I

103D CONGRESS
2D SESSION

H. R. 4202

To increase access to high quality, affordable health insurance.

IN THE HOUSE OF REPRESENTATIVES

APRIL 13, 1994

Mr. MCCRERY (for himself, Mr. TAUZIN, Mr. BAKER of Louisiana, Mr. DELAY, Mr. DOOLITTLE, Mr. HOUGHTON, Mr. INHOFE, Mr. SAM JOHNSON of Texas, Mr. LIVINGSTON, Mr. HAYES, Mr. INGLIS of South Carolina, and Mr. HOKE) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, the Judiciary, and Education and Labor

---

A BILL

To increase access to high quality, affordable health insurance.

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 Savings and Security Act of 1994''.

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

TITLE I—INSURANCE REFORM

Subtitle A—Insurance Provisions

PART 1—REQUIREMENTS FOR TAX-FAVORED HEALTH PLANS

Sec. 101. Requirements for high deductible umbrella insurance plans and managed health care plans 6
Sec. 102. Benefits 9
Sec. 103. Rating practices 13
Sec. 104. Guaranteed issue 14
Sec. 105. Guaranteed renewability 16
Sec. 106. Restrictions on agent compensation and broker activities 17

PART 2—CERTIFICATION OF HIGH DEDUCTIBLE UMBRELLA INSURANCE PLANS AND MANAGED CARE HEALTH PLANS

Sec. 111. Establishment of regulatory program for certification of plans 18
Sec. 112. Standards for regulatory programs 20

Subtitle B—Promoting Development of Voluntary Health Plan Purchasing Cooperatives

Sec. 121. Establishment of standards; application in States 28
Sec. 122. Specification of HPPC areas 32
Sec. 123. Standards for health plan purchasing cooperatives 32
Sec. 124. Functions of health plan purchasing cooperatives 36
Sec. 125. Qualified health carriers 44
Sec. 126. Marketing HPPC plans 50
Sec. 127. Collection and submission of data 51
Sec. 128. Role of State; oversight; evaluation 53
Sec. 129. Definitions 55

Subtitle C—Federal Preemption

Sec. 141. Prohibition of State benefit mandates for group health plans 58
Sec. 142. Prohibition of provisions prohibiting employer groups from purchasing health insurance 59
Sec. 143. Restrictions on managed care 59
Sec. 144. Exemption of state laws preventing denial of lifesaving medical treatment pending transfer to another health care provider 61
Sec. 145. Definitions 62

Subtitle D—Rules of Construction Regarding Abortion Services; Inseverability

Sec. 151. Rules of construction regarding abortion services 64
Sec. 152. Inseverability 65

TITLE II—AMENDMENTS OF INTERNAL REVENUE CODE OF 1986

Subtitle A—Limitations on Employer Deduction for Health Care Coverage for Employees and on Employee Exclusion for Employer-Provided Health Care Coverage

Sec. 201. Employer deduction for health care coverage for employees limited to coverage under high-deductible plans and managed care plans and to contributions to medical savings accounts for employees 66

Sec. 202. Limitation on exclusion for employer-provided coverage under health plan 74
Sec. 203. Health benefits may not be provided under cafeteria plans ... 77
Sec. 204. Effective date 78

Subtitle B—Credits for Contributions to Medical Savings Accounts, for Purchase of Coverage Under Tax-Qualified Health Care Plans, and for Routine Preventive Care

Sec. 211. Credit for contributions to medical savings accounts 79
Sec. 212. Refundable credit for purchase of coverage under tax-qualified health care plans 97
Sec. 213. Credit for cost of routine preventive care 103
Sec. 214. Effective date 105

Subtitle C—Repeal of Medical Expense Deduction

Sec. 221. Repeal of medical expense deduction 105

Subtitle D—Veterans Medical Benefits and Services Unaffected

Sec. 231. Veterans medical benefits and services unaffected 106

TITLE III—SAVINGS IN MEDICARE AND MEDICAID PROGRAMS

Subtitle A—Medicare Program

Sec. 301. Increase in Medicare part B premium for individuals with high income 106
Sec. 302. Imposition of 20 percent coinsurance on clinical laboratory services under Medicare 110
Sec. 303. Annual indexing of part B deductible 110

Subtitle B—Medicaid Program

PART 1—ACHIEVING SAVINGS IN PROGRAM

Sec. 311. Cap on Federal payments made for acute medical services furnished under the Medicaid program 111

PART 2—OPTIONAL ENROLLMENT OF LOW-INCOME INDIVIDUALS UNDER HIGH DEDUCTIBLE UMBRELLA INSURANCE PLANS AND MANAGED HEALTH CARE PLANS

Sec. 321. Optional enrollment under plans 119

PART 3—INCREASING STATE FLEXIBILITY TO USE MANAGED CARE UNDER MEDICAID

Sec. 331. Modification of Federal requirements to allow States more flexibility in contracting for coordinated care services under Medicaid 128

PART 4—LIMITATIONS ON FUNDING OF ABORTION SERVICES UNDER MEDICAID

Sec. 341. Limitations on funding of abortion services under Medicaid 182

TITLE IV—CONTAINING HEALTH CARE COSTS

Subtitle A—Medical Malpractice Liability Reform

PART 1—GENERAL PROVISIONS

Sec. 401. Federal reform of medical malpractice liability actions 183
Sec. 402. Definitions 185
Sec. 403. Effective date 190

PART 2—MEDICAL MALPRACTICE AND PRODUCT LIABILITY REFORM

Sec. 411. Requirement for initial resolution of action through alternative dispute resolution 191
Sec. 412. Calculation and payment of damages 195
Sec. 413. Requiring party contesting ADR ruling to pay attorney's fees and other costs 198
Sec. 414. Joint and several liability for noneconomic damages 201
Sec. 415. Statute of limitations 202
Sec. 416. Uniform standard for determining negligence 202
Sec. 417. Special provision for certain obstetric services 202

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

Sec. 421. Basic requirements 203
Sec. 422. Certification of State systems; applicability of alternative Federal system 206
Sec. 423. Reports on implementation and effectiveness of alternative dispute resolution systems 208

PART 4—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

Sec. 431. Permitting State professional societies to participate in disciplinary activities 209
Sec. 432. Study of incentives to encourage voluntary service by physicians 211
Sec. 433. Requirements for risk management programs 212
Sec. 434. Grants for medical safety promotion 213

Subtitle B—Treatment of Certain Activities Under the Antitrust Laws

Sec. 451. Exemption from antitrust laws for certain competitive and collaborative activities 216
Sec. 452. Safe harbors 218
Sec. 453. Designation of additional safe harbors 222
Sec. 454. Certificates of review 225
Sec. 455. Notifications providing reduction in certain penalties under antitrust law for health care cooperative ventures 237
Sec. 456. Review and reports on safe harbors and certificates of review 246
Sec. 457. Rules, regulations, and guidelines 247
Sec. 458. Establishment of HHS Office of Health Care Competition Policy 249
Sec. 459. Definitions 249

TITLE V—SPECIAL ASSISTANCE FOR FRONTIER, RURAL, AND URBAN UNDERSERVED AREAS

Subtitle A—Frontier, Rural, and Urban Underserved Areas

Sec. 501. Establishment of program to make community-based primary health grants and health service access grants for Federally-qualified health centers 252
Sec. 502. Tax incentives for practice in frontier, rural, and urban underserved areas 276
Sec. 503. Rural emergency access care hospitals 290
Sec. 504. Grants to States regarding aircraft for transporting rural victims of medical emergencies 295
Sec. 505. Demonstration projects to encourage the development and operation of rural health networks 301

Subtitle B—Primary Care Provider Education

Sec. 511. Graduate medical education demonstration projects 311
Sec. 512. Funding under Medicare for training in nonhospital-owned facilities 323
Sec. 513. Increase in National Health Service Corps funding 326
Sec. 514. Increase in health professions funding for primary care physicians 326
Sec. 515. Health professions funding for nurse practitioners and physician assistants programs 327
Sec. 516. State grants to increase the number of primary care providers 330

Subtitle C—Programs Relating to Primary and Preventive Care Services

Sec. 521. Maternal and infant care coordination 331
Sec. 522. Frontier States 335

Subtitle D—Limitation on Funding for Abortions

Sec. 531. Limitation on funding for abortions 335

TITLE VI—ADMINISTRATIVE COST SAVINGS

Subtitle A—Standardization of Claims Processing

Sec. 601. Adoption of data elements, uniform claims, and uniform electronic transmission standards 336
Sec. 602. Application of standards 338
Sec. 603. Periodic review and revision of standards 342
Sec. 604. Health insurance plan defined 343

Subtitle B—Electronic Medical Data Standards

Sec. 611. Medical data standards for hospitals and other providers 343
Sec. 612. Application of electronic data standards to certain hospitals 345
Sec. 613. Electronic transmission to Federal agencies 348
Sec. 614. Limitation on data requirements where standards in effect ... 348
Sec. 615. Advisory commission 350

Subtitle C—Development and Distribution of Comparative Value Information

Sec. 621. State comparative value information programs for health care purchasing 351
Sec. 622. Federal implementation 354
Sec. 623. Comparative value information concerning Federal programs 354

Subtitle D—Preemption of State Quill Pen Laws

Sec. 631. Preemption of State quill pen laws 355

TITLE VII—ANTI-FRAUD AND ANTI-RATIONING

Subtitle A—Criminal Prosecution of Health Care Fraud

Sec. 701. Penalties for health care fraud 356
Sec. 702. Rewards for information leading to prosecution and conviction 357

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

Sec. 711. Application of Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health insurance plan 359

Subtitle C—Protection Against Rationing of Treatment

Sec. 721. Prohibition on denial or treatment based on age, disability, degree of medical need, or quality of life 363
Sec. 722. Enforcement 364

TITLE I—INSURANCE REFORM

Subtitle A—Insurance Provisions

PART 1—REQUIREMENTS FOR TAX-FAVORED HEALTH PLANS

SEC. 101. REQUIREMENTS FOR HIGH DEDUCTIBLE UMBRELLA INSURANCE PLANS AND MANAGED HEALTH CARE PLANS.

(a) IN GENERAL.—For purposes of section 162(o) of the Internal Revenue Code of 1986 and this Act:

(1) HIGH DEDUCTIBLE UMBRELLA INSURANCE PLAN.—A ''high deductible umbrella insurance plan''

is a health insurance plan offered, issued, or renewed on or after January 1, 1996, which is certified by the applicable regulatory authority as meeting, at a minimum, the applicable requirements of sections 102, 103, 104, 105, and 106 with respect to such a plan and providing for the regulatory program described in section 112.

(2) MANAGED HEALTH CARE PLAN.—A ''managed health care plan'' is a health insurance plan offered, issued, or renewed on or after January 1, 1996, which is certified by the applicable regulatory authority as meeting, at a minimum, the applicable requirements of sections 102, 103, 104, 105, and 106 with respect to such a plan and providing for the regulatory program described in section 112.

(3) TAX-QUALIFIED HEALTH CARE PLAN.—The term ''tax-qualified health care plan'' means a high deductible umbrella insurance plan or managed health care plan.

(b) GENERAL DEFINITIONS.—As used in this title:

(1) HEALTH INSURANCE PLAN.—The term ''health insurance plan'' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract and, in States which have dis-

tinct licensure requirements, a multiple employer welfare arrangement, but does not include any (or any combination) of the following offered by an insurer:

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

(B) Coverage issued as a supplement to liability insurance.

(C) Workers' compensation or similar insurance.

(D) Automobile medical-payment insurance.

(2) APPLICABLE REGULATORY AUTHORITY.—The term ''applicable regulatory authority'' means—

(A) in the case of a State with a program described in section 111, the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance; or

(B) if the State has not established such a program or such program has been decertified under section 111(b), the Secretary.

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

(4) STATE.—The term ''State'' means each of the several States of the United 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.

(c) ESTABLISHMENT OR OPERATION OF MANAGED HEALTH CARE PLANS BY STATES.—A State may establish or operate a managed health care plan.

SEC. 102. BENEFITS.

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

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

(2) does not exclude coverage for selected illnesses or selected treatments if consistent with medically accepted practices, and

(3) meets the applicable patient cost-sharing requirements of subsection (c).

(b) ACUTE MEDICAL CARE.—Acute medical care described in this subsection includes—

(1) physician services,

(2) inpatient, outpatient, and emergency hospital services and appropriate alternatives to hospitalization, and

(3) inpatient and outpatient prescription drugs.

(c) COST SHARING REQUIREMENTS.—The requirements of this subsection are as follows:

(1) LIMITATION ON DEDUCTIBLES.—

(A) HIGH DEDUCTIBLE UMBRELLA HEALTH INSURANCE PLAN.—

(i) IN GENERAL.—In the case of a high deductible umbrella insurance plan, the plan shall provide a deductible amount for benefits provided in any plan year which is at least $1,500 (but not to exceed $3,000) for items and services furnished to a family (composed of one or more individuals) enrolled under the plan in a year.

(ii) INDEXING DOLLAR AMOUNTS.—For any calendar year beginning with 1997, the dollar amount specified in clause (i) (as previously increased under this clause) shall be increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending with September of the preceding calendar year. Any dollar amount in-

creased under the previous sentence that is not a multiple of $10, shall be rounded to the next highest multiple of $10.

(B) MANAGED HEALTH CARE PLANS.—In the case of a managed health care plan, the plan may provide a deductible the amount of which does not exceed the amount of the deductible permitted under subparagraph (A).

(2) LIMITATION ON COPAYMENTS AND COINSURANCE.—

(A) IN GENERAL.—A health insurance plan may not require the payment of any copayment or coinsurance for an item or service for which coverage is required under this section after an individual or a family covered under the plan has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit for a plan year.

(B) LIMIT ON OUT-OF-POCKET EXPENSES.—As used in this paragraph—

(i) OUT-OF-POCKET EXPENSES DEFINED.—The term ''out-of-pocket expenses'' means, with respect to an individual or a family in a plan year, amounts payable under the plan as deductibles and

coinsurance with respect to items and services provided under the plan and furnished in the plan year on behalf of the individual or the family covered under the plan.

(ii) OUT-OF-POCKET LIMIT DEFINED.—The term ''out-of-pocket limit'' means for a plan year beginning in—

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

(II) for a subsequent calendar year, the limit specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the limit computed under subclause (II) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

SEC. 103. RATING PRACTICES.

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

(1) a variation in premium rates only—

(A) on the basis of age, sex, geography, and family enrollment,

(B) on the basis of individual and group coverage, and

(C) in the case of group coverage, on the basis of the number of individuals covered within the group;

(2) a charge of the same premium rates to new applicants and existing policyholders with the same age, sex, geographic characteristics, and family enrollment; and

(3) the highest premium for the plan for a particular class of family enrollment and geographic characteristics may not exceed four times the lowest premium for such plan for the same enrollment and geographic characteristics.

(b) INCENTIVE DISCOUNTS.—A plan may discount an individual's premium rate by not more than 10 percent as an incentive for participating in a program, approved by the applicable regulatory authority to be offered in con-

junction with the coverage, which has as its objective, 1 or more of the following:

(1) To promote healthy behavior.

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

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

(c) CLASSES OF FAMILY ENROLLMENT DESCRIBED.—In this section, each of the following shall be considered a separate ''class of family enrollment'':

(1) Single individual without children.

(2) Married couple without children.

(3) Single individual with 1 or more children.

(4) Married couple with 1 or more children.

(d) TREATMENT OF HPPCS.—For purposes of subsection (a), any coverage obtained through a health plan purchasing cooperative approved under subtitle B shall be treated as a form of group coverage.

SEC. 104. GUARANTEED ISSUE.

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

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

(2) does not exclude from coverage, or limit coverage for, any preexisting condition except as provided in subsection (b).

(b) TREATMENT OF PREEXISTING CONDITIONS.—

(1) NO EXCLUSION FOR PREEXISTING CONDITION FOR APPLICANTS CONTINUOUSLY COVERED.—A health insurance plan may not exclude from coverage, or limit coverage for, any preexisting condition for any applicant who, on the date the application is made, has been continuously insured for a period of at least 6 months prior to the date of the application under 1 or more of the following health insurance plans or programs:

(A) A high deductible umbrella insurance plan or a managed health care plan.

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

(C) An individual health insurance plan in effect before such date.

(D) A program described in—

(i) title XVIII or XIX of the Social Security Act,

(ii) chapter 55 of title 10, United States Code,

(iii) chapter 17 of title 38, United States Code,

(iv) chapter 89 of title 5, United States Code, or

(v) the Indian Health Care Improvement Act.

(2) LIMITATION ON PERIOD OF EXCLUSION FOR OTHER APPLICANTS.—In the case of an applicant not described in paragraph (1), the health insurance plan may exclude from coverage, or limit coverage for, any preexisting condition for a period no greater than the lesser of—

(A) the number of months immediately prior to the date of the application during which the individual was not insured since the illness or condition in question was first diagnosed, or

(B) 6 months.

(c) PREEXISTING CONDITION.—For purposes of this section, the term ''preexisting condition'' means, with respect to coverage under a health insurance plan, a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

SEC. 105. GUARANTEED RENEWABILITY.

The requirements of this section are met, if the health insurance plan provides the policyholder with a con-

tractual right to renew the coverage which stipulates that the insurer cannot cancel or refuse to renew the coverage except for cases of—

(1) nonpayment of premiums by the policyholder, or

(2) fraud or misrepresentation by the policyholder.

SEC. 106. RESTRICTIONS ON AGENT COMPENSATION AND BROKER ACTIVITIES.

The requirements of this section are not met if—

(1) the health insurance plan varies compensation or commissions to an agent, broker, contractor, or producer based, directly or indirectly, on the anticipated or actual claims experience or health status associated with particular small employers or eligible individuals to which each plan is sold, or

(2) the health insurance plan (or agent, broker, contractor, or producer for a health insurance plan) engages, directly, or indirectly, in any activity or marketing practice that would encourage small employers or eligible individuals to refrain from enrolling in the plan, or seek coverage from another health insurance plan, because of the health status or claims experience of the employer or individual.

PART 2—CERTIFICATION OF HIGH DEDUCTIBLE UMBRELLA INSURANCE PLANS AND MANAGED CARE HEALTH PLANS

SEC. 111. ESTABLISHMENT OF REGULATORY PROGRAM FOR CERTIFICATION OF PLANS.

(a) ENFORCEMENT OF PROGRAM THROUGH STATES.—

(1) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in paragraph (2), a report on steps the State is taking to implement and enforce the regulatory program developed under section 112 with respect to high deductible umbrella insurance plans and managed care health plans offered not later than such deadline.

(2) DEADLINE FOR REPORT.—

(A) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to subparagraph (B), the deadline under this paragraph is 1 year after the date the regulatory program is developed under section 112.

(B) EXCEPTION FOR LEGISLATION.—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 high deductible umbrella insur-

ance plans and managed care health plans to meet the requirements of the program developed under section 112, but

(ii) having a legislature which is not scheduled to meet in 1996 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, 1996. 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.

(b) FEDERAL ROLE.—

(1) FAILURE OF STATE TO ENFORCE PROGRAM.—If the Secretary determines that a State has failed to submit a report by the deadline specified under subsection (a) or finds that the State has not implemented and provided adequate enforcement of the regulatory program developed under section 112, the Secretary shall notify the State and provide the

State a period of 60 days in which to submit such report or to implement and enforce such program.

(2) PROCEDURES FOR FEDERAL ENFORCEMENT.—If, after the 60-day period referred to in paragraph (1), the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such program in the State as the Secretary determines to be appropriate. Such implementation and enforcement shall take effect with respect to high deductible umbrella insurance plans and managed care health plans offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected.

SEC. 112. STANDARDS FOR REGULATORY PROGRAMS.

(a) IN GENERAL.—The Secretary, in consultation with the National Association of Insurance Commissioners (in this section referred to as ''NAIC'') shall develop by not later than 1 year after the date of the enactment of this Act, in the form of model Acts and model regulations, State regulatory program standards which include—

(1) procedures for certifying that the requirements of part 1 of this subtitle have been met by a

health insurance plan applying for certification as a high deductible umbrella insurance plan or a managed care health plan,

(2) the requirements described in subsections (b) and (c) with respect to such a plan,

(3) requirements with respect to solvency standards and guaranty funds for carriers of such plans, and

(4) reporting requirements under which carriers report to the Internal Revenue Service regarding the acquisition and termination by individuals of coverage under such plans.

(b) MARKETING PRACTICES.—The requirements of this subsection are met, if the carrier offering the plan retains the right to select agents with whom such plan contracts and to determine the amount and form of compensation to such agents, except that—

(1) if the carrier chooses to contract with an agent, the carrier may not terminate or refuse to renew the agency contract for any reason related to the age, sex, health status, claims experience, occupation, or geographic location of the insureds placed by the agent with such plan, and

(2) the carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement

with an agent that provides for, or results in, any consideration provided to such agent for the issuance or renewal of such a plan to vary on account of the age, sex, health status, claims experience, occupation, or geographic location of the insureds placed by the agent with such plan.

(c) REINSURANCE OR ALLOCATION OF RISK MECHANISMS.—

(1) ESTABLISHMENT OF STANDARDS.—

(A) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, models for reinsurance or allocation of risk mechanisms (each in this section referred to as a ''reinsurance or allocation of risk mechanism'') for high deductible umbrella insurance plans and managed care health plans made available to individuals for whom an insurer is at risk of incurring high costs under the plan. If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for an effective reinsurance or allocation of risk mechanism. Such review shall be completed within 30 days after the date the models are developed. Unless the

Secretary determines within such period that such a model is not an effective reinsurance or allocation of risk mechanism, such remaining models shall serve as the models under this subsection, with such amendments as the Secretary deems necessary.

(B) CONTINGENCY.—If the NAIC does not develop such models within such period or the Secretary determines that all such models do not provide for an effective reinsurance or allocation of risk mechanism, the Secretary shall specify, within 15 months after the date of the enactment of this Act, models to carry out this subsection.

(2) IMPLEMENTATION OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS.—

(A) BY STATES.—Each State shall establish and maintain one or more reinsurance or allocation of risk mechanisms that are consistent with a model established under paragraph (1) by not later than the deadline specified in section 111(a)(2). A State may establish and maintain such a mechanism jointly with one or more other States.

(B) FEDERAL ROLE.—

(i) IN GENERAL.—If the Secretary determines that a State has failed to establish or maintain a reinsurance or allocation of risk mechanism in accordance with subparagraph (A), the Secretary shall establish and maintain such a reinsurance or allocation of risk mechanism meeting the requirements of this subparagraph.

(ii) REINSURANCE MECHANISM.—Unless the Secretary determines under clause (iii) that an allocation of risk mechanism is the appropriate mechanism to use in a State under this subparagraph, the Secretary shall establish and maintain for use under this subsection for each State an appropriate reinsurance mechanism.

(iii) ALLOCATION OF RISK MECHANISM.—If the Secretary determines that, due to the nature of the health coverage market in the State (including a relatively small number of high deductible umbrella insurance plans or managed care health plans offered or a relatively small number of uninsurable individuals), an allocation of risk mechanism would be a better mecha-

nism than a reinsurance mechanism, the Secretary shall establish and maintain for use under this section for a State an allocation of risk mechanism under which uninsurable individuals would be equitably assigned among insurers offering high deductible umbrella insurance plans or managed care health plans.

(iv) FINANCING DEFICIT FOR REINSURANCE MECHANISMS.—

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

"SEC. 4980D. ADDITIONAL TAX TO FUND REINSURANCE IN STATES UNDER FEDERAL REINSURANCE.

''(a) IMPOSITION OF TAX.—There is hereby imposed a tax on the providing of any high deductible umbrella insurance plan or managed care health plan which covers any individual in a Federal reinsurance State.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The tax imposed by subsection (a) shall be equal to the applicable percent-

age of the amount received by the insurer for providing such plan in such Federal reinsurance State.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means, with respect to any State for any period, the lowest percentage estimated by the Secretary as generating sufficient revenues to carry out section 112(c)(2)(B) of the Health Savings and Security Act of 1994 in such State for such period.

''(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the insurer.

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

''(1) HIGH DEDUCTIBLE INSURANCE PLAN; MANAGED CARE HEALTH PLAN.—The terms 'high deductible insurance plan' and 'managed care health plan' have the meaning given such terms in section 101(a) of the Health Savings and Security Act of 1994.

''(2) FEDERAL REINSURANCE STATE.—The term 'Federal reinsurance State' means any State with respect to which a determination is in effect under section 112(c)(2)(B) of the Health Savings and Security Act of 1994 and for which the Secretary of Health and Human Services has estab-

lished and is maintaining a reinsurance mechanism under clause (ii) of such section for the State.

''(3) INSURER.—The term 'insurer' means a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization offering such a plan, and includes a similar organization regulated under State law for solvency.''

(II) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end thereof the following new item:

''Sec. 4980D. Additional tax to fund reinsurance in States under Federal reinsurance.''

(3) CONSTRUCTION.—Nothing in this section shall be construed to prohibit reinsurance or allocation of risk arrangements relating to high deductible umbrella insurance plans or managed care health plans, whether on a State or multi-state basis, not required under this subsection.

Subtitle B—Promoting Development of Voluntary Health Plan Purchasing Cooperatives

SEC. 121. ESTABLISHMENT OF STANDARDS; APPLICATION IN STATES.

(a) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the National Association of Insurance Commissioners, shall establish standards under this subtitle to carry out the requirements of this subtitle, including standards relating to—

(A) the establishment of health plan purchasing cooperatives (or HPPCs),

(B) qualifications for qualified health carriers, and

(C) the roles of States under this subtitle.

(2) DEADLINE.—The Secretary shall establish and publish the standards by not later than 6 months after the date of the enactment of this Act.

(3) REVISION.—The Secretary from time to time may revise standards established under this subsection. The revisions shall only become effective in a manner that permits States sufficient time to

change laws and regulations in order to implement the revisions.

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) APPLICATION OF STANDARDS.—

(A) IN GENERAL.—Subject to subsection (c), each State shall submit to the Secretary, by the deadline specified in subparagraph (B), a report on steps the State is taking to implement the standards established under subsection (a) in order to permit HPPCs to be established and operate in all parts of the State, and to conform its insurance laws to meet the requirements of this subtitle, not later than that deadline.

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date the standards are established under subsection (a).

(ii) EXCEPTION FOR LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the National

Association of Insurance Commissioners, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for carriers and health plans offered to meet the standards established under subsection (a), 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 subparagraph 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, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature.

(2) FEDERAL ROLE.—

(A) NOTICE TO STATES.—If the Secretary determines that a State has failed to submit a report by the deadline specified under para-

graph (1) or finds that the State has not taken sufficient steps to permit establishment and operation of HPPCs in accordance with the standards established under subsection (a), the Secretary shall notify the State and provide the State a period of 60 days in which to submit the report or to implement the standards under paragraph (1).

(B) FEDERAL FALL-BACK PARTICIPATION.—If, after the 60-day period, the Secretary finds that the failure has not been corrected, the Secretary shall provide for such mechanism as will—

(i) permit the establishment and operation of HPPCs in accordance with the standards established under subsection (a) in the State as the Secretary determines to be appropriate, and

(ii) provide for the Secretary assuming the role of the State otherwise provided under this subtitle.

(C) DURATION.—The Secretary's exercise of authority under subparagraph (B) shall take effect with respect to carriers, and health plans offered or renewed, on or after 3 months after

the date of the Secretary's finding under that subparagraph and until the date the Secretary finds that the failure of the State has been corrected.

(c) IMPLEMENTATION.—The report under subsection (b) shall specify the State official (or officials), or State board, commission, or department, responsible for carrying out the standards under subsection (a).

SEC. 122. SPECIFICATION OF HPPC AREAS.

(a) IN GENERAL.—Each State shall establish boundaries for HPPC areas in the State.

(b) STANDARDS.—Each part of the State shall be in one, and only one, HPPC area. Each HPPC area shall include a sufficient number of potential enrollees, health care providers, and qualified health carriers to carry out the purposes of this subtitle. A HPPC area may include portions of more than one State.

(c) REVISIONS.—A State may revise the boundaries of HPPC areas not more frequently than annually.

SEC. 123. STANDARDS FOR HEALTH PLAN PURCHASING CO-OPERATIVES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—One or more State-chartered, nonprofit private corporations may be established in accordance with this section to serve as a

HPPC for each HPPC area specified under section 122 for the benefit of small employers and eligible individuals in the area. A carrier may not form, underwrite, or possess a majority vote of a HPPC, but may administer a HPPC.

(2) RULES OF CONSTRUCTION.—

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

(i) that a HPPC be established in each HPPC area; and

(ii) that there be only one HPPC established with respect to any HPPC area.

(B) SINGLE ORGANIZATION SERVING MULTIPLE AREAS.—Nothing in this section shall be construed as preventing a single not-for-profit corporation from being a HPPC for more than one HPPC area.

(b) BYLAWS AND BOARD OF DIRECTORS.—

(1) BYLAWS.—Each HPPC shall establish bylaws, consistent with this section, for its operation, including the election of members of its board of directors.

(2) BOARD OF DIRECTORS.—

(A) IN GENERAL.—Each HPPC shall operate under the supervision of a board of directors established under the bylaws of the HPPC. A majority of the members of the board shall be small employers or eligible individuals, or representatives thereof, that participate in the HPPC.

(B) APPOINTMENT AND ELECTION.—After the initial appointment of members to the board of directors of a HPPC (in accordance with the articles of incorporation of the HPPC), the board shall be elected by small employer members and individual members of the HPPC in accordance with bylaws of the HPPC. The elections shall occur not less frequently than once every 2 years. The standards may provide, at the option of a State, for different voting rights for members that are small employers to reflect the number of individuals receiving coverage through those employers.

(3) LIMITATION ON LIABILITY.—There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member of the board of directors of a HPPC, or its employees or agent, for any action taken in good faith by them in

the performance of duties of HPPCs specified in this subtitle.

(c) OFFICERS AND EMPLOYEES.—Each HPPC shall provide, consistent with its bylaws, for—

(1) the appointment of officers from among its members, and

(2) the appointment of an executive director to serve as the chief operating officer of the HPPC.

(d) ADVISORY COMMITTEES.—Each HPPC shall establish such advisory committees as may be necessary to assist in carrying out its duties under this subtitle. An advisory committee may include representation from qualified health carriers, agents, and health care providers.

(e) ANNUAL REPORT; RECORDS; AUDIT.—Each HPPC shall—

(1) prepare, and submit to the State and the Secretary, an annual report on its operations, including its program and financial operations;

(2) conduct such annual internal and independent audits as it determines to be appropriate; and

(3) maintain records on its operations.

(f) GENERAL AUTHORITIES; LIMITATIONS ON AUTHORITY.—

(1) IN GENERAL.—A HPPC may—

(A) sue (or be sued), and

(B) subject to paragraph (2), accept and expend grants or funds from any public or private agency.

(2) LIMITATIONS.—A HPPC may not—

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

(B) assume financial risk for the cost or provision of health care services;

(C) contract directly with health care providers (other than with qualified health carriers under section 124) for the provision of health care services for members; or

(D) accept any funds from any private agency that is (or is affiliated with) a qualified health carrier or other party that would pose a conflict of interest (as specified by the Secretary).

SEC. 124. FUNCTIONS OF HEALTH PLAN PURCHASING CO-OPERATIVES.

(a) CONTRACTS WITH QUALIFIED HEALTH CARRIERS; ENROLLMENT IN PLANS.—

(1) CONTRACTS WITH PLANS.—Each HPPC shall enter into contracts and hold policies with

qualified health carriers which elect to offer HPPC plans to members, in accordance with subsection (d).

(2) ENROLLMENT.—

(A) IN GENERAL.—Each HPPC shall provide for the enrollment of eligible employees of small employers and eligible individuals in HPPC plans of qualified health carriers offered by the HPPC.

(B) OPEN ENROLLMENT PERIODS.—Each HPPC shall provide for an annual open enrollment period of 30 days to be available within 60 days before the anniversary date of each member's coverage under a HPPC plan.

(3) PROVISION OF INFORMATION.—Each HPPC shall provide to its members and eligible employees of small employer members comparison sheets, in accordance with standards established by the Secretary, which provide clear standardized information on each qualified health carrier and each HPPC plan offered by a qualified health carrier, including information on price, consumer satisfaction, and (if feasible) health outcomes and enrollment and enrollee responsibilities and obligations.

(b) MEMBERSHIP REQUIREMENTS.—

(1) IN GENERAL.—Each HPPC shall establish requirements for participation of small employers and eligible individuals as members of the HPPC consistent with any standards the Secretary establishes consistent with this subsection. Each HPPC shall maintain eligibility records to carry out its functions.

(2) SMALL EMPLOYER STANDARDS.—Under those standards—

(A) each small employer in the area that meets requirements for membership is permitted to become a member;

(B) a small employer that is not a valid small employer group and was formed for the purpose of securing health benefits coverage shall be denied membership;

(C) each small employer member shall offer to eligible employees a choice of at least 2 different HPPC plans, of which—

(i) at least one is a high deductible umbrella insurance plan, and

(ii) at least one is a managed care health plan;

(D) no small employer is required, as a condition of membership, to make any contribu-

tion towards the premium for coverage of any eligible employee; and

(E) if a small employer member terminates coverage purchased through the HPPC, the former member shall be ineligible to purchase a HPPC plan through the HPPC for a period of 12 months.

(3) INDIVIDUAL MEMBERS.—Under those standards, eligible individuals residing in a HPPC area may become individual members of the HPPC for the area. Nothing in this subtitle shall be construed as requiring as a condition of membership for a HPPC serving a HPPC area that individual be residing in the area.

(4) PAYMENT OF PREMIUMS.—

(A) IN GENERAL.—A HPPC may condition membership upon prepayment of a monthly premium (or compliance with other mechanisms) to assure that payment will be made for coverage of members on a timely basis.

(B) NOTIFICATION OF FAILURE TO RECEIVE PREMIUM.—If a HPPC fails to receive payment on a premium due with respect to an individual covered under a qualified health carrier offered by the HPPC, the HPPC shall pro-

vide notice of the failure to the individual within the 20-day period after the date on which the premium payment was due.

(C) DIRECT PAYMENT ALLOWED IN CASE OF EMPLOYER NONPAYMENT.—In the case a small employer member of a HPPC fails to make payment of premiums due with respect to an eligible employee covered under a qualified health carrier offered through the HPPC, the HPPC shall notify the employee of the nonpayment and shall allow the employee to make direct payments to the HPPC effective with the next succeeding payment period.

(5) DISPUTE RESOLUTION PROCEDURES.—Each HPPC shall establish, in accordance with standards established under this subtitle dispute resolution procedures to resolve disputes between the HPPC and its members and disputes between the HPPC and qualified health carriers. Under those procedures, a member or HPPC may appeal the proposed resolution of a dispute to the State.

(c) CONTRACTS WITH MEMBERS.—

(1) PREMIUM PAYMENTS.—

(A) IN GENERAL.—Each contract between a member and a HPPC shall provide that pay-

ment of all premiums shall be transmitted by the member (which in the case of a small employer member shall be on behalf of eligible employees) to (or on behalf of) the HPPC for the benefit of the qualified health carrier in which the eligible employee or individual is enrolled. The HPPC shall provide for procedures for the collection of premiums from members (including, in the case of a small employer member, eligible employees).

(B) AT LEAST BIMONTHLY.—The premiums are payable not less often than bimonthly.

(C) LATE CHARGES.—A HPPC may provide for penalties for late payment.

(D) NONPAYMENT.—Nonpayment of premiums by a member shall constitute a breach of the contract, a breach of the health care policy, and a default on the member's obligation.

(2) CONTRACT HOLDER.—The contract shall provide that—

(A) the HPPC may be the contract holder of the health benefit policy on behalf of the member (including eligible employees), and

(B) all eligible employees who obtain coverage under the HPPC plan offered by a small employer must obtain the coverage through any HPPC plan offered by a qualified health carrier through the HPPC.

(3) PREMIUM AMOUNTS.—The amount of premiums imposed shall include an amount that includes the fixed overhead allowance percentage established by the HPPC under subsection (e).

(d) CONTRACTS WITH PLANS.—

(1) IN GENERAL.—Each contract between a qualified health carrier and a HPPC shall provide—

(A) that premiums of members shall be forwarded to the plan in which they are enrolled, subject to any adjustment under section 128, on the effective date of coverage (if that occurs more than once a month), on a monthly basis, or as agreed in the contract (but in no event less frequently than monthly); and

(B) that the HPPC shall transmit enrollment and eligibility information to the plan on a timely basis.

(2) TERMINATION.—A qualified health carrier may not terminate the contract unless the plan—

(A) provides advance notice to the HPPC, and

(B) provides notice at least 180 days before the nonrenewal of any HPPC plan to enrollees.

In the case of a contract termination, the qualified health carrier shall not write new business with the HPPC for a period of 3 years from the date of the notice of termination.

(e) OVERHEAD ALLOWANCE.—Each HPPC shall establish a fixed overhead allowance percentage that shall be—

(1) applied as addition to the premiums charged for enrollment in a qualified health carrier offered through the HPPC to its members, and

(2) used to cover administrative costs of the HPPC, as well as defaults by members of premium payments.

(f) UNIFORM ADMINISTRATIVE AND ACCOUNTING PROCEDURES.—Each HPPC shall establish such uniform administrative and accounting procedures as are needed to conform with applicable national standards identified by the Secretary.

(g) CONTRACTS FOR ADMINISTRATIVE SERVICES.—

(1) IN GENERAL.—Each HPPC shall contract with a qualified, independent third party for any service necessary to carry out its duties under this subtitle. The contracts shall include—

(A) contracts with agents to assist in contracting with qualified health carriers and small employer members, and

(B) contracts to market and publicize the availability of HPPC plans through the HPPC.

(2) INFORMATION.—Unless permission is specifically granted by the HPPC, a third party may not release, publish, or otherwise use any information to which the party has access under its contract.

(g) CONSTRUCTION.—Nothing in this subtitle shall be construed as requiring a small employer or eligible individual to obtain coverage from or through a HPPC.

SEC. 125. QUALIFIED HEALTH CARRIERS.

(a) DESIGNATION.—Each State shall establish a process whereby a carrier that demonstrates to the satisfaction of the State insurance commissioner that it has the capability to fulfill the following requirements (directly or through subcontracts) is designated as a qualified health carrier for purposes of this subtitle:

(1) LICENSURE.—The carrier is licensed and in good standing with the State insurance commissioner (or other comparable official for a State).

(2) ADMINISTRATIVE CAPACITY.—The carrier has the capacity to administer HPPC plans.

(3) ACCESS.—In the case of a carrier with a contractual obligation to provide or arrange for health services included in a HPPC plan, the ability to provide enrollees with adequate access to these covered services within the carrier's service area.

(4) GRIEVANCE PROCEDURES.—The carrier has grievance procedures, including the ability to respond to enrollees' calls, questions, and complaints.

(5) UTILIZATION MANAGEMENT PROCEDURES.—The carrier has established utilization management procedures.

(6) QUALITY.—The carrier has the ability to monitor and evaluate the quality and cost-effectiveness of care.

(7) INFORMATION.—The carrier has the ability to provide information on enrollee satisfaction (based on standard surveys described in section 127(b)(4)).

(8) DATA.—The carrier has the ability to provide standard data elements (identified under section 127(b)).

(b) FUNCTIONS OF QUALIFIED HEALTH CARRIERS.—

(1) IN GENERAL.—In every HPPC with which it has a contract under section 124(d), each qualified health carrier shall provide for activities described in this subsection.

(2) OFFERING PLAN.—Each qualified health carrier shall offer HPPC plans. If a qualified health carrier offers a high deductible umbrella insurance plan or a managed health care plan in a State (or geographic area) to employers that are not small employers, the carrier shall offer, as a HPPC plan, a similar high deductible umbrella insurance plan or managed health care plan in that State or geographic area.

(3) PERFORMANCE INFORMATION.—Each qualified health carrier shall provide for the collection and reporting to the State and to the appropriate HPPC of information on the performance of the plan regarding the effectiveness in providing services, consistent with section 127(b).

(4) COMPLIANCE WITH REQUIREMENTS.—Each qualified health carrier shall—

(A) meet the requirements of part 1 of subtitle A (relating to benefits, rating practices, guaranteed issue, guaranteed renewability, and restrictions on agent compensation and broker activities) with respect to HPPC plans it offers; and

(B) file on a quarterly basis with the HPPC in which it is participating the premium rates for HPPC plans offered by the carrier.

(5) NOTICE OF TERMINATION OF HPPC CONTRACT.—Each qualified health carrier may only terminate its contract with the HPPC in accordance with section 124(d)(2).

(6) GRIEVANCE PROCEDURES.—Each qualified health carrier shall provide a procedure for addressing grievances that arise between the carrier and the HPPC or members of the HPPC (and, in the case of small employer members, their eligible employees) that requires both parties to fully exhaust the remedies provided under the procedure to resolve grievance before seeking any relief other than as provided in the procedure.

(7) USE OF UNIFORM CLAIMS FORMS.—Each qualified health carrier shall use standardized forms, including uniform claims forms, identified by the Secretary with respect to HPPC plans.

(c) COVERAGE.—

(1) IN GENERAL.—Coverage under a HPPC plan offered by a qualified health carrier shall be available to any member of the HPPC at the anniversary date of each member's coverage under a HPPC plan (or in the case of an employer or individual who has applied to become a member of a HPPC when the member first joins the HPPC).

(2) EXCEPTION.—A qualified health carrier is not required to offer coverage or accept enrollment if—

(A) the eligible individual or employee does not reside within the plan's service area (as approved by the State insurance commissioner);

(B) the plan provides 90 days prior notice that it will not have the capacity to deliver services adequately in the HPPC area to additional enrollees because of its obligations to existing groups and enrollees; or

(C) the State insurance commissioner determines that the acceptance of an application

or applications would place the plan in a financially impaired condition.

(3) CONDITIONS.—

(A) INSUFFICIENT CAPACITY.—A qualified health carrier that cannot offer coverage under paragraph (2)(B) may not offer coverage to the employees of a new employer group until the later of 90 days following that refusal or the date on which the plan notifies the HPPC and the State insurance commissioner that it has regained capacity to deliver services to eligible individuals in the service area.

(B) FINANCIAL IMPAIRMENT.—A qualified health carrier that cannot offer coverage under paragraph (2)(C) may not offer coverage or accept applications for any individual or employer group until a determination by the State insurance commissioner that acceptance of an application will not put the plan in a financially impaired condition.

(d) DEEMED COMPLIANCE.—Carriers which comply with any of the requirements of a paragraph of subsection (a) through a requirement of State law shall be deemed to be in compliance with the corresponding paragraph of that subsection. Carriers receiving accreditation by nation-

ally recognized, health related accreditation organizations (including the National Committee on Quality Assurance, the Utilization Review Accreditation Commission, the Joint Commission on Accreditation of Health Care Organizations), or qualification by Federal agencies, shall be deemed in compliance with the requirements of subsection (a) as they pertain to the relevant accreditation activities of the organizations.

(e) DETERMINATIONS.—Each State shall provide for a determination of whether a carrier is a qualified health carrier within 30 days of a completed application being submitted to the State.

(f) TERMINATION.—After notice and hearing, a State may suspend or revoke the designation as a qualified health carrier of a carrier that fails to maintain compliance with the requirements in subsections (a), (b), and (c).

SEC. 126. MARKETING HPPC PLANS.

(a) IN GENERAL.—Each HPPC shall use efficient and standardized means to notify small employers of the availability of HPPC plans through the HPPC.

(b) MARKETING MATERIALS.—Each HPPC shall make available to small employer and individual members marketing materials that accurately summarize the HPPC

plans, cost, and other relevant information concerning qualified health carriers offered by the HPPC.

(c) USE OF BROKERS.—Nothing in this subtitle shall be construed to prohibit a HPPC or qualified health carrier from using the services of an agent, broker, contractor, or producer in order to assist in marketing.

(d) MONITORING.—Each HPPC shall notify the State insurance commissioner (or other official identified by the State) of any marketing practices or materials that it finds contrary to the fair and affirmative marketing of qualified health carriers and HPPC plans under this subtitle.

(e) STATE ROLE.—Each State insurance commissioner shall monitor compliance with the marketing requirements of this subtitle and subtitle A, including the conduct of agents, brokers, contractors, and producers and investigate complaints of violations of those requirements.

SEC. 127. COLLECTION AND SUBMISSION OF DATA.

(a) FROM HPPCS TO STATES.—Each HPPC shall submit such data to the State, on a quarterly basis, as the Secretary may specify. The data shall include the following:

(1) With respect to small employer members—

(A) employer enrollment by employer size, industry sector, previous insurance status, and

number of eligible employees within each small employer, and

(B) number of total eligible employers in the HPPC area.

(2) With respect to eligible individuals, the demographic characteristics of those individuals, including age, gender, employment status and employment sector, and previous insurance status.

(3) Premium ranges for each HPPC plan for HPPC member categories.

(4) HPPC overhead charges.

(5) HPPC financial statements.

(b) COLLECTION OF DATA BY HPPCS.—

(1) IN GENERAL.—The Secretary shall establish uniform standards for data that a HPPC collects from qualified health carriers and providers and disseminates.

(2) COLLECTION.—Under the standards, each HPPC shall collect only such data as are necessary for evaluation of the performance of qualified health carriers (and any provider networks used by those carriers) by consumers and providers. The Secretary shall establish the standards consistent with the method of operation of qualified health carriers, with national health care data collection initiatives, and

with not imposing an unreasonable cost of compliance on qualified health carriers. The Secretary shall establish the standards only after a study of the feasibility and cost-effectiveness.

(3) DISSEMINATION.—Under the standards, each HPPC shall release the data collected in a uniform and standardized format which compares all qualified health carriers or providers (as the case may be).

(4) ENROLLEE SATISFACTION SURVEYS.—All enrollee satisfaction surveys used by qualified health carriers in reporting to HPPCs shall be in a standardized format promulgated by the Secretary.

SEC. 128. ROLE OF STATE; OVERSIGHT; EVALUATION.

(a) OVERSIGHT.—Each State shall—

(1) assure compliance of HPPCs, small employers, and eligible employees and individuals with the requirements of this subtitle; and

(2) conduct reviews, not less frequently than annually, on the performance of each HPPC in assuring access to health coverage to small employers and eligible individuals in the HPPC area in accordance with this subtitle.

(b) DISPUTE RESOLUTION.—Each State shall receive, review, and act on appeals of disputes, between a

HPPC and a member, not resolved by the HPPC under section 124(b)(5).

(c) ANALYSIS OF INFORMATION.—Each State shall analyze information collected from qualified health carriers and other sources and report findings that assist consumers, HPPCs, qualified health carriers, or health care providers in improving the delivery or purchase of cost-effective health care.

(d) DISSEMINATION OF INFORMATION.—Each State shall prepare and make available to HPPCs and employers located in the State (and to eligible individuals upon request) information, in comparative form, concerning the HPPC plans in the State and HPPCs operating in the State. The information shall include a description of the following:

(1) The HPPCs in the State and HPPC plans of qualified health carriers available with respect to each HPPC.

(2) The existence of HPPCs within each HPPC area.

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

(e) ANNUAL REPORT.—Each State shall report to the Secretary, at a frequency (not more often than annually) specified by the Secretary, on the impact of the reforms

under this subtitle in expanding the availability and affordability of health coverage to eligible employees and eligible individuals.

(f) ANTITRUST PROTECTION.—Each State shall actively supervise HPPCs to ensure that actions that affect market competition accomplish the objectives of this subtitle, so as to provide State and Federal protection to HPPCs and the board of directors of HPPCs against Federal and State laws intended to protect commerce from unlawful restraints, monopolies, and unfair business practices.

(g) NON-PREEMPTION.—Nothing in this subtitle shall be construed as preempting a State from taking any actions that are in addition to, and not directly inconsistent with, the provisions of this subtitle.

SEC. 129. DEFINITIONS.

In this subtitle:

(1) CARRIER.—The term ''carrier'' means a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization offering a health benefit plan, and includes a similar organization regulated under State law for solvency.

(2) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, an

employee who normally performs on a monthly basis at least 30 hours of service per week for that employer.

(3) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means an individual residing in the United States who is a citizen or national of the United States or an alien lawfully residing permanently in the United States.

(4) EMPLOYER.—The term ''employer'' has the meaning given that term in section 3(5) of the Employee Retirement Income Security Act of 1974.

(5) HEALTH PLAN PURCHASING COOPERATIVE; HPPC.—The terms ''health plan purchasing cooperative'' and ''HPPC'' mean a State-chartered, nonprofit organization that—

(A) provides health coverage purchasing services to members in a HPPC area regarding HPPC plans offered by qualified health carriers, and

(B) is established in accordance with section 123.

(6) HPPC AREA.—The term ''HPPC area'' means an area designated under section 123.

(7) HPPC PLAN.—The term ''HPPC plan'' means, with respect to a HPPC, a high deductible

umbrella insurance plan or managed health care plan, as defined in section 101, offered by the HPPC that is marketed in accordance with section 126 and submits data in accordance with section 127.

(8) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' includes, as determined under standards established by the Secretary, a health insurance plan that meets specified standards and that offers to provide health services on a prepaid, at-risk basis primarily through a defined set of providers.

(9) MEMBER.—The term ''member'' means, with respect to a HPPC, a small employer or eligible individual that meets membership requirements for the HPPC under section 124(b).

(10) QUALIFIED HEALTH CARRIER.—The term ''qualified health carrier'' means a carrier designated under section 125(a) by a State insurance commissioner.

(11) SERVICE AREA.—The term ''service area'' means a geographic region in which a carrier is licensed to operate.

(12) SMALL EMPLOYER.—The term ''small employer'' means, with respect to a calendar year, an

employer that normally employs more than 1 but less than 501 eligible employees on a typical business day in any 3-consecutive-month-period in the year. For the purposes of this paragraph, the term ''employee'' includes a self-employed individual. For purposes of determining if an employer is a small employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

(13) SMALL EMPLOYER MEMBER.—The term ''small employer member'' means, with respect to a HPPC, a small employer that is a member of the HPPC.

(14) STATE INSURANCE COMMISSIONER.—The term ''State insurance commissioner'' includes a State superintendent of insurance and includes, with respect to a health maintenance organization or other carrier not regulated by that official, the State official who is responsible for regulation of the organization or carrier.

Subtitle C—Federal Preemption

SEC. 141. PROHIBITION OF STATE BENEFIT MANDATES FOR GROUP HEALTH PLANS.

In the case of a group health plan, no provision of State or local law shall apply that requires the coverage

of one or more specific benefits, services, or categories of health care, or services of any class or type of provider of health care.

SEC. 142. PROHIBITION OF PROVISIONS PROHIBITING EMPLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.

No provision of State or local law shall apply that prohibits 2 or more employers from obtaining coverage under an insured multiple employer health plan.

SEC. 143. RESTRICTIONS ON MANAGED CARE.

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

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a group health plan to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a group health plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

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

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

(B) requires that such review be made (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being reviewed,

(C) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews,

(D) requires payments to providers for the expenses of responding to utilization review requests, or

(E) imposes liability for delays in performing such review.

Nothing in subparagraph (B) shall be construed as prohibiting a State from (i) requiring a licensed physician or other health care professional be available at some time in the review or appeal process, or (ii)

requiring that any decision in an appeal from such a review be made by a licensed physician.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effectiveness of the use of managed care in the delivery of health services.

(2) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations (including whether the provisions of subsection (a) should be extended) as may be appropriate.

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

SEC. 144. EXEMPTION OF STATE LAWS PREVENTING DENIAL OF LIFESAVING MEDICAL TREATMENT PENDING TRANSFER TO ANOTHER HEALTH CARE PROVIDER.

Nothing in this subtitle shall be construed to invalidate any State law that has the effect of preventing involuntary denial of lifesaving medical treatment when such denial would cause the involuntary death of the patient

pending transfer of the patient to a health care provider willing to provide such treatment.

SEC. 145. DEFINITIONS.

In this subtitle, the following definitions shall apply:

(1) EMPLOYER.—The term ''employer'' shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(2) GROUP HEALTH PLAN; PLAN.—(A) The term ''group health plan'' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance plan.

(B) The term ''plan'' means, unless used with a modifying term or the context specifically indicates otherwise, a group health plan (including any such plan which is a multiemployer plan), an exempted multiple employer health plan, or an insured multiple employer health plan.

(3) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance

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, or

(v) automobile medical-payment insurance,

or any combination thereof.

(4) INSURED MULTIPLE EMPLOYER HEALTH PLAN.—The term ''insured multiple employer health plan'' means a fully insured multiple employer welfare arrangement under which benefits consist solely of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974

(disregarding such incidental benefits as the Secretary shall specify by regulations).

(5) INSURER.—The term ''insurer'' means a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization offering such a plan to an employer, and includes a similar organization regulated under State law for solvency.

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

(7) STATE.—The term ''State'' means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Subtitle D—Rules of Construction Regarding Abortion Services; Inseverability

SEC. 151. RULES OF CONSTRUCTION REGARDING ABORTION SERVICES.

Nothing in this title or title II may be construed—

(1) to require any health plan to include any abortion services, or

(2) to condition tax deductibility on the inclusion of such services.

SEC. 152. INSEVERABILITY.

If section 151 is judicially determined to be invalid or any provision in this title or title II is judicially determined—

(1) to require any health plan to include any abortion services, or

(2) to condition tax deductibility on the inclusion of such services,

then all the provisions of this title and title II shall be deemed to be invalid and shall not be given any effect.

TITLE II—AMENDMENTS OF INTERNAL REVENUE CODE OF 1986

Subtitle A—Limitations on Employer Deduction for Health Care Coverage for Employees and on Employee Exclusion for Employer-Provided Health Care Coverage

SEC. 201. EMPLOYER DEDUCTION FOR HEALTH CARE COVERAGE FOR EMPLOYEES LIMITED TO COVERAGE UNDER HIGH-DEDUCTIBLE PLANS AND MANAGED CARE PLANS AND TO CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS FOR EMPLOYEES.

(a) IN GENERAL.—Part IX of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items not deductible) is amended by adding at the end the following new section:

"SEC. 280I. CERTAIN HEALTH CARE COVERAGE FOR EMPLOYEES.

''(a) IN GENERAL.—Except as otherwise provided in this section, no deduction shall be allowed under this chapter to any employer for health care coverage for any employee.

''(b) EXCEPTIONS.—

''(1) IN GENERAL.—Subsection (a) shall not apply to coverage under—

''(A) a high deductible umbrella insurance plan, or

''(B) a managed health care plan.

''(2) MEDICAL SAVINGS ACCOUNTS PERMITTED WITH HIGH DEDUCTIBLE UMBRELLA INSURANCE PLAN COVERAGE.—In the case of an employer who provides coverage under a high deductible umbrella insurance plan for an employee, subsection (a) also shall not apply to employer contributions to a medical savings account (as defined in section 23(c)) for the benefit of such employee.

''(3) PERMITTED COVERAGE.—Subsection (a) shall not apply to permitted coverage (as defined in subsection (e)).

''(c) MAXIMUM DEDUCTION FOR PROVISION OF TAX-QUALIFIED HEALTH CARE PLANS AND MEDICAL SAVINGS ACCOUNTS.—The amount allowed as a deduction by reason of paragraphs (1) and (2) of subsection (b) for any taxable year with respect to an employee shall not exceed the health care tax benefit limitation for such taxable year.

''(d) HEALTH CARE TAX BENEFIT LIMITATION.—

''(1) IN GENERAL.—The health care tax benefit limitation for any taxable year is the sum of—

''(A) $2,500 ($4,000 in the case of a joint return filed by individuals both of whom are covered under a tax-qualified health care plan provided by the employer), plus

''(B) $1,000 if any individual (other than the taxpayer and the spouse (if any) of the taxpayer) is covered under such plan by reason of their relationship to such taxpayer or spouse.

''(2) VARIATION OF MAXIMUM DEDUCTION BY GEOGRAPHIC AREA.—

''(A) IN GENERAL.—In the case of any calendar year after 1996, each of the dollar amounts applicable under paragraph (1) (after the adjustment under paragraph (3)) shall be adjusted by the Secretary to reflect variations in the cost of tax-qualified health care plans between statistical areas (as defined in section 143(k)(2)). The amounts prescribed by the Secretary under this subparagraph for any calendar year shall apply to taxable years beginning in such calendar year.

''(B) METHOD.—

''(i) IN GENERAL.—Amounts prescribed under subparagraph (A) for any area for any calendar year shall be determined by multiplying the dollar amounts applicable under paragraph (1) (after the adjustment under paragraph (3)) by the cost-of-living multiplier for such area for such calendar year. If any adjustment under the preceding sentence is not a multiple of $50, such adjustment shall be rounded to the nearest multiple of $50.

''(ii) MULTIPLIER.—The cost-of-living multiplier for any area for any calendar year is the fraction—

''(I) the numerator of which is the cost-of-living for such area for such calendar year; and

''(II) the denominator of which is the average cost-of-living for the United States for such calendar year.

The Secretary shall determine the cost-of-living for an area using retail market prices selected and used under the same methodology as is used by the Bureau of Labor Statistics in developing the

Consumer Price Index for All Urban Consumers. The cost-of-living for any calendar year is the cost-of-living as of the close of the 12-month period ending on August 31 of such calendar year.

''(3) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of any calendar year after 1996, each dollar amount contained in paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) the inflation adjustment for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(B) METHOD OF ADJUSTMENT.—For purposes of subparagraph (A), the inflation adjustment for any calendar year is the greater of—

''(i) the CPI adjustment, or

''(ii) the MEI adjustment.

''(C) CPI ADJUSTMENT.—The CPI adjustment for any calendar year is the percentage (if any) by which the CPI–U for the preceding cal-

endar year exceeds the CPI–U for the second preceding calendar year.

''(D) MEI ADJUSTMENT.—The MEI adjustment for any calendar year is—

''(i) the percentage (if any) by which MEI for the preceding calendar year exceeds the MEI for the second preceding calendar year, reduced by

''(ii) 2 percentage points (1 percentage point in the case of adjustments for calendar years 1997 and 1998).

''(E) INDEX FOR ANY CALENDAR YEAR.—For purposes of this paragraph, the CPI–U and MEI for any calendar year is the CPI–U and MEI as of the close of the 12-month period ending on August 31 of such calendar year.

''(F) CPI–U AND MEI.—For purposes of this paragraph—

''(i) The term 'CPI–U' means the Consumer Price Index for all-urban consumers published by the Department of Labor.

''(ii) The term 'MEI' means the Medicare Economic Index referred to in the 4th

sentence of section 1842(b)(3) of the Social Security Act.

''(e) PERMITTED COVERAGE.—For purposes of this section, the term 'permitted coverage' means—

''(1) any coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury,

''(2) any coverage providing for payments referred to in section 105(c),

''(3) insurance that limits benefits with respect to specific diseases (or conditions),

''(4) hospital or nursing home indemnity insurance,

''(5) insurance with respect to accidents,

''(6) any coverage provided to an employee or former employee after such employee has attained age 65, unless such coverage is provided by reason of the current employment of the individual (within the meaning of section 1862(b)(1)(A)(i)(I) of the Social Security Act) with the employer providing the coverage,

''(7) any coverage provided under Federal law to any individual (or spouse or dependent thereof) by reason of such individual being—

''(A) a member of the Armed Forces of the United States, or

''(B) a veteran, and

''(8) any other coverage to the extent that the Secretary determines that the continuation of an exclusion for such coverage is not inconsistent with the purposes of this section.

Insurance shall be treated as described in paragraph (3), (4), or (5) only if the amount of the benefits under the insurance do not vary based on the amount of expenses incurred.

''(f) SPECIAL RULES FOR DETERMINING AMOUNT OF DEDUCTION.—

''(1) IN GENERAL.—For purposes of this section, the cost of any coverage for an employee, his spouse, and dependents shall be determined on the basis of the average cost of providing such coverage to the beneficiaries receiving such coverage.

''(2) SPECIAL RULE.—To the extent provided by the Secretary, cost determinations under paragraph (1) may be made on the basis of reasonable estimates.

''(g) DEFINITIONS.—For purposes of this section, the terms 'high deductible umbrella insurance plan', 'managed health care plan', and 'tax-qualified health care plan' have

the respective meanings given such terms by section 101 of Health Savings and Security Act of 1994.''

(b) CLERICAL AMENDMENT.—The table of sections for such part IX is amended by adding at the end the following new item:

''Sec. 280I. Certain health care coverage for employees.''

SEC. 202. LIMITATION ON EXCLUSION FOR EMPLOYER-PROVIDED COVERAGE UNDER HEALTH PLAN.

(a) IN GENERAL.—The text of section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended to read as follows:

''(a) IN GENERAL.—Except as provided in subsection (b), gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) LIMITATIONS.—

''(1) ONLY CERTAIN COVERAGE EXCLUDABLE.—Gross income of an employee shall include employer-provided coverage under any accident or health plan except to the extent that—

''(A) such coverage consists of coverage under a tax-qualified health care plan (as defined in section 101 of the Health Savings and Security Act of 1994),

''(B) such coverage consists of contributions to a medical savings account (as defined

in section 23(c)) for the benefit of an employee, or

''(C) such coverage consists of permitted coverage (as defined in section 280I(e)).

''(2) MAXIMUM EXCLUSION FOR EMPLOYER-PROVIDED TAX-QUALIFIED HEALTH CARE PLANS AND MEDICAL SAVINGS ACCOUNTS.—

''(A) IN GENERAL.—The amount excluded from gross income by reason of subparagraphs (A) and (B) of paragraph (1) for any taxable year shall not exceed the health care tax benefit limitation for such taxable year determined under section 280I(d).

''(B) SPOUSES WITH DUAL COVERAGE.—If the taxpayer or the spouse of the taxpayer are covered under more than 1 tax-qualified health care plan, coverage under the least expensive such plan shall not be subject to subparagraph (A) and such coverage shall not be taken into account in applying subparagraph (A) to the other such plan.

''(c) SPECIAL RULES FOR DETERMINING AMOUNT OF INCLUSION.—

''(1) IN GENERAL.—For purposes of this section, the value of any coverage shall be determined

on the basis of the average cost of providing such coverage to the beneficiaries receiving such coverage.

''(2) SPECIAL RULE.—To the extent provided by the Secretary, cost determinations under paragraph (1) may be made on the basis of reasonable estimates.''

(b) EMPLOYMENT TAX TREATMENT.—

(1) SOCIAL SECURITY TAX.—

(A) Subsection (a) of section 3121 of such Code is amended by inserting after paragraph (21) the following new sentence:

''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(B) Subsection (a) of section 209 of the Social Security Act is amended by inserting after paragraph (21) the following new sentence:

''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b) of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Paragraph (1) of section 3231(e) of such Code is amended by adding at the end thereof the following new sen-

tence: ''Nothing in clause (i) of the second sentence of this paragraph shall exclude from the term 'compensation' any amount which is required to be included in gross income under section 106(b).''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by inserting after paragraph (16) the following new sentence: ''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(4) WAGE WITHHOLDING.—Subsection (a) of section 3401 of such Code is amended by adding at the end thereof the following new sentence: ''Nothing in the preceding provisions of this subsection shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

SEC. 203. HEALTH BENEFITS MAY NOT BE PROVIDED UNDER CAFETERIA PLANS.

(a) GENERAL RULE.—Subsection (f) of section 125 (defining qualified benefits) is amended by adding at the end thereof the following new sentence: ''Such term shall not include any benefits or coverage (other than benefits or coverage described in paragraph (1), (2), (3), (4), or (5) of section 280I(e)) under an accident or health plan.''

(b) CONFORMING AMENDMENT.—Subsection (g) of section 125 is amended by striking paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

SEC. 204. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall take effect on January 1, 1996.

(b) COLLECTIVELY BARGAINED PLANS.—In the case of a plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before March 15, 1994, the amendments made by this subtitle shall not apply to health coverage pursuant to such plan before the earlier of—

(1) the later of—

(A) January 1, 1997, or

(B) the date on which the last of such collective bargaining agreements terminates (determined without regard to any extension thereof after March 14, 1994), or

(2) January 1, 1999.

Subtitle B—Credits for Contributions to Medical Savings Accounts, for Purchase of High Deductible Umbrella Insurance, and for Routine Preventive Care

SEC. 211. CREDIT FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable credits) is amended by inserting after section 22 the following new section:

"SEC. 23. MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.

''(a) EXCLUSION.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to 31 percent of the medical savings account contributions of the individual for the taxable year.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—The amount of medical savings account contributions by an eligible individual which may be taken into account under subsection (a) for any taxable year shall not exceed the excess of—

''(A) the lesser of—

''(i) the account limitation, or

''(ii) the excess health care tax benefit limitation for the taxable year, over

''(B) the amount (if any) allowable as a credit under section 35 to the taxpayer for the taxable year.

''(2) ACCOUNT LIMITATION.—

''(A) IN GENERAL.—For purposes of paragraph (1), the account limitation is $2,000.

''(B) HIGHER ACCOUNT LIMITATION IF TAXPAYER HAS DEPENDENTS.—The $2,000 amount in subparagraph (A) shall be increased by the lesser of—

''(i) $500 for each other individual who is covered under the high deductible umbrella insurance plan (as defined in section 101 of the Health Savings and Security Act of 1994) by reason of such individual's relationship to the taxpayer, or

''(ii) $1,500.

In the case of a married individual (as defined in section 7703) who does not file a joint return with such individual's spouse, the $1,500 amount in clause (ii) shall be divided equally

between such individual and spouse unless they agree on a different division of such amount.

''(C) PRORATION OF LIMITATION IF PART-YEAR ELIGIBILITY.—In the case of an individual who is an eligible individual only for a portion (but not all) of the calendar year ending with or within the taxable year, the account limitation under this paragraph for such taxable year shall be an amount which bears the same ratio to such limitation (determined without regard to this paragraph) as such portion bears to the entire calendar year.

''(3) EXCESS HEALTH CARE TAX BENEFIT LIMITATION.—For purposes of paragraph (1), the excess health care tax benefit limitation for any taxable year is the excess (if any) of—

''(A) the health care tax benefit limitation under section 280I(d) for such taxable year, over

''(B) the amount excluded from the taxpayer's gross income by reason of subparagraphs (A) and (B) of section 106(b)(1) for such taxable year.

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

''(1) MEDICAL SAVINGS ACCOUNT.—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 account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

''(A) No contribution will be accepted unless it is in cash, and contributions will not be accepted during any calendar year in excess of the limitation under subsection (b).

''(B) 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 person will administer the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any individual who is covered

under a high deductible umbrella insurance plan (as defined in section 101 of Health Savings and Security Act of 1994) other than—

''(A) an individual who is covered by—

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

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

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

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

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

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

''(B) an individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in

the calendar year in which the individual's taxable year begins, and

''(C) an individual if the amendments made by subtitle A of title II of the Health Savings and Security Act of 1994 do not apply to such individual's health coverage by reason of section 204(b) of such Act.

''(3) MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'medical expenses' means, with respect to the account beneficiary, the amount paid by such beneficiary for medical care (as defined in section 213(d)) of such beneficiary and the spouse and dependents (as defined in section 152) of such beneficiary.

''(B) LIMITATION ON AMOUNTS PAID FOR HEALTH INSURANCE.—Such term shall include amounts paid for insurance only if—

''(i) the account beneficiary is not eligible to participate in any subsidized health plan maintained by any employer of such beneficiary or of the spouse of such beneficiary, and

''(ii) the insurance is a high deductible umbrella insurance plan (as defined in

section 101 of the Health Savings and Security Act of 1994.

''(4) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'medical savings account contributions' means any amount paid in cash for the taxable year by or on behalf of an individual to a medical savings account for such individual's benefit.

''(5) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual for whose benefit the medical savings account is established.

''(d) OTHER DEFINITIONS AND SPECIAL RULES.—

''(1) 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).

''(2) MARRIED INDIVIDUALS.—The maximum credit under subsection (b) shall be computed separately for each individual.

''(3) EMPLOYER PAYMENTS.—For purposes of this title, any amount paid by an employer to a medical savings account shall be treated as a payment of compensation to the employee (other than a self-

employed individual who is an employee within the meaning of section 401(c)(1)) includible in his gross income for the taxable year for which the amount was contributed, whether or not a credit for such payment is allowable under this section to the employee.

''(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 account beneficiary unless such amount is used exclusively to pay—

''(A) the medical expenses of such beneficiary or of the spouse and dependents (as defined in section 152) of such beneficiary, or

''(B) the expenses for long-term care (including long-term care insurance) for any of such individuals who have attained age 65 as of the date such expenses are paid.

''(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 excludable 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) ROLLOVERS TO INDIVIDUAL RETIREMENT PLANS.—Paragraph (1) shall not apply to any payment or distribution to the account beneficiary if—

''(A) the payment or distribution is made on or after the date such beneficiary attains age 65, and

''(B) the entire amount received (including money and other property) is paid into an individual retirement plan for the benefit of such beneficiary not later than the 60th day after the day on which the individual receives the payment or distribution.

The dollar limitation under section 408(a)(1) shall not apply to amounts paid under the preceding sentence.

''(4) PENALTY FOR DISTRIBUTIONS NOT USED FOR MEDICAL EXPENSES, ETC.—

''(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 includible in gross income under paragraph (1) shall be increased by 10 percent of the amount which is so includible.

''(B) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 65.—Subparagraph (A) shall not apply to any distribution or payment after the date on which the account beneficiary attains age 65.

''(C) DISABILITY OR DEATH CASES.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

''(f) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A medical savings account is exempt from taxation under this subtitle, unless such account has ceased to be a medical savings ac-

count by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account is 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 account beneficiary 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 account beneficiary uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed and not used to pay medical expenses.

''(g) INFLATION ADJUSTMENT.—In the case of any calendar year after 1996, each dollar amount in subsection (b) shall be increased by an amount equal to—

''(1) such dollar amount, multiplied by

''(2) the inflation adjustment (determined under section 280I(d)(3)) for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(h) 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 (c).

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.

''(i) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the account beneficiary 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.

''(j) OTHER DEFINITIONS.—For purposes of this section—

''(1) EMPLOYER.—The term 'employer' includes persons treated as an employer under section 401(c)(4).

''(2) EMPLOYEE.—The term 'employee' includes an individual who is an employee within the meaning of section 401(c)(1).''

(b) EMPLOYER PAYMENTS EXCLUDED FROM EMPLOYMENT TAX BASE.—

(1) SOCIAL SECURITY TAXES.—

(A) Subsection (a) of section 3121 of such Code 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) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to take such payment into account in determining the credit under section 23.''

(B) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting ''; or'', and by inserting after paragraph (19) the following new paragraph:

''(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to take such payment into account in determining the credit under section 23 of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

''(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to take such payment into account in determining the credit under section 23.''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code 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) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to take such payment into account in determining the credit under section 23.''

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code 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) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to take such payment into account in determining the credit under section 23.''

(c) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to individual retirement 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 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 23(c)),'',

(3) by striking ''or'' at the end of paragraph (1) of subsection (a), and

(4) by adding at the end thereof 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 23(c)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount which may be taken into account in determining the credit under section 23 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 23(e)(2) applies shall be treated as an amount not contributed.''

(d) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (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 23(c)) 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 medi-

cal savings account by reason of the application of section 23(f)(2)(A) to such account.'', and

(2) by inserting ''or a medical savings account described in section 23(c)'' in subsection (e)(1) after ''described in section 408(a)''.

(e) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement account 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 23(i) 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.''

(f) CLERICAL AMENDMENTS.—

(1) 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 22:

''Sec. 23. Medical savings account contributions.''

(2) The table of sections for chapter 43 of such Code 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 of such Code is amended by inserting ''or on medical savings accounts'' after ''annuities'' in the item relating to section 6693.

SEC. 212. REFUNDABLE CREDIT FOR PURCHASE OF COVERAGE UNDER TAX-QUALIFIED HEALTH CARE PLANS.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

''SEC. 35. PURCHASE OF COVERAGE UNDER TAX-QUALIFIED HEALTH CARE PLANS.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to 31 percent of the amount paid by the taxpayer during the taxable year for coverage under a tax-qualified health care plan (as defined in section 101 of the Health

Savings and Security Act of 1994) for the taxpayer, the spouse of the taxpayer, and any dependent (as defined in section 152) of the taxpayer.

''(b) COVERAGE OF CERTAIN INDIVIDUALS NOT INCLUDED.—There shall not be taken into account under subsection (a) amounts paid for coverage for any individual if—

''(1) such individual is covered by—

''(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, or

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

''(2) the amendments made by subtitle A of title II of the Health Savings and Security Act of 1994 do not apply to such individual's health coverage by reason of section 204(b) of such Act.

''(c) COORDINATION WITH HEALTH INSURANCE CREDIT CERTIFICATES.—

''(1) IN GENERAL.—If any health insurance credit certificate is used pursuant to section 212(b) of the Health Savings and Security Act of 1994 by the taxpayer to pay for coverage under a tax-qualified health care plan during any taxable year, then the tax imposed by this chapter for such taxable year shall be increased by the aggregate dollar amount of the certificates so used during such taxable year.

''(2) RECONCILIATION OF CERTIFICATES AND CREDIT ALLOWED.—Any increase in tax under paragraph (1) shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit (other than the credit allowed by subsection (a)) allowable under this subpart.''

(b) HEALTH INSURANCE CERTIFICATES FOR LOW-INCOME INDIVIDUALS ELIGIBLE FOR CREDIT.—

(1) IN GENERAL.—The Secretary of the Treasury shall establish a program under which individuals provide certificates to any provider of a tax-qualified health care plan (as defined in section 101 of this Act) in full or partial payment of the provider's premium for the individual for the year. If an individual presents the provider with such a certificate, the provider shall accept the certificate toward payment of the provider's premium for the individual for the year.

(2) INDIVIDUALS ELIGIBLE FOR CERTIFICATES.—Under the program established pursuant to paragraph (1), certificates shall be available only to individuals—

(A) to whom a credit under section 35 of the Internal Revenue Code of 1986 (as added by subsection (a)) is allowable for the taxable year, and

(B) whose liability for tax under subtitle A of such Code (determined without regard to such credit) is likely (as determined by the Secretary) to be less than the amount of such credit allowable for such taxable year.

(3) AMOUNT OF CERTIFICATES.—The dollar amount of the certificates provided under such program to an individual for any taxable year shall not exceed the amount of the credit under such section 35 that the Secretary estimates will be allowable to such individual for such taxable year.

(4) PAYMENT TO PROVIDERS.—

(A) AMOUNT.—Except as otherwise provided in this paragraph, a provider of any tax-qualified health care plan shall be entitled, upon presentation to the Secretary (or his designee) of an individual's certificate and of information used by the provider to determine the individual's applicable premium, to payment equal to the dollar amount of the certificate.

(B) PREMIUM LESS THAN CERTIFICATE DOLLAR AMOUNT.—If the certificate dollar amount is greater than the amount of the individual's applicable premium, the provider of the tax-qualified health care plan to the individual shall be entitled to payment under subparagraph (A) only in the amount of the individual's applicable premium.

(C) OFFSETTING PAYMENTS.—If a provider of a tax-qualified health care plan has re-

ceived prepayment of an individual's applicable premium for any period for which the individual's certificate is in effect, the amount of the payment to which the provider is otherwise entitled under subparagraph (A) shall be reduced to the extent of such premium paid.

(D) ACCEPTANCE OF CERTAIN IMPROPER CERTIFICATES.—The Secretary may not deny payment under subparagraph (A) to a provider of a tax-qualified health care plan because a certificate presented for payment was invalid, unless the entity had knowledge of such invalidity at the time of its acceptance of the certificate.

(5) HEALTH PLANS PROVIDED BY STATES.—In the case of a tax-qualified health care plan provided pursuant to a program described in section 1932 of the Social Security Act, the State shall be treated for purposes of this subsection as the provider of such plan.

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (l) of section 162 of such Code is hereby repealed.

(2) The table of sections for such subpart C is amended by striking the last item and inserting the following new items:

''Sec. 35. Purchase of coverage under tax-qualified health care plans.
''Sec. 36. Overpayments of tax.''

(3) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period ''or from section 35 of such Code''.

SEC. 213. CREDIT FOR COST OF ROUTINE PREVENTIVE CARE.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable credits) is amended by inserting after section 23 the following new section:

''SEC. 24. COST OF ROUTINE PREVENTIVE CARE.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to 31 percent of the amount paid by the taxpayer during the taxable year for routine preventive care for the taxpayer, the spouse of the taxpayer, and any dependent (as defined in section 152) of the taxpayer.

''(b) CARE OF CERTAIN INDIVIDUALS NOT INCLUDED.—There shall not be taken into account under subsection (a) amounts paid for routine preventive care for—

''(1) any individual who is the beneficiary of a medical savings account (as defined in section 23(c)) or the spouse or a dependent of such a beneficiary,

''(2) any individual who is covered under a managed health care plan (as defined in section 101 of Health Savings and Security Act of 1994),

''(3) any individual who is covered by—

''(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

''(4) any individual if the amendments made by subtitle A of title II of the Health Savings and Security Act of 1994 do not apply to such individual's health coverage by reason of section 204(b) of such Act.

''(c) ROUTINE PREVENTIVE CARE.—For purposes of this section, the term 'routine preventive care' means any service provided in accordance with the recommended schedule of clinical preventive services of the United States Preventive Services Task Force.''

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 23 the following new item:

''Sec. 24. Cost of routine preventive care.''

SEC. 214. EFFECTIVE DATE.

The amendments made by this subtitle shall apply to taxable years beginning after December 31, 1995.

Subtitle C—Repeal of Medical Expense Deduction

SEC. 221. REPEAL OF MEDICAL EXPENSE DEDUCTION.

Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended by adding at the end thereof the following new subsection:

''(f) TERMINATION.—No deduction shall be allowed under this section for any taxable year beginning after December 31, 1995.''

Subtitle D—Veterans Medical Benefits and Services Unaffected

SEC. 231. VETERANS MEDICAL BENEFITS AND SERVICES UNAFFECTED.

Nothing in this title or the amendments made by this title shall affect the eligibility of any veteran (or spouse or dependent thereof) for medical benefits and services provided under title 38, United States Code.

TITLE III—SAVINGS IN MEDICARE AND MEDICAID PROGRAMS

Subtitle A—Medicare Program

SEC. 301. 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 thereof 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 TAX.—In the case of an individual to whom this section applies for the taxable year, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax for such taxable year equal to the

aggregate of the Medicare part B premium taxes for each of the months during such year that such individual is covered by Medicare part B.

''(b) INDIVIDUALS TO WHOM SECTION APPLIES.—This section shall apply to any individual for any taxable year if—

''(1) such individual is covered under Medicare part B for any month during such year, and

''(2) the modified adjusted gross income of the taxpayer for such taxable year exceeds the threshold amount.

''(c) MEDICARE PART B PREMIUM TAX FOR MONTH.—

''(1) IN GENERAL.—The Medicare part B premium tax for any month is ⅔ the amount equal to the excess of—

''(A) 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

''(B) 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).

''(2) PHASEIN OF TAX.—If the modified adjusted gross income of the taxpayer for any taxable years exceeds the threshold amount by less than $50,000, the Medicare part B premium tax for any month during such taxable year shall be an amount which bears the same ratio to the amount determined under paragraph (1) (without regard to this paragraph) as such excess bears to $50,000. The preceding sentence shall not apply to any individual whose threshold amount is zero.

''(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, $100,000,

''(B) $125,000 in the case of a joint return, and

''(C) zero in the case of a taxpayer who—

''(i) is married at the close of the taxable year 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) MEDICARE PART B COVERAGE.—An individual shall be treated as covered under Medicare part B for any month if a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part for the month.

''(4) MARRIED INDIVIDUAL.—The determination of whether an individual is married shall be made in accordance with section 7703.''

(b) 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.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months after December 1993 in taxable years ending after December 31, 1995.

SEC. 302. IMPOSITION OF 20 PERCENT COINSURANCE ON CLINICAL LABORATORY SERVICES UNDER MEDICARE.

(a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of section 1833(a) of the Social Security Act (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) REPEAL OF MANDATORY ASSIGNMENT.—Section 1833(h)(5) of such Act (42 U.S.C. 1395l(h)(5)) is amended by striking subparagraphs (C) and (D).

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to tests furnished on or after January 1, 1996.

SEC. 303. ANNUAL INDEXING OF PART B DEDUCTIBLE.

Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended by striking ''1991 and subsequent years'' and inserting the following: ''calendar years 1991 through 1995, and, for calendar year 1996 and each subsequent year, by a deductible equal to the deductible under this subsection for the previous year increased by the percentage increase in the consumer price index for all urban

consumers (U.S. city average) for the 12-month period ending with June of the previous year''.

Subtitle B—Medicaid Program

PART 1—ACHIEVING SAVINGS IN PROGRAM

SEC. 311. CAP ON FEDERAL PAYMENTS MADE FOR ACUTE MEDICAL SERVICES FURNISHED UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Title XIX of the Social Security Act (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:

''CAP ON FEDERAL PAYMENT MADE FOR ACUTE MEDICAL SERVICES

''SEC. 1931. (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)) 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 20 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 gross amount of payments under the State plan under this title 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) for fiscal year 1997, the greater of—

''(i) the estimated percentage change in the Consumer Price Index through the midpoint of fiscal year 1996, plus 3 percentage points, or

''(ii) the medicare economic index referred to in the fourth sentence of section 1842(b)(3) applicable to services provided as of January 1 of the fiscal year, minus 1 percentage point;

''(B) for fiscal year 1998, the greater of—

''(i) the estimated percentage change in the Consumer Price Index through the midpoint of fiscal year 1997, plus 2 percentage points, or

''(ii) the medicare economic index referred to in the fourth sentence of section 1842(b)(3) applicable to services provided as of January 1 of the fiscal year, minus 1 percentage point;

''(C) for fiscal year 1999, the greater of—

''(i) the estimated percentage change in the Consumer Price Index through the midpoint of fiscal year 1998, plus 1 percentage point, or

''(ii) the medicare economic index referred to in the fourth sentence of section 1842(b)(3) applicable to services provided as of January 1 of the fiscal year, minus 2 percentage points; and

''(D) for fiscal year 2000 and each succeeding fiscal year, the greater of—

''(i) the estimated percentage change in the Consumer Price Index through the midpoint of the previous fiscal year, or

''(ii) the medicare economic index referred to in the fourth sentence of section 1842(b)(3) applicable to services provided as of January 1 of the fiscal year, minus 2 percentage points.

''(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 in-

dividual 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) of such Act (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) 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) of such Act (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) EFFECTIVE DATE.—The amendments made by this section shall become effective on October 1, 1995.

PART 2—OPTIONAL ENROLLMENT OF LOW-INCOME INDIVIDUALS UNDER HIGH DEDUCTIBLE UMBRELLA INSURANCE PLANS AND MANAGED HEALTH CARE PLANS

SEC. 321. OPTIONAL ENROLLMENT UNDER PLANS.

(a) STATE OPTION.—Section 1902(a) of the Social Security Act (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 acute medical services (as de-

fined in section 1931(c)(1)) through enrollment with a high deductible umbrella insurance plan or a managed health care plan (as defined in section 1932(f)(2)) under the program described in section 1932, in accordance with the requirements of section 1932.''.

(b) REQUIREMENTS DESCRIBED.—Title XIX of such Act (42 U.S.C. 1396 et seq.), as amended by section 311(a)(1), is further amended by redesignating section 1932 as section 1933 and by inserting after section 1931 the following new section:

''OPTIONAL STATE PROGRAM TO ENROLL INDIVIDUALS IN HIGH DEDUCTIBLE UMBRELLA INSURANCE PLANS OR MANAGED HEALTH CARE PLANS

''SEC. 1932. (a) IN GENERAL.—For purposes of section 1902(a)(63), a program under this section is a program under which the State makes payments to high deductible umbrella insurance plans and managed health care plans for enrolling eligible individuals (as described in subsection (c)) for coverage of acute medical services under such plans, including all necessary payments of premiums, copayments, and deductibles applicable under such a plan on behalf of such an individual.

''(b) TREATMENT OF PAYMENTS AS MEDICAL ASSISTANCE.—

''(1) IN GENERAL.—Subject to paragraph (3), 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 the program under this section shall be treated as expenditures for medical assistance under the State plan for such quarter, without regard to whether or not such payments are on behalf of individuals who (but for this section) would not otherwise be eligible for medical assistance under the State plan under this title.

''(2) FEDERAL PAYMENT RESTRICTED TO ACUTE MEDICAL SERVICES.—No amounts expended under a qualified health plan on behalf of an individual enrolled under such a plan pursuant to this section that are attributable to medical assistance for other than acute medical services shall be included in the total amount expended as medical assistance under the State plan under paragraph (1). No amounts expended for abortions or services directly related to the performance of abortions, except when necessary to prevent the death of the mother, shall be included in the total amount expended as medical assistance under the State plan under paragraph (1).

''(3) LIMITATION.—In no case shall this subsection result in (A) the total Federal payments to the State for the quarter under this title (including payments attributable to this section and section 1923), exceeding (B) the total Federal payments that the Secretary estimates would have been paid under this title to the State for the quarter if the State did not have a program under this section.

''(c) ELIGIBILITY OF INDIVIDUALS TO PARTICIPATE IN PROGRAM.—

''(1) AUTOMATIC ELIGIBILITY OF MEDICAID CATEGORICALLY ELIGIBLE INDIVIDUALS.—Subject to subsection (d), any individual to whom the State makes medical assistance available under the State plan under this title pursuant to clause (i) of section 1902(a)(10)(A) shall be eligible to participate in the program under this section.

''(2) MANDATORY ELIGIBILITY OF INDIVIDUALS WITH INCOME UNDER THE POVERTY LEVEL.—

''(A) IN GENERAL.—Subject to subsection (e) and subparagraph (B), an individual lawfully residing in the State shall be eligible to participate in the program if the income of the individual's family is equal to or less than 100 percent of the 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 1991) applicable to a family of the size involved.

''(B) EXCEPTION.—If the application of subparagraph (A) would result in—

''(i) the total State expenditures for a quarter under this title (including expenditures attributable to this section and section 1923), exceeding

''(ii) the total State expenditures that the Secretary estimates would have been made under this title for the quarter if the State did not have a program under this section,

then there shall be substituted for 100 percent in subparagraph (A) such percent as would result in the amount described in clause (i) equaling the amount described in clause (ii).

''(3) OPTIONAL ELIGIBILITY OF INDIVIDUALS WITH INCOME UP TO 160 PERCENT OF POVERTY LEVEL.—

''(A) IN GENERAL.—Subject to subsection (e), a State operating a program under this sec-

tion may make an individual lawfully residing in the State eligible to participate in the program if the income of the individual's family is greater than 100 percent (but less than such percentage, not to exceed 160 percent, as the State may specify) of such official poverty line.

''(B) CONTRIBUTION MAY BE REQUIRED.—In the case of an individual who is participating in the program pursuant to this paragraph, the program may require such an individual to contribute all (or a portion) of the premiums and cost-sharing of such a high deductible umbrella insurance plan or managed care health plan if the amount of such contribution is determined in accordance with a sliding scale based on the individual's family income.

''(4) OPTIONAL ENROLLMENT OF OTHER INDIVIDUALS.—

''(A) IN GENERAL.—Subject to subsection (e), a State operating a program under this section may make any individual (or class of individuals) who is not described in paragraph (1), (2), or (3) and who is not otherwise offered coverage under a high deductible umbrella insur-

ance plan or managed care health plan eligible to participate in the program.

''(B) SPECIAL RULES.—

''(i) CONTRIBUTION MAY BE REQUIRED.—In the case of an individual who is participating in the program pursuant to this paragraph, the program may require such an individual to contribute all (or a portion) of the premiums and cost-sharing of such a high deductible umbrella insurance plan or managed health care plan.

''(ii) NO FEDERAL MATCHING PAYMENTS.—For purposes of payment to States under section 1903(a), no amounts expended by the State under the program during a fiscal year on behalf of an individual enrolled pursuant to subparagraph (A) may be included in the total amount expended during the fiscal year as medical assistance under the State plan.

''(5) OFFERING OF COVERAGE THROUGH OTHER PROGRAMS.—Nothing in this section shall be construed as preventing a State which—

''(A) does not operate a State program under this section from assuring that individ-

uals in the State who are not offered coverage under a high deductible umbrella insurance plan or managed health care plan are offered coverage under a health plan, or

''(B) does operate such a program from assuring that individuals in the State who are not described in paragraph (1), (2), or (3) and who are not offered coverage under a high deductible umbrella insurance plan or managed health care plan are offered coverage under a health plan other than through such program.''.

''(d) EXCLUSION AND USE OF RESOURCE STANDARD.—

''(1) EXCLUSION OF ELDERLY MEDICARE-ELIGIBLE INDIVIDUALS.—No individual shall be eligible to participate in the program under this section if the individual is entitled to benefits under title XVIII of the Social Security Act pursuant to section 226 of such Act.

''(2) USE OF RESOURCE STANDARD.—A State may require an individual to meet a resource standard as a condition of eligibility to participate in the program only if the Secretary approves the State's use of such a standard.

''(e) CONSTRUCTION.—No provision of any Federal law shall prevent a State from enrolling any employee or other individual in accordance with this section. The previous sentence shall not be construed as permitting a State to require the employer of an individual participating in the program to contribute toward the individual's premium required for such participation.

''(f) DEFINITIONS.—For purposes of this section:

''(1) ACUTE MEDICAL SERVICES.—The term 'acute medical services' means the care and services described in section 1932(c)(1).

''(2) HIGH DEDUCTIBLE UMBRELLA INSURANCE PLAN; MANAGED HEALTH CARE PLAN.—The terms 'high deductible umbrella insurance plan' and 'managed health care plan' have the meaning given such terms in section 101(a) of the Health Savings and Security Act of 1994.''.

(c) REDUCTION IN DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR PARTICIPATING STATES.—Section 1923 of the Social Security Act (42 U.S.C. 1396r–4), as amended by section 13621(b)(1) of the Omnibus Budget Reconciliation Act of 1993, is amended by adding at the end the following new subsection:

''(h) REDUCTION IN PAYMENT ADJUSTMENTS FOR STATES ENROLLING INDIVIDUALS IN CERTAIN PRIVATE

HEALTH PLANS.—In the case of a State operating a program under section 1932 to make payments to enroll individuals in high deductible umbrella insurance plans or managed health care plans in a fiscal year, the Secretary shall reduce the total payment adjustments made under this section for hospitals in the State for quarters in the year by such amount as the Secretary determines to be necessary to ensure that the total amount paid to the State under section 1903(a)(1) for the year does not exceed the amount that would have been paid to the State under such section for the year if the State did not operate such a program.''.

PART 3—INCREASING STATE FLEXIBILITY TO USE MANAGED CARE UNDER MEDICAID

SEC. 331. 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) of the Social Security Act (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 contracting 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 of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by sections 311(a)(1) and 321(b), is further 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 speci-

fied 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 assistance 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 re-

imbursed 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 subsection (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 serv-

ices 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 respon-

sibilities 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,

''(iv) patient surveys, spot checks, or other appropriate methods to determine whether—

''(I) enrollees are able to obtain timely appointments with primary care providers and specialists, and

''(II) enrollees are otherwise guaranteed access and care as provided under paragraph (2),

''(v) provision of written information to health care providers and other personnel on the outcomes, quality, availability, accessibility, and appropriateness of care, and

''(vi) implementation of corrective actions,

''(E) includes standards for timely enrollee access to information and care which at a minimum shall incorporate standards used by the State or professional or accreditation bodies for

facilities furnishing perinatal and neonatology care and other forms of specialized medical and surgical care,

''(F) includes standards for the facilities in 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 re-

quirements 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 primary 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.

''(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 com-

pliance with the requirements of such entity's contract under subsection (b)(3), and shall undertake 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 provide 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 meth-

ods, 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).

''(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 con-

ditions 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 determining 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) of the Social Security Act (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) of such Act (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 contracting 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 management entity (as those terms are defined in section 1933(a)).''.

(d) ENHANCED MATCH RELATED TO QUALITY REVIEW.—Section 1903(a)(3)(C) of such Act (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) of such Act (42 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(2) Section 1902(a)(23) of such Act (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) of such Act (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) of such Act (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) of such Act (42 U.S.C. 1396a), as amended by section 321(a), is amended—

(A) by striking ''and'' at the end of paragraph (62);

(B) by striking the period at the end of paragraph (63) and inserting ''; and''; and

(C) by adding at the end the following new paragraphs:

''(64) at State option, provide for a primary care case management program in accordance with section 1933; and

''(65) 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) of such Act (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) of such Act (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) of such Act (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) of such Act (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) of such Act (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) of such Act (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) of such Act (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) of such Act (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''.

(14) Section 1927(j)(1) of such Act (42 U.S.C. 1396r–8(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))''.

(g) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to calendar quarters beginning on or after January 1, 1995.

PART 4—LIMITATIONS ON FUNDING OF ABORTION SERVICES UNDER MEDICAID

SEC. 341. LIMITATIONS ON FUNDING OF ABORTION SERVICES UNDER MEDICAID.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by sections 311(a)(1), 321(b), and 331(a)(2), is further amended by redesignating section 1934 as section 1935 and by inserting after section 1933 the following new section:

''LIMITATIONS ON FUNDING OF ABORTION SERVICES

''SEC. 1934. (a) None of the funds authorized by this title may be used to provide abortions, except to prevent the death of the mother.

''(b) Nothing in this title shall be construed—

''(1) to require any State to pay for abortions, except those necessary to prevent the death of the mother, or

''(2) to require any health plan or other entity to provide abortions in order to participate in any program authorized by this title, or

''(3) to authorize any State to impose such a requirement for participation in any program authorized by this title.''.

TITLE IV—CONTAINING HEALTH CARE COSTS

Subtitle A—Medical Malpractice Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 401. FEDERAL REFORM OF MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any medical malpractice liability claim and to any medical malpractice liability action brought in any State or Federal court, except that this subtitle—

(1) 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, and

(2) it shall not apply to a claim or action for damages brought pursuant to subtitle C of title VII.

(b) PREEMPTION.—The provisions of this subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this subtitle shall not preempt any State law that provides for defenses or places limitations

on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(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 subtitle shall be construed to establish any jurisdiction in the district courts of the United States over medical

malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 402. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under this subtitle that provides for the resolution of medical malpractice liability claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice liability 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) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evi-

dence, but less than that required for proof beyond a reasonable doubt.

(4) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an individual for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(5) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(6) 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 the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(7) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice liability claim.

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability ac-

tion'' means a civil action brought in a State or Federal court against a health care provider or health care professional in which the plaintiff alleges a medical malpractice liability claim, but does not include any action in which the plaintiff's sole allegation is an allegation of an intentional tort.

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

(10) MEDICAL PRODUCT.—

(A) IN GENERAL.—The term ''medical product'' means, with respect to the allegation of a claimant, a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) if—

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or

360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect to the safety of the formulation or performance of the aspect of such drug or device which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(C) EXCEPTION IN THE CASE OF ABORTION-INDUCING DRUGS AND DEVICES.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any drug or device which is used as a contraceptive or abortifacient and which has as one of its known effects the interference with implantation of a fertilized human ovum or embryo or the termination of pregnancy after implantation with intent other than to produce a live birth.

(11) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary losses, but does not include punitive damages.

(12) PUNITIVE DAMAGES; EXEMPLARY DAMAGES.—The terms ''punitive damages'' and ''exemplary damages'' mean compensation, in addition to compensation for actual harm suffered, that is awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

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

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

SEC. 403. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b) and section 417(c), this subtitle shall apply with respect to claims accruing or actions brought on or after the expiration of the 3-year period that begins on the date of the enactment of this Act.

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

(1) APPLICATION.—A State may submit an application to the Secretary requesting the early implementation of this subtitle with respect to claims or actions brought in the State.

(2) DECISION BY SECRETARY.—The Secretary shall issue a response to a State's application under paragraph (1) not later than 90 days after receiving the application. If the Secretary determines that the State meets the requirements of this subtitle at the time of submitting its application, the Secretary shall approve the State's application, and this sub-

title shall apply with respect to actions brought in the State on or after the expiration of the 90-day period that begins on the date the Secretary issues the response. If the Secretary denies the State's application, the Secretary shall provide the State with a written explanation of the grounds for the decision.

PART 2—MEDICAL MALPRACTICE AND PRODUCT LIABILITY REFORM

SEC. 411. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 422(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section 422(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in

any Federal court under section 1332 of title 28, United States Code, during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system referred to in paragraph (1) that applied in the State whose law applies in such action.

(3) CLAIMS AGAINST UNITED STATES.—

(A) ESTABLISHMENT OF PROCESS FOR CLAIMS.—The Attorney General shall establish an alternative dispute resolution process for the resolution of tort claims consisting of medical malpractice liability claims brought against the United States under chapter 171 of title 28, United States Code. Under such process, the resolution of a claim shall occur after the completion of the administrative claim process applicable to the claim under section 2675 of such title.

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A) may not be brought in any Federal court unless the claim has been initially resolved under the

alternative dispute resolution process established by the Attorney General under such subparagraph.

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is ''initially resolved'' under an alternative dispute resolution system if—

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

(B) if the ADR determines that the defendant is liable, the ADR reaches a decision on the amount of damages assessed against the defendant.

(c) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice liability claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

(2) DEADLINE FOR FILING ACTION.—A medical malpractice liability action may not be brought by a party unless—

(A) the party has filed the notice of intent required by paragraph (1); and

(B) the party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term ''court of competent jurisdiction'' means—

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

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court. The

previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (c)(1).

SEC. 412. CALCULATION AND PAYMENT OF DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant and the members of the claimant's family for losses resulting from the injury which is the subject of a medical malpractice liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) BASIS FOR RECOVERY.—Punitive or exemplary damages shall not be awarded in a medical malpractice liability action unless the claimant establishes by clear and convincing evidence that the injury suffered was the direct result of conduct manifesting a malicious, wanton, willful, or excessively reckless disregard of the safety of others.

(2) NO AWARD AGAINST MANUFACTURER OF MEDICAL PRODUCT.—In the case of a medical malpractice liability action in which the plaintiff alleges a claim against the manufacturer of a medical prod-

uct, no punitive or exemplary damages may be awarded against such manufacturer.

(3) PAYMENTS TO STATE FOR MEDICAL QUALITY ASSURANCE ACTIVITIES.—

(A) IN GENERAL.—Any punitive or exemplary damages awarded in a medical malpractice liability action shall be paid to the State in which the action is brought or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided.

(B) ACTIVITIES DESCRIBED.—A State shall use amounts paid pursuant to subparagraph (A) to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

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

(ii) operating alternative dispute resolution systems;

(iii) carrying out public education programs relating to medical malpractice and

the availability of alternative dispute resolution systems in the State; and

(iv) carrying out programs to reduce malpractice-related costs for retired providers or other providers volunteering to provide services in medically underserved areas.

(C) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to subparagraph (A) to supplement and not to replace amounts spent by the State for the activities described in subparagraph (B).

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) WAIVER.—A court may waive the application of paragraph (1) with respect to a defendant if the court determines that it is not in the best inter-

ests of the plaintiff to receive payments for damages on such a periodic basis.

SEC. 413. REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.

(a) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to section 411(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim under the alternative dispute resolution system), but only if—

(1) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action does not exceed the amount of damages awarded to the party under the ADR system by at least 10 percent; and

(2) in the case of an action in which the party that contested the ruling is the defendant, the

amount of damages assessed against the party under the action is not at least 10 percent less than the amount of damages assessed under the ADR system.

(b) EXCEPTIONS.—Subsection (a) shall not apply if—

(1) the party contesting the ruling made under the previous alternative dispute resolution system shows that—

(A) the ruling was procured by corruption, fraud, or undue means,

(B) there was partiality or corruption under the system,

(C) there was other misconduct under the system that materially prejudiced the party's rights, or

(D) the ruling was based on an error of law;

(2) the party contesting the ruling made under the alternative dispute resolution system presents new evidence before the trier of fact that was not available for presentation under the ADR system;

(3) the medical malpractice liability action raised a novel issue of law; or

(4) the court finds that the application of such paragraph to a party would constitute an undue

hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(c) REQUIREMENT FOR PERFORMANCE BOND.—The court in a medical malpractice liability action shall require the party that (pursuant to section 411(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability 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 subsection to pay the opposing party the costs incurred by the opposing party under the action.

(d) LIMIT ON ATTORNEY'S FEES PAID.—Attorneys' fees that are required to be paid under subsection (a) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency fee agreement, the amount of attorneys' fees for purposes of the preceding sentence shall not exceed the reasonable value of those services.

(e) RECORDS.—In order to receive attorneys' fees under subsection (a), counsel of record in the medical malpractice liability action involved shall maintain accurate, complete records of hours worked on the action, regardless of the fee arrangement with the client involved.

(f) 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. 414. JOINT AND SEVERAL LIABILITY FOR NONECONOMIC DAMAGES.

A defendant may be held severally but not jointly liable in a medical malpractice action for noneconomic damages. A person found liable for such damages in any such action may be found liable, if at all, only for those damages directly attributable to the person's proportionate share of fault or responsibility for the injury, and may not be found liable for damages attributable to the proportionate share of fault or responsibility of any other person (without regard to whether that person is a party to the action) for the injury, including any person bringing the action.

SEC. 415. STATUTE OF LIMITATIONS.

A medical malpractice liability claim may not be brought after the expiration of the 7-year period that begins on the date the alleged injury that is the subject of the claim occurred. If the commencement of such an action is stayed or enjoined, the running of the statute of limitations under this section shall be suspended for the period of the stay or injunction.

SEC. 416. UNIFORM STANDARD FOR DETERMINING NEGLIGENCE.

A defendant in a medical malpractice liability action may not be found to have acted negligently unless the defendant's conduct at the time of providing the health care services that are the subject of the action was not reasonable.

SEC. 417. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IMPOSITION OF HIGHER STANDARD OF PROOF.—In the case of a medical malpractice liability claim relating to services provided during labor or the delivery of a baby, if the health care professional against whom the claim is brought did not previously treat the individual alleged to have been injured for the pregnancy, the trier of fact may not find that the defendant committed malpractice and may not assess damages against the health care profes-

sional unless the malpractice is proven by clear and convincing evidence.

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another health care professional.

(c) EFFECTIVE DATE.—This section shall apply with respect to claims accruing or actions brought on or after the expiration of the 2-year period that begins on the date of the enactment of this Act.

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

SEC. 421. BASIC REQUIREMENTS.

(a) IN GENERAL.—A State's alternative dispute resolution system meets the requirements of this section if the system—

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

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

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

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator for Health Care Policy and Research of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of part 2 shall apply with respect to claims

brought under a State alternative dispute resolution system or the alternative Federal system in the same manner as such provisions apply with respect to medical malpractice liability actions brought in the State.

SEC. 422. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) IN GENERAL.—Not later than October 1 of each year (beginning with 1995), the Secretary, in consultation with the Attorney General, shall determine whether a State's alternative dispute resolution system meets the requirements of this part for the following calendar year.

(2) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection for a calendar year if the Secretary determines under paragraph (1) that the system meets the requirements of section 421.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1995, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims

during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 421(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims brought under the system shall be heard and resolved by arbitrators appointed by the Secretary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year—

(A) the State shall reimburse the United States (at such time and in such manner as the Secretary may require) for the costs incurred by the United States during the year as a result of the application of the system with respect to the State; and

(B) notwithstanding any other provision of law, no funds may be paid to the State (or to any unit of local government in the State) or to any entity in the State pursuant to the Public Health Service Act.

SEC. 423. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this part and the alternative Federal system established under section 422(b).

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

(A) the effect of the alternative dispute resolution systems on the cost of health care within each State,

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within the State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which medical malpractice liability claims shall be resolved on a no-fault basis.

PART 4—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 431. PERMITTING STATE PROFESSIONAL SOCIETIES TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.

(a) ROLE OF PROFESSIONAL SOCIETIES.—Notwithstanding any other provision of State or Federal law, a State agency responsible for the conduct of disciplinary actions for a type of health care practitioner may enter into agreements with State or county professional societies

of such type of health care practitioner to permit such societies to participate in the licensing of such health care practitioner, and to review any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of any such health care practitioner. Any such agreement shall comply with subsection (b).

(b) REQUIREMENTS OF AGREEMENTS.—Any agreement entered into under subsection (a) for licensing activities or the review of any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of a health care practitioner shall provide that—

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

(2) after the completion of such review, such society shall report its findings to the State agency with which it entered into such agreement;

(3) the conduct of such activities or review and the reporting of such findings be conducted in a manner which assures the preservation of confidentiality of health care information and of the review process; and

(4) no individual affiliated with such society is liable for any damages or injury directly caused by

the individual's actions in conducting such activities or review.

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

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

SEC. 432. STUDY OF INCENTIVES TO ENCOURAGE VOLUNTARY SERVICE BY PHYSICIANS.

(a) STUDY.—The Secretary shall conduct a study analyzing the existence and effectiveness of incentives adopted by State and local governments, insurers, medical societies, and other entities to encourage physicians (whether practicing or retired) to volunteer to provide health care services in medically underserved areas.

(b) REPORTS.—(1) Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit an interim report to Congress on the study conducted under subsection (a), together with the Secretary's recommendations for actions to increase the number of physicians volunteering to provide health care services in medically underserved areas.

(2) Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit a final report

to the Congress on the study conducted under subsection (a) (taking into account the effects of this subtitle on the incidence and costs of medical malpractice), together with the Secretary's recommendations for actions to increase the number of physicians volunteering to provide health care services in medically underserved areas.

SEC. 433. REQUIREMENTS FOR RISK MANAGEMENT PROGRAMS.

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

(b) REQUIREMENTS FOR INSURERS.—Each State shall require each entity which provides health care professional or provider liability insurance to health care professionals and health care providers in the State to—

(1) establish risk management programs based on data available to such entity or sanction programs of risk management for health care professionals and health care providers provided by other entities; and

(2) require each such professional or provider, as a condition of maintaining insurance, to partici-

pate in one program described in paragraph (1) at least once in each 3-year period.

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

SEC. 434. GRANTS FOR MEDICAL SAFETY PROMOTION.

(a) RESEARCH ON MEDICAL INJURY PREVENTION AND COMPENSATION.

(1) IN GENERAL.—The Secretary shall make grants for the conduct of basic research in the prevention of and compensation for injuries resulting from health care professional or health care provider malpractice, and research of the outcomes of health care procedures.

(2) PREFERENCE FOR RESEARCH ON CERTAIN ACTIVITIES.—In making grants under paragraph (1), the Secretary shall give preference to applications for grants to conduct research on the behavior of health care providers and health care professionals in carrying out their professional duties and of other participants in systems for compensating individuals injured by medical malpractice, the effects of financial and other incentives on such behavior, the determinants of compensation system outcomes, and the costs and benefits of alternative compensation policy options.

(3) APPLICATION.—The Secretary may not make a grant under paragraph (1) unless an applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary may require.

(b) GRANTS FOR LICENSING AND DISCIPLINARY ACTIVITIES.—

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

(2) USES FOR GRANTS.—A State may use a grant awarded under subsection (a) to develop and implement improved mechanisms for monitoring the practices of health care professionals or for conducting disciplinary activities.

(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States receiving grants under paragraph (1) to assist them in evaluating their medical practice acts and procedures and to encourage the use of efficient and effective early warning systems and other mechanisms for detecting practices which endanger patient safety and for disciplining health care professionals.

(4) APPLICATIONS.—The Secretary may not make a grant under paragraph (1) unless the applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary shall require.

(c) GRANTS FOR PUBLIC EDUCATION PROGRAMS.—

(1) IN GENERAL.—The Secretary shall make grants to States and to local governments, private nonprofit organizations, and health professional schools (as defined in paragraph (3)) for—

(A) educating the general public about the appropriate use of health care and realistic expectations of medical intervention;

(B) educating the public about the resources and role of health care professional licensing and disciplinary boards in investigating claims of incompetence or health care malpractice; and

(C) developing programs of faculty training and curricula for educating health care professionals in quality assurance, risk management, and medical injury prevention.

(2) APPLICATIONS.—The Secretary may not make a grant under paragraph (1) unless the applicant submits an application to the Secretary at such

time, in such form, in such manner, and containing such information as the Secretary shall require.

(3) HEALTH PROFESSIONAL SCHOOL DEFINED.—In paragraph (1), the term ''health professional school'' means a school of nursing (as defined in section 853(2) of the Public Health Service Act) or a school or program under section 799(1) of such Act.

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

Subtitle B—Treatment of Certain Activities Under the Antitrust Laws

SEC. 451. 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 452;

(2) the activity is within an additional safe harbor designated by the Attorney General under section 453; 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 454 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. 452. SAFE HARBORS.

The following activities are safe harbors for purposes of section 451(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 technology 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 453,

(C) that is the subject of an application for a certificate of review under section 454, or

(D) that is deemed a submission of a notification under section 455(a)(2)(B),

without regard to whether such an activity is carried out.

SEC. 453. 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 451(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 negotiate 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. 454. 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 453(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 457.

(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 453(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 necessary 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 deter-

mination 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 certificate 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 453(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 Secretary 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.—Information 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 nec-

essary 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 establishing that a person is entitled to the protections provided by such a certificate.

SEC. 455. 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 notification with respect to the venture under paragraph (1):

(A) SUBMISSION OF APPLICATION FOR CERTIFICATE OF REVIEW.—Any health care co-

operative venture for which an application for a certificate of review is filed with the Attorney General under section 453.

(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 454.

(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 subsection (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. 456. 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 452, the additional safe harbors designated under section 453, and the certificates of review issued under section 454, and—

(1) with respect to the safe harbors described in section 452, submit such recommendations to Congress as the Attorney General considers appropriate for modifications of such safe harbors;

(2) with respect to the additional safe harbors under designated under section 453, 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. 457. 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 452, 453, 454, and 455, including guidelines defining or relating 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 453 and grant certificates of review under section 454, 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 452 or 453; and

(B) describing specific types of activities which would meet the requirements for a certificate of review under section 454, 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. 458. 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. 459. 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. 501. ESTABLISHMENT OF PROGRAM TO MAKE COMMUNITY-BASED PRIMARY HEALTH GRANTS AND HEALTH SERVICE ACCESS GRANTS FOR FEDERALLY-QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—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. GRANTS FOR EXPANDED ACCESS TO PRIMARY HEALTH SERVICES.

''(a) COMMUNITY-BASED PRIMARY HEALTH CARE GRANT PROGRAM.—

''(1) 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.

''(2) ALLOTMENTS TO STATES.—

''(A) IN GENERAL.—From the amount available for allotment under subsection (c) 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 subparagraph (B)) multiplied by such amount available.

''(B) GRANT SHARE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the grant share of a State shall be the product of the need-adjusted population of the State (as determined under clause (ii)) multiplied by the Federal matching percentage of the State (as determined under clause (iii)), expressed as a percentage of the sum of the products of such factors for all States.

''(ii) NEED-ADJUSTED POPULATION.—

''(I) IN GENERAL.—For purposes of clause (i), 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 subclause (B)).

''(II) NEED INDEX.—For purposes of subclause (I), the need index of a State shall be the ratio of—

''(aa) the weighted sum of the geographic percentage of the State (as determined under subclause (III)), the poverty percentage of the State (as determined under subclause (IV)), and the multiple grant percentage of the State (as determined under subclause (V)); to

''(bb) the general population percentage of the State (as determined under subclause (VI)).

''(III) GEOGRAPHIC PERCENTAGE.—For purposes of subclause (II)(a), the geographic percentage of the State shall be the estimated population of the State that is residing in nonurbanized areas expressed as a percentage of the total nonurbanized population of all States. For purposes

of the preceding sentence, 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 current estimated population of the State.

''(IV) POVERTY PERCENTAGE.—For purposes of subclause (II)(aa), the poverty percentage of the State shall be the estimated number of people residing in the State with incomes below 160 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 subclause

(II)(aa), 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 subclause (VI) or be less than one-half of the States general population percentage.

''(VI) GENERAL POPULATION PERCENTAGE.—For purposes of subclause (II)(bb), 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.

''(iii) FEDERAL MATCHING PERCENTAGE.—

''(I) IN GENERAL.—For purposes of clause (i), the Federal matching

percentage of the State shall be equal to one, less the State matching percentage (as determined under subclause (B)).

''(II) STATE MATCHING PERCENTAGE.—For purposes of clause (i), the State matching percentage of the State shall be 0.50 multiplied by the ratio of the total taxable resource percentage (as determined under subclause (III)) to the need-adjusted population of the State (as determined under clause (ii)).

''(III) TOTAL TAXABLE RESOURCE PERCENTAGE.—For purposes of subclause (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.

''(C) ANNUAL ESTIMATES.—

''(i) IN GENERAL.—If the Secretary of Commerce does not produce the annual es-

timates required under subparagraph (B)(ii)(IV), such estimates shall be determined by multiplying the percentage of the population of the State that is below 160 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 clause (ii), the calculations required under this clause shall be made based on the most recent 3-year average of the total taxable resources of individuals within the State.

''(ii) DISTRICT OF COLUMBIA.—Notwithstanding clause (i), the calculations required under such clause 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.

''(iii) STATE OF ALASKA.—Notwithstanding clause (i), the calculations re-

quired under such clause 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.

''(D) MATCHING REQUIREMENT.—A State that receives an allotment under this subsection shall make available State resources (either directly or indirectly) to carry out this subsection in an amount that shall equal the State matching percentage for the State (as determined under subparagraph (B)(iii)(II)) divided by the Federal matching percentage (as determined under subparagraph (B)(iii)).

''(3) APPLICATION.—

''(A) IN GENERAL.—To be eligible to receive an allotment under this subsection, 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.

''(B) ASSURANCES.—A State application submitted under subparagraph (A) shall contain an assurance that—

''(i) the State will use amounts received under its allotment consistent with the requirements of this subsection; and

''(ii) the State will provide, from non-Federal sources, the amounts required under paragraph (2)(D).

''(4) USE OF FUNDS.—

''(A) IN GENERAL.—The State shall use amounts received under this subsection 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.

''(B) ELIGIBILITY.—To be eligible to receive a grant under subparagraph (A), an entity or consortium shall—

''(i) 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 subparagraph (C);

''(ii) 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

''(iii) 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.

''(C) SERVICES.—The services to be provided under a grant awarded under subparagraph (A) shall include—

''(i) one or more of the types of primary health services described in section 330(b)(1);

''(ii) one or more of the types of supplemental health services described in section 330(b)(2); and

''(iii) any other services determined appropriate by the administering entity of the State.

''(D) TARGET POPULATIONS.—Entities or consortia receiving grants under subparagraph (A) shall, in providing the services described in subparagraph (C), 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.

''(E) PRIORITY.—In awarding grants under subparagraph (A), the State shall—

''(i) give priority to entities or consortia that can demonstrate through the plan submitted under subparagraph (B) 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

''(ii) ensure that an equitable distribution of funds is achieved among urban and rural entities or consortia.

''(5) REPORTS AND AUDITS.—Each State shall prepare and submit to the Secretary annual reports concerning the State's activities under this subsection 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 subsection are being disbursed properly and are accounted for, and include the results of audits conducted under such procedures in the reports submitted under this paragraph.

''(6) PAYMENTS.—

''(A) ELIGIBILITY.—Each State for which an application has been approved by the Secretary under this subsection shall be eligible to receive payments under this subsection for each fiscal year in an amount not to exceed the State's allotment under paragraph (2) to be ex-

pended by the State in accordance with the terms of the application for the fiscal year for which the allotment is to be made.

''(B) 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.

''(C) STATE SPENDING OF PAYMENTS.—Payments to a State from the allotment under paragraph (2) for any fiscal year must be expended by the State in that fiscal year or in the succeeding fiscal year.

''(7) DEFINITION.—As used in this subsection, 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.

''(b) HEALTH SERVICES ACCESS GRANTS.—

''(1) ESTABLISHMENT OF PROGRAM.—From amounts appropriated under this subsection, the Secretary shall, acting through the Bureau of Health Care Delivery Assistance, award grants under this subsection to Federally Qualified Health

Centers (hereinafter referred to in this subsection as 'FQHC's') and other entities and organizations submitting applications under this subsection (as described in paragraph (3)) for the purpose of providing access to services for medically underserved populations (as defined in section 330(b)(3)) or in high impact areas (as defined in section 329(a)(5)) not currently being served by a FQHC.

''(2) ELIGIBILITY FOR GRANTS.—

''(A) IN GENERAL.—The Secretary shall award grants under this subsection to entities or organizations described in this subparagraph and subparagraph (B) 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—

''(i) 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

''(ii) have submitted applications to the Secretary to qualify as FQHC's under such section 1905(l)(2)(B); or

''(iii) have submitted a plan to the Secretary which provides that the entity will meet the requirements to qualify as a FQHC when operational.

''(B) NON FQHC ENTITIES.—

''(i) ELIGIBILITY.—The Secretary shall also make grants under this subsection 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 orga-

nizations (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.

''(ii) LIMITATION.—The Secretary shall provide in making grants to entities or organizations described in this subparagraph that no more than 10 percent of the funds provided for grants under this subsection shall be made available for grants to such entities or organizations.

''(3) APPLICATION REQUIREMENTS.—

''(A) IN GENERAL.—In order to be eligible to receive a grant under this subsection, 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 paragraph.

''(B) REQUIREMENTS.—An application submitted under this subsection must provide—

''(i)(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);

''(ii) 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

''(iii) 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 clause (ii); and

''(II) from patients not entitled to benefits under any such programs.

''(4) LIMITATIONS ON USE OF FUNDS.—

''(A) IN GENERAL.—From the amounts awarded to an entity or organization under this subsection, funds may be used for purposes of planning but may only be expended for the costs of—

''(i) assessing the needs of the populations or proposed areas to be served;

''(ii) preparing a description of how the needs identified will be met; and

''(iii) 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.

''(B) RECRUITING, TRAINING AND COMPENSATION OF STAFF.—From the amounts awarded to an entity or organization under this subsection, 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 expended existing sites.

''(C) FACILITIES AND EQUIPMENT.—From the amounts awarded to an entity or organization under this subsection, funds may be expended for the purposes of acquiring facilities and equipment but only for the cost of—

''(i) construction of new buildings (to the extent that new construction is found to be the most cost-efficient approach by the Secretary);

''(ii) acquiring, expanding, and modernizing of existing facilities;

''(iii) purchasing essential (as determined by the Secretary) equipment; and

''(iv) amortization of principal and payment of interest on loans obtained for purposes of site construction, acquisition, modernization, or expansion, as well as necessary equipment.

''(D) SERVICES.—From the amounts awarded to an entity or organization under this

subsection, funds may be expanded for the payment of services but only for the costs of—

''(i) 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;

''(ii) providing or arranging for any other service that a FQHC may provide and be reimbursed for under title XIX of such Act; and

''(iii) providing any unreimbursed costs of providing services as described in section 330(a) to patients.

''(5) PRIORITIES IN THE AWARDING OF GRANTS.—

''(A) CERTIFIED FQHC's.—The Secretary shall give priority in awarding grants under this subsection 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 subsection 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.

''(B) 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 subsection, 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.

''(C) 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 project and are able to demonstrate that such entity will incur

significant unreimbursed costs in providing such expanded services.

''(6) RETURN OF FUNDS TO SECRETARY FOR COSTS REIMBURSED FROM OTHER SOURCES.—To the extent that an entity or organization receiving funds under this subsection 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.

''(7) TERMINATION OF GRANTS.—

''(A) FAILURE TO MEET FQHC REQUIREMENTS.—

''(A) IN GENERAL.—With respect to any entity that is receiving funds awarded under this subsection 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 subsection, the Secretary shall terminate the award of funds under this subsection to such entity.

''(ii) NOTICE.—Prior to any termination of funds under this subsection 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 subsection.

''(B) REQUIREMENTS.—Upon any termination of funding under this subsection, the Secretary may (to the extent practicable)—

''(i) sell any property (including equipment) acquired or constructed by the entity using funds made available under this subsection 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 subsection; and

''(ii) recoup any funds provided to an entity terminated under this subsection.

''(c) AUTHORIZATION OF APPROPRIATIONS; ALLOCATION AMONG PROGRAMS.—

''(1) AUTHORIZATION.—There are authorized to be appropriated to carry out this section, $400,000,000 for fiscal year 1995, $800,000,000 for fiscal year 1996, $1,200,000,000 for fiscal year 1997, $1,600,000,000 for fiscal year 1998, and $1,600,000,000 for fiscal year 1999.

''(2) ALLOCATION.—Of the amounts appropriated pursuant to the authorization described in paragraph (1) to carry out this section in a fiscal year, 50 percent shall be allocated for grants under subsection (a) and 50 percent shall be allocated for grants under subsection (b).''.

(b) STUDY AND REPORT ON SERVICES PROVIDED BY COMMUNITY HEALTH CENTERS AND HOSPITALS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (hereinafter referred to in this subsection as the ''Secretary'') shall provide for a study to examine the relationship and interaction between community health centers and hospitals in providing services to individuals residing in medically underserved areas. The Secretary shall ensure that the

National Rural Research Centers participate in such study.

(2) REPORT.—The Secretary shall provide to the appropriate committees of Congress a report 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. 502. 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 National 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) or 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 recapture 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 pri-

mary 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 personal 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 in-

terest' 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 subsection (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. 503. 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'';

(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 determin-

ing 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. 504. 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) demonstrate 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; and

''(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 provi-

sion 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 FUNDINGS.—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 determines 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 for fiscal years 1996 and 1997.''.

SEC. 505. 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 title 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 con-

ducted 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 networks;

(iii) information demonstrating that the public or private entity has consulted with interested parties with respect to the operation of the rural health network, in-

cluding 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 public 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 aggre-

gate 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 network 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 conducted 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).

Subtitle B—Primary Care Provider Education

SEC. 511. 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

''(iii) 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 beginnning 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 Secu-

rity 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. 512. 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 Secu-

rity 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. 513. 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. 514. 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. 515. 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 OR 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 received 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. 516. 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. In reviewing such applications, the Secretary may not consider whether or not a State permits persons other than licensed physicians to perform legal abortions, and nothing in this Act or any other Act may be construed to conflict with any State law or regulation or program guideline pertaining to the professional qualifications required to perform or assist in abortions.

''(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. 521. 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 nonprofit 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. 522. 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.

Subtitle D—Limitation on Funding for Abortions

SEC. 531. LIMITATION ON FUNDING FOR ABORTIONS.

(a) IN GENERAL.—Nothing in this title shall be construed to authorize funding for any abortion, except to prevent the death of the mother.

(b) NO REQUIREMENT ON STATE AS A CONDITION OF FUNDING.—The provision of abortion services by a

State or any other entity shall not be regarded as a condition for participation in any grant or benefit authorized in this title.

TITLE VI—ADMINISTRATIVE COST SAVINGS

Subtitle A—Standardization of Claims Processing

SEC. 601. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary shall adopt standards relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health insurance plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

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

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the submission of paper claims for such services. Standards under paragraph (3) shall include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(b) USE OF TASK FORCES.—In adopting standards under this section—

(1) the Secretary shall take into account the recommendations of current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute;

(2) the Secretary shall consult with the National Association of Insurance Commissioners (and, with respect to standards under subsection (a)(3), the American National Standards Institute); and

(3) the Secretary shall, to the maximum extent practicable, seek to make the standards consistent with any uniform clinical data sets which have been adopted and are widely recognized.

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

(1) subsection (a)(1) relating to claims processing data, by not later than 12 months after the date of the enactment of this Act;

(2) subsection (a)(2) (relating to uniform claims forms) by not later than 12 months after the date of the enactment of this Act; and

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of the enactment of this Act, and

(B) subsection (a)(3) relating to transmission of information on other services, by such later date as the Secretary may determine it to be feasible.

(d) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

SEC. 602. APPLICATION OF STANDARDS.

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 601 with respect to

classes of services, that a significant number of claims for benefits for such services under health insurance plans are not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of such services must submit claims to health insurance plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection (a) for a class of services only if the Secretary finds that there would be a significant, measurable additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

(1) IN GENERAL.—If the Secretary imposes the requirement under subsection (a)—

(A) in the case of a requirement that imposes the standards relating to electronic transmission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health

insurance plan shall transmit electronically and directly to the plan on behalf of the beneficiary involved a claim for such services in accordance with such standards;

(B) any health insurance plan may reject any claim subject to the standards adopted under section 601 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health insurance plan (i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards or (ii) to require, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 601(a)(1); and

(D) the Secretary may impose a civil money penalty on any provider that knowingly and repeatedly submits claims in violation of such standards or on any health insurance plan (other than a health insurance plan described in paragraph (2)) that knowingly and repeatedly rejects claims in violation of subparagraph (B),

in an amount not to exceed $100 for each such claim.

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraph (D) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health insurance plan—

(A) that is subject to regulation by a State, and

(B) with respect to which the Secretary finds that—

(i) the State provides for application of the standards established under section 601, and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c)(1), the plan shall permit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic

manner that meets the requirements for acceptance of the claim under such subsection.

SEC. 603. PERIODIC REVIEW AND REVISION OF STANDARDS.

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 601;

(2) establish a schedule for the periodic review of such standards; and

(3) based upon such comments, suggestions, and review, revise such standards and promulgate such revisions.

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in 601, then, in the case of any claim for benefits submitted under a health insurance plan more than the minimum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a)(3), such standards shall apply under section 602 instead of the standards previously promulgated.

SEC. 604. HEALTH INSURANCE PLAN DEFINED.

In this title, the term ''health insurance plan'' has the meaning given such term in section 101(b)(1) and includes—

(1) the medicare program (under title XVIII of the Social Security Act) and medicare supplemental health insurance, and

(2) a State medicaid plan (approved under title XIX of such Act).

Subtitle B—Electronic Medical Data Standards

SEC. 611. MEDICAL DATA STANDARDS FOR HOSPITALS AND OTHER PROVIDERS.

(a) PROMULGATION OF HOSPITAL DATA STANDARDS.—

(1) IN GENERAL.—Between July 1, 1995, and January 1, 1996, the Secretary shall promulgate standards described in subsection (b) for hospitals concerning electronic medical data.

(2) REVISION.—The Secretary may from time to time revise the standards promulgated under this subsection.

(b) CONTENTS OF DATA STANDARDS.—The standards promulgated under subsection (a) shall include at least the following:

(1) A definition of a standard set of data elements for use by utilization and quality control peer review organizations.

(2) A definition of the set of comprehensive data elements, which set shall include for hospitals the standard set of data elements defined under paragraph (1).

(3) Standards for an electronic patient care information system with data obtained at the point of care, including standards to protect against the unauthorized use and disclosure of information.

(4) A specification of, and manner of presentation of, the individual data elements of the sets and system under this subsection.

(5) Standards concerning the transmission of electronic medical data.

(6) Standards relating to confidentiality of patient-specific information.

The standards under this section shall be consistent with standards for data elements established under section 601.

(c) OPTIONAL DATA STANDARDS FOR OTHER PROVIDERS.—

(1) IN GENERAL.—The Secretary may promulgate standards described in paragraph (2) concerning electronic medical data for providers that are not

hospitals. The Secretary may from time to time revise the standards promulgated under this subsection.

(2) CONTENTS OF DATA STANDARDS.—The standards promulgated under paragraph (1) for non-hospital providers may include standards comparable to the standards described in paragraphs (2), (4), and (5) of subsection (b) for hospitals.

(d) CONSULTATION.—In promulgating and revising standards under this section, the Secretary shall—

(1) consult with the American National Standards Institute, hospitals, with the advisory commission established under section 615, and with other affected providers, health insurance plans, and other interested parties, and

(2) take into consideration, in developing standards under subsection (b)(1), the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

SEC. 612. APPLICATION OF ELECTRONIC DATA STANDARDS TO CERTAIN HOSPITALS.

(a) MEDICARE REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—As of January 1, 1996, subject to paragraph (2), each hospital, as a requirement of

each participation agreement under section 1866 of the Social Security Act, shall—

(1) maintain clinical data included in the set of comprehensive data elements under section 611(b)(2) in electronic form on all inpatients,

(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically the data set, and

(3) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set, in accordance with the standards promulgated under section 611(a).

(b) WAIVER AUTHORITY.—Until January 1, 2000:

(1) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is a small rural hospital, for such period as the hospital demonstrates compliance with such requirements would constitute an undue financial hardship.

(2) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is in the process of developing a system to provide the required data set and executes agreements

with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 2000).

(3) The Secretary may waive the application of the requirement of subsection (a)(1) for a hospital that agrees to obtain from its records the data elements that are needed to meet the requirements of paragraphs (2) and (3) of subsection (a) and agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

(c) APPLICATION TO HOSPITALS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall provide that each hospital of the Department of Veterans Affairs shall comply with the requirements of subsection (a) in the same manner as such requirements would apply to the hospital if it were participating in the Medicare program.

(2) WAIVER.—The Secretary of Veterans Affairs may waive the application of such requirements to a hospital in the same manner as the Secretary of Health and Human Services may waive under subsection (b) the application of the requirements of subsection (a).

SEC. 613. ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.

(a) IN GENERAL.—Effective January 1, 2000, if a provider is required under a Federal program to transmit a data element that is subject to a presentation or transmission standard (as defined in subsection (b)), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(b) PRESENTATION OR TRANSMISSION STANDARD DEFINED.—In subsection (a), the term ''presentation or transmission standard'' means a standard, promulgated under subsection (b) or (c) of section 611, described in paragraph (4) or (5) of section 611(b).

SEC. 614. LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.

(a) IN GENERAL.—If standards with respect to data elements are promulgated under section 611 with respect to a class of provider, a health insurance plan may not require, for the purpose of utilization review or as a condition of providing benefits under the plan, that a provider in the class—

(1) provide any data element not in the set of comprehensive data elements specified under such standards, or

(2) transmit or present any such data element in a manner inconsistent with the applicable standards for such transmission or presentation.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health insurance plan (other than a health insurance plan described in paragraph (2)) that fails to comply with subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health insurance plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

SEC. 615. ADVISORY COMMISSION.

(a) IN GENERAL.—The Secretary shall establish an advisory commission including hospital executives, hospital data base managers, physicians, health services researchers, and technical experts in collection and use of data and operation of data systems. Such commission shall include, as ex officio members, a representative of the Director of the National Institutes of Health, the Administrator for Health Care Policy and Research, the Secretary of Veterans Affairs, and the Director of the Centers for Disease Control.

(b) FUNCTIONS.—The advisory commission shall monitor and advise the Secretary concerning—

(1) the standards established under this subtitle, and

(2) operational concerns about the implementation of such standards under this subtitle.

(c) STAFF.—From the amounts appropriated under subsection (d), the Secretary shall provide sufficient staff to assist the advisory commission in its activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for each of fiscal years 1995 through 2000 to carry out this section.

Subtitle C—Development and Distribution of Comparative Value Information

SEC. 621. STATE COMPARATIVE VALUE INFORMATION PROGRAMS FOR HEALTH CARE PURCHASING.

(a) PURPOSE.—In order to assure the availability of comparative value information to purchasers of health care in each State, the Secretary shall determine whether each State is developing and implementing a health care value information program that meets the criteria and schedule set forth in subsection (b).

(b) CRITERIA AND SCHEDULE FOR STATE PROGRAMS.—The criteria and schedule for a State health care value information program in this subsection shall be specified by the Secretary as follows:

(1) The State begins promptly after enactment of this Act to develop (directly or through contractual or other arrangements with 1 or more States, coalitions of health insurance purchasers, other entities, or any combination of such arrangements) information systems regarding comparative health values.

(2) The information contained in such systems covers at least the average prices of common health care services (as defined in subsection (d)) and

health insurance plans, and, where available, measures of the variability of these prices within a State or other market areas.

(3) The information described in paragraph (2) is made available within the State beginning not later than 1 year after the date of the enactment of this Act, and is revised as frequently as reasonably necessary, but at intervals of no greater than 1 year.

(4) Not later than 6 years after the date of the enactment of this Act the State has developed information systems that provide comparative costs, quality, and outcomes data with respect to health insurance plans and hospitals and made the information broadly available within the relevant market areas.

Nothing in this section shall preclude a State from providing additional information, such as information on prices and benefits of different health insurance plans, available.

(c) GRANTS TO STATES FOR THE DEVELOPMENT OF STATE PROGRAMS.—

(1) GRANT AUTHORITY.—The Secretary may make grants to each State to enable such State to plan the development of its health care value information program and, if necessary, to initiate the implementation of such program. Each State seeking such a grant shall submit an application therefor,

containing such information as the Secretary finds necessary to assure that the State is likely to develop and implement a program in accordance with the criteria and schedule in subsection (b).

(2) OFFSET AUTHORITY.—If, at any time within the 3-year period following the receipt by a State of a grant under this subsection, the Secretary is required by section 622 to implement a health care information program in the State, the Secretary may recover the amount of the grant under this subsection by offset against any other amount payable to the State under the Social Security Act. The amount of the offset shall be made available (from the appropriation account with respect to which the offset was taken) to the Secretary to carry out such section.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to make grants under this subsection, to remain available until expended.

(d) COMMON HEALTH CARE SERVICES DEFINED.—In this section, the term ''common health care services'' includes such procedures as the Secretary may specify and any additional health care services which a State may wish to include in its comparative value information program.

(e) STATE DEFINED.—In this title, the term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

SEC. 622. FEDERAL IMPLEMENTATION.

(a) IN GENERAL.—If the Secretary finds, at any time, that a State has failed to develop or to continue to implement a health care value information program in accordance with the criteria and schedule in section 621(b), the Secretary shall take the actions necessary, directly or through grants or contract, to implement a comparable program in the State.

(b) FEES.—Fees may be charged by the Secretary for the information materials provided pursuant to a program under this section. Any amounts so collected shall be deposited in the appropriation account from which the Secretary's costs of providing such materials were met, and shall remain available for such purposes until expended.

SEC. 623. COMPARATIVE VALUE INFORMATION CONCERNING FEDERAL PROGRAMS.

(a) DEVELOPMENT.—The head of each Federal agency with responsibility for the provision of health insurance or of health care services to individuals shall promptly develop health care value information relating to each program that such head administers and covering the same

types of data that a State program meeting the criteria of section 621(b) would provide.

(b) DISSEMINATION OF INFORMATION.—Such information shall be made generally available to States and to providers and consumers of health care services.

Subtitle D—Preemption of State Quill Pen Laws

SEC. 631. PREEMPTION OF STATE QUILL PEN LAWS.

(a) IN GENERAL.—Effective January 1, 1996, no effect shall be given to any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic form.

(b) SECRETARIAL AUTHORITY.—The Secretary may issue regulations to carry out subsection (a). Such regulations may provide for such exceptions to subsection (a) as the Secretary determines to be necessary to prevent fraud and abuse, with respect to controlled substances, and in such other cases as the Secretary deems appropriate.

TITLE VIII—ANTI-FRAUD AND ANTI-RATIONING

Subtitle A—Criminal Prosecution of Health Care Fraud

SEC. 701. 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. 702. 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.''.

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

SEC. 711. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO ALL FRAUD AND ABUSE AGAINST ANY HEALTH INSURANCE 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), in the matter before subparagraph (A), by inserting ''or of any health insurance plan,'' after ''subsection (i)(1)),''.

(2) In subsection (b)(1)(A), by inserting ''or under a health insurance 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 insurance plan, the portion of such amounts as is determined to have been paid by the plan shall be repaid to the plan.''.

(4) In subsection (i)—

(A) in paragraph (2), by inserting ''or under a health insurance plan'' before the period at the end, and

(B) in paragraph (5), by inserting ''or under a health insurance 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 INSURANCE 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 insurance 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 insurance plan''.

(D) In the second sentence of subsection (a)—

(i) by inserting after ''title XIX'' the following: ''or a health insurance 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 insurance 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 insurance 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 insurance plan''.

(H) In subsection (d)(2)—

(i) by striking ''title XIX,'' and inserting ''title XIX or under a health insurance plan,'', and

(ii) by striking ''State plan,'' and inserting ''State plan or the health insurance plan,''.

(2) TREBLE DAMAGES FOR CRIMINAL SANCTIONS.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

''(f) In addition to the fines that may be imposed under subsection (a), (b), or (c), any individual found to have violated the provisions of any of such subsections may be subject to treble damages.''.

(3) 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:

''(g) The Secretary shall—

''(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 INSURANCE 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 INSURANCE PLAN DEFINED.—For purposes of sections 1128A and 1128B, the term 'health insurance plan' means a health insurance program other than the medicare program, the medicaid program, or a State health care program.''.

(d) CONFORMING AMENDMENT.—Section 1128(b)(8)(B)(ii) of such Act (42 U.S.C. 1320a–7(b)(8)(B)(ii)) is amended by striking ''1128A'' and inserting ''1128A (other than a penalty arising from a health insurance plan, as defined in subsection (i))''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1995.

Subtitle C—Protection Against Rationing of Treatment

SEC. 721. PROHIBITION ON DENIAL OR TREATMENT BASED ON AGE, DISABILITY, DEGREE OF MEDICAL NEED, OR QUALITY OF LIFE.

No health care provider or health insurance plan may deny medical treatment, or insurance coverage of medical treatment, that a patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incom-

petent, against the wishes of the patient's guardian, on the basis of the patient's present or predicted age, disability, degree of medical need, or quality of life.

SEC. 722. ENFORCEMENT.

The remedies and procedures set forth in subsections (a) and (b) of Civil Rights Act of 1964 (42 U.S.C. 2000a–3) are the remedies and procedures available under this subtitle to nay person who is being subjected to denial of medical treatment or denial of insurance coverage for medical treatment, or who has reasonable grounds for believing that such person is about to be subjected to such denial, in violation of this subtitle. A person who has been subjected to such denial in violation of this subtitle, or if that person has died, a person who would be entitled to bring a cause of action for the dead person's wrongful death under the laws of the State in which the denial of treatment occurred, may also obtain damages, including reasonable and appropriate punitive damages.

○

HR 4202 IH——2

HR 4202 IH——3

HR 4202 IH——4

HR 4202 IH——5

HR 4202 IH——6

HR 4202 IH——7

HR 4202 IH——8

HR 4202 IH——9

HR 4202 IH——10

HR 4202 IH——11

HR 4202 IH——12

HR 4202 IH——13

HR 4202 IH——14

HR 4202 IH——15

HR 4202 IH——16

HR 4202 IH——17

HR 4202 IH——18

HR 4202 IH——19

HR 4202 IH——20

HR 4202 IH——21

HR 4202 IH——22

HR 4202 IH——23

HR 4202 IH——24