

103^D CONGRESS
2^D SESSION

H. R. 4469

To restrain health care costs and ensure adequate medical care for all Americans by providing for a State and market-based system of choice among qualified health plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 20, 1994

Mr. PETRI 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 restrain health care costs and ensure adequate medical care for all Americans by providing for a State and market-based system of choice among qualified health plans, and for other purposes.

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

3 **SECTION 1. SHORT TITLES; TABLE OF CONTENTS.**

4 (a) SHORT TITLES.—This Act may be cited as the
5 “Multiple Choice Health Care Act of 1994” or the
6 “Multicare Act of 1994”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Goals and strategies.
- Sec. 3. General definitions.

TITLE I—ESTABLISHMENT OF STATE MULTICARE PROGRAMS;
TAX CHANGES

Subtitle A—Establishment of State Multicare Programs

- Sec. 101. Grants to States for State multicare programs.
- Sec. 102. Requirement for certification of multicare plans.
- Sec. 103. Requirement for enrollment process.
- Sec. 104. Suggestive list of multicare services; limits on cost-sharing; treatment practice guidelines.
- Sec. 105. Continuity of coverage.
- Sec. 106. Contribution toward premium costs for eligible individuals.
- Sec. 107. Additional subsidies for poor and near poor individuals.
- Sec. 108. Establishment of reinsurance mechanism.
- Sec. 109. Consumer education and assistance.
- Sec. 110. Consumer rights enforcement.
- Sec. 111. Compliance of State income tax laws.
- Sec. 112. Distribution of information on average prices of common health care services.

Subtitle B—Federal Contribution Toward Multicare Plan Premiums; Tax Law Changes

- Sec. 121. Computation of amount of Federal contribution.
- Sec. 122. Termination of exclusion for employer-provided health care coverage and of deduction for health insurance costs of self-employed.
- Sec. 123. Termination of deduction for medical care.

TITLE II—REQUIREMENTS FOR MULTICARE PLANS

Subtitle A—General Requirements

- Sec. 201. Enrollment and continuity of coverage.
- Sec. 202. Covered services.
- Sec. 203. Premiums and cost-sharing; catastrophic protection.
- Sec. 204. Participation in reinsurance system.
- Sec. 205. Data requirement.
- Sec. 206. Medical malpractice reform and administrative cost savings.
- Sec. 207. Consumer rights.

Subtitle B—Multiple Employer Health Benefits Protections

- Sec. 211. Limited exemption under preemption rules for multiple employer plans providing health benefits subject to certain Federal standards.

“Part 7—Multiple Employer Health Plans

- “Sec. 701. Definitions.
- “Sec. 702. Exempted multiple employer plans providing benefits in the form of medical care relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.
- “Sec. 703. Exemption procedure.

- “Sec. 704. Eligibility requirements.
- “Sec. 705. Additional requirements applicable to exempted arrangements.
- “Sec. 706. Disclosure to participating employers by arrangements providing medical care.
- “Sec. 707. Maintenance of reserves.
- “Sec. 708. Corrective actions.
- “Sec. 709. Expiration, suspension, or revocation of exemption.
- “Sec. 710. Review of actions of the Secretary.

- Sec. 212. Clarification of scope of preemption rules.
- Sec. 213. Clarification of treatment of single employer arrangements.
- Sec. 214. Clarification of treatment of certain collectively bargained arrangements.
- Sec. 215. Employee leasing healthcare arrangements.
- Sec. 216. Enforcement provisions relating to multiple employer welfare arrangements and employee leasing healthcare arrangements.
- Sec. 217. Filing requirements for health benefit multiple employer welfare arrangements.
- Sec. 218. Cooperation between Federal and State authorities.
- Sec. 219. Effective date; transitional rules.

Subtitle C—Repeal of COBRA Continuation Requirements

- Sec. 221. Repeal of requirements of the Internal Revenue Code of 1954.
- Sec. 222. Repeal of requirements of Employee Retirement Income Security Act of 1974.
- Sec. 223. Repeal of requirements of Public Health Service Act.

TITLE III—STATES WITHOUT STATE MULTICARE PROGRAMS; FEDERAL HEALTH CARE PROGRAMS; NATIONAL REINSURANCE POOL

Subtitle A—Multicare Plans in States without State Multicare Programs

- Sec. 301. General provisions.

Subtitle B—Federal Health Care Programs

- Sec. 321. Medicare program.
- Sec. 322. Federal Employees Health Benefit Program.
- Sec. 323. Report recommending integration of CHAMPUS, Veterans health, and Indian Health Services.
- Sec. 324. Consumer rights for individuals in Federal programs.

Subtitle C—National Reinsurance Mechanism

- Sec. 331. National reinsurance mechanism.

TITLE IV—MEDICAL MALPRACTICE LIABILITY REFORM

Subtitle A—Medical Malpractice Liability Reform

PART 1—GENERAL PROVISIONS

- Sec. 401. Federal reform of medical malpractice liability actions.
- Sec. 402. Definitions.
- Sec. 403. Effective date.

PART 2—UNIFORM STANDARDS FOR MEDICAL MALPRACTICE LIABILITY
ACTIONS

- Sec. 411. Statute of limitations.
- Sec. 412. Requirement for initial resolution of action through alternative dispute resolution.
- Sec. 413. Relation to alternative dispute resolution of Federal agencies.
- Sec. 414. Mandatory pre-trial settlement conference.
- Sec. 415. Calculation and payment of damages.
- Sec. 416. Treatment of attorney's fees and other costs.
- Sec. 417. Joint and several liability.
- Sec. 418. Uniform standard for determining negligence.
- Sec. 419. Application of medical practice guidelines in malpractice liability actions.
- Sec. 420. Special provision for certain obstetric services.
- Sec. 421. Preemption.

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

- Sec. 431. Basic requirements for ADR.
- Sec. 432. Certification of State systems.
- Sec. 433. Reports on implementation and effectiveness of alternative dispute resolution systems.

Subtitle B—Other Requirements and Programs

- Sec. 441. Facilitating development and use of medical practice guidelines.
- Sec. 442. Permitting State professional societies to participate in disciplinary activities.

TITLE V—ADMINISTRATIVE COST SAVINGS

Subtitle A—Standardization of Claims Processing

- Sec. 501. Adoption of data elements, uniform claims, and uniform electronic transmission standards.
- Sec. 502. Application of standards.
- Sec. 503. Periodic review and revision of standards.
- Sec. 504. Health benefit plan defined.

Subtitle B—Electronic Medical Data Standards

- Sec. 511. Medical data standards for hospitals and other providers.
- Sec. 512. Application of electronic data standards to certain hospitals.
- Sec. 513. Electronic transmission to Federal agencies.
- Sec. 514. Limitation on data requirements where standards in effect.
- Sec. 515. Advisory commission.

TITLE VI—REMOVING RESTRICTIONS ON MANAGED CARE

- Sec. 601. Removing restrictions on managed care.

TITLE VII—MODIFICATION OF THE OPERATION OF THE
ANTITRUST LAWS TO HOSPITALS

- Sec. 701. Purpose.
- Sec. 702. Exemptions from the operation of the antitrust laws.

Sec. 703. Reports.
Sec. 704. Definitions.

1 **SEC. 2. GOALS AND STRATEGIES.**

2 (a) GOALS.—The goals of this Act are—

3 (1) to restrain health care price inflation
4 through market incentives and competition,

5 (2) to ensure adequate medical care for all
6 Americans,

7 (3) to distribute Federal health subsidies more
8 fairly across the population,

9 (4) to allow meaningful consumer choice among
10 health care plans and providers,

11 (5) to allow States flexibility to tailor health
12 programs to local needs, and

13 (6) to accomplish these goals at no added cost
14 to taxpayers.

15 (b) STRATEGIES.—The strategies to be used in this
16 Act to achieve these goals are—

17 (1) to increase the role and flexibility of State
18 and local governments in providing health care infor-
19 mation to consumers, in ensuring health care for the
20 needy, and in promoting competition among health
21 plans,

22 (2) to replace the current tax exemption for em-
23 ployer-paid insurance with a payment towards health
24 care premiums for all Americans,

1 (3) to increase public-private partnership by al-
2 lowing individuals in public programs to meet their
3 health care needs through the purchase of private
4 health insurance,

5 (4) to reduce the amount of direct regulation of
6 health care providers, and

7 (5) to allow individuals to participate in open
8 enrollment health plans.

9 **SEC. 3. GENERAL DEFINITIONS.**

10 In this Act:

11 (1) The term “acute care services” means such
12 services, identified by the Secretary, of the type cov-
13 ered under multicare plans.

14 (2) The term “eligible individual” means, with
15 respect to a State, an individual—

16 (A) who is a citizen or national of the
17 United States, an alien lawfully admitted for
18 permanent residence, or an alien otherwise law-
19 fully residing permanently in the United States
20 under color of law, and

21 (B) who is a resident of the State (as de-
22 fined by the Secretary).

23 (3) The term “exempt individual” means an in-
24 dividual who—

1 (A) is entitled to benefits under part A or
2 part B of title XVIII of the Social Security
3 Act);

4 (B) is entitled to medicare and dental care
5 under section 1074(a) of title 10, United States
6 Code; or

7 (C) is a member on active duty (as defined
8 in section 101(22) of such title) of the armed
9 forces of the United States.

10 (4) The term “family income” means the total
11 value of income of the individual and the individual’s
12 family members (as defined by the Secretary), as de-
13 fined by the State in which the individual resides
14 and includes at least—

15 (A) cash income,

16 (B) aid under title IV of the Social Secu-
17 rity Act (relating to the aid to families with de-
18 pendent children program) and assistance re-
19 ceived under title XVI of such Act,

20 (C) the value of State or Federal housing
21 assistance (as determined by the State),

22 (D) the cash value of food stamps,

23 (E) general relief, and

24 (F) other State and local cash welfare pay-
25 ment.

1 (5) The term “Federal official poverty level”
2 means the income official poverty line defined by the
3 Office of Management and Budget and revised an-
4 nually in accordance with section 673(2) of the Om-
5 nibus Budget Reconciliation Act of 1981.

6 (6) The term “medicaid eligible individual”
7 means an individual who is entitled to medical as-
8 sistance under a State medicaid plan, or would be so
9 eligible but for the election of a State under section
10 101(c)(1)(A).

11 (7) The terms “medicaid opt-out State” and
12 “medicaid opt-in State” mean a State that in its
13 multicare program has elected the option described
14 in section 101(c)(1)(A) or in section 101(c)(1)(B),
15 respectively.

16 (8) The term “multicare plan” means a health
17 benefits plan which is determined to meet the re-
18 quirements of title II, and includes a health benefit
19 plan in which an individual is enrolled under chapter
20 89 of title 5, United States Code, if the plan partici-
21 pates in a reinsurance system that meets the re-
22 quirements of section 108.

23 (9) The term “near poor individual” means an
24 individual whose family income is greater than 100
25 percent, but does not exceed 150 percent, of the

1 Federal official poverty level applicable to a family
2 of the size involved.

3 (10) The term “open enrollment multicare
4 plan” means a multicare plan offered in an area of
5 a State that permits all eligible residents of the area
6 to enroll under the plan.

7 (11) The term “poor individual” means an indi-
8 vidual whose family income does not exceed the Fed-
9 eral official poverty level applicable to a family of
10 the size involved.

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

13 (13) The term “State” includes the District of
14 Columbia, Puerto Rico, the Virgin Islands, Guam,
15 American Samoa, and the Northern Mariana Is-
16 lands.

17 (14) The term “State medicaid plan” means
18 the plan of a State approved under title XIX of the
19 Social Security Act, and includes a statewide medi-
20 cal assistance plan operating under section 1115 of
21 such Act.

22 (15) The term “State multicare program”
23 means such a program that the Secretary finds
24 meets the requirements of title I.

1 **TITLE I—ESTABLISHMENT OF**
2 **STATE MULTICARE PRO-**
3 **GRAMS; TAX CHANGES**

4 **Subtitle A—Establishment of State**
5 **Multicare Programs**

6 **SEC. 101. GRANTS TO STATES FOR STATE MULTICARE PRO-**
7 **GRAMS.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services shall provide grants to each State to es-
10 tablish a State multicare program for the offering of com-
11 peting multicare plans in the State.

12 (b) GRANT APPLICATION.—No grant may be made
13 under this section to a State unless—

14 (1) the State has submitted an application in
15 such form and manner as the Secretary shall speci-
16 fy, and

17 (2) the Secretary determines that the applica-
18 tion provides for the operation of a State multicare
19 program that meets the requirements of the succeed-
20 ing sections of this title.

21 (c) AMOUNT OF GRANT.—

22 (1) BASE AMOUNT.—For any State, subject to
23 the succeeding provisions of this subsection, the
24 amount of a grant under this section, with respect
25 to each eligible individual (other than an exempt in-

1 dividual) enrolled in a multicare plan, is equal to the
2 Federal contribution amount (determined under sec-
3 tion 121) for the class of enrollment involved.

4 (2) SUPPLEMENTAL PAYMENT TO STATES.—
5 The amount of such a grant shall be increased, with
6 respect to each eligible individual (other than an ex-
7 empt individual) who is not enrolled in a multicare
8 plan, by an amount equal to the amount that would
9 have been paid under paragraph (1) if the individual
10 were enrolled in a multicare plan.

11 (3) ADDITIONAL AMOUNTS.—The amount of
12 such a grant shall be further increased by the sum
13 of the following:

14 (A) MEDICAID SAVINGS.—

15 (i) IN GENERAL.—The amount de-
16 scribed in clause (ii) for the State, in-
17 creased (for each year after the last full
18 year referred to in clause (ii)(I), up to the
19 year involved) by the applicable inflator
20 (specified in section 107(b)(2)(D)) for the
21 year, and subject to any adjustment for
22 changes in population under section
23 107(b)(4).

1 (ii) AMOUNT DESCRIBED.—The
2 amount described in this clause for a State
3 is—

4 (I) the total amount of Federal
5 payments made to the State under
6 section 1903(a) of the Social Security
7 Act for acute care services during the
8 last full year prior to the implementa-
9 tion of a State multicare program in
10 the State, reduced by

11 (II) the product of \$400 and the
12 average number of individuals entitled
13 to assistance for such services under
14 the medicaid program in the State
15 during that year.

16 (B) CASH ASSISTANCE SAVINGS.—The
17 total amount of the reductions in Federal pay-
18 ments under title IV or XVI of the Social Secu-
19 rity Act, the Food Stamp Act, and other Fed-
20 eral welfare programs for residents of a State
21 resulting directly from the implementation of
22 the financial assistance provided under section
23 107 as a substitute for medical assistance for
24 acute care services under the State medicaid
25 plan.

1 (d) USE OF FUNDS.—

2 (1) USE OF BASE AMOUNTS.—At least 97 per-
3 cent of the funds provided to a State under sub-
4 section (c)(1) with respect to enrollment of an eligi-
5 ble individual shall be used only, in accordance with
6 section 106, for payment of all or a portion of the
7 premium for enrollment of such an eligible individual
8 in a multicare plan under the multicare program.

9 (2) USE OF FEDERAL SUPPLEMENTAL
10 AMOUNTS.—At least 97 percent of the funds pro-
11 vided to the State under subsection (c)(2) shall be
12 used only towards—

13 (A) financing the State reinsurance mecha-
14 nism under section 108, or

15 (B) providing additional subsidies for poor
16 and near poor individuals under section 107.

17 (3) USE OF ADDITIONAL AMOUNTS FOR FINAN-
18 CIAL ASSISTANCE.—At least 97 percent of the funds
19 provided to the State under subsection (c)(3) shall
20 be used only for additional financial assistance for
21 poor and near poor individuals under section 107.

22 (4) APPLICATION TOWARD ADMINISTRATIVE
23 COSTS.—

24 (A) IN GENERAL.—Except as provided in
25 the previous paragraphs, Federal grant funds

1 may only be used to finance administrative
2 costs.

3 (B) ADMINISTRATIVE COSTS.—In this
4 paragraph, the term “administrative costs” in-
5 cludes costs associated with—

6 (i) soliciting bids and negotiating with
7 multicare plans and certifying compliance
8 of plans with the requirements of title II,

9 (ii) preparing and disseminating com-
10 parative value information on multicare
11 plans,

12 (iii) planning, developing, and imple-
13 menting the process for enrollment of eligi-
14 ble individuals in multicare plans, and

15 (iv) establishing and administering the
16 reinsurance mechanism under section 108
17 (not including reinsurance payments made
18 under such a mechanism).

19 (5) REQUIRED USE OF STATE SUPPLEMENTAL
20 FUNDS.—

21 (A) IN GENERAL.—Each State multicare
22 program shall assure that—

23 (i) at least 97 percent of the funds de-
24 scribed in subparagraph (C) are used to-
25 wards—

1 (I) financing the State reinsur-
2 ance mechanism under section 108, or

3 (II) providing additional sub-
4 sidies for poor and near poor individ-
5 uals under section 107, and

6 (ii) at least 97 percent of the funds
7 described in section 107(b)(5) (relating to
8 State welfare savings) are used towards
9 providing additional subsidies for poor and
10 near poor individuals under section 107.

11 (B) STATE SUPPLEMENTAL FUNDS DE-
12 SCRIBED.—The funds described in this sub-
13 paragraph are the amount by which (i) the
14 State aggregate contribution amount (described
15 in section 106(b)(2)), exceeds (ii) the aggregate
16 amounts of the contributions paid by the State
17 under section 106(b)(1)(B) (determined as if
18 the reference to “97 percent” in such section
19 were a reference to “100 percent”).

20 (e) SPECIAL RULES FOR TERRITORIES.—The Sec-
21 retary may establish such special rules as may be appro-
22 priate to adapt the provisions of this title (and titles II
23 and III) in the case of Puerto Rico, the Virgin Islands,
24 Guam, American Samoa, and the Northern Mariana Is-
25 lands.

1 **SEC. 102. REQUIREMENT FOR CERTIFICATION OF**
2 **MULTICARE PLANS.**

3 (a) PROCESS.—

4 (1) IN GENERAL.—Each State multicare pro-
5 gram shall provide a mechanism for certifying at
6 least 2 competing open enrollment multicare plans in
7 all areas of the State.

8 (2) WAIVER AUTHORITY.—The Secretary may
9 waive the requirement of paragraph (1) that a State
10 multicare program offer more than 1 open enroll-
11 ment multicare plan in all areas of a State if the
12 Secretary finds that a single, coordinated open en-
13 rollment multicare plan would be more cost-effective.

14 (b) REQUIREMENTS FOR CERTIFICATION.—A pro-
15 gram shall not certify a multicare plan for purposes of
16 subsection (a) unless the program determines that the
17 plan—

18 (1) is in compliance with the requirements of
19 title II (including requirements relating to consumer
20 education and assistance and consumer rights) and
21 other Federal health care regulations, and

22 (2) meets such standards as the program or the
23 Secretary may establish relating to financial solvency
24 and quality of care.

25 (c) TREATMENT OF MULTI-STATE REGIONS.—The
26 State multicare programs of one or more adjacent States

1 may establish agreements, consistent with the require-
2 ments of this Act, governing the certification and oper-
3 ation of multicare plans that enroll individuals residing in
4 an area that includes portions of such States.

5 (d) GENERAL AUTHORITY OF STATES.—Nothing in
6 this Act shall be construed as preventing a State—

7 (1) from sponsoring a multicare plan,

8 (2) from requiring individuals to select enroll-
9 ment under the plan,

10 (3) from providing additional subsidies for indi-
11 viduals selecting such a plan, or

12 (4) from requiring employers to provide for
13 payment of multicare premiums of employees
14 through automatic payroll deductions.

15 (e) TREATMENT OF FEHBP PLANS.—Nothing in
16 this title (other than section 108) shall be construed as
17 authorizing a State to regulate health plans offered under
18 the Federal Employees Health Benefits Program, under
19 chapter 89, of title 5, United States Code.

20 **SEC. 103. REQUIREMENT FOR ENROLLMENT PROCESS.**

21 (a) REQUIREMENT.—

22 (1) IN GENERAL.—Each State multicare pro-
23 gram—

24 (A) shall provide a mechanism for the en-
25 rollment, during open season periods, of eligible

1 individuals (other than exempt individuals) who
2 are residents of the State in multicare plans,
3 and

4 (B) may require each eligible individual
5 (other than such an exempt individual or an in-
6 dividual described in paragraph (2)) residing in
7 the State to be enrolled in a multicare plan and
8 may require that such a plan be a multicare
9 plan operated directly by the program.

10 (2) EXCEPTION.—A State may, at its option,
11 except from the requirement described in paragraph
12 (1)(B) any of the following:

13 (A) An individual who is within a class of
14 individuals eligible for health care benefits from
15 the Department of Veterans Affairs.

16 (B) An individual who is incarcerated.

17 (C) An individual who is within any other
18 class of individuals with respect to whom the
19 State determines that members of the class are
20 likely to have health care coverage reasonably
21 comparable to the coverage available through
22 enrollment in a multicare plan.

23 (b) PERMITTING CLOSED ENROLLMENT PLANS.—

24 (1) IN GENERAL.—A State multicare program
25 may not deny approval of a plan (such as an em-

1 employer self-insured plan or a plan based on an asso-
2 ciation with or membership in a group) as a
3 multicare plan because the plan is not an open en-
4 rollment multicare plan and limits enrollment to in-
5 dividuals associated with an employer or association.

6 (2) CONSTRUCTION.—Nothing in this sub-
7 section shall be construed as waiving the require-
8 ment under section 204 that a multicare plan par-
9 ticipate in a reinsurance system (established under
10 the State multicare program under section 108 or by
11 the Secretary under section 301 or 331).

12 (c) DISTRIBUTION OF COMPARATIVE VALUE INFOR-
13 MATION.—

14 (1) IN GENERAL.—Each State multicare pro-
15 gram shall provide for the distribution to eligible in-
16 dividuals of comparative value information. Such
17 program may require that the information conform
18 to the national standards established under para-
19 graph (3).

20 (2) CONTENTS.—The comparative value infor-
21 mation shall include, with respect to each multicare
22 plan offered, information on—

23 (A) benefits, premiums costs, and patient
24 cost-sharing arrangements (including projected
25 annual costs for medium-risk individuals), and

1 (B) indicators of the quality of health care
2 offered under the plan.

3 (3) STANDARDS.—The Secretary shall establish
4 national standards for the collection and distribution
5 of comparative value information.

6 (d) USE OF EMPLOYERS.—A State multicare pro-
7 gram may require employers to distribute the comparative
8 value information concerning multicare plans to employees
9 and to require automatic payroll deductions for payment
10 of premiums for such plans by such employees.

11 **SEC. 104. SUGGESTIVE LIST OF MULTICARE SERVICES; LIM-**
12 **ITS ON COST-SHARING; TREATMENT PRAC-**
13 **TICE GUIDELINES.**

14 (a) MULTICARE SERVICES.—

15 (1) NATIONAL SUGGESTED LIST.—The Sec-
16 retary shall develop a national list of services which
17 may be covered by a multicare plan. Such list shall
18 include those services identified as cost-effective by
19 the Secretary.

20 (2) STATE SUGGESTED LIST.—

21 (A) ESTABLISHMENT.—Each State
22 multicare program shall establish a State-spe-
23 cific list of covered health care services. Such
24 list may, but need not, include the services in-

1 cluded in the national standard list developed
2 under paragraph (1).

3 (B) LIMITATIONS.—A State multicare pro-
4 gram may, with respect to a covered service,
5 limit the amount, duration, or scope of the serv-
6 ice to be included in the list of services.

7 (b) CATASTROPHIC PROTECTION.—A State multicare
8 program may decrease, under section 203(e)(2)(C) or oth-
9 erwise, the amount of the cost-sharing limit otherwise per-
10 mitted under multicare plans.

11 (c) SUGGESTED TREATMENT PRACTICE GUIDE-
12 LINES.—The Secretary shall publish and distribute treat-
13 ment practice guidelines for use by multicare plans under
14 State multicare programs.

15 **SEC. 105. CONTINUITY OF COVERAGE.**

16 (a) PROCESS.—Each State multicare program shall
17 establish procedures, including procedures for administer-
18 ing changes in enrollment in cases of changes in area of
19 residence, employment, and family status, to ensure for
20 eligible individuals residing in each State continuity of cov-
21 erage under a multicare plan.

22 (b) GUARANTEED ISSUANCE AND PROHIBITION OF
23 PREEXISTING CONDITION EXCLUSIONS.—In addition,
24 each State multicare program shall establish procedures
25 to ensure—

1 (1) the multicare plans do not deny coverage to
2 any eligible individual, and

3 (2) multicare plans do not exclude coverage on
4 the basis of preexisting conditions.

5 **SEC. 106. CONTRIBUTION TOWARD PREMIUM COSTS FOR**
6 **ELIGIBLE INDIVIDUALS.**

7 (a) IN GENERAL.—Each State multicare program
8 shall provide, for each eligible individual (other than an
9 exempt individual) enrolled in a multicare plan under the
10 program for a contribution toward the premium cost of
11 such enrollment.

12 (b) AMOUNT OF CONTRIBUTION.—

13 (1) IN GENERAL.—The amount of the contribu-
14 tion under subsection (a) with respect to an eligible
15 individual is equal to the sum of—

16 (A) not less than 97 percent of the funds
17 provided to a State under section 101(d)(1)
18 with respect to enrollment of the eligible indi-
19 vidual, and

20 (B) not less than 97 percent of the amount
21 specified under paragraph (2) with respect to
22 the enrollment of the individual.

23 Except as the Secretary may otherwise permit, such
24 contribution shall be provided on a monthly basis.

25 (2) STATE CONTRIBUTION AMOUNT.—

1 (A) INITIAL AMOUNT.—

2 (i) IN GENERAL.—Subject to subpara-
3 graph (C), the State aggregate contribu-
4 tion amount for a year is equal to—

5 (I) the total amount of available
6 funds (determined under clause (ii))
7 for the year, divided by

8 (II) the average number of indi-
9 viduals described in clause (iii) for the
10 year.

11 (ii) FUNDS AVAILABLE.—The total
12 amount of available funds for a year is
13 equal to the increase in all State revenues
14 (including employment-related excise taxes)
15 effected as a result of section 111 and the
16 amendment made by section 123.

17 (iii) INDIVIDUALS DESCRIBED.—The
18 number of individuals described in this
19 clause for a year is the estimated total av-
20 erage population of the State in the year,
21 less the sum of the average number of ex-
22 empt individuals (as defined in section
23 121(d)) in the State in the year.

24 (B) APPLICATION BY ENROLLMENT
25 CLASS.—The State shall adjust the State aggre-

1 gate contribution amount determined under this
2 section among enrollment classes established
3 under section 121(c)(1) in the same manner as
4 the Secretary provides for adjustment of the
5 Federal contribution amount among such class-
6 es under section 121(c)(2).

7 **SEC. 107. ADDITIONAL SUBSIDIES FOR POOR AND NEAR**
8 **POOR INDIVIDUALS.**

9 (a) REQUIREMENT.—

10 (1) IN GENERAL.—Each State multicare pro-
11 gram shall include a mechanism for providing addi-
12 tional financial assistance, consistent with this sec-
13 tion, to poor individuals and near poor individuals
14 (as defined in section 3) to assist them in purchas-
15 ing coverage under multicare plans.

16 (2) INCOME DETERMINATIONS.—Each such
17 program is responsible for making income deter-
18 minations necessary to determine if individuals are
19 poor or near poor individuals.

20 (b) MAINTENANCE OF EFFORT REQUIRED.—

21 (1) IN GENERAL.—The financial assistance pro-
22 vided under this section shall not be less than the
23 maintenance-of-effort level described in paragraph
24 (2).

1 (2) MAINTENANCE-OF-EFFORT LEVEL.—Sub-
2 ject to paragraphs (4) and (5), for a State for a
3 year, the “maintenance-of-effort level” described in
4 this subparagraph is equal to—

5 (A) the total amount of expenditures made
6 under the State medicaid plan (net of any Fed-
7 eral payments under section 1903(a) of the So-
8 cial Security Act) during the last full year prior
9 to the implementation of a State multicare pro-
10 gram in the State for acute care services, in-
11 creased

12 (B) for each subsequent year (up to the
13 year involved) by the applicable inflator (speci-
14 fied in paragraph (3)) for the year.

15 Expenditures under paragraph (A) shall include pay-
16 ments to disproportionate share hospitals under sec-
17 tion 1923 of the Social Security Act.

18 (3) APPLICABLE INFLATOR.—For purposes of
19 paragraph (1)(B), the applicable inflator for a year
20 is the lesser of—

21 (A) the rate of health care inflation for the
22 year, as determined by the Secretary, or

23 (B) the percentage increase in the
24 consumer price index for all urban consumers

1 (all items; U.S. city average) for the year (as
2 specified by the Secretary), plus—

3 (i) for the first year in which the
4 State multicare program is implemented, 3
5 percentage points,

6 (ii) for the second such year, 2.5 per-
7 centage points,

8 (iii) for the third such year, 2.0 per-
9 centage points,

10 (iv) for the fourth such year, 1.5 per-
11 centage points,

12 (v) for the fifth such year, 1.0 per-
13 centage points,

14 (vi) for the sixth such year 0.5 per-
15 centage points, and

16 (vii) for any subsequent year, 0 per-
17 centage points.

18 (4) ADJUSTMENT TO REFLECT CHANGES IN
19 POPULATION.—The Secretary may adjust the main-
20 tenance-of-effort level of a State to reflect changes
21 in the population of poor and near poor individuals
22 in the State between the year described in paragraph
23 (2)(A) and the year involved.

24 (5) STATE SAVINGS FROM WELFARE PRO-
25 GRAMS.—The maintenance-of-effort level for a State

1 shall be increased by the total amount of the reduc-
2 tions in State payments under title IV or XVI of the
3 Social Security Act, the Food Stamp Act, and other
4 Federal welfare programs (net of any Federal pay-
5 ments) for residents of a State resulting directly
6 from the implementation of the financial assistance
7 provided under this section as a substitute for medi-
8 cal assistance for acute care services under the State
9 medicaid plan.

10 (c) MEDICAID REVISIONS.—Notwithstanding any
11 other provision of law—

12 (1) a State may deny medical assistance for
13 acute care services under its State medicaid plan to
14 any poor or near poor individual who is eligible to
15 enroll under a multicare plan and for whom addi-
16 tional financial assistance is made available under
17 this section; and

18 (2) no Federal financial participation is allow-
19 able under section 1903(a) of the Social Security
20 Act for expenditures relating to acute care services
21 to any poor or near poor individual who is eligible
22 to enroll under a multicare plan and for whom addi-
23 tional financial assistance is made available under
24 this section.

1 Expenditures under paragraph (2) shall include payments
2 to disproportionate share hospitals under section 1923 of
3 the Social Security Act.

4 (d) SPECIFIC LIMITATIONS ON COST-SHARING.—

5 (1) SLIDING SCALE.—The premiums and cost-
6 sharing imposed under the lowest cost multicare
7 plans for poor and near poor individuals shall be de-
8 termined on a sliding scale based on the family in-
9 come of an individual.

10 (2) MAXIMUM LEVEL.—Such premiums and
11 cost-sharing may not exceed—

12 (A) in the case of a poor individual, 5 per-
13 cent of the individual's family income, and

14 (B) in the case of a near-poor individual,
15 5 percent of the Federal official poverty level
16 (applicable to a family of the size involved) plus
17 10 percent of the amount by which the individ-
18 ual's family income exceeds such poverty level.

19 **SEC. 108. ESTABLISHMENT OF REINSURANCE MECHANISM.**

20 (a) ESTABLISHMENT.—

21 (1) IN GENERAL.—Each State multicare pro-
22 gram shall include a reinsurance mechanism for high
23 risk individuals enrolled (or enrolling) in multicare
24 plans offered in the State.

1 (2) GOVERNANCE.—The mechanism shall be
2 governed by a commission appointed by the chief ex-
3 ecutive officer of the State. The membership of the
4 commission shall include such officer (or the officer’s
5 designee) and representatives of plan sponsors,
6 major providers, labor, consumers, State govern-
7 ments, and the business community.

8 (b) REQUIREMENTS.—The mechanism under this
9 section shall require all multicare plans—

10 (1) to pay into a common fund for each below-
11 average-risk individual an amount related to the de-
12 gree to which the individual’s risk is below the aver-
13 age risk, and

14 (2) to receive from the common fund for each
15 above-average-risk individual an amount related to
16 the degree to which the individual’s risk is above the
17 average risk.

18 The mechanism may not use the fact that a plan is a
19 below-average-cost plan as an indicator that the plan
20 serves below-average-risk individuals.

21 (c) OPTIONS.—

22 (1) STOP-LOSS.—The mechanism also may pro-
23 vide for additional payments from the common fund
24 to multicare plans for individuals whose costs exceed
25 a particular threshold, and may require all plans (in-

1 cluding plans participating in the Federal Employees
2 Health Benefits program under chapter 89 of title
3 5, United States Code) to make contributions to the
4 fund to offset such additional payments.

5 (2) CONTINUOUS COVERAGE INCENTIVES.—The
6 mechanism may provide for appropriate incentives to
7 encourage continuous coverage of individuals and
8 groups.

9 (3) COST-SHARING LIMIT.—The mechanism
10 may provide for limits on the non-premium cost-
11 sharing of enrollees.

12 (4) MULTI-STATE OPTION.—State multicare
13 programs may cooperate and establish multistate re-
14 insurance mechanisms to carry out this section.

15 (d) TREATMENT OF SELF-INSURED PLANS.—

16 (1) IN GENERAL.—In the case of a multicare
17 plan that is a self-insured plan (as defined by the
18 Secretary), except as provided in paragraph (2), the
19 plan is subject to the requirements of this section,
20 notwithstanding any provision of the Employee Re-
21 tirement Income Security Act of 1974 to the con-
22 trary.

23 (2) EXCEPTION.—Paragraph (1) and the provi-
24 sions of subsections (a) through (c) shall not apply
25 to a self-insured plan that operates in at least 3

1 States and that has elected, under section 331(c), to
2 participate in the national reinsurance mechanism
3 (under section 331) rather than in State reinsurance
4 mechanisms under this section.

5 **SEC. 109. CONSUMER EDUCATION AND ASSISTANCE.**

6 (a) IN GENERAL.—Each State multicare program
7 shall establish procedures—

8 (1) for collecting, publishing, and distributing
9 comparative value information (described in section
10 103(c)) on multicare plans to consumers, and

11 (2) for educating individuals eligible for State
12 health care subsidies regarding their health care op-
13 tions and the requirements under section 107 to
14 qualify for reduced cost-sharing.

15 (b) DISTRIBUTION OF PLAN INFORMATION
16 THROUGH EMPLOYERS.—A State multicare program may
17 require employers to supply basic information on
18 multicare plans in the State (whether prepared by the pro-
19 gram or the plans) to their employees.

20 **SEC. 110. CONSUMER RIGHTS ENFORCEMENT.**

21 Each State multicare program shall assure compli-
22 ance of multicare plans with the consumer rights under
23 section 203.

1 **SEC. 111. COMPLIANCE OF STATE INCOME TAX LAWS.**

2 Each State multicare program shall provide for as-
3 surances that any income tax laws of the State, insofar
4 as they provide for the determination of tax based upon
5 income as determined under the Federal income tax laws,
6 treat employer payments for health care premiums and ex-
7 penses of employees or dependents as payment of wages
8 to such employees and dependents.

9 **SEC. 112. DISTRIBUTION OF INFORMATION ON AVERAGE**
10 **PRICES OF COMMON HEALTH CARE SERV-**
11 **ICES.**

12 Each State multicare program shall provide for the
13 distribution, on both a State and local level, of information
14 on the average prices of common health care services, in-
15 cluding such services as the Secretary may specify.

16 **Subtitle B—Federal Contribution**
17 **Toward Multicare Plan Pre-**
18 **miums; Tax Law Changes**

19 **SEC. 121. COMPUTATION OF AMOUNT OF FEDERAL CON-**
20 **TRIBUTION.**

21 (a) DETERMINATION OF AMOUNT.—The Secretary
22 shall determine for each year (beginning with 1996) an
23 annual Federal contribution amount in accordance with
24 this section.

25 (b) AMOUNT.—Subject to subsection (c):

26 (1) AMOUNT FOR YEARS BEFORE 2002.—

1 (A) IN GENERAL.—The Federal contribu-
2 tion amount for a year before 2002 is equal
3 to—

4 (i) the total amount of available funds
5 (determined under subparagraph (B)) for
6 the year, divided by

7 (ii) the average number of individuals
8 described in subparagraph (C) for the
9 year.

10 (B) FUNDS AVAILABLE.—The total
11 amount of available funds for a year is equal to
12 the sum of the following:

13 (i) ADDITIONAL NET FEDERAL REVE-
14 NUES.—The amount described in this sub-
15 paragraph is the amount by which—

16 (I) the increase in all Federal
17 revenues (including employment-relat-
18 ed excise taxes) resulting from the
19 amendments made by sections 122
20 and 123, exceeds

21 (II) the increase in appropria-
22 tions resulting from the increase in
23 authorization of appropriations pro-
24 vided under section 441(a) (relating

1 to facilitating development and use of
2 medical practice guidelines).

3 (ii) ADDITIONAL MEDICAID-RELATED
4 AMOUNT.—The product described in sec-
5 tion 101(c)(3)(A)(ii)(II) for the State, in-
6 creased (for each year after the last full
7 year referred to in section
8 101(c)(3)(A)(ii)(I), up to the year in-
9 volved) by the applicable inflator (specified
10 in section 107(b)(2)(D)) for the year, and
11 subject to any adjustment for changes in
12 population under section 107(b)(4).

13 (C) INDIVIDUALS DESCRIBED.—

14 (i) IN GENERAL.—The number of in-
15 dividuals described in this subparagraph
16 for a year is—

17 (I) the estimated total average
18 population of the United States in the
19 year, less

20 (II) the sum of the average num-
21 ber of exempt individuals in the year.

22 (2) YEARS BEGINNING WITH 2002.—The Fed-
23 eral contribution amount for a year after 2001 is
24 equal to the Federal contribution amount deter-
25 mined under this subsection for the previous year in-

1 creased by the applicable inflator for the year in-
2 volved (as specified under section 107(b)(3)).

3 (c) APPLICATION BY ENROLLMENT CLASS.—

4 (1) ESTABLISHMENT OF ENROLLMENT CLASS-
5 ES.—

6 (A) IN GENERAL.—The Secretary shall es-
7 tablish one or more sets of enrollment classes
8 based on both—

9 (i) family composition, and

10 (ii) ages of family members.

11 (B) USE OF COMMON CLASSIFICATIONS
12 FOR FAMILY ENROLLMENT.—The family classi-
13 fications under subparagraph (A)(i) shall be
14 based on common family enrollment categories,
15 such as individual only, individual with children,
16 married couple without children, and a married
17 couple with children.

18 (2) ADJUSTMENT OF FEDERAL CONTRIBUTION
19 BASED ON ENROLLMENT CLASS.—The Secretary
20 shall adjust the Federal contribution amount deter-
21 mined under this section for each of the enrollment
22 classes so that, without changing the total amount
23 of the Federal contribution, the ratio of the Federal
24 contribution amount for enrollees in the different
25 classes is equal to the ratio of average costs under

1 multicare plans for enrollees in the respective class-
2 es.

3 **SEC. 122. TERMINATION OF EXCLUSION FOR EMPLOYER-**
4 **PROVIDED HEALTH CARE COVERAGE AND OF**
5 **DEDUCTION FOR HEALTH INSURANCE COSTS**
6 **OF SELF-EMPLOYED.**

7 (a) TERMINATION OF EXCLUSION FOR EMPLOYER-
8 PROVIDED HEALTH CARE COVERAGE.—

9 (1) IN GENERAL.—The text of section 106 of
10 the Internal Revenue Code of 1986 is amended to
11 read as follows:

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

15 “(b) TERMINATION.—

16 “(1) IN GENERAL.—This section shall not apply
17 to any taxable year beginning on or after the first
18 day of the second calendar year beginning after the
19 date of the enactment of this subsection.

20 “(2) EXCEPTION.—Paragraph (1) shall not
21 apply to a medical or dental care plan provided
22 under section 1074(a) of title 10, United States
23 Code.

24 “(c) SPECIAL RULES FOR DETERMINING AMOUNT OF
25 INCLUSION.—

1 “(1) IN GENERAL.—For purposes of this sec-
2 tion, the value of any coverage shall be determined
3 on the basis of the average cost of providing such
4 coverage to the beneficiaries receiving such coverage.

5 “(2) SPECIAL RULE.—To the extent provided
6 by the Secretary, cost determinations under para-
7 graph (1) may be made on the basis of reasonable
8 estimates but shall not vary based on the age of em-
9 ployees or their dependents.”

10 (2) REPORTING ON W-2 FORM.—Subsection (a)
11 of section 6051 of such Code (relating to receipts for
12 employees) is amended by striking “and” at the end
13 of paragraph (8), by striking the period at the end
14 of paragraph (9) and inserting “, and”, and by in-
15 serting after paragraph (9) the following new para-
16 graph:

17 “(10) the value of the employer-provided cov-
18 erage under any accident or health plan (determined
19 in accordance with section 106(c)) which is not ex-
20 cludable from gross income under section 106 by
21 reason of section 106(b) and the number of months
22 during such calendar year that such coverage was
23 provided.”

24 (b) TERMINATION OF DEDUCTION FOR HEALTH IN-
25 SURANCE COSTS OF SELF-EMPLOYED.—Subsection (l) of

1 section 162 of such Code is amended by adding at the
2 end thereof the following new paragraph:

3 “(7) TERMINATION ON IMPLEMENTATION OF
4 MULTICARE.—In no event shall this subsection apply
5 to any taxable year beginning on or after the first
6 day of the second calendar year beginning after the
7 date of the enactment of this paragraph.”

8 (c) APPLICATION OF FICA TAXES AND INCOME TAX
9 WITHHOLDING.—

10 (1) FICA TAXES.—Subsection (a) of section
11 3121 of such Code is amended by adding at the end
12 thereof the following new flush sentence:

13 “Paragraphs (2) and (4) shall not apply to any amount
14 paid for coverage of an employee or any of his dependents
15 under an accident or health plan.”

16 (2) WAGE WITHHOLDING.—Subsection (a) of
17 section 3401 of such Code is amended by adding at
18 the end thereof the following new flush sentence:

19 “The term ‘wages’ shall include amounts paid for coverage
20 of an employee or any of his dependents under an accident
21 or health plan.”

22 (3) EFFECTIVE DATE.—The amendments made
23 by this subsection shall apply to taxable years begin-
24 ning on or after the first day of the second calendar

1 year beginning after the date of the enactment of
2 this Act.

3 **SEC. 123. TERMINATION OF DEDUCTION FOR MEDICAL**
4 **CARE.**

5 Section 213 of the Internal Revenue Code of 1986
6 is amended by adding at the end the following new sub-
7 section:

8 “(f) TERMINATION ON IMPLEMENTATION OF
9 MULTICARE.—In no event shall this section apply to any
10 taxable year beginning on or after the first day of the sec-
11 ond calendar year beginning after the date of the enact-
12 ment of this subsection.”

13 **TITLE II—REQUIREMENTS FOR**
14 **MULTICARE PLANS**

15 **Subtitle A—General Requirements**

16 **SEC. 201. ENROLLMENT AND CONTINUITY OF COVERAGE.**

17 (a) IN GENERAL.—Each multicare plan shall—

18 (1) accept for enrollment (except to the extent
19 the Secretary may provide) all individuals eligible for
20 enrollment, except as provided in section 103(b); and

21 (2) not condition or limit the provision or pay-
22 ment for services based on any pre-existing condi-
23 tion.

24 (b) CERTIFICATION OF ENROLLMENT FOR PURPOSES
25 OF RECEIPT OF FEDERAL CONTRIBUTION.—Each

1 multicare plan shall provide for notice to the Secretary
2 or the State multicare program of such information as the
3 Secretary may require in order to establish the entitlement
4 of the plan to payment from a State multicare program
5 under section 106.

6 **SEC. 202. COVERED SERVICES.**

7 A multicare plan must—

8 (1) clearly disclose to each enrollee (in a man-
9 ner specified by the State multicare program) the
10 differences between the services covered under the
11 plan and the list of services established under sec-
12 tion 104(a)(2)(A), and

13 (2) include, for purposes of applying the cata-
14 strophic protection under section 203(e), hospital,
15 professional, and other services specified by the Sec-
16 retary.

17 **SEC. 203. PREMIUMS AND COST-SHARING; CATASTROPHIC**
18 **PROTECTION.**

19 (a) IN GENERAL.—Except as a State multicare pro-
20 gram otherwise provides under title I and except as pro-
21 vided in this section, a multicare plan—

22 (1) may impose cost-sharing in the form of pre-
23 miums, deductibles, coinsurance, and copayments,
24 and

1 (2) shall disclose the portion of such a premium
2 which is met through the contribution provided
3 under section 106.

4 (b) LIMITS ON PREMIUM VARIATIONS.—

5 (1) IN GENERAL.—Except as provided in para-
6 graph (2), the premiums with respect to multicare
7 plans offered in an area of a State shall be estab-
8 lished, and shall vary, based only on the enrollment
9 classes provided under section 121(c)(1). Each plan
10 shall fairly allocate the costs of such premiums
11 among such classes.

12 (2) USE OF BEHAVIORAL FACTORS.—Premiums
13 under a multicare plan may vary based on factors
14 (such as smoking, substance abuse, and excessive
15 weight) which are defined by the Secretary and for
16 which personal behavior is clearly related to receipt
17 of health care services.

18 (c) LIMITATION ON ADJUSTMENT OF COINSURANCE
19 AND COPAYMENTS.—A multicare plan—

20 (1) may adjust coinsurance or copayment rates
21 to encourage enrollees to use (A) preferred provid-
22 ers, (B) providers that charge lower amounts, or (C)
23 different procedures, but

1 (2) may not adjust coinsurance based on indi-
2 vidual patient characteristics, including the age, sex,
3 wellness, or medical history of the individual.

4 (d) USE OF MEDICAL SAVINGS ACCOUNTS.—A
5 multicare plan may establish for its enrollees medical sav-
6 ings accounts—

7 (1) from which payments for services (below a
8 catastrophic limit) are made by the enrollees, and

9 (2) for which balances may be carried forward
10 from year to year and may be applied against future
11 expenses, be rebated to the enrollee, or used for re-
12 tirement purposes.

13 (e) CATASTROPHIC PROTECTION.—

14 (1) IN GENERAL.—A multicare plan shall in-
15 clude a maximum limit on the annual amount of pa-
16 tient cost-sharing for premiums and out-of-pocket
17 expenses for covered services.

18 (2) LIMIT.—

19 (A) IN GENERAL.—Subject to the succeed-
20 ing provisions of this paragraph, such annual
21 maximum limit shall not exceed—

22 (i) \$5,000 for any individual, and

23 (ii) \$10,000, in the aggregate, for all
24 members of a family.

1 (B) INDEXING.—For any year, after the
2 year in which this Act is enacted, the dollar
3 amounts specified under subparagraph (A) shall
4 be the dollar amounts specified under this para-
5 graph for the previous year (taking into account
6 any previous application of this subparagraph)
7 increased by the applicable inflator for the year
8 (as specified under section 107(b)(3)).

9 (C) ADDITIONAL LIMITS.—A State
10 multicare program may—

11 (i) impose dollar limits that are less
12 than the limits otherwise specified under
13 this paragraph; and

14 (ii) provide for the application of lim-
15 its for expenses over a multi-year period.

16 (D) STATE AUTHORITY.—If a State
17 multicare program provides for a subsidy of
18 stop-loss limits for catastrophic coverage for
19 lower income residents (under its reinsurance
20 mechanism under section 108), the program
21 may establish regulations designed to prevent
22 manipulation of household size and membership
23 so as to qualify for catastrophic protection ben-
24 efits.

1 (f) APPLICATION OF EXCESS CONTRIBUTION
2 AMOUNT TOWARDS COST SHARING.—If the amount of the
3 State contribution under section 106(b) toward the pre-
4 mium of an individual exceeds the individual’s premium
5 for a multicare plan, the excess amount shall be counted
6 by the plan towards the cost sharing for the individual
7 under the plan.

8 **SEC. 204. PARTICIPATION IN REINSURANCE SYSTEM.**

9 Each multicare plan shall participate in the applica-
10 ble reinsurance system (established by the State multicare
11 program under section 108 or by the Secretary pursuant
12 to section 301 or 331).

13 **SEC. 205. DATA REQUIREMENT.**

14 (a) IN GENERAL.—Each multicare plan (and health
15 care providers participating in the plan) shall collect and
16 provide to the State multicare program data on costs of
17 health care, prices for services, and patient outcomes, in
18 accordance with standards established by the Secretary by
19 regulation.

20 (b) PRICING INFORMATION.—A multicare plan shall
21 condition the payment under the plan for services of a pro-
22 vider upon the provider disclosing to the public, in a form,
23 manner, and at a time specified by the Secretary, such
24 information on the provider’s charges as the State

1 multicare program specifies, in accordance with guidelines
2 of the Secretary.

3 **SEC. 206. MEDICAL MALPRACTICE REFORM AND ADMINIS-**
4 **TRATIVE COST SAVINGS.**

5 Each multicare plan (and health care providers par-
6 ticipating in the plan) shall comply with the applicable re-
7 quirements of—

8 (1) title IV (relating to medical malpractice li-
9 ability reform),

10 (2) subtitle A of title V (relating to standard-
11 ization of claims processing), and

12 (3) subtitle B of title V (relating to electronic
13 medical data standards).

14 **SEC. 207. CONSUMER RIGHTS.**

15 (a) NOTICE OF RIGHTS; ENFORCEMENT.—

16 (1) NOTICE.—Each multicare plan shall notify
17 enrollees of their consumer rights under this section
18 and of the procedures established by the plan to en-
19 sure these rights.

20 (2) DEVELOPMENT OF REGULATIONS.—The
21 Secretary shall develop regulation to implement the
22 consumer rights established under this section.

23 (3) STATE ENFORCEMENT.—States are respon-
24 sible, under their multicare programs, for assuring

1 compliance of multicare plans with the requirements
2 of this section.

3 (b) PROVISION OF PATIENT COST-SHARING INFOR-
4 MATION.—

5 (1) IN GENERAL.—Each multicare plan which
6 provides for cost-sharing (other than premiums)
7 shall ensure that enrollees are provided, in advance
8 of the receipt of treatment (except as provided in
9 paragraph (3)), with information on the expected
10 total costs of treatment and their expected share of
11 the costs. Such information may be based on the es-
12 timates for the average cost for such treatment.

13 (2) TOTAL COST.—For purposes of paragraph
14 (1), the total cost of treatment—

15 (A) in the case of a patient's initial visit,
16 shall consist of the initial visit only, and

17 (B) in the case of subsequent treatment,
18 shall include all expenses resulting from the
19 treatment procedure prescribed by the provider.

20 (3) EXCEPTION FOR EMERGENCIES.—In the
21 case of emergency treatment, the information under
22 this subsection shall be provided at the earliest rea-
23 sonable time after such treatment is initiated.

24 (c) PROVISION OF PRICE INFORMATION BY HEALTH
25 CARE PROVIDERS.—

1 (1) IN GENERAL.—Each health care provider is
2 required to make available information on the pro-
3 vider’s prices for health care services. Such informa-
4 tion shall be made available to the public and to in-
5 dividuals and organizations upon request.

6 (2) STANDARDS.—Such information shall be
7 made available in accordance with standards and a
8 common format established by the Secretary.

9 (d) PATIENT ACCESS TO MEDICAL INFORMATION.—
10 Each individual has a right to obtain, through the
11 multicare plan in which the individual is enrolled, informa-
12 tion contained in the medical record of a provider that
13 has provided health care services for which payment may
14 be made under the plan.

15 **Subtitle B—Multiple Employer**
16 **Health Benefits Protections**

17 **SEC. 211. LIMITED EXEMPTION UNDER PREEMPTION**
18 **RULES FOR MULTIPLE EMPLOYER PLANS**
19 **PROVIDING HEALTH BENEFITS SUBJECT TO**
20 **CERTAIN FEDERAL STANDARDS.**

21 (a) IN GENERAL.—Subtitle B of title I of the Em-
22 ployee Retirement Income Security Act of 1974 is amend-
23 ed by adding at the end the following new part:

1 “Part 7—Multiple Employer Health Plans

2 **“SEC. 701. DEFINITIONS.**

3 “For purposes of this part:

4 “(1) INSURER.—The term ‘insurer’ means an
5 insurance company, insurance service, or insurance
6 organization, licensed to engage in the business of
7 insurance by a State.

8 “(2) PARTICIPATING EMPLOYER.—The term
9 ‘participating employer’ means, in connection with a
10 multiple employer welfare arrangement, any em-
11 ployer if any of its employees, or any of the depend-
12 ents of its employees, are or were covered under
13 such arrangement during the employment of the
14 employees.

15 “(3) EXCESS/STOP LOSS COVERAGE.—The term
16 ‘excess/stop loss coverage’ means, in connection with
17 a multiple employer welfare arrangement, a contract
18 under which an insurer provides for payment with
19 respect to claims under the arrangement, relating to
20 participants or beneficiaries individually or other-
21 wise, in excess of an amount or amounts specified in
22 such contract.

23 “(4) QUALIFIED ACTUARY.—The term ‘quali-
24 fied actuary’ means an individual who is a member
25 of the American Academy of Actuaries or meets

1 such reasonable standards and qualifications as the
2 Secretary may provide by regulation.

3 “(5) SPONSOR.—The term ‘sponsor’ means, in
4 connection with a multiple employer welfare arrange-
5 ment, the association or other entity which estab-
6 lishes or maintains the arrangement.

7 “(6) STATE LOCATION OF COVERED INDIVID-
8 UALS.—

9 “(A) IN GENERAL.—A multiple employer
10 welfare arrangement shall be treated as cover-
11 ing individuals located in a State only if the
12 minimum required number of individuals who
13 are covered under the arrangement are located
14 in such State, except that if the minimum re-
15 quired number of individuals are not located in
16 any State, such arrangement shall be treated as
17 covering individuals in any State in which any
18 covered individual is located.

19 “(B) MINIMUM REQUIRED NUMBER.—For
20 purposes of subparagraph (A), the minimum re-
21 quired number is the greater of—

22 “(i) 5 percent of the total number of
23 individuals described in subparagraph (A),

24 or

25 “(ii) 50.

1 “(C) LOCATION OF INDIVIDUALS IN
2 STATE.—For purposes of subparagraph (A), an
3 individual shall be treated as located in a State
4 if such individual is employed in such State or
5 the address of such individual last known by
6 the arrangement is located in such State.

7 “(7) STATE INSURANCE COMMISSIONER.—The
8 term ‘State insurance commissioner’ means the in-
9 surance commissioner (or similar official) of a State.

10 “(8) DOMICILE STATE.—The term ‘domicile
11 State’ means, in connection with a multiple employer
12 welfare arrangement, the State in which, according
13 to the application for an exemption under this part,
14 most individuals to be covered under the arrange-
15 ment are located, except that, in any case in which
16 information contained in the latest annual report of
17 the arrangement filed under this part indicates that
18 most individuals covered under the arrangement are
19 located in a different State, such term means such
20 different State.

21 “(9) FULLY INSURED ARRANGEMENT.—A mul-
22 tiple employer welfare arrangement shall be treated
23 as fully insured only if one or more insurers, health
24 maintenance organizations, similar organizations
25 regulated under State law for solvency, or any com-

1 bination thereof are liable under one or more insur-
2 ance policies or contracts for all benefits under the
3 arrangement (irrespective of any recourse they may
4 have against other parties).

5 “(10) MULTIPLE EMPLOYER HEALTH PLAN.—
6 The term ‘multiple employer health plan’ means a
7 multiple employer welfare arrangement treated as an
8 employee welfare benefit plan by reason of an
9 exemption under this part.

10 **“SEC. 702. EXEMPTED MULTIPLE EMPLOYER PLANS PRO-**
11 **VIDING BENEFITS IN THE FORM OF MEDICAL**
12 **CARE RELIEVED OF CERTAIN RESTRICTIONS**
13 **ON PREEMPTION OF STATE LAW AND TREAT-**
14 **ED AS EMPLOYEE WELFARE BENEFIT PLANS.**

15 “(a) IN GENERAL.—Subject to subsection (b), a mul-
16 tiple employer welfare arrangement which is not fully in-
17 sured and with respect to which there is in effect an ex-
18 emption granted by the Secretary under this part (or with
19 respect to which there is pending a complete application
20 for such an exemption and the Secretary determines that
21 provisional protection under this part is appropriate)—

22 “(1) shall be treated for purposes of subtitle A
23 and the preceding parts of this subtitle as an em-
24 ployee welfare benefit plan, irrespective of whether

1 such arrangement is an employee welfare benefit
2 plan, and

3 “(2) shall be exempt from section
4 514(b)(6)(A)(ii).

5 “(b) BENEFITS MUST CONSIST OF MEDICAL
6 CARE.—Subsection (a) shall apply to a multiple employer
7 welfare arrangement only if the benefits provided there-
8 under consist solely of medical care described in section
9 607(1) (disregarding such incidental benefits as the
10 Secretary shall specify by regulation).

11 “(c) RESTRICTION ON COMMENCEMENT OF NEW AR-
12 RANGEMENTS.—A multiple employer welfare arrangement
13 providing benefits which consist of medical care described
14 in section 607(1) which has not commenced operations as
15 of January 1, 1994, may commence operations only if an
16 exemption granted to the arrangement under this part is
17 in effect (or there is pending with respect to the arrange-
18 ment a complete application for such an exemption and
19 the Secretary determines that provisional protection under
20 this part is appropriate).

21 **“SEC. 703. EXEMPTION PROCEDURE.**

22 “(a) IN GENERAL.—The Secretary shall grant an ex-
23 emption described in section 702(a) to a multiple employer
24 welfare arrangement if—

1 “(1) an application for such exemption with re-
2 spect to such arrangement, identified individually or
3 by class, has been duly filed in complete form with
4 the Secretary in accordance with this part,

5 “(2) such application demonstrates compliance
6 with the requirements of section 704 with respect to
7 such arrangement, and

8 “(3) the Secretary finds that such exemption
9 is—

10 “(A) administratively feasible,

11 “(B) not adverse to the interests of the in-
12 dividuals covered under the arrangement, and

13 “(C) protective of the rights and benefits
14 of the individuals covered under the arrange-
15 ment.

16 “(b) NOTICE AND HEARING.—Before granting an ex-
17 emption under this section, the Secretary shall publish no-
18 tice in the Federal Register of the pendency of the exemp-
19 tion, shall require that adequate notice be given to inter-
20 ested persons, including the State insurance commissioner
21 of each State in which covered individuals under the ar-
22 rangement are, or are expected to be, located, and shall
23 afford interested persons opportunity to present views.
24 The Secretary may not grant an exemption under this sec-
25 tion unless the Secretary affords an opportunity for a

1 hearing and makes a determination on the record with re-
2 spect to the findings required under subsection (a)(3). The
3 Secretary shall, to the maximum extent practicable, make
4 a final determination with respect to any application filed
5 under this section in the case of a newly established ar-
6 rangement within 90 days after the date which the Sec-
7 retary determines is the date on which such application
8 is filed in complete form.

9 **“SEC. 704. ELIGIBILITY REQUIREMENTS.**

10 “(a) APPLICATION FOR EXEMPTION.—

11 “(1) IN GENERAL.—An exemption may be
12 granted by the Secretary under this part only on the
13 basis of an application filed with the Secretary in
14 such form and manner as shall be prescribed in reg-
15 ulations of the Secretary. Any such application shall
16 be signed by the operating committee and the spon-
17 sor of the arrangement.

18 “(2) FILING FEE.—The arrangement shall pay
19 to the Secretary at the time of filing an application
20 under this section a filing fee in the amount of
21 \$5,000, which shall be available, to the extent pro-
22 vided in appropriation Acts, to the Secretary for the
23 sole purpose of administering the exemption proce-
24 dures under this part.

1 “(3) INFORMATION INCLUDED.—An application
2 filed under this section shall include, in a manner
3 and form prescribed in regulations of the Secretary,
4 at least the following information:

5 “(A) IDENTIFYING INFORMATION.—The
6 names and addresses of—

7 “(i) the sponsor, and

8 “(ii) the members of the operating
9 committee of the arrangement.

10 “(B) STATES IN WHICH ARRANGEMENT IN-
11 TENDS TO DO BUSINESS.—The States in which
12 individuals covered under the arrangement are
13 to be located and the number of such individ-
14 uals expected to be located in each such State.

15 “(C) BONDING REQUIREMENTS.—Evidence
16 provided by the operating committee that the
17 bonding requirements of section 412 will be met
18 as of the date of the application.

19 “(D) PLAN DOCUMENTS.—A copy of the
20 documents governing the arrangement (includ-
21 ing any bylaws and trust agreements), the sum-
22 mary plan description, and other material de-
23 scribing the benefits and coverage that will be
24 provided to individuals covered under the ar-
25 rangement.

1 “(E) AGREEMENTS WITH SERVICE PROVID-
2 ERS.—A copy of any agreements between the
3 arrangement and contract administrators and
4 other service providers.

5 “(F) FUNDING REPORT.—A report setting
6 forth information determined as of a date with-
7 in the 120-day period ending with the date of
8 the application, including the following:

9 “(i) RESERVES.—A statement, cer-
10 tified by the operating committee of the ar-
11 rangement, and a statement of actuarial
12 opinion, signed by a qualified actuary, that
13 all applicable requirements of section 707
14 are or will be met in accordance with regu-
15 lations which the Secretary shall prescribe.

16 “(ii) ADEQUACY OF CONTRIBUTION
17 RATES.—A statement of actuarial opinion,
18 signed by a qualified actuary, which sets
19 forth a description of the extent to which
20 contribution rates are adequate to provide
21 for the payment of all obligations and the
22 maintenance of required reserves under the
23 arrangement for the 12-month period be-
24 ginning with such date within such 120-
25 day period, taking into account the ex-

1 pected coverage and experience of the ar-
2 rangement. If the contribution rates are
3 not fully adequate, the statement of actu-
4 arial opinion shall indicate the extent to
5 which the rates are inadequate and the
6 changes needed to ensure adequacy.

7 “(iii) CURRENT AND PROJECTED
8 VALUE OF ASSETS AND LIABILITIES.—A
9 statement of actuarial opinion signed by a
10 qualified actuary, which sets forth the cur-
11 rent value of the assets and liabilities accu-
12 mulated under the arrangement and a pro-
13 jection of the assets, liabilities, income,
14 and expenses of the arrangement for the
15 12-month period referred to in clause (ii).
16 The income statement shall identify sepa-
17 rately the arrangement’s administrative ex-
18 penses and claims.

19 “(iv) COSTS OF COVERAGE TO BE
20 CHARGED AND OTHER EXPENSES.—A
21 statement of the costs of coverage to be
22 charged, including an itemization of
23 amounts for administration, reserves, and
24 other expenses associated with the oper-
25 ation of the arrangement.

1 “(v) OTHER INFORMATION.—Any
2 other information which may be prescribed
3 in regulations of the Secretary as nec-
4 essary to carry out the purposes of this
5 part.

6 “(b) OTHER REQUIREMENTS.—A complete applica-
7 tion for an exemption under this part shall include infor-
8 mation which the Secretary determines to be complete and
9 accurate and sufficient to demonstrate that the following
10 requirements are met with respect to the arrangement:

11 “(1) SPONSOR.—The sponsor is, and has been
12 (together with its immediate predecessor, if any) for
13 a continuous period of not less than 3 years before
14 the date of the application, organized and main-
15 tained in good faith, with a constitution and bylaws
16 specifically stating its purpose, as a trade associa-
17 tion, an industry association, a professional associa-
18 tion, or a chamber of commerce or other business
19 group, for substantial purposes other than that of
20 obtaining or providing medical care described in sec-
21 tion 607(1), and the applicant demonstrates to the
22 satisfaction of the Secretary that the sponsor is es-
23 tablished as a permanent entity which receives the
24 active support of its members.

1 “(2) OPERATING COMMITTEE.—The arrange-
2 ment is operated, pursuant to a trust agreement, by
3 an operating committee which has complete fiscal
4 control over the arrangement and which is respon-
5 sible for all operations of the arrangement, and the
6 operating committee has in effect rules of operation
7 and financial controls, based on a 3-year plan of op-
8 eration, adequate to carry out the terms of the ar-
9 rangement and to meet all requirements of this title
10 applicable to the arrangement. The members of the
11 committee are individuals selected from individuals
12 who are the owners, officers, directors, or employees
13 of the participating employers or who are partners
14 in the participating employers and actively partici-
15 pate in the business. No such member is an owner,
16 officer, director, or employee of, or partner in, a con-
17 tract administrator or other service provider to the
18 arrangement, except that officers or employees of a
19 sponsor which is a service provider (other than a
20 contract administrator) to the arrangement may be
21 members of the committee if they constitute not
22 more than 25 percent of the membership of the com-
23 mittee and they do not provide services to the ar-
24 rangement other than on behalf of the sponsor. The
25 committee has sole authority to approve applications

1 for participation in the arrangement and to contract
2 with a service provider to administer the day-to-day
3 affairs of the arrangement.

4 “(3) CONTENTS OF GOVERNING INSTRU-
5 MENTS.—The instruments governing the arrange-
6 ment include a written instrument, meeting the re-
7 quirements of an instrument required under section
8 402(a)(1), which—

9 “(A) provides that the committee serves as
10 the named fiduciary required for plans under
11 section 402(a)(1) and serves in the capacity of
12 a plan administrator (referred to in section
13 3(16)(A)),

14 “(B) provides that the sponsor is to serve
15 as plan sponsor (referred to in section
16 3(16)(B)),

17 “(C) incorporates the requirements of sec-
18 tion 707, and

19 “(D) provides that, effective upon the
20 granting of an exemption under this part—

21 “(i) all participating employers must
22 be members or affiliated members of the
23 sponsor, except that, in the case of a spon-
24 sor which is a professional association or
25 other individual-based association, if at

1 least one of the officers, directors, or em-
2 ployees of an employer, or at least one of
3 the individuals who are partners in an em-
4 ployer and who actively participates in the
5 business, is a member or affiliated member
6 of the sponsor, participating employers
7 may also include such employer, and

8 “(ii) all individuals thereafter com-
9 mencing coverage under the arrangement
10 must be—

11 “(I) active or retired owners, offi-
12 cers, directors, or employees of, or
13 partners in, participating employers,
14 or

15 “(II) the beneficiaries of individ-
16 uals described in subclause (I).

17 “(4) CONTRIBUTION RATES.—The contribution
18 rates referred to in subsection (a)(3)(F)(ii) are
19 adequate.

20 “(5) REGULATORY REQUIREMENTS.—Such
21 other requirements as the Secretary may prescribe
22 by regulation as necessary to carry out the purposes
23 of this part.

24 “(c) TREATMENT OF PARTY SEEKING EXEMPTION
25 WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

1 “(1) IN GENERAL.—In the case of any applica-
2 tion for an exemption under this part with respect
3 to a multiple employer welfare arrangement, if the
4 Secretary determines that the sponsor of the ar-
5 rangement or any other person associated with the
6 arrangement is subject to disqualification under
7 paragraph (2), the Secretary may deny the exemp-
8 tion with respect to such arrangement.

9 “(2) DISQUALIFICATION.—A person is subject
10 to disqualification under this paragraph if such per-
11 son—

12 “(A) has intentionally made a material
13 misstatement in the application for exemption,

14 “(B) has obtained or attempted to obtain
15 an exemption under this part through misrepre-
16 sentation or fraud,

17 “(C) has misappropriated or converted to
18 such person’s own use, or improperly withheld,
19 money held under a plan or any multiple
20 employer welfare arrangement,

21 “(D) is prohibited (or would be prohibited
22 if the arrangement were a plan) from serving in
23 any capacity in connection with the arrange-
24 ment under section 411,

1 “(E) has failed to appear without reason-
2 able cause or excuse in response to a subpoena,
3 examination, warrant, or any other order law-
4 fully issued by the Secretary compelling such
5 response,

6 “(F) has previously been subject to a de-
7 termination under this part resulting in the de-
8 nial, suspension, or revocation of an exemption
9 under this part on similar grounds, or

10 “(G) has otherwise violated any provision
11 of this title with respect to a matter which the
12 Secretary determines of sufficient consequence
13 to merit disqualification for purposes of this
14 part.

15 “(d) FRANCHISE NETWORKS.—In the case of a mul-
16 tiple employer welfare arrangement established and main-
17 tained by a franchisor for a franchise network consisting
18 of its franchisees, such franchisor shall be treated as the
19 sponsor referred to in the preceding provisions of this sec-
20 tion, such network shall be treated as an association re-
21 ferred to in such provisions, and each franchisee shall be
22 treated as a member (of the association and the sponsor)
23 referred to in such provisions, if all participating employ-
24 ers are such franchisees and the requirements of sub-

1 section (b)(1) with respect to a sponsor are met with
2 respect to the network.

3 “(e) CERTAIN COLLECTIVELY BARGAINED ARRANGE-
4 MENTS.—In applying the preceding provisions of this sec-
5 tion in the case of a multiple employer welfare arrange-
6 ment which would be described in section 3(40)(A)(i) but
7 for the failure to meet any requirement of section
8 3(40)(C)—

9 “(1) paragraphs (1) and (2) of subsection (b)
10 and subparagraphs (A), (B), and (D) of paragraph
11 (3) of subsection (b) shall be disregarded, and

12 “(2) the joint board of trustees shall be consid-
13 ered the operating committee of the arrangement.

14 “(f) CERTAIN ARRANGEMENTS NOT MEETING SIN-
15 GLE EMPLOYER REQUIREMENT.—

16 “(1) IN GENERAL.—In any case in which the
17 majority of the employees covered under a multiple
18 employer welfare arrangement are employees of a
19 single employer (within the meaning of clauses (i)
20 and (ii) of section 3(40)(B)), if all other employees
21 covered under the arrangement are employed by em-
22 ployers who are related to such single employer, sub-
23 section (b)(3)(D) shall be disregarded.

24 “(2) RELATED EMPLOYERS.—For purposes of
25 paragraph (1), employers are ‘related’ if there is

1 among all such employers a common ownership in-
2 terest or a substantial commonality of business oper-
3 ations based on common suppliers or customers.

4 **“SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO**
5 **EXEMPTED ARRANGEMENTS.**

6 “(a) NOTICE OF MATERIAL CHANGES.—In the case
7 of any multiple employer welfare arrangement with respect
8 to which there is in effect an exemption granted under
9 this part, descriptions of material changes in any informa-
10 tion which was required to be submitted with the applica-
11 tion for the exemption shall be filed in such form and man-
12 ner as shall be prescribed in regulations of the Secretary.
13 The Secretary may require by regulation prior notice of
14 material changes with respect to specified matters which
15 might serve as the basis for suspension or revocation of
16 the exemption.

17 “(b) REPORTING REQUIREMENTS.—Under regula-
18 tions of the Secretary, the requirements of sections 102,
19 103, and 104 shall apply with respect to any multiple em-
20 ployer welfare arrangement with respect to which there is
21 or has been in effect an exemption granted under this part
22 in the same manner and to the same extent as such re-
23 quirements apply to employee welfare benefit plans, irre-
24 spective of whether such exemption continues in effect.
25 The annual report required under section 103 for any plan

1 year in the case of any such multiple employer welfare ar-
2 rangement shall also include information described in sec-
3 tion 704(a)(3)(F) with respect to the plan year and, not-
4 withstanding section 104(a)(1)(A), shall be filed not later
5 than 90 days after the close of the plan year.

6 “(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The
7 operating committee of each multiple employer welfare ar-
8 rangement with respect to which there is or has been in
9 effect an exemption granted under this part shall engage,
10 on behalf of all covered individuals, a qualified actuary
11 who shall be responsible for the preparation of the mate-
12 rials comprising information necessary to be submitted by
13 a qualified actuary under this part. The qualified actuary
14 shall utilize such assumptions and techniques as are nec-
15 essary to enable such actuary to form an opinion as to
16 whether the contents of the matters reported under this
17 part—

18 “(1) are in the aggregate reasonably related to
19 the experience of the arrangement and to reasonable
20 expectations, and

21 “(2) represent such actuary’s best estimate of
22 anticipated experience under the arrangement.

23 The opinion by the qualified actuary shall be made with
24 respect to, and shall be made a part of, the annual report.

1 “(d) FILING NOTICE OF EXEMPTION WITH
2 STATES.—An exemption granted to a multiple employer
3 welfare arrangement under this part shall not be effective
4 unless written notice of such exemption is filed with the
5 State insurance commissioner of each State in which at
6 least 5 percent of the individuals covered under the ar-
7 rangement are located. For purposes of this paragraph,
8 an individual shall be considered to be located in the State
9 in which a known address of such individual is located or
10 in which such individual is employed. The Secretary may
11 by regulation provide in specified cases for the application
12 of the preceding sentence with lesser percentages in lieu
13 of such 5 percent amount.

14 **“SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY**
15 **ARRANGEMENTS PROVIDING MEDICAL CARE.**

16 “(a) IN GENERAL.—A multiple employer welfare ar-
17 rangement providing benefits consisting of medical care
18 described in section 607(1) shall issue to each participat-
19 ing employer—

20 “(1) a document equivalent to the summary
21 plan description required of plans under part 1,

22 “(2) information describing the contribution
23 rates applicable to participating employers, and

24 “(3) a statement indicating—

1 “(A) whether or not the arrangement is
2 fully insured,

3 “(B) whether or not there is in effect with
4 respect to the arrangement an exemption grant-
5 ed under this part and, if there is in effect such
6 an exemption, that the arrangement is (or is
7 treated as) an employee welfare benefit plan
8 under this title, and

9 “(C) that the arrangement is not a li-
10 censed insurer under the laws of any State.

11 “(b) TIME FOR DISCLOSURE.—Such information
12 shall be issued to employers within such reasonable period
13 of time before becoming participating employers as may
14 be prescribed in regulations of the Secretary.

15 **“SEC. 707. MAINTENANCE OF RESERVES.**

16 “(a) IN GENERAL.—Each multiple employer welfare
17 arrangement with respect to which there is or has been
18 in effect an exemption granted under this part and which
19 is not fully insured shall establish and maintain reserves,
20 consisting of—

21 “(1) a reserve for unearned contributions,

22 “(2) a reserve for payment of claims reported
23 and not yet paid and claims incurred but not yet re-
24 ported, and for expected administrative costs with
25 respect to such claims, and

1 “(3) a reserve, in an amount recommended by
2 the qualified actuary, for any other obligations of
3 the arrangement.

4 “(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—
5 The total of the reserves described in subsection (a)(2)
6 shall not be less than an amount equal to 25 percent of
7 expected incurred claims and expenses for the plan year.

8 “(c) REQUIRED MARGIN.—In determining the
9 amounts of reserves required under this section in connec-
10 tion with any multiple employer welfare arrangement, the
11 qualified actuary shall include a margin for error and
12 other fluctuations taking into account the specific
13 circumstances of such arrangement.

14 “(d) ADDITIONAL REQUIREMENTS.—The Secretary
15 may provide such additional requirements relating to re-
16 serves and excess/stop loss coverage as the Secretary con-
17 siders appropriate. Such requirements may be provided,
18 by regulation or otherwise, with respect to any arrange-
19 ment or any class of arrangements.

20 “(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COV-
21 ERAGE.—The Secretary may provide for adjustments to
22 the levels of reserves otherwise required under subsections
23 (a) and (b) with respect to any arrangement or class of
24 arrangements to take into account excess/stop loss cov-

1 erage provided with respect to such arrangement or ar-
2 rangements.

3 **“SEC. 708. CORRECTIVE ACTIONS.**

4 “(a) ACTIONS TO AVOID DEPLETION OF RE-
5 SERVES.—A multiple employer welfare arrangement with
6 respect to which there is or has been in effect an exemp-
7 tion granted under this part shall continue to meet the
8 requirements of section 707, irrespective of whether such
9 exemption continues in effect. The operating committee of
10 such arrangement shall determine semiannually whether
11 the requirements of section 707 are met. In any case in
12 which the committee determines that there is reason to
13 believe that there is or will be a failure to meet such re-
14 quirements, or the Secretary makes such a determination
15 and so notifies the committee, the committee shall imme-
16 diately notify the qualified actuary engaged by the ar-
17 rangement, and such actuary shall, not later than the end
18 of the next following month, make such recommendations
19 to the committee for corrective action as the actuary deter-
20 mines necessary to ensure compliance with section 707.
21 Not later than 10 days after receiving from the actuary
22 recommendations for corrective actions, the committee
23 shall notify the Secretary (in such form and manner as
24 the Secretary may prescribe by regulation) of such rec-
25 ommendations of the actuary for corrective action, to-

1 gether with a description of the actions (if any) that the
2 committee has taken or plans to take in response to such
3 recommendations. The committee shall thereafter report
4 to the Secretary, in such form and frequency as the Sec-
5 retary may specify to the committee, regarding corrective
6 action taken by the committee until the requirements of
7 section 707 are met.

8 “(b) TERMINATION.—

9 “(1) NOTICE OF TERMINATION.—In any case in
10 which the operating committee of a multiple em-
11 ployer welfare arrangement with respect to which
12 there is or has been in effect an exemption granted
13 under this part determines that there is reason to
14 believe that the arrangement will terminate, the
15 committee shall so inform the Secretary, shall de-
16 velop a plan for winding up the affairs of the ar-
17 rangement in connection with such termination in a
18 manner which will result in timely payment of all
19 benefits for which the arrangement is obligated, and
20 shall submit such plan in writing to the Secretary.
21 Actions required under this paragraph shall be taken
22 in such form and manner as may be prescribed in
23 regulations of the Secretary.

24 “(2) ACTIONS REQUIRED IN CONNECTION WITH
25 TERMINATION.—In any case in which—

1 “(A) the Secretary has been notified under
2 subsection (a) of a failure of a multiple em-
3 ployer welfare arrangement with respect to
4 which there is or has been in effect an exemp-
5 tion granted under this part to meet the re-
6 quirements of section 707 and has not been no-
7 tified by the operating committee of the ar-
8 rangement that corrective action has restored
9 compliance with such requirements, and

10 “(B) the Secretary determines that the
11 continuing failure to meet the requirements of
12 section 707 can be reasonably expected to result
13 in a continuing failure to pay benefits for which
14 the arrangement is obligated,

15 the operating committee of the arrangement shall, at
16 the direction of the Secretary, terminate the ar-
17 rangement and, in the course of the termination,
18 take such actions as the Secretary may require as
19 necessary to ensure that the affairs of the arrange-
20 ment will be, to the maximum extent possible, wound
21 up in a manner which will result in timely payment
22 of all benefits for which the arrangement is
23 obligated.

1 **“SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF**
2 **EXEMPTION.**

3 “(a) EXPIRATION AND RENEWAL OF EXEMPTION.—
4 An exemption granted to a multiple employer welfare ar-
5 rangement under this part shall expire 3 years after the
6 date on which the exemption is granted. An exemption
7 which has expired may be renewed by means of application
8 for an exemption in accordance with section 704.

9 “(b) SUSPENSION OR REVOCATION OF EXEMPTION
10 BY SECRETARY.—The Secretary may suspend or revoke
11 an exemption granted to a multiple employer welfare
12 arrangement under this part—

13 “(1) for any cause that may serve as the basis
14 for the denial of an initial application for such an
15 exemption under section 704, or

16 “(2) if the Secretary finds that—

17 “(A) the arrangement, or the sponsor
18 thereof, in the transaction of business while
19 under the exemption, has used fraudulent, coer-
20 cive, or dishonest practices, or has dem-
21 onstrated incompetence, untrustworthiness, or
22 financial irresponsibility,

23 “(B) the arrangement, or the sponsor
24 thereof, is using such methods or practices in
25 the conduct of its operations, so as to render its
26 further transaction of operations hazardous or

1 injurious to participating employers, or covered
2 individuals,

3 “(C) the arrangement, or the sponsor
4 thereof, has refused to be examined in accord-
5 ance with this part or to produce its accounts,
6 records, and files for examination in accordance
7 with this part, or

8 “(D) any of the officers of the arrange-
9 ment, or the sponsor thereof, has refused to
10 give information with respect to the affairs of
11 the arrangement or the sponsor or to perform
12 any other legal obligation relating to such an
13 examination when required by the Secretary in
14 accordance with this part.

15 Any such suspension or revocation under this subsection
16 shall be effective only upon a final decision of the Sec-
17 retary made after notice and opportunity for a hearing
18 is provided in accordance with section 710.

19 “(c) SUSPENSION OR REVOCATION OF EXEMPTION
20 UNDER COURT PROCEEDINGS.—An exemption granted to
21 a multiple employer welfare arrangement under this part
22 may be suspended or revoked by a court of competent ju-
23 risdiction in an action by the Secretary brought under
24 paragraph (2), (5), or (6) of section 502(a), except that
25 the suspension or revocation under this subsection shall

1 be effective only upon notification of the Secretary of such
2 suspension or revocation.

3 “(d) NOTIFICATION OF PARTICIPATING EMPLOY-
4 ERS.—All participating employers in a multiple employer
5 welfare arrangement shall be notified of the expiration,
6 suspension, or revocation of an exemption granted to such
7 arrangement under this part, by such persons and in such
8 form and manner as shall be prescribed in regulations of
9 the Secretary, not later than 20 days after such expiration
10 or after receipt of notice of a final decision requiring such
11 suspension or revocation.

12 “(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS,
13 AND REVOCATIONS.—The Secretary shall publish all expi-
14 rations of, and all final decisions to suspend or revoke,
15 exemptions granted under this part.

16 **“SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.**

17 “(a) IN GENERAL.—Any decision by the Secretary
18 which involves the denial of an application by a multiple
19 employer welfare arrangement for an exemption under this
20 part or the suspension or revocation of such an exemption
21 shall contain a statement of the specific reason or reasons
22 supporting the Secretary’s action, including reference to
23 the specific terms of the exemption and the statutory pro-
24 vision or provisions relevant to the determination.

1 “(b) DENIALS OF APPLICATIONS.—In the case of the
2 denial of an application for an exemption under this part,
3 the Secretary shall send a copy of the decision to the appli-
4 cant by certified or registered mail at the address specified
5 in the records of the Secretary. Such decision shall con-
6 stitute the final decision of the Secretary unless the ar-
7 rangement, or any party that would be prejudiced by the
8 decision, files a written appeal of the denial within 30 days
9 after the mailing of such decision. The Secretary may af-
10 firm, modify, or reverse the initial decision. The decision
11 on appeal shall become final upon the mailing of a copy
12 by certified or registered mail to the arrangement or party
13 that filed the appeal.

14 “(c) SUSPENSIONS OR REVOCATIONS OF EXEMP-
15 TION.—In the case of the suspension or revocation of an
16 exemption granted under this part, the Secretary shall
17 send a copy of the decision to the arrangement by certified
18 or registered mail at its address, as specified in the
19 records of the Secretary. Upon the request of the arrange-
20 ment, or any party that would be prejudiced by the sus-
21 pension or revocation, filed within 15 days of the mailing
22 of the Secretary’s decision, the Secretary shall schedule
23 a hearing on such decision by written notice, sent by cer-
24 tified or registered mail to the arrangement or party
25 requesting such hearing. Such notice shall set forth—

1 “(1) a specific date and time for the hearing,
2 which shall be within the 10-day period commencing
3 20 days after the date of the mailing of the notice,
4 and

5 “(2) a specific place for the hearing, which shall
6 be in the District of Columbia or in the State and
7 county thereof (or parish or other similar political
8 subdivision thereof) in which is located the arrange-
9 ment’s principal place of business.

10 The decision as affirmed or modified in such hearing shall
11 constitute the final decision of the Secretary, unless such
12 decision is reversed in such hearing.”.

13 (b) CONFORMING AMENDMENT TO DEFINITION OF
14 PLAN SPONSOR.—Section 3(16)(B) of such Act (29
15 U.S.C. 1002(16)(B)) is amended by adding at the end the
16 following new sentence: “Such term also includes the spon-
17 sor (as defined in section 701(5)) of a multiple employer
18 welfare arrangement, or a multiple employer health plan
19 (as defined in section 701(10)), with respect to which
20 there is or has been in effect an exemption granted under
21 part 7.”.

22 (c) ALTERNATIVE MEANS OF DISTRIBUTION OF
23 SUMMARY PLAN DESCRIPTIONS.—Section 110 of such
24 Act (29 U.S.C. 1030) is amended by adding at the end
25 the following new subsection:

1 “(c) The Secretary shall prescribe, as an alternative
 2 method for distributing summary plan descriptions in
 3 order to meet the requirements of section 104(b)(1) in the
 4 case of multiple employer welfare arrangements providing
 5 benefits consisting of medical care described in section
 6 607(1), a means of distribution of such descriptions by
 7 participating employers.”.

8 (d) CLERICAL AMENDMENT.—The table of contents
 9 in section 1 of the Employee Retirement Income Security
 10 Act of 1974 is amended by inserting after the item relat-
 11 ing to section 608 the following new items:

“PART 7—MULTIPLE EMPLOYER HEALTH PLANS

“Sec. 701. Definitions.

“Sec. 702. Exempted multiple employer welfare arrangements treated as em-
 ployee welfare benefit plans and exempt from certain restric-
 tions on preemption.

“Sec. 703. Exemption procedure.

“Sec. 704. Eligibility requirements.

“Sec. 705. Additional requirements applicable to exempted arrangements.

“Sec. 706. Disclosure to participating employers by arrangements providing
 medical care.

“Sec. 707. Maintenance of reserves.

“Sec. 708. Corrective actions.

“Sec. 709. Expiration, suspension, or revocation of exemption.

“Sec. 710. Review of actions of the Secretary.”.

12 **SEC. 212. CLARIFICATION OF SCOPE OF PREEMPTION**

13 **RULES.**

14 (a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the
 15 Employee Retirement Income Security Act of 1974 (29
 16 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting “, but
 17 only, in the case of an arrangement which provides medi-
 18 cal care described in section 607(1) and with respect to

1 which an exemption under part 7 is not in effect,” before
2 “to the extent not inconsistent with the preceding sections
3 of this title”.

4 (b) CROSS-REFERENCE.—Section 514(b)(6) of such
5 Act (29 U.S.C. 1144(b)(6)) is amended by adding at the
6 end the following new subparagraph:

7 “(E) For additional rules relating to exemption from
8 subparagraph (A)(ii) of multiple employer welfare ar-
9 rangements providing medical care, see part 7.”.

10 **SEC. 213. CLARIFICATION OF TREATMENT OF SINGLE EM-**
11 **PLOYER ARRANGEMENTS.**

12 Section 3(40)(B) of the Employee Retirement Income
13 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-
14 ed—

15 (1) in clause (i), by inserting “for any plan year
16 of any such plan, or any fiscal year of any such
17 other arrangement,” after “single employer”, and by
18 inserting “during such year or at any time during
19 the preceding 1-year period” after “common con-
20 trol”,

21 (2) in clause (iii), by striking “common control
22 shall not be based on an interest of less than 25 per-
23 cent” and inserting “an interest of greater than 25
24 percent may not be required as the minimum inter-

1 est necessary for common control”, and by striking
2 “and” at the end,

3 (3) by redesignating clause (iv) as clause (v),
4 and

5 (4) by inserting after clause (iii) the following
6 new clause:

7 “(iv) in determining, after the application of
8 clause (i), whether benefits are provided to employ-
9 ees of two or more employers, the arrangement shall
10 be treated as having only 1 participating employer
11 if, at the time the determination under clause (i) is
12 made, the number of individuals who are employees
13 and former employees of any one participating em-
14 ployer and who are covered under the arrangement
15 is greater than 95 percent of the aggregate number
16 of all individuals who are employees or former em-
17 ployees of participating employers and who are
18 covered under the arrangement.”.

19 **SEC. 214. CLARIFICATION OF TREATMENT OF CERTAIN**
20 **COLLECTIVELY BARGAINED ARRANGE-**
21 **MENTS.**

22 (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-
23 ployee Retirement Income Security Act of 1974 (29
24 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

1 “(i) under or pursuant to one or more collective
2 bargaining agreements,”.

3 (b) LIMITATIONS.—Section 3(40) of such Act (29
4 U.S.C. 1002(40)) is amended by adding at the end the
5 following new subparagraphs:

6 “(C) Clause (i) of subparagraph (A) shall
7 apply only if—

8 “(i) the plan or other arrangement,
9 and the employee organization or any other
10 entity sponsoring the plan or other ar-
11 rangement, do not—

12 “(I) utilize the services of any li-
13 censed insurance agent or broker for
14 soliciting or enrolling employers or in-
15 dividuals as participating employers or
16 covered individuals under the plan or
17 other arrangement, or

18 “(II) pay a commission or any
19 other type of compensation to a per-
20 son that is related either to the vol-
21 ume or number of employers or indi-
22 viduals solicited or enrolled as partici-
23 pating employers or covered individ-
24 uals under the plan or other arrange-
25 ment, or to the dollar amount or size

1 of the contributions made by partici-
2 pating employers or covered individ-
3 uals to the plan or other arrangement,

4 “(ii) not less than 85 percent of the
5 covered individuals under the plan or other
6 arrangement are individuals who—

7 “(I) are employed within a bar-
8 gaining unit covered by at least one of
9 the collective bargaining agreements
10 with a participating employer (or are
11 covered on the basis of an individual’s
12 employment in such a bargaining
13 unit), or

14 “(II) are present or former em-
15 ployees of the sponsoring employee or-
16 ganization, of an employer who is or
17 was a party to at least one of the col-
18 lective bargaining agreements, or of
19 the plan or other arrangement or a
20 related plan or arrangement (or are
21 covered on the basis of such present
22 or former employment),

23 “(iii) the plan or other arrangement
24 does not provide benefits to individuals
25 (other than individuals described in clause

1 (ii)(II)) who work outside the standard
2 metropolitan statistical area in which the
3 sponsoring employee organization rep-
4 resents employees (or to individuals (other
5 than individuals described in clause
6 (ii)(II)) on the basis of such work by oth-
7 ers), except that in the case of a sponsor-
8 ing employee organization that represents
9 employees who work outside of any stand-
10 ard metropolitan statistical area, this
11 clause shall be applied by reference to the
12 State in which the sponsoring organization
13 represents employees, and

14 “(iv) the employee organization or
15 other entity sponsoring the plan or other
16 arrangement certifies to the Secretary each
17 year, in a form and manner which shall
18 be prescribed in regulations of the Sec-
19 retary—

20 “(I) that the plan or other ar-
21 rangement meets the requirements of
22 clauses (i), (ii), and (iii), and

23 “(II) if, for any year, 10 percent
24 or more of the covered individuals
25 under the plan are individuals not de-

1 scribed in subclause (I) or (II) of
2 clause (ii), the total number of cov-
3 ered individuals and the total number
4 of covered individuals not so de-
5 scribed.

6 “(D)(i) Clause (i) of subparagraph (A)
7 shall not apply to a plan or other arrangement
8 that is established or maintained pursuant to
9 one or more collective bargaining agreements
10 which the National Labor Relations Boards de-
11 termines to have been negotiated or otherwise
12 agreed to in a manner or through conduct
13 which violates section 8(a)(2) of the National
14 Labor Relations Act (29 U.S.C. 158(a)(2)).

15 “(ii)(I) Whenever a State insurance com-
16 missioner has reason to believe that this sub-
17 paragraph is applicable to part or all of a plan
18 or other arrangement, the State insurance com-
19 missioner may file a petition with the National
20 Labor Relations Board for a determination
21 under clause (i), along with sworn written testi-
22 mony supporting the petition.

23 “(II) The Board shall give any such peti-
24 tion priority over all other petitions and cases,
25 other than other petitions under subclause (I)

1 or cases given priority under section 10 of the
2 National Labor Relations Act (29 U.S.C. 160).

3 “(III) The Board shall determine, upon
4 the petition and any response, whether, on the
5 facts before it, the plan or other arrangement
6 was negotiated, created, or otherwise agreed to
7 in a manner or through conduct which violates
8 section 8(a)(2) of the National Labor Relations
9 Act (29 U.S.C. 158(a)(2)). Such determination
10 shall constitute a final determination for pur-
11 poses of this subparagraph and shall be binding
12 in all Federal or State actions with respect to
13 the status of the plan or other arrangement
14 under this subparagraph.

15 “(IV) A person aggrieved by the deter-
16 mination of the Board under subclause (III)
17 may obtain review of the determination in any
18 United States court of appeals in the circuit in
19 which the collective bargaining at issue oc-
20 curred. Commencement of proceedings under
21 this subclause shall not, unless specifically or-
22 dered by the court, operate as a stay of any
23 State administrative or judicial action or pro-
24 ceeding related to the status of the plan or
25 other arrangement, except that in no case may

1 the court stay, before the completion of the re-
2 view, an order which prohibits the enrollment of
3 new individuals into coverage under a plan or
4 arrangement.”.

5 **SEC. 215. EMPLOYEE LEASING HEALTHCARE ARRANGE-**
6 **MENTS.**

7 (a) EMPLOYEE LEASING HEALTHCARE ARRANGE-
8 MENT DEFINED.—Section 3 of the Employee Retirement
9 Income Security Act of 1974 (29 U.S.C. 1002) is amended
10 by adding at the end the following new paragraph:

11 “(43) EMPLOYEE LEASING HEALTHCARE ARRANGE-
12 MENT.—

13 “(A) IN GENERAL.—Subject to subparagraph
14 (B), the term ‘employee leasing healthcare arrange-
15 ment’ means any labor leasing arrangement, staff
16 leasing arrangement, extended employee staffing or
17 supply arrangement, or other arrangement under
18 which—

19 “(i) one business or other entity (herein-
20 after in this paragraph referred to as the ‘les-
21 see’), under a lease or other arrangement en-
22 tered into with any other business or other en-
23 tity (hereinafter in this paragraph referred to
24 as the ‘lessor’), receives from the lessor the

1 services of individuals to be performed under
2 such lease or other arrangement, and

3 “(ii) benefits consisting of medical care de-
4 scribed in section 607(1) are provided to such
5 individuals or such individuals and their de-
6 pendants as participants and beneficiaries.

7 “(B) EXCEPTION.—Such term does not include
8 an arrangement described in subparagraph (A) if,
9 under such arrangement, the lessor retains, both le-
10 gally and in fact, a complete right of direction and
11 control within the scope of employment over the in-
12 dividuals whose services are supplied under such
13 lease or other arrangement, and such individuals
14 perform a specified function for the lessee which is
15 separate and divisible from the primary business or
16 operations of the lessee.”.

17 (b) TREATMENT OF EMPLOYEE LEASING
18 HEALTHCARE ARRANGEMENTS AS MULTIPLE EMPLOYER
19 WELFARE ARRANGEMENTS.—Section 3(40) of such Act
20 (29 U.S.C. 1002(40)) (as amended by the preceding provi-
21 sions of this subtitle) is further amended by adding at the
22 end the following new subparagraph:

23 “(E) The term ‘multiple employer welfare arrange-
24 ment’ includes any employee leasing healthcare arrange-
25 ment, except that such term does not include any employee

1 leasing healthcare arrangement which is a multiple em-
2 ployer health plan (as defined in section 701(10)).”.

3 (c) SPECIAL RULES FOR EMPLOYEE LEASING
4 HEALTHCARE ARRANGEMENTS.—

5 (1) IN GENERAL.—Part 7 of subtitle B of title
6 I of such Act (as added by the preceding provisions
7 of this subtitle) is amended by adding at the end the
8 following new section:

9 **“SEC. 711. SPECIAL RULES FOR EMPLOYEE LEASING**
10 **HEALTHCARE ARRANGEMENTS.**

11 “(a) IN GENERAL.—The requirements of paragraphs
12 (1), (2), and (3) of section 704(b) shall be treated as satis-
13 fied in the case of a multiple employer welfare arrange-
14 ment that is an employee leasing healthcare arrangement
15 if the application for exemption includes information
16 which the Secretary determines to be complete and accu-
17 rate and sufficient to demonstrate that the following
18 requirements are met with respect to the arrangement:

19 “(1) 3-YEAR TENURE.—The lessor has been in
20 operation for not less than 3 years.

21 “(2) SOLICITATION RESTRICTIONS.—Employee
22 leasing services provided under the arrangement are
23 not solicited, advertised, or marketed through li-
24 censed insurance agents or brokers acting in such
25 capacity.

1 “(3) CREATION OF EMPLOYMENT RELATION-
2 SHIP.—

3 “(A) DISCLOSURE STATEMENT.—Written
4 notice is provided to each applicant for employ-
5 ment subject to coverage under the arrange-
6 ment, at the time of application for employment
7 and before commencing coverage under the ar-
8 rangement, stating that the employer is the les-
9 sor under the arrangement.

10 “(B) INFORMED CONSENT.—Each such
11 applicant signs a written statement consenting
12 to the employment relationship with the lessor.

13 “(C) INFORMED RECRUITMENT OF LES-
14 SEE’S EMPLOYEES.—In any case in which the
15 lessor offers employment to an employee of a
16 lessee under the arrangement, the lessor in-
17 forms each employee in writing that his or her
18 acceptance of employment with the lessor is vol-
19 untary and that refusal of such offer will not be
20 deemed to be resignation from or abandonment
21 of current employment.

22 “(4) REQUISITE EMPLOYER-EMPLOYEE RELA-
23 TIONSHIP UNDER ARRANGEMENT.—Under the em-
24 ployer-employee relationship with the employees of
25 the lessor—

1 “(A) the lessor retains the ultimate author-
2 ity to hire, terminate, and reassign such em-
3 ployees,

4 “(B) the lessor is responsible for the pay-
5 ment of wages, payroll-related taxes, and em-
6 ployee benefits, without regard to payment by
7 the lessee to the lessor for its services,

8 “(C) the lessor maintains the right of di-
9 rection and control over its employees, except to
10 the extent that the lessee is responsible for su-
11 pervision of the work performed consistent with
12 the lessee’s responsibility for its product or
13 service,

14 “(D) in accordance with section 301(a) of
15 the Labor Management Relations Act, 1947 (29
16 U.S.C. 185(a)), the lessor retains in the ab-
17 sence of an applicable collective bargaining
18 agreement, the right to enter into arbitration
19 and to decide employee grievances, and

20 “(E) no owner, officer, or director of, or
21 partner in, a lessee is an employee of the lessor,
22 and not more than 10 percent of the individuals
23 covered under the arrangement consist of own-
24 ers, officers, or directors of, or partners in,
25 such a lessee (or any combination thereof).

1 “(b) DEFINITIONS.—For purposes of this section:

2 “(1) LESSOR.—The term ‘lessor’ means the
3 business or other entity from which services of indi-
4 viduals are obtained under an employee leasing
5 healthcare arrangement.

6 “(2) LESSEE.—The term ‘lessee’ means a busi-
7 ness or other entity which receives the services of in-
8 dividuals provided under an employee leasing
9 healthcare arrangement.”.

10 (2) CLERICAL AMENDMENT.—The table of con-
11 tents in section 1 of such Act (as amended by the
12 preceding provisions of this subtitle) is further
13 amended by inserting after the item relating to sec-
14 tion 710 the following new item:

“Sec. 711. Employee leasing healthcare arrangements.”.

15 **SEC. 216. ENFORCEMENT PROVISIONS RELATING TO MUL-**
16 **TIPLE EMPLOYER WELFARE ARRANGEMENTS**
17 **AND EMPLOYEE LEASING HEALTHCARE AR-**
18 **RANGEMENTS.**

19 (a) ENFORCEMENT OF FILING REQUIREMENTS.—
20 Section 502 of the Employee Retirement Income Security
21 Act of 1974 (29 U.S.C. 1132) is amended—

22 (1) in subsection (a)(6), by striking “subsection
23 (c)(2) or (i) or (l)” and inserting “paragraph (2) or
24 (4) of subsection (c) or subsection (i) or (l)”; and

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

3 “(4) The Secretary may assess a civil penalty against
4 any person of up to \$1,000 a day from the date of such
5 person’s failure or refusal to file the information required
6 to be filed with the Secretary under section 101(d).”.

7 (b) ACTIONS BY STATES IN FEDERAL COURT.—Sec-
8 tion 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

9 (1) in paragraph (5), by striking “or” at the
10 end;

11 (2) in paragraph (6), by striking the period and
12 inserting “, or”; and

13 (3) by adding at the end the following:

14 “(7) by a State official having authority under
15 the law of such State to enforce the laws of such
16 State regulating insurance, to enjoin any act or
17 practice which violates any provision of part 7 which
18 such State has the power to enforce under part 7.”.

19 (c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
20 MISREPRESENTATIONS.—Section 501 of such Act (29
21 U.S.C. 1131) is amended—

22 (1) by inserting “(a)” after “SEC. 501.”; and

23 (2) by adding at the end the following new sub-
24 section:

1 “(b) Any person who, either willfully or with willful
2 blindness, falsely represents, to any employee, any employ-
3 ee’s beneficiary, any employer, the Secretary, or any State,
4 an arrangement established or maintained for the purpose
5 of offering or providing any benefit described in section
6 3(1) to employees or their beneficiaries as being a multiple
7 employer welfare arrangement granted an exemption
8 under part 7, as being an employee leasing healthcare ar-
9 rangement under such an exemption, or as having been
10 established or maintained under or pursuant to a collective
11 bargaining agreement shall, upon conviction, be impris-
12 oned not more than five years, be fined under title 18,
13 United States Code, or both.”.

14 (d) CEASE ACTIVITIES ORDERS.—Section 502 of
15 such Act (29 U.S.C. 1132) is amended by adding at the
16 end the following new subsection:

17 “(m)(1) Subject to paragraph (2), upon application
18 by the Secretary showing the operation, promotion, or
19 marketing of a multiple employer welfare arrangement
20 providing benefits consisting of medical care described in
21 section 607(1) that—

22 “(A) is not licensed, registered, or otherwise ap-
23 proved under the insurance laws of the States in
24 which the arrangement offers or provides benefits, or

1 “(B) is not operating in accordance with the
2 terms of an exemption granted by the Secretary
3 under part 7,

4 a district court of the United States shall enter an order
5 requiring that the arrangement cease activities.

6 “(2) Paragraph (1) shall not apply in the case of a
7 multiple employer welfare arrangement if the arrangement
8 shows that it—

9 “(A) is fully insured, within the meaning of
10 section 701(9),

11 “(B) is licensed, registered, or otherwise ap-
12 proved in each State in which it offers or provides
13 benefits, except to the extent that such State does
14 not require licensing, registration, or approval of
15 fully insured multiple employer welfare arrange-
16 ments, and

17 “(C) with respect to each such State, is operat-
18 ing in accordance with applicable State insurance
19 laws that are not superseded under section 514.

20 “(3) The court may grant such additional equitable
21 or remedial relief, including any relief available under this
22 title, as it deems necessary to protect the interests of the
23 public and of persons having claims for benefits against
24 the arrangement.”.

1 (e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—
2 Section 503 of such Act (29 U.S.C. 1133) is amended by
3 adding at the end (after and below paragraph (2)) the fol-
4 lowing new sentence: “The terms of each multiple em-
5 ployer welfare arrangement to which this section applies
6 and which provides benefits consisting of medical care de-
7 scribed in section 607(1) shall require the operating com-
8 mittee or the named fiduciary (as applicable) to ensure
9 that the requirements of this section are met in connection
10 with claims filed under the arrangement.”.

11 **SEC. 217. FILING REQUIREMENTS FOR HEALTH BENEFIT**
12 **MULTIPLE EMPLOYER WELFARE ARRANGE-**
13 **MENTS.**

14 Section 101 of the Employee Retirement Income Se-
15 curity Act of 1974 (29 U.S.C. 1021) is amended—

16 (1) by redesignating subsection (e) as sub-
17 section (f); and

18 (2) by inserting after subsection (d) the follow-
19 ing new subsection:

20 “(e)(1) Each multiple employer welfare arrangement
21 shall file with the Secretary a registration statement de-
22 scribed in paragraph (2) within 60 days before commenc-
23 ing operations (in the case of an arrangement commencing
24 operations on or after January 1, 1994) and no later than
25 February 15 of each year (in the case of an arrangement

1 in operation since the beginning of such year), unless, as
2 of the date by which such filing otherwise must be made,
3 such arrangement provides no benefits consisting of medi-
4 cal care described in section 607(1).

5 “(2) Each registration statement—

6 “(A) shall be filed in such form, and contain
7 such information concerning the multiple employer
8 welfare arrangement and any persons involved in its
9 operation (including whether the arrangement is
10 fully insured), as shall be provided in regulations
11 which shall be prescribed by the Secretary, and

12 “(B) if the arrangement is not fully insured,
13 shall contain a certification that copies of such reg-
14 istration statement have been transmitted by cer-
15 tified mail to—

16 “(i) in the case of an arrangement with re-
17 spect to which an exemption under part 7 is in
18 effect, the State insurance commissioner of the
19 domicile State of such arrangement, or

20 “(ii) in the case of an arrangement which
21 is not so exempt, the State insurance commis-
22 sioner of each State in which the arrangement
23 is located.

24 “(3) The person or persons responsible for filing the
25 annual registration statement are—

1 “(A) the trustee or trustees so designated by
2 the terms of the instrument under which the mul-
3 tiple employer welfare arrangement is established or
4 maintained, or

5 “(B) in the case of a multiple employer welfare
6 arrangement for which the trustee or trustees can-
7 not be identified, or upon the failure of the trustee
8 or trustees of an arrangement to file, the person or
9 persons actually responsible for the acquisition, dis-
10 position, control, or management of the cash or
11 property of the arrangement, irrespective of whether
12 such acquisition, disposition, control, or management
13 is exercised directly by such person or persons or
14 through an agent designated by such person or
15 persons.

16 “(4) Any agreement entered into under section
17 506(c) with a State as the primary domicile State with
18 respect to any multiple employer welfare arrangement
19 shall provide for simultaneous filings of reports required
20 under this subsection with the Secretary and with the
21 State insurance commissioner of such State.”.

1 **SEC. 218. COOPERATION BETWEEN FEDERAL AND STATE**
2 **AUTHORITIES.**

3 Section 506 of the Employee Retirement Income Se-
4 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
5 at the end the following new subsection:

6 “(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE
7 EMPLOYER WELFARE ARRANGEMENTS.—

8 “(1) STATE ENFORCEMENT.—

9 “(A) AGREEMENTS WITH STATES.—A
10 State may enter into an agreement with the
11 Secretary for delegation to the State of some or
12 all of the Secretary’s authority under sections
13 502 and 504 to enforce the provisions of this
14 title applicable to multiple employer welfare ar-
15 rangements with respect to which an exemption
16 under part 7 is or has been in effect. The Sec-
17 retary shall enter into the agreement if the Sec-
18 retary determines that the delegation provided
19 for therein would not result in a lower level or
20 quality of enforcement of the provisions of this
21 title.

22 “(B) DELEGATIONS.—Any department,
23 agency, or instrumentality of a State to which
24 authority is delegated pursuant to an agree-
25 ment entered into under this paragraph may, if
26 authorized under State law and to the extent

1 consistent with such agreement, exercise the
2 powers of the Secretary under this title which
3 relate to such authority.

4 “(C) CONCURRENT AUTHORITY OF THE
5 SECRETARY.—If the Secretary delegates author-
6 ity to a State in an agreement entered into
7 under subparagraph (A), the Secretary may
8 continue to exercise such authority concurrently
9 with the State.

10 “(D) RECOGNITION OF PRIMARY DOMICILE
11 STATE.—In entering into any agreement with a
12 State under subparagraph (A), the Secretary
13 shall ensure that, as a result of such agreement
14 and all other agreements entered into under
15 subparagraph (A), only one State will be recog-
16 nized, with respect to any particular multiple
17 employer welfare arrangement, as the primary
18 domicile State to which authority has been dele-
19 gated pursuant to such agreements.

20 “(2) ASSISTANCE TO STATES.—The Secretary
21 shall—

22 “(A) provide enforcement assistance to the
23 States with respect to multiple employer welfare
24 arrangements, including, but not limited to, co-
25 ordinating Federal and State efforts through

1 the establishment of cooperative agreements
2 with appropriate State agencies under which
3 the Pension and Welfare Benefits Administra-
4 tion keeps the States informed of the status of
5 its cases and makes available to the States in-
6 formation obtained by it,

7 “(B) provide continuing technical assist-
8 ance to the States with respect to issues involv-
9 ing multiple employer welfare arrangements
10 and this Act,

11 “(C) assist the States in obtaining from
12 the Office of Regulations and Interpretations
13 timely and complete responses to requests for
14 advisory opinions on issues described in sub-
15 paragraph (B), and

16 “(D) distribute copies of all advisory opin-
17 ions described in subparagraph (C) to the State
18 insurance commissioner of each State.”.

19 **SEC. 219. EFFECTIVE DATE; TRANSITIONAL RULES.**

20 (a) **EFFECTIVE DATE.**—The amendments made by
21 this subtitle shall take effect January 1, 1994, except that
22 the Secretary of Labor may issue regulations before such
23 date under such amendments. The Secretary shall issue
24 all regulations necessary to carry out the amendments
25 made by this subtitle before the effective date thereof.

1 (b) TRANSITIONAL RULES.—If the sponsor of a mul-
2 tiple employer welfare arrangement which, as of January
3 1, 1994, provides benefits consisting of medical care de-
4 scribed in section 607(1) of the Employee Retirement In-
5 come Security Act of 1974 (29 U.S.C. 1167(1)) files with
6 the Secretary of Labor an application for an exemption
7 under part 7 of subtitle B of title I of such Act within
8 180 days after such date and the Secretary has not, as
9 of 90 days after receipt of such application, found such
10 application to be materially deficient, section 514(b)(6)(A)
11 of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply
12 with respect to such arrangement during the 18-month pe-
13 riod following such date. If the Secretary determines, at
14 any time after the date of enactment of this Act, that any
15 such exclusion from coverage under the provisions of such
16 section 514(b)(6)(A) of a multiple employer welfare ar-
17 rangement would be detrimental to the interests of individ-
18 uals covered under such arrangement, such exclusion shall
19 cease as of the date of the determination. Any determina-
20 tion made by the Secretary under this subsection shall be
21 in the Secretary's sole discretion.

1 **Subtitle C—Repeal of COBRA**
2 **Continuation Requirements**

3 **SEC. 221. REPEAL OF REQUIREMENTS OF THE INTERNAL**
4 **REVENUE CODE OF 1954.**

5 (a) **IN GENERAL.**—Section 4980B of the Internal
6 Revenue Code of 1986 is repealed.

7 (b) **CONFORMING AMENDMENTS.**—Section 414 of
8 such Code is amended—

9 (1) in subsection (n)(3)(C), by striking “505,
10 and 4980B” and inserting “and 505”, and

11 (2) in subsection (t)(2), by striking “505, or
12 4980B” and inserting “or 505”.

13 (c) **EFFECTIVE DATE.**—The repeal effected by sub-
14 section (a) shall apply to health plans offered in a State
15 by an employer as of the first date that a State multicare
16 program is in effect in the State.

17 **SEC. 222. REPEAL OF REQUIREMENTS OF EMPLOYEE RE-**
18 **TIREMENT INCOME SECURITY ACT OF 1974.**

19 (a) **IN GENERAL.**—Part 6 of subtitle B of title I of
20 the Employee Retirement Income Security Act of 1974 is
21 repealed.

22 (b) **CONFORMING AMENDMENT.**—Section 502(c)(1)
23 of such Act (29 U.S.C. 1132(c)(1)) is amended by striking
24 “paragraph (1) or (4) of section 606 or”.

1 (c) EFFECTIVE DATE.—The repeal effected by sub-
 2 section (a) shall apply to health plans offered in a State
 3 by an employer as of the first date that a State multicare
 4 program is in effect in the State.

5 **SEC. 223. REPEAL OF REQUIREMENTS OF PUBLIC HEALTH**
 6 **SERVICE ACT.**

7 (a) IN GENERAL.—Title XXII of the Public Health
 8 Service Act is repealed.

9 (b) EFFECTIVE DATE.—The repeal effected by sub-
 10 section (a) shall apply to health plans offered in a State
 11 by an employer as of the first date that a State multicare
 12 program is in effect in the State.

13 **TITLE III—STATES WITHOUT**
 14 **STATE MULTICARE PRO-**
 15 **GRAMS; FEDERAL HEALTH**
 16 **CARE PROGRAMS; NATIONAL**
 17 **REINSURANCE POOL**

18 **Subtitle A—Multicare Plans in**
 19 **States without State Multicare**
 20 **Programs**

21 **SEC. 301. GENERAL PROVISIONS.**

22 (a) IN GENERAL.—In the case of a State without a
 23 State multicare program approved under title I, the Sec-
 24 retary may provide for—

1 (1) the operation (through the Department of
2 Health and Human Services) of such a program in
3 the State, and

4 (2) the approval and offering of multistate
5 plans in the State,

6 in the same manner as such a program and plans would
7 have been offered if a State multicare program were in
8 operation in the State.

9 (b) APPLICATION OF ALL REQUIREMENTS.—In the
10 case of multicare plans offered pursuant to subsection (a),
11 such plans shall meet all the same requirements of title
12 II (including requirements relating to consumer rights)
13 that would have applied if the plans were offered under
14 a State multicare program.

15 (c) CONSUMER EDUCATION AND ASSISTANCE.—In
16 the case of a State without a State multicare program ap-
17 proved under title I:

18 (1) DISTRIBUTION OF PLAN INFORMATION.—
19 The Secretary shall provide, through local Social Se-
20 curity Administration offices and State welfare of-
21 fices, for assistance to medicare, medicaid, and low-
22 income beneficiaries in the selection of multicare
23 plans pursuant to this section. Such offices shall
24 provide eligible individuals with the information nec-

1 essary to qualify them for reduced cost-sharing and
2 to explain their available options.

3 (2) DISTRIBUTION OF PLAN INFORMATION.—

4 The Secretary shall provide for distribution of infor-
5 mation on approved multicare plans.

6 **Subtitle B—Federal Health Care**
7 **Programs**

8 **SEC. 321. MEDICARE PROGRAM.**

9 (a) NEGOTIATION AUTHORITY.—The Secretary of
10 Health and Human Services is authorized to negotiate an
11 agreement with a State multicare program to provide med-
12 icare-eligible individuals with access to multicare plans.

13 (b) TERMS OF AGREEMENTS.—

14 (1) IN GENERAL.—Under an agreement under
15 this section, medicare-eligible individuals—

16 (A) are permitted to choose to enroll in
17 multicare plans, and

18 (B) are provided payment of an amount to-
19 wards the cost of enrolling in the plan.

20 (2) OTHER TERMS.—An agreement under this
21 section—

22 (A) may not increase the total Federal cost
23 of care, and

24 (B) shall ensure that medicare-eligible in-
25 dividuals can easily compare the benefits of en-

1 rollment under a multicare plan to the benefits
2 provided under the medicare program.

3 (c) SPECIAL RULES.—

4 (1) NO FEDERAL CONTRIBUTION.—No Federal
5 contribution is available to a State under section
6 101(c)(1) with respect to enrollment of an individual
7 with a multicare plan under an agreement under
8 this section.

9 (2) CONSTRUCTION.—Nothing in this section
10 shall be construed as—

11 (A) requiring a State multicare program to
12 enter into an agreement under this section as a
13 condition of approval of the program under this
14 Act or otherwise, or

15 (B) as authorizing the Secretary or a State
16 to require a medicare-eligible individual to en-
17 roll with a multicare plan under the agreement.

18 **SEC. 322. FEDERAL EMPLOYEES HEALTH BENEFIT PRO-**
19 **GRAM.**

20 (a) USE OF FEDERAL CONTRIBUTION TOWARD PUR-
21 CHASE OF MULTICARE PLAN.—In the case of an individ-
22 ual who is a Federal employee or annuitant eligible to en-
23 roll in a health benefit plan under chapter 89 of title 5,
24 United States Code and is residing in a State—

1 (1) with a State multicare program, instead of
2 enrolling under such a plan the individual is entitled
3 to elect (in a form and manner specified by the Di-
4 rector of the Office of Personnel Management in
5 consultation with the Secretary) to have the amount
6 of the Federal Government contribution toward such
7 plan under such chapter applied toward enrollment
8 of the individual (and qualified family members)
9 under a multicare plan; and

10 (2) without a State multicare program, instead
11 of enrolling under such a plan the individual is enti-
12 tled to elect (in a form and manner specified by the
13 Director of the Office of Personnel Management in
14 consultation with the Secretary) to have the amount
15 of the Federal Government contribution toward such
16 plan under such chapter applied toward enrollment
17 of the individual (and qualified family members)
18 under a Federally approved multicare plan.

19 (b) APPROVAL OF FEHBP PLANS.—The Secretary
20 may approve a health benefit plan offered under chapter
21 89 of title 5, United States Code, as a multicare plan
22 under this Act if the plan—

23 (1) participates in a reinsurance mechanism
24 that meets the requirements of section 107, and

1 (2) otherwise complies with the requirements
2 for a multicare plan under title II.

3 (c) TREATMENT OF FEHBP PLANS AS MULTICARE
4 PLANS FOR PURPOSES OF FEDERAL CONTRIBUTION.—
5 For purposes of section 121, a health benefit plan in which
6 an individual is enrolled under chapter 89 of title 5, Unit-
7 ed States Code is treated as a multicare plan in which
8 the individual is enrolled.

9 (d) CONSTRUCTION.—Nothing in this section shall be
10 construed as authorizing the Office of Personnel Manage-
11 ment to require any individual to enroll with a multicare
12 plan under this section.

13 **SEC. 323. REPORT RECOMMENDING INTEGRATION OF**
14 **CHAMPUS, VETERANS HEALTH, AND INDIAN**
15 **HEALTH SERVICES.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services, in coordination with the Secretary of
18 Veterans Affairs, the Secretary of Defense, and the Sec-
19 retary of the Interior, shall submit to Congress a report
20 that includes recommendations on how (and the extent to
21 which) the Civilian Health and Medical Program of the
22 Uniformed Services (CHAMPUS), the health care pro-
23 grams of the Department of Veterans Affairs, and the In-
24 dian Health Service may be integrated with the multicare
25 program established under this Act.

1 (b) DEADLINE.—The report under subsection (a)
2 shall be submitted not later than 2 years after the date
3 of the enactment of this Act to the Committees on Armed
4 Services, Energy and Commerce, Interior, Veterans' Af-
5 fairs, and Ways and Means of the House of Representa-
6 tives and to the Committees on Armed Services, Finance,
7 Labor and Human Resources, and Veterans' Affairs of the
8 Senate.

9 **SEC. 324. CONSUMER RIGHTS FOR INDIVIDUALS IN FED-**
10 **ERAL PROGRAMS.**

11 (a) NOTICE OF RIGHTS; ENFORCEMENT.—

12 (1) NOTICE.—The Secretary shall notify indi-
13 viduals provided health care services under a Federal
14 health care program of their consumer rights under
15 this section and of the procedures established by the
16 Secretary to ensure these rights.

17 (2) DEVELOPMENT OF REGULATIONS.—The
18 Secretary shall develop regulation to implement the
19 consumer rights established under this section.

20 (3) STATE ENFORCEMENT.—The Secretary is
21 responsible, through modification of requirements of
22 Federal health care programs, for assuring compli-
23 ance of physicians with the requirements of this sec-
24 tion.

1 (b) PROVISION OF PATIENT COST-SHARING INFOR-
2 MATION.—

3 (1) IN GENERAL.—Each physician who fur-
4 nishes professional services for which payment may
5 be made under a Federal health care program shall
6 provide, as a condition for the payment of funds for
7 such services under such program, that a patient is
8 provided, in advance of the receipt of the services
9 (except as provided by the Secretary in the case of
10 emergency services), with information on the ex-
11 pected total costs of the services and an estimate of
12 the patient's share of the costs. Such information
13 may be based on the estimates for the average cost
14 for such services.

15 (2) TOTAL COST.—For purposes of paragraph
16 (1), the total cost of treatment—

17 (A) in the case of a patient's initial visit,
18 shall consist of the initial visit only, and

19 (B) in the case of subsequent treatment,
20 shall include all expenses resulting from the
21 treatment procedure prescribed by the physi-
22 cian.

23 (3) EXCEPTION FOR EMERGENCIES.—In the
24 case of emergency services, the information under

1 this subsection shall be provided at the earliest rea-
2 sonable time after such services are provided.

3 (c) PATIENT ACCESS TO MEDICAL INFORMATION.—

4 In the case of an individual who receives professional serv-
5 ices from a physician for which payment may be made
6 under a Federal health care program, the individual has
7 a right to obtain information contained in the individual's
8 medical record maintained by the physician.

9 (d) FEDERAL HEALTH CARE PROGRAM.—In this sec-
10 tion, the term “Federal health care program” includes the
11 medicare program, the medicaid program, and the Federal
12 employees health benefits program.

13 **Subtitle C—National Reinsurance** 14 **Mechanism**

15 **SEC. 331. NATIONAL REINSURANCE MECHANISM.**

16 (a) ESTABLISHMENT.—

17 (1) IN GENERAL.—The Secretary shall establish
18 a national reinsurance mechanism for use by self-in-
19 sured closed multicare plans described in subsection
20 (b) which have not made an election described in
21 subsection (c). Such a mechanism shall be designed
22 to meet the requirements described in section
23 107(b).

24 (2) GOVERNANCE.—The mechanism shall be
25 governed by a commission appointed by the Sec-

1 retary. The membership of the commission shall in-
 2 clude the Secretary (or the Secretary’s designee) and
 3 representatives of plan sponsors, major providers,
 4 labor, State reinsurance mechanisms, consumers,
 5 State governments, and the business community.

6 (b) PLANS COVERED.—The plans described in this
 7 subsection are self-insured plans that operate in 3 or more
 8 States.

9 (c) ELECTION.—A plan described in subsection (b)
 10 shall be permitted to make a one-time election as to wheth-
 11 er to participate in the national reinsurance mechanism
 12 under this section or to participate in State reinsurance
 13 mechanisms established under section 107 (or by the Sec-
 14 retary under section 301).

15 **TITLE IV—MEDICAL MAL-**
 16 **PRACTICE LIABILITY RE-**
 17 **FORM**

18 **Subtitle A—Medical Malpractice**
 19 **Liability Reform**

20 PART 1—GENERAL PROVISIONS

21 **SEC. 401. FEDERAL REFORM OF MEDICAL MALPRACTICE**
 22 **LIABILITY ACTIONS.**

23 (a) CONGRESSIONAL FINDINGS.—

24 (1) EFFECT ON INTERSTATE COMMERCE.—

25 Congress finds that the health care and insurance

1 industries are industries affecting interstate com-
2 merce and the medical malpractice litigation systems
3 existing throughout the United States affect inter-
4 state commerce by contributing to the high cost of
5 health care and premiums for malpractice insurance
6 purchased by health care providers.

7 (2) EFFECT ON FEDERAL SPENDING.—Con-
8 gress finds that the medical malpractice litigation
9 systems existing throughout the United States have
10 a significant effect on the amount, distribution, and
11 use of Federal funds because of—

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

15 (B) the large number of individuals who
16 benefit because of the exclusion from Federal
17 taxes of the amounts spent by their employers
18 to provide them with health insurance benefits;

19 (C) the large number of health care provid-
20 ers and health care professionals who provide
21 items or services for which the Federal Govern-
22 ment makes payments; and

23 (D) the large number of such providers
24 and professionals who have received direct or
25 indirect financial assistance from the Federal

1 Government because of their status as such
2 professionals or providers.

3 (b) APPLICABILITY.—This subtitle shall apply with
4 respect to any medical malpractice liability claim and to
5 any medical malpractice liability action brought in any
6 State or Federal court, except that this subtitle shall not
7 apply to—

8 (1) a claim or action for damages arising from
9 a vaccine-related injury or death to the extent that
10 title XXI of the Public Health Service Act applies to
11 the action; or

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

15 (c) PREEMPTION OF STATE LAW.—Subject to section
16 421, this subtitle supersedes State law only to the extent
17 that State law differs from any provision of law estab-
18 lished by or under this subtitle. Any issue that is not gov-
19 erned by any provision of law established by or under this
20 subtitle shall be governed by otherwise applicable State or
21 Federal law.

22 (d) FEDERAL COURT JURISDICTION NOT ESTAB-
23 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in
24 this subtitle shall be construed to establish any jurisdiction
25 in the district courts of the United States over medical

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

3 **SEC. 402. DEFINITIONS.**

4 As used in this subtitle:

5 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
6 TEM; ADR.—The term “alternative dispute resolu-
7 tion system” or “ADR” means a system established
8 by a State that provides for the resolution of medical
9 malpractice liability claims in a manner other than
10 through medical malpractice liability actions.

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

16 (3) ECONOMIC DAMAGES.—The term “economic
17 damages” means damages paid to compensate an in-
18 dividual for losses for hospital and other medical ex-
19 penses, lost wages, lost employment, and other pecu-
20 niary losses.

21 (4) HEALTH CARE PROFESSIONAL.—The term
22 “health care professional” means any individual who
23 provides health care services in a State and who is
24 required by State law or regulation to be licensed or

1 certified by the State to provide such services in the
2 State.

3 (5) HEALTH CARE PROVIDER.—The term
4 “health care provider” means any organization or
5 institution that is engaged in the delivery of health
6 care services in a State and that is required by State
7 law or regulation to be licensed or certified by the
8 State to engage in the delivery of such services in
9 the State.

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

13 (7) MEDICAL MALPRACTICE LIABILITY AC-
14 TION.—The term “medical malpractice liability ac-
15 tion” means a civil action (other than an action in
16 which the plaintiff’s sole allegation is an allegation
17 of an intentional tort) brought in a State or Federal
18 court against a health care provider or health care
19 professional (regardless of the theory of liability on
20 which the action is based) in which the plaintiff al-
21 leges a medical malpractice liability claim.

22 (8) MEDICAL MALPRACTICE LIABILITY
23 CLAIM.—The term “medical malpractice liability
24 claim” means a claim in which the claimant alleges

1 that injury was caused by the provision of (or the
2 failure to provide) health care services.

3 (9) MEDICAL PRODUCT.—The term “medical
4 product” means a device (as defined in section
5 201(h) of the Federal Food, Drug, and Cosmetic
6 Act) or a drug (as defined in section 201(g)(1) of
7 the Federal Food, Drug, and Cosmetic Act).

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

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

18 (12) STATE.—The term “State” means each of
19 the several States, the District of Columbia, the
20 Commonwealth of Puerto Rico, the Virgin Islands,
21 Guam, and American Samoa.

22 **SEC. 403. EFFECTIVE DATE.**

23 (a) IN GENERAL.—Except as provided in subsection
24 (b) and sections 419 and 442, this subtitle shall apply with
25 respect to claims accruing or actions brought on or after

1 the expiration of the 3-year period that begins on the date
2 of the enactment of this Act.

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

5 (1) APPLICATION.—A State may submit an ap-
6 plication to the Secretary requesting the early imple-
7 mentation of this subtitle with respect to claims or
8 actions brought in the State.

9 (2) DECISION BY SECRETARY.—The Secretary
10 shall issue a response to a State’s application under
11 paragraph (1) not later than 90 days after receiving
12 the application. If the Secretary determines that the
13 State meets the requirements of this subtitle at the
14 time of submitting its application, the Secretary
15 shall approve the State’s application, and this sub-
16 title shall apply with respect to actions brought in
17 the State on or after the expiration of the 90-day
18 period that begins on the date the Secretary issues
19 the response. If the Secretary denies the State’s ap-
20 plication, the Secretary shall provide the State with
21 a written explanation of the grounds for the deci-
22 sion.

1 PART 2—UNIFORM STANDARDS FOR MEDICAL
2 MALPRACTICE LIABILITY ACTIONS

3 **SEC. 411. STATUTE OF LIMITATIONS.**

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

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

18 **SEC. 412. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**
19 **TION THROUGH ALTERNATIVE DISPUTE RES-**
20 **OLUTION.**

21 (a) IN GENERAL.—No medical malpractice liability
22 action may be brought in any State court unless the medi-
23 cal malpractice liability claim that is the subject of the
24 action has been initially resolved under an alternative dis-

1 pute resolution system certified by the Secretary under
2 section 432(b).

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

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

9 (2) if the ADR determines that the defendant
10 is liable, the ADR determines the amount of dam-
11 ages assessed against the defendant.

12 (c) PROCEDURES FOR FILING ACTIONS.—

13 (1) DEADLINE.—No medical malpractice liabil-
14 ity action may be brought unless the action is filed
15 in a court of competent jurisdiction not later than
16 90 days after an opinion resolving the medical mal-
17 practice liability claim that is the subject of the ac-
18 tion is issued under the applicable alternative dis-
19 pute resolution system.

20 (2) COURT OF COMPETENT JURISDICTION.—
21 For purposes of paragraph (1), the term “court of
22 competent jurisdiction” means—

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

1 (B) with respect to actions filed in a Fed-
2 eral court, the appropriate United States dis-
3 trict court.

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

10 (e) TREATMENT OF ADR DECISION.—

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

17 (A) show that—

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

20 (ii) there was partiality or corruption
21 under the system,

22 (iii) there was other misconduct under
23 the system that materially prejudiced the
24 party's rights, or

1 (iv) the decision was based on an
2 error of law; or

3 (B) present new evidence before the trier
4 of fact that was not available for presentation
5 under the ADR system.

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

13 **SEC. 413. RELATION TO ALTERNATIVE DISPUTE RESOLU-**
14 **TION OF FEDERAL AGENCIES.**

15 (a) MANDATORY APPLICATION OF FEDERAL ADR IN
16 MALPRACTICE CLAIMS AGAINST UNITED STATES.—Sec-
17 tion 2672 of title 28, United States Code, is amended by
18 striking the period at the end of the first paragraph and
19 inserting the following: “, except that each Federal agency
20 shall use arbitration or such alternative means of dispute
21 resolution to settle any tort claim against the United
22 States consisting of a medical malpractice liability claim
23 (as defined in section 402(8) of the Multicare Act of
24 1994).”.

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

7 “(k) Each agency shall transmit on a regular basis
8 to the Administrator for Health Care Policy and Research
9 information on issues in controversy consisting of medical
10 malpractice liability claims (as defined in section 402(8)
11 of Multicare Act of 1994) that are resolved under the
12 agency’s dispute resolution proceeding under this sub-
13 chapter, in a manner that assures that the identity of the
14 parties to such proceedings shall not be revealed.”.

15 **SEC. 414. MANDATORY PRE-TRIAL SETTLEMENT CON-**
16 **FERENCE.**

17 (a) IN GENERAL.—Before the beginning of the trial
18 phase of any medical malpractice liability action, the par-
19 ties shall attend a conference called by the court for pur-
20 poses of determining whether grounds exist upon which
21 the parties may negotiate a settlement for the action.

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

1 **SEC. 415. CALCULATION AND PAYMENT OF DAMAGES.**

2 (a) **LIMITATION ON NONECONOMIC DAMAGES.**—The
3 total amount of noneconomic damages that may be award-
4 ed to a plaintiff and the members of the plaintiff's family
5 for losses resulting from the injury which is the subject
6 of a medical malpractice liability action may not exceed
7 \$250,000, regardless of the number of parties against
8 whom the action is brought or the number of actions
9 brought with respect to the injury.

10 (b) **TREATMENT OF PUNITIVE DAMAGES.**—

11 (1) **LIMITATION ON AMOUNT.**—The total
12 amount of punitive damages that may be imposed
13 under a medical malpractice liability action may not
14 exceed twice the total of the damages awarded to the
15 plaintiff and the members of the plaintiff's family.

16 (2) **PAYMENTS TO STATE FOR MEDICAL QUAL-**
17 **ITY ASSURANCE ACTIVITIES.**—

18 (A) **IN GENERAL.**—Any punitive damages
19 imposed under a medical malpractice liability
20 action shall be paid to the State in which the
21 action is brought.

22 (B) **ACTIVITIES DESCRIBED.**—A State
23 shall use amount paid pursuant to subpara-
24 graph (A) to carry out activities to assure the
25 safety and quality of health care services pro-

1 vided in the State, including (but not limited
2 to)—

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

6 (ii) operating alternative dispute reso-
7 lution systems;

8 (iii) carrying out public education pro-
9 grams relating to medical malpractice and
10 the availability of alternative dispute reso-
11 lution systems in the State; and

12 (iv) carrying out programs to reduce
13 malpractice-related costs for retired provid-
14 ers or other providers volunteering to pro-
15 vide services in medically underserved
16 areas.

17 (C) MAINTENANCE OF EFFORT.—A State
18 shall use any amounts paid pursuant to sub-
19 paragraph (A) to supplement and not to replace
20 amounts spent by the State for the activities
21 described in subparagraph (B).

22 (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—If
23 more than \$100,000 in damages for expenses to be in-
24 curred in the future is awarded to the plaintiff in a medi-
25 cal malpractice liability action, the defendant shall provide

1 for payment for such damages on a periodic basis deter-
2 mined appropriate by the court (based upon projections
3 of when such expenses are likely to be incurred), unless
4 the court determines that it is not in the plaintiff's best
5 interests to receive payments for such damages on such
6 a periodic basis.

7 (d) MANDATORY OFFSETS FOR DAMAGES PAID BY
8 A COLLATERAL SOURCE.—

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

16 (A) Federal or State disability or sickness
17 programs;

18 (B) Federal, State, or private health insur-
19 ance programs;

20 (C) private disability insurance programs;

21 (D) employer wage continuation programs;

22 and

23 (E) any other source of payment intended
24 to compensate the plaintiff for such injury.

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

4 (A) the total amount of any payments
5 (other than such award) that have been made
6 or that will be made to the plaintiff to com-
7 pensate the plaintiff for the injury that was the
8 subject of the action; minus

9 (B) the amount paid by the plaintiff (or by
10 the spouse, parent, or legal guardian of the
11 plaintiff) to secure the payments described in
12 subparagraph (A).

13 **SEC. 416. TREATMENT OF ATTORNEY'S FEES AND OTHER**
14 **COSTS.**

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

20 (1) 25 percent of the first \$150,000 of any
21 award or settlement paid to the plaintiff; or

22 (2) 15 percent of any additional amounts paid
23 to the plaintiff.

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

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

16 (2) PERMITTING COURT TO WAIVE OR MODIFY
17 IMPOSITION OF COSTS.—A court may issue a written
18 order waiving or modifying the application of para-
19 graph (1) to a party if the court finds that the appli-
20 cation of such paragraph to the party would con-
21 stitute an undue hardship, or if the medical mal-
22 practice liability action raised a novel issue of law.
23 The order shall specify the grounds for the court’s
24 decision to waive or modify the application of such
25 paragraph.

1 **SEC. 417. JOINT AND SEVERAL LIABILITY.**

2 The liability of each defendant in a medical mal-
3 practice liability action shall be several only and shall not
4 be joint, and each defendant shall be liable only for the
5 amount of damages allocated to the defendant in direct
6 proportion to the defendant's percentage of responsibility
7 (as determined by the trier of fact).

8 **SEC. 418. UNIFORM STANDARD FOR DETERMINING NEG-**
9 **LIGENCE.**

10 Except as provided in subsection (b), a defendant in
11 a medical malpractice liability action may not be found
12 to have acted negligently unless the defendant's conduct
13 at the time of providing the health care services that are
14 the subject of the action was not reasonable.

15 **SEC. 419. APPLICATION OF MEDICAL PRACTICE GUIDE-**
16 **LINES IN MALPRACTICE LIABILITY ACTIONS.**

17 (a) USE OF GUIDELINES AS AFFIRMATIVE DE-
18 FENSE.—In any medical malpractice liability action, it
19 shall be a complete defense to any allegation that the de-
20 fendant was negligent that, in the provision of (or the fail-
21 ure to provide) the services that are the subject of the
22 action, the defendant followed the appropriate practice
23 guideline.

24 (b) RESTRICTION ON GUIDELINES CONSIDERED AP-
25 PROPRIATE.—

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

9 (2) PROCESS FOR SANCTIONING GUIDELINES.—
10 Not less frequently than October 1 of each year (be-
11 ginning with 1995), the Secretary, shall review the
12 practice guidelines and standards developed by the
13 Administrator for Health Care Policy and Research
14 pursuant to section 1142 of the Social Security Act,
15 and shall sanction those guidelines which the Sec-
16 retary considers appropriate for purposes of an af-
17 firmative defense to medical malpractice liability ac-
18 tions brought during the next calendar year as ap-
19 propriate practice guidelines for purposes of sub-
20 section (a).

21 (3) USE OF STATE GUIDELINES.—Upon the ap-
22 plication of a State, the Secretary may sanction
23 practice guidelines selected by the State for purposes
24 of an affirmative defense to medical malpractice li-
25 ability actions brought in the State as appropriate

1 practice guidelines for purposes of subsection (a) if
2 the guidelines meet such requirements as the Sec-
3 retary may impose.

4 (c) PROHIBITING APPLICATION OF FAILURE TO FOL-
5 LOW GUIDELINES AS PRIMA FACIE EVIDENCE OF NEG-
6 LIGENCE.—No plaintiff in a medical malpractice liability
7 action may be deemed to have presented prima facie evi-
8 dence that a defendant was negligent solely by showing
9 that the defendant failed to follow the appropriate practice
10 guideline.

11 **SEC. 420. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**
12 **SERVICES.**

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

14 (1) IN GENERAL.—In the case of a medical
15 malpractice liability action relating to services pro-
16 vided during labor or the delivery of a baby, if the
17 defendant health care professional did not previously
18 treat the plaintiff for the pregnancy, the trier of fact
19 may not find that the defendant committed mal-
20 practice and may not assess damages against the de-
21 fendant unless the malpractice is proven by clear
22 and convincing evidence.

23 (2) APPLICABILITY TO GROUP PRACTICES OR
24 AGREEMENTS AMONG PROVIDERS.—For purposes of
25 paragraph (1), a health care professional shall be

1 considered to have previously treated an individual
2 for a pregnancy if the professional is a member of
3 a group practice whose members previously treated
4 the individual for the pregnancy or is providing serv-
5 ices to the individual during labor or the delivery of
6 a baby pursuant to an agreement with another pro-
7 fessional.

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

17 (c) EFFECTIVE DATE.—This section shall apply to
18 claims accruing or actions brought on or after the expira-
19 tion of the 2-year period that begins on the date of the
20 enactment of this Act.

21 **SEC. 421. PREEMPTION.**

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

24 (1) permits the recovery of a greater amount of
25 damages by a plaintiff;

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

3 (3) establishes a longer period during which a
4 medical malpractice liability claim may be initiated;
5 or

6 (4) establishes a stricter standard for determin-
7 ing whether a defendant was negligent or for deter-
8 mining the liability of defendants described in sec-
9 tion 420(a) in actions described in such section.

10 (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
11 OF LAW OR VENUE.—Nothing in subsection (a) shall be
12 construed to—

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

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

18 (3) affect the applicability of any provision of
19 the Foreign Sovereign Immunities Act of 1976;

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

23 (5) affect the right of any court to transfer
24 venue or to apply the law of a foreign nation or to
25 dismiss a claim of a foreign nation or of a citizen

1 of a foreign nation on the ground of inconvenient
2 forum.

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

5 **SEC. 431. BASIC REQUIREMENTS FOR ADR.**

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

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

11 (2) requires that a written opinion resolving the
12 dispute be issued that contains findings of fact relat-
13 ing to the dispute;

14 (3) requires individuals who hear and resolve
15 claims under the system to meet such qualifications
16 as the State may require (in accordance with regula-
17 tions of the Secretary);

18 (4) is approved by the State or by local govern-
19 ments in the State;

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

22 (A) permits the parties to a dispute to se-
23 lect the procedure to be used for the resolution
24 of the dispute under the system, and

1 (B) if the parties do not agree on the pro-
2 cedure to be used for the resolution of the dis-
3 pute, assigns a particular procedure to the par-
4 ties;

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

15 (7) provides for the regular transmittal to the
16 Administrator for Health Care Policy and Research
17 of information on disputes resolved under the sys-
18 tem, in a manner that assures that the identity of
19 the parties to a dispute shall not be revealed.

20 (b) APPLICATION OF MALPRACTICE LIABILITY
21 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—

22 The provisions of part 2 shall apply with respect to claims
23 brought under a State's alternative dispute resolution sys-
24 tem in the same manner as such provisions apply with

1 respect to medical malpractice liability actions brought in
2 the State.

3 **SEC. 432. CERTIFICATION OF STATE SYSTEMS.**

4 (a) IN GENERAL.—Not later than October 1 of each
5 year (beginning with 1995), the Secretary, in consultation
6 with the Attorney General, shall determine whether a
7 State’s alternative dispute resolution system meets the re-
8 quirements of this part for the following calendar year.

9 (b) BASIS FOR CERTIFICATION.—The Secretary shall
10 certify a State’s alternative dispute resolution system
11 under this subsection if the Secretary determines under
12 subsection (a) that the system meets the requirements of
13 section 431.

14 **SEC. 433. REPORTS ON IMPLEMENTATION AND EFFECTIVE-**
15 **NESS OF ALTERNATIVE DISPUTE RESOLU-**
16 **TION SYSTEMS.**

17 (a) IN GENERAL.—Not later than 5 years after the
18 date of the enactment of this Act, the Secretary shall pre-
19 pare and submit to Congress a report describing and eval-
20 uating State alternative dispute resolution systems oper-
21 ated pursuant to this part.

22 (b) CONTENTS OF REPORT.—The Secretary shall in-
23 clude in the report prepared and submitted under sub-
24 section (a)—

25 (1) information on—

1 (A) the effect of such systems on the cost
2 of health care within the State,

3 (B) the impact of such systems on the ac-
4 cess of individuals to health care within the
5 State, and

6 (C) the effect of such systems on the qual-
7 ity of health care provided within such State;
8 and

9 (2) to the extent that such report does not pro-
10 vide information on no-fault systems operated by
11 States as alternative dispute resolution systems pur-
12 suant to this part, an analysis of the feasibility and
13 desirability of establishing a system under which
14 medical malpractice liability claims shall be resolved
15 on a no-fault basis.

16 **Subtitle B—Other Requirements** 17 **and Programs**

18 **SEC. 441. FACILITATING DEVELOPMENT AND USE OF** 19 **MEDICAL PRACTICE GUIDELINES.**

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

24 “(D) \$158,000,000 for fiscal year 1995 (of
25 which \$10,000,000 shall be used for sanction-

1 ing practice guidelines for purposes of an af-
2 firmative defense in medical malpractice liabil-
3 ity actions);

4 “(E) \$200,000,000 for fiscal year 1996 (of
5 which \$20,000,000 shall be used for sanction-
6 ing practice guidelines for purposes of an af-
7 firmative defense in medical malpractice liabil-
8 ity actions); and

9 “(F) \$20,000,000 for fiscal year 1997, to
10 be used for sanctioning practice guidelines for
11 purposes of an affirmative defense in medical
12 malpractice liability actions.”.

13 (b) CONSIDERATION OF MALPRACTICE LIABILITY
14 DATA IN DEVELOPING AND UPDATING GUIDELINES.—
15 Section 1142(c)(5) of such Act (42 U.S.C. 1320b-
16 12(c)(5)) is amended by striking “claims data” and all
17 that follows through “patients” and inserting the follow-
18 ing: “claims data, data on clinical and functional status
19 of patients, and data on medical malpractice liability ac-
20 tions”.

21 (c) DEVELOPMENT OF REPORTING FORMS FOR
22 STATE ADR SYSTEMS.—The Secretary, in consultation
23 with the Administrator for Health Care Policy and Re-
24 search, shall develop a standard reporting form to be used
25 by State alternative dispute resolution systems in trans-

1 mitting information to the Administrator pursuant to sec-
2 tion 431(a)(6) on disputes resolved under such systems.

3 (d) STUDY OF EFFECT OF GUIDELINES ON MEDICAL
4 MALPRACTICE.—

5 (1) STUDY.—The Secretary shall conduct a
6 study of the effect of the use of the medical practice
7 guidelines developed by the Administrator for Health
8 Care Policy and Research on the incidence of and
9 the costs associated with medical malpractice.

10 (2) REPORTS.—(A) Not later than 1 year after
11 the date of the enactment of this Act, the Secretary
12 shall submit an interim report to Congress describ-
13 ing the availability and use of medical practice
14 guidelines and the aggregate costs associated with
15 medical malpractice.

16 (B) Not later than 5 years after the date of the
17 enactment of this Act, the Secretary shall submit a
18 report to Congress on the study conducted under
19 paragraph (1), together with recommendations re-
20 garding expanding the use of medical practice guide-
21 lines for determining the liability of health care pro-
22 fessionals and health care providers for medical mal-
23 practice.

1 **SEC. 442. PERMITTING STATE PROFESSIONAL SOCIETIES**
2 **TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.**
3 **TIES.**

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

16 (b) **REQUIREMENTS OF AGREEMENTS.**—Any agree-
17 ment entered into under subsection (a) for licensing activi-
18 ties or the review of any health care malpractice action,
19 health care malpractice claim or allegation, or other infor-
20 mation concerning the practice patterns of a health care
21 practitioner shall provide that—

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

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

1 (3) the conduct of such activities or review and
2 the reporting of such findings be conducted in a
3 manner which assures the preservation of confiden-
4 tiality of health care information and of the review
5 process; and

6 (4) no individual affiliated with such society is
7 liable for any damages or injury directly caused by
8 the individual's actions in conducting such activities
9 or review.

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

14 (d) EFFECTIVE DATE.—This section shall take effect
15 2 years after the date of the enactment of this Act.

16 **TITLE V—ADMINISTRATIVE**
17 **COST SAVINGS**
18 **Subtitle A—Standardization of**
19 **Claims Processing**

20 **SEC. 501. ADOPTION OF DATA ELEMENTS, UNIFORM**
21 **CLAIMS, AND UNIFORM ELECTRONIC TRANS-**
22 **MISSION STANDARDS.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services (in this title referred to as the “Sec-

1 retary”) shall adopt standards relating to each of the fol-
2 lowing:

3 (1) Data elements for use in paper and elec-
4 tronic claims processing under health benefit plans,
5 as well as for use in utilization review and manage-
6 ment of care (including data fields, formats, and
7 medical nomenclature, and including plan benefit
8 and insurance information).

9 (2) Uniform claims forms (including uniform
10 procedure and billing codes for uses with such forms
11 and including information on other health benefit
12 plans that may be liable for benefits).

13 (3) Uniform electronic transmission of the data
14 elements (for purposes of billing and utilization re-
15 view).

16 Standards under paragraph (3) relating to electronic
17 transmission of data elements for claims for services shall
18 supersede (to the extent specified in such standards) the
19 standards adopted under paragraph (2) relating to the
20 submission of paper claims for such services.

21 (b) USE OF TASK FORCES.—In adopting standards
22 under this section—

23 (1) the Secretary shall take into account the
24 recommendations of current taskforces, including at
25 least the Workgroup on Electronic Data Inter-

1 change, National Uniform Billing Committee, the
2 Uniform Claim Task Force, and the Computer-based
3 Patient Record Institute;

4 (2) the Secretary shall consult with the Na-
5 tional Association of Insurance Commissioners (and,
6 with respect to standards under subsection (a)(3),
7 the American National Standards Institute); and

8 (3) the Secretary shall, to the maximum extent
9 practicable, seek to make the standards consistent
10 with any uniform clinical data sets which have been
11 adopted and are widely recognized.

12 (c) DEADLINES FOR PROMULGATION.—The Sec-
13 retary shall promulgate the standards under—

14 (1) subsection (a)(1) relating to claims process-
15 ing data, by not later than 12 months after the date
16 of the enactment of this Act;

17 (2) subsection (a)(2) (relating to uniform
18 claims forms) by not later than 12 months after the
19 date of the enactment of this Act; and

20 (3)(A) subsection (a)(3) relating to trans-
21 mission of information concerning hospital and phy-
22 sicians services, by not later than 24 months after
23 the date of the enactment of this Act, and

1 (B) subsection (a)(3) relating to transmission
2 of information on other services, by such later date
3 as the Secretary may determine it to be feasible.

4 (d) REPORT TO CONGRESS.—Not later than 3 years
5 after the date of the enactment of this Act, the Secretary
6 shall report to Congress recommendations regarding re-
7 structuring the medicare peer review quality assurance
8 program given the availability of hospital data in elec-
9 tronic form.

10 **SEC. 502. APPLICATION OF STANDARDS.**

11 (a) IN GENERAL.—If the Secretary determines, at
12 the end of the 2-year period beginning on the date that
13 standards are adopted under section 501 with respect to
14 classes of services, that a significant number of claims for
15 benefits for such services under health benefit plans are
16 not being submitted in accordance with such standards,
17 the Secretary may require, after notice in the Federal
18 Register of not less than 6 months, that all providers of
19 such services must submit claims to health benefit plans
20 in accordance with such standards. The Secretary may
21 waive the application of such a requirement in such cases
22 as the Secretary finds that the imposition of the require-
23 ment would not be economically practicable.

24 (b) SIGNIFICANT NUMBER.—The Secretary shall
25 make an affirmative determination described in subsection

1 (a) for a class of services only if the Secretary finds that
2 there would be a significant, measurable additional gain
3 in efficiencies in the health care system that would be ob-
4 tained by imposing the requirement described in such
5 paragraph with respect to such services.

6 (c) APPLICATION OF REQUIREMENT.—

7 (1) IN GENERAL.—If the Secretary imposes the
8 requirement under subsection (a)—

9 (A) in the case of a requirement that imposes
10 the standards relating to electronic trans-
11 mission of claims for a class of services, each
12 health care provider that furnishes such services
13 for which benefits are payable under a health
14 benefit plan shall transmit electronically and di-
15 rectly to the plan on behalf of the beneficiary
16 involved a claim for such services in accordance
17 with such standards;

18 (B) any health benefit plan may reject any
19 claim subject to the standards adopted under
20 section 501 but which is not submitted in ac-
21 cordance with such standards;

22 (C) it is unlawful for a health benefit plan
23 (i) to reject any such claim on the basis of the
24 form in which it is submitted if it is submitted
25 in accordance with such standards or (ii) to re-

1 quire, for the purpose of utilization review or as
2 a condition of providing benefits under the plan,
3 a provider to transmit medical data elements
4 that are inconsistent with the standards estab-
5 lished under section 501(a)(1); and

6 (D) the Secretary may impose a civil
7 money penalty on any provider that knowingly
8 and repeatedly submits claims in violation of
9 such standards or on any health benefit plan
10 (other than a health benefit plan described in
11 paragraph (2)) that knowingly and repeatedly
12 rejects claims in violation of subparagraph (B),
13 in an amount not to exceed \$100 for each such
14 claim.

15 The provisions of section 1128A of the Social Secu-
16 rity Act (other than the first sentence of subsection
17 (a) and other than subsection (b)) shall apply to a
18 civil money penalty under subparagraph (D) in the
19 same manner as such provisions apply to a penalty
20 or proceeding under section 1128A(a) of such Act.

21 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
22 ULATION.—A plan described in this paragraph is a
23 health benefit plan—

24 (A) that is subject to regulation by a
25 State, and

1 (B) with respect to which the Secretary
2 finds that—

3 (i) the State provides for application
4 of the standards established under section
5 501, and

6 (ii) the State regulatory program pro-
7 vides for the appropriate and effective en-
8 forcement of such standards.

9 (d) TREATMENT OF REJECTIONS.—If a plan rejects
10 a claim pursuant to subsection (c)(1), the plan shall per-
11 mit the person submitting the claim a reasonable oppor-
12 tunity to resubmit the claim on a form or in an electronic
13 manner that meets the requirements for acceptance of the
14 claim under such subsection.

15 **SEC. 503. PERIODIC REVIEW AND REVISION OF**
16 **STANDARDS.**

17 (a) IN GENERAL.—The Secretary shall—

18 (1) provide for the ongoing receipt and review
19 of comments and suggestions for changes in the
20 standards adopted and promulgated under section
21 501;

22 (2) establish a schedule for the periodic review
23 of such standards; and

1 (3) based upon such comments, suggestions,
2 and review, revise such standards and promulgate
3 such revisions.

4 (b) APPLICATION OF REVISED STANDARDS.—If the
5 Secretary under subsection (a) revises the standards de-
6 scribed in 501, then, in the case of any claim for benefits
7 submitted under a health benefit plan more than the mini-
8 mum period (of not less than 6 months specified by the
9 Secretary) after the date the revision is promulgated
10 under subsection (a)(3), such standards shall apply under
11 section 502 instead of the standards previously promul-
12 gated.

13 **SEC. 504. HEALTH BENEFIT PLAN DEFINED.**

14 In this title, the term “health benefit plan” has the
15 meaning given such term in section 111(6) and includes—

16 (1) the medicare program (under title XVIII of
17 the Social Security Act), and

18 (2) a State medicaid plan (approved under title
19 XIX of such Act).

20 **Subtitle B—Electronic Medical**
21 **Data Standards**

22 **SEC. 511. MEDICAL DATA STANDARDS FOR HOSPITALS AND**
23 **OTHER PROVIDERS.**

24 (a) PROMULGATION OF HOSPITAL DATA STAND-
25 ARDS.—

1 (1) IN GENERAL.—Between July 1, 1996, and
2 January 1, 1997, the Secretary shall promulgate
3 standards described in subsection (b) for hospitals
4 concerning electronic medical data.

5 (2) REVISION.—The Secretary may from time
6 to time revise the standards promulgated under this
7 subsection.

8 (b) CONTENTS OF DATA STANDARDS.—The stand-
9 ards promulgated under subsection (a) shall include at
10 least the following:

11 (1) A definition of a standard set of data ele-
12 ments for use by utilization and quality control peer
13 review organizations.

14 (2) A definition of the set of comprehensive
15 data elements, which set shall include for hospitals
16 the standard set of data elements defined under
17 paragraph (1).

18 (3) Standards for an electronic patient care in-
19 formation system with data obtained at the point of
20 care, including standards to protect against the un-
21 authorized use and disclosure of information.

22 (4) A specification of, and manner of presen-
23 tation of, the individual data elements of the sets
24 and system under this subsection.

1 (5) Standards concerning the transmission of
2 electronic medical data.

3 (6) Standards relating to confidentiality of pa-
4 tient-specific information.

5 The standards under this section shall be consistent with
6 standards for data elements established under section 501.

7 (c) OPTIONAL DATA STANDARDS FOR OTHER PRO-
8 VIDERS.—

9 (1) IN GENERAL.—The Secretary may promul-
10 gate standards described in paragraph (2) concern-
11 ing electronic medical data for providers that are not
12 hospitals. The Secretary may from time to time re-
13 vise the standards promulgated under this sub-
14 section.

15 (2) CONTENTS OF DATA STANDARDS.—The
16 standards promulgated under paragraph (1) for non-
17 hospital providers may include standards comparable
18 to the standards described in paragraphs (2), (4),
19 and (5) of subsection (b) for hospitals.

20 (d) CONSULTATION.—In promulgating and revising
21 standards under this section, the Secretary shall—

22 (1) consult with the American National Stand-
23 ards Institute, hospitals, with the advisory commis-
24 sion established under section 515, and with other

1 affected providers, health benefit plans, and other
2 interested parties, and

3 (2) take into consideration, in developing stand-
4 ards under subsection (b)(1), the data set used by
5 the utilization and quality control peer review pro-
6 gram under part B of title XI of the Social Security
7 Act.

8 **SEC. 512. APPLICATION OF ELECTRONIC DATA STANDARDS**
9 **TO CERTAIN HOSPITALS.**

10 (a) **MEDICARE REQUIREMENT FOR SHARING OF**
11 **HOSPITAL INFORMATION.**—As of January 1, 1998, sub-
12 ject to paragraph (2), each hospital, as a requirement of
13 each participation agreement under section 1866 of the
14 Social Security Act, shall—

15 (1) maintain clinical data included in the set of
16 comprehensive data elements under section
17 511(b)(2) in electronic form on all inpatients,

18 (2) upon request of the Secretary or of a utili-
19 zation and quality control peer review organization
20 (with which the Secretary has entered into a con-
21 tract under part B of title XI of such Act), transmit
22 electronically the data set, and

23 (3) upon request of the Secretary, or of a fiscal
24 intermediary or carrier, transmit electronically any
25 data (with respect to a claim) from such data set,

1 in accordance with the standards promulgated under sec-
2 tion 511(a).

3 (b) WAIVER AUTHORITY.—Until January 1, 2000:

4 (1) The Secretary may waive the application of
5 the requirements of subsection (a) for a hospital
6 that is a small rural hospital, for such period as the
7 hospital demonstrates compliance with such require-
8 ments would constitute an undue financial hardship.

9 (2) The Secretary may waive the application of
10 the requirements of subsection (a) for a hospital
11 that is in the process of developing a system to pro-
12 vide the required data set and executes agreements
13 with its fiscal intermediary and its utilization and
14 quality control peer review organization that the hos-
15 pital will meet the requirements of subsection (a) by
16 a specified date (not later than January 1, 2000).

17 (3) The Secretary may waive the application of
18 the requirement of subsection (a)(1) for a hospital
19 that agrees to obtain from its records the data ele-
20 ments that are needed to meet the requirements of
21 paragraphs (2) and (3) of subsection (a) and agrees
22 to subject its data transfer process to a quality as-
23 surance program specified by the Secretary.

24 (c) APPLICATION TO HOSPITALS OF THE DEPART-
25 MENT OF VETERANS AFFAIRS.—

1 (1) IN GENERAL.—The Secretary of Veterans
2 Affairs shall provide that each hospital of the De-
3 partment of Veterans Affairs shall comply with the
4 requirements of subsection (a) in the same manner
5 as such requirements would apply to the hospital if
6 it were participating in the medicare program.

7 (2) WAIVER.—Such Secretary may waive the
8 application of such requirements to a hospital in the
9 same manner as the Secretary of Health and
10 Human Services may waive under subsection (b) the
11 application of the requirements of subsection (a).

12 **SEC. 513. ELECTRONIC TRANSMISSION TO FEDERAL AGEN-**
13 **CIES.**

14 (a) IN GENERAL.—Effective January 1, 2000, if a
15 provider is required under a Federal program to transmit
16 a data element that is subject to a presentation or trans-
17 mission standard (as defined in subsection (b)), the head
18 of the Federal agency responsible for such program (if not
19 otherwise authorized) is authorized to require the provider
20 to present and transmit the data element electronically in
21 accordance with such a standard.

22 (b) PRESENTATION OR TRANSMISSION STANDARD
23 DEFINED.—In subsection (a), the term “presentation or
24 transmission standard” means a standard, promulgated

1 under subsection (b) or (c) of section 511, described in
2 paragraph (4) or (5) of section 511(b).

3 **SEC. 514. LIMITATION ON DATA REQUIREMENTS WHERE**
4 **STANDARDS IN EFFECT.**

5 (a) IN GENERAL.—If standards with respect to data
6 elements are promulgated under section 511 with respect
7 to a class of provider, a health benefit plan may not re-
8 quire, for the purpose of utilization review or as a condi-
9 tion of providing benefits under the plan, that a provider
10 in the class—

11 (1) provide any data element not in the set of
12 comprehensive data elements specified under such
13 standards, or

14 (2) transmit or present any such data element
15 in a manner inconsistent with the applicable stand-
16 ards for such transmission or presentation.

17 (b) COMPLIANCE.—

18 (1) IN GENERAL.—The Secretary may impose a
19 civil money penalty on any health benefit plan (other
20 than a health benefit plan described in paragraph
21 (2)) that fails to comply with subsection (a) in an
22 amount not to exceed \$100 for each such failure.
23 The provisions of section 1128A of the Social Secu-
24 rity Act (other than the first sentence of subsection
25 (a) and other than subsection (b)) shall apply to a

1 civil money penalty under this paragraph in the
2 same manner as such provisions apply to a penalty
3 or proceeding under section 1128A(a) of such Act.

4 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
5 ULATION.—A plan described in this paragraph is a
6 health benefit plan that is subject to regulation by
7 a State, if the Secretary finds that—

8 (A) the State provides for application of
9 the requirement of subsection (a), and

10 (B) the State regulatory program provides
11 for the appropriate and effective enforcement of
12 such requirement with respect to such plans.

13 **SEC. 515. ADVISORY COMMISSION.**

14 (a) IN GENERAL.—The Secretary shall establish an
15 advisory commission including hospital executives, hospital
16 data base managers, physicians, health services research-
17 ers, and technical experts in collection and use of data
18 and operation of data systems. Such commission shall in-
19 clude, as ex officio members, a representative of the Direc-
20 tor of the National Institutes of Health, the Administrator
21 for Health Care Policy and Research, the Secretary of
22 Veterans' Affairs, and the Director of the Centers for Dis-
23 ease Control.

24 (b) FUNCTIONS.—The advisory commission shall
25 monitor and advise the Secretary concerning—

1 (1) the standards established under this sub-
2 title, and

3 (2) operational concerns about the implementa-
4 tion of such standards under this subtitle.

5 (c) STAFF.—From the amounts appropriated under
6 subsection (d), the Secretary shall provide sufficient staff
7 to assist the advisory commission in its activities under
8 this section.

9 (d) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated \$2,000,000 for each of
11 fiscal years 1995 through 1999 to carry out this section.

12 **TITLE VI—REMOVING RESTRIC-** 13 **TIONS ON MANAGED CARE**

14 **SEC. 601. REMOVING RESTRICTIONS ON MANAGED CARE.**

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

18 (1) RESTRICTIONS ON REIMBURSEMENT RATES
19 OR SELECTIVE CONTRACTING.—Any law that re-
20 stricts the ability of a carrier to negotiate reimburse-
21 ment rates with providers or to contract selectively
22 with one provider or a limited number of providers.

23 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-
24 CIAL INCENTIVES.—Any law that limits the financial
25 incentives that a health benefit plan may require a

1 beneficiary to pay when a non-plan provider is used
2 on a non-emergency basis.

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

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

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

14 (C) requires the use of specified standards
15 of health care practice in such reviews or re-
16 quires the disclosure of the specific criteria used
17 in such reviews,

18 (D) requires payments to providers for the
19 expenses of responding to utilization review re-
20 quests, or

21 (E) imposes liability for delays in perform-
22 ing such review.

23 Nothing in subparagraph (B) shall be construed as
24 prohibiting a State from (i) requiring that utilization
25 review be conducted by a licensed health care profes-

1 sional or (ii) requiring that any appeal from such a
2 review be made by a licensed physician or by a li-
3 censed physician in any particular specialty or with
4 any board certified specialty of the same medical
5 specialty as the provider whose services are being re-
6 viewed.

7 (b) GAO STUDY.—

8 (1) IN GENERAL.—The Comptroller General
9 shall conduct a study of the benefits and cost effec-
10 tiveness of the use of managed care in the delivery
11 of health services.

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

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

1 **TITLE VII—MODIFICATION OF**
2 **THE OPERATION OF THE**
3 **ANTITRUST LAWS TO HOS-**
4 **PITALS**

5 **SEC. 701. PURPOSE.**

6 The purpose of this title is to encourage cooperation
7 among hospitals in order to contain costs and achieve a
8 more efficient health care delivery system through the
9 elimination of unnecessary duplication and proliferation of
10 expensive medical services or expensive high technology
11 equipment.

12 **SEC. 702. EXEMPTIONS FROM THE OPERATION OF THE**
13 **ANTITRUST LAWS.**

14 (a) **GENERAL EXEMPTION.**—It shall not be unlawful
15 under the antitrust laws for 2 or more hospitals to engage
16 in conduct solely for the purpose of negotiating a proposed
17 agreement, to be submitted under subsection (b), to share
18 expensive medical services or expensive high technology
19 equipment.

20 (b) **SPECIFIC EXEMPTIONS.**—

21 (1) **AUTHORITY TO GRANT WAIVER.**—The Sec-
22 retary of Health and Human Services shall issue
23 waivers in accordance with paragraph (4) to exempt
24 from the operation of the antitrust laws conduct en-

1 gaged in by hospitals to carry out agreements con-
2 tained in applications approved under paragraph (3).

3 (2) ELIGIBILITY.—To be eligible to receive a
4 waiver under paragraph (1), 2 or more hospitals
5 shall submit to the Secretary an application that
6 contains (in accordance with guidelines established
7 by the Secretary)—

8 (A) a proposed agreement that only—

9 (i) provides that such hospitals shall
10 share the expensive medical services or ex-
11 pensive high technology equipment identi-
12 fied in such agreement,

13 (ii) specifies the period of time during
14 which such agreement shall be in effect,

15 (iii) describes the particular medical
16 services or high technology equipment to
17 be shared under such agreement, and

18 (iv) contains such other terms and
19 conditions as the Secretary may reasonably
20 require, and

21 (B) such information and assurances as
22 the Secretary may reasonably require.

23 (3) APPROVAL.—For purposes of determining
24 whether to approve an application submitted under

1 paragraph (2), the Secretary shall consider wheth-
2 er—

3 (A) the proposed agreement contained in
4 such application satisfies the guidelines issued
5 under paragraph (6), and

6 (B) implementation of such agreement will
7 result in—

8 (i) enhancement of the quality of hos-
9 pital care or hospital-related care,

10 (ii) the preservation of hospital serv-
11 ices in geographical proximity to the com-
12 munities traditionally served by the appli-
13 cants,

14 (iii) improvement in the cost-effective-
15 ness of high-technology services provided
16 by the applicants,

17 (iv) improvement in the efficient utili-
18 zation of hospital resources and capital
19 equipment,

20 (v) the provision of services that
21 would not otherwise be available, or

22 (vi) the avoidance of duplication of
23 hospital resources.

24 (4) ISSUANCE AND EFFECT OF WAIVER.—If—

1 (A) the Secretary approves under para-
2 graph (3) an application submitted under para-
3 graph (2), and

4 (B) the applicants enter into the proposed
5 agreement contained in such application, modi-
6 fied as the Secretary may require as a condition
7 for approval,

8 then the Secretary shall issue a waiver with respect
9 to the agreement entered into. Except as provided in
10 paragraph (5), such waiver shall exempt the appli-
11 cants from the operation of the antitrust laws for
12 conduct the applicants engage in during the period
13 specified in such waiver and solely to carry out the
14 agreement with respect to which such waiver is is-
15 sued.

16 (5) REVOCATION OF WAIVER.—(A) If the Sec-
17 retary determines that a hospital with respect to
18 which a waiver is in effect under paragraph (4) is
19 not carrying out, or has not carried out, fully the
20 terms of the agreement with respect to which a
21 waiver is issued under paragraph (4), the Secretary
22 may revoke such waiver.

23 (B) If the Secretary revokes such waiver—

1 (i) the Secretary shall specify the period
2 during which such hospital did not carry out
3 fully the terms of such agreement, and

4 (ii) such waiver shall have no legal effect
5 with respect to such period.

6 (6) ISSUANCE OF GUIDELINES.—Not later than
7 6 months after the date of the enactment of this
8 Act, the Secretary shall establish the guidelines for
9 applications under paragraph (2).

10 (c) DELEGATION OF AUTHORITY.—The Secretary is
11 authorized to delegate the authority under this section
12 with respect to a hospital in a State to the State multicare
13 program established under title I. To the extent the Sec-
14 retary delegates authority to a State under the previous
15 sentence with respect to hospitals in a State, any subse-
16 quent in this title to the “Secretary” is deemed a reference
17 to the State multicare program.

18 **SEC. 703. REPORTS.**

19 (a) REPORTS TO THE SECRETARY.—Each hospital
20 with respect to which a waiver is issued under section
21 702(b)(4) shall submit to the Secretary—

22 (1) during the period such waiver is in effect,
23 an annual report at such time, in such form, and
24 containing such information as the Secretary may
25 require, including a detailed description of the imple-

1 mentation of the agreement to which such waiver
2 applies, and

3 (2) such other information as the Secretary
4 may require for purposes of determining compliance
5 with section 702.

6 (b) REPORT TO COMMITTEES OF THE CONGRESS.—

7 (1) CHAIRMEN OF COMMITTEES.—Not later
8 than 7 years after the date of the enactment of this
9 Act, the Secretary shall submit the report described
10 in paragraph (2) to—

11 (A) the chairman of the Committee on the
12 Judiciary of the House of Representatives,

13 (B) the chairman of the Committee on
14 Ways and Means of the House of Representa-
15 tives,

16 (C) the chairman of the Committee on En-
17 ergy and Commerce of the House of Represent-
18 atives,

19 (D) the chairman of the Committee on the
20 Judiciary of the Senate,

21 (E) the chairman of the Committee on Fi-
22 nance of the Senate, and

23 (F) the chairman of the Committee on
24 Labor and Human Resources of the Senate.

1 (2) CONTENTS OF REPORT.—The report re-
2 quired by paragraph (1) shall contain a description
3 of the nature of the agreements with respect to
4 which the Secretary issued waivers under section
5 702(b)(4) and of the results of implementing such
6 agreements, including an assessment of whether
7 such agreements caused—

8 (A) a reduction in health care costs,

9 (B) an increase in access to medical serv-
10 ices, and

11 (C) improvement in the quality of health
12 care.

13 Such report shall also contain the recommendations
14 of the Secretary with respect to other arrangements
15 to facilitate cooperative activities to achieve the re-
16 sults specified in subparagraphs (A), (B), and (C).

17 **SEC. 704. DEFINITIONS.**

18 For purposes of this title:

19 (1) The term “antitrust laws” has the meaning
20 given it in subsection (a) of the first section of the
21 Clayton Act (15 U.S.C. 12(a)), except that such
22 term includes—

23 (A) section 5 of the Federal Trade Com-
24 mission Act (15 U.S.C. 45) to the extent such

1 section applies to unfair methods of competi-
2 tion, and

3 (B) any State law similar to the antitrust
4 laws.

5 (2) The term “high technology equipment” in-
6 cludes drugs, devices, equipment, and medical and
7 surgical procedures utilized in medical care, and the
8 organizational and support systems within which
9 such care is provided, that—

10 (A) have high capital costs or extremely
11 high annual operating costs, and

12 (B) use technologies with respect to which
13 there is a reasonable expectation that shared
14 ownership will avoid a significant degree of the
15 potential excess capacity of service in the geo-
16 graphical area to be served.

17 (3) The term “medical services” includes serv-
18 ices that—

19 (A) either have high capital costs or ex-
20 tremely high annual operating costs, and

21 (B) with respect to which there is a rea-
22 sonable expectation that shared ownership will
23 avoid a significant degree of the potential ex-
24 cess capacity of such services in the geographi-
25 cal area to be served,

1 and may include mobile services.

2 (4) The term “hospital” means a hospital
3 that—

4 (A) has entered into, and has in effect, a
5 participation agreement under section 1866(a)
6 of the Social Security Act, or

7 (B) which has in effect a participation
8 agreement under title XIX of such Act with the
9 State in which the hospital is located.

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

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