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103D CONGRESS
1ST SESSION

H. R. 3704

To provide comprehensive reform of the health care system of the United States, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 22, 1993

Mr. THOMAS of California (for himself, Mrs. JOHNSON of Connecticut, Mr. GUNDERSON, and Mr. MACHTLEY) 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

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A BILL

To provide comprehensive reform of the health care system of the United States, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Equity and Access Reform Today Act of 1993''.

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

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TITLE I—BASIC REFORMS TO EXPAND ACCESS TO HEALTH INSURANCE COVERAGE AND TO ENSURE UNIVERSAL COVERAGE

Subtitle A—Universal Access

SEC. 1001. ACCESS FOR EACH INDIVIDUAL.

Each individual who is a citizen or lawful permanent resident of the United States is provided access to health insurance coverage under a qualified health plan under this title.

SEC. 1002. PROMOTION OF COVERAGE THROUGH EXPANDED TAX DEDUCTIBILITY.

For provisions expanding health insurance tax deductibility, see section 2002.

SEC. 1003. LOW-INCOME ASSISTANCE WITH QUALIFIED HEALTH PLAN PREMIUMS.

(a) PREMIUM ASSISTANCE TO QUALIFIED INDIVIDUALS AND FAMILIES.—With respect to each calendar year, in the case of a qualified family (as defined in subsection (b)), the Secretary shall provide for payment through a voucher of the voucher amount (specified in subsection (c)), which may be applied against the cost of the premium for a qualified health plan under this title.

(b) QUALIFIED FAMILY.—For purposes of this section—

(1) IN GENERAL.—Subject to paragraph (3), the term ''qualified family'' means a family (as defined in section 1601(8)) the family income of which does not exceed the phase-in eligibility percentage (specified in paragraph (2)) of the poverty line for a family of the size involved.

(2) PHASE-IN ELIGIBILITY PERCENTAGE.—For purposes of paragraph (1) and subject to subsection (d), the phase-in eligibility percentage shall be determined under the following table:

Calendar year:	Applicable phase-in percentage:
1997	90
1998	110
1999	130
2000	150
2001	170
2002	190
2003	210
2004	230
2005	240.

(3) NOT QUALIFIED DURING PERIOD OF COVERAGE UNDER MEDICAID.—No family is eligible for a voucher if such family is a member of a class or category described in 1902(a)(64) of the Social Security Act (as added by section 6011(b)).

(c) AMOUNT OF VOUCHER.—

(1) IN GENERAL.—The amount of a voucher specified in this subsection for a qualified family is the lesser of—

(A) the annual premium paid the individual or family for such year for coverage under a qualified health plan in which the family is enrolled, or

(B) the voucher percentage (specified in paragraph (2)) of the applicable dollar limit for such year for such family (determined under section 91(b)(2) of the Internal Revenue Code of 1986, as added by section 2001 of this Act, and determined on an annual basis).

(2) VOUCHER PERCENTAGE.—For purposes of paragraph (1), the term ''voucher percentage'' means, for a family, 100 percent reduced (but not below zero percent) by the ratio of 100 to 140 for each 1 percentage point (or portion thereof) such family's income equals or exceeds 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(d) MODIFICATION OF PHASE-IN OF ELIGIBILITY.—

(1) ESTIMATION OF TOTAL EXPENDITURES.—Between July 15 and August 1 of each calendar year (beginning with 1997), the Director of the Office of Management and Budget (in this subsection referred to as the ''Director'') shall estimate the sum of—

(A) the expenditures under titles XVIII and XIX of the Social Security Act for the fiscal year beginning in such year, and

(B) the total amount of the vouchers to be provided under this section in that fiscal year.

(2) COMPARISON WITH BASELINE.—

(A) MORE SAVINGS THAN ANTICIPATED.—If the sum estimated under paragraph (1) for a fiscal year is less than the baseline amount under paragraph (3) for the fiscal year, then paragraph (4) shall apply for the fiscal year.

(B) LESS SAVINGS THAN ANTICIPATED.—If the sum estimated under paragraph (1) for a fiscal year is more than the baseline amount under paragraph (3), then paragraph (5)(B) shall apply for the fiscal year (except as provided in paragraph (5)(A)).

(C) REPORT TO CONGRESS.—The Director shall promptly report to Congress on determinations under subparagraph (A).

(3) BASELINE.—For purposes of this subsection, the baseline amount under this paragraph for fiscal year—

(A) 1997, is $318,000,000,000;

(B) 1998, is $352,000,000,000;

(C) 1999, is $391,000,000,000;

(D) 2000, is $435,000,000,000;

(E) 2001, is $483,000,000,000;

(F) 2002, is $535,000,000,000;

(G) 2003, is $593,000,000,000; or

(H) 2004 and any succeeding fiscal year, is the baseline under this paragraph for the previous fiscal year increased by the percentage increase in the per capita Gross Domestic Product for the previous fiscal year.

(4) APPLICATION OF SAVINGS TO INCREASE ELIGIBILITY FOR VOUCHERS.—

(A) IN GENERAL.—If this paragraph applies for a year (before 2005), subject to subparagraph (B), the applicable percentage under subsection (b)(2) for the year shall be increased by such whole number of percentage points as the Director estimates will result in aggregate additional expenditures in the year that do not exceed the amount by which the baseline amount under paragraph (3) for the fiscal year will exceed the sum estimated under paragraph (1) for the fiscal year. Such increase shall only apply to that calendar year involved.

(B) LIMITATION.—In no case shall the increase under subparagraph (A) for a year result in an applicable percentage exceeding the applicable percentage specified in the table in subsection (b)(2) for the following year.

(5) RECOVERY OF DEFICIT THROUGH ADJUSTMENT MECHANISM.—

(A) IN GENERAL.—In the case described in paragraph (2)(B), the Director shall submit to the Benefits Commission a report on the deficit for the year. With respect to a fiscal year in which subparagraph (B)(i) applies, the Commission may submit recommended modifications to the Congress in response to such a deficit. With respect to a fiscal year in which subparagraph (B)(ii) applies, the Commission shall submit recommended modifications to the Congress in response to such a deficit. If Congress adopts the modifications recommended by the Commission under such section, then subparagraph (B) shall not apply for such year.

(B) ADJUSTMENT MECHANISM.—

(i) BEFORE FULL PHASE-IN.—If this subparagraph applies for a year (up to the full phase-in year (as defined in clause (iii), then for the following year the phase-in eligibility percentage under subsection (b)(2) shall be decreased by such whole number of percentage points as the Director estimates will result in aggregate de-

crease in expenditures that are equal to the amount by which the sum estimated under paragraph (1) for the fiscal year will exceed the baseline amount under paragraph (3) for the fiscal year. Such decrease shall only apply to the year involved.

(ii) AFTER FULL PHASE-IN.—If this subparagraph applies for a year (after the full phase-in year), then for the following year the phase-in eligibility percentage under subsection (b)(2) shall be decreased by such whole number of percentage points as the Director estimates will result in aggregate decrease in expenditures that are equal to the amount by which the sum estimated under paragraph (1) for the fiscal year will exceed the baseline amount under paragraph (3) for the fiscal year. Such decrease shall only apply to the year involved.

(iii) FULL PHASE-IN YEAR DEFINED.—In this subparagraph, the term ''full phase-in year'' means the first year in which the phase-in eligibility percentage under subsection (b)(2) has equaled 240 percent.

(C) REPORT TO CONGRESS.—The Director shall submit to Congress a report on any determinations and any adjustments under this paragraph.

(6) ACCUMULATION OF SMALL DEFICITS.—If the sum estimated under paragraph (1) for a fiscal year is determined by the Director to be such a small amount as to not be administratively cost efficient, no adjustments need be made.

(7) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review of any determination under this subsection.

(e) APPLICATION FOR ASSISTANCE.—

(1) IN GENERAL.—Any family may file an application for a voucher under this section at any time in accordance with this subsection.

(2) USE OF SIMPLE FORM.—The Secretary shall use an application which shall be as simple in form as possible and understandable to the average individual. The application may require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance. The Secretary shall use, as deemed practicable by the Secretary, any existing forms employed for Fed-

eral income tax filings as an application for assistance.

(3) AVAILABILITY OF FORMS.—The Secretary shall make application forms available through health care providers and plans, public assistance offices, public libraries, and at other locations (including post offices) accessible to a broad cross-section of families.

(4) SUBMISSION OF APPLICATION FORM.—An application form under this subsection may be submitted in such manner as the Secretary shall provide.

(5) PERMITTING SUBMISSION OF REVISED APPLICATION.—During a year, a family may submit a revised application to reflect changes in the estimated income of the family, including changes in employment status of family members, during the year. The voucher amount shall be revised to reflect such a revised application.

(6) ENROLLMENT AT POINT OF APPLICATION.—To the extent practicable, the Secretary shall provide for the option of enrollment in a qualified health plan as part of the application and approval process for assistance under this section. In providing for such an option, the Secretary may require

the State of residence to provide such information and assistance regarding qualified health plans and purchasing groups as may be necessary.

(f) DETERMINATION OF ELIGIBILITY.—

(1) IN GENERAL.—The Secretary shall provide in a prompt manner for—

(A) a determination of eligibility on each application for a voucher submitted under subsection (e), and

(B) notice of such determination to the family involved.

(2) ELECTION WITH RESPECT TO INCOME DETERMINATION.—As elected by a family at the time of submission of an application for a voucher under this section, income shall be determined either—

(A) by multiplying by a factor of 4 the income for the 3-month period immediately preceding the month in which the application is made, or

(B) based upon estimated income for the entire year in which the application is submitted.

(g) USE OF VOUCHER.—A voucher provided to a family under this section shall be remitted by any individual in such family to the qualified health plan, the pur-

chasing group, or, in the case of an employment-related qualified health plan, to the employee's employer, as the case may be, for payment by the Secretary. The qualified health plan, purchasing group, or employer shall make proper adjustments in billing statements to reflect such family's remaining premium obligations (if any).

(h) RECONCILIATION.—

(1) NOTICE OF VOUCHER AMOUNT BY SECRETARY.—In the case of a qualified family that has received a voucher under this section for any month in a year, the Secretary shall, not later than January 31 of the following year, notify such family of the total amount of the vouchers that such family received during the year.

(2) FILING OF NOTICE.—A family that receives a notice under paragraph (1) shall attach such notice to the tax return filed by such family for the year involved. The Secretary of the Treasury shall establish a procedure to enable a family that is not required to file a tax return for the year involved to file the notice received under paragraph (1).

(3) RECONCILIATION OF ASSISTANCE BASED ON ACTUAL INCOME.—

(A) IN GENERAL.—Based on and using the information contained in the notice filed under

paragraph (2) with respect to a family, the Secretary of the Treasury shall compute the amount of the voucher that should have been provided under this section with respect to the family in the year involved.

(B) OVERPAYMENT OF VOUCHER.—If the amount of the voucher provided was greater than the amount computed under subparagraph (A), the excess amount shall be treated as an underpayment of a tax imposed by chapter 1 of the Internal Revenue Code of 1986 and paid by the Secretary of the Treasury to the family involved.

(C) UNDERPAYMENT OF VOUCHER.—If the amount computed under subparagraph (A) is greater than the amount of the voucher provided, the amount of the difference shall be treated as an overpayment of tax imposed by such chapter, or in the event such family is entitled to a refund of such a tax, subject to the provisions of section 6402(d) of such Code.

(4) FAILURE TO FILE.—In the case of any family that is required to file a notice under paragraph (2) for a year and that fails to file such a notice by the deadline specified by the Secretary, the entire

amount of the voucher provided in such year shall be considered the excess amount under paragraph (3)(B). The Secretary shall waive the application of this paragraph if the family establishes, to the satisfaction of the Secretary, good cause for the failure to file the notice on a timely basis.

(5) PENALTIES FOR FALSE INFORMATION.—Any individual who knowingly makes a material misrepresentation of information in an application for assistance under this section, shall be liable to the Federal Government for excess payments made based on such misrepresentation and interest on such excess payments at a rate specified by the Secretary, and, in addition, shall be liable to the Federal Government for $1,000 or, if greater, 3 times the excess payments made based on such misrepresentation.

(6) INSTRUCTIONS FOR FILING NOTICE.—The Secretary shall provide instructions for filing the notice described in paragraph (2) (in such form as the Secretary prescribes) no later than January 31 of the year following the year involved.

(i) ADMINISTRATION BY A STATE.—Upon application of a State, the Secretary may provide for the administra-

tion of this section in a State through an appropriate State agency.

(j) DEFINITIONS AND DETERMINATION OF INCOME.—For purposes of this section:

(1) POVERTY LINE.—The term ''poverty line'' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(2) DETERMINATIONS OF INCOME.—

(A) IN GENERAL.—The term ''income'' means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

(i) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code; and

(ii) increased by—

(I) the amount of interest received or accrued which is exempt from tax, plus

(II) the amount of social security benefits (described in section 86(d) of such Code) which is not includible in

gross income under section 86 of such Code.

(B) FAMILY INCOME.—The term ''family income'' means, with respect to a family, the sum of the income for all members of the family (as defined in section 1601(8)), not including the income of a dependent child with respect to which no return is required under the Internal Revenue Code of 1986.

(C) FAMILY SIZE.—The family size to be applied under this section, with respect to family income, is the number of individuals included in the family for purposes of coverage under a qualified health plan.

SEC. 1004. EXPANDED ACCESS TO EMPLOYER PLANS.

(a) QUALIFIED HEALTH PLANS MADE AVAILABLE.—Each employer shall make available, either directly, through a purchasing group, or otherwise, enrollment in a qualified health plan to each eligible employee of such employer. A small employer may meet the requirement of the previous sentence only through a qualified insured health plan.

(b) FORWARDING INFORMATION.—

(1) INFORMATION REGARDING PLANS.—An employer must provide each employee of such employer

(including any part-time or seasonal employee) with information provided by the State under section 1405 regarding all qualified health plans offered in the health care coverage area (in this title referred to as a ''HCCA'') in which the employer is located and, if the employee resides in another HCCA, information regarding how to obtain information on qualified health plans offered to residents of such other HCCA.

(2) INFORMATION REGARDING EMPLOYEES.—An employer must forward the name and address (and any other necessary identifying information specified by the Secretary) of each eligible employee—

(A) to the qualified health plan in which such employee is enrolled, or

(B) to the purchasing group (if any) through which such enrollment is made.

(c) PAYROLL DEDUCTION.—

(1) IN GENERAL.—If an employer is advised by a qualified health plan (or by a purchasing group on behalf of a qualified insured health plan) that an eligible employee is enrolled in such a plan, the employer, upon authorization by the employee, shall provide for the deduction, from the employee's wages

or other compensation, of the premium amount due (less any employer contribution) to the plan or purchasing group.

(2) APPLICATION OF VOUCHER.—The employer shall reduce the amount so deducted by the amount of any voucher (described in section 1003) presented by the employee to the employer.

(d) LIMITED EMPLOYER OBLIGATION.—Nothing in this section shall be construed as requiring an employer to make, or preventing such employer from making, an employer contribution toward coverage of employees (and their dependents) under a qualified health plan.

(e) NO REQUIREMENT TO ENROLL IN EMPLOYER-PROVIDED PLAN.—An eligible employee of a small employer may elect not to enroll in a qualified health plan offered by an employer under this section. Such an employee may enroll—

(1) in any qualified health plan offered in the HCCA in which the employee works or in which the employee resides (including qualified health plans offered through purchasing groups serving such HCCA), or

(2) in a plan offered by an association which is organized for purposes other than to offer health plan coverage to the association's members and

which is offering such coverage as of the date of the enactment of this Act.

Subtitle B—Qualified General Access Plans in the Small Employer and Individual Marketplace

PART I—STANDARDS FOR GENERAL ACCESS PLANS

Subpart A—Establishment and Application of Standards

SEC. 1101. QUALIFIED GENERAL ACCESS PLANS.

(a) IN GENERAL.—In order to be a qualified general access plan, a health plan must be certified under subtitle E as meeting the applicable standards established under section 1102 for a qualified general access plan.

(b) SPECIAL RULES FOR LARGE EMPLOYER PLANS.—For special rules regarding the application of similar standards to large employer plans, see part I of subtitle C.

(c) CONSTRUCTION.—Whenever in this title a requirement or standard is imposed on a health plan, the requirement or standard is deemed to have been imposed on the insurer or health plan sponsor of the plan in relation to that plan.

SEC. 1102. ESTABLISHMENT OF STANDARDS.

(a) ROLE OF THE NAIC.—The Secretary shall request that the National Association of Insurance Commissioners—

(1) develop specific standards, in the form of a model Act and model regulations, to implement the requirements of sections 1111 through 1117 and 1122 of subpart B; and

(2) report to the Secretary on such standards, within 6 months after the date of the enactment of this Act. If such Association develops such standards within such period and the Secretary finds that such standards implement the requirements of such section, such standards shall be applicable under this part.

(b) ROLE OF THE SECRETARY.—If the National Association of Insurance Commissioners Association fails to develop and report on the standards described in subsection (a) by the date specified in such subsection or the Secretary finds that such standards do not implement the requirements of sections 1111 through 1117 and 1122, the Secretary shall develop and publish such standards, by not later than the date that is 1 year after the date of enactment of this Act, and such standards shall be applicable under this part.

(c) REFERENCE TO INSURANCE REFORM STANDARDS.—For purposes of this subtitle, the term ''insurance

reform standards'' means the standards developed under this section and applicable under this part and includes the requirements under sections 1118 through 1122 of subpart B.

SEC. 1103. APPLICATION OF INTERIM REQUIREMENTS.

(a) IN GENERAL.—Prior to the date on which a State establishes a certification program under subsection (a), an insurer may only offer an insured health plan in such State if such plan meets the requirements specified in subsection (c) applicable to qualified general access plans.

(b) NONCOMPLIANCE.—An insurer that offers an insured health plan in a State referred to in subsection (a) that fails to meet the requirements of subsection (c) shall be subject to a sanction under the amendment made by section 2403(a).

(c) REQUIREMENTS APPLICABLE.—For purposes of this section, the requirements of this subsection are the requirements specified in the following provisions:

(1) Subsections (a), (e), and (f) of section 1111 (relating to guaranteed eligibility, availability, and renewability).

(2) Section 1112 (relating to nondiscrimination based on health status), except (for purposes of this section) that—

(A) any reference to 3 months in section 1112(b)(1)(A) is deemed a reference to 6 months,

(B) any reference to 6 months in section 1112(b)(1)(B) is deemed a reference to 9 months, and

(C) any reference to 3-month period in section 1112(b)(3)(B) is deemed a reference to 6-month period.

(3) Section 1114 (relating to financial solvency requirements).

(4) Section 1116(d) (relating to rating limitations).

(5) Section 1120 (relating to mediation procedures).

Subpart B—Standards

SEC. 1111. GUARANTEED ELIGIBILITY, AVAILABILITY, AND RENEWABILITY.

(a) IN GENERAL.—Except as otherwise provided in this section, no insurer may exclude from coverage under a qualified general access plan any eligible employee or eligible individual applying for coverage.

(b) STANDARDS.—The insurance reform standards shall prohibit marketing or other practices by an insurer intended to discourage or limit the issuance of a qualified

general access plan to an eligible employee or eligible individual on the basis of health status, employer size or industry, geographic area, or other risk factors.

(c) AVAILABILITY.—A qualified general access plan must be made available throughout the entire HCCA in which such plan is offered.

(d) GEOGRAPHIC LIMITATIONS.—A qualified general access plan may deny coverage under the plan to an eligible employee or eligible individual who resides outside the HCCA in which such plan is offered, but only if such denial is applied uniformly, without regard to health status or insurability of individuals.

(e) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a qualified general access plan may apply to the appropriate certifying authority (as defined in section 1601(1)) to cease enrolling eligible employees and eligible individuals under the plan if—

(A) the plan ceases to enroll any new eligible employees and eligible individuals; and

(B) the plan can demonstrate to the applicable certifying authority that its financial or provider capacity to serve previously covered groups or individuals (and additional individuals who will be expected to enroll because of

affiliation with such previously covered groups or individuals) will be impaired if it is required to enroll other eligible employees and eligible individuals.

(2) FIRST-COME-FIRST-SERVED.—A qualified general access plan is only eligible to exercise the limitations provided for in paragraph (1) if such plan provides for enrollment of eligible employees and eligible individuals on a first-come-first-served basis (except in the case of additional individuals described in paragraph (1)(B)).

(f) RENEWABILITY.—

(1) IN GENERAL.—A qualified general access plan that is issued to a small employer, eligible employee, or eligible individual shall be renewed, at the option of the employer, employee, or individual, unless the plan is terminated for a reason specified in paragraph (2) or (3).

(2) GROUNDS FOR REFUSAL TO RENEW.—An insurer may refuse to renew, or may terminate, a qualified general access plan under this subtitle only for—

(A) nonpayment of premiums;

(B) fraud or misrepresentation; or

(C) change in residence to a HCCA not served under the plan.

(3) TERMINATION.—

(A) IN GENERAL.—An insurer is not required to renew or make available a qualified general access plan through a particular type of delivery system (as defined in section 1601) with respect to a small employer, eligible employee, or eligible individual, if the insurer—

(i) elects not to renew all of its qualified general access plans using such delivery system issued to small employers, eligible employees, and eligible individuals in a HCCA; and

(ii) provides notice to the appropriate certifying authority and to each small employer and eligible individual covered under the plan of such termination at least 180 days before the date of expiration of the plan.

(B) PROHIBITION ON MARKET REENTRY.—In the case of such a termination, the insurer may not provide for issuance of any qualified general access plan using such a delivery system to an eligible employer, eligible employee,

or eligible individual in the State during the 5-year period beginning on the date of the termination of the last plan not so renewed.

(g) EXCEPTION DURING TRANSITION.—

(1) IN GENERAL.—Until the date specified in section 1501, an insurer may exclude from coverage any individual who does not apply for enrollment on a timely basis, consistent with this subsection.

(2) CLARIFICATION OF TIMELY ENROLLMENT.—

(A) GENERAL INITIAL ENROLLMENT REQUIREMENT.—Except as provided in this paragraph, an insurer may consider enrollment of an eligible employee or eligible individual in a plan not to be timely if such employee or individual fails to enroll in the plan during an initial enrollment period, if such period is at least 30 days long.

(B) ENROLLMENT DUE TO LOSS OF PREVIOUS EMPLOYER COVERAGE.—Enrollment in a qualified general access plan is considered to be timely in the case of an eligible employee or eligible individual who—

(i) was covered under another health plan at the time of the individual's initial enrollment period,

(ii) stated at the time of the initial enrollment period that coverage under a health plan was the reason for declining enrollment,

(iii) lost coverage under another health plan (as a result of the termination of the other plan's coverage, termination or reduction of employment, or other reason), and

(iv) requests enrollment within 30 days after termination of such coverage.

(C) REQUIREMENT APPLIES DURING OPEN ENROLLMENT PERIODS.—Each qualified general access plan shall provide for at least one period (of not less than 30 days) each year during which enrollment under the plan shall be considered to be timely.

(D) EXCEPTION FOR COURT ORDERS.—Enrollment of a spouse or minor child of an eligible employee or eligible individual shall be considered to be timely if—

(i) a court has ordered that coverage be provided for the spouse or child under a covered employee's or individual's health plan, and

(ii) a request for enrollment is made within 30 days after the date the court issues the order.

(E) ENROLLMENT OF SPOUSES AND DEPENDENTS.—

(i) IN GENERAL.—Enrollment of the spouse (including a child of the spouse) and any dependent child of an eligible employee or eligible individual shall be considered to be timely if a request for enrollment is made either—

(I) within 30 days of the date of the marriage or of the date of the birth or adoption of a child, if family coverage is available as of such date, or

(II) within 30 days of the date family coverage is first made available.

(ii) COVERAGE.—If a plan makes family coverage available and enrollment is

made under the plan on a timely basis under clause (i)(I), the coverage shall become effective not later than the first day of the first month beginning after the date of the marriage or the date of birth or adoption of the child (as the case may be).

SEC. 1112. NONDISCRIMINATION BASED ON HEALTH STATUS.

(a) IN GENERAL.—Except as provided under subsection (b), a qualified health plan may not deny, limit, or condition the coverage under (or benefits of) the plan based on the health status, claims experience, receipt of health care, execution of an advance directive, medical history, or lack of evidence of insurability, of an individual.

(b) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

(1) IN GENERAL.—A qualified health plan may not impose (and an insurer may not require a small employer under a qualified health plan to impose through a waiting period for coverage under a plan or similar requirement) a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual if—

(A) the condition relates to a condition that was not diagnosed or treated during the 3-month period ending on the day before the first date of coverage under the plan;

(B) the limitation or exclusion extends over more than 6 months after the date of coverage under the plan;

(C) the limitation or exclusion applies to an individual who, as of the date of birth, was covered under the plan; or

(D) the limitation or exclusion relates to pregnancy.

In the case of an individual who is eligible for coverage under a qualified health plan but for a waiting period imposed by an employer, in applying subparagraphs (A) and (B), the individual shall be treated as having been covered under the plan as of the earliest date of the beginning of the waiting period.

(2) CREDITING OF PREVIOUS COVERAGE.—A qualified health plan shall provide that if an individual under such plan is in a period of continuous coverage with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall

be reduced by 1 month for each month in the period of continuous coverage.

(3) DEFINITIONS.—As used in this subsection:

(A) PERIOD OF CONTINUOUS COVERAGE.—The term ''period of continuous coverage'' means, with respect to particular services, the period beginning on the date an individual is enrolled under a qualified health plan or an equivalent health care program which provides benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(B) PREEXISTING CONDITION.—The term ''preexisting condition'' means, with respect to coverage under a qualified health plan, a condition the diagnosis of which was known or which was treated, within the 3-month period ending on the day before the first date of such coverage (without regard to any waiting period).

SEC. 1113. BENEFITS OFFERED.

(a) IN GENERAL.—A qualified general access plan shall—

(1) offer to all enrollees in the plan coverage for the covered items and services specified under subtitle D;

(2) imposes on such enrollees the cost sharing requirements for such items and services specified under such subtitle;

(3) demonstrate the ability to provide such items and services throughout the HCCA in which the plan enrolls individuals; and

(4) covers the routine medical costs of certain investigational treatments referred to in section 1301(d)(3).

However, no specific procedure or treatment is required to be covered in such a plan.

(b) AVAILABILITY OF SERVICES IN ENTIRE COVERAGE AREA.—Each qualified general access plan offered in a HCCA shall provide assurances to the appropriate certifying authority that it has the capacity to deliver the full range of covered items and services to potential enrollees who reside within the HCCA served by the plan.

(c) LIMITATION ON OFFERING ADDITIONAL BENEFITS.—An insurer offering a qualified general access plan may only offer coverage of items and services that are not covered items or services, or a reduction in cost sharing below the cost sharing specified under subtitle D for the benefit package applicable, if—

(1) such additional coverage is offered and priced separately from the standard or catastrophic package offered;

(2) the purchase of the plan is not conditioned upon the purchase of such additional coverage; and

(3) coverage of such additional items and services is offered to individuals who are not enrolled in such plan.

(d) APPLICATION OF ARBITRATION.—A qualified general access plan shall provide for a mandatory binding arbitration in accordance with the process described in section 1407.

SEC. 1114. FINANCIAL SOLVENCY REQUIREMENTS.

(a) SOLVENCY PROTECTION.—Each insurer offering a qualified general access plan shall meet financial solvency requirements to assure protection of enrollees with respect to potential insolvency.

(b) PROTECTION AGAINST PROVIDER CLAIMS.—In the case of a failure of a qualified general access plan to make payments with respect to covered items and services, an individual who is enrolled under the plan is not liable to any health care provider or practitioner with respect to the provision of such items and services for payments in excess of the amount for which the enrollee would have

been liable if the plan were to have made payments in a timely manner.

SEC. 1115. ENROLLMENT.

(a) ENROLLMENT PROCESS.—

(1) IN GENERAL.—A qualified general access plan shall establish an enrollment process consistent with this subsection.

(2) INITIAL ENROLLMENT PERIOD.—Each eligible employee or eligible individual, at the time the individual first becomes an eligible employee or eligible individual in the HCCA in which a qualified general access plan is offered, shall have an initial enrollment period (of not less than 30 days) in which to enroll in the plan.

(3) GENERAL ENROLLMENT PERIOD.—Each qualified general access plan shall permit eligible employees and eligible individuals to enroll (or change enrollment) in the plan during each general annual enrollment period specified by the appropriate certifying authority under section 1408.

(4) SPECIAL ENROLLMENT PERIODS.—In the case of an eligible employee or eligible individual who—

(A) through marriage, divorce, birth, or adoption of a child, or similar circumstances, experiences a change in family composition;

(B) experiences a change in employment status (including a significant change in the terms and conditions of employment); or

(C) changes residence to another HCCA;

each qualified general access plan shall provide for a special enrollment period in which the employee or individual is permitted to change the individual or family basis of coverage or the plan in which the employee or individual is enrolled. The circumstances under which such special enrollment periods are required and the duration of such periods shall be specified in the insurance reform standards.

(5) TRANSITIONAL ENROLLMENT PERIOD.—Each qualified general access plan that will be offered at the beginning of the first certification year (as defined in section 1601(9)) shall provide for a special transitional enrollment period (during a period beginning in the months of October through December of the previous year) during which eligible employees and eligible individuals may first enroll.

(b) PERIOD OF COVERAGE.—

(1) INITIAL ENROLLMENT PERIOD.—In the case of an eligible employee or eligible individual who enrolls with a qualified general access plan during an initial enrollment period, coverage under the plan shall begin on such date (not later than the first day of the first month that begins at least 15 days after the date of enrollment) as the insurance reform standards specify.

(2) GENERAL ENROLLMENT PERIODS.—In the case of an eligible employee or eligible individual who enrolls with a qualified general access plan during a general enrollment period, coverage under the plan shall begin on the first day of the first month beginning at least 15 days after the end of such period.

(3) SPECIAL ENROLLMENT PERIODS.—

(A) IN GENERAL.—In the case of an eligible employee or eligible individual who enrolls with a qualified general access plan during a special enrollment period described in subsection (a)(4), coverage under the plan shall begin on such date (not later than the first day of the first month that begins at least 15 days after the date of enrollment) as the insurance reform standards specify, except that coverage of family members shall begin as soon as pos-

sible on or after the date of the event that gives rise to the special enrollment period.

(B) TRANSITIONAL SPECIAL ENROLLMENT PERIOD.—In the case of an eligible employee or eligible individual who enrolls with a qualified general access plan during the transitional special enrollment period described in subsection (a)(5), coverage under the plan shall begin on January 1 of the first certification year.

(4) MINIMUM PERIOD OF ENROLLMENT.—

(A) IN GENERAL.—In order to avoid adverse selection, each qualified general access plan may require, consistent with the insurance reform standards, that enrollments with the plan be for not less than a specified minimum enrollment period (with exceptions permitted for such exceptional circumstances as the standards may recognize).

(B) SUNSET.—Subparagraph (A) shall not apply on and after the date that the universal coverage requirement of section 1501 first applies.

SEC. 1116. RATING LIMITATIONS.

(a) LIMIT ON VARIATION OF PREMIUMS FOR ENROLLEES UNDER AGE 65.—

(1) IN GENERAL.—Subject to paragraph (2), the premium charged by an insurer for coverage under a qualified general access plan offered to all eligible employees and eligible individuals within an age band specified under subsection (b) for a class of family enrollment in a HCCA may not exceed such premium within another age band for such class and HCCA so specified by more than—

(A) 20 percent, for the first certification year,

(B) 18, 16, 14, and 12 percent, for each of the next 4 respective years, and

(C) 10 percent for each succeeding year thereafter.

(2) ADJUSTMENT BASED ON DIFFERENCES IN ADMINISTRATIVE COSTS.—In accordance with the insurance reform standards, an insurer may vary the premiums based on identifiable differences in marketing and other legitimate administrative costs (as defined in such standards), except that such premiums may not vary under this paragraph with respect to enrollees within a particular purchasing group.

(b) ESTABLISHMENT OF CLASSES OF FAMILY ENROLLMENT AND AGE BANDS.—

(1) CLASSES OF FAMILY ENROLLMENT.—For purposes of this title, there are 2 classes of family enrollment:

(A) Enrollment of an individual without dependents (in this section referred to as ''individual enrollment'').

(B) Enrollment of an individual with dependents.

(2) AGE BANDS.—For purposes of this title, the insurance reform standards shall specify age bands for individuals under 65 years of age, which shall be applied to the premium for each class of family enrollment based on the age of the principal or other enrollee (as specified under such standards).

(c) STANDARD PREMIUMS WITH RESPECT TO ELIGIBLE EMPLOYEES AND ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Each qualified general access plan to be offered to an eligible employee or eligible individual which provides for—

(A) the standard package, shall establish a standard premium for such package, or

(B) the catastrophic package, shall establish a standard premium for such package,

for individual enrollment within each HCCA in which the plan is offered. Subject to paragraph (2),

within a HCCA for eligible employees and eligible individuals, the standard premium for each such package for all such employees and individuals shall be the same.

(2) APPLICATION TO INDIVIDUALS.—The premium charged for coverage in a qualified general access plan shall be the product of—

(A) the standard premium (established under paragraph (1));

(B) in the case of enrollment other than individual enrollment, the family adjustment factor specified under paragraph (3); and

(C) the age factor (specified under paragraph (4)) for the age band in which the enrollment is classified.

(3) FAMILY ADJUSTMENT FACTOR.—The insurance reform standards shall specify a family adjustment factor that reflects the relative actuarial costs of benefit packages based on a family enrollment (as compared with such costs for individual enrollment). Such factor may be different for the standard package and the catastrophic package, but may not differ based on the geographic area in which the plan is offered.

(4) AGE ADJUSTMENT FACTOR.—

(A) IN GENERAL.—The insurance reform standards shall specify, for each age band established under subsection (b)(2), an age adjustment factor that reflects the relative actuarial costs of benefit packages among enrollees classified in the different age bands. Such factors may be different for the standard package and the catastrophic package.

(B) LIMIT ON VARIATION IN AGE ADJUSTMENT FACTORS.—The highest age adjustment factor may not exceed twice the lowest age adjustment factor.

(d) FULL DISCLOSURE OF RATING PRACTICES.—

(1) IN GENERAL.—At the time an insurer offers a qualified general access plan, the insurer shall fully disclose rating practices for such plan.

(2) NOTICE ON EXPIRATION.—An insurer providing a qualified general access plan shall provide for notice, at least 60 days before the date of expiration of the plan, of the terms for renewal of the plan. Such notice shall include an explanation of the extent to which any increase in premiums is due to actual or expected claims experience of the individuals covered under the plan contract.

(e) NOTIFICATION OF FAILURE TO RECEIVE PREMIUM.—If a qualified general access plan fails to receive payment on a premium due with respect to an individual covered under the plan, the plan shall provide notice of such failure to the individual within the 20-day period after the date on which such premium payment was due.

(f) ACTUARIAL CERTIFICATION.—Each insurer shall file annually with the appropriate certifying authority a written statement by a member of the American Academy of Actuaries (or other individual acceptable to such authority) certifying that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for qualified general access plans—

(1) the insurer is in compliance with the applicable provisions of this section; and

(2) the rating methods are actuarially sound.

Each insurer shall retain a copy of such statement for examination by any individual at its principal place of business.

(g) PAYMENT OF PREMIUMS.—

(1) IN GENERAL.—With respect to a new enrollee in a qualified general access plan, the plan may require advanced payment of an amount equal

to monthly applicable premium for the plan at the time such individual is enrolled.

(2) REQUIREMENT FOR PAYROLL DEDUCTIONS.—

(A) IN GENERAL.—Subject to subparagraph (C)(ii), a qualified general access plan may require, in the case of an individual enrolled under the plan as an eligible employee, that payment of premiums with respect to the individual be made through payroll deduction.

(B) FREQUENCY.—In the case of an eligible employee who is paid wages or other compensation—

(i) on a monthly or more frequent basis, a qualified general access plan may not require the employer to provide for payment of such an amount other than at the same time at which such an amount is deducted from such wages or other compensation, or

(ii) less frequently than monthly, a qualified general access plan may require the employer to provide for payment of such an amount on a monthly basis.

(C) EMPLOYEE PROTECTIONS.—

(i) WITHHOLDING CONSTITUTES SATISFACTION OF OBLIGATION.—Withholding of an amount by an employer under this paragraph shall constitute satisfaction of the employee's obligation to pay the qualified general access plan with respect to such amount.

(ii) DIRECT PAYMENT ALLOWED IN CASE OF NONPAYMENT.—In the case of the nonpayment to a qualified general access plan of any amount withheld by an employer, the plan shall notify such employee of such nonpayment and shall allow the employee to make direct payments to the plan effective with the next succeeding payment period.

SEC. 1117. RISK ADJUSTMENT.

(a) IN GENERAL.—Each qualified general access plan shall participate in a risk adjustment program of the State (or the Secretary if the Secretary is the appropriate certifying authority) described in section 1406.

(b) RISK ADJUSTMENT PROCESS AND FACTORS.—

(1) IN GENERAL.—The insurance reform standards shall specify the risk adjustment process and

factors to be used under such risk adjustment programs.

(2) FACTORS.—

(A) IN GENERAL.—Such risk-adjustment factors shall be established for each class of family enrollment in a qualified general access plan based on all individuals in such class enrolled in the plan. Each factor shall be correlated with increased or diminished risk for consumption of the type of health services included in the covered items and services under section 1301. To the maximum extent practicable, such factors shall be determined without regard to the delivery system used by individual qualified general access plans in the provision of such items and services.

(B) RULES.—In determining such a factor for a class, in the case of a qualified general access plan that—

(i) on average has a lower-than-average risk for consumption of the covered items and services, the factor shall be a number, less than zero, reflecting the degree of such lower risk;

(ii) has an average risk for consumption of such items and services, the factor shall be zero; or

(iii) on average has a higher-than-average risk for consumption of such items and services, the factor shall be a number, greater than zero, reflecting the degree of such higher risk.

SEC. 1118. COLLECTION AND PROVISION OF STANDARDIZED INFORMATION.

(a) IN GENERAL.—A qualified health plan shall provide the State (at a time, not less frequently than annually) such information as the Secretary shall prescribe by regulation as necessary, consistent with this section and sections 1405 and 3301, to evaluate the performance of the qualified health plan and to prepare the comparative materials described in section 1405. A qualified general access plan shall provide each State with such additional information as such State may determine to be necessary with respect to qualified general access plans. The data collection standards shall specify the standardized format for such information (including model forms) for use by qualified health plans in providing information under this subsection. Such standards shall be consistent with subtitle B of title III.

(b) USE OF UNIFORM CLAIMS FORMS.—Each qualified health plan shall use standardized forms, including uniform claims forms, identified by the insurance reform standards.

(c) CONDITIONING CERTAIN PROVIDER PAYMENTS.—

(1) IN GENERAL.—In order to assure the collection of all information required from the direct providers of services for which benefits are available through a qualified general access plan, a qualified general access plan may not provide payment for services (other than emergency services) furnished under a benefits package unless the provider has given the plan standard information (specified in or pursuant to the insurance reform standards) respecting the services.

(2) FORWARDING INFORMATION.—If information under paragraph (1) is given to the qualified general access plan, the plan is responsible for forwarding the information to the State (or the Secretary) under subsection (a).

(d) INFORMATION REGARDING A PATIENT'S RIGHT TO SELF DETERMINATION REGARDING HEALTH CARE.—Each qualified health plan shall provide written information to each individual enrolling in such plan of such indi-

vidual's right under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives (as defined in section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3))), and the written policies of the qualified health plan with respect to such right.

SEC. 1119. QUALITY ASSURANCE.

Each qualified general access plan shall establish and maintain a quality assurance program that complies with the standards developed under section 3001.

SEC. 1120. MEDIATION PROCEDURES RELATING TO MALPRACTICE CLAIMS.

Each qualified general access plan shall establish and maintain a mediation procedures program that complies with the standards developed under section 4011.

SEC. 1121. SERVICE TO DESIGNATED UNDERSERVED AREAS.

Each qualified general access plan shall contain assurances of compliance with any requirements relating to the provision of covered items and services in designated underserved areas as determined by the appropriate certifying authority.

SEC. 1122. ADDITIONAL REQUIREMENTS.

Each qualified general access plan shall comply with the requirements of part III and meet such other requirements as may be imposed under the insurance reform standards or by the appropriate certifying authority. If such authority is a State, the authority may require such a plan to enter into an agreement under section 1933(b)(3) of the Social Security Act, as added by section 6021(a) of this Act, for the provision of items and services on a capitated basis under the medicaid program.

PART II—INDIVIDUAL AND SMALL EMPLOYER PURCHASING GROUPS

SEC. 1141. ESTABLISHMENT AND ORGANIZATION.

(a) IN GENERAL.—Individual and small employer purchasing groups (in this Act referred to as ''purchasing groups'') may be established in accordance with this part. Each purchasing group shall be chartered under State law and operated as a not-for-profit corporation. An insurer may not form, underwrite, or possess a majority vote of a purchasing group, but may administer such a group.

(b) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each purchasing group shall be governed by a Board of Directors. Such Board shall initially be appointed under procedures under section 1404(a). Subsequently, the Board shall be elected by the members of the group in accordance

with paragraph (3). Such Board shall be composed of individuals who are small employers (or representatives of small employers), eligible employees of small employers (or representatives of such employees), and eligible individuals in the HCCA in which the group operates.

(2) MEMBERSHIP.—A purchasing group shall accept all small employers, eligible employees, and eligible individuals residing within the HCCA served by the group as members if such employers, employees or individuals request such membership.

(3) VOTING.—Members of a purchasing group shall have voting rights consistent with the rules established under section 1404(b).

(c) DUTIES OF PURCHASING GROUPS.—

(1) IN GENERAL.—Subject to paragraph (2), each purchasing group shall—

(A) market qualified general access plans to members throughout the entire HCCA served by the group;

(B) enter into agreements with qualified general access plans under section 1142;

(C) enter into agreements with small employers under section 1143;

(D) enroll individuals in qualified general access plans, only in accordance with section 1144; and

(E) carry out other functions provided for under this title.

(2) LIMITATION ON ACTIVITIES.—A purchasing group shall not—

(A) perform any activity (including review, approval, or enforcement) relating to payment rates for providers;

(B) perform any activity (including certification or enforcement) relating to compliance of general access plans with the requirements of part 1 of this subtitle;

(C) assume financial risk in relation to any such plan; or

(D) perform other activities identified by the State as being inconsistent with the performance of its duties under paragraph (1).

(d) RULES OF CONSTRUCTION.—

(1) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

(A) that a purchasing group be established in each HCCA; and

(B) that there be only one purchasing group established with respect to a HCCA.

(2) SINGLE ORGANIZATION SERVING MULTIPLE HCCAS.—Nothing in this section shall be construed as preventing a single not-for-profit corporation from being the purchasing group for more than one HCCA.

SEC. 1142. AGREEMENTS WITH QUALIFIED GENERAL ACCESS PLANS.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (3), each purchasing group for a HCCA shall enter into an agreement under this section with each qualified general access plan that desires to be made available through the purchasing group in accordance with procedures under section 1404.

(2) TERMINATION OF AGREEMENT.—An agreement under paragraph (1) shall remain in effect for a 12-month period, except that the purchasing group may terminate an agreement under paragraph (1) if the qualified general access plan's certification under section 1402 is terminated or for other good cause shown.

(3) LIMITATION ON RENEWAL OF AGREEMENTS.—Subsequent to the 12-month period described in paragraph (2), a purchasing group may—

(A) refuse to enter into a subsequent agreement with a qualified general access plan if the group determines that the plan enrollment or plan premium is too low, and

(B) if a previous agreement with a qualified general access plan was terminated for good cause and the group determines appropriate actions have not been taken to correct the problems, refuse to enter into a subsequent agreement with the plan.

(4) NO PROHIBITION ON OFFERING OF PLANS.—Nothing in this subsection shall be construed as prohibiting a qualified general access plan that does not enter into an agreement under paragraph (1) from being offered to small employers and eligible individuals within a HCCA.

(b) RECEIPT OF PREMIUMS ON BEHALF OF PLANS.—

(1) IN GENERAL.—Under an agreement under this section between a purchasing group and a qualified general access plan, payment of premiums may be made by individuals (or employers on their be-

half) directly to the purchasing group for the benefit of the plan.

(2) TIMING OF PAYMENT OF PREMIUMS.—Premiums may be payable on a monthly basis (or, at the option of an eligible employee or individual, on a quarterly basis). The purchasing group may provide for reasonable penalties and grace periods for late payment.

(3) QUALIFIED GENERAL ACCESS PLANS RETAIN RISK OF NONPAYMENT.—Nothing in this subsection shall be construed as placing upon a purchasing group any risk associated with the failure of individuals and employers to make prompt payment of premiums (other than the portion of the premium representing the purchasing group administrative fee under section 1145). Each small employer and eligible individual who enrolls with a qualified general access plan through the purchasing group is liable to the plan for premiums.

(c) FORWARDING OF PREMIUMS.—

(1) IN GENERAL.—If, under an agreement under subsection (a), premium payments under a qualified general access plan are made to the purchasing group, the purchasing group shall forward to the plan the amount of the premiums.

(2) PAYMENTS.—Payments shall be made by the purchasing group under this subsection within a period of days (specified by the Secretary and not to exceed 7 days) after receipt of the premium from the small employer of the eligible employee or the eligible individual, as the case may be.

SEC. 1143. PROVISION OF INFORMATION.

(a) IN GENERAL.—Each purchasing group for a HCCA shall provide to each small employer that employs individuals in the HCCA and to each eligible individual who resides in the HCCA—

(1) information provided to the purchasing group under section 1405 by the State in which such group is located, and

(2) the opportunity to enter into an agreement with the group for the purchase of a qualified general access plan.

(b) FORWARDING INFORMATION AND PAYROLL DEDUCTIONS.—As part of an agreement entered into under this section, a small employer shall forward the information and make the payroll deductions required under section 1004.

SEC. 1144. ENROLLING ELIGIBLE EMPLOYEES AND ELIGIBLE INDIVIDUALS IN QUALIFIED GENERAL ACCESS PLANS THROUGH A PURCHASING GROUP.

A purchasing group shall offer, on behalf of each qualified general access plan with which an agreement was entered into under section 1142 and in accordance with the enrollment procedures of such plans, enrollment in the plan only to—

(1) all eligible employees employed by small employers in the HCCA served by the purchasing group; and

(2) all eligible individuals residing in such HCCA.

SEC. 1145. RESTRICTION ON CHARGES.

(a) IN GENERAL.—A purchasing group may impose an administrative fee with respect to a eligible employee or eligible individual enrolled under a qualified general access plan offered through the purchasing group.

(b) FEE.—A purchasing group that elects to impose a fee under subsection (a) shall ensure that such fee is set as a percentage of the premium for each such plan and is imposed uniformly with respect to all qualified general access plans offered through the group.

PART III—CONSUMER PROTECTION AND MARKET REFORMS

SEC. 1161. REQUIREMENT FOR PROVISION OF INFORMATION BY BROKERS.

Brokers or insurers who offer coverage under a qualified general access plan to small employers (or eligible employees of small employers) or eligible individuals must disclose to such prospective enrollees the information developed by the State under section 1405.

SEC. 1162. PROHIBITION OF IMPROPER INCENTIVES.

(a) LIMITATION ON FINANCIAL INCENTIVES.—No insurer that offers a qualified general access plan may vary the commission or financial or other remuneration to a person based on the claims experience or health status of individuals enrolled by or through the person.

(b) PROHIBITION OF TIE-IN ARRANGEMENTS.—No insurer that offers a qualified general access plan may require the purchase of any other insurance or product as a condition for the purchase of a qualified general access plan.

SEC. 1163. PROHIBITION OF SALE OF DUPLICATE COVERAGE OR SALE TO CERTAIN POPULATIONS.

(a) DUPLICATE COVERAGE PROHIBITION.—It is unlawful for a person to sell or issue a qualified insured general access plan to an individual—

(1) with knowledge that the individual is covered under a qualified health plan or under an equivalent health care program, or

(2) without obtaining such information as the Secretary may specify (taking into account the type of information described in section 1882(d)(1)(B) of the Social Security Act).

(b) EXCEPTION.—Subsection (a) shall not apply to a plan the sale or issuance of which is intended to replace another qualified health plan. Subsection (a) also does not apply in the case of coverage for insurance described in section 1601(14)(B).

(c) ENFORCEMENT.—Any person who violates subsection (a) is subject to a civil money penalty not to exceed $10,000 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

Subtitle C—Qualified Health Plans in the Large Employer Marketplace

PART I—REQUIREMENTS ON LARGE EMPLOYER PLANS

SEC. 1201. STANDARDS APPLIED TO LARGE EMPLOYER PLANS.

Each large employer plan (as defined in section 1601(16)) shall meet the applicable standards developed under section 1202.

SEC. 1202. ESTABLISHMENT OF STANDARDS APPLICABLE TO LARGE EMPLOYER PLANS.

(a) ESTABLISHMENT OF STANDARDS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall develop and publish standards applicable to large employer plans relating to the requirements described in paragraph (2). The Secretary shall develop and publish such standards by not later than the date that is 6 months after the date of enactment of this Act. Such standards shall be the insurance standards applicable under this part.

(2) REQUIREMENTS SPECIFIED.—Subject to paragraph (3), the requirements referred to in para-

graph (1) are requirements specified in the following provisions:

(A) Subsection (a) of section 1111 (relating to guaranteed eligibility), subject to subsections (d) and (e) of such section, except that such subsection shall be applied (for purposes of this subsection) only with respect to eligible employees of the large employer.

(B) Section 1112 (relating to nondiscrimination based on health status).

(C) Section 1113 (relating to benefits).

(D) Section 1115 (relating to enrollment) or establish such comparable enrollment procedures as the Secretary of Labor specifies, other than the requirement for a general enrollment period under subsection (a)(3) of such section.

(E) Section 1118 (relating to collection and provision of standardized information).

(F) Section 1119 (relating to quality assurance).

(3) COLLECTIVE BARGAINING EXCEPTION.—Paragraph (2)(A) shall not apply to a large employer plan that is providing benefits pursuant to a collective bargaining agreement.

(4) REFERENCE TO ENFORCEMENT.—For provision enforcing requirements of this subsection, see the amendments made by sections 2402, 2411, and 2412.

(b) ESTABLISHMENT OF STANDARDS BY SECRETARY OF LABOR.—

(1) IN GENERAL.—The Secretary of Labor, in consultation with the Secretary of Health and Human Services, shall develop and publish standards applicable to large employer plans relating to the requirements specified in paragraph (2). The Secretary shall develop and publish such standards by not later than the date that is 6 months after the date of enactment of this Act. Such standards shall be the insurance standards applicable under this part.

(2) REQUIREMENTS SPECIFIED.—Subject to paragraph (3), the requirements referred to in paragraph (1) are requirements specified in the following provisions:

(A) Section 1114 (relating to financial solvency) or such standards similar to the standards established under such section as the Secretary of Labor specifies, except that such standards shall be consistent with the applicable

rules under section 414 of the Employee Retirement Income Security Act of 1974.

(B) Section 1116(g) (relating to payment of premiums).

(C) Section 1120 (relating to mediation procedures relating to malpractice claims).

(D) Section 1203 (relating to required offer of different benefit packages).

(c) CONSIDERATION OF NAIC STANDARDS.—In establishing standards under this section, the Secretary of Health and Human Services and the Secretary of Labor shall take into account standards established under subtitle B relating to comparable requirements.

(d) APPLICATION OF STANDARDS TO HEALTH PLANS OFFERED UNDER FEHBP.—Notwithstanding any other provision of law, each health plan offered under chapter 89 of title 5, United States Code, shall meet the standards applicable to large employer plans under this subtitle, in the same manner and as of the same date such standards first apply to such plans.

SEC. 1203. OFFER OF DIFFERENT BENEFIT PACKAGES REQUIRED.

(a) IN GENERAL.—Each large employer shall make available to each eligible employee at least—

(1) a qualified large employer plan that includes the standard package, and

(2) a qualified large employer plan that includes the catastrophic package.

(b) SELECTION OF PLANS BY MAJORITY OF EMPLOYEES.—

(1) IN GENERAL.—The large employer shall make the selections of qualified large employer plans under paragraphs (1) and (2) of subsection (a) on an annual basis. In making each such selection, the large employer shall comply with any selection of a qualified large employer plan made by at least 50 percent of the eligible employees of the large employer. The Secretary of Labor shall prescribe rules which shall govern the manner in which employees may make such a selection. Nothing in this subsection shall be construed to require an employer to make any financial contribution towards the cost of such a qualified large employer plan or for such an employer to refuse to offer such a plan for good cause.

(2) LIMITATION.—Paragraph (1) shall not apply in the case of a large employer that contributes to the cost of the qualified large employer plan.

(c) ENFORCEMENT.—For enforcement of the requirement of this section, see amendment made by section 2402(b) of this Act.

SEC. 1204. ENROLLMENT IN LARGE EMPLOYER PLANS IN SATISFACTION OF ENROLLMENT REQUIREMENT.

In the case of an individual who qualifies for coverage under large employer plan (and is not eligible for coverage under an equivalent health care program or under a qualified health plan that is not a large employer plan), the individual shall satisfy the requirement of section 1501 through enrollment in the large employer plan.

SEC. 1205. DEVELOPMENT OF LARGE OR MULTIPLE EMPLOYER PURCHASING GROUPS.

(a) IN GENERAL.—Nothing in this title shall be construed as prohibiting 2 or more large employers from forming a purchasing group with respect to the employees of such employer or employers.

(b) NO USE OF INDIVIDUAL AND SMALL EMPLOYER PURCHASING GROUPS.—A large employer shall be ineligible to purchase health insurance through an individual and small employer purchasing group.

SEC. 1207. CORRECTIVE ACTIONS.

(a) IN GENERAL.—The plan sponsor of each large employer plan shall determine semiannually whether the

requirements of this part are met. In any case in which the plan sponsor determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary or the Secretary of Labor makes such a determination and so notifies the plan sponsor, the plan sponsor shall, within 90 days after making such determination or receiving such notification, notify such Secretary (in such form and manner as the such Secretary may prescribe by regulation) of a description of the corrective actions (if any) that the plan sponsor has taken or plans to take in response to such recommendations. The plan sponsor shall thereafter report to such Secretary, in such form and frequency as such Secretary may specify to the plan sponsor, regarding corrective action taken by the plan sponsor until the such requirements are met. Either such Secretary may make a determination that a large employer plan has ceased to be a qualified large employer plan only if such Secretary is satisfied that the necessary corrective action cannot reasonably be expected to occur on a timely basis necessary to avoid failure to provide benefits for which the plan is obligated.

(b) DISQUALIFICATION OR TERMINATION OF PLAN.—

(1) IN GENERAL.—In any case in which the plan sponsor of a large employer plan determines

that there is reason to believe that the plan will cease to be a qualified large employer plan or will terminate, the plan sponsor shall so inform the Secretary and the Secretary of Labor, shall develop a plan for winding up the affairs of the plan in connection with such disqualification or termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and shall submit such plan in writing to such Secretaries. Actions required under this subparagraph shall be taken in such form and manner as may be prescribed in regulations jointly prescribed by such Secretaries.

(2) ACTIONS REQUIRED IN CONNECTION WITH DISQUALIFICATION OR TERMINATION.—

(A) IN GENERAL.—In any case in which—

(i) the Secretary or the Secretary of Labor has been notified under paragraph (1) of a failure of a large employer plan to meet the requirements of this part and has not been notified by the plan sponsor that corrective action has restored compliance with such requirements, and

(ii) such Secretary determines, in consultation with the other Secretary referred

to in clause (i), that the continuing failure to meet such requirements can be reasonably expected to result in a continuing failure to pay benefits for which the plan is obligated,

the plan sponsor and the large employer shall comply with the requirements of subparagraph (B) or (C), as applicable.

(B) ACTIONS BY PLAN SPONSOR.—Upon a determination by the Secretary or the Secretary of Labor under subparagraph (A)(ii), the plan sponsor shall, at the direction of such Secretary, terminate the plan and, in the course of the termination, take such actions as such Secretary, in consultation with the other Secretary referred to in subparagraph (A)(i), may require as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely payment of all benefits for which the plan is obligated.

(C) ACTIONS BY LARGE EMPLOYER.—Upon a determination by the Secretary or the Secretary of Labor under subparagraph (A)(ii), the large employer shall provide for such con-

tingency coverage for all eligible employees of the employer in accordance with regulations which shall be prescribed in joint regulations of such Secretaries. Such regulations may provide for temporary coverage of such employees under a plan provided by a purchasing group in the appropriate HCCA, a plan provided under chapter 89 of title 5, United States Code, or other appropriate means established in such regulations.

PART II—AMENDMENTS TO ERISA

SEC. 1221. LIMITATION ON COVERAGE OF GROUP HEALTH PLANS UNDER TITLE I OF ERISA.

(a) IN GENERAL.—Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended—

(1) in subsection (a), by striking ''subsection (b)'' and inserting ''subsections (b) and (c)'';

(2) in subsection (b), by striking ''The provisions'' and inserting ''Except as provided in subsection (c), the provisions''; and

(3) by adding at the end the following new subsection:

''(c) COVERAGE OF GROUP HEALTH PLANS.—

"(1) LIMITED INCLUSION.—This title shall apply to a group health plan to the extent provided in this subsection. For purposes of this title, a plan, fund, or program shall not be treated as a group health plan solely because an employer makes the plan available (and takes related actions) in compliance with the applicable requirements of section 1004 or section 1203 of the Health Equity and Access Reform Today Act of 1993.

"(2) COVERAGE UNDER CERTAIN PROVISIONS WITH RESPECT TO LARGE EMPLOYER PLANS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), parts 1 and 4 of subtitle B shall apply to a large employer plan.

"(B) INAPPLICABILITY WITH RESPECT TO INSURED QUALIFIED HEALTH PLANS.—Subparagraph (A) shall not apply with respect to any employee welfare benefit plan to the extent such plan provides for health benefits under or through a qualified insured health plan (as defined in section 1601 of the Health Equity and Access Reform Today Act of 1993).

"(3) CLAIMS PROCEDURE.—Section 503 shall apply in the case of any large employer plan.

"(4) CIVIL ACTIONS BY PARTICIPANTS, BENEFICIARIES, AND FIDUCIARIES AND BY THE SECRETARY.—Section 502 shall apply in the case of any large employer plan and any other group health plan for which the plan sponsor makes a contribution.

"(5) DEFINITIONS AND ENFORCEMENT PROVISIONS.—Sections 3, 501, 504, 505, 506, 510, and 511 and the preceding provisions of this section shall apply to a group health plan to the extent necessary to effectively carry out, and enforce the requirements under, the provisions of this title as they apply pursuant to this subsection.

"(6) APPLICABILITY OF PREEMPTION RULES.—Section 514 shall apply in the case of any group health plan to the extent that parts 1 and 4 of subtitle B apply to such plan under paragraph (2).".

(b) REPORTING AND DISCLOSURE REQUIREMENTS APPLICABLE TO GROUP HEALTH PLANS.—

(1) IN GENERAL.—Part 1 of subtitle B of title I of such Act is amended—

(A) in the heading for section 110, by adding "BY PENSION PLANS" at the end;

(B) by redesignating section 111 as section 112; and

(C) by inserting after section 110 the following new section:

''SPECIAL RULES FOR GROUP HEALTH PLANS

''SEC. 111. (a) IN GENERAL.—The Secretary may by regulation provide special rules for the application of this part to group health plans which are consistent with the purposes of this title and the Health Equity and Access Reform Today Act of 1993 and which take into account the special needs of participants, beneficiaries, and health care providers under such plans.

''(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—Such special rules may include rules providing for—

''(1) reductions in the periods of time referred to in this part,

''(2) increases in the frequency of reports and disclosures required under this part, and

''(3) such other changes in the provisions of this part as may result in more expeditious reporting and disclosure of plan terms and changes in such terms to the Secretary and to plan participants and beneficiaries,

to the extent that the Secretary determines that the rules described in this subsection are necessary to ensure timely reporting and disclosure of information consistent with the purposes of this part and the Health Equity and Access

Reform Today Act of 1993 as they relate to group health plans.

''(c) ADDITIONAL REQUIREMENTS.—Such special rules may include rules providing for reporting and disclosure to the Secretary and to participants and beneficiaries of additional information or at additional times with respect to group health plans to which this part applies under section 4(c)(2), if such reporting and disclosure would be comparable to and consistent with similar requirements applicable under the Health Equity and Access Reform Today Act of 1993 with respect to small employer plans and applicable regulations of the Secretary of Health and Human Services prescribed thereunder.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by striking the items relating to sections 110 and 111 and inserting the following new items:

''Sec. 110. Alternative methods of compliance by pension plans.
''Sec. 111. Special rules for group health plans.
''Sec. 112. Repeal and effective date.''.

(c) TREATMENT OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

(1) INAPPLICABILITY OF PREEMPTION RULES.—Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended by adding at the end (after and below clause (ii)) the following new sentence:

"This paragraph shall not apply in the case of a group health plan.".

(2) SPECIAL RULES FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENT PROVIDING HEALTH BENEFITS.—

(A) IN GENERAL.—Subject to subparagraph (B), any multiple employer welfare arrangement with respect to which there is in effect a certification by the Secretary of Labor under this paragraph shall be treated for purposes of this title as a large employer plan.

(B) REQUIREMENTS.—Subparagraph (A) shall apply to a multiple employer welfare arrangement only if—

(i) the benefits provided under the arrangement consist solely of medical care (as defined in section 213(d) of the Internal Revenue Code of 1986),

(ii) such arrangement meets the requirements of clause (i) of section 514(b)(6)(A) of the Employee Retirement Income Security Act of 1974 (as in effect immediately before the amendment made by paragraph (1)), and

(iii) the sponsoring entity is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce or other business group, for substantial purposes other than that of obtaining or providing medical care described in section 213(d) of the Internal Revenue Code of 1986, and the applicant demonstrates to the satisfaction of the Secretary that the sponsoring entity is established as a permanent entity which receives the active support of its members.

(C) RESTRICTION ON COMMENCEMENT OF NEW ARRANGEMENTS.—A multiple employer welfare arrangement providing benefits which consist of medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) which has not commenced operations as of January 1, 1994, may commence operations only if a certification of the arrangement under this paragraph is in effect.

(D) CERTIFICATION PROCEDURE.—The Secretary of Labor shall certify a multiple em-

ployer welfare arrangement under this paragraph if—

(i) an application for such certification with respect to such arrangement, identified individually or by class, has been duly filed in complete form with the Secretary of Labor in accordance with this paragraph,

(ii) such application demonstrates compliance with the requirements of section 1202, and

(iii) the Secretary of Labor finds that such certification is—

(I) administratively feasible,

(II) not adverse to the interests of the individuals covered under the arrangement, and

(III) protective of the rights and benefits of the individuals covered under the arrangement.

In the case of an arrangement which has commenced operations as of January 1, 1994, an application under this paragraph must be filed not later than January 1, 1996.

(E) DESIGNATION OF PLAN SPONSOR.—The Secretary of Labor shall provide by regulation for designation of the entities to be treated as the plan sponsor.

(F) REVOCATION OF CERTIFICATION.—The Secretary of Labor may revoke a certification under this paragraph for any cause that may serve as the basis for the denial of an initial application for such a certification under this paragraph.

(G) REVIEW OF ACTIONS BY SECRETARY OF LABOR.—Any decision by the Secretary of Labor which involves the denial of an application by a multiple employee welfare arrangement for certification under this paragraph or the revocation of such a certification shall contain a statement of the specific reason or reasons supporting the Secretary's action, including reference to the specific terms of the certification and the statutory provision or provisions relevant to the determination. Any such denial or revocation shall be subject to review as provided in section 502 of the Employee Retirement Income Security Act of 1974.

PART III—REVISION OF COBRA CONTINUATION COVERAGE REQUIREMENTS

SEC. 1231. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) PERIOD OF COVERAGE.—Subparagraph (D) of section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161(2)) is amended—

(1) by striking ''or'' at the end of clause (i), by striking the period at the end of clause (ii) and inserting '', or'', and by adding at the end the following new clause:

''(iii) eligible for coverage under a qualified health plan in accordance with title I of the Health Equity and Access Reform Today Act of 1993.'', and

(2) by striking ''OR MEDICARE ENTITLEMENT'' in the heading and inserting '', MEDICARE ENTITLEMENT, OR QUALIFIED HEALTH PLAN ELIGIBILITY''.

(b) QUALIFIED BENEFICIARY.—Section 607(3) of such Act (29 U.S.C. 1167(2)) is amended by adding at the end the following new subparagraph:

''(D) SPECIAL RULE FOR INDIVIDUALS COVERED BY HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993.—The term 'qualified beneficiary' shall not include any individual who, upon termination of coverage under a

group health plan, is eligible for coverage under a qualified health plan in accordance with title I of the Health Equity and Access Reform Today Act of 1993.''

(c) REPEAL UPON IMPLEMENTATION OF HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993.—

(1) IN GENERAL.—Part 6 of subtitle B of title I of such Act (29 U.S.C. 601 et seq.) is amended by striking sections 601 through 608 and by redesignating section 609 as section 601.

(2) CONFORMING AMENDMENTS.—

(A) Section 502(a)(7) of such Act (29 U.S.C. 1132(a)(7)) is amended by striking ''609(a)(2)(A)'' and inserting ''601(a)(2)(A)''.

(B) Section 502(c)(1) is amended by striking ''paragraph (1) or (4) of section 606''.

(C) Section 514 of such Act (29 U.S.C. 1144) is amended by striking ''609'' each place it appears in subsections (b)(7) and (b)(8) and inserting ''601''.

(D) The table of contents in section 1 of such Act is amended by striking the items relating to sections 601 through 609 and inserting the following new item:

''Sec. 601. Additional standards for group health plans.''

(d) EFFECTIVE DATE.—

(1) SUBSECTIONS (a) AND (b).—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act.

(2) SUBSECTION (c).—The amendments made by subsection (c) shall take effect on the first January 1 following the deadline specified in section 1401(c)(2) of this Act.

SEC. 1232. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.

(a) PERIOD OF COVERAGE.—Subparagraph (D) of section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb–2(2)) is amended—

(1) by striking ''or'' at the end of clause (i), by striking the period at the end of clause (ii) and inserting '', or'', and by adding at the end the following new clause:

''(iii) eligible for coverage under a qualified health plan in accordance with title I of the Health Equity and Access Reform Today Act of 1993.'', and

(2) by striking ''OR MEDICARE ENTITLEMENT'' in the heading and inserting '', MEDICARE ENTITLEMENT, OR QUALIFIED HEALTH PLAN ELIGIBILITY''.

(b) QUALIFIED BENEFICIARY.—Section 2208(3) of such Act (42 U.S.C. 300bb–8(3)) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE FOR INDIVIDUALS COVERED BY THE HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993.—The term 'qualified beneficiary' shall not include any individual who, upon termination of coverage under a group health plan, is eligible for coverage under a qualified health plan in accordance with title I of the Health Equity and Access Reform Today Act of 1993.".

(c) REPEAL UPON IMPLEMENTATION OF HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993.—

(1) IN GENERAL.—Title XXII of such Act (42 U.S.C. 300bb–1 et seq.) is hereby repealed.

(2) CONFORMING AMENDMENT.—The table of contents of such Act is amended by striking the item relating to title XXII.

(d) EFFECTIVE DATE.—

(1) SUBSECTIONS (a) AND (b).—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act.

(2) SUBSECTION (c).—The amendments made by subsection (c) shall take effect on the first January 1 following the deadline specified in section 1401(c)(2) of this Act.

SEC. 1233. ADDITIONAL REVISIONS.

For additional revisions, see the amendments made by section 2005 of this Act.

Subtitle D—Benefits; Benefits Commission

PART I—BENEFITS

SEC. 1301. OFFERING OF BENEFIT PACKAGES.

(a) BENEFIT PACKAGES.—Each qualified health plan shall provide one (or both) of the following benefit packages:

(1) STANDARD PACKAGE.—The standard package consists of the covered items and services specified under subsection (b), subject to the applicable cost sharing requirement specified under subsection (c)(1) for such a package.

(2) CATASTROPHIC PACKAGE.—The catastrophic package consists of the covered items and services (specified under subsection (b)), subject to the applicable cost sharing requirement specified under subsection (c)(2) for such a package.

(b) COVERED ITEMS AND SERVICES.—Subject to the procedures for clarification and modification described in part II, covered items and services consist of the following items and services, but only when the provision of the item or service is medically necessary or appropriate:

(1) Medical and surgical services (and supplies incident to such services).

(2) Medical equipment.

(3) Prescription drugs and biologicals.

(4) Preventive services.

(5) Rehabilitation and home health services related to an acute care episode.

(6) Services for severe mental illness.

(7) Substance abuse services.

(8) Hospice services.

(9) Emergency transportation and transportation for non-elective medically necessary services in frontier and similar areas.

(c) COST SHARING.—

(1) STANDARD PACKAGE.—The standard package shall include deductibles, copayments, coinsurance, and out-of-pocket limits on cost sharing established for such package pursuant to part II.

(2) CATASTROPHIC PACKAGE.—The catastrophic package shall include a general deductible amount and an out-of-pocket limit on cost sharing established for such package pursuant to part II (and may include such other deductibles, copayments, and coinsurance as a qualified health plan may provide consistent with such part).

(3) LIMITATION.—In establishing cost sharing requirements under part II, the Commission shall establish a limit on the total amount of cost-sharing that may be incurred by a family within a class of family enrollment in a year.

(d) CRITERIA FOR DETERMINATION OF MEDICAL NECESSITY AND APPROPRIATENESS.—

(1) IN GENERAL.—A qualified health plan shall provide for coverage of the items and services described in subsection (b) only for treatments and diagnostic procedures that are medically necessary or appropriate. In the case of dispute concerning a determination of medical necessity or appropriateness and subject to the succeeding provisions of this subsection, for purposes of this title, a treatment (as defined in subparagraph (6)(A)) or diagnostic procedure shall be considered to be ''medically necessary or appropriate'' if the following criteria are met:

(A) TREATMENT OR DIAGNOSIS OF MEDICAL CONDITION.—

(i) IN GENERAL.—The treatment or diagnostic procedure is for a medical condition.

(ii) MEDICAL CONDITION DEFINED.—The term ''medical condition'' means a dis-

ease, illness, injury, or biological or psychological condition or status for which treatment is indicated to improve, maintain, or stabilize a health outcome (as defined in paragraph (6)(B)) or which, in the absence of treatment, could lead to an adverse change in a health outcome.

(iii) ADVERSE CHANGE IN HEALTH OUTCOME DEFINED.—In clause (ii), an adverse change in a health outcome occurs if there is a biological or psychological decremental change in a health status.

(B) NOT INVESTIGATIONAL.—There must be sufficient evidence on which to base conclusions about the existence and magnitude of the change in health outcome resulting from the treatment or diagnostic procedure compared with the best available alternative (or with no treatment or diagnostic procedure if no alternative treatment or procedure is available).

(C) EFFECTIVE AND SAFE.—The evidence must demonstrate that the treatment or diagnostic procedure can reasonably be expected to produce the intended health result or provide intended information and is safe and the treat-

ment or diagnostic procedure provides a clinically meaningful benefit with respect to safety and effectiveness in comparison to other available alternatives or the patients current health status.

(2) RELATIONSHIP TO FDA REVIEW.—

(A) APPROVED DRUGS, BIOLOGICALS, AND MEDICAL DEVICES.—

(i) DRUGS.—A drug that has been found to be safe and effective under section 505 of the Federal Food, Drug, and Cosmetic Act is deemed to meet the requirements of paragraphs (1)(B) and (1)(C) (relating to not investigational and safety and effectiveness).

(ii) BIOLOGICALS.—A biological that has been found to be safe and effective under section 351 of the Public Health Service Act is deemed to meet the requirements of paragraphs (1)(B) and (1)(C) (relating to not investigational and safety and effectiveness).

(iii) MEDICAL DEVICES.—A medical device that is marketed after the provision of a notice under section 510(k) of the

Federal Food, Drug, and Cosmetic Act or that has an application for premarket approval approved under section 515 of such Act is deemed to meet the requirements of paragraphs (1)(B) and (1)(C) (relating to not investigational and safety and effectiveness).

(B) OTHER DRUGS, BIOLOGICALS, AND DEVICES.—A drug, biological, or medical device not described in subparagraph (A) shall be considered to be investigational. Nothing shall prohibit a qualified health plan from covering (nor as compelling such a plan to cover) such drugs, biologicals, and medical devices, including treatment investigational new drugs.

(3) COVERAGE OF INVESTIGATIONAL TREATMENTS IN APPROVED RESEARCH TRIALS.—

(A) IN GENERAL.—Coverage of the routine medical costs (as defined in subparagraph (C)) associated with the delivery of investigational treatments (as defined in subparagraph (B)) shall be considered to be medically necessary or appropriate only if the treatment is part of an approved research trial (as defined in subparagraph (D)).

(B) INVESTIGATIONAL TREATMENT DEFINED.—In subparagraph (A), the term ''investigational treatment'' means a treatment for which there is not sufficient evidence to determine the health outcome of the treatment compared with the best available alternative treatment (or with no treatment if there is no alternative treatment).

(C) ROUTINE MEDICAL COSTS DEFINED.—In subparagraph (A), the term ''routine medical costs'' means the cost of health services required to provide treatment according to the design of the trial, except those costs normally paid for by other funding sources (as defined by the Secretary). Such costs do not include the cost of the investigational agent, devices or procedures themselves, the costs of any nonhealth services that might be required for a person to receive the treatment, or the costs of managing the research.

(D) APPROVED RESEARCH TRIAL DEFINED.—In subparagraph (A), the term ''approved research trial'' means a trial—

(i) conducted for the primary purpose of determining the safety, effectiveness, ef-

ficacy, or health outcomes of a treatment, compared with the best available alternative treatment, and

(ii) approved by the Secretary.

A trial is deemed to be approved under clause (ii) if it is approved by the National Institutes of Health, the Food and Drug Administration (through an investigational new drug exemption), the Department of Veterans Affairs, the Department of Defense, or by a qualified non-governmental research entity (as identified in guidelines issued by one or more of the National Institutes of Health).

(4) DOCUMENTATION.—

(A) IN GENERAL.—Each qualified health plan is responsible for maintaining documentary evidence supporting the plan's decisions to cover or to deny coverage based on the criteria specified in this subsection.

(B) DISCLOSURE.—Each qualified health plan shall disclose to its enrollees, in a manner specified by the State, its coverage decisions and must submit information on such decisions to the State.

(5) BINDING ARBITRATION EVIDENCE.—The evidence that may be used in making coverage decisions under a binding arbitration process under this section and section 1407 includes—

(A) published peer-reviewed literature,

(B) opinions of medical specialty groups and other medical experts; and

(C) evidence of general acceptance by the medical community.

(6) TREATMENT AND HEALTH OUTCOME DEFINED.—As used in this subsection:

(A) IN GENERAL.—The term ''treatment'' means any health care intervention undertaken, with respect to a specific indication, to improve, maintain, or stabilize a health outcome or to prevent or mitigate an adverse change in a health outcome.

(B) HEALTH OUTCOME.—The term ''health outcome'' means an outcome that affects the length and quality of an enrollee's life.

(e) APPLICATION IN BINDING ARBITRATION PROCESS.—The criteria specified in subsection (d) shall be applied by arbitrators under the binding arbitration process for disputes described in paragraphs (1)(C) and (2) of section 1407.

(f) FREEDOM TO OFFER BENEFITS.—Nothing in this section shall be construed to prohibit a health plan that is not a qualified health plan from offering any health care benefits.

PART II—BENEFITS COMMISSION

SEC. 1311. ESTABLISHMENT.

There is established a commission to be known as the Benefits Commission (in this part referred to as the ''Commission'').

SEC. 1312. DUTIES.

(a) INITIAL PROPOSAL.—Not later than the termination of the 6-month period beginning on the date of the enactment of this Act, the Commission shall develop and submit to the Congress a proposal for legislation that includes the following:

(1) CLARIFICATION OF COVERED ITEMS AND SERVICES.—A clarification of the items and services to be included in the covered items and services under section 1301(b). Such clarification—

(A) may eliminate a category of items or services described in paragraphs (1) through (7) of such section;

(B) may not specify the categories of health care providers who are authorized to deliver items or services;

(C) with respect to covered items and services, may not specify (in this Act or by regulations) particular procedures or treatments, or classes thereof;

(D) may not establish limitations or cost sharing requirements with respect to services for severe mental illness that do not apply with respect to other items or services; and

(E) with respect to section 1301(b)(9), shall, after consultation with the Federal Aviation Administration, provide for maximum flexibility to air ambulance services, consistent with basic public safety requirements, in order to avoid an adverse change in health outcomes (within the meaning of section 1301(d)(1)(A)) for persons using such services.

(2) SPECIFICATION OF COST SHARING.—A specification of the precise deductibles, copayments, coinsurance, and out-of-pocket limits on cost sharing that are to apply to the standard package and the catastrophic package under section 1301(c). Such specification—

(A) shall establish multiple cost sharing schedules that vary depending on the delivery

system by which health care is delivered to individuals enrolled in a qualified health plan; and

(B) shall provide that the general deductible amount described in section 1301(c)(2) is greater than any general deductible amount applicable to the standard package.

(3) COST ESTIMATE.—An estimate of the cost of the standard package and the catastrophic package in 5 diverse regions of the United States.

(4) NO ADDITION OF BENEFITS.—A clarification under this subsection may not add a new category of items or services.

(b) RESUBMISSION OF INITIAL PROPOSAL.—If the proposal described in subsection (a) is not approved by the Congress, the Commission shall submit to the Congress a second proposal conforming to the requirements of subsection (a) not later than the termination of the 6-month period beginning on the date an approval resolution with respect to the first proposal is subject to a vote on final passage in the last House to consider the resolution under section 1314. If such second proposal is not approved, the Commission shall submit to the Congress a third proposal in accordance with the procedure described in the preceding sentence. If such third proposal is not approved by the Congress, the members of the Commis-

sion shall vacate their positions, and new members shall be appointed under section 1313 to fill such vacancies. Such new members shall submit to the Congress not more than three proposals conforming to the requirements of subsection (a) in accordance with the procedure described in this subsection.

(c) PROPOSED MODIFICATIONS.—

(1) IN GENERAL.—Not earlier than January 1 of the year that occurs 1 year after a legislative proposal described in subsection (a) or (b) is enacted, and not more frequently than annually, the Commission may submit to the Congress a proposal for legislation containing recommended modifications to such enactment. Such a proposal shall be treated as an initial proposal under subsection (a) for purposes of consideration in the Congress under section 1314 and implementation under section 1315. Subsection (a)(4) shall not apply to such a proposal.

(2) SUBMISSION OF PROPOSAL IF DEFICIT.—If the Commission receives a report concerning a deficit under section 1003(d)(5)(A) for a year, within 60 days after receiving such report, the Commission may submit under paragraph (1) a proposal to make modifications (which may only include modifications

described in paragraph (3)) that will result in the sum of—

(A) the amount of the reduction in Federal expenditures for vouchers under section 1003, and

(B) the amount of the increase in Federal revenues,

for the next fiscal year being equal to the aggregate amount of such deficit. The Commission shall submit such a proposal in the case of any year after the full phase-in year (as defined in section 1003(d)(5)(B)(iii)).

(3) MODIFICATIONS.—Modifications described in this paragraph are—

(A) changes in the items, services, and cost sharing under sections 1301(b) and 1301(c);

(B) a reduction in the applicable phase-in percentage (specified in the table under section 1003(b)(2));

(C) reductions in expenditures under the medicare program, the medicaid program, or both; and

(D) a reduction in the applicable dollar limit determined under section 91(b)(2) of the

Internal Revenue Code of 1986, based on family income.

SEC. 1313. OPERATION OF THE COMMISSION.

(a) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall be composed of 5 members appointed by the President.

(2) CONSULTATION.—In selecting individuals for nominations for appointments for the Commission, the President should consult with—

(A) the Speaker of the House of Representatives concerning the appointment of 1 member;

(B) the Majority Leader of the Senate concerning the appointment of 1 member;

(C) the Minority Leader of the House of Representatives concerning the appointment of 1 member; and

(D) the Minority Leader of the Senate concerning the appointment of 1 member.

(3) CHAIRPERSON.—The President shall designate 1 individual described in paragraph (1) who shall serve as Chairperson of the Commission.

(b) COMPOSITION.—The membership of the Commission shall include individuals with national recognition for their expertise in health economics, hospital and health

plan management, health services, medical research and effectiveness, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representatives, including physicians and other providers of health care services, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care.

(c) TERMS.—The terms of members of the Commission shall be for 3 years, except that of the members first appointed 2 shall be appointed for a term of 1 year and 2 shall be appointed for a term of 2 years.

(d) VACANCIES.—A vacancy in the Commission shall be filled in the same manner as the original appointment, but the individual appointed to fill the vacancy shall serve only for the unexpired portion of the term for which the individual's predecessor was appointed.

(e) ADMINISTRATIVE PROVISIONS.—

(1) MEETINGS.—Each meeting of the Commission shall be open to the public.

(2) PAY AND TRAVEL EXPENSES.—

(A) IN GENERAL.—Each member, other than the chairperson of the Commission, shall

be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission.

(B) CHAIRPERSON.—The chairperson of the Commission shall be paid for each day referred to in subparagraph (A) at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

(C) TRAVEL EXPENSES.—Members shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(3) DIRECTOR OF STAFF.—

(A) IN GENERAL.—The Commission shall, without regard to section 5311(b) of title 5, United States Code, appoint a Director.

(B) PAY.—The Director shall be paid at the rate of basic pay payable for level IV of the

Executive Schedule under section 5315 of title 5, United States Code.

(4) STAFF.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Director, with the approval of the Commission, may appoint and fix the pay of additional personnel.

(B) PAY.—The Director may make such appointments without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and any personnel so appointed may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of 120 percent of the annual rate of basic pay payable for GS–15 of the General Schedule.

(C) DETAILED PERSONNEL.—

(i) IN GENERAL.—Upon request of the Director, the head of any Federal department or agency may detail any of the personnel of that department or agency to

the Commission to assist the Commission in carrying out its duties under this Act.

(ii) AGREEMENT WITH COMPTROLLER GENERAL.—The Comptroller General of the United States shall provide assistance, including the detailing of employees, to the Commission in accordance with an agreement entered into with the Commission.

(5) OTHER AUTHORITY.—

(A) CONTRACT SERVICES.—The Commission may procure by contract, to the extent funds are available, the temporary or intermittent services of experts or consultants pursuant to section 3109 of title 5, United States Code.

(B) LEASES AND PROPERTY.—The Commission may lease space and acquire personal property to the extent funds are available.

SEC. 1314. CONGRESSIONAL CONSIDERATION OF COMMISSION PROPOSALS.

(a) CONSIDERATION.—A legislative proposal submitted to the Congress by the Commission (except in the case of a proposal submitted pursuant to the second sentence of section 1003(d)(5)(A)) shall be considered by the Congress under the procedures described in this section.

(b) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of approval resolutions described in subsection (c), and supersedes other rules only to the extent that such rules are inconsistent therewith; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

(c) TERMS OF THE RESOLUTION.—For purposes of this part, the term ''approval resolution'' means only a joint resolution of the two Houses of the Congress, providing in—

(1) the matter after the resolving clause of which is as follows: ''That the Congress approves the recommendations of the Benefits Commission as submitted by the Commission on

_____''. the blank space being filled in with the appropriate date; and

(2) the title of which is as follows: ''Joint Resolution approving the recommendation of the Benefits Commission''.

(d) INTRODUCTION AND REFERRAL.—On the day on which a recommendation of the Commission is transmitted to the House of Representatives and the Senate, an approval resolution with respect to such recommendation shall be introduced (by request) in the House of Representatives by the majority leader of the House, for himself or herself and the minority leader of the House, or by Members of the House designated by the majority leader and minority leader of the House; and shall be introduced (by request) in the Senate by the majority leader of the Senate, for himself or herself and the minority leader of the Senate, or by Members of the Senate designated by the majority leader and minority leader of the Senate. If either House is not in session on the day on which such recommendation is transmitted, the approval resolution with respect to such recommendation shall be introduced in the House, as provided in the preceding sentence, on the first day thereafter on which the House is in session. The approval resolution introduced in the House of Rep-

resentatives and the Senate shall be referred to the appropriate committees of each House.

(e) AMENDMENTS PROHIBITED.—No amendment to an approval resolution shall be in order in either the House of Representatives or the Senate; and no motion to suspend the application of this subsection shall be in order in either House, nor shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this subsection by unanimous consent.

(f) PERIOD FOR COMMITTEE AND FLOOR CONSIDERATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), if the committee or committees of either House to which an approval resolution has been referred have not reported it at the close of the 30th day after its introduction, such committee or committees shall be automatically discharged from further consideration of the approval resolution and it shall be placed on the appropriation calendar. A vote on final passage of the approval resolution shall be taken in each House on or before the close of the 30th day after the approval resolution is reported by the committees or committee of that House to which it was referred, or after such committee or commit-

tees have been discharged from further consideration of the approval resolution. If prior to the passage by one House of an approval resolution of that House, that House receives the same approval resolution from the other House then—

(A) the procedure in that House shall be the same as if no approval resolution had been received from the other House; but

(B) the vote on final passage shall be on the approval resolution of the other House.

(2) COMPUTATION OF DAYS.—For purposes of paragraph (1), in computing a number of days in either House, there shall be excluded any day on which the House is not in session.

(g) FLOOR CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(1) MOTION TO PROCEED.—A motion in the House of Representatives to proceed to the consideration of an approval resolution shall be highly privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(2) DEBATE.—Debate in the House of Representatives on an approval resolution shall be lim-

ited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the bill or resolution. A motion further to limit debate shall not be debatable. It shall not be in order to move to recommit an approval resolution or to move to reconsider the vote by which an approval resolution is agreed to or disagreed to.

(3) MOTION TO POSTPONE.—Motions to postpone, made in the House of Representatives with respect to the consideration of an approval resolution, and motions to proceed to the consideration of other business, shall be decided without debate.

(4) APPEALS.—All appeals from the decisions of the chairperson relating to the application of the Rules of the House of Representatives to the procedure relating to an approval resolution shall be decided without debate.

(5) GENERAL RULES APPLY.—Except to the extent specifically provided in the preceding provisions of this subsection, consideration of an approval resolution shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions in similar circumstances.

(h) FLOOR CONSIDERATION IN THE SENATE.—

(1) MOTION TO PROCEED.—A motion in the Senate to proceed to the consideration of an approval resolution shall be privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(2) GENERAL DEBATE.—Debate in the Senate on an approval resolution, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the majority leader and the minority leader or their designees.

(3) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with an approval resolution shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the approval resolution, except that in the event the manager of the approval resolution is in favor of any such motion or appeal, the time in opposition thereto, shall be controlled by the Minority Leader or his designee. Such leaders, or either of them, may, from time under their control on the passage of an approval resolution, allot additional

time to any Senator during the consideration of any debatable motion or appeal.

(4) OTHER MOTIONS.—A motion in the Senate to further limit debate is not debatable. A motion to recommit an approval resolution is not in order.

SEC. 1315. IMPLEMENTATION.

The provisions of a legislative proposal approved under section 1314 shall become effective and a part of the certification process of each State (and the Secretary) on January 1 of the year following the year of the date of approval of such proposal (unless such period of time is less than 3 months, in which case such provisions shall become effective on January 1 of the second year following the date of approval of such proposal).

Subtitle E—State and Federal Responsibilities in Relation to Qualified Health Plans

PART I—STATE RESPONSIBILITIES

Subpart A—General Responsibilities

SEC. 1401. ESTABLISHMENT OF STATE INSURANCE MARKET REFORM PROGRAMS.

(a) IN GENERAL.—Each State shall establish a program (in this part referred to as a ''State program'') to carry out State responsibilities specified in this part.

(b) SUMMARY OF RESPONSIBILITIES.—The State responsibilities under this subtitle include—

(1) the certification of insured health plans as qualified insured health plans under section 1402, including the enforcement of the insurance reform standards;

(2) dissemination of information under section 1403;

(3) establishment of procedures for establishment and operation of purchasing groups under section 1404;

(4) preparation of information concerning plans and purchasing groups under section 1405;

(5) providing for a risk adjustment program and adjustment for differences in nonpayments among qualified insured health plans under section 1406;

(6) development of a binding arbitration process under section 1407; and

(7) specification of an annual general enrollment period under section 1408.

(c) DEADLINE.—

(1) IN GENERAL.—Each State shall establish a State program under this section by not later than the deadline specified in paragraph (2).

(2) DEADLINE.—The deadline specified in this paragraph is the date that occurs 1 year after the date of the insurance reform standards are established under section 1102.

(d) PERIODIC SECRETARIAL REVIEW OF STATE PROGRAMS.—

(1) IN GENERAL.—The Secretary may periodically review State programs established under subsection (a) to determine if such programs continue to meet the requirements of subsection (b).

(2) REPORTING REQUIREMENTS OF STATES.—For purposes of paragraph (1), each State shall submit to the Secretary, at intervals established by the Secretary, a report on the compliance of the State with the requirements of subsection (b).

(3) FAILURE OF STATE.—If the Secretary finds that a State has failed to establish a State program under subsection (a) by the deadline specified in subsection (c)(2) or its State program has failed to meet the requirements of subsection (b), the Secretary shall notify the State of such finding and shall assume, with respect to insured health plans and groups in the State, the responsibilities of the State with such a program under this part.

SEC. 1402. CERTIFICATION OF INSURED HEALTH PLANS.

Each State program shall provide for the certification of insured health plans as qualified insured health plans if the appropriate certifying authority finds that the plan meets the applicable requirements of subtitle B.

SEC. 1403. ESTABLISHMENT OF HEALTH CARE COVERAGE AREAS.

(a) ESTABLISHMENT.—Each State program shall provide, by not later than the deadline specified in section 1401(c)(2), for the division of the State into 1 or more health care coverage areas or HCCAs. The program may revise the boundaries of such areas from time to time consistent with this section.

(b) MULTIPLE AREAS.—With respect to a HCCA—

(1) no metropolitan statistical area in a State may be incorporated into more than 1 HCCA in such State;

(2) the number of individuals residing within a HCCA may not be less than 250,000; and

(3) no area incorporated in a HCCA may be incorporated into another HCCA.

(c) INTERSTATE AREAS.—Two or more contiguous States may provide for the establishment of a HCCA that includes adjoining portions of the States so long as all portions of any metropolitan statistical area within such States are within the same HCCA.

SEC. 1404. PROCEDURES FOR PURCHASING GROUPS.

(a) PROCEDURES.—Consistent with part II of subtitle B, each State program shall have procedures for the establishment and operation of individual and small employer purchasing groups with respect to HCCAs within such State.

(b) VOTING RIGHTS.—Such procedures shall specify the voting rights of members of a purchasing group.

SEC. 1405. PREPARATION OF INFORMATION CONCERNING PLANS AND PURCHASING GROUPS.

Each State program shall prepare and make available to purchasing groups and employers located in the State (and to eligible individuals upon request) information, in comparative form, concerning the qualified health plans certified by such State and purchasing groups operating in the State. Such information shall include a description of the following:

(1) The prices, outcomes, enrollee satisfaction, and other information pertaining to the quality of such plans.

(2) The HCCAs in the State and the qualified health plans available with respect to each HCCA.

(3) The existence of purchasing groups within each such HCCA.

(4) Any other information determined appropriate by the State.

SEC. 1406. RISK ADJUSTMENT PROGRAM.

(a) IN GENERAL.—Each State program under this part shall provide for a risk adjustment program using the risk adjustment process and factors described in section 1117(b) to adjust the premiums of qualified general access plans to reflect the relative actuarial risk of eligible employees and eligible individuals enrolled in the qualified general access plans participating in the program. The program shall apply such risk-adjustment factors, in accordance with a methodology established under the standards under such section, so that the sum of such factors is zero for all participating qualified general access plans, within a class of family enrollment in each HCCA.

(b) ADJUSTMENT FOR DIFFERENCES IN NONPAYMENT RATES.—In accordance with rules established by the Secretary, each State program under this part shall provide that if the rates of nonpayment of premiums for qualified general access plans during grace periods (established under section 1142(b)(2) or otherwise) vary appreciably among qualified general access plans, the State program shall provide for such adjustments in the payments made among such plans as will place each qualified general access plan in the same position as if the rates of nonpayment were the same.

SEC. 1407. DEVELOPMENT OF BINDING ARBITRATION PROCESS.

Each State program shall establish an arbitration process that—

(1) resolves in a timely manner disputes concerning—

(A) a claim for payment or provision of benefits under a qualified insured health plan;

(B) a request for preauthorization of items or services which is submitted to such a plan prior to receipt of the items or services; or

(C) decisions by a plan relating to the coverage of a particular item or service for enrollees generally; and

(2) with respect to disputes involving a determination by a plan that an item or service is not medically necessary or appropriate with respect to a specific enrollee, requires a person who contests such determination to demonstrate to an arbitrator by a preponderance of the evidence that the determination is inappropriate based on the available scientific evidence.

SEC. 1408. SPECIFICATION OF ANNUAL GENERAL ENROLLMENT PERIOD.

Each State program shall specify an annual period, of not less than 30 days, during which eligible employees

and eligible individuals in the State may enroll in qualified insured health plans or change the qualified insured health plan in which the individual is enrolled.

Subpart B—Waiver of Requirements

SEC. 1421. ALTERNATE STATE SYSTEMS ALLOWED.

(a) WAIVER AUTHORITY.—

(1) IN GENERAL.—In accordance with this section, each State may submit an application to the Secretary to waive the requirements specified in subsection (b) as they apply to the State (and to qualified insured health plans and purchasing groups in the State).

(2) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the approval of such waiver applications.

(3) EXPEDITED PROCEDURE.—The Secretary shall establish an expedited procedure for the consideration and disposition of waiver applications under this subsection. The procedure established by the Secretary shall provide that such consideration and disposition shall be completed within 90 days.

(b) REQUIREMENTS SPECIFIED.—The requirements specified in this subsection are as follows:

(1) AVAILABILITY.—The requirements of section 1111(c) (relating to availability of qualified health plans).

(2) MSA BOUNDARIES.—Subject to subsection (c)(1), the requirements of paragraphs (1) and (3) of section 1403(b) (relating to the treatment of metropolitan statistical areas in drawing the boundaries of HCCAs).

(3) CORPORATE STRUCTURE OF PURCHASING GROUPS.—The requirement of section 1141(a) (relating to corporate structure of a purchasing group), insofar as it prevents the establishment of a public (or quasi-public) entity as a purchasing group.

(4) COVERED ITEMS AND SERVICES.—Subject to subsection (c)(2), the items and services included as covered items and services under the standard and catastrophic packages under section 1301(b).

(c) LIMITATIONS ON WAIVERS.—

(1) ANTI-REDLINING.—In establishing boundaries for HCCAs, a State may not discriminate on the basis of or otherwise take into account race, religion, national origin, socio-economic status, disability, or perceived health status.

(2) SUBSTITUTION OF ACTUARIALLY EQUIVALENT BENEFITS.—A State may not waive the re-

quirement described in subsection (b)(4) unless the State provides for the inclusion of benefits that are actuarially equivalent to the benefits not included.

(c) CONSTRUCTION.—Nothing in this section shall be construed as allowing a State to waive all the requirements of subtitle B in order to establish a single-payer system.

SEC. 1422. STATE OPT-OUT.

Any State that applies to the Secretary and demonstrates to the satisfaction of the Secretary that, because of unique geographic and related features that inhibit a competitive market, no more than two qualified general access plans are made available in the State, the Secretary may waive such requirements of this title as may be necessary to assure the provision of covered items and services to all eligible employees and eligible individuals.

SEC. 1423. WAIVER OF CERTAIN MEDICAID REQUIREMENTS.

For provisions authorizing States to waive certain medicaid requirements, in order to permit managed care, etc., see section 6001.

Subpart C—Preemption of Certain State Laws

SEC. 1431. PREEMPTION FROM STATE BENEFIT MANDATES.

Effective as of January 1, 1995, no State shall establish or enforce any law or regulation that—

(1) requires the offering, as part of a qualified health plan, of any services, category of care, or

services of any class or type of provider that is different from the covered items and services specified under subtitle C;

(2) specifies the individuals to be covered under such a plan or the duration of such coverage; or

(3) requires a right of conversion from a group health plan that is a qualified health plan to an individual health plan.

SEC. 1432. PREEMPTION OF STATE LAW RESTRICTIONS ON NETWORK PLANS.

(a) LIMITATION ON RESTRICTIONS ON NETWORK PLANS.—Effective as of January 1, 1995—

(1) a State may not prohibit or limit a network plan from including incentives for enrollees to use the services of participating providers;

(2) a State may not prohibit or limit a network plan from limiting coverage of services to those provided by a participating provider;

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers under a network plan;

(4) a State may not prohibit or limit a network plan from limiting the number of participating providers;

(5) a State may not prohibit or limit a network plan from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers; and

(6) a State may not prohibit or limit the corporate practice of medicine.

(b) DEFINITIONS.—In this section:

(1) NETWORK PLAN.—The term ''network plan'' means a qualified health plan—

(A) which—

(i) limits coverage of covered items and services to those provided by participating providers, or

(ii) provides, with respect to such services provided by persons who are not participating providers, for cost-sharing which are in excess of those permitted under the standard or catastrophic package for participating providers;

(B) which has a sufficient number and distribution of participating providers to assure that the uniform set of effective benefits (i) is available and accessible to each enrollee, within the area served by the plan, with reasonable promptness and in a manner which assures con-

tinuity, and (ii) when medically necessary, is available and accessible twenty-four hours a day and seven days a week; and

(C) which provides benefits for covered items and services not furnished by participating providers if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(2) PARTICIPATING PROVIDER.—The term ''participating provider'' means an entity or individual which provides, sells, or leases health care services under a contract with a network plan, which contract does not permit—

(A) cost sharing in excess of the cost-sharing permitted under a standard or catastrophic package, and

(B) any enrollee charges (for covered items or services) in excess of such cost sharing.

PART II—FEDERAL RESPONSIBILITIES

SEC. 1441. FEDERAL ROLE WITH RESPECT TO MULTI-STATE EMPLOYER PLANS.

In the case of an insured health plan offered by an employer which has employees who are employed in 2 or more States, the Secretary shall carry out activities under this section in the same manner as a State program would

carry out activities under part I with respect to a health plan subject to such part.

SEC. 1442. FEDERAL ROLE IN THE CASE OF A DEFAULT BY A STATE.

(a) FAILURE TO ESTABLISH STATE PROGRAM.—If a State fails to establish a State program under part I or, having established such a program, the program fails to continue to meet the requirements of such part, the Secretary shall, after notice and opportunity for correction, terminate such program and shall carry out activities under part I in the same manner as a State program would carry out activities under such part.

(b) FAILURE OF STATE TO DESIGNATE HCCAS.—If a State fails to designate 1 or more HCCAs under section 1403(a) by the deadline specified in section 1401(c)(2), the Secretary shall make such designation.

SEC. 1443. ESTABLISHMENT OF RESIDENCY RULES.

The Secretary shall establish rules relating to identifying the State (and HCCA) in which individuals reside. Such rules shall be based on the principal residence of such an individual.

SEC. 1444. RULES DETERMINING SEPARATE EMPLOYER STATUS.

Under rules of the Secretary, employers that are related (as defined under such rules) shall be treated under

this title as a single employer if a reason for their separation relates to the health risk characteristics of eligible employees of such employers.

Subtitle F—Universal Coverage

SEC. 1501. REQUIREMENT OF COVERAGE.

(a) IN GENERAL.—Effective January 1, 2005, each individual who is a citizen or lawful permanent resident of the United States shall be covered under—

(1) a qualified health plan, or

(2) an equivalent health care program (as defined in section 1601(7)).

(b) EXCEPTION.—Subsection (a) shall not apply in the case of an individual who is opposed for religious reasons to health plan coverage, including an individual who declines health plan coverage due to a reliance on healing using spiritual means through prayer alone.

Subtitle G—Definitions

SEC. 1601. DEFINITIONS.

Unless specifically provided otherwise, as used in this Act:

(1) APPROPRIATE CERTIFYING AUTHORITY.—The term ''appropriate certifying authority'' means—

(A) in the case of a health plan offered in a State with a qualified health plan certification

program meeting the requirements of this Act, the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance; or

(B) in all other cases, the Secretary.

(2) COVERED ITEMS AND SERVICES.—The term ''covered items and services'' means items and services described in section 1301(b).

(3) DELIVERY SYSTEM.—Each of the following is considered to be a distinct ''delivery system'' with respect to a health plan:

(A) Fee-for-service.

(B) Use of preferred providers.

(C) Staff or group model health maintenance organizations.

(D) Such other systems as the Secretary may recognize.

(4) DEPENDENT.—The term ''dependent'' means, with respect to any individual, any person who is—

(A) the spouse of such individual, or

(B) under regulations of the Secretary, a child (including an adopted child) of such individual and who—

(i) is under 19 years of age,

(ii) is under 25 years of age and a full-time student, or

(iii) regardless of age is incapable of self-support because of mental or physical disability.

(5) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, in any month after the month which includes the hiring date, an employee who normally performs at least 30 hours of service per week for that employer, and includes any dependent of such employee.

(6) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means an individual who—

(A) is otherwise not eligible for coverage under an employer-based qualified health plan or 1 of the equivalent health care programs (as defined in paragraph (7)), or

(B) in the case of eligible employee of a small employer, has elected not to enroll in a qualified health plan offered by such employer.

(7) EQUIVALENT HEALTH CARE PROGRAM.—The term ''equivalent health care program'' means—

(A) part A or part B of the medicare program under title XVIII of the Social Security Act,

(B) the medicaid program under title XIX of the Social Security Act,

(C) the health care program for active military personnel under title 10, United States Code,

(D) the veterans health care program under chapter 17 of title 38, United States Code,

(E) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code,

(F) the Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), and

(G) any other plan recognized by the Secretary the purpose of which is to provide retiree health benefits.

(8) FAMILY.—The term ''family'' means an individual and includes the individual's dependents (if any), as defined in paragraph (4), but only if such an individual or dependent is a citizen or lawful permanent resident of the United States.

(9) FIRST CERTIFICATION YEAR.—The term ''first certification year'' means, with respect to a

qualified health plan in a State, the first year in which the State has in effect a State program under part I of subtitle E as of January 1 of such year, but not later than the first January 1 following the deadline specified in section 1401(c)(2).

(10) GENERAL ACCESS PLAN.—The term ''general access plan'' means an insured health plan offered with respect to eligible employees of small employers and eligible individuals under subtitle B.

(11) HCCA.—The term ''HCCA'' means a health care coverage area established under section 1403.

(12) HEALTH PLAN.—The term ''health plan'' means an insured health plan and a self-insured health plan.

(13) HEALTH PLAN SPONSOR.—The term ''health plan sponsor'' means, with respect to an insured health plan or self-insured health plan, the insurer offering the plan or the self-insured sponsor for the plan, respectively.

(14) INSURED HEALTH PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''insured health plan'' means any hospital or medical service policy or certificate, hospital or medical service

plan contract, or health maintenance organization group contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following—

(i) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance,

(v) automobile medical-payment insurance,

(vi) coverage for a specified disease or illness, or

(vii) a hospital or fixed indemnity policy (unless the Secretary determines that such a policy provides sufficiently comprehensive coverage of a benefit so that it should be treated as an insured health plan),

or any combination thereof.

(15) INSURER.—The term ''insurer'' means—

(A) a licensed insurance company,

(B) a prepaid hospital or medical service plan,

(C) a health maintenance organization, or

(D) other entity providing a plan of health insurance or health benefits,

with respect to which State regulation is not preempted by reason of section 514(b)(2) of the Employee Retirement Income Security Act of 1974.

(16) LARGE EMPLOYER.—The term ''large employer'' means an employer that is not a small employer.

(17) LARGE EMPLOYER PLAN.—The term ''large employer plan'' means a qualified health plan which is made available by a large employer, whether the plan is insured or self-insured.

(18) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—The term ''multiple employer welfare arrangement'' has the meaning given such term in section 3(40) of the Employee Retirement Income Security Act of 1974.

(19) PURCHASING GROUP.—The term ''purchasing group'' means an individual and small employer purchasing group established under section 1141.

(20) QUALIFIED HEALTH PLAN.—The term ''qualified'' means—

(A) with respect to a insured health plan, a health plan that is certified as qualified under section 1402, or

(B) with respect to a self-insured health plan, a health plan that meets the requirements of a large employer plan under section 1201.

(21) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(22) SELF-INSURED HEALTH PLAN.—The term ''self-insured health plan''—

(A) means an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits and that is funded in a manner other than through the purchase of one or more insured health plans, but

(B) does not include any coverage or insurance described in paragraph (14)(B).

(23) SELF-INSURED SPONSOR.—The term ''self-insured sponsor'' includes, with respect to a self-insured plan, any entity which establishes or maintains the plan.

(24) SMALL EMPLOYER.—

(A) IN GENERAL.—The term ''small employer'' means, with respect to a calendar year, an employer that normally employs 1 or more but less than 101 eligible employees on a typical business day.

(B) TREATMENT OF SELF-EMPLOYED.—For the purposes of subparagraph (A), the term ''employee'' includes a self-employed individual.

(C) TREATMENT OF LINES OF BUSINESS, ETC.—For purposes of making a determination under subparagraph (A), an employer may treat each line of business or each geographic location as a separate employer.

(25) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

TITLE II—TAX AND ENFORCEMENT PROVISIONS

SEC. 2000. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a

section or other provision of the Internal Revenue Code of 1986.

Subtitle A—General Tax Provisions

SEC. 2001. CERTAIN EMPLOYER HEALTH PLAN CONTRIBUTIONS INCLUDED IN INCOME.

(a) EXCLUSION FOR EMPLOYER HEALTH PLAN CONTRIBUTIONS LIMITED TO CONTRIBUTIONS TO QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—Section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

"SEC. 106. CONTRIBUTIONS BY EMPLOYER TO QUALIFIED HEALTH PLANS.

''Except as provided in section 91, gross income of an employee does not include employer-provided coverage under a qualified health plan (as defined in section 1601(20) of the Health Equity and Access Reform Today Act of 1993) or employer-provided contributions to such employee's medical savings account''.

(b) CLERICAL AMENDMENT.—The table of sections of part III of subchapter B of chapter 1 is amended by striking the item relating to section 106 and inserting the following new item:

''Sec. 106. Contributions by employer to qualified health plans.''

(b) INCLUSION IN INCOME.—

(1) IN GENERAL.—Part II of subchapter B of chapter 1 (relating to items specifically included in gross income) is amended by adding at the end the following new section:

"SEC. 91. EXCESS EMPLOYER CONTRIBUTIONS TO QUALIFIED HEALTH PLANS.

''(a) GENERAL RULE.—Notwithstanding section 106, if—

''(1) an employee is covered by a qualified health plan at any time during any month, and

''(2) there is an excess employer contribution with respect to the employee to such plan for such month,

the gross income of such employee for the taxable year which includes such month shall include an amount equal to such excess employer contribution for such month.

''(b) EXCESS EMPLOYER CONTRIBUTION DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'excess employer contribution' means, with respect to an employee enrolled in a qualified health plan for any month, the excess of—

''(A) the employer contribution to such plan for such month, over

"(B) the applicable dollar limit for such employee for such month.

"(2) APPLICABLE DOLLAR LIMIT.—For purposes of paragraph (1)—

"(A) IN GENERAL.—The applicable dollar limit for an employee for any month is equal to 1/12 of the average premium cost for the calendar year of the lowest priced ½ of standard packages (within the meaning of section 1301(a)(1) of the Health Equity and Access Reform Today Act of 1993) of qualified health plans offered in such year in the HCCA (as defined in section 1601(11) of such Act) within which is offered the qualified health plan in which the employee is enrolled.

"(B) DETERMINATION OF LIMIT.—

"(i) ANNUAL DETERMINATION.—The applicable dollar limit shall be determined annually by the Secretary, in consultation with the Secretary of Health and Human Services, from information submitted by each State with respect to each HCCA.

"(ii) DETERMINATION BASED ON ENROLLMENT AND AGE STATUS.—

"(I) IN GENERAL.—The applicable dollar limit shall be determined with respect to individual and family enrollments, and within each such enrollment status, determined with respect to the age of the principal enrollee.

"(II) AGE BANDS ESTABLISHED.—In carrying out subclause (I), the Secretary shall establish reasonable age bands (consistent with such bands established under section 1116 of the Health Equity and Access Reform Today Act of 1993) within which premium amounts will not vary for a type of enrollment.

"(c) SPECIAL RULE FOR MULTIEMPLOYER HEALTH PLANS.—In the case of employer contributions with respect to any employee made to a multiemployer health plan on a basis other than per employee per month, the Secretary may by regulations prescribe the method of determining that portion of such contributions that is not included in gross income of the employee.

"(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' shall have the meaning given to such term by section 1601(20) of the Health Equity and Access Reform Today Act of 1993.

"(2) EMPLOYEE INCLUDES FORMER EMPLOYEE.—The term 'employee' includes a former employee.

"(3) DETERMINATION OF EMPLOYER CONTRIBUTION.—

"(A) IN GENERAL.—The employer contribution to any qualified health plan for any month shall be that portion of the cost of such plan for such month which is incurred by the employer.

"(B) SELF-INSURED PLAN MAY USE ANNUAL ESTIMATES.—An employer who maintains a self-insured health plan may elect (in such manner and at such time as may be provided in regulations) to determine the actual employer contribution under subsection (b)(1)(A) for any period of not more than 12 months on the basis of a reasonable estimate of the cost of providing coverage for such month. To the extent practicable, such estimate shall be made on an actuarial basis, and in the making of any such esti-

mate, there shall be taken into account such factors as may be required under regulations.

''(C) EMPLOYEES ONLY TAKEN INTO ACCOUNT FOR PERIODS COVERED.—For purposes of determining the employer contribution, amounts shall be taken into account with respect to an employee only for periods during which such employee is covered by the plan.

''(4) COVERAGE FOR ONLY PART OF MONTH.—If an employee is covered under a qualified health plan for only a portion of a month, the amount required to be included under subsection (a) in the gross income of such employee with respect to such month shall be an amount which bears the same ratio to the excess employer contribution for such month as such portion bears to the entire month.

''(5) CERTAIN RELATED EMPLOYERS TREATED AS 1 EMPLOYER.—Rules similar to the rules provided by subsections (b) and (c) of section 414 shall apply.

''(6) MONTH.—The term 'month' means a calendar month.

''(7) MULTIEMPLOYER HEALTH PLAN.—The term 'multiemployer health plan' means a qualified health plan which is part of an employee welfare

benefit plan (within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974)—

''(A) to which more than 1 employer is required to contribute, and

''(B) which is maintained pursuant to 1 or more collective bargaining agreements between 1 or more employee organizations and more than 1 employer.''

(2) CLERICAL AMENDMENT.—The table of sections for part II of subchapter B of chapter 1 is amended by adding at the end the following:

''Sec. 91. Excess employer contributions to qualified health plans.''

(c) EMPLOYMENT TAX AMENDMENTS.—

(1) GENERAL RULE.—Chapter 25 (relating to general provisions relating to employment taxes) is amended by adding at the end the following new section:

''SEC. 3510. TREATMENT OF EXCESS EMPLOYER CONTRIBUTIONS.

''(a) IN GENERAL.—For purposes of this subtitle and section 209 of the Social Security Act, any amount required to be included in the gross income of an employee under section 91(a) with respect to any month—

''(1) shall be treated as paid in cash to such employee at the close of such month, and

"(2) shall not be treated as paid under a health or similar plan of the employer.

For purposes of paragraph (1), an employer may elect to prorate any such amount to any payroll period (or portion thereof) covering such month rather than treat it as being paid at the close of such month.

"(b) SPECIAL RULES IN THE CASE OF SELF-INSURED PLANS.—

"(1) SAFE HARBOR FOR EMPLOYEES WHOSE ESTIMATES ARE AT LEAST 95 PERCENT OF ACTUAL EMPLOYER CONTRIBUTIONS.—In the case of an employer who maintains a self-insured qualified health plan, if for any calendar year the excess of—

"(A) the actual employer contributions determined under section 91 with respect to all employees for such year, over

"(B) the amount estimated by the employer under section 91(d)(3)(B) as the employer contributions with respect to all employees for such year,

is not greater than 5 percent of the amount determined under subparagraph (A) then, except as provided in paragraph (2), no penalty shall be imposed under section 6672 on the employer for failure to

pay, or to deduct and withhold, any tax imposed by this subtitle on such excess.

''(2) EMPLOYER MUST PAY CERTAIN TAXES ON EXCESS.—Paragraph (1) shall not apply to any tax imposed, or required to be deducted and withheld, under sections 3111, 3221, 3301, and 3402 on the excess described in paragraph (1) unless the employer pays any such tax within the time prescribed by the Secretary under regulations.

''(3) SPECIAL RULES FOR EMPLOYEE'S SOCIAL SECURITY TAX AND CREDIT.—In the case of the excess described in paragraph (1)—

''(A) no tax shall be imposed by section 3101, and

''(B) the amount of such excess shall not be taken into account for purposes of section 209 of the Social Security Act.

''(c) LIABILITY FOR WITHHOLDING AND PAYMENT OF TAX.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the applicable payor shall withhold, and be liable for, payment of any tax required to be withheld or paid under this subtitle on any amount described in subsection (a).

"(2) SPECIAL RULES FOR MULTIEMPLOYER HEALTH PLANS.—In the case of any multiemployer health plan, the plan administrator shall comply with such rules with respect to the withholding of, and liability for, any tax required to be withheld or paid under this subtitle as the Secretary may require by regulations.

"(d) DEFINITIONS.—For purposes of this section—

"(1) APPLICABLE PAYOR.—The term 'applicable payor' means the payor of remuneration for services which qualifies the employee for coverage under a multiemployer health plan.

"(2) EMPLOYEE.—The term 'employee' does not include a former employee.

"(3) MULTIEMPLOYER HEALTH PLAN.—The term 'multiemployer health plan' has the meaning given such term by section 91(d)(7)."

(2) CLERICAL AMENDMENT.—The table of sections for chapter 25 is amended by adding at the end the following new item:

"Sec. 3510. Treatment of excess employer contributions."

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to taxable years beginning after the first December 31 following the deadline specified in section 1401(c)(2) of this Act.

(2) EMPLOYMENT TAX.—The amendments made by subsection (c) shall take effect on and after the first January 1 following the deadline specified in such section 1401(c)(2).

SEC. 2002. DEDUCTIONS FOR COSTS OF QUALIFIED HEALTH PLANS.

(a) BUSINESS EXPENSE DEDUCTION FOR HEALTH INSURANCE.—Section 162 (relating to trade or business expenses) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following new subsection:

''(m) GROUP HEALTH PLANS.—The amount of expenses paid or incurred by an employer for a group health plan or as contributions to an employee's medical savings account shall not be allowed as a deduction under this section—

''(1) unless the plan is a qualified health plan (as defined in section 1601(20) of the Health Equity and Access Reform Today Act of 1993), and

''(2) with respect to each employee, to the extent such amount exceeds the applicable dollar limit for such employee (within the meaning of section 91(b)(2) and determined on an annual basis).''

(b) PERMANENT EXTENSION AND INCREASE IN HEALTH INSURANCE TAX DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.—

(1) PERMANENT EXTENSION OF DEDUCTION.—

(A) IN GENERAL.—Subsection (l) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 1993.

(2) INCREASE IN AMOUNT OF DEDUCTION; INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—

(A) INCREASE IN AMOUNT OF DEDUCTION.—Paragraph (1) of section 162(l) is amended—

(i) by striking ''25 percent of'' and inserting ''100 percent of'', and

(ii) by striking ''dependents.'' and inserting ''dependents, and only to the extent such amount does not exceed the applicable dollar limit for such taxpayer (within the meaning of section 91(b)(2) and determined on an annual basis).''

(B) INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—Paragraph (2) of section 162(l) is amended by adding at the end the following new subparagraph:

''(C) INSURANCE MUST MEET CERTAIN STANDARDS.—Paragraph (1) shall apply only to insurance which is a qualified health plan (as defined in section 1601(20) of the Health Equity and Access Reform Today Act of 1993).''

(C) TREATMENT OF MULTIEMPLOYER HEALTH PLANS.—Subsection (l) of section 162 is amended by adding at the end the following new paragraph:

''(6) TREATMENT OF MULTIEMPLOYER HEALTH PLANS.—For purposes of this subsection, an amount paid into a multiemployer health plan (as defined in section 91(d)(7) shall be deemed to be an amount paid for insurance which constitutes medical care.''

(c) RULES RELATING TO DEDUCTIONS FOR INDIVIDUALS.—

(1) DEDUCTION FOR PREMIUMS LIMITED TO QUALIFIED HEALTH PLANS.—Subparagraph (C) of section 213(d)(1) (defining medical care) is amended by striking ''for insurance'' and inserting ''for a qualified health plan (as defined in section 1601(20)

of the Health Equity and Access Reform Today Act of 1993).''

(2) DEDUCTION NOT SUBJECT TO AGI LIMITATION.—Section 213 (relating to medical, dental, etc., expenses) is amended by adding at the end the following new subsection:

''(f) SPECIAL RULES FOR QUALIFIED HEALTH CARE PREMIUM EXPENSES.—

''(1) IN GENERAL.—In computing the deduction under subsection (a) with respect to amounts paid for premiums for coverage under a qualified health plan (as defined in section 1601(20) of the Health Equity and Access Reform Today Act of 1993)—

''(A) the limitation under subsection (a) based on adjusted gross income shall not apply to such amounts (and such amounts shall not be taken into account in determining whether such limitation applies to other amounts), and

''(B) no deduction shall be allowed to the extent such amounts exceed the applicable dollar limit for the taxpayer (within the meaning of section 91(b)(2) and determined on an annual basis).

''(2) LIMIT.—In computing the amount allowed as a deduction under paragraph (1) with respect to

the cost of providing coverage for any individual, the applicable dollar limit shall be reduced by the aggregate amount of payments to, or on behalf of, such individual by—

''(A) the Secretary of Health and Human Services under section 1003 of the Health Equity and Access Reform Today Act of 1993, and

''(B) all other entities (including any employer or governmental agency),

for coverage of such individual under a qualified health plan (as so defined).''

(3) DEDUCTION ALLOWED AGAINST GROSS INCOME.—Section 62(a) (defining adjusted gross income) is amended by inserting after paragraph (15) the following new paragraph:

''(16) DEDUCTION FOR QUALIFIED HEALTH PLAN PREMIUMS.—The deduction allowed under section 213(f).''

(d) EFFECTIVE DATE.—Except as provided in subsection (b)(1)(B), the amendments made by this section shall apply to taxable years beginning after the first December 31 following the deadline specified in section 1401(c)(2) of this Act.

SEC. 2003. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. MEDICAL SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—In the case of an eligible individual, there shall be allowed as a deduction the amounts paid in cash during the taxable year by such individual to a medical savings account for the benefit of such individual or for the benefit of any spouse or dependent of such individual who is an eligible individual.

''(b) LIMITATIONS.—

''(1) ONLY 1 ACCOUNT PER FAMILY.—Except as provided in regulations prescribed by the Secretary, no deduction shall be allowed under subsection (a) for amounts paid to any medical savings account for the benefit of an individual, such individual's spouse, or any dependent of such individual if such individual, spouse, or dependent is a beneficiary of any other medical savings account.

''(2) DOLLAR LIMITATION.—The amount allowable as a deduction under subsection (a) with respect to any individual for the taxable year shall not exceed the excess of—

''(A) the applicable dollar limit with respect to such individual (within the meaning of section 91(b)(2) and determined on an annual basis), over

''(B) the sum of—

''(i) the aggregate amount paid by, or on behalf of such individual, as a premium for a catastrophic health plan covering such eligible individual for such taxable year, plus

''(ii) the aggregate amount contributed to the eligible individual's medical savings account by persons other than the eligible individual.

''(c) DEFINITIONS.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any individual who is covered under a catastrophic health plan during any portion of the calendar year with or within which the taxable year begins.

''(2) CATASTROPHIC HEALTH PLAN.—For purposes of paragraph (1), the term 'catastrophic health plan' means a qualified health plan providing health plan coverage through a catastrophic package. For purposes of the preceding sentence, the terms 'quali-

fied health plan' and 'catastrophic package' have the meanings given to such terms by sections 1601(20) and 1301(a)(2) of the Health Equity and Access Reform Today Act of 1993.

''(d) MEDICAL SAVINGS ACCOUNTS.—For purposes of this section—

''(1) MEDICAL SAVINGS ACCOUNT.—

''(A) IN GENERAL.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the medical expenses of the beneficiaries of such trust, but only if the written governing instrument creating the trust meets the following requirements:

''(i) Except in the case of a rollover contribution described in subsection (e)(4), no contribution will be accepted unless it is in cash, and, subject to subsection (e)(2), contributions will not be accepted in excess of the amount allowed as a deduction under this section for the taxable year.

''(ii) The trustee is a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which such per-

son will administer the trust will be consistent with the requirements of this section.

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

''(iv) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(v) The interest of an individual in the balance in his account is nonforfeitable.

''(vi) Under regulations prescribed by the Secretary, rules similar to the rules of section 401(a)(9) shall apply to the distribution of the entire interest of beneficiaries of such trust.

''(B) TREATMENT OF COMPARABLE ACCOUNTS HELD BY INSURANCE COMPANIES.—For purposes of this section, an account held by an insurance company in the United States shall be treated as a medical savings account (and such company shall be treated as a bank) if—

"(i) such account is part of a health insurance plan that includes a catastrophic health plan (as defined in subsection (c)(2)),

"(ii) such account is exclusively for the purpose of paying the medical expenses of the beneficiaries of such account who are covered under such catastrophic health plan, and

"(iii) the written instrument governing the account meets the requirements of clauses (i), (v), and (vi) of subparagraph (A).

"(2) MEDICAL EXPENSES.—

"(A) IN GENERAL.—The term 'medical expenses' means, with respect to an individual, amounts paid or incurred by such individual for—

"(i) medical care (as defined in section 213), or

"(ii) long-term care (as defined in paragraph (3)),

for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent

such amounts are not compensated for by insurance or otherwise.

''(B) HEALTH PLAN COVERAGE MAY NOT BE PURCHASED FROM ACCOUNT.—

''(i) IN GENERAL.—Such term shall not include any amount paid for coverage under a health plan.

''(ii) EXCEPTION.—Clause (i) shall not apply—

''(I) in the case of coverage of an individual under 65 years of age under a catastrophic health plan or under a long-term care insurance plan, or

''(II) in the case of coverage of an individual 65 years of age or older under a medicare supplemental policy or under a long-term care insurance plan or for payment of premiums under part A or part B of title XVIII of the Social Security Act.

''(3) LONG-TERM CARE.—

''(A) IN GENERAL.—The term 'long-term care' means diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care

services which are required by, and provided to, a functionally impaired individual, which have as their primary purpose the direct provision of needed assistance with 1 or more activities of daily living (or the alleviation of the conditions necessitating such assistance) that the individual is certified under subparagraph (B) as being unable to perform, and which are provided in a setting other than an acute care unit of a hospital pursuant to a continuing plan of care prescribed by a physician or registered professional nurse. Such term does not include food or lodging provided in an institutional or other setting, or basic living services associated with the maintenance of a household or participation in community life, such as case management, transportation or legal services, or the performance of home maintenance or household chores.

"(B) FUNCTIONALLY IMPAIRED INDIVIDUAL.—The term 'functionally impaired individual' means an individual who is certified by a physician or registered professional nurse as being unable to perform at least 3 activities of daily living without substantial assistance from

another individual. For purposes of this paragraph, the term 'activities of daily living' means bathing, dressing, eating, toileting, transferring, and walking.

''(4) TIME WHEN CONTRIBUTIONS DEEMED MADE.—A contribution shall be deemed to be made on the last day of the preceding taxable year if the contribution is made on account of such taxable year and is made not later than the time prescribed by law for filing the return for such taxable year (not including extensions thereof).

''(e) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—Any amount paid or distributed out of a medical savings account shall be included in the gross income of the individual for whose benefit such account was established unless such amount is used exclusively to pay the medical expenses of such individual or the spouse or any dependent of such individual.

''(2) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid during a taxable year to a medical savings account to the extent that such contribution exceeds the

amount allowable as a deduction under subsection (a) if—

"(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

"(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

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

"(3) PENALTY FOR DISTRIBUTIONS NOT USED FOR MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a medical savings account which is not used to pay the medical expenses of the individual for whose benefit the account was established, shall be increased by 10 percent of the amount of such payment or distribution which is includible in gross income under paragraph (1).

"(B) ACCOUNT BALANCE LIMITATION.—If—

"(i) the tax imposed by this chapter is required to be increased under subparagraph (A) by reason of a distribution, and

"(ii) after such distribution, the balance of the medical savings account established for the benefit of the individual, is less than the amount of the deductible under the catastrophic health plan covering such individual,

subparagraph (A) shall be applied by substituting '50 percent' for '10 percent'.

"(4) ROLLOVERS.—Paragraph (1) shall not apply to any amount paid or distributed out of a medical savings account to the individual for whose benefit the account is maintained, if the entire amount received (including money and any other property) is paid into another medical savings account for the benefit of such individual not later than the 60th day after the day on which the individual received the payment or distribution.

"(5) PENALTY FOR MANDATORY DISTRIBUTIONS NOT MADE FROM ACCOUNT.—

"(A) IN GENERAL.—If during any taxable year—

"(i) there is a payment of a mandatory distribution expense incurred by a beneficiary of a medical savings account, and

"(ii) the person making such payment is not reimbursed for such payment with a distribution from such account before the 60th day after such payment,

the taxpayer's tax imposed by this chapter for such taxable year shall be increased by 100 percent of the excess of the amount of such payment over the amount of reimbursement made before such 60th day.

"(B) MANDATORY DISTRIBUTION EXPENSE.—For purposes of subparagraph (A), the term 'mandatory distribution expense' means—

"(i) any expense incurred which may be counted toward a deductible, or for a copayment or coinsurance, under the catastrophic health plan covering such beneficiary, and

"(ii) in the case of a beneficiary who has attained age 65, any expense for coverage described in subsection (d)(2)(B)(ii)(II) and any expense incurred which may be counted toward a deductible, or for a copayment or coinsurance, under title XVIII of the Social Security Act.

"(f) TAX TREATMENT OF ACCOUNTS.—

"(1) EXEMPTION FROM TAX.—Any medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

"(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

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

"(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, paragraph (1) of subsection (e) shall be applied as if there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day) and no portion of such distribution were used to pay medical expenses.

"(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the individual for whose benefit a medical savings account was established uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed to that individual and not used to pay medical expenses.

"(g) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

"(1) the assets of such account are held by a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer

the account will be consistent with the requirements of this section, and

''(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (d).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

''(h) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 (defining adjusted gross income), as amended by section 2002(c)(3), is amended by inserting after paragraph (16) the following new paragraph:

''(17) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) DISTRIBUTIONS FROM MEDICAL SAVINGS ACCOUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUCTION.—Section 213 (relating to medical, dental, etc., expenses), as amended by section 2002(c)(2), is amended by adding at the end the following new subsection:

''(g) COORDINATION WITH MEDICAL SAVINGS ACCOUNTS.—The amount otherwise taken into account under subsection (a) as expenses paid for medical care shall be reduced by the amount (if any) of the distributions from any medical savings account of the taxpayer during the taxable year which is not includible in gross income by reason of being used for medical care.''

(d) EXCLUSION OF EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS FROM EMPLOYMENT TAXES.—

(1) SOCIAL SECURITY TAXES.—

(A) Subsection (a) of section 3121 (defining wages) is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to be-

lieve that a corresponding deduction is allowable under section 220.''

(B) Subsection (a) of section 209 of the Social Security Act (42 U.S.C. 409) is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by inserting after paragraph (18) the following new paragraph:

''(19) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220 of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 (defining compensation) is amended by adding at the end the following new paragraph:

''(10) EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—The term 'compensation' shall not include any payment made to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 (defining wages) is amended by striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 (defining wages) is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 (relating to tax on excess contributions to individual re-

tirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by striking ''or'' at the end of paragraph (1) of subsection (a),

(3) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(d)), or'', and

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

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings account (within the meaning of section 220(d)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount deductible under section 220 for such taxable year. For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(e)(2) applies shall be treated as an amount not contributed.''

(f) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 (relating to prohibited transactions) is amended—

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

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(f)(2)(A) to such account.'', and

(2) by inserting ''or a medical savings account described in section 220(d)'' in subsection (e)(1) after ''described in section 408(a)''.

(g) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 (relating to failure to provide reports on individual retirement accounts or annuities) is amended—

(1) by inserting ''**OR ON MEDICAL SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

(2) by adding at the end of subsection (a) the following: ''The person required by section 220(h) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.''

(h) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following:

''Sec. 220. Medical savings accounts.
''Sec. 221. Cross reference.''

(2) The table of sections for chapter 43 is amended by striking the item relating to section 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 annuities.''

(3) The table of sections for subchapter B of chapter 68 is amended by inserting ''or on medical savings accounts'' after ''annuities'' in the item relating to section 6693.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the first December 31 following the deadline specified in section 1401(c)(2) of this Act.

SEC. 2004. ELIMINATING COMMONALITY OF INTEREST OR GEOGRAPHIC LOCATION REQUIREMENT FOR TAX EXEMPT TRUST STATUS.

(a) IN GENERAL.—Paragraph (9) of section 501(c) (relating to exempt organizations) is amended—

(1) by inserting ''(A)'' after ''(9)''; and

(2) by adding at the end the following:

''(B) Any determination of whether a health plan maintained by one or more large employers (within the meaning of section 1601(16) of the Health Equity and Access Reform Today Act of 1993) is a voluntary employees' beneficiary association meeting the requirements of this paragraph shall be made without regard to any determination of commonality of interest or geographic location if the plan is a qualified health plan (as defined in such section).''

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to determinations made on or after January 1, 1994.

SEC. 2005. REVISION OF COBRA CONTINUATION COVERAGE REQUIREMENTS.

(a) PERIOD OF COVERAGE.—Clause (iv) of section 4980B(f)(2)(B) (defining period of coverage) is amended—

(1) by striking ''or'' at the end of subclause (I), by striking the period at the end of subclause (II) and inserting '', or'', and by adding at the end the following new subclause:

''(III) eligible for coverage under a qualified health plan in accordance with title I of the Health Equity and Access Reform Today Act of 1993.'', and

(2) by striking ''OR MEDICARE ENTITLEMENT'' in the heading and inserting '', MEDICARE ENTITLEMENT, OR QUALIFIED HEALTH PLAN ELIGIBILITY''.

(b) QUALIFIED BENEFICIARY.—Section 4980B(g)(1) (defining qualified beneficiary) is amended by adding at the end the following new subparagraph:

''(E) SPECIAL RULE FOR INDIVIDUALS COVERED BY HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993.—The term 'qualified beneficiary' shall not include any individual who, upon termination of coverage under a group health plan, is eligible coverage under a qualified health plan in accordance with title I of the Health Equity and Access Reform Today Act of 1993.''

(c) REPEAL UPON IMPLEMENTATION OF HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993.—

(1) IN GENERAL.—Section 4980B (relating to failure to satisfy continuation coverage requirements of group health care plans) is hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Section 414(n)(3)(C) is amended by striking ''505, and 4980B'' and inserting ''and 505''.

(B) Section 414(t)(2) is amended by striking ''505, or 4980B'' and inserting ''or 505''.

(C) The table of sections for chapter 43 is amended by striking the item relating to section 4980B.

(d) EFFECTIVE DATE.—

(1) SUBSECTIONS (a) AND (b).—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act.

(2) SUBSECTION (c).—The amendments made by subsection (c) shall take effect on the first January 1 following the deadline specified in section 1401(c)(2) of this Act.

Subtitle B—Provisions Relating to Acceleration of Death Benefits

SEC. 2101. TAX TREATMENT OF PAYMENTS UNDER LIFE INSURANCE CONTRACTS FOR TERMINALLY ILL INDIVIDUALS .

(a) GENERAL RULE.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF AMOUNTS PAID WITH RESPECT TO TERMINALLY ILL INDIVIDUALS.—

''(1) IN GENERAL.—For purposes of this section, any amount paid to an individual under a life insurance contract on the life of an insured who is a terminally ill individual shall be treated as an amount paid by reason of the death of such insured.

''(2) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who has been certified by a licensed physician as having an illness or physical condition which can reasonably be expected to result in death in 12 months or less.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1993.

SEC. 2102. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED TERMINAL ILLNESS RIDERS.

(a) QUALIFIED TERMINAL ILLNESS RIDER TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED TERMINAL ILLNESS RIDER TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to life insurance shall be treated as including a reference to a qualified terminal illness rider.

''(2) QUALIFIED TERMINAL ILLNESS RIDER.—For purposes of this subsection, the term 'qualified terminal illness rider' means any rider or addendum on, or other provision of, a life insurance contract which provides for payments to an individual upon the insured becoming a terminally ill individual (as defined in section 101(g)(2)).''

(b) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—

(1) RIDER TREATED AS QUALIFIED ADDITIONAL BENEFIT.—Paragraph (5)(A) of section 7702(f) is amended by striking ''or'' at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

"(v) any qualified terminal illness rider (as defined in section 818(g)(2)), or".

(2) TRANSITIONAL RULE.—For purposes of applying section 7702 or 7702A of the Internal Revenue Code of 1986 to any contract (or determining whether either such section applies to such contract), the issuance of a qualified terminal illness rider (as defined in section 818(g)(2) of such Code) with respect to any contract shall not be treated as a modification or material change of such contract.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning before, on, or after December 31, 1993.

Subtitle C—Long-Term Care Tax Provisions

PART I—GENERAL PROVISIONS

SEC. 2201. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care), as amended by section 2002(c)(1), is amended by striking "or" at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

"(C) for qualified long-term care services (as defined in subsection (g)), or".

(b) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to deduction for medical, dental, etc. expenses), as amended by section 2002(c)(2), is amended by adding at the end the following new subsection:

"(g) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, rehabilitative, and maintenance (including personal care) services—

"(A) which are required by an individual during any period during which such individual is a functionally impaired individual,

"(B) which have as their primary purpose the provision of needed assistance with 1 or more activities of daily living which a functionally impaired individual is certified as being unable to perform under paragraph (2)(A), and

"(C) which are provided pursuant to a continuing plan of care prescribed by a licensed health care practitioner (other than a relative of such individual).

"(2) FUNCTIONALLY IMPAIRED INDIVIDUAL.—

"(A) IN GENERAL.—The term 'functionally impaired individual' means any individual who is certified by a licensed health care practitioner (other than a relative of such individual) as being unable to perform, without substantial assistance from another individual (including assistance involving verbal reminding, physical cueing, or substantial supervision), at least 3 activities of daily living described in paragraph (3).

"(B) SPECIAL RULE FOR HOME HEALTH CARE SERVICES.—In the case of services which are provided during any period during which an individual is residing within the individual's home (whether or not the services are provided within the home), subparagraph (A) shall be applied by substituting '2' for '3'. For purposes of this subparagraph, a nursing home or similar facility shall not be treated as a home.

"(3) ACTIVITIES OF DAILY LIVING.—Each of the following is an activity of daily living:

"(A) Eating.

"(B) Transferring.

"(C) Toileting.

"(D) Dressing.

"(E) Bathing.

"(4) LICENSED HEALTH CARE PRACTITIONER.—

"(A) IN GENERAL.—The term 'licensed health care practitioner' means—

"(i) a physician or registered professional nurse,

"(ii) a qualified community care case manager (as defined in subparagraph (B)), or

"(iii) any other individual who meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

"(B) QUALIFIED COMMUNITY CARE CASE MANAGER.—The term 'qualified community care case manager' means an individual or entity which—

"(i) has experience or has been trained in providing case management services and in preparing individual care plans;

"(ii) has experience in assessing individuals to determine their functional and cognitive impairment;

"(iii) is not a relative of the individual receiving case management services; and

"(iv) meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

"(5) RELATIVE.—The term 'relative' means an individual bearing a relationship to another individual which is described in paragraphs (1) through (8) of section 152(a)."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended to read as follows:

"(D) for a qualified health plan (as defined in section 1601(20) of the Health Equity and Access Reform Today Act of 1993) (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged)—

"(i) covering medical care referred to in subparagraphs (A) and (B), or

"(ii) covering medical care referred to in subparagraph (C), but only if such coverage is provided under a qualified long-term care insurance contract (as defined in section 7702B(b))."

(2) Paragraph (6) of section 213(d) is amended—

(A) by striking "subparagraphs (A) and (B)" in the matter preceding subparagraph (A) and inserting "subparagraphs (A), (B), and (C)", and

(B) by striking "paragraph (1)(C)" in subparagraph (A) and inserting "paragraph (1)(D)".

(3) Paragraph (7) of section 213(d) is amended by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)".

SEC. 2202. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

"SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

''(a) GENERAL RULE.—For purposes of this title—

''(1) a qualified long-term care insurance contract shall be treated as an accident or health insurance contract,

''(2) any plan of an employer providing coverage of qualified long-term care services shall be treated as an accident or health plan with respect to such services,

''(3) amounts received under such a contract or plan with respect to qualified long-term care services shall be treated as amounts received for personal injuries or sickness, and

''(4) payments described in subsection (b)(5) shall be treated as payments made with respect to qualified long-term care services.

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—

''(1) IN GENERAL.—For purposes of this title, the term 'qualified long-term care insurance contract' means any insurance contract if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

''(B) such contract meets the requirements of paragraphs (2), (3), and (4), and

''(C) such contract is issued by a qualified issuer.

''(2) PREMIUM REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to a contract if such contract provides that—

''(i) premium payments may not be made earlier than the date such payments would have been made if the contract provided for level annual payments over the life of the contract (or, if shorter, 20 years), and

''(ii) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

A contract shall not be treated as failing to meet the requirements of clause (i) solely by reason of a provision providing for a waiver of premiums if the policyholder becomes a functionally impaired individual.

"(B) REFUNDS UPON DEATH OR COMPLETE SURRENDER OR CANCELLATION.—Subparagraph (A)(ii) shall not apply to any refund on the death of the policyholder, or on any complete surrender or cancellation of the contract, if, under the contract, the amount refunded may not exceed the amount of the premiums paid under the contract. For purposes of this title, any refund described in the preceding sentence shall be includible in gross income to the extent that any deduction or exclusion was allowed with respect to the refund.

"(3) BORROWING, PLEDGING, OR ASSIGNING PROHIBITED.—The requirements of this paragraph are met with respect to a contract if such contract provides that no money may be borrowed under such contract and that such contract (or any portion thereof) may not be assigned or pledged as collateral for a loan.

"(4) PROHIBITION OF DUPLICATE PAYMENT.—The requirements of this paragraph are met with respect to a contract if such contract does not cover expenses incurred to the extent that such expenses are reimbursable under title XVIII of the Social Security Act.

"(5) PER DIEM AND OTHER PERIODIC PAYMENTS PERMITTED.—

"(A) IN GENERAL.—For purposes of subsection (a)(4), and except as provided in subparagraph (B), payments are described in this paragraph for any calendar year if, under the contract, such payments are made to (or on behalf of) a functionally impaired individual on a per diem or other periodic basis without regard to the expenses incurred or services rendered during the period to which the payments relate.

"(B) EXCEPTION WHERE AGGREGATE PAYMENTS EXCEED LIMIT.—If the aggregate payments under the contract for any period (whether on a periodic basis or otherwise) exceed the dollar amount in effect for such period—

"(i) subparagraph (A) shall not apply for such period, and

"(ii) the requirements of paragraph (1)(A) shall be met only if such payments are made with respect to qualified long-term care services provided during such period.

"(C) DOLLAR AMOUNT.—The dollar amount in effect under this paragraph shall be $100 per day (or the equivalent amount in the case of payments on another periodic basis).

"(D) ADJUSTMENTS FOR INCREASED COSTS.—

"(i) IN GENERAL.—In the case of any calendar year after 1995, the dollar amount in effect under subparagraph (C) for any period occurring during such calendar year shall be equal to the sum of—

"(I) the amount in effect under subparagraph (C) for the preceding calendar year (after application of this subparagraph), plus

"(II) the applicable percentage of the amount under subclause (I).

"(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term 'applicable percentage' means, with respect to any calendar year, the greater of—

"(I) 5 percent, or

"(II) the cost-of-living adjustment for such calendar year.

"(iii) COST-OF-LIVING ADJUSTMENT.—For purposes of clause (ii), the cost-of-living adjustment for any calendar year is the percentage (if any) by which the cost index under clause (iv) for the preceding calendar year exceeds such index for the second preceding calendar year. In the case of any calendar year beginning before 1997, this clause shall be applied by substituting the Consumer Price Index (as defined in section 1(f)(5)) for the cost index under clause (iv).

"(iv) COST INDEX.—The Secretary, in consultation with the Secretary of Health and Human Services, shall before January 1, 1997, establish a cost index to measure increases in costs of nursing home and similar facilities. The Secretary may from time to time revise such index to the extent necessary to accurately measure increases or decreases in such costs.

"(E) AGGREGATION RULE.—For purposes of this paragraph, all contracts issued with respect to the same policyholder by the same company shall be treated as 1 contract.

"(c) QUALIFIED ISSUER.—For purposes of this section, the term 'qualified issuer' means any person which at the time of the issuance of a long-term care insurance contract—

"(1) uses a one year preliminary term method for setting up reserves, and

"(2) maintains a capital ratio equal to not less than 25 percent of long-term care insurance premium receivables.

"(d) SPECIAL RULES FOR TAX TREATMENT OF POLICYHOLDERS.—For purposes of this title, solely with respect to the policyholder under any qualified long-term care insurance contract—

"(1) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—If the aggregate payments under all qualified long-term care insurance contracts with respect to a policyholder for any period (whether on a periodic basis or otherwise) exceed the dollar amount in effect for such period under subsection (b)(5)—

"(A) subsection (b)(5) shall not apply for such period, and

"(B) such payments shall be treated as made for qualified long-term care services only if made with respect to such services provided during such period.

"(2) ASSIGNMENT OR PLEDGE.—Such contract shall not be treated as a qualified long-term care insurance contract during any period on or after the date on which the contract (or any portion thereof) is assigned or pledged as collateral for a loan.

"(e) TREATMENT OF COVERAGE AS PART OF A LIFE INSURANCE CONTRACT.—Except as provided in regulations, in the case of coverage of qualified long-term care services provided as part of a life insurance contract, the requirements of this section shall apply as if the portion of the contract providing such coverage was a separate contract.

"(f) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' has the meaning given such term by section 213(g).

"(2) RECERTIFICATION.—If an individual has been certified as a functionally impaired individual under section 213(g)(2)(A), services shall not be treated as qualified long-term care services with respect to the individual unless such individual is recertified no less frequently than annually as a functionally impaired individual in the same manner as under such section, except that such

recertification may be made by any licensed health care practitioner (as defined in section 213(g)(4)), other than a relative (as defined by section 213(g)(5)) of such individual.

''(g) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Section 4980B shall not apply to—

''(1) qualified long-term care insurance contracts, or

''(2) plans described in subsection (a)(2).

''(h) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent the avoidance of this section by providing qualified long-term care services under a life insurance contract.''

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

''Sec. 7702B. Treatment of long-term care insurance or plans.''

SEC. 2203. EFFECTIVE DATES.

(a) SECTION 2201.—The amendments made by section 2201 shall apply to taxable years beginning after December 31, 1994.

(b) SECTION 2202.—The amendments made by section 2202 shall apply to contracts issued after December 31, 1994.

(c) TRANSITION RULE.—If, after the date of the enactment of this Act and before January 1, 1995, a contract providing coverage for services which are similar to qualified long-term care services (as defined in section 213(g) of the Internal Revenue Code of 1986) and issued on or before January 1, 1994, is exchanged for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), such exchange shall be treated as an exchange to which section 1035 of such Code applies.

PART II—CONSUMER PROTECTION PROVISIONS

SEC. 2301. POLICY REQUIREMENTS.

(a) IN GENERAL.—Section 7702B (as added by section 2202) is amended by redesignating subsection (h) as subsection (i) and by inserting after subsection (g) the following new subsection:

''(h) CONSUMER PROTECTION PROVISIONS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

''(A) the requirements of the model regulation and model Act described in paragraph (2),

''(B) the disclosure requirement of paragraph (3),

"(C) the requirements relating to nonforfeitability under paragraph (4), and

"(D) the requirements relating to rate stabilization under paragraph (5).

"(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

"(i) MODEL REGULATION.—The following requirements of the model regulation:

"(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

"(II) Section 7B (relating to prohibitions on limitations and exclusions).

"(III) Section 7C (relating to extension of benefits).

"(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

"(ii) MODEL ACT.—The following requirements of the model Act:

"(I) Section 6C (relating to preexisting conditions).

"(II) Section 6D (relating to prior hospitalization).

"(B) DEFINITIONS.—For purposes of this paragraph—

"(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted in January of 1993).

"(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

"(3) TAX DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to

any policy if such policy meets the requirements of section 4980D(d)(1).

''(4) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision.

''(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

"(iii) The nonforfeiture provision shall provide at least one of the following:

"(I) Reduced paid-up insurance.

"(II) Extended term insurance.

"(III) Shortened benefit period.

"(IV) Other similar offerings approved by the Secretary.

"(5) RATE STABILIZATION.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to any long-term care insurance policy, including any group master policy, if—

"(i) such policy contains the minimum rate guarantees specified in subparagraph (B), and

"(ii) the issuer of such policy meets the requirements specified in subparagraph (C).

"(B) MINIMUM RATE GUARANTEES.—The minimum rate guarantees specified in this subparagraph are as follows:

"(i) Rates under the policy shall be guaranteed for a period of at least 3 years from the date of issue of the policy.

"(ii) After the expiration of the 3-year period required under clause (i), any rate increase shall be guaranteed for a period of at least 2 years from the effective date of such rate increase.

"(iii) In the case of any individual age 75 or older who has maintained coverage under a long-term care insurance policy for 10 years, rate increases under such policy shall not exceed 10 percent in any 12-month period.

"(C) INCREASES IN PREMIUMS.—The requirements specified in this subparagraph are as follows:

"(i) IN GENERAL.—If an issuer of any long-term care insurance policy, including any group master policy, plans to increase the premium rates for a policy, such issuer shall, at least 90 days before the effective date of the rate increase, offer to each individual policyholder under such policy the option to remain insured under the policy at a reduced level of benefits which maintains the premium rate at the rate in effect

on the day before the effective date of the rate increase.

''(ii) INCREASES OF MORE THAN 50 PERCENT.—

''(I) IN GENERAL.—If an issuer of any long-term care insurance policy, including any group master policy, increases premium rates for a policy by more than 50 percent in any 3-year period—

''(aa) in the case of a group master long-term care insurance policy, the issuer shall discontinue issuing all group master long-term care insurance policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase; and

''(bb) in the case of an individual long-term care insurance policy, the issuer shall discontinue issuing all individual long-term care policies in any State in which the issuer issues

such policy for a period of 2 years from the effective date of such premium increase.

''(II) APPLICABILITY.—Subclause (I) shall apply to any issuer of long-term care insurance policies or any other person that purchases or otherwise acquires any long-term care insurance policies from another issuer or person.

''(D) MODIFICATIONS OR WAIVERS OF REQUIREMENTS.—The Secretary may modify or waive any of the requirements under this paragraph if—

''(i) such requirements will adversely effect an issuer's solvency;

''(ii) such modification or waiver is required for the issuer to meet other State or Federal requirements;

''(iii) medical developments, new disabling diseases, changes in long-term care delivery, or a new method of financing long-term care will result in changes to mortality and morbidity patterns or assumptions;

''(iv) judicial interpretation of a policy's benefit features results in unintended claim liabilities; or

''(v) in the case of a purchase or other acquisition of long-term care insurance policies of an issuer or other person, the continued sale of other long-term care insurance policies by the purchasing issuer or person is in the best interests of individual consumers.

''(6) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term 'long-term care insurance policy' has the meaning given such term by section 4980D(e).''.

(b) CONFORMING AMENDMENT.—Section 7702B(b)(1)(B) (as added by section 2202) is amended by inserting ''and of subsection (h)'' after ''and (4)''.

SEC. 2302. ADDITIONAL REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43, as amended by section 2403, is amended by adding at the end the following new section:

"SEC. 4980D. FAILURE TO MEET REQUIREMENTS FOR LONG-TERM CARE INSURANCE POLICIES.

''(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirements of subsection (c), (d), or (e) are not met with respect to each long-term care insurance policy.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

''(c) ADDITIONAL RESPONSIBILITIES.—The requirements of this subsection are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 13 (relating to application forms and replacement coverage).

1 ''(ii) Section 14 (relating to reporting
2 requirements), except that the issuer shall
3 also report at least annually the number of
4 claims denied during the reporting period
5 for each class of business (expended as a
6 percentage of claims denied), other than
7 claims denied for failure to meet the wait-
8 ing period or because of any applicable
9 pre-existing condition.
10 ''(iii) Section 20 (relating to filing re-
11 quirements for marketing).
12 ''(iv) Section 21 (relating to standards
13 for marketing), including inaccurate com-
14 pletion of medical histories, other than sec-
15 tion 21C(1) and 21C(6) thereof, except
16 that—
17 ''(I) in addition to such require-
18 ments, no person shall, in selling or
19 offering to sell a long-term care insur-
20 ance policy, misrepresent a material
21 fact; and
22 ''(II) no such requirements shall
23 include a requirement to inquire or
24 identify whether a prospective appli-
25 cant or enrollee for long-term care in-

surance has accident and sickness insurance.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

"(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(h)(2)(B).

"(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificate-holder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

"(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate-holder (or representative)—

"(A) provide a written explanation of the reasons for the denial, and

"(B) make available all information directly relating to such denial.

"(d) DISCLOSURE.—The requirements of this subsection are met if either of the following statements, whichever is applicable, is prominently displayed on the front page of any long-term care insurance policy and in

the outline of coverage required under subsection (c)(1)(B)(ii):

"(1) A statement that: 'This policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

"(2) A statement that: 'This policy is not intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

"(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance."

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43, as amended by section 2403, is amended by adding at the end the following new item:

"Sec. 4980D. Failure to meet requirements for long-term care insurance policies."

SEC. 2303. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this subtitle shall be construed as preventing a State from applying standards that provide greater protection of policyholders of long-term care insurance policies (as defined in section 4980D(e) of the Internal Revenue Code of 1986).

SEC. 2304. UNIFORM LANGUAGE AND DEFINITIONS.

(a) IN GENERAL.—The National Association of Insurance Commissioners shall not later than January 1, 1995, promulgate standards for the use of uniform language and definitions in long-term care insurance policies (as defined in section 4980D(e) of the Internal Revenue Code 1986).

(b) VARIATIONS.—Standards under subsection (a) may permit the use of nonuniform language to the extent required to take into account differences among States in the licensing of nursing facilities and other providers of long-term care.

SEC. 2305. EFFECTIVE DATES.

(a) SECTION 2301.—The amendments made by section 2301 shall apply to contracts issued after December 31, 1994. The provisions of section 2203(c) of this Act shall apply to such contracts.

(b) SECTION 2302.—The amendments made by section 2302 shall apply to actions taken after December 31, 1994.

Subtitle D—Enforcement Provisions

PART I—GENERAL PROVISIONS

SEC. 2401. UNIVERSAL COVERAGE.

(a) REQUIRED REPORTING.—

(1) IN GENERAL.—Section 1144 of the Social Security Act (42 U.S.C. 1320b–14) is amended to read as follows:

''HEALTH INSURANCE COVERAGE DATA BANK

''SEC. 1144. (a) ESTABLISHMENT OF DATA BANK.—The Secretary shall establish a Health Insurance Coverage Data Bank (hereafter in this section referred to as the 'Data Bank') to—

''(1) further the purposes of subtitle F of title I of the Health Equity and Access Reform Today Act of 1993,

''(2) further the purposes of section 1862(b) in the identification of, and collection from, third parties responsible for payment for health care items and services furnished to medicare beneficiaries, and

''(3) assist in the identification of, and the collection from, third parties responsible for the reimbursement of costs incurred by any State plan under title XIX with respect to medicaid beneficiaries, upon request by the State agency described in section 1902(a)(5) administering such plan.

''(b) INFORMATION IN DATA BANK.—

''(1) IN GENERAL.—The Data Bank shall contain information obtained pursuant to section 6103(l)(12) of the Internal Revenue Code of 1986 and subsection (c).

"(2) DISCLOSURE OF INFORMATION IN DATA BANK.—The Secretary is authorized until September 30, 1998—

"(A) (subject to the restriction in subparagraph (D)(i) of section 6103(l)(12) of the Internal Revenue Code of 1986) to disclose any information in the Data Bank obtained pursuant to such section solely for the purposes of such section,

"(B) (subject to the restriction in subsection (c)(5)) to disclose any other information in the Data Bank to any State agency described in section 1902(a)(5), employer, or qualified health plan solely for the purposes described in subsection (a), and

"(C) to disclose any other information in the Data Bank to the Secretary of the Treasury for the purpose of carrying out the purposes of section 5000A of the Internal Revenue Code of 1986.

"(c) REQUIREMENT TO REPORT INFORMATION.—

"(1) REPORTING REQUIREMENT.—

"(A) IN GENERAL.—Any employer described in paragraph (2), any qualified health plan in the case of individuals enrolling in non-

employer-provided plans, and any governmental or nongovernmental official responsible for any equivalent health care program (as defined in section 1601(7) of the Health Equity and Access Reform Today Act of 1993 shall report to the Secretary (in such form and manner as the Secretary determines will minimize the burden of such reporting) with respect to each individual the information required under paragraph (3) for each applicable calendar year.

''(B) SPECIAL RULE.—To the extent a qualified health plan provides information required under paragraph (3) in a form and manner specified by the Secretary (in consultation with the Secretary of Labor) on behalf of an employer in accordance with section 101(f) of the Employee Retirement Income Security Act of 1974, the employer has complied with the reporting requirement under subparagraph (A) with respect to the reporting of such information.

''(C) APPLICABLE YEAR.—For purposes of this paragraph, the term 'applicable calendar year' means any calendar year beginning after 1994, and before the calendar year with respect

to which the Secretary makes a determination that the health care data interchange system established under subtitle B of title III of the Health Equity and Access Reform Today Act of 1993 is providing the information necessary to meet the purposes described in subsection (a).

''(2) EMPLOYER DESCRIBED.—

''(A) IN GENERAL.—An employer is described in this paragraph if such employer has, or contributes to, a qualified health plan, with respect to which at least 1 employee of such employer is an electing individual.

''(B) ELECTING INDIVIDUAL.—For purposes of this paragraph, the term 'electing individual' means an individual associated or formerly associated with the employer in a business relationship who elects coverage under the employer's qualified health plan.

''(C) CERTAIN INDIVIDUALS EXCLUDED.—For purposes of this paragraph, an individual providing service referred to in section 3121(a)(7)(B) of the Internal Revenue Code of 1986 shall not be considered an employee or electing individual with respect to an employer.

"(3) INFORMATION REQUIRED.—For purposes of paragraph (1), each employer, qualified health plan, or Secretary shall provide the following information:

"(A) The name and TIN of the individual.

"(B) The type of qualified health plan coverage (single or family) elected by the individual.

"(C) The name, address, and identifying number of the qualified health plan elected by such individual.

"(D) The name and TIN of each other individual covered under the qualified health plan pursuant to such election.

"(E) The period during which such coverage is elected.

"(F) The name, address, and TIN of the employer or qualified health plan.

"(4) TIME OF FILING.—For purposes of determining the date for filing the report under paragraph (1), such report shall be treated as a statement described in section 6051(d) of the Internal Revenue Code of 1986.

"(5) LIMITS ON DISCLOSURE OF INFORMATION REPORTED.—

"(A) IN GENERAL.—The disclosure of the information reported under paragraph (1) shall be restricted by the Secretary under rules similar to the rules of subsections (a) and (p) of section 6103 of the Internal Revenue Code of 1986.

"(B) PENALTY FOR UNAUTHORIZED WILLFUL DISCLOSURE OF INFORMATION.—The unauthorized disclosure of any information reported under paragraph (1) shall be subject to the penalty described in paragraph (1), (2), (3), or (4) of section 7213(a) of such Code.

"(6) PENALTY FOR FAILURE TO REPORT.—In the case of the failure of an employer (other than a Federal or other governmental entity) or a qualified health plan to report under paragraph (1)(A) with respect to each individual, the Secretary shall impose a penalty as described in part II of subchapter B of chapter 68 of the Internal Revenue Code of 1986.

"(d) FEES FOR DATA BANK SERVICES.—The Secretary shall establish fees for services provided under this section which shall remain available, without fiscal year limitation, to the Secretary to cover the administrative costs to the Data Bank of providing such services.

"(e) DEFINITIONS.—In this section:

"(1) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual entitled to benefits under part A, or enrolled under part B, of title XVIII, but does not include such an individual enrolled in part A under section 1818.

"(2) MEDICAID BENEFICIARY.—The term 'medicaid beneficiary' means an individual entitled to benefits under a State plan for medical assistance under title XIX (including a State plan operating under a statewide waiver under section 1115).

"(3) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' shall have the meaning given to such term by section 1601(20) of the Health Equity and Access Reform Today Act of 1993.

"(4) TIN.—The term 'TIN' shall have the meaning given to such term by section 7701(a)(41) of such Code.".

(2) MEDICAID CONFORMING AMENDMENTS.—Section 1902(a)(25)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(25)(A)(i)) is amended by striking "Medicare and Medicaid Coverage Data Bank" and inserting "Health Insurance Coverage Data Bank".

(3) CONFORMING AMENDMENTS TO ERISA.—Section 101(f) of the Employee Retirement Income

Security Act of 1974 (29 U.S.C. 1021(f)) is amended—

(A) by striking ''(as added by section 13581 of the Omnibus Budget Reconciliation Act of 1993)'' in paragraph (1)(A), and

(B) by striking ''Medicare and Medicaid Coverage Data Bank'' in paragraph (1)(A)(i) and inserting ''Health Insurance Coverage Data Bank'',

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on and after the first January 1 following the deadline specified in section 1401(c)(2) of this Act.

(b) ENFORCEMENT.—

(1) IN GENERAL.—Chapter 47 (relating to excise taxes on qualified pension, etc. plans) is amended by inserting after section 5000 the following new section:

''SEC. 5000A. FAILURE OF INDIVIDUALS WITH RESPECT TO HEALTH INSURANCE.

''(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any individual to comply with the requirements of section 1501 of the Health Equity and Access Reform Today Act of 1993.

"(b) AMOUNT OF TAX.—The amount of tax imposed by subsection (a) with respect to any calendar year shall be equal to 120 percent of the applicable dollar limit for such year for such individual (within the meaning of section 91(b)(2) and determined on an annual basis).

"(c) LIMITATION ON TAX.—

"(1) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

"(A) such failure was due to reasonable cause and not to willful neglect, and

"(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the 1st date any of the individuals on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

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

"(3) LOW-ASSISTANCE EXEMPTION.—No tax shall be imposed by subsection (a) on any individual who would have received a voucher for the calendar year under section 1003, but for a decrease in the phase-in eligibility percentage provided under subsection (d)(5)(B) thereof.".

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

"Sec. 5000A. Failure of individuals with respect to health insurance.".

(3) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2005.

SEC. 2402. ROLE OF EMPLOYERS AND LARGE EMPLOYER PLANS.

(a) IN GENERAL.—Chapter 47 (relating to excise taxes on qualified pension, etc. plans), as amended by section 2401(b)(1), is amended by inserting after section 5000A the following new section:

"SEC. 5000B. FAILURE OF EMPLOYERS OR LARGE EMPLOYER PLANS WITH RESPECT TO HEALTH INSURANCE.

"(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any person or plan to comply with the requirements of section 1004 or section 1201 of the Health Equity and Access Reform Today Act of 1993 with

respect to any employee of the person or enrollee of the plan.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure with respect to an employee or enrollee shall be $100 for each day in the noncompliance period with respect to such failure.

''(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'noncompliance period' means, with respect to any failure, the period—

''(A) beginning on the date such failure first occurs, and

''(B) ending on the date such failure is corrected.

''(3) CORRECTION.—A failure of a person or plan to comply with the requirements of section 1004 or section 1201 of the Health Equity and Access Reform Today Act of 1993 with respect to any employee of the person or enrollee of the plan shall be treated as corrected if—

''(A) such failure is retroactively undone to the extent possible, and

''(B) the employee or enrollee is placed in a financial position which is as good as such

employee or enrollee would have been in had such failure not occurred.

''(c) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the first date any of the persons referred to in subsection (d) knew, or exercising reasonable diligence would have known, that such failure existed.

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

''(d) LIABILITY FOR TAX.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the following shall be liable for the tax imposed by subsection (a) on a failure:

"(A) In the case of a health plan other than a multiemployer plan, the employer.

"(B) In the case of a multiemployer plan, the plan.

"(C) Each person who is responsible (other than in a capacity as an employee) for administering or providing benefits under the health plan and whose act or failure to act caused (in whole or in part) the failure.

"(2) SPECIAL RULES FOR PERSONS DESCRIBED IN PARAGRAPH (1)(C).—A person described in subparagraph (C) (and not in subparagraphs (A) and (B)) of paragraph (1) shall be liable for the tax imposed by subsection (a) on any failure only if such person assumed (under a legally enforceable written agreement) responsibility for the performance of the act to which the failure relates."

(b) CLERICAL AMENDMENT.—The table of sections for chapter 47, as amended by section 2401(b)(2), is amended by adding at the end the following new item:

"Sec. 5000B. Failure of employers and large employer plans with respect to health insurance."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on or after the first January 1 following the deadline specified in section 1401(c)(2).

SEC. 2403. ENFORCEMENT BEFORE STATE CERTIFICATION PROGRAMS OR STANDARDS IN PLACE.

(a) ENFORCEMENT BY EXCISE TAX FOR INSURERS.—Chapter 43 (relating to qualified pension, etc., plans) is amended by adding at the end the following new section:

"SEC. 4980C. FAILURE OF INSURER OR LARGE EMPLOYER PLAN TO COMPLY WITH CERTAIN PLAN STANDARDS.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of an insurer or of a sponsor of a large employer plan to comply with the requirements applicable to such insurer or plan under section 1103(c) or subparagraph (A) or (B) of section 1202(a)(2) of the Health Equity and Access Reform Today Act of 1993.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by an insurer in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an insurer.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a)

shall be $100 for each day during which such failure persists for each individual to which such failure relates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

''(2) LIMITATION.—The amount of the tax imposed by subsection (a) for an insurer or plan sponsor with respect to a health plan shall not exceed 25 percent of the amounts received under the plan for coverage during the period such failure persists.

''(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the insurer or plan sponsor.

''(d) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the first date the insurer or plan sponsor knows, or exercising reasonable diligence could have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to

willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

''(e) DEFINITIONS.—For purposes of this section, the terms 'health plan', 'insurer', and 'self-insured health plan' have the meanings given such terms in section 1601 of the Health Equity and Access Reform Today Act of 1993.''

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Failure of insurer or large employer plan to comply with certain plan standards.''

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 2404. DISCLOSURE OF INFORMATION REGARDING RECONCILIATION OF ASSISTANCE.

Paragraph (7) of section 6103(l) (relating to disclosure of return information to Federal, State, and local agencies administering certain programs under the Social Security Act, the Food Stamp Act of 1977, or title 38, United States Code, or certain housing assistance programs) is amended—

(1) by striking the semicolon at the end of clauses (i), (ii), (iii), (iv), (v), and (vi) and inserting a period,

(2) by striking ''; and'' at the end of the matter following clause (viii) and inserting a period, and

(3) by adding at the end (following the matter following clause (ix)) the following new clause:

''(x) voucher assistance provided under section 1003 of the Health Equity and Access Reform Today Act of 1993.''

PART II—OTHER ENFORCEMENT PROVISIONS

SEC. 2411. CONFORMING ERISA CHANGES REGARDING ENFORCEMENT OF EMPLOYER FAILURES.

(a) IN GENERAL.—Section 502(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)) is amended by striking ''or'' at the end of paragraph (5), by striking the period at the end of paragraph (6) and inserting ''; or'', and by inserting at the end the following new paragraph:

''(7) by an employee of any person, or by the Secretary—

''(A) for the relief provided in subsection (c)(4), or

''(B) to enjoin any act or practice which violates section 1004 of the Health Equity and

Access Reform Today Act of 1993, or to obtain other appropriate equitable relief to redress such violation or to enforce the provisions of such section.''

(b) CIVIL PENALTY.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by adding at the end the following new paragraph:

''(4)(A) The Secretary may assess a civil penalty against any employer who fails to meet the requirements of section 1004 of the Health Equity and Access Reform Today Act of 1993 in an amount not to exceed $100 per day from the date of the failure. Such penalty shall not be assessed if a tax has been imposed under section 5000B with respect to the failure.

''(B) No penalty shall be imposed under subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

''(C) No penalty shall be imposed by subparagraph (A) on any failure if—

''(i) such failure was due to reasonable cause and not to willful neglect, and

''(ii) such failure is corrected during the 30-day period beginning on the first date the employer knew, or exercising reasonable diligence would have known, that such failure existed.

''(D) In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.''

SEC. 2412. EQUITABLE RELIEF REGARDING INSURERS FAILING TO COMPLY WITH QUALIFIED HEALTH PLAN STANDARDS.

(a) IN GENERAL.—The Secretary of Labor may—

(1) assess a civil penalty against any insurer who fails to comply with the requirements applicable to the insurer under subtitle B of title I of the Health Equity and Access Reform Today Act of 1993 in an amount not to exceed $100 for each day during which the failure persists, except that the aggregate amount of the penalty with respect to any failure shall not exceed 25 percent of the amounts received under the plan during the period during which the failure persists, or

(2) bring a civil action—

(A) to enjoin an insurer from any such failure, or

(B) to obtain other appropriate equitable relief to address any such failure or to enforce the provisions of such subtitle.

(b) EXCEPTIONS TO PENALTY.—

(1) IN GENERAL.—The provisions of subparagraphs (B), (C), and (D) of section 502(c)(4) of the Employee Retirement Income Security Act of 1974 shall apply to any failure to which subsection (a)(1) applies.

(2) EXCEPTION.—Subsection (a)(1) shall not apply to a failure by an insurer in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an insurer.

(3) COORDINATION WITH TAX.—No penalty shall be assessed under subsection (a)(1) if a tax has been imposed under section 5000C with respect to the failure.

(c) APPLICABLE RULES.—The provisions of part 5 of title I of the Employee Retirement Income Security Act of 1974 shall apply to the extent necessary to effectively

carry out, and enforce the requirements under, subsection (a).

TITLE III—QUALITY ASSURANCE AND SIMPLIFICATION

Subtitle A—Quality Assurance

PART I—STANDARDS AND MEASUREMENTS OF QUALITY

SEC. 3001. STANDARDS FOR QUALITY ASSURANCE AND PERFORMANCE MEASURES PROGRAMS.

(a) DEVELOPMENT.—The Secretary, in consultation with relevant agencies (such as the Agency for Health Care Policy and Research and other agencies determined appropriate by the Secretary) and recognized private entities engaged in quality assurance activities related to health insurance (such as the Joint Commission on Accreditation of Health Care Organizations and the National Committee for Quality Assurance), shall develop and publish in the Federal Register standards that quality assurance programs must comply with. Such standards shall apply to all facilities, including network providers. Such standards may be annually modified if determined appropriate by the Secretary.

(b) QUALITY DATA.—

(1) REQUIREMENT.—The Secretary shall ensure that the standards developed under subsection

(a) contain a requirement that a qualified health plan annually provide quality data, including information concerning treatment outcomes and effectiveness under the plan, to the Secretary, the relevant HCCA and to individuals enrolled in a qualified health plan.

(2) FORMAT.—The Secretary shall develop and publish in the Federal Register a quality data format that a qualified health plan must adhere to in providing quality data as required under paragraph (1).

(c) PERFORMANCE MEASURES.—In developing the standards under subsection (a), the Secretary shall ensure that appropriate performance measures are established. Such measures shall be utilized by the Health Care Data Panel established under section 3214 as the basis upon which the specifications and requirements for information under subtitle B of this title will be developed.

(d) PROVIDER RISK PROGRAMS.—The Secretary shall ensure that the standards developed under subsection (a) contain a requirement that a qualified health plan provide for a provider risk program to prevent or provide early warning of practices that may result in injury.

SEC. 3002. NATIONAL HEALTH DATA SYSTEM.

(a) STANDARDIZATION OF INFORMATION.—

(1) IN GENERAL.—The Secretary, in consultation with the States, shall establish standards for the periodic provision by qualified health plans of information under section 1118 to the States and the auditing of the information so provided by the Secretary.

(2) PATIENT CONFIDENTIALITY.—The standards developed under paragraph (1) shall be established in a manner that protects the confidentiality of individual enrollees, but may provide for the disclosure of information which discloses particular providers within a qualified health plan.

(b) ANALYSIS OF INFORMATION.—

(1) IN GENERAL.—The Secretary shall analyze the information provided to the States under section 1118 with respect to qualified health plans.

(2) CENTRAL ACCESS.—The Secretary shall make available, in a central location and consistent with subsection (a)(2), all of such analyses.

(3) DISTRIBUTION OF ANALYSES.—The Secretary shall distribute the analyses in a form, consistent with subsection (a)(2), that reports, on a National, State and community basis, the levels and trends of health care expenditures, the rates and trends in the provision of individual procedures, and

(to the extent such procedures are priced separately) the price levels and rates of price change for such procedures. The reports shall include both aggregate and per capita measures for areas and shall include comparative data for different areas.

(c) DISTRIBUTION OF INFORMATION.—

(1) ANNUAL REPORT ON EXPENDITURES.—The Secretary shall publish annually (beginning with 1997) a report on expenditures for procedures, volumes of procedures, and, to the extent such procedures are priced separately, the prices of procedures. Such report shall be distributed to each qualified health plan, each purchasing group, each Governor, and each State legislature.

(2) ANNUAL REPORTS.—The Secretary shall publish an annual report, based on analyses under this section, that identifies—

(A) procedures for which, as reflected in variations in use or rates of increase, there appear to be the greatest need to develop valid clinical protocols for clinical decision-making and review,

(B) procedures for which, as reflected in price variations and price inflation, there ap-

pear to be the greatest need for strengthening competitive purchasing, and

(C) States and localities for which, as reflected in expenditure levels and rates of increase, there appear to be the greatest need for additional cost control measures.

(3) SPECIAL DISTRIBUTIONS.—The Secretary may provide for the distribution to—

(A) a qualified health plan of such information relating to the plan as may be appropriate in order to encourage the plan to improve its delivery of care, and

(B) business, consumer, and other groups and individuals of such information as may improve their ability to effect improvements in the outcomes, quality, and efficiency of health services.

(4) ACCESS BY AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—The Secretary shall make available to the Agency for Health Care Policy and Research information obtained under this section in a manner consistent with subsection (a)(2).

SEC. 3003. MEASURES OF QUALITY OF CARE OF SPECIALIZED CENTERS OF CARE.

(a) COLLECTION OF INFORMATION.—The Secretary shall provide a process whereby a specialized center of care (as defined in subsection (d)) may submit to the Secretary, or such independent entity as the Secretary may designate, such clinical and other information bearing on the quality of care provided with respect to the covered items and services under section 1301 at the center as the Secretary may specify. Such information shall include sufficient information to take into account outcomes and the risk factors associated with individuals receiving care through the center. Such information shall be provided at such frequency (not less often than annually) as the Secretary specifies.

(b) MEASURES OF QUALITY.—Using information submitted under subsection (a) and information reported under section 3002, the Secretary shall—

(1) analyze the performance of such centers with respect to the quality of care provided,

(2) rate the performance of such a center with respect to a class of services relative to the performance of other specialized centers of care and relative to the performance of qualified health plans generally, and

(3) publish such ratings.

(c) USE OF SERVICE MARK FOR SPECIALIZED CENTERS OF CARE.—The Secretary may establish a service mark for specialized centers of care the performance of which has been rated under subsection (b). Such service mark shall be treated as if registered under the Trademark Act of 1946. For purposes of such Act, such service mark shall be deemed to be used in commerce. For purposes of this subsection, the ''Trademark Act of 1946'' refers to the Act entitled ''An Act to provide for the registration and protection of trademarks used in commerce, to carry out the provisions of international conventions, and for other purposes'', approved July 5, 1946 (15 U.S.C. 1051 et seq.).

(d) SPECIALIZED CENTER OF CARE DEFINED.—As used in this section, the term ''specialized center of care'' means an institution or other organized system for the provision of specific services, which need not be multi-disciplinary, and does not include (except as the Secretary may provide) individual practitioners.

SEC. 3004. CLINICAL EVALUATIONS.

(a) ESTABLISHMENT.—The Secretary shall examine the feasibility of creating an Agency for Clinical Evaluations (to be headed by an Administrator) under which the following responsibilities will be consolidated:

(1) Responsibilities of the Administrator for Health Care Policy and Research, under title IX of the Public Health Service Act and under section 1142 of the Social Security Act.

(2) Responsibilities of the Director of the National Center for Health Statistics (under section 306 of the Public Health Service Act).

(3) Responsibilities of the Director of the Office of Medical Applications of Research at the National Institutes of Health.

(4) Responsibilities of the Director of the Office of Research and Demonstrations of the Health Care Financing Administration, insofar as such responsibilities relate to clinical evaluations.

(b) SPECIFIC DUTIES.—In addition to carrying out subsection (a), the Secretary shall—

(1) set priorities for the research community to strengthen the research base;

(2) support research and evaluation (both on a contract and investigator-initiated basis) on medical effectiveness through technology assessment, consensus development, outcomes research practice guidelines, and other appropriate activities;

(3) conduct effectiveness trials in collaboration with medical specialty societies, medical educators, and qualified health plans;

(4) maintain a clearinghouse and other registries on clinical trials and outcomes research data;

(5) assure the systematic evaluation of existing as well as new treatments and diagnostic technologies in a constant, continuous effort to upgrade the knowledge base for clinical decisionmaking and policy choice; and

(6) design a computerized dissemination system for providers to provide an interactive system of information on outcomes research, practice guidelines, and other information.

(c) ASSISTANCE.—The Secretary shall provide the Benefits Commission established under subtitle D of title I with such information, on evaluations related to the covered items and services under section 1301 and any other information developed in the scope of carrying out the responsibilities of the Secretary, as may be appropriate.

(d) COOPERATION WITH OTHER AGENCIES.—In carrying out responsibilities under this section, the Secretary shall cooperate and consult with the Director of the National Institutes of Health, the Commissioner of Food and

Drugs, the Secretary of Veterans Affairs, and the heads of any other interested Federal department or agency.

(e) ADDITIONAL AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated $250,000,000 for each fiscal year (beginning with fiscal year 1995).

SEC. 3005. REPORT AND RECOMMENDATIONS ON ACHIEVING UNIVERSAL COVERAGE.

(a) FACTORS AFFECTING COVERAGE.—

(1) COLLECTION OF INFORMATION.—The Secretary, on a continuing basis, shall collect information concerning, and analyze the number and characteristics of, eligible individuals (as defined in subsection (c)) who are not enrolled with qualified health plans compared to such number and characteristics of individuals so enrolled. Such characteristics shall include age, sex, race, ethnicity, family status, employment status, whether the individual is an eligible employee, income, health status, health risk factors, geography, whether the individual resides in a rural or medically underserved area, and such other factors as may affect the election of an eligible individual to obtain health insurance coverage.

(2) REPORT.—Not later than April 1 of each year (beginning with 1997), the Secretary shall pre-

pare and submit to the appropriate committees of Congress a report analyzing the information collected under paragraph (1). Such report shall include a description of the primary factors contributing to lack of coverage of identifiable groups of eligible individuals.

(b) RECOMMENDATIONS FOR INCREASING COVERAGE.—

(1) IN GENERAL.—Not later than January 1, 1998, the Secretary shall prepare and submit to Congress recommendations on the feasibility, cost-effectiveness, and the economic impact of using different voluntary and other methods for increasing the coverage of eligible individuals.

(2) INDIVIDUAL MANDATE.—The Secretary shall specifically make recommendations under paragraph (1) regarding establishing a requirement that all eligible individuals obtain health coverage through enrollment with a qualified health plan.

(c) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term ''eligible individual'' has the same meaning given such term by section 1601(6).

SEC. 3006. MONITORING REINSURANCE MARKET.

(a) IN GENERAL.—The Secretary shall monitor the reinsurance market for qualified health plans.

(b) PERIODIC REPORTS.—The Secretary shall periodically report to Congress respecting the availability of reinsurance for qualified health plans at reasonable rates and the impact of such availability on the establishment of new plans and on the financial solvency of current plans.

SEC. 3007. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to the Benefits Commission established under subtitle D of title I for each of fiscal years 1995 through 2001 such sums as may be necessary to carry out activities under this Act.

PART II—AGENCY FOR HEALTH CARE POLICY AND RESEARCH

SEC. 3101. AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) in section 902(a) (42 U.S.C. 299a(a))—

(A) in the matter preceding paragraph (1), by inserting after ''guideline development,'' the following: ''effectiveness trials (in collaboration with medical speciality societies and qualified health plans under the Health Equity and Access Reform Today Act of 1993),'';

(B) in paragraph (7), by striking ''and'' at the end thereof;

(C) in paragraph (8), by striking the period and inserting ''; and''; and

(D) by adding at the end thereof the following new paragraph:

''(9) priorities that would enable the research community to strengthen and expand the health care research base.'';

(2) in section 902, by adding at the end thereof the following new subsections:

''(f) CLEARINGHOUSE.—The Administrator shall establish within the Agency a clearinghouse, and such other registries as the Administrator determines are appropriate, to compile and make available information and research data concerning clinical trials undertaken under this title.

''(g) FUND INVESTIGATOR.—The Administrator shall appoint an individual to serve as the fund investigator of the Agency. The fund investigator shall be responsible for initiating research, through grants or contracts under this title, with respect to the relationship between health care treatments and outcomes. The fund investigator shall be compensated in accordance with section 925(a)(2).''; and

(3) in section 911(b)(2) (42 U.S.C. 299b–(b)(2)), by striking ''and medical review organizations'' and inserting '', medical review organizations, and qualified health plans under the Health Equity and Access Reform Today Act of 1993''.

PART III—NATIONAL FUND FOR MEDICAL RESEARCH

SEC. 3201. NATIONAL FUND FOR MEDICAL RESEARCH.

(a) DESIGNATION OF OVERPAYMENTS AND CONTRIBUTIONS FOR THE NATIONAL FUND FOR MEDICAL RESEARCH.—

(1) IN GENERAL.—Subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to returns and records) is amended by adding at the end the following new part:

"PART IX—DESIGNATION OF OVERPAYMENTS AND CONTRIBUTIONS FOR THE NATIONAL FUND FOR MEDICAL RESEARCH

''Sec. 6097. Amounts for the National Fund for Medical Research.

"SEC. 6097. AMOUNTS FOR THE NATIONAL FUND FOR MEDICAL RESEARCH.

''(a) IN GENERAL.—Every individual (other than a nonresident alien) may designate that—

"(1) a portion (not less than $1) of any overpayment of the tax imposed by chapter 1 for the taxable year, and

"(2) a cash contribution (not less than $1),

be paid over to the National Fund for Medical Research. In the case of a joint return of a husband and wife, each spouse may designate one-half of any such overpayment of tax (not less than $2).

"(b) MANNER AND TIME OF DESIGNATION.—Any designation under subsection (a) may be made with respect to any taxable year only at the time of filing the original return of the tax imposed by chapter 1 for such taxable year. Such designation shall be made either on the 1st page of the return or on the page bearing the taxpayer's signature.

"(c) OVERPAYMENTS TREATED AS REFUNDED.—For purposes of this section, any overpayment of tax designated under subsection (a) shall be treated as being refunded to the taxpayer as of the last day prescribed for filing the return of tax imposed by chapter 1 (determined with regard to extensions) or, if later, the date the return is filed.

"(d) DESIGNATED AMOUNTS NOT DEDUCTIBLE.—No amount designated pursuant to subsection (a) shall be

allowed as a deduction under section 170 or any other section for any taxable year.

''(e) TERMINATION.—This section shall not apply to taxable years beginning in a calendar year after a determination by the Secretary that the sum of all designations under subsection (a) for taxable years beginning in the second and third calendar years preceding the calendar year is less than $5,000,000.''.

(2) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 61 of such Code is amended by adding at the end the following new item:

''Part IX. Designation of overpayments and contributions for the National Fund for Medical Research.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1993.

(b) ESTABLISHMENT OF THE NATIONAL FUND FOR MEDICAL RESEARCH.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to the trust fund code) is amended by adding at the end the following new section:

''SEC. 9512. NATIONAL FUND FOR MEDICAL RESEARCH.

''(a) CREATION OF FUND.—There is established in the Treasury of the United States a fund to be known

as the ''National Fund for Medical Research'', consisting of such amounts as may be credited or paid to such Fund as provided in this section or section 9602(b).

''(b) TRANSFERS TO FUND.—There is hereby transferred to the National Fund for Medical Research amounts equivalent to—

''(1) the amounts designated under section 6097 (relating to designation of overpayments and contributions to the Fund), and

''(2) amounts equivalent to the civil penalties imposed under section 502(c)(4) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) and section 2412 of the Health Equity and Access Reform Today Act of 1993.

''(c) EXPENDITURES FROM FUND.—

''(1) IN GENERAL.—The Secretary shall pay annually, within 30 days after the President signs an appropriations Act for the Departments of Labor, Health and Human Services, and Education, and related agencies, or by the end of the first quarter of the fiscal year, to the Secretary of Health and Human Services on behalf of the National Institutes of Health, an amount equal to the amount in the National Fund for Medical Research at the time of such payment, to carry out the purposes of section

404F of the Public Health Service Act, less any administrative expenses which may be paid under paragraph (2).

''(2) ADMINISTRATIVE EXPENSES.—Amounts in the National Fund for Medical Research shall be available to pay the administrative expenses of the Department of the Treasury directly allocable to—

''(A) modifying the individual income tax return forms to carry out section 6097,

''(B) carrying out this chapter with respect to such Fund, and

''(C) processing amounts received under section 6097 and transferring such amounts to such Fund.

''(d) BUDGET TREATMENT OF AMOUNTS IN FUND.—The amounts in the National Fund for Medical Research shall be excluded from, and shall not be taken into account, for purposes of any budget enforcement procedure under the Congressional Budget Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9512. National Fund for Medical Research.''.

(c) PURPOSES FOR EXPENDITURES FROM FUND.—Part A of title IV of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 404F. EXPENDITURES FROM THE NATIONAL FUND FOR MEDICAL RESEARCH.

''(a) DISTRIBUTION OF AMOUNTS.—From amounts received for any fiscal year from the National Fund for Medical Research, the Secretary shall distribute—

''(1) 3 percent of such amounts to the Director of NIH to be allocated at the Director's discretion for—

''(A) carrying out the responsibilities of the Director of NIH, including the Office of Research on Women's Health, the Office of Research on Minority Health, the Office on Alternative Medicine, and the Office of Rare Disease Research;

''(B) construction of, and acquisition of equipment for, facilities of or used by the National Institutes of Health; and

''(C) transfer to the National Center for Research Resources to carry out section 481A concerning biomedical and behavioral research facilities;

"(2) 1 percent of such amounts for carrying out section 301 and part D of this title with respect to health information communications; and

"(3) the remainder of such amounts to member institutes and centers of the National Institutes of Health in the same proportion to the total amount received under this subsection, as the amount of annual appropriations under appropriations Acts for each member institute or center for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and centers of the National Institutes of Health for the fiscal year.

"(b) PLANS OF ALLOCATION.—The amounts transferred under subsection (a) shall be allocated by the Director of NIH or the various directors of the institutes and centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.

"(c) GRANTS AND CONTRACTS FULLY FUNDED IN FIRST YEAR.—With respect to any grant or contract funded by amounts distributed under subsection (a), the full amount of the total obligation of such grant or contract shall be funded in the first year of such grant or contract, and shall remain available until expended.

"(d) MAINTENANCE OF EFFORT.—No amounts transferred under subsection (a) shall replace or reduce the amount of appropriations for the National Institutes of Health under appropriations Acts.".

Subtitle B—Administrative Simplification

SEC. 3301. ESTABLISHMENT OF HEALTH CARE DATA INTERCHANGE SYSTEM.

(a) IN GENERAL.—In accordance with the procedures provided in this subtitle, there shall be established a health care data interchange system the purpose of which is to make health care data available on a uniform basis to all participants in the health care system.

(b) GENERAL REQUIREMENTS FOR SYSTEM.—The system described in subsection (a) shall ensure—

(1) the integration of all participants in the health care system;

(2) the use of uniform processes which will permit participants in the health care system to communicate electronically for the submission and receipt of health care data;

(3) the privacy of individuals who are patients receiving health care services and the confidentiality of information in the data interchange system;

(4) that the data in the system is verifiable, timely, accurate, reliable, useful, complete, relevant, time and date stamped, and comparable; and

(5) an overall reduction in the administrative burdens and costs of the health care system, an overall increase in the productivity, effectiveness, and efficiency of the system, and an overall increase in the quality of care furnished by the system.

(c) GENERAL IMPLEMENTATION.—The system described in subsection (a) shall be implemented through—

(1) the development of proposed regulations as provided under section 3302 by the Health Care Data Panel established under section 3313 (referred to in this subtitle as the ''Panel''); and

(2) the development of final regulations through the Office of Management and Budget (referred to in this subtitle as ''OMB'') as provided under section 3303.

SEC. 3302. DEVELOPMENT OF PROPOSED REGULATIONS BY PANEL.

(a) IN GENERAL.—The Panel shall, in consultation with the National Health Informatics Commission established under section 3314, develop proposed regulations for the implementation and ongoing operation of an integrated electronic health care data interchange system that

are based on the operating standards, conventions, requirements, and procedures for the system established, selected, or developed by the Panel under sections 3304 through 3310.

(b) REQUIREMENTS RELATING TO PROPOSED REGULATIONS.—The proposed regulations developed under subsection (a) shall—

(1) be submitted to OMB not later than 30 days after the date on which the Panel is required to establish, select, or develop any of such operating standards, conventions, requirements, and procedures for the system; and

(2) provide that the general requirements for the system referred to in section 3301(b) are met.

(c) MODIFICATIONS.—The Panel shall continuously monitor the implementation of the regulations promulgated by OMB under section 3303 and shall submit to OMB any proposed modifications to such regulations determined appropriate by the Panel. The requirements of section 3303 shall apply to any such proposed modifications in the same manner as such requirements apply to the proposed regulations initially submitted by the Panel.

SEC. 3303. PROMULGATION AND IMPLEMENTATION OF PROPOSED REGULATIONS BY OMB.

(a) PROMULGATION OF REGULATIONS.—OMB shall promulgate regulations based on the proposed regulations submitted under section 3302 within 90 days after the date such proposed regulations are submitted.

(b) APPLICABILITY.—

(1) IN GENERAL.—The regulations promulgated by OMB shall apply to all participants in the health care system.

(2) SPECIAL RULE REGARDING THE MEDICARE PROGRAM.—The Secretary may incorporate the capabilities of the common working file used in the medicare program under title XVIII of the Social Security Act into a uniform working file system developed and operated according to the regulations referred to in subsection (a).

(c) COMPLIANCE WITH REGULATIONS.—

(1) IN GENERAL.—Not later than 1 year after the date on which any regulations (other than the regulations described in paragraph (2)) are promulgated by OMB, all participants in the health care system shall be required to comply with such regulations.

(2) COMPREHENSIVE QUALITY MEASUREMENT DATA.—Not later than 2 years after the date on

which any regulations relating to standards, conventions, and requirements for comprehensive quality measurement data (as described in subsection 3304(e)(3)) are promulgated by OMB, all participants in the health care system shall be required to comply with such regulations.

SEC. 3304. SELECTION AND ESTABLISHMENT OF DATA AND TRANSACTION STANDARDS, CONVENTIONS, AND REQUIREMENTS FOR THE DATA INTERCHANGE SYSTEM.

(a) IN GENERAL.—The Panel, in consultation with the American National Standards Institute (referred to in this subtitle as ''ANSI''), shall select and establish data and transaction standards, conventions, and requirements that permit the electronic interchange of any health care data the Panel determines necessary for the efficient and effective administration of the health care system.

(b) MINIMUM REQUIREMENTS.—The data and transaction standards, conventions, and requirements selected and established by the Panel under this section shall, at a minimum—

(1) ensure that the data interchange system shall have the capability to comply with such standards, conventions, and requirements; and

(2) be based on any standards that are in use and generally accepted on the date of the enactment of this subtitle or that are recommended by nationally recognized standard setting groups, including ANSI, the National Uniform Billing Committee, the Uniform Claim Form Task Force, the National Committee for Prescription Drug Programs, and the Healthcare Informatics Standards Planning Panel.

(c) APPLICABILITY.—The proposed regulations developed by the Panel shall provide that—

(1) any participant in the health care system who has the capability to interchange data through a uniform working file developed by the Panel under section 3305 shall be required to transmit and receive such data using the standards, conventions, and requirements developed by the Panel under this section; and

(2) any participant in the health care system who does not have such capability shall be required to transmit and receive data through a health care information clearinghouse or a health care value-added network that is certified under the procedure established pursuant to 3311.

(d) ADDITIONAL REQUIREMENTS.—

(1) IN GENERAL.—The proposed regulations developed by the Panel shall provide that no participant in the health care system shall be permitted to establish data requirements in addition to such standards, conventions, and requirements established by the Panel and included in regulations promulgated by OMB—

(A) unless 2 or more participants voluntarily establish such additional requirements and the requirements meet all of the privacy and confidentiality standards developed by the Panel under this subtitle and included in any regulations promulgated by OMB; or

(B) unless a waiver is granted under paragraph (2) to establish such additional requirements.

(2) CONDITIONS FOR WAIVERS.—

(A) IN GENERAL.—The proposed regulations developed by the Panel shall provide that any participant in the health care system may request a waiver to establish additional data requirements.

(B) CONSIDERATION OF WAIVER REQUESTS.—The proposed regulations developed by the Panel shall provide that no waiver shall

be granted under this paragraph unless the entity granting such waiver considers the value of the additional data to be exchanged for research or other purposes determined appropriate by the Panel, the administrative cost of the additional data requirements, the burden of the additional data requirements, and the burden of the timing of the imposition of the additional data requirements.

(C) CERTAIN REQUESTS FOR WAIVERS.—The proposed regulations developed by the Panel shall provide that if a participant in the health care system attempts to impose additional data requirements on any other such participant, the participant on which such requirements are being imposed may contact the Secretary. The Panel shall develop a procedure under which any participant in the health care system contacting the Secretary under the preceding sentence shall remain anonymous. The Secretary shall notify the participant imposing the additional data requirements that such requirements may not be imposed on any other participant unless such other participant volun-

tarily agrees to such requirements or a waiver is obtained under this paragraph.

(e) TIMETABLE FOR STANDARDS, CONVENTIONS, AND REQUIREMENTS.—

(1) STANDARDS, CONVENTIONS, AND REQUIREMENTS RELATING TO FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—Not later than 9 months after the date of the enactment of this subtitle, the Panel shall develop data and transaction standards, conventions, and requirements for the following items relating to the financing and administration of health care:

(A) Enrollment.

(B) Eligibility.

(C) Payment and remittance advice.

(D) Claims.

(E) Claims status.

(F) Coordination of benefits.

(G) Crossover billing.

(H) First report of injury.

(I) Standardized claim attachments.

(J) Any other items relating to the financing and administration of health care delivery.

(2) STANDARDS, CONVENTIONS, AND REQUIREMENTS RELATING TO INITIAL QUALITY MEASURE-

MENT INDICATORS.—Not later than 12 months after the date of the enactment of this subtitle, the Panel shall develop data and transaction standards, conventions, and requirements for participants in the health care system to transmit data derived from the financial and administrative transactions data described in paragraph (1) on quality measurement, utilization monitoring, risk assessment, patient satisfaction, outcomes, and access.

(3) STANDARDS, CONVENTIONS, AND REQUIREMENTS RELATING TO COMPREHENSIVE QUALITY MEASUREMENT DATA.—Not later than 24 months after the date of the enactment of this subtitle, the Panel shall develop standards, conventions, and requirements for participants in the health care system to transmit comprehensive data collected at the site of care on quality measurement, utilization monitoring, risk assessment, patient satisfaction, outcomes, and access.

(4) STANDARDS, CONVENTIONS, AND REQUIREMENTS RELATING TO DATA ON PATIENT CARE RECORDS.—Not later than 36 months after the date of the enactment of this subtitle, the Panel shall develop standards, conventions, and requirements related to the inclusion of data from patient care

records into the health care data interchange system, including standards, conventions, and requirements on the identification of the origin of any data from such records that is included in such system.

(5) STANDARDS, CONVENTIONS, AND REQUIREMENTS FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION.—Not later than 36 months after the date of the enactment of this subtitle, the Panel, in collaboration with the Centers for Disease Control and Prevention (referred to in this subtitle as the ''CDCP'') and in consultation with State departments of health, shall develop standards, conventions, and requirements for the electronic interchange of data on vital health statistics collected by CDCP or the States or any other such data as CDCP determines appropriate.

(f) WAIVERS OF COMPLIANCE.—

(1) FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—The proposed regulations developed by the Panel shall provide that any of the data and transaction standards, conventions, and requirements relating to financial and administrative transactions developed by the Panel under subsection (e)(1) may be waived until January 1, 1995, for a health care provider that—

(A) does not have access to a health care information clearinghouse or a health care value-added network, is in the process of developing a system that complies with such standards, conventions, and requirements, and executes an agreement with the appropriate regulatory entity that such provider will meet such standards, conventions, and requirements by a specified date (not later than January 1, 1995); or

(B) is a small rural hospital (as defined by the Panel and included in regulations promulgated by OMB).

(2) COMPREHENSIVE QUALITY MEASUREMENT DATA.—The proposed regulations developed by the Panel shall provide that any of the data and transaction standards, conventions, and requirements relating to comprehensive quality measurement data developed by the Panel under subsection (e)(3) may be waived until January 1, 1998, for a health care provider that—

(A) does not have access to a health care information clearinghouse or a health care value-added network, is in the process of developing a system that complies with such stand-

ards, conventions, and requirements, and executes an agreement with the appropriate regulatory entity that such provider will meet such standards and requirements by a specified date (not later than January 1, 1998); or

(B) agrees to obtain from such provider's records the data elements that are needed to meet the standards and requirements developed under subsection (e)(3) and agrees to subject the provider's data transfer process to a quality assurance program that is satisfactory to the appropriate regulatory entity.

SEC. 3305. STANDARDS FOR OPERATION OF A UNIFORM WORKING FILE.

Not later than 24 months after the date of the enactment of this subtitle the Panel shall establish standards for the development and operation of a uniform working file system that is national in scope. Such standards shall ensure—

(1) that all participants in the health care system may be linked electronically (directly or indirectly) to the uniform working file system;

(2) that any privacy and confidentiality standards established by the Panel under section 3308 are satisfied;

(3) that the uniform working file system improves the efficiency and effectiveness of the administration of the health care system, including health care quality measurement;

(4) the interoperability of the uniform working file system by—

(A) supporting the data and transaction standards, conventions, and requirements selected and established by the Panel; and

(B) making use of such standards, conventions, and requirements; and

(5) the support of any other requirements selected or established by the Panel.

SEC. 3306. CODE SETS FOR SYSTEM.

Not later than 9 months after the date of the enactment of this subtitle, the Panel shall select and establish code sets that are maintained by private and public entities as the Panel's official code sets for use in a national uniform working file system. The proposed regulations developed by the Panel shall provide that any changes or updates to such code sets that are established or requested by the private or public entity which maintains the code set—

(1) shall preserve the informational value of data retained either within the uniform working file

system or within the information systems of parties making use of the data and transactions standards, conventions, and requirements;

(2) shall include instructions on how existing data containing such codes is to be converted or translated so as to preserve its value;

(3) shall be incorporated into the official code set in such a manner as to minimize the disruption to the national uniform working file system and minimize the cost to all entities within the system for reprogramming to accommodate such changes or updates; and

(4) shall be implemented—

(A) only after at least 90 days advance notice has been provided to participants in the health care system; and

(B) no more frequently than on an annual basis.

SEC. 3307. ESTABLISHMENT OF UNIQUE IDENTIFIERS.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this subtitle, the Panel shall develop unique identifiers for each participant in the health care system.

(b) SPECIAL RULES.—

(1) INDIVIDUALS.—Each individual shall have a unique identifier developed by the Panel.

(2) HEALTH PLANS OR PROVIDERS.—In developing unique identifiers for each health plan or provider, the Panel shall take into account multiple uses for such identifiers and shall consider multiple physical locations and specialty classifications for providers. The unique identifiers for health plans or providers may be based on the system used under title XVIII of the Social Security Act on the date of the enactment of this subtitle.

SEC. 3308. PRIVACY AND CONFIDENTIALITY STANDARDS.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this subtitle, the Panel, after taking into consideration the Insurance Information and Privacy Protection Model Act of the National Association of Insurance Commissioners, other model legislation, and international guidelines, shall develop requirements that protect the privacy of participants in the health care system and ensure the confidentiality of information in the data interchange system.

(b) PRINCIPLES CONSIDERED.—In developing the requirements referred to in subsection (a), the Panel shall take into consideration the following principles:

(1) Information relating to an identifiable or identified individual should be collected only to the extent necessary to carry out the purpose for which the information is collected.

(2) Information relating to an identifiable or identified individual collected for a particular purpose should generally not be used for another purpose without the individual's informed consent unless the pooling of information renders an individual's data unidentifiable.

(3) Information relating to an identifiable or identified individual should be disposed of when no longer necessary to carry out the purpose for which it was collected, unless the pooling of information renders an individual's data unidentifiable.

(4) Methods to ensure the verifiability, timeliness, accuracy, reliability, utility, completeness, relevance, and comparability of information relating to an identifiable or identified individual should be instituted.

(5) An individual should be notified in advance of the collection of information relating to such individual with regard to—

(A) whether the furnishing of information is mandatory or voluntary;

(B) the recordkeeping practices with respect to any information provided; and

(C) the uses to be made of any information provided.

(6) If informed consent is necessary for the intended primary or secondary use of information relating to an identifiable or identified individual, the individual should be provided the opportunity to reject such uses at the time the information is collected, except where such uses are necessary to comply with law.

(7) An individual should be permitted to inspect and correct any information which concerns such individual and should be able to obtain information on how such information is being used.

SEC. 3309. TRANSFER OF INFORMATION BETWEEN HEALTH PLANS.

Not later than 9 months after the date of the enactment of this subtitle, the Panel shall develop rules and procedures—

(1) for determining the financial liability of health plans when health care benefits are payable under two or more health plans; and

(2) concerning the transfer among health plans of appropriate official data sets needed to carry out

the coordination of benefits, the sequential processing of claims, and other health data as determined necessary by the Panel for individuals who have more than one health plan, according to the priorities established under the rules and procedures established under paragraph (1).

SEC. 3310. FINES AND PENALTIES FOR FAILURE TO COMPLY.

(a) DEVELOPMENT BY THE PANEL.—

(1) COMPLIANCE WITH STANDARDS FOR PRIVACY AND CONFIDENTIALITY.—Not later than 9 months after the date of the enactment of this subtitle, the Panel shall develop civil fines and penalties, as determined appropriate by the Panel, to enforce any of the requirements developed by the Panel under section 3308 relating to privacy and confidentiality. The civil fines and penalties developed by the Panel under this paragraph shall not be less than $1,000 for each violation.

(2) COMPLIANCE WITH OTHER REQUIREMENTS.—

(A) IN GENERAL.—Not later than 9 months after the date of the enactment of this subtitle, the Panel shall develop civil fines and penalties, as determined appropriate by the

Panel, to enforce any of the requirements developed by the Panel under this subtitle other than the requirements related to privacy and confidentiality. The civil fines and penalties developed by the Panel under this paragraph shall not exceed $100 for each violation.

(B) LIMITATIONS.—

(i) PENALTIES NOT TO APPLY WHERE NONCOMPLIANCE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil fine or penalty developed by the Panel under this paragraph shall be imposed if it is established that the person liable for the fine or penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with any of the requirements described in subparagraph (A).

(ii) PENALTIES NOT TO APPLY TO COMPLIANCE FAILURES CORRECTED WITHIN 30 DAYS.—No civil fine or penalty developed by the Panel under this paragraph shall be imposed if—

(I) the failure to comply was due to reasonable cause and not to willful neglect, and

(II) the failure to comply is corrected during the 30-day period beginning on the 1st date the person liable for the fine or penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

(iii) WAIVER.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any civil fine or penalty developed by the Panel under this paragraph may be waived to the extent that the payment of such fine or penalty would be excessive relative to the compliance failure involved.

(b) LEGISLATIVE PROPOSAL ON CERTAIN CRIMINAL FINES AND PENALTIES.—Not later than 12 months after the date of the enactment of this subtitle, the Panel shall submit to Congress a legislative proposal relating to any criminal fines and penalties determined appropriate by the Panel to enforce any of the requirements developed by the

Panel under section 3308 relating to privacy and confidentiality.

SEC. 3311. OVERSIGHT OF UNIFORM WORKING FILE, HEALTH CARE INFORMATION CLEARINGHOUSES, AND VALUE-ADDED NETWORKS.

(a) PERIODIC REVIEWS.—Not later than 9 months after the date of the enactment of this subtitle, the Secretary shall establish a procedure for the periodic review of business practices, performance, and fees with respect to the uniform working file and each health care information clearinghouse and value-added network to ensure that such entities are not taking unfair advantage of participants in the health care system through the application of any regulations promulgated by OMB.

(b) CERTIFICATION PROCEDURE.—Not later than 12 months after the date of the enactment of this subtitle, the Panel shall establish a certification procedure for the uniform working file, health care information clearinghouses, and value-added networks. The requirements for certification shall include—

(1) adherence to the data and transaction standards and requirements and the privacy and confidentiality standards included in any regulations promulgated by OMB;

(2) making public standardized indicators of performance such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicators determined appropriate by the Secretary; and

(3) any other requirements determined appropriate by the Secretary.

SEC. 3312. ANNUAL REPORTS TO CONGRESS.

(a) IN GENERAL.—The Panel shall annually prepare and submit to Congress a report on—

(1) the status of the data interchange system, including the system's ability to provide data on cost, quality, and patient satisfaction;

(2) the savings and costs of implementing the data interchange system; and

(3) any legislative recommendations related to the data interchange system.

(b) AVAILABILITY TO THE PUBLIC.—Any information in the report submitted to Congress under subsection (a) shall be made available to the public unless such information may not be disclosed by law.

SEC. 3313. HEALTH CARE DATA PANEL.

(a) ESTABLISHMENT.—There is established a panel to be known as the Health Care Data Panel.

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Panel shall be composed of the following members:

(A) The Secretary.

(B) The Secretary of Defense.

(C) The Secretary of Veterans Affairs.

(D) A representative of the Agency for Health Care Policy and Research.

(E) A representative of the National Institute of Standards and Technology.

(F) A representative of the National Telecommunication and Information Administration.

(G) Six additional Federal officers determined appropriate by the Secretary.

(2) CHAIR.—The Secretary shall be the Chair of the Panel.

(c) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Panel shall meet at the call of the Chair.

(2) INITIAL AND SUBSEQUENT MEETINGS.—The Panel shall hold a meeting not later than 30 days after the date of the enactment of this section and at least annually thereafter.

(3) QUORUM.—A majority of the members of the Panel shall constitute a quorum, but a lesser number of members may hold hearings.

(d) POWERS OF THE PANEL.—

(1) HEARINGS.—The Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers advisable to carry out the purposes of this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Panel may secure directly from any Federal department or agency such information as the Panel considers necessary to carry out the provisions of this section. Upon request of the Chair of the Panel, the head of such department or agency shall furnish such information to the Panel.

(3) POSTAL SERVICES.—The Panel may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(4) GIFTS.—The Panel may accept, use, and dispose of gifts or donations of services or property.

(e) PANEL PERSONNEL MATTERS.—

(1) COMPENSATION OF MEMBERS.—Members of the Panel shall serve without compensation in addi-

tion to that received for their services as officers or employees of the Federal Government.

(2) STAFF.—

(A) DETAIL OF GOVERNMENT EMPLOYEES.—Upon the request of the Chair, any Federal Government employee may be detailed to the Panel without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(B) CONTRACTS.—The Chair may enter into contracts or other arrangements that may be necessary for the Panel to perform its duties.

(C) INTERNAL ORGANIZATION.—The Chair may prescribe such rules as the Chair determines necessary with respect to the internal organization of the Panel.

SEC. 3314. NATIONAL HEALTH INFORMATICS COMMISSION.

(a) APPOINTMENT.—The Panel shall provide for appointment of a National Health Informatics Commission (referred to in this section as the ''Commission'') to advise the Panel on its activities.

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall consist of 15 members. The Panel shall designate 1 member of the Commission as the Chair.

(2) EXPERTISE.—Members of the Commission shall be individuals who—

(A) represent different professions and different geographic areas, including urban and rural areas;

(B) represent Federal or State government health programs;

(C) represent applicable standard-setting groups, including the National Uniform Billing Committee, the Uniform Claim Form Task Force, American National Standards Institute, and the Healthcare Informatics Standards Planning Panel;

(D) represent consumers of health care services; and

(E) have expertise in—

(i) electronic data interchange of health care information and computerized information systems associated with the operation and administration of matters relating to health care;

(ii) the provision and financing of health care;

(iii) conducting and interpreting health economics research;

(iv) research and development of technological and scientific advances in health care;

(v) health care eligibility, enrollment, and claims administration;

(vi) health care financial management;

(vii) health care reimbursement; or

(viii) health care outcomes research.

(3) TERMS.—The Chair shall serve on the Commission at the pleasure of the Panel. Each other member of the Commission shall be appointed for a term of 5 years, except with respect to the members first appointed—

(A) 3 members shall be appointed for a term of 1 year;

(B) 3 members shall be appointed for terms of 2 years;

(C) 3 members shall be appointed for terms of 3 years;

(D) 3 members shall be appointed for terms of 4 years; and

(E) 2 members shall be appointed for terms of 5 years.

(4) VACANCIES.—

(A) IN GENERAL.—A vacancy on the Commission shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

(c) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Commission shall meet at the call of the Chair.

(2) INITIAL MEETING.—No later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting.

(3) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(d) DUTIES.—

(1) IN GENERAL.—Not later than 60 days prior to any date on which the Panel is required to select, establish, or develop any requirements relating to the data interchange system, the Commission shall make recommendations to the Panel with respect to the issues relating to such requirements.

(2) ADDITIONAL STUDIES AND PROJECTS.—As directed by the Panel, the Commission shall undertake such studies and projects as the Panel may deem necessary.

(e) POWERS OF THE COMMISSION.—

(1) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this section. Upon request of the Chair,

the head of such department or agency shall furnish such information to the Commission.

(3) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(4) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(f) COMMISSION PERSONNEL MATTERS.—

(1) COMPENSATION OF MEMBERS.—Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, includ-

ing per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF.—

(A) IN GENERAL.—The Chair may, without regard to civil service laws and regulations, appoint and terminate such personnel as may be necessary to enable the Commission to perform its duties.

(B) COMPENSATION.—The Chair may fix the compensation of personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(C) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without

interruption or loss of civil service status or privilege.

(D) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chair may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(E) CONTRACTS.—The Chair may enter into contracts or other arrangements that may be necessary for the Commission to perform its duties.

(F) INTERNAL ORGANIZATION.—The Chair may prescribe such rules as the Chair determines necessary with respect to the internal organization of the Commission. The Commission shall create such committees (composed of Commission members and others as appointed by the Chair) as necessary to enable the Commission to meet its responsibilities and functions.

(g) REPORTS.—The Commission shall submit to the Panel such reports as may be requested by the Panel on

each study or project conducted by the Commission. Such reports shall contain such information as requested by the Panel.

(h) TERMINATION OF COMMISSION.—The Commission shall terminate 20 years after the date of the enactment of this title.

(i) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until expended.

SEC. 3315. DEFINITIONS.

For purposes of this subtitle:

(1) ADMINISTRATOR.—The term ''administrator'' has the meaning given that term in section 3(16)(A) of the Employee Retirement Income Security Act of 1974.

(2) CODE SETS.—The term ''code sets'' means any codes used for supplying specific data in a uniform data set, including tables of terms, medical diagnostic codes, medical procedure codes, identification numbers, and any code sets of the National

Uniform Billing Committee, the Health Care Financing Administration, or ANSI.

(3) EMPLOYEE WELFARE BENEFIT PLAN.—The term ''employee welfare benefit plan'' has the meaning given that term in section 3(1) of the Employee Retirement Income Security Act of 1974.

(4) HEALTH CARE INFORMATION CLEARINGHOUSE.—The term ''health care information clearinghouse'' means a public or private entity that—

(A) processes data that cannot be sent directly due to lack of proper formatting or editing; and

(B) facilitates the translation of data to the standardized data set and code sets between persons who normally would send or receive the transaction;

but does not store information processed beyond the time required to complete its task and communicate the information.

(5) HEALTH CARE VALUE-ADDED NETWORK.—The term ''health care value-added network'' means any entity that provides additional services beyond the transmission of data or value, such as the storage of electronic data or value and the transfer of such data or value between health care entities.

(6) INSURER.—The term ''insurer'' means any entity that offers a health plan under which such entity is at risk for all or part of the cost of benefits under the plan, and includes any agent of such entity.

(7) PARTICIPANT IN THE HEALTH CARE SYSTEM.—The term ''participant in the health care system'' means any Federal health care program, State, employee welfare benefit plan, health plan, administrator, insurer, or provider.

(8) PROVIDER.—The term ''provider'' means a physician, hospital, pharmacy, laboratory, or other person licensed or otherwise authorized under applicable State laws to furnish health care items or services.

TITLE IV—JUDICIAL REFORMS

Subtitle A—Medical Liability Reform

SEC. 4001. DEFINITIONS.

For purposes of this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care malpractice claims

in a manner other than through health care malpractice actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a health care malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) ECONOMIC LOSSES.—The term ''economic losses'' means losses for hospital and medical expenses, lost wages, lost employment, and other pecuniary losses incurred by an individual with respect to which a health care malpractice claim or action is pursued.

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

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by State or Federal law or regulation to be licensed or cer-

tified by the State or Federal Government to engage in the delivery of such services in a State.

(6) HEALTH CARE NEGLIGENCE.—The term ''health care negligence'' means an act or omission by a health care provider or a health care professional which deviates from the applicable State standard of care and causes an injury.

(7) HEALTH CARE MALPRACTICE ACTION.—The term ''health care malpractice action'' means a civil action brought in a State or Federal court against a health care provider, health care professional, or other defendant joined in the action (regardless of the theory of liability on which the claim is based) in which the claimant alleges a health care malpractice claim.

(8) HEALTH CARE MALPRACTICE CLAIM.—The term ''health care malpractice claim'' means a claim brought against a health care provider, health care professional, or other defendant joined in a claim alleging that an injury was suffered by the claimant as the result of health care negligence or gross negligence, breach of express or implied warranty or contract, or failure to discharge a duty to warn or instruction to obtain consent arising from the provision of (or failure to provide) health care services.

(9) INJURY.—The term ''injury'' means an injury, illness, disease, or other harm suffered by an individual as a result of the provision of health care services by a health care provider or health care professional.

(10) NONECONOMIC LOSSES.—The term ''noneconomic losses'' means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, and other nonpecuniary losses incurred by an individual with respect to which a health care malpractice claim or action is pursued.

PART I—MEDIATION AND ALTERNATIVE DISPUTE RESOLUTION

SEC. 4011. MEDIATION.

(a) REQUIREMENTS FOR QUALIFIED HEALTH PLANS.—In accordance with section 1120, a qualified health plan shall provide effective mediation procedures for hearing and resolving health care malpractice claims.

(b) CERTIFICATION AND STANDARDS.—

(1) CERTIFICATION.—A qualified health plan meets the requirement of subsection (a) if the mediation procedures provided under the plan are certified by the State as being in compliance with the standards developed under paragraph (2).

(2) STANDARDS.—

(A) IN GENERAL.—The standards developed under subpart B of part I of subtitle B of title I shall contain minimum mediation standards that qualified health plans must meet in order to be certified by the State under paragraph (1).

(B) MEDIATION SERVICES.—The standards developed under subparagraph (A) shall require a qualified health plan to provide mediation services through—

(i) the Federal Mediation and Conciliation Service; or

(ii) a private mediation service that has been certified by the State as being eligible to mediate health care malpractice claims.

(c) NOTIFICATION.—A qualified health plan shall provide notice to enrollees and potential enrollees concerning the mediation procedures available under the plan and the procedures under which an enrollee commences the mediation process.

(d) PARTICIPATION.—

(1) REQUIREMENT.—A party to a dispute brought to mediation under this section shall be re-

quired to participate in the mediation if requested by another party.

(2) PRIVILEGE.—All information disclosed in a mediation procedure under this section shall be privileged and may not be used in any other proceeding unless such information is discovered independently of such mediation procedure.

SEC. 4012. FAILURE OF MEDIATION.

With respect to a claim submitted to mediation as provided for in section 4011, if the mediation process fails to resolve the dispute from which such claim arose, the parties to such claim shall participate in an applicable alternative dispute resolution method under section 4013.

SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.

(a) APPLICATION TO HEALTH CARE MALPRACTICE CLAIMS UNDER PLANS.—In the case of any health care malpractice claim, no health care malpractice action may be brought with respect to such claim until the final resolution of the claim under the alternative dispute resolution method adopted by the State under subsection (b).

(b) ADOPTION OF MECHANISM BY STATES.—Each State shall—

(1) adopt at least one of the alternative dispute resolution methods specified under this part for the

resolution of health care malpractice claims arising from the provision of health care services; and

(2) require that health plans disclose to enrollees (and potential enrollees), in accordance with standards established by the Secretary, the availability and procedures for consumer grievances under the plan, including mediation and the alternative dispute resolution method or methods adopted under this section.

(c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE DISPUTE RESOLUTION METHODS.—

(1) IN GENERAL.—The Secretary shall, by regulation, develop alternative dispute resolution methods for the use by States in resolving health care malpractice claims under subsection (a). Such methods shall include at least the following:

(A) BINDING ARBITRATION.—The use of binding arbitration.

(B) FAULT-BASED SYSTEMS.—The use of fault-based administrative systems, expedited review and dismissal of claims when not adequately supported.

(C) EARLY OFFERS OF SETTLEMENT.—The use of a process under which parties have the option to make early offers of settlement.

(D) CATASTROPHIC SYSTEMS.—The use of catastrophic injury compensation systems.

(2) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under paragraph (1), the Secretary shall assure that the methods promote the resolution of health care malpractice claims in a manner that—

(A) is affordable for the parties involved;

(B) provides for timely resolution of claims;

(C) provides for the consistent and fair resolution of claims; and

(D) provides for reasonably convenient access to dispute resolution for individuals enrolled in qualified health plans.

(d) STATE INITIATED ALTERNATIVE.—A State will be permitted to operate an alternative dispute resolution method (other than a method described in subsection (c)) that otherwise complies with this part if such system—

(1) is determined by the Secretary to accomplish the purposes and otherwise meet the requirements of this part; and

(2) is certified by the Secretary as an appropriate alternative dispute resolution method.

(e) FAILURE TO ESTABLISH SYSTEM.—If a State fails to establish an alternative resolution system that meets the requirements of this part, the Secretary shall provide for the operation of an approved alternative dispute resolution method in such State until such time as a system under this part is adopted.

SEC. 4014. COURT ACTIONS.

(a) IN GENERAL.—The extent to which any party seeks further redress (subsequent to a decision of an alternative dispute resolution method) concerning a health care malpractice claim or action in a Federal or State court shall be dependent upon the methods of alternative dispute resolution adopted by the State. With respect to such further redress, if the party initiating such court action receives a worse result, with respect to liability or level of damages, under the decision of the court than under the State alternative dispute resolution method, such party shall bear the costs, including legal fees, incurred in the court action by the other party or parties to such action.

(b) REQUIREMENT FOR PERFORMANCE BOND.—The court in a health care malpractice action may require the party that contested the ruling of the alternative dispute resolution method with respect to the health care malpractice claim that is the subject of the action to post a performance bond (in such amount and consisting of such

funds and assets as the court determines to be appropriate), except that the court may waive the application of such requirement to a party if the court determines that the posting of such a bond is not necessary to ensure that the party shall meet the requirements of this section to pay the opposing party the costs incurred by the opposing party under the action.

PART II—LIABILITY REFORM

SEC. 4021. APPLICABILITY

(a) IN GENERAL.—This part shall apply with respect to any health care malpractice action brought in any State or Federal court, except that this part shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(b) PREEMPTION.—The provisions of this part shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this part shall not preempt any State law that provides for liability defenses or places limitations on a person's liability for damages in addition to those contained in this subtitle, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this part.

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

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

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

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

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

(d) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this part shall be construed to establish any jurisdiction in the district courts of the United States over health care malpractice actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4022. LIMITATION ON AMOUNT OF ATTORNEY'S CONTINGENCY FEES.

(a) IN GENERAL.—An attorney who represents, on a contingency fee basis, a plaintiff in a health care malpractice claim or action may not charge, demand, receive, or collect for services rendered in connection with such action (including the resolution of the claim that is the subject of the action under any alternative dispute resolution) in excess of 25 percent of the total amount recovered by judgment or settlement in such action.

(b) CALCULATION OF FEES IN THE EVENT OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subsection (a) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(c) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 4023. REFORM OF DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—With respect to a health care malpractice claim or action brought in any forum, the total amount of damages that may be awarded to an individual and the family members of such individual for noneconomic losses resulting from an injury alleged under such claim or action may not exceed $250,000, regardless of the number of health care professionals, health care providers and other defendants against whom the action is brought or the number of actions brought with respect to the injury. With respect to actions heard by a jury, the jury may not be informed of limitation contained in this subsection, and if necessary, a reduction in the jury's damage award shall be made by the court.

(b) MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.—

(1) IN GENERAL.—With respect to a health care malpractice claim or action, the total amount of damages received by an individual under such action shall be reduced, in accordance with paragraph (2), by any other payment that has been, or will be, made to an individual to compensate such individual for the injury that was the subject of such action.

(2) AMOUNT OF REDUCTION.—The amount by which an award of damages to an individual for an

injury shall be reduced under paragraph (1) shall be—

(A) the total amount of any payments (other than such award) that have been made or that will be made to such individual to pay costs of or compensate such individual for the injury that was the subject of the action; minus

(B) the amount paid by such individual (or by the spouse, parent, or legal guardian of such individual) to secure the payments described in subparagraph (A).

(c) PERIODIC PAYMENTS.—With respect to a health care malpractice action referred to in subsection (a), no person may be required to pay more than $100,000 for future damages in a single payment of a damages award, but a person shall be permitted to make such payments of the award on a periodic basis. The periods for such payments shall be determined by the adjudicating body, based upon projections of future losses and shall be reduced to present value.

(d) PUNITIVE DAMAGES.—

(1) FUND.—Each State shall establish a health care education and disciplinary program, to be approved by the Secretary, and a fund consisting of

such amounts as are transferred to the fund under paragraph (2).

(2) TRANSFER OF AMOUNTS.—Each State shall require that 75 percent of all awards of punitive damages resulting from all health care malpractice claims or actions in that State be transferred to the fund established under paragraph (1) in the State.

(3) OBLIGATIONS FROM FUND.—The chief executive officer of a State shall obligate such sums as are available in the fund established in that State under paragraph (1) to provide additional resources to State health care practitioner disciplinary boards for the monitoring, education, and disciplining of health care practitioners.

(e) ATTORNEY DISCLOSURE.—Attorneys hired to represent any parties involved in a health care malpractice action referred to in subsection (a) shall, at the time of entering into the agreement with respect to such hiring, disclose—

(1) the estimated probability of success on the action;

(2) the number of hours the attorney estimates will be needed to handle the action;

(3) an estimate of the attorney fee required (and whether any costs will be assessed outside the contingency fee arrangement); and

(4) an alternative fee type or rate (hourly or contingency) if available.

At the close of the action, an attorney shall provide to the client, and the court if the action was litigated, a full, documented disclosure of the hours spent, a description of the work conducted during those hours, the total compensation received and the calculated hourly fee concerning such action. Failure to provide the information required in this subsection will result in a fee limit of 10 percent of the award.

SEC. 4024. REFORM OF PROCEDURES.

(a) STATUTE OF LIMITATIONS.—

(1) IN GENERAL.—Except as provided in paragraph (2), no health care malpractice claim or action may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury and its cause should reasonably have been discovered, but in no event later than 6 years after the date of the alleged occurrence of the injury.

(2) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, no health care malpractice

claim or action may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury and its cause should reasonably have been discovered, but in no event later than 6 years after the date of the alleged occurrence of the injury and its cause or the date on which the minor attains 12 years of age, whichever is later.

(b) JOINT AND SEVERAL LIABILITY.—

(1) IN GENERAL.—With respect to a health care malpractice claim or action, the liability of each defendant for noneconomic and punitive damages shall be several only, and shall not be joint. Each defendant shall be liable only for the amount of noneconomic and punitive damages allocated to such defendant in direct proportion to such defendant's percentage of responsibility as determined under paragraph (2).

(2) PROPORTION OF RESPONSIBILITY.—For purposes of this subsection, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

(c) FRIVOLOUS ACTIONS.—

(1) BY ATTORNEY.—With respect to a health care malpractice claim or action, if the court or the adjudicating body determines that the claim or ac-

tion, or any part thereof, was pursued by an attorney where the attorney does not have reasonable grounds to believe that the action was well grounded in fact and was warranted by existing law, the court shall impose an appropriate sanction, including the reasonable costs and attorneys fees attributable to the frivolous claims.

(2) BY CLAIMANT.—Sanctions under paragraph (1) may apply against a claimant if the court determines that the frivolous nature of the action was a result of the misrepresentation of facts by the claimant to the attorney.

SEC. 4025. PRACTICE GUIDELINES.

(a) REBUTTABLE PRESUMPTION.—

(1) DEVELOPMENT.—Each State shall develop, for certification by the Secretary, a set of specialty clinical practice guidelines, based on recommended guidelines developed by the Agency for Health Care Policy and Research.

(2) PROVISION OF HEALTH CARE UNDER GUIDELINES.—Notwithstanding any other provision of law, in any claim or action brought in a Federal or State court or other forum arising from the provision of a health care service to an individual, if the service was provided to the individual in accordance

with the guidelines developed by the State (that certified or regulates the health plan involved in the action) and certified by the Secretary under paragraph (1), the guidelines—

(A) may be introduced by a provider who is a party to the claim or action;

(B) if introduced, shall establish a rebuttable presumption that the service prescribed by the guidelines is the appropriate standard of medical care; and

(C) if used to establish a rebuttable presumption, may only be overcome by the presentation of clear and convincing evidence on behalf of the party against whom the presumption operates.

(b) ABSOLUTE DEFENSE.—With respect to new or experimental treatments that are part of approved research trials (as defined in subsection (c)), no health care provider may be required to provide or held liable for failing to provide such treatment until that treatment is found to be safe and efficacious by the Agency for Health Care Policy and Research.

(c) DEFINITIONS.—As used in this section:

(1) NEW OR EXPERIMENTAL TREATMENTS.—The term ''new or experimental treatments'' means

a treatment for which there is not sufficient evidence to determine the health outcome of the treatment compared with the best available alternative treatment (or with no treatment if there is no alternative treatment).

(2) APPROVED RESEARCH TRIALS.—The term ''approved research trial'' means a trial—

(A) conducted for the primary purpose of determining the safety, effectiveness, efficacy, or health outcomes of a treatment, compared with the best available alternative treatment, and

(B) approved by the Secretary.

A trial is deemed to be approved under subparagraph (B) if it is approved by the National Institutes of Health, the Food and Drug Administration (through an investigational new drug exemption), the Department of Defense, the Department of Veterans Affairs, or by a qualified nongovernmental research entity (as identified in guidelines issued by one or more of the National Institutes of Health).

SEC. 4026. DRUGS AND DEVICES.

(a) DEFINITIONS.—For purposes of this section:

(1) DEVICE.—The term ''device'' has the meaning given the term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(2) DRUG.—The term ''drug'' has the meaning given the term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(3) HEALTH CARE PRODUCER.—The term ''health care producer'' means any firm or business enterprise that designs, manufactures, produces, or sells a drug or device that is the subject of a health care malpractice claim or action.

(b) LIMITATION.—

(1) IN GENERAL.—Punitive damages otherwise permitted by applicable law shall not be awarded in a health care malpractice claim or action under this Act against a health care producer of a drug or device (or other defendant joined in such claim or action) that caused the harm complained of by the claimant if—

(A) the drug or device—

(i) was subject to approval under section 505 (21 U.S.C. 355) or premarket approval under section 515 (21 U.S.C. 360e), respectively, of the Federal Food, Drug,

and Cosmetic Act, by the Food and Drug Administration, with respect to—

(I) the safety of the formulation or performance of the aspect of the drug or device that caused the harm; or

(II) the adequacy of the packaging or labeling of the drug or device; and

(ii) was approved by the Food and Drug Administration; or

(B) the drug or device is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(2) WITHHELD INFORMATION; MISREPRESENTATION; ILLEGAL PAYMENT.—The provisions of paragraph (1) shall not apply in any case in which the defendant—

(A) withheld from or misrepresented to the Food and Drug Administration or any other agency or official of the Federal Government, information that is material and relevant to the performance of the drug or device; or

(B) made an illegal payment to an official of the Food and Drug Administration for the purpose of securing approval of the drug or device.

(c) SEPARATE PROCEEDING.—

(1) CONSIDERATIONS.—At the request of the health care producer, or other defendant joined, in an action described in subsection (b), the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of the award; or

(B) the amount of punitive damages following a determination of punitive liability.

(2) EVIDENCE.—If a separate proceeding is requested in accordance with paragraph (1), evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(d) AMOUNT OF PUNITIVE DAMAGES.—In determining the amount of punitive damages in an action described in subsection (b) or (c), the trier of fact shall consider all relevant evidence, including—

(1) the financial condition of the health care producer;

(2) the severity of the harm caused by the conduct of the health care producer;

(3) the duration of the conduct or any concealment of the conduct by the health care producer;

(4) the profitability of the conduct to the health care producer;

(5) the number of products sold by the health care producer of the kind causing the harm complained of by the claimant;

(6) awards of punitive or exemplary damages to persons similarly situated to the claimant;

(7) prospective awards of compensatory damages to persons similarly situated to the claimant;

(8) any criminal penalties imposed on the health care producer as a result of the conduct complained of by the claimant; and

(9) the amount of any civil fines assessed against the defendant as a result of the conduct complained of by the claimant.

(e) STRICT LIABILITY DEFENSE.—In a civil action brought by a claimant in a Federal or State court under which the claimant alleges that a health care producer of a drug or device is strictly liable to such claimant for injuries sustained from the use of such drug or device, a showing by the defendant that such drug or devices was subject

to approval and was approved by the Food and Drug Administration as described in subsection (b)(1)(A) shall be an absolute defense to such strict liability claims.

SEC. 4027. REPORT.

The Secretary shall continuously monitor the operation of the provision of this subtitle. Not later than 3 years after the date of enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report outlining the effects of this subtitle on—

(1) access to health care;

(2) the costs of health care;

(3) the cost reductions passed on to the consumers of health care;

(4) the number of health care malpractice actions filed;

(5) the time needed to resolve these claims;

(6) the numbers of claims resolved through alternative dispute resolution; and

(7) the effect on the quality of health care.

Subtitle B—Anti-Fraud and Abuse Control Program

PART I—ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM

SEC. 4101. ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1995, the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act and other statutes applicable to health care fraud and abuse.

(2) COORDINATION WITH HEALTH CARE PLANS.—In carrying out the program established under paragraph (1), the Attorney General shall

consult with, and arrange for the sharing of data with the Attorney General.

(3) REGULATIONS.—

(A) IN GENERAL.—The Attorney General shall by regulation establish standards to carry out the program under paragraph (1).

(B) INFORMATION STANDARDS.—

(i) IN GENERAL.—Such standards shall include standards relating to the furnishing of information by health care plans, providers, and others to enable the Attorney General to carry out the program (including coordination with health care plans under paragraph (2)).

(ii) CONFIDENTIALITY.—Such standards shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall

apply to a person providing information to the Attorney General under the program under this section, with respect to the Attorney General's performance of duties under the program, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act, with respect to the performance of such a contract.

(C) DISCLOSURE OF OWNERSHIP INFORMATION.—

(i) IN GENERAL.—Such standards shall include standards relating to the disclosure of ownership information described in clause (ii) by any entity providing health care services and items.

(ii) OWNERSHIP INFORMATION DESCRIBED.—The ownership information described in this clause includes—

(I) a description of such items and services provided by such entity;

(II) the names and unique physician identification numbers of all physicians with a financial relationship

(as defined in section 1877(a)(2) of the Social Security Act) with such entity;

(III) the names of all other individuals with such an ownership or investment interest in such entity; and

(IV) any other ownership and related information required to be disclosed by such entity under section 1124 or section 1124A of the Social Security Act.

(D) INTEGRITY OF ISSUANCE OF PROVIDER IDENTIFICATION CODES.—Such standards shall, insofar as they relate to the issuance of unique provider codes (described in section 4121(c)(4))—

(i) include standards relating to the information (including ownership information described in subparagraph (C)(ii) and other information needed in the administration of the program) to be required for the issuance of such codes, and

(ii) provide for the issuance of such a code upon the presentation of such information as would be sufficient to provide

for the issuance of similar codes under the medicare program.

(4) AUTHORIZATION OF APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appropriated to the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated additional amounts as may be necessary to enable the Attorney General to conduct investigations and audits of allegations of health care fraud and abuse and otherwise carry out the program established under paragraph (1) in a fiscal year.

(5) HEALTH CARE PLAN DEFINED.—For the purposes of this subsection, the term ''health care plan'' shall have the meaning given such term in section 1128(i) of the Social Security Act.

(b) ESTABLISHMENT OF ANTI-FRAUD AND ABUSE TRUST FUND.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ''Anti-Fraud and Abuse Trust Fund'' (in this section referred to as the ''Trust Fund''). The Trust

Fund shall consist of such gifts and bequests as may be made as provided in subparagraph (B) and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in subsection (a)(5), and title XI of the Social Security Act.

(B) AUTHORIZATION TO ACCEPT GIFTS.—The Managing Trustee of the Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Trust Fund, or any activity financed through the Trust Fund.

(2) MANAGEMENT.—

(A) IN GENERAL.—The Trust Fund shall be managed by the Secretary and the Attorney General through a Managing Trustee designated by the Secretary and the Attorney General.

(B) INVESTMENT OF FUNDS.—

(i) IN GENERAL.—It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in the Managing Trustee's judgment, required to meet current withdrawals.

(ii) GENERAL FORM OF INVESTMENT.—Investments described in clause (i) may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (I) on original issue at the issue price, or (II) by purchase of outstanding obligations at market price.

(iii) ISSUANCE OF PUBLIC-DEBT OBLIGATIONS.—The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such

issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month, except that where such average is not a multiple of ⅛ of 1 percent, the rate of interest on such obligations shall be the multiple of ⅛ of 1 percent nearest such market yield.

(iv) PURCHASES OF OTHER OBLIGATIONS.—The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where the Managing Trustee determines that the purchase of such other obligations is in the public interest.

(C) SALE OF OBLIGATIONS.—Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-

debt obligations may be redeemed at par plus accrued interest.

(D) INTEREST ON OBLIGATIONS AND PROCEEDS FROM SALE OR REDEMPTION OF OBLIGATIONS.—The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(E) RECEIPTS AND DISBURSEMENTS NOT INCLUDED IN UNITED STATES GOVERNMENT BUDGET TOTALS.—The receipts and disbursements of the Secretary and the Attorney General in the discharge of the functions of the Secretary and the Attorney General under the all-payer fraud and abuse control program established under subsection (a) shall be included in the totals of the budget of the United States Government. The United States is not liable for any obligation or liability incurred by the Trust Fund.

(3) USE OF FUNDS.—

(A) IN GENERAL.—Amounts in the Trust Fund shall be used without regard to fiscal year limitation to assist the Attorney General in car-

rying out the all-payer fraud and abuse control program established under subsection (a).

(B) OVERALL ADMINISTRATION.—The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary and the Attorney General certifies are necessary to carry out the all-payer fraud and abuse control program established under subsection (a).

(C) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES INTO TRUST FUND.—Section 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a–7a(f)(3)) is amended by striking ''as miscellaneous receipts of the Treasury of the United States'' and inserting ''in the Anti-Fraud and Abuse Trust Fund established under section 4101(b) of the Health Equity and Access Reform Today Act of 1993''.

(D) USE OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-SHARING.—Section 1128A(f) of the Social Security Act (42 U.S.C. 1320a–7a(f)) is amended in the matter preceding paragraph (1) by striking ''Secretary and

disposed of as follows:'' and inserting the following: ''Secretary. If the person against whom such a penalty or assessment was assessed collected a payment from an individual for providing to the individual the service that is the subject of the penalty or assessment, the Secretary shall pay a portion of the amount recovered to the individual in the nature of restitution in an amount equal to the payment so collected. The Secretary shall dispose of any remaining amounts recovered under this section as follows:''.

(4) ANNUAL REPORT.—The Managing Trustee shall be required to submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Trust Fund in each fiscal year. Such report shall include an estimate of the amount of additional appropriations authorized under subsection (a)(5) necessary for the Secretary and the Attorney General to conduct the all-payer fraud and abuse program established under subsection (a) in the next fiscal year.

SEC. 4102. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO ALL FRAUD AND ABUSE AGAINST ANY HEALTH CARE PLAN.

(a) CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended as follows:

(1) In subsection (a)(1), by inserting ''or of any health care plan (as defined in section 1128(i)),'' after ''subsection (i)(1)),''.

(2) In subsection (b)(1)(A), by inserting ''or under a health care plan'' after ''title XIX''.

(3) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

''(3) With respect to amounts recovered arising out of a claim under a health care plan, the portion of such amounts as is determined to have been paid by the plan shall be repaid to the plan, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by subtitle B of title IV of the Health Equity and Access Reform Today Act of 1993 (as estimated by the Secretary) shall be deposited into the Anti-Fraud and Abuse Trust Fund.''.

(4) In subsection (i)—

(A) in paragraph (2), by inserting ''or under a health care plan'' before the period at the end, and

(B) in paragraph (5), by inserting ''or under a health care plan'' after ''or XX''.

(b) CRIMES.—

(1) SOCIAL SECURITY ACT.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended as follows:

(A) In the heading, by adding at the end the following: ''OR HEALTH CARE PLANS''.

(B) In subsection (a)(1)—

(i) by striking ''title XVIII or'' and inserting ''title XVIII,'', and

(ii) by adding at the end the following: ''or a health care plan (as defined in section 1128(i)),''.

(C) In subsection (a)(5), by striking ''title XVIII or a State health care program'' and inserting ''title XVIII, a State health care program, or a health care plan''.

(D) In the second sentence of subsection (a)—

(i) by inserting after ''title XIX'' the following: ''or a health care plan'', and

(ii) by inserting after ''the State'' the following: ''or the plan''.

(E) In subsection (b)(1), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''title XVIII, a State health care program, or a health care plan''.

(F) In subsection (b)(2), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''title XVIII, a State health care program, or a health care plan''.

(G) In subsection (b)(3), by striking ''title XVIII or a State health care program'' each place it appears in subparagraphs (A) and (C) and inserting ''title XVIII, a State health care program, or a health care plan''.

(2) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is further amended by adding at the end the following new subsection:

''(f) The Secretary may—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

(c) HEALTH CARE PLAN DEFINED.—Section 1128 of such Act (42 U.S.C. 1320a–7) is amended by redesignating subsection (i) as subsection (j) and by inserting after subsection (h) the following new subsection:

''(i) HEALTH CARE PLAN DEFINED.—For purposes of sections 1128A and 1128B, the term 'health care plan' means a public or private program for the delivery of or payment for health care items or services other than the medicare program, the medicaid program, or a State health care program.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1995.

SEC. 4103. REPORTING OF FRAUDULENT ACTIONS UNDER MEDICARE.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a program

through which individuals entitled to benefits under the medicare program may report to the Secretary on a confidential basis (at the individual's request) instances of suspected fraudulent actions arising under the program by providers of items and services under the program.

PART II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 4111. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO FRAUD.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to

fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 4112. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 4113. CIVIL MONETARY PENALTIES.

Section 1128A(a)(1) of such Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting the following: ''claimed, including any person who presents or causes to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'';

(2) in subparagraph (C), by striking ''or'' at the end;

(3) in subparagraph (D), by striking ''; or'' and inserting '', or''; and

(4) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or''.

SEC. 4114. ACTIONS SUBJECT TO CRIMINAL PENALTIES.

Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended by adding the following new paragraph:

''(3) Any person (including any organization, agency, or other entity, but excluding a beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128(B)(b) of this title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In addition, such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).''.

SEC. 4115. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) of such Act (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) of such Act (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

(c) AMOUNT OF CIVIL MONEY PENALTY.—Section 1156(b)(3) of such Act (42 U.S.C. 1320c–5(b)(3)) is

amended by striking ''the actual or estimated cost'' and inserting the following: ''up to $10,000 for each instance''.

SEC. 4116. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) of the Social Security Act (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting the following: ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section;

''(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

"(D) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).".

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

"(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

"(i) civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

"(ii) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists; and

''(iii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) of such Act (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an entity has a history of deficiencies or has

not taken action to correct deficiencies the Secretary has brought to their attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 1876(i)(6)(B) of such Act (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(B) PROCEDURAL PROVISIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(2) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1994, the Secretary shall develop a model of the agreement that an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act must enter into with an entity providing peer review services with respect to services provided by the organization under section 1876(i)(7)(A) of such Act.

(3) REPORT BY GAO.—

(A) STUDY.—The Comptroller General shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of such Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary to assess the

quality of services provided by such eligible organizations.

(B) REPORT TO CONGRESS.—Not later than July 1, 1996, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subparagraph (A).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1995.

SEC. 4117. EFFECTIVE DATE.

The amendments made by this part shall take effect January 1, 1995.

PART III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

SEC. 4121. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) GENERAL PURPOSE.—Not later than January 1, 1995, the Attorney General, in consultation with the Secretary, shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements where no find-

ing of liability has been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

(b) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each government agency and health care plan shall report any final adverse action (not including settlements where no finding of liability has been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

(C) The nature of the final adverse action.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Attorney General determines by regulation is

required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Attorney General shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Attorney General prescribes. Such information shall first be required to be reported on a date specified by the Attorney General.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Attorney General and placed in a national fraud and abuse data bank established by the Attorney General. The data bank established by the Attorney General under the preceding sentence shall be governed by such privacy and confidentiality requirements as determined appropriate by the Attorney General.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements where no finding of liability has been made) reported to the Attorney General under this section respecting a health care provider, supplier, or practitioner, the Attorney General shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health care plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Attorney General prescribes by regulation.

(d) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Attorney General in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(e) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) The term ''final adverse action'' includes:

(A) Civil judgments against a health care provider in Federal or State court related to the delivery of a health care item or service.

(B) Federal or State criminal convictions related to the delivery of a health care item or service.

(C) Actions by State or Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation.

(D) Exclusion from participation in Federal or State health care programs.

(E) Any other adjudicated actions or decisions that the Attorney General shall establish by regulation.

(2) The terms ''licensed health care practitioner'', ''licensed practitioner'', and ''practitioner'' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to pro-

vide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) The term ''health care provider'' means a provider of services as defined in section 1861(u) of the Social Security Act, and any entity, including a health maintenance organization, group medical practice, or any other entity listed by the Attorney General in regulation, that provides health care services.

(4) The term ''supplier'' means a supplier of health care items and services described in sections 1819 (a) and (b), and section 1861 of the Social Security Act.

(5) The term ''Government agency'' shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

(D) State law enforcement agencies.

(E) State medicaid fraud and abuse units.

(F) State or Federal agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(6) The term ''health care plan'' has the meaning given to such term by section 1128(i) of the Social Security Act.

(7) For purposes of paragraph (2), the existence of a conviction shall be determined under paragraph (4) of section 1128(j) of the Social Security Act.

(f) CONFORMING AMENDMENT.—Section 1921(d) of the Social Security Act is amended by inserting ''and section 4121 of the Health Equity and Access Reform Today Act of 1993'' after ''section 422 of the Health Care Quality Improvement Act of 1986''.

SEC. 4122. QUARTERLY PUBLICATION OF ADVERSE ACTIONS TAKEN.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

''QUARTERLY PUBLICATION OF ADVERSE ACTIONS TAKEN

''SEC. 1144. Not later than 30 days after the end of each calendar quarter, the Secretary shall publish in the Federal Register a listing of all final adverse actions taken during the quarter under this part (including pen-

alties imposed under section 1107, exclusions under section 1128, the imposition of civil monetary penalties under section 1128A, and the imposition of criminal penalties under section 1128B) and under section 1156.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to calendar quarters beginning on or after January 1, 1995.

PART IV—AMENDMENTS TO CRIMINAL LAW

SEC. 4131. PENALTIES FOR HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

''(a) OFFENSE.—Whoever, being a health care provider, knowingly engages in any scheme or artifice to defraud any person in connection with the provision of health care shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) DEFINITION.—In this section, the term 'health care provider' means—

''(1) a physician, nurse, dentist, therapist, pharmacist, or other professional provider of health care; and

''(2) a hospital, health maintenance organization, pharmacy, laboratory, clinic, or other health

care facility or a provider of medical services, medical devices, medical equipment, or other medical supplies.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following new item:

''1347. Health care fraud.''.

SEC. 4132. BROADENING APPLICATION OF MAIL FRAUD STATUTE.

Section 1341 of title 18, United States Code, is amended—

(1) by inserting ''or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier,'' after ''Postal Service,''; and

(2) by inserting ''or such carrier'' after ''causes to be delivered by mail''.

SEC. 4133. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for the purposes of carrying out the purposes of this part and the amendments made by this part—

(1) such sums as may be necessary for the Federal Bureau of Investigation to hire, equip, and train no fewer than 275 special agents and support staff to investigate health-care fraud cases; and

(2) such sums as may be necessary to hire, equip, and train no fewer than 50 assistant United States Attorneys and support staff to prosecute health-care fraud cases.

SEC. 4134. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following new subsection:

''(c)(1) In special circumstances and in the Attorney General's sole discretion, the Attorney General may make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution under section 1101.

''(2) A person is not eligible for a payment under paragraph (1) if—

''(A) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

''(B) the person knowingly participated in the offense;

''(C) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

''(i) in a criminal, civil, or administrative proceeding;

''(ii) in a congressional, administrative or General Accounting Office report, hearing, audit, or investigation; or

''(iii) by the news media, unless the person is the original source of the information; or

''(D) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

''(3) For the purposes of paragraph (2)(C)(iii), the term 'original source' means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

''(4) Neither the failure of the Attorney General to authorize a payment under paragraph (1) nor the amount authorized shall be subject to judicial review.''.

SEC. 4135. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

Section 982(a) of title 18, United States Code, is amended by inserting after paragraph (5) the following:

''(6)(A) If the court determines that a Federal health care offense is of a type that poses a serious threat to the health of any person or has a significant detrimental impact on the health care system, the court, in imposing sentence on a person convicted of that offense, shall order that person to forfeit property, real or personal, that—

''(i)(I) is used in the commission of the offense; or

''(II) constitutes or is derived from proceeds traceable to the commission of the offense; and

''(ii) is of a value proportionate to the seriousness of the offense.

''(B) For purposes of this paragraph, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(i) section 1347 of this title;

''(ii) section 1128B of the Social Security Act;

''(iii) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title if the violation or conspiracy relates to health care fraud;

''(iv) section 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud; and

''(v) section 301, 303(a)(2), or 303 (b) or (e) of the Federal Food, Drug and Cosmetic Act, if the violation or conspiracy relates to health care fraud.''.

SEC. 4136. INJUNCTIVE RELIEF RELATING TO FEDERAL HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense (as defined in section 982(a)(6)(B) of this title);''.

Subtitle C—Treatment of Certain Activities Under the Antitrust Laws

SEC. 4201. EXEMPTION FROM ANTITRUST LAWS FOR CERTAIN COMPETITIVE AND COLLABORATIVE ACTIVITIES.

(a) EXEMPTION DESCRIBED.—An activity relating to the provision of health care services shall be exempt from the antitrust laws if—

(1) the activity is within one of the categories of safe harbors described in section 4202;

(2) the activity is within an additional safe harbor designated by the Attorney General under section 4203; or

(3) the activity is specified in and in compliance with the terms of a certificate of review issued by the Attorney General under section 4204 and the activity occurs—

(A) while the certificate is in effect, or

(B) in the case of a certificate issued during the 2-year period beginning on the date of the enactment of this Act, at any time on or after the first day of the 2-year period that ends on the date the certificate takes effect.

(b) AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.—

(1) IN GENERAL.—If any person brings an action alleging a claim under the antitrust laws and the activity on which the claim is based is found by the court to be exempt from such laws under subsection (a), the court shall, at the conclusion of the action—

(A) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(B) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(2) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant to paragraph (1) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party

that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

SEC. 4202. SAFE HARBORS.

The following activities are safe harbors for purposes of section 4201(a)(1):

(1) COMBINATIONS WITH MARKET SHARE BELOW THRESHOLD.—Activities relating to health care services of any combination of health care providers if the number of each type or specialty of provider in question does not exceed 20 percent of the total number of such type or specialty of provider in the relevant market area.

(2) ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—

(A) IN GENERAL.—Subject to subparagraph (B), any activity of a medical self-regulatory entity relating to standard setting or standard enforcement activities that are designed to promote the quality of health care provided to patients.

(B) EXCEPTION.—No activity of a medical self-regulatory entity may be deemed to fall under the safe harbor established under this paragraph if the activity is conducted for purposes of financial gain.

(3) PARTICIPATION IN SURVEYS.—The participation of a provider of health care services in a written survey of the prices of services, reimbursement levels, or the compensation and benefits of employees and personnel, but only if—

(A) the survey is conducted by a third party, such as a purchaser of health care services, governmental entity, institution of higher education, or trade association;

(B) the information provided by participants in the survey is based on prices charged, reimbursements received, or compensation and benefits paid prior to the third month preceding the month in which the information is provided; and

(C) if the results of the survey are disseminated, the results are aggregated in a manner that ensures that no recipient of the results may identify the prices charged, reimbursement received, or compensation and benefits paid by any particular provider.

(4) JOINT VENTURES FOR HIGH TECHNOLOGY AND COSTLY EQUIPMENT AND SERVICES.—Any activity of a health care cooperative venture relating to the purchase, operation, or marketing of high tech-

nology or other expensive medical equipment, or the provision of high cost or complex services, but only if the number of participants in the venture does not exceed the lowest number needed to support the venture. Other providers may be included in the venture, but only if such other providers could not purchase, operate, or market such equipment or provide a competing service either alone or through the formation of a competing venture.

(5) HOSPITAL MERGERS.—Activities relating to a merger of 2 hospitals if, during the 3-year period preceding the merger, one of the hospitals had an average of 150 or fewer operational beds and an average daily inpatient census of less than 50 percent of such beds.

(6) JOINT PURCHASING ARRANGEMENTS.—Any joint purchasing arrangement among health care providers if—

(A) the purchases under the arrangement represent less than 35 percent of the total sales of the product or service purchased in the relevant market; and

(B) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or

services sold by each participant in the joint purchasing arrangement.

(7) NEGOTIATIONS.—Activities consisting of good faith negotiations to carry out any activity—

(A) described in this section,

(B) within an additional safe harbor designated by the Attorney General under section 4203,

(C) that is the subject of an application for a certificate of review under section 4204, or

(D) that is deemed a submission of a notification under section 4205(a)(2)(B),

without regard to whether such an activity is carried out.

SEC. 4203. DESIGNATION OF ADDITIONAL SAFE HARBORS.

(a) IN GENERAL.—

(1) SOLICITATION OF PROPOSALS.—Not later than 30 days after the date of the enactment of this Act, the Attorney General shall publish a notice in the Federal Register soliciting proposals for additional safe harbors.

(2) REVIEW AND REPORT ON PROPOSED SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary of Health and

Human Services and the Chair of the Federal Trade Commission) shall—

(A) review the proposed safe harbors submitted under paragraph (1); and

(B) submit a report to Congress describing the proposals to be included in the publication of additional safe harbors described in paragraph (3) and the proposals that are not to be so included, together with explanations therefore.

(3) PUBLICATION OF ADDITIONAL SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary of Health and Human Services and the Chair of the Federal Trade Commission) shall publish in the Federal Register proposed additional safe harbors for purposes of section 4201(a)(2) for providers of health care services. Not later than 180 days after publishing such proposed safe harbors in the Federal Register, the Attorney General shall issue final rules establishing such safe harbors.

(b) CRITERIA FOR SAFE HARBORS.—In establishing safe harbors under subsection (a), the Attorney General shall take into account the following:

(1) The extent to which a competitive or collaborative activity will accomplish any of the following:

(A) An increase in access to health care services.

(B) The enhancement of the quality of health care services.

(C) The establishment of cost efficiencies that will be passed on to consumers, including economies of scale and reduced transaction and administrative costs.

(D) An increase in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(E) An improvement in the utilization of health care resources or the reduction in the inefficient duplication of the use of such resources.

(2) Whether the designation of an activity as a safe harbor under subsection (a) will result in the following outcomes:

(A) Health plans and other health care insurers, consumers of health care services, and health care providers will be better able to ne-

gotiate payment and service arrangements which will reduce costs to consumers.

(B) Taking into consideration the characteristics of the particular purchasers and providers involved, competition will not be unduly restricted.

(C) Equally efficient and less restrictive alternatives do not exist to meet the criteria described in paragraph (1).

(D) The activity will not unreasonably foreclose competition by denying competitors a necessary element of competition.

SEC. 4204. CERTIFICATES OF REVIEW.

(a) ESTABLISHMENT OF PROGRAM.—In consultation with the Secretary and the Chair, the Attorney General shall (not later than 180 days after the date of the enactment of this Act) issue certificates of review in accordance with this section for providers of health care services and advise and assist any person with respect to applying for such a certificate of review.

(b) PROCEDURES FOR APPLICATION FOR CERTIFICATE.—

(1) FORM; CONTENT.—To apply for a certificate of review, a person shall submit to the Attorney General a written application which—

(A) specifies the activities relating to the provision of health care services which satisfy the criteria described in section 4203(b) and which will be included in the certificate; and

(B) is in a form and contains any information, including information pertaining to the overall market in which the applicant operates, required by rule or regulation promulgated under section 4207.

(2) PUBLICATION OF NOTICE IN FEDERAL REGISTER.—Within 10 days after an application submitted under paragraph (1) is received by the Attorney General, the Attorney General shall publish in the Federal Register a notice that announces that an application for a certificate of review has been submitted, identifies each person submitting the application, and describes the conduct for which the application is submitted.

(3) ESTABLISHMENT OF PROCEDURES FOR ISSUANCE OF CERTIFICATE.—In consultation with the Chair and the Secretary, the Attorney General shall establish procedures to be used in applying for and in determining whether to approve an application for a certificate of review under this subtitle. Under such procedures the Attorney General shall approve

an application if the Attorney General determines that the activities to be covered under the certificate will satisfy the criteria described in section 4203(b) for additional safe harbors designated under such section and that the benefits of the issuance of the certificate will outweigh any disadvantages that may result from reduced competition.

(4) TIMING FOR DECISION ON APPLICATION.—

(A) IN GENERAL.—Within 90 days after the Attorney General receives an application for a certificate of review, the Attorney General shall determine whether the applicant's health care market activities are in accordance with the procedures described in paragraph (3). If the Attorney General, with the concurrence of the Secretary, determines that such procedures are met, the Attorney General shall issue to the applicant a certificate of review. The certificate of review shall specify—

(i) the health care market activities to which the certificate applies,

(ii) the person to whom the certificate of review is issued, and

(iii) any terms and conditions the Attorney General or the Secretary deems nec-

essary to assure compliance with the applicable procedures described in paragraph (3).

(B) APPLICATIONS DEEMED APPROVED.—If the Attorney General does not reject an application before the expiration of the 90-period beginning on the date the Attorney General receives the application, the Attorney General shall be deemed to have approved the application and to have issued a certificate of review relating to the applicant's health care market activities covered under the application.

(5) EXPEDITED ACTION.—If the applicant indicates a special need for prompt disposition, the Attorney General and the Secretary may expedite action on the application, except that no certificate of review may be issued within 30 days of publication of notice in the Federal Register under subsection (b)(2).

(6) ACTIONS UPON DENIAL.—

(A) NOTIFICATION.—If the Attorney General denies in whole or in part an application for a certificate, the Attorney General shall notify the applicant of the Attorney General's determination and the reasons for it.

(B) REQUEST FOR RECONSIDERATION.—An applicant may, within 30 days of receipt of notification that the application has been denied in whole or in part, request the Attorney General to reconsider the determination. The Attorney General, with the concurrence of the Secretary, shall notify the applicant of the determination upon reconsideration within 30 days of receipt of the request.

(C) RETURN OF DOCUMENTS.—If the Attorney General denies an application for the issuance of a certificate of review and thereafter receives from the applicant a request for the return of documents submitted by the applicant in connection with the application for the certificate, the Attorney General and the Secretary shall return to the applicant, not later than 30 days after receipt of the request, the documents and all copies of the documents available to the Attorney General and the Secretary, except to the extent that the information has been made public under an exception to the rule against public disclosure described in subsection (g)(2)(B).

(7) FRAUDULENT PROCUREMENT.—A certificate of review shall be void ab initio with respect to any health care market activities for which the certificate was procured by fraud.

(c) AMENDMENT AND REVOCATION OF CERTIFICATES.—

(1) NOTIFICATION OF CHANGES.—Any applicant who receives a certificate of review—

(A) shall promptly report to the Attorney General any change relevant to the matters specified in the certificate; and

(B) may submit to the Attorney General an application to amend the certificate to reflect the effect of the change on the conduct specified in the certificate.

(2) AMENDMENT TO CERTIFICATE.—An application for an amendment to a certificate of review shall be treated as an application for the issuance of a certificate. The effective date of an amendment shall be the date on which the application for the amendment is submitted to the Attorney General.

(3) REVOCATION.—

(A) GROUNDS FOR REVOCATION.—In accordance with this paragraph, the Attorney General may revoke in whole or in part a cer-

tificate of review issued under this section. The following shall be considered grounds for the revocation of a certificate:

(i) After the expiration of the 2-year period beginning on the date a person's certificate is issued, the activities of the person have not substantially accomplished the purposes for the issuance of the certificate.

(ii) The person has failed to comply with any of the terms or conditions imposed under the certificate by the Attorney General or the Secretary under subsection (b)(4).

(iii) The activities covered under the certificate no longer satisfy the criteria set forth in section 4203(b).

(B) REQUEST FOR COMPLIANCE INFORMATION.—If the Attorney General or Secretary has reason to believe that any of the grounds for revocation of a certificate of review described in subparagraph (A) may apply to a person holding the certificate, the Attorney General shall request such information from such person as the Attorney General or the Sec-

retary deems necessary to resolve the matter of compliance. Failure to comply with such request shall be grounds for revocation of the certificate under this paragraph.

(C) PROCEDURES FOR REVOCATION.—If the Attorney General or the Secretary determines that any of the grounds for revocation of a certificate of review described in subparagraph (A) apply to a person holding the certificate, or that such person has failed to comply with a request made under subparagraph (B), the Attorney General shall give written notice of the determination to such person. The notice shall include a statement of the circumstances underlying, and the reasons in support of, the determination. In the 60-day period beginning 30 days after the notice is given, the Attorney General shall revoke the certificate or modify it as the Attorney General or the Secretary deems necessary to cause the certificate to apply only to activities that meet the procedures for the issuance of certificates described in subsection (b)(2).

(D) INVESTIGATION AUTHORITY.—For purposes of carrying out this paragraph, the

Attorney General may conduct investigations in the same manner as the Attorney General conducts investigations under section 3 of the Antitrust Civil Process Act, except that no civil investigative demand may be issued to a person to whom a certificate of review is issued if such person is the target of such investigation.

(d) REVIEW OF DETERMINATIONS.—

(1) AVAILABILITY OF REVIEW FOR CERTAIN ACTIONS.—If the Attorney General denies, in whole or in part, an application for a certificate of review or for an amendment to a certificate, or revokes or modifies a certificate pursuant to paragraph (3), the applicant or certificate holder (as the case may be) may, within 30 days of the denial or revocation, bring an action in any appropriate district court of the United States to set aside the determination on the ground that such determination is erroneous based on the preponderance of the evidence.

(2) NO OTHER REVIEW PERMITTED.—Except as provided in paragraph (1), no action by the Attorney General or the Secretary pursuant to this subtitle shall be subject to judicial review.

(3) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an

application for a certificate of review or for an amendment to a certificate, or revokes or amends a certificate, neither the negative determination nor the statement of reasons therefore shall be admissible in evidence, in any administrative or judicial proceeding, concerning any claim under the antitrust laws.

(e) PUBLICATION OF DECISIONS.—The Attorney General shall publish a notice in the Federal Register on a timely basis of each decision made with respect to an application for a certificate of review under this section or the amendment or revocation of such a certificate, in a manner that protects the confidentiality of any proprietary information relating to the application.

(f) ANNUAL REPORTS.—Every person to whom a certificate of review is issued shall submit to the Attorney General an annual report, in such form and at such time as the Attorney General may require, that contains any necessary updates to the information required under subsection (b) and a description of the activities of the holder under the certificate during the preceding year.

(g) RESTRICTIONS ON DISCLOSURE OF INFORMATION.—

(1) WAIVER OF DISCLOSURE REQUIREMENTS UNDER ADMINISTRATIVE PROCEDURE ACT.—Infor-

mation submitted by any person in connection with the issuance, amendment, or revocation of a certificate of review shall be exempt from disclosure under section 552 of title 5, United States Code.

(2) RESTRICTIONS ON DISCLOSURE OF COMMERCIAL OR FINANCIAL INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), no officer or employee of the United States shall disclose commercial or financial information submitted in connection with the issuance, amendment, or revocation of a certificate of review if the information is privileged or confidential and if disclosure of the information would cause harm to the person who submitted the information.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply with respect to information disclosed—

(i) upon a request made by the Congress or any committee of the Congress,

(ii) in a judicial or administrative proceeding, subject to appropriate protective orders,

(iii) with the consent of the person who submitted the information,

(iv) in the course of making a determination with respect to the issuance, amendment, or revocation of a certificate of review, if the Attorney General deems disclosure of the information to be necessary in connection with making the determination,

(v) in accordance with any requirement imposed by a statute of the United States, or

(vi) in accordance with any rule or regulation promulgated under subsection (i) permitting the disclosure of the information to an agency of the United States or of a State on the condition that the agency will disclose the information only under the circumstances specified in clauses (i) through (v).

(3) PROHIBITION AGAINST USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—Any information disclosed in an application for a certificate of review under this section shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of es-

tablishing that a person is entitled to the protections provided by such a certificate.

SEC. 4205. NOTIFICATIONS PROVIDING REDUCTION IN CERTAIN PENALTIES UNDER ANTITRUST LAW FOR HEALTH CARE COOPERATIVE VENTURES.

(a) NOTIFICATIONS DESCRIBED.—

(1) SUBMISSION OF NOTIFICATION BY VENTURE.—Any party to a health care cooperative venture, acting on such venture's behalf, may, not later than 90 days after entering into a written agreement to form such venture or not later than 90 days after the date of the enactment of this Act, whichever is later, file with the Attorney General a written notification disclosing—

(A) the identities of the parties to such venture,

(B) the nature and objectives of such venture, and

(C) such additional information as the Attorney General may require by regulation.

(2) ACTIVITIES DEEMED SUBMISSION OF NOTIFICATION.—The following health care cooperative ventures shall be deemed to have filed a written noti-

fication with respect to the venture under paragraph (1):

(A) SUBMISSION OF APPLICATION FOR CERTIFICATE OF REVIEW.—Any health care cooperative venture for which an application for a certificate of review is filed with the Attorney General under section 4203.

(B) CERTAIN VENTURES.—Any health care cooperative venture meeting the following requirements:

(i) The venture consists of a network of non-institutional providers not greater than—

(I) in the case of a nonexclusive network in which the participating members are permitted to create or join other competing networks, 50 percent of the providers of health care services in the relevant geographic area and 50 percent of the members of the provider specialty group in the relevant market; or

(II) in the case of an exclusive network in which the participating members are not permitted to create

or join other competing networks, 35 percent of the providers of health care services in the relevant geographic area and 35 percent of the members of the provider specialty group in the relevant market.

(ii) Each member of the venture assumes substantial financial risk for the operation of the venture through risk-sharing arrangements, including (but not limited to)—

(I) the acceptance of capitation contracts;

(II) the acceptance of contracts with fee withholding mechanisms relating to the ability to meet established goals for utilization review and management; and

(III) the holding by members of significant ownership or equity interests in the venture, where the capital contributed by the members is used to fund the operational costs of the venture such as administration, marketing, and computer-operated medical

information, if the venture develops and operates comprehensive programs for utilization management and quality assurance that include controls over the use of institutional, specialized, and ancillary medical services.

(3) SUBMISSION OF ADDITIONAL INFORMATION.—

(A) REQUEST OF ATTORNEY GENERAL.—At any time after receiving a notification filed under paragraph (1), the Attorney General may require the submission of additional information or documentary material relevant to the proposed health care cooperative venture.

(B) PARTIES TO VENTURE.—Any party to a health care cooperative venture may submit such additional information on the venture's behalf as may be appropriate to ensure that the venture will receive the protections provided under subsection (b).

(C) REQUIRED SUBMISSION OF INFORMATION ON CHANGES TO VENTURE.—A health care cooperative venture for which a notification is in effect under this section shall submit information on any change in the membership of the

venture not later than 90 days after such change occurs.

(4) PUBLICATION OF NOTIFICATION.—

(A) INFORMATION MADE PUBLICLY AVAILABLE.—Not later than 30 days after receiving a notification with respect to a venture under paragraph (1), the Attorney General shall publish in the Federal Register a notice with respect to the venture that identifies the parties to the venture and generally describes the purpose and planned activity of the venture. Prior to its publication, the contents of the notice shall be made available to the parties to the venture.

(B) RESTRICTION ON DISCLOSURE OF OTHER INFORMATION.—All information and documentary material submitted pursuant to this section and all information obtained by the Attorney General in the course of any investigation or case with respect to a potential violation of the antitrust laws by the health care cooperative venture (other than information and material described in subparagraph (A)) shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made

publicly available by any agency of the United States to which such section applies except in a judicial proceeding in which such information and material is subject to any protective order.

(5) WITHDRAWAL OF NOTIFICATION.—Any person who files a notification pursuant to this section may withdraw such notification before a publication by the Attorney General pursuant to paragraph (4). Any person who is deemed to have filed a notification under paragraph (2)(A) shall be deemed to have withdrawn the notification if the certificate of review in question is revoked or withdrawn under section 4204.

(6) NO JUDICIAL REVIEW PERMITTED.—Any action taken or not taken by the Attorney General with respect to notifications filed pursuant to this subsection shall not be subject to judicial review.

(b) PROTECTIONS FOR VENTURES SUBJECT TO NOTIFICATION.—

(1) IN GENERAL.—

(A) PROTECTIONS DESCRIBED.—The provisions of paragraphs (2), (3), (4), and (5) shall apply with respect to any action under the antitrust laws challenging conduct within the scope

of a notification which is in effect pursuant to subsection (a)(1).

(B) TIMING OF PROTECTIONS.—The protections described in this subsection shall apply to the venture that is the subject of a notification under subsection (a)(1) as of the earlier of—

(i) the date of the publication in the Federal Register of the notice published with respect to the notification; or

(ii) if such notice is not published during the period required under subsection (a)(4), the expiration of the 30-day period that begins on the date the Attorney General receives any necessary information required to be submitted under subsection (a)(1) or any additional information required by the Attorney General under subsection (a)(3)(A).

(2) APPLICABILITY OF RULE OF REASON STANDARD.—In any action under the antitrust laws, the conduct of any person which is within the scope of a notification filed under subsection (a) shall not be deemed illegal per se, but shall be judged on the basis of its reasonableness, taking into account all

relevant factors affecting competition, including, but not limited to, effects on competition in relevant markets.

(3) LIMITATION ON RECOVERY TO ACTUAL DAMAGES AND INTEREST.—Notwithstanding section 4 of the Clayton Act, any person who is entitled to recovery under the antitrust laws for conduct that is within the scope of a notification filed under subsection (a) shall recover the actual damages sustained by such person and interest calculated at the rate specified in section 1961 of title 28, United States Code, for the period beginning on the earliest date for which injury can be established and ending on the date of judgment, unless the court finds that the award of all or part of such interest is unjust under the circumstances.

(4) AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.—

(A) IN GENERAL.—In any action under the antitrust laws brought against a health care cooperative venture for conduct that is within the scope of a notification filed under subsection (a), the court shall, at the conclusion of the action—

(i) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(ii) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(B) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant to subparagraph (A) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

(5) RESTRICTIONS ON ADMISSIBILITY OF INFORMATION.—

(A) IN GENERAL.—Any information disclosed in a notification submitted under sub-

section (a)(1) and the fact of the publication of a notification by the Attorney General under subsection (a)(4) shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing that a party to a health care cooperative venture is entitled to the protections described in this subsection.

(B) ACTIONS OF ATTORNEY GENERAL.—No action taken by the Attorney General pursuant to this section shall be admissible into evidence in any judicial or administrative proceeding for the purpose of supporting or answering any claim under the antitrust laws.

SEC. 4206. REVIEW AND REPORTS ON SAFE HARBORS AND CERTIFICATES OF REVIEW.

(a) IN GENERAL.—The Attorney General (in consultation with the Secretary and the Chair) shall periodically review the safe harbors described in section 4202, the additional safe harbors designated under section 4203, and the certificates of review issued under section 4204, and—

(1) with respect to the safe harbors described in section 4202, submit such recommendations to Con-

gress as the Attorney General considers appropriate for modifications of such safe harbors;

(2) with respect to the additional safe harbors designated under section 4203, issue proposed revisions to such activities and publish the revisions in the Federal Register; and

(3) with respect to the certificates of review, submit a report to Congress on the issuance of such certificates, and shall include in the report a description of the effect of such certificates on increasing access to high quality health care services at reduced costs.

(b) RECOMMENDATIONS FOR LEGISLATION.—The Attorney General shall include in the reports submitted under subsection (a)(3) any recommendations of the Attorney General for legislation to improve the program for the issuance of certificates of review established under this subtitle.

SEC. 4207. RULES, REGULATIONS, AND GUIDELINES.

(a) SAFE HARBORS, CERTIFICATES, AND NOTIFICATIONS.—The Attorney General, with the concurrence of the Secretary, shall promulgate such rules, regulations, and guidelines as are necessary to carry out sections 4202, 4203, 4204, and 4205, including guidelines defining or re-

lating to relevant geographic and product markets for health care services and providers of health care services.

(b) GUIDANCE FOR PROVIDERS.—

(1) IN GENERAL.—To promote greater certainty regarding the application of the antitrust laws to activities in the health care market, the Attorney General, in consultation with the Secretary and the Chair, shall (not later than 1 year after the date of the enactment of this Act), taking into account the criteria used to designate additional safe harbors under section 4203 and grant certificates of review under section 4204, publish guidelines—

(A) to assist providers of health care services in analyzing whether the activities of such providers may be subject to a safe harbor under sections 4202 or 4203; and

(B) describing specific types of activities which would meet the requirements for a certificate of review under section 4204, and summarizing the factual and legal bases on which the activities would meet the requirements.

(2) PERIODIC UPDATE.—The Attorney General shall periodically update the guidelines published under paragraph (1) as the Attorney General considers appropriate.

(3) WAIVER OF ADMINISTRATIVE PROCEDURE ACT.—Section 553 of title 5, United States Code, shall not apply to the issuance of guidelines under paragraph (1).

SEC. 4208. ESTABLISHMENT OF HHS OFFICE OF HEALTH CARE COMPETITION POLICY.

(a) IN GENERAL.—There is established within the Department of Health and Human Services an Office to be known as the Office of Health Care Competition Policy (hereafter in this section referred to as the ''Office''). The Office shall be headed by a director, who shall be appointed by the Secretary.

(b) DUTIES.—The Office shall coordinate the responsibilities of the Secretary under this subtitle and otherwise assist the Secretary in developing policies relating to the competitive and collaborative activities of providers of health care services.

SEC. 4209. DEFINITIONS.

In this subtitle, the following definitions shall apply:

(1) The term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act

(15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) The term ''Chair'' means the Chair of the Federal Trade Commission.

(3) The term ''health care cooperative venture'' means any activities, including attempts to enter into or perform a contract or agreement, carried out by 2 or more persons for the purpose of providing health care services.

(4) The term ''health care services'' means any services for which payment may be made under a health plan, including services related to the delivery or administration of such services.

(5) The term ''medical self-regulatory entity'' means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

(6) The term ''person'' includes a State or unit of local government.

(7) The term ''provider of health care services'' means any individual or entity that is engaged in the

delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(8) The term ''specialty group'' means a medical specialty or subspecialty in which a provider of health care services may be licensed to practice by a State (as determined by the Secretary in consultation with the certification boards for such specialties and subspecialties).

(9) The term ''standard setting and enforcement activities'' means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

TITLE V—SPECIAL ASSISTANCE FOR FRONTIER, RURAL, AND URBAN UNDERSERVED AREAS

Subtitle A—Frontier, Rural, and Urban Underserved Areas

SEC. 5001. ESTABLISHMENT OF GRANT PROGRAM.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new section:

"SEC. 330A. COMMUNITY-BASED PRIMARY HEALTH CARE GRANT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish and administer a program to provide allotments to States to enable such States to provide grants for the creation or enhancement of community-based primary health care entities that provide services to low-income or medically underserved populations.

''(b) ALLOTMENTS TO STATES.—

''(1) IN GENERAL.—From the amount available for allotment under subsection (h) for a fiscal year, the Secretary shall allot to each State an amount equal to the product of the grant share of the State (as determined under paragraph (2)) multiplied by such amount available.

''(2) GRANT SHARE.—

"(A) IN GENERAL.—For purposes of paragraph (1), the grant share of a State shall be the product of the need-adjusted population of the State (as determined under subparagraph (B)) multiplied by the Federal matching percentage of the State (as determined under subparagraph (C)), expressed as a percentage of the sum of the products of such factors for all States.

"(B) NEED-ADJUSTED POPULATION.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the need-adjusted population of a State shall be the product of the total population of the State (as estimated by the Secretary of Commerce) multiplied by the need index of the State (as determined under clause (ii)).

"(ii) NEED INDEX.—For purposes of clause (i), the need index of a State shall be the ratio of—

"(I) the weighted sum of the geographic percentage of the State (as determined under clause (iii)), the poverty percentage of the State (as determined under clause (iv)), and the

multiple grant percentage of the State (as determined under clause (v)); to

''(II) the general population percentage of the State (as determined under clause (vi)).

''(iii) GEOGRAPHIC PERCENTAGE.—

''(I) IN GENERAL.—For purposes of clause (ii)(I), the geographic percentage of the State shall be the estimated population of the State that is residing in nonurbanized areas (as determined under subclause (II)) expressed as a percentage of the total nonurbanized population of all States.

''(II) NONURBANIZED POPULATION.—For purposes of subclause (I), the estimated population of the State that is residing in nonurbanized areas shall be one minus the urbanized population of the State (as determined using the most recent decennial census), expressed as a percentage of the total population of the State (as determined using the most recent decennial census), multiplied by the cur-

rent estimated population of the State.

''(III) STATE OF ALASKA.—Notwithstanding subclause (I), the geographic percentage for the State of Alaska shall be the relative population density of the State expressed as the ratio of—

''(aa) the average number of individuals residing in Alaska per square mile; to

''(bb) the average number of individuals residing in the United States per square mile.

''(iv) POVERTY PERCENTAGE.—For purposes of clause (ii)(I), the poverty percentage of the State shall be the estimated number of people residing in the State with incomes below 200 percent of the income official poverty line (as adjusted for actual costs and incomes in each State and as determined by the Office of Management and Budget) expressed as a percentage of the total number of such people residing in all States.

"(v) MULTIPLE GRANT PERCENTAGE.—For purposes of clause (ii)(I), the multiple grant percentage of the State shall be the amount of Federal funding received by the State under grants awarded under sections 329, 330, and 340, expressed as a percentage of the total amounts received under such grants by all States. With respect to a State, such percentage shall not exceed twice the general population percentage of the State under clause (vi) or be less than one-half of the States general population percentage.

"(vi) GENERAL POPULATION PERCENTAGE.—For purposes of clause (ii)(II), the general population percentage of the State shall be the total population of the State (as determined by the Secretary of Commerce) expressed as a percentage of the total population of all States.

"(C) FEDERAL MATCHING PERCENTAGE.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the Federal matching percentage of the State shall be equal to

one, less the State matching percentage (as determined under clause (ii)).

''(ii) STATE MATCHING PERCENTAGE.—For purposes of clause (i), the State matching percentage of the State shall be 0.25 multiplied by the ratio of the total taxable resource percentage (as determined under clause (iii)) to the need-adjusted population of the State (as determined under subparagraph (B)).

''(iii) TOTAL TAXABLE RESOURCE PERCENTAGE.—For purposes of clause (ii), the total taxable resources percentage of the State shall be the total taxable resources of a State (as determined by the Secretary of the Treasury) expressed as a percentage of the sum of the total taxable resources of all States.

''(3) ANNUAL ESTIMATES.—

''(A) IN GENERAL.—If the Secretary of Commerce does not produce the annual estimates required under paragraph (2)(B)(iv), such estimates shall be determined by multiplying the percentage of the population of the State that is below 200 percent of the income

official poverty line as determined using the most recent decennial census by the most recent estimate of the total population of the State. Except as provided in subparagraph (B), the calculations required under this subparagraph shall be made based on the most recent 3-year average of the total taxable resources of individuals within the State.

''(B) DISTRICT OF COLUMBIA.—Notwithstanding subparagraph (A), the calculations required under such subparagraph with respect to the District of Columbia shall be based on the most recent 3-year average of the personal income of individuals residing within the District as a percentage of the personal income for all individuals residing within the District, as determined by the Secretary of Commerce.

''(C) STATE OF ALASKA.—Notwithstanding subparagraph (A), the calculations required under such subparagraph with respect to the State of Alaska shall be based on the quotient of—

''(i) the most recent 3-year average of the per capita income of individuals residing in the State; divided by

"(ii) 1.25.

"(4) MATCHING REQUIREMENT.—A State that receives an allotment under this section shall make available State resources (either directly or indirectly) to carry out this section in an amount that shall equal the State matching percentage for the State (as determined under paragraph (2)(C)(ii)) divided by the Federal matching percentage (as determined under paragraph (2)(C)).

"(c) APPLICATION.—

"(1) IN GENERAL.—To be eligible to receive an allotment under this section, a State shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may by regulation require.

"(2) ASSURANCES.—A State application submitted under paragraph (1) shall contain an assurance that—

"(A) the State will use amounts received under its allotment consistent with the requirements of this section; and

"(B) the State will provide, from non-Federal sources, the amounts required under subsection (b)(4).

"(d) USE OF FUNDS.—

"(1) IN GENERAL.—The State shall use amounts received under this section to award grants to eligible public and nonprofit private entities, or consortia of such entities, within the State to enable such entities or consortia to provide services of the type described in paragraph (2) of section 329(h) to low-income or medically underserved populations.

"(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity or consortium shall—

"(A) prepare and submit to the administering entity of the State, an application at such time, in such manner, and containing such information as such administering entity may require, including a plan for the provision of services of the type described in paragraph (3);

"(B) provide assurances that services will be provided under the grant at fee rates established or determined in accordance with section 330(e)(3)(F); and

"(C) provide assurances that in the case of services provided to individuals with health insurance, such insurance shall be used as the primary source of payment for such services.

"(3) SERVICES.—The services to be provided under a grant awarded under paragraph (1) shall include—

"(A) one or more of the types of primary health services described in section 330(b)(1);

"(B) one or more of the types of supplemental health services described in section 330(b)(2); and

"(C) any other services determined appropriate by the administering entity of the State.

"(4) TARGET POPULATIONS.—Entities or consortia receiving grants under paragraph (1) shall, in providing the services described in paragraph (3), substantially target populations of low-income or medically underserved populations within the State who reside in medically underserved or health professional shortage areas, areas certified as underserved under the rural health clinic program, or other areas determined appropriate by the administering entity of the State, within the State.

"(5) PRIORITY.—In awarding grants under paragraph (1), the State shall—

"(A) give priority to entities or consortia that can demonstrate through the plan submitted under paragraph (2) that—

"(i) the services provided under the grant will expand the availability of primary care services to the maximum number of low-income or medically underserved populations who have no access to such care on the date of the grant award; and

"(ii) the delivery of services under the grant will be cost-effective; and

"(B) ensure that an equitable distribution of funds is achieved among urban and rural entities or consortia.

"(e) REPORTS AND AUDITS.—Each State shall prepare and submit to the Secretary annual reports concerning the State's activities under this section which shall be in such form and contain such information as the Secretary determines appropriate. Each such State shall establish fiscal control and fund accounting procedures as may be necessary to assure that amounts received under this section are being disbursed properly and are ccounted for, and include the results of audits conducted under such procedures in the reports submitted under this subsection.

"(f) PAYMENTS.—

"(1) ENTITLEMENT.—Each State for which an application has been approved by the Secretary under this section shall be entitled to payments

under this section for each fiscal year in an amount not to exceed the State's allotment under subsection (b) to be expended by the State in accordance with the terms of the application for the fiscal year for which the allotment is to be made.

''(2) METHOD OF PAYMENTS.—The Secretary may make payments to a State in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Secretary may determine.

''(3) STATE SPENDING OF PAYMENTS.—Payments to a State from the allotment under subsection (b) for any fiscal year must be expended by the State in that fiscal year or in the succeeding fiscal year.

''(g) DEFINITION.—As used in this section, the term 'administering entity of the State' means the agency or official designated by the chief executive officer of the State to administer the amounts provided to the State under this section.

''(h) FUNDING.—Notwithstanding any other provision of law, the Secretary shall use 50 percent of the amounts that the Secretary is required to utilize under section 330B(h) in each fiscal year to carry out this section.''.

SEC. 5002. ESTABLISHMENT OF NEW PROGRAM TO PROVIDE FUNDS TO ALLOW FEDERALLY QUALIFIED HEALTH CENTERS AND OTHER ENTITIES OR ORGANIZATIONS TO PROVIDE EXPANDED SERVICES TO MEDICALLY UNDERSERVED INDIVIDUALS.

(a) IN GENERAL.—Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) (as amended by section 5001) is amended by adding at the end the following new section:

"SEC. 330B. ESTABLISHMENT OF NEW PROGRAM TO PROVIDE FUNDS TO ALLOW FEDERALLY QUALIFIED HEALTH CENTERS AND OTHER ENTITIES OR ORGANIZATIONS TO PROVIDE EXPANDED SERVICES TO MEDICALLY UNDERSERVED INDIVIDUALS.

''(a) ESTABLISHMENT OF HEALTH SERVICES ACCESS PROGRAM.—From amounts appropriated under this section, the Secretary shall, acting through the Bureau of Health Care Delivery Assistance, award grants under this section to federally qualified health centers (hereinafter referred to in this section as 'FQHC's') and other entities and organizations submitting applications under this section (as described in subsection (c)) for the purpose of providing access to services for medically underserved populations (as defined in section 330(b)(3)) or in high im-

pact areas (as defined in section 329(a)(5)) not currently being served by a FQHC.

''(b) ELIGIBILITY FOR GRANTS.—

''(1) IN GENERAL.—The Secretary shall award grants under this section to entities or organizations described in this paragraph and paragraph (2) which have submitted a proposal to the Secretary to expand such entities or organizations operations (including expansions to new sites (as determined necessary by the Secretary)) to serve medically underserved populations or high impact areas not currently served by a FQHC and which—

''(A) have as of January 1, 1991, been certified by the Secretary as a FQHC under section 1905(l)(2)(B) of the Social Security Act; or

''(B) have submitted applications to the Secretary to qualify as FQHC's under such section 1905(l)(2)(B); or

''(C) have submitted a plan to the Secretary which provides that the entity will meet the requirements to qualify as a FQHC when operational.

''(2) NON FQHC ENTITIES.—

"(A) ELIGIBILITY.—The Secretary shall also make grants under this section to public or private nonprofit agencies, health care entities or organizations which meet the requirements necessary to qualify as a FQHC except, the requirement that such entity have a consumer majority governing board and which have submitted a proposal to the Secretary to provide those services provided by a FQHC as defined in section 1905(l)(2)(B) of the Social Security Act and which are designed to promote access to primary care services or to reduce reliance on hospital emergency rooms or other high cost providers of primary health care services, provided such proposal is developed by the entity or organizations (or such entities or organizations acting in a consortium in a community) with the review and approval of the Governor of the State in which such entity or organization is located.

"(B) LIMITATION.—The Secretary shall provide in making grants to entities or organizations described in this paragraph that no more than 10 percent of the funds provided for

grants under this section shall be made available for grants to such entities or organizations.

''(c) APPLICATION REQUIREMENTS.—

''(1) IN GENERAL.—In order to be eligible to receive a grant under this section, a FQHC or other entity or organization must submit an application in such form and at such time as the Secretary shall prescribe and which meets the requirements of this subsection.

''(2) REQUIREMENTS.—An application submitted under this section must provide—

''(A)(i) for a schedule of fees or payments for the provision of the services provided by the entity designed to cover its reasonable costs of operations; and

''(ii) for a corresponding schedule of discounts to be applied to such fees or payments, based upon the patient's ability to pay (determined by using a sliding scale formula based on the income of the patient);

''(B) assurances that the entity or organization provides services to persons who are eligible for benefits under title XVIII of the Social Security Act, for medical assistance under title XIX of such Act or for assistance for medical

expenses under any other public assistance program or private health insurance program; and

''(C) assurances that the entity or organization has made and will continue to make every reasonable effort to collect reimbursement for services—

''(i) from persons eligible for assistance under any of the programs described in subparagraph (B); and

''(ii) from patients not entitled to benefits under any such programs.

''(d) LIMITATIONS ON USE OF FUNDS.—

''(1) IN GENERAL.—From the amounts awarded to an entity or organization under this section, funds may be used for purposes of planning but may only be expended for the costs of—

''(A) assessing the needs of the populations or proposed areas to be served;

''(B) preparing a description of how the needs identified will be met;

''(C) development of an implementation plan that addresses—

''(i) recruitment and training of personnel; and

"(ii) activities necessary to achieve operational status in order to meet FQHC requirements under 1905(l)(2)(B) of the Social Security Act.

"(2) RECRUITING, TRAINING AND COMPENSATION OF STAFF.—From the amounts awarded to an entity or organization under this section, funds may be used for the purposes of paying for the costs of recruiting, training and compensating staff (clinical and associated administrative personnel (to the extent such costs are not already reimbursed under title XIX of the Social Security Act or any other State or Federal program)) to the extent necessary to allow the entity to operate at new or expanded existing sites.

"(3) FACILITIES AND EQUIPMENT.—From the amounts awarded to an entity or organization under this section, funds may be expended for the purposes of acquiring facilities and equipment but only for the costs of—

"(A) construction of new buildings (to the extent that new construction is found to be the most cost-efficient approach by the Secretary);

"(B) acquiring, expanding, or modernizing of existing facilities;

"(C) purchasing essential (as determined by the Secretary) equipment; and

"(D) amortization of principal and payment of interest on loans obtained for purposes of site construction, acquisition, modernization, or expansion, as well as necessary equipment.

"(4) SERVICES.—From the amounts awarded to an entity or organization under this section, funds may be expended for the payment of services but only for the costs of—

"(A) providing or arranging for the provision of all services through the entity necessary to qualify such entity as a FQHC under section 1905(l)(2)(B) of the Social Security Act;

"(B) providing or arranging for any other service that a FQHC may provide and be reimbursed for under title XIX of such Act; and

"(C) providing any unreimbursed costs of providing services as described in section 330(a) to patients.

"(e) PRIORITIES IN THE AWARDING OF GRANTS.—

"(1) CERTIFIED FQHC'S.—The Secretary shall give priority in awarding grants under this section to entities which have, as of January 1, 1991, been certified as a FQHC under section 1905(l)(2)(B) of

the Social Security Act and which have submitted a proposal to the Secretary to expand their operations (including expansion to new sites) to serve medically underserved populations for high impact areas not currently served by a FQHC. The Secretary shall give first priority in awarding grants under this section to those FQHCs or other entities which propose to serve populations with the highest degree of unmet need, and which can demonstrate the ability to expand their operations in the most efficient manner.

''(2) QUALIFIED FQHC'S.—The Secretary shall give second priority in awarding grants to entities which have submitted applications to the Secretary which demonstrate that the entity will qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act before it provides or arranges for the provision of services supported by funds awarded under this section, and which are serving or proposing to serve medically underserved populations or high impact areas which are not currently served (or proposed to be served) by a FQHC.

''(3) EXPANDED SERVICES AND PROJECTS.—The Secretary shall give third priority in awarding grants in subsequent years to those FQHCs or other

entities which have provided for expanded services and projects and are able to demonstrate that such entity will incur significant unreimbursed costs in providing such expanded services.

''(f) RETURN OF FUNDS TO SECRETARY FOR COSTS REIMBURSED FROM OTHER SOURCES.—To the extent that an entity or organization receiving funds under this section is reimbursed from another source for the provision of services to an individual, and does not use such increased reimbursement to expand services furnished, areas served, to compensate for costs of unreimbursed services provided to patients, or to promote recruitment, training, or retention of personnel, such excess revenues shall be returned to the Secretary.

''(g) TERMINATION OF GRANTS.—

''(1) FAILURE TO MEET FQHC REQUIREMENTS.—

''(A) IN GENERAL.—With respect to any entity that is receiving funds awarded under this section and which subsequently fails to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) or is an entity that is not required to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act but fails to meet the

requirements of this section, the Secretary shall terminate the award of funds under this section to such entity.

''(B) NOTICE.—Prior to any termination of funds under this section to an entity, the entities shall be entitled to 60 days prior notice of termination and, as provided by the Secretary in regulations, an opportunity to correct any deficiencies in order to allow the entity to continue to receive funds under this section.

''(2) REQUIREMENTS.—Upon any termination of funding under this section, the Secretary may (to the extent practicable)—

''(A) sell any property (including equipment) acquired or constructed by the entity using funds made available under this section or transfer such property to another FQHC, provided, that the Secretary shall reimburse any costs which were incurred by the entity in acquiring or constructing such property (including equipment) which were not supported by grants under this section; and

''(B) recoup any funds provided to an entity terminated under this section.

1 ''(h) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section,
3 $400,000,000 for fiscal year 1995, $800,000,000 for fis-
4 cal year 1996, $1,200,000,000 for fiscal year 1997,
5 $1,600,000,000 for fiscal year 1998, and $1,600,000,000
6 for fiscal year 1999.''.

7 (b) EFFECTIVE DATE.—The amendments made by
8 subsection (a) shall become effective with respect to serv-
9 ices furnished by a federally qualified health center or
10 other qualifying entity described in this section beginning
11 on or after October 1, 1995.

12 (c) STUDY AND REPORT ON SERVICES PROVIDED BY
13 COMMUNITY HEALTH CENTERS AND HOSPITALS.—

14 (1) IN GENERAL.—The Secretary of Health and
15 Human Services (hereinafter referred to in this sub-
16 section as the ''Secretary'') shall provide for a study
17 to examine the relationship and interaction between
18 community health centers and hospitals in providing
19 services to individuals residing in medically under-
20 served areas. The Secretary shall ensure that the
21 National Rural Research Centers participate in such
22 study.

23 (2) REPORT.—The Secretary shall provide to
24 the appropriate committees of Congress a report
25 summarizing the findings of the study within 90

days of the end of each project year and shall include in such report recommendations on methods to improve the coordination of and provision of services in medically underserved areas by community health centers and hospitals.

(3) AUTHORIZATION.—There are authorized to be appropriated to carry out the study provided for in this subsection $150,000 for each of fiscal years 1995 and 1996.

SEC. 5003. TAX INCENTIVES FOR PRACTICE IN FRONTIER, RURAL, AND URBAN UNDERSERVED AREAS.

(a) NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.—

(1) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25 the following new section:

"SEC. 25A. PRIMARY HEALTH SERVICES PROVIDERS.

''(a) ALLOWANCE OF CREDIT.—In the case of a qualified primary health services provider, there is allowed as a credit against the tax imposed by this chapter for any taxable year in a mandatory service period an amount equal to the product of—

''(1) the lesser of—

''(A) the number of months of such period occurring in such taxable year, or

''(B) 36 months, reduced by the number of months taken into account under this paragraph with respect to such provider for all preceding taxable years (whether or not in the same mandatory service period), multiplied by

''(2) $1,000 ($500 in the case of a qualified primary health services provider who is a physician assistant or a nurse practitioner).

''(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term 'qualified primary health services provider' means any physician, physician assistant, or nurse practitioner who for any month during a mandatory service period is certified by the Bureau to be a primary health services provider who—

''(1) is providing primary health services—

''(A) full time, and

''(B) to individuals at least 80 percent of whom reside in a health professional shortage area (as defined in subsection (d)(2)),

''(2) is not receiving during such year a scholarship under the National Health Service Corps Scholarship Program or a loan repayment under the Na-

tional Health Service Corps Loan Repayment Program,

''(3) is not fulfilling service obligations under such Programs, and

''(4) has not defaulted on such obligations.

''(c) MANDATORY SERVICE PERIOD.—For purposes of this section, the term 'mandatory service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider.

''(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) BUREAU.—The term 'Bureau' means the Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration of the United States Public Health Service.

''(2) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' means—

''(A) a geographic area in which there are 6 or fewer individuals residing per square mile;

''(B) a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act),

"(C) an area which is determined by the Secretary of Health and Human Services as equivalent to an area described in subparagraph (A) and which is designated by the Bureau of the Census as not urbanized, or

"(D) a community that is certified as underserved by the Secretary for purposes of participation in the rural health clinic program under title XVIII of the Social Security Act.

"(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

"(4) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

"(5) PRIMARY HEALTH SERVICES PROVIDER.—The term 'primary health services provider' means a provider of primary health services (as defined in section 330(b)(1) of the Public Health Service Act).

"(e) RECAPTURE OF CREDIT.—

"(1) IN GENERAL.—If, during any taxable year, there is a recapture event, then the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

''(A) the applicable percentage, and

''(B) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

''(2) APPLICABLE RECAPTURE PERCENTAGE.—

''(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

"If the recapture event occurs during:	**The applicable recaptrue percentage is:**
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Months 61 and thereafter	0.

''(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

''(3) RECAPTURE EVENT DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means the failure of the taxpayer to be a qualified primary health services provider for any month during any mandatory service period.

''(B) CESSATION OF DESIGNATION.—The cessation of the designation of any area as a rural health professional shortage area after the beginning of the mandatory service period for

any taxpayer shall not constitute a recapture event.

''(C) SECRETARIAL WAIVER.—The Secretary may waive any recapture event caused by extraordinary circumstances.

''(4) NO CREDITS AGAINST TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under subpart A, B, or D of this part.''.

(2) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25 the following new item:

''Sec. 25A. Primary health services providers.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after the date of the enactment of this Act.

(b) NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as

section 138 and by inserting after section 136 the following new section:

"SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

''(a) GENERAL RULE.—Gross income shall not include any qualified loan repayment.

''(b) QUALIFIED LOAN REPAYMENT.—For purposes of this section, the term 'qualified loan repayment' means any payment made on behalf of the taxpayer by the National Health Service Corps Loan Repayment Program under section 338B(g) of the Public Health Service Act.''.

(2) CONFORMING AMENDMENT.—Paragraph (3) of section 338B(g) of the Public Health Service Act is amended by striking ''Federal, State, or local'' and inserting ''State or local''.

(3) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 136 and inserting the following:

''Sec. 137. National Health Service Corps loan repayments.
''Sec. 138. Cross references to other Acts.''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to payments made under section 338B(g) of the Public Health Service Act after the date of the enactment of this Act.

(c) EXPENSING OF MEDICAL EQUIPMENT.—

(1) IN GENERAL.—Section 179 of the Internal Revenue Code of 1986 (relating to election to expense certain depreciable business assets) is amended—

(A) by striking paragraph (1) of subsection (b) and inserting the following:

''(1) DOLLAR LIMITATION.—

''(A) GENERAL RULE.—The aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $17,500.

''(B) RURAL HEALTH CARE PROPERTY.—In the case of rural health care property, the aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $32,500, reduced by the amount otherwise taken into account under subsection (a) for such year.''; and

(B) by adding at the end of subsection (d) the following new paragraph:

''(11) RURAL HEALTH CARE PROPERTY.—For purposes of this section, the term 'rural health care property' means section 179 property—

''(A) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment,

''(B) which is owned (directly or indirectly) and used by a physician (as defined in section 1861(r) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a rural health professional shortage area (as defined in section 25A(d)(5)), and

''(C) substantially all the use of which is in such area.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to property placed in service in taxable years beginning after the date of enactment of this Act.

(d) DEDUCTION FOR STUDENT LOAN PAYMENTS BY MEDICAL PROFESSIONALS PRACTICING IN RURAL AREAS.—

(1) INTEREST ON STUDENT LOANS NOT TREATED AS PERSONAL INTEREST.—Section 163(h)(2) of the Internal Revenue Code of 1986 (defining per-

sonal interest) is amended by striking ''and'' at the end of subparagraph (D), by striking the period at the end of subparagraph (E) and inserting '', and'', and by adding at the end thereof the following new subparagraph:

''(F) any qualified medical education interest (within the meaning of subsection (k)).''.

(2) QUALIFIED MEDICAL EDUCATION INTEREST DEFINED.—Section 163 of such Code (relating to interest expenses) is amended by redesignating subsection (k) as subsection (l) and by inserting after subsection (j) the following new subsection:

''(k) QUALIFIED MEDICAL EDUCATION INTEREST OF MEDICAL PROFESSIONALS PRACTICING IN RURAL AREAS.—

''(1) IN GENERAL.—For purposes of subsection (h)(2)(F), the term 'qualified medical education interest' means an amount which bears the same ratio to the interest paid on qualified educational loans during the taxable year by an individual performing services under a qualified rural medical practice agreement as—

''(A) the number of months during the taxable year during which such services were performed, bears to

"(B) the number of months in the taxable year.

"(2) DOLLAR LIMITATION.—The aggregate amount which may be treated as qualified medical education interest for any taxable year with respect to an individual shall not exceed $5,000.

"(3) QUALIFIED RURAL MEDICAL PRACTICE AGREEMENT.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'qualified rural medical practice agreement' means a written agreement between an individual and an applicable rural community under which the individual agrees—

"(i) in the case of a medical doctor, upon completion of the individual's residency (or internship if no residency is required), or

"(ii) in the case of a registered nurse, nurse practitioner, or physician's assistant, upon completion of the education to which the qualified education loan relates,

to perform full-time services as such a medical professional in the applicable rural community for a period of 24 consecutive months. An individual and an applicable rural community may

elect to have the agreement apply for 36 consecutive months rather than 24 months.

''(B) SPECIAL RULE FOR COMPUTING PERIODS.—An individual shall be treated as meeting the 24- or 36-consecutive month requirement under subparagraph (A) if, during each 12-consecutive month period within either such period, the individual performs full-time services as a medical doctor, registered nurse, nurse practitioner, or physician's assistant, whichever applies, in the applicable rural community during 9 of the months in such 12-consecutive month period. For purposes of this subsection, an individual meeting the requirements of the preceding sentence shall be treated as performing services during the entire 12-month period.

''(C) APPLICABLE RURAL COMMUNITY.—The term 'applicable rural community' means—

''(i) any political subdivision of a State which—

''(I) has a population of 5,000 or less, and

''(II) has a per capita income of $15,000 or less, or

"(ii) an Indian reservation which has a per capita income of $15,000 or less.

"(4) QUALIFIED EDUCATIONAL LOAN.—The term 'qualified educational loan' means any indebtedness to pay qualified higher education expenses (within the meaning of section 135(c)(2)) and reasonable living expenses—

"(A) which are paid or incurred—

"(i) as a candidate for a degree as a medical doctor at an educational institution described in section 170(b)(1)(A)(ii), or

"(ii) in connection with courses of instruction at such an institution necessary for certification as a registered nurse, nurse practitioner, or physician's assistant, and

"(B) which are paid or incurred within a reasonable time before or after such indebtedness is incurred.

"(5) RECAPTURE.—If an individual fails to carry out a qualified rural medical practice agreement during any taxable year, then—

"(A) no deduction with respect to such agreement shall be allowable by reason of sub-

section (h)(2)(F) for such taxable year and any subsequent taxable year, and

''(B) there shall be included in gross income for such taxable year the aggregate amount of the deductions allowable under this section (by reason of subsection (h)(2)(F)) for all preceding taxable years.

''(6) DEFINITIONS.—For purposes of this subsection, the terms 'registered nurse', 'nurse practitioner', and 'physician's assistant' have the meaning given such terms by section 1861 of the Social Security Act.''.

(3) DEDUCTION ALLOWED IN COMPUTING ADJUSTED GROSS INCOME.—Section 62(a) of such Code, as amended by sections 2002(c)(3) and 2003(b), is amended by inserting after paragraph (17) the following new paragraph:

''(18) INTEREST ON STUDENT LOANS OF RURAL HEALTH PROFESSIONALS.—The deduction allowable by reason of section 163(h)(2)(F) (relating to student loan payments of medical professionals practicing in rural areas).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 5004. RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) RURAL EMERGENCY ACCESS CARE HOSPITALS DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

''(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and negative operating losses, and the closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

''(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility

and receive data from and transmit data to the facility.

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

''(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

''(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs

(C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'), except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means medical and other health services furnished by a rural emergency access care hospital.''.

(b) COVERAGE OF AND PAYMENT FOR SERVICES.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).''.

(c) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1833(a)(6) of the Social Security Act (42 U.S.C. 1395l(a)(6)) is amended by striking ''services,'' and inserting ''services and rural emergency access care hospital services,''.

(2) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in the heading, by striking ''SERVICES'' and inserting ''SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES''; and

(B) in paragraph (1), by striking ''during a year before 1993'' and inserting ''during a year before the prospective payment system described in paragraph (2) is in effect'';

(C) in paragraph (1), by adding at the end the following:

"The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.";

(D) in paragraph (2), by striking "January 1, 1993," and inserting "January 1, 1996,"; and

(E) by adding at the end the following new paragraph:

"(3) APPLICATION OF METHODS TO PAYMENT FOR RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES.—The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1994.

SEC. 5005. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d–51 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL VICTIMS OF MEDICAL EMERGENCIES.

''(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

''(b) APPLICATION AND PLAN.—

''(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

''(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

''(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

''(B) demonstrates that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

"(C) demonstrate that there is a lack of facilities available and equipped to deliver advanced levels of medical care in the geographic areas to be served;

"(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

"(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are effectively meeting the emergency medical needs of the populations they serve;

"(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

"(G) demonstrate that the State, in utilizing the grant proceeds, will—

"(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than

the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received; and

''(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

''(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan;

''(I) contain such other information as the Secretary may determine appropriate.

''(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

''(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

"(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

"(d) STATE ADMINISTRATION AND USE OF GRANT.—

"(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

"(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

"(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions

thereto) and facilitate comments from interested persons.

''(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

''(f) REPORTS.—

''(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

''(A) a description of the manner in which the grant proceeds were utilized;

''(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

''(C) such other information as the Secretary may require.

''(2) TERMINATION OF FUNDING.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary deter-

mines that the State comes into compliance with such plan.

''(g) DEFINITION.—As used in this section, the term 'rural areas' means geographic areas that are located outside of standard metropolitan statistical areas, as identified by the Secretary.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, $15,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997.''.

SEC. 5006. DEMONSTRATION PROJECTS TO ENCOURAGE THE DEVELOPMENT AND OPERATION OF RURAL HEALTH NETWORKS.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary may conduct a demonstration project under which public and private entities may apply for waivers of any of the provisions of titles XVIII and XIX of the Social Security Act in order to operate rural health networks (as defined in subsection (d)(1)) which—

(i) improve the access of medicare beneficiaries (as defined in subsection

(d)(2))) and medicaid beneficiaries (as defined in subsection (d)(3)) to health care services;

(ii) improve the quality of health care services furnished to such beneficiaries; and

(iii) improve the outcomes of health care services furnished to such beneficiaries.

(B) NUMBER OF WAIVERS.—The Secretary may grant waivers to operate rural health networks under the demonstration project conducted under this section to a number of public and private entities determined appropriate by the Secretary.

(2) APPLICATIONS.—

(A) IN GENERAL.—In order to participate in the demonstration project conducted under this subsection, a public or private entity desiring to operate a rural health network shall submit an application to the Secretary which meets the requirements of subparagraph (B). Such application shall be submitted in such manner and at such time as the Secretary shall require.

(B) REQUIREMENTS.—An application submitted by a public or private entity under this subsection must provide—

(i) a description of the health care providers participating in the rural health network;

(ii) a description of the geographic area served by the rural health network;

(iii) information demonstrating that the public or private entity has consulted with interested parties with respect to the operation of the rural health network, including local government entities and community groups;

(iv) a description of the operational structure of the rural health network, including whether the network is a managed care entity or a fee-for-service provider;

(v) a proposal for how payments should be made to the rural health network under titles XVIII and XIX of the Social Security Act, including a statement as to whether such payments should be made pursuant to the provisions of such titles or

pursuant to an alternative payment methodology described in the application;

(vi) assurances that medicare beneficiaries served by the rural health network will receive care and services of the same quality as the care and services received by other beneficiaries under title XVIII of the Social Security Act;

(vii) assurances that medicaid beneficiaries served by the rural health network will receive care and services of the same quality as the care and services received by other beneficiaries under title XIX of the Social Security Act;

(viii) a description of how the rural health network plans to handle any situation in which a medicare beneficiary or medicaid beneficiary served by the network receives health care services from providers outside the network;

(ix) assurances that the rural health network is furnishing health care services to a significant number of individuals who are not receiving benefits under titles XVIII and XIX of the Social Security Act;

(x) assurances that through sharing of facilities, land, and equipment, the rural health network will result in a reduction of total capital costs for the area served by the network;

(xi) a plan for cooperation in service delivery by health care providers participating in the rural health network that demonstrates the elimination of unnecessary duplication and, when appropriate, the consolidation of specialized services within the area served by the network;

(xii) evidence that the rural health network furnishes services which address the special access needs of the medicare beneficiaries and medicaid beneficiaries served by the network;

(xiii) evidence of capability and expertise in network planning and management; and

(xiv) such additional information as the Secretary determines appropriate.

(C) APPROVAL OF APPLICATION.—

(i) INITIAL REVIEW.—Within 60 days after an application is submitted by a pub-

lic or private entity under this subsection, the Secretary shall review and approve such application or provide the entity with a list of the modifications that are necessary for such application to be approved.

(ii) ADDITIONAL REVIEW.—Within 60 days after a public or private entity resubmits any application under this subsection, the Secretary shall review and approve such application or provide the entity with a summary of which items included on the list provided to the State under clause (i) remain unsatisfied. An entity may resubmit an application under this subparagraph as many times as necessary to gain approval.

(3) COORDINATION WITH OTHER PROGRAMS.—The Secretary shall coordinate the demonstration project conducted under this subsection with any other relevant Federal or State programs in order to prevent duplication and improve the quality and delivery of health care services to medicare beneficiaries and medicaid beneficiaries.

(4) PAYMENTS TO NETWORKS.—

(A) IN GENERAL.—The Secretary shall determine the amount of payments to be made under titles XVIII and XIX to a rural health network participating in a demonstration project under this subsection based on historic costs adjusted based on population and geographic area as the Secretary determines appropriate to take into account the costs of furnishing health care services in the area served by the network.

(B) BUDGET NEUTRALITY.—The Secretary shall provide that in carrying out the demonstration project under this section, the aggregate payments under titles XVIII and XIX of the Social Security Act to providers participating in a rural health network shall be no greater or lesser than what such payments would have been if such providers were not participating in such network.

(5) DURATION OF WAIVERS.—Any waiver granted under the demonstration project conducted under this subsection shall be granted for a period determined appropriate by the Secretary. The Secretary may terminate such a waiver at any time if the Secretary determines that the rural health net-

work has failed to furnish health care services in accordance with the terms of the waiver.

(6) REPORTS.—

(A) IN GENERAL.—Each public or private entity receiving a waiver to operate a rural health network under the demonstration project conducted under this subsection shall, through an independent entity, evaluate the network and submit interim and final reports to the Secretary at such times and containing such information as the Secretary shall require.

(B) REPORT TO CONGRESS.—Not later than 60 days after the receipt of a final report by a rural health network under subparagraph (A) the Secretary shall submit a report to Congress.

(b) GRANTS FOR THE DEVELOPMENT OF RURAL HEALTH NETWORKS.—

(1) IN GENERAL.—The Secretary shall award grants to public and private entities which have received a waiver under the demonstration project conducted under subsection (a) for the purpose of planning and developing rural health networks.

(2) APPLICATION PROCESS.—

(A) SUBMISSION OF APPLICATION.—Each public or private entity desiring to receive a grant under this subsection shall submit an application to the Secretary at such time and containing such information as the Secretary determines appropriate.

(B) CONSIDERATION OF APPLICATIONS.—The Secretary shall develop a system for determining the priority for distributing grants under this subsection and such grants shall be distributed in accordance with such system.

(3) USE OF GRANT FUNDS.—A State that is awarded grant funds under this subsection may use such funds for all costs associated with assisting public or private entities in planning and developing rural health networks.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purposes of awarding grants under this subsection.

(c) GRANTS FOR THE OPERATION OF RURAL HEALTH NETWORKS.—

(1) IN GENERAL.—The Secretary shall award grants to public and private entities which have received a waiver under the demonstration project con-

ducted under subsection (a) for the operation of rural health networks.

(2) APPLICATION PROCESS.—

(A) SUBMISSION OF APPLICATION.—Any public or private entity which desires to receive a grant under this subsection shall submit an application to the Secretary at such time and containing such information as the Secretary determines appropriate.

(B) CONSIDERATION OF APPLICATIONS.—The Secretary shall develop a system for determining the priority for distributing grants under this subsection and such grants shall be distributed in accordance with such priority.

(3) USE OF GRANT FUNDS.—A public or private entity that is awarded grant funds under this subsection may use such funds for all costs associated with operating a rural health network.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purposes of awarding grants under this subsection.

(d) DEFINITIONS.—For purposes of this section:

(1) RURAL HEALTH NETWORK.—The term ''rural health network'' means a formal cooperative

arrangement between participating hospitals, physicians, and other health care providers which—

(A) furnishes health care services to medicare beneficiaries and medicaid beneficiaries;

(B) is located in a rural area; and

(C) is governed by a board of directors selected by participating health care providers.

(2) MEDICAID BENEFICIARY.—The term ''medicaid beneficiary'' means an individual receiving benefits under title XIX of the Social Security Act who resides in a rural area or who receives health care services from a health care provider located in a rural area.

(3) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual receiving benefits under title XVIII of the Social Security Act who resides in a rural area or who receives health care services from a health care provider located in a rural area.

(4) RURAL AREA.—The term ''rural area'' means a rural area as described in section 1886(d)(2)(D).

SEC. 5007. STUDY ON EXPANDING BENEFITS UNDER QUALIFIED HEALTH PLANS FOR INDIVIDUALS RESIDING IN RURAL AREAS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the possible benefits of a program under which issuers of qualified health plans covering individuals who reside in rural areas may—

(A) develop a package of benefits targeted at improving access to health care services which would supplement the benefits included under such plan; and

(B) receive premium payments for such package of benefits from the Secretary.

(2) CONSULTATION WITH CERTAIN ENTITIES.—In conducting the study under paragraph (1), the Secretary shall consult with the Office of Rural Health Policy and private and public entities with expertise in rural health issues.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act the Secretary shall submit a report to Congress containing the results of the study conducted under subsection (a) and any legislative recommendations determined appropriate by the Secretary.

Subtitle B—Primary Care Provider Education

SEC. 5101. GRADUATE MEDICAL EDUCATION DEMONSTRATION PROJECTS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293j et seq.) is amended by adding at the end the following new section:

"SEC. 753. GRADUATE MEDICAL EDUCATION DEMONSTRATION PROJECTS.

''(a) STATE DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to in this section as the ''Secretary'') acting through the Administrator of the Health Resources and Services Administration shall provide for the establishment of demonstration projects in no more than 7 States for the purpose of testing and evaluating mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice through the use of funds otherwise available for direct graduate medical education costs under section 1886(h) of the Social Security Act.

''(2) APPLICATIONS.—

"(A) IN GENERAL.—Each State desiring to conduct a demonstration project under this subsection shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

"(i) information demonstrating that the State has consulted with interested parties with respect to conducting a demonstration project under this subsection, including State medical associations, State hospital associations, and medical schools located in the State;

"(ii) an assurance that in conducting a demonstration project under this subsection no single teaching hospital located in the State will lose more than 10 percent of such hospital's approved medical residency positions in any year; and

"(ii) an explanation of a plan for evaluating the project.

"(B) APPROVAL OF APPLICATIONS.—A State that submits an application under subparagraph (A) may begin a demonstration project under this subsection—

"(i) upon approval of such application by the Secretary; or

"(ii) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

"(C) NOTICE AND COMMENT.—A State shall issue a public notice on the date it submits an application under subparagraph (A) which contains a general description of the proposed demonstration project. Any interested party may comment on the proposed demonstration project to the State or the Secretary during the 30-day period beginning on the date the public notice is issued.

"(3) FUNDING FOR DEMONSTRATION PROJECTS.—

"(A) ALLOCATION OF GME FUNDS.—

"(i) IN GENERAL.—For each year a State conducts a demonstration project under this subsection the Secretary shall pay to such State an amount equal to the total amount available to hospitals located in the State under section 1886(h) of the Social Security Act. In the case of a State

which establishes any health care training consortium under clause (ii)(II), the State shall designate a teaching hospital for each resident assigned to such a consortium which the Secretary shall use to calculate the State's payment amount under such section. Such teaching hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

''(ii) USE OF FUNDS.—Each State that receives a payment under clause (i) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice as follows:

''(I) The State may apply weighting factors that are different than the weighting factors set forth in section 1886(h)(4)(C) of the Social Security Act for the purpose of making direct graduate medical education payments. In applying different

weighting factors, the State may require entities receiving payments to use a portion of such payments to increase stipends paid to primary care residents relative to nonprimary care residents.

''(II) The State may use funds to provide for the establishment and operation of any health care training consortium. The State shall make payments to any such consortium through an entity identified by the consortium as appropriate for receiving payment on behalf of the consortium. The consortium shall have discretion in determining the purposes for which such payments may be used and may direct such payments to consortium medical schools for primary care medical student education programs.

''(B) GRANTS FOR PLANNING AND EVALUATIONS.—

''(i) IN GENERAL.—The Secretary may award grants to States conducting

demonstration projects under this subsection for the purpose of developing and evaluating such projects. A State may conduct such an evaluation or contract with a private entity to conduct the evaluation. Each State desiring to receive a grant under this subparagraph shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(ii) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subparagraph for fiscal years 1995 through 2003.

''(4) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this subsection shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

''(b) CONSORTIUM DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources

and Services Administration, shall provide for the establishment of demonstration projects for no more than 7 health care training consortia which are located in States that are not conducting a demonstration project under subsection (a) for the purpose of testing and evaluating mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice through the use of funds otherwise available for direct graduate medical education costs under section 1886(h) of the Social Security Act.

''(2) APPLICATIONS.—

''(A) IN GENERAL.—Each health care training consortium desiring to conduct a demonstration project under this subsection shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including an explanation of a plan for evaluating the project.

''(B) APPROVAL OF APPLICATIONS.—A consortium that submits an application under subparagraph (A) may begin a demonstration project under this subsection—

"(i) upon approval of such application by the Secretary; or

"(ii) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

"(3) FUNDING FOR DEMONSTRATION PROJECTS.—

"(A) ALLOCATION OF GME FUNDS.—

"(i) IN GENERAL.—For each year a consortium conducts a demonstration project under this subsection the Secretary shall pay to such consortium an amount equal to the total amount available to hospitals that are members of the consortium under section 1886(h) of the Social Security Act. The consortium shall designate a teaching hospital for each resident assigned to the consortium which the Secretary shall use to calculate the consortium's payment amount under such section. Such teaching hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

"(ii) USE OF FUNDS.—

"(I) TESTING AND EVALUATION.—Each consortium that receives a payment under clause (i) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice.

"(II) ESTABLISHMENT AND OPERATION.—Each consortium that receives a payment under clause (i) may also use such funds for the establishment and operation of the consortium. The Secretary shall make payments to the consortium through an entity identified by the consortium as appropriate for receiving payment on behalf of the consortium. The consortium shall have discretion in determining the purposes for which such payments may be used and may direct such payments to consortium medical schools

for primary care medical student education programs.

''(B) GRANTS FOR PLANNING AND EVALUATIONS.—

''(i) IN GENERAL.—The Secretary may award grants to consortia conducting demonstration projects under this subsection for the purpose of developing and evaluating such projects. Each consortium desiring to receive a grant under this subparagraph shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(ii) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subparagraph for fiscal years 1995 through 2003.

''(4) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this subsection shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

"(c) DURATION.—A demonstration project under this section shall be conducted for a period not to exceed 8 years. The Secretary may terminate a project if the Secretary determines that the State or consortium conducting the project is not in substantial compliance with the terms of the application approved by the Secretary under this section.

"(d) EVALUATIONS AND REPORTS.—

"(1) EVALUATIONS.—Each State or consortium that conducts a demonstration project under this section shall submit to the Secretary a final evaluation of such project within 360 days of the termination of such project and such interim evaluations as the Secretary may require.

"(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this section begins, and annually thereafter for each year in which a project is conducted under this section, the Secretary shall submit a report to the appropriate committees of the Congress which evaluates the effectiveness of the demonstration projects conducted under this section and includes any legislative recommendations determined appropriate by the Secretary.

"(e) DEFINITIONS.—For purposes of this section:

"(1) AMBULATORY TRAINING SITES.—The term 'ambulatory training sites' includes, but is not limited to, health maintenance organizations, federally qualified health centers, community health centers, migrant health centers, rural health clinics, nursing homes, hospice, and other community-based providers, including private practices.

"(2) HEALTH CARE TRAINING CONSORTIUM.—The term 'health care training consortium' means a State, regional, or local entity which—

"(A) includes teaching hospitals, ambulatory training sites, and one or more schools of medicine located in the same geographic region; and

"(B) is operated in a manner intended to ensure that by the end of the 8 year demonstration project at least 50 percent of the graduates of the schools included in the entity will become primary care providers during the 1-year period immediately following the date such graduates complete their residency training.

"(3) PRIMARY CARE.—The term 'primary care' means family practice, general internal medicine, and general pediatrics, and may also include obstetrics and gynecology if such care is person-centered,

comprehensive care that is not organ or problem specific.''.

SEC. 5102. FUNDING UNDER MEDICARE FOR TRAINING IN NONHOSPITAL-OWNED FACILITIES.

(a) RESIDENCY TRAINING TIME IN NONHOSPITAL-OWNED FACILITIES COUNTED IN DETERMINING FULL-TIME-EQUIVALENT RESIDENTS FOR DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended by striking '', if the hospital incurs all, or substantially all, of the costs for the training program in that setting''.

(b) RESIDENCY TRAINING TIME IN NONHOSPITAL-OWNED FACILITIES COUNTED IN DETERMINING FULL-TIME-EQUIVALENT RESIDENTS FOR INDIRECT MEDICAL EDUCATION PAYMENTS.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended to read as follows:

''(iv) In determining such adjustment, the Secretary shall count interns and residents—

''(I) assigned to any patient service environment which is part of the hospital's approved medical residency

training program (as defined in section 1886(h)(5)(A)), or

''(II) providing services at any entity receiving a grant under section 330 of the Public Health Service Act that is under the ownership or control of the hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents),

as part of the calculation of the full-time-equivalent number of interns and residents.''.

(2) ADJUSTMENT OF INDIRECT TEACHING ADJUSTMENT FACTOR TO ACHIEVE BUDGET NEUTRALITY.—Section 1886(d)(5)(B)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

''(ii)(I) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to $1.89 \times (((1 + r \times t)$ to the nth power$) - 1)$.

''(II) For purposes of subclause (i)—

"(aa) 'r' is the ratio of the hospital's full-time-equivalent interns and residents to beds;

"(bb) 't' is the ratio of the number of full-time-equivalent interns and residents of all hospitals paid under this paragraph and used in the calculation of 'r' on June 1, 1993, to the number of full-time-equivalent interns and residents of all hospitals paid under this paragraph and used in the calculation of 'r' on June 1, 1994; and

"(cc) 'n' equals .405.".

SEC. 5103. INCREASE IN NATIONAL HEALTH SERVICE CORPS FUNDING.

(a) GENERAL AUTHORIZATION.—Section 338H(b)(1) of the Public Health Service Act (42 U.S.C. 254q(b)(1)) is amended—

(1) by striking "1991, and" and inserting "1991,"; and

(2) by striking "through 2000" and inserting ", 1993, and 1994, $120,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 through 1998".

(b) GRANTS FOR STATE LOAN REPAYMENT PROGRAMS.—Section 338I(i)(1) of such Act (42 U.S.C. 254q–1(i)(1)) is amended to read as follows:

"(1) IN GENERAL.—The Secretary shall ensure that not less than one-third of the amounts appropriated under section 338H(b)(1) for each fiscal year shall be made available for grants under this section.".

SEC. 5104. INCREASE IN HEALTH PROFESSIONS FUNDING FOR PRIMARY CARE PHYSICIANS.

(a) FAMILY MEDICINE.—Section 747(d)(1) of the Public Health Service Act (42 U.S.C. 293k(d)(1)) is amended by striking "for each of" and all that follows through "1995" and inserting "for each of the fiscal years 1993 and 1994, $67,500,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

(b) GENERAL INTERNAL MEDICINE AND PEDIATRICS.—Section 748(c) of the Public Health Service Act (42 U.S.C. 293l(c)) is amended by striking "for each of" and all that follows through "1995" and inserting "for each of the fiscal years 1993 and 1994, $31,250,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

SEC. 5105. HEALTH PROFESSIONS FUNDING FOR NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS PROGRAMS.

(a) PHYSICIAN ASSISTANTS.—Section 750(d)(1) of the Public Health Service Act (42 U.S.C. 293n(d)(1)) is amended by striking ''for each of the fiscal years 1993 through 1995'' and inserting ''for each of the fiscal years 1993 and 1994, $11,250,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997''.

(b) NURSE PRACTITIONERS.—Section 822(d) of such Act (42 U.S.C. 296m(d)) is amended by striking ''1994.'' and inserting ''1994, $25,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997''.

(c) ADVANCED EDUCATION OF PROFESSIONAL NURSES.—Section 830(f)(1) of the Public Health Service Act (42 U.S.C. 297(f)(1)) is amended by striking ''for each of'' and all that follows through ''1995'' and inserting ''for each of the fiscal years 1993 and 1994, $25,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997''.

(d) SCHOLARSHIP PROGRAM FOR PHYSICIAN ASSISTANTS.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293j et seq.), as amended by section 511,

is further amended by adding at the end thereof the following new section:

"SEC. 754. PHYSICIAN ASSISTANT SCHOLARSHIP PROGRAM.

''(a) IN GENERAL.—The Secretary may award grants to public and nonprofit private entities to enable such entities to meet the cost of providing traineeships for individuals in baccalaureate and advanced-degree programs in order to educate such individuals to serve in and prepare for practice as physician assistants.

''(b) SPECIAL CONSIDERATION IN MAKING GRANTS.—In awarding grants for traineeships under subsection (a), the Secretary shall give special consideration to entities submitting applications for the conduct of traineeship programs that conform to the guidelines established by the Secretary under section 750(b)(2).

''(c) PREFERENCES IN AWARDING GRANTS.—The Secretary may award a grant under subsection (a) only if the grant applicant involved agrees that, in providing traineeships under such grant, the applicant will give preference to individuals who are residents of health professional shortage areas designated under section 332.

''(d) USE OF GRANT.—The Secretary may award a grant under subsection (a) only if the grant applicant involved agrees that traineeships provided with amounts re-

ceived under the grant will pay all or part of the costs of—

''(1) the tuition, books, and fees of the physician assistants' program with respect to which the traineeship is provided; and

''(2) amounts necessary to pay the reasonable living expenses of the individual involved during the period for which the traineeship is provided.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $25,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997.''.

SEC. 5106. STATE GRANTS TO INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end thereof the following new section:

''SEC. 320A. PRIMARY CARE DEMONSTRATION GRANTS.

''(a) AUTHORIZATION.—The Secretary, acting through the Health Resources and Services Administration, shall award grants to States or nonprofit entities to fund not less than 10 demonstration projects to enable such States or entities to evaluate one or more of the following:

''(1) State mechanisms, including changes in the scope of practice laws, to enhance the delivery of primary care by nurse practitioners or physician assistants.

''(2) The feasibility of, and the most effective means to train subspecialists to deliver primary care as primary care providers.

''(3) State mechanisms to increase the supply or improve the distribution of primary care providers.

''(b) APPLICATION.—To be eligible to receive a grant under this section a State or nonprofit entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $9,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 through 1998.''.

Subtitle C—Programs Relating to Primary and Preventive Care Services

SEC. 5201. MATERNAL AND INFANT CARE COORDINATION.

(a) PURPOSE.—It is the purpose of this section to assist States in the development and implementation of coordinated, multidisciplinary, and comprehensive primary health care and social services, and health and nutrition education programs, designed to improve maternal and child health.

(b) GRANTS FOR IMPLEMENTATION OF PROGRAMS.—

(1) AUTHORITY.—The Secretary of Health and Human Services (hereafter referred to in this section as the ''Secretary'') is authorized to award grants to States to enable such States to plan and implement coordinated, multidisciplinary, and comprehensive primary health care and social service programs targeted to pregnant women and infants.

(2) ELIGIBILITY.—To be eligible to receive a grant under this section, a State shall—

(A) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(B) as part of the State application, provide assurances that under the program established with amounts received under a grant, individuals will have access to a broad range of primary health care services, social services, and health and nutrition programs designed to improve maternal and child health and a description of how coordination of such services will improve maternal and child health based upon the goals of ''Healthy People 2000: National Health Promotion and Disease Prevention Objectives'';

(C) as part of the State application, submit a plan for the coordination of existing and proposed Federal and State resources, as appropriate, including amounts provided under the medicaid program under title XIX of the Social Security Act, the special supplemental food program under section 17 of the Child Nutrition Act of 1966, family planning programs, substance abuse programs, State maternal and child health programs funded under title V of the Social Security Act, community and migrant health center programs under the Public

Health Service Act, and other publicly, or where practicable, privately supported programs;

(D) demonstrate that the major service providers to be involved, including private non-profit entities committed to improving maternal and infant health, are committed to and involved in the program to be funded with amounts received under the grant;

(E) with respect to States with high infant mortality rates among minority populations, demonstrate the involvement of major health, multiservice, professional, or civic group representatives of such minority groups in the planning and implementation of the State program; and

(F) demonstrate that activities under the State program are targeted to women of childbearing age, particularly those at risk for having low birth weight babies.

(3) TERM OF GRANT.—A grant awarded under this subsection shall be for a period of 5 years.

(4) USE OF AMOUNTS.—Amounts received by a State under a grant awarded under this subsection shall be used to establish a State program to provide coordinated, multidisciplinary, and comprehensive

primary health care and social services, and health and nutrition education program services, that are designed to improve maternal and child health. Such amounts shall not be used for the construction of buildings or the purchase of medical equipment.

(5) MAINTENANCE OF EFFORT.—Any funds received by a State under this subsection shall supplement, and shall not supplant, funds that are expended for similar purposes by the State.

(6) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subsection for fiscal years 1995 through 1998.

SEC. 5202. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.

Section 4605 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 3155) is amended to read as follows:

"SEC. 4605. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

''(a) PURPOSE.—It is the purpose of this section to establish a comprehensive school health education and prevention program for elementary and secondary school students.

1 ''(b) PROGRAM AUTHORIZED.—The Secretary,
2 through the Office of Comprehensive School Health Edu-
3 cation established in subsection (d), shall award grants to
4 States to enable such States to—
5 ''(1) award grants to local or intermediate edu-
6 cational agencies, and consortia thereof, to enable
7 such agencies or consortia to establish, operate and
8 improve local programs of comprehensive health edu-
9 cation and prevention, early health intervention, and
10 health education, in elementary and secondary
11 schools (including preschool, kindergarten, inter-
12 mediate, and junior high schools); and
13 ''(2) develop training, technical assistance and
14 coordination activities for the programs assisted pur-
15 suant to paragraph (1).
16 ''(c) USE OF FUNDS.—Grant funds under this sec-
17 tion may be used to improve elementary and secondary
18 education in the areas of—
19 ''(1) personal health and fitness;
20 ''(2) prevention of chronic diseases;
21 ''(3) prevention and control of communicable
22 diseases;
23 ''(4) nutrition;
24 ''(5) substance use and abuse;
25 ''(6) accident prevention and safety;

"(7) community and environmental health;

"(8) mental and emotional health; and

"(9) the effective use of the health services delivery system.

"(d) OFFICE OF COMPREHENSIVE SCHOOL HEALTH EDUCATION.—The Secretary shall establish within the Office of the Secretary an Office of Comprehensive School Health Education which shall have the following responsibilities:

"(1) To recommend mechanisms for the coordination of school health education programs conducted by the various departments and agencies of the Federal Government.

"(2) To advise the Secretary on formulation of school health education policy within the Department of Education.

"(3) To disseminate information on the benefits to health education of utilizing a comprehensive health curriculum in schools.

"(e) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subsection for fiscal years 1995 through 1998.

"(2) AVAILABILITY.—Funds appropriated pursuant to the authority of paragraph (1) in any fiscal year shall remain available for obligation and expenditure until the end of the fiscal year succeeding the fiscal year for which such funds were appropriated.".

SEC. 5203. FRONTIER STATES.

(a) IN GENERAL.—Frontier States (including Alaska, Wyoming and Montana) may implement proposals to offer preventive services, including mobile preventive health centers which may include centers equipped with various preventive health services, such as mammography, eye care, X-ray, and other advanced equipment, and which may be located on aircraft, watercraft, or other forms of transportation.

(b) DEMONSTRATION PROJECTS.—Frontier States may participate in demonstration projects under this or any other Act to improve recruitment, retention, and training of rural providers, including nurse practitioners and physician assistants. Such demonstration projects shall give special consideration to the diverse needs of Frontier States, and shall involve cooperative agreements with a range of service delivery systems and teaching hospitals.

TITLE VI—TREATMENT OF EXISTING FEDERAL PROGRAMS

SEC. 6000. REFERENCES IN TITLE.

Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

Subtitle A—Medicaid Program

PART I—OPTIONAL COVERAGE UNDER QUALIFIED HEALTH PLANS

SEC. 6001. OPTIONAL COVERAGE UNDER QUALIFIED HEALTH PLANS.

(a) STATE OPTION.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking ''and'' at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(63) at the option of the State, provide that an individual eligible for medical assistance under the State plan has the option to receive medical assistance consisting of the items or services covered

under the standard benefit package required to be offered by a qualified health plan (as defined in section 1931(d)(2)) through enrollment with such a qualified health plan offered in the health care coverage area (as defined in section 1931(d)(1)) in which such individual resides instead of through enrollment in the State plan, in accordance with the requirements of section 1931.''.

(b) REQUIREMENTS DESCRIBED.—Title XIX (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

''REQUIREMENTS FOR STATES PROVIDING OPTIONAL COVERAGE UNDER QUALIFIED HEALTH PLANS

''SEC. 1931. (a) IN GENERAL.—For purposes of section 1902(a)(63), a State meets the requirements of this section with respect to individuals eligible for medical assistance under the State plan if the State meets the following requirements:

''(1) CHOICE OF PLANS.—The State may not restrict the individual's choice of a qualified health plan under such section, except that nothing in this paragraph may be construed to waive any limits on the capacity of a qualified health plan applicable under title I of the Health Equity and Access Reform Today Act of 1993.

"(2) INFORMED CHOICE.—The State shall ensure that each individual who is eligible for medical assistance under the State plan is provided sufficient information to make an informed choice about enrolling in a qualified health plan under such section and selecting such a plan.

"(3) PAYMENTS TO QUALIFIED HEALTH PLANS BY STATES.—

"(A) IN GENERAL.—Subject to subparagraph (B), the State shall make all necessary payments of premiums, copayments, and deductibles applicable under a qualified health plan on behalf of an individual who enrolls in a qualified health plan under such section.

"(B) LIMITATION ON AMOUNT OF PREMIUM PAYMENTS.—With respect to an individual who is enrolled in a qualified health plan in a health care coverage area under such section, the State is not required to pay more than the applicable dollar limit for such area (as determined under section 2001 of the Health Equity and Access Reform Today Act of 1993).

"(4) ANNUAL STUDIES AND REPORTS.—

"(1) ANNUAL STUDY.—The State shall provide for an annual study focusing on the health outcomes

of individuals in the State who have elected to enroll in qualified health plans under such section.

''(2) ANNUAL REPORTS.—The results of the studies conducted pursuant to paragraph (1) shall be summarized in reports submitted to the Secretary at such time and in such manner as the Secretary determines appropriate.

''(b) TREATMENT OF PAYMENTS AS MEDICAL ASSISTANCE.—For purposes of determining the amount of Federal financial participation for a State under section 1903 in a quarter, any payments made by a State under subsection (a)(3) shall be treated as expenditures for medical assistance under the State plan for such quarter.

''(c) LIMITATION ON NUMBER OF INDIVIDUALS PERMITTED TO MAKE ELECTION.—

''(1) IN GENERAL.—

''(A) LIMITATION.—The number of AFDC-eligible and SSI-eligible individuals electing to enroll in a qualified health plan under section 1902(a)(63) in a State during a year may not exceed the applicable percentage of the Secretary's estimate of the number of such individuals in the State who are eligible to enroll in qualified health plans under such section during the year.

"(B) APPLICABLE PERCENTAGE DESCRIBED.—In subparagraph (A), the 'applicable percentage' with respect to a State for a year—

"(i) for each of the first 3 years for which the State exercises the option described in such section, 15 percent; and

"(ii) for each succeeding year for which the State exercises such option, the applicable percentage under this subparagraph for the preceding year, increased by 10 percent.

"(2) WAIVER OF LIMITATION.—The limit on the number of individuals provided in paragraph (1) may be waived by the Secretary with respect to a State if the Secretary determines that such a waiver is appropriate.

"(3) DEFINITIONS.—

"(A) AFDC RECIPIENT.—The term 'AFDC recipient' means an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV.

"(B) SSI RECIPIENT.—The term 'SSI recipient' means an individual—

"(i) with respect to whom supplemental security income benefits are being paid under title XVI,

"(ii) who is receiving a supplementary payment under section 1616 or under section 212 of Public Law 93–66, or

"(iii) who is receiving monthly benefits under section 1619(a) (whether or not pursuant to section 1616(c)(3)).

"(d) DEFINITIONS.—For purposes of this section:

"(1) HEALTH CARE COVERAGE AREA.—The term 'health care coverage area' means a health care coverage area established under section 1403 of the Health Equity and Access Reform Today Act of 1993.

"(2) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' means a health plan that is certified as a qualified health plan under section 1402 of the Health Equity and Access Reform Today Act of 1993.".

PART II—LIMITATION ON CERTAIN FEDERAL MEDICAID PAYMENTS.

SEC. 6011. CAP ON FEDERAL PAYMENTS MADE FOR ACUTE MEDICAL SERVICES FURNISHED UNDER THE MEDICAID PROGRAM.

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

''CAP ON FEDERAL PAYMENT MADE FOR ACUTE MEDICAL SERVICES

''SEC. 1932. (a) ANNUAL FEDERAL CAP.—Federal financial participation is not available under section 1903(a)(1) for expenditures for acute medical services (as defined in subsection (c)(1)), including expenditures consisting of payments to qualified health plans under section 1931(a)(3) on behalf of individuals enrolling in such plans under section 1902(a)(63), for a class of medicaid categorical individuals (as defined in subsection (c)(2)) for a State for a quarter in a fiscal year, to the extent such expenditures exceed ¼ of the product of—

''(1) the per-capita limit determined under subsection (b) for the State for such fiscal year for such class, multiplied by

''(2) the average number of medicaid categorical individuals in such class entitled to receive medi-

cal assistance under the State plan in any month in the quarter.

''(b) PER-CAPITA LIMIT.—

''(1) IN GENERAL.—For purposes of subsection (a), the per-capita limit for a class of medicaid categorical individuals for a State for—

''(A) fiscal year 1996, is an amount equal to the base per-capita funding amount (as determined under paragraph (2)) for such class for such State, increased by 18.8 percent; and

''(B) fiscal year 1997 and each succeeding fiscal year, is an amount equal to the amount determined under this paragraph for the previous fiscal year for the class updated by the applicable percentage for such fiscal year (described in paragraph (3)).

''(2) BASE PER-CAPITA FUNDING AMOUNT.—

''(A) IN GENERAL.—The base per-capita funding amount for a State for a class is an amount equal to the quotient of—

''(i) the total expenditures made under the State plan with respect to medical assistance furnished for acute medical services for individuals within such class for calendar quarters in fiscal year 1994,

but does not include such expenditures for which no Federal financial participation is provided under such plan; divided by

''(ii) the average total number of medicaid categorical individuals in such class in the State in any month during fiscal year 1994.

''(B) DISPROPORTIONATE SHARE PAYMENTS NOT INCLUDED.—In applying subparagraph (A), payments made under section 1923 shall not be counted in the gross amount of payments.

''(C) TREATMENT OF DISALLOWANCES.—The amount determined under this paragraph shall take into account amounts (or an estimate of amounts) disallowed.

''(3) APPLICABLE PERCENTAGE.—In paragraph (1), the applicable percentage for a fiscal year is equal to—

''(A) 6 percent, for each of fiscal years 1997 through 2000; and

''(B) 5 percent, for fiscal year 2001 and each succeeding fiscal year.

"(4) ESTIMATIONS OF AND ADJUSTMENTS TO STATE TOTAL FUNDING AMOUNT.—The Secretary shall—

"(A) establish a process for estimating the limit on expenditures for acute medical services applicable under subsection (a) at the beginning of each fiscal year and adjusting such amount during such fiscal year; and

"(B) notifying each State of the estimations and adjustments referred to in subparagraph (A).

"(c) DEFINITIONS.—For purposes of this section and section 1931:

"(1) ACUTE MEDICAL SERVICES.—The term 'acute medical services' means items and services described in section 1905(a) other than the following:

"(A) Nursing facility services (as defined in section 1905(f)).

"(B) Intermediate care facility for the mentally retarded services (as defined in section 1905(d)).

"(C) Personal care services (as described in section 1905(a)(24)).

"(D) Private duty nursing services (as referred to in section 1905(a)(8)).

"(E) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915.

"(F) Home and community care furnished to functionally disabled elderly individuals under section 1929.

"(G) Community supported living arrangements services under section 1930.

"(H) Case-management services (as described in section 1915(g)(2)).

"(I) Home health care services (as referred to in section 1905(a)(7)), clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in a previous subparagraph.

"(J) Hospice care.

"(2) MEDICAID CATEGORICAL INDIVIDUAL.—The term 'medicaid categorical individual' means an individual described in section 1902(a)(10)(A).

"(3) CLASS OF MEDICAID CATEGORICAL INDIVIDUALS.—The term 'class' means individuals within each of the following classes:

"(A) SSI-RELATED INDIVIDUALS.—Medicaid categorical individuals—

"(i) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act,

"(ii) who receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93–66, or

"(iii) who receiving monthly benefits under section 1619(a) of such Act (whether or not pursuant to section 1616(c)(3) of such Act).

"(B) OTHER INDIVIDUALS.—Medicaid categorical individuals not described in subparagraph (A).".

(b) REQUIRING STATE MAINTENANCE OF EFFORT.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 6001(a), is amended—

(1) by striking "and" at the end of paragraph (62);

(2) by striking the period at the end of paragraph (63) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(64) provide that the State will continue to make eligible for medical assistance under section

1902(a)(10)(A) any class or category of individuals eligible for medical assistance under such section during fiscal year 1994.''.

(c) DISCONTINUATION OF REIMBURSEMENT STANDARDS FOR INPATIENT HOSPITAL SERVICES.—Section 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)) is amended—

(1) by striking ''hospital services, nursing facility services, and'' and inserting ''nursing facilities services and'';

(2) by striking '', in the case of hospitals,'' and all that follows through ''(v)(1)(G))) which'';

(3) by striking ''and to assure'' and all that follows through ''adequate quality''; and

(4) by striking ''each hospital, nursing facility, and'' and inserting ''each nursing facility and''.

(d) REVISION OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR CERTAIN STATES.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended—

(1) by redesignating clauses (1) and (2) as clauses (2) and (3) and by inserting after ''except that'' the following: ''(1) for Alaska and Hawaii, the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the adjusted per capita income of such State

bears to the square of the per capita income of the United States;''; and

(2) by inserting after the first sentence the following: ''The 'adjusted per capita income' for Alaska shall be determined by dividing the State 3-year average per capita income by 1.25, and for Hawaii by dividing the State 3-year average per capita income by 1.15.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall become effective on October 1, 1995.

PART III—STATE FLEXIBILITY TO CONTRACT FOR COORDINATED CARE SERVICES

SEC. 6021. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CONTRACTING FOR COORDINATED CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—

(1) PAYMENT PROVISIONS.—Section 1903(m) (42 U.S.C. 1396b(m)) is amended to read as follows:

''(m)(1) No payment shall be made under this title to a State with respect to expenditures incurred by such State for payment to an entity which is at risk (as defined in section 1933(a)(4)) for services provided by such entity to individuals eligible for medical assistance under the State plan under this title, unless the entity is a risk con-

tracting entity (as defined in section 1933(a)(3)) and the State and such entity comply with the applicable provisions of section 1933.

''(2) No payment shall be made under this title to a State with respect to expenditures incurred by such State for payment for services provided to an individual eligible for medical assistance under the State plan under this title if such payment by the State is contingent upon the individual receiving such services from a specified health care provider or subject to the approval of a specified health care provider, unless the entity receiving payment is a primary care case management entity (as defined in section 1933(a)(2)) and the State and such entity comply with the applicable provisions of section 1933.''.

(2) REQUIREMENTS FOR COORDINATED CARE SERVICES.—Title XIX (42 U.S.C. 1396 et seq.) is amended by redesignating section 1933 as section 1934 and by inserting after section 1932 the following new section:

''REQUIREMENTS FOR COORDINATED CARE SERVICES

''SEC. 1933. (a) DEFINITIONS.—For purposes of this title—

''(1) PRIMARY CARE CASE MANAGEMENT PROGRAM.—The term 'primary care case management program' means a program operated by a State agency under which such State agency enters into

contracts with primary care case management entities for the provision of health care items and services which are specified in such contracts and the provision of case management services to individuals who are—

''(A) eligible for medical assistance under the State plan,

''(B) enrolled with such primary care case management entities, and

''(C) entitled to receive such specified health care items and services and case management services only as approved and arranged for, or provided, by such entities.

''(2) PRIMARY CARE CASE MANAGEMENT ENTITY.—The term 'primary care case management entity' means a health care provider which—

''(A) must be a physician, group of physicians, a Federally qualified health center, a rural health clinic, or an entity employing or having other arrangements with physicians operating under a contract with a State to provide services under a primary care case management program,

''(B) receives payment on a fee for service basis (or, in the case of a Federally qualified

health center or a rural health clinic, on a reasonable cost per encounter basis) for the provision of health care items and services specified in such contract to enrolled individuals,

''(C) receives an additional fixed fee per enrollee for a period specified in such contract for providing case management services (including approving and arranging for the provision of health care items and services specified in such contract on a referral basis) to enrolled individuals, and

''(D) is not an entity that is at risk (as defined in paragraph (4)) for such case management services.

''(3) RISK CONTRACTING ENTITY.—The term 'risk contracting entity' means an entity which has a contract with the State agency (or a health insuring organization described in subsection (n)(2)) under which the entity—

''(A) provides or arranges for the provision of health care items or services which are specified in such contract to individuals eligible for medical assistance under the State plan, and

''(B) is at risk (as defined in paragraph (4)) for part or all of the cost of such items or

services furnished to individuals eligible for medical assistance under such plan.

''(4) AT RISK.—The term 'at risk' means an entity which—

''(A) has a contract with the State agency under which such entity is paid a fixed amount for providing or arranging for the provision of health care items or services specified in such contract to an individual eligible for medical assistance under the State plan and enrolled with such entity, regardless of whether such items or services are furnished to such individual, and

''(B) is liable for all or part of the cost of furnishing such items or services, regardless of whether such cost exceeds such fixed payment.

''(5) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'Federally qualified health center' means a Federally qualified health center as defined in section 1905(l)(2)(B).

''(6) RURAL HEALTH CLINIC.—The term 'rural health clinic' means a rural health clinic as defined in section 1905(l)(1).

''(b) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

"(1) ORGANIZATION.—A risk contracting entity meets the requirements of this section only if such entity—

"(A)(i) is a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as determined by the Secretary pursuant to section 1312 of such Act; or

"(ii) is described in subparagraph (C), (D), (E), (F), or (G) of subsection (e)(4);

"(B) is a federally qualified health center or a rural health clinic which has made adequate provision against the risk of insolvency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical assistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency; or

"(C) is an entity which meets all applicable State licensing requirements and has made adequate provision against the risk of insolvency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical as-

sistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency.

''(2) GUARANTEES OF ENROLLEE ACCESS.—A risk contracting entity meets the requirements of this section only if—

''(A) the geographic locations, hours of operation, patient to staff ratios, and other relevant characteristics of such entity are sufficient to afford individuals eligible for medical assistance under the State plan access to such entities that is at least equivalent to the access to health care providers that would be available to such individuals if such individuals were not enrolled with such entity;

''(B) such entity has reasonable and adequate hours of operation, including 24-hour availability of—

''(i)(I) treatment for an unforeseen illness, injury, or condition of an individual eligible for medical assistance under the State plan and enrolled with such entity; or

''(II) referral to other health care providers for such treatment; and

"(ii) other information, as determined by the Secretary or the State; and

"(C) such entity complies with such other requirements relating to access to care as the Secretary or the State may impose.

"(3) CONTRACT WITH STATE AGENCY.—A risk contracting entity meets the requirements of this section only if such entity has a written contract with the State agency which provides—

"(A) that the entity will comply with all applicable provisions of this section, that the State has the right to penalize the entity for failure to comply with such requirements and to terminate the contract in accordance with subsection (j), and that the entity will be subject to penalties imposed by the Secretary under subsection (i) for failure to comply with such requirements;

"(B) for a payment methodology based on experience rating or another actuarially sound methodology approved by the Secretary, which guarantees (as demonstrated by such models or formulas as the Secretary may approve) that—

"(i) payments to the entity under the contract shall not exceed an amount equal

to 100 percent of the costs (which shall include administrative costs and which may include costs for inpatient hospital services that would have been incurred in the absence of such contract) that would have been incurred by the State agency in the absence of the contract; and

''(ii) the financial risk for inpatient hospital services is limited to an extent established by the State;

''(C) that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain—

''(i) to the ability of the entity (or a subcontractor) to bear the risk of potential financial losses; or

''(ii) to services performed or determinations of amounts payable under the contract;

''(D) that in the entity's enrollment, reenrollment, or disenrollment of individuals eligible for medical assistance under the State plan and eligible to enroll, reenroll, or disenroll

with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of such individuals' health status or requirements for health care services;

''(E)(i) individuals eligible for medical assistance under the State plan who have enrolled with the entity are permitted to terminate such enrollment without cause as of the beginning of the first calendar month (or in the case of an entity described in subsection (e)(4), as of the beginning of the first enrollment period) following a full calendar month after a request is made for such termination;

''(ii) that when an individual has relocated outside the entity's service area, and the entity has been notified of the relocation, services (within reasonable limits) furnished by a health care provider outside the service area will be reimbursed either by the entity or by the State agency; and

''(iii) for written notification of each such individual's right to terminate enrollment, which shall be provided at the time of such individual's enrollment, and, in the case of a child with special health care needs as defined in sub-

section (e)(1)(B)(ii), at the time the entity identifies such a child;

''(F) in the case of services immediately required to treat an unforeseen illness, injury, or condition, of an individual eligible for medical assistance under the State plan and enrolled with the entity—

''(i) that such services shall not be subject to a preapproval requirement; and

''(ii) where such services are furnished by a health care provider other than the entity, for reimbursement of such provider either by the entity or by the State agency;

''(G) for disclosure of information in accordance with subsection (h) and section 1124;

''(H) that any physician incentive plan operated by the entity meets the requirements of section 1876(i)(8);

''(I) for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients;

''(J) that the entity will comply with the requirement of section 1902(w) with respect to each enrollee;

''(K) that the entity will implement a grievance system, inform enrollees in writing about how to use such grievance system, ensure that grievances are addressed in a timely manner, and report grievances to the State at intervals to be determined by the State;

''(L) that contracts between the entity and each subcontractor of such entity will require each subcontractor—

''(i) to cooperate with the entity in the implementation of its internal quality assurance program under paragraph (4) and adhere to the standards set forth in the quality assurance program, including standards with respect to access to care, facilities in which patients receive care, and availability, maintenance, and review of medical records;

''(ii) to cooperate with the Secretary, the State agency and any contractor to the State in monitoring and evaluating the quality and appropriateness of care provided to enrollees as required by Federal or State laws and regulations; and

"(iii) where applicable, to adhere to regulations and program guidance with respect to reporting requirements under section 1905(r);

"(M) that, where the State deems it necessary to ensure the timely provision to enrollees of the services listed in subsection (f)(2)(C)(ii), the State may arrange for the provision of such services by health care providers other than the entity and may adjust its payments to the entity accordingly;

"(N) that the entity and the State will comply with guidelines and regulations issued by the Secretary with respect to procedures for marketing and information that must be provided to individuals eligible for medical assistance under the State plan;

"(O) that the entity must provide payments to hospitals for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital, in accordance with paragraphs (2) and (3) of section 1902(s);

"(P) that the entity shall report to the State, at such time and in such manner as the State shall require, on the rates paid for hospital services (by type of hospital and type of service) furnished to individuals enrolled with the entity;

"(Q) detailed information regarding the relative responsibilities of the entity and the State, for providing (or arranging for the provision of), and making payment for, the following items and services:

"(i) immunizations;

"(ii) the purchase of vaccines;

"(iii) lead screening and treatment services;

"(iv) screening and treatment for tuberculosis;

"(v) screening and treatment for, and preventive services related to, sexually transmitted diseases, including HIV infection;

"(vi) screening, diagnostic, and treatment services required under section 1905(r);

"(vii) family planning services;

''(viii) services prescribed under—

''(I) an Individual Education Plan or Individualized Family Service Plan under part B or part H of the Individuals with Disabilities Education Act; and

''(II) any other individual plan of care or treatment developed under this title or title V;

''(ix) transportation needed to obtain services to which the enrollee is entitled under the State plan or pursuant to an individual plan of care or treatment described in subclauses (I) and (II) of clause (viii); and

''(x) such other services as the Secretary may specify;

''(R) detailed information regarding the procedures for coordinating the relative responsibilities of the entity and the State to ensure prompt delivery of, compliance with any applicable reporting requirements related to, and appropriate record keeping with respect to, the items and services described in subparagraph (Q); and

"(S) such other provisions as the Secretary may require.

"(4) INTERNAL QUALITY ASSURANCE.—A risk contracting entity meets the requirements of this section only if such entity has in effect a written internal quality assurance program which includes a systematic process to achieve specified and measurable goals and objectives for access to, and quality of, care, which—

"(A) identifies the organizational units responsible for performing specific quality assurance functions, and ensures that such units are accountable to the governing body of the entity and that such units have adequate supervision, staff, and other necessary resources to perform these functions effectively,

"(B) if any quality assurance functions are delegated to other entities, ensures that the risk contracting entity remains accountable for all quality assurance functions and has mechanisms to ensure that all quality assurance activities are carried out,

"(C) includes methods to ensure that physicians and other health care professionals under contract with the entity are licensed or

certified as required by State law, or are otherwise qualified to perform the services such physicians and other professionals provide, and that these qualifications are ensured through appropriate credentialing and recredentialing procedures,

''(D) provides for continuous monitoring of the delivery of health care, through—

''(i) identification of clinical areas to be monitored, including immunizations, prenatal care, services required under section 1905(r), and other appropriate clinical areas, to reflect care provided to enrollees eligible for medical assistance under the State plan,

''(ii) use of quality indicators and standards for assessing the quality and appropriateness of care delivered, and the availability and accessibility of all services for which the entity is responsible under such entity's contract with the State,

''(iii) use of epidemiological data or chart review, as appropriate, and patterns of care overall,

1 ''(iv) patient surveys, spot checks, or
2 other appropriate methods to determine
3 whether—
4 ''(I) enrollees are able to obtain
5 timely appointments with primary
6 care providers and specialists, and
7 ''(II) enrollees are otherwise
8 guaranteed access and care as pro-
9 vided under paragraph (2),
10 ''(v) provision of written information
11 to health care providers and other person-
12 nel on the outcomes, quality, availability,
13 accessibility, and appropriateness of care,
14 and
15 ''(vi) implementation of corrective ac-
16 tions,
17 ''(E) includes standards for timely enrollee
18 access to information and care which at a mini-
19 mum shall incorporate standards used by the
20 State or professional or accreditation bodies for
21 facilities furnishing perinatal and neonatology
22 care and other forms of specialized medical and
23 surgical care,
24 ''(F) includes standards for the facilities in
25 which patients receive care,

"(G) includes standards for managing and treating medical conditions prevalent among such entity's enrollees eligible for medical assistance under the State plan,

"(H) includes mechanisms to ensure that enrollees eligible for medical assistance under the State plan receive services for which the entity is responsible under the contract which are consistent with standards established by the applicable professional societies or government agencies,

"(I) includes standards for the availability, maintenance, and review of medical records consistent with generally accepted medical practice,

"(J) provides for dissemination of quality assurance procedures to health care providers under contract with the entity, and

"(K) meets any other requirements prescribed by the Secretary or the State.

"(c) GENERAL REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT PROGRAMS.—A primary care case management program implemented by a State under this section shall—

"(1) provide that each primary care case management entity participating in such program has a written contract with the State agency,

"(2) include methods for selection and monitoring of participating primary care case management entities to ensure—

"(A) that the geographic locations, hours of operation, patient to staff ratio, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance under the State plan access to such entities that is at least equivalent to the access to health care providers that would be available to such individuals if such individuals were not enrolled with such entity,

"(B) that such entities and their professional personnel are licensed as required by State law and qualified to provide case management services, through methods such as ongoing monitoring of compliance with applicable requirements and providing information and technical assistance, and

"(C) that such entities—

"(i) provide timely and appropriate primary care to such enrollees consistent

with standards established by applicable professional societies or governmental agencies, or such other standards prescribed by the Secretary or the State, and

''(ii) where other items and services are determined to be medically necessary, give timely approval of such items and services and referral to appropriate health care providers,

''(3) provide that no preapproval shall be required for emergency health care items or services, and

''(4) permit individuals eligible for medical assistance under the State plan who have enrolled with a primary care case management entity to terminate such enrollment without cause not later than the beginning of the first calendar month following a full calendar month after the request is made for such termination.

''(d) EXEMPTIONS FROM STATE PLAN REQUIREMENTS.—A State plan may permit or require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity without regard to the requirements set forth in the following paragraphs of section 1902(a):

"(1) Paragraph (1) (concerning statewideness).

"(2) Paragraph (10)(B) (concerning comparability of benefits), to the extent benefits not included in the State plan are provided.

"(3) Paragraph (23) (concerning freedom of choice of provider), except with respect to services described in section 1905(a)(4)(C) and except as required under subsection (e).

"(e) STATE OPTIONS WITH RESPECT TO ENROLLMENT AND DISENROLLMENT.—

"(1) MANDATORY ENROLLMENT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a State plan may require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity only if the individual is permitted a choice within a reasonable service area (as defined by the State)—

"(i) between or among 2 or more risk contracting entities,

"(ii) among a risk contracting entity and a primary care case management program, or

"(iii) among primary care case management entities.

"(B) SPECIAL NEEDS CHILDREN.—

"(i) IN GENERAL.—A State may not require a child with special health care needs (as defined in clause (ii)) to enroll with a risk contracting entity or a primary care case management entity.

"(ii) DEFINITION.—For purposes of this subparagraph, the term 'child with special health care needs' refers to an individual eligible for supplemental security income under title XVI, a child described under section 501(a)(1)(D), or a child described in section 1902(e)(3).

"(2) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

"(A) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this section,

"(B) in the next month (or next 2 months) is not eligible for such medical assistance, but

"(C) in the succeeding month is again eligible for such benefits,

the State agency (subject to subsection (b)(3)(E)) may enroll the individual for that succeeding month with such entity, if the entity continues to have a contract with the State agency under this subsection.

"(3) DISENROLLMENT.—

"(A) RESTRICTIONS ON DISENROLLMENT WITHOUT CAUSE.—Except as provided in subparagraph (C), a State plan may restrict the period in which individuals enrolled with risk contracting entities described in paragraph (4) may terminate such enrollment without cause to the first month of each period of enrollment (as defined in subparagraph (B)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

"(B) PERIOD OF ENROLLMENT.—For purposes of this paragraph, the term 'period of enrollment' means—

"(i) a period not to exceed 6 months in duration, or

"(ii) a period not to exceed 1 year in duration, in the case of a State that, on the effective date of this paragraph, had in effect a waiver under section 1115 of requirements under this title under which the State could establish a 1-year minimum period of enrollment with risk contracting entities.

"(C) SPECIAL NEEDS CHILDREN.—A State may not restrict disenrollment of a child with special health care needs (as defined in paragraph (1)(B)(ii)).

"(4) ENTITIES ELIGIBLE FOR DISENROLLMENT RESTRICTIONS.—A risk contracting entity described in this paragraph is—

"(A) a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act,

"(B) an eligible organization with a contract under section 1876,

"(C) an entity that is receiving (and has received during the previous 2 years) a grant of at least $100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act,

"(D) an entity that—

"(i) received a grant of at least $100,000 under section 329(d)(1)(A) or section 330(d)(1) of the Public Health Service Act in the fiscal year ending June 30, 1976, and has been a grantee under either such section for all periods after that date, and

"(ii) provides to its enrollees, on a prepaid capitation or other risk basis, all of the services described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) (and the services described in section 1905(a)(7), to the extent required by section 1902(a)(10)(D)),

"(E) an entity that is receiving (and has received during the previous 2 years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,

"(F) a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

"(i) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

"(ii) which, for all periods after such date, either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services on a prepaid capitation or other risk basis under a contract with the State agency initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract,

"(G) an entity that had contracted with the State agency prior to 1970 for the provision, on a prepaid risk basis, of services (which did not include inpatient hospital services) to individuals eligible for medical assistance under the State plan,

"(H) a program pursuant to an undertaking described in subsection (n)(3) in which at

least 25 percent of the membership enrolled on a prepaid basis are individuals who—

''(i) are not insured for benefits under part B of title XVIII or eligible for medical assistance under the State plan, and

''(ii) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity,

''(I) an entity that, on the date of enactment of this provision, had a contract with the State agency under a waiver under section 1115 or 1915(b) and was not subject to a requirement under this title to permit disenrollment without cause, or

''(J) an entity that has a contract with the State agency under a waiver under section 1915(b)(5).

''(f) STATE MONITORING AND EXTERNAL REVIEW.—

''(1) STATE GRIEVANCE PROCEDURE.—A State contracting with a risk contracting entity or a pri-

mary care case management entity under this section shall provide for a grievance procedure for enrollees of such entity with at least the following elements:

"(A) a toll-free telephone number for enrollee questions and grievances,

"(B) periodic notification of enrollees of their rights with respect to such entity or program,

"(C) periodic sample reviews of grievances registered with such entity or program or with the State, and

"(D) periodic survey and analysis of enrollee satisfaction with such entity or program, including interviews with individuals who disenroll from the entity or program.

"(2) STATE MONITORING OF QUALITY AND ACCESS.—

"(A) RISK CONTRACTING ENTITIES.—A State contracting with a risk contracting entity under this section shall provide for ongoing monitoring of such entity's compliance with the requirements of subsection (b), including compliance with the requirements of such entity's contract under subsection (b)(3), and shall un-

dertake appropriate followup activities to ensure that any problems identified are rectified and that compliance with the requirements of subsection (b) and the requirements of the contract under subsection (b)(3) is maintained.

''(B) PRIMARY CARE CASE MANAGEMENT ENTITIES.—A State electing to implement a primary care case management program shall provide for ongoing monitoring of the program's compliance with the requirements of subsection (c) and shall undertake appropriate followup activities to ensure that any problems identified are rectified and that compliance with subsection (c) is maintained.

''(C) SERVICES.—

''(i) IN GENERAL.—The State shall establish procedures (in addition to those required under subparagraphs (A) and (B)) to ensure that the services listed in clause (ii) are available in a timely manner to an individual enrolled with a risk contracting entity or a primary care case management entity. Where necessary to ensure the timely provision of such services, the State shall arrange for the provision of

such services by health care providers other than the risk contracting entity or the primary care case management entity in which an individual is enrolled.

''(ii) SERVICES LISTED.—The services listed in this clause are:

''(I) prenatal care;

''(II) immunizations;

''(III) lead screening and treatment;

''(IV) prevention, diagnosis and treatment of tuberculosis, sexually transmitted diseases (including HIV infection), and other communicable diseases; and

''(V) such other services as the Secretary may specify.

''(iii) REPORT.—The procedures referred to in clause (i) shall be described in an annual report to the Secretary provided by the State.

''(3) EXTERNAL INDEPENDENT REVIEW.—

''(A) IN GENERAL.—Except as provided in paragraph (4), a State contracting with a risk contracting entity under this section shall pro-

vide for an annual external independent review of the quality and timeliness of, and access to, the items and services specified in such entity's contract with the State agency. Such review shall be conducted by a utilization control and peer review organization with a contract under section 1153 or another organization unaffiliated with the State government or with any risk contracting entity and approved by the Secretary.

''(B) CONTENTS OF REVIEW.—An external independent review conducted under this paragraph shall include the following:

''(i) a review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of quality of care and inappropriate utilization (including overutilization) and treatment,

''(ii) a review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine trends in quality and appropriateness of care,

"(iii) notification of the entity and the State when the review under this paragraph indicates inappropriate care, treatment, or utilization of services (including overutilization), and

"(iv) other activities as prescribed by the Secretary or the State.

"(C) AVAILABILITY.—The results of each external independent review conducted under this paragraph shall be available to the public consistent with the requirements for disclosure of information contained in section 1160.

"(4) DEEMED COMPLIANCE WITH EXTERNAL INDEPENDENT QUALITY OF CARE REVIEW REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary may deem the State to have fulfilled the requirement for independent external review of quality of care with respect to an entity which has been accredited by an organization described in subparagraph (B) and approved by the Secretary.

"(B) ACCREDITING ORGANIZATION.—An accrediting organization described in this subparagraph must—

"(i) exist for the primary purpose of accrediting coordinated care organizations;

"(ii) be governed by a group of individuals representing health care providers, purchasers, regulators, and consumers (a minority of which shall be representatives of health care providers);

"(iii) have substantial experience in accrediting coordinated care organizations, including an organization's internal quality assurance program;

"(iv) be independent of health care providers or associations of health care providers;

"(v) be a nonprofit organization; and

"(vi) have an accreditation process which meets requirements specified by the Secretary.

"(5) FEDERAL MONITORING RESPONSIBILITIES.—The Secretary shall review the external independent reviews conducted pursuant to paragraph (3) and shall monitor the effectiveness of the State's monitoring and followup activities required under subparagraph (A) of paragraph (2). If the Secretary determines that a State's monitoring and followup

activities are not adequate to ensure that the requirements of paragraph (2) are met, the Secretary shall undertake appropriate followup activities to ensure that the State improves its monitoring and followup activities.

''(g) PARTICIPATION OF FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

''(1) IN GENERAL.—Each risk contracting entity shall, with respect to each electing essential community provider (as defined in paragraph (5)) located within the plan's service area, either—

''(A) enter into a written provider participation agreement (described in paragraph (2)) with the provider, or

''(B) enter into a written agreement under which the plan shall make payment to the provider in accordance with paragraph (3).

''(2) PARTICIPATION AGREEMENT.—A participation agreement between a risk contracting entity and an electing essential community provider under this subsection shall provide that the entity agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other participating providers with the risk

contracting entity with respect to each of the following:

''(A) The scope of services for which payment is made by the entity to the provider.

''(B) The rate of payment for covered care and services.

''(C) The availability of financial incentives to participating providers.

''(D) Limitations on financial risk provided to other participating providers.

''(E) Assignment of enrollees to participating providers.

''(F) Access by the provider's patients to providers in medical specialties or subspecialties participating in the plan.

''(3) PAYMENTS FOR PROVIDERS WITHOUT PARTICIPATION AGREEMENTS.—Payment in accordance with this paragraph is payment based on payment methodologies and rates used under the applicable Medicare payment methodology and rates (or the most closely applicable methodology under such program as the Secretary of Health and Human Services specifies in regulations).

''(4) ELECTION.—

"(A) IN GENERAL.—In this subsection, the term 'electing essential community provider' means, with respect to a risk contracting entity, an essential community provider that elects this subpart to apply to the entity.

"(B) FORM OF ELECTION.—An election under this paragraph shall be made in a form and manner specified by the Secretary, and shall include notice to the risk contracting entity involved. Such an election may be made annually with respect to an entity, except that the entity and provider may agree to make such an election on a more frequent basis.

"(5) PROVIDERS DESCRIBED.—The categories of providers and organizations described in this subsection are as follows:

"(A) MIGRANT HEALTH CENTERS.—A recipient or subrecipient of a grant under section 329 of the Public Health Service Act.

"(B) COMMUNITY HEALTH CENTERS.—A recipient or subrecipient of a grant under section 330 of the Public Health Service Act.

"(C) HOMELESS PROGRAM PROVIDERS.—A recipient or subrecipient of a grant under section 340 of the Public Health Service Act.

"(D) PUBLIC HOUSING PROVIDERS.—A recipient or subrecipient of a grant under section 340A of the Public Health Service Act.

"(E) FAMILY PLANNING CLINICS.—A recipient or subrecipient of a grant under title X of the Public Health Service Act.

"(F) INDIAN HEALTH PROGRAMS.—A service unit of the Indian Health Service, a tribal organization, or an urban Indian program, as defined in the Indian Health Care Improvement Act.

"(G) AIDS PROVIDERS UNDER RYAN WHITE ACT.—A public or private nonprofit health care provider that is a recipient or subrecipient of a grant under title XXIII of the Public Health Service Act.

"(H) MATERNAL AND CHILD HEALTH PROVIDERS.—A public or private nonprofit entity that provides prenatal care, pediatric care, or ambulatory services to children, including children with special health care needs, and that receives funding for such care or services under title V of the Social Security Act.

"(I) FEDERALLY QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC.—A Federally-

qualified health center or a rural health clinic (as such terms are defined in section 1861(aa)).

''(6) SUBRECIPIENT DEFINED.—In this subsection, the term 'subrecipient' means, with respect to a recipient of a grant under a particular authority, an entity that—

''(A) is receiving funding from such a grant under a contract with the principal recipient of such a grant, and

''(B) meets the requirements established to be a recipient of such a grant.

''(7) SUNSET OF REQUIREMENT.—The requirements of this subsection shall only apply to risk contracting entities during calendar years 1995 through 2000.

''(h) TRANSACTIONS WITH PARTIES IN INTEREST.—

''(1) IN GENERAL.—Each risk contracting entity which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General of the United States a description of transactions between the entity and a party in interest (as defined in section

1318(b) of such Act), including the following transactions:

"(A) Any sale or exchange, or leasing of any property between the entity and such a party.

"(B) Any furnishing for consideration of goods, services (including management services), or facilities between the entity and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

"(C) Any lending of money or other extension of credit between the entity and such a party.

The State or the Secretary may require that information reported with respect to a risk contracting entity which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the risk contracting entity and such entity.

"(2) AVAILABILITY OF INFORMATION.—Each risk contracting entity shall make the information reported pursuant to paragraph (1) available to its enrollees upon reasonable request.

"(i) REMEDIES FOR FAILURE TO COMPLY.—

"(1) IN GENERAL.—If the Secretary determines that a risk contracting entity or a primary care case management entity—

"(A) fails substantially to provide services required under section 1905(r), when such an entity is required to do so, or provide medically necessary items and services that are required to be provided to an individual enrolled with such an entity, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(B) imposes premiums on individuals enrolled with such an entity in excess of the premiums permitted under this title;

"(C) acts to discriminate among individuals in violation of the provision of subsection (b)(3)(D), including expulsion or refusal to reenroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the entity whose medical condition or history indicates a need for substantial future medical services;

"(D) misrepresents or falsifies information that is furnished—

"(i) to the Secretary or the State under this section; or

"(ii) to an individual or to any other entity under this section; or

"(E) fails to comply with the requirements of section 1876(i)(8),

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in paragraph (2).

"(2) ADDITIONAL REMEDIES.—The remedies described in this paragraph are—

"(A) civil money penalties of not more than $25,000 for each determination under paragraph (1), or, with respect to a determination under subparagraph (C) or (D)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph

(1)(C), $15,000 for each individual not enrolled as a result of a practice described in such paragraph, or

''(B) denial of payment to the State for medical assistance furnished by a risk contracting entity or a primary care case management entity under this section for individuals enrolled after the date the Secretary notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(j) TERMINATION OF CONTRACT BY STATE.—Any State which has a contract with a risk contracting entity or a primary care case management entity may terminate such contract if such entity fails to comply with the terms of such contract or any applicable provision of this section.

''(k) FAIR HEARING.—Nothing in this section shall affect the rights of an individual eligible to receive medical

assistance under the State plan to obtain a fair hearing under section 1902(a)(3) or under applicable State law.

''(l) DISPROPORTIONATE SHARE HOSPITALS.—Nothing in this section shall affect any requirement on a State to comply with section 1923.

''(m) REFERRAL PAYMENTS.—For 1 year following the date on which individuals eligible for medical assistance under the State plan in a service area are required to enroll with a risk contracting entity or a primary care case management entity, Federally qualified health centers and rural health centers located in such service area or providing care to such enrollees, shall receive a fee for educating such enrollees about the availability of services from the risk contracting entity or primary care case management entity with which such enrollees are enrolled.

''(n) SPECIAL RULES.—

''(1) NONAPPLICABILITY OF CERTAIN PROVISIONS TO CERTAIN RISK CONTRACTING ENTITIES.—In the case of any risk contracting entity which—

''(A)(i) is an individual physician or a physician group practice of less than 50 physicians, and

''(ii) is not described in paragraphs (A) and (B) of subsection (b)(1), and

"(B) is at risk only for the health care items and services directly provided by such entity,

paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4) of subsection (b), and paragraph (3) of subsection (f), shall not apply to such entity.

"(2) EXCEPTION FROM DEFINITION OF RISK CONTRACTING ENTITY.—For purposes of this section, the term 'risk contracting entity' shall not include a health insuring organization which was used by a State before April 1, 1986, to administer a portion of the State plan of such State on a statewide basis.

"(3) NEW JERSEY.—The rules under section 1903(m)(6) as in effect on the day before the effective date of this section shall apply in the case of an undertaking by the State of New Jersey (as described in such section 1903(m)(6)).

"(o) CONTINUATION OF CERTAIN COORDINATED CARE PROGRAMS.—The Secretary may provide for the continuation of any coordinated care program operating under section 1115 or 1915 without requiring compliance with any provision of this section which conflicts with the continuation of such program and without requiring any additional waivers under such sections 1115 and 1915 if

the program has been successful in assuring quality and containing costs (as determined by the Secretary) and is likely to continue to be successful in the future.

''(p) GUIDELINES, REGULATIONS, AND MODEL CONTRACT.—

''(1) GUIDELINES AND REGULATIONS ON SOLVENCY.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines and regulations concerning solvency standards for risk contracting entities and subcontractors of such risk contracting entities. Such guidelines and regulations shall take into account characteristics that may differ among risk contracting entities including whether such an entity is at risk for inpatient hospital services.

''(2) GUIDELINES AND REGULATIONS ON MARKETING.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines and regulations concerning—

''(A) marketing undertaken by any risk contracting entity or any primary care case management program to individuals eligible for medical assistance under the State plan, and

''(B) information that must be provided by States or any such entity to individuals eligible

for medical assistance under the State plan with respect to—

''(i) the options and rights of such individuals to enroll with, and disenroll from, any such entity, as provided in this section, and

''(ii) the availability of services from any such entity (including a list of services for which such entity is responsible or must approve and information on how to obtain services for which such entity is not responsible).

In developing the guidelines and regulations under this paragraph, the Secretary shall address the special circumstances of children with special health care needs (as defined in subsection (e)(1)(B)(ii)) and other individuals with special health care needs.

''(3) MODEL CONTRACT.—The Secretary shall develop a model contract to reflect the requirements of subsection (b)(3) and such other requirements as the Secretary determines appropriate.''

(b) WAIVERS FROM REQUIREMENTS ON COORDINATED CARE PROGRAMS.—Section 1915(b) (42 U.S.C. 1396n) is amended—

(1) in the matter preceding paragraph (1), by striking ''as may be necessary'' and inserting '', and section 1933 as may be necessary'';

(2) in paragraph (1), by striking ''a primary care case management system or'';

(3) by striking ''and'' at the end of paragraph (3);

(4) by striking the period at the end of paragraph (4) and inserting '', and''; and

(5) by inserting after paragraph (4) the following new paragraph:

''(5) to permit a risk contracting entity (as defined in section 1933(a)(3)) to restrict the period in which individuals enrolled with such entity may terminate such enrollment without cause in accordance with section 1933(e)(3)(A).''.

(c) STATE OPTION TO GUARANTEE MEDICAID ELIGIBILITY.—Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is amended—

(1) in subparagraph (A), by striking all that precedes ''(but for this paragraph)'' and inserting ''In the case of an individual who is enrolled—

''(i) with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) or with a risk con-

tracting entity (as defined in section 1933(a)(3)), or

''(ii) with any risk contracting entity (as defined in section 1933(a)(3)) in a State that, on the effective date of this provision, had in effect a waiver under section 1115 of requirements under this title under which the State could extend eligibility for medical assistance for enrollees of such entity, or

''(iii) with an eligible organization with a contract under section 1876,

and who would'',

(2) in subparagraph (B), by striking ''organization or'' each place it appears, and

(3) by adding at the end the following new subparagraph:

''(C) The State plan may provide, notwithstanding any other provision of this title, that an individual shall be deemed to continue to be eligible for benefits under this title until the end of the month following the month in which such individual would (but for this paragraph) lose such eligibility because of excess income and resources, if the individual is enrolled with a risk contracting entity or primary care case manage-

ment entity (as those terms are defined in section 1933(a)).''.

(d) ENHANCED MATCH RELATED TO QUALITY REVIEW.—Section 1903(a)(3)(C) (42 U.S.C. 1396b(a)(3)(C)) is amended—

(1) by striking ''organization or by'' and inserting ''organization, by''; and

(2) by striking ''section 1152, as determined by the Secretary,'' and inserting ''section 1152, as determined by the Secretary, or by another organization approved by the Secretary which is unaffiliated with the State government or with any risk contracting entity (as defined in section 1933(a)(3)),''.

(e) ACCUMULATION OF RESERVES BY CERTAIN ENTITIES—Any organization referred to in section 329, 330, or 340, of the Public Health Service Act which has contracted with a State agency as a risk contracting entity under section 1933(g)(3)(A) of the Social Security Act may accumulate reserves with respect to payments made to such organization under section 1933(g)(3)(C) of such Act.

(f) CONFORMING AMENDMENTS.—

(1) Section 1128(b)(6)(C)(i) (42 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking ''health main-

tenance organization'' and inserting ''risk contracting entity''.

(2) Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)) is amended by striking ''primary care-case management system (described in section 1915(b)(1)), a health maintenance organization,'' and inserting ''primary care case management program (as defined in section 1933(a)(1)), a risk contracting entity (as defined in section 1933(a)(3)),''.

(3) Section 1902(a)(30)(C) (42 U.S.C. 1396a(a)(30)(C)) is amended by striking ''use a utilization'' and all that follows through ''with the results'' and inserting ''provide for independent review and quality assurance of entities with contracts under section 1933, in accordance with subsection (f) of such section 1933, with the results''.

(4) Section 1902(a)(57) (42 U.S.C. 1396a(a)(57)) is amended by striking ''or health maintenance organization (as defined in section 1903(m)(1)(A))'' and inserting ''risk contracting entity, or primary care case management entity (as defined in section 1933(a))''.

(5) Section 1902(a) (42 U.S.C. 1396a), as amended by sections 6001(a) and 6011(b), is amended—

(A) by striking ''and'' at the end of paragraph (63);

(B) by striking the period at the end of paragraph (64) and inserting ''; and''; and

(C) by adding at the end the following new paragraphs:

''(65) at State option, provide for a primary care case management program in accordance with section 1933; and

''(66) at State option, provide for a program under which the State contracts with risk contracting entities in accordance with section 1933.''.

(6) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2)) is amended by striking ''health maintenance organization (as defined in section 1903(m))'' and inserting ''risk contracting entity (as defined in section 1933(a)(3))''.

(7) Section 1902(w) (42 U.S.C. 1396a(w)) is amended—

(A) in paragraph (1), by striking ''section 1903(m)(1)(A)'' and inserting ''section 1933(a)(3)'', and

(B) in paragraph (2)(E)—

(i) by striking ''health maintenance organization'' and inserting ''risk contracting entity'', and

(ii) by striking ''organization'' and inserting ''entity''.

(8) Section 1903(k) (42 U.S.C. 1396b(k)) is amended by striking ''health maintenance organization which meets the requirements of subsection (m) of this section'' and inserting ''risk contracting entity which meets the requirements of section 1933''.

(9) Section 1903(w)(7)(A)(viii) (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking ''health maintenance organizations (and other organizations with contracts under section 1903(m))'' and inserting ''risk contracting entities with contracts under section 1933''.

(10) Section 1905(a) (42 U.S.C. 1396d(a)) is amended, in the matter preceding clause (i), by inserting ''(which may be on a prepaid capitation or other risk basis)'' after ''payment''.

(11) Section 1916(b)(2)(D) (42 U.S.C. 1396o(b)(2)(D)) is amended by striking ''health maintenance organization (as defined in section 1903(m))'' and inserting ''risk contracting entity (as defined in section 1933(a)(3))''.

(12) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended—

(A) in the heading, by striking ''**HMO**'' and inserting ''**RISK CONTRACTING ENTITY**'',

(B) by striking ''health maintenance organization (as defined in section 1903(m)(1)(A))'' and inserting ''risk contracting entity (as defined in section 1933(a)(3)'', and

(C) by striking ''health maintenance organization in accordance with section 1903(m)'' and inserting ''risk contracting entity in accordance with section 1933''.

(13) Paragraphs (1) and (2) of section 1926(a) (42 U.S.C. 1396r–7(a)) are each amended by striking ''health maintenance organizations under section 1903(m)'' and inserting ''risk contracting entities under section 1933''.

(13) Section 1927(j)(1) is amended by striking ''* * * Health Maintenance Organizations, including those organizations that contract under section 1903(m)'' and inserting ''risk contracting entities (as defined in section 1933(a)(3))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to calendar quarters beginning on or after January 1, 1995.

PART IV—OTHER PROVISIONS

SEC. 6031. PHASED-IN ELIMINATION OF MEDICAID HOSPITAL DISPROPORTIONATE SHARE ADJUSTMENT PAYMENTS.

(a) IN GENERAL.—Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

''(g) PHASED-IN ELIMINATION OF FEDERAL FINANCIAL PARTICIPATION FOR DISPROPORTIONATE SHARE ADJUSTMENTS.—Notwithstanding any other provisions of this section, the amount of payments under section 1903(a) with respect to any payment adjustment made under this section for hospitals in a State for quarters—

''(1) in fiscal year 1996, shall not exceed 80 percent of the amount otherwise determined under subsection (f);

''(2) in fiscal year 1997, shall not exceed 60 percent of the amount otherwise determined under subsection (f);

''(3) in fiscal year 1998, shall not exceed 40 percent of the amount otherwise determined under subsection (f);

''(4) in fiscal year 1999, shall not exceed 20 percent of the amount otherwise determined under subsection (f); and

''(5) in fiscal year 2000 and each succeeding fiscal year, shall not exceed the amount otherwise determined under subsection (f).''.

(b) IN GENERAL.—The amendments made by subsection (a) shall be effective on the date of the enactment of this Act.

Subtitle B—Medicare

PART I—ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS

SEC. 6101. LEGISLATIVE PROPOSAL ON ENROLLING MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a proposal for legislation which provides for the enrollment of medicare beneficiaries in qualified health plans.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term ''medicare beneficiary'' means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) CONTENTS OF THE PROPOSAL.—A proposal for legislation submitted under subsection (a) shall—

(1) provide for an appropriate methodology by which the Secretary shall make payment to qualified health plans for the enrollment of medicare beneficiaries;

(2) provide individuals the opportunity to remain enrolled in a qualified plan without an interruption in coverage upon becoming medicare beneficiaries; and

(3) provide medicare beneficiaries with the opportunity to enroll in a qualified health plan.

SEC. 6102. INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.

(a) INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—Notwithstanding title XVIII of the Social Security Act, the Secretary shall provide for a monthly payment as provided under subsection (b)(1) to a qualified health plan on behalf of enrolled medicare beneficiaries.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term ''medicare beneficiary'' means an individual who is eligible for benefits under part

A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) PAYMENT SPECIFIED.—

(1) FEDERAL PAYMENT.—

(A) IN GENERAL.—The amount of payment specified in this paragraph for an individual who is enrolled in a qualified health plan is the lesser of—

(i) the applicable rate specified in section 1876(a)(1)(C) of the Social Security Act (but at 100 percent, rather than 95 percent, of the applicable amount); or

(ii) the monthly premium charged the individual for coverage under the qualified health plan.

(B) SOURCE OF PAYMENT.—The payment to a qualified health plan under this paragraph for individuals entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, with the allocation to be determined by the Secretary.

(2) INDIVIDUAL'S SHARE.—If the monthly premium for the qualified health plan in which the individual is enrolled is greater than the amount specified under paragraph (1)(A)(i), the individual shall be responsible for paying to the qualified health plan the difference between the monthly premium charged the individual for coverage under the qualified health plan and the amount specified in paragraph (1)(A)(i).

(c) PAYMENTS UNDER THIS SECTION AS SOLE MEDICARE BENEFITS.—Payments made under this section shall be instead of the amounts that would otherwise be payable, pursuant to sections 1814(b) and 1833(a) of the Social Security Act, for services furnished to medicare beneficiaries.

PART II—ENHANCEMENT OF MEDICARE RISK CONTRACTS

SEC. 6111. REVISIONS IN THE PAYMENT METHODOLOGY FOR RISK CONTRACTORS.

Section 4204(b) of the Omnibus Budget Reconciliation Act of 1990 is amended to read as follows:

''(b) REVISIONS IN THE PAYMENT METHODOLOGY FOR RISK CONTRACTORS.—(1)(A) Not later than 1 year after the date of the enactment of the Health Equity and Access Reform Today Act of 1993, the Secretary of

Health and Human Services (in this subsection referred to as the 'Secretary') shall submit a proposal to the Congress that provides for revisions to the payment method to be applied in years beginning with 1996 for organizations with a risk-sharing contract under section 1876(g) of the Social Security Act.

''(B) In proposing the revisions required under subparagraph (A), the Secretary shall consider—

''(i) the difference in costs associated with medicare beneficiaries with differing health status and demographic characteristics;

''(ii) the difference in costs associated with medicare beneficiaries who receive health benefits from a primary payer other than medicare; and

''(iii) the effects of using alternative geographic classifications on the determinations of costs associated with beneficiaries residing in different areas.

''(2) Not later than 3 months after the date of submittal of the proposal under paragraph (1), the Physician Payment Review Commission and the Prospective Payment Assessment Commission shall review the proposal and shall report to Congress on the appropriateness of the proposed modifications.''.

SEC. 6112. ADJUSTMENT IN MEDICARE CAPITATION PAYMENTS TO TAKE INTO ACCOUNT SECONDARY PAYER STATUS.

(a) IN GENERAL.—In defining the classes to be used in determining the annual per capita rate of payment under section 1876(a)(1)(B) of the Social Security Act to an eligible organization with a risk-sharing contract under such section (for months beginning after June 1994), the Secretary shall treat as a separate class individuals entitled to benefits under title XVIII of such Act with respect to whom there is a group health plan that is a primary plan (within the meaning of section 1862(b)(2)(A) of such Act).

(b) DEADLINE FOR ANNOUNCEMENT OF RATES.—Not later than May 15, 1994, the Secretary shall announce annual per capita rates of payment for eligible organizations described in subsection (a) that take into account the separate treatment of individuals with respect to whom there is a group health plan that is a primary plan.

SEC. 6113. ESTABLISHMENT OF OUTLIER POOL.

(a) GENERAL RULE.—Section 1876(a)(1) (42 U.S.C. 1395mm(a)(1)) is amended by adding at the end the following new subparagraph:

''(G)(i) In the case of an eligible organization with a risk-sharing contract, the Secretary may make addi-

tional payments to the organization equal to not more than 50 percent of reasonable cost above the threshold amount of items and services covered under parts A and B and provided (or paid for) in a year by the organization to any individual enrolled with the organization under this section.

''(ii) For purposes of clause (i), the 'threshold amount' is an amount determined by the Secretary from time to time, adjusted by the geographic factor utilized in determining payments to the organization under subparagraph (C) and rounded to the nearest multiple of $100, such that the total amount to be paid under this subparagraph for a year is estimated to be 5 percent or less of the total amount to be paid under risk-sharing contracts for services furnished for that year.

''(iii) An eligible organization shall submit a claim for additional payments under subsection (i) within such time as the Secretary may specify.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished after 1994.

PART III—MEDICARE SELECT

SEC. 6121. MEDICARE SELECT.

(a) AMENDMENTS TO PROVISIONS RELATING TO MEDICARE SELECT POLICIES.—

(1) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 is hereby repealed.

(2) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

''(1)(A) If a medicare supplemental policy meets the requirements of the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

''(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

''(ii) in the case of a policy described in subparagraph (C)(i)—

''(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

''(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

''(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those requirements if the policy meets the requirements of subparagraph (B).

''(B) A policy meets the requirements of this subparagraph if—

''(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

''(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network,

''(iii) the network offers sufficient access,

''(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

1 ''(v)(I) the issuer of the policy provides to each
2 enrollee at the time of enrollment an explanation
3 of—
4 ''(aa) the restrictions on payment under
5 the policy for services furnished other than by
6 or through the network,
7 ''(bb) out of area coverage under the pol-
8 icy,
9 ''(cc) the policy's coverage of emergency
10 services and urgently needed care, and
11 ''(dd) the availability of a policy through
12 the entity that meets the 1991 Model NAIC
13 Regulation or 1991 Federal Regulation without
14 regard to this subsection and the premium
15 charged for such policy, and
16 ''(II) each enrollee prior to enrollment acknowl-
17 edges receipt of the explanation provided under
18 subclause (I), and
19 ''(vi) the issuer of the policy makes available to
20 individuals, in addition to the policy described in this
21 subsection, any policy (otherwise offered by the is-
22 suer to individuals in the State) that meets the 1991
23 Model NAIC Regulation or 1991 Federal Regulation
24 and other requirements of this section without re-
25 gard to this subsection.

''(C)(i) A policy described in this subparagraph—

''(I) is offered by an eligible organization (as defined in section 1876(b)),

''(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

''(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

''(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).''.

(b) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking ''(1) Each'' and inserting ''(1)(A) Except as provided in subparagraph (B), each'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new subparagraph:

''(B)(i) In the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy; except that, if such individual moves to a geographic area where such issuer, or where an affiliate of such issuer, is issuing medicare supplemental policies, such individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other

medicare supplemental policies offered by the issuer or its affiliates.

''(ii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.''.

(c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking ''(2)'' and inserting ''(2)(A)'';

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as redesignated—

(A) by striking ''paragraph (1)(E)(i)'' and inserting ''paragraph (1)(B)(v)(I); and

(B) by striking ''paragraph (1)(E)(ii)'' and inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking ''the previous sentence'' and inserting ''this subparagraph''; and

(5) by adding at the end the following new subparagraph:

''(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount

not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(d) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the ''1994 NAIC Model Regulation'').

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in paragraph (1), the Secretary of Health and Human Services (hereafter in this subsection referred to as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the ''1994 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1994 NAIC Model Regulation or the 1994 Federal Regulation, or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1994 NAIC Model Regulation or the 1994 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

PART IV—OTHER PROVISIONS

SEC. 6131. MEDICARE PART B PREMIUM.

Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

(1) in paragraph (1)(A)—

(A) by striking ''(A)''; and

(B) by striking ''and prior to January 1999'';

(2) in paragraph (1)(B), by striking ''(B)'' and inserting ''(2)''; and

(3) by striking paragraph (2).

SEC. 6132. INCREASE IN MEDICARE PART B PREMIUM FOR INDIVIDUALS WITH HIGH INCOME.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

''PART VIII—MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

''Sec. 59B. Medicare part B premium tax.

''SEC. 59B. MEDICARE PART B PREMIUM TAX.

''(a) IMPOSITION OF RECAPTURE AMOUNT.—In the case of an individual, if the modified adjusted gross income of the taxpayer for the taxable year exceeds the threshold amount, such taxpayer shall pay (in addition to any other amount imposed by this subtitle) a recapture amount for such taxable year equal to the sum of the aggregate of the medicare part B recapture amounts (if any) for months during such year that a premium is paid under

part B of title XVIII of the Social Security Act for the coverage of the individual under such part.

''(b) MEDICARE PART B PREMIUM RECAPTURE AMOUNT FOR MONTH.—For purposes of this section, the medicare part B premium recapture amount for any month is the amount equal to the excess of—

''(1) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

''(2) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

''(c) PHASE-IN OF RECAPTURE AMOUNT.—If the modified adjusted gross income of the taxpayer for any taxable year exceeds the threshold amount by less than $10,000, the recapture amount imposed by this section for such taxable year shall be an amount which bears the same ratio to the recapture amount which would (but for this subsection) be imposed by this section for such taxable year as such excess bears to $10,000.

''(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(A) except as otherwise provided in this paragraph, $90,000,

"(B) $115,000 in the case of a joint return, and

"(C) zero in the case of a taxpayer who—

"(i) is married (as determined under section 7703) but does not file a joint return for such year, and

"(ii) does not live apart from his spouse at all times during the taxable year.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 135, 911, 931, and 933, and

"(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) JOINT RETURNS.—In the case of a joint return—

"(A) the recapture amount under subsection (a) shall be the sum of the recapture

amounts determined separately for each spouse, and

''(B) subsections (a) and (c) shall be applied by taking into account the combined modified adjusted gross income of the spouses.

''(4) COORDINATION WITH OTHER PROVISIONS.—

''(A) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the recapture amount imposed by this section shall be treated as if it were a tax imposed by section 1.

''(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The recapture amount imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

''(i) the amount of any credit allowable under this chapter, or

''(ii) the amount of the minimum tax under section 55.''.

(b) TRANSFERS TO SUPPLEMENTAL MEDICAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—There are hereby appropriated to the Supplemental Medical Insurance Trust Fund amounts equivalent to the aggregate in-

crease in liabilities under chapter 1 of the Internal Revenue Code of 1986 that are attributable to the application of section 59B(a) of such Code, as added by this section.

(2) TRANSFERS.—The amounts appropriated by paragraph (1) to the Supplemental Medical Insurance Trust Fund shall be transferred from time to time (but not less frequently than quarterly) from the general fund of the Treasury on the basis of estimates made by the Secretary of the Treasury of the amounts referred to in paragraph (1). Any quarterly payment shall be made on the first day of such quarter and shall take into account the recapture amounts referred to in such section 59B(a) for such quarter. Proper adjustments shall be made in the amounts subsequently transferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

(c) REPORTING REQUIREMENTS.—

(1)(A) Paragraph (1) of section 6050F(a) of the Internal Revenue Code of 1986 (relating to returns relating to social security benefits) is amended by striking ''and'' at the end of subparagraph (B) and by inserting after subparagraph (C) the following new subparagraph:

"(D) the number of months during the calendar year for which a premium was paid under part B of title XVIII of the Social Security Act for the coverage of such individual under such part, and".

(B) Paragraph (2) of section 6050F(b) of such Code is amended to read as follows:

"(2) the information required to be shown on such return with respect to such individual.".

(C) Subparagraph (A) of section 6050F(c)(1) of such Code is amended by inserting before the comma "and in the case of the information specified in subsection (a)(1)(D)".

(D) The heading for section 6050F of such Code is amended by inserting "**AND MEDICARE PART B COVERAGE**" before the period.

(E) The item relating to section 6050F in the table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting "and medicare part B coverage" before the period.

(d) WAIVER OF ESTIMATED TAX PENALTIES FOR 1996.—No addition to tax shall be imposed under section 6654 of the Internal Revenue Code of 1986 (relating to failure to pay estimated income tax) for any period before

April 16, 1997, with respect to any underpayment to the extent that such underpayment resulted from section 59B(a) of the Internal Revenue Code of 1986, as added by this section.

(e) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

> ''Part VIII. Medicare Part B Premiums for High-Income Individuals.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to periods after December 31, 1994, in taxable years ending after such date.

SEC. 6133. PERMANENT 10-PERCENT REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS OF OUTPATIENT HOSPITAL SERVICES.

Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''fiscal years 1992 through 1998'' and inserting ''fiscal year 1992, and each subsequent fiscal year,''.

SEC. 6134. PERMANENT REDUCTION IN PAYMENTS FOR OTHER COSTS OF OUTPATIENT HOSPITAL SERVICES.

Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''fiscal years 1991 through 1998'' and inserting ''fiscal year 1991, and each subsequent fiscal year''.

SEC. 6135. IMPOSITION OF COINSURANCE ON LABORATORY SERVICES.

(a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

(1) by striking ''(or 100 percent'' and all that follows through ''the first opinion))''; and

(2) by striking ''100 percent of such negotiated rate'' and inserting ''80 percent of such negotiated rate''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to tests furnished on or after January 1, 1995.

SEC. 6136. IMPOSITION OF COPAYMENT FOR CERTAIN HOME HEALTH VISITS.

(a) IN GENERAL.—

(1) PART A.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

''(5) The amount payable for home health services furnished to an individual under this part shall be reduced by a copayment amount equal to 20 percent of the average of all per visit costs for home health services furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year), unless such services were furnished to the individual during the 30-

day period that begins on the date the individual is discharged as an inpatient from a hospital.''.

(2) PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(A) in subparagraph (A), by striking ''to home health services,'' and by striking the comma after ''opinion)'';

(B) in subparagraph (D), by striking ''and'' at the end;

(C) in subparagraph (E), by striking the semicolon at the end and inserting ''; and''; and

(D) by adding at the end the following new subparagraph:

''(F) with respect to home health services—

''(i) the lesser of —

''(I) the reasonable cost of such services, as determined under section 1861(v), or

''(II) the customary charges with respect to such services,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A),

''(ii) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2), or

''(iii) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section,

less a copayment amount equal to 20 percent of the average of all per visit costs for home health services furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year), unless such services were furnished to the individual during the 30-day period that begins on the date the individual is discharged as an inpatient from a hospital;''.

(3) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(A) by striking ''deduction or coinsurance'' and inserting ''deduction, coinsurance, or copayment''; and

(B) by striking ''or (a)(4)'' and inserting ''(a)(4), or (a)(5)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to home health services furnished on or after January 1, 1995.

SEC. 6137. PHASED-IN ELIMINATION OF MEDICARE HOSPITAL DISPROPORTIONATE SHARE ADJUSTMENT PAYMENTS.

Section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking ''The amount of such payment'' and inserting ''Subject to clause (ix), the amount of such payment''; and

(2) by adding at the end the following new clause:

''(ix) The amount of the additional payment made under this paragraph for a discharge shall be equal to—

''(I) for discharges occurring during fiscal year 1996, 80 percent of the amount otherwise determined for the discharge under clause (ii);

''(II) for discharges occurring during fiscal year 1997, 60 percent of the amount otherwise determined for the discharge under clause (ii);

''(III) for discharges occurring during fiscal year 1998, 40 percent of the amount otherwise determined for the discharge under clause (ii);

''(IV) for discharges occurring during fiscal year 1999, 20 percent of the amount otherwise determined for the discharge under clause (ii); and

''(V) for discharges occurring during fiscal year 2000, and each subsequent fiscal year, 0 percent of the amount otherwise determined for the discharge under clause (ii).''.

SEC. 6138. ELIMINATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.

(a) IN GENERAL.—Effective October 1, 1995, in making any payment to hospitals under title XVIII of the Social Security Act, the Secretary shall discontinue payments under title XVIII of such Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title.

(b) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—(A) Subsection (c) of section 4008 of the Omnibus Budget Reconciliation Act of 1987 is repealed.

(B) Section 1833 (42 U.S.C. 1395l) is amended—

(i) in subsection (l)(5), by striking subparagraph (C); and

(ii) in subsection (r), by striking paragraph (4).

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on October 1, 1995.

SEC. 6139. MEDICARE AS SECONDARY PAYER.

(a) PERMANENT EXTENSION OF DATA MATCH PROGRAM.—

(1) IN GENERAL.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) PERMANENT EXTENSION OF CERTAIN TAXPAYER IDENTITY INFORMATION DISCLOSURE REQUIREMENTS.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) PERMANENT EXTENSION OF MEDICARE SECONDARY PAYER TO DISABLED BENEFICIARIES.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)), is amended—

(1) in the heading, by striking ''SUNSET'' and inserting ''EFFECTIVE DATE''; and

(2) by striking '', and October 1, 1998''.

(c) PERMANENT EXTENSION OF 18-MONTH RULE FOR ESRD BENEFICIARIES.—The second sentence of section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended by striking ''and on or before October 1, 1998,''.

TITLE VII—PATIENT'S RIGHT TO SELF-DETERMINATION REGARDING HEALTH CARE

SEC. 7001. TREATMENT OF ADVANCE DIRECTIVES.

(a) IN GENERAL.—An advance directive that fails to meet the formalities of execution, form, or language required by State law shall be given effect to the extent that the treating health care provider in good faith believes that such directive constitutes a reliable expression of the wishes of the individual executing such directive concerning such individual's health care.

(b) CONSTRUCTION.—Nothing in subsection (a) may be construed to authorize the administration, withholding,

or withdrawal of health care otherwise prohibited by the laws of the State.

SEC. 7002. EFFECT ON OTHER LAWS.

Written policies and written information adopted by health care providers pursuant to sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), shall be modified within 6 months of enactment of this title to conform to the provisions of this title.

SEC. 7003. INFORMATION PROVIDED TO CERTAIN INDIVIDUALS.

The Secretary shall provide on a periodic basis written information regarding an individual's right to consent to, or to decline, medical treatment as provided in this title to individual's who are beneficiaries under titles II, XVI, XVIII, and XIX of the Social Security Act.

SEC. 7004. RECOMMENDATIONS TO THE CONGRESS ON ISSUES RELATING TO A PATIENT'S RIGHT OF SELF-DETERMINATION.

Not later than 180 days after the date of the enactment of this Act the Secretary shall study the implementation of sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) and provide recommendations to the Congress concerning the results of the study and the medical, legal, ethical, social,

and educational issues related to provisions of this title. In developing recommendations under this section the Secretary shall address the following issues:

(1) Issues pertaining to the education of the public regarding their rights to execute advance directives.

(2) Issues pertaining to the education and training of health care professionals concerning patients' self-determination rights.

(3) Issues pertaining to health care professionals' duties with respect to patients' rights, and health care professionals' roles in identifying, assessing, and presenting for patient consideration medically indicated treatment options.

(4) Such other issues as the Secretary may identify.

SEC. 7005. EFFECTIVE DATE.

This title shall take effect on the date that is 6 months after the date of enactment of this Act.

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