE FOR PROVIDERS.—

24 (1) IN GENERAL.—To promote greater cer-
25 tainty regarding the application of the antitrust laws

1 to activities in the health care market, the Attorney
2 General, in consultation with the Secretary and the
3 Chair, shall (not later than 1 year after the date of
4 the enactment of this Act), taking into account the
5 criteria used to designate additional safe harbors
6 under section 603 and grant certificates of review
7 under section 604, publish guidelines—

8 (A) to assist providers of health care serv-
9 ices in analyzing whether the activities of such
10 providers may be subject to a safe harbor under
11 sections 602 or 603; and

12 (B) describing specific types of activities
13 which would meet the requirements for a cer-
14 tificate of review under section 604, and sum-
15 marizing the factual and legal bases on which
16 the activities would meet the requirements.

17 (2) PERIODIC UPDATE.—The Attorney General
18 shall periodically update the guidelines published
19 under paragraph (1) as the Attorney General consid-
20 ers appropriate.

21 (3) WAIVER OF ADMINISTRATIVE PROCEDURE
22 ACT.—Section 553 of title 5, United States Code,
23 shall not apply to the issuance of guidelines under
24 paragraph (1).

1 **SEC. 608. DEFINITIONS.**

2 In this title, the following definitions shall apply:

3 (1) The term “antitrust laws”—

4 (A) has the meaning given it in subsection
5 (a) of the first section of the Clayton Act (15
6 U.S.C. 12(a)), except that such term includes
7 section 5 of the Federal Trade Commission Act
8 (15 U.S.C. 45) to the extent such section ap-
9 plies to unfair methods of competition; and

10 (B) includes any State law similar to the
11 laws referred to in subparagraph (A).

12 (2) The term “Chair” means the Chair of the
13 Federal Trade Commission.

14 (3) The term “health insurance plan” has the
15 meaning given such term in section 111(b).

16 (4) The term “health care cooperative venture”
17 means any activities, including attempts to enter
18 into or perform a contract or agreement, carried out
19 by 2 or more persons for the purpose of providing
20 health care services.

21 (5) The term “health care services” means any
22 services for which payment may be made under a
23 health insurance plan, including services related to
24 the delivery or administration of such services.

25 (6) The term “medical self-regulatory entity”
26 means a medical society or association, a specialty

1 board, a recognized accrediting agency, or a hospital
2 medical staff, and includes the members, officers,
3 employees, consultants, and volunteers or commit-
4 tees of such an entity.

5 (7) The term “person” includes a State or unit
6 of local government.

7 (8) The term “provider of health care services”
8 means any individual or entity that is engaged in the
9 delivery of health care services in a State and that
10 is required by State law or regulation to be licensed
11 or certified by the State to engage in the delivery of
12 such services in the State.

13 (9) The term “specialty group” means a medi-
14 cal specialty or subspecialty in which a provider of
15 health care services may be licensed to practice by
16 a State (as determined by the Secretary in consulta-
17 tion with the certification boards for such specialties
18 and subspecialties).

19 (10) The term “standard setting and enforce-
20 ment activities” means—

21 (A) accreditation of health care practition-
22 ers, health care providers, medical education in-
23 stitutions, or medical education programs,

24 (B) technology assessment and risk man-
25 agement activities,

1 (C) the development and implementation of
2 practice guidelines or practice parameters, or

3 (D) official peer review proceedings under-
4 taken by a hospital medical staff (or committee
5 thereof) or a medical society or association for
6 purposes of evaluating the professional conduct
7 or quality of health care provided by a medical
8 professional.

9 **TITLE VII—LONG-TERM CARE**

10 **SEC. 701. EXCLUSION FROM GROSS INCOME FOR AMOUNTS** 11 **WITHDRAWN FROM INDIVIDUAL RETIRE-** 12 **MENT PLANS OR 401(k) PLANS FOR LONG-** 13 **TERM CARE INSURANCE.**

14 (a) IN GENERAL.—Part III of subchapter B of chap-
15 ter 1 of the Internal Revenue Code of 1986 (relating to
16 items specifically excluded from gross income) is amended
17 by redesignating section 137 as section 138 and by insert-
18 ing after section 136 the following new section:

19 **“SEC. 137. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT** 20 **ACCOUNTS AND SECTION 401(k) PLANS FOR** 21 **LONG-TERM CARE INSURANCE.**

22 “(a) GENERAL RULE.—The amount includible in the
23 gross income of an individual for the taxable year by rea-
24 son of qualified distributions during such taxable year
25 shall not exceed the excess of—

1 “(1) the amount which would (but for this sec-
2 tion) be so includible by reason of such distributions,
3 over

4 “(2) the aggregate premiums paid by such indi-
5 vidual during such taxable year for any long-term
6 care insurance contract for the benefit of such indi-
7 vidual or the spouse of such individual.

8 “(b) QUALIFIED DISTRIBUTION.—For purposes of
9 this section, the term ‘qualified distribution’ means any
10 distribution to an individual from an individual retirement
11 account or a section 401(k) plan if such individual has
12 attained age 59½ on or before the date of the distribution
13 (and, in the case of a distribution used to pay premiums
14 for the benefit of the spouse of such individual, such
15 spouse has attained age 59½ on or before the date of the
16 distribution).

17 “(c) DEFINITIONS AND SPECIAL RULES RELATING
18 TO LONG-TERM INSURANCE CONTRACTS.—

19 “(1) LONG-TERM CARE INSURANCE CON-
20 TRACT.—

21 “(A) IN GENERAL.—For purposes of this
22 section, the term ‘long-term care insurance con-
23 tract’ means any insurance contract issued if—

24 “(i) the only insurance protection pro-
25 vided under such contract is coverage of

1 qualified long-term care services and bene-
2 fits incidental to such coverage,

3 “(ii) the maximum benefit under the
4 policy for expenses incurred for any day
5 does not exceed \$200,

6 “(iii) such contract does not cover ex-
7 penses incurred for services or items to the
8 extent that such expenses are reimbursable
9 under title XVIII of the Social Security
10 Act or would be so reimbursable but for
11 the application of a deductible or coinsur-
12 ance amount,

13 “(iv) such contract is guaranteed re-
14 newable,

15 “(v) such contract does not have any
16 cash surrender value, and

17 “(vi) all refunds of premiums, and all
18 policyholder dividends or similar amounts,
19 under such contract are to be applied as a
20 reduction in future premiums or to in-
21 crease future benefits.

22 “(B) SPECIAL RULES.—

23 “(i) PER DIEM, ETC. PAYMENTS PER-
24 MITTED.—A contract shall not fail to be
25 treated as described in subparagraph

1 (A)(i) by reason of payments being made
2 on a per diem or other periodic basis with-
3 out regard to the expenses incurred during
4 the period to which the payments relate.

5 “(ii) CONTRACT MAY COVER MEDI-
6 CARE REIMBURSABLE EXPENSES WHERE
7 MEDICARE IS SECONDARY PAYOR.—Sub-
8 paragraph (A)(iii) shall not apply to ex-
9 penses which are reimbursable under title
10 XVIII of the Social Security Act only as a
11 secondary payor.

12 “(iii) REFUNDS OF PREMIUMS.—Sub-
13 paragraph (A)(vi) shall not apply to any
14 refund of premiums on surrender or can-
15 cellation of the contract.

16 “(2) QUALIFIED LONG-TERM CARE SERVICES.—

17 For purposes of this subsection—

18 “(A) IN GENERAL.—The term ‘qualified
19 long-term care services’ means necessary diag-
20 nostic, preventive, therapeutic, and rehabilita-
21 tive services, and maintenance or personal care
22 services, which—

23 “(i) are required by a chronically ill
24 individual in a qualified facility, and

1 “(ii) are provided pursuant to a plan
2 of care prescribed by a licensed health care
3 practitioner.

4 “(B) CHRONICALLY ILL INDIVIDUAL.—

5 “(i) IN GENERAL.—The term ‘chron-
6 ically ill individual’ means any individual
7 who has been certified by a licensed health
8 care practitioner as—

9 “(I) being unable to perform
10 (without substantial assistance from
11 another individual) at least 2 activi-
12 ties of daily living (as defined in
13 clause (ii)) for a period of at least 90
14 days due to a loss of functional capac-
15 ity, or having a similar level of disabil-
16 ity (as determined by the Secretary in
17 consultation with the Secretary of
18 Health and Human Services), or

19 “(II) having a similar level of
20 disability due to cognitive impairment.

21 “(ii) ACTIVITIES OF DAILY LIVING.—
22 For purposes of clause (i), each of the fol-
23 lowing is an activity of daily living:

24 “(I) MOBILITY.—The process of
25 walking or wheeling on a level surface

1 which may include the use of an
2 assistive device such as a cane, walk-
3 er, wheelchair, or brace.

4 “(II) DRESSING.—The overall
5 complex behavior of getting clothes
6 from closets and drawers and then
7 getting dressed.

8 “(III) TOILETING.—The act of
9 going to the toilet room for bowel and
10 bladder function, transferring on and
11 off the toilet, cleaning after elimi-
12 nation, and arranging clothes or the
13 ability to voluntarily control bowel and
14 bladder function, or in the event of in-
15 continence, the ability to maintain a
16 reasonable level of personal hygiene.

17 “(IV) TRANSFER.—The process
18 of getting in and out of bed or in and
19 out of a chair or wheelchair.

20 “(V) EATING.—The process of
21 getting food from a plate or its equiv-
22 alent into the mouth.

23 “(C) QUALIFIED FACILITY.—The term
24 ‘qualified facility’ means—

1 “(i) a nursing, rehabilitative, hospice,
2 or adult day care facility (including a hos-
3 pital, retirement home, nursing home,
4 skilled nursing facility, intermediate care
5 facility, or similar institution)—

6 “(I) which is licensed under
7 State law, or

8 “(II) which is a certified facility
9 for purposes of title XVIII or XIX of
10 the Social Security Act, or

11 “(ii) an individual’s home if a licensed
12 health care practitioner certifies that with-
13 out home care the individual would have to
14 be cared for in a facility described in
15 clause (i).

16 “(D) MAINTENANCE OR PERSONAL CARE
17 SERVICES.—The term ‘maintenance or personal
18 care services’ means any care the primary pur-
19 pose of which is to provide needed assistance
20 with any of the activities of daily living de-
21 scribed in subparagraph (B)(ii).

22 “(E) LICENSED HEALTH CARE PRACTI-
23 TIONER.—The term ‘licensed health care practi-
24 tioner’ means any physician (as defined in sec-
25 tion 1861(r) of the Social Security Act) and

1 any registered professional nurse, licensed social
2 worker, or other individual who meets such re-
3 quirements as may be prescribed by the Sec-
4 retary.

5 “(3) INFLATION ADJUSTMENT OF \$200 BENE-
6 FIT LIMIT.—

7 “(A) IN GENERAL.—In the case of a cal-
8 endar year after 1995, the \$200 amount con-
9 tained in paragraph (1)(A)(ii) shall be in-
10 creased for such calendar year by the medical
11 care cost adjustment for such calendar year. If
12 any increase determined under the preceding
13 sentence is not a multiple of \$10, such increase
14 shall be rounded to the nearest multiple of \$10.

15 “(B) MEDICAL CARE COST ADJUST-
16 MENT.—For purposes of subparagraph (A), the
17 medical care cost adjustment for any calendar
18 year is the percentage (if any) by which—

19 “(i) the medical care component of
20 the Consumer Price Index (as defined in
21 section 1(f)(5)) for August of the preced-
22 ing calendar year, exceeds

23 “(ii) such component for August of
24 1994.”

1 “(d) OTHER DEFINITIONS.—For purposes of this
2 section—

3 “(1) INDIVIDUAL RETIREMENT ACCOUNT.—The
4 term ‘individual retirement account’ has the mean-
5 ing given such term by section 408(a).

6 “(2) SECTION 401(k) PLAN.—The term ‘section
7 401(k) plan’ means any employer plan which meets
8 the requirements of section 401(a) and which in-
9 cludes a qualified cash or deferred arrangement (as
10 defined in section 401(k)).

11 “(e) SPECIAL RULES FOR SECTION 401(k) PLANS.—

12 “(1) WITHDRAWALS CANNOT EXCEED ELEC-
13 TIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR
14 DEFERRED ARRANGEMENT.—This section shall not
15 apply to any distribution from a section 401(k) plan
16 to the extent the aggregate amount of such distribu-
17 tions for the use described in subsection (a) exceeds
18 the aggregate employer contributions made pursuant
19 to the employee’s election under section 401(k)(2).

20 “(2) WITHDRAWALS NOT TO CAUSE DISQUALI-
21 FICATION.—A plan shall not be treated as failing to
22 satisfy the requirements of section 401, and an ar-
23 rangement shall not be treated as failing to be a
24 qualified cash or deferred arrangement (as defined
25 in section 401(k)(2)), merely because under the plan

1 or arrangement distributions are permitted which
 2 are excludable from gross income by reason of this
 3 section.”

4 (b) CONFORMING AMENDMENTS.—

5 (1) Section 401(k) of such Code is amended by
 6 adding at the end the following new paragraph:

7 “(11) CROSS REFERENCE.—

“For provision permitting tax-free withdrawals
 for payment of long-term care premiums, see section
 137.”

8 (2) Section 408(d) of such Code is amended by
 9 adding at the end the following new paragraph:

10 “(8) CROSS REFERENCE.—

“For provision permitting tax-free withdrawals
 from individual retirement accounts for payment of
 long-term care premiums, see section 137.”

11 (3) The table of sections for such part III is
 12 amended by striking the last item and inserting the
 13 following new items:

“Sec. 137. Distributions from individual retirement accounts and
 section 401(k) plans for long-term care insurance.
 “Sec. 138. Cross references to other Acts.”

14 **SEC. 702. CERTAIN EXCHANGES OF LIFE INSURANCE CON-**
 15 **TRACTS FOR LONG-TERM CARE INSURANCE**
 16 **CONTRACTS NOT TAXABLE.**

17 Subsection (a) of section 1035 of the Internal Reve-
 18 nue Code of 1986 (relating to certain exchanges of insur-
 19 ance contracts) is amended by striking the period at the

1 end of paragraph (3) and inserting “; or”, and by adding
2 at the end thereof the following new paragraph:

3 “(4) a contract of life insurance or an endow-
4 ment or annuity contract for a long-term care insur-
5 ance contract (as defined in section 137(c)(1)).”

6 **SEC. 703. TAX TREATMENT OF ACCELERATED DEATH BENE-**
7 **FITS UNDER LIFE INSURANCE CONTRACTS.**

8 Section 101 of the Internal Revenue Code of 1986
9 (relating to certain death benefits) is amended by adding
10 at the end thereof the following new subsection:

11 “(g) TREATMENT OF CERTAIN ACCELERATED
12 DEATH BENEFITS.—

13 “(1) IN GENERAL.—For purposes of this sec-
14 tion, any amount paid or advanced to an individual
15 under a life insurance contract on the life of an in-
16 sured—

17 “(A) who is a terminally ill individual, or

18 “(B) who is a chronically ill individual (as
19 defined in section 137(c)(2)(B)) who is confined
20 to a qualified facility (as defined in section
21 137(c)(2)(C)(i)),

22 shall be treated as an amount paid by reason of the
23 death of such insured.

24 “(2) TERMINALLY ILL INDIVIDUAL.—For pur-
25 poses of this subsection, the term ‘terminally ill indi-

1 vidual' means an individual who has been certified
2 by a physician as having an illness or physical condi-
3 tion which can reasonably be expected to result in
4 death in 12 months or less.

5 “(3) PHYSICIAN.—For purposes of this sub-
6 section, the term ‘physician’ has the meaning given
7 to such term by section 137(c)(2)(E).”

8 **SEC. 704. EFFECTIVE DATE.**

9 The amendments made by this subtitle shall apply to
10 taxable years beginning after December 31, 1994.

11 **TITLE VI—WELFARE**
12 **RESTRICTIONS FOR ALIENS**

13 **SEC. 801. INELIGIBILITY OF ALIENS FOR PUBLIC WELFARE**
14 **ASSISTANCE.**

15 (a) IN GENERAL.—Notwithstanding any other provi-
16 sion of law and except as provided in subsections (b) and
17 (c), no alien shall be eligible for any program referred to
18 in subsection (d).

19 (b) EXCEPTIONS.—

20 (1) REFUGEE EXCEPTION.—Subsection (a)
21 shall not apply to an alien admitted to the United
22 States as a refugee under section 207 of the Immig-
23 ration and Nationality Act until 6 years after the
24 date of such alien’s arrival into the United States.

1 (2) AGED EXCEPTION.—Subsection (a) shall
2 not apply to an alien who—

3 (A) has been lawfully admitted to the
4 United States for permanent residence;

5 (B) is over 75 years of age; and

6 (C) has resided in the United States for at
7 least 5 years.

8 (3) CURRENT RESIDENT EXCEPTION.—Sub-
9 section (a) shall not apply to the eligibility of an
10 alien for a program referred to in subsection (d)
11 until 1 year after the date of the enactment of this
12 Act if, on such date of enactment, the alien is resid-
13 ing in the United States and is eligible for the pro-
14 gram.

15 (c) PROGRAMS FOR WHICH ALIENS MAY BE ELIGI-
16 BLE.—The limitation under subsection (a) shall not apply
17 to the following programs:

18 (1) Medical assistance with respect to emer-
19 gency services (as defined for purposes of section
20 1916(a)(2)(D) of the Social Security Act).

21 (d) PROGRAMS FOR WHICH ALIENS ARE INELI-
22 GIBLE.—The programs referred to in this subsection are
23 the following:

1 (1) The program of medical assistance under
2 title XIX of the Social Security Act, except emer-
3 gency services as provided in subsection (c).

4 (2) The Maternal and Child Health Services
5 Block Grant Program under title V of the Social Se-
6 curity Act.

7 (3) The program established in section 330 of
8 the Public Health Service Act (relating to commu-
9 nity health centers).

10 (4) The program established in section 1001 of
11 the Public Health Service Act (relating to family
12 planning methods and services).

13 (5) The program established in section 329 of
14 the Public Health Service Act (relating to migrant
15 health centers).

16 (6) The program of aid and services to needy
17 families with children under part A of title IV of the
18 Social Security Act.

19 (7) The child welfare services program under
20 part B of title IV of the Social Security Act.

21 (8) The supplemental security income program
22 under title XVI of the Social Security Act.

23 (9) The program of foster care and adoption
24 assistance under part E of title IV of the Social Se-
25 curity Act.

1 (10) The food stamp program, as defined in
2 section 3(h) of the Food Stamp Act of 1977 (7
3 U.S.C. 2012(h)).

4 (11) The school lunch program carried out
5 under the National School Lunch Act (42 U.S.C.
6 1751 et seq.).

7 (12) The special supplemental food program for
8 women, infants, and children carried out under sec-
9 tion 17 of the Child Nutrition Act of 1966 (42
10 U.S.C. 1786).

11 (13) The nutrition programs carried out under
12 part C of title III of the Older Americans Act of
13 1965 (42 U.S.C. 3030e et seq.).

14 (14) The school breakfast program carried out
15 under section 4 of the Child Nutrition Act of 1966
16 (42 U.S.C. 1773).

17 (15) The child and adult care food program
18 carried out under section 17 of the National School
19 Lunch Act (42 U.S.C. 1766).

20 (16) The Emergency Food Assistance Act of
21 1983 (7 U.S.C. 612c note).

22 (17) The summer food service program for chil-
23 dren carried out under section 13 of the National
24 School Lunch Act (42 U.S.C. 1761).

1 (18) The commodity supplemental food pro-
2 gram authorized by section 4(a) of the Agriculture
3 and Consumer Protection Act of 1973 (7 U.S.C.
4 612c note).

5 (19) The special milk program carried out
6 under section 3 of the Child Nutrition Act of 1966
7 (42 U.S.C. 1772).

8 (20) The program of rental assistance on behalf
9 of low-income families provided under section 8 of
10 the United States Housing Act of 1937 (42 U.S.C.
11 1437f).

12 (21) The program of assistance to public hous-
13 ing under title I of the United States Housing Act
14 of 1937 (42 U.S.C. 1437 et seq.).

15 (22) The loan program under section 502 of the
16 Housing Act of 1949 (42 U.S.C. 1472).

17 (23) The program of interest reduction pay-
18 ments pursuant to contracts entered into by the Sec-
19 retary of Housing and Urban Development under
20 section 236 of the National Housing Act (12 U.S.C.
21 1715z-1).

22 (24) The program of loans for rental and coop-
23 erative housing under section 515 of the Housing
24 Act of 1949 (42 U.S.C. 1485).

1 (25) The program of rental assistance pay-
2 ments pursuant to contracts entered into under sec-
3 tion 521(a)(2)(A) of the Housing Act of 1949 (42
4 U.S.C. 1490a(a)(2)(A)).

5 (26) The program of assistance payments on
6 behalf of homeowners under section 235 of the Na-
7 tional Housing Act (12 U.S.C. 1715z).

8 (27) The program of rent supplement payments
9 on behalf of qualified tenants pursuant to contracts
10 entered into under section 101 of the Housing and
11 Urban Development Act of 1965 (12 U.S.C. 1701s).

12 (28) The loan and grant programs under sec-
13 tion 504 of the Housing Act of 1949 (42 U.S.C.
14 1474) for repairs and improvements to rural dwell-
15 ings.

16 (29) The loan and assistance programs under
17 sections 514 and 516 of the Housing Act of 1949
18 (42 U.S.C. 1484, 1486) for housing for farm labor.

19 (30) The program of grants for preservation
20 and rehabilitation of housing under section 533 of
21 the Housing Act of 1949 (42 U.S.C. 1490m).

22 (31) The program of grants and loans for mu-
23 tual and self-help housing and technical assistance
24 under section 523 of the Housing Act of 1949 (42
25 U.S.C. 1490c).

1 (32) The program of site loans under section
2 524 of the Housing Act of 1949 (42 U.S.C. 1490d).

3 (33) The program under part B of title IV of
4 the Higher Education Act of 1965.

5 (34) The program under subpart 1 of part A of
6 title IV of the Higher Education Act of 1965.

7 (35) The program under part C of title IV of
8 the Higher Education Act of 1965.

9 (36) The program under subpart 3 of part A of
10 title IV of the Higher Education Act of 1965.

11 (37) The program under part E of title IV of
12 the Higher Education Act of 1965.

13 (38) The program under subpart 4 of part A of
14 title IV of the Higher Education Act of 1965.

15 (39) The program under title IX of the Higher
16 Education Act of 1965.

17 (40) The program under subpart 5 of part A of
18 title IV of the Higher Education Act of 1965.

19 (41) The programs established in sections 338A
20 and 338B of the Public Health Service Act and the
21 programs established in part A of title VII of such
22 Act (relating to loans and scholarships for education
23 in the health professions).

24 (42) The program established in section
25 317(j)(1) of the Public Health Service Act (relating

1 to grants for immunizations against vaccine-prevent-
2 able diseases).

3 (43) The program established in section 317A
4 of the Public Health Service Act (relating to grants
5 for screening, referrals, and education regarding
6 lead poisoning in infants and children).

7 (44) The program established in part A of title
8 XIX of the Public Health Service Act (relating to
9 block grants for preventive health and health serv-
10 ices).

11 (45) The programs established in subparts I
12 and II of part B of title XIX of the Public Health
13 Service Act.

14 (46)(A) The program of training for disadvan-
15 taged adults and youth under part A of title II of
16 the Job Training Partnership Act (29 U.S.C. 1601
17 et seq.), as in effect before July 1, 1993.

18 (B)(i) The program of training for disadvan-
19 taged adults under part A of title II of the Job
20 Training Partnership Act (29 U.S.C. 1601 et seq.),
21 as in effect on and after July 1, 1993.

22 (ii) The program of training for disadvantaged
23 youth under part C of title II of the Job Training
24 Partnership Act (29 U.S.C. 1641 et seq.), as in ef-
25 fect on and after July 1, 1993.

1 (47) The Job Corps program under part B of
2 title IV of the Job Training Partnership Act (29
3 U.S.C. 1692 et seq.).

4 (48) The summer youth employment and train-
5 ing programs under part B of title II of the Job
6 Training Partnership Act (29 U.S.C. 1630 et seq.).

7 (49) The programs carried out under the Older
8 American Community Service Employment Act (42
9 U.S.C. 3001 et seq.).

10 (50) The programs under title III of the Older
11 Americans Act of 1965.

12 (51) The programs carried out under part B of
13 title II of the Domestic Volunteer Service Act of
14 1973 (42 U.S.C. 5011–5012).

15 (52) The programs carried out under part C of
16 title II of the Domestic Volunteer Service Act of
17 1973 (42 U.S.C. 5013).

18 (53) The program under the Low-Income En-
19 ergy Assistance Act of 1981 (42 U.S.C. 8621 et
20 seq.).

21 (54) The weatherization assistance program
22 under title IV of the Energy Conservation and Pro-
23 duction Act (42 U.S.C. 6851).

1 (55) The program of block grants to States for
2 social services under title XX of the Social Security
3 Act.

4 (56) The programs carried out under the Com-
5 munity Services Block Grant Act (42 U.S.C. 9901
6 et seq.).

7 (57) The program of legal assistance to eligible
8 clients and other programs under the Legal Services
9 Corporation Act (42 U.S.C. 2996 et seq.).

10 (58) The program for emergency food and shel-
11 ter grants under title III of the Stewart B. McKin-
12 ney Homeless Assistance Act (42 U.S.C. 11331 et
13 seq.).

14 (59) The programs carried out under the Child
15 Care and Development Block Grant Act of 1990 (42
16 U.S.C. 9858 et seq.).

17 (60) A State program for providing child care
18 under section 402(i) of the Social Security Act.

19 (61) The program of State legalization impact-
20 assistance grants (SLIAG) under section 204 of the
21 Immigration Reform and Control Act of 1986.

22 (e) NOTIFICATION OF ALIENS.—Any Federal agency
23 that administers a program referred to in subsection (d)
24 shall, directly or through the States, notify each alien re-

1 ceiving benefits under the program whose eligibility for the
2 program is or will be terminated by reason of this section.

3 **SEC. 802. STATE AFDC AGENCIES REQUIRED TO PROVIDE**
4 **INFORMATION ON ILLEGAL ALIENS TO THE**
5 **IMMIGRATION AND NATURALIZATION SERV-**
6 **ICE.**

7 Section 402(a) of the Social Security Act (42 U.S.C.
8 602(a)) is amended—

9 (1) by striking “and” at the end of paragraph
10 (44);

11 (2) by striking the period at the end of para-
12 graph (45) and inserting “; and”; and

13 (3) by inserting after paragraph (45) the fol-
14 lowing:

15 “(46) require the State agency to provide to the
16 Immigration and Naturalization Service the name,
17 address, and other identifying information that the
18 agency has with respect to any individual unlawfully
19 in the United States any of whose children is a citi-
20 zen of the United States.”.

1 **TITLE IX—INCREASE IN ASSIST-**
2 **ANCE TO COMMUNITY AND**
3 **MIGRANT HEALTH CENTERS**
4 **FROM RESIDUAL SAVINGS**

5 **SEC. 901. GRANT PROGRAM TO PROMOTE PRIMARY**
6 **HEALTH CARE SERVICES FOR UNDERSERVED**
7 **POPULATIONS.**

8 (a) AUTHORIZATION.—The Secretary of Health and
9 Human Services shall provide for a program of grants to
10 migrant and community health centers (receiving grants
11 or contracts under section 329, 330, or 340 of the Public
12 Health Service Act) in order to promote the provision of
13 primary health care services for underserved individuals.
14 Such grants may be used—

15 (1) to promote the provision of off-site services
16 (through means such as mobile medical clinics);

17 (2) to improve birth outcomes in areas with
18 high infant mortality and morbidity;

19 (3) to establish primary care clinics in areas
20 identified as in need of such clinics; and

21 (4) for recruitment and training costs of nec-
22 essary providers and operating costs for unreim-
23 bursed services.

1 (b) CONDITIONS.—(1) Grants under this subsection
2 shall only be made upon application, approved by the Sec-
3 retary.

4 (2) The amount of grants made under this section
5 shall be determined by the Secretary.

6 (c) AUTHORIZATION OF APPROPRIATIONS.—

7 (1) IN GENERAL.—Subject to paragraph (2),
8 there are authorized to be appropriated for each fis-
9 cal year, in the 5-fiscal-year period beginning with
10 fiscal year 1995, such amounts as the Secretary esti-
11 mates, in consultation with the Director of the Of-
12 fice of Management and Budget, reflects the net
13 savings to the Federal Government in the fiscal year
14 of the enactment of this Act.

15 (2) LIMITATION.—The total amount of funds
16 made available under this section in such 5-fiscal-
17 year period may not exceed \$13,100,000,000.

18 (3) USE OF FUNDS.—Of the amounts appro-
19 priated each fiscal year under this section, at least
20 10 percent shall be used for grants described in sub-
21 section (a)(1) and at least 10 percent shall be used
22 for grants described in subsection (a)(2). The Sec-
23 retary may use not to exceed 50 percent of the
24 amounts appropriated to carry out this section for
25 the purpose of making new grants or contracts

1 under sections 329, 330, and 340 of the Public
2 Health Service Act.

3 (d) STUDY AND REPORT.—The Secretary shall con-
4 duct a study of the impact of the grants made under this
5 section to migrant and community health centers on ac-
6 cess to health care, birth outcomes, and the use of emer-
7 gency room services. Not later than 2 years after the date
8 of the enactment of this Act, the Secretary shall submit
9 to Congress a report on such study and on recommenda-
10 tions for changes in the programs under this section in
11 order to promote the appropriate use of cost-effective out-
12 patient services.

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