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103D CONGRESS
2D SESSION

H. R. 5228

To reform the health insurance market, to promote the availability and continuity of health coverage, to remove financial barriers to access, to reform the medicaid program, to enhance health care quality, to contain costs through market incentives and administrative reforms, to provide incentives to purchase long-term care insurance, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 6, 1994

Mr. ROWLAND (for himself, Mr. COOPER, Mr. BILIRAKIS, Mr. GRANDY, Mr. MCCURDY, Mr. GOSS, Mr. PARKER, Mr. HASTERT, Mr. STENHOLM, and Mr. THOMAS of California) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, the Judiciary, and Veterans' Affairs

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A BILL

To reform the health insurance market, to promote the availability and continuity of health coverage, to remove financial barriers to access, to reform the medicaid program, to enhance health care quality, to contain costs through market incentives and administrative reforms, to provide incentives to purchase long-term care insurance, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUBTITLES.

(a) SHORT TITLE.—This Act may be cited as the ''Bipartisan Health Care Reform Act of 1994''.

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

TITLE I—ASSURING AVAILABILITY AND CONTINUITY OF HEALTH COVERAGE

Subtitle A—Insurance Reforms
Subtitle B—Benefits
Subtitle C—Employer Responsibilities
Subtitle D—Standards and Certification; Enforcement; Preemption
Subtitle E—Multiple Employer Health Benefits Protections and Related Provisions
Subtitle F—Definitions; General Provisions

TITLE II—REMOVAL OF FINANCIAL BARRIERS TO ACCESS

Subtitle A—Tax Deductibility for Individuals and Self-Employed
Subtitle B—Premium and Cost-Sharing Subsidy Program for Low-Income Individuals

TITLE III—MEDICAID REFORMS

Subtitle A—Treatment of Acute Care Benefits for AFDC and Non-cash Beneficiaries
Subtitle B—Flexibility in Expenditures for Supplemental Benefits for AFDC and Non-cash Beneficiaries
Subtitle C—Increased State Flexibility in Contracting for Coordinated Care
Subtitle D—Additional Medicaid Reforms

TITLE IV—ACCESS IMPROVEMENTS

Subtitle A—Expanding Access in Underserved Areas
Subtitle B—Improved Access in Rural Areas
Subtitle C—Academic Health Centers
Subtitle D—United States-Mexico Border Health Commission

TITLE V—HEALTH CARE QUALITY ENHANCEMENT

Subtitle A—Quality Assurance
Subtitle B—Primary Care Provider Education

TITLE VI—MARKET INCENTIVES TO CONTAINING COSTS

Subtitle A—Facilitating Establishment of Health Plan Purchasing Organization (HPPOs)
Subtitle B—Preemption of State Benefit Mandates and Anti-Managed Care Laws
Subtitle C—Malpractice Reform

Subtitle D—Administrative Simplification
Subtitle E—Fair Health Information Practices
Subtitle F—Antitrust
Subtitle G—Fraud and Abuse
Subtitle H—Billing for Laboratory Services

TITLE VII—MEDICARE

Subtitle A—Increased Beneficiary Choice; Improved Program Efficiency
Subtitle B—Savings

TITLE VIII—INCENTIVES TO PURCHASE LONG-TERM CARE INSURANCE

Subtitle A—Establishment of Federal Standards for Long-term Care Insurance
Subtitle B—Tax Treatment of Long-term Care Insurance

TITLE IX—DEPARTMENT OF VETERANS AFFAIRS

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TITLE I—ASSURING AVAILABILITY AND CONTINUITY OF HEALTH COVERAGE

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Subtitle A—Insurance Reform

PART 1—GUARANTEED ACCESS TO HEALTH COVERAGE

SEC. 1001. GUARANTEED OFFER BY CARRIERS.

(a) IN GENERAL.—Each carrier that offers health insurance coverage in the individual/small group market in a fair rating area (as defined in section 1903) shall make available, to each qualifying individual (as defined in section 1904(3)) or small employer (covered in such market) in such fair rating area—

(1) qualified standard coverage consistent with section 1102, and

(2) subject to subsection (b), qualified high-deductible coverage consistent with section 1103.

(b) HIGH-DEDUCTIBLE COVERAGE.—

(1) EXCEPTION FOR HEALTH MAINTENANCE ORGANIZATIONS.—The requirement of subsection (a)(2) shall not apply with respect to health insurance coverage that—

(A) is provided by a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), or

(B) is not provided by such an organization but is provided by an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

(2) LIMITATION ON OFFER OF HIGH-DEDUCTIBLE COVERAGE.—Qualified high-deductible coverage may not be made available by a carrier to a qualifying individual (or to a small employer with respect to an employee) unless the carrier also makes available qualified standard coverage that has identical

benefits (other than the amount of the deductible) and the individual or employee demonstrates to the carrier that the individual or employee has available assets (as defined by the Secretary) equal to at least the deductible amount established under section 1104(b)(1) applicable to the high-deductible coverage. A carrier may not make available to an individual health coverage (other than coverage for supplemental benefits) the actuarial value of which is less than the actuarial value of qualified high-deductible coverage, unless the individual has available assets (as defined by the Secretary) equal to at least the deductible amount of the coverage offered.

(3) OPTION TO OFFER MEDISAVE COVERAGE.—The offer of high-deductible coverage under subsection (a)(2) may be accompanied by the contribution by an employer to a medical savings account (in accordance with section 7705 of the Internal Revenue Code of 1986).

(c) COVERAGE OF ENTIRE RATING AREA.—

(1) IN GENERAL.—With respect to each fair rating area for which a carrier offers health insurance coverage, the carrier shall provide for coverage of benefits for items and services furnished throughout the fair rating area.

(2) SPECIAL RULE FOR CARRIERS OFFERING COVERAGE IN MULTI-STATE METROPOLITAN STATISTICAL AREAS.—In the case of a carrier that offers qualified health insurance coverage in the individual/small employer market in a portion of a State that is located in an interstate metropolitan statistical area, the carrier may not provide such coverage with respect to an individual or employer in such metropolitan statistical area unless the carrier also offers such coverage in other portions of the area located in other States.

(3) SPECIAL RULE FOR COVERAGE THROUGH MANAGED CARE ARRANGEMENT.—In the case of coverage offered by a carrier or under a group health plan to the extent that it provides benefits through a managed care arrangement in a fair rating area, this subsection shall not be construed as requiring the establishment of facilities throughout the area, if the facilities are located consistent with section 1002(b)(1).

(d) FAMILY COVERAGE OPTION.—The offer of coverage under this section with respect to an individual shall include the option of coverage of family members of the individual.

(e) LIMITATION ON CARRIERS.—A carrier may not require an employer under a group health plan to impose through a waiting period for health coverage under a plan or similarly require a limitation or condition on health coverage or benefits based on—

(1) the health status of an individual,

(2) claims experience of an individual,

(3) receipt of health care by an individual,

(4) medical history of an individual,

(5) receipt of public subsidies by an individual, or

(6) lack of evidence of insurability of an individual.

SEC. 1002. GUARANTEED ISSUE BY CARRIERS.

(a) IN GENERAL.—Subject to subsections (b) and (c) and section 1003, each carrier that offers health insurance coverage in the individual/small group market in a fair rating area—

(1) must accept every small employer in the area that applies for such coverage during an enrollment period provided under section 1005; and

(2) must accept for enrollment under such coverage every qualifying individual (and family member of such an individual) who applies for enrollment during an enrollment period provided under section

1005 and may not place any restriction on the eligibility of an individual to enroll so long as such individual is a qualifying individual.

(b) SPECIAL RULES FOR MANAGED CARE ARRANGEMENTS.—In the case of coverage offered by a carrier or under a group health plan that provides benefits through a managed care arrangement in a fair rating area, the carrier or plan—

(1) need not establish facilities for the delivery of health care services throughout the area so long as such facilities are located in a manner that does not discriminate on the basis of health status of individuals residing in proximity to such facilities, and

(2) may deny such coverage in a fair rating area to employers or individuals if the organization demonstrates to the applicable regulatory authority that—

(A) it will not have the capacity to deliver services adequately to enrollees of any additional groups or additional enrollees because of its obligations to existing group contract holders and enrollees, and

(B) it is applying this paragraph uniformly to all employers and individuals without regard to the health status, claims experience, or dura-

tion of coverage of those employers and their employees.

Coverage may be denied under paragraph (2) only if the denial is applied during a consecutive period of at least 180 days.

(c) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—In addition to the authority provided under subsection (b)(2), in the case of coverage offered by any carrier, the carrier may deny coverage to a small employer or individual if the carrier demonstrates to the applicable regulatory authority that—

(1) it does not have the financial reserves necessary to underwrite additional coverage, and

(2) it is applying this subsection uniformly to all employers and individuals without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

Coverage may be denied under this subsection only if the denial is applied during a consecutive period of at least 180 days.

SEC. 1003. GUARANTEED RENEWAL.

(a) LIMITATION ON TERMINATION BY CARRIERS.—A carrier may not deny, cancel, or refuse to renew health coverage of a qualifying individual or eligible employer

within a type of coverage option described in section 1903(15) except—

(1) on the basis of nonpayment of premiums,

(2) on the basis of fraud or misrepresentation, or

(3) subject to subsection (b), in a fair rating area because the carrier is ceasing to provide any health insurance coverage in the individual/small group market within such type of coverage option in the area.

(b) LIMITATIONS ON MARKET EXIT BY CARRIERS.—

(1) NOTICE, ETC.—Subsection (a)(3) shall not apply to a carrier ceasing to provide health insurance coverage unless—

(A) such termination of coverage takes effect at the end of a contract year, and

(B) the carrier provides notice of such termination to employers and individuals covered at least 30 days before the date of an annual open enrollment period established with respect to the employer or individual under section 1005.

(2) LIMITATION ON REENTRY IN INDIVIDUAL/SMALL GROUP MARKET.—If a carrier ceases to offer or provide health insurance coverage in an area with

respect to the individual/small group market for a type of coverage option, the insurer may not offer health insurance coverage in the area in such market within such type of coverage option until 5 years after the date of the termination.

(c) RULE FOR MULTIEMPLOYER PLANS AND CERTIFIED MULTIPLE EMPLOYER HEALTH.—A multiemployer plan and a certified multiple employer health plan may not cancel coverage or deny renewal of coverage under such a plan with respect to an employer other than—

(1) for nonpayment of contributions,

(2) for fraud or other misrepresentation by the employer, or

(3) because the plan is ceasing to provide any coverage in a geographic area.

SEC. 1004. RESTRICTING PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—Except as provided in this section, a carrier or group health plan providing health coverage may not exclude health coverage with respect to services related to treatment of a condition based on the fact that the condition of an individual existed before the effective date of coverage of the individual.

(b) LIMITED 6-MONTH EXCLUSION PERMITTED.—

(1) IN GENERAL.—Subject to paragraph (2) and subsections (c) through (e), a carrier or group health plan providing health coverage may exclude health coverage with respect to services related to treatment of a condition of an individual based on the fact that the condition existed before the effective date of coverage of the individual only if the period of the exclusion does not exceed 6 months beginning on the date of coverage.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A carrier or group health plan providing health coverage shall provide that if a covered individual is in a period of continuous coverage (as defined in subparagraph (C)) as of a date upon which coverage is initiated or reinitiated, any period of exclusion of coverage with respect to a preexisting condition (as defined in subparagraph (B)) for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(B) PREEXISTING CONDITION DEFINED.—In this paragraph, the term ''preexisting condition'' means, with respect to health coverage, a condition which has been diagnosed or treated

during the 3-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(C) PERIOD OF CONTINUOUS COVERAGE.—In this part, the term ''period of continuous coverage'' means the period beginning on the date an individual has health coverage (or coverage under a public plan providing medical benefits) and ends on the date the individual does not have such coverage for a continuous period of more than 3 months (or 6 months in the case of an individual who loses coverage due to involuntary termination of employment, other than by reason of an employee's gross misconduct).

(c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—Any exclusion of coverage under subsection (b)(1) shall not apply if the exclusion relates to pregnancy.

(d) EXCLUSION NOT APPLICABLE TO NEWBORNS AND ADOPTED CHILDREN.—

(1) NEWBORNS.—Any exclusion of coverage under subsection (b)(1) shall not apply to a child who is covered at the time of birth and remains in a period of continuous coverage after such time.

(2) ADOPTED CHILDREN.—Any exclusion of coverage under subsection (b)(1) shall not apply (beginning on the date of adoption) to an adopted child who is covered at the time of adoption and remains in a period of continuous coverage after such time.

(e) EXCLUSION NOT APPLICABLE TO INDIVIDUALS ENROLLED OR ENROLLING DURING CERTAIN OPEN ENROLLMENT PERIODS.—

(1) INDIVIDUALS ENROLLING DURING PERIOD.—In the case of an individual who enrolls and obtains coverage during an open enrollment period described in section 1005(b), any exclusion of coverage under subsection (b)(1) shall not apply so long as the individual remains in a period of continuous coverage.

(2) INDIVIDUALS ENROLLED AT BEGINNING OF PERIOD.—In the case of an individual who has health coverage as of the first day of the initial open enrollment period described in section 1005(b)(1), any exclusion of coverage under subsection (b)(1) shall not apply as of such date and so long as the individual is in a period of continuous coverage.

(f) APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization that provides health insurance coverage shall

not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwithstanding that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provisions of this part so long as such exclusion is applied consistent with the provisions of this part.

SEC. 1005. ENROLLMENT PERIODS.

(a) IN GENERAL.—Each carrier and each group health plan providing health coverage (and each health plan purchasing organization under subtitle A of title V) in the individual/small group market shall permit qualifying individuals and eligible employers to obtain health coverage from the carrier or group health plan during each enrollment period provided under this section.

(b) OPEN ENROLLMENT PERIODS FOR WHICH PREEXISTING CONDITION EXCLUSIONS WAIVED.—

(1) INITIAL PERIOD.—There shall be an initial open enrollment period, with respect to individuals and employees who are residents of a State, during the 60-day period beginning on January 1, 1997.

(2) INDIVIDUALS ELIGIBLE FOR SUBSIDIES.—There shall be an individual open enrollment period with respect to an individual at the time the individual first becomes eligible for any premium assistance under part A of title XXI of the Social Security Act,

during the 60-day period beginning on the first date the individual meets eligibility criteria within any 12-month period.

(3) COURT ORDERS.—If a court has ordered that coverage be provided for a spouse or child of an employee or individual under health coverage of the employee or individual, there shall be an open enrollment period during the 30-day period beginning on the date of issuance of the court order.

(4) ENROLLMENT OF NEWBORNS AND NEWLY ADOPTED CHILDREN.—There shall be an open enrollment period with respect to a newborn child and a newly adopted child during the 30-day period beginning on the date of the birth or adoption of a child, if family coverage is available as of such date.

(c) ANNUAL OPEN ENROLLMENT PERIODS FOR WHICH PREEXISTING CONDITION EXCLUSIONS MAY APPLY.—

(1) IN GENERAL.—Each carrier and each group health plan providing health coverage (and each health plan purchasing organization under subtitle A of title V) in the individual/small group market shall provide for at least one annual open enrollment period (of not less than 30 days) each year. Such pe-

riod shall be in addition to the open enrollment periods described in subsection (b).

(2) COORDINATION.—

(A) CARRIERS IN INDIVIDUAL/SMALL GROUP MARKET.—Such annual open enrollment periods with respect to carriers in the individual/small group market are subject to coordination by States.

(B) GROUP HEALTH PLANS.—Such annual open enrollment periods with respect to any group health plan are subject to coordination in order to meet the requirement of section 1201(a)(2)(F).

(d) OTHER OPEN ENROLLMENT PERIODS FOR WHICH PREEXISTING CONDITION EXCLUSIONS MAY APPLY.—

(1) TERMINATION OF RESIDENCE AREA.—For each qualifying individual, at the time the individual terminates residence in the service area of coverage provided by a carrier to the individual, there shall be an open enrollment period (of not less than 30 days) during which the individual may enroll in health coverage.

(2) FAMILY OR EMPLOYMENT CHANGES.—In the case of a qualifying individual who—

(A) through divorce or death of a family member experiences a change in family composition, or

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

there shall be an open enrollment period (of at least 30 days) in which the individual is permitted to change the individual or family basis of coverage or the health coverage in which the individual is enrolled. The circumstances under which such enrollment periods are required and the duration of such periods shall be specified by the Secretary.

(3) ENROLLMENT DUE TO LOSS OF PREVIOUS COVERAGE.—In the case of a qualifying individual who—

(A) had health coverage at the time of an individual's enrollment period,

(B) stated at the time of such period that having other health coverage was the reason for declining enrollment, and

(C) lost the other health coverage as a result of the termination of the coverage, termi-

nation or reduction of employment, or other reason, except termination at the option of the individual,

there shall be an open enrollment period during the 30-day period beginning on the date of termination of the other coverage.

(4) ENROLLMENT AT TIME OF MARRIAGE.—There shall be an open enrollment period with respect to the spouse of an individual (including children of the spouse) during the 30-day period beginning on the date of the marriage, if family coverage is available as of such date.

(5) NO EFFECT ON COBRA CONTINUATION BENEFITS.—Nothing in this subsection shall be construed as affecting rights of individuals to continuation coverage under section 4980B of the Internal Revenue Code of 1986, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXII of the Public Health Service Act.

(e) PERIOD OF COVERAGE.—

(1) IN GENERAL.—In the case of a qualifying individual who enrolls under health coverage during an open enrollment period under this section, coverage shall begin on such date (not later than the

first day of the first month that begins at least 15 days after the date of enrollment) as the Secretary shall specify, consistent with this subsection.

(2) COVERAGE OF FAMILY MEMBERS.—In the case of an open enrollment period described in subsection (b)(3), (b)(4), or (d)(4), the Secretary shall provide for coverage of family members to begin as soon as possible on or after the date of the event that gives rise to the special enrollment period (or, in the case of birth or adoption, as of the date of birth or adoption).

SEC. 1006. TREATMENT OF RELIGIOUS FRATERNAL BENEFIT SOCIETIES.

(a) IN GENERAL.—Sections 1001 and 1002 shall not apply to any religious fraternal benefit society in existence as of September 1993, which—

(1) bears the risk of providing insurance to its members, and

(2) is an organization described in section 501(c)(8) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code.

(b) DEFINITION.—In subsection (a), the term ''fraternal benefit society'' includes any affiliate or wholly-owned subsidiary of a fraternal benefit society, including

a health maintenance organization insofar as it is utilized directly or indirectly to provide managed care to members of the society.

PART 2—PROVISION OF BENEFITS

SEC. 1011. STANDARDS FOR MANAGED CARE ARRANGEMENTS.

(a) APPLICATION OF REQUIREMENTS.—Each group health plan, and each carrier providing health insurance coverage, that provides for health care through a managed care arrangement (as defined in section 1903(12)(A)) shall comply with the applicable requirements of this section.

(b) SCOPE OF ARRANGEMENTS WITH PROVIDERS.—

(1) ACCESS TO CARE.—The entity providing for a managed care arrangement with respect to health coverage shall enter into such agreements with health care providers (including primary and specialty providers, such as providers for children) or have such other arrangements as may be necessary to assure that covered individuals have reasonably prompt access through the entity's provider network to all items and services contained in the package of benefits for which coverage is provided (including access to emergency services on a 24-hour basis where medically necessary), in a manner that assures the

continuity of the provision of such items and services. Such access shall take into account the diverse needs of enrollees and proximity to the workplaces or residences of enrollees.

(2) ACCESS TO CENTERS OF EXCELLENCE.—

(A) IN GENERAL.—The entity providing for a managed care arrangement under health coverage shall demonstrate that covered individuals (including individuals with chronic diseases) have access through the entity's provider network to specialized treatment expertise. Such entity may demonstrate such access through contracts with centers of excellence described in subparagraph (B).

(B) DESIGNATION OF CENTERS OF EXCELLENCE.—The Secretary shall establish a process for the designation of facilities, including children's hospitals and other pediatric facilities, as centers of excellence for purposes of this paragraph. A facility may not be designated unless the facility is determined—

(i) to provide specialty care,

(ii) to deliver care for complex cases requiring specialized treatment and for individuals with chronic diseases, and

(iii) to meet other requirements that may be established by the Secretary relating to specialized education and training of health professionals, participation in peer-reviewed research, or treatment of patients from outside the geographic area of the facility.

(3) CHOICE OF PERSONAL PHYSICIAN.—The entity providing for a managed care arrangement under health coverage shall permit each enrollee to choose a personal physician from among available participating physicians and change that selection as appropriate.

(c) PROVISION OF EMERGENCY CARE SERVICES.—

(1) IN GENERAL.—The entity providing for a managed care arrangement under health coverage must cover medically necessary emergency care services provided to covered individuals (including trauma services, such as those provided by designated trauma centers), without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the entity to provide items or services to covered individuals and, in the case of services furnished for the treatment of an emergency medical condition (as defined in sec-

tion 1867(e)(1) of the Social Security Act), without regard to prior authorization.

(2) DESIGNATED TRAUMA CENTERS DEFINED.—In paragraph (1), the term ''designated trauma center''—

(A) has the meaning given such term in section 1231 of the Public Health Service Act, and

(B) includes (for years prior to 2001) a trauma center that—

(i) is located in a State that has not designated trauma centers under section 1213 of such Act, and

(ii) the Secretary finds it meets the standards under such section to be a designated trauma center.

(d) DUE PROCESS STANDARDS RELATING TO PROVIDER NETWORKS.—

(1) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—

(A) ESTABLISHMENT.—The entity providing for a managed care arrangement under health coverage shall establish standards (including criteria for quality, efficiency, credentialing, and services) to be used by the

entity for contracting with health care providers with respect to the entity's provider network. Such standards shall be established in consultation with providers who are members of the network, including providers who are members of the advisory committee established under paragraph (3)(D).

(B) DISTRIBUTION OF INFORMATION.—Descriptive information regarding these standards and criteria shall be made available to enrollees, providers who are members of the network, and prospective enrollees and prospective participating providers, including notice of when applications for participation will be accepted.

(C) NOTICE OF DENIALS.—The entity shall provide written notice to the provider of any denial of an application to participate in the provider network.

(2) TERMINATION PROCESS.—

(A) IN GENERAL.—The entity may not terminate or refuse to renew a participation agreement with a provider in the entity's provider network unless the entity provides written notification to the provider of the entity's decision to terminate or refuse to renew the agreement.

The notification shall include a statement of the reasons for the entity's decision, consistent with the standards established under paragraph (1).

(B) TIMING OF NOTIFICATION.—The entity shall provide the notification required under subparagraph (A) at least 45 days prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of a covered individual.

(3) REVIEW PROCESS.—

(A) IN GENERAL.—The entity shall provide a process under which the provider may request a review of the entity's decision to terminate or refuse to renew the provider's participation agreement. Such review shall be conducted by a group of individuals the majority of whom are health care providers who are members of the entity's provider network or employees of the entity, and who are members of the same profession as the provider who requests the review.

(B) COUNSEL.—If the provider requests in advance, the entity shall permit an attorney

representing the provider to be present at the provider's review.

(C) REVIEW ADVISORY.—The findings and conclusions of a review under this paragraph may be advisory and non-binding.

(D) ADVISORY COMMITTEE.—The entity shall establish an advisory committee of participating physicians with whom it consults, on an advisory basis, on the termination of physicians who have been participating in the provider network. In making recommendations to the entity, such an advisory committee shall consider such features of the physician's practice, relating to case mix and age of patients, as may lead the physician to have higher than expected treatment costs for the patients of the physician who are enrollees.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed to affect any other provision of law that provides an appeals process or other form of relief to a provider of health care services or an entity providing for a managed care arrangement.

(e) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—A carrier or group health plan may not

require an individual to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

SEC. 1012. UTILIZATION REVIEW.

(a) ESTABLISHMENT OF STANDARDS BY SECRETARY.—The Secretary shall establish standards for utilization review programs, consistent with subsection (c), and shall periodically review and update such standards to reflect changes in the delivery of health care services. The Secretary shall establish such standards in consultation with appropriate parties.

(b) REQUIRING REVIEW TO MEET STANDARDS.—A group health plan or carrier providing health insurance coverage may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets the standards established by the Secretary under this section.

(c) REQUIREMENTS FOR STANDARDS.—Under the standards established under subsection (a)—

(1) individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage;

(2) negative determinations of the medical necessity or appropriateness of services or the site at

which services are furnished may be made only by clinically qualified personnel;

(3) the utilization review program shall provide for a process under which an enrollee or provider may obtain timely review of a denial of coverage, including upon request a review conducted by the medical director of the carrier or plan or a physician designated by the carrier or plan;

(4) utilization review shall be conducted in accordance with uniformly applied standards that are based on currently available medical evidence; and

(5) providers shall participate in the development of the utilization review program.

(d) PREEMPTION.—For provision preempting State laws relating to utilization review, see section 6103.

SEC. 1013. REQUIREMENTS FOR ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.

(a) REQUIREMENT.—

(1) IN GENERAL.—Subject to subsection (d), each group health plan and each carrier providing qualified health coverage to individuals residing in a fair rating area (or service area in the case of a carrier that is a health maintenance organization) shall, with respect to at least one essential community provider (as defined in subsection (c)) within each class

of such a provider (as described in paragraph (2)) located within the area, enter into a written provider participation agreement (described in subsection (b)) with the provider, unless all the providers in the class have declined to enter into such a contract with the plan or carrier.

(2) CLASS DEFINED.—For purposes of the paragraph (1), providers described in each paragraph of subsection (c) shall constitute a separate ''class'' of providers.

(b) PARTICIPATION AGREEMENT.—A participation agreement between a group health plan or carrier and an essential community provider under this subsection shall provide that the plan or carrier agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers with a participation agreement with the plan or carrier with respect to the scope of services for which payment is made by the plan or carrier to the provider.

(c) ESSENTIAL COMMUNITY PROVIDERS DESCRIBED.—In this section, an ''essential community provider'' means any of the following:

(1) CERTAIN MEDICARE DISPROPORTIONATE SHARE HOSPITALS.—A hospital—

(A) described in section 1886(d)(5)(F)(i)(II) of the Social Security Act;

(B) described in section 1886(d)(5)(F)(iv)(I) of such Act with a disproportionate patient percentage (as defined in section 1886(d)(5)(F)(vi) of such Act) greater than 20.2; or

(C) that would be described in subparagraph (A) or (B) if the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act).

(2) SOLE COMMUNITY HOSPITALS.—A sole community hospital (as described in section 1886(d)(5)(D)(iii) of such Act).

(3) MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—A medicare-dependent, small rural hospital (as described in section 1886(d)(5)(G)(iii) of such Act), or a hospital that would be a medicare-dependent, small rural hospital if the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act).

(4) FEDERALLY QUALIFIED HEALTH CENTERS.—A Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act) or an entity that would be such a center but

for its failure to meet the requirement described in section 329(f)(2)(G)(i) of the Public Health Service Act or the requirement described in section 330(e)(3)(G)(i) of such Act (relating to the composition of the entity's governing board).

(5) RURAL HEALTH CLINICS.—A rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act).

(6) LOCAL HEALTH DEPARTMENTS.—A health department of a unit of State or local government which provides health services directly to individuals.

(7) CERTAIN CHILDREN'S HOSPITALS.—A hospital whose inpatients are predominantly individuals under 18 years of age and that would be described in subparagraph (A) or (B) of paragraph (1) if the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act) with more than 100 beds.

(d) SUNSET.—The requirement of subsection (a) shall not apply to health coverage provided after December 31, 1999.

SEC. 1014. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Chapter 79 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 7705. MEDICAL SAVINGS ACCOUNTS.

''(a) GENERAL RULE.—For purposes of this title, the term 'medical savings account' means a trust created or organized in the United States for the exclusive benefit of an individual or his beneficiaries, but only if the written instrument creating the trust meets the following requirements:

''(1) Except in the case of a rollover contribution described in subsection (d)(3), no contribution will be accepted unless—

''(A) it is in cash, and

''(B) such individual is an eligible employee for the period for which such contribution is made.

''(2) The trustee is a bank (as defined in section 408(n)), insurance company (as defined in section 816), or such other person who demonstrates to the satisfaction of the Secretary that the manner in which such other person will administer the trust will be consistent with the requirements of this section.

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

''(4) The interest of an individual in the balance of the account is nonforfeitable.

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

''(b) ELIGIBLE EMPLOYEE.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible employee' means any employee who has high-deductible coverage (as defined in section 1103 of the Bipartisan Health Care Reform Act of 1994) offered by the employer.

''(2) EXCEPTION.—An employee shall be treated as not being an eligible employee for any calendar year if, for any month during such year, it is reasonably expected that such employee—

''(A) will have adjusted gross income that is less than 100 percent of the income official poverty line (as determined by the Director of the Office of Management and Budget) for a family of the size involved; or

''(B) is an AFDC recipient or SSI recipient.

''(3) DEFINITIONS.—For purposes of paragraph (2)—

''(A) AFDC RECIPIENT.—The term 'AFDC recipient' means, for a month, an indi-

vidual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act for the month.

''(B) SSI RECIPIENT.—The term 'SSI recipient' means, for a month, an individual—

''(i) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

''(ii) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93–66 for the month,

''(iii) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month, or

''(iv) who is treated under section 1619(b) of the Social Security Act as receiving supplemental security income benefits in a month for purposes of title XIX of such Act.

''(c) TAX TREATMENT OF ACCOUNTS.—

''(1) ACCOUNT TAXED AS GRANTOR TRUST.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the account beneficiary of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

''(B) TREATMENT OF CAPITAL LOSSES.—With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall be allowed only to the extent of capital gains from such assets for such taxable year. Any capital loss which is disallowed under the preceding sentence shall be treated as a capital loss from the sale or exchange of such an asset in the next taxable year. For purposes of this subparagraph, all medical savings accounts of the account beneficiary shall be treated as 1 account.

''(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

''(A) IN GENERAL.—If, during any taxable year of the account beneficiary, such beneficiary engages in any transaction prohibited by section 4975 with respect to the account, the account shall cease to be a medical savings account as of the first day of such taxable year.

''(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, subsection (d) shall be applied as if—

''(i) there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day), and

''(ii) no portion of such distribution were used to pay qualified medical expenses.

''(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the account beneficiary uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed and not used to pay qualified medical expenses.

''(d) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary or of the spouse or dependents (as defined in section 152) of such beneficiary shall be included in the gross income of such beneficiary to the extent such amount does not exceed the excess of—

''(i) the aggregate contributions to such account which were not includible in gross income by reason of section 106(2), over

''(ii) the aggregate prior payments or distributions from such account which were includible in gross income under this paragraph.

''(B) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all medical savings accounts of the account beneficiary shall be treated as 1 account,

''(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

''(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by chapter 1 on the account beneficiary for any taxable year in which there is a payment or distribution from a medical savings account of such beneficiary which is includible in gross income under paragraph (1) shall be increased by 100 percent of the amount which is so includible.

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

''(C) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the

account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

''(3) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—Paragraph (1) shall not apply to any amount paid or distributed from a medical savings account to the account beneficiary to the extent the amount received is paid into a medical savings account for the benefit of such beneficiary not later than the 60th day after the day on which he receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in his gross income because of the application of this paragraph.

''(4) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care to the extent of the amount of such payment or distribution which is excludable from gross income solely by reason of paragraph (1)(A).

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

''(1) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' means any expense for medical care (as defined in section 213(d)); except that such term shall not include any amount paid for insurance.

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

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

''(1) the assets of such account are held by a bank (as defined in section 408(n)), insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer

the account will be consistent with the requirements of this section, and

''(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (a).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

''(g) REPORTS.—The trustee of a medical savings account shall keep such records and make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by such regulations.''

(b) INCOME AND EMPLOYMENT TAX TREATMENT OF EMPLOYER CONTRIBUTIONS.—

(1) EMPLOYER PAYMENTS EXCLUDED FROM GROSS INCOME.—The text of section 106 of such Code is amended to read as follows:

''Gross income of an employee does not include—

''(1) employer-provided coverage under an accident or health plan, and

''(2) employer contributions to any medical savings account (as defined in section 7705) of an eligible employee, but only to the extent that the amount contributed does not exceed the excess of premium for standard coverage over the premium for high-deductible coverage (as such terms are defined in section 1903 of the Bipartisan Health Care Reform Act of 1994).''

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

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 of such Code is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2).''

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

''(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2) of the Internal Revenue Code of 1986.''

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

''(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2).''

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by

striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2).''

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2).''

(c) TECHNICAL AMENDMENTS.—

(1) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to prohibited transactions) is amended—

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

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 7705) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 7705(c)(2)(A) to such account.'', and

(B) by inserting ''or a medical savings account described in section 7705'' in subsection (e)(1) after ''described in section 408(a)''.

(2) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement account or annuities) is amended—

(A) by inserting ''**OR ON MEDICAL SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

(B) by adding at the end of subsection (a) the following: ''The person required by section

7705(g) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.''

(3) CLERICAL AMENDMENTS.—

(A) The table of sections for chapter 79 of such Code is amended by adding at the end the following:

''Sec. 7705. Medical savings accounts.''

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

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

PART 3—FAIR RATING PRACTICES

SEC. 1021. USE OF FAIR RATING PRACTICES.

(a) USE OF FAIR RATING PRACTICES.—The premium rate established by a carrier for health insurance coverage in the individual/small group market (including the premium rate for coverage for a small employer through a multiple employer welfare arrangement that is fully-insured) may not vary except by the following:

(1) AGE.—By age, based on classes of age established by the Secretary, in consultation with the NAIC, consistent with subsection (b).

(2) GEOGRAPHIC AREA.—By geographic area, as identified by a State consistent with subsection (c).

(3) FAMILY CLASS.—By family class, based on the following 4 classes of family coverage: individual, individual with one or more children, married couple without a child, and married couple with one or more children.

(4) BENEFIT DESIGN.—By benefit design of coverage, including by type of coverage, such as standard coverage and high-deductible coverage, and by type of coverage option (described in section 1903(15)) with respect to standard coverage.

(5) ADMINISTRATIVE CATEGORIES.—By permitted expense category, based on differences in expenses among such categories, consistent with subsection (d).

The premiums shall be established for the different benefit designs (including standard coverage and high-deductible coverage) based on the actuarial value of the coverage for the population of the individual/small group market in the fair rating area, without regard to the distribution of such

population among the types of coverage or type of coverage options.

(b) LIMITATION ON VARIATION BY AGE.—

(1) IN GENERAL.—Any variation in premium rates by age under subsection (a)(1) for age classes of individuals under 65 years of age may not result in the ratio of the highest age rate to the lowest age rate exceeding the limiting ratio described in paragraph (2).

(2) LIMITING RATIO.—For purposes of paragraph (1), the limiting ratio described in this paragraph is—

(A) 4-to-1, for premiums for months in 1997,

(B) 3.67-to-1, for premiums for months in 1998,

(C) 3.33-to-1, for premiums for months in 1999, and

(D) 3-to-1, for premiums for months in 2000 and any succeeding year.

(3) SEPARATE AGE CLASSES FOR INDIVIDUALS 65 YEARS OF AGE OR OLDER.—The Secretary shall establish one or more separate age classes for individuals 65 years of age or older.

(4) PREEMPTION.—For preemption of State laws relating to establishment of premium rates, see section 6105.

(c) GEOGRAPHIC AREA VARIATIONS.—For purposes of subsection (a)(2), a State—

(1) may not identify an area that divides a 3-digit zip code, a county, or all portions of a metropolitan statistical area,

(2) shall not permit premium rates for coverage offered in a portion of an interstate metropolitan statistical area to vary based on the State in which the coverage is offered, and

(3) may, upon agreement with one or more adjacent States, identify multi-state geographic areas consistent with paragraphs (1) and (2).

(d) ADMINISTRATIVE VARIATIONS.—

(1) EXPENSE CATEGORIES.—Expense categories shall be established under subsection (a)(5) by a carrier in a manner that only reflects differences based on marketing, commissions, and similar expenses. Such categories shall take into account health plan purchasing organizations.

(2) LIMITATION ON VARIATIONS.—The variation provided among expense categories under subsection (a)(5) may not result in a premium for the

highest expense category exceeding 120 percent of the premium for the lowest expense category.

(e) PREMIUM RATING IN GROUP HEALTH PLANS.—The premium rate established under a group health plan for health insurance coverage may not vary within a benefit design except by the factors described in subsection (a) and subject to the limitation specified in subsection (b).

(f) ACTUARIAL CERTIFICATION.—Each carrier that offers health insurance coverage in a State shall file annually with the State commissioner of insurance a written statement by a member of the American Academy of Actuaries (or other individual acceptable to the commissioner) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the carrier and methods used by the carrier in establishing premium rates for applicable health insurance coverage—

(1) the carrier is in compliance with the applicable provisions of this section, and

(2) the rating methods are actuarially sound.

Each such carrier shall retain a copy of such statement for examination at its principal place of business.

(g) CONSTRUCTION.—The provisions of this section shall apply to premium rates established by carriers for multiple employer welfare arrangements that are fully-in-

sured or for fully-insured coverage offered with respect to individuals and small employers in the individual/small group market. Such premium rates shall apply based on the fair rating area in which the covered individual or employee resides to reflect the population in the individual/small group market.

SEC. 1022. COORDINATION WITH PREMIUM ASSISTANCE CERTIFICATE PROGRAM.

Each carrier or group health plan providing qualified health coverage shall accept and apply (as a reduction against premiums otherwise imposed) any premium certificate issued under a State premium assistance program under part A of title XXI of the Social Security Act.

SEC. 1023. ESTABLISHMENT OF RISK ADJUSTMENT MECHANISMS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) DEVELOPMENT OF MODELS.—

(A) IN GENERAL.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act and in consultation with the American Academy of Actuaries, a model risk adjustment system composed of one or more risk adjustment mechanisms under which premiums applicable to health insurance coverage in the individual/

small group market and coverage under small employer pooling arrangements and under multiple employer welfare arrangements that are fully insured (without regard to whether such an arrangement is offered through an association) would be adjusted to take into account such factors as may be appropriate to predict the future need and the efficient use of services by covered individuals in the market. Such factors may include the age, gender, geographic residence, health status, or other demographic characteristics of individuals enrolled in such plans and shall include consideration of enrollment of a disproportionate share of individuals who enroll during the initial open enrollment period under section 1005(b)(1).

(B) PROMULGATION AS PROPOSED RULE.—If the NAIC develops such model within such period, the Secretary shall publish the model as a proposed rule under section 553 of title 5, United States Code. If the NAIC has not developed such model within such period, the Secretary shall publish (not later than 60 days after the end of such period) a proposed

rule that specifies a proposed model that provides for effective risk adjustment mechanisms.

(2) RULE MAKING PROCESS.—The Secretary shall provide for a period (described in section 553(c) of title 5, United States Code) of not less than 30 days for public comment on a proposed rule published under paragraph (1)(B). The Secretary shall publish a final rule, by not later than January 1, 1996, that specifies risk adjustment mechanisms that the Secretary finds are effective for purposes of carrying out this section. Such rule shall include models developed by the NAIC if the Secretary finds that such models provide for effective risk adjustment mechanisms.

(3) MODIFICATION.—The Secretary, at the request of the NAIC or otherwise, may by regulation modify the model risk adjustment system established under this subsection.

(b) IMPLEMENTATION OF RISK ADJUSTMENT SYSTEM.—Each State shall establish and maintain a risk adjustment system that conforms with the model established under this section by not later than January 1, 1997. A State may establish and maintain such a system jointly with one or more other States.

(c) APPLICATION TO SMALL EMPLOYER POOLING ARRANGEMENTS AND FULLY-INSURED MEWAS.—As required under sections 704(b)(6)(B) and 711(c)(1)(B) of the Employee Retirement Income Security Act of 1974, as added by section 1401 of this Act, this section applies to small employer pooling arrangements and to multiple employer welfare arrangements that are fully insured (without regard to whether such an arrangement is offered through an association), with respect to individuals covered in the individual/small employer market, in such form and manner as the Secretary of Labor prescribes in regulation, in consultation with the Secretary of Health and Human Services. In applying this section to a small employer pooling arrangement, the regulation shall provide that assessments and credits under this section shall be provided through coordination with an insurer that provides excess/stop loss coverage (as defined in section 701 of such Act) with respect to the arrangement.

PART 4—CONSUMER PROTECTIONS

SEC. 1031. REQUIREMENT FOR PROVISION OF INFORMATION.

(a) CARRIERS.—

(1) IN GENERAL.—Each carrier that offers health insurance coverage to small employers (or eligible employees of small employers) or qualifying in-

dividuals must disclose to such prospective enrollees, to brokers, and to health plan purchasing organizations the information that the Secretary may specify relating to the performance of the carrier in providing such coverage, consistent with any quality measures established under section 5002, and relating to differences between the coverage provided and the most similar model benefit package established under section 1104(b)(2). If a carrier offers to individuals or employers coverage the actuarial value of which is more than the actuarial value for high-deductible coverage but less than such value for standard coverage, the carrier must disclose to such employers or individuals detailed information on how the coverage offered compares to any standard and high-deductible coverage offered by the carrier to such individuals and employers.

(2) MARKETING MATERIAL.—Each carrier that provides any health insurance coverage in a State shall file with the State those marketing materials relating to the offer and sale of health insurance coverage to be used for distribution before the materials are used. Such materials shall be in a uniform format specified under the standards established under section 1301.

(b) GROUP HEALTH PLANS.—Each group health plan that provides health coverage must disclose to enrollees and potential enrollees information, similar to the information described in subsection (a), relating to performance of the plan in providing such coverage, consistent with any quality measures established under section 5002, and relating to differences between the coverage provided and the most similar model benefit package established under section 1104(b)(2).

(c) INFORMATION RELATING TO RISK ADJUSTMENT.—Each carrier or group health plan providing coverage in the individual/small group market (including small employer pooling arrangements and certified multiple employer health plans that are fully insured, without regard to whether such an arrangement or plan is offered through an association) shall provide to the State such information as the State may require in order to carry out section 1023 (relating to risk adjustment mechanisms).

SEC. 1032. PROHIBITION OF IMPROPER INCENTIVES.

(a) LIMITATION ON FINANCIAL INCENTIVES.—No carrier that provides health insurance coverage may vary the commission or financial or other remuneration to a person based on the claims experience or health status of individuals enrolled by or through the person.

(b) NONDISCRIMINATION IN AGENT COMPENSATION.—A carrier—

(1) may not vary or condition the compensation provided to an agent or broker related to the sale or renewal of health insurance coverage because of the health status or claims experience of any individuals enrolled with the carrier through the agent or broker; and

(2) may not terminate, fail to renew, or limit its contract or agreement of representation with an agent or broker for any reason related to the health status or claims experience of any individuals enrolled with the carrier through the agent or broker.

(c) PROHIBITION OF TIE-IN ARRANGEMENTS.—No carrier that offers health insurance coverage may require the purchase of any other insurance or product as a condition for the purchase of such coverage.

SEC. 1033. WRITTEN POLICIES AND PROCEDURES RESPECTING ADVANCE DIRECTIVES.

A carrier and a group health plan offering health coverage shall meet the requirements of section 1866(f) of the Social Security Act (relating to maintaining written policies and procedures respecting advance directives), insofar as such requirements would apply to the carrier or plan if the carrier or plan were an eligible organization.

Subtitle B—Benefits

SEC. 1101. QUALIFIED HEALTH COVERAGE.

In this Act, the term ''qualified health coverage'' means health coverage that—

(1) provides—

(A) standard coverage consistent with section 1102(a), or

(B) high-deductible coverage consistent with section 1103; and

(2) meets other requirements of subtitle A applicable to the coverage and the carrier or group health plan providing the coverage.

SEC. 1102. STANDARD COVERAGE.

(a) IN GENERAL.—Health insurance coverage is considered to provide standard coverage consistent with this subsection and for preventive benefits under subsection (b)(4) if—

(1) benefits under such coverage are provided within at least each of the required categories of benefits described in paragraph (1) of subsection (b) and consistent with such subsection;

(2) the actuarial value of the benefits meets the requirements of subsection (c), and

(3) the benefits comply with the minimum requirements specified in subsection (d).

(b) REQUIRED CATEGORIES OF COVERED BENEFITS.—

(1) IN GENERAL.—The categories of covered benefits described in this paragraph are the types of benefits specified in each of subparagraphs (A), (B), (C), (D), (E), and (F) of paragraph (1), and subparagraphs (E) and (F) of paragraph (2), of section 8904(a) of title 5, United States Code (relating to types of benefits required to be in health insurance offered to Federal employees).

(2) COVERAGE OF TREATMENTS IN APPROVED RESEARCH TRIALS.—

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

(B) ROUTINE MEDICAL COSTS DEFINED.—In subparagraph (A), the term ''routine medical costs'' means the cost of health services required to provide treatment according to the design of the trial, except those costs normally paid for by other funding sources (as defined by the Secretary). Such costs do not include the

cost of the investigational agent, devices or procedures themselves, the costs of any nonhealth services that might be required for a person to receive the treatment, or the costs of managing the research.

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

(i) conducted for the primary purpose of determining the safety, effectiveness, efficacy, or health outcomes of a treatment, compared with the best available alternative treatment, and

(ii) approved by the Secretary.

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

(3) COVERAGE OF OFF-LABEL USE.—An off-label use for a drug that has been found to be safe and effective under section 505 of the Federal Food,

Drug, and Cosmetic Act shall be covered if the medical indication for which it is used is listed in one of the following 3 compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

(4) PREVENTIVE BENEFITS.—The following are preventive benefits that shall be covered without any deductibles, copayment, coinsurance, or other cost-sharing:

(A) NEWBORN, WELL-BABY AND WELL-CHILD CARE.—Newborn care, well-baby care, and well-child care for individuals under 19 years of age, including routine physical examinations, routine immunizations, and routine tests, as specified by the Secretary based on the schedule recommended by the American Academy of Pediatricians.

(B) MAMMOGRAMS.—Routine screening mammograms (including their interpretation), limited to 1 mammogram for a woman who is at least 35 (but less than 40) years of age, 1 mammogram every 2 years for a woman who is at least 40 (but less than 50) years of age, and

1 mammogram every year for a woman who is at least 50 years of age.

(C) SCREENING PAP SMEARS AND PELVIC EXAMS.—Screening pap smears and pelvic exams for women over 17 years of age, limited to 1 each year.

(D) COLORECTAL SCREENING.—Colorectal screening for individuals over 18 years of age at high risk, consisting of 1 fecal occult blood screening test every year, 1 screening sigmoidoscopy every 5 years, and 1 screening colonoscopy every 4 years.

(E) SCREENING TUBERCULIN TESTS.—Screening tuberculin tests annually for individuals at risk of contracting tuberculosis.

(F) PRENATAL CARE.—Prenatal care.

(G) ADULT IMMUNIZATIONS.—Routine immunizations for an individual over 17 years of age (including booster immunizations against tetanus and diphtheria, but limited to 1 such immunization every 10 years).

(H) PROSTATE CANCER SCREENING.—Routine cancer screening for a man who is at least 40 years of age through a prostate specific antigen test, limited to 1 test each year.

(c) STANDARD ACTUARIAL VALUE.—

(1) IN GENERAL.—The actuarial value of the benefits under standard coverage in a fair rating area meets the requirements of this subsection if such value is equivalent to the standard actuarial value described in paragraph (2) for the area. The actuarial value of benefits under standard coverage shall be determined using the adjustment under paragraph (3) for a standardized population and set of standardized utilization and cost factors.

(2) STANDARD ACTUARIAL VALUE DESCRIBED.—The standard actuarial value described in this paragraph for coverage in a geographic area is the actuarial value of benchmark coverage during 1994 in such area. Such actuarial value shall be determined using the adjustment under paragraph (3) for a standardized population and set of standardized utilization and cost factors and updated annually in accordance with section 1104(a).

(3) ADJUSTMENTS FOR STANDARDIZED POPULATION, STANDARDIZED UTILIZATION AND COST FACTORS, AND GEOGRAPHIC AREA.—The adjustment under this paragraph—

(A) for a standardized population shall be made by not taking into account individuals 65

years of age or older, employees of the United States Postal Service, retirees, and annuitants; and

(B)(i) except as provided in clause (ii), for a geographic area shall be made in a manner that reflects the ratio of the actuarial value of benchmark coverage in such geographic area (as adjusted under subparagraph (A)) to such actuarial value for such benchmark coverage for the United States as a whole, taking into account standardized actuarial utilization and cost factors, and

(ii) in the case of a group health plan operating in more than one geographic area, the ratio described in clause (i) shall be determined in accordance with regulations promulgated by the Secretary.

At the election of a group health plan under subparagraph (B)(ii), the ratio under such subparagraph shall be 1.

(d) MINIMUM REQUIREMENTS WITHIN A CATEGORY.—Benefits offered in any standard coverage within any category of benefits shall be not less than the narrowest scope and shortest duration of benefits within that category in any of the approved health benefits plans offered

under chapter 89 of title 5, United States Code (relating to Federal Employees Health Benefits Program) in 1994. Benefits offered in the standard plan within the category of preventive services shall not require payment of cost-sharing for covered items and services.

(e) NO COVERAGE OF SPECIFIC TREATMENT, PROCEDURES, OR CLASSES REQUIRED.—Nothing in this section (or section 1103) may be construed to require the coverage of any specific procedure or treatment or class of service in health coverage under this Act or through regulation.

(f) CONSTRUCTION.—Nothing in this section (or section 1103) shall be construed as requiring coverage to include benefits for items and services that are not medically necessary or appropriate.

SEC. 1103. HIGH-DEDUCTIBLE COVERAGE.

Health insurance coverage is considered to provide high-deductible coverage consistent with this section if—

(1) benefits under such coverage comply with—

(A) the requirements described in section 1102(b) (relating to required categories of covered benefits), and

(B) the requirements described in section 1102(d) (relating to minimum requirements within a category);

(2) the deductible amount is the amount established under section 1104(b)(1);

(3) benefits under the coverage in any year (other than preventive benefits described in section 1102(b)(4)) are covered only to the extent expenses incurred for items and services included in the coverage for the year exceed the deductible amount specified in paragraph (2); and

(4) the actuarial value of the coverage (as determined under rules consistent with section 1102(c)) is equivalent to 80 percent of the actuarial value established under such section for standard coverage.

SEC. 1104. ACTUARIAL VALUATION OF BENEFITS.

(a) IN GENERAL.—The Secretary, in consultation with the NAIC and the American Academy of Actuaries, shall establish (and may from time to time modify) procedures by which health insurance benefits are valued for purposes of this subtitle.

(b) DEDUCTIBLE; MODEL BENEFIT PACKAGES.—The Secretary, in consultation with the NAIC and the American Academy of Actuaries, shall establish—

(1) the deductible amount for high-deductible coverage for the purposes of section 1103(2) such that the actuarial value of high-deductible coverage

described in section 1103 is 20 percent less than the actuarial value of standard coverage described in section 1102(a); and

(2) model benefit packages that may be treated, for purposes of this title, as meeting the requirements for standard or high-deductible coverage under sections 1102(a) and 1103, respectively, and which shall include model cost sharing arrangements for fee-for-service options, managed care options, and point-of-service options.

SEC. 1105. LIMITATION ON OFFERING SUPPLEMENTAL BENEFITS.

A carrier or group health plan offering qualified health coverage may offer coverage of items and services only in addition to the qualified standard coverage offered (whether in the form of coverage of additional items and services or a reduction in cost sharing) and only if—

(1) such supplemental coverage is offered and priced separately from the standard coverage offered and is only made available to individuals who obtain qualified standard coverage through the carrier or plan;

(2) the purchase of the qualified health coverage is not conditioned upon the purchase of such supplemental coverage; and

(3) in the case of supplemental coverage that consists of a reduction in the cost-sharing otherwise applicable, the premium for the supplemental coverage takes into account any expected increase in utilization of items and services included in the qualified health coverage resulting from obtaining the supplemental coverage.

SEC. 1106. FAMILY COVERAGE OPTION; SUPPLEMENTAL COVERAGE.

(a) FAMILY COVERAGE OPTION.—Each carrier and group health plan that offers health insurance coverage shall provide for an option under which children under 26 years of age (without regard to whether they are full-time students or disabled) will be treated (with respect to family coverage) as family members. The carrier or plan may impose an additional premium for such option.

(b) CONSTRUCTION.—Nothing in this title shall be construed as limiting the benefits that may be offered as part of a group health plan or health insurance coverage.

SEC. 1107. LEVEL PLAYING FIELD FOR PROVIDERS.

(a) IN GENERAL.—Nothing in this subtitle may be construed to require or prohibit the use of a particular class of provider, among the providers that are legally authorized to provide such treatment.

(b) COVERAGE OF CERTAIN OTHER PROVIDERS.—

(1) IN GENERAL.—For purposes of this subtitle, benefits under standard coverage shall include the following:

(A) Coverage provided at an individual's home by a Christian Science practitioner or Christian Science nurse.

(B) Coverage provided in a Christian Science Sanitorium (as defined in section 1861(y) of the Social Security Act), including coverage provided by a Christian Science practitioner.

(2) QUALIFICATIONS OF PROVIDERS.—A Christian Science practitioner or Christian Science nurse is qualified for purposes of paragraph (1) if the practitioner or nurse is listed as such a practitioner or nurse by the First Church of Christ, Scientist, in Boston, Massachusetts.

Subtitle C—Employer Responsibilities

SEC. 1201. REQUIRING EMPLOYERS TO OFFER OPTION OF COVERAGE.

(a) IN GENERAL.—Subject to subsections (c) and (d), each employer shall make available with respect to each qualifying employee qualified health coverage under a group health plan (whether fully-insured or self-insured)

which meets the following requirements (and the applicable requirements of subtitle A):

(1) ANNUAL OFFERING.—The employee may elect health coverage for the employee and family members on an annual basis for each plan year and at such other times as may be specified by the Secretary of Labor, in a manner consistent with the standards established to carry out section 1105.

(2) CHOICE OF COVERAGE.—

(A) IN GENERAL.—Subject to subsection (c) and subparagraph (G), such coverage is provided for at least—

(i) a competing choice of qualified standard coverage (consistent with section 1102(a)), including at least one option (either a fee-for-service option or a point-of-service option) that permits covered individuals to obtain benefits through an unrestricted choice of the lawful providers for which benefits are made available; and

(ii) high-deductible coverage (consistent with section 1103).

(B) COVERAGE FLOOR.—With respect to any health coverage (other than coverage for

supplemental benefits or qualified standard coverage) offered under the group health plan—

(i) the coverage shall meet the requirements specified in paragraphs (1) and (3) of section 1102(a), and

(ii) the actuarial value of such coverage shall not be less than the actuarial value of high-deductible coverage.

(C) DISCLOSURE FOR CERTAIN COVERAGE.—If an employer offers, in addition to the coverage required to be offered under subparagraph (A), coverage the actuarial value of which is more than the actuarial value for high-deductible coverage but less than such value for standard coverage, the employer must disclose to the employees detailed information on how the coverage offered compares to the standard and high-deductible coverage offered by the employer.

(D) USE OF STANDARDIZED FACTORS.—For purposes of this paragraph, the actuarial value of coverage shall be determined using the standardized population and standardized utilization and cost factors described in section 1102(c)(3).

(E) FAMILY COVERAGE OPTION.—The offer of coverage under this section with respect to a qualifying employee shall include the option of coverage of family members of the employee.

(F) ANNUAL ENROLLMENT PERIOD FOR CHOICE OF COVERAGE.—The group health plan provides, with respect to any qualifying employee, a single annual open enrollment period (of not less than 30 days) in which the employee may choose among the coverage options required under this paragraph.

(G) LIMITATION ON OFFER OF HIGH-DEDUCTIBLE COVERAGE.—Qualified high-deductible coverage may not be made available under a group health plan with respect to an employee unless the employee demonstrates to the plan administrator that the employee has available assets (as defined by the Secretary) equal to at least the deductible amount established under section 1104(b)(1) applicable to the high-deductible coverage.

(3) PAYROLL WITHHOLDING.—The employee electing such coverage may elect to have any premiums owed by the employee collected through payroll deduction.

(4) NONDISCRIMINATION IN CONTRIBUTIONS BASED ON PRICE OF COVERAGE SELECTED WITH RESPECT TO INDIVIDUAL EMPLOYEES.—

(A) IN GENERAL.—The employer may not vary the dollar amount of any employer contribution, within a class of family coverage, with respect to such coverage for an individual employee, solely on the basis of the total premium price of the coverage selected by the employee.

(B) SPECIAL RULES.—In applying subparagraph (A)—

(i) the ''total premium price'' shall include, in the case of high-deductible coverage, amounts paid by an employer into a medical savings account (established under section 7705 of the Internal Revenue Code of 1986); and

(ii) if the employee selects health coverage the premium for which is less than the amount of the employer contribution, the employer shall pay the amount of such difference to the employee (or, at the employee's option in the case of an employee who has high-deductible coverage, to such a medical savings account).

(b) NO EMPLOYER MANDATE.—Subject to subsection (a)(4) (relating to equal contribution rule), an employer is not required under this section to make any contribution to the cost of health coverage.

(c) GRANDFATHER FOR EXISTING COLLECTIVE BARGAINING AGREEMENTS.—

(1) IN GENERAL.—The requirement of subsection (a)(2) shall not apply to a group health plan for a plan year if—

(A) the group health plan is in effect in the plan year in which July 1, 1994, occurs, and

(B) the employer makes (or offers to make), in such plan year and the plan year involved, a contribution to the plan on behalf of each employee who is eligible to participate in the plan under a collective bargaining agreement or similar contract.

(2) SUNSET.—Paragraph (1) shall only apply to a group health plan until the expiration of the collective bargaining agreement or similar contract in effect on the date of the enactment of this Act or, if earlier, January 1, 2000.

(d) SPECIAL RULES.—

(1) EMPLOYERS CONTRACTING WITH HEALTH PLAN PURCHASING ORGANIZATIONS, ETC.—An employer is deemed to have satisfied the requirements of subsection (a) with respect to an employee if the employer enters into a contract with a health plan purchasing organization (established under subtitle A of title VI), a small employer pooling arrangement (described in section 711 of the Employee Retirement Income Security Act of 1974), a multiemployer plan providing health benefits, or a certified multiple employer health plan (as defined in section 701(9) of the Employee Retirement Income Security Act of 1974) to offer coverage with respect to the employee.

(2) EXCLUSION OF NEW EMPLOYERS AND CERTAIN SMALL EMPLOYERS.—Subsection (a) shall not apply to any small employer for any plan year if, as of the beginning of such plan year—

(A) such employer (including any predecessor thereof) has been an employer for less than 1 year,

(B) such employer has no more than 2 qualifying employees, or

(C) no more than 2 qualifying employees of the employer are not covered under any group health plan.

(3) EXCLUSION OF FAMILY MEMBERS.—Under such procedures as the Secretary may prescribe, any relative of an employer may be, at the election of the employer, excluded from consideration as a qualifying employee for purposes of applying the requirements of subsection (a). In the case of an employer that is not an individual, an employee who is a relative of a key employee (as defined in section 416(i)(1) of the Internal Revenue Code of 1986) of the employer may, at the election of the key employee, be considered a relative excludable under this paragraph.

(e) CONSTRUCTION ON RANGE OF COVERAGE OFFERINGS.—Nothing in this section shall be construed—

(1) as limiting the number of standard and high-deductible coverage options that an employer may offer to an employee,

(2) as preventing employers from offering supplemental coverage described in section 1105, or

(3) as preventing an employer from providing for contributions to a medical savings account in connection with the offering of high-deductible coverage, subject to subsection (a)(4) and the requirements of section 7705 of the Internal Revenue Code of 1986.

SEC. 1202. NONDISCRIMINATION UNDER GROUP HEALTH PLANS.

(a) APPLICATION OF RULES SIMILAR TO MEDICARE NONDISCRIMINATION RULES.—The provisions of paragraphs (1)(A), (1)(D), (1)(E), (3)(A), and (3)(C) of section 1862(b) of the Social Security Act shall apply to a premium or cost-sharing assistance eligible individual under part A of title XXI of such Act in relation to an employer in the same manner as such provisions apply to an individual age 65 or over who is entitled to benefits under title XVIII of such Act under section 226(a) of such Act in relation to such employer.

(b) RULES OF APPLICATION.—In applying subsection (a)—

(1) in applying clauses (ii) and (iii) of section 1862(b)(1)(A) of the Social Security Act, any reference to ''20 or more employees'' is deemed a reference to ''5 or more employees'';

(2) clause (iv) of section 1862(b)(1)(A) of such Act shall not apply; and

(3) any reference to title XVIII of such Act is deemed a reference to assistance under part A of title XXI of such Act (as added by subtitle A of title II of this Act).

(c) ENFORCEMENT.—

(1) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to excise taxes on qualified pension, etc. plans) is amended by inserting after section 5000 the following new section:

"SEC. 5000A. EMPLOYER REQUIREMENTS.

''(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any employer to comply with the requirements of section 1201 and section 1202 of the Bipartisan Health Care Reform Act of 1994.

''(b) AMOUNT OF TAX.—The amount of tax imposed by subsection (a) shall be equal to $100 for each day for each individual for which such a failure occurs.

''(c) LIMITATION ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the 1st date any of the individuals on whom the tax is imposed knew, or exercising reasonable dili-

gence would have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.''.

(2) CLERICAL AMENDMENT.—The table of sections for such chapter 47 is amended by adding at the end the following new item:

''Sec. 5000A. Employer requirements.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 1997.

SEC. 1203. EFFECTIVE DATES.

Except as otherwise provided, the requirements of sections 1201 and 1202 shall apply to plan years beginning after December 31, 1996.

Subtitle D—Standards and Certification; Enforcement; Preemption; General Provisions

SEC. 1301. ESTABLISHMENT OF STANDARDS.

(a) ROLE OF NAIC.—

(1) IN GENERAL.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, model regulations that specify standards with respect to the requirements of this subtitle as applicable to carriers and health insurance coverage.

(2) REVIEW OF STANDARDS.—If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirements, such standards shall serve as the standards under this subtitle, with such amendments as the Secretary deems necessary.

(b) CONTINGENCY.—If the NAIC does not develop such model regulations within such period or the Secretary determines that such regulations do not specify standards that meet the requirements described in subsection (a), the Secretary shall specify, within 15 months after the date of the enactment of this Act, standards to carry out those requirements.

SEC. 1302. APPLICATION OF STANDARDS TO CARRIERS THROUGH STATES.

(a) APPLICATION OF STANDARDS.—

(1) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in paragraph (2), a report on steps the State is taking to implement and enforce the standards established under section 1301 with respect to carriers and health insurance coverage offered or renewed not later than such deadline.

(2) DEADLINE FOR REPORT.—The deadline under this paragraph is 1 year after the date the standards are established under section 1301.

(b) FEDERAL ROLE.—

(1) NOTICE OF DEFICIENCY.—If the Secretary determines that a State has failed to submit a report by the deadline specified under subsection (a)(2) or finds that the State has not implemented and provided adequate enforcement of the standards established under section 1301, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards.

(2) IMPLEMENTATION OF ALTERNATIVE.—

(A) IN GENERAL.—If, after such 60-day period, the Secretary finds that such a failure

has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards in the State as the Secretary determines to be appropriate.

(B) EFFECTIVE PERIOD.—Such implementation and enforcement shall take effect with respect to carriers, and health insurance coverage offered or renewed, on or after 3 months after the date of the Secretary's finding under subparagraph (A), and until the date the Secretary finds that such a failure has been corrected.

SEC. 1303. APPLICATION TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Subject to subsection (b), sections 1301 and 1302 shall apply to group health plans providing health coverage in the same manner as they apply to carriers providing health insurance coverage.

(b) SUBSTITUTION OF REFERENCES.—For purposes of subsection (a), any reference in section 1301 or 1302 to—

(1) a State or the Secretary of Health and Human Services is deemed a reference to the Secretary of Labor, and

(2) a carrier or health insurance coverage is deemed a reference to a group health plan and health coverage, respectively.

SEC. 1304. ENFORCEMENT.

(a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR EMPLOYERS AND GROUP HEALTH PLANS.—

(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of this title insofar as they relate to group health plans or employers shall be deemed to be provisions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor under this subtitle pursuant to paragraph (1), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

(b) ENFORCEMENT BY EXCISE TAX FOR CARRIERS.—

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

"SEC. 4980C. FAILURE OF CARRIER TO COMPLY WITH HEALTH INSURANCE STANDARDS.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of a carrier to comply with the requirements applicable to the carrier under parts 1 through 4 of subtitle A and subtitle B of title I of the Bipartisan Health Care Reform Act of 1994.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by a carrier in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such a carrier.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each individual to which such failure relates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

''(2) LIMITATION.—The amount of the tax imposed by subsection (a) for a carrier with respect to health insurance coverage shall not exceed 25 percent of the amounts received for such coverage during the period such failure persists.

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

''(d) EXCEPTIONS.—

''(1) CORRECTIONS WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) by reason of any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected within the 30-day period beginning on the earliest date the carrier knew, or exercising reasonable diligence would have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of such tax would be excessive relative to the failure involved.

''(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance coverage' and 'carrier' have the respective meanings given such terms in section 1903 of the Bipartisan Health Care Reform Act of 1994.''

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

''Sec. 4980C. Failure of carrier to comply with health insurance standards.''

SEC. 1305. LIMITATION ON SELF INSURANCE FOR SMALL EMPLOYERS.

A single employer plan (as defined in section 3(40)(B) of the Employee Retirement Income Security Act of 1974) may not offer health coverage other than through a carrier unless the plan has at least 100 eligible employees.

Subtitle E—Multiple Employer Health Benefits Protections and Related Provisions

PART 1—MULTIPLE EMPLOYER HEALTH BENEFITS PROTECTIONS

SEC. 1401. LIMITED EXEMPTION FROM CERTAIN RESTRICTIONS ON ERISA PREEMPTION OF STATE LAW FOR HEALTH PLANS MAINTAINED BY MULTIPLE EMPLOYERS SUBJECT TO CERTAIN FEDERAL STANDARDS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

''PART 7—MULTIPLE EMPLOYER HEALTH PLANS

''SEC. 701. DEFINITIONS.

''For purposes of this part—

''(1) INSURER.—The term 'insurer' means an insurance company, insurance service, or insurance organization, licensed to engage in the business of insurance by a State.

''(2) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the dependents of its employees, are or were covered under such arrangement in connection with the employment of the employees.

''(3) EXCESS/STOP LOSS COVERAGE.—The term 'excess/stop loss coverage' means, in connection with a multiple employer welfare arrangement, a contract under which an insurer provides for payment with respect to claims under the arrangement, relating to participants or beneficiaries individually or otherwise, in excess of an amount or amounts specified in such contract.

''(4) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

''(5) SPONSOR.—The term 'sponsor' means, in connection with a multiple employer welfare arrangement, the association or other entity which establishes or maintains the arrangement.

''(6) STATE INSURANCE COMMISSIONER.—The term 'State insurance commissioner' means the insurance commissioner (or similar official) of a State.

''(7) DOMICILE STATE.—The term 'domicile State' means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for a certification under this part, most individuals to be covered under the arrangement are located, except that, in any case in which information contained in the latest annual report of the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different State.

''(8) FULLY INSURED.—Coverage under a multiple employer welfare arrangement is 'fully insured' if one or more insurers, health maintenance organizations, similar organizations regulated under State law for solvency, or any combination thereof are liable under one or more insurance policies or contracts for all benefits under the arrangement (irrespective

of any recourse they may have against other parties).

''(9) CERTIFIED MULTIPLE EMPLOYER HEALTH PLAN.—The term 'certified multiple employer health plan' means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of certification under this part.

"SEC. 702. CERTIFIED MULTIPLE EMPLOYER HEALTH PLANS RELIEVED OF CERTAIN RESTRICTIONS ON PREEMPTION OF STATE LAW AND TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.

''(a) IN GENERAL.—Subject to subsection (b), a multiple employer welfare arrangement under which coverage is not fully insured and with respect to which there is in effect a certification granted by the Secretary under this part (or with respect to which there is pending a complete application for such a certification and the Secretary determines that provisional protection under this part is appropriate)—

''(1) shall be treated for purposes of subtitle A and the preceding parts of this subtitle as an employee welfare benefit plan, irrespective of whether such arrangement is an employee welfare benefit plan, and

''(2) shall be exempt from section 514(b)(6)(A)(ii).

''(b) BENEFITS MUST CONSIST OF MEDICAL CARE.—Subsection (a) shall apply to a multiple employer welfare arrangement only if the benefits provided thereunder consist solely of medical care described in section 607(1) (disregarding such incidental benefits as the Secretary shall specify by regulation).

"SEC. 703. CERTIFICATION PROCEDURE.

''(a) IN GENERAL.—The Secretary shall grant a certification described in section 702(a) to a multiple employer welfare arrangement if—

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

''(2) such application demonstrates compliance with the requirements of section 704 with respect to such arrangement, and

''(3) the Secretary finds that such certification is—

''(A) administratively feasible,

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

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

''(b) NOTICE AND HEARING.—Before granting a certification under this section, the Secretary shall publish notice in the Federal Register of the pendency of the certification, shall require that adequate notice be given to interested persons, including the State insurance commissioner of each State in which covered individuals under the arrangement are, or are expected to be, located, and shall afford interested persons opportunity to present views. The Secretary may not grant a certification under this section unless the Secretary affords an opportunity for a hearing and makes a determination on the record with respect to the findings required under subsection (a)(3). The Secretary shall, to the maximum extent practicable, make a final determination with respect to any application filed under this section in the case of a newly established arrangement within 90 days after the date which the Secretary determines is the date on which such application is filed in complete form.

"SEC. 704. ELIGIBILITY REQUIREMENTS.

''(a) APPLICATION FOR CERTIFICATION.—

''(1) IN GENERAL.—A certification may be granted by the Secretary under this part only on the

basis of an application filed with the Secretary in such form and manner as shall be prescribed in regulations of the Secretary. Any such application shall be signed by the operating committee and the sponsor of the arrangement.

''(2) FILING FEE.—The arrangement shall pay to the Secretary at the time of filing an application under this section a filing fee in the amount of $5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the certification procedures under this part.

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

''(A) IDENTIFYING INFORMATION.—The names and addresses of—

''(i) the sponsor, and

''(ii) the members of the operating committee of the arrangement.

''(B) STATES IN WHICH ARRANGEMENT INTENDS TO DO BUSINESS.—The States in which individuals covered under the arrangement are

to be located and the number of such individuals expected to be located in each such State.

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

''(D) PLAN DOCUMENTS.—A copy of the documents governing the arrangement (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits and coverage that will be provided to individuals covered under the arrangement.

''(E) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the arrangement and contract administrators and other service providers.

''(F) FUNDING REPORT.—A report setting forth information determined as of a date within the 120-day period ending with the date of the application, including the following:

''(i) RESERVES.—A statement, certified by the operating committee of the arrangement, and a statement of actuarial opinion, signed by a qualified actuary, that

all applicable requirements of section 707 are or will be met in accordance with regulations which the Secretary shall prescribe.

''(ii) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the arrangement for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the arrangement. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(iii) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the arrangement and a pro-

jection of the assets, liabilities, income, and expenses of the arrangement for the 12-month period referred to in clause (ii). The income statement shall identify separately the arrangement's administrative expenses and claims.

''(iv) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the arrangement.

''(v) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

''(b) OTHER REQUIREMENTS.—A complete application for a certification under this part shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

''(1) SPONSOR.—

''(A) IN GENERAL.—Subject to subparagraph (B), the sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care described in section 607(1), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members.

''(B) SPECIAL RULE FOR EMPLOYERS IN THE SAME TRADE OR BUSINESS.—In the case of an arrangement under which all participating employers are engaged in a common type of trade or business, the sponsor is the operating committee of the arrangement.

''(2) OPERATING COMMITTEE.—The arrangement is operated, pursuant to a trust agreement, by an operating committee which has complete fiscal

control over the arrangement and which is responsible for all operations of the arrangement, and the operating committee has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the committee are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the committee if they constitute not more than 25 percent of the membership of the committee and they do not provide services to the arrangement other than on behalf of the sponsor. The committee has sole authority to approve applications for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

''(3) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the arrangement include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the committee serves as the named fiduciary required for plans under such section and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

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

''(C) incorporates the requirements of section 707, and

''(D) provides that, effective upon the granting of a certification under this part—

''(i) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an em-

ployer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

''(ii) all individuals thereafter commencing coverage under the arrangement must be—

''(I) active or retired owners, officers, directors, or employees of, or partners in, participating employers, or

''(II) the beneficiaries of individuals described in subclause (I).

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

''(5) OPTION OF FAMILY COVERAGE.—If the arrangement provides for coverage with respect to an employee, the arrangement shall make available the option of coverage of family members of the individual (as defined in section 1901(2) of the Bipartisan Health Care Reform Act of 1994).

''(6) MISCELLANEOUS REQUIREMENTS.—(A) The requirements of the title I of the Bipartisan

Health Care Reform Act of 1994 (insofar as they apply to group health plans), including the following:

''(i) Section 1003(c) (relating to guaranteed renewal).

''(ii) Section 1004 (relating to restricting preexisting condition exclusions).

''(iii) Section 1005 (relating to choice of coverage through open enrollment).

''(iv) Section 1011 (relating to standards for managed care arrangements).

''(v) Section 1012 (relating to utilization review).

''(vi) Section 1013 (relating to standards for essential community providers).

''(vii) Section 1021(d) (relating to use of fair rating practices).

''(viii) Section 1022 (relating to coordination with premium assistance certificate program).

''(B) The requirements of section 1023 of the Bipartisan Health Care Reform Act of 1994 (relating to establishment of risk adjustment mechanisms) insofar as such requirements apply to carriers but only with respect to covered individuals in the individual/small group market.

''(7) REGULATORY REQUIREMENTS.—Such other requirements as the Secretary may prescribe by regulation as necessary to carry out the purposes of this part.

''(c) TREATMENT OF PARTY SEEKING CERTIFICATION WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

''(1) IN GENERAL.—In the case of any application for a certification under this part with respect to a multiple employer welfare arrangement, if the Secretary determines that the sponsor of the arrangement or any other person associated with the arrangement is subject to disqualification under paragraph (2), the Secretary may deny the certification with respect to such arrangement.

''(2) DISQUALIFICATION.—A person is subject to disqualification under this paragraph if such person—

''(A) has intentionally made a material misstatement in the application for certification;

''(B) has obtained or attempted to obtain a certification under this part through misrepresentation or fraud;

''(C) has misappropriated or converted to such person's own use, or improperly withheld, money held under a plan or any multiple employer welfare arrangement;

''(D) is prohibited (or would be prohibited if the arrangement were a plan) from serving in any capacity in connection with the arrangement under section 411;

''(E) has failed to appear without reasonable cause or excuse in response to a subpoena, examination, warrant, or any other order lawfully issued by the Secretary compelling such response;

''(F) has previously been subject to a determination under this part resulting in the denial, suspension, or revocation of a certification under this part on similar grounds; or

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

''(d) FRANCHISE NETWORKS.—In the case of a multiple employer welfare arrangement established and maintained by a franchisor for a franchise network consisting

of its franchisees, such franchisor shall be treated as the sponsor referred to in the preceding provisions of this section, such network shall be treated as an association referred to in such provisions, and each franchisee shall be treated as a member (of the association and the sponsor) referred to in such provisions, if all participating employers are such franchisees and the requirements of subsection (b)(1) with respect to a sponsor are met with respect to the network.

''(e) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In applying the preceding provisions of this section in the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but for the failure to meet any requirement of section 3(40)(C)—

''(1) paragraphs (1) and (2) of subsection (b) and subparagraphs (A), (B), and (D) of paragraph (3) of subsection (b) shall be disregarded, and

''(2) the joint board of trustees shall be considered the operating committee of the arrangement.

''(f) CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

''(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple employer welfare arrangement are employees of a

single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer, subsection (b)(3)(D) shall be disregarded.

''(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are 'related' if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

"SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO CERTIFIED MULTIPLE EMPLOYER HEALTH PLANS.

''(a) NOTICE OF MATERIAL CHANGES.—In the case of any certified multiple employer health plan, descriptions of material changes in any information which was required to be submitted with the application for the certification granted under this part shall be filed in such form and manner as shall be prescribed in regulations of the Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(b) REPORTING REQUIREMENTS.—Under regulations of the Secretary, the requirements of sections 102,

103, and 104 shall apply with respect to any multiple employer welfare arrangement which is or has been a certified multiple employer health plan in the same manner and to the same extent as such requirements apply to employee welfare benefit plans, irrespective of whether such certification continues in effect. The annual report required under section 103 for any plan year in the case of any such multiple employer welfare arrangement shall also include information described in section 704(a)(3)(F) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year.

''(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The operating committee of each multiple employer welfare arrangement which is or has been a certified multiple employer health plan shall engage, on behalf of all covered individuals, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the arrangement and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the arrangement.

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

''(d) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted to a multiple employer welfare arrangement under this part shall not be effective unless written notice of such certification is filed with the State insurance commissioner of each State in which at least 5 percent of the individuals covered under the arrangement are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed. The Secretary may by regulation provide in specified cases for the application of the preceding sentence with lesser percentages in lieu of such 5 percent amount.

"SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY ARRANGEMENTS PROVIDING MEDICAL CARE.

''(a) IN GENERAL.—A multiple employer welfare arrangement providing benefits consisting of medical care

described in section 607(1) shall issue to each participating employer—

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

''(2) information describing the contribution rates applicable to participating employers, and

''(3) a statement indicating—

''(A) that the arrangement is not a licensed insurer under the laws of any State,

''(B) whether coverage under the arrangement is fully insured, and

''(C) if coverage under the arrangement if not fully insured, (i) whether the arrangement is (or has ceased to be) a certified multiple employer health plan, and (ii) if such an arrangement is a certified multiple employer health plan, that such arrangement is treated as an employee welfare benefit plan under this title.

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

"SEC. 707. MAINTENANCE OF RESERVES.

''(a) IN GENERAL.—Each multiple employer welfare arrangement which is or has been a certified multiple em-

ployer health plan and under which coverage is not fully insured shall establish and maintain such excess/stop loss coverage as the Secretary considers appropriate and shall establish and maintain reserves, consisting of—

''(1) a reserve for unearned contributions,

''(2) a reserve for payment of claims reported and not yet paid and claims incurred but not yet reported, and for expected administrative costs with respect to such claims, and

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

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

''(c) REQUIRED MARGIN.—In determining the amounts of reserves required under this section in connection with any multiple employer welfare arrangement, the qualified actuary shall include a margin for error and other fluctuations taking into account the specific circumstances of such arrangement.

''(d) ADDITIONAL REQUIREMENTS.—The Secretary may provide such additional requirements relating to reserves and excess/stop loss coverage as the Secretary con-

siders appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any arrangement or any class of arrangements.

''(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COVERAGE.—The Secretary may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such arrangement or arrangements.

''(f) ALTERNATIVE MEANS OF COMPLIANCE.—The Secretary may permit an arrangement to substitute, for all or part of the reserves required under subsection (a), such security, guarantee, or other financial arrangement as the Secretary determines to be adequate to enable the arrangement to fully meet all its financial obligations on a timely basis.

"SEC. 708. CORRECTIVE ACTIONS.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—A multiple employer welfare arrangement with respect to which there is or has been in effect a certification granted under this part shall continue to meet the requirements of section 707, irrespective of whether such certification continues in effect. The operating committee of such arrangement shall determine semiannually wheth-

er the requirements of section 707 are met. In any case in which the committee determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination and so notifies the committee, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the end of the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with section 707. Not later than 10 days after receiving from the actuary recommendations for corrective actions, the committee shall notify the Secretary (in such form and manner as the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the committee has taken or plans to take in response to such recommendations. The committee shall thereafter report to the Secretary, in such form and frequency as the Secretary may specify to the committee, regarding corrective action taken by the committee until the requirements of section 707 are met.

''(b) TERMINATION.—

''(1) NOTICE OF TERMINATION.—In any case in which the operating committee of a multiple em-

ployer welfare arrangement which is or has been a certified multiple employer health plan determines that there is reason to believe that the arrangement will terminate, the committee shall so inform the Secretary, shall develop a plan for winding up the affairs of the arrangement in connection with such termination in a manner which will result in timely payment of all benefits for which the arrangement is obligated, and shall submit such plan in writing to the Secretary. Actions required under this paragraph shall be taken in such form and manner as may be prescribed in regulations of the Secretary.

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

''(A) the Secretary has been notified under subsection (a) of a failure of a multiple employer welfare arrangement which is or has been a certified multiple employer health plan to meet the requirements of section 707 and has not been notified by the operating committee of the arrangement that corrective action has restored compliance with such requirements, and

''(B) the Secretary determines that the continuing failure to meet the requirements of

section 707 can be reasonably expected to result in a continuing failure to pay benefits for which the arrangement is obligated,

the operating committee of the arrangement shall, at the direction of the Secretary, terminate the arrangement and, in the course of the termination, take such actions as the Secretary may require as necessary to ensure that the affairs of the arrangement will be, to the maximum extent possible, wound up in a manner which will result in timely payment of all benefits for which the arrangement is obligated.

"SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF CERTIFICATION.

''(a) EXPIRATION AND RENEWAL OF CERTIFICATION.—A certification granted to a multiple employer welfare arrangement under this part shall expire 3 years after the date on which the certification is granted. A certification which has expired may be renewed by means of application for a certification in accordance with section 704.

''(b) SUSPENSION OR REVOCATION OF CERTIFICATION BY SECRETARY.—The Secretary may suspend or revoke a certification granted to a multiple employer welfare arrangement under this part—

''(1) for any cause that may serve as the basis for the denial of an initial application for such a certification under section 704, or

''(2) if the Secretary finds that—

''(A) the arrangement, or the sponsor thereof, in the transaction of business while under the certification, has used fraudulent, coercive, or dishonest practices, or has demonstrated incompetence, untrustworthiness, or financial irresponsibility,

''(B) the arrangement, or the sponsor thereof, is using such methods or practices in the conduct of its operations, so as to render its further transaction of operations hazardous or injurious to participating employers, or covered individuals,

''(C) the arrangement, or the sponsor thereof, has refused to be examined in accordance with this part or to produce its accounts, records, and files for examination in accordance with this part, or

''(D) any of the officers of the arrangement, or the sponsor thereof, has refused to give information with respect to the affairs of the arrangement or the sponsor or to perform

any other legal obligation relating to such an examination when required by the Secretary in accordance with this part.

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

''(c) SUSPENSION OR REVOCATION OF CERTIFICATION UNDER COURT PROCEEDINGS.—A certification granted to a multiple employer welfare arrangement under this part may be suspended or revoked by a court of competent jurisdiction in an action by the Secretary brought under paragraph (2), (5), or (6) of section 502(a), except that the suspension or revocation under this subsection shall be effective only upon notification of the Secretary of such suspension or revocation.

''(d) NOTIFICATION OF PARTICIPATING EMPLOYERS.—All participating employers in a multiple employer welfare arrangement shall be notified of the expiration, suspension, or revocation of a certification granted to such arrangement under this part, by such persons and in such form and manner as shall be prescribed in regulations of the Secretary, not later than 20 days after such expiration or after receipt of notice of a final decision requiring such suspension or revocation.

''(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS, AND REVOCATIONS.—The Secretary shall publish all expirations of, and all final decisions to suspend or revoke, certifications granted under this part.

"SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.

''(a) IN GENERAL.—Any decision by the Secretary which involves the denial of an application by a multiple employer welfare arrangement for a certification under this part or the suspension or revocation of such a certification shall contain a statement of the specific reason or reasons supporting the Secretary's action, including reference to the specific terms of the certification and the statutory provision or provisions relevant to the determination.

''(b) DENIALS OF APPLICATIONS.—In the case of the denial of an application for a certification under this part, the Secretary shall send a copy of the decision to the applicant by certified or registered mail at the address specified in the records of the Secretary. Such decision shall constitute the final decision of the Secretary unless the arrangement, or any party that would be prejudiced by the decision, files a written appeal of the denial within 30 days after the mailing of such decision. The Secretary may affirm, modify, or reverse the initial decision. The decision on appeal shall become final upon the mailing of a copy

by certified or registered mail to the arrangement or party that filed the appeal.

''(c) SUSPENSIONS OR REVOCATIONS OF CERTIFICATION.—In the case of the suspension or revocation of a certification granted under this part, the Secretary shall send a copy of the decision to the arrangement by certified or registered mail at its address, as specified in the records of the Secretary. Upon the request of the arrangement, or any party that would be prejudiced by the suspension or revocation, filed within 15 days of the mailing of the Secretary's decision, the Secretary shall schedule a hearing on such decision by written notice, sent by certified or registered mail to the arrangement or party requesting such hearing. Such notice shall set forth—

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

''(2) a specific place for the hearing, which shall be in the District of Columbia or in the State and county thereof (or parish or other similar political subdivision thereof) in which is located the arrangement's principal place of business.

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

"SEC. 711. SMALL EMPLOYER POOLING ARRANGEMENTS.

''(a) REQUIREMENTS FOR SEPAS APPLICABLE WHERE SIGNIFICANT NUMBER OF SMALL EMPLOYERS PARTICIPATE.—In any case in which coverage is provided for the current plan year under a multiple employer health plan and more than 10 percent of the participating employers in the arrangement are small employers (as defined in section 1902 of the Bipartisan Health Care Reform Act of 1994), the entity sponsoring such arrangement shall ensure that such arrangement is maintained for such year in the form of a small employer pooling arrangement.

''(b) REQUIREMENTS FOR SMALL EMPLOYER POOLING ARRANGEMENTS.—For purposes of this part, an arrangement is maintained in the form of a small employer pooling arrangement for any applicable fiscal year, if—

''(1) the benefits under the arrangement consist solely of medical care described in section 607(1) (disregarding such incidental benefits as the Secretary of Labor shall specify by regulations),

''(2) the general requirements of subsection (c) are met with respect to the arrangement, and

''(3) the arrangement constitutes a certified multiple employer health plan under this part and the requirements of subsection (c) are met with respect to the arrangement.

''(c) REQUIREMENTS FOR ARRANGEMENTS PROVIDING SELF-INSURED COVERAGE.—

''(1) IN GENERAL.—The requirements of this subsection with respect to a small employer purchasing arrangement are as follows:

''(A) The arrangement meets the guaranteed issue requirements specified in paragraph (2).

''(B) The arrangement participates in any risk adjustment mechanisms established under section 1023 of the Bipartisan Health Care Reform Act of 1994.

''(C) Under the arrangement, with respect to all participating employers as of the beginning of each plan year, the total number of eligible employees is not less than 100.

''(2) REQUIRED SCOPE OF ELIGIBILITY FOR PARTICIPATING EMPLOYERS.—

''(A) IN GENERAL.—Under the terms of the written instruments governing the arrangement, all restrictions on the eligibility of em-

ployers to be participating employers in the arrangement are specifically set forth and consist solely of criteria described in subparagraph (B), and all employers with respect to whom such criteria are met may be participating employers. No such restrictions under the arrangement shall be considered enforceable unless they are so specified.

''(B) CRITERIA FOR RESTRICTIONS ON PARTICIPATING EMPLOYERS.—The terms of the arrangement shall define restrictions on eligibility of employers to be participating employers only by reference to one or more of the following criteria:

''(i) Participating employers are restricted to those located in one or more specified geographic locations.

''(ii) Participating employers are restricted to those who are (or whose owners, officers, or employees are) members of one or more trade associations, industry associations, professional associations, or chambers of commerce (or similar business groups).

''(iii) Participating employers are restricted to those who are otherwise related by specified supply contracts, franchise arrangements, or common ownership interests.

''(iv) Participating employers are restricted to employers whose employees are covered under one or more specified collective bargaining agreements.

''(d) REFERENCE TO LIMITATION ON SELF-INSURANCE BY SMALL EMPLOYERS.—For restriction on self-insurance by small employers, see section 1305 of the Bipartisan Health Care Reform Act of 1994.''.

(b) CONFORMING AMENDMENT TO DEFINITION OF PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 1002(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes the sponsor (as defined in section 701(5)) of a multiple employer welfare arrangement which is or has been a certified multiple employer health plan (as defined in section 701(9)).''.

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

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

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

''PART 7—MULTIPLE EMPLOYER HEALTH PLANS

''Sec. 701. Definitions.
''Sec. 702. Certified multiple employer health plans relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.
''Sec. 703. Certification procedure.
''Sec. 704. Eligibility requirements.
''Sec. 705. Additional requirements applicable to certified multiple employer health plans.
''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 certification.
''Sec. 710. Review of actions of the Secretary.
''Sec. 711. Small employer pooling arrangement.''.

SEC. 1402. CLARIFICATION OF SCOPE OF PREEMPTION RULES.

(a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting '', but only, in the case of an arrangement which provides medi-

cal care described in section 607(1) and with respect to which a certification under part 7 is not in effect,'' before ''to the extent not inconsistent with the preceding sections of this title''.

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

''(E) For additional rules relating to exemption from subparagraph (A)(ii) of multiple employer welfare arrangements providing medical care, see part 7.''.

SEC. 1403. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement,'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''common control'';

(2) in clause (iii), by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum inter-

est necessary for common control'', and by striking ''and'' at the end;

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi); and

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

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, at the time the determination under clause (i) is made, the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 95 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 1404. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

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

''(i) under or pursuant to one or more collective bargaining agreements,''.

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

''(C) Clause (i) of subparagraph (A) shall apply only if—

''(i) the plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement, or

''(II) pay a commission or any other type of compensation to a person that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement,

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

''(I) are employed within a bargaining unit covered by at least one of the collective bargaining agreements with a participating employer (or are covered on the basis of an individual's employment in such a bargaining unit), or

''(II) are present or former employees of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (or are covered on the basis of such present or former employment),

''(iii) the plan or other arrangement does not provide benefits to individuals (other than individuals described in clause (ii)(II)) who work outside the standard metropolitan statistical area in which the sponsoring employee organization represents employees (or to individuals (other than individuals described in clause (ii)(II)) on the basis of such work by others), except that in the case of a sponsoring employee organization that represents employees who work outside of any standard metropolitan sta-

tistical area, this clause shall be applied by reference to the State in which the sponsoring organization represents employees, and

''(iv) the employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary—

''(I) that the plan or other arrangement meets the requirements of clauses (i), (ii), and (iii), and

''(II) if, for any year, 10 percent or more of the covered individuals under the plan are individuals not described in subclause (I) or (II) of clause (ii), the total number of covered individuals and the total number of covered individuals not so described.

''(D)(i) Clause (i) of subparagraph (A) shall not apply to a plan or other arrangement that is established or maintained pursuant to one or more collective bargaining agreements which the National Labor Relations Board determines to have been negotiated or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)).

''(ii)(I) Whenever a State insurance commissioner has reason to believe that this subparagraph is applicable to part or all of a plan or other arrangement, the State insurance commissioner may file a petition with the National Labor Relations Board for a determination under clause (i), along with sworn written testimony supporting the petition.

''(II) The Board shall give any such petition priority over all other petitions and cases, other than other petitions under subclause (I) or cases given priority under section 10 of the National Labor Relations Act (29 U.S.C. 160).

''(III) The Board shall determine, upon the petition and any response, whether, on the facts before it, the plan or other arrangement was negotiated, created, or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)). Such determination shall constitute a final determination for purposes of this subparagraph and shall be binding in all Federal or State actions with respect to the status of the plan or other arrangement under this subparagraph.

''(IV) A person aggrieved by the determination of the Board under subclause (III) may obtain review of the determination in any United States court of appeals in the

circuit in which the collective bargaining at issue occurred. Commencement of proceedings under this subclause shall not, unless specifically ordered by the court, operate as a stay of any State administrative or judicial action or proceeding related to the status of the plan or other arrangement, except that in no case may the court stay, before the completion of the review, an order which prohibits the enrollment of new individuals into coverage under a plan or arrangement.''.

SEC. 1405. EMPLOYEE LEASING HEALTH CARE ARRANGEMENTS.

(a) EMPLOYEE LEASING HEALTH CARE ARRANGEMENT DEFINED.—Section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

''(43)(A) Subject to subparagraph (B), the term 'employee leasing health care arrangement' means any labor leasing arrangement, staff leasing arrangement, extended employee staffing or supply arrangement, or other arrangement under which—

''(i) one business or other entity (hereinafter in this paragraph referred to as the 'lessee'), under a lease or other arrangement entered into with any other business or other entity (hereinafter in this paragraph referred to as the 'lessor'), receives from

the lessor the services of individuals to be performed under such lease or other arrangement, and

''(ii) benefits consisting of medical care described in section 607(1) are provided to such individuals or such individuals and their dependents as participants and beneficiaries.

''(B) Such term does not include an arrangement described in subparagraph (A) if, under such arrangement, the lessor retains, both legally and in fact, a complete right of direction and control within the scope of employment over the individuals whose services are supplied under such lease or other arrangement, and such individuals perform a specified function for the lessee which is separate and divisible from the primary business or operations of the lessee.''.

(b) TREATMENT OF EMPLOYEE LEASING HEALTH CARE ARRANGEMENTS AS MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) (as amended by section 1404(b)) is further amended by adding at the end the following new subparagraph:

''(E) The term 'multiple employer welfare arrangement' includes any employee leasing health care arrangement.''.

(c) SPECIAL RULES FOR EMPLOYEE LEASING HEALTH CARE ARRANGEMENTS.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of such Act (as added by section 1401(a)) is amended by adding at the end the following new section:

"SEC. 712. SPECIAL RULES FOR EMPLOYEE LEASING HEALTH CARE ARRANGEMENTS.

''(a) IN GENERAL.—The requirements of paragraphs (1), (2), and (3) of section 704(b) shall be treated as satisfied in the case of a multiple employer welfare arrangement that is an employee leasing health care arrangement if the application for certification includes information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

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

''(2) SOLICITATION RESTRICTIONS.—Employee leasing services provided under the arrangement are not solicited, advertised, or marketed through licensed insurance agents or brokers acting in such capacity.

''(3) CREATION OF EMPLOYMENT RELATIONSHIP.—

''(A) DISCLOSURE STATEMENT.—Written notice is provided to each applicant for employment subject to coverage under the arrangement, at the time of application for employment and before commencing coverage under the arrangement, stating that the employer is the lessor under the arrangement.

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

''(C) INFORMED RECRUITMENT OF LESSEE'S EMPLOYEES.—In any case in which the lessor offers employment to an employee of a lessee under the arrangement, the lessor informs each employee in writing that his or her acceptance of employment with the lessor is voluntary and that refusal of such offer will not be deemed to be resignation from or abandonment of current employment.

''(4) REQUISITE EMPLOYER-EMPLOYEE RELATIONSHIP UNDER ARRANGEMENT.—Under the employer-employee relationship with the employees of the lessor—

''(A) the lessor retains the ultimate authority to hire, terminate, and reassign such employees,

''(B) the lessor is responsible for the payment of wages, payroll-related taxes, and employee benefits, without regard to payment by the lessee to the lessor for its services,

''(C) the lessor maintains the right of direction and control over its employees, except to the extent that the lessee is responsible for supervision of the work performed consistent with the lessee's responsibility for its product or service, and

''(D) in accordance with section 301(a) of the Labor Management Relations Act, 1947 (29 U.S.C. 185(a)), the lessor retains in the absence of an applicable collective bargaining agreement, the right to enter into arbitration and to decide employee grievances, and

''(E) no owner, officer, or director of, or partner in, a lessee is an employee of the lessor, and not more than 10 percent of the individuals covered under the arrangement consist of owners, officers, or directors of, or partners in, such a lessee (or any combination thereof).

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

''(1) LESSOR.—The term 'lessor' means the business or other entity from which services of individuals are obtained under an employee leasing health care arrangement.

''(2) LESSEE.—The term 'lessee' means a business or other entity which receives the services of individuals provided under an employee leasing health care arrangement.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act (as amended by section 1401(d)) is further amended by inserting after the item relating to section 711 the following new item:

''Sec. 712. Employee leasing health care arrangements.''.

SEC. 1406. ENFORCEMENT PROVISIONS RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND EMPLOYEE LEASING HEALTH CARE ARRANGEMENTS.

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

(1) in subsection (a)(6), by striking ''subsection (c)(2) or (i) or (l)'' and inserting ''paragraph (2) or (4) of subsection (c) or subsection (i) or (l)''; and

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

''(4) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of such person's failure or refusal to file the information required to be filed with the Secretary under section 101(g).''.

(b) ACTIONS BY STATES IN FEDERAL COURT.—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(1) in paragraph (5), by striking ''or'' at the end;

(2) in paragraph (6), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

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

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

(1) by inserting ''(a)'' after ''SEC. 501.''; and

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

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being a certified multiple employer health plan (as defined in section 701(9)),

''(2) being an employee leasing health care arrangement under a certification granted under part 7, or

''(3) having been established or maintained under or pursuant to a collective bargaining agreement,

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

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

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

''(A) is not licensed, registered, or otherwise approved under the insurance laws of the States in which the arrangement offers or provides benefits, or

''(B) is not operating in accordance with the terms of a certification granted by the Secretary under part 7,

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

''(2) Paragraph (1) shall not apply in the case of a multiple employer welfare arrangement if the arrangement shows that—

''(A) coverage under it is fully insured, within the meaning of section 701(8),

''(B) it is licensed, registered, or otherwise approved in each State in which it offers or provides benefits, except to the extent that such State does not require licensing, registration, or approval of multiple employer welfare arrangements under which all coverage is fully insured, and

''(C) with respect to each such State, it is operating in accordance with applicable State insurance laws that are not superseded under section 514.

''(3) The court may grant such additional equitable or remedial relief, including any relief available under this title, as it deems necessary to protect the interests of the

public and of persons having claims for benefits against the arrangement.''.

(e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by adding at the end (after and below paragraph (2)) the following new sentence: ''The terms of each multiple employer welfare arrangement to which this section applies and which provides benefits consisting of medical care described in section 607(1) shall require the operating committee or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the arrangement.''.

SEC. 1407. FILING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS PROVIDING HEALTH BENEFITS.

Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended—

(1) by redesignating subsection (g) as subsection (h); and

(2) by inserting after subsection (f) the following new subsection:

''(g)(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing

operations on or after January 1, 1997) and no later than February 15 of each year (in the case of an arrangement in operation since the beginning of such year), unless, as of the date by which such filing otherwise must be made, such arrangement provides no benefits consisting of medical care described in section 607(1).

''(2) Each registration statement—

''(A) shall be filed in such form, and contain such information concerning the multiple employer welfare arrangement and any persons involved in its operation (including whether coverage under the arrangement is fully insured), as shall be provided in regulations which shall be prescribed by the Secretary, and

''(B) if coverage under the arrangement is not fully insured, shall contain a certification that copies of such registration statement have been transmitted by certified mail to—

''(i) in the case of an arrangement which is a certified multiple employer health plan (as defined in section 701(9)), the State insurance commissioner of the domicile State of such arrangement, or

''(ii) in the case of an arrangement which is not a certified multiple employer health plan,

the State insurance commissioner of each State in which the arrangement is located.

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

''(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or

''(B) in the case of a multiple employer welfare arrangement for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually responsible for the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.

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

SEC. 1408. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

''(1) STATE ENFORCEMENT.—

''(A) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the provisions of this title applicable to multiple employer welfare arrangements which are or have been certified multiple employer health plans (as defined in section 701(9)). The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

''(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent

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

''(C) CONCURRENT AUTHORITY OF THE SECRETARY.—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

''(D) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular multiple employer welfare arrangement, as the primary domicile State to which authority has been delegated pursuant to such agreements.

''(2) ASSISTANCE TO STATES.—The Secretary shall—

''(A) provide enforcement assistance to the States with respect to multiple employer welfare arrangements, including, but not limited to, coordinating Federal and State efforts through

the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

''(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act,

''(C) assist the States in obtaining from the Office of Regulations and Interpretations timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

''(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.''.

SEC. 1409. EFFECTIVE DATE; TRANSITIONAL RULES.

(a) EFFECTIVE DATE.—The amendments made by this part shall take effect January 1, 1997, except that the Secretary of Labor shall first issue regulations to carry out such amendments by not later than January 1, 1996. The Secretary shall issue all regulations necessary to carry out such amendments before the effective date thereof.

(b) TRANSITIONAL RULES.—If the sponsor of a multiple employer welfare arrangement which, as of January 1, 1996, provides benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)) files with the Secretary of Labor an application for a certification under part 7 of subtitle B of title I of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement during the 18-month period following such date. If the Secretary determines, at any time after the date of enactment of this Act, that any such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such Act of a multiple employer welfare arrangement would be detrimental to the interests of individuals covered under such arrangement, such exclusion shall cease as of the date of the determination. Any determination made by the Secretary under this subsection shall be in the Secretary's sole discretion.

PART 2—SIMPLIFYING FILING OF REPORTS FOR EMPLOYERS COVERED UNDER MULTIPLE EMPLOYER WELFARE ARRANGEMENTS PROVIDING FULLY INSURED COVERAGE CONSISTING OF MEDICAL CARE

SEC. 1411. SINGLE ANNUAL FILING FOR ALL PARTICIPATING EMPLOYERS.

(a) IN GENERAL.—Section 110 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1030), as amended by section 1401(c) of this subtitle, is amended by adding at the end the following new subsection:

''(d) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are participating employers under a multiple employer welfare arrangement under which all coverage consists of medical care (described in section 607(1)) and is fully insured (as defined in section 701(8)).''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. The Secretary of Labor shall prescribe the alternative method referred to in section 110(d) of the Employee Retirement Income Security Act of 1974, as added by such amendment, within 90 days after the date of the enactment of this Act.

Subtitle F—Definitions; General Provisions

PART 1—DEFINITIONS

SEC. 1901. GENERAL DEFINITIONS.

For purposes of this Act:

(1) APPLICABLE REGULATORY AUTHORITY.—The term ''applicable regulatory authority'' means, with respect to a carrier operating in a State—

(A) the State insurance commissioner, or

(B) the Secretary, in the case described in section 1302(b)(2).

(2) FAMILY MEMBER.—

(A) IN GENERAL.—Individuals are considered to be members of a family if—

(i) they are married, or

(ii) they have a legal parent-to-child relationship (whether by natural birth or adoption), if the child is—

(I) under 19 years of age,

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

(III) an unmarried dependent regardless of age who is incapable of self-support because of mental or

physical disability which existed before age 22.

(B) SPECIAL RULES.—Family members—

(i) include an adopted child and a recognized natural child;

(ii) include a stepchild or foster child with respect to an individual but only if the child lives with the individual in a regular parent-child relationship; and

(iii) include such other children as the Secretary may specify, but shall not include an emancipated minor.

(3) PRISONER.—The term ''prisoner'' means, as specified by the Secretary, an individual during a period of imprisonment under Federal, State, or local authority after conviction as an adult.

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

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

SEC. 1902. DEFINITIONS RELATING TO EMPLOYMENT.

(a) APPLICATION OF ERISA DEFINITIONS.—Except as otherwise provided in this Act, terms used in this Act

shall have the meanings applicable to such terms under section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002).

(b) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) COUNTABLE EMPLOYEE.—The term ''countable employee'' means, with respect to an employer for a month, any employee other than an employee whose normal work week is less than 10 hours.

(2) LARGE EMPLOYER.—The term ''large employer'' means an employer that is not a small employer (as defined in paragraph (4)).

(3) QUALIFYING EMPLOYEE.—

(A) IN GENERAL.—The term ''qualifying employee'' means, with respect to an employer for a month, any employee other than—

(i) a part-time, seasonal, or temporary employee (as defined in subparagraph (B)); or

(ii) an employee who is a child described in section 1901(2)(A)(ii).

(B) PART-TIME, SEASONAL, OR TEMPORARY EMPLOYEE DEFINED.—For purposes of subparagraph (A), the term ''part-time, seasonal, or temporary employee'' means any of

the following employees with respect to a month:

(i) CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal work week is reasonably expected as of the first day of such month to be less than 20 hours.

(ii) SEASONAL OR TEMPORARY EMPLOYEES.—Any employee who is not reasonably expected as of the first day of such month to be employed by the employer for a period of 120 consecutive days during any 365-day period that includes such first day.

(iii) DELAY FOR CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal work week is reasonably expected as of the first day of such month to be at least 20 hours, but less than 35 hours, and the normal work week of the employee during the preceding 3 months was less than 20 hours.

(4) SMALL EMPLOYER.—The term ''small employer'' means, with respect to a calendar year, an employer that normally employs more than 1 but

less than 100 countable employees on a typical business day. For the purposes of this paragraph, the term ''employee'' includes a self-employed individual. For purposes of determining if an employer is a small employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

SEC. 1903. DEFINITIONS RELATING TO HEALTH COVERAGE, PLANS, AND CARRIERS.

Except as otherwise provided, for purposes of this Act:

(1) BENCHMARK COVERAGE.—The term ''benchmark coverage'' means the standard option of the Blue Cross-Blue Shield plan offered under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code, as in effect during 1994.

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

(3) CERTIFIED MULTIPLE EMPLOYER HEALTH PLAN.—The term ''certified multiple employer health plan'' means a multiple employer welfare arrange-

ment treated as an employee welfare benefit plan by reason of a certification under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by section 1401(a)).

(4) CLASS OF FAMILY COVERAGE.—The term ''class of family coverage'' means the 4 classes described in section 1021(a)(3).

(5) FAIR RATING AREA.—The term ''fair rating area'' means a geographic area identified by a State for purposes of section 1021(a)(2).

(6) GROUP HEALTH PLAN.—The term ''group health plan'' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance coverage under paragraph (8)(B).

(7) HEALTH COVERAGE.—The term ''health coverage'' means health insurance coverage provided by a carrier or medical care provided under a group health plan.

(8) HEALTH INSURANCE COVERAGE.—

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

coverage'' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by a carrier.

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

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

(ii) Medicare supplemental health insurance.

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

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers' compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital or fixed indemnity policy.

(ix) Coverage provided exclusively to individuals who are not eligible individuals.

(9) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' includes, as defined in standards established under section 1103, an organization that provides health insurance coverage which meets specified standards and under which health services are offered to be provided on a prepaid, at-risk basis primarily through a defined set of providers.

(10) HEALTH PLAN PURCHASING ORGANIZATION.—The term ''health plan purchasing organization'' means an organization established under subtitle A of title VI.

(11) INDIVIDUAL/SMALL GROUP MARKET.—The term ''individual/small group market'' means the insurance market offered—

(A) to individuals seeking health insurance coverage on behalf of themselves (and their dependents) insofar as no employer is seeking such coverage on behalf of the individual, and

(B) to small employers seeking health insurance coverage on behalf of their employees (and their dependents),

regardless of whether or not such coverage is made available directly or through a multiple employer welfare arrangement, association, or otherwise.

(12) MANAGED CARE ARRANGEMENTS.—

(A) MANAGED CARE ARRANGEMENT.—The term ''managed care arrangement'' means, with respect to a group health plan or under health insurance coverage, an arrangement under such plan or coverage under which providers agree to provide items and services covered under the arrangement to individuals covered under the plan or who have such coverage.

(B) PROVIDER NETWORK.—The term ''provider network'' means, with respect to a group health plan or health insurance coverage, providers who have entered into an agreement described in subparagraph (A).

(13) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—The term ''multiple employer welfare arrangement'' shall have the meaning applicable under section 3(40) of the Employee Retirement Income Security Act of 1974.

(14) NAIC.—The term ''NAIC'' means the National Association of Insurance Commissioners.

(15) OPTIONS.—Each of the following is a ''type of coverage option'' in relation to standard coverage:

(A) FEE-FOR-SERVICE OPTION.—Standard coverage is considered to provide a ''fee-for-service option'' if, regardless of whether covered individuals may receive benefits through a provider network, benefits with respect to the covered items and services in the coverage are made available for such items and services provided through any lawful provider of such covered items and services and payment is made to such a provider whether or not there is a contractual arrangement between the provider and the carrier or plan.

(B) MANAGED CARE OPTION.—Standard coverage is considered to provide a ''managed care option'' if benefits with respect to the covered items and services in the coverage are made available exclusively through a provider network, except in the case of emergency services and as otherwise required under law.

(C) POINT-OF-SERVICE OPTION.—Standard coverage is considered to provide a ''point-of-service option'' if the benefits with respect to

covered items and services in the coverage are made available principally through a managed care arrangement, with the choice of the enrollee to obtain such benefits for items and services provided through any lawful provider of such covered items and services. The coverage may provide for different cost sharing schedules based on whether the items and services are provided through such an arrangement or outside such an arrangement.

(16) QUALIFIED HEALTH COVERAGE.—The term ''qualified health coverage'' has the meaning given such term in section 1101.

(17) STANDARD COVERAGE.—The term ''standard coverage'' means coverage provided consistent with section 1102(a).

(18) STATE COMMISSIONER OF INSURANCE.—The term ''State commissioner of insurance'' includes a State superintendent of insurance.

SEC. 1904. DEFINITIONS RELATING TO RESIDENCE AND IMMIGRATION STATUS.

Except as otherwise provided, for purposes of this Act:

(1) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term

''alien permanently residing in the United States under color of law'' means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following (such status not having changed):

(A) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(B) An alien who is granted asylum under section 208 of such Act.

(C) An alien whose deportation is withheld under section 243(h) of such Act.

(D) An alien whose deportation is suspended pursuant to section 244 of such Act.

(E) An alien who is granted conditional entry pursuant to section 203(a)(7) of such Act as in effect before April 1, 1980.

(F) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(G) An alien who is within a class of aliens lawfully present in the United States pursuant to any other provision of such Act, if (i) the Attorney General determines that the continued

presence of such class of aliens serves a humanitarian or other compelling public interest, and (ii) the Secretary determines that such interest would be further served by treating each such alien within such class as a ''legal permanent resident'' for purposes of this Act or who has been granted extended voluntary departure as a member of a nationality group.

(H) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(I) An alien within such other classification of permanent resident aliens as the Secretary may establish by regulation.

(2) LONG-TERM NONIMMIGRANT.—The term ''long-term nonimmigrant'' means a nonimmigrant described in subparagraph (E), (H), (I), (K), (L), (N), (O), (Q), or (R) of section 101(a)(15) of the Immigration and Nationality Act.

(3) QUALIFYING INDIVIDUAL.—The term ''qualifying individual'' means, an individual who is

a resident of the United States, who is not a prisoner, and is—

(A) a citizen or national of the United States;

(B) an alien permanently residing in the United States under color of law (as defined in paragraph (1)); or

(C) a long-term nonimmigrant (as defined in paragraph (2)).

SEC. 1905. EFFECTIVE DATES.

The requirements of this title shall apply with respect to—

(1) group health plans for plan years beginning on or after January 1, 1997, and

(2) carriers (with respect to coverage other than under a group health plan) as of January 1, 1997.

PART 2—REPORT AND RECOMMENDATIONS ON HEALTH COVERAGE AND ACCESS

SEC. 1911. OBJECTIVE OF FULL ACCESS AND COVERAGE.

It is an objective of this Act to assure by 2002 that—

(1) all eligible individuals in the United States have access to private or public health coverage, and

(2) at least 95 percent of such individuals have such coverage.

SEC. 1912. REPORT AND RECOMMENDATIONS ON ACHIEVEMENT OF OBJECTIVE FOR HEALTH COVERAGE AND ACCESS.

(a) STUDY.—The Secretary shall monitor and evaluate the extent to which eligible individuals in the United States have access to health coverage and have health coverage.

(b) REPORT.—Not later than January 31, 2002, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). The Secretary shall include in the report a determination of whether the objective described in section 1911 has been met.

(c) RECOMMENDATIONS.—If the Secretary determines that such objective has not been met, the Secretary shall include in the report such recommendations as may be appropriate to achieve the objective at the earliest possible date.

TITLE II—REMOVAL OF FINANCIAL BARRIERS TO ACCESS

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Subtitle A—Tax Deductibility for Individuals and Self-Employed

SEC. 2001. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED AND MADE PERMANENT.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking ''25 percent'' and inserting ''the applicable percentage''.

(b) DEDUCTION MADE PERMANENT; APPLICABLE PERCENTAGE.—Paragraph (6) of section 162(l) of such Code is amended to read as follows:

''(6) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

''In the case of taxable years beginning in calendar year:	**The applicable percentage is:**
1994, 1995, 1996, 1997, or 1998	25 percent
1999	50 percent
2000 or thereafter	100 percent.''

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

SEC. 2002. DEDUCTION FOR HEALTH INSURANCE COSTS OF INDIVIDUALS WHO ARE NOT SELF-EMPLOYED.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

''SEC. 220. HEALTH INSURANCE COSTS OF INDIVIDUALS WHO ARE NOT SELF-EMPLOYED.

''(a) IN GENERAL.—In the case of an individual who is not a self-employed individual (as defined in section 401(c)(1)), there shall be allowed as a deduction an amount equal to 25 percent of the amount paid during

the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(b) COORDINATION WITH DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.—The amount which would (but for this paragraph) be allowed as a deduction under subsection (a) for the taxable year shall be reduced (but not below zero) by the amount (if any) allowed as a deduction under section 162(l) for such taxable year.

''(c) OTHER COVERAGE.—Subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer.

''(d) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).''

(b) DEDUCTION ALLOWED WHETHER OR NOT TAXPAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by adding at the end the following new paragraph:

''(16) HEALTH INSURANCE COSTS.—The deduction allowed by section 220.''

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 220. Health insurance costs of individuals who are not self-employed.
''Sec. 221. Cross reference.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 2003. RESTRICTIONS ON HEALTH BENEFITS PROVIDED THROUGH CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended to read as follows:

''SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

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

''(b) INCLUSION OF CERTAIN BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—Gross income of an employee shall include such employer-provided coverage which is provided through a flexible

spending or similar arrangement if any amount of deductible, copayment, coinsurance, or similar cost-sharing may be paid for or reimbursed under such arrangement.''

(b) CAFETERIA PLANS.—Subsection (f) of section 125 of such Code (defining qualified benefits) is amended by adding at the end thereof the following new sentence: ''Such term shall not include any benefits or coverage under an accident or health plan if any amount of deductible, copayment, coinsurance, or similar cost-sharing under such a plan, or more than 20 percent of any premium (or comparable amount in the case of a plan not provided through insurance) for such a plan, may be paid for or reimbursed under the cafeteria plan.''

(c) EMPLOYMENT TAX TREATMENT.—

(1) SOCIAL SECURITY TAX.—

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

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

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

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

(2) RAILROAD RETIREMENT TAX.—Paragraph (1) of section 3231(e) of such Code is amended by adding at the end thereof the following new sentence: ''Nothing in clause (i) of the second sentence of this paragraph shall exclude from the term 'compensation' any amount which is required to be included in gross income under section 106(b).''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by inserting after paragraph (16) the following new sentence:

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

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

''Nothing in the preceding provisions of this subsection shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

Subtitle B—Premium and Cost-Sharing Subsidy Program for Low-Income Individuals

SEC. 2100. DESCRIPTION OF TRANSITION FROM CURRENT MEDICAID SYSTEM TO NEW ACUTE CARE LOW-INCOME SUBSIDY PROGRAMS FOR AFDC RECIPIENTS AND NON-CASH MEDICAID BENEFICIARIES.

The amendments made by this subtitle and title III provide for a transition from the current medicaid system to a new system of acute care low-income assistance through the following:

(1) IMMEDIATE MEDICAID REFORMS.—During 1995, 1996, and 1997, States are permitted—

(A) to enroll medicaid recipients under coordinated care arrangements, but are restricted from eliminating eligibility categories currently in effect; and

(B) to provide certain classes of acute care services to such recipients through a State supplemental benefits program,

under the amendments made by section 3101.

(2) ESTABLISHMENT OF NEW PREMIUM AND COST-SHARING SUBSIDY PROGRAM AND SUPPLEMENTAL BENEFITS PROGRAM AND INTEGRATION OF AFDC AND NON-CASH BENEFICIARIES.—Beginning January 1, 1998—

(A) States are required to establish a new premium and cost-sharing subsidy program under part A of title XXI of the Social Security Act (as added by section 2101); and

(B) with respect to AFDC and non-cash medicaid beneficiaries and other low-income individuals—

(i) States are required to provide for premium and cost-sharing assistance for core benefits for premium and cost-sharing assistance eligible individuals through that program and additional benefits through a supplemental benefits grant program under part B of title XXI of the Social Security Act (as added by section 3101), and

(ii) States will no longer provide such individuals with medicaid coverage for acute care services.

SEC. 2101. STATE PREMIUM AND COST-SHARING SUBSIDY PROGRAMS.

(a) REQUIREMENTS FOR PROGRAMS.—The Social Security Act is amended by adding at the end the following new title:

''TITLE XXI—STATE ACUTE CARE BENEFITS PROGRAMS FOR LOW-INCOME INDIVIDUALS; FINANCING FAILSAFE MECHANISM

''PART A—STATE PREMIUM AND COST-SHARING SUBSIDY PROGRAMS

"SEC. 2101. ESTABLISHMENT OF STATE PROGRAMS.

''(a) IN GENERAL.—As a requirement under section 1902(a)(65), effective January 1, 1998, each State shall establish and maintain a premium and cost-sharing subsidy program (in this title referred to as a 'State subsidy program') that provides for—

''(1) premium assistance described in section 2103 to premium assistance eligible individuals described in section 2102(a) in accordance with this part,

''(2) cost-sharing assistance described in section 2103 to cost-sharing assistance eligible individuals described in section 2102(b) in accordance with this part, and

''(3) State maintenance-of-effort payments in accordance with section 2107.

''(b) AVAILABILITY OF FUNDS.—Each State with a State subsidy program approved under this part is entitled, for calendar quarters beginning on or after January 1, 1998, to payment under section 2106.

''(c) APPROVAL OF STATE PROGRAMS.—The Secretary may not approve a State subsidy program unless the State has submitted a detailed description that specifies the form and manner in which it will carry out the program and the Secretary finds that the program meets the requirements of this part.

''(d) DESIGNATION OF STATE AGENCY.—A State shall designate an appropriate State agency to administer the State subsidy program. Such agency shall be the same agency as the agency designated to administer the State supplemental medical benefits program under part B.

"**SEC. 2102. ELIGIBILITY.**

''(a) ASSISTANCE.—

''(1) PREMIUM ASSISTANCE.—Each premium assistance eligible individual (as defined in subsection (b)) is entitled to premium assistance under section 2103(a)(1).

''(2) COST-SHARING ASSISTANCE.—Each cost-sharing assistance eligible individual (as defined in subsection (c)) is entitled to cost-sharing assistance described in section 2103(a)(2).

''(b) PREMIUM ASSISTANCE ELIGIBLE INDIVIDUAL DEFINED.—

''(1) IN GENERAL.—In this title, subject to the succeeding provisions of this section and part C, the term 'premium assistance eligible individual' means an individual who has been determined under section 2104 to have family modified adjusted income below the following applicable percentage of the applicable poverty line (as defined in section 2147(2)):

"Calendar year:	Applicable percentage:
1998	100
1999	115
2000	130
2001	145
2002	160
2003	175
2004	200

''(2) SPECIAL RULE FOR CHILDREN AND PREGNANT WOMEN.—In this title, subject to the succeeding provisions of this section and part C, the term 'premium assistance eligible individual' includes an individual who is a child under 19 years of age or a pregnant woman and who has been determined under section 2104 to have family modified adjusted income below the following applicable percentage of the applicable poverty line:

"Calendar year:	Applicable percentage:
1998	185
1999	185
2000	185
2001	185

2002	185
2003	200
2004	240

''(c) COST-SHARING ASSISTANCE ELIGIBLE INDIVIDUAL DEFINED.—In this title, subject to the succeeding provisions of this section and part C, the term 'cost-sharing assistance eligible individual' means an individual who has been determined under section 2104 to have family modified adjusted income below 100 percent of the applicable poverty line.

''(d) EXCLUSION OF CERTAIN INDIVIDUALS.—In this title—

''(1) IN GENERAL.—The terms 'premium assistance eligible individual' and 'cost-sharing assistance eligible individual' do not include, with respect to a month, any of the following individuals:

''(A) MEDICARE BENEFICIARY.—An individual who is entitled to benefits under part A or B of title XVIII for the month.

''(B) SSI RECIPIENT.—An individual who is an SSI recipient (as defined in paragraph (2)) for the month.

''(C) INMATES.—An individual who as of the first day of the month is an inmate of a public institution (except as a patient of a medical institution).

''(D) CERTAIN ALIENS.—An alien who is not lawfully admitted for permanent residence or not otherwise permanently residing in the United States under color of law (as defined in paragraph (3)).

''(E) NONRESIDENTS.—An individual who is not residing in any State.

''(2) SSI RECIPIENT.—The term 'SSI recipient' means, for a month, an individual—

''(A) with respect to whom supplemental security income benefits are being paid under title XVI for the month,

''(B) who is receiving a supplemental payment under section 1616 or under section 212 of Public Law 93–66 for the month,

''(C) who is receiving monthly benefits under section 1619(a) (whether or not pursuant to section 1616(c)(3)) for the month, or

''(D) who is treated under section 1619(b) as receiving supplemental security income benefits in a month for purposes of title XIX.

''(3) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term 'alien permanently residing in the United States under color of law' means an alien lawfully admitted

for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

''(A) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

''(B) An alien who is granted asylum under section 208 of such Act.

''(C) An alien whose deportation is withheld under section 243(h) of such Act.

''(D) An alien whose deportation is suspended under section 244 of such Act.

''(E) An alien who is granted conditional entry pursuant to section 203(a)(7) of such Act, as in effect before April 1, 1980.

''(F) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

''(G) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

''(H) An alien who is the spouse or unmarried child under 21 years of age of a citizen of

the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

''(e) PROTECTION OF CURRENT BENEFICIARIES.—

''(1) IN GENERAL.—In this title, the term 'premium assistance eligible individual' also includes, with respect to a State as of December 31, 1997, an individual described in paragraph (2) whose eligibility for premium assistance has not terminated under paragraph (3).

''(2) CURRENT BENEFICIARIES DESCRIBED.—An individual described in this paragraph is an individual who—

''(A) is not excluded under subsection (d),

''(B) is enrolled to receive medical assistance under the State plan under title XIX (and for which Federal financial participation was available) as of December 31, 1997, and

''(C) would remain enrolled to receive such assistance under the State plan under title XIX but for amendments made by the Bipartisan Health Care Reform Act of 1994.

''(3) LIMITATION.—An individual is a premium assistance eligible individual pursuant to this subsection only until the earlier of—

''(A) June 30, 1998, or

''(B) the first date after December 31, 1997, on which the individual's eligibility for medical assistance under the State plan under title XIX would have been terminated if the amendments made by the Bipartisan Health Care Reform Act of 1994 had not been enacted.

"SEC. 2103. PREMIUM AND COST-SHARING ASSISTANCE.

''(a) IN GENERAL.—

''(1) PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—The premium assistance under a State subsidy program shall be in the form of a premium assistance certificate that is in the amount computed under subsection (b) and that may be applied toward qualifying coverage (as defined in subparagraph (B)). A carrier or group health plan providing such coverage that is tendered such a certificate with respect to an individual shall reduce the amount of the premium by the amount of the certificate, except as provided in subsection (c)(1)(C).

''(B) QUALIFYING COVERAGE DEFINED.—For purposes of this part—

''(i) IN GENERAL.—Except as provided in clause (ii), the term 'qualifying coverage' means standard coverage described in section 1102 of the Bipartisan Health Care Reform Act of 1994.

''(ii) OPTIONAL USE OF HIGH-DEDUCTIBLE COVERAGE.—At the election of a premium assistance eligible individual, the term 'qualifying coverage' includes high-deductible coverage described in section 1103 of the Bipartisan Health Care Reform Act of 1994 with respect to an individual, but only if the individual—

''(I) has been determined under section 2104 to have family modified adjusted income not less than 100 percent of the applicable poverty line (or in the case of an individual described in section 2102(a)(2), 185 percent of such applicable poverty line), and

''(II) demonstrates to the satisfaction of the State that the individual

meets the requirements of section 1101(b)(2) of the Bipartisan Health Care Reform Act of 1994 (relating to requirement for available assets).

''(iii) TREATMENT OF VA HEALTH COVERAGE.—For purposes of this part, VA health coverage (as defined in section 1801(2) of title 38, United States Code) provided by the Department of Veterans Affairs shall be considered to be standard health insurance coverage (referred to in subparagraph (A)) provided by a carrier.

''(2) COST-SHARING ASSISTANCE.—The cost-sharing assistance under a State subsidy program shall be in the form of a cost-sharing assistance certificate (or other means) that may be applied with respect to standard coverage. A carrier providing health insurance coverage or a group health plan that is tendered such a certificate with respect to an individual shall reduce the cost-sharing otherwise imposed with respect to health coverage to amounts that are nominal (as specified by the State, consistent with the regulations established to carry out section 1916(a)(3)) and shall not impose any cost-sharing in the case of preventive benefits described in

section 1102(b)(4) of the Bipartisan Health Care Reform Act of 1994.

''(3) CONSOLIDATED AND ELECTRONIC CERTIFICATES.—Nothing in this section shall be construed as preventing a State from—

''(A) in the case of an individual who is both a premium assistance eligible individual and a cost-sharing assistance eligible individual, from consolidating the premium and cost-sharing certificates of the individual, and

''(B) providing premium and cost-sharing assistance certificates through electronic or other means.

''(b) AMOUNT OF PREMIUM ASSISTANCE.—

''(1) AMOUNT OF ASSISTANCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the amount of premium assistance under this subsection for a month for an individual is the lesser of—

''(i) the premium assistance reference amount determined under paragraph (2), or

''(ii) the amount of the monthly premium for the qualifying coverage provided to the individual.

''(B) TAKING INTO ACCOUNT EMPLOYER CONTRIBUTIONS.—If an employer is making a contribution for the health coverage of a premium assistance eligible individual, the amount of the premium assistance under this subsection for a month shall not exceed the amount by which the premium amount described in subparagraph (A)(ii) exceeds the amount of the employer contribution.

''(2) PREMIUM ASSISTANCE REFERENCE AMOUNT DETERMINED.—

''(A) IN GENERAL.—Subject to paragraph (4), the premium assistance reference amount determined under this paragraph is an amount equal to 1/12 of the premium assistance percentage (as defined in paragraph (3)) multiplied by the weighted average annual premium (determined in accordance with subparagraph (B)) for the individual's family class of enrollment for qualified standard health coverage offered in the fair rating area (as defined in section 1903 of the Bipartisan Health Care Reform Act of 1994) in the individual/small group market in which the individual resides.

''(B) DETERMINATION OF WEIGHTED AVERAGE ANNUAL PREMIUM.—For purposes of subparagraph (A), the weighted average annual premium for a family class of enrollment for qualified standard health coverage shall be based on the number of families (or individuals in the case of the individual class of enrollment) so covered in the class and area involved.

''(C) FAMILY CLASS OF ENROLLMENT.—In this paragraph, the term 'family class of enrollment' means a class of enrollment described in section 1021(a)(3) of the Bipartisan Health Care Reform Act of 1994.

''(3) PREMIUM ASSISTANCE PERCENTAGE.—For purposes of this part and subject to section 2141(e)(3)—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'premium assistance percentage' means 100 percent reduced (but not below zero) by the number of percentage points (rounded to the nearest whole number) by which such individual's family income (expressed as a percent) exceeds 100 percent of the applicable poverty line.

''(B) CHILDREN AND PREGNANT WOMEN.—In the case of a premium assistance eligible individual described in paragraph (2) of section 2102(b), the term 'premium assistance percentage' means 100 percent reduced (but not below zero) by 1 percentage point for each .55 percentage points by which such individual's family income (expressed as a percent) exceeds 185 percent of the applicable poverty line.

''(C) CURRENT MEDICAID BENEFICIARIES.—In the case of an individual who is a premium assistance eligible individual pursuant to 2102(d), the term 'premium assistance percentage' means 100 percent.

''(4) SPECIAL RULE FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN.—In the case of a family consisting of premium assistance eligible individuals in which the modified adjusted gross income exceeds 100 percent of the applicable poverty line, but which includes one or more individuals described in paragraph (2) of section 2102(b), the premium assistance amount may be computed in a manner (specified by the Secretary in regulations) based on the sum of separate premium amounts for family members based on individual class of enrollment,

rather than based on the appropriate family class of enrollment.

''(c) PAYMENTS OF ASSISTANCE.—

''(1) PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—The State issuing a premium assistance certificate shall, upon tender to the State of such certificate by the carrier or group health plan providing qualiyfing coverage, pay the carrier or plan the amount of the certificate.

''(B) TIMING OF PAYMENTS.—Payments under this paragraph shall commence in the first month during which the individual obtains qualifying coverage and is determined under section 2104 to be a premium assistance eligible individual.

''(C) TREATMENT OF SURPLUSES AND DEFICITS.—

''(i) DEFICIT.—If the premium for coverage is greater than the amount of the premium assistance for an individual, the individual is responsible for payment of any difference.

''(ii) SURPLUS.—If the premium for coverage is less than the amount of the

premium assistance for an individual, the difference shall not be paid to the individual or the carrier or plan but shall revert to the Federal Government.

''(2) COST-SHARING ASSISTANCE.

''(A) IN GENERAL.—The State issuing a cost-sharing assistance certificate shall, upon presentation to the State of evidence of such certificate by the carrier or group health plan providing coverage and evidence of cost-sharing amounts otherwise incurred for which a reduction in cost-sharing is available under the certificate, pay the carrier or plan the amount of the reduction in cost-sharing in relation to standard coverage.

''(B) TIMING OF PAYMENTS.—Payments under this paragraph shall be provided at the time an individual has obtained qualified standard health coverage, is determined under section 2104 to be a cost-sharing assistance eligible individual, and has incurred health care expenses of the type for which a cost-sharing reduction is available under subparagraph (A).

''(3) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium or cost-sharing as-

sistance paid based on an eligibility determination error to the extent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

"SEC. 2104. ELIGIBILITY DETERMINATIONS.

''(a) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State subsidy programs with respect to determining eligibility for premium and cost-sharing assistance, including requirements with respect to—

''(1) application procedures;

''(2) information verification procedures;

''(3) timeliness of eligibility determinations;

''(4) procedures for applicants to appeal adverse decisions; and

''(5) any other matters determined appropriate by the Secretary.

''(b) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under subsection (a) shall include the following requirements:

''(1) FREQUENCY OF APPLICATIONS.—A State program shall provide that an individual may file an application for assistance with an agency designated by the State at any time, in person.

''(2) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under subsection (c)(2).

''(3) DISTRIBUTION OF APPLICATIONS.—A State program shall distribute applications for assistance widely, including to employers, health plan purchasing organizations, brokers for health coverage, and appropriate public agencies.

''(4) CONVENIENT LOCATION TO SUBMIT APPLICATIONS.—A State program shall provide convenient locations for premium and cost-sharing assistance eligible individuals to apply for premium and cost-sharing assistance.

''(5) REQUIREMENT TO SUBMIT REVISED APPLICATION.—A State program shall, in accordance with regulations promulgated by the Secretary, require individuals to submit revised applications during a year to reflect changes in estimated family incomes, including changes in employment status of family members, and changes in eligibility status described in section 2002(c) during the year. The State shall revise the amount of any premium and cost-sharing assistance based on such a revised application.

''(6) AFDC APPLICANTS.—A State program shall include a procedure under which individuals applying for benefits under title IV shall have an opportunity to apply for assistance under this part in connection with such application.

''(7) VERIFICATION.—A State program shall provide for verification of the information supplied in applications under this part. Such verification may include examining return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

''(c) ADMINISTRATION OF STATE PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish standards for States operating programs under this part which ensure that such programs are operated in a uniform manner with respect to application procedures, data standards, and such other administrative activities as the Secretary determines to be necessary.

''(2) APPLICATION FORMS.—The Secretary shall develop an application form for assistance which shall—

''(A) be simple in form and understandable to the average individual;

''(B) require the provision of information necessary to make a determination as to whether an individual is a premium or cost-sharing assistance eligible individual including a declaration of estimated family income by the individual; and

''(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

''(3) OUTREACH ACTIVITIES.—A State operating a program under this part shall conduct such outreach activities as the Secretary determines appropriate.

''(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM AND COST-SHARING ASSISTANCE.—A determination by a State that an individual is a premium or cost-sharing assistance eligible individual shall be effective for the calendar year for which such determination is made unless a revised application submitted under subsection (b)(5) indicates that an individual is no longer eligible for premium or cost-sharing assistance.

''(e) PENALTIES FOR MATERIAL MISREPRESENTATIONS.—

''(1) IN GENERAL.—Any individual who knowingly makes a material misrepresentation of information in an application for assistance under this part shall be liable to the Federal Government for the amount any premium and cost-sharing assistance received by an individual on the basis of a misrepresentation and interest on such amount at a rate specified by the Secretary, and shall, in addition, be liable to the Federal Government for $2,000 or, if greater, 3 times the amount any premium and cost-sharing assistance provided on the basis of a misrepresentation.

''(2) COLLECTION OF PENALTY AMOUNTS.—A State which receives an application for assistance with respect to which a material misrepresentation has been made shall collect the penalty amount required under paragraph (1) and submit 50 percent of such amount to the Secretary in a timely manner.

"SEC. 2105. END-OF-YEAR RECONCILIATION FOR PREMIUM ASSISTANCE.

''(a) IN GENERAL.—

''(1) REQUIREMENT TO FILE STATEMENT.—An individual who received premium assistance under this part from a State for any month in a calendar year shall file with the State an income reconcili-

ation statement to verify the individual's family income for the year. Such a statement shall be filed at such time, and contain such information, as the State may specify in accordance with regulations promulgated by the Secretary.

''(2) NOTICE OF REQUIREMENT.—A State shall provide a written notice of the requirement under paragraph (1) at the end of the year to an individual who received assistance under this part from such State in any month during the year.

''(b) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—

''(1) IN GENERAL.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to an individual, the State shall compute the amount of premium assistance that should have been provided under this part with respect to the individual for the year involved.

''(2) OVERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was greater than the amount computed under paragraph (1), the excess amount shall be treated as an underpayment of a tax imposed by chapter 1 of the Internal Revenue Code of 1986.

''(3) UNDERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was less than the amount computed under paragraph (1), the amount of the difference shall be treated as an overpayment of tax imposed by such chapter, or in the event the taxpayer involved is entitled to a refund of such a tax, subject to the provisions of section 6402(d) of such Code.

''(c) VERIFICATION.—Each State may use such information as it has available to verify income of individuals with applications filed under this part, including return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

''(d) PENALTIES FOR FAILURE TO FILE.—In the case of an individual who is required to file a statement under this section in a year who fails to file such a statement by such date as the Secretary shall specify in regulations, the entire amount of the premium assistance provided in such year shall be considered an excess amount under subsection (b)(2) and such individual shall not be eligible for premium assistance under this part until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the individual establishes, to the satisfaction of the State

under such rules, good cause for the failure to file the statement on a timely basis.

''(e) PENALTIES FOR FALSE INFORMATION.—Any individual who provides false information in a statement filed under subsection (a) is subject to the same penalties as are provided under section 2104(e) for a misrepresentation of material fact described in such section.

''(f) NO RECONCILIATION FOR COST-SHARING ASSISTANCE.—No reconciliation statement is required under this section with respect to cost-sharing assistance.

"SEC. 2106. PAYMENTS TO STATES.

''(a) PAYMENTS FOR PREMIUM AND COST-SHARING ASSISTANCE.—Subject to subsection (b) and section 2141, the Secretary shall provide for payment to each State operating a State subsidy program in an amount equal to the sum of—

''(1) the amount expended by the State under the program for premium assistance on behalf of premium assistance eligible individuals, and

''(2) the amount expended by the State under the program for cost-sharing assistance on behalf of cost-sharing assistance eligible individuals.

''(b) NO PAYMENT FOR MAINTENANCE-OF-EFFORT EXPENDITURES OR ADMINISTRATION.—No payment shall be made under subsection (a)—

''(1) for any State maintenance-of-effort expenditures required under section 2107, or

''(2) for any expenditures relating to administration of a State subsidy program.

For payment to States for administrative expenditures for State subsidy programs, see section 2142.

''(c) FUNDING.—The amount paid to States under subsection (a) shall be paid by the Secretary, from the Health Care Assurance Trust Fund (established under section 2143), at such time and in such form as provided in regulations promulgated by the Secretary, based on the form and manner in which payments are made to States under section 1903.

"SEC. 2107. REQUIREMENT OF STATE MAINTENANCE-OF-EFFORT EXPENDITURES.

''(a) IN GENERAL.—Payment to a State under section 2106 for any quarter in a year is conditioned upon—

''(1) the State making expenditures under this part from non-Federal funds (consistent with subsection (d)) for premium assistance on behalf of premium assistance eligible individuals and for cost-sharing assistance on behalf of cost-sharing assistance eligible individuals equal to at least the assistance maintenance-of-effort amount computed under subsection (b) for the quarter, and

''(2) the State meeting the maintenance-of-effort requirement of section 2125(a)(1) for the quarter.

''(b) ASSISTANCE MAINTENANCE-OF-EFFORT AMOUNT.—

''(1) IN GENERAL.—The assistance maintenance-of-effort amount computed under this subsection for a State for a quarter in a year is equal to ¼ of the product of the Federal-to-State conversion factor (specified under paragraph (5)) and the following:

''(A) 1998.—For 1998, the product of—

''(i) the 1997 per capita core benefit amount (described in paragraph (3)) for the State, and

''(ii) the average monthly number of AFDC recipients and non-cash medicaid beneficiaries (as defined in section 1931(a)(2)) in the State during 1997,

increased by the assistance increase factor (as defined in paragraph (4)) for 1998.

''(B) 1999 AND THEREAFTER.—For quarters in 1999 or any succeeding year, the amount computed under subparagraph (A) or this subparagraph for the State for the preced-

ing year increased by the assistance increase factor under paragraph (4) for the year.

''(2) ESTIMATIONS OF AND ADJUSTMENTS TO STATE TOTAL FUNDING AMOUNT.—The Secretary shall—

''(A) establish a process for estimating the assistance maintenance-of-effort amount for each State under paragraph (1) at the beginning of each fiscal year and adjusting such amount during such fiscal year; and

''(B) notifying each State of the estimations and adjustments referred to in subparagraph (A).

''(3) 1997 PER CAPITA CORE BENEFIT AMOUNT DEFINED.—For purposes of paragraph (1), the '1997 per capita core benefit amount' for a State is equal to the base per capita core benefit Federal payment limit for AFDC recipients and non-cash medicaid beneficiaries (specified in section 1931(c)(2)(A)) multiplied (for each of years 1995, 1996, and 1997) by a factor equal to 1 plus the FEHBP State rolling increase percentage (as defined in subsection (c)(2)) for the respective year.

''(4) ASSISTANCE INCREASE FACTOR DESCRIBED.—For purposes of paragraph (1)(A), the

‘assistance increase factor’ for a year for a State is equal to the sum of—

‘‘(A) the FEHBP State rolling increase factor (described in subsection (c)(2)) for the year,

‘‘(B) the annual percentage change (which may be positive or negative) in the population of the State (as estimated by the Secretary), and

‘‘(C)(i) 1 percentage point for 1998,

‘‘(ii) ⅔ percentage point for 1999,

‘‘(iii) ⅓ percentage point for 2000, and

‘‘(iv) 0 percentage points for each subsequent year.

‘‘(5) FEDERAL-TO-STATE CONVERSION FACTOR.—For purposes of this title, the ‘Federal-to-State conversion factor’ for a State is equal to the ratio of—

‘‘(A) 1 minus the Federal medical assistance percentage (as defined in section 1905(b)) for the State for 1994, to

‘‘(B) such Federal medical assistance percentage.

‘‘(c) FEHBP NATIONAL AND STATE ROLLING INCREASE PERCENTAGES.—

''(1) NATIONAL INCREASE PERCENTAGE.—For purposes of this title, the term 'FEHBP national rolling increase percentage' means, for a year, the 5-year weighted average of the annual national percentage increase in the premiums for health plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code) for the 5-year period ending with the previous year.

''(2) STATE INCREASE PERCENTAGE.—For purposes of this title, the term 'FEHBP State rolling increase percentage' means, for a year with respect to a State, the 5-year weighted average of the annual percentage increase in the premiums for health plans offered in the State under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code) for the 5-year period ending with the previous year.

''(3) DETERMINATION.—The increase percentages under paragraphs (1) and (2) shall be determined by the Secretary, in consultation with the Director of Office of Personnel Management, based on the best information available. Such increases shall be adjusted—

''(A) to take into account the age distribution in the Federal workforce (not taking into account individuals 65 years of age or older, employees of the United States Postal Service, retirees, and annuitants) relative to the age distribution in the population of AFDC recipients and non-cash medicaid beneficiaries, and

''(B) to disregard any changes due to changes in the benefit package under the Federal Employees Health Benefits Program after 1994.

''(d) USE OF STATE FUNDS.—Each State subsidy program shall provide assurances satisfactory to the Secretary that Federal funds will not be used, directly or indirectly, to provide for the State expenditures required under this section.

''PART C—FINANCING FAILSAFE MECHANISM AND GENERAL PROVISIONS

"SEC. 2141. ENSURING DEFICIT NEUTRAL SPENDING ON PREMIUM AND COST-SHARING ASSISTANCE AND SUPPLEMENTAL ACUTE CARE BENEFITS.

''(a) LIMITATION ON FEDERAL EXPENDITURES.—

''(1) IN GENERAL.—In each fiscal year (beginning with 1998), Federal payments under this title shall be limited to the amount by which—

''(A) the aggregate limitation described in subsection (b) for the year, exceeds

''(B) the amount of the mandatory Federal expenditures under title XVIII and XIX for the year, including any offsetting receipts required under title XVIII but excluding any discretionary expenditures under such title or title XIX.

''(2) CONTINGENCY.—Any direct payment authority provided under part A or B with respect to premium and cost-sharing assistance or supplemental acute care benefits is subject to the operation of this section.

''(b) AGGREGATE LIMITATION.—For purposes of this section, subject to subsection (d), the aggregate limitation described in this subsection—

''(1) for fiscal year 1998, is $351 billion;

''(2) for fiscal year 1999, is $392 billion;

''(3) for fiscal year 2000, is $433 billion;

''(4) for fiscal year 2001, is $482 billion;

''(5) for fiscal year 2002, is $535 billion;

''(6) for fiscal year 2003, is $594 billion;

''(7) for fiscal year 2004, is $660 billion; and

''(8) for each succeeding fiscal year is the aggregate limitation under this subsection for the pre-

ceding fiscal year increased by the same percentage as the percentage growth in national health expenditures (as estimated by the Secretary) from the second preceding fiscal year to the preceding fiscal year.

''(c) MID-SESSION BUDGET REVIEW ESTIMATES.—As part the President's supplemental summary providing revised estimates of the budget (commonly called the 'mid-session review of the budget') for each fiscal year (beginning with fiscal year 1997), the President shall issue the following:

''(1) ESTIMATE FOR UPCOMING YEAR.—An estimate of expenditures under titles XVIII and XIX and parts A and B of this title for the upcoming fiscal year (determined without regard to this section).

''(2) INFORMATION ON ACTUAL EXPENDITURES FOR PRECEDING YEAR.—Information on actual expenditures under titles XVIII and XIX and parts A and B of this title for the preceding fiscal year determined taking into account adjustments under this section. Such information shall first be provide in the mid-session review for the fiscal year 1999 budget.

''(3) INFORMATIONAL ESTIMATE FOR CURRENT YEAR.—An estimate of expenditures under titles

XVIII and XIX and parts A and B of this title for the current fiscal year. Such information shall first be provided in the mid-session review for the fiscal year 1998 budget.

''(d) RETROSPECTIVE ADJUSTMENT.—If the information provided under subsection (c)(2) during a fiscal year indicates (taking into account any adjustment under this section) that the amount of mandatory expenditures described in subsection (a)(1)(B) for the preceding fiscal year exceeded the aggregate limitation described in subsection (b) for the year, for the succeeding fiscal year the aggregate limitation under subsection (b) shall be decreased by the amount of such excess.

''(e) PROSPECTIVE ADJUSTMENT.—

''(1) IN GENERAL.—If the estimate provided under subsection (c)(1) during a fiscal year indicates that the amount of mandatory expenditures described in subsection (a)(1)(B) for the upcoming fiscal year will exceed the aggregate limitation described in subsection (b) for the year, then for the succeeding fiscal year, the Director of the Office of Management and Budget, after consultation with the Secretary—

''(A) shall apply the adjustments described in paragraph (2) to the extent necessary to eliminate such excess, and

''(B) if such adjustments are insufficient to eliminate such excess, shall apply the adjustments described in paragraph (3).

''(2) REDUCTIONS IN AMOUNTS AVAILABLE FOR SUPPLEMENTAL ACUTE CARE BENEFITS PROGRAMS.—

''(A) IN GENERAL.—An adjustment under this paragraph consists of reduction in the limitations on payments to States established under section 2124(b).

''(B) MANNER OF REDUCTION.—Such reduction shall be made in a proportional manner and shall provide for an aggregate reduction in the limits equal to the amount of such the reduction required to comply with the requirement of subsection (a).

''(3) REDUCTION IN PREMIUM ASSISTANCE AMOUNT.—

''(A) IN GENERAL.—An adjustment under this paragraph consists of uniform proportional reduction in the premium assistance percentage applied under section 2103(b)(3), but only with

respect to individuals who are not cost-sharing assistance eligible individuals.

''(B) MANNER OF REDUCTION.—The proportion of the uniform proportional reduction shall be calculated by the Director, in consultation with the Secretary, in a manner that results in an aggregate reduction in the payments to States under part A in an amount that assures (taking into account reductions resulting from the adjustment under paragraph (2)) compliance with the requirement of subsection (a).

''(4) NOTICE TO CONGRESS.—Before effecting any adjustment under this subsection, the Director shall submit to Congress a report that describes the adjustment to be made and the basis for making the adjustment.

''(5) NO AFFECT ON STATE MAINTENANCE-OF-EFFORT REQUIREMENTS.—Any adjustment under this subsection shall not affect the requirements for States under sections 2107 or 2125.

''(f) PRESIDENT'S BUDGET TO INCLUDE PREMIUM ASSISTANCE ESTIMATES.—

''(1) IN GENERAL.—When the President submits a budget (as required by section 1105 of title 31), the President shall include in such budget—

''(A) estimates of Federal expenditures under titles XVIII and XIX and parts A and B of this title otherwise provided without regard to this section; and

''(B) a comparison of the Federal expenditures under titles XVIII and XIX with the aggregate limitation established under subsection (b); and

''(C) estimates of adjustments under subsection (d) that are necessary to comply with enforcement of the limitation under subsection (a).

''(2) FISCAL YEARS COVERED.—The President shall submit such estimates for the upcoming fiscal year and the following 4 fiscal years beginning with the budget submitted for fiscal year 1997, and

''(A) beginning with the budget for fiscal year 1998, the current fiscal year; and

''(B) beginning with the budget for fiscal year 1999, the current fiscal year and the preceding fiscal year.

''(g) CBO INFORMATION AND ANALYSES.—

''(1) CBO TECHNICAL CORRECTIONS REPORT.—In or about January of each year when the Congressional Budget Office changes the economic and technical assumptions in the budget baseline used by such Office, the Director of such Office shall submit to the Congress a report on such changes. The report shall include an explanation of what the aggregate limitation amounts under subsection (b) might have been if they had been computed based on such changed assumptions.

''(2) CBO ANALYSIS.—In or about March of each year, after having an opportunity to analyze the report submitted under subsection (e)(1), the Director of the Congressional Budget Office shall submit to Congress a report that contains an analysis of the differences between the estimates contained in the President's report and the estimates of such Office based on the economic and technical assumptions referred to in paragraph (1).

"SEC. 2142. PAYMENTS FOR ADMINISTRATIVE EXPENSES UNDER TITLE.

''(a) IN GENERAL.—Subject to subsection (b), the Secretary shall pay to each State operating a State program under this part or part B, for each quarter beginning with the quarter commencing January 1, 1998, an

amount equal to 50 percent of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of such programs in the State, not including any State maintenance-of-effort expenditures required under section 2107 or 2125.

''(b) LIMITATION.—

''(1) IN GENERAL.—The amount of funds which the Secretary is otherwise obligated to pay a State for quarters in a year under subsection (a) shall not exceed such proportion of the amount specified in paragraph (2) as the Secretary determines, taking into account relevant factors including the proportion of premium assistance eligible individuals (including cost-sharing assistance eligible individuals) who reside in the State, the relative costs of administrative services in the State (compared to the national average costs of administrative services), and total non-administrative expenditures by the State under this title.

''(2) TOTAL AVAILABLE ADMINISTRATIVE AMOUNT.—For purposes of this subsection, the amount specified in this paragraph for all calendar quarters in a year for payments to States shall not exceed—

''(A) $2.3 billion for 1998,

''(B) $2.5 billion for 1999,

''(C) $2.7 billion for 2000,

''(D) $2.9 billion for 2001,

''(E) $3.1 billion for 2002,

''(F) $3.3 billion for 2003, and

''(G) $3.6 billion for 2004.

"SEC. 2143. HEALTH CARE ASSURANCE TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Assurance Trust Fund' (in this section referred to as the 'Trust Fund'), consisting of such amounts as may be appropriated or credited to it under this section.

''(b) TRANSFERS TO THE TRUST FUND.—

''(1) IN GENERAL.—There are hereby appropriated to the Trust Fund the amount determined by the Secretary of the Treasury, after consultation with the Secretary of Health and Human Services, to be equal to the sum of—

''(A) the decrease in Federal expenditures resulting from the provisions of, and the amendments made by, the Bipartisan Health Care Reform Act of 1994, and

''(B) amounts received by the Secretary pursuant to sections 2104(e), 2105(b)(2), and 2105(e).

''(2) TRANSFERS FROM OTHER TRUST FUNDS.—The Secretary of Health and Human Services shall transfer each fiscal year to the Trust Fund from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund the amount which the Secretary estimates is equal to the decrease in expenditures in each such trust fund attributable to the provisions of the Bipartisan Health Care Reform Act of 1994.

''(3) TRANSFERS FROM GIFTS AND BEQUESTS.—The Secretary of Health and Human Services shall transfer each fiscal year to the Trust Fund any money gifts or bequests made to or on behalf of the United States for allocation to the Trust Fund.

''(c) EXPENDITURES.—Amounts in the Trust Fund shall be used as follows:

''(1) Amounts shall be appropriated to the Secretary for payments to States in a fiscal year for the programs under parts A and B of this title (and to the extent any such amount is not expended during

any fiscal year, such amount shall be available for such purpose for subsequent fiscal years).

''(2) Amounts shall be transferred to an account in the General Fund of the Treasury in an amount equal to the estimate of the Secretary of the Treasury of the reductions in revenues deposited in the General Fund resulting from the amendments made to the Internal Revenue Code of 1986 by the Bipartisan Health Care Reform Act of 1994.

''(d) NATURE OF PAYMENT OBLIGATION.—Subject to section 2141, sections 2106, 2124, and 2142 constitute budget authority in advance of appropriations Acts, and represent the obligation of the Federal Government to provide payments to States under such sections in accordance with the applicable provisions of this title.

"SEC. 2144. LIMITATION ON USE OF FUNDS FOR ABORTIONS.

''None of the funds appropriated to carry out this title shall be expended for premium assistance under this part that provides coverage of any abortion, for cost-sharing assistance under this part with respect to expenses incurred for any abortion, or for supplemental acute care benefits under part B for any abortion, except in the case of an abortion where the procedure is necessary to save

the life of the mother or where the pregnancy is the result of an act of rape or incest.

"SEC. 2145. AUDITS.

''The Secretary shall conduct regular audits of the activities under the State programs conducted under this title.

"SEC. 2146. DEMONSTRATION PROJECT AUTHORITY.

''(a) IN GENERAL.—In the case of any experimental, pilot, or demonstration project which in the judgment of the Secretary is likely to assist in promoting the objectives of this title in a State or States, the Secretary may waive compliance with any of the requirements of this title to the extent and for the period the Secretary finds necessary to enable the Secretary to carry out the project.

''(b) RESTRICTION.—

''(1) FINDINGS.—The Secretary may authorize a waiver under subsection (a) only if the Secretary determines that under the waiver—

''(A) all individuals who would be premium assistance eligible individuals remain eligible for premium assistance,

''(B) benefits under part A are not reduced below the level of benefits otherwise provided, and

''(C) the amount of payments made by the Federal Government do not exceed the amount of payments otherwise provided.

''(2) LIMITATION.—The Secretary may not authorize a waiver of sections 2107 or 2125 (relating to State maintenance-of-effort).

"SEC. 2147. DEFINITIONS AND DETERMINATIONS OF INCOME.

''For purposes of this title:

''(1) DETERMINATIONS OF INCOME.—

''(A) FAMILY INCOME.—The term 'family income' means, with respect to an individual who—

''(i) is not a dependent (as defined in subparagraph (B)) of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (D)) for the individual, the individual's spouse, and dependents of the individual; or

''(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes for the other individual, the other individual's spouse, and dependents of the other individual.

''(B) DEPENDENT.—The term 'dependent' shall have the meaning given such term under paragraphs (1) or (2) of section 152(a) of the Internal Revenue Code of 1986.

''(C) SPECIAL RULE FOR FOSTER CHILDREN.—For purposes of subparagraph (A), a child who is placed in foster care by a State agency shall not be considered a dependent of another individual.

''(D) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 162(l), 220, 911, 931, and 933 of such Code, and

''(ii) increased by—

''(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax,

''(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during

the taxable year to the extent not included in gross income under section 86 of such Code,

''(III) the amount of aid to families with dependent children received during the taxable year under part A of title IV to the extent not included in gross income under such Code, and

''(IV) the amount of any supplemental security income benefits provided under title XVI.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

''(E) ELECTION WITH RESPECT TO INCOME DETERMINATION.—As elected by a family at the time of submission of an application for a premium or cost-sharing assistance under this part, family income shall be determined either—

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

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

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

''(A) in the case of a family of less than five individuals, is applicable to a family of the size involved; and

''(B) in the case of a family of more than four individuals, is applicable to a family of four persons.

''(3) PREGNANT WOMAN.—The term 'pregnant woman' includes a woman during the 60-day period beginning on the last day of the pregnancy.

''(4) PREMIUM.—Any reference to the term 'premium' includes a reference to premium equivalence for self-insured plans.''.

SEC. 2102. OPERATION OF PROGRAM AS STATE PLAN REQUIREMENT UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 3303(a)(1), 3003(a), and 3201(f)(5), is amended—

(1) by striking ''and'' at the end of paragraph (63);

(2) by striking the period at the end of paragraph (64) and inserting ''; and''; and

(3) by inserting after paragraph (64) the following new paragraph:

''(65) provide for a State program furnishing premium subsidies for low-income individuals in accordance with part A of title XXI.''.

(b) EFFECTIVE DATE.—The requirement of section 1902(a)(65) of the Social Security Act (as added by subsection (a)) shall apply to Federal financial participation for calendar quarters beginning on or after January 1, 1998.

SEC. 2103. APPLICATION OF MISCELLANEOUS PROVISIONS.

(a) APPLICATION OF SAVE PROVISIONS.—Section 1137(b) of the Social Security Act (42 U.S.C. 1320b–7(b)) is amended—

(1) by striking ''and'' at the end of paragraph (4),

(2) by striking the period at the end of paragraph (5) and inserting ''; and'', and

(3) by adding at the end the following:

''(6) a State subsidy program under part A of title XXI.''.

(b) DISCLOSURE OF CERTAIN INFORMATION.

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(15) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT HEALTH PREMIUM ASSISTANCE CERTIFICATE PROGRAM.—The Secretary shall, upon written request from a State, disclose to officials of the State return information for purposes of determining or verifying whether any individual is entitled to a premium assistance certificate under part A of title XXI of the Social Security Act and the amount thereof. Return information disclosed under this paragraph may be used by such officers and employees only for the purposes of, and to the extent necessary in, making such determination or verification.''.

(2) CONFORMING CHANGE.—Paragraph (4) of section 6103(p) of such Code is amended by striking

''or (14)'' each place it appears and inserting ''(14) or (15)''.

(c) APPLICATION OF DEFINITION OF STATE.—Section 1001(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) is amended by striking ''title XX'' and inserting ''titles XX and XXI''.

TITLE III—MEDICAID REFORMS

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Subtitle A—Treatment of Acute Care Benefits for AFDC and Non-cash Beneficiaries

SEC. 3001. DIVISION OF MEDICAID BENEFITS INTO CORE BENEFITS AND SUPPLEMENTAL BENEFITS FOR AFDC AND NON-CASH BENEFICIARIES; LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR CORE BENEFITS; SUNSET IN MEDICAL ASSISTANCE.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

''MEDICAID REFORM RULES FOR BENEFITS FOR ACUTE MEDICAL SERVICES FOR AFDC RECIPIENTS AND NON-CASH MEDICAID BENEFICIARIES

''SEC. 1931. (a) APPLICATION OF SECTION.—

''(1) IN GENERAL.—This section applies with respect to medical assistance for acute medical services (as defined in paragraph (2)) under State plans under this title for calendar quarters beginning on or after January 1, 1995, provided to AFDC recipients and non-cash medicaid categorical beneficiaries. To the extent this section applies, it supersedes any

contrary provision of this title or of other applicable law.

''(2) DEFINITIONS.—In this section:

''(A) ACUTE MEDICAL SERVICES.—The term 'acute medical services' means items and services described in section 1905(a) other than the following:

''(i) Nursing facility services (as defined in section 1905(f)).

''(ii) Intermediate care facility for the mentally retarded services (as defined in section 1905(d)).

''(iii) Personal care services (as described in section 1905(a)(24)).

''(iv) Private duty nursing services (as referred to in section 1905(a)(8)).

''(v) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915.

''(vi) Home and community care furnished to functionally disabled elderly individuals under section 1929.

''(vii) Community supported living arrangements services under section 1930.

''(viii) Case-management services (as described in section 1915(g)(2)).

''(ix) Home health care services (as referred to in section 1905(a)(7)), clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in a previous clause.

''(x) Hospice care.

''(B) AFDC RECIPIENT.—The term 'AFDC recipient' means, for a month, an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV for the month.

''(C) CORE BENEFITS.—The term 'core benefits' means benefits with respect to acute medical services which the Secretary identifies under subsection (b)(1) as typically included in the services covered under benchmark coverage (as defined in section 1903(1) of the Bipartisan Health Care Reform Act of 1994).

''(D) NON-CASH MEDICAID BENEFICIARY.—The term 'non-cash medicaid bene-

ficiary' means an individual described in section 1902(a)(10)(A) who is not an AFDC recipient or an SSI recipient.

''(E) SSI RECIPIENT.—The term 'SSI recipient' means, for a month, an individual—

''(i) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

''(ii) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93–66 for the month,

''(iii) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month, or

''(iv) who is treated under section 1619(b) of the Social Security Act as receiving supplemental security income benefits in a month for purposes of title XIX of such Act.

''(F) SUPPLEMENTAL ACUTE CARE BENEFITS.—The term 'supplemental acute care bene-

fits' means benefits for acute medical services which are not—

''(i) core benefits, and

''(ii) benefits for items or services described in clauses (i) through (x) of subparagraph (A).

''(b) DIVISION OF ACUTE MEDICAL SERVICE BENEFITS INTO CORE BENEFITS AND SUPPLEMENTAL ACUTE CARE BENEFITS.—The Secretary shall divide the class of benefits for acute medical services into the following benefit groups:

''(1) CORE BENEFITS.—A group of benefits consisting of core benefits (as defined in subsection (a)(2)(C)).

''(2) SUPPLEMENTAL ACUTE CARE BENEFITS.—A group of benefits consisting of supplemental acute care benefits (as defined in subsection (a)(2)(F)).

''(c) LIMITATION ON AMOUNT OF FEDERAL FINANCIAL PARTICIPATION FOR BENEFITS FOR ACUTE MEDICAL SERVICES FOR AFDC RECIPIENT AND NON-CASH MEDICAID BENEFICIARIES.—

''(1) LIMITATION ON CORE BENEFITS FOR 1995 THROUGH 1997.—With respect to expenditures for medical assistance for core benefits for AFDC re-

cipients and non-cash medicaid beneficiaries in a State the following rules shall apply:

''(A) 1995.—For all quarters in calendar year 1995, Federal financial participation under section 1903(a)(1) shall not be payable to the extent that per capita expenditures for such assistance exceed a per capita limiting amount equal to the base per capita core benefit Federal payment limit for AFDC recipients and non-cash medicaid beneficiaries (specified in paragraph (2)(A)) increased by the FEHBP national rolling increase percentage (as defined in section 2107(c)(1)) for 1995.

''(B) 1996 AND 1997.—For all quarters in calendar year 1996 and for all quarters in calendar year 1997, Federal financial participation under section 1903(a)(1) shall not be payable to the extent that per capita expenditures for such assistance for such year exceed a per capita limiting amount equal to the per capita limiting amount established under subparagraph (A) or this subparagraph, respectively, for the preceding year increased by the FEHBP national rolling increase percentage (as defined in

section 2107(c)(1)) for 1996 or 1997, respectively.

''(C) ESTIMATIONS AND ADJUSTMENTS.—The Secretary shall—

''(i) establish a process for estimating the limiting amounts under this paragraph at the beginning of each year and adjusting such amount during such year; and

''(ii) notifying each State of the estimations and adjustments referred to in clause (i).

''(2) BASE PER CAPITA CORE BENEFIT FEDERAL PAYMENT LIMIT FOR AFDC RECIPIENTS AND NON-CASH MEDICAID BENEFICIARIES.—

''(A) IN GENERAL.—In paragraph (1)(A), the 'base per capita core benefit Federal payment limit for AFDC recipients and non-cash medicaid beneficiaries' specified in this subparagraph, for a State, is—

''(i) the baseline Federal medicaid core benefit payments for AFDC recipients and non-cash medicaid beneficiaries (as defined in subparagraph (B)) for the State, divided by

''(ii) the number of AFDC recipients and non-cash medicaid beneficiaries enrolled in the State plan under this title in 1994, as determined under subparagraph (C).

''(B) DETERMINATION OF BASELINE FEDERAL MEDICAID CORE BENEFIT PAYMENTS FOR AFDC RECIPIENTS AND NON-CASH MEDICAID BENEFICIARIES.—For purposes of subparagraph (A)(i), the 'baseline medicaid core benefit expenditures for AFDC recipients and non-cash medicaid beneficiaries' for a State is the amount of Federal payments made under section 1903(a)(1) with respect to medical assistance furnished for core benefits for AFDC recipients and non-cash medicaid beneficiaries for all calendar quarters in 1994.

''(C) DETERMINATION OF NUMBER OF AFDC RECIPIENTS AND NON-CASH MEDICAID BENEFICIARIES.—For purposes of subparagraph (A)(ii), the number of AFDC recipients and non-cash medicaid beneficiaries for a State for 1994 shall be determined based on actual reports submitted by the State to the Secretary. In the case of individuals who were not recipi-

ents or beneficiaries for the entire fiscal year, the number shall take into account only the portion of the year in which they were such recipients. The Secretary may audit such reports.

''(3) LIMITATION ON BENEFITS FOR ACUTE MEDICAL SERVICES AFTER 1997.—With respect to expenditures for medical assistance for acute medical services benefits for AFDC recipients and non-cash medicaid beneficiaries in a State for quarters in a calendar year after 1997—

''(A) no such Federal financial participation shall be payable under section 1903(a)(1), and

''(B) such a recipient or beneficiary is not entitled to receive any medical assistance for such benefits under the State plan under this title.

''(4) ADDITIONAL RULES.—For purposes of this subsection—

''(A) DISPROPORTIONATE SHARE PAYMENTS NOT INCLUDED.—Payments attributable to section 1923 shall not be counted in the amount of Federal payments.

''(B) TREATMENT OF DISALLOWANCES.—The amount of Federal payments shall take

into account amounts (or an estimate of amounts) disallowed.

''(C) APPLICATION TO PARTICULAR ITEMS AND SERVICES.—In determining the Federal payment with respect to a category of items and services (within the core benefits) furnished in a State, there shall be counted only that proportion of such expenditures (determined only with respect to medical assistance furnished to AFDC recipients and non-cash medicaid beneficiaries) that were attributable to items and services included in the core benefits (taking into account any limitation on amount, duration, or scope of items and services included in such benefits).

''(d) CONDITIONING FEDERAL FINANCIAL PARTICIPATION ON STATE MAINTENANCE-OF-EFFORT.—

''(1) IN GENERAL.—Payment to a State under section 1903(a) for a quarter during 1995, 1996, or 1997 is conditioned upon the State making expenditures under this title from non-Federal funds (consistent with paragraph (3)) for core benefits for AFDC recipients and non-cash medicaid beneficiaries equal to at least the State maintenance-of-

effort amount computed under paragraph (2) for the year.

''(2) STATE MAINTENANCE-OF-EFFORT AMOUNT.—The State maintenance-of-effort amount computed under this paragraph for a State for a year is equal to the product of—

''(A) the amount that would be computed as the per capita limiting amount under subsection (c)(1) for the State for the year if the FEHBP State rolling increase percentage (as defined in section 2107(c)(2)) were substituted for any reference to the FEHBP national rolling increase percentage in such subsection; and

''(B) the Federal-to-State conversion factor (as defined in section 2107(b)(5)).

''(3) USE OF STATE FUNDS.—Each State shall provide assurances satisfactory to the Secretary that Federal funds will not be used, directly or indirectly, to provide for the State expenditures required under this subsection.''.

(b) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by section 3303(a)(3), is amended—

(1) by striking ''or'' at the end of paragraph (12),

(2) by striking the period at the end of paragraph (13) and inserting ''; or'', and

(3) by inserting after paragraph (13) the following:

''(14) in accordance with section 1931, with respect to amounts expended for medical assistance—

''(A) for supplemental acute care benefits (as defined in section 1931(a)(2)(F)) for AFDC recipients and non-cash medicaid beneficiaries for calendar quarters beginning on or after January 1, 1995,

''(B) for core benefits (as defined in section 1931(a)(2)(C)) for AFDC recipients and non-cash medicaid beneficiaries for calendar quarters beginning on or after January 1, 1995, and before January 1, 1998, to the extent they exceed limits specified in section 1931(c)(1), and

''(C) for core benefits for AFDC recipients and non-cash medicaid beneficiaries for calendar quarters beginning on or after January 1, 1998.''.

SEC. 3002. CONTINUATION OF STATE MEDICAID ELIGIBILITY CATEGORIES.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1369a(a)), as amended by section 3303(a)(1), is amended—

(1) by striking ''and'' at the end of paragraph (60);

(2) by striking the period at the end of paragraph (61) and inserting ''; and ''; and

(3) by inserting after paragraph (61) the following new paragraph:

''(62) provide for the continuation through December 31, 1997, of eligibility for medical assistance under section 1902(a)(10)(A) of any class or category of individuals eligible for medical assistance under such section during fiscal year 1994.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for calendar quarters beginning on or after January 1, 1995.

Subtitle B—Flexibility in Expenditures for Supplemental Benefits for AFDC and Non-cash Beneficiaries

SEC. 3101. PROVISION OF SUPPLEMENTAL ACUTE CARE BENEFITS THROUGH STATE SUPPLEMENTAL ACUTE CARE BENEFIT PROGRAMS.

(a) IN GENERAL.—Title XXI of the Social Security Act, as added by section 2101(a), is amended by inserting after part A the following new part:

''PART B—STATE SUPPLEMENTAL ACUTE CARE BENEFITS PROGRAMS

"SEC. 2121. ESTABLISHMENT OF STATE SUPPLEMENTAL ACUTE CARE BENEFITS PROGRAMS.

''(a) IN GENERAL.—Each State shall establish a State supplemental acute care benefits program (each in this part referred to as a 'State supplemental acute care benefits program') that provides supplemental acute care benefits for supplemental benefit eligible individuals.

''(b) AVAILABILITY OF FUNDS.—Each State with a State supplemental acute care benefits program approved under this part is entitled, for calendar quarters beginning on or after January 1, 1995, to payment under section 2124.

''(c) APPROVAL OF STATE PROGRAMS; PROGRAM DESCRIPTIONS.—The Secretary may not approve a State supplemental acute care benefits program unless the State has submitted a detailed description of the form and manner in which it will carry out the program (consistent with the applicable requirements of this part) and the Secretary finds that the program meets such applicable requirements.

"SEC. 2122. ELIGIBILITY.

''(a) IN GENERAL.—In this part, the term 'supplemental benefit eligible individual' means an individual who, as of the time of provision of supplemental acute care benefits, is described as follows:

''(1) 1995 THROUGH 1997.—The individual is an AFDC recipient or a non-cash medicaid beneficiary (as such terms are defined in section 1931(a)(2)).

''(2) 1998 AND THEREAFTER.—The individual is a premium assistance eligible individual (as defined in section 2102(a)).

''(b) CONSTRUCTION.—Nothing in this part shall be construed to create an entitlement for any specific supplemental benefit eligible individual.

''SEC. 2123. SCOPE AND PROVISION OF BENEFITS; BENEFITS ADMINISTRATION.

''(a) IN GENERAL.—The supplemental acute care benefits that may be made available under a State supplemental acute care benefits program may include supplemental acute care benefits (as defined in section 1931(a)(2)(F)).

''(b) COVERAGE OF BENEFITS.—Each State supplemental acute care benefits program—

''(1) shall establish methods and standards to select the types, and the amount, duration, and scope, of supplemental acute care benefits included in the program and to assure access to, and the quality of, services included in such benefits;

''(2) in providing benefits for supplemental benefit eligible individuals—

''(A) may vary the supplemental acute care benefits provided among reasonable classes of such individuals, and

''(B) may take into account the individual needs of individuals; and

''(3) shall coordinate the provision of such benefits with other health insurance coverage and health benefit programs in a manner that avoids duplication of benefits.

''(c) PAYMENT METHODS.—Benefits under a program may be made available in the form of direct provision of services, reimbursement of providers, prepayment to providers or health plans on a capitation basis, reimbursement of supplemental benefit eligible individuals for expenses incurred for supplemental acute care benefits, or a combination of these methods.

''(d) ADMINISTRATION.—

''(1) STATE AGENCY.—Each State supplemental acute care benefits program shall designate any appropriate State agency to administer the program.

''(2) COORDINATION.—The State supplemental acute care benefits program shall specify how the program—

''(A) will be coordinated with the State medicaid plan, titles V and XX of the Social Security Act, part A of this title, and any other Federal or State programs that provide services or assistance targeted to supplemental benefit eligible individuals, and

''(B) will be coordinated with qualified health coverage.

''(e) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—Each State supplemental acute care benefits program shall furnish to the Secretary—

''(1) such reports, and cooperate with such audits, as the Secretary determines are needed concerning the State's administration of the program under this part, including the processing of any claims under the program, and

''(2) such data and information as the Secretary may require in order to carry out the Secretary's responsibilities.

"SEC. 2124. PAYMENTS TO STATES.

''(a) IN GENERAL.—

''(1) PAYMENTS FOR SUPPLEMENTAL ACUTE CARE BENEFITS.—Subject to paragraph (2), subsection (b), and sections 2125 and 2141, the Secretary shall provide for payment to each State operating an approved State supplemental acute care benefits program in an amount equal to the amount expended by the State under the program during the quarter for supplemental acute care benefits for supplemental benefit eligible individuals.

''(2) NO PAYMENT FOR MAINTENANCE-OF-EFFORT EXPENDITURES OR ADMINISTRATION.—No payment shall be made under paragraph (1)—

''(A) for any State maintenance-of-effort expenditures required under section 2125, or

''(B) for any expenditures relating to administration of a State subsidy program.

''(3) PAYMENTS FOR RELATED ADMINISTRATIVE EXPENSES.—

''(A) 1995 THROUGH 1997.—

''(i) IN GENERAL.—Subject to sections 2123(d)(2), 2124(b), 2125, and 2141, and clause (ii), the Secretary shall pay to each State operating a State supplemental acute care benefits program, for each quarter beginning with the quarter commencing January 1, 1995, and ending before January 1, 1998, an amount equal to 50 percent of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of such program, not including any State maintenance-of-effort expenditures required under section 2125.

''(ii) LIMITATION.—The Secretary shall not find under clause (i) amounts expended to be for the proper and efficient administration of a State supplemental acute care benefits program if such amounts exceed 3 percent of the total ex-

penditures under the program in the quarter (including State maintenance-of-effort expenditures under section 2125).

''(B) REFERENCE TO PAYMENT FOR ADMINISTRATIVE EXPENSES AFTER 1997.—For payment for administrative expenses under this part after 1997, see section 2142.

''(4) FUNDING.—Payments to States under this subsection shall be made by the Secretary, from the Health Care Assurance Trust Fund (established under section 2143), at such time and in such form as provided in regulations promulgated by the Secretary, based on the form and manner in which payments are made under section 1903.

''(b) LIMITATION ON PAYMENTS FOR SUPPLEMENTAL ACUTE CARE BENEFITS.—

''(1) IN GENERAL.—Subject to section 2141 and paragraphs (2) and (3), the total amount of payments that may be made to a State under subsection (a)(1) for all quarters in a calendar year may not exceed the following:

''(A) 1995.—For 1995, the product of—

''(i) the initial per capita supplemental acute care benefit Federal payment

limit (described in subsection (c)) for the State, and

''(ii) the average monthly number of supplemental benefit eligible individuals in the State in 1995.

''(B) 1996 AND 1997.—For each of calendar years 1996 and 1997, the product of—

''(i) the limit specified in this clause (or subparagraph (A)(i)) for the State for the previous year increased by the FEHBP national rolling increase factor for the year (as defined in section 2107)(c)(1)), and

''(ii) the average monthly number of supplemental benefit eligible individuals in the State in the year.

''(C) 1998 AND THEREAFTER.—For 1998 or any succeeding year, the amount computed under this subparagraph (or subparagraph (B)) for the State for the preceding year increased by the supplemental acute care benefit increase factor under subsection (d) for the year.

''(2) ADJUSTMENT FOR AVAILABILITY OF ADDITIONAL FUNDS.—If the Secretary determines for a year that the total amount of the Federal payments under section 2124 for a year for all the States is

less than the sum of the limitations for the year for all the States established under paragraph (1), the limitation for each State under this subsection shall be increased in a pro-rata manner by such an amount as will not result in such total Federal payments under section 2124 exceeding the sum of such limits for all the States for the year.

''(3) ESTIMATIONS AND ADJUSTMENTS.—The Secretary shall—

''(A) establish a process for estimating the limit established under this subsection for a year at the beginning of the year and adjusting such amount during such year; and

''(B) notifying each State of the estimations and adjustments referred to in subparagraph (A).

''(c) INITIAL PER CAPITA SUPPLEMENTAL ACUTE CARE BENEFIT FEDERAL PAYMENT LIMIT DEFINED.—

''(1) IN GENERAL.—For purposes of subsection (b)(1)(A), the 'initial per capita supplemental acute care benefit Federal payment limit' for a State for a year is equal to the base per capita supplemental acute care Federal payments (described in paragraph (2)) increased by the FEHBP national rolling

increase percentage (as defined in section 2107(c)(1)) for 1995.

''(2) BASE PER CAPITA SUPPLEMENTAL ACUTE CARE FEDERAL PAYMENTS.—For purposes of paragraph (1), the 'base per capita supplemental acute care Federal payments' described in this paragraph, for a State, is—

''(A) the baseline Federal medicaid supplemental acute care benefit expenditures (as defined in paragraph (3)) for the State, divided by

''(B) the number of AFDC recipients and non-cash medicaid beneficiaries (as described in section 1931(a)(2)) enrolled in the State plan under title XIX in 1994, as determined under paragraph (4) consistent with section 1931(c)(3)(C).

''(3) DETERMINATION OF BASELINE FEDERAL MEDICAID SUPPLEMENTAL ACUTE CARE PAYMENTS.—

''(A) IN GENERAL.—For purposes of paragraph (2)(A), the 'baseline Federal medicaid supplemental acute care payments' for a State is the amount of Federal payments made under section 1903(a)(1) with respect to medical as-

sistance furnished for supplemental acute care benefits (as defined in section 1931(b)(2)) for AFDC recipients and non-cash medicaid beneficiaries for all calendar quarters in 1994.

''(B) DISPROPORTIONATE SHARE PAYMENTS NOT INCLUDED.—In applying subparagraph (A), payments attributable to section 1923 shall not be counted in the amount of payments.

''(C) TREATMENT OF DISALLOWANCES.—The amount determined under this paragraph shall take into account amounts (or an estimate of amounts) disallowed under title XIX.

''(4) APPLICATION TO PARTICULAR ITEMS AND SERVICES.—For purposes of this subsection, in determining the per capita supplemental medical benefit expenditure limit for a category of items and services (within the supplemental acute care benefits) furnished in a State, there shall be counted only that proportion of such expenditures (determined only with respect to medical assistance furnished to AFDC recipients and non-cash medicaid beneficiaries) that were attributable to items and services included in the supplemental acute care benefits (taking into account any limitation on amount, dura-

tion, or scope of items and services included in such benefits).

''(d) SUPPLEMENTAL ACUTE CARE BENEFIT INCREASE FACTOR DESCRIBED.—For purposes of subsection (b)(1)(C), the 'supplemental medical benefit increase factor' for a year for a State is equal to the sum of—

''(1) the FEHBP national rolling increase factor (as defined in section 2107(c)(1)) for the year,

''(2) the annual percentage change (which may be positive or negative) in the population of the State (as estimated by the Secretary for purposes of section 2107(c)(4)(B)), and

''(3)(A) 1 percentage point for 1998,

''(B) ⅔ percentage point for 1999,

''(C) ⅓ percentage point for 2000, and

''(D) 0 percentage points for each subsequent year.

"SEC. 2125. STATE MAINTENANCE-OF-EFFORT REQUIREMENT.

''(a) IN GENERAL.—Payment to a State under section 2124 for a quarter in a year (beginning with 1995) is conditioned upon—

''(1) the State making expenditures for supplemental acute care benefits under this part from non-

Federal funds (consistent with subsection (d)) for supplemental benefit eligible individuals equal to at least the supplemental benefit maintenance-of-effort amount computed under subsection (b) for the quarter, and

''(2) for quarters beginning on or after January 1, 1998, the State meeting the maintenance-of-effort requirement under section 2107(a)(1) for the quarter.

''(b) SUPPLEMENTAL BENEFITS MAINTENANCE-OF-EFFORT AMOUNT.—The supplemental benefits maintenance-of-effort amount computed under this subsection for a State for a quarter in a year is equal to ¼ of the product of—

''(1) the amount that would be computed as the minimum limitation under section 2124(b) for the State for all quarters in the year (determined without regard to section 2124(b)(2)) if the FEHBP State rolling increase percentage (as defined in section 2107(b)(2)) were substituted for the FEHBP national rolling increase percentage in section 2124(c)(1)(A) and in determining the supplemental medical benefit increase factor under 2124(d); and

''(2) the Federal-to-State conversion factor (specified under section 2107(b)(5)).

''(c) USE OF STATE FUNDS.—Each State supplemental acute care benefits program shall provide assurances satisfactory to the Secretary that Federal funds will not be used, directly or indirectly, to provide for the State expenditures required under this section.''.

(b) CONFORMING AMENDMENT TO MEDICAID PROGRAM.—Section 1931 of the Social Security Act, as added by section 3001, is amended by adding at the end the following:

''(e) ELIMINATION OF ENTITLEMENT FOR SUPPLEMENTAL ACUTE CARE BENEFITS.—With respect to medical assistance for supplemental acute care benefits for AFDC recipients and non-cash medicaid beneficiaries in a State for quarters in 1995 or any succeeding year—

''(1) no Federal financial participation shall be payable under section 1903(a)(1),

''(2) the State may receive payments for such supplemental acute care benefits under part B of title XXI, and

''(3) such a recipient or beneficiary is not entitled to receive any medical assistance for such benefits under the State plan under this title.''.

Subtitle C—Increased State Flexibility in Contracting for Coordinated Care

SEC. 3201. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CONTRACTING FOR COORDINATED CARE SERVICES.

(a) IN GENERAL.—

(1) PAYMENT PROVISIONS.—Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended to read as follows:

''(m)(1) No payment shall be made under this title to a State with respect to expenditures incurred by such State for payment to an entity which is at risk (as defined in section 1932(a)(4)) for services provided by such entity to individuals eligible for medical assistance under the State plan under this title, unless the entity is a risk contracting entity (as defined in section 1932(a)(3)) and the State and such entity comply with the applicable provisions of section 1932.

''(2) No payment shall be made under this title to a State with respect to expenditures incurred by such State for payment for services provided to an individual eligible for medical assistance under the State plan under this title if such payment by the State is contingent upon

the individual receiving such services from a specified health care provider or subject to the approval of a specified health care provider, unless the entity receiving payment is a primary care case management entity (as defined in section 1932(a)(2)) and the State and such entity comply with the applicable provisions of section 1932.''.

(2) REQUIREMENTS FOR COORDINATED CARE SERVICES.—Title XIX of such Act (42 U.S.C. 1396 et seq.), as amended by section 2001(a), is amended by redesignating section 1932 as section 1933 and by inserting after section 1931 the following new section:

''REQUIREMENTS FOR COORDINATED CARE SERVICES

''SEC. 1932. (a) DEFINITIONS.—For purposes of this title—

''(1) PRIMARY CARE CASE MANAGEMENT PROGRAM.—The term 'primary care case management program' means a program operated by a State agency under which such State agency enters into contracts with primary care case management entities for the provision of health care items and services which are specified in such contracts and the provision of case management services to individuals who are—

''(A) eligible for medical assistance under the State plan,

''(B) enrolled with such primary care case management entities, and

''(C) entitled to receive such specified health care items and services and case management services only as approved and arranged for, or provided, by such entities.

''(2) PRIMARY CARE CASE MANAGEMENT ENTITY.—The term 'primary care case management entity' means a health care provider which—

''(A) must be a physician, group of physicians, a Federally qualified health center, a rural health clinic, a community health authority (under section 1934), or an entity employing or having other arrangements with physicians operating under a contract with a State to provide services under a primary care case management program,

''(B) receives payment on a fee for service basis (or, in the case of a Federally qualified health center or a rural health clinic, on a reasonable cost per encounter basis) for the provision of health care items and services specified in such contract to enrolled individuals,

''(C) receives an additional fixed fee per enrollee for a period specified in such contract

for providing case management services (including approving and arranging for the provision of health care items and services specified in such contract on a referral basis) to enrolled individuals, and

''(D) is not an entity that is at risk (as defined in paragraph (4)) for such case management services.

''(3) RISK CONTRACTING ENTITY.—The term 'risk contracting entity' means an entity which has a contract with the State agency (or a health insuring organization described in subsection (n)(2)) under which the entity—

''(A) provides or arranges for the provision of health care items or services which are specified in such contract to individuals eligible for medical assistance under the State plan, and

''(B) is at risk (as defined in paragraph (4)) for part or all of the cost of such items or services furnished to individuals eligible for medical assistance under such plan.

''(4) AT RISK.—The term 'at risk' means an entity which—

''(A) has a contract with the State agency under which such entity is paid a fixed amount

for providing or arranging for the provision of health care items or services specified in such contract to an individual eligible for medical assistance under the State plan and enrolled with such entity, regardless of whether such items or services are furnished to such individual, and

''(B) is liable for all or part of the cost of furnishing such items or services, regardless of whether such cost exceeds such fixed payment.

''(b) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

''(1) ORGANIZATION.—A risk contracting entity meets the requirements of this section only if such entity—

''(A)(i) is a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as determined by the Secretary pursuant to section 1312 of such Act; or

''(ii) is described in subparagraph (C), (D), (E), (F), or (G) of subsection (e)(4);

''(B) is a Federally qualified health center, a rural health clinic, or a community health authority (under section 1934) which has made adequate provision against the risk of insol-

vency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical assistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency; or

''(C) is an entity which meets all applicable State licensing requirements and has made adequate provision against the risk of insolvency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical assistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency.

''(2) GUARANTEES OF ENROLLEE ACCESS.—A risk contracting entity meets the requirements of this section only if—

''(A) the geographic locations, hours of operation, patient to staff ratios, and other relevant characteristics of such entity are sufficient to afford individuals eligible for medical assistance under the State plan access to such entities that is at least equivalent to the access to health care providers that would be available

to such individuals if such individuals were not enrolled with such entity;

''(B) such entity has reasonable and adequate hours of operation, including 24-hour availability of—

''(i)(I) treatment for an unforeseen illness, injury, or condition of an individual eligible for medical assistance under the State plan and enrolled with such entity; or

''(II) referral to other health care providers for such treatment; and

''(ii) other information, as determined by the Secretary or the State; and

''(C) such entity complies with such other requirements relating to access to care as the Secretary or the State may impose.

''(3) CONTRACT WITH STATE AGENCY.—A risk contracting entity meets the requirements of this section only if such entity has a written contract with the State agency which provides—

''(A) that the entity will comply with all applicable provisions of this section, that the State has the right to penalize the entity for failure to comply with such requirements and to

terminate the contract in accordance with subsection (j), and that the entity will be subject to penalties imposed by the Secretary under subsection (i) for failure to comply with such requirements;

''(B) for a payment methodology based on experience rating or another actuarially sound methodology approved by the Secretary, which guarantees (as demonstrated by such models or formulas as the Secretary may approve) that—

''(i) payments to the entity under the contract shall not exceed an amount equal to 100 percent of the costs (which shall include administrative costs and which may include costs for inpatient hospital services that would have been incurred in the absence of such contract) that would have been incurred by the State agency in the absence of the contract; and

''(ii) the financial risk for inpatient hospital services is limited to an extent established by the State;

''(C) that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect

any books and records of the entity (and of any subcontractor) that pertain—

''(i) to the ability of the entity (or a subcontractor) to bear the risk of potential financial losses; or

''(ii) to services performed or determinations of amounts payable under the contract;

''(D) that in the entity's enrollment, reenrollment, or disenrollment of individuals eligible for medical assistance under the State plan and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of such individuals' health status or requirements for health care services;

''(E)(i) individuals eligible for medical assistance under the State plan who have enrolled with the entity are permitted to terminate such enrollment without cause as of the beginning of the first calendar month (or in the case of an entity described in subsection (e)(4), as of the beginning of the first enrollment period) following a full calendar month after a request is made for such termination;

''(ii) that when an individual has relocated outside the entity's service area, and the entity has been notified of the relocation, services (within reasonable limits) furnished by a health care provider outside the service area will be reimbursed either by the entity or by the State agency; and

''(iii) for written notification of each such individual's right to terminate enrollment, which shall be provided at the time of such individual's enrollment, and, in the case of a child with special health care needs as defined in subsection (e)(1)(B)(ii), at the time the entity identifies such a child;

''(F) in the case of services immediately required to treat an unforeseen illness, injury, or condition, of an individual eligible for medical assistance under the State plan and enrolled with the entity—

''(i) that such services shall not be subject to a preapproval requirement; and

''(ii) where such services are furnished by a health care provider other than the entity, for reimbursement of such provider either by the entity or by the State agency;

''(G) for disclosure of information in accordance with subsection (h) and section 1124;

''(H) that any physician incentive plan operated by the entity meets the requirements of section 1876(i)(8);

''(I) for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients;

''(J) that the entity will comply with the requirement of section 1902(w) with respect to each enrollee;

''(K) that the entity will implement a grievance system, inform enrollees in writing about how to use such grievance system, ensure that grievances are addressed in a timely manner, and report grievances to the State at intervals to be determined by the State;

''(L) that contracts between the entity and each subcontractor of such entity will require each subcontractor—

''(i) to cooperate with the entity in the implementation of its internal quality assurance program under paragraph (4) and adhere to the standards set forth in the quality assurance program, including

standards with respect to access to care, facilities in which patients receive care, and availability, maintenance, and review of medical records;

''(ii) to cooperate with the Secretary, the State agency and any contractor to the State in monitoring and evaluating the quality and appropriateness of care provided to enrollees as required by Federal or State laws and regulations; and

''(iii) where applicable, to adhere to regulations and program guidance with respect to reporting requirements under section 1905(r);

''(M) that, where the State deems it necessary to ensure the timely provision to enrollees of the services listed in subsection (f)(2)(C)(ii), the State may arrange for the provision of such services by health care providers other than the entity and may adjust its payments to the entity accordingly;

''(N) that the entity and the State will comply with guidelines and regulations issued by the Secretary with respect to procedures for marketing and information that must be pro-

vided to individuals eligible for medical assistance under the State plan;

''(O) that the entity must provide payments to hospitals for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital, in accordance with paragraphs (2) and (3) of section 1902(s);

''(P) that the entity shall report to the State, at such time and in such manner as the State shall require, on the rates paid for hospital services (by type of hospital and type of service) furnished to individuals enrolled with the entity;

''(Q) detailed information regarding the relative responsibilities of the entity and the State, for providing (or arranging for the provision of), and making payment for, the following items and services:

''(i) immunizations;

''(ii) the purchase of vaccines;

''(iii) lead screening and treatment services;

''(iv) screening and treatment for tuberculosis;

''(v) screening and treatment for, and preventive services related to, sexually transmitted diseases, including HIV infection;

''(vi) screening, diagnostic, and treatment services required under section 1905(r);

''(vii) family planning services;

''(viii) services prescribed under—

''(I) an Individual Education Plan or Individualized Family Service Plan under part B or part H of the Individuals with Disabilities Education Act; and

''(II) any other individual plan of care or treatment developed under this title or title V;

''(ix) transportation needed to obtain services to which the enrollee is entitled under the State plan or pursuant to an individual plan of care or treatment described in subclauses (I) and (II) of clause (viii); and

''(x) such other services as the Secretary may specify;

''(R) detailed information regarding the procedures for coordinating the relative responsibilities of the entity and the State to ensure prompt delivery of, compliance with any applicable reporting requirements related to, and appropriate record keeping with respect to, the items and services described in subparagraph (Q); and

''(S) such other provisions as the Secretary may require.

''(4) INTERNAL QUALITY ASSURANCE.—A risk contracting entity meets the requirements of this section only if such entity has in effect a written internal quality assurance program which includes a systematic process to achieve specified and measurable goals and objectives for access to, and quality of, care, which—

''(A) identifies the organizational units responsible for performing specific quality assurance functions, and ensures that such units are accountable to the governing body of the entity and that such units have adequate supervision,

staff, and other necessary resources to perform these functions effectively,

''(B) if any quality assurance functions are delegated to other entities, ensures that the risk contracting entity remains accountable for all quality assurance functions and has mechanisms to ensure that all quality assurance activities are carried out,

''(C) includes methods to ensure that physicians and other health care professionals under contract with the entity are licensed or certified as required by State law, or are otherwise qualified to perform the services such physicians and other professionals provide, and that these qualifications are ensured through appropriate credentialing and recredentialing procedures,

''(D) provides for continuous monitoring of the delivery of health care, through—

''(i) identification of clinical areas to be monitored, including immunizations, prenatal care, services required under section 1905(r), and other appropriate clinical areas, to reflect care provided to enrollees

eligible for medical assistance under the State plan,

''(ii) use of quality indicators and standards for assessing the quality and appropriateness of care delivered, and the availability and accessibility of all services for which the entity is responsible under such entity's contract with the State,

''(iii) use of epidemiological data or chart review, as appropriate, and patterns of care overall,

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

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

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

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

''(vi) implementation of corrective actions,

''(E) includes standards for timely enrollee access to information and care which at a minimum shall incorporate standards used by the State or professional or accreditation bodies for facilities furnishing perinatal and neonatology care and other forms of specialized medical and surgical care,

''(F) includes standards for the facilities in which patients receive care,

''(G) includes standards for managing and treating medical conditions prevalent among such entity's enrollees eligible for medical assistance under the State plan,

''(H) includes mechanisms to ensure that enrollees eligible for medical assistance under the State plan receive services for which the entity is responsible under the contract which are consistent with standards established by the applicable professional societies or government agencies,

''(I) includes standards for the availability, maintenance, and review of medical records

consistent with generally accepted medical practice,

''(J) provides for dissemination of quality assurance procedures to health care providers under contract with the entity, and

''(K) meets any other requirements prescribed by the Secretary or the State.

''(5) TRANSITIONAL AGREEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.—A risk contracting entity meets the requirements of this section only if such entity complies with the requirements of section 1013 of the Bipartisan Health Care Reform Act of 1994 (subject to the sunset contained in subsection (j) of such section).

''(c) GENERAL REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT PROGRAMS.—A primary care case management program implemented by a State under this section shall—

''(1) provide that each primary care case management entity participating in such program has a written contract with the State agency,

''(2) include methods for selection and monitoring of participating primary care case management entities to ensure—

''(A) that the geographic locations, hours of operation, patient to staff ratio, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance under the State plan access to such entities that is at least equivalent to the access to health care providers that would be available to such individuals if such individuals were not enrolled with such entity,

''(B) that such entities and their professional personnel are licensed as required by State law and qualified to provide case management services, through methods such as ongoing monitoring of compliance with applicable requirements and providing information and technical assistance, and

''(C) that such entities—

''(i) provide timely and appropriate primary care to such enrollees consistent with standards established by applicable professional societies or governmental agencies, or such other standards prescribed by the Secretary or the State, and

''(ii) where other items and services are determined to be medically necessary,

give timely approval of such items and services and referral to appropriate health care providers,

''(3) provide that no preapproval shall be required for emergency health care items or services, and

''(4) permit individuals eligible for medical assistance under the State plan who have enrolled with a primary care case management entity to terminate such enrollment without cause not later than the beginning of the first calendar month following a full calendar month after the request is made for such termination.

''(d) EXEMPTIONS FROM STATE PLAN REQUIREMENTS.—A State plan may permit or require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity without regard to the requirements set forth in the following paragraphs of section 1902(a):

''(1) Paragraph (1) (concerning statewideness).

''(2) Paragraph (10)(B) (concerning comparability of benefits), to the extent benefits not included in the State plan are provided.

''(3) Paragraph (23) (concerning freedom of choice of provider), except with respect to services

described in section 1905(a)(4)(C) and except as required under subsection (e).

''(e) STATE OPTIONS WITH RESPECT TO ENROLLMENT AND DISENROLLMENT.—

''(1) MANDATORY ENROLLMENT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a State plan may require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity only if the individual is permitted a choice within a reasonable service area (as defined by the State)—

''(i) between or among 2 or more risk contracting entities,

''(ii) among a risk contracting entity and a primary care case management program, or

''(iii) among primary care case management entities.

''(B) SPECIAL NEEDS CHILDREN.—

''(i) IN GENERAL.—A State may not require a child with special health care needs (as defined in clause (ii)) to enroll

with a risk contracting entity or a primary care case management entity.

''(ii) DEFINITION.—For purposes of this subparagraph, the term 'child with special health care needs' refers to an individual eligible for supplemental security income under title XVI, a child described under section 501(a)(1)(D), or a child described in section 1902(e)(3).

''(2) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

''(A) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this section,

''(B) in the next month (or next 2 months) is not eligible for such medical assistance, but

''(C) in the succeeding month is again eligible for such benefits,

the State agency (subject to subsection (b)(3)(E)) may enroll the individual for that succeeding month with such entity, if the entity continues to have a contract with the State agency under this subsection.

''(3) DISENROLLMENT.—

''(A) RESTRICTIONS ON DISENROLLMENT WITHOUT CAUSE.—Except as provided in subparagraph (C), a State plan may restrict the period in which individuals enrolled with risk contracting entities described in paragraph (4) may terminate such enrollment without cause to the first month of each period of enrollment (as defined in subparagraph (B)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

''(B) PERIOD OF ENROLLMENT.—For purposes of this paragraph, the term 'period of enrollment' means—

''(i) a period not to exceed 6 months in duration, or

''(ii) a period not to exceed 1 year in duration, in the case of a State that, on the effective date of this paragraph, had in effect a waiver under section 1115 of re-

quirements under this title under which the State could establish a 1-year minimum period of enrollment with risk contracting entities.

''(C) SPECIAL NEEDS CHILDREN.—A State may not restrict disenrollment of a child with special health care needs (as defined in paragraph (1)(B)(ii)).

''(4) ENTITIES ELIGIBLE FOR DISENROLLMENT RESTRICTIONS.—A risk contracting entity described in this paragraph is—

''(A) a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act,

''(B) an eligible organization with a contract under section 1876,

''(C) an entity that is receiving (and has received during the previous 2 years) a grant of at least $100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act,

''(D) an entity that—

''(i) received a grant of at least $100,000 under section 329(d)(1)(A) or section 330(d)(1) of the Public Health Service Act in the fiscal year ending June

30, 1976, and has been a grantee under either such section for all periods after that date, and

''(ii) provides to its enrollees, on a prepaid capitation or other risk basis, all of the services described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) (and the services described in section 1905(a)(7), to the extent required by section 1902(a)(10)(D)),

''(E) an entity that is receiving (and has received during the previous 2 years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,

''(F) a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

''(i) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

''(ii) which, for all periods after such date, either has been the recipient of a

grant, subgrant, or subcontract under such Act or has provided services on a prepaid capitation or other risk basis under a contract with the State agency initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract,

''(G) an entity that had contracted with the State agency prior to 1970 for the provision, on a prepaid risk basis, of services (which did not include inpatient hospital services) to individuals eligible for medical assistance under the State plan,

''(H) a program pursuant to an undertaking described in subsection (n)(3) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who—

''(i) are not insured for benefits under part B of title XVIII or eligible for medical assistance under the State plan, and

''(ii) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of

health care costs that would have been paid in whole or in part by any governmental entity,

''(I) an entity that, on the date of enactment of this provision, had a contract with the State agency under a waiver under section 1115 or 1915(b) and was not subject to a requirement under this title to permit disenrollment without cause, or

''(J) an entity that has a contract with the State agency under a waiver under section 1915(b)(5).

''(f) STATE MONITORING AND EXTERNAL REVIEW.—

''(1) STATE GRIEVANCE PROCEDURE.—A State contracting with a risk contracting entity or a primary care case management entity under this section shall provide for a grievance procedure for enrollees of such entity with at least the following elements:

''(A) A toll-free telephone number for enrollee questions and grievances.

''(B) Periodic notification of enrollees of their rights with respect to such entity or program.

''(C) Periodic sample reviews of grievances registered with such entity or program or with the State.

''(D) Periodic survey and analysis of enrollee satisfaction with such entity or program, including interviews with individuals who disenroll from the entity or program.

''(2) STATE MONITORING OF QUALITY AND ACCESS.—

''(A) RISK CONTRACTING ENTITIES.—A State contracting with a risk contracting entity under this section shall provide for ongoing monitoring of such entity's compliance with the requirements of subsection (b), including compliance with the requirements of such entity's contract under subsection (b)(3), and shall undertake appropriate followup activities to ensure that any problems identified are rectified and that compliance with the requirements of subsection (b) and the requirements of the contract under subsection (b)(3) is maintained.

''(B) PRIMARY CARE CASE MANAGEMENT ENTITIES.—A State electing to implement a primary care case management program shall provide for ongoing monitoring of the pro-

gram's compliance with the requirements of subsection (c) and shall undertake appropriate followup activities to ensure that any problems identified are rectified and that compliance with subsection (c) is maintained.

''(C) SERVICES.—

''(i) IN GENERAL.—The State shall establish procedures (in addition to those required under subparagraphs (A) and (B)) to ensure that the services listed in clause (ii) are available in a timely manner to an individual enrolled with a risk contracting entity or a primary care case management entity. Where necessary to ensure the timely provision of such services, the State shall arrange for the provision of such services by health care providers other than the risk contracting entity or the primary care case management entity in which an individual is enrolled.

''(ii) SERVICES LISTED.—The services listed in this clause are—

''(I) prenatal care;

''(II) immunizations;

''(III) lead screening and treatment;

''(IV) prevention, diagnosis and treatment of tuberculosis, sexually transmitted diseases (including HIV infection), and other communicable diseases; and

''(V) such other services as the Secretary may specify.

''(iii) REPORT.—The procedures referred to in clause (i) shall be described in an annual report to the Secretary provided by the State.

''(3) EXTERNAL INDEPENDENT REVIEW.—

''(A) IN GENERAL.—Except as provided in paragraph (4), a State contracting with a risk contracting entity under this section shall provide for an annual external independent review of the quality and timeliness of, and access to, the items and services specified in such entity's contract with the State agency. Such review shall be conducted by a utilization control and peer review organization with a contract under section 1153 or another organization unaffiliated with the State government or with any

risk contracting entity and approved by the Secretary.

''(B) CONTENTS OF REVIEW.—An external independent review conducted under this paragraph shall include the following:

''(i) A review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of quality of care and inappropriate utilization (including overutilization) and treatment.

''(ii) A review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine trends in quality and appropriateness of care.

''(iii) Notification of the entity and the State when the review under this paragraph indicates inappropriate care, treatment, or utilization of services (including overutilization).

''(iv) Other activities as prescribed by the Secretary or the State.

''(C) AVAILABILITY.—The results of each external independent review conducted under

this paragraph shall be available to the public consistent with the requirements for disclosure of information contained in section 1160.

''(4) DEEMED COMPLIANCE WITH EXTERNAL INDEPENDENT QUALITY OF CARE REVIEW REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary may deem the State to have fulfilled the requirement for independent external review of quality of care with respect to an entity which has been accredited by an organization described in subparagraph (B) and approved by the Secretary.

''(B) ACCREDITING ORGANIZATION.—An accrediting organization described in this subparagraph must—

''(i) exist for the primary purpose of accrediting coordinated care organizations;

''(ii) be governed by a group of individuals representing health care providers, purchasers, regulators, and consumers (a minority of which shall be representatives of health care providers);

''(iii) have substantial experience in accrediting coordinated care organizations,

including an organization's internal quality assurance program;

''(iv) be independent of health care providers or associations of health care providers;

''(v) be a nonprofit organization; and

''(vi) have an accreditation process which meets requirements specified by the Secretary.

''(5) FEDERAL MONITORING RESPONSIBILITIES.—The Secretary shall review the external independent reviews conducted pursuant to paragraph (3) and shall monitor the effectiveness of the State's monitoring and followup activities required under subparagraph (A) of paragraph (2). If the Secretary determines that a State's monitoring and followup activities are not adequate to ensure that the requirements of paragraph (2) are met, the Secretary shall undertake appropriate followup activities to ensure that the State improves its monitoring and followup activities.

''(g) PARTICIPATION OF CERTAIN PROVIDERS.—Each risk contracting entity shall meet the requirements of section 1013 of the Bipartisan Health Care Reform Act

of 1994 in the same manner as they would apply to a group health plan (when such section becomes effective).

''(h) TRANSACTIONS WITH PARTIES IN INTEREST.—

''(1) IN GENERAL.—Each risk contracting entity which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General of the United States a description of transactions between the entity and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

''(A) Any sale or exchange, or leasing of any property between the entity and such a party.

''(B) Any furnishing for consideration of goods, services (including management services), or facilities between the entity and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

''(C) Any lending of money or other extension of credit between the entity and such a party.

The State or the Secretary may require that information reported with respect to a risk contracting entity which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the risk contracting entity and such entity.

''(2) AVAILABILITY OF INFORMATION.—Each risk contracting entity shall make the information reported pursuant to paragraph (1) available to its enrollees upon reasonable request.

''(i) REMEDIES FOR FAILURE TO COMPLY.—

''(1) IN GENERAL.—If the Secretary determines that a risk contracting entity or a primary care case management entity—

''(A) fails substantially to provide services required under section 1905(r), when such an entity is required to do so, or provide medically necessary items and services that are required to be provided to an individual enrolled with such an entity, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

''(B) imposes premiums on individuals enrolled with such an entity in excess of the premiums permitted under this title;

''(C) acts to discriminate among individuals in violation of the provision of subsection (b)(3)(D), including expulsion or refusal to reenroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the entity whose medical condition or history indicates a need for substantial future medical services;

''(D) misrepresents or falsifies information that is furnished—

''(i) to the Secretary or the State under this section; or

''(ii) to an individual or to any other entity under this section; or

''(E) fails to comply with the requirements of section 1876(i)(8),

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in paragraph (2).

''(2) ADDITIONAL REMEDIES.—The remedies described in this paragraph are—

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1), or, with respect to a determination under subparagraph (C) or (D)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(C), $15,000 for each individual not enrolled as a result of a practice described in such paragraph, or

''(B) denial of payment to the State for medical assistance furnished by a risk contracting entity or a primary care case management entity under this section for individuals enrolled after the date the Secretary notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for

such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and(b)) shall apply to a civil money penalty under subparagraph (A) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(j) TERMINATION OF CONTRACT BY STATE.—Any State which has a contract with a risk contracting entity or a primary care case management entity may terminate such contract if such entity fails to comply with the terms of such contract or any applicable provision of this section.

''(k) FAIR HEARING.—Nothing in this section shall affect the rights of an individual eligible to receive medical assistance under the State plan to obtain a fair hearing under section 1902(a)(3) or under applicable State law.

''(l) DISPROPORTIONATE SHARE HOSPITALS.—Nothing in this section shall affect any requirement on a State to comply with section 1923.

''(m) REFERRAL PAYMENTS.—For 1 year following the date on which individuals eligible for medical assistance under the State plan in a service area are required to enroll with a risk contracting entity or a primary care case management entity, Federally qualified health centers and rural health centers located in such service area

or providing care to such enrollees, shall receive a fee for educating such enrollees about the availability of services from the risk contracting entity or primary care case management entity with which such enrollees are enrolled.

''(n) SPECIAL RULES.—

''(1) NONAPPLICABILITY OF CERTAIN PROVISIONS TO CERTAIN RISK CONTRACTING ENTITIES.—In the case of any risk contracting entity which—

''(A)(i) is an individual physician or a physician group practice of less than 50 physicians, and

''(ii) is not described in paragraphs (A) and (B) of subsection (b)(1), and

''(B) is at risk only for the health care items and services directly provided by such entity,

paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4) of subsection (b), and paragraph (3) of subsection (f), shall not apply to such entity.

''(2) EXCEPTION FROM DEFINITION OF RISK CONTRACTING ENTITY.—For purposes of this section, the term 'risk contracting entity' shall not include a health insuring organization which was used by a State before April 1, 1986, to administer a por-

tion of the State plan of such State on a statewide basis.

''(3) NEW JERSEY.—The rules under section 1903(m)(6) as in effect on the day before the effective date of this section shall apply in the case of an undertaking by the State of New Jersey (as described in such section 1903(m)(6)).

''(o) CONTINUATION OF CERTAIN COORDINATED CARE PROGRAMS.—The Secretary may provide for the continuation of any coordinated care program operating under section 1115 or 1915 without requiring compliance with any provision of this section which conflicts with the continuation of such program and without requiring any additional waivers under such sections 1115 and 1915 if the program has been successful in assuring quality and containing costs (as determining by the Secretary) and is likely to continue to be successful in the future.

''(p) GUIDELINES, REGULATIONS, AND MODEL CONTRACT.—

''(1) GUIDELINES AND REGULATIONS ON SOLVENCY.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines and regulations concerning solvency standards for risk contracting entities and subcontractors of such risk contracting entities. Such

guidelines and regulations shall take into account characteristics that may differ among risk contracting entities including whether such an entity is at risk for inpatient hospital services.

''(2) GUIDELINES AND REGULATIONS ON MARKETING.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines and regulations concerning—

''(A) marketing undertaken by any risk contracting entity or any primary care case management program to individuals eligible for medical assistance under the State plan, and

''(B) information that must be provided by States or any such entity to individuals eligible for medical assistance under the State plan with respect to—

''(i) the options and rights of such individuals to enroll with, and disenroll from, any such entity, as provided in this section, and

''(ii) the availability of services from any such entity (including a list of services for which such entity is responsible or must approve and information on how to

obtain services for which such entity is not responsible).

In developing the guidelines and regulations under this paragraph, the Secretary shall address the special circumstances of children with special health care needs (as defined in subsection (e)(1)(B)(ii)) and other individuals with special health care needs.

''(3) MODEL CONTRACT.—The Secretary shall develop a model contract to reflect the requirements of subsection (b)(3) and such other requirements as the Secretary determines appropriate.''.

(b) WAIVERS FROM REQUIREMENTS ON COORDINATED CARE PROGRAMS.—Section 1915(b) of such Act (42 U.S.C. 1396n) is amended—

(1) in the matter preceding paragraph (1), by striking ''as may be necessary'' and inserting '', and section 1932 as may be necessary'';

(2) in paragraph (1), by striking ''a primary care case management system or'';

(3) by striking ''and'' at the end of paragraph (3);

(4) by striking the period at the end of paragraph (4) and inserting '', and''; and

(5) by inserting after paragraph (4) the following new paragraph:

''(5) to permit a risk contracting entity (as defined in section 1932(a)(3)) to restrict the period in which individuals enrolled with such entity may terminate such enrollment without cause in accordance with section 1932(e)(3)(A).''.

(c) STATE OPTION TO GUARANTEE MEDICAID ELIGIBILITY.—Section 1902(e)(2) of such Act (42 U.S.C. 1396a(e)(2)) is amended—

(1) in subparagraph (A), by striking all that precedes ''(but for this paragraph)'' and inserting ''In the case of an individual who is enrolled—

''(i) with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) or with a risk contracting entity (as defined in section 1932(a)(3)), or

''(ii) with any risk contracting entity (as defined in section 1932(a)(3)) in a State that, on the effective date of this provision, had in effect a waiver under section 1115 of requirements under this title under which the State could extend eligibility for medical assistance for enrollees of such entity, or

''(iii) with an eligible organization with a contract under section 1876,

and who would'',

(2) in subparagraph (B), by striking ''organization or'' each place it appears, and

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

''(C) The State plan may provide, notwithstanding any other provision of this title, that an individual shall be deemed to continue to be eligible for benefits under this title until the end of the month following the month in which such individual would (but for this paragraph) lose such eligibility because of excess income and resources, if the individual is enrolled with a risk contracting entity or primary care case management entity (as those terms are defined in section 1932(a)).''.

(d) ENHANCED MATCH RELATED TO QUALITY REVIEW.—Section 1903(a)(3)(C) of such Act (42 U.S.C. 1396b(a)(3)(C)) is amended—

(1) by striking ''organization or by'' and inserting ''organization, by''; and

(2) by striking ''section 1152, as determined by the Secretary,'' and inserting ''section 1152, as determined by the Secretary, or by another organization approved by the Secretary which is unaffiliated

with the State government or with any risk contracting entity (as defined in section 1932(a)(3)),''.

(e) ACCUMULATION OF RESERVES BY CERTAIN ENTITIES.—Any organization referred to in section 329, 330, or 340, of the Public Health Service Act which has contracted with a State agency as a risk contracting entity under section 1932(g)(3)(A) of the Social Security Act may accumulate reserves with respect to payments made to such organization under section 1932(g)(3)(C) of such Act.

(f) CONFORMING AMENDMENTS.—

(1) Section 1128(b)(6)(C)(i) of such Act (42 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(2) Section 1902(a)(23) of such Act (42 U.S.C. 1396a(a)(23)) is amended by striking ''primary care-case management system (described in section 1915(b)(1)), a health maintenance organization,'' and inserting ''primary care case management program (as defined in section 1932(a)(1)), a risk contracting entity (as defined in section 1932(a)(3)),''.

(3) Section 1902(a)(30)(C) of such Act (42 U.S.C. 1396a(a)(30)(C)) is amended by striking ''use a utilization'' and all that follows through

''with the results'' and inserting ''provide for independent review and quality assurance of entities with contracts under section 1932, in accordance with subsection (f) of such section 1932, with the results''.

(4) Section 1902(a)(57) of such Act (42 U.S.C. 1396a(a)(57)) is amended by striking ''or health maintenance organization (as defined in section 1903(m)(1)(A))'' and inserting ''risk contracting entity, or primary care case management entity (as defined in section 1932(a))''.

(5) Section 1902(a) of such Act (42 U.S.C. 1396a), as amended by sections 3303(a)(1) and 3002(a), is amended—

(A) by striking ''and'' at the end of paragraph (61);

(B) by striking the period at the end of paragraph (62) and inserting ''; and''; and

(C) by inserting after paragraph (62) the following new paragraphs:

''(63) at State option, provide for a primary care case management program in accordance with section 1932; and

''(64) at State option, provide for a program under which the State contracts with risk contracting entities in accordance with section 1932.''.

(6) Section 1902(p)(2) of such Act (42 U.S.C. 1396a(p)(2)) is amended by striking ''health maintenance organization (as defined in section 1903(m))'' and inserting ''risk contracting entity (as defined in section 1932(a)(3))''.

(7) Section 1902(w) of such Act (42 U.S.C. 1396a(w)) is amended—

(A) in paragraph (1), by striking ''section 1903(m)(1)(A)'' and inserting ''section 1932(a)(3)'', and

(B) in paragraph (2)(E)—

(i) by striking ''health maintenance organization'' and inserting ''risk contracting entity'', and

(ii) by striking ''organization'' and inserting ''entity''.

(8) Section 1903(k) of such Act (42 U.S.C. 1396b(k)) is amended by striking ''health maintenance organization which meets the requirements of subsection (m) of this section'' and inserting ''risk contracting entity which meets the requirements of section 1932''.

(9) Section 1903(w)(7)(A)(viii) of such Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking ''health maintenance organizations (and other organizations with contracts under section 1903(m))'' and inserting ''risk contracting entities with contracts under section 1932''.

(10) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding clause (i), by inserting ''(which may be on a prepaid capitation or other risk basis)'' after ''payment''.

(11) Section 1916(b)(2)(D) of such Act (42 U.S.C. 1396o(b)(2)(D)) is amended by striking ''health maintenance organization (as defined in section 1903(m))'' and inserting ''risk contracting entity (as defined in section 1932(a)(3))''.

(12) Section 1925(b)(4)(D)(iv) of such Act (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended—

(A) in the heading, by striking ''**HMO**'' and inserting ''**RISK CONTRACTING ENTITY**'',

(B) by striking ''health maintenance organization (as defined in section 1903(m)(1)(A))'' and inserting ''risk contracting entity (as defined in section 1932(a)(3)'', and

(C) by striking ''health maintenance organization in accordance with section 1903(m)''

and inserting ''risk contracting entity in accordance with section 1932''.

(13) Paragraphs (1) and (2) of section 1926(a) of such Act (42 U.S.C. 1396r–7(a)) are each amended by striking ''health maintenance organizations under section 1903(m)'' and inserting ''risk contracting entities under section 1932''.

(14) Section 1927(j)(1) of such Act is amended by striking ''* * * Health Maintenance Organizations, including those organizations that contract under section 1903(m)'' and inserting ''risk contracting entities (as defined in section 1932(a)(3))''.

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

Subtitle D—Additional Medicaid Reforms

SEC. 3301. REDUCTION IN AMOUNT OF PAYMENT ADJUSTMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) IN GENERAL.—Section 1923 of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

''(h) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION FOR DISPROPORTIONATE SHARE ADJUST-

MENTS.—Notwithstanding any other provision of this section, the amount of payments under section 1903(a) with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year shall not exceed the following percent of the amount otherwise determined under subsection (f):

''(1) For fiscal years 1995, 1996, 1997 and 1998, 75 percent.

''(2) For fiscal years 1999 and 2000, 70 percent.

''(3) For fiscal years 2001 and 2002, 65 percent.

''(4) For fiscal year 2003 and thereafter, 63 percent.''.

(b) CONFORMING AMENDMENT.—Section 1923(c) of such Act (42 U.S.C. 1396r–4(c)) is amended in the matter preceding paragraph (1) by striking ''(f) and (g)'' and inserting ''(f), (g), and (h)''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to quarters in fiscal years beginning on or after October 1, 1994.

SEC. 3302. ELIMINATION OF MEDICALLY NEEDY PROGRAM FOR INDIVIDUALS NOT IN AN INSTITUTION.

(a) IN GENERAL.—Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)) is amended

by inserting ''such assistance is restricted to individuals in institutions and'' after '', then''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to calendar quarters beginning on or after January 1, 1998.

SEC. 3303. ELIMINATION OF MEDICAID PEDIATRIC IMMUNIZATION PROGRAM.

(a) IN GENERAL.—Effective as if included in the enactment of the 13621 of the Omnibus Budget Reconciliation Act of 1993, title XIX of the Social Security Act is amended as follows:

(1) Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by inserting ''and'' at the end of paragraph (60),

(B) in paragraph (61), by striking ''; and'' and inserting a period, and

(C) by striking paragraph (62).

(2) Section 1928 (42 U.S.C. 1396s) is repealed.

(3) Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by inserting ''or'' at the end of paragraph (12),

(B) by striking the semicolon at the end of paragraph (13) and inserting a period, and

(C) by striking paragraphs (14) and (15).

(4) Section 1902(a)(32)(D) is amended by striking ''before October 1, 1994''.

(5) Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (11)(B)—

(i) by inserting ''and'' before ''(ii)'', and

(ii) by striking ''to the individual under section 1903, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services'' and inserting ''to him under section 1903'';

(B) in paragraph (11)(C), by striking '', including the provision of information and education on pediatric vaccinations and the delivery of immunization services,'' and

(C) in paragraph (43)(A), by striking ''and the need for age-appropriate immunizations against vaccine-preventable diseases''.

(6) Section 1905(r)(1) (42 U.S.C. 1396d(r)(1)) is amended—

(A) in subparagraph (A)(i), by striking ''and, with respect to immunizations under sub-

paragraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines''; and

(B) in subparagraph (B)(iii), by striking ''(according to the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines)''.

(b) ESTABLISHMENT OF ALTERNATIVE DELIVERY PROGRAMS.—

(1) IN GENERAL.—At the request of a State, the Secretary of Health and Human Services shall negotiate and enter into contracts with manufacturers of listed pediatric vaccines (which manufacturers have entered into agreements under section 1902(a)(32)(D) of the Social Security Act) or with other licensed distributors of such vaccines to provide for the delivery of such vaccines under a replacement vaccine delivery program described in section 1902(a)(32)(D) of the Social Security Act or under an alternative delivery program described in paragraph (2).

(2) ALTERNATIVE DELIVERY PROGRAM.—An alternative delivery program described in this paragraph is a program operated by a State under which listed pediatric vaccines are distributed through the manufacturer (or other licensed distributor) to indi-

viduals and entities providing such vaccines under the State plan under title XIX of the Social Security Act and other providers of vaccines to children who are in families eligible for premium assistance under part A of title XXI of such Act if the providers are registered to participate in the program and if the State demonstrates that the operation of the program under this paragraph will not result in greater delivery costs or additional purchases of vaccine than would have resulted under the program described in section 1902(a)(32)(D) of such Act.

(3) LISTED PEDIATRIC VACCINE.—In this subsection, the term ''listed pediatric vaccine'' means a pediatric vaccine contained on the list established (and periodically reviewed and as appropriate revised) by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

(4) LIMITATION ON PAYMENT.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by subsection (a)(3) and section 2002(b), is amended—

(A) by striking ''or'' at the end of paragraph (13),

(B) by striking the period at the end of paragraph (14) and inserting ''; or'', and

(C) by inserting after paragraph (14) the following:

''(15) with respect to amounts expended for a listed pediatric vaccine (as defined in paragraph (3) of section 3303(b) of the Bipartisan Health Care Reform Act of 1994) if the amounts exceed the applicable price negotiated under a contract entered into under subsection (b) of such section.''.

TITLE IV—ACCESS IMPROVEMENTS

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Subtitle A—Expanding Access in Underserved Areas

SEC. 4001. COMMUNITY HEALTH AUTHORITIES DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by sections 3001(a) and 3201(a)(2), is amended—

(1) by redesignating section 1933 as section 1934; and

(2) by inserting after section 1932 the following new section:

''COMMUNITY HEALTH AUTHORITIES DEMONSTRATION PROJECTS

''SEC. 1933. (a) IN GENERAL.—In order to test the effectiveness of various innovative health care delivery approaches through the operation of community health authorities, the Secretary shall operate a program under which States establish projects to demonstrate the effectiveness of such approaches in providing access to cost-effective preventive and primary care and related services for various areas and populations, including low-income residents of medically underserved areas or for medically underserved populations. A State may operate more than one such project.

''(b) SELECTION OF STATE PROJECTS.—

''(1) IN GENERAL.—A State is eligible to participate in the program, and establish a demonstration project, under this section only if—

''(A) the State submits to the Secretary an application, at such time and in such form as the Secretary may require, for participation in the program; and

''(B) the Secretary finds that—

''(i) the application contains assurances that the State will support the development of a community health authority that meets the requirements of this section,

''(ii) the community health authority will meet the requirements for such an authority under subsection (c),

''(iii) the State provides sufficient assurances that the demonstration project of a community health authority meets (or, when operational, will meet) the requirements of subsection (d), and

''(iv) the State will comply with the requirements of subsections (g) and (h).

''(2) CONTENTS OF APPLICATION.—Each application submitted under paragraph (1) for a dem-

onstration project shall include at least the following:

''(A) A description of the proposed community health authority and of the area or population that the authority will serve.

''(B) A demonstration that the CHA will serve at least one geographic area or population group that is designated as medically underserved under section 330 of the Public Health Service Act or as having a shortage of health professionals under section 332 of such Act.

''(C) An assessment of the area's or population's need for services and an assurance that the services of the CHA will be responsive to those needs.

''(D) A list of the items and services to be furnished by the CHA under the project, broken down by those items and services that are treated as medical assistance under the State plan under this title and other items and services that will be provided by the CHA (either directly or through coordination with other entities).

''(E) An assurance that the CHA has entered into (or plans to enter into) written par-

ticipation agreements with a sufficient number of providers to enable the CHA to furnish all of such items and services to enrolled individuals.

''(F) An assurance that the State plan under this title will provide payment to the authority in accordance with subsection (e).

''(G) Evidence of support and assistance from other State agencies with responsibility for providing or supporting the provision of preventive and primary care services to underserved and at-risk populations.

''(H) A proposed budget for the CHA.

''(3) PERIOD OF APPROVAL.—Each project approved under this section shall be approved for a period of not less than 3 years, subject to renewal for subsequent periods unless such approval is withdrawn for cause by the Secretary or at the request of the State.

''(c) COMMUNITY HEALTH AUTHORITY (CHA) DEFINED.—In this section, the terms 'community health authority' and 'CHA' mean a nonprofit entity that meets the following requirements:

''(1) The entity serves (or will serve at the time it becomes operational under a project) a geographic

area or population group that includes those designated—

''(A) under section 330 of the Public Health Service Act as medically underserved, or

''(B) under section 332 of such Act as a health professions shortage area.

''(2) The entity enrolls—

''(A) individuals and families who are medicaid-eligible;

''(B) within the limits of its available resources and capacity, other individuals who have incomes below 200 percent of the Federal official poverty level; and

''(C) within the limits of its available resources and capacity, other individuals and families who are able to pay the costs of enrollment.

''(3) Through its participating providers, the entity provides or, through contracts, arranges for the provision of (or, by the time it become operational, will so provide or arrange for the provision of) at least preventive services, primary care services, inpatient and outpatient hospital services, and any other service provided by a participating pro-

vider for which payment may be made under the State plan under this title to enrolled individuals.

''(4) The entity must include (to the maximum extent practicable) as participating providers any of the following providers that furnish services provided by (or arranged by) the entity that are located in or serve the area or population to be covered:

''(A) Federally-qualified health centers.

''(B) Rural health clinics.

''(C) Local public health agencies that furnish such services.

''(D) A hospital (or other provider of inpatient or outpatient hospital services) which has a participation agreement in effect with the State under its plan under this title, which is located in or serving the area or population to be served.

''(5) The entity may include as participating providers other providers (which may include private physicians or group practice offices, other community clinics, limited service providers (such as prenatal clinics), and health professionals teaching programs (such as area health educational centers)) and take other appropriate steps, to the extent needed to assure that the network is reasonable in size

and able to provide (or arrange for the provision of) the services it proposes to furnish to its enrollees.

''(6) The entity must maintain written agreements with each participating provider under which the provider agrees to participate in the CHA and agrees to accept payment from the CHA as payment in full for services furnished to individuals enrolled with the CHA.

''(7) Under the written agreements described in paragraph (6), if a majority of the board of directors of the entity has determined that a participating provider is failing to meet any of the requirements of the participation agreement, the board may terminate the provider's participation agreement in accordance with the following requirements:

''(A) Subject to subparagraph (B), prior to any termination of a provider's participation agreement, the provider shall be entitled to 30 days prior notice, a reasonable opportunity to correct any deficiencies, and an opportunity for a full and fair hearing conducted by the entity to dispute the reasons for termination. The provider shall be entitled to appeal the board of directors' decision directly to a committee consist-

ing of representatives of all of the entity's participating providers.

''(B) If a majority of the board of directors of the entity determines that the continued participation of a provider presents an immediate threat to the health and safety of patients or a substantial risk of improper diversion of funds, the board may suspend the provider's participation agreement (including the receipt of funds under the agreement) for a period of up to 60 days. During this period, the entity shall take steps to ensure that patients who were assigned to or cared for by the suspended provider are appropriately assigned or referred to alternative participating providers. The suspended provider shall be entitled to a hearing within the period of the suspension to show cause why the suspension should be lifted and its participation agreement restored. If dissatisfied with the board's decision, the provider shall be entitled to appeal the decision directly to a committee consisting of representatives of all of the entity's participating providers.

''(C) For all other disputes between the entity and its participating providers (including

disputes over the amounts due or interim rates to be paid to a provider), the entity shall provide an opportunity for a full and fair hearing.

''(8) The entity must be governed by a board of directors that includes representatives of the participating providers and, as appropriate, other health professionals, civic or business leaders, elected officials, and residents of the area or population served. Not less than 51 percent of such board shall be composed of individuals who are enrolled in the CHA and who are representatives of the community served.

''(d) DEMONSTRATION PROJECT REQUIREMENTS.—The requirements of this subsection, with respect to a demonstration project of a CHA under this section, are as follows:

''(1)(A) All services furnished by the CHA under the project shall be available and accessible to all enrolled individuals and, except as provided in subparagraph (B), must be available without regard to an individual's ability to pay for such services.

''(B) A CHA shall prepare a schedule of discounts to be applied to the payment of premiums by individuals who are not medicaid-eligible individuals

which shall be adjusted on the basis of the individual's ability to pay.

''(2) The CHA shall take appropriate steps to emphasize the provision of preventive and primary care services, and shall ensure that each enrolled individual is assigned to a primary care physician (to the greatest extent appropriate and feasible), except that the CHA shall establish a process through which an enrolled individual may be assigned to another primary care physician for good cause shown.

''(3) The CHA must make reasonable efforts to reduce the unnecessary or inappropriate use of hospital or other high-cost services through an emphasis on preventive and primary care services, the implementation of utilization review or other appropriate methods.

''(4) The State must regularly provide the CHA with information on other medical, health, and related benefits that may be available to individuals enrolled with the CHA under programs other than the State plan under this title, and the CHA must provide its enrolled individuals with enrollment information and other non-cash assistance to assist them in obtaining such benefits.

''(5) The State and the CHA must meet such financial standards and requirements and reporting requirements as the Secretary specifies and must prepare and submit to the Secretary an annual independent financial audit conducted in accordance with requirements specified by the Secretary.

''(6) In collaboration with the State, the CHA must adopt and use community-oriented, patient-responsive quality assurance and control systems in accordance with requirements specified by the Secretary. Such systems must include at least an ongoing quality assurance program that measures consumer satisfaction with the care provided under the network, stresses improved health outcomes, and operates a community health status improvement process that identifies and investigates community health problems and implements measures designed to remedy them.

''(e) CAPITATION PAYMENTS.—

''(1) IN GENERAL.—Under a demonstration project under this section, the State shall enter into an annual contract with the CHA under which the State shall make monthly payments to the CHA for covered services furnished through the CHA to individuals entitled to medical assistance under this title

in the amount specified in paragraph (2). Payment shall be made at the beginning of each month on the basis of estimates of the amounts payable and amounts subsequently paid are subject to adjustment to reflect the amounts by which previous payments were greater or less than the amount of payments that should have been made.

''(2) AMOUNT OF CAPITATION PAYMENT.—The amount of a monthly payment under paragraph (1) during a contract year, shall be not less than 1/12 of the product of—

''(A)(i) the average per capita amounts expended under this title under the State plan for covered services to be furnished under the demonstration project for similar Medicaid-eligible individuals for the most recent 12-month period ending before the date of the enactment of this section, increased by (ii) the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) during the period that begins upon the expiration of such 12-month period and ends upon the expiration of the most recent 12-month period ending before the first month of the contract year for

which complete financial data on such index is available, and

''(B) the number of Medicaid-eligible individuals enrolled under the project as of the 15th day of the month prior to the first month of the contract year (or, in the case of the first year for which a contract is in effect under this subsection, the CHA's reasonable estimate of the number of such individuals who will be enrolled in the project as of the 15th day of such month).

''(f) ADDITIONAL STATE ASSISTANCE FOR PLANNING, DEVELOPMENT, AND OPERATIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), in addition to the payments under subsection (e), demonstration projects approved under this section are eligible to have approved expenditures described in paragraph (3) treated, for purposes of section 1903(a)(7), as expenditures found necessary by the Secretary for the proper and efficient administration of the State plan under this title.

''(2) SPECIAL RULES.—

''(A) LIMITATION WITH RESPECT TO ANY COMMUNITY HEALTH AUTHORITY.—The total amount of expenditures with respect to any CHA that may be treated as expenditures for medical assistance under paragraph (1) for any 12-month period shall not exceed $250,000.

''(B) LIMITATION ON NUMBER OF YEARS.—The number of 12-month periods for which expenditures are treated as expenditures for medical assistance under paragraph (1) for a CHA shall not exceed—

''(i) 2 for expenditures for planning and development assistance, described in paragraph (3)(A), and

''(ii) 2 for expenditures for operational assistance, described in paragraph (3)(B).

''(C) NO RESULTING REDUCTION IN AMOUNTS PROVIDED UNDER PHSA GRANTS.—No grant to a CHA or one of its participating providers under the Public Health Service Act or this Act may be reduced on the ground that activities of the CHA that are considered approved expenditures under paragraph (3) are

activities for which the CHA or the participating providers received funds under such Act.

''(3) APPROVED EXPENDITURES.—The approved expenditures described in this paragraph are as follows:

''(A) PLANNING AND DEVELOPMENT.—Expenditures for planning and development with respect to a CHA, including—

''(i) developing internal management, legal and financial and clinical, information, and reporting systems for the CHA, and carrying out other operating activities of the CHA;

''(ii) recruiting, training and compensating management staff of the CHA and, as appropriate and necessary, management and clinical staff of any participating provider;

''(iii) purchasing essential equipment and acquiring, modernizing, expanding, or (if cost-effective) renovating facilities for the CHA and for participating providers (including amortization costs and payment of interest on loans); and

''(iv) entering into arrangements to obtain or participate in emerging medical technologies, including telemedicine.

''(B) OPERATIONS.—Expenditures in support of the operations of a CHA, including—

''(i) the ongoing management of the CHA, including daily program administration, recordkeeping and reporting, assurance of proper financial management (including billings and collections) and oversight of program quality;

''(ii) developing and operating systems to enroll eligible individuals in the CHA;

''(iii) data collection, in collaboration with the State medicaid agency and the State health department, designed to measure changes in patient access to care, the quality of care furnished, and patient health status, and health care outcomes;

''(iv) ongoing community outreach and community education to all residents of the area or population served, to promote the enrollment of eligible individuals and the appropriate utilization of health services by such individuals;

''(v) the establishment of necessary reserves or purchase of stop-loss coverage; and

''(vi) activities relating to health professions training, including residency training at participating provider sites.

''(g) ADDITIONAL REQUIREMENTS.—

''(1) MANDATORY ENROLLMENT OF MEDICAID-ELIGIBLE INDIVIDUALS.—Notwithstanding any provision of section 1903(m), a State participating in a demonstration project under this section may, until December 31, 1997, require that each medicaid-eligible resident in the service area of a CHA operating under the project is not eligible to receive any medical assistance under the State plan that may be obtained through enrollment with the CHA unless the individual receives such assistance through enrollment with the CHA.

''(2) CONTINUED ENTITLEMENT TO ADDITIONAL BENEFITS.—In the case of a medicaid-eligible individual enrolled with a CHA under a demonstration project under this section, the individual shall remain entitled to medical assistance for services which are not covered services under the project, until December 31, 1997.

''(3) HMO-RELATED REQUIREMENTS.—A CHA under this section shall be deemed to meet the requirements of section 1903(m) (subject to paragraph (1)) in the same manner as an entity listed under section 1903(m)(2)(G).

''(4) OUTSTATIONING ELIGIBILITY WORKERS.—Under the project, the State may (in addition to meeting the requirements of section 1902(a)(55) until December 31, 1997) provide for, or pay the reasonable costs of, stationing eligibility workers at appropriate service sites under the project, and may permit medicaid-eligible individuals to be enrolled under the State plan at such a CHA or at such a site.

''(5) PURCHASE OF STOP-LOSS COVERAGE.—The State shall ensure that the CHA has purchased stop-loss coverage to protect against default on its obligations under the project. If an entity otherwise qualified to serve as a CHA is prohibited under State law from purchasing such coverage, the State shall waive the application of such law to the extent necessary to permit the entity to purchase such coverage.

''(h) EVALUATION AND REPORTING.—

''(1) CHA.—Each CHA in a State with a demonstration project approved under this section shall prepare and submit to the State an annual report on its activities during the previous year.

''(2) STATE.—Taking into account the reports submitted pursuant to paragraph (1), each State with a demonstration project approved under this section shall prepare and submit to the Secretary an annual evaluation of its activities and services under this section. Such evaluation shall include an analysis of the effectiveness of the project in providing cost-effective health care to enrolled individuals.

''(3) REPORT TO CONGRESS.—Not later than June 30, 1997, the Secretary shall submit to Congress a report on the demonstration projects conducted under this section. Such report shall include an analysis of the effectiveness of such projects in providing cost-effective health care for the areas or populations served.

''(i) COLLABORATION IN ADMINISTRATION.—In carrying out this section, the Secretary shall assure the highest possible level of collaboration between the Health Care Financing Administration and the Public Health Service. Such collaboration may include (if appropriate and feasible) any of the following:

''(1) The provision by the Public Health Service of new or increased grant support to eligible entities participating in a CHA, in order to expand the availability of services (particularly preventive and primary care services).

''(2) The placement of health professionals at eligible locations and collaboration with Federally-assisted health professions training programs located in or near the areas served by community health authorities.

''(3) The provision of technical and other non-financial assistance.

''(j) DEFINITIONS.—In this section:

''(1) MEDICAID-ELIGIBLE INDIVIDUAL.—The term 'medicaid-eligible individual' means an individual described in section 1902(a)(10)(A) and entitled to medical assistance under the State plan.

''(2) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to a CHA, a provider that has entered into an agreement with the CHA for the provision of covered services under a project under this section.

''(3) PREVENTIVE AND PRIMARY CARE SERVICES.—'Preventive' and 'primary' services include those services described in section 1905(l)(2)(A) and

included as Federally qualified health center services.''.

(b) EXCEPTION TO ANTI-KICKBACK LAW.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D),

(2) by striking the period at the end of subparagraph (E) and inserting ''; and'', and

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

''(F) any remuneration paid, or received, by a Federally qualified health center, rural health clinic, or other entity which is a participating provider under a demonstration project under section 1933 as part of an arrangement for the procurement of goods or services or the referral of patients or the lease or purchase of space or equipment.''.

(c) TRANSITION.—A premium subsidy eligible individual may use premium assistance certificates issued under title XXI of the Social Security Act to purchase qualified health coverage offered by a community health authority that complies with the requirements for a carrier under title I.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 4002. HEALTH CENTER PROGRAM AMENDMENTS.

(a) AUTHORIZATION OF GRANTS FOR NETWORK DEVELOPMENT.—

(1) MIGRANT HEALTH CENTERS.—

(A) IN GENERAL.—Section 329 of the Public Health Service Act (42 U.S.C. 254b) is amended by adding at the end the following:

''(j)(1) The Secretary may make a grant, to an entity receiving a grant under this section or to a group of such entities, to support the planning and development of health service networks (as defined in paragraph (3)) which will serve high impact areas, medically underserved areas, or medically underserved populations within the area they serve (or propose to serve).

''(2) A grant under this subsection for the planning and development of a health service network may be used for the following costs:

''(A) The costs of developing the network corporate entity, including planning and needs assessment.

''(B) The costs of developing internal management for the network, as well as costs of developing

legal, financial, clinical, information, billing, and reporting systems, and other costs necessary to achieve operational status.

''(C) The costs of recruitment, training, and compensation of management staff of the network and, as appropriate and necessary, the management and clinical staff of any participating provider.

''(D) The costs of developing additional primary health and related service sites, including costs related to purchase of essential equipment, acquisition, modernization, expansion, or, if cost-effective, construction of facilities.

''(3) In this subsection, the term 'health service network' means a nonprofit private entity that—

''(A) through its participating providers (which may provide services directly or through contract) assures the provision of primary health and related services and, as appropriate, supplemental health services to residents of the high impact area or medically underserved area or members of the medically underserved population covered by the network,

''(B) includes, as participating providers, at least all recipients of grants under this section or section 330, 340, or 340A that provide primary health and related services to the residents of the

area it serves (or proposes to serve), and that may include, at the entity's option, any other providers of primary health or supplemental health services to residents of the high impact area or medically underserved area or members of the medically underserved population covered by the network, but only if such participating providers agree to provide services without regard to an individual's ability to pay, and

''(C) is governed by individuals a majority of whom are patients, employees, or board members of its participating providers that receive grants under this section or section 330, 340, or 340A.''.

(B) CONFORMING CHANGE.—Section 329(h)(1)(A) of such Act (42 U.S.C. 254b(h)(1)(A)) is amended by inserting ''and subsection (j)'' after ''through (e)''.

(2) COMMUNITY HEALTH CENTERS.—Section 330 of such Act (42 U.S.C. 254c) is amended by adding at the end the following:

''(l)(1) The Secretary may make a grant, to an entity receiving a grant under this section or to a group of such entities, to support the planning and development of health service networks (as defined in section 329(j)(3)) which will serve high impact areas, medically underserved

areas, or medically underserved populations within the area they serve (or propose to serve).

''(2) A grant under this subsection for the planning and development of a health service network may be used for the costs described in section 329(j)(2).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(b) REGULATIONS DEFINING MEDICALLY UNDERSERVED POPULATIONS AND FRONTIER AREAS.—Within 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations that define medically underserved populations and frontier areas for purposes of title III of the Public Health Service Act.

(c) EXTENSION OF AUTHORIZATION OF APPROPRIATIONS.—For extension of authorization of appropriations for migrant health centers and community health centers, see section 4131.

Subtitle B—Improved Access in Rural Areas

PART 1—GRANTS TO ENCOURAGE COMMUNITY RURAL HEALTH NETWORKS

SEC. 4101. ASSISTANCE FOR DEVELOPMENT OF ACCESS PLANS FOR CHRONICALLY UNDERSERVED AREAS.

(a) AVAILABILITY OF FINANCIAL ASSISTANCE TO IMPLEMENT ACTION PLANS TO INCREASE ACCESS.—

(1) IN GENERAL.—The Secretary shall provide grants (in amounts determined in accordance with paragraph (3)) over a 3-year period to an eligible State for the development of plans to increase access to health care services during such period for residents of areas in the State that are designated as chronically underserved areas in accordance with subsection (b).

(2) ELIGIBILITY REQUIREMENTS.—A State is eligible to receive grants under this section if the State submits to the Secretary (at such time and in such form as the Secretary may require) assurances that the State has developed (or is in the process of developing) a plan to increase the access of residents of a chronically underserved area to health care services that meets the requirements of subsection (c),

together with such other information and assurances as the Secretary may require.

(3) AMOUNT OF ASSISTANCE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amount of assistance provided to a State under this subsection with respect to any plan during a 3-year period shall be equal to—

(i) for the first year of the period, an amount equal to 100 percent of the amounts expended by the State during the year to implement the plan described in paragraph (1) (as reported to the Secretary in accordance with such requirements as the Secretary may impose);

(ii) for the second year of the period, an amount equal to 50 percent of the amounts expended by the State during the year to implement the plan; and

(iii) for the third year of the period, an amount equal to 33 percent of the amounts expended by the State during the year to implement the plan.

(B) AGGREGATE PER PLAN LIMIT.—The amount of assistance provided to a State under

this subsection with respect to any plan may not exceed $100,000 during any year of the 3-year period for which the State receives assistance.

(b) DESIGNATION OF AREAS.—

(1) DESIGNATION BY GOVERNOR.—In accordance with the guidelines developed under paragraph (2), the Governor of a State may designate an area in the State as a chronically underserved area for purposes of this section upon the request of a local official of the area or upon the Governor's initiative.

(2) GUIDELINES FOR DESIGNATION.—

(A) DEVELOPMENT BY SECRETARY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop guidelines for the designation of areas as chronically underserved areas under this section.

(B) FACTORS CONSIDERED IN DEVELOPMENT OF GUIDELINES.—In developing guidelines under paragraph (1), the Secretary shall consider the following factors:

(i) Whether the area (or a significant portion of the area)—

(I) is designated as a health professional shortage area (under section

332(a) of the Public Health Service Act), or meets the criteria for designation as such an area; or

(II) was previously designated as such an area or previously met such criteria for an extended period prior to the designation of the area under this section (in accordance with criteria established by the Secretary).

(ii) The availability and adequacy of health care providers and facilities for residents of the area.

(iii) The extent to which the availability of assistance under other Federal and State programs has failed to alleviate the lack of access to health care services for residents of the area.

(iv) The percentage of residents of the area whose income is at or below the poverty level.

(v) The percentage of residents of the area who are age 65 or older.

(vi) The existence of cultural or geographic barriers to access to health care

services in the area, including weather conditions.

(3) REVIEW BY SECRETARY.—No designation under paragraph (1) shall take effect under this section unless the Secretary—

(A) has been notified of the proposed designation; and

(B) has not, within 60 days after the date of receipt of the notice, disapproved the designation.

(4) PERIOD OF DESIGNATION.—A designation under this section shall be effective during a period specified by the Governor of not longer than 3 years. The Governor may extend the designation for additional 3-year periods, except that a State may not receive assistance under subsection (a)(3) for amounts expended during any such additional periods.

(c) REQUIREMENTS FOR STATE ACCESS PLANS.—A State plan to increase the access of residents of chronically underserved areas to health care services meets the requirements of this section if the Secretary finds that the plan was developed with the participation of health care providers and facilities and residents of the area that is

the subject of the plan, together with such other requirements as the Secretary may impose.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for assistance under this section $10,000,000 for each of the first 3 fiscal years beginning after the date on which the Secretary develops guidelines for the designation of areas as chronically underserved areas under subsection (b)(2).

SEC. 4102. TECHNICAL ASSISTANCE GRANTS FOR NETWORKS.

(a) IN GENERAL.—The Secretary shall make funds available under this section to provide technical assistance (including information regarding eligibility for other Federal programs) and advice for entities described in subsection (b) seeking to establish or enhance a community rural health network in an underserved rural area.

(b) ENTITIES ELIGIBLE TO RECEIVE FUNDS.—The following entities are eligible to receive funds for technical assistance under this section:

(1) An entity receiving a grant under section 4103.

(2) A State or unit of local government.

(3) An entity providing health care services (including health professional education services) in the area involved.

(c) USE OF FUNDS.—

(1) IN GENERAL.—Funds made available under this section may be used—

(A) for planning a community health network and the submission of the plan for the network to the Secretary under section 4103(c) (subject to the limitation described in paragraph (2));

(B) to provide assistance in conducting community-based needs and prioritization, identifying existing regional health resources, and developing networks, utilizing existing local providers and facilities where appropriate;

(C) to provide advice on obtaining the proper balance of primary and secondary facilities for the population served by the network;

(D) to provide assistance in coordinating arrangements for tertiary care;

(E) to provide assistance in recruitment and retention of health care professionals;

(F) to provide assistance in coordinating the delivery of emergency services with the provision of other health care services in the area served by the network;

(G) to provide assistance in coordinating arrangements for mental health and substance abuse treatment services; and

(H) to provide information regarding the area or proposed network's eligibility for Federal and State assistance for health care-related activities, together with information on funds available through private sources.

(2) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in paragraph (1) may not exceed $50,000 and may not be available for a period of time exceeding 1 year.

(d) USE OF RURAL HEALTH OFFICES.—In carrying out this section with respect to entities in rural areas, the Secretary shall make funds available through—

(1) not more than 10 regional centers acting as clearinghouses for the distribution of such funds; and

(2) State Offices of Rural Health, or any combination of such centers and Offices.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 for each of fiscal years 1996 and 1997 and $30,000,000 for each of fiscal years 1998 through 2000 to carry out this sec-

tion. Amounts appropriated under this section shall be available until expended.

SEC. 4103. DEVELOPMENT GRANTS FOR NETWORKS.

(a) IN GENERAL.—The Secretary shall provide financial assistance to eligible entities in order to provide for the development and implementation of community rural health networks.

(b) ELIGIBLE ENTITIES.—

(1) IN GENERAL.—An entity is eligible to receive financial assistance under this section only if the entity—

(A) is (i) based in a rural area or (ii) is described in paragraph (2), (3), or (4) of section 4102(b),

(B) is undertaking to develop and implement a community rural health network in an underserved rural area (or underserved rural areas) with the active participation of at least 3 health care providers or facilities in the area, and

(C) has consulted with the local governments of the area to be served by the network and with individuals who reside in the area.

(2) COORDINATION WITH PROVIDERS OUTSIDE OF AREA PERMITTED.—Nothing in this section shall

be construed as preventing an entity that coordinates the delivery of services in an underserved rural area with an entity outside the area from qualifying for financial assistance under this section, or as preventing an entity consisting of a consortia of members located in adjoining States from qualifying for such assistance.

(3) PERMITTING ENTITIES NOT RECEIVING FUNDING FOR DEVELOPMENT OF PLAN TO RECEIVE FUNDING FOR IMPLEMENTATION.—An entity that is eligible to receive financial assistance under this section may receive assistance to carry out activities described in subsection (c)(1)(B) notwithstanding that the entity does not receive assistance to carry out activities described in subsection (c)(1)(A).

(c) USE OF FUNDS.—

(1) IN GENERAL.—Financial assistance made available to eligible entities under this section may be used only—

(A) for the development of a community health network and the submission of the plan for the network to the Secretary; and

(B) after the Secretary approves the plan for the network, for activities to implement the network, including (but not limited to)—

(i) establishing information systems, including telecommunications,

(ii) recruiting health care providers,

(iii) providing services to enable individuals to have access to health care services, including transportation and language interpretation services (including interpretation services for the hearing-impaired), and

(iv) establishing and operating a community health advisor program described in paragraph (2).

(2) COMMUNITY HEALTH ADVISOR PROGRAM.—

(A) PROGRAM DESCRIBED.—In paragraph (1), a ''community health advisor program'' is a program under which community health advisors carry out the following activities:

(i) Collaborating efforts with health care providers and related entities to facilitate the provision of health services and health-related social services.

(ii) Providing public education on health promotion and disease prevention and efforts to facilitate the use of available

health services and health-related social services.

(iii) Providing health-related counseling.

(iv) Making referrals for available health services and health-related social services.

(v) Improving the ability of individuals to use health services and health-related social services under Federal, State, and local programs through assisting individuals in establishing eligibility under the programs.

(vi) Providing outreach services to inform the community of the availability of the services provided under the program.

(B) COMMUNITY HEALTH ADVISOR DEFINED.—In subparagraph (A), the term ''community health advisor'' means, with respect to a community health advisor program, an individual—

(i) who has demonstrated the capacity to carry out one or more of the activities carried out under the program; and

(ii) who, for not less than one year, has been a resident of the community in which the program is to be operated.

(3) LIMITATIONS ON ACTIVITIES FUNDED.—Financial assistance made available under this section may not be used for any of the following:

(A) For a telecommunications system unless such system is coordinated with, and does not duplicate, a system existing in the area.

(B) For construction or remodeling of health care facilities.

(4) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in paragraph (1)(A) may not exceed $50,000 and may not be made available for a period of time exceeding 1 year.

(d) APPLICATION.—

(1) IN GENERAL.—No financial assistance shall be provided under this section to an entity unless the entity has submitted to the Secretary, in a time and manner specified by the Secretary, and had approved by the Secretary an application.

(2) INFORMATION TO BE INCLUDED.—Each such application shall include—

(A) a description of the community rural health network, including service area and capacity, and

(B) a description of how the proposed network will utilize existing health care facilities in a manner that avoids unnecessary duplication.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for each of fiscal years 1996 and 1997, $120,000,000 for fiscal year 1998, $130,000,000 for fiscal year 1999, $140,000,000 for fiscal year 2000, $150,000,000 for fiscal year 2001, $160,000,000 for fiscal year 2002, $170,000,000 for fiscal year 2003, and $180,000,000 for fiscal year 2004, to carry out this section. Amounts appropriated under this section shall be available until expended.

(2) INTEGRATION OF OTHER AUTHORIZATIONS.—In order to provide for the authorization of appropriations under paragraph (1), notwithstanding any other provision of law, no funds are authorized to be appropriated to carry out the following programs in fiscal years after fiscal year 1994:

(A) The rural health transition grant program (under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987).

(B) The rural health outreach program (for which appropriations were annually provided under the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Acts).

(3) ANNUAL LIMIT ON ASSISTANCE TO GRANTEE.—The amount of financial assistance provided to an entity under this section during a year may not exceed $250,000.

SEC. 4104. DEFINITIONS.

For purposes of this part:

(1) COMMUNITY RURAL HEALTH NETWORK.—The term ''community rural health network'' means a formal cooperative arrangement between participating hospitals, physicians, and other health care providers which—

(A) is located in an underserved rural area;

(B) furnishes health care services to individuals residing in the area; and

(C) is governed by a board of directors selected by participating health care providers and residents of the area.

(2) RURAL AREA.—The term ''rural area'' has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

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

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

(5) UNDERSERVED RURAL AREA.—The term ''underserved rural area'' means a rural area designated—

(A) as a health professional shortage area under section 332(a) of the Public Health Service Act; or

(B) as a chronically underserved area under section 4101.

PART 2—INCENTIVES FOR HEALTH PROFESSIONALS TO PRACTICE IN RURAL AREAS

Subpart A—National Health Service Corps Program

SEC. 4111. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

''SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

''(a) GENERAL RULE.—Gross income shall not include any qualified loan repayment.

''(b) QUALIFIED LOAN REPAYMENT.—For purposes of this section, the term 'qualified loan repayment' means any payment made on behalf of the taxpayer by the National Health Service Corps Loan Repayment Program under section 338B(g) of the Public Health Service Act.''.

(b) CONFORMING AMENDMENT.—Paragraph (3) of section 338B(g) of the Public Health Service Act is amended by striking ''Federal, State, or local'' and inserting ''State or local''.

(c) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal

Revenue Code of 1986 is amended by striking the item relating to section 137 and inserting the following:

''Sec. 137. National Health Service Corps loan repayments.
''Sec. 138. Cross references to other Acts.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made under section 338B(g) of the Public Health Service Act after the date of the enactment of this Act.

SEC. 4112. MODIFICATION IN CRITERIA FOR DESIGNATION AS HEALTH PROFESSIONAL SHORTAGE AREA.

(a) RELEVANCE OF TRAVEL TIMES WITHIN FRONTIER AREAS.—Section 332(a) of the Public Health Service Act (42 U.S.C. 245e(a)) is amended by adding at the end the following new paragraph:

''(4) With respect to meeting the criteria under paragraph (1)(A) for an area to be designated as a health professional shortage area, the Secretary shall, in the case of a frontier area, make the determination of whether the frontier area is a rational area for the delivery of health services without regard to—

''(A) the travel time between population centers in the frontier area; or

''(B) the travel time to contiguous area resources in the frontier area.''.

(b) REGULATIONS DEFINING HEALTH PROFESSIONAL SHORTAGE AREAS.—Within 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations that define health professional shortage areas for purposes of title III of the Public Health Service Act.

(c) AGENCY RECOMMENDATIONS FOR IMPROVEMENTS.—Not later than July 1, 1995, the Secretary of Health and Human Services shall submit to the Congress a report specifying the recommendations of the Secretary for improving the manner of determining the extent to which a geographic area has a need for assignments of members of the National Health Service Corps, and for equitably allocating such assignments among the geographic areas with a need for such assignments.

(d) EFFECTIVE DATE.—This section shall take effect on October 1, 1994, or upon the date of the enactment of this Act, whichever occurs later.

SEC. 4113. OTHER PROVISIONS REGARDING NATIONAL HEALTH SERVICE CORPS.

(a) SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—

(1) AUTHORIZATION OF APPROPRIATIONS.—Section 338H(b)(1) of the Public Health Service Act (42 U.S.C. 254q(b)(1)) is amended—

(A) by striking ''and'' after ''1991,''; and

(B) by striking ''through 2000.'' and inserting ''through 1994, $150,000,000 for fiscal year 1995, $175,000,000 for fiscal year 1996, $200,000,000 for fiscal year 1997, $275,000,000 for fiscal year 1998, $275,000,000 for fiscal year 1999, $275,000,000 for fiscal year 2000, $300,000,000 for fiscal year 2001, $325,000,000 for fiscal year 2002, $350,000,000 for fiscal year 2003, and $375,000,000 for fiscal year 2004.''.

(2) ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP PROGRAM.—Section 338H(b)(2) of the Public Health Service Act (42 U.S.C. 254q(b)(2)) is amended by adding at the end the following subparagraph:

''(C) Of the amounts appropriated under paragraph (1) for fiscal year 1995 and subsequent fiscal years, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program, the total number who are being educated

as nurses or are serving as nurses, respectively, is increased to 20 percent.''.

(b) INCREASE IN NUMBER OF MENTAL HEALTH PROFESSIONALS IN SHORTAGE AREAS.—

(1) IN GENERAL.—Section 338H(b) of the Public Health Service Act (42 U.S.C. 254q(b)) is amended by adding at the end the following paragraph:

''(3) MENTAL HEALTH PROFESSIONALS.—In providing contracts under this subpart for scholarships and loan repayments, the Secretary shall ensure that an appropriate number of mental health professionals is assigned under section 333 for health professional shortage areas.''.

(2) APPLICABILITY.—With respect to contracts for scholarships and loan repayments under subpart III of part D of title III of the Public Health Service Act, the amendment made by subsection (a) applies with respect to contracts entered into on or after October 1, 1994.

Subpart B—Incentives Under Other Programs

SEC. 4121. EXTENSION OF ADDITIONAL PAYMENT UNDER MEDICARE FOR PHYSICIANS' SERVICES FURNISHED IN FORMER SHORTAGE AREAS.

(a) IN GENERAL.—Section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)) is amended by striking ''area,'' and inserting ''area (or, in the case of an area for which the designation as a health professional shortage area under such section is withdrawn, in the case of physicians' services furnished to such an individual during the 3-year period beginning on the effective date of the withdrawal of such designation),''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to physicians' services furnished in an area for which the designation as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act is withdrawn on or after January 1, 1995.

SEC. 4122. REFINEMENT OF GEOGRAPHIC ADJUSTMENT FACTOR FOR MEDICARE PHYSICIANS' SERVICES.

(a) DEADLINE FOR INITIAL REVIEW AND REVISION.—Section 1848(e)(1)(C) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(C)) is amended by adding at

the end the following: ''The first such review and revision shall apply to services furnished on or after January 1, 1995.''.

(b) AUTHORITY TO ADJUST INDEX VALUE FOR INPUT COMPONENT UNDER CERTAIN CIRCUMSTANCES.—(1) Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)) is amended—

(A) in subparagraph (A), by striking ''(B) and (C)'' and inserting ''(B), (C), and (D)'';

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following:

''(C) SPECIAL ADJUSTMENT TO CORRECT FOR UNIQUE LOCAL CIRCUMSTANCES.—The Secretary may adjust the value assigned to an input component of an index in a fee schedule area if the Secretary determines that the value that would otherwise apply in such area does not accurately reflect the relative costs of such input for such area because of unique local circumstances.''.

(2) Section 1848(i)(1)(D) of the Social Security Act (42 U.S.C. 1395w–4(i)(1)(D)) is amended by inserting

''(including any adjustment under subparagraph (C) thereof)'' after ''subsection (e)''.

(c) REPORT ON REVIEW PROCESS.—Not later than April 1, 1996, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall study and report to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on—

(1) the data necessary to review and revise the indices established under section 1848(e)(1)(A) of the Social Security Act, including—

(A) the shares allocated to physicians' work effort, practice expenses (other than malpractice expenses), and malpractice expenses;

(B) the weights assigned to the input components of such shares; and

(C) the index values assigned to such components;

(2) any limitations on the availability of data necessary to review and revise such indices at least every three years;

(3) ways of addressing such limitations, with particular attention to the development of alternative data sources for input components for which current

index values are based on data collected less frequently than every three years; and

(4) the costs of developing more accurate and timely data sources.

(d) STUDY ON LOW-VOLUME ADJUSTMENT IN ISOLATED AREAS.—(1) Not later than July 1, 1996, the Physician Payment Review Commission shall study and report to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on the feasibility and desirability of providing for a special adjustment to the index value of the medical equipment and supplies input component of the index used under section 1848(e) of the Social Security Act with respect to services described in paragraph (2).

(2) Services described in this paragraph are services—

(A) furnished by a physician who practices in an isolated area;

(B) requiring the presence of expensive medical equipment and supplies in the physician's office; and

(C) with respect to which the cost per service of operating the equipment is increased because of the low volume of patients of such physician.

SEC. 4123. DEVELOPMENT OF MODEL STATE SCOPE OF PRACTICE LAW.

(a) IN GENERAL.—The Secretary of Health and Human Services shall develop and publish a model law that may be adopted by States to increase the access of individuals residing in underserved rural areas to health care services by expanding the services which non-physician health care professionals may provide in such areas.

(b) DEADLINE.—The Secretary shall publish the model law developed under subsection (a) not later than 1 year after the date of the enactment of this Act.

PART 3—ASSISTANCE FOR INSTITUTIONAL PROVIDERS

Subpart A—Community and Migrant Health Centers

SEC. 4131. COMMUNITY AND MIGRANT HEALTH CENTERS.

(a) MIGRANT HEALTH CENTERS.—Section 329(h)(1)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(1)(A)) is amended—

(1) by striking ''and'' after ''1991,''; and

(2) by inserting before the period the following: '', $75,000,000 for fiscal year 1996, $80,000,000 for fiscal year 1997, $155,000,000 for fiscal year 1998, $165,000,000 for fiscal year 1999, $175,000,000 for fiscal year 2000, $185,000,000 for fiscal year 2001, $195,000,000 for fiscal year 2002,

$205,000,000 for fiscal year 2003, and $210,000,000 for fiscal year 2004''.

(b) COMMUNITY HEALTH CENTERS.—Section 330(g)(1)(A) of the Public Health Service Act (42 U.S.C. 254c(g)(1)(A)) is amended—

(1) by striking ''and'' after ''1991,''; and

(2) by inserting before the period the following: '', $638,000,000 for fiscal year 1996, $655,000,000 for fiscal year 1997, $845,000,000 for fiscal year 1998, $865,000,000 for fiscal year 1999, $885,000,000 for fiscal year 2000, $905,000,000 for fiscal year 2001, $925,000,000 for fiscal year 2002, $945,000,000 for fiscal year 2003, and $965,000,000 for fiscal year 2004''.

Subpart B—Emergency Medical Systems

SEC. 4141. EMERGENCY MEDICAL SERVICES.

(a) ESTABLISHMENT OF FEDERAL OFFICE.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in the heading for the title, by striking ''**TRAUMA CARE**'' and inserting ''**EMERGENCY MEDICAL AND TRAUMA CARE SERVICES**'';

(2) in the heading for part A, by striking ''General'' and all that follows and inserting ''General Authorities and Duties''; and

(3) by amending section 1201 to read as follows:

"SEC. 1201. ESTABLISHMENT OF OFFICE OF EMERGENCY MEDICAL AND TRAUMA CARE SERVICES.

''(a) IN GENERAL.—The Secretary shall establish an office to be known as the Office of Emergency Medical and Trauma Care Services, which shall be headed by a director appointed by the Secretary. The Secretary shall carry out this title acting through the Director of such Office.

''(b) GENERAL AUTHORITIES AND DUTIES.—With respect to emergency medical services (including trauma care), the Secretary shall—

''(1) conduct and support research, training, evaluations, and demonstration projects;

''(2) foster the development of appropriate, modern systems of such services through the sharing of information among agencies and individuals involved in the study and provision of such services;

''(3) foster the development of regional systems for the provision of such services;

''(4) sponsor workshops and conferences;

''(5) as appropriate, disseminate to public and private entities information obtained in carrying out paragraphs (1) through (4);

''(6) provide technical assistance to State and local agencies;

''(7) coordinate activities of the Department of Health and Human Services; and

''(8) as appropriate, coordinate activities of such Department with activities of other Federal agencies.

''(c) CERTAIN REQUIREMENTS.—With respect to emergency medical services (including trauma care), the Secretary shall ensure that activities under subsection (b) are carried out regarding—

''(1) maintaining an adequate number of health professionals with expertise in the provision of the services, including hospital-based professionals and prehospital-based professionals;

''(2) developing, periodically reviewing, and revising as appropriate, in collaboration with appropriate public and private entities, guidelines for the provision of such services (including, for various typical circumstances, guidelines on the number and variety of professionals, on equipment, and on training);

''(3) the appropriate use of available technologies, including communications technologies; and

''(4) the unique needs of underserved inner-city areas and underserved rural areas.

''(d) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—In carrying out subsections (b) and (c), the Secretary may make grants and enter into cooperative agreements and contracts.

''(e) DEFINITIONS.—For purposes of this part:

''(1) The term 'hospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at a medical facility.

''(2) The term 'prehospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at the site of the medical emergency or during transport to a medical facility.''.

(b) STATE OFFICES OF EMERGENCY MEDICAL SERVICES; DEMONSTRATION PROGRAM REGARDING TELECOMMUNICATIONS.—Part A of title XII of the Public Health Service Act (42 U.S.C. 300d et seq.), as amended

by section 601(b) of Public Law 103-183 (107 Stat. 2238), is amended—

(1) by redesignating sections 1202 and 1203 as sections 1203 and 1204, respectively;

(2) by inserting after section 1201 the following section:

"SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL SERVICES.

''(a) PROGRAM OF GRANTS.—The Secretary may make grants to States for the purpose of improving the availability and quality of emergency medical services through the operation of State offices of emergency medical services.

''(b) REQUIREMENT OF MATCHING FUNDS.—

''(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such subsection, to provide non-Federal contributions toward such costs in an amount that—

''(A) for the first fiscal year of payments under the grant, is not less than $1 for each $3 of Federal funds provided in the grant;

''(B) for any second fiscal year of such payments, is not less than $1 for each $1 of Federal funds provided in the grant; and

''(C) for any third fiscal year of such payments, is not less than $3 for each $1 of Federal funds provided in the grant.

''(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—

''(A) Subject to subparagraph (B), non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(B) The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

''(i) for the first fiscal year of payments under the grant, 100 percent or less of the non-Federal contributions required in paragraph (1) will be provided in the form of in-kind contributions;

''(ii) for any second fiscal year of such payments, not more than 50 percent of such non-Federal contributions will be provided in the form of in-kind contributions; and

''(iii) for any third fiscal year of such payments, such non-Federal contributions will be provided solely in the form of cash.

''(c) CERTAIN REQUIRED ACTIVITIES.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that activities carried out by an office operated pursuant to such subsection will include—

''(1) coordinating the activities carried out in the State that relate to emergency medical services;

''(2) activities regarding the matters described in paragraphs (1) through (4) section 1201(b); and

''(3) identifying Federal and State programs regarding emergency medical services and providing technical assistance to public and nonprofit private entities regarding participation in such programs.

''(d) REQUIREMENT REGARDING ANNUAL BUDGET FOR OFFICE.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, for any fiscal year for which the State receives such a grant, the office operated pursuant to subsection (a) will

be provided with an annual budget of not less than $50,000.

''(e) CERTAIN USES OF FUNDS.—

''(1) RESTRICTIONS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

''(A) if research with respect to emergency medical services is conducted pursuant to the grant, not more than 10 percent of the grant will be expended for such research; and

''(B) the grant will not be expended to provide emergency medical services (including providing cash payments regarding such services).

''(2) ESTABLISHMENT OF OFFICE.—Activities for which a State may expend a grant under subsection (a) include paying the costs of establishing an office of emergency medical services for purposes of such subsection.

''(f) REPORTS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees to submit to the Secretary reports containing such information as the Secretary may require regarding activities carried out under this section by the State.

''(g) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless

an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.''; and

(3) in section 1204 (as redesignated by paragraph (1) of this subsection)—

(A) by redesignating subsection (c) as subsection (d); and

(B) by inserting after subsection (b) the following new subsection:

''(c) DEMONSTRATION PROGRAM REGARDING TELECOMMUNICATIONS.—

''(1) LINKAGES FOR RURAL FACILITIES.—Projects under subsection (a)(1) shall include demonstration projects to establish telecommunications between rural medical facilities and medical facilities that have expertise or equipment that can be utilized by the rural facilities through the telecommunications.

''(2) MODES OF COMMUNICATION.—The Secretary shall ensure that the telecommunications technologies demonstrated under paragraph (1) include interactive video telecommunications, static video imaging transmitted through the telephone

system, and facsimiles transmitted through such system.''.

(c) FUNDING.—Section 1232 of the Public Health Service Act (42 U.S.C. 300d-32) is amended by striking subsections (a) and (b) and inserting the following:

''(a) EMERGENCY MEDICAL SERVICES GENERALLY.—For the purpose of carrying out section 1201 other than with respect to trauma care, and for the purpose of carrying out section 1204(c), there are authorized to be appropriated $2,000,000 for each of the fiscal years 1996, 1997, and 1998.

''(b) STATE OFFICES.—For the purpose of carrying out section 1202, there are authorized to be appropriated $3,000,000 for each of the fiscal years 1996, 1997, and 1998.''.

SEC. 4142. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d-51 et seq.) is amended by adding at the end the following new section:

''SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL VICTIMS OF MEDICAL EMERGENCIES.

''(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhance-

ment of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

''(b) APPLICATION AND PLAN.—

''(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

''(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

''(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

''(B) demonstrate that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

''(C) demonstrate that there is a lack of facilities available and equipped to deliver ad-

vanced levels of medical care in the geographic areas to be served;

''(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

''(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are effectively meeting the emergency medical needs of the populations they serve;

''(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

''(G) demonstrate that the State, in utilizing the grant proceeds, will—

''(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding

the fiscal year for which the grant is received; and

''(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

''(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan; and

''(I) contain such other information as the Secretary may determine appropriate.

''(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

''(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

''(2) give preference to States with State plans that demonstrate an effective integration of the pro-

posed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

''(d) STATE ADMINISTRATION AND USE OF GRANT.—

''(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

''(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

''(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

''(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

''(f) REPORTS.—

''(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

''(A) a description of the manner in which the grant proceeds were utilized;

''(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

''(C) such other information as the Secretary may require.

''(2) TERMINATION OF FUNDING.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

''(g) DEFINITION.—As used in this section, the term 'rural areas' means geographic areas that are located outside of standard metropolitan statistical areas, as identified by the Secretary.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, $15,000,000 for each of the fiscal years 1996 and 1997, $20,000,000 for fiscal year 1998, $25,000,000 for fiscal year 1999, and $30,000,000 for fiscal year 2000.''.

Subpart C—Assistance to Rural Providers Under Medicare

SEC. 4151. AMENDMENTS TO ESSENTIAL ACCESS COMMUNITY HOSPITAL (EACH) PROGRAM UNDER MEDICARE.

(a) INCREASING NUMBER OF PARTICIPATING STATES.—Section 1820(a)(1) of the Social Security Act (42 U.S.C. 1395i-4(a)(1)) is amended by striking ''7'' and inserting ''9''.

(b) TREATMENT OF INPATIENT HOSPITAL SERVICES PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

(1) IN GENERAL.—Section 1820(f)(1)(F) of such Act (42 U.S.C. 1395i-4(f)(1)(F)) is amended to read as follows:

''(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care to patients requiring stabilization before discharge or transfer to a hospital, except that the facility may not provide any inpatient hospital services—

''(i) to any patient whose attending physician does not certify that the patient may reasonably be expected to be discharged or transferred to a hospital within 72 hours of admission to the facility; or

''(ii) consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A)), unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.''.

(2) LIMITATION ON AVERAGE LENGTH OF STAY.—Section 1820(f) of such Act (42 U.S.C.

1395i-4(f)) is amended by adding at the end the following new paragraph:

''(4) LIMITATION ON AVERAGE LENGTH OF INPATIENT STAYS.—The Secretary may terminate a designation of a rural primary care hospital under paragraph (1) if the Secretary finds that the average length of stay for inpatients at the facility during the previous year in which the designation was in effect exceeded 72 hours. In determining the compliance of a facility with the requirement of the previous sentence, there shall not be taken into account periods of stay of inpatients in excess of 72 hours to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.''.

(3) CONFORMING AMENDMENT.—Section 1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is amended by striking ''such services'' and all that follows and inserting ''the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital.''.

(4) GAO REPORTS.—Not later than 2 years after the date of the enactment of this Act, the

Comptroller General shall submit reports to Congress on—

(A) the application of the requirements under section 1820(f) of the Social Security Act (as amended by this subsection) that rural primary care hospitals provide inpatient care only to those individuals whose attending physicians certify may reasonably be expected to be discharged within 72 hours after admission and maintain an average length of inpatient stay during a year that does not exceed 72 hours; and

(B) the extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited the ability of such hospitals to provide needed services.

(c) DESIGNATION OF HOSPITALS.—

(1) PERMITTING DESIGNATION OF HOSPITALS LOCATED IN URBAN AREAS.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i-4) is amended—

(i) by striking paragraph (1) of subsection (e) and redesignating paragraphs

(2) through (6) as paragraphs (1) through (5);

(ii) in subsection (e)(1)(A) (as redesignated by subparagraph (A))—

(I) by striking ''is located'' and inserting ''except in the case of a hospital located in an urban area, is located'',

(II) by striking '', (ii)'' and inserting ''or (ii)'', and

(III) by striking ''or (iii)'' and all that follows through ''section,''; and

(iii) in subsection (i)(1)(B), by striking ''paragraph (3)'' and inserting ''paragraph (2)''.

(B) NO CHANGE IN MEDICARE PROSPECTIVE PAYMENT.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(i) in clause (iii)(III), by inserting ''located in a rural area and'' after ''that is'', and

(ii) in clause (v), by inserting ''located in a rural area and'' after ''in the case of a hospital''.

(2) PERMITTING HOSPITALS LOCATED IN ADJOINING STATES TO PARTICIPATE IN STATE PROGRAM.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i-4) is amended—

(i) by redesignating subsection (k) as subsection (l); and

(ii) by inserting after subsection (j) the following new subsection:

''(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN PARTICIPATING STATES.—Notwithstanding any other provision of this section—

''(1) for purposes of including a hospital or facility as a member institution of a rural health network, a State may designate a hospital or facility that is not located in the State as an essential access community hospital or a rural primary care hospital if the hospital or facility is located in an adjoining State and is otherwise eligible for designation as such a hospital;

''(2) the Secretary may designate a hospital or facility that is not located in a State receiving a grant under subsection (a)(1) as an essential access community hospital or a rural primary care hospital if the hospital or facility is a member institution of

a rural health network of a State receiving a grant under such subsection; and

''(3) a hospital or facility designated pursuant to this subsection shall be eligible to receive a grant under subsection (a)(2).''.

(B) CONFORMING AMENDMENTS.—(i) Section 1820(c)(1) of such Act (42 U.S.C. 1395i-4(c)(1)) is amended by striking ''paragraph (3)'' and inserting ''paragraph (3) or subsection (k)''.

(ii) Paragraphs (1)(A) and (2)(A) of section 1820(i) of such Act (42 U.S.C. 1395i-4(i)) are each amended—

(I) in clause (i), by striking ''(a)(1)'' and inserting ''(a)(1) (except as provided in subsection (k))'', and

(II) in clause (ii), by striking ''subparagraph (B)'' and inserting ''subparagraph (B) or subsection (k)''.

(d) SKILLED NURSING SERVICES IN RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(3) of such Act (42 U.S.C. 1395i-4(f)(3)) is amended by striking ''because the facility'' and all that follows and inserting the following: ''because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in

effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital.''.

(e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—Section 1814(l)(2) of such Act (42 U.S.C. 1395f(l)(2)) is amended by striking ''January 1, 1993'' and inserting ''January 1, 1996''.

(f) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in paragraph (1), by striking ''during a year before 1993'' and inserting ''during a year before the prospective payment system described in paragraph (2) is in effect''; and

(B) in paragraph (2), by striking ''January 1, 1993,'' and inserting ''January 1, 1996,''.

(2) NO USE OF CUSTOMARY CHARGE IN DETERMINING PAYMENT.—Section 1834(g)(1) of such Act (42 U.S.C. 1395m(g)(1)) is amended by adding at the end the following new flush sentence: ''The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.''.

(g) CLARIFICATION OF PHYSICIAN STAFFING REQUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(1)(H) of such Act (42 U.S.C. 1395i–4(f)(1)(H)) is amended by striking the period and inserting the following: '', except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).''.

(h) TECHNICAL AMENDMENTS RELATING TO PART A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILL-

NESS.—(1) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)) is amended—

(A) by striking ''inpatient hospital services'' the first place it appears and inserting ''inpatient hospital services or inpatient rural primary care hospital services'';

(B) by striking ''inpatient hospital services'' the second place it appears and inserting ''such services''; and

(C) by striking ''and inpatient rural primary care hospital services''.

(2) Sections 1813(a) and 1813(b)(3)(A) of such Act (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking ''inpatient hospital services'' each place it appears and inserting ''inpatient hospital services or inpatient rural primary care hospital services''.

(3) Section 1813(b)(3)(B) of such Act (42 U.S.C. 1395e(b)(3)(B)) is amended by striking ''inpatient hospital services'' and inserting ''inpatient hospital services, inpatient rural primary care hospital services''.

(4) Section 1861(a) of such Act (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by striking ''inpatient hospital services'' and inserting ''inpatient hospital

services, inpatient rural primary care hospital services''; and

(B) in paragraph (2), by striking ''hospital'' and inserting ''hospital or rural primary care hospital''.

(i) AUTHORIZATION OF APPROPRIATIONS.—Section 1820(l) of such Act (42 U.S.C. 1395i–4(l)), as redesignated by subsection (c)(2)(A), is amended by striking ''1990, 1991, and 1992'' and inserting ''1990 through 2000''.

(j) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 4152. RURAL EMERGENCY ACCESS CARE HOSPITALS DESCRIBED.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

''(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and negative operating losses, and the closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

''(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

''(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

''(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part time, off-site basis.

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of

that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital:

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).''.

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) of such Act (42 U.S.C. 1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))''.

SEC. 4153. COVERAGE OF AND PAYMENT FOR SERVICES.

(a) COVERAGE UNDER PART B.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

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

''(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).''.

(b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1833(a)(6) of the Social Security Act (42 U.S.C. 1395l(a)(6)) is amended by striking ''services,'' and inserting ''services and rural emergency access care hospital services,''.

(2) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in the heading, by striking ''SERVICES'' and inserting ''SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES'';

(B) in paragraph (1), by striking ''during a year before 1993'' and inserting ''during a year before the prospective payment system described in paragraph (2) is in effect'';

(C) in paragraph (1), by adding at the end the following: ''The amount of payment shall be determined under either method without regard

to the amount of the customary or other charge.'';

(D) in paragraph (2), by striking ''January 1, 1993,'' and inserting ''January 1, 1996,''; and

(E) by adding at the end the following new paragraph:

''(3) APPLICATION OF METHODS TO PAYMENT FOR RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES.—The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.''.

SEC. 4154. EFFECTIVE DATE.

The amendments made by this subpart shall apply to fiscal years beginning on or after October 1, 1994.

Subpart D—Demonstration Projects to Encourage Primary Care and Rural-Based Graduate Medical Education

SEC. 4161. STATE AND CONSORTIUM DEMONSTRATION PROJECTS.

(a) IN GENERAL.—

(1) PARTICIPATION OF STATES AND CONSORTIA.—The Secretary shall establish and conduct a demonstration project to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice under which the Secretary shall make payments in accordance with subsection (d)—

(A) to not more than 10 States for the purpose of testing and evaluating mechanisms to meet the goals described in section 4162; and

(B) to not more than 10 health care training consortia for the purpose of testing and evaluating mechanisms to meet such goals.

(2) EXCLUSION OF CONSORTIA IN PARTICIPATING STATES.—A consortia may not receive payments under the demonstration project under paragraph (1)(B) if any of its members is located in a State receiving payments under the project under paragraph (1)(A).

(b) APPLICATIONS.—

(1) IN GENERAL.—Each State and consortium desiring to conduct a demonstration project under this section shall prepare and submit to the Secretary an application, at such time, in such manner,

and containing such information as the Secretary may require to assure that the State or consortium will meet the goals described in section 4162. In the case of an application of a State, the application shall include—

(A) information demonstrating that the State has consulted with interested parties with respect to the project, including State medical associations, State hospital associations, and medical schools located in the State;

(B) an assurance that no hospital conducting an approved medical residency training program in the State will lose more than 10 percent of such hospital's approved medical residency positions in any year as a result of the project; and

(C) an explanation of a plan for evaluating the impact of the project in the State.

(2) APPROVAL OF APPLICATIONS.—A State or consortium that submits an application under paragraph (1) may begin a demonstration project under this subsection—

(A) upon approval of such application by the Secretary; or

(B) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

(3) NOTICE AND COMMENT.—A State or consortium shall issue a public notice on the date it submits an application under paragraph (1) which contains a general description of the proposed demonstration project. Any interested party may comment on the proposed demonstration project to the State or consortium or the Secretary during the 30-day period beginning on the date the public notice is issued.

(c) SPECIFIC REQUIREMENTS FOR PARTICIPANTS.—

(1) REQUIREMENTS FOR STATES.—Each State participating in the demonstration project under this subtitle shall use the payments provided under subsection (d) to test and evaluate either of the following mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice:

(A) USE OF ALTERNATIVE WEIGHTING FACTORS.—

(i) IN GENERAL.—The State may make payments to hospitals in the State for direct graduate medical education costs in amounts determined under the methodology provided under section 1886(h) of the Social Security Act, except that the State shall apply weighting factors that are different than the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(ii) USE OF PAYMENTS FOR PRIMARY CARE RESIDENTS.—In applying different weighting factors under clause (i), the State shall ensure that the amount of payment made to hospitals for costs attributable to primary care residents shall be greater than the amount that would have been paid to hospitals for costs attributable to such residents if the State had applied the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(B) PAYMENTS FOR MEDICAL EDUCATION THROUGH CONSORTIUM.—The State may make payments for graduate medical education costs

through payments to a health care training consortium (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium) that is established in the State but that is not otherwise participating in the demonstration project.

(2) REQUIREMENTS FOR CONSORTIUM.—

(A) IN GENERAL.—In the case of a consortium participating in the demonstration project under this subtitle, the Secretary shall make payments for graduate medical education costs through a health care training consortium whose members provide medical residency training (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium).

(B) USE OF PAYMENTS.—

(i) IN GENERAL.—Each consortium receiving payments under subparagraph (A) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice, and may use

such funds for the operation of the consortium.

(ii) PAYMENTS TO PARTICIPATING PROGRAMS.—The consortium shall ensure that the majority of the payments received under subparagraph (A) are directed to consortium members for primary care residency programs, and shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the consortium's payment amount under the project. Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, non-ambulatory training experience.

(d) ALLOCATION OF PORTION OF MEDICARE GME PAYMENTS FOR ACTIVITIES UNDER PROJECT.—Notwithstanding any provision of title XVIII of the Social Security Act, the following rules apply with respect to each State and each health care training consortium participating in the demonstration project established under this section during a year:

(1) In the case of a State—

(A) the Secretary shall reduce the amount of each payment made to hospitals in the State during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(B) the Secretary shall pay the State an amount equal to the Secretary's estimate of the sum of the reductions made during the year under subparagraph (A) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(2) In the case of a consortium—

(A) the Secretary shall reduce the amount of each payment made to hospitals who are members of the consortium during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(B) the Secretary shall pay the consortium an amount equal to the Secretary's estimate of the sum of the reductions made during the year under subparagraph (A) (as adjusted by the Secretary in subsequent years for over- or

under-estimations in the amount estimated under this subparagraph in previous years).

(e) ADDITIONAL GRANT FOR PLANNING AND EVALUATION.—

(1) IN GENERAL.—The Secretary may award grants to States and consortia participating in the demonstration project under this section for the purpose of developing and evaluating such projects. A State or consortia may conduct such an evaluation or contract with a private entity to conduct the evaluation. Each State and consortia desiring to receive a grant under this paragraph shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for grants under this paragraph for fiscal years 1996 through 2000.

(f) DURATION.—A demonstration project under this section shall be conducted for a period not to exceed 5 years. The Secretary may terminate a project if the Secretary determines that the State or consortium conducting the project is not in substantial compliance with the terms of the application approved by the Secretary.

(g) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—Each State or consortium participating in the demonstration project shall submit to the Secretary a final evaluation within 360 days of the termination of the State or consortium's participation and such interim evaluations as the Secretary may require.

(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this subtitle begins, and annually thereafter for each year in which such a project is conducted, the Secretary shall submit a report to Congress which evaluates the effectiveness of the State and consortium activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(h) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project under this subtitle shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

SEC. 4162. GOALS FOR PROJECTS.

The goals referred to in this section for a State or consortium participating in the demonstration project under this subtitle are as follows:

(1) The training of an equal number of physician and non-physician primary care providers.

(2) The recruiting of residents for graduate medical education training programs who received a portion of undergraduate training in a rural area.

(3) The allocation of not less than 50 percent of the training spent in a graduate medical residency training program at sites at which acute care inpatient hospital services are not furnished.

(4) The rotation of residents in approved medical residency training programs among practices that serve residents of rural areas.

(5) The development of a plan under which, after a 5-year transition period, not less than 50 percent of the residents who begin an initial residency period in an approved medical residency training program shall be primary care residents.

SEC. 4163. DEFINITIONS.

In this subpart:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term ''approved medical residency training program'' has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act.

(2) HEALTH CARE TRAINING CONSORTIUM.—The term ''health care training consortium'' means

a State, regional, or local entity consisting of at least one of each of the following:

(A) A hospital operating an approved medical residency training program at which residents receive training at ambulatory training sites located in rural areas.

(B) A school of medicine or osteopathic medicine.

(C) A school of allied health or a program for the training of physician assistants (as such terms are defined in section 799 of the Public Health Service Act).

(D) A school of nursing (as defined in section 853 of the Public Health Service Act).

(3) PRIMARY CARE.—The term ''primary care'' means family practice, general internal medicine, general pediatrics, and obstetrics and gynecology.

(4) RESIDENT.—The term ''resident'' has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

(5) RURAL AREA.—The term ''rural area'' has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

PART 4—HOSPITAL AFFILIATED PRIMARY CARE CENTER

SEC. 4171. HOSPITAL-AFFILIATED PRIMARY CARE CENTERS.

(a) DEFINITIONS.—For purposes of this section:

(1) COMMUNITY HOSPITAL.—The term ''community hospital'' means a public general hospital, owned and operated by a State, county or local unit of government, or a private community hospital that—

(A) has less than 50 beds; and

(B) primarily serves a medically underserved population as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254c(b)(3)) or a health professional shortage area as defined in section 322(a)(1) of such Act (42 U.S.C. 254c(a)(1).

(2) HOSPITAL-AFFILIATED PRIMARY CARE CENTER.—The term ''hospital-affiliated primary care center'' (referred to in this section as a ''primary care center'') means a distinct administrative unit of a community hospital, located in, or adjacent to, the hospital, that—

(A) delivers primary health services as defined in section 330(b)(1) of such Act (42 U.S.C. 354c(b)(1)) to a catchment area deter-

mined by the hospital and approved by the Secretary; and

(B) provides referrals to providers of supplemental health services as defined in section 330(b)(2) of such Act (42 U.S.C. 354c(b)(2)).

(3) PRIMARY CARE GROUP PRACTICE.—

(A) The term ''primary care group practice'' means any combination of 3 or more primary care physicians who are—

(i) organized to provide primary health services in a manner that is consistent with the needs of the population served;

(ii) located in, or adjacent to, the community hospital;

(iii) who have admitting privileges at the community hospital; and

(iv)(I) who are salaried by the hospital such that a majority of the members of the group practice is full time in the primary care center; or

(II) who are organized into a legal entity (partnership, corporation, or professional association) that has a contract approved by the Secretary with the commu-

nity hospital to provide primary health services.

(B) SPECIAL RULE FOR HPSAS AND NEAR-HPSAS.—In the case of a group that is located in an area that—

(i) is designated as a primary care health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e); or

(ii) would meet the requirements for designation as a primary care health professional shortage area if there were 25 percent fewer physicians in the area;

the requirement that a group practice have 3 or more primary care physicians may be met by substituting a nurse practitioner or a physician assistant for 1 member of the group.

(C) SPECIAL RULE FOR FRONTIER AREAS.—In the case of a group that is located in a frontier area, subparagraph (A) shall be applied by substituting ''two'' for ''three'' in the matter preceding clause (i).

(D) OTHER REQUIREMENTS FOR GROUP.—

(i) physicians in specialties other than primary care specialties may become mem-

bers of a primary care group practice as needed, but may not be used to satisfy the requirement of subsection (b)(2)(D); and

(ii) nonphysician providers, particularly physician assistants, certified nurse midwives, and nurse practitioners, shall be used where practicable in concert with the physicians of a primary care group practice.

(4) FRONTIER AREA.—The term ''frontier area'' means a county in which there are 6 or fewer individuals residing per square mile.

(5) PRIMARY CARE PHYSICIAN.—The term ''primary care physician'' means a physician in the specialty of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.

(6) PRIMARY CARE RESIDENT.—The term ''primary care resident'' means a graduate physician in training, whose training program is approved by appropriate certifying bodies and is in a primary care specialty.

(b) ESTABLISHMENT OF GRANT PROGRAM.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall make grants to community hos-

pitals to assist such hospitals in planning, developing, and operating primary care services in medically underserved areas. In making such grants, the Secretary shall avoid duplication of efforts in areas where existing community health centers, migrant health centers, rural emergency access care hospitals, federally qualified health centers, and other facilities are adequate to meet the needs of the medically underserved population.

(2) ELIGIBILITY FOR GRANTS.—In order to be eligible for a grant under this subsection, a community hospital shall submit an application that contains or is supported by assurances, satisfactory to the Secretary, that—

(A) the services of the primary care center will be delivered through a primary care group practice;

(B) to the extent practicable, primary health services in the community hospital will be delivered only through the primary care center;

(C) qualified personnel trained in triage will be placed in the emergency room, the outpatient department, and the primary care cen-

ter to screen and direct patients to the appropriate location for care;

(D) each patient of the primary care center will have an identified member of the group practice responsible for continuous management of the patient, including emergency services and referrals of the patients for inpatient or outpatient services;

(E) to the extent practicable, excess facilities and equipment in or owned by the community hospital will be covered for use in the primary care center;

(F) the hospital and the primary care center will avoid unnecessary duplication of facilities and equipment, except that the primary care center may install appropriate support equipment for routine primary health services;

(G) the primary care center will be maintained as a separate and distinct cost and revenue center for accounting purposes;

(H) the primary care center will be operated in accordance with all of the requirements specified for community health centers in section 330(e)(3) of the Public Health Service Act (other than subparagraph (G));

(I) the hospital has an advisory committee that—

(i) is composed of individuals, a majority of whom are health consumers in the catchment area of the hospital; and

(ii) meets at least 6 times a year to review the operations of the primary care center and develop recommendations to the governing board of the hospital about the operation of the center and the types of services to be provided; and

(J) the primary care center will maintain an information program for its patients that fully discloses—

(i) the covered professional services and referral capabilities offered by the primary care center; and

(ii) the method by which patients of the primary care center may resolve grievances about billing for covered professional services and the quality of such services.

(3) OTHER REQUIREMENTS.—

(A) USE OF PRIMARY CARE RESIDENTS.—(i) Primary health services may be delivered by primary care residents if such services are deliv-

ered under the supervision of a member of the group practice.

(ii)(I) Medical and other health science students may receive primary care training in the primary care center, except that no full-time member of the group practice may also spend full time in the teaching of residents and students.

(II) The Secretary shall issue regulations to assure that teaching does not detract significantly from the actual delivery of service in the primary care center.

(B) COSTS OF PRIMARY CARE CENTERS.—(i) Only costs clearly associated with the provision of services in the primary care setting may be assigned to a primary care center.

(ii) Inpatient-related costs may not be included in the costs of operating a primary care center.

(iii) Costs associated with the education and training of residents, medical, and other health science students may not be included in the costs of operating a primary care center, except that salaries and other costs associated with the delivery of services by residents may be

included in such costs as long as such costs are prorated based on the actual percentage of time spent by the resident in the primary care center.

(C) ADVISORY COMMITTEE.—(i) The advisory committee referred to in paragraph (2)(I) shall participate in the development of an application for a grant under this section and the development of any grant renewal application.

(ii) The Secretary may not approve the application for a grant under this subsection unless the application has been approved by the advisory committee.

(4) USE OF GRANTS.—(A) A grant under this subsection may be used to cover costs associated with (i) planning, (ii) developing (including modernization and renovation of space), and (iii) operating primary care centers.

(B) Not more than 25 percent of any grant may be used for the purposes specified in subparagraph (A)(ii).

(c) TECHNICAL ASSISTANCE.—The Secretary shall, upon request, provide technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management) to a community

hospital to assist it in developing plans for, and in operating, a primary care center. Funds appropriated under this section may be used to carry out the purposes of this section.

(d) RETENTION OF EARNED INCOME.—The Secretary shall establish, by regulation, a plan to allow primary care centers to retain earned income from the operation of the center if the income is used to—

(1) expand or improve the services of the center;

(2) expand the population eligible to utilize the services of the center;

(3) make managerial or physical improvements to the center; or

(4) establish a reserve fund for conversion to a prepaid reimbursement methodology.

(e) USE OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $12,000,000 for fiscal year 1996, $21,000,000 for fiscal year 1997, $150,000,000 for fiscal year 1998, $160,000,000 for fiscal year 1999, $180,000,000 for fiscal year 2000, and $190,000,000 for each of fiscal years 2001 through 2004.

Subtitle C—Academic Health Centers

SEC. 4201. STUDY OF PAYMENTS FOR MEDICAL EDUCATION AT SITES OTHER THAN HOSPITALS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the feasibility and desirability of making payments to facilities that are not hospitals for the direct and indirect costs of graduate medical education attributable to residents trained at such facilities. In conducting the study, the Secretary shall evaluate new payment methodologies—

(1) under which each entity which incurs costs of graduate medical education shall receive reimbursement for such costs; and

(2) which would encourage the training of primary care physicians.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress a report on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate.

SEC. 4202. STUDY OF FUNDING NEEDS OF HEALTH PROFESSIONS SCHOOLS.

(a) IN GENERAL.—The Secretary shall conduct a study for the purpose of determining the funding needs

of health professions schools, including schools of medicine and osteopathic medicine, schools of dentistry, and schools of public health.

(b) CONSIDERATION OF CERTAIN COSTS.—In conducting the study under subsection (a), the Secretary shall also consider the following costs regarding the funding needs of health professions schools:

(1) Uncompensated costs incurred in providing health care.

(2) Costs resulting from reduced productivity due to teaching responsibilities.

(3) Increased costs of caring for the health needs of patients with severe medical complications.

(4) Uncompensated costs incurred by faculty, residents, and students in providing consultations for hospitalized patients.

(5) Uncompensated costs incurred in conducting clinical research.

(c) CONSIDERATIONS REGARDING ADDITIONAL FUNDING.—In conducting the study under subsection (a), the Secretary shall determine the following:

(1) Whether the health professions schools involved have a significant need for an increase in the amount of funds available to the schools.

(2) If there is such a need—

(A) recommendations regarding the sources of funds to provide the increase; and

(B) recommendations for a methodology for determining the amount that should be provided to the schools involved.

(d) REPORT TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Congress a report describing the findings and recommendations made in the study.

Subtitle D—United States-Mexico Border Health Commission

SEC. 4301. AGREEMENT TO ESTABLISH BINATIONAL COMMISSION.

The President is authorized and encouraged to conclude an agreement with Mexico to establish a binational commission to be known as the United States-Mexico Border Health Commission.

SEC. 4302. DUTIES.

It should be the duty of the Commission—

(1) to conduct a comprehensive needs assessment in the United States-Mexico border area for the purposes of identifying, evaluating, preventing, and resolving health problems that affect the general population of the area;

(2) to implement the actions recommended by the needs assessment by—

(A) assisting in the coordination of the efforts of public and private entities to prevent and resolve such health problems,

(B) assisting in the coordination of the efforts of public and private entities to educate such population concerning such health problems, and

(C) assisting in the development and implementation of programs to prevent and resolve such health problems and (where necessary) to educate such population concerning such health programs; and

(3) to formulate recommendations to the Governments of the United States and Mexico concerning a fair and reasonable method by which the government of one country would reimburse a public or private entity in the other country for the cost of a health care service that the entity furnishes to a citizen of the first country who is unable, through insurance or otherwise, to pay for the service.

SEC. 4303. OTHER AUTHORIZED FUNCTIONS.

In addition to the duties described in section 4302, the Commission should be authorized to perform the fol-

lowing additional functions as the Commission determines to be appropriate:

(1) To conduct or sponsor investigations, research, or studies designed to identify, study, and monitor health problems that affect the general population in the United States-Mexico border area.

(2) To provide financial, technical, or administrative assistance to public or private entities who act to prevent, resolve, or educate such population concerning such health problems.

SEC. 4304. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT OF UNITED STATES SECTION.—The United States section of the Commission should be composed of 13 members. The section should consist of the following members:

(1) The Secretary of Health and Human Services or such individual's delegate.

(2) The commissioners of health from the States of Texas, New Mexico, California, and Arizona or such individuals' delegates.

(3) 2 individuals from each of the States of Texas, New Mexico, California, and Arizona who are nominated by the chief executive officer of one of such States and are appointed by the President from among individuals who have demonstrated ties to

community-based organizations and have a demonstrated interest in health issues of the United States-Mexico border area.

(b) COMMISSIONER.—The Commissioner of the United States section of the Commission should be the Secretary of Health and Human Services or such individual's delegate to the Commission. The Commissioner should be the leader of the section.

SEC. 4305. REGIONAL OFFICES.

The Commission should establish no fewer than 2 regional border offices in locations selected by the Commission.

SEC. 4306. REPORTS.

Not later than February 1 of each year that occurs more than 1 year after the date of the establishment of the Commission, the Commission should submit an annual report to both the United States Government and the Government of Mexico regarding all activities of the Commission during the preceding calendar year.

SEC. 4307. DEFINITIONS.

For purposes of this subtitle:

(1) COMMISSION.—The term ''Commission'' means the United States-Mexico Border Health Commission authorized in section 4301.

(2) HEALTH PROBLEM.—The term ''health problem'' means a disease or medical ailment or an environmental condition that poses the risk of disease or medical ailment. The term includes diseases, ailments, or risks of disease or ailment caused by or related to environmental factors, control of animals and rabies, control of insect and rodent vectors, disposal of solid and hazardous waste, and control and monitoring of air and water quality.

(3) UNITED STATES-MEXICO BORDER AREA.—The term ''United States-Mexico border area'' means the area located in the United States and Mexico within 100 kilometers of the border between the United States and Mexico.

TITLE V—HEALTH CARE QUALITY ENHANCEMENT

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Subtitle A—Quality Assurance

SEC. 5001. HEALTH QUALITY ADVISORY COUNCIL.

(a) ESTABLISHMENT.—The Secretary shall provide for the establishment of an advisory council to be known as the ''Health Quality Advisory Council'' (in this subtitle referred to as the ''Council'').

(b) DUTIES.—

(1) INITIAL MEASURES AND REQUIREMENTS.—

(A) DEVELOPMENT OF QUALITY MEASURES.—The Council shall develop an initial set of quality measures to be used to assess the quality of carriers, group health plans, and multiple employer welfare arrangements. The quality measures shall include measures that provide information with respect to such entities on the following subjects:

(i) Outcomes of care for specified medical conditions.

(ii) Health status of enrollees.

(iii) Health promotion activities.

(iv) Prevention of diseases, disorders, disabilities, injuries, and other adverse health conditions.

(v) Risk management and reduction.

(vi) Consumer satisfaction.

(B) RECOMMENDATIONS.—Not later than the date that is 9 months from the date of the enactment of this Act, the Council shall recommend to the Secretary—

(i) the initial set of quality measures developed under subparagraph (A);

(ii) a standard set of data to be developed and collected in a uniform form and manner by carriers, group health plans, and multiple employer welfare arrangements in order to permit such a carrier, plan, or arrangement to assess its quality using such initial set of measures;

(iii) a standard methodology to be used by such entities to carry out the assessments described in clause (ii);

(iv) a standard format to be used by such entities publicly to report the results of such assessments; and

(v) a schedule for implementing, in succession—

(I) the data development and collection requirements recommended under clause (ii);

(II) the assessment requirements recommended under clause (iii); and

(III) the reporting requirements recommended under clause (iv).

(2) MODIFYING MEASURES.—The Council shall make recommendations to the Secretary with respect to modifying, as additional information with respect to carriers, group health plans, and multiple employer welfare arrangements becomes valid and available, a set of quality measures selected by the Secretary under section 5002. A recommendation under the preceding sentence shall be accompanied by recommendations for modifications to a data set, assessment methodology, reporting format, or schedule for implementation selected by the Secretary under such section that the Council determines would be necessary in order to implement appropriately a modification in the set of quality measures.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Council shall be voting members, other than officials

designated under paragraph (3) as ex officio members of the Council.

(2) APPOINTED MEMBERS.—The Secretary shall appoint to the Council 9 appropriately qualified individuals who are not officers or employees of the United States. Members appointed under this paragraph shall include—

(A) individuals distinguished in the field of health outcomes;

(B) representatives of carriers, group health plans, and multiple employer welfare arrangements;

(C) health care providers; and

(D) consumers of health care.

(3) EX OFFICIO MEMBERS.—The Secretary may designate as ex officio members of the Council the Director of the National Institutes of Health, the Director of the Centers for Disease Control, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), and the Chief Medical Officer of the Department of Veterans Affairs.

(d) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council appointed under subsection (c)(2) shall serve for a term of 3 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (c)(2), the Secretary shall appoint 3 members to serve for a term of 3 years, 3 members to serve for a term of 2 years, and 3 members to serve for a term of 1 year.

(3) SERVICE BEYOND TERM.—A member of the Council appointed under subsection (c)(2) may continue to serve after the expiration of the term of the member until a successor is appointed.

(e) VACANCIES.—If a member of the Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

(f) CHAIR.—The Secretary shall, from among the members of the Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Council.

(g) MEETINGS.—The Council shall meet at the call of the chair or the Secretary.

(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

(1) APPOINTED MEMBERS.—Members of the Council appointed under subsection (c)(2) shall receive compensation for each day (including travel-time) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable under section 5376 of title 5, United States Code.

(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Council may not receive compensation for service on the Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

(i) STAFF.—The Secretary shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(j) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise provided by law.

SEC. 5002. QUALITY ASSESSMENT USING MEASURES.

(a) INITIAL MEASURES AND REQUIREMENTS.—

(1) EVALUATION OF RECOMMENDATIONS.—If the Council makes the recommendations to the Secretary that are described in section 5001(b)(1)(B) not later than the deadline described in such section, the Secretary shall evaluate the recommendations to determine whether they will provide for effective measurement and reporting of the quality of carriers, group health plans, and multiple employer welfare arrangements. The Secretary shall complete such evaluation not later than the date that is 90 days from the date on which the Secretary receives the recommendations of the Council.

(2) MODIFICATION.—Prior to the initiation of a rule making under paragraph (3), the Secretary may, as the Secretary determines appropriate based on the evaluation under paragraph (1), modify any quality measure, data set, assessment methodology, reporting format, or schedule for implementation recommended by the Council under section 5001(b)(1)(B).

(3) RULE MAKING.—After notice and opportunity for public comment, the Secretary shall promulgate a rule that—

(A) establishes an initial set of quality measures of the type described in section 5001(b)(1)(A);

(B) establishes a standard data set, methodology, reporting format, and an implementation schedule of the types described in section 5001(b)(1)(B) and requirements on carriers, group health plans, and multiple employer welfare arrangements in accordance with such standards and schedule;

(C) requires each carrier, group health plans, and multiple employer welfare arrangement periodically to publish a report, using the standard reporting format established under subparagraph (B), and to send the report to employers, brokers, health plan purchasing organizations, and consumers in its service area;

(D) specifies the amount and nature of the data that carriers, group health plans, and multiple employer welfare arrangements shall transmit under paragraphs (2) and (4) of subsection (b) in order to permit States and the Secretary of Labor to conduct audits under paragraphs (1) and (4) of such subsection; and

(E) specifies the frequency with which, and the method by which, such data shall be transmitted to States or the Secretary of Labor.

(b) COMPLIANCE.—

(1) PERIODIC AUDITS.—Each State shall conduct periodic audits to evaluate whether carriers providing health insurance coverage in the State are complying with the requirements established under subsection (a). Such audits shall include an assessment of the completeness, accuracy, and validity of any data developed or collected by a carrier under such subsection and any report published by such an entity under such subsection. A State may satisfy the requirements of this paragraph by entering into a contract or other agreement with any appropriate individual or entity.

(2) DATA TRANSMISSION.—A carrier providing health insurance coverage in a State shall transmit to the State, in accordance with the requirements promulgated under subsection (a)(3)(E), the data determined to be necessary by the Secretary under subsection (a)(3)(D).

(3) ENSURING COMPLIANCE.—A State may take appropriate action to ensure compliance by carriers with the requirements of subsection (a) and

paragraph (2). Such action may include the imposition of a penalty on a carrier that transmits incomplete, false, or misleading data to the State.

(4) APPLICATION TO GROUP HEALTH PLANS AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

(A) AUDITS AND DATA TRANSMISSION.—The Secretary of Labor shall undertake the duties, and may exercise the authorities, of States that are described in paragraph (1) with respect to each group health plan, and each multiple employer welfare arrangement, that does not provide health coverage through a carrier. Such a plan or arrangement shall transmit to the Secretary of Labor, in accordance with the requirements promulgated under subsection (a)(3)(E), the data determined to be necessary by the Secretary of Health and Human Services under subsection (a)(3)(D).

(B) ENSURING COMPLIANCE.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of this section shall be considered to be provisions of title I of such Act, but only to the extent that this section applies

to group health plans and multiple employer welfare arrangements that do not provide health coverage through a carrier.

(c) MODIFYING MEASURES.—

(1) IN GENERAL.—The Secretary may modify any set of quality measures established under subsection (a). The Secretary may make any modification to a set of data, standard methodology, standard reporting format, implementation schedule, or requirement on carriers, group health plans, and multiple employer welfare arrangements established under such subsection that the Secretary determines is necessary to implement appropriately a modification in the set of quality measures.

(2) PROCEDURE.—Prior to implementing a modification under paragraph (1), the Secretary shall—

(A) receive the recommendations of the Council with respect to the modification;

(B) provide notice and opportunity for public comment; and

(C) promulgate a rule.

SEC. 5003. DEFINITIONS.

For purposes of this subtitle:

(1) The term ''carrier'' means a carrier (as defined in section 1903(2)) providing health insurance coverage (as defined in section 1903(7)).

(2) The term ''multiple employer welfare arrangement'' means a multiple employer welfare arrangement (as defined in section 1903(12)) providing benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974.

Subtitle B—Primary Care Provider Education

SEC. 5101. AREA HEALTH EDUCATION CENTERS.

Section 746(i)(1)(A) of the Public Health Service Act (42 U.S.C. 293j(i)(1)(A)) is amended by striking ''through 1995'' and inserting ''through 1994 and $30,000,000 for each of the fiscal years 1995 through 1999''.

SEC. 5102. PUBLIC HEALTH AND PREVENTIVE MEDICINE.

Section 765(a) of the Public Health Service Act (42 U.S.C. 294c(a)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 5103. FAMILY MEDICINE.

Section 747(d)(1) of the Public Health Service Act (42 U.S.C. 293k(d)(1)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 5104. GENERAL INTERNAL MEDICINE AND PEDIATRICS.

Section 748(c) of the Public Health Service Act (42 U.S.C. 293l(c)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 5105. PHYSICIAN ASSISTANTS.

Section 750(d)(1) of the Public Health Service Act (42 U.S.C. 293n(d)(1)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 5106. ALLIED HEALTH PROJECT GRANTS AND CONTRACTS.

Section 767(d) of the Public Health Service Act (42 U.S.C. 294e(d)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 5107. NURSE PRACTITIONER AND NURSE MIDWIFE PROGRAMS.

Section 822(d) of the Public Health Service Act (42 U.S.C. 296m(d)) is amended by striking ''and 1994'' and inserting ''through 1999''.

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Subtitle A—Facilitating Establishment of Health Plan Purchasing Organization (HPPOs)

PART 1—HEALTH PLAN PURCHASING ORGANIZATIONS

SEC. 6001. ESTABLISHMENT AND ORGANIZATION.

(a) IN GENERAL.—Health plan purchasing organizations (each in this part referred to as a ''purchasing organization'') may be established in accordance with this part. Each purchasing organization shall be chartered under State law and operated as a not-for-profit corporation. A

carrier may not form, underwrite, or possess a majority vote of a purchasing organization, but may administer such an organization.

(b) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each purchasing organization shall be governed by a Board of Directors. Such Board shall initially be appointed under procedures established by the State in which it operates. Subsequently, the Board shall be elected by the members of the organization in accordance with paragraph (3). Such Board shall be composed of individuals who are small employers (or representatives of small employers), eligible employees of small employers (or representatives of such employees), and qualifying individuals in the area in which the organization operates.

(2) MEMBERSHIP.—A purchasing organization shall accept all small employers and eligible employees and other individuals who are in the individual/small employer market within the area served by the organization as members if such employers, employees, or individuals request such membership.

(3) VOTING.—Members of a purchasing organization shall have voting rights consistent with the

rules established under the bylaws governing the organization.

(c) DUTIES OF PURCHASING ORGANIZATIONS.—

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

(A) market health insurance coverage in the individual/small group market throughout the entire area served by the organization;

(B) enter into agreements under section 6002 with carriers offering qualified health coverage under this subtitle;

(C) enter into agreements with small employers under section 6003;

(D) enroll individuals with carriers offering qualified health coverage, only in accordance with section 6004;

(E) disseminate quality information under section 4002; and

(F) carry out other functions provided for under this part.

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

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

(B) perform any activity (including certification or enforcement) relating to compliance of carriers (and health coverage provided by carriers) with the requirements of subtitle A of title I;

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

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

(3) CHARACTERISTICS OF SERVICE AREA.—

(A) IN GENERAL.—A purchasing organization need not serve geographic areas that are contiguous, but the geographic boundaries of such areas shall be consistent with the boundaries established under section 1021 for fair rating areas.

(B) SERVICE OF ENTIRE METROPOLITAN STATISTICAL AREA.—If a purchasing organization serves a part of a metropolitan statistical area the organization shall serve the entire area.

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

(1) that a purchasing organization be established in each area of a State in which it operates; and

(2) that there be only one purchasing organization established with respect to any area.

SEC. 6002. AGREEMENTS TO OFFER QUALIFIED HEALTH COVERAGE.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (3), each purchasing organization for an area shall enter into an agreement under this section with each carrier that desires to make available qualified health coverage through the purchasing organization (consistent with any procedures established by the State).

(2) TERMINATION OF AGREEMENT.—An agreement under paragraph (1) shall remain in effect for a 12-month period, except that the purchasing organization may terminate an agreement under paragraph (1) if the carrier's license or certification under State law is terminated or for other good cause shown.

(3) LIMITATION ON RENEWAL OF AGREEMENTS.—Subsequent to the 12-month period de-

scribed in paragraph (2), a purchasing organization may—

(A) refuse to enter into a subsequent agreement with a carrier if the organization determines that the number of enrollees or the premium for coverage is too low, and

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

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

(1) IN GENERAL.—Under an agreement under this section between a purchasing organization and a carrier—

(A) premiums shall be payable, and

(B) payment of premiums may be made by individuals (or employers on their behalf) directly to the purchasing organization for the benefit of the carrier.

(2) TIMING OF PAYMENT OF PREMIUMS.—Premiums may be payable on a monthly basis (or, at the option of an eligible employee or individual, on

a quarterly basis). The purchasing organization may provide for reasonable penalties and grace periods for late payment.

(3) CARRIERS RETAIN RISK OF NONPAYMENT.—Nothing in this subsection shall be construed as placing upon a purchasing organization any risk associated with the failure of individuals and employers to make prompt payment of premiums (other than the portion of the premium representing the purchasing organization administrative fee under section 6005). Each small employer and qualifying individual who enrolls with a carrier providing qualified health coverage through the purchasing organization is liable to the carrier for premiums.

(c) FORWARDING OF PREMIUMS.—

(1) IN GENERAL.—If, under an agreement under subsection (a), premium payments for qualified health coverage are made to the purchasing organization, the purchasing organization shall forward to the carrier the amount of the premiums.

(2) PAYMENTS.—Payments shall be made by the purchasing organization under this subsection within a period of days (specified by the Secretary and not to exceed 7 days) after receipt of the pre-

mium from the small employer of the eligible employee or the qualifying individual, as the case may be.

(d) PAYMENT OF COMMISSIONS.—

(1) IN GENERAL.—Subject to paragraph (2), nothing in this part shall be construed to preclude a carrier from paying a commission or other remuneration in connection with the purchase of health care coverage by individuals or groups, consistent with State law.

(2) LIMITATION ON VARIATION.—A carrier may not vary such compensation or remuneration based, directly or indirectly, on the anticipated or actual claims experience associated with the group or individuals purchasing health care coverage.

SEC. 6003. PROVISION OF INFORMATION.

(a) IN GENERAL.—Each purchasing organization for an area shall make available to small employers that employ individuals in the area and to qualifying individuals who reside in the area—

(1) information provided to the purchasing organization by the State or carriers, and

(2) the opportunity to enter into an agreement with the organization for the purchase of qualified health coverage.

(b) FORWARDING INFORMATION AND PAYROLL DEDUCTIONS.—As part of an agreement entered into under this section, a small employer shall forward the information and make the payroll deductions required under section 1201(a).

SEC. 6004. ENROLLING ELIGIBLE EMPLOYEES AND QUALIFYING INDIVIDUALS FOR QUALIFIED HEALTH COVERAGE THROUGH A PURCHASING ORGANIZATION.

A purchasing organization shall offer, on behalf of each carrier with which an agreement was entered into under section 6002 and in accordance with the enrollment procedures of such carriers and the enrollment periods provided under 1005, enrollment for the coverage only to individuals in the individual/small group market in the area served by the purchasing organization. Each purchasing organization shall coordinate annual open enrollment periods (described in section 1005(c)) of all carriers through which coverage is offered by the organization so that there is one common annual open enrollment period for all such carriers with respect to each individual enrolled for coverage through the organization. Nothing in this section shall preclude a purchasing organization from having different common annual open enrollment periods for different individuals.

SEC. 6005. RESTRICTION ON CHARGES.

(a) IN GENERAL.—A purchasing organization may impose an administrative fee with respect to an eligible employee or qualifying individual enrolled for qualified health coverage offered through the purchasing organization.

(b) FEE.—A purchasing organization that elects to impose a fee under subsection (a) shall ensure that such fee is set as a percentage of the premium for each such coverage option, is imposed uniformly with respect to all coverage options offered through the organization, and is disclosed explicitly as an addition to the premium.

SEC. 6006. STATE REPORT ON ESTABLISHMENT OF PURCHASING ORGANIZATIONS.

(a) IN GENERAL.—Not later than January 1, 2000, each State shall conduct a review of access of residents of the State who are not employees of large employers or medicare beneficiaries to obtaining standard health insurance coverage through a purchasing organization.

(b) RESPONSE.—If the State determines, based on such review, that such residents are unable to obtain such coverage through such an organization, the State shall take such actions as the State determines appropriate to ensure public or private entities provide access to such an organization by such residents.

PART 2—ENCOURAGEMENT OF MULTIPLE EMPLOYER ARRANGEMENTS PROVIDING BASIC HEALTH BENEFITS

SEC. 6011. ELIMINATING COMMONALITY OF INTEREST OR GEOGRAPHIC LOCATION REQUIREMENT FOR TAX EXEMPT TRUST STATUS.

(a) IN GENERAL.—Paragraph (9) of section 501(c) of the Internal Revenue Code of 1986 (relating to exempt organizations) is amended—

(1) by inserting ''(A)'' after ''(9)''; and

(2) by adding at the end the following:

''(B) Any determination of whether a certified multiple employer health plan (as defined in section 701(9) of the Employee Retirement Income Security Act of 1974), a multiple employer welfare arrangement which is fully insured, or a plan described in clause (ii) or (iii) of section 3(40)(A) of such Act is a voluntary employees' beneficiary association meeting the requirements of this paragraph shall be made without regard to any determination of commonality of interest or geographic location.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to determinations made on or after the date of the enactment of this Act.

PART 3—TAX EXEMPTION FOR HIGH RISK POOLS

SEC. 6021. TAX EXEMPTION FOR HIGH RISK INSURANCE POOLS.

(a) IN GENERAL.—Subsection (c) of section 501 of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

''(27) In the case of taxable years beginning before January 1, 1997, any corporation, association, or similar legal entity which is created by any State or political subdivision thereof to establish a risk pool to provide health insurance coverage to any person unable to obtain health insurance coverage in the private insurance market because of health conditions and no part of the net earnings of which inures to the benefit of any private shareholder, member, or individual.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1989.

Subtitle B—Preemption of State Benefit Mandates and Anti-Managed Care Laws

SEC. 6101. PREEMPTION FROM STATE BENEFIT MANDATES.

Effective as of January 1, 1997, no State shall establish or enforce any law or regulation that—

(1) requires the offering, as part of health insurance coverage, of any services, category of care, or services of any class or type of provider, except as provided in section 1013; or

(2) specifies the individuals to be provided health insurance coverage or the duration of such coverage.

SEC. 6102. PREEMPTION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.

(a) LIMITATION ON RESTRICTIONS ON NETWORK PLANS.—Effective as of January 1, 1997—

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

(2) a State may not prohibit or limit such a carrier or plan from limiting coverage of services to those provided by a participating provider, except as provided in section 1013;

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers by such a carrier or plan with respect to health coverage;

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

(5) a State may not prohibit or limit such a carrier or plan from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers or, except as provided in section 1011(e), from requiring enrollees to obtain referral in order to have coverage for treatment by a specialist or health institution; and

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

(b) DEFINITIONS.—In this section:

(1) MANAGED CARE COVERAGE.—The term ''managed care coverage'' means health coverage to the extent the coverage is provided through a managed care arrangement (as defined in section 1903(11)(A)) that meets the applicable requirements of such section.

(2) PARTICIPATING PROVIDER.—The term ''participating provider'' means an entity or individual which provides, sells, or leases health care services as part of a provider network (as defined in section 1903(11)(B)).

(c) REFERENCE TO STANDARDS FOR MANAGED CARE ARRANGEMENTS.—For requirements relating to managed care arrangements, see section 1011.

SEC. 6103. PREEMPTION OF STATE LAWS RESTRICTING UTILIZATION REVIEW PROGRAMS.

(a) IN GENERAL.—Effective January 1, 1997, no State law or regulation shall prohibit or regulate activities under a utilization review program (as defined in subsection (b)).

(b) UTILIZATION REVIEW PROGRAM DEFINED.—In this section, the term ''utilization review program'' means a system of reviewing the medical necessity and appropriateness of patient services (which may include inpatient and outpatient services) using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

(c) EXEMPTION OF LAWS PREVENTING DENIAL OF LIFESAVING MEDICAL TREATMENT PENDING TRANSFER TO ANOTHER HEALTH CARE PROVIDER.—Nothing in this subtitle shall be construed to invalidate any State law that has the effect of preventing involuntary denial of life-preserving medical treatment when such denial would cause the involuntary death of the patient pending transfer of

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

SEC. 6104. PROHIBITION OF PROVISIONS PROHIBITING EMPLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.

No provision of State or local law shall apply that prohibits 2 or more employers from obtaining coverage that is fully insured (within the meaning of section 701(8) of the Employee Retirement Income Security Act of 1974, as added by section 1401(a) of this Act) under a multiple employer health plan.

SEC. 6105. PREEMPTION RELATING TO DIFFERENT INSURANCE STANDARDS.

A State may not establish or enforce standards for health insurance coverage made available in the individual and small group markets that are different from the standards established under title I.

SEC. 6106. GAO STUDY ON MANAGED CARE.

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

(b) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted

under subsection (a) and shall include in the report such recommendations as may be appropriate.

Subtitle C—Malpractice Reform

PART 1—UNIFORM STANDARDS FOR MALPRACTICE CLAIMS

SEC. 6201. APPLICABILITY.

Except as provided in section 6221, this part shall apply to any medical malpractice liability action brought in a Federal or State court, and to any medical malpractice claim subject to an alternative dispute resolution system, that is initiated on or after January 1, 1996.

SEC. 6202. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 6212(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section 6222(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in any Federal court under section 1332 of title 28, United States Code, during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system referred to in paragraph (1) that applied in the State whose law applies in such action.

(3) CLAIMS AGAINST UNITED STATES.—

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

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A)

may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process established by the Attorney General under such subparagraph.

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

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

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

(c) PROCEDURES FOR FILING ACTIONS.—

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

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

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

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

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

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

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

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

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

SEC. 6203. OPTIONAL APPLICATION OF PRACTICE GUIDELINES.

(a) DEVELOPMENT AND CERTIFICATION OF GUIDELINES.—Each State may develop, for certification by the Secretary, a set of specialty clinical practice guidelines, based on recommended guidelines from national specialty societies, to be updated annually. In the absence of recommended guidelines from such societies, each State may develop such guidelines based on such criteria as the State considers appropriate (including based on recommended guidelines developed by the Agency for Health Care Policy and Research).

(b) PROVISION OF HEALTH CARE UNDER GUIDELINES.—Notwithstanding any other provision of law, in any medical malpractice liability action arising from the conduct of a health care provider or health care professional, if such conduct was in accordance with a guideline developed by the State in which the conduct occurred and certified by the Secretary under subsection (a), the guideline—

(1) may be introduced by any party to the action (including a health care provider, health care professional, or patient); and

(2) if introduced, shall establish a rebuttable presumption that the conduct was in accordance with the appropriate standard of medical care, which may only be overcome by the presentation of clear and convincing evidence on behalf of the party against whom the presumption operates.

SEC. 6204. TREATMENT OF NONECONOMIC AND PUNITIVE DAMAGES.

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

(b) NO AWARD OF PUNITIVE DAMAGES AGAINST MANUFACTURER OF MEDICAL PRODUCT.—In the case of a medical malpractice liability action in which the plaintiff alleges a claim against the manufacturer of a medical product, no punitive or exemplary damages may be awarded against such manufacturer.

(c) JOINT AND SEVERAL LIABILITY FOR NONECONOMIC DAMAGES.—The liability of each defendant for noneconomic damages shall be several only and shall not be joint, and each defendant shall be liable only for the amount of noneconomic damages allocated to the defendant in direct proportion to the defendant's percentage of responsibility (as determined by the trier of fact).

(d) USE OF PUNITIVE DAMAGE AWARDS FOR OPERATION OF ADR SYSTEMS IN STATES.—

(1) IN GENERAL.—The total amount of any punitive damages awarded in a medical malpractice liability action shall be paid to the State in which the action is brought (or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided), and shall be used by the State solely to implement and operate the State alternative dispute resolution system certified by the Secretary under section 6222 (except as provided in paragraph (2)).

(2) USE OF REMAINING AMOUNTS FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVITIES.—If the amount of punitive damages paid to a State under paragraph (1) for a year is greater than the State's costs of implementing and operating the

State alternative dispute resolution system during the year, the balance of such punitive damages paid to the State shall be used solely to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

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

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

(3) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to paragraph (1) to supplement and not to replace amounts spent by the State for implementing and operating the State alternative dispute resolution system or carrying out the activities described in paragraph (2).

SEC. 6205. PERIODIC PAYMENTS FOR FUTURE LOSSES.

(a) IN GENERAL.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but may be permitted to make such payments on

a periodic basis. The periods for such payments shall be determined by the court, based upon projections of when such expenses are likely to be incurred.

(b) WAIVER.—A court may waive the application of subsection (a) with respect to a defendant if the court determines that it is not in the best interests of the plaintiff to receive payments for damages on such a periodic basis.

SEC. 6206. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(1) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to section 6202(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim under the alternative dispute resolution system), but only if—

(A) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action is less than the amount of damages awarded to the party under the ADR system; and

(B) in the case of an action in which the party that contested the ruling is the defendant, the amount of damages assessed against the party under the action is greater than the amount of damages assessed under the ADR system.

(2) EXCEPTIONS.—Paragraph (1) shall not apply if—

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

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

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

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

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

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

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

(D) the court finds that the application of such paragraph to a party would constitute an undue hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(3) LIMIT ON ATTORNEYS' FEES PAID.—Attorneys' fees that are required to be paid under paragraph (1) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency fee agreement, the amount of attorneys' fees for purposes of the preceding sentence shall not exceed the reasonable value of those services.

(4) RECORDS.—In order to receive attorneys' fees under paragraph (1), counsel of record in the medical malpractice liability action involved shall maintain accurate, complete records of hours worked on the action, regardless of the fee arrangement with the client involved.

(b) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 6207. UNIFORM STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Except as provided in subsection (b), no medical malpractice claim may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of such claim was discovered, but in no event may such a claim be initiated after the expiration of the 4-year period that begins on the date on which the alleged injury that is the subject of such claim occurred.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, a medical malpractice claim may not be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject

of such claim was discovered or should reasonably have been discovered, but in no event may such a claim be initiated after the date on which the minor attains 12 years of age.

SEC. 6208. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IN GENERAL.—In the case of a medical malpractice claim relating to services provided during labor or the delivery of a baby, if the health care professional or health care provider against whom the claim is brought did not previously treat the claimant for the pregnancy, the trier of fact may not find that such professional or provider committed malpractice and may not assess damages against such professional or provider unless the malpractice is proven by clear and convincing evidence.

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

SEC. 6209. JURISDICTION OF FEDERAL COURTS.

Nothing in this part shall be construed to establish any jurisdiction over any medical malpractice liability action in the district courts of the United States on the basis of sections 1331 or 1337 of title 28, United States Code.

SEC. 6210. PREEMPTION.

(a) IN GENERAL.—The provisions of this part shall preempt any State law to the extent such law is inconsistent with such provisions, except that the provisions of this part shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this part, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this part.

(b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this part shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

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

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground in inconvenient forum.

PART 2—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS (ADR)

SEC. 6221. BASIC REQUIREMENTS.

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

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

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

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

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

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

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

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

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

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

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining

health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

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

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of part 1 (other than section 6202) shall apply with respect to claims brought under a State alternative dispute resolution system or the alternative Federal system in the same manner as such provisions apply with respect to medical malpractice liability actions brought in the State.

SEC. 6222. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

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

(2) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection for a calendar year if the Secretary determines under paragraph (1) that the system meets the requirements of section 6221, including the requirement described in section 6204 that punitive damages awarded under the system are paid to the State for the uses described in such section.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1995, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

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

(A) paragraphs (1), (2), (6), and (7) of section 6221(a) shall apply to claims brought under the system;

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

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

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year, the State shall make a payment to the United States (at such time and in such manner as the Secretary may require) in an amount equal to 110 percent of

the costs incurred by the United States during the year as a result of the application of the system with respect to the State.

SEC. 6223. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this part and the alternative Federal system established under section 6222(b).

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

(1) information on—

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

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

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

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

PART 3—DEFINITIONS

SEC. 6231. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM.—The term ''alternative dispute resolution system'' means a system that is enacted or adopted by a State to resolve medical malpractice claims other than through a medical malpractice liability action.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such an action is brought.

(3) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established,

except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

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

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

(6) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

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

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means any civil action brought pursuant to State law in which a plaintiff alleges a medical malpractice claim against a health care provider or health care professional, but does not include any action in which the plaintiff's sole allegation is an allegation of an intentional tort.

(9) MEDICAL MALPRACTICE CLAIM.—The term ''medical malpractice claim'' means any claim relating to the provision of (or the failure to provide) health care services or the use of a medical product, without regard to the theory of liability asserted, and includes any third-party claim, cross-claim, counterclaim, or contribution claim in a medical malpractice liability action.

(10) MEDICAL PRODUCT.—

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

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect to the safety of the formulation or performance of the aspect of such drug or device which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

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

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Ad-

ministration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

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

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

Subtitle D—Administrative Simplification

SEC. 6300. PURPOSE.

It is the purpose of this subtitle to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act, by encouraging the development of a health

information network through the adoption of standards and the establishment of requirements for the electronic transmission of certain health information.

SEC. 6301. DEFINITIONS.

For purposes of this subtitle:

(1) CODE SET.—The term ''code set'' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(2) COORDINATION OF BENEFITS.—The term ''coordination of benefits'' means determining and coordinating the financial obligations of plan sponsors when health care benefits are payable by more than one such sponsor.

(3) HEALTH INFORMATION.—The term ''health information'' means any information that relates to the past, present, or future physical or mental health or condition or functional status of an individual, the provision of health care to an individual, or payment for the provision of health care to an individual.

(4) HEALTH INFORMATION NETWORK.—The term ''health information network'' means the health information system that is formed through the appli-

cation of the requirements and standards established under this subtitle.

(5) HEALTH INFORMATION NETWORK SERVICE.—The term ''health information network service''—

(A) means a private entity or an entity operated by a State that enters into contracts—

(i) to process or facilitate the processing of nonstandard data elements of health information into standard data elements;

(ii) to provide the means by which persons are connected to the health information network for purposes of meeting the requirements of this subtitle, including the holding of standard data elements of health information;

(iii) to provide authorized access to health information through the health information network; or

(iv) to provide specific information processing services, such as automated coordination of benefits and claims transaction routing; and

(B) includes a health information security organization.

(6) HEALTH INFORMATION SECURITY ORGANIZATION.—The term ''health information security organization'' means a private entity or an entity operated by a State that accesses standard data elements of health information through the health information network, processes such information into non-identifiable health information, and may store such information.

(7) HEALTH PROVIDER.—The term ''health provider'' includes a provider of services (as defined in section 1861(u) of the Social Security Act), a provider of medical or other health services (as defined in section 1861(s) of such Act), and any other person (other than a plan sponsor) furnishing health care items or services.

(8) NON-IDENTIFIABLE HEALTH INFORMATION.—The term ''non-identifiable health information'' means health information that is not protected health information (as defined in subtitle E).

(9) PLAN SPONSOR.—The term ''plan sponsor'' means—

(A) a carrier (as defined in section 1903(2)) providing health insurance coverage (as defined in section 1903(7));

(B) a group health plan;

(C) an association or other entity which establishes or maintains a multiple employer welfare arrangement (as defined in section 1903(12)) providing benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974; and

(D) a State, or the Federal Government, acting in a capacity as a provider of health benefits to eligible individuals that is equivalent to that of a carrier.

(10) STANDARD.—The term ''standard'', when used with reference to a transaction or to data elements of health information, means that the transaction or data elements meet any standard adopted by the Secretary under part 1 that applies to the transaction or data elements.

PART 1—STANDARDS FOR DATA ELEMENTS AND TRANSACTIONS

SEC. 6311. GENERAL REQUIREMENTS ON SECRETARY.

(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this part that are—

(1) consistent with the objective of reducing the costs of providing and paying for health care; and

(2) in use and generally accepted, developed, or modified by the standard-setting organizations accredited by the American National Standard Institute.

(b) INITIAL STANDARDS.—The Secretary may develop an expedited process for the adoption of initial standards under this part.

(c) PROTECTION OF COMMERCIAL INFORMATION.—In adopting standards under this part, the Secretary may not require disclosure of trade secrets and confidential commercial information by any person.

SEC. 6312. STANDARDS FOR DATA ELEMENTS OF HEALTH INFORMATION.

(a) IN GENERAL.—The Secretary shall adopt standards necessary to make uniform and compatible for electronic transmission through the health information network the data elements of any health information that the Secretary determines is appropriate for transmission in connection with a transaction described in section 6321.

(b) ADDITIONS.—The Secretary may make additions to any set of data elements adopted under subsection (a) as the Secretary determines appropriate in a manner that minimizes the disruption and cost of compliance with such additions.

(c) CERTAIN DATA ELEMENTS.—

(1) UNIQUE HEALTH IDENTIFIERS.—The Secretary shall establish a system to provide for a standard unique health identifier for each individual, employer, plan sponsor, and health provider for use in the health care system.

(2) CODE SETS.—

(A) IN GENERAL.—The Secretary, in consultation with experts from the private sector and Federal agencies, shall—

(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution of code sets and modifications to code sets.

SEC. 6313. INFORMATION TRANSACTION STANDARDS.

(a) IN GENERAL.—The Secretary shall adopt technical standards that are consistent with subtitle E relating to the method by which standard data elements of health information may be transmitted electronically, including

standards with respect to the format in which such data elements may be transmitted.

(b) SPECIAL RULE FOR COORDINATION OF BENEFITS.—Any standard adopted by the Secretary under paragraph (1) that relates to coordination of benefits shall provide that a claim for reimbursement for health services furnished shall be tested, by an algorithm specified by the Secretary, against all records of enrollment and eligibility for the individual who received such services that are available to the recipient of the claim through the health information network to determine any primary and secondary obligors for payment.

(c) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which shall be deemed to satisfy State and Federal statutory requirements for written signatures with respect to transactions described in section 6321 and written signatures on health records and prescriptions.

(d) STANDARDS FOR CLAIMS FOR CLINICAL LABORATORY TESTS.—The standards under this section shall provide that claims for clinical laboratory tests for which benefits are payable by a plan sponsor shall be submitted directly by the person or entity that performed (or super-

vised the performance of) the tests to the sponsor in a manner consistent with (and subject to such exceptions as are provided under) the requirement for direct submission of such claims under the medicare program.

SEC. 6314. TIMETABLES FOR ADOPTION OF STANDARDS.

(a) INITIAL STANDARDS FOR DATA ELEMENTS.—The Secretary shall adopt standards relating to—

(1) the data elements for the information described in section 6312(a) not later than 9 months after the date of the enactment of this Act (except in the case of standards with respect to data elements for claims attachments, which shall be adopted not later than 24 months after the date of the enactment of this Act); and

(2) any addition to a set of data elements, in conjunction with making such an addition.

(b) INITIAL STANDARDS FOR INFORMATION TRANSACTIONS.—The Secretary shall adopt standards relating to information transactions under section 6313 not later than 9 months after the date of the enactment of this Act (except in the case of standards for claims attachments, which shall be adopted not later than 24 months after the date of the enactment of this Act).

(c) MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this part and shall adopt modified standards as determined appropriate, but not more frequently than once every 6 months. Any modification to standards shall be completed in a manner which minimizes the disruption to, and costs of compliance incurred by, a plan sponsor, health provider, or health plan purchasing organization that is required to comply with part 2.

(2) SPECIAL RULES.—

(A) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is adopted, unless the Secretary determines that the modification is necessary in order to permit a plan sponsor, a health provider, or a health plan purchasing organization to comply with part 2.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements that were encoded prior to the modification are to be converted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption to, and costs of compliance incurred by, a plan sponsor, health provider, or health plan purchasing organization that is required to comply with part 2.

(d) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this part. Such process may include demonstration projects and analyses of the cost of implementing such standards and modifications.

PART 2—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION

SEC. 6321. STANDARD TRANSACTIONS AND INFORMATION.

(a) TRANSACTIONS BY SPONSORS.—

(1) TRANSACTIONS WITH PROVIDERS.—If a plan sponsor conducts any of the transactions described in paragraph (3) with a health provider—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by the sponsor to the provider or by the provider to the sponsor in connection with the transaction shall be in the form of standard data elements.

(2) TRANSACTIONS WITH SPONSORS.—If a plan sponsor conducts any of the transactions described in paragraph (3) with another plan sponsor—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by either sponsor in connection with the transaction shall be in the form of standard data elements.

(3) TRANSACTIONS.—The transactions referred to in paragraphs (1) and (2) are the following:

(A) Verification of eligibility for benefits.

(B) Coordination of benefits.

(C) Claim submission.

(D) Claim attachment submission.

(E) Claim status notification.

(F) Claim status verification.

(G) Claim adjudication.

(H) Payment and remittance advice.

(I) Certification or authorization of a referral to a health provider who is not part of a provider network.

(b) TRANSACTIONS BY PURCHASING ORGANIZATIONS.—

(1) IN GENERAL.—If a health plan purchasing organization conducts any of the transactions described in paragraph (2) with a plan sponsor—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by the organization to the sponsor or by the sponsor to the organization in connection with the transaction shall be in the form of standard data elements.

(2) TRANSACTIONS.—The transactions referred to in paragraph (1) are the following:

(A) Enrollment and disenrollment.

(B) Premium payment.

(c) USE OF HEALTH INFORMATION NETWORK SERVICES.—A plan sponsor, a health provider, or a health plan purchasing organization may comply with any provision of this section by entering into an agreement or other arrangement with a health information network service certified under section 6331 pursuant to which the service undertakes the duties applicable to the sponsor, provider, or organization under the provision.

SEC. 6322. ACCESSING HEALTH INFORMATION FOR AUTHORIZED PURPOSES.

(a) PROCUREMENT RULE FOR GOVERNMENT AGENCIES.—

(1) IN GENERAL.—A health information security organization that is certified under section 6331 shall make available to a Federal or State agency, pursuant to a cost-type contract (as defined under the Federal Acquisition Regulation), any non-identifiable health information, including non-identifiable health information that is derived from protected health information, that—

(A) is held by the service or may be obtained by the service under paragraph (2) or subsection (b);

(B) consists of data elements that are subject to a standard under part 1; and

(C) is requested by the agency to fulfill a requirement under this Act.

(2) CERTAIN INFORMATION AVAILABLE AT LOW COST.—If a health information security organization requires health information consisting of data elements that are subject to a standard under part 1 from a plan sponsor or a health provider in order to comply with a request made by a Federal or State agency under paragraph (1), the sponsor or provider shall make such information available to such organization for a charge that does not exceed the reasonable cost of transmitting the information.

(b) PROCUREMENT RULE FOR INFORMATION SECURITY ORGANIZATIONS.—A health information security organization that makes non-identifiable health information available to a Federal or State agency under subsection (a) shall make such non-identifiable information available, for a charge that does not exceed the reasonable cost of transmitting the information, to any other health information security organization that—

(A) is certified under section 6331; and

(B) requests the information.

SEC. 6323. ENSURING AVAILABILITY OF INFORMATION.

The Secretary shall establish a procedure under which a plan sponsor or health provider that does not have the ability to transmit standard data elements directly, and does not have access to a health information network service certified under section 6331, may comply with the provisions of this part.

SEC. 6324. TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.

(a) INITIAL COMPLIANCE.—

(1) IN GENERAL.—Not later than 12 months after the date on which standards are adopted under part 1 with respect to a type of transaction, or data elements for a type of health information, a plan sponsor, health provider, or health plan purchasing organization shall comply with the requirements of this part with respect to such transaction or information.

(2) ADDITIONAL DATA ELEMENTS.—Not later than 12 months after the date on which the Secretary adopts an addition to a set of data elements for health information under section 6312, a plan sponsor, health provider, or health plan purchasing organization shall comply with the requirements of this part using such data elements.

(b) COMPLIANCE WITH MODIFIED STANDARDS.—

(1) IN GENERAL.—If the Secretary adopts a modified standard under section 6314(c), a plan sponsor, health provider, or health plan purchasing organization shall comply with the modified standard at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification.

(2) SPECIAL RULE.—In the case of a modification to a standard that does not occur within the 12-month period beginning on the date the standard is adopted, the time determined appropriate by the Secretary under paragraph (1) may not be—

(A) earlier than the last day of the 90-day period beginning on the date the modified standard is adopted; or

(B) later than the last day of the 12-month period beginning on the date the modified standard is adopted.

PART 3—MISCELLANEOUS PROVISIONS

SEC. 6331. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK SERVICES.

(a) STANDARDS FOR OPERATION.—The Secretary shall establish standards with respect to the operation of health information network services, including standards ensuring that such services—

(1) develop, operate, and cooperate with one another to form the health information network;

(2) meet all of the requirements under subtitle E that are applicable to the services;

(3) make public information concerning their performance, as measured by uniform indicators such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicator determined appropriate by the Secretary;

(4) have security procedures that are consistent with the requirements under subtitle E, including secure methods of accessing and transmitting data; and

(5) if they are part of a larger organization, have policies and procedures in place which isolate their activities with respect to processing information in a manner that prevents access to such information by such larger organization.

(b) CERTIFICATION BY THE SECRETARY.—

(1) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall establish a certification procedure for health information network services which ensures that certified services are qualified to meet

the requirements of this subtitle and the standards established by the Secretary under this section. Such certification procedure shall be implemented in a manner that minimizes the costs and delays of operations for such services.

(2) APPLICATION.—Each entity desiring to be certified as a health information network service shall apply to the Secretary for certification in a form and manner determined appropriate by the Secretary.

(3) AUDITS AND REPORTS.—The procedure established under paragraph (1) shall provide for audits by the Secretary and reports by an entity certified under this section as the Secretary determines appropriate in order to monitor such entity's compliance with the requirements of this subtitle, subtitle E, and the standards established by the Secretary under this section.

(4) RECERTIFICATION.—A health information network service shall be recertified under this subsection at least every 3 years.

(c) LOSS OF CERTIFICATION.—

(1) MANDATORY TERMINATION.—Except as provided in paragraph (2), if a health information network service violates a requirement imposed on

such service under subtitle E, its certification under this section shall be terminated unless the Secretary determines that appropriate corrective action has been taken.

(2) CONDITIONAL CERTIFICATION—The Secretary may establish a procedure under which a health information network service may remain certified on a conditional basis if the service is operating consistently with a plan intended to correct any violations described in paragraph (1). Such procedure may provide for the appointment of a trustee to continue operation of the service until the requirements for full certification are met.

(d) CERTIFICATION BY PRIVATE ENTITIES.—The Secretary may designate private entities to conduct the certification procedures established by the Secretary under this section. A health information network service certified by such an entity in accordance with such designation shall be considered to be certified by the Secretary.

(e) INFORMATION HELD BY HEALTH INFORMATION NETWORK SERVICES.—If a health information network service certified under this section loses its certified status or takes any action that would threaten the continued availability of the standard data elements of health information held by such service, such data elements shall be

transferred to another health information network service certified under this section that has been designated by the Secretary.

SEC. 6332. IMPOSITION OF ADDITIONAL REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (c), after the Secretary has established standards under section 6312 that are necessary to make uniform and compatible for electronic transmission the data elements that the Secretary determines are appropriate for transmission in connection with a transaction described in part 2, an individual or entity may not require an individual or entity, to provide in any manner any additional data element in connection with—

(1) the transaction; or

(2) an inquiry with respect to the transaction.

(b) TRANSMISSION METHOD.—Except as provided in subsection (c), after the Secretary has established standards under section 6313 relating to the method by which data elements that the Secretary determines are appropriate for transmission in connection with a transaction described in part 2 may be transmitted electronically, an individual or entity may not require an individual or entity to transmit any data element in a manner inconsistent with the standards in connection with—

(1) the transaction; or

(2) an inquiry with respect to the transaction.

(c) EXCEPTION.—Subsections (a) and (b) do not apply if—

(1) an individual or entity voluntarily agrees to provide the additional data element; or

(2) a waiver is granted under subsection (d) to permit the requirement to be imposed.

(d) CONDITIONS FOR WAIVERS.—

(1) IN GENERAL.—An individual or entity may request a waiver from the Secretary in order to impose on an individual or entity a requirement otherwise prohibited under subsection (a) or (b). Subject to paragraph (2), the Secretary may grant such a waiver.

(2) CONSIDERATION OF WAIVER REQUESTS.—A waiver may not be granted under this subsection to impose an otherwise prohibited requirement unless the Secretary determines that the value of any additional information to be provided under the requirement for research or other purposes significantly outweighs the administrative cost of the imposition of the requirement, taking into account the burden of the timing of the imposition of the requirement.

(e) ANONYMOUS REPORTING.—If an individual or entity attempts to impose on an individual or entity a re-

quirement prohibited under subsection (a) or (b), the individual or entity on whom the requirement is being imposed may contact the Secretary. The Secretary shall develop a procedure under which an individual or entity that contacts the Secretary under the preceding sentence shall remain anonymous. The Secretary shall notify the individual or entity imposing the requirement that the requirement may not be imposed unless the other individual or entity voluntarily agrees to such requirement or a waiver is obtained under subsection (d).

SEC. 6333. EFFECT ON STATE LAW.

(a) IN GENERAL.—Except as otherwise provided in this section, a provision, requirement, or standard under this subtitle shall supersede any contrary provision of State law.

(b) STATE ''QUILL AND PEN'' LAWS.—A State may not establish, continue in effect, or enforce any provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form, except where the Secretary determines that the provision is necessary to prevent fraud and abuse, with respect to controlled substances, or for other purposes.

(c) PUBLIC HEALTH REPORTING.—Nothing in this subtitle shall be construed to invalidate or limit the au-

thority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

(d) PUBLIC USE FUNCTIONS.—Nothing in this subtitle shall be construed to limit the authority of a Federal or State agency to make non-identifiable health information available for public use.

(e) PAYMENT FOR HEALTH CARE SERVICES OR PREMIUMS.—Nothing in this subtitle shall be construed to prohibit a consumer from paying for health care items or services, or plan or health insurance coverage premiums, by debit, credit, or other payment cards or numbers or other electronic payment means.

SEC. 6334. GRANTS FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary may make grants for demonstration projects to promote the development and use of electronically integrated community-based clinical information systems and computerized patient medical records.

(b) APPLICATIONS.—

(1) SUBMISSION.—To apply for a grant under this section for any fiscal year, an applicant shall submit an application to the Secretary in accordance with the procedures established by the Secretary.

(2) CRITERIA FOR APPROVAL.—The Secretary may not approve an application submitted under paragraph (1) unless the application includes assurances satisfactory to the Secretary regarding the following:

(A) USE OF EXISTING TECHNOLOGY.—Funds received under this section will be used to apply telecommunications and information systems technology that is in existence on the date the application is submitted in a manner that improves the quality of health care, reduces the costs of such care, and protects the privacy and confidentiality of information relating to the physical or mental condition of an individual.

(B) USE OF EXISTING INFORMATION SYSTEMS.—Funds received under this section will be used—

(i) to enhance telecommunications or information systems that are operating on the date the application is submitted;

(ii) to integrate telecommunications or information systems that are operating on the date the application is submitted; or

(iii) to connect additional users to telecommunications or information networks or systems that are operating on the date the application is submitted.

(C) CONSISTENCY WITH OTHER PROVISIONS.—Funds received under this section will be used for demonstration projects whose information collection and disclosure requirements are consistent with this subtitle and subtitle A of title V.

(D) MATCHING FUNDS.—The applicant shall make available funds for the demonstration project in an amount that equals at least 20 percent of the cost of the project.

(c) GEOGRAPHIC DIVERSITY.—In making any grants under this section, the Secretary shall, to the extent practicable, make grants to persons representing different geographic areas of the United States, including urban and rural areas.

(d) REVIEW AND SANCTIONS.—The Secretary shall review at least annually the compliance of a person receiving a grant under this section with the provisions of this section. The Secretary shall establish a procedure for determining whether such a person has failed to comply sub-

stantially within the provisions of this section and the sanctions to be imposed for any such noncompliance.

(e) ANNUAL REPORT.—The Secretary shall submit an annual report to the President for transmittal to Congress containing a description of the activities carried out under this section. The report shall evalute each demonstration project that received funds under this section in the year to which the report pertains with respect to the following:

(1) The usefulness of the project in facilitating outcomes measurement, health provider decision-making, and health research.

(2) The cost and burden of the project on health providers and other participants in the project.

(3) Efficiency and effectiveness of the project in improving health care delivery and evaluation.

PART 4—ASSISTANCE TO THE SECRETARY

SEC. 6341. GENERAL REQUIREMENT ON SECRETARY.

In complying with any requirements imposed on the Secretary under this subtitle, the Secretary shall rely on recommendations of the Health Information Advisory Committee established under section 6342 and shall consult with appropriate Federal agencies.

SEC. 6342. HEALTH INFORMATION ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—There is established a committee to be known as the Health Care Information Advisory Committee.

(b) DUTY.—

(1) IN GENERAL.—The committee shall—

(A) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this subtitle and subtitle E;

(B) be generally responsible for advising the Secretary and the Congress on the status of the health information network; and

(C) make recommendations to correct any problems that may occur in the network's implementation and ongoing operations and to refine and improve the network.

(2) TECHNICAL ASSISTANCE.—In performing its duties under this subsection, the committee shall receive technical assistance from appropriate Federal agencies.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The committee shall consist of 15 members to be appointed by the President not later than 60 days after the date of the enactment of this Act. The President shall designate 1 member as the Chair.

(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the committee. At least 1 member of the committee shall be a member of the Health Quality Advisory Council established under section 4001.

(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of no more than 3 members expire at one time.

(4) VACANCIES.—

(A) IN GENERAL.—A vacancy on the committee shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

(5) CONFLICTS OF INTEREST.—Members of the committee shall disclose upon appointment to the committee or at any subsequent time that it may occur, conflicts of interest.

(d) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the committee shall meet at the call of the Chair.

(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the committee have been appointed, the committee shall hold its first meeting.

(3) QUORUM.—A majority of the members of the committee shall constitute a quorum, but a lesser number of members may hold hearings.

(e) POWER TO HOLD HEARINGS.—The committee may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the committee considers advisable to carry out the purposes of this section.

(f) OTHER ADMINISTRATIVE PROVISIONS.—Subparagraphs (C), (D), and (H) of section 1886(e)(6) of the Social Security Act shall apply to the committee in the same manner as they apply to the Prospective Payment Assessment Commission.

(g) REPORTS.—

(1) IN GENERAL.—The committee shall annually prepare and submit to Congress and the Secretary a report including at least an analysis of—

(A) the status of the health information network established under this subtitle, including whether the network is fulfilling the purpose described in section 6300;

(B) the savings and costs of the network;

(C) the activities of health information network services certified under section 6331, health providers, and plan sponsors under this subtitle;

(D) the extent to which entities described in subparagraph (C) are meeting the standards adopted under this subtitle and working together to form an integrated network that meets the needs of its users;

(E) the extent to which entities described in subparagraph (C) are meeting the privacy and security protections of subtitle E;

(F) whether the Federal Government and State Governments are receiving information of sufficient quality to meet their responsibilities under this Act;

(G) any problems with respect to implementation of the network;

(H) the extent to which timetables under this subtitle for the adoption and implementation of standards are being met; and

(I) any legislative recommendations related to the health information network.

(2) AVAILABILITY TO THE PUBLIC.—Any information in the report submitted to Congress under paragraph (1) shall be made available to the public, unless such information may not be disclosed by law.

(h) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the committee shall continue in existence until otherwise provided by law.

Subtitle E—Fair Health Information Practices

SEC. 6400. DEFINITIONS.

(a) DEFINITIONS RELATING TO PROTECTED HEALTH INFORMATION.—For purposes of this subtitle:

(1) DISCLOSE.—The term ''disclose'', when used with respect to protected health information that is held by a health information trustee, means to provide access to the information, but only if such access is provided by the trustee to a person other than—

(A) the trustee or an officer or employee of the trustee;

(B) an affiliated person of the trustee; or

(C) a protected individual who is a subject of the information.

(2) DISCLOSURE.—The term ''disclosure'' means the act or an instance of disclosing.

(3) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' means any information, whether oral or recorded in any form or medium—

(A) that is created or received in a State by—

(i) a health care provider;

(ii) a health benefit plan sponsor;

(iii) a health oversight agency;

(iv) a health information service organization; or

(v) a public health authority;

(B) that relates in any way to the past, present, or future physical or mental health or condition or functional status of a protected individual, the provision of health care to a protected individual, or payment for the provision of health care to a protected individual; and

(C) that—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(4) PROTECTED INDIVIDUAL.—The term ''protected individual'' means an individual who, with respect to a date—

(A) is living on the date; or

(B) has died within the 2-year period ending on the date.

(5) USE.—The term ''use'', when used with respect to protected health information that is held by a health information trustee, means—

(A) to use, or provide access to, the information in any manner that does not constitute a disclosure; or

(B) any act or instance of using, or providing access, described in subparagraph (A).

(b) DEFINITIONS RELATING TO HEALTH INFORMATION TRUSTEES.—For purposes of this subtitle:

(1) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) any contract of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract, that is provided by a carrier; and

(B) an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits and is funded in a manner other than through the purchase of one or more policies or contracts described in subparagraph (A).

(2) HEALTH BENEFIT PLAN SPONSOR.—The term ''health benefit plan sponsor'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a carrier providing a health benefit plan;

(B) any other provider of a health benefit plan, including any public entity that provides payments for health care items and services under a health benefit plan that are equivalent to payments provided by a private person under such a plan; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who is licensed, certified, registered, or otherwise authorized by law to provide an item or service that constitutes health care in the ordinary course of business or practice of a profession;

(B) a Federal or State program that directly provides items or services that constitute health care to beneficiaries; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(4) HEALTH INFORMATION SERVICE ORGANIZATION.—The term ''health information service organization'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person, other than an affiliated person, who performs specific functions for which the Secretary has authorized (by means of a designation or certification) the person to receive access to health care data in electronic or magnetic form that are regulated by this Act; or

(B) an officer or employee of a person described in subparagraph (A).

(5) HEALTH INFORMATION TRUSTEE.—The term ''health information trustee'' means—

(A) a health care provider;

(B) a health information service organization;

(C) a health oversight agency;

(D) a health benefit plan sponsor;

(E) a public health authority;

(F) a health researcher;

(G) a person who, with respect to a specific item of protected health information, is not described in subparagraphs (A) through (F) but receives the information—

(i) pursuant to—

(I) section 6417 (relating to emergency circumstances);

(II) section 6418 (relating to judicial and administrative purposes);

(III) section 6419 (relating to law enforcement); or

(IV) section 6420 (relating to subpoenas, warrants, and search warrants); or

(ii) while acting in whole or in part in the capacity of an officer or employee of a person described in clause (i).

(6) HEALTH OVERSIGHT AGENCY.—The term ''health oversight agency'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers;

(B) a person who—

(i) performs or oversees the performance of an audit, assessment, evaluation, determination, or investigation relating to

the effectiveness of, compliance with, or applicability of, legal, fiscal, medical, or scientific standards or aspects of performance related to the delivery of, or payment for, health care; and

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a State or Federal statute regulating the assessment, evaluation, determination, or investigation; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(7) HEALTH RESEARCHER.—The term ''health researcher'' means a person who, with respect to a specific item of protected health information, receives the information—

(A) pursuant to section 6416 (relating to health research); or

(B) while acting in whole or in part in the capacity of an officer or employee of a person described in subparagraph (A).

(8) PUBLIC HEALTH AUTHORITY.—The term ''public health authority'' means a person who, with respect to a specific item of protected health infor-

mation, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) an authority of the United States, a State, or a political subdivision of a State that is responsible for public health matters;

(B) a person acting under the direction of such an authority; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

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

(1) AFFILIATED PERSON.—The term ''affiliated person'' means a person who—

(A) is not a health information trustee;

(B) is a contractor, subcontractor, associate, or subsidiary of a person who is a health information trustee; and

(C) pursuant to an agreement or other relationship with such trustee, receives, creates, uses, maintains, or discloses protected health information.

(2) APPROVED HEALTH RESEARCH PROJECT.—The term ''approved health research project'' means a biomedical, epidemiological, or health services re-

search or statistics project, or a research project on behavioral and social factors affecting health, that has been approved by a certified institutional review board.

(3) CERTIFIED INSTITUTIONAL REVIEW BOARD.—The term ''certified institutional review board'' means a board—

(A) established by an entity to review research involving protected health information and the rights of protected individuals conducted at or supported by the entity;

(B) established in accordance with regulations of the Secretary under section 6416(e)(1); and

(C) certified by the Secretary under section 6416(e)(2).

(4) HEALTH CARE.—The term ''health care''—

(A) means—

(i) any preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service, or procedure—

(I) with respect to the physical or mental condition, or functional status, of an individual; or

(II) affecting the structure or function of the human body or any part of the human body, including banking of blood, sperm, organs, or any other tissue; or

(ii) any sale or dispensing of a drug, device, equipment, or other item to an individual, or for the use of an individual, pursuant to a prescription; but

(B) does not include any item or service that is not furnished for the purpose of maintaining or improving the health of an individual.

(5) LAW ENFORCEMENT INQUIRY.—The term ''law enforcement inquiry'' means a lawful investigation or official proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

(6) PERSON.—The term ''person'' includes an authority of the United States, a State, or a political subdivision of a State.

PART 1—DUTIES OF HEALTH INFORMATION TRUSTEES

SEC. 6401. INSPECTION OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Except as provided in subsection (b), a health information trustee described in subsection (g)—

(1) shall permit a protected individual to inspect any protected health information about the individual that the trustee maintains, any accounting with respect to such information required under section 6404, and any copy of an authorization required under section 6412 that pertains to such information;

(2) shall provide the protected individual with a copy of the information upon request by the individual and subject to any conditions imposed by the trustee under subsection (d);

(3) shall permit a person who has been designated in writing by the protected individual to inspect the information on behalf of the individual or to accompany the individual during the inspection; and

(4) may offer to explain or interpret information that is inspected or copied under this subsection.

(b) EXCEPTIONS.—A health information trustee is not required by this section to permit inspection or copying of protected health information by a protected individual if any of the following conditions apply:

(1) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psychological, or mental health treatment notes about the individual, the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the notes would cause sufficient harm to the protected individual so as to outweigh the desirability of permitting access, and the trustee does not disclose the notes to any person not directly engaged in treating the individual, except with the authorization of the individual or under compulsion of law.

(2) INFORMATION ABOUT OTHERS.—The information relates to an individual, other than the protected individual or a health care provider, and the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the information would cause sufficient harm to one or both of the individuals so as to outweigh the desirability of permitting access.

(3) ENDANGERMENT TO LIFE OR SAFETY.—Inspection or copying of the information could reason-

ably be expected to endanger the life or physical safety of an individual.

(4) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of an individual (other than a health care provider) who provided information under a promise of confidentiality to a health care provider concerning a protected individual who is a subject of the information.

(5) ADMINISTRATIVE PURPOSES.—The information—

(A) is used by the trustee solely for administrative purposes and not in the provision of health care to a protected individual who is a subject of the information; and

(B) is not disclosed by the trustee to any person.

(6) DUPLICATIVE INFORMATION.—The information duplicates information available for inspection under subsection (a).

(7) INFORMATION COMPILED IN ANTICIPATION OF LITIGATION.—The information is compiled principally—

(A) in anticipation of a civil, criminal, or administrative action or proceeding; or

(B) for use in such an action or proceeding.

(c) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A health information trustee shall permit inspection and copying under subsection (a) of any reasonably segregable portion of a record after deletion of any portion that is exempt under subsection (b).

(d) CONDITIONS.—A health information trustee may—

(1) require a written request for the inspection and copying of protected health information under this section; and

(2) charge a reasonable cost-based fee for—

(A) permitting inspection of information under this section; and

(B) providing a copy of protected health information under this section.

(e) STATEMENT OF REASONS FOR DENIAL.—If a health information trustee denies in whole or in part a request for inspection or copying under this section, the trustee shall provide the protected individual who made the request with a written statement of the reasons for the denial.

(f) DEADLINE.—A health information trustee shall comply with or deny a request for inspection or copying

of protected health information under this section within the 30-day period beginning on the date the trustee receives the request.

(g) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health benefit plan sponsor;

(2) a health care provider;

(3) a health information service organization;

(4) a health oversight agency; or

(5) a public health authority.

SEC. 6402. AMENDMENT OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—A health information trustee described in subsection (f) shall, within the 45-day period beginning on the date the trustee receives from a protected individual about whom the trustee maintains protected health information a written request that the trustee correct or amend the information, complete the duties described in one of the following paragraphs:

(1) CORRECTION OR AMENDMENT AND NOTIFICATION.—The trustee shall—

(A) make the correction or amendment requested;

(B) inform the protected individual of the amendment or correction that has been made;

(C) make reasonable efforts to inform any person who is identified by the protected individual, who is not an employee of the trustee, and to whom the uncorrected or unamended portion of the information was previously disclosed of the correction or amendment that has been made; and

(D) at the request of the individual, make reasonable efforts to inform any known source of the uncorrected or unamended portion of the information about the correction or amendment that has been made.

(2) REASONS FOR REFUSAL AND REVIEW PROCEDURES.—The trustee shall inform the protected individual of—

(A) the reasons for the refusal of the trustee to make the correction or amendment;

(B) any procedures for further review of the refusal; and

(C) the individual's right to file with the trustee a concise statement setting forth the requested correction or amendment and the individual's reasons for disagreeing with the refusal of the trustee.

(b) STANDARDS FOR CORRECTION OR AMENDMENT.—A trustee shall correct or amend protected health information in accordance with a request made under subsection (a) if the trustee determines that the information is not accurate, relevant, timely, or complete for the purposes for which the information may be used or disclosed by the trustee.

(c) STATEMENT OF DISAGREEMENT.—After a protected individual has filed a statement of disagreement under subsection (a)(2)(C), the trustee, in any subsequent disclosure of the disputed portion of the information, shall include a copy of the individual's statement and may include a concise statement of the trustee's reasons for not making the requested correction or amendment.

(d) CONSTRUCTION.—This section may not be construed to require a health information trustee to conduct a hearing or proceeding concerning a request for a correction or amendment to protected health information the trustee maintains.

(e) CORRECTION.—For purposes of subsection (a), a correction is deemed to have been made to protected health information when—

(1) information that is not timely, accurate, relevant, or complete is clearly marked as incorrect; or

(2) supplementary correct information is made part of the information and adequately cross-referenced.

(f) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health benefit plan sponsor;

(2) a health care provider;

(3) a health information service organization;

(4) a health oversight agency; or

(5) a public health authority.

SEC. 6403. NOTICE OF INFORMATION PRACTICES.

(a) PREPARATION OF NOTICE.—A health information trustee described in subsection (d) shall prepare a written notice of information practices describing the following:

(1) The rights under this subtitle of a protected individual who is the subject of protected health information, including the right to inspect and copy such information and the right to seek amendments to such information, and the procedures for authorizing disclosures of protected health information and for revoking such authorizations.

(2) The procedures established by the trustee for the exercise of such rights.

(3) The uses and disclosures of protected health information that are authorized under this subtitle.

(b) DISSEMINATION OF NOTICE.—A health information trustee—

(1) shall, upon request, provide any person with a copy of the trustee's notice of information practices (described in subsection (a)); and

(2) shall make reasonable efforts to inform persons in a clear and conspicuous manner of the existence and availability of such notice.

(c) MODEL NOTICES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate model notices of information practices for use by health information trustees under this section.

(d) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health benefit plan sponsor;

(2) a health care provider;

(3) a health information service organization; or

(4) a health oversight agency.

SEC. 6404. ACCOUNTING FOR DISCLOSURES.

(a) IN GENERAL.—Except as provided in subsection (b) and section 6414, each health information trustee shall create and maintain, with respect to any protected health information the trustee discloses, a record of—

(1) the date and purpose of the disclosure;

(2) the name of the person to whom the disclosure was made;

(3) the address of the person to whom the disclosure was made or the location to which the disclosure was made; and

(4) where practicable, a description of the information disclosed.

(b) REGULATIONS.—Not later than July 1, 1996, the Secretary shall promulgate regulations that exempt a health information trustee from maintaining a record under subsection (a) with respect protected health information disclosed by the trustee for purposes of peer review, licensing, certification, accreditation, and similar activities.

SEC. 6405. SECURITY.

(a) IN GENERAL.—Each health information trustee who receives or creates protected health information that is subject to this subtitle shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(1) to ensure the integrity and confidentiality of the information;

(2) to protect against any reasonably anticipated—

(A) threats or hazards to the security or integrity of the information; and

(B) unauthorized uses or disclosures of the information; and

(3) otherwise ensure compliance with this subtitle by the trustee and the officers and employees of the trustee.

(b) GUIDELINES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate guidelines for the implementation of this section. The guidelines shall take into account—

(1) the technical capabilities of record systems used to maintain protected health information;

(2) the costs of security measures;

(3) the need for training persons who have access to protected health information; and

(4) the value of audit trails in computerized record systems.

PART 2—USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SEC. 6411. GENERAL LIMITATIONS ON USE AND DISCLOSURE.

(a) USE.—Except as otherwise provided under this subtitle, a health information trustee may use protected health information only for a purpose—

(1) that is compatible with and directly related to the purpose for which the information—

(A) was collected; or

(B) was received by the trustee; or

(2) for which the trustee is authorized to disclose the information under this subtitle.

(b) DISCLOSURE.—A health information trustee may disclose protected health information only as authorized under this subtitle.

(c) SCOPE OF USES AND DISCLOSURES.—

(1) IN GENERAL.—A use or disclosure of protected health information by a health information trustee shall be limited, when practicable, to the minimum amount of information necessary to accomplish the purpose for which the information is used or disclosed.

(2) GUIDELINES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall issue guidelines to implement

paragraph (1), which shall take into account the technical capabilities of the record systems used to maintain protected health information and the costs of limiting use and disclosure.

(d) IDENTIFICATION OF DISCLOSED INFORMATION AS PROTECTED INFORMATION.—Except with respect to protected health information that is disclosed under section 6414 (relating to next of kin and directory information), a health information trustee may disclose protected health information only if the recipient has been notified that the information is protected health information that is subject to this subtitle.

(e) AGREEMENT TO LIMIT USE OR DISCLOSURE.—A health information trustee who receives protected health information from any person pursuant to a written agreement to restrict use or disclosure of the information to a greater extent than otherwise would be required under this subtitle shall comply with the terms of the agreement, except where use or disclosure of the information in violation of the agreement is required by law. A trustee who fails to comply with the preceding sentence shall be subject to section 6451 (relating to civil actions) with respect to such failure.

(f) NO GENERAL REQUIREMENT TO DISCLOSE.—Nothing in this subtitle shall be construed to require a

health information trustee to disclose protected health information not otherwise required to be disclosed by law.

SEC. 6412. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) WRITTEN AUTHORIZATIONS.—A health information trustee, other than a health information service organization, may disclose protected health information pursuant to an authorization executed by the protected individual who is the subject of the information, if each of the following requirements is satisfied:

(1) WRITING.—The authorization is in writing, signed by the individual, and dated on the date of such signature.

(2) SEPARATE FORM.—The authorization is not on a form used to authorize or facilitate the provision of, or payment for, health care.

(3) TRUSTEE DESCRIBED.—The trustee is specifically named or generically described in the authorization as authorized to disclose such information.

(4) RECIPIENT DESCRIBED.—The person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed.

(5) STATEMENT OF INTENDED USES AND DISCLOSURES RECEIVED.—The authorization contains an acknowledgment that the individual has received a statement described in subsection (b) from such person.

(6) INFORMATION DESCRIBED.—The information to be disclosed is described in the authorization.

(7) AUTHORIZATION TIMELY RECEIVED.—The authorization is received by the trustee during a period described in subsection (c)(1).

(8) DISCLOSURE TIMELY MADE.—The disclosure occurs during a period described in subsection (c)(2).

(b) STATEMENT OF INTENDED USES AND DISCLOSURES.—

(1) IN GENERAL.—A person who wishes to receive from a health information trustee protected health information about a protected individual pursuant to an authorization executed by the individual shall supply the individual, in writing and on a form that is distinct from the authorization, with a statement of the uses for which the person intends the information and the disclosures the person intends to make of the information. Such statement shall be supplied before the authorization is executed.

(2) ENFORCEMENT.—If the person uses or discloses the information in a manner that is inconsistent with such statement, the person shall be subject to section 6451 (relating to civil actions) with respect to such failure, except where such use or disclosure is required by law.

(3) MODEL STATEMENTS.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate model statements of intended uses and disclosures of the type described in paragraph (1).

(c) TIME LIMITATIONS ON AUTHORIZATIONS.—

(1) RECEIPT BY TRUSTEE.—For purposes of subsection (a)(7), an authorization is timely received if it is received by the trustee during—

(A) the 1-year period beginning on the date that the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to—

(i) a health benefit plan sponsor;

(ii) a health care provider;

(iii) a health oversight agency;

(iv) a public health authority;

(v) a health researcher; or

(vi) a person who provides counseling or social services to individuals; or

(B) the 30-day period beginning on the date that the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person other than a person described in subparagraph (A).

(2) DISCLOSURE BY TRUSTEE.—For purposes of subsection (a)(8), a disclosure is timely made if it occurs before—

(A) the date or event (if any) specified in the authorization upon which the authorization expires; and

(B) the expiration of the 6-month period beginning on the date the trustee receives the authorization.

(d) REVOCATION OR AMENDMENT OF AUTHORIZATION.—

(1) IN GENERAL.—A protected individual in writing may revoke or amend an authorization described in subsection (a), in whole or in part, at any time, except insofar as—

(A) disclosure of protected health information has been authorized to permit validation of

expenditures based on health condition by a government authority; or

(B) action has been taken in reliance on the authorization.

(2) NOTICE OF REVOCATION.—A health information trustee who discloses protected health information in reliance on an authorization that has been revoked shall not be subject to any liability or penalty under this subtitle if—

(A) the reliance was in good faith;

(B) the trustee had no notice of the revocation; and

(C) the disclosure was otherwise in accordance with the requirements of this section.

(e) ADDITIONAL REQUIREMENTS OF TRUSTEE.—A health information trustee may impose requirements for an authorization that are in addition to the requirements in this section.

(f) COPY.—A health information trustee who discloses protected health information pursuant to an authorization under this section shall maintain a copy of the authorization.

(g) CONSTRUCTION.—This section may not be construed—

(1) to require a health information trustee to disclose protected health information; or

(2) to limit the right of a health information trustee to charge a fee for the disclosure or reproduction of protected health information.

(h) SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.—If a health information trustee discloses protected health information pursuant to an authorization in order to comply with an administrative subpoena or warrant or a judicial subpoena or search warrant, the authorization—

(1) shall specifically authorize the disclosure for the purpose of permitting the trustee to comply with the subpoena, warrant, or search warrant; and

(2) shall otherwise meet the requirements in this section.

SEC. 6413. TREATMENT, PAYMENT, AND OVERSIGHT.

(a) DISCLOSURES BY PLANS, PROVIDERS, AND OVERSIGHT AGENCIES.—A health information trustee described in subsection (d) may disclose protected health information to a health benefit plan sponsor, health care provider, or health oversight agency if the disclosure is—

(1) for the purpose of providing health care and a protected individual who is a subject of the infor-

mation has not previously objected to the disclosure in writing;

(2) for the purpose of providing for the payment for health care furnished to an individual; or

(3) for use by a health oversight agency for a purpose that is described in subparagraph (A) or (B)(i) of section 6400(b)(6).

(b) DISCLOSURES BY CERTAIN OTHER TRUSTEES.—A health information trustee may disclose protected health information to a health care provider if—

(1) the disclosure is for the purpose described in subsection (a)(1); and

(2) the trustee—

(A) is a public health authority;

(B) received protected health information pursuant to section 6417 (relating to emergency circumstances); or

(C) is an officer or employee of a trustee described in subsection (B).

(c) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation

arising out of and related to receipt of health care or payment for health care.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any of the following:

(1) A health benefit plan sponsor.

(2) A health care provider.

(3) A health oversight agency.

(4) A health information service organization.

SEC. 6414. NEXT OF KIN AND DIRECTORY INFORMATION.

(a) NEXT OF KIN.—A health information trustee who is a health care provider, who received protected health information pursuant to section 6417 (relating to emergency circumstances), or who is an officer or employee of such a recipient may orally disclose protected health information about a protected individual to the next of kin of the individual (as defined under State law), or to a person with whom the individual has a close personal relationship, if—

(1) the trustee has no reason to believe that the individual would consider the information especially sensitive;

(2) the individual has not previously objected to the disclosure;

(3) the disclosure is consistent with good medical or other professional practice; and

(4) the information disclosed is limited to information about health care that is being provided to the individual at or about the time of the disclosure.

(b) DIRECTORY INFORMATION.—

(1) IN GENERAL.—A health information trustee who is a health care provider, who received protected health information pursuant to section 6417 (relating to emergency circumstances), or who is an officer or employee of a such a recipient may disclose to any person the information described in paragraph (2) if—

(A) a protected individual who is a subject of the information has not objected in writing to the disclosure;

(B) the disclosure is otherwise consistent with good medical and other professional practice; and

(C) the information does not reveal specific information about the physical or mental condition or functional status of a protected individual or about the health care provided to a protected individual.

(2) INFORMATION DESCRIBED.—The information referred to in paragraph (1) is the following:

(A) The name of an individual receiving health care from a health care provider on a premises controlled by the provider.

(B) The location of the individual on such premises.

(C) The general health status of the individual, described in terms of critical, poor, fair, stable, satisfactory, or terms denoting similar conditions.

(c) NO ACCOUNTING REQUIRED.—A health information trustee who discloses protected health information under this section is not required to maintain an accounting of the disclosure under section 6404.

(d) RECIPIENTS.—A person to whom protected health information is disclosed under this section shall not, by reason of such disclosure, be subject to any requirement under this subtitle.

SEC. 6415. PUBLIC HEALTH.

(a) IN GENERAL.—A health information trustee who is a health care provider or a public health authority may disclose protected health information to—

(1) a public health authority for use in legally authorized—

(A) disease or injury reporting;

(B) public health surveillance; or

(C) public health investigation or intervention; or

(2) an individual who is authorized by law to receive the information in a public health intervention.

(b) USE IN ACTION AGAINST INDIVIDUAL.—A public health authority who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except where the use or disclosure is authorized by law for protection of the public health.

(c) INDIVIDUAL RECIPIENTS.—An individual to whom protected health information is disclosed under subsection (a)(2) shall not, by reason of such disclosure, be subject to any requirement under this subtitle.

SEC. 6416. HEALTH RESEARCH.

(a) IN GENERAL.—A health information trustee described in subsection (d) may disclose protected health information to a person if—

(1) the person is conducting an approved health research project;

(2) the information is to be used in the project; and

(3) the project has been determined by a certified institutional review board to be—

(A) of sufficient importance so as to outweigh the intrusion into the privacy of the protected individual who is the subject of the information that would result from the disclosure; and

(B) impracticable to conduct without the information.

(b) DISCLOSURES BY HEALTH INFORMATION SERVICE ORGANIZATIONS.—A health information service organization may disclose protected health information under subsection (a) only if the certified institutional review board referred to in subsection (a)(3) has been certified as being qualified to make determinations under such subsection with respect to disclosures by such organizations.

(c) LIMITATIONS ON USE AND DISCLOSURE; OBLIGATIONS OF RECIPIENT.—A health researcher who receives protected health information about a protected individual pursuant to subsection (a)—

(1) may use the information solely for purposes of an approved health research project;

(2) may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual; and

(3) shall remove or destroy, at the earliest opportunity consistent with the purposes of the approved health research project in connection with which the disclosure was made, information that would enable an individual to be identified, unless a certified institutional review board has determined that there is a health or research justification for retention of such identifiers and there is an adequate plan to protect the identifiers from use and disclosure that is inconsistent with this subtitle.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any health information trustee other than a person who, with respect to the specific protected health information to be disclosed under such subsection, received the information—

(1) pursuant to—

(A) section 6418 (relating to judicial and administrative purposes);

(B) paragraph (1), (2), or (3) of section 6419(a) (relating to law enforcement); or

(C) section 6420 (relating to subpoenas, warrants, and search warrants); or

(2) while acting in whole or in part in the capacity of an officer or employee of a person described in paragraph (1).

(e) REQUIREMENTS FOR INSTITUTIONAL REVIEW BOARDS.—

(1) REGULATIONS.—Not later than July 1, 1996, the Secretary, after opportunity for notice and comment, shall promulgate regulations establishing requirements for certified institutional review boards under this subtitle. The regulations shall be based on regulations promulgated under section 491(a) of the Public Health Service Act and shall ensure that certified institutional review boards are qualified to assess and protect the confidentiality of research subjects. The regulations shall include specific requirements for certified institutional review boards that make determinations under subsection (a)(3) with respect to disclosures by health information service organizations.

(2) CERTIFICATION.—The Secretary shall certify that an institutional review board satisfies the requirements of the regulations promulgated under paragraph (1).

SEC. 6417. EMERGENCY CIRCUMSTANCES.

(a) IN GENERAL.—A health information trustee may disclose protected health information if the trustee believes, on reasonable grounds, that the disclosure is nec-

essary to prevent or lessen a serious and imminent threat to the health or safety of an individual.

(b) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and related to receipt of health care or payment for health care.

SEC. 6418. JUDICIAL AND ADMINISTRATIVE PURPOSES.

(a) IN GENERAL.—A health information trustee described in subsection (d) may disclose protected health information—

(1) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules of other courts or administrative agencies in connection with litigation or proceedings to which a protected individual who is a subject of the information is a party and in which the individual has placed the individual's physical or mental condition or functional status in issue;

(2) if directed by a court in connection with a court-ordered examination of an individual; or

(3) to assist in the identification of a dead individual.

(b) WRITTEN STATEMENT.—A person seeking protected health information about a protected individual held by health information trustee under—

(1) subsection (a)(1)—

(A) shall notify the protected individual or the attorney of the protected individual of the request for the information;

(B) shall provide the trustee with a signed document attesting—

(i) that the protected individual is a party to the litigation or proceedings for which the information is sought;

(ii) that the individual has placed the individual's physical or mental condition or functional status in issue; and

(iii) the date on which the protected individual or the attorney of the protected individual was notified under subparagraph (A); and

(C) shall not accept any requested protected health information from the trustee until the termination of the 10-day period beginning

on the date notice was given under subparagraph (A); or

(2) subsection (a)(3) shall provide the trustee with a written statement that the information is sought to assist in the identification of a dead individual.

(c) USE AND DISCLOSURE.—A person to whom protected health information is disclosed under this section may use and disclose the information only to accomplish the purpose for which the disclosure was made.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any of the following:

(1) A health benefit plan sponsor.

(2) A health care provider.

(3) A health oversight agency.

(4) A person who, with respect to the specific protected health information to be disclosed under such subsection, received the information—

(A) pursuant to—

(i) section 6417 (relating to emergency circumstances); or

(ii) section 6420 (relating to subpoenas, warrants, and search warrants); or

(B) while acting in whole or in part in the capacity of an officer or employee of a person described in subparagraph (A).

SEC. 6419. LAW ENFORCEMENT.

(a) IN GENERAL.—A health information trustee, other than a health information service organization, may disclose protected health information to a law enforcement agency, other than a health oversight agency—

(1) if the information is disclosed for use in an investigation or prosecution of a health information trustee;

(2) in connection with criminal activity committed against the trustee or an affiliated person of the trustee or on premises controlled by the trustee; or

(3) if the information is needed to determine whether a crime has been committed and the nature of any crime that may have been committed (other than a crime that may have been committed by the protected individual who is the subject of the information).

(b) ADDITIONAL AUTHORITY OF CERTAIN TRUSTEES.—A health information trustee who is not a health information service organization, a public health authority, or a health researcher may disclose protected health

information to a law enforcement agency (other than a health oversight agency)—

(1) to assist in the identification or location of a victim, fugitive, or witness in a law enforcement inquiry;

(2) pursuant to a law requiring the reporting of specific health care information to law enforcement authorities; or

(3) if the information is specific health information described in paragraph (2) and the trustee is operated by a Federal agency;

(c) CERTIFICATION.—Where a law enforcement agency requests a health information trustee to disclose protected health information under subsection (a) or (b)(1), the agency shall provide the trustee with a written certification that—

(1) is signed by a supervisory official of a rank designated by the head of the agency;

(2) specifies the information requested; and

(3) states that the information is needed for a lawful purpose under this section.

(d) RESTRICTIONS ON DISCLOSURE AND USE.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information—

(1) in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and directly related to the action or investigation for which the information was obtained; and

(2) otherwise unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained and is not prohibited by any other provision of law.

SEC. 6420. SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.

(a) IN GENERAL.—A health information trustee described in subsection (g) may disclose protected health information if the disclosure is pursuant to any of the following:

(1) A subpoena issued under the authority of a grand jury and the trustee is provided a written certification by the grand jury that the grand jury has complied with the applicable access provisions of section 6431.

(2) An administrative subpoena or warrant or a judicial subpoena or search warrant and the trustee is provided a written certification by the person seeking the information that the person has com-

plied with the applicable access provisions of section 6431 or 6433(a).

(3) An administrative subpoena or warrant or a judicial subpoena or search warrant and the disclosure otherwise meets the conditions of one of sections 6413 through 6419.

(b) AUTHORITY OF ALL TRUSTEES.—Any health information trustee may disclose protected health information if the disclosure is pursuant to subsection (a)(3).

(c) RESTRICTIONS ON USE AND DISCLOSURE.—Protected health information about a protected individual that is disclosed by a health information trustee pursuant to—

(1) subsection (a)(2) may not be otherwise used or disclosed by the recipient unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained; and

(2) subsection (a)(3) may not be used or disclosed by the recipient unless the recipient complies with the conditions and restrictions on use and disclosure with which the recipient would have been required to comply if the disclosure by the trustee had been made under the section referred to in subsection (a)(3) the conditions of which were met by the disclosure.

(d) RESTRICTIONS ON GRAND JURIES.—Protected health information that is disclosed by a health information trustee under subsection (a)(1)—

(1) shall be returnable on a date when the grand jury is in session and actually presented to the grand jury;

(2) shall be used only for the purpose of considering whether to issue an indictment or report by that grand jury, or for the purpose of prosecuting a crime for which that indictment or report is issued, or for a purpose authorized by rule 6(e) of the Federal Rules of Criminal Procedure or a comparable State rule;

(3) shall be destroyed or returned to the trustee if not used for one of the purposes specified in paragraph (2); and

(4) shall not be maintained, or a description of the contents of such information shall not be maintained, by any government authority other than in the sealed records of the grand jury, unless such information has been used in the prosecution of a crime for which the grand jury issued an indictment or presentment or for a purpose authorized by rule 6(e) of the Federal Rules of Criminal Procedure or a comparable State rule.

(e) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and directly related to the inquiry for which the information was obtained;

(f) CONSTRUCTION.—Nothing in this section shall be construed as authority for a health information trustee to refuse to comply with a valid administrative subpoena or warrant or a valid judicial subpoena or search warrant that meets the requirements of this subtitle.

(g) APPLICABILITY.—A health information trustee referred to in subsection (a) is any trustee other than the following:

(1) A health information service organization.

(2) A public health authority.

(3) A health researcher.

SEC. 6421. HEALTH INFORMATION SERVICE ORGANIZATIONS.

A health information trustee may disclose protected health information to a health information service organization for the purpose of permitting the organization to perform a function for which the Secretary has authorized

(by means of a designation or certification) the organization to receive access to health care data in electronic or magnetic form that are regulated by this Act.

PART 3—ACCESS PROCEDURES AND CHALLENGE RIGHTS

SEC. 6431. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.

(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about a protected individual from a health information trustee under paragraph (1) or (2) of section 6420(a) for use in a law enforcement inquiry unless there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

(b) WARRANTS AND SEARCH WARRANTS.—A government authority that obtains protected health information about a protected individual from a health information trustee under circumstances described in subsection (a) and pursuant to a warrant or search warrant shall, not later than 30 days after the date the warrant was served on the trustee, serve the individual with, or mail to the last known address of the individual, a copy of the warrant.

(c) SUBPOENAS.—Except as provided in subsection (d), a government authority may not obtain protected health information about a protected individual from a health information trustee under circumstances described in subsection (a) and pursuant to a subpoena unless a copy of the subpoena has been served by hand delivery upon the individual, or mailed to the last known address of the individual, on or before the date on which the subpoena was served on the trustee, together with a notice (published by the Secretary under section 6435(1)) of the individual's right to challenge the subpoena in accordance with section 6432, and—

(1) 30 days have passed from the date of service, or 30 days have passed from the date of mailing, and within such time period the individual has not initiated a challenge in accordance with section 6432; or

(2) disclosure is ordered by a court under section 6432.

(d) APPLICATION FOR DELAY.—

(1) IN GENERAL.—A government authority may apply to an appropriate court to delay (for an initial period of not longer than 90 days) serving a copy of a subpoena and a notice otherwise required under subsection (c) with respect to a law enforcement in-

quiry. The government authority may apply to the court for extensions of the delay.

(2) REASONS FOR DELAY.—An application for a delay, or extension of a delay, under this subsection shall state, with reasonable specificity, the reasons why the delay or extension is being sought.

(3) EX PARTE ORDER.—The court shall enter an ex parte order delaying, or extending the delay of, the notice and an order prohibiting the trustee from revealing the request for, or the disclosure of, the protected health information being sought if the court finds that—

(A) the inquiry being conducted is within the lawful jurisdiction of the government authority seeking the protected health information;

(B) there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry being conducted by the government authority;

(C) the government authority's need for the information outweighs the privacy interest of the protected individual who is the subject of the information; and

(D) there are reasonable grounds to believe that receipt of a notice by the individual will result in—

(i) endangering the life or physical safety of any individual;

(ii) flight from prosecution;

(iii) destruction of or tampering with evidence or the information being sought; or

(iv) intimidation of potential witnesses.

(4) SERVICE OF APPLICATION ON INDIVIDUAL.—Upon the expiration of a period of delay of notice under this subsection, the government authority shall serve upon the individual, with the service of the subpoena and the notice, a copy of any applications filed and approved under this subsection.

SEC. 6432. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS.

(a) MOTION TO QUASH SUBPOENA.—Within 30 days of the date of service, or 30 days of the date of mailing, of a subpoena of a government authority seeking protected health information about a protected individual from a health information trustee under paragraph (1) or (2) of section 6420(a) (except a subpoena to which section 6433

applies), the individual may file (without filing fee) a motion to quash the subpoena—

(1) in the case of a State judicial subpoena, in the court which issued the subpoena;

(2) in the case of a subpoena issued under the authority of a State that is not a State judicial subpoena, in a court of competent jurisdiction;

(3) in the case of a subpoena issued under the authority of a Federal court, in any court of the United States of competent jurisdiction; or

(4) in the case of any other subpoena issued under the authority of the United States, in—

(A) the United States district court for the district in which the individual resides or in which the subpoena was issued; or

(B) another United States district court of competent jurisdiction.

(b) COPY.—A copy of the motion shall be served by the individual upon the government authority by delivery of registered or certified mail.

(c) AFFIDAVITS AND SWORN DOCUMENTS.—The government authority may file with the court such affidavits and other sworn documents as sustain the validity of the subpoena. The individual may file with the court, within 5 days of the date of the authority's filing, affidavits and

sworn documents in response to the authority's filing. The court, upon the request of the individual, the government authority, or both, may proceed in camera.

(d) PROCEEDINGS AND DECISION ON MOTION.—The court may conduct such proceedings as it deems appropriate to rule on the motion. All such proceedings shall be completed, and the motion ruled on, within 10 calendar days of the date of the government authority's filing.

(e) EXTENSION OF TIME LIMITS FOR GOOD CAUSE.—The court, for good cause shown, may at any time in its discretion enlarge the time limits established by subsections (c) and (d).

(f) STANDARD FOR DECISION.—A court may deny a motion under subsection (a) if it finds that there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry being conducted by the government authority, unless the court finds that the individual's privacy interest outweighs the government authority's need for the information. The individual shall have the burden of demonstrating that the individual's privacy interest outweighs the need established by the government authority for the information.

(g) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (f)

whether an individual's privacy interest outweighs the government authority's need for the information, the court shall consider—

(1) the particular purpose for which the information was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the inquiry being conducted by the government authority, and the importance of the information to that inquiry; and

(5) any other factor deemed relevant by the court.

(h) ATTORNEY'S FEES.—In the case of any motion brought under subsection (a) in which the individual has substantially prevailed, the court, in its discretion, may assess against a government authority a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

(i) NO INTERLOCUTORY APPEAL.—A court ruling denying a motion to quash under this section shall not be deemed a final order and no interlocutory appeal may be taken therefrom by the individual. An appeal of such a

ruling may be taken by the individual within such period of time as is provided by law as part of any appeal from a final order in any legal proceeding initiated against the individual arising out of or based upon the protect health information disclosed.

SEC. 6433. ACCESS AND CHALLENGE PROCEDURES FOR OTHER SUBPOENAS.

(a) IN GENERAL.—A person (other than a government authority seeking protected health information under circumstances described in section 6431(a)) may not obtain protected health information about a protected individual from a health information trustee pursuant to a subpoena under section 6420(a)(2) unless—

(1) a copy of the subpoena has been served upon the individual or mailed to the last known address of the individual on or before the date on which the subpoena was served on the trustee, together with a notice (published by the Secretary under section 6435(2)) of the individual's right to challenge the subpoena, in accordance with subsection (b); and

(2) either—

(A) 30 days have passed from the date of service or 30 days have passed from the date of the mailing and within such time period the in-

dividual has not initiated a challenge in accordance with subsection (b); or

(B) disclosure is ordered by a court under such subsection.

(b) MOTION TO QUASH.—Within 30 days of the date of service or 30 days of the date of mailing of a subpoena seeking protected health information about a protected individual from a health information trustee under subsection (a), the individual may file (without filing fee) in any court of competent jurisdiction, a motion to quash the subpoena, with a copy served on the person seeking the information. The individual may oppose, or seek to limit, the subpoena on any grounds that would otherwise be available if the individual were in possession of the information.

(c) STANDARD FOR DECISION.—The court shall grant an individual's motion under subsection (b) if the person seeking the information has not sustained the burden of demonstrating that—

(1) there are reasonable grounds to believe that the information will be relevant to a lawsuit or other judicial or administrative proceeding; and

(2) the need of the person for the information outweighs the privacy interest of the individual.

(d) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (c) whether the need of the person for the information outweighs the privacy interest of the individual, the court shall consider—

(1) the particular purpose for which the information was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the information to the lawsuit or proceeding; and

(5) any other factor deemed relevant by the court.

(e) ATTORNEY'S FEES.—In the case of any motion brought under subsection (b) by an individual against a person in which the individual has substantially prevailed, the court, in its discretion, may assess against the person a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

SEC. 6434. CONSTRUCTION OF PART; SUSPENSION OF STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Nothing in this part shall affect the right of a health information trustee to challenge a request for protected health information. Nothing in this part shall entitle a protected individual to assert the rights of a health information trustee.

(b) EFFECT OF MOTION ON STATUTE OF LIMITATIONS.—If an individual who is the subject of protected health information files a motion under this part which has the effect of delaying the access of a government authority to such information, the period beginning on the date such motion was filed and ending on the date on which the motion is decided shall be excluded in computing any period of limitations within which the government authority may commence any civil or criminal action in connection with which the access is sought.

SEC. 6435. RESPONSIBILITIES OF SECRETARY.

Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate brief, clear, and easily understood model notices—

(1) for use under subsection (c) of section 6431, detailing the rights of a protected individual who wishes to challenge, under section 6432, the dis-

closure of protected health information about the individual under such subsection; and

(2) for use under subsection (a) of section 6433, detailing the rights of a protected individual who wishes to challenge, under subsection (b) of such section, the disclosure of protected health information about the individual under such section.

PART 4—MISCELLANEOUS PROVISIONS

SEC. 6441. PAYMENT CARD AND ELECTRONIC PAYMENT TRANSACTIONS.

(a) PAYMENT FOR HEALTH CARE THROUGH CARD OR ELECTRONIC MEANS.—If a protected individual pays a health information trustee for health care by presenting a debit, credit, or other payment card or account number, or by any other electronic payment means, the trustee may disclose to a person described in subsection (b) only such protected health information about the individual as is necessary for the processing of the payment transaction or the billing or collection of amounts charged to, debited from, or otherwise paid by, the individual using the card, number, or other electronic payment means.

(b) TRANSACTION PROCESSING.—A person who is a debit, credit, or other payment card issuer, is otherwise directly involved in the processing of payment transactions involving such cards or other electronic payment trans-

actions, or is otherwise directly involved in the billing or collection of amounts paid through such means, may only use or disclose protected health information about a protected individual that has been disclosed in accordance with subsection (a) when necessary for—

(1) the authorization, settlement, billing or collection of amounts charged to, debited from, or otherwise paid by, the individual using a debit, credit, or other payment card or account number, or by other electronic payment means;

(2) the transfer of receivables, accounts, or interest therein;

(3) the audit of the credit, debit, or other payment card account information;

(4) compliance with Federal, State, or local law; or

(5) a properly authorized civil, criminal, or regulatory investigation by Federal, State, or local authorities.

SEC. 6442. ACCESS TO PROTECTED HEALTH INFORMATION OUTSIDE OF THE UNITED STATES.

(a) IN GENERAL.—Notwithstanding the provisions of part 2, and except as provided in subsection (b), a health information trustee may not permit any person who is not in a State to have access to protected health information

about a protected individual unless one or more of the following conditions exist:

(1) SPECIFIC AUTHORIZATION.—The individual has specifically consented to the provision of such access outside of the United States in an authorization that meets the requirements of section 6412.

(2) EQUIVALENT PROTECTION.—The provision of such access is authorized under this subtitle and the Secretary has determined that there are fair information practices for protected health information in the jurisdiction where the access will be provided that provide protections for individuals and protected health information that are equivalent to the protections provided for by this subtitle.

(3) ACCESS REQUIRED BY LAW.—The provision of such access is required under—

(A) a Federal statute; or

(B) a treaty or other international agreement applicable to the United States.

(b) EXCEPTIONS.—Subsection (a) does not apply where the provision of access to protected health information—

(1) is to a foreign public health authority;

(2) is authorized under section 6414 (relating to next of kin and directory information), 6416 (re-

lating to health research), or 6417 (relating to emergency circumstances); or

(3) is necessary for the purpose of providing for payment for health care that has been provided to an individual.

SEC. 6443. STANDARDS FOR ELECTRONIC DOCUMENTS AND COMMUNICATIONS.

(a) STANDARDS.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment and in consultation with appropriate private standard-setting organizations and other interested parties, shall establish standards with respect to the creation, transmission, receipt, and maintenance, in electronic and magnetic form, of each type of written document specifically required or authorized under this subtitle. Where a signature is required under any other provision of this part, such standards shall provide for an electronic or magnetic substitute that serves the functional equivalent of a signature.

(b) TREATMENT OF COMPLYING DOCUMENTS AND COMMUNICATIONS.—An electronic or magnetic document or communication that satisfies the standards established under subsection (a) with respect to such document or communication shall be treated as satisfying the require-

ments of this subtitle that apply to an equivalent written document.

SEC. 6444. DUTIES AND AUTHORITIES OF AFFILIATED PERSONS.

(a) REQUIREMENTS ON TRUSTEES.—

(1) PROVISION OF INFORMATION.—A health information trustee may provide protected health information to a person who, with respect to the trustee, is an affiliated person and may permit the affiliated person to use such information, only for the purpose of conducting, supporting, or facilitating an activity that the trustee is authorized to undertake.

(2) NOTICE TO AFFILIATED PERSON.—A health information trustee shall notify a person who, with respect to the trustee, is an affiliated person of any duties under this subtitle that the affiliated person is required to fulfill and of any authorities under this subtitle that the affiliated person is authorized to exercise.

(b) DUTIES OF AFFILIATED PERSONS.—

(1) IN GENERAL.—An affiliated person shall fulfill any duty under this subtitle that—

(A) the health information trustee with whom the person has an agreement or relation-

ship described in section 6400(c)(1)(C) is required to fulfill; and

(B) the person has undertaken to fulfill pursuant to such agreement or relationship.

(2) CONSTRUCTION OF OTHER PARTS.—With respect to a duty described in paragraph (1) that an affiliated person is required to fulfill, the person shall be considered a health information trustee for purposes of this subtitle. The person shall be subject to part 5 (relating to enforcement) with respect to any such duty that the person fails to fulfill.

(3) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not relieve a health information trustee of any duty or liability under this subtitle.

(c) AUTHORITIES OF AFFILIATED PERSONS.—

(1) IN GENERAL.—An affiliated person may only exercise an authority under this subtitle that the health information trustee with whom the person is affiliated may exercise and that the person has been given by the trustee pursuant to an agreement or relationship described in section 6400(c)(1)(C). With respect to any such authority, the person shall be considered a health information trustee for purposes of this subtitle. The person shall be subject to

part 5 (relating to enforcement) with respect to any act that exceeds such authority.

(2) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not affect the authority of a health information trustee under this subtitle.

SEC. 6445. AGENTS AND ATTORNEYS.

(a) IN GENERAL.—Except as provided in subsections (b) and (c), a person who is authorized by law (on grounds other than an individual's minority), or by an instrument recognized under law, to act as an agent, attorney, proxy, or other legal representative for a protected individual or the estate of a protected individual, or otherwise to exercise the rights of the individual or estate, may, to the extent authorized, exercise and discharge the rights of the individual or estate under this subtitle.

(b) HEALTH CARE POWER OF ATTORNEY.—A person who is authorized by law (on grounds other than an individual's minority), or by an instrument recognized under law, to make decisions about the provision of health care to an individual who is incapacitated may exercise and discharge the rights of the individual under this subtitle to the extent necessary to effectuate the terms or purposes of the grant of authority.

(c) NO COURT DECLARATION.—If a health care provider determines that an individual, who has not been declared to be legally incompetent, suffers from a medical condition that prevents the individual from acting knowingly or effectively on the individual's own behalf, the right of the individual to authorize disclosure under section 6412 may be exercised and discharged in the best interest of the individual by—

(1) a person described in subsection (b) with respect to the individual;

(2) a person described in subsection (a) with respect to the individual, but only if a person described in paragraph (1) cannot be contacted after a reasonable effort;

(3) the next of kin of the individual, but only if a person described in paragraph (1) or (2) cannot be contacted after a reasonable effort; or

(4) the health care provider, but only if a person described in paragraph (1), (2), or (3) cannot be contacted after a reasonable effort.

SEC. 6446. MINORS.

(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

(1) who is 18 years of age or older, all rights of the individual shall be exercised by the individual, except as provided in section 6445; or

(2) who, acting alone, has the legal capacity to apply for and obtain health care and has sought such care, the individual shall exercise all rights of an individual under this subtitle with respect to protected health information relating to such care.

(b) INDIVIDUALS UNDER 18.—Except as provided in subsection (a)(2), in the case of an individual who is—

(1) under 14 years of age, all the individual's rights under this subtitle shall be exercised through the parent or legal guardian of the individual; or

(2) 14, 15, 16, or 17 years of age, the right of inspection (under section 6401), the right of amendment (under section 6402), and the right to authorize disclosure of protected health information (under section 6412) of the individual may be exercised either by the individual or by the parent or legal guardian of the individual.

SEC. 6447. MAINTENANCE OF CERTAIN PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—A State shall establish a process under which the protected health information described in subsection (b) that is maintained by a person described

in subsection (c) is delivered to, and maintained by, the State or an individual or entity designated by the State.

(b) INFORMATION DESCRIBED.—The protected health information referred to in subsection (a) is protected health information that—

(1) is recorded in any form or medium;

(2) is created by—

(A) a health care provider; or

(B) a health benefit plan sponsor that provides benefits in the form of items and services to enrollees and not in the form of reimbursement for items and services; and

(3) relates in any way to the past, present, or future physical or mental health or condition or functional status of a protected individual or the provision of health care to a protected individual.

(c) PERSONS DESCRIBED.—A person referred to in subsection (a) is any of the following:

(1) A health care facility previously located in the State that has closed.

(2) A professional practice previously operated by a health care provider in the State that has closed.

(3) A health benefit plan sponsor that—

(A) previously provided benefits in the form of items and services to enrollees in the State; and

(B) has ceased to do business.

PART 5—ENFORCEMENT

SEC. 6451. CIVIL ACTIONS.

(a) IN GENERAL.—Any individual whose right under this subtitle has been knowingly or negligently violated—

(1) by a health information trustee, or any other person, who is not described in paragraph (2), (3), (4), or (5) may maintain a civil action for actual damages and for equitable relief against the health information trustee or other person;

(2) by an officer or employee of the United States while the officer or employee was acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the United States;

(3) by an officer or employee of any government authority of a State that has waived its sovereign immunity to a claim for damages resulting from a violation of this subtitle while the officer or employee was acting within the scope of the office or employment may maintain a civil action for actual damages

and for equitable relief against the State government;

(4) by an officer or employee of a government of a State that is not described in paragraph (3) may maintain a civil action for actual damages and for equitable relief against the officer or employee; or

(5) by an officer or employee of a government authority while the officer or employee was not acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the officer or employee.

(b) KNOWING VIOLATIONS.—Any individual entitled to recover actual damages under this section because of a knowing violation of a provision of this subtitle (other than subsection (c) or (d) of section 6411) shall be entitled to recover the amount of the actual damages demonstrated or $5,000, whichever is greater.

(c) ACTUAL DAMAGES.—For purposes of this section, the term ''actual damages'' includes damages paid to compensate an individual for nonpecuniary losses such as physical and mental injury as well as damages paid to compensate for pecuniary losses.

(d) PUNITIVE DAMAGES; ATTORNEY'S FEES.—In any action brought under this section in which the com-

plainant has prevailed because of a knowing violation of a provision of this subtitle (other than subsection (c) or (d) of section 6411), the court may, in addition to any relief awarded under subsections (a) and (b), award such punitive damages as may be warranted. In such an action, the court, in its discretion, may allow the prevailing party a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

(e) LIMITATION.—A civil action under this section may not be commenced more than 2 years after the date on which the aggrieved individual discovered the violation or the date on which the aggrieved individual had a reasonable opportunity to discover the violation, whichever occurs first.

(f) INSPECTION AND AMENDMENT.—If a health information trustee has established a formal internal procedure that allows an individual who has been denied inspection or amendment of protected health information to appeal the denial, the individual may not maintain a civil action in connection with the denial until the earlier of—

(1) the date the appeal procedure has been exhausted; or

(2) the date that is 4 months after the date on which the appeal procedure was initiated.

(g) NO LIABILITY FOR PERMISSIBLE DISCLOSURES.—A health information trustee who makes a disclosure of protected health information about a protected individual that is permitted by this subtitle and not otherwise prohibited by State or Federal statute shall not be liable to the individual for the disclosure under common law.

(h) NO LIABILITY FOR INSTITUTIONAL REVIEW BOARD DETERMINATIONS.—If the members of a certified institutional review board have in good faith determined that an approved health research project is of sufficient importance so as to outweigh the intrusion into the privacy of an individual pursuant to section 6416(a)(1), the members, the board, and the parent institution of the board shall not be liable to the individual as a result of such determination.

(i) GOOD FAITH RELIANCE ON CERTIFICATION.—A health information trustee who relies in good faith on a certification by a government authority or other person and discloses protected health information about an individual in accordance with this subtitle shall not be liable to the individual for such disclosure.

SEC. 6452. CIVIL MONEY PENALTIES.

(a) VIOLATION.—Any health information trustee who the Secretary determines has demonstrated a pattern or

practice of failure to comply with the provisions of this subtitle shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such failure. In determining the amount of any penalty to be assessed under the procedures established under subsection (b), the Secretary shall take into account the previous record of compliance of the person being assessed with the applicable requirements of this subtitle and the gravity of the violation.

(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A of such Act.

SEC. 6453. ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—Not later than July 1, 1996, the Secretary shall, by regulation, develop alternative dispute resolution methods for use by individuals, health information trustees, and other persons in resolving claims under section 6451.

(b) EFFECT ON INITIATION OF CIVIL ACTIONS.—

(1) IN GENERAL.—Subject to paragraph (2), the regulations established under subsection (a) may provide that an individual alleging that a right of the individual under this subtitle has been violated shall pursue at least one alternative dispute resolution method developed under such subsection as a condition precedent to commencing a civil action under section 6451.

(2) LIMITATION.—Such regulations may not require an individual to refrain from commencing a civil action to pursue one or more alternative dispute resolution method for a period that is greater than 6 months.

(3) SUSPENSION OF STATUTE OF LIMITATIONS.—The regulations established by the Secretary under subsection (a) may provide that a period in which an individual described in paragraph (1) pursues (as defined by the Secretary) an alternative dispute resolution method under this section shall be excluded in computing the period of limitations under section 6451(e).

(c) METHODS.—The methods under subsection (a) shall include at least the following:

(1) ARBITRATION.—The use of arbitration.

(2) MEDIATION.—The use of mediation.

(3) EARLY OFFERS OF SETTLEMENT.—The use of a process under which parties make early offers of settlement.

(d) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under subsection (a), the Secretary shall ensure that the methods promote the resolution of claims in a manner that—

(1) is affordable for the parties involved;

(2) provides for timely and fair resolution of claims; and

(3) provides for reasonably convenient access to dispute resolution for individuals.

SEC. 6454. AMENDMENTS TO CRIMINAL LAW.

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 89 the following:

"CHAPTER 90—PROTECTED HEALTH INFORMATION

''Sec.
''1831. Definitions.
''1832. Obtaining protected health information under false pretenses.
''1833. Monetary gain from obtaining protected health information under false pretenses.
''1834. Knowing and unlawful obtaining of protected health information.
''1835. Monetary gain from knowing and unlawful obtaining of protected health information.
''1836. Knowing and unlawful use or disclosure of protected health information.
''1837. Monetary gain from knowing and unlawful sale, transfer, or use of protected health information.

"§ 1831. Definitions

''As used in this chapter—

''(1) the term 'health information trustee' has the meaning given such term in section 6400(b)(5) of the Bipartisan Health Care Reform Act of 1994;

''(2) the term 'protected health information' has the meaning given such term in section 6400(a)(3) of such Act; and

''(3) the term 'protected individual' has the meaning given such term in section 6400(a)(4) of such Act.

"§ 1832. Obtaining protected health information under false pretenses

''Whoever under false pretenses—

''(1) requests or obtains protected health information from a health information trustee; or

''(2) obtains from a protected individual an authorization for the disclosure of protected health information about the individual maintained by a health information trustee;

shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1833. Monetary gain from obtaining protected health information under false pretenses

''Whoever under false pretenses—

''(1) requests or obtains protected health information from a health information trustee with the

intent to sell, transfer, or use such information for profit or monetary gain; or

''(2) obtains from a protected individual an authorization for the disclosure of protected health information about the individual maintained by a health information trustee with the intent to sell, transfer, or use such authorization for profit or monetary gain;

and knowingly sells, transfers, or uses such information or authorization for profit or monetary gain shall be fined under this title or imprisoned not more than 10 years, or both.

"§ 1834. Knowing and unlawful obtaining of protected health information

''Whoever knowingly obtains protected health information from a health information trustee in violation of subtitle E of title VI of the Bipartisan Health Care Reform Act of 1994, knowing that such obtaining is unlawful, shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1835. Monetary gain from knowing and unlawful obtaining of protected health information

''Whoever knowingly—

''(1) obtains protected health information from a health information trustee in violation of subtitle

E of title VI of the Bipartisan Health Care Reform Act of 1994, knowing that such obtaining is unlawful and with the intent to sell, transfer, or use such information for profit or monetary gain; and

''(2) knowingly sells, transfers, or uses such information for profit or monetary gain;

shall be fined under this title or imprisoned not more than 10 years, or both.

''§ 1836. Knowing and unlawful use or disclosure of protected health information

''Whoever knowingly uses or discloses protected health information in violation of subtitle E of title VI of the Bipartisan Health Care Reform Act of 1994, knowing that such use or disclosure is unlawful, shall be fined under this title or imprisoned not more than 5 years, or both.

''§ 1837. Monetary gain from knowing and unlawful sale, transfer, or use of protected health information

''Whoever knowingly sells, transfers, or uses protected health information in violation of subtitle E of title VI of the Bipartisan Health Care Reform Act of 1994, knowing that such sale, transfer, or use is unlawful, shall be fined under this title or imprisoned not more than 10 years, or both.''.

(b) CLERICAL AMENDMENT.—The table of chapters for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 89 the following:

"90. Protected health information ..... 1831".

PART 6—AMENDMENTS TO TITLE 5, UNITED STATES CODE

SEC. 6461. AMENDMENTS TO TITLE 5, UNITED STATES CODE.

(a) NEW SUBSECTION.—Section 552a of title 5, United States Code, is amended by adding at the end the following:

''(w) MEDICAL EXEMPTIONS.—The head of an agency that is a health information trustee (as defined in section 6400(b)(5) of the Bipartisan Health Care Reform Act of 1994) shall promulgate rules, in accordance with the requirements (including general notice) of subsections (b)(1), (b)(2), (b)(3), (c), and (e) of section 553 of this title, to exempt a system of records within the agency, to the extent that the system of records contains protected health information (as defined in section 6400(a)(3) of such Act), from all provisions of this section except subsections (e)(1), (e)(2), subparagraphs (A) through (C) and (E) through (I) of subsection (e)(4), and subsections

(e)(5), (e)(6), (e)(9), (e)(12), (l), (n), (o), (p), (q), (r), and (u).''.

(b) REPEAL.—Section 552a(f)(3) of title 5, United States Code, is amended by striking ''pertaining to him,'' and all that follows through the semicolon and inserting ''pertaining to the individual;''.

PART 7—REGULATIONS, RESEARCH, AND EDUCATION; EFFECTIVE DATES; APPLICABILITY; AND RELATIONSHIP TO OTHER LAWS

SEC. 6471. REGULATIONS; RESEARCH AND EDUCATION.

(a) REGULATIONS.—Not later than July 1, 1996, the Secretary shall prescribe regulations to carry out this subtitle.

(b) RESEARCH AND TECHNICAL SUPPORT.—The Secretary may sponsor—

(1) research relating to the privacy and security of protected health information;

(2) the development of consent forms governing disclosure of such information; and

(3) the development of technology to implement standards regarding such information.

(c) EDUCATION.—The Secretary shall establish education and awareness programs—

(1) to foster adequate security practices by health information trustees;

(2) to train personnel of health information trustees respecting the duties of such personnel with respect to protected health information; and

(3) to inform individuals and employers who purchase health care respecting their rights with respect to such information.

SEC. 6472. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this subtitle, and the amendments made by this subtitle, shall take effect on January 1, 1997.

(b) PROVISIONS EFFECTIVE IMMEDIATELY.—A provision of this subtitle shall take effect on the date of the enactment of this Act if the provision—

(1) imposes a duty on the Secretary to develop, establish, or promulgate regulations, guidelines, notices, statements, or education and awareness programs; or

(2) authorizes the Secretary to sponsor research or the development of forms or technology.

SEC. 6473. APPLICABILITY.

(a) PROTECTED HEALTH INFORMATION.—Except as provided in subsections (b) and (c), the provisions of this subtitle shall apply to any protected health information that is received, created, used, maintained, or disclosed by a health information trustee in a State on or after Janu-

ary 1, 1997, regardless of whether the information existed or was disclosed prior to such date.

(b) EXCEPTION.—

(1) IN GENERAL.—The provisions of this subtitle shall not apply to a trustee described in paragraph (2), except with respect to protected health information that is received by the trustee on or after January 1, 1997.

(2) APPLICABILITY.—A trustee referred to in paragraph (1) is—

(A) a health researcher; or

(B) a person who, with respect to specific protected health information, received the information—

(i) pursuant to—

(I) section 6417 (relating to emergency circumstances);

(II) section 6418 (relating to judicial and administrative purposes);

(III) section 6419 (relating to law enforcement); or

(IV) section 6420 (relating to subpoenas, warrants, and search warrants); or

(ii) while acting in whole or in part in the capacity of an officer or employee of a person described in clause (i).

(c) AUTHORIZATIONS FOR DISCLOSURES.—An authorization for the disclosure of protected health information about a protected individual that is executed by the individual before January 1, 1997, and is recognized and valid under State law on December 31, 1996, shall remain valid and shall not be subject to the requirements of section 6412 until January 1, 1998, or the occurrence of the date or event (if any) specified in the authorization upon which the authorization expires, whichever occurs earlier.

SEC. 6474. RELATIONSHIP TO OTHER LAWS.

(a) STATE LAW.—Except as otherwise provided in subsections (b), (c), (d), and (f), a State may not establish, continue in effect, or enforce any State law to the extent that the law is inconsistent with, or imposes additional requirements with respect to, any of the following:

(1) A duty of a health information trustee under this subtitle.

(2) An authority of a health information trustee under this subtitle to disclose protected health information.

(3) A provision of part 3 (relating to access procedures and challenge rights), part 4 (miscellaneous provisions), or part 5 (relating to enforcement).

(b) LAWS RELATING TO PUBLIC HEALTH AND MENTAL HEALTH.—This subtitle does not preempt, supersede, or modify the operation of any State law regarding public health or mental health to the extent that the law prohibits or regulates a disclosure of protected health information that is permitted under this subtitle.

(c) CRIMINAL PENALTIES.—A State may establish and enforce criminal penalties with respect to a failure to comply with a provision of this subtitle.

(d) PRIVILEGES.—A privilege that a person has under law in a court of a State or the United States or under the rules of any agency of a State or the United States may not be diminished, waived, or otherwise affected by—

(1) the execution by a protected individual of an authorization for disclosure of protected health information under this subtitle, if the authorization is executed for the purpose of receiving health care or providing for the payment for health care; or

(2) any provision of this subtitle that authorizes the disclosure of protected health information for the

purpose of receiving health care or providing for the payment for health care.

(e) DEPARTMENT OF VETERANS AFFAIRS.—The limitations on use and disclosure of protected health information under this subtitle shall not be construed to prevent any exchange of such information within and among components of the Department of Veterans Affairs that determine eligibility for or entitlement to, or that provide, benefits under laws administered by the Secretary of Veterans Affairs.

(f) CERTAIN DUTIES UNDER STATE OR FEDERAL LAW.—This subtitle shall not be construed to preempt, supersede, or modify the operation of any of the following:

(1) Any law that provides for the reporting of vital statistics such as birth or death information.

(2) Any law requiring the reporting of abuse or neglect information about any individual.

(3) Subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications of emergency response employees of possible exposure to infectious diseases).

(4) The Americans with Disabilities Act of 1990.

(5) Any Federal or State statute that establishes a privilege for records used in health professional peer review activities.

(g) SECRETARIAL AUTHORITY.—

(1) SECRETARY OF HEALTH AND HUMAN SERVICES.—A provision of this subtitle does not preempt, supersede, or modify the operation of section 543 of the Public Health Service Act, except to the extent that the Secretary of Health and Human Services determines through regulations promulgated by such Secretary that the provision provides greater protection for protected health information, and the rights of protected individuals, than is provided under such section 543.

(2) SECRETARY OF VETERANS AFFAIRS.—A provision of this subtitle does not preempt, supersede, or modify the operation of section 7332 of title 38, United States Code, except to the extent that the Secretary of Veterans Affairs determines through regulations promulgated by such Secretary that the provision provides greater protection for protected health information, and the rights of protected individuals, than is provided under such section 7332.

Subtitle F—Antitrust

SEC. 6501. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF HEALTH PLANS.

(a) IN GENERAL.—The Attorney General shall provide for the development and publication of explicit guidelines on the application of antitrust laws to the activities of health plans. The guidelines shall be designed to facilitate development and operation of plans, consistent with the antitrust laws.

(b) REVIEW PROCESS.—The Attorney General shall establish a review process under which the administrator or sponsor of a health plan (or organization that proposes to administer or sponsor a health plan) may submit a request to the Attorney General to obtain a prompt opinion (but in no event later than 90 days after the Attorney General receives the request) from the Department of Justice on the plan's conformity with the Federal antitrust laws.

(c) DEFINITIONS.—In this section—

(1) the term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act

(15 U.S.C. 45) to the extent such section applies to unfair methods of competition, and

(B) includes any State law similar to the laws referred to in subparagraph (A); and

(2) the term ''health plan'' means any contract or arrangement under which an entity bears all or part of the cost of providing health care items and services, including a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, but does not include—

(A) coverage only for accident, dental, vision, disability, or long term care, medicare supplemental health insurance, or any combination thereof,

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

(C) workers' compensation or similar insurance, or

(D) automobile medical-payment insurance.

SEC. 6502. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary,

shall issue in accordance with this section a certificate of public advantage to each eligible health care collaborative activity that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such activity, and the parties to such activity, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such activity if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

(1) STANDARDS TO BE MET.—The Attorney General shall issue a certificate to an eligible health care collaborative activity if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the activity outweigh the reduction in competition (if any) that is likely to result from the activity, and

(B) such reduction in competition is necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the activity is likely—

(i) to maintain or to increase the quality of health care by providing new services not currently offered in the relevant market,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs, that cannot be achieved by the provision of available services and facilities in the relevant market,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care collaborative activity and the entities responsible for making payments to such providers to negotiate societally optimal payment and service arrangements,

(ii) the effects of the health care collaborative activity on premiums and other charges imposed by the entities described in clause (i), and

(iii) the availability of equally efficient, less restrictive alternatives to achieve the benefits that are intended to be achieved by carrying out the activity.

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall

specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care collaborative activity (in the case of an activity in existence as of the time of the application) and implementation plan for the collaborative activity.

(d) ELIGIBLE HEALTH CARE COLLABORATIVE ACTIVITY.—To be an eligible health care collaborative activity for purposes of this section, a health care collaborative activity shall submit to the Attorney General an application that complies with the rules in effect under subsection (c) and that includes—

(1) an agreement by the parties to the activity that the activity will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the activity,

(2) an agreement that the activity will submit to the Attorney General annually a report that describes the operations of the activity and information

regarding the impact of the activity on health care and on competition in health care, and

(3) an agreement that the parties to the activity will notify the Attorney General and the Secretary of the termination of the activity not later than 30 days after such termination occurs.

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 90 days after an eligible health care collaborative activity submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 90-day period, the Attorney General may extend the time for issuance for good cause.

(f) REVOCATION OF CERTIFICATE.—Whenever the Attorney General finds that a health care collaborative activity with respect to which a certificate is in effect does not meet the standards specified in subsection (b), the Attorney General shall revoke such certificate.

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an application for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial

or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section

without an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

(2) to attempt to enter into any health care collaborative activity with respect to which such a certificate is in effect.

(i) DEFINITIONS.—In this section:

(1) The term ''antitrust laws'' has the meaning given it in section 6501(c)(1).

(2) The term ''certificate'' means a certificate of public advantage authorized to be issued under subsection (a).

(3) The term ''health care collaborative activity'' means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of

sharing in the provision and coordination of health care services and that involves substantial integration and financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

(4) The term ''health care services'' includes services related to the delivery or administration of health care services.

(5) The term ''liable'' means liable for any civil or criminal violation of the antitrust laws.

(6) The term ''provider of health care services'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

SEC. 6503. STUDY OF IMPACT ON COMPETITION.

The Attorney General, in consultation with the Chairman of the Federal Trade Commission, annually shall submit to the Congress a report as part of the annual budget oversight proceedings concerning the Antitrust Division of the Department of Justice. The report shall enable the Congress to determine how enforcement of antitrust laws

is affecting the formation of efficient, cost-saving joint ventures and if the certificate of public advantage procedure set forth in section 6502 has resulted in undesirable reduction in competition in the health care marketplace. The report shall include an evaluation of the factors set forth in paragraphs (2)(A) and (2)(B) of section 6502(b).

Subtitle G—Fraud and Abuse

PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

SEC. 6601. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1996, the Attorney General shall establish a program—

(1) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

(2) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(3) in consultation with the Inspector General of the Department of Health and Human Services, to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Secu-

rity Act and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH THIRD PARTY INSURERS.—In carrying out the program established under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data with representatives of private sponsors of health benefit plans and other providers of health insurance.

(d) REGULATIONS.—

(1) IN GENERAL.—The Attorney General shall by regulation establish standards to carry out the program under subsection (a).

(2) INFORMATION STANDARDS.—

(A) IN GENERAL.—Such standards shall include standards relating to the furnishing of information by health insurers (including self-insured health benefit plans), providers, and others to enable the Attorney General to carry

out the program (including coordination with law enforcement agencies under subsection (b) and third party insurers under subsection (c)).

(B) CONFIDENTIALITY.—Such standards shall include procedures to assure that such information is provided and utilized in a manner that protects the confidentiality of the information and the privacy of individuals receiving health care services.

(C) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information to the Attorney General under the program under this section, with respect to the Attorney General's performance of duties under the program, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act, with respect to the performance of such a contract.

SEC. 6602. AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.

In addition to any other amounts authorized to be appropriated to the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such sums as may be necessary to enable the Attorney General to conduct investigations of allegations of health care fraud and otherwise carry out the program established under section 6601 in a fiscal year.

SEC. 6603. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE TRUST FUND.

(a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ''Anti-Fraud and Abuse Trust Fund'' (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this part and section 1128A(f)(3) of the Social Security Act.

(b) MANAGEMENT.—

(1) IN GENERAL.—The Trust Fund shall be managed by the Attorney General through a Managing Trustee designated by the Attorney General.

(2) INVESTMENT OF FUNDS.—It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in the trustee's judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the

end of such calendar month, except that where such average is not a multiple of ⅛ of 1 percent, the rate of interest on such obligations shall be the multiple of ⅛ of 1 percent nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where the Trustee determines that the purchase of such other obligations is in the public interest.

(3) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(4) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(5) The receipts and disbursements of the Attorney General in the discharge of the functions of the Attorney General shall not be included in the totals of the budget of the United States Government.

For purposes of part C of the Balanced Budget and Emergency Deficit Control Act of 1985, the Attorney General and the Trust Fund shall be treated in the same manner as the Federal Retirement Thrift Investment Board and the Thrift Savings Fund, respectively. The United States is not liable for any obligation or liability incurred by the Trust Fund.

(c) USE OF FUNDS.—Of the amounts in the Trust Fund—

(1) not less than 60 percent shall be used to support educational activities to prevent the occurrence of violations of anti-fraud and abuse laws, including the issuance of advisory opinions under section 1129 and 1877(i) of the Social Security Act (as added by part 4) and fraud alerts, seminars for providers, and program updates; and

(2) any amounts remaining after use for activities under paragraph (1) shall be used to assist the Attorney General in carrying out the all-payer fraud and abuse control program established under section 6601(a) in the fiscal year involved.

(d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES INTO TRUST FUND.—Section 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a–7a(f)(3)) is amended by striking ''as miscellaneous re-

ceipts of the Treasury of the United States'' and inserting ''in the Anti-Fraud and Abuse Trust Fund established under section 6603(a) of the Bipartisan Health Care Reform Act of 1994''.

(e) USE OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-SHARING.—Section 1128A(f) of the Social Security Act (42 U.S.C. 1320a–7a(f)) is amended in the matter preceding paragraph (1) by striking ''Secretary and disposed of as follows:'' and inserting the following: ''Secretary. If the person against whom such a penalty or assessment was assessed collected a payment from an individual for providing to the individual the service that is the subject of the penalty or assessment, the Secretary shall pay a portion of the amount recovered to the individual in the nature of restitution in an amount equal to the payment so collected. The Secretary shall dispose of any remaining amounts recovered under this section as follows:''.

PART 2—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 6611. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO FRAUD.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service on or after the date of the enactment of this paragraph, or with respect to any act or omission on or after such date in a program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 6612. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 6613. REVISIONS TO CRIMINAL PENALTIES.

(a) CLARIFICATION OF DISCOUNT EXCEPTION TO ANTI-KICKBACK PROVISIONS.—Section 1128B(b)(3)(A) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)(A)) is amended—

(1) by inserting ''(regardless of its timing or availability)'' after ''in price''; and

(2) by striking ''program;'' and inserting ''program and is not paid in the form of currency or coin;''.

(b) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

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

''(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or service, if—

''(A) the item or service is provided through an organization described in section 1877(b)(3), or

''(B) the item or service is provided through such an organization on behalf of another entity (including but not limited to a self-insured employer or indemnity plan) that assumes financial risk for the provision of the item or service.''.

(c) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN PROTECTED FINANCIAL RELATIONSHIPS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)), as amended by subsection (b), is further amended—

(1) by striking ''and'' at the end of subparagraph (E);

(2) by striking the period at the end of subparagraph (F) and inserting ''; and''; and

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

''(G) any amount in a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in section 1877(a)(2), if section 1877(a)(1) does not apply to that amount or financial relationship.''.

(d) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED PERSONS.—

(1) IN GENERAL.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)), as amended by subsections (b) and (c), is further amended—

(A) by striking ''and'' at the end of subparagraph (F);

(B) by striking the period at the end of subparagraph (G) and inserting ''; and''; and

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

''(F) any remuneration paid by or to a recipient or subrecipient of Federal grant funds under or in connection with an arrangement for the procurement of goods or services by the recipient or subrecipient, the referral of patients, or the lease or purchase of space or equipment, if—

''(i) the arrangement is in writing and signed by the parties;

''(ii) the arrangement will result in the savings of Federal grant funds or increased revenues to the recipient or subrecipient that will be used to increase the

availability or accessibility of services to a medically underserved population served by the recipient or subrecipient or an improvement in the quality of services to such population, except that the recipient or subrecipient may seek a prior determination from the Public Health Service that this requirement is met and, if the recipient or subrecipient does so, Public Health Service approval shall be conclusive and binding on the Federal Government;

''(iii) the arrangement will not result in private inurement to any current employees or members of the Board of Directors of the recipient or subrecipient, or to agents of the recipient or subrecipient who were involved in recommending or negotiating the arrangement;

''(iv) with respect to an arrangement under which a recipient or subrecipient is procuring goods or services, the provider of the goods or services is the only provider able to supply such goods or services, or the recipient or subrecipient has engaged in a competitive process to procure the

goods or services that meets the requirements for competition under Federal grant awards;

''(v) with respect to an arrangement for a referral of patients, the arrangement will assure that all patients covered or affected by the arrangement are advised that they may request a referral to any person or entity of their choosing, subject to appropriate contractual limitations under which the recipient or subrecipient may operate as a health plan or as a contract health plan provider and such limitations as the patient may be under as an enrollee of a health plan;

''(vi) with respect to an arrangement for a referral of patients, the arrangement will not interfere with the discretion of health professionals to refer patients in a manner they believe will most appropriately deal with a patient's particular circumstances, subject to appropriate contractual limitations under which the recipient or subrecipient may operate as a health plan or as a contract health plan

provider and such limitations as the patient may be under as an enrollee of a health plan; and

''(vii) with respect to an arrangement that does not meet the requirements of any of the preceding clauses, the recipient or subrecipient of Federal grant funds involved has applied to the Secretary for approval of the arrangement and the Secretary, after consultation with the Inspector General of the Department of Health and Human Services, has approved the arrangement based upon a finding that the arrangement will produce a substantial benefit to a medically underserved population that outweighs the arrangement's failure to fully satisfy all of the above requirements.

In this subparagraph, a 'recipient' means a public or nonprofit private entity that receives a grant or cooperative agreement under the Public Health Service Act or title V, and a 'subrecipient' means a public or nonprofit private entity that performs substantive work under a grant or cooperative agreement under

the Public Health Service Act or title V to a recipient.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect after the expiration of the 6-month period that begins on the date of the enactment of this Act.

SEC. 6615. REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

(a) CLARIFICATION OF COVERAGE OF RADIOLOGY OR DIAGNOSTIC SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraph (D).

(b) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—Section 1877(b) of such Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

''(4) SHARED FACILITY SERVICES.—

''(A) IN GENERAL.—In the case of a shared facility service of a shared facility—

''(i) that is furnished—

''(I) personally by the referring physician who is a shared facility phy-

sician or personally by an individual directly employed or directly supervised by such a physician,

''(II) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

''(III) to a patient of a shared facility physician; and

''(ii) that is billed by the referring physician.

''(B) SHARED FACILITY RELATED DEFINITIONS.—

''(i) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

''(ii) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

''(iii) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician who has a financial relationship under a shared facility arrangement with the facility.

''(iv) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

''(I) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

''(II) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

''(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.''.

(c) REVISION TO RURAL PROVIDER EXCEPTION.—Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2)) is amended by striking ''substantially all'' and inserting ''not less than 75 percent (as determined in accordance with regulations of the Secretary)''.

(d) CLARIFICATION OF REFERRALS BY NEPHROLOGISTS.—Section 1877(h)(5)(C) of such Act (42 U.S.C. 1395nn(H)(5)(C)) is amended—

(1) by striking ''and a request'' and inserting ''a request'';

(2) by inserting after ''radiation therapy,'' the following: ''and a request by a nephrologist for items or services related to renal dialysis,''; and

(3) by striking ''or radiation oncologist'' and inserting ''radiation oncologist, or nephrologist''.

(e) REVISION OF REPORTING REQUIREMENTS.—Section 1877(f) of such Act (42 U.S.C. 1395nn(f)) is amended—

(1) by striking ''Each entity'' and all that follows through paragraph (2) and inserting the following: ''The Secretary may require each entity (other than a physician or physician group practice) providing designated health services to provide the Secretary with the following information concerning the

entity's ownership, investment, and compensation arrangements:

''(1) the designated health services provided by the entity; and

''(2) the names and unique physician identifier numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)) or with a compensation interest (as described in subsection (a)(2)(B)) in the entity, or whose immediate relatives have such an ownership, investment, or compensation interest in the entity.''; and

(2) by striking the fifth sentence.

(f) EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) of such Act (42 U.S.C. 1395nn(b)(3)) is amended—

(1) by striking ''or'' at the end of subparagraph (C);

(2) by striking the period at the end of subparagraph (D) and inserting a comma; and

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

''(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)); or

''(F) which meets State regulatory requirements applicable to health maintenance organizations and which—

''(i) provides designated health services directly or through contractual arrangements with providers;

''(ii) assumes financial risk for the provision of services or provides services on behalf of another individual or entity (including but not limited to a self-insured employer, indemnity plan, physician, or physician group) that assumes financial risk for the provision of the item or service; and

''(iii) subjects the services to a program of utilization review offered by an organization described in a preceding subparagraph, an organization meeting State regulatory requirements applicable to utilization review, or an organization accredited to perform utilization review considered appropriate by the Secretary.''.

(g) PREEMPTION OF STATE LAW.—Section 1877(g) of such Act (42 U.S.C. 1395nn(g)) is amended by adding at the end the following new paragraph:

''(6) PREEMPTION OF STATE LAW.—The provisions of this section shall supersede any State law to the extent State law prohibits a physician from making a referral, or an entity from presenting a bill, for the furnishing of a service which is not subject to the restrictions applicable under paragraph (1).''.

(h) REVISION OF EFFECTIVE DATE EXCEPTION PROVISION.—Section 13562(b)(2) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking subparagraphs (A) and (B) and inserting the following:

''(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

''(B) section 1877(b)(4) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply;

''(C) the requirements of section 1877(c)(2) of the Social Security Act (as amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Secu-

rity Act (as in effect on the day before the date of the enactment of this Act);

''(D) section 1877(e)(3) of the Social Security Act (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

''(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of the Social Security Act (as amended by this Act) shall not apply; and

''(F) section 1877(h)(4)(B) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act).''.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to referrals made on or after January 1, 1995, except that the amendments made by subsection (h) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993.

SEC. 6616. MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) STUDY ON COSTS OF PEER REVIEW CONTRACTS FOR MEDICARE HMO'S.—The Comptroller General shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of the Social Security Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary of Health and Human Services to assess the quality of services provided by such eligible organizations.

(b) REPORT TO CONGRESS.—Not later than July 1, 1997, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subsection (a).

SEC. 6617. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this part shall take effect January 1, 1996.

PART 3—AMENDMENTS TO CRIMINAL LAW

SEC. 6621. PENALTIES FOR HEALTH CARE FRAUD.

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

''(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health care plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be guilty of a felony, and fined under this title or imprisoned not more than 5 years, or both.

''(b) In determining the amount or scope of any penalty or assessment, the court shall take into account—

''(1) the nature of the false or fraudulent claims and the circumstances under which they are presented;

''(2) the degree of culpability and history of prior offenses by the convicted health care provider;

''(3) the extent to which restitution is paid; and

''(4) such other matters as justice may require.

''(c) A principal is liable for penalties and assessments under this section for the acts of the principal's agents acting within the scope of the agency.

''(d) For purposes of this section, the term 'health care plan' means a Federally-funded public program or private program for the delivery of or payment for health care items or services.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

SEC. 6622. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following new subsection:

''(c)(1) In special circumstances and in the Attorney General's sole discretion, the Attorney General may make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution under section 1347.

''(2) A person is not eligible for a payment under paragraph (1) if—

''(A) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

''(B) the person knowingly participated in the offense;

''(C) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

''(i) in a criminal, civil, or administrative proceeding;

''(ii) in a congressional, administrative or General Accounting Office report, hearing, audit or investigation; or

''(iii) by the news media, unless the person is the original source of the information; or

''(D) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

''(3) For the purposes of paragraph (2)(C)(iii), the term 'original source' means a person who has direct and independent knowledge of the information that is fur-

nished and has voluntarily provided the information to the Government prior to disclosure by the news media.

''(4) Neither the failure of the Attorney General to authorize a payment under paragraph (1) nor the amount authorized shall be subject to judicial review.''.

SEC. 6623. BROADENING APPLICATION OF MAIL FRAUD STATUTE.

Section 1341 of title 18, United States Code, is amended—

(1) by inserting ''or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier,'' after ''Postal Service,''; and

(2) by inserting ''or such carrier'' after ''causes to be delivered by mail''.

PART 4—ADVISORY OPINIONS

SEC. 6631. AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ISSUE ADVISORY OPINIONS UNDER TITLE XI.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''ADVISORY OPINIONS

''SEC. 1129. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as provided in this section.

''(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

''(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

''(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

''(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

''(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section 1128B(b).

''(5) Whether an arrangement, activity or proposed arrangement or proposed activity violates any other provision of this Act.

''(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

''(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

''(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

''(d) EFFECT OF ADVISORY OPINIONS.—

''(1) Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(2) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

''(e) REGULATIONS.—The Secretary within 180 days of the date of enactment, shall issue regulations establishing a system for the issuance of advisory opinions. Such regulations shall provide for—

''(1) the procedure to be followed by a party applying for an advisory opinion;

''(2) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(3) the interval in which the Secretary shall respond;

''(4) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(5) the manner in which advisory opinions will be made available to the public.

''(f) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed 30 days.''.

SEC. 6632. AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ISSUE ADVISORY OPINIONS RELATING TO PHYSICIAN OWNERSHIP AND REFERRAL.

Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended by the addition of the following new subsection:

''(i) ADVISORY OPINIONS.—

''(1) IN GENERAL.—The Secretary shall issue advisory opinions on whether an arrangement or proposed arrangement will result in a prohibited referral within the meaning of this section.

''(2) EFFECT OF ADVISORY OPINIONS.—

''(A) Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(B) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of this section.

''(3) REGULATIONS.—The Secretary within one hundred and eighty days of the date of enactment, shall issue regulations establishing a system for the issuance of advisory opinions. Such regulations shall provide for—

''(A) the procedure to be followed by a party applying for an advisory opinion;

''(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(C) the interval in which the Secretary shall respond;

''(D) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(E) the manner in which advisory opinions will be made available to the public.

''(4) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed thirty days.''.

SEC. 6633. EFFECTIVE DATE.

Unless otherwise specified, the amendments made by this part shall be effective upon the enactment of this Act.

PART 5—PAYMENTS FOR STATE HEALTH CARE FRAUD CONTROL UNITS

SEC. 6641. ESTABLISHMENT OF STATE FRAUD UNITS.

(a) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL UNIT.—Each State shall, consistent with State law, establish and maintain in accordance with subsection (b) a State agency to act as a Health Care Fraud and Abuse Control Unit for purposes of this part.

(b) DEFINITION.—In this section, a ''State Fraud Unit'' means a Health Care Fraud and Abuse Control Unit designated under subsection (a) that the Attorney General certifies meets the requirements of this part.

SEC. 6642. REQUIREMENTS FOR STATE FRAUD UNITS.

(a) IN GENERAL.—The State Fraud Unit must—

(1) be a single identifiable entity of the State government;

(2) be separate and distinct from any State agency with principal responsibility for the administration of any Federally-funded or mandated health care program; and

(3) meet the other requirements of this section.

(b) SPECIFIC REQUIREMENTS DESCRIBED.—The State Fraud Unit shall—

(1) be a Unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations;

(2) if it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, (A) assure its referral of suspected criminal violations to the appropriate authority or authorities in the State for prosecution, and (B) assure its assistance of, and coordination with, such authority or authorities in such prosecutions; or

(3) have a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which provide effective coordination of activities between the Fraud Unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to any Federally-funded or mandated health care programs.

(c) STAFFING REQUIREMENTS.—The Fraud Unit must—

(1) employ attorneys, auditors, investigators and other necessary personnel; and

(2) be organized in such a manner and provide sufficient resources as is necessary to promote the effective and efficient conduct of Fraud Unit activities.

(d) COOPERATIVE AGREEMENTS; MEMORANDA OF UNDERSTANDING.—The Fraud Unit must have cooperative agreements with—

(1) Federally-funded or mandated health care programs;

(2) similar Fraud Units in other States, as exemplified through membership and participation in the National Association of Medicaid Fraud Control Units or its successor; and

(3) the Attorney General of the United States and the Inspector General of the Department of Health and Human Services.

(e) REPORTS.—The Fraud Unit shall submit to the Attorney General an application and an annual report containing such information as the Attorney General determines to be necessary to determine whether the Fraud Unit meets the requirements of this section.

(f) FUNDING SOURCE; PARTICIPATION IN ALL-PAYER PROGRAM.—The Fraud Unit may receive funding

for its activities from such sources as the State considers appropriate. The Fraud Unit shall participate in the all-payer fraud and abuse control program established under section 6601.

(g) USE OF MEDICAID FRAUD CONTROL UNITS.—If a State has a medicaid fraud control unit under title XIX of the Social Security Act in operation as of the date of the enactment of this Act, such unit shall be deemed to meet the requirements of this part and to serve as the State Fraud Unit under this part if the State demonstrates that the Unit will be able to carry out the activities described in section 6643.

SEC. 6643. SCOPE AND PURPOSE.

The Fraud Unit shall carry out the following activities:

(1) The Fraud Unit shall conduct a statewide program for the investigation and prosecution (or referring for prosecution) of violations of all applicable state laws regarding any and all aspects of fraud in connection with any aspect of the administration and provision of health care services and activities of providers of such services under any Federally-funded or mandated health care programs.

(2) The Fraud Unit shall have procedures for reviewing complaints of the abuse or neglect of pa-

tients of facilities (including patients in residential facilities and home health care programs) that receive payments under any Federally-funded or mandated health care programs, and, where appropriate, to investigate and prosecute such complaints under the criminal laws of the State or for referring the complaints to other State agencies for action.

(3) The Fraud Unit shall provide for the collection, or referral for collection to the appropriate agency, of overpayments that are made under any Federally-funded or mandated health care program and that are discovered by the Fraud Unit in carrying out its activities.

SEC. 6644. PAYMENTS TO STATES.

(a) IN GENERAL.—

(1) MATCHING PAYMENTS TO STATES.—Subject to subsection (c), for each year for which a State has a Fraud Unit approved under section 6642(b) in operation the Attorney General shall pay to the State for each quarter in a fiscal year an amount equal to the applicable percentage of the sums expended during the quarter by the Fraud Unit.

(2) TIME OF PAYMENT.—The Attorney General shall make a payment under paragraph (1) for a

quarter by not later than 30 days after the end of the quarter.

(b) APPLICABLE PERCENTAGE DEFINED.—

(1) IN GENERAL.—In subsection (a), the ''applicable percentage'' with respect to a State for a fiscal year is—

(A) 90 percent, for quarters occurring during the first 3 years for which the Fraud Unit is in operation; or

(B) 75 percent, for any other quarters.

(2) TREATMENT OF STATES WITH MEDICAID FRAUD CONTROL UNITS.—In the case of a State with a State medicaid fraud control unit in operation prior to or as of the date of the enactment of this Act, in determining the number of years for which the State's Fraud Unit under this part has been in operation, there shall be included the number of years for which such State medicaid fraud control unit was in operation.

(c) LIMIT ON PAYMENT.—Notwithstanding subsection (a), the total amount of payments made to a State under this section for a fiscal year may not exceed—

(1) for fiscal year 1996, 4 times the amount paid to the State under section 1903(a)(6) of the

Social Security Act during the first quarter of 1995; and

(2) for each succeeding fiscal year, the amount determined under this subsection in the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the year.

Subtitle H—Billing for Laboratory Services

SEC. 6701. EASING RESTRICTIONS ON BILLING FOR LABORATORY AND OTHER SERVICES.

(a) IN GENERAL.—The Public Health Service Act is amended—

(1) by redesignating title XXVII (42 U.S.C. 300cc et seq.) as title XXVIII; and

(2) by inserting after title XXVI the following new title:

"TITLE XXVII—RESTRICTIONS ON BILLING

"SEC. 2701. PROHIBITION.

''(a) BILLING OF OTHERS FOR ANCILLARY HEALTH SERVICES.—Except as provided in section 2702, it shall be unlawful for any person (including any individual or entity) who furnishes ancillary health services (as defined in section 2705(1)) to present or cause to be presented,

a claim, bill, or demand for payment to any person other than the patient receiving such services.

''(b) BILLING OF RECIPIENT OF SERVICES.—Except as provided in section 2702, it shall be unlawful for any physician, or the agent of any physician, to present, or cause to be presented, a claim, bill, or demand for payment for ancillary health services to any recipient of such services unless the services covered by the claim, bill, or demand were furnished—

''(1) personally by, or under the supervision of, the referring physician;

''(2) personally by, or under the supervision of, a physician who is a member of the same group practice as the referring physician; or

''(3) personally by individuals who are employed by such physician or group practice and who are personally supervised by the physician or by another physician in the group practice.

''(c) GENERAL EXCEPTION FOR SERVICES UNDER MEDICARE.—This section does not apply with respect to any ancillary health services for which payment may be made under title XVIII of the Social Security Act.

''SEC. 2702. EXCEPTIONS.

''Notwithstanding the provisions of section 2701, a person who furnishes ancillary health services to an indi-

vidual may present, or cause to be presented, for payment for actual services rendered a claim, bill, or demand to—

''(1) an immediate family member of the recipient of the services or any other person legally responsible for the debts or care of the recipient of the services;

''(2) a third party payer designated by the recipient of the services;

''(3) a health maintenance organization, or other health plan providing coverage through a managed care arrangement, in which the recipient of the services is enrolled;

''(4) a hospital or skilled nursing facility where the recipient of the services was an inpatient or outpatient at the time the services were provided;

''(5) an employer where the recipient of the services is an employee of such employer and the employer is responsible for payment for the services;

''(6) a governmental agency or specified agent, on behalf of the recipient of the services;

''(7) a substance abuse program where the clients of such a program were the recipient of the services;

''(8) a clinic or other health care provider that has been designated (or that is operated by an orga-

nization that has been designated) as tax-exempt pursuant to section 501(c)(3) of the Internal Revenue Code of 1986 whose purpose is the promotion of public health, if the services rendered relate to testing for sexually transmitted disease, acquired immune deficiency syndrome, pregnancy, pregnancy termination, or other conditions where the Secretary has determined that compliance with section 2701 could seriously compromise the recipient's need for confidentiality;

''(9) a person engaged in bona fide research studies;

''(10) the party requesting the ancillary health services where Federal, State, or local law requires that the identity of the recipient be kept confidential;

''(11) another person furnishing the same ancillary health services for which payment is sought (hereafter referred to in this paragraph as the 'requesting party') where the person presenting, or causing to be presented, the claim, bill, or demand for payment furnished the services at the request of the requesting party, except that the requesting party may not be a facility owned or operated by the physician requesting the ancillary health service; and

''(12) an entity approved to receive such claims, bills or demands by the Secretary in regulations.

The persons described in paragraphs (1) through (12) who have received a claim, bill, or demand for payment for such ancillary health services may present, or cause to be presented, such claim, bill, or demand to the responsible party.

"SEC. 2703. SANCTIONS.

''(a) PAYMENT.—No payment may be made for a service that is provided in violation of section 2701.

''(b) COLLECTION OF AMOUNTS.—

''(1) LIABILITY ON COLLECTION.—If a person collects any amounts that were billed in violation of section 2701(a), such person shall be liable for, and shall refund on a timely basis to the individual whom such amounts were collected, any amounts so collected.

''(2) COLLECTION BY PHYSICIAN.—If a physician collects any amounts from a recipient of services, or from another person on behalf of the recipient of services (including a third-party payer) that were billed in violation of section 2701(b), such physician shall be liable for, and shall refund on a timely basis to the recipient or person, any amounts so collected.

''(c) REPEATED CLAIMS.—Any person that presents, or causes to be presented, on a repeated basis, a bill or a claim that such person knows, or should have known, is for a service for which payment may not be made under subsection (a), or for which a refund has not been made under subsection (b), shall be subject to a civil money penalty of not more than $5,000 for each such bill or claim. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and subsection (b)) shall apply to a civil money penalty assessed under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under such section 1128A(a).

''(d) SUSPENSION OF LABORATORY CERTIFICATION.—If the Secretary finds, after reasonable notice and opportunity for a hearing, that a laboratory which holds a certificate pursuant to section 353 has violated section 2701, the Secretary may suspend, revoke or limit such certification in accordance with the procedures established in section 353(k).

''(e) EXCLUSION FROM OTHER PROGRAMS.—

''(1) AUTHORITY.—The Secretary may exclude from participation in any program under title XVIII of the Social Security Act, any individual or entity that the Secretary determines has violated section

2701 and may direct that such individual and entity be excluded from participation in any State health care program receiving Federal funds.

''(2) APPLICATION OF OTHER LAW.—The provisions of section 1128(e) of the Social Security Act shall apply to any exclusion under paragraph (1) in the same manner as such provisions apply to a proceeding under such section 1128.

"SEC. 2704. REGULATIONS.

''The Secretary shall by regulation impose such other requirements as may be necessary to implement the purposes of this title.

"SEC. 2705. DEFINITIONS.

''As used in this title:

''(1) ANCILLARY HEALTH SERVICES.—The term 'ancillary health services' means—

''(A) clinical laboratory services;

''(B) diagnostic x-ray tests and other diagnostic imaging services including CT and magnetic resonance imaging services;

''(C) other diagnostic tests;

''(D) durable medical equipment; and

''(E) physical therapy services.

''(2) GROUP PRACTICES.—The term 'group practice' means a group of 2 or more physicians le-

gally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

''(A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel;

''(B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group;

''(C) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and

''(D) which meets such other standards as the Secretary may impose by regulation.

In the case of a faculty practice plan associated with a hospital with an approved medical residency training program in which physician members may provide a variety of different specialty services and pro-

vide professional services both within and outside the group (as well as perform other tasks, such as research), the definition of such term shall be limited with respect to the services provided outside of the faculty practice plan.

''(3) IMMEDIATE FAMILY MEMBER.—The term 'immediate family member' shall include spouses, natural and adoptive parents, natural and adoptive children, natural and adopted siblings, stepparents, stepchildren and stepsiblings, fathers-in-law, mothers-in-law, brothers-in-law, sisters-in-law, sons-in-law and daughters-in-law, grandparents and grandchildren, and such additional family members as may be specified in regulations adopted by the Secretary.

''(4) PHYSICIAN.—The term 'physician' means—

''(A) a doctor of medicine or osteopathy legally authorized to practice medicine and perform surgery by the State in which such individual performs such function or action;

''(B) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry in the State in which such individual performs such functions;

''(C) a doctor of podiatric medicine;

''(D) a doctor of optometry; or

''(E) a chiropractor.

''(5) THIRD PARTY PAYER.—The term 'third party payer' means any health care insurer, including any hospital services corporation, health services corporation, medical expense indemnity corporation, mutual insurance company, or self-insured corporation, that provides coverage for health or health-related items or service.''.

(b) CONFORMING AMENDMENTS.—

(1) Sections 2701 through 2714 of the Public Health Service Act (42 U.S.C. 300cc through 300cc–15) are redesignated as sections 2801 through 2814, respectively.

(2)(A) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289) are amended by striking out ''2701'' each place that such appears and inserting in lieu thereof ''2801''.

(B) Section 305(i) of such Act (42 U.S.C. 242c(i)) is amended by striking out ''2711'' each place that such appears and inserting in lieu thereof ''2811''.

SEC. 6702. EFFECTIVE DATE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act, as added by section 6701(a), shall become effective December 31, 1994.

(b) REGULATIONS.—Not later than July 1, 1995, the Secretary of Health and Human Services shall promulgate such regulations as may be appropriate to carry out such title.

TITLE VII—MEDICARE

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Subtitle A—Increased Beneficiary Choice; Improved Program Efficiency

PART 1—INCREASED BENEFICIARY CHOICE

SEC. 7001. REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS UNDER MEDICARE.

(a) USE OF METROPOLITAN STATISTICAL AREAS TO DETERMINE ADJUSTED AVERAGE PER CAPITA COST.—Section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) is amended by striking ''in a geographic area served by an eligible organization or in a similar area'' and inserting ''in the metropolitan statistical area (as defined by the Office of Management and Budget) in which the individual resides, or in the entire portion of the State in which the individual resides which is not located in a metropolitan statistical area in the case of an individual who does not reside in a metropolitan statistical area''.

(b) DETERMINATION OF MODEL ADDITIONAL HEALTH BENEFIT PACKAGES.—Section 1876(g) of such Act (42 U.S.C. 1395mm(g)) is amended by inserting after paragraph (3) the following new paragraph:

''(4) The Secretary shall develop the following model packages of additional health benefits (referred to in paragraph (3)(B)) which an eligible organization may provide (at its option) under paragraph (2):

''(A) Coverage for catastrophic illness (subject to a limit on out-of-pocket expenditures).

''(B) Coverage for prescription drugs.

''(C) Coverage for preventive services.''.

(c) REVISION OF MEMBERSHIP LIMITATION.—Section 1876(f) of such Act (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1), by striking ''one-half'' and inserting ''25 percent''; and

(2) in paragraph (2)(A), by striking ''50 percent'' and inserting ''75 percent''.

(d) ENROLLMENT PERIODS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.—

(1) UNIFORM OPEN ENROLLMENT PERIOD.—Section 1876(c)(3)(A)(i) of such Act (42 U.S.C. 1395mm(c)(3)(A)(i)) is amended by striking ''must have'' and all that follows through ''and including''

and inserting the following: ''shall have open enrollment during an annual uniform open enrollment period established by the Secretary for all eligible organizations, together with''.

(2) OPEN ENROLLMENT FOR CERTAIN DISENROLLED INDIVIDUALS.—Section 1876(c)(3)(A)(ii)(I) of such Act (42 U.S.C. 1395mm(c)(3)(A)(ii)(I)) is amended by adding at the end the following: ''Each eligible organization with a risk-sharing contract under this section shall have an open enrollment period for individuals residing in the organization's service area who disenroll from another eligible organization with a risk-sharing contract under this section on the grounds that the individual's primary care physician is no longer a member of the organization's provider network or for cause (in accordance with such standards, and as demonstrated through an appeals process that meets such requirements, as the Secretary may establish).

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into on or after the date of the enactment of this Act.

SEC. 7002. EXPANSION AND REVISION OF MEDICARE SELECT POLICIES.

(a) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—

(1) IN GENERAL.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 (hereafter referred to as ''OBRA–1990'') is hereby repealed.

(2) CONFORMING AMENDMENT.—Section 4358 of OBRA–1990 is amended by redesignating subsection (d) as subsection (c).

(b) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) of the Social Security Act (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

''(1)(A) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

''(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

''(ii) in the case of a policy described in subparagraph (C)(i)—

''(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

''(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

''(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those standards if the policy meets the requirements of subparagraph (B).

''(B) A policy meets the requirements of this subparagraph if—

''(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

''(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition

and it is not reasonable given the circumstances to obtain the services through the network,

''(iii) the network offers sufficient access,

''(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

''(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

''(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

''(bb) out of area coverage under the policy,

''(cc) the policy's coverage of emergency services and urgently needed care, and

''(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

''(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

''(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

''(C)(i) A policy described in this subparagraph—

''(I) is offered by an eligible organization (as defined in section 1876(b)),

''(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

''(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

''(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except

in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).''.

(c) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) of the Social Security Act (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking ''(1) Each'' and inserting ''(1)(A) Except as provided in subparagraph (B), each'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

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

''(B)(i) Except as provided in clause (ii), in the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy.

''(ii) If an individual described in clause (i) moves to a geographic area where an issuer described in clause (i), or where an affiliate of such issuer, is issuing medicare supplemental policies, such

individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

''(iii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.''.

(d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of the Social Security Act (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking ''(2)'' and inserting ''(2)(A)'';

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as so redesignated—

(A) by striking ''paragraph (1)(E)(i)'' and inserting ''paragraph (1)(B)(v)(I), and

(B) by striking ''paragraph (1)(E)(ii)'' and inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking ''the previous sentence'' and inserting ''this subparagraph''; and

(5) by adding at the end the following new subparagraph:

''(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(e) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall

be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the ''1994 NAIC Model Regulation'').

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in paragraph (1), the Secretary of Health and Human Services (in this subsection as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the ''1994 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1994 NAIC Model Regulation or the 1994 Federal Regulation; or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1994 NAIC Model Regulation or the 1994 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after Janu-

ary 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 7003. INCLUDING NOTICE OF AVAILABLE HEALTH MAINTENANCE ORGANIZATIONS IN ANNUAL NOTICE TO BENEFICIARIES.

Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended—

(1) by striking ''and'' at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting '', and''; and

(3) by inserting after paragraph (3) the following new paragraph:

''(4) with respect to the area in which the individual receiving the notice resides, a description of the eligible organizations under section 1833(a)(1) or section 1876 and the carriers offering a medicare supplemental policy described in section 1882(t)(1) which serve the area in which the individual receiving the notice resides.''.

SEC. 7004. LEGISLATIVE PROPOSAL ON ENROLLING MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a proposal for legislation which provides for the voluntary enrollment of medicare beneficiaries in private health insurance plans.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term ''medicare beneficiary'' means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) CONTENTS OF THE PROPOSAL.—A proposal for legislation submitted under subsection (a) shall—

(1) provide for an appropriate methodology by which the Secretary shall make payment to private health insurance plans for the enrollment of medicare beneficiaries;

(2) provide individuals the opportunity to remain enrolled in such a plan without an interruption in coverage upon becoming medicare beneficiaries; and

(3) provide medicare beneficiaries with the opportunity to enroll in a private health insurance plan.

SEC. 7005. OPTIONAL INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN PRIVATE HEALTH PLANS.

(a) INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—Notwithstanding title XVIII of the Social Security Act, the Secretary shall provide for a monthly payment as provided under subsection (b)(1) to a private health insurance plan on behalf of enrolled medicare beneficiaries who choose to enroll in such a plan.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term ''medicare beneficiary'' means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) PAYMENT SPECIFIED.—

(1) FEDERAL PAYMENT.—

(A) IN GENERAL.—The amount of payment specified in this paragraph for an individual who is enrolled in a private health insurance plan is the lesser of—

(i) the applicable rate specified in section 1876(a)(1)(C) of the Social Security Act; or

(ii) the monthly premium charged the individual for coverage under the private health insurance plan.

(B) SOURCE OF PAYMENT.—The payment to a private health insurance plan under this paragraph for individuals entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, with the allocation to be determined by the Secretary.

(2) INDIVIDUAL'S SHARE.—If the monthly premium for the private plan in which the individual is enrolled is greater than the amount specified under paragraph (1)(A)(i), the individual shall be responsible for paying to the plan the difference between the monthly premium charged the individual for coverage under the plan and the amount specified in paragraph (1)(A)(i).

(3) BUDGET-NEUTRALITY.—The total amount of payments made by the Secretary under this sec-

tion with respect to a beneficiary for a year may not exceed the amount of payment that would have been made under title XVIII of the Social Security Act during the year if the beneficiary did not choose to enroll in a private health insurance plan during the year.

(c) PAYMENTS UNDER THIS SECTION AS SOLE MEDICARE BENEFITS.—Payments made under this section shall be instead of the amounts that would otherwise be payable, pursuant to sections 1814(b) and 1833(a) of the Social Security Act, for services furnished to medicare beneficiaries.

(d) INCLUSION IN ANNUAL NOTICE TO BENEFICIARIES.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2), as amended by section 7003, is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting '', and''; and

(3) by inserting after paragraph (4) the following new paragraph:

''(5) a description of the option provided pursuant to section 7005 of the Bipartisan Health Care Reform Act of 1994 for payment to be made by the

Secretary on the individual's behalf for enrollment in a private health insurance plan.''.

PART 2—IMPROVED PROGRAM EFFICIENCY

SEC. 7011. IMPROVED EFFICIENCY THROUGH CONSOLIDATION OF ADMINISTRATION OF PARTS A AND B.

(a) IN GENERAL.—The Secretary of Health and Human Services shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act) over a 5-year period.

(b) COMBINATION OF INTERMEDIARY AND CARRIER FUNCTIONS.—In taking such steps, the Secretary shall contract with a single entity that combines the fiscal intermediary and carrier functions in each area except where the Secretary finds that special regional or national contracts are appropriate.

(c) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this section.

PART 3—NOTICE OF ADVANCE DIRECTIVE RIGHTS

SEC. 7021. PROVIDING NOTICE OF RIGHTS REGARDING MEDICAL CARE TO INDIVIDUALS ENTERING MEDICARE.

(a) IN GENERAL.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period at the end and inserting '', and''; and

(3) by inserting after paragraph (3) the following new paragraph:

''(4) a description of an individual's rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in section 1866(f)(3)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to notices provided under section 1804 of the Social Security Act on or after January 1 of the first year beginning after the date of the enactment of this Act.

Subtitle B—Savings

PART 1—SAVINGS RELATING TO PART A

SEC. 7101. REDUCTION IN UPDATE FOR PAYMENTS FOR INPATIENT HOSPITAL SERVICES.

Section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) in subclause (XII)—

(A) by striking ''fiscal year 1997'' and inserting ''for each of the fiscal years 1997 through 2000'', and

(B) by striking ''0.5 percentage point'' and inserting ''2.0 percentage points''; and

(2) in subclause (XIII), by striking ''fiscal year 1998'' and inserting ''fiscal year 2005''.

SEC. 7102. REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) PPS HOSPITALS.—

(1) REDUCTION IN BASE PAYMENT RATES.—Section 1886(g)(1)(A) of the Social Security Act (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: ''In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 percent the

unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Bipartisan Health Care Reform Act of 1994) and shall reduce by 10.41 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the Health Security Act).''.

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

(A) in subparagraph (B)(i)—

(i) by striking ''and (II)'' and inserting ''(II)'', and

(ii) by striking the semicolon at the end and inserting the following: '', and (III) an annual update factor established for the prospective payment rates applicable to discharges in a fiscal year which (subject to reduction under subparagraph (C)) will be based upon such factor as the Secretary determines appropriate to take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality;'';

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following new subparagraph:

''(C)(i) With respect to payments attributable to portions of cost reporting periods or discharges occurring during each of the fiscal years 1996 through 2005, the Secretary shall include a reduction in the annual update factor established under subparagraph (B)(i)(III) for discharges in the year equal to the applicable update reduction described in clause (ii) to adjust for excessive increases in capital costs per discharge for fiscal years prior to fiscal year 1992 (but in no event may such reduction result in an annual update factor less than zero).

''(ii) In clause (i), the term 'applicable update reduction' means, with respect to the update factor for a fiscal year—

''(I) 4.9 percentage points; or

''(II) if the annual update factor for the previous fiscal year was less than the applicable update reduction for the previous year, the sum of 4.9 percentage points and the difference between the annual update factor for the previous

year and the applicable update reduction for the previous year.''.

(b) PPS-EXEMPT HOSPITALS.—Section 1861(v)(1) of such Act (42 U.S.C. 1395x(v)(1)) is further amended by adding at the end the following new subparagraph:

''(T) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to the capital-related costs of inpatient hospital services furnished by a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)), the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during each of the fiscal years 1996 through 2005.''.

PART 2—SAVINGS RELATING TO PART B

SEC. 7111. ESTABLISHMENT OF CUMULATIVE EXPENDITURE GOALS FOR PHYSICIAN SERVICES.

(a) USE OF CUMULATIVE PERFORMANCE STANDARD.—Section 1848(f)(2) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)) is amended—

(1) in subparagraph (A)—

(A) in the heading, by striking ''IN GENERAL'' and inserting ''FISCAL YEARS 1991 THROUGH 1994.—'',

(B) in the matter preceding clause (i), by striking ''a fiscal year (beginning with fiscal year 1991)'' and inserting ''fiscal years 1991, 1992, 1993, and 1994'', and

(C) in the matter following clause (iv), by striking ''subparagraph (B)'' and inserting ''subparagraph (C)'';

(2) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''subparagraphs (A) and (B)'';

(3) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(4) by inserting after subparagraph (A) the following new subparagraph:

''(B) FISCAL YEARS BEGINNING WITH FISCAL YEAR 1995.—Unless Congress otherwise provides, the performance standard rate of increase, for all physicians' services and for each category of physicians' services, for a fiscal year beginning with fiscal year 1995 shall be equal to the performance standard rate of increase

determined under this paragraph for the previous fiscal year, increased by the product of—

''(i) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services or for the category of physicians' services, respectively, under this part for portions of calendar years included in the fiscal year involved,

''(ii) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

''(iii) 1 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians' services or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

''(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services or of the category of physicians' services, respectively, in the fiscal year (compared with the previous fiscal year) which are estimated to result from changes in law or regulations affecting the percentage increase described in clause (i) and which is not taken into account in the percentage increase described in clause (i), minus 1, multiplied by 100, and reduced by the performance standard factor (specified in subparagraph (C)).''.

(b) TREATMENT OF DEFAULT UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3)(B) of such Act (42 U.S.C. 1395w–4(d)(3)(B)) is amended—

(A) in clause (i)—

(i) in the heading, by striking ''IN GENERAL'' and inserting ''1992 THROUGH 1996'', and

(ii) by striking ''for a year'' and inserting ''for 1992, 1993, 1994, 1995, and 1996''; and

(B) by adding after clause (ii) the following new clause:

''(iii) YEARS BEGINNING WITH 1997.—

''(I) IN GENERAL.—The update for a category of physicians' services for a year beginning with 1997 provided under subparagraph (A) shall be increased or decreased by the same percentage by which the cumulative percentage increase in actual expenditures for such category of physicians' services for such year was less or greater, respectively, than the performance standard rate of increase (established under subsection (f)) for such category of services for such year.

''(II) CUMULATIVE PERCENTAGE INCREASE DEFINED.—In subclause (I), the 'cumulative percentage increase in actual expenditures' for a year shall be equal to the product of the adjusted increases for each year beginning with 1995 up to and including the year involved, minus 1 and

multiplied by 100. In the previous sentence, the 'adjusted increase' for a year is equal to 1 plus the percentage increase in actual expenditures for the year.''.

(2) CONFORMING AMENDMENT.—Section 1848(d)(3)(A)(i) of such Act (42 U.S.C. 1395w–4(d)(3)(A)(i)) is amended by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''.

(c) USE OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY.—Section 1848(f)(2)(B)(iii) of such Act (42 U.S.C. 1395w–4(f)(2)(B)(iii)), as added by subsection (a), is amended to read as follows:

''(iii) 1 plus the average per capita growth in the real gross domestic product (divided by 100) for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for the category of services consisting of primary care services), and''.

(d) REPEAL OF RESTRICTION ON MAXIMUM REDUCTION.—Section 1848(d)(3)(B)(ii) of such Act (42 U.S.C. 1395w–4(d)(3)(B)(ii)) is amended—

(1) in the heading, by inserting ''IN CERTAIN YEARS'' after ''ADJUSTMENT'';

(2) in the matter preceding subclause (I), by striking ''for a year'';

(3) in subclause (I), by adding ''and'' at the end;

(4) in subclause (II), by striking '', and'' and inserting a period; and

(5) by striking subclause (III).

(e) REPEAL OF PERFORMANCE STANDARD FACTOR.—

(1) IN GENERAL.—Section 1842(f)(2) of such Act, as amended by subsection (a)(3), is amended by striking subparagraph (C) and redesignating subparagraph (D) as subparagraph (C).

(2) CONFORMING AMENDMENT.—Section 1842(f)(2)(B) of such Act, as added by subsection (a), is amended in the matter following clause (iv) by striking ''1, multiplied by 100'' and all that follows through ''subparagraph (C))'' and inserting ''1 and multiplied by 100''.

(f) REDUCTION IN CONVERSION FACTOR FOR PHYSICIAN FEE SCHEDULE FOR 1995.—Section 1848(d)(1) of the Social Security Act (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) in subparagraph (A), by inserting after ''subparagraph (B)'' the following: '', and, in the case of 1995, specified in subparagraph (C)'';

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL PROVISION FOR 1995.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph for 1995 is—

''(i) in the case of physicians' services included in the category of primary care services (as defined in subsection (j)(1)), the conversion factor established under this subsection for 1994 adjusted by the update established under paragraph (3) for 1995; and

''(ii) in the case of any other physicians' services, the conversion factor established under this subsection for 1994 reduced by 3 percentage points and adjusted by the update established under paragraph (3) for 1995.''.

SEC. 7112. IMPOSITION OF COINSURANCE ON LABORATORY SERVICES.

(a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) are each amended—

(1) by striking ''(or 100 percent'' and all that follows through ''the first opinion))''; and

(2) by striking ''100 percent of such negotiated rate'' and inserting ''80 percent of such negotiated rate''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to tests furnished on or after January 1, 1995.

SEC. 7113. INCREASE IN MEDICARE PART B PREMIUM FOR INDIVIDUALS WITH HIGH INCOME.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new part:

''PART VIII—MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

''Sec. 59B. Medicare part B premium tax.

''SEC. 59B. MEDICARE PART B PREMIUM TAX.

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

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

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

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

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

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

''(1) IN GENERAL.—The Medicare part B premium tax for any month is the applicable percentage (as defined in paragraph (2)) of the amount equal to the excess of—

''(A) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

''(B) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

''(2) PHASE-IN OF TAX.—If the modified adjusted gross income of the taxpayer for any taxable years exceeds the threshold amount by—

''(A) less than $25,000, the applicable percentage under this paragraph is 33⅓ percent,

''(B) at least $25,000, but less than $50,000, the applicable percentage under this paragraph is 66⅔ percent,

''(C) at least $50,000, but less than $75,000, the applicable percentage under this paragraph is 65/75 (expressed as a percent), or

''(D) at least $75,000, the applicable percentage under this paragraph is 100 percent.

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

''(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

''(A) except as otherwise provided in this paragraph, $75,000,

''(B) $100,000 in the case of a joint return, and

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

''(i) is married at the close of the taxable year but does not file a joint return for such year, and

''(ii) does not live apart from his spouse at all times during the taxable year.

''(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

''(A) determined without regard to sections 135, 911, 931, and 933, and

''(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

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

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

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

''Part VIII. Medicare Part B Premiums For High-Income Individuals.''.

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

SEC. 7114. EXTENSION OF 25 PERCENT PART B PREMIUM.

Section 1839(e) of the Social Security Act (42 U.S.C. 1395r(e)) is amended—

(1) in paragraph (1)(A), by striking ''after after December 1995 and prior to January 1999'' and inserting ''after December 1995'';

(2) by striking ''(1)(A)'' and inserting ''(1)'';

(3) by striking paragraph (2); and

(4) by redesignating subparagraph (B) of paragraph (1) as paragraph (2) (and redesignating the clauses of such subparagraph accordingly).

SEC. 7115. REDUCTION IN HOSPITAL OUTPATIENT SERVICES THROUGH ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1833(a)(2)(B) of the Social Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended by striking ''section 1886)—'' and all that follows and inserting the following: ''section 1886), an amount equal to a prospectively determined payment rate established by the Secretary that provides for payments for such items and services to be based upon a national rate adjusted to take into account the relative costs of furnishing such

items and services in various geographic areas, except that for items and services furnished during cost reporting periods (or portions thereof) in years beginning with 1996, such amount shall be equal to 95 percent of the amount that would otherwise have been determined;''.

(b) ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.—Not later than July 1, 1995, the Secretary of Health and Human Services shall establish the prospective payment system for hospital outpatient services necessary to carry out section 1833(a)(2)(B) of the Social Security Act (as amended by subsection (a)).

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

PART 3—SAVINGS RELATING TO PARTS A AND B

SEC. 7121. REDUCTION IN HOME HEALTH SERVICES THROUGH ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—

(1) PAYMENTS UNDER PART A.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended—

(A) in subsection (b) in the matter preceding paragraph (1)—

(i) by striking ''(other than'' and all that follows through ''medical equipment)'', and

(ii) by striking ''the provisions of'' and inserting ''the succeeding provisions of this section and''; and

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

''Payments for Home Health Services

''(m) The amount of payment under this part for home health services shall be equal to a prospectively determined payment rate established by the Secretary that provides for payments for such services to be based upon a national rate adjusted to take into account the relative costs of furnishing such services in various geographic areas, except that for services furnished during cost reporting periods (or portions thereof) in years beginning with 1996, such amount shall be equal to 95 percent of the amount that would otherwise have been determined.''.

(2) PAYMENTS UNDER PART B.—Section 1833(a)(2)(A) of the Social Security Act (42 U.S.C. 1395l(a)(2)(A)) is amended by striking ''section 1861(s)(10)(A), the lesser of—'' and all that follows and inserting the following: ''section 1861(s)(10)(A), an amount equal to a prospectively determined pay-

ment rate established by the Secretary that provides for payments for such services to be based upon a national rate adjusted to take into account the relative costs of furnishing such services in various geographic areas, except that for services furnished during cost reporting periods (or portions thereof) in years beginning with 1996, such amount shall be equal to 95 percent of the amount that would otherwise have been determined;''.

(b) ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.—Not later than July 1, 1995, the Secretary of Health and Human Services shall establish the prospective payment system for home health services necessary to carry out sections 1814(m) and 1833(a)(2)(A) of the Social Security Act (as amended by subsection (a)).

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

SEC. 7122. MEDICARE SECONDARY PAYER.

(a) DELAY IN SUNSET OF DATA MATCHING REQUIREMENTS.—(1) Section 1862(b)(5)(C)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(5)(C)(iii)) is amended by striking ''1998'' and inserting ''2005''.

(2) Section 6103(l)(12)(F) of the Internal Revenue Code of 1986 is amended—

(A) in clause (i), by striking ''1998'' and inserting ''2005'',

(B) in clause (ii)(I), by striking ''1997'' and inserting ''2004'', and

(C) in clause (ii)(II), by striking ''1998'' and inserting ''2005''.

(b) EXTENSION OF MEDICARE SECONDARY PAYER TO DISABLED BENEFICIARIES.—Section 1862(b)(1)(B)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended by striking ''1998'' and inserting ''2005''.

(c) EXTENSION OF COVERAGE FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the second sentence, by striking ''October 1, 1998'' and inserting ''October 1, 1995''; and

(2) by adding at the end the following: ''Effective for items and services furnished on or after October 1, 1995, and before October 1, 2005 (with respect to periods beginning on or after April 1, 1994), clauses (i) and (ii) shall be applied by substituting '24-month' for '12-month' each place it appears.''.

(d) APPLICATION TO DISABLED BENEFICIARIES IN ALL GROUP HEALTH PLANS.—Section 1862(b)(1)(B) of such Act (42 U.S.C. 1395y(b)(1)(B)) is amended—

(1) in the heading, by striking ''IN LARGE GROUP HEALTH PLANS'';

(2) in clause (i), by striking ''large group health plan (as defined in clause (v))'' and inserting ''group health plan (as defined in subparagraph (A)(v))''; and

(3) by striking clause (iv) and inserting the following:

''(iv) SMALL EMPLOYER EXEMPTION.—Clauses (ii) and (iii) of subparagraph (A) shall apply with respect to clause (i) in the same manner as they apply to subparagraph (A)(i).''.

TITLE VIII—INCENTIVES TO PURCHASE LONG-TERM CARE INSURANCE

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Subtitle A—Establishment of Federal Standards for Long-Term Care Insurance

SEC. 8001. ESTABLISHMENT OF FEDERAL STANDARDS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—The Social Security Act, as amended by section 2101(a), is amended by adding at the end the following new title:

''TITLE XXII—LONG-TERM CARE INSURANCE STANDARDS

''PART A—PROMULGATION OF STANDARDS AND MODEL BENEFITS

"SEC. 2201. STANDARDS.

''(a) APPLICATION OF STANDARDS.—

''(1) NAIC.—The Secretary shall request that the National Association of Insurance Commissioners (hereinafter in this title referred to as the 'NAIC'), in consultation with the advisory committee provided under subsection (d)—

''(A) to develop specific standards that incorporate the requirements of this title; and

''(B) to report to the Secretary on such standards,

by not later than 12 months after enactment of this title. If the NAIC develops such model standards that incorporate the requirements of this title within such period and the Secretary finds that such standards implement the requirements of this title, such standards shall be the standards applied under this title.

''(2) DEFAULT.—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Sec-

retary shall promulgate, within 12 months after such deadline, a regulation that provides standards that incorporate the requirements of this title and such standards shall apply as provided for in this title.

''(3) STATE STANDARDS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B)—

''(i) a State may not establish, implement, or continue in effect standards different from those established under this title;

''(ii) carriers shall be exempt from any State law, rule, regulation, or order not meeting the requirements of this title; and

''(iii) nothing in this title shall prevent carriers from marketing or selling long-term care insurance policies in any State in which the carrier is licensed to sell such policies, if the carrier and such policies meet the applicable requirements established under Federal law.

''(B) EXCEPTION.—

''(i) IN GENERAL.—If, upon application by an appropriate State agency and

taking into account the considerations described in clause (iii), the Secretary determines that a State has a law that establishes a standard which is different from the standards established under section 2701(a) and the standard meets the requirements of clause (ii), the Secretary may permit by order or regulation implementation and enforcement of the standard.

''(ii) REQUIREMENTS FOR STANDARD.—The requirements of this clause are, with respect to a standard, that—

''(I) the standard would more effectively and to an appreciable greater degree promote the availability and affordability of long-term care insurance than the standards established under this title,

''(II) the standard would not be directly inconsistent with or in conflict with the specific requirements of this title, and

''(III) the standard would not unduly burden interstate commerce.

''(iii) CONSIDERATIONS.—In permitting such a State standard under clause (i), the Secretary shall consider a standard favorably to the extent that the Secretary finds that following apply with respect to the standard:

''(I) There will be no negative economic impact of such a standard on carriers and employers.

''(II) The cost of complying with the standard will be low.

''(III) There will be a minimal impact of the standard on the solvency of carriers.

''(IV) The standard will promote the continuation of a competitive market for long-term care insurance policies.

''(V) There is a high probability of other States applying for such an exception under this subparagraph with respect to the standard.

''(VI) There will be no significant negative impact on national uniform-

ity in long-term care insurance policy standards.

''(iv) PERIODIC REVIEW.—The Secretary shall periodically review the impact of standards permitted under this subparagraph, taking into account the considerations described in clause (iii) and the requirements of clause (ii). If the Secretary determines that a standard of a State permitted under clause (i) should no longer be permitted because it no longer meets such requirements taking into account such considerations, the Secretary, after notice and opportunity for rebuttal by the State, may revoke or rescind the order or regulation permitting the State to implement the standard.

''(b) DEADLINE FOR APPLICATION OF STANDARDS.—

''(1) IN GENERAL.—Subject to paragraph (2), the date specified in this subsection for a State is—

''(A) the date the State adopts the standards established under subsection (a)(1); or

''(B) the date that is 1 year after the first day of the first regular legislative session that

begins after the date such standards are first established under subsection (a)(2);

whichever is earlier.

''(2) STATE REQUIRING LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

''(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

''(B) having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

''(c) ITEMS INCLUDED IN STANDARDS.—The standards promulgated under subsection (a) shall include—

''(1) minimum Federal standards for long-term care insurance consistent with the provisions of this title;

''(2) standards for the enhanced protection of consumers with long-term care insurance;

''(3) procedures for the modification of the standards established under paragraph (1) in a manner consistent with future laws to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program; and

''(4) other activities determined appropriate by Congress.

''(d) CONSULTATION.—In establishing standards and models of benefits under this section, the Secretary shall provide for and consult with an advisory committee to be chosen by the Secretary, and composed of—

''(1) three individuals who are representatives of carriers;

''(2) three individuals who are representatives of consumer groups;

''(3) three representatives who are representatives of providers of long-term care services;

''(4) three other individuals who are not representatives of carriers or of providers of long-term

care services and who have expertise in the delivery and financing of such services; and

''(5) the Secretary of Veterans Affairs.

''(e) DUTIES.—The advisory committee established under subsection (d) shall—

''(1) recommend the appropriate inflationary index to be used with respect to the inflation protection benefit portion of the standards;

''(2) recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy;

''(3) recommend appropriate standards for benefits under section 2215(c); and

''(4) perform such other activities as determined appropriate by the Secretary.

''(f) ADMINISTRATIVE PROVISIONS.—The following provisions of section 1886(e)(6) shall apply to the advisory committee chosen under subsection (d) in the same manner as such provisions apply under such section:

''(1) Subparagraph (C) (relating to staffing and administration).

''(2) Subparagraph (D) (relating to compensation of members).

''(3) Subparagraph (F) (relating to access to information).

''(4) Subparagraph (G) (relating to use of funds).

''(5) Subparagraph (H) (relating to periodic GAO audits).

''(6) Subparagraph (J) (relating to requests for appropriations).

''PART B—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

"SEC. 2211. IMPLEMENTATION OF POLICY STANDARDS.

''(a) IN GENERAL.—

''(1) REGULATORY PROGRAM.—No long-term care policy (as defined in section 2221) may be issued, sold, or offered for sale as a long-term care insurance policy in a State on or after the date specified in section 2201(b) unless—

''(A) the Secretary determines that the State has established a regulatory program that—

''(i) provides for the application and enforcement of the standards established under section 2201(a); and

''(ii) complies with the requirements of subsection (b);

by the date specified in section 2201(b), and the policy has been approved by the State com-

missioner or superintendent of insurance under such program; or

''(B) if the State has not established such a program, or if the State's regulatory program has been decertified, the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 2201(a) by the date specified in section 2201(b).

For purposes of this subsection, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

''(2) REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review regulatory programs described in paragraph (1)(A) to determine if they continue to provide for the application and enforcement of the standards and procedures established under section 2201(a) and (b). If the Secretary determines that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the

program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under paragraph (1)(B) with respect to certifying policies in the State and shall exercise full authority under section 2201 for carriers, agents, or associations or its subsidiary in the State plans in the State.

''(b) ADDITIONAL REQUIREMENTS FOR APPROVAL OF STATE REGULATORY PROGRAMS.—For purposes of subsection (a)(1)(A)(ii), the requirements of this subsection for a State regulatory program are as follows:

''(1) ENFORCEMENT.—The enforcement under the program—

''(A) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards;

''(B) shall provide for notice in the annual report required under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period; and

''(C) shall provide, in addition to any other penalties provided by the laws of a State, that any carrier, agent, or association that is found under the program to have violated such standards shall each be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved or $10,000, whichever is greater.

''(2) PROCESS.—The enforcement process under each State regulatory program shall provide for—

''(A) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the standards;

''(B) responding on a timely basis to such complaints;

''(C) the investigation of—

''(i) those complaints which have a reasonable probability of validity, and

''(ii) such other alleged violations of the standards as the program finds appropriate; and

''(D) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty as provided

for in section 2218) in the case of a carrier, agent, or association or its subsidiary determined to have violated the standards.

''(3) CONSUMER ACCESS TO COMPLIANCE INFORMATION.—

''(A) IN GENERAL.—A State regulatory program must provide for consumer access to complaints filed with the State commissioner or superintendent of insurance with respect to long-term care insurance policies.

''(B) CONFIDENTIALITY.—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

''(4) PROCESS FOR APPROVAL OF PREMIUMS.—

''(A) IN GENERAL.—Each State regulatory program shall—

''(i) provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care insurance policies; and

''(ii) establish a policy for receipt and consideration of public comments before approving such a premium increase or decrease.

''(B) CONDITIONS FOR APPROVAL.—No premium increase shall be approved (or deemed approved) under subparagraph (A) unless the proposed increase is accompanied by an actuarial memorandum which—

''(i) includes a description of the assumptions that justify the increase;

''(ii) contains such information as may be required under the standards established under section 2701(a); and

''(iii) is made available to the public.

''(C) APPLICATION.—Except as provided in subparagraph (D), this paragraph shall not apply to a group long-term care insurance policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such group policy.

''(D) EXCEPTION.—Subparagraph (C) shall not apply to—

''(i) group conversion policies;

''(ii) the group continuation feature of a group policy if the carrier separately rates employee and continuation coverages; and

''(iii) group policies where the function of the employer is limited solely to collecting premiums (through payroll deductions or dues checkoff) and remitting them to the carrier.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the NAIC from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

''(5) ANNUAL REPORTS.—Each State regulatory program shall provide for annual reports to be submitted to the Secretary on the implementation and enforcement of the standards in the State, including information concerning violations in excess of 30 days.

''(6) ACCESS TO OTHER INFORMATION.—The State regulatory program must provide for consumer access to actuarial memoranda provided under paragraph (4).

''(7) DEFAULT.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the enforcement activities described in subsection (c).

''(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall exercise authority under this subsection in the case of a State that does not have a regulatory program approved under this section.

''(2) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

''(A) for individuals and entities to file written, signed complaints respecting alleged violations of the requirements of this title;

''(B) for responding on a timely basis to such complaints; and

''(C) for the investigation of—

''(i) those complaints that have a reasonable probability of validity; and

''(ii) such other alleged violations of the requirements of this title as the Secretary determines to be appropriate.

In conducting investigations under this subsection, agents of the Secretary shall have reasonable access necessary to enable such agents to examine evidence

of any carrier, agent, or association or its subsidiary being investigated.

''(3) HEARINGS.—

''(A) IN GENERAL.—Prior to imposing an order described in paragraph (4) against a carrier, agent, or association or its subsidiary under this section for a violation of the requirements of this title, the Secretary shall provide the carrier, agent, association or subsidiary with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary by regulation) of the date of the notice, a hearing respecting the violation.

''(B) CONDUCT OF HEARING.—Any hearing requested under subparagraph (A) shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

''(C) AUTHORITY IN HEARINGS.—In conducting hearings under this paragraph—

''(i) agents of the Secretary and administrative law judges shall have reasonable access necessary to enable such agents

and judges to examine evidence of any carrier, agent, or association or its subsidiary being investigated; and

''(ii) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subparagraph and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

''(D) ISSUANCE OF ORDERS.—If an administrative law judge determines in a hearing under this paragraph, upon the preponderance of the evidence received, that a carrier, agent, or association or its subsidiary named in the complaint has violated the requirements of this title, the administrative law judge shall state the findings of fact and issue and cause to be

served on such carrier, agent, association, or subsidiary an order described in paragraph (4).

''(4) CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.—

''(A) IN GENERAL.—Subject to the provisions of subparagraphs (B) through (F), an order under this paragraph—

''(i) shall require the agent, association or its subsidiary, or a carrier—

''(I) to cease and desist from such violations; and

''(II) to pay a civil penalty in an amount not to exceed 3 times the amount of any commissions paid for each policy involved or $10,000, whichever is greater, for each such violation; and

''(ii) may require the agent, association or its subsidiary, or a carrier to take such other remedial action as is appropriate.

''(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this paragraph by reason of any violation if the carrier, agent, or

association or its subsidiary establishes to the satisfaction of the Secretary that—

''(i) such violation was due to reasonable cause and was not intentional and was not due to willful neglect; and

''(ii) such violation is corrected within the 30-day period beginning on the earliest date the carrier, agent, association, or subsidiary knew, or exercising reasonable diligence could have known, that such a violation was occurring.

''(C) WAIVER BY SECRETARY.—In the case of a violation under this title that is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed under subparagraph (A)(i)(II) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

''(D) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this paragraph shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary

modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this paragraph.

''(E) JUDICIAL REVIEW.—A carrier, agent, or association or its subsidiary or any other individual adversely affected by a final order issued under this paragraph may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

''(F) ENFORCEMENT OF ORDERS.—If a carrier, agent, or association or its subsidiary fails to comply with a final order issued under this paragraph against the carrier, agent, association or subsidiary after opportunity for judicial review under subparagraph (E), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

"SEC. 2212. REGULATION OF SALES PRACTICES.

''(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

''(1) IN GENERAL.—Each agent (as defined in section 2233) or association that is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

''(2) PROHIBITED PRACTICES.—An agent or association is considered to have violated paragraph (1) if the agent or association engages in any of the following practices:

''(A) TWISTING.—

''(i) IN GENERAL.—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or carriers for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

''(ii) POLICY REPLACEMENT FORM.—With respect to any person who elects to replace or effect a change in a long-term care insurance policy, the individual that is selling such policy shall ensure that such person completes a policy replacement

form developed by the NAIC. A copy of such form shall be provided to such person and additional copies shall be delivered by the selling individual to the old policy issuer and the new issuer and kept on file for inspection by the State regulatory agency.

''(B) HIGH PRESSURE TACTICS.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through force, fright, threat or undue pressure, whether explicit or implicit.

''(C) COLD LEAD ADVERTISING.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

''(D) OTHERS.—Engaging in such other practices determined inappropriate under guidelines issued by the NAIC.

''(b) FINANCIAL STANDARDS.—The NAIC shall develop recommended financial minimum standards (includ-

ing both income and asset criteria) for the purpose of advising individuals considering the purchase of a long-term care insurance policy.

''(c) PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.—An agent, an association, or a carrier may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under title XIX of the Social Security Act.

''(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE SERVICE BENEFIT POLICIES.—An agent, association or its subsidiary, or a carrier may not sell or issue a service-benefit long-term care insurance policy to an individual knowing that the policy provides for coverage that duplicates existing coverage already provided in another service-benefit long-term care insurance policy held by such individual unless—

''(1) the policy is intended to replace such other policy, or

''(2) the benefits under the new policy are fully payable directly to or on behalf of the individual without regard to other long-term care coverage of the individual.

In this subsection, the term 'service-benefit long-term care insurance policy' means a long-term care insurance policy

which provides for benefits based on the type and amount of services furnished.

''(e) PROHIBITION BASED ON ELIGIBILITY FOR OTHER BENEFITS.—A carrier may not sell or issue a long-term care insurance policy that reduces, limits or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

''(f) PROVISION OF OUTLINE OF COVERAGE.—No agent, association or its subsidiary, or carrier may sell or offer for a sale a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) without providing to the purchaser or potential purchaser (or representative) an outline of coverage that complies with the standards established under section 2201(a).

''(g) AGENT TRAINING AND CERTIFICATION REQUIREMENTS.—The NAIC, shall establish requirements for long-term care insurance agent training and certification that—

''(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care insurance policies; and

''(2) specify procedures for certifying agents who have completed such training and who are as

qualified to sell or offer for sale long-term care insurance policies.

"SEC. 2213. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

''(a) REFUND OF PREMIUMS.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 2217, the carrier shall refund directly to the applicant, or in the case of an employer to whomever remits the premium, and not by delivery by the agent, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy (or certificate).

''(b) MAILING OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall provide the applicant, or in the case of a group plan the employer, the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(c) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the carrier shall, within 30 days of the date of a written

request by the policyholder or certificate holder (or representative)—

''(1) provide a written explanation of the reasons for the denial; and

''(2) make available all medical and patient records directly relating to such denial.

Except as provided in subsection (e) of section 2215, no claim under such a policy may be denied on the basis of a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

''(d) REPORTING OF INFORMATION.—A carrier that issues one or more long-term care insurance policies shall periodically (not less often than annually) report, in a form and in a manner determined by the NAIC, to the commissioner or superintendent of insurance of each State in which the policy is delivered, and shall make available to the Secretary, upon request, information in a form and manner determined by the NAIC concerning—

''(1) the long-term care insurance policies of the carrier that are in force;

''(2) the most recent premiums for such policies and the premiums imposed for such policies since their initial issuance;

''(3) the lapse rate, replacement rate, and rescission rates by policy;

''(4) the names of that 10 percent of its agents that—

''(A) have the greatest lapse and replacement rate; and

''(B) have produced at least $50,000 of long-term care insurance sales in the previous year; and

''(5) the claims denied (expressed as a number and as a percentage of claims submitted) by policy. Information required under this subsection shall be reported in a format specified in the standards established under section 2201(a). For purposes of paragraph (3), there shall be included (but reported separately) data concerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

''(e) INFORMATION ON AGENT COMMISSIONS.—A carrier that issues one or more long-term care insurance policies shall provide to the State commissioner or superintendent of insurance such information relating to agent sales commissions and compensation as the commissioner

or superintendent may require in order to monitor and make recommendations for regulatory action relating to such commissions and compensation.

"SEC. 2214. RENEWABILITY STANDARDS FOR ISSUANCE, AND BASIS FOR CANCELLATION OF POLICIES.

''(a) IN GENERAL.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation or fraud.

''(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

''(1) IN GENERAL.—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

''(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facilities, may provide continuation benefits which are substantially

equivalent to the benefits of the existing group policy.

''(3) BASIS FOR CONVERSION.—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

''(A) whose coverage under the group policy would otherwise be terminated for any reason; and

''(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

''(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

''(5) GROUP REPLACEMENT OF POLICIES.—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased

by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

''(c) STANDARDS FOR ISSUANCE.—

''(1) IN GENERAL.—

''(A) GUARANTEE.—An agent, association or carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual, or eligible individual in the case of a group plan, if such individual meets the minimum medical underwriting requirements of such policy.

''(B) PREMIUM FOR CONVERTED POLICY.—If a group policy from which conversion is made is a replacement for a previous group policy, the premium for the converted policy shall be calculated on the basis of the insured's age at the inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be cal-

culated on the basis of the insured's age at inception of coverage under the group policy replaced.

''(2) UPGRADE FOR POLICIES.—

''(A) CURRENT POLICIES.—Each long-term care insurance policy in effect as of the effective date of the standards established under section 2701(a) shall permit the policyholder to purchase a policy that complies with all such standards and the carrier shall directly inform each such policyholder of the right to purchase an upgraded policy under this paragraph.

''(B) FUTURE UPGRADES.—

''(i) IN GENERAL.—If a carrier providing a long-term care insurance policy provides for the issuance of policies with benefits that are greater than the benefits previously provided under such policies, the policyholder of a long-term care insurance policy previous issued by that carrier and still in force has the right to purchase a policy that provides for such upgraded benefits and the carrier shall directly inform each such policyholder of the existence of such an upgraded policy and the right to

purchase an upgraded policy under this paragraph.

''(ii) LIMITATION.—Clause (i) shall not apply to a policyholder who is eligible (or was eligible at any time within the previous 6 months) for benefits under the long-term care insurance policy.

''(C) LIMITATION ON MEDICAL UNDERWRITING OF UPGRADED POLICIES REQUIRED UNDER FEDERAL OR STATE LAW.—With respect to a long-term care insurance policy that offers upgraded benefits in accordance with a requirement of Federal or State law, the carrier issuing the policy may not impose additional medical underwriting criteria, except that—

''(i) the carrier may utilize an age rate for such policy, and

''(ii) the carrier may impose additional medical underwriting criteria in relation to benefits to the extent they were not included in the previously issued policy.

''(D) LIMITATION ON MEDICAL UNDERWRITING ON OTHER UPGRADED POLICIES.—With respect to an upgraded long-term care insurance policy that offers benefits that are

greater than the benefits required under Federal or State requirements, the carrier issuing the policy—

''(i) except as provided in clause (ii), may not impose additional medical underwriting criteria in relation to benefits that are the same as the benefits under the previously issued policy and the premiums charged with respect to such benefits may not be greater than the premiums charged with respect to such benefits under the previously issued policy, but

''(ii) may impose additional medical underwriting criteria in relation to benefits to the extent they were not included in the previously issued policy.

''(d) EFFECT OF INCAPACITATION.—

''(1) IN GENERAL.—

''(A) PROHIBITION.—Except as provided in paragraph (2), a long-term care insurance policy in effect as of the effective date of the standards established under section 2201(a) may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care pro-

vider, independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

''(B) REINSTATEMENT.—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the carrier is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a period of not less than 5 months after termination and shall allow for the collection of past due premium.

''(2) PERMITTED CANCELLATION.—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

''(A) the period of such nonpayment is in excess of 30 days; and

''(B) notice of intent to cancel is provided to the policyholder or designated representative of the policy holder not less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

"SEC. 2215. BENEFIT STANDARDS.

''(a) USE OF STANDARD DEFINITIONS AND TERMINOLOGY AND UNIFORM FORMAT.—Each long-term care insurance policy shall, with respect to services, providers or facilities, pursuant to standards established under section 2201(a)—

''(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with respect to definitions and terminology used for long-term care services and providers; and

''(2) use a uniform format for presenting the outline of coverage under such a policy;

as prescribed under guidelines issued by the NAIC, after consultation with the advisory committee provided for under section 2701(d), and periodically updated.

''(b) DISCLOSURE.—

''(1) OUTLINE OF COVERAGE.—

''(A) REQUIREMENT.—Each carrier that sells or offers for sale a long-term care insurance policy shall provide an outline of coverage under such policy that meets the applicable standards established pursuant to section 2201(a), complies with the requirements of subparagraph (B), and is in a uniform format as

prescribed in guidelines issued by the NAIC and periodically updated.

''(B) CONTENTS.—The outline of coverage for each long-term care insurance policy shall include at least the following:

''(i) A description of the principal benefits and coverage under the policy.

''(ii) A statement of the principal exclusions, reductions, and limitations contained in the policy.

''(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

''(iv) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern, except that such summary shall sub-

stantially and accurately reflect the contents of the policy or the master policy.

''(v) A description of the terms, specified in section 2217, under which a policy or certificate may be returned and premium refunded.

''(vi) A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.

''(2) CERTIFICATES.—A certificate issued pursuant to a group long-term care insurance policy shall include—

''(A) a description of the principal benefits and coverage provided in the policy;

''(B) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

''(C) a statement that the group master policy determines governing contractual provisions.

''(3) LONG-TERM CARE AS PART OF LIFE INSURANCE.—In the case of a long-term care insurance policy issued as a part of, or a rider on, a life

insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

''(A) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

''(B) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person; and

''(C) any exclusions, reductions, and limitations on benefits of long-term care.

''(4) ADDITIONAL INFORMATION.—The Secretary shall collect and distribute to each State commissioner or superintendent of insurance on an annual basis information on national average costs for nursing facility and home care. This information shall be delivered to prospective policyholders of long-term care insurance policies in the following manner:

''(A) In the case of agent solicitations, agents shall deliver the information to prospective policyholders prior to the presentation of an application or enrollment form.

''(B) In the case of direct response solicitations, the information shall be presented in conjunction with any application or enrollment form.

''(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.—

''(1) IN GENERAL.—A long-term care insurance policy may not condition or limit eligibility—

''(A) for benefits for a type of services to the need for or receipt of any other services;

''(B) for any benefit on the medical necessity for such benefit;

''(C) for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC; or

''(D) for residential care (if covered under the policy) only—

''(i) to care provided in facilities which provide a higher level of care; or

''(ii) to care provided in facilities which provide for 24-hour or other nursing

care not required in order to be licensed by the State.

''(2) HOME HEALTH CARE OR COMMUNITY-BASED SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified home health care or community-based services, the policy—

''(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

''(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or licensed or certified home care worker, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC;

''(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

''(D) must provide, at a minimum, benefits for personal care services (including home health aide and home care worker services as defined by the NAIC) home health services,

adult day care, and respite care in an individual's home or in another setting in the community, or any of these benefits on a respite care basis.

''(3) NURSING FACILITY SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified nursing facility services, the policy must provide such benefits with respect to all nursing facilities (as defined in section 1919(a) or until such time as subsequently provided for by the NAIC in establishing uniform language and definitions under section 2215(a)(1)) in the State.

''(4) PER DIEM POLICIES.—

''(A) DEFINITION.—For purposes of this title, the term 'per diem long-term care insurance policy' means a long-term care insurance policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

''(B) LIMITATION.—No per diem long-term care insurance policy (or certificate) may condi-

tion or otherwise exclude benefit payments based on the receipt of any type of nursing facility, home health care or community-based services.

''(d) PROHIBITION OF DISCRIMINATION.—A long-term care insurance policy may not treat benefits under the policy in the case of an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other cognitive or mental impairment differently from an individual having another medical condition for which benefits may be made available.

''(e) LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.—

''(1) INITIAL ISSUANCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the issuance of the policy.

''(B) 6-MONTH LIMIT.—

''(i) IN GENERAL.—No long-term care insurance policy or certificate issued under

this title shall utilize a definition of 'pre-existing condition' that is more restrictive than the following: The term 'preexisting condition' means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured individual.

''(ii) PROHIBITION ON EXCLUSION OF COVERAGE.—No long-term care insurance policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of the coverage of the insured individual.

''(2) REPLACEMENT POLICIES.—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

''(f) ELIGIBILITY FOR BENEFITS.—

''(1) LONG-TERM CARE POLICIES.—Each long-term care insurance policy shall—

''(A) describe the level of benefits available under the policy; and

''(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive, or mental impairment required in order to receive benefits under the policy.

''(2) FUNCTIONAL ASSESSMENT.—In order to submit a claim under any long-term care insurance policy, each claimant shall have a professional functional assessment of his or her physical, cognitive, and mental abilities. Such initial assessment shall be conducted by an individual or entity, meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and that such individual meets any applicable State licensure and certification requirements. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy. For purposes of this paragraph and paragraph (4), the term 'control' means the direct or indirect possession of the power to direct the management and policies of a person. Control is pre-

sumed to exist, if any person directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent of the voting securities of another person.

''(3) CLAIMS REVIEW.—Except as provided in paragraph (4), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

''(4) APPEALS PROCESS.—

''(A) IN GENERAL.—Each long-term care insurance policy shall provide for a timely and independent appeals process, meeting standards established by the NAIC, for individuals who dispute the results of the claims review, conducted under paragraph (3), of the claimant's functional assessment, conducted under paragraph (2).

''(B) INDEPENDENT ASSESSMENT.—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's physical, cognitive or mental abilities.

''(C) CONDUCT.—An independent assessment under subparagraph (B) shall be con-

ducted by an individual or entity meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

''(i) by an individual who has a direct or indirect significant or controlling interest in, or direct affiliation or relationship with, the issuer of the policy;

''(ii) by an entity that provides services to the policyholder or certificateholder for which benefits are available under the long-term care insurance policy; or

''(iii) by an individual or entity in control of, or controlled by, the issuer of the policy.

''(5) STANDARD ASSESSMENTS.—Not later than 2 years after the date of enactment of this title, the advisory committee established under section 2201(d) shall recommend uniform needs assessment mechanisms for the determination of eligibility for benefits under such assessments.

''(g) INFLATION PROTECTION.—

''(1) OPTION TO PURCHASE.—A carrier may not offer a long-term care insurance policy unless the carrier also offers to the proposed policyholder, including each group policyholder, the option to purchase a policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not offer to a policyholder an inflation protection feature that is less favorable to the policyholder than one of the following:

''(A) With respect to policies that provide for automatic periodic increases in benefits, the policy provides for an annual increase in benefits in a manner so that such increases are computed annually at a rate of not less than 5 percent.

''(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous pe-

riod was not declined. The amount of any such additional benefit may not be less than the difference between—

''(i) the existing policy benefit; and

''(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and extending until the year in which the offer of increase is made.

''(C) With respect to service benefit policies, the policy covers a specified percentage of the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

''(2) EXCEPTION.—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

''(3) REQUIRED INFORMATION.—Carriers shall include the following information in or together with the outline of coverage provided under this title:

''(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison shall show

benefit levels over not less than a 20-year period.

''(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

''(4) CONTINUATION OF PROTECTION.—Inflation protection benefit increases under this subsection under a policy that contains such protection shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

''(5) CONSTANT PREMIUM.—An offer of inflation protection under this subsection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

''(6) REJECTION.—Inflation protection under this subsection shall be included in a long-term care

insurance policy unless a carrier obtains a written rejection of such protection signed by the policyholder.

"SEC. 2216. OFFER OF NONFORFEITURE BENEFITS.

''The issuer of a long-term care insurance policy shall offer to the policyholder (including any certificate holder under the policy) a nonforfeiture benefit provision that meets the following requirements:

''(1) The provision is appropriately captioned.

''(2) The provision provides for a benefit available in the event of a default in the payment of any premiums and the amount of such benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in premiums rates. The percent or amount of benefits shall increase based upon the policyholder's equity in the policy.

''(3) The provision includes at least one of the following:

''(A) Reduced paid-up insurance.

''(B) Extended term insurance.

''(C) Shortened benefit period.

''(D) Another similar offering specified under the standards established under section 2701(a).

"SEC. 2217. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

''(a) CONTESTABILITY.—A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or material misrepresentation relating to the issuance of the policy unless notice of such fraud or material misrepresentation is provided within a time period to be determined by the NAIC.

''(b) RIGHT TO RETURN.—Each applicant for a long-term care insurance policy shall have the right to return the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

"SEC. 2218. CIVIL MONEY PENALTY.

''(a) CARRIER.—Any carrier, association or its subsidiary that sells or offers for sale a long-term care insurance policy and that—

''(1) fails to make a refund in accordance with section 2213(a);

''(2) fails to transmit a policy in accordance with section 2213(b);

''(3) fails to provide, make available, or report information in accordance with subsections (c), (d), or (e) of section 2213;

''(4) fails to provide an outline of coverage in violation of section 2215(b)(1); or

''(5) issues a policy without obtaining certain information in violation of section 2215(f);

is subject to a civil money penalty of not to exceed $25,000 for each such violation.

''(b) AGENTS.—Any agent that sells or offers for sale a long-term care insurance policy and that—

''(1) fails to make a refund in accordance with section 2213(a);

''(2) fails to transmit a policy in accordance with section 2213(b);

''(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2213;

''(4) fails to provide an outline of coverage in violation of section 2215(b)(1); or

''(5) issues a policy without obtaining certain information in violation of section 2215(f);

is subject to a civil money penalty of not to exceed $15,000 for each such violation.

''PART C—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND ENDORSEMENTS

"SEC. 2221. LONG-TERM CARE INSURANCE POLICY DEFINED.

''(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance policy, rider or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

''(1) group and individual annuities and life insurance policies, riders or certificates that provide directly, or that supplement long-term care insurance; and

''(2) a policy, rider or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

''(b) ISSUANCE.—Long-term care insurance policies may be issued by—

''(1) carriers;

''(2) fraternal benefit societies;

''(3) nonprofit health, hospital, and medical service corporations;

''(4) prepaid health plans;

''(5) health maintenance organizations; or

''(6) any similar organization to the extent they are otherwise authorized to issue life or health insurance.

''(c) POLICIES EXCLUDED.—The term 'long-term care insurance policy' shall not include any insurance policy, rider or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance, such term shall not include life insurance policies, riders or certificates that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

''(d) APPLICATIONS.—Notwithstanding any other provision of this title, this title shall apply to any product advertised, marketed or offered as a long-term insurance policy, rider or certificate.

"SEC. 2222. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

''Not later than 1 year after the date of enactment of this title the NAIC shall issue guidelines that shall apply to organizations and associations, other than employers and labor organizations that do not accept compensation, and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association. Such guidelines shall include at minimum the following:

''(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations may not function primarily as sales agents for insurance companies.

''(2) Organizations and associations shall provide objective information regarding long-term care insurance policies sold or endorsed by such organiza-

tions and associations to ensure that members of such organizations and associations have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

''(3) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the manner in which such policies and the insurance company issuing such policies were selected. If the organization or association and the insurance company have interlocking directorates, the organization or association shall disclose such fact to their members.

''(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or association receives) from the endorsement or sale of the policy to its members.

''(5) The Boards of Directors of organizations and associations selling or endorsing long-term care

insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.

''PART D—MISCELLANEOUS PROVISIONS

"SEC. 2231. DEFINITIONS.

''As used in this title:

''(1) AGENT.—The term 'agent' means—

''(A) prior to 2 years after the date of enactment of this Act, an individual who sells or offers for sale a long-term care insurance policy subject to the requirements of this title and is licensed or required to be licensed under State law for such purpose; and

''(B) after the date referred to in subparagraph (A), an individual who meets the training and certification requirements established under section 2212(f).

''(2) ASSOCIATION.—The term 'association' includes the association and its subsidiaries.

''(3) CARRIER.—The term 'carrier' means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical

service plan, a health maintenance organization, a self-insured carrier, a reinsurance carrier, and a multiple employer welfare arrangement (a combination of employers associated for the purpose of providing health benefit plan coverage for their employees).''.

Subtitle B—Tax Treatment of Long-Term Care Insurance

SEC. 8101. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Subpart E of part I of subchapter L of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 818 the following new section:

"**SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.**

''(a) GENERAL RULE.—For purposes of this part, a long-term care insurance contract shall be treated as an accident or health insurance contract.

''(b) LONG-TERM CARE INSURANCE CONTRACT.—

''(1) IN GENERAL.—For purposes of this part, the term 'long-term care insurance contract' means any insurance contract issued if—

''(A) the only insurance protection provided under such contract is coverage of quali-

fied long-term care services and benefits incidental to such coverage,

''(B) the maximum benefit under the policy for expenses incurred for any day does not exceed $200,

''(C) such contract does not cover expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(D) such contract is guaranteed renewable,

''(E) such contract does not have any cash surrender value, and

''(F) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

''(2) SPECIAL RULES.—

''(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be treated as described in paragraph (1)(A) by reason of payments being made on a per diem or other

periodic basis without regard to the expenses incurred during the period to which the payments relate.

''(B) CONTRACT MAY COVER MEDICARE REIMBURSABLE EXPENSES WHERE MEDICARE IS SECONDARY PAYOR.—Paragraph (1)(C) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

''(C) REFUNDS OF PREMIUMS.—Paragraph (1)(F) shall not apply to any refund of premiums on surrender or cancellation of the contract.

''(3) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage provided by rider on a life insurance contract—

''(A) IN GENERAL.—This subsection shall be applied as if the portion of the contract providing such coverage were a separate contract.

''(B) PREMIUMS AND CHARGES FOR LONG-TERM CARE COVERAGE.—Premium payments for coverage under a long-term care insurance

contract and charges against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage shall be treated as premiums for purposes of paragraph (1)(F).

''(C) APPLICATION OF SECTION 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date, by the excess of—

''(i) the sum of any charges (but not premium payments) described in subparagraph (B) made on or before such date under the contract, over

''(ii) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(D) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in subparagraph (B), unless such charges are includible in income as a result of the application of section

72(e)(10) and the coverage provided by the rider is a long-term care insurance contract under subsection (b)(1).

''(E) AMOUNT OF DISTRIBUTION UNDER RIDER.—This paragraph shall not apply to any rider on a life insurance contract unless the percentage reduction in the cash surrender value of the contract by reason of any payment under the rider does not exceed the percentage reduction in the death benefit payable under the contract by reason of the payment.

For purposes of this paragraph, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a long-term care insurance contract, except that the coverage under a rider described in this paragraph shall not fail to be treated as such an addition by reason of a reduction in the contract's death benefit or cash surrender value resulting from any payment under the rider.

''(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, pre-

ventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which—

''(A) are required by a chronically ill individual in a qualified facility, and

''(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

''(i)(I) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in subparagraph (B)) for a period of at least 90 days due to a loss of functional capacity, or

''(II) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subclause (I), or

''(ii) having a similar level of disability due to cognitive impairment.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) MOBILITY.—The process of walking or wheeling on a level surface which may include the use of an assistive device such as a cane, walker, wheelchair, or brace.

''(ii) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

''(iii) TOILETING.—The act of going to the toilet room for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes or the ability to voluntarily control bowel and bladder function, or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

''(iv) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

''(v) EATING.—The process of getting food from a plate or its equivalent into the mouth.

''(3) QUALIFIED FACILITY.—The term 'qualified facility' means—

''(A) a nursing, rehabilitative, hospice, or adult day care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility, or similar institution)—

''(i) which is licensed under State law, or

''(ii) which is a certified facility for purposes of title XVIII or XIX of the Social Security Act, or

''(B) an individual's home if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a facility described in subparagraph (A).

''(4) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is to provide needed assistance with any of the activities of daily living described in paragraph (2)(B).

''(5) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r) of the Social Security Act) and any reg-

istered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

''(d) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—This section shall not apply in determining whether section 4980B (relating to failure to satisfy continuation coverage requirements of group health plans) applies.

''(e) INFLATION ADJUSTMENT OF $200 BENEFIT LIMIT.—

''(1) IN GENERAL.—In the case of a calendar year after 1994, the $200 amount contained in subsection (b)(1)(B) shall be increased for such calendar year by the medical care cost adjustment for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(A) the medical care component of the Consumer Price Index (as defined in section

1(f)(5)) for August of the preceding calendar year, exceeds

''(B) such component for August of 1993.''

(b) RESERVES.—Clause (iii) of section 807(d)(3)(A) of such Code is amended by inserting ''(other than a long-term care insurance contract within the meaning of section 818A)'' after ''contract''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart E of part I of subchapter L of chapter 1 of such Code is amended by inserting after the item relating to section 818 the following new item:

''Sec. 818A. Treatment of long-term care insurance or plans.''

SEC. 8102. EXCLUSION FOR BENEFITS PROVIDED UNDER LONG-TERM CARE INSURANCE AND FOR CERTAIN EMPLOYER-PROVIDED COVERAGE.

(a) IN GENERAL.—Subsection (a) of section 104 of the Internal Revenue Code of 1986 (relating to compensation for injuries or sickness) is amended by striking ''and'' at the end of paragraph (4), by striking the period at the end of paragraph (5) and inserting '', and'', and by inserting after paragraph (5) the following new paragraph:

''(6) benefits under a long-term care insurance contract (as defined in section 818A(b)).''

(b) EMPLOYER-PROVIDED COVERAGE.—Section 106 of such Code (relating to contributions by employer to accident and health plans), as amended by section 2003, is

amended by adding at the end the following new subsection:

''(c) TREATMENT OF LONG-TERM CARE INSURANCE CONTRACTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a long-term care insurance contract (as defined in section 818A(b)) shall be treated as a health plan for purposes of subsection (a).

''(2) EXCEPTION FOR CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—Paragraph (1) shall not apply to coverage under a long-term care insurance contract (as so defined) which is provided through a cafeteria plan (as defined in section 125(c)) or flexible spending or similar arrangement.''.

SEC. 8103. QUALIFIED LONG-TERM SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 818A(c)), or''.

(b) DEDUCTION FOR LONG-TERM CARE EXPENSES FOR PARENT OR GRANDPARENT.—Section 213 of such Code (relating to deduction for medical expenses) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE EXPENSES.—For purposes of subsection (a), the term 'dependent' shall include any parent or grandparent of the taxpayer for whom the taxpayer has expenses for long-term care services described in section 818A(c), but only to the extent of such expenses.''

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) of such Code (as redesignated by subsection (a)) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(2)(A) Paragraph (1) of section 213(d) of such Code is amended by adding at the end thereof the following new flush sentence:

''In the case of a long-term care insurance contract (as defined in section 818A), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).''

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

''(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

''(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any long-term care insurance contract (as defined in section 818A) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

"In the case of an individual with an attained age before the close of the taxable year of:	**The limitation is:**
40 or less	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	1,600
More than 70	2,000.

''(B) INDEXING.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, each dollar amount contained in paragraph (1) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(II) such component for August of 1991.''

(3) Paragraph (6) of section 213(d) of such Code is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(4) Paragraph (7) of section 213(d) of such Code is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

SEC. 8104. EXCLUSION FROM GROSS INCOME FOR AMOUNTS OTHERWISE INCLUDIBLE ON THE SURRENDER OR CANCELLATION OF ANY LIFE INSURANCE POLICY WHICH ARE USED FOR LONG-TERM CARE INSURANCE PREMIUMS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

"SEC. 137. AMOUNTS RECEIVED ON CANCELLATION, ETC., OF LIFE INSURANCE CONTRACTS AND USED TO PAY PREMIUMS FOR QUALIFIED LONG-TERM CARE INSURANCE.

''No amount which would (but for this section) be includible in the gross income of an individual shall be included in gross income on the whole or partial surrender, cancellation, or exchange of any life insurance contract during the taxable year if—

''(1) such individual has attained age 65 on or before the date of the transaction, and

''(2) the amount otherwise includible in gross income is used during such year to pay premiums for any qualified long-term care insurance policy (as defined in section 2721(a) of the Public Health Service Act) for the benefit of such individual or the

spouse of such individual if such spouse has attained age 65 on or before the date of the transaction.''.

(b) CLERICAL AMENDMENT.—The table of sections for such part III is amended by striking the last item and inserting the following new items:

''Sec. 137. Amounts received on cancellation, etc., of life insurance contracts and used to pay premiums for qualified long-term care insurance.
''Sec. 138. Cross references to other Acts.''.

SEC. 8105. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply to taxable years beginning after December 31, 1995.

(b) TRANSITION RULE.—If, after the date of enactment of this Act and before January 1, 1996, a contract providing for long-term care insurance coverage is exchanged solely for a long-term care insurance contract, no gain or loss shall be recognized on the exchange. If, in addition to a long-term care insurance contract, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this subsection, the cancellation of a contract providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a long-term care insurance contract within 60 days thereafter shall be treated as an exchange. For purposes of this subsection,

the term ''long-term care insurance contract'' has the meaning given to such term by section 818A(b) of the Internal Revenue Code of 1986.

(c) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract, the issuance of a rider on a life insurance contract providing long-term care insurance coverage shall not be treated as a modification or material change of such contract.

Subtitle C—Studies

SEC. 8201. FEASIBILITY OF ENCOURAGING HEALTH CARE PROVIDERS TO DONATE SERVICES TO HOMEBOUND PATIENTS.

The Comptroller General of the United States shall conduct a study on the feasibility of encouraging health care providers to donate their services to homebound patients. Such study shall include an examination of the effects of qualifying such services as a charitable contribution.

SEC. 8202. FEASIBILITY OF TAX CREDIT FOR HEADS OF HOUSEHOLDS WHO CARE FOR ELDERLY FAMILY MEMBERS IN THEIR HOMES.

The Comptroller General of the United States shall conduct a study on the feasibility of providing heads of

households who care for elderly family members in their homes with a tax credit. Such study shall estimate the cost of such a tax credit which would apply to expenses incurred in the custodial care of such an elderly family member to the extent such expenses exceed 5 percent of adjusted gross income.

SEC. 8203. CASE MANAGEMENT OF CURRENT LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the feasibility of encouraging or requiring the use of a single designated public or nonprofit agency (such as an area agency on aging) to coordinate, through case management, the provision of long-term care benefits under current Federal, State, and local programs in a geographic area.

(b) REPORT.—The Secretary shall submit to Congress a report on the study conducted under subsection (a) by not later than 1 year after the date of the enactment of this Act. Such report shall include such recommendations regarding changes in legislation to encourage or require the use (described in subsection (a)) of an agency to coordinate long-term care benefits as may be appropriate.

SEC. 8204. SUBACUTE CARE STUDY.

(a) STUDY.—The Secretary of Health and Human Services shall—

(1) define the level and type of care that should constitute subacute care;

(2) determine the appropriateness of furnishing subacute care in different settings by evaluating the quality of care and patient outcomes;

(3) determine the cost and effectiveness of providing subacute care under the medicare program under title XVIII of the Social Security Act to individuals who are eligible for benefits under part A of such title;

(4) determine the extent to which hospital DRG prospective payment rates under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) are appropriate for the less restrictive institutional settings that provide subacute care; and

(5) study the relationships between institutions and their payment methodologies in order to develop ways in which to maximize the continuity of care for each patient episode in which subacute care is furnished.

(b) REPORT.—Not later than October 1, 1996, the Secretary shall submit to the Congress a report on the matters described in subsection (a).

SEC. 8205. STUDY OF LONG-TERM CARE INSURANCE.

(a) REPORT.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall report to Congress on alternatives for extending access to long-term care through the private insurance market. The Secretary shall specifically study the cost of current policies, their effectiveness in providing care and their availability to the general population.

(b) RECOMMENDATIONS.—The Secretary shall recommend any changes in Federal law which may be necessary to increase access to long-term care for all Americans through the private insurance market. In conducting this study, the Secretary shall consult with the National Association of Insurance Commissioners and other private entities with expertise in private health insurance and long-term care.

TITLE IX—DEPARTMENT OF VETERANS AFFAIRS

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SEC. 9001. BENEFITS AND ELIGIBILITY THROUGH DEPARTMENT OF VETERANS AFFAIRS MEDICAL SYSTEM.

(a) DVA AS A PARTICIPANT IN HEALTH CARE REFORM.—

(1) IN GENERAL.—Title 38, United States Code, is amended by inserting after chapter 17 the following new chapter:

"CHAPTER 18—ELIGIBILITY AND BENEFITS UNDER ENROLLMENT-BASED SYSTEM

''SUBCHAPTER I—GENERAL

''1801. Definitions.

''SUBCHAPTER II—ENROLLMENT

''1811. Enrollment: veterans.
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''SUBCHAPTER I—GENERAL

"§ 1801. Definitions

''For purposes of this chapter:

''(1) The term 'qualified health coverage' has the meaning given such term in section 1101 of the Bipartisan Health Care Reform Act of 1994.

''(2) The term 'VA health coverage' means qualified health coverage provided by the Secretary under section 7341 of this title.

''(3) The term 'VA enrollee' means an individual enrolled under subchapter II of this chapter with VA health coverage.

''(4) The term 'standard coverage' has the meaning given such term in section 1102 of the Bipartisan Health Care Reform Act of 1994.

''SUBCHAPTER II—ENROLLMENT

''§ 1811. Enrollment: veterans

''Subject to section 1814, each veteran residing in the United States may enroll to obtain VA health coverage. A veteran who wants to receive the standard coverage through the Department shall enroll to obtain VA health coverage.

''§ 1812. Enrollment: CHAMPVA eligibles

''(a) ELIGIBILITY.—Subject to section 1814, an individual described in subsection (b) who resides in the United States may enroll to obtain VA health coverage.

''(b) APPLICABILITY.—This section applies to the following individuals who are not otherwise eligible for medical care under chapter 55 of title 10 (CHAMPUS):

''(1) The surviving spouse or child of a veteran who (A) died as a result of a service-connected dis-

ability, or (B) at the time of death had a total disability permanent in nature, resulting from a service-connected disability.

''(2) The surviving spouse or child of a person who died in the active military, naval, or air service in the line of duty and not due to such person's own misconduct.

''(c) DEFINITION OF CHILD.—For purposes of this section, the term 'child' includes a child described in section 1901(2)(B) of the Bipartisan Health Care Reform Act of 1994.

"§ 1813. Enrollment: family members

''(a) ELIGIBILITY.—Subject to section 1814, members of the family of an enrollee under section 1811 or 1812 of this title may enroll to obtain VA health coverage. The enrollee shall have the option of enrolling to obtain VA health coverage as an individual or with family members. If the enrollee chooses to enroll to obtain VA health coverage with family members, all such family members must be so enrolled.

''(b) REQUIRED PAYMENTS.—Any family member with VA health coverage shall (except as provided in section 1831(c)(2)(B) of this title) be subject to payment of premiums, deductibles, copayments, and coinsurance in

accordance with the Bipartisan Health Care Reform Act of 1994.

''(c) ENROLLMENT ELIGIBILITY TO SURVIVE DEATH OF VETERAN.—An individual with VA health coverage pursuant to subsection (a) as a member of the family of a veteran enrolled under section 1811 of this title shall not lose eligibility to obtain such coverage by reason of the death of that veteran.

''(d) MEMBERS OF FAMILY.—For purposes of this section, the members of the family of an enrollee are those individuals (other than the enrollee) included as family members under section 1901(2) of the Bipartisan Health Care Reform Act of 1994.

"§ 1814. Enrollment ceilings

''(a) The Secretary shall limit the number of individuals eligible to enroll for VA health coverage by establishing and applying enrollment ceilings in accordance with this section.

''(b) The Secretary shall establish separate enrollment ceilings under subsection (a) applicable to individuals described in subsections (b), (c)(1), and (c)(2), respectively, of section 1831 of this title. The Secretary shall set such enrollment ceilings for each applicable enrollment period at levels that, when multiplied by an estimate (based on prior Department experience) of the cost to the

Secretary of providing the items and services in standard coverage under the Bipartisan Health Care Reform Act of 1994, would (1) result in a total cost that can be accommodated within the appropriation available for this purpose in each fiscal year, and (2) avoid any need for the Secretary to take actions described in section 1821(b) of this title.

''(c) In establishing and managing enrollment ceilings under this section applicable to individuals described in section 1831(b), the Secretary shall establish and implement priorities for enrollment consistent with priorities in chapter 17 of this title in effect on the day preceding the date of the enactment of the Bipartisan Health Care Reform Act of 1994.

''SUBCHAPTER III—BENEFITS

"§ 1821. Benefits for VA enrollees

''(a) To the extent that such items and services can be provided consistent with appropriations for that purpose, the Secretary shall ensure that each individual enrolled with VA health coverage is provided the items and services in standard coverage under the Bipartisan Health Care Reform Act of 1994 which the Secretary determines are clinically necessary for such individual.

''(b) In the event that the Secretary determines at any time during a fiscal year that appropriations are in-

sufficient to provide individuals enrolled with VA health coverage all needed items and services in standard coverage under the Bipartisan Health Care Reform Act of 1994, the Secretary shall take appropriate action to limit expenditures to the amount appropriated. Such actions may include revising the scope of coverage described in subsection (a). At least 15 days before taking an action under this subsection, the Secretary shall submit to the Committees on Veterans Affairs of the House of Representatives and the Senate a report describing such proposed action and the circumstances requiring the Secretary to take such proposed action.

"§ 1822. Chapter 17 benefits

''(a) CARE AND SERVICES NOT INCLUDED IN STANDARD COVERAGE.—In the case of care and services that may be provided under chapter 17 of this title that are not included in standard coverage, the Secretary shall provide to any veteran (whether or not enrolled with qualified health coverage) the care and services authorized under that chapter in accordance with the terms and conditions applicable to that veteran and that care under that chapter.

''(b) VETERANS WHO ARE NOT ELIGIBLE TO ENROLL UNDER THE BIPARTISAN HEALTH CARE REFORM ACT OF 1994.—In the case of a veteran who is not eligible

for enrollment under this chapter, the Secretary shall provide to the veteran the care and services that may be provided under chapter 17 of this title through any facility of the department, whether or not the facility is operating pursuant to VA health coverage.

''(c) PRESERVATION OF SPECIALIZED DVA TREATMENT CAPACITIES.—In carrying out subsection (a), the Secretary shall ensure that the Department maintains the capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that affords those veterans reasonable access to care and services for those specialized needs. The Secretary shall ensure that overall capacity of the Department to provide such specialized services is not reduced below the capacity of the Department, nationwide, to provide those services, as of the date of the enactment of this chapter. Nothing in this subsection precludes the Secretary from expanding the number or type of facilities or programs that provide treatment and rehabilitation services for the specialized needs of such veterans, including provision of specialized services on an outpatient basis.

''(d) ANNUAL REPORT.—Not later than March 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing the actions the Secretary has taken to carry out subsection (c) during the preceding fiscal year. Each such report shall include a statement of the number of veterans to whom the Department provided specialized services that are covered by the report and the expense of providing those services, and a description of the alternatives available in the private sector for the provision of those services to veterans.

"§ 1823. Supplemental benefits packages and policies

''Subject to section 1814, VA health coverage may include supplemental health benefits packages and supplemental cost sharing policies consistent with the Bipartisan Health Care Reform Act of 1994. However, such coverage may not include a supplemental health benefits package to a veteran that provides coverage for services that the Department is required to provide to that veteran under chapter 17 of this title.

"§ 1824. Limitation regarding veterans who elect not to enroll to obtain VA health coverage

''(a) REIMBURSEMENT REQUIRED.—A veteran who is residing in an area in which the Department offers VA health coverage and who elects not to enroll to obtain such

coverage may be provided the items and services in standard coverage through VA health coverage offered in that area only if (except as provided in subsection (b)) the Secretary is reimbursed for the cost of the care provided.

''(b) EXCEPTION.—The Secretary may not impose on or collect from a veteran described in subsection (a) a cost-share charge of any kind in the case of treatment for a service-connected disability that (as determined by the Secretary) requires a specialized treatment capacity for which the Department has particular expertise.

''§ 1825. Limitation on use of funds for abortions

''None of the funds appropriated to carry out this title shall be expended for any abortion except when it is made known to the Secretary that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

''SUBCHAPTER IV—FINANCIAL MATTERS

''§ 1831. Premiums, copayments, etc.

''(a) EXEMPTION OF CERTAIN VETERANS.—Subject to subsection (f), in the case of a veteran described in subsection (b) who is a VA enrollee, there may not be imposed or collected from the veteran a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge) for items and services in

standard coverage that are provided to the veteran by the Secretary within a VA plan provider network.

''(b) VETERANS EXEMPT FROM CHARGES.—The veterans referred to in subsection (a) are the following:

''(1) Any veteran with a service-connected disability rated at 10 percent or greater.

''(2) Any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty.

''(3) Any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section.

''(4) Any veteran who is a former prisoner of war.

''(5) Any veteran of the Mexican border period or World War I.

''(6) Any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

''(c) OTHER ENROLLEES.—(1) In the case of a VA enrollee who is not described in subsection (b), the Secretary shall (except as provided in paragraph (2)) charge premiums and shall establish copayments, deductibles, and coinsurance amounts.

''(2) The Secretary may not collect from an enrollee a premium in the case of—

''(A) an individual with VA health coverage by reason of eligibility under section 1812 of this title; or

''(B) an individual with VA health coverage by reason of eligibility under section 1813 of this title and who is described in paragraph (1) of section 1713(a) of this title.

''(3) The Secretary may not charge a copayment, deductible, or other coinsurance amount in the case of care for any disease covered under section 1710(e)(1) of this title.

''(d) ESTABLISHMENT OF RATES.—The premium rate, and the rates for deductibles and copayments, applicable under VA health coverage shall be established by the Secretary based on rules applicable to all health coverage offered in the geographic area in which such VA health coverage is offered.

''(e) DUTIES OF EMPLOYERS.—The obligations (including obligations with respect to payment of premiums) under the Bipartisan Health Care Reform Act of 1994 of an employer with respect to employees with VA health coverage, and with respect to such coverage, shall be the same as those that apply with respect to other employees and other health coverage.

''(f) ACCEPTANCE OF PREMIUM CERTIFICATES.—In the case of a veteran who has been issued a premium certificate or voucher under the Bipartisan Health Care Reform Act of 1994, the Secretary may require the veteran to tender the certificate to the Secretary as a condition of enrollment and the Secretary may accept the certificate.

"§ 1832. Recovery of cost of certain care and services

''(a) RECOVERY FROM THIRD PARTIES.—In the case of an individual provided care or services through VA health coverage who has coverage under any supplemental health insurance policy, including a Medicare supplemental health insurance plan, the Secretary has the right to recover or collect charges for care or services (as determined by the Secretary, but not including care or services for a service-connected disability) from the party providing that coverage to the extent that the individual (or the provider of the care or services) would be eligible to receive payment for such care or services from such party if the

care or services had not been furnished by a department or agency of the United States.

''(b) PROCEDURES.—The provisions of subsections (b) through (f) of section 1729 of this title shall apply with respect to claims by the United States under subsection (a) in the same manner as they apply to claims under subsection (a) of that section.

"§ 1833. Health Coverage Fund

''(a) ESTABLISHMENT OF FUND.—There is hereby established in the Treasury a revolving fund to be known as the 'Department of Veterans Affairs Health Coverage Fund'.

''(b) CREDITING OF AMOUNTS TO FUND.—There shall be credited to the revolving fund any amount received by the Department by reason of the furnishing of health care under VA health coverage and any amount received by the Department by reason of the enrollment of an individual with VA health coverage (including amounts received as premiums, premium certificates or vouchers, copayments or coinsurance, and deductibles), any amount received as a third-party reimbursement, and any amount received as a reimbursement from other health coverage for care furnished to one of its enrollees.

''(c) CREDITING TO TREASURY.—Any amounts deposited to the revolving fund that are attributable to

amounts received by the Department as a premium, including a premium certificate or voucher, by reason of the enrollment with VA health coverage of a veteran described in section 1831(b) of this title shall be covered into the General Fund of the Treasury.

''(d) AMOUNTS NOT PERMITTED TO BE RETAINED.—Notwithstanding subsection (b), the Department may not retain amounts received for care furnished to a VA enrollee in a case in which the costs of such care have been covered by appropriations. Such amounts shall be deposited in the General Fund of the Treasury.

''(e) AVAILABILITY OF FUNDS.—Amounts in the revolving fund are hereby made available for all expenses, both direct and indirect, related to the delivery through VA health coverage of the items and services in standard coverage and any supplemental benefits package or policy offered through such coverage.''.

(b) PRESERVATION OF EXISTING BENEFITS FOR FACILITIES NOT OFFERING SERVICES THROUGH QUALIFIED HEALTH COVERAGE.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1704 the following new section:

''§ 1705. Facilities not offering qualified health coverage; veterans not eligible to enroll to obtain coverage

''The provisions of this chapter shall apply with respect to the furnishing of care and services—

''(1) by any facility of the Department that (A) is not offering qualified health coverage under the Bipartisan Health Care Reform Act of 1994, and (B) is not located in a State (or portion of a State) that is a single payer area; and

''(2) by any facility of the Department (whether or not offering qualified health coverage under the Bipartisan Health Care Reform Act of 1994) in the case of a veteran who is not eligible for enrollment under chapter 18 of this title.''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1704 the following new item:

''1705. Facilities not offering qualified health coverage; veterans not eligible to enroll to obtain coverage.''.

SEC. 9002. ORGANIZATION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES AS FACILITIES OFFERING QUALIFIED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 73 of title 38, United States Code, is amended—

(1) by redesignating subchapter IV as subchapter V; and

(2) by inserting after subchapter III the following new subchapter:

''SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

''§ 7341. Organization of health care facilities as facilities offering qualified health coverage

''(a) Except as provided in section 7342 of this title, the Secretary may, subject to the availability of appropriations, organize Department plans and facilities as entities and facilities offering qualified health coverage under the Bipartisan Health Care Reform Act of 1994 subject to adjustment under subsection (g). The Secretary shall prescribe regulations establishing standards for the operation of Department health care facilities as facilities offering qualified health coverage under the Bipartisan Health Care Reform Act of 1994. In prescribing those standards, the Secretary shall assure that they conform, to the maximum extent practicable, to the requirements for qualified health coverage generally set forth in the Bipartisan Health Care Reform Act of 1994.

''(b) Within a geographic area or region, health care facilities of the Department located within that area or region may be organized to operate as a single entity offer-

ing qualified health coverage encompassing all Department facilities within that area or region or may be organized to operate as several entities offering qualified health coverage.

''(c) A health plan purchasing organization operating within one or more fair rating areas shall offer as an option to eligible individuals enrollment to obtain VA health coverage that is offered in such area.

''(d) Any health insurance program that is provided for Federal employees shall include enrollment to obtain VA health coverage as enrollment options for eligible individuals. Premiums shall be paid for VA health coverage under any such insurance program based upon enrollment with that program in the same manner as to any other health coverage.

''(e)(1) In establishing and operating standard health coverage, the Secretary, in consultation with the Comptroller General, shall take appropriate steps to ensure the financial solvency and stability of the VA health coverage and of contractors and subcontractors providing services pursuant to section 7343 of this title.

''(2) In carrying out paragraph (1), the Secretary may purchase from commercial sources insurance to insure the Department against the financial risks involved in the offering of VA health coverage.

''(3) Notwithstanding any other provision of law, there shall be no requirements applicable to the offering of VA health coverage with respect to the maintenance of a reserve fund, requirements to reinsure, or payments into any other financial integrity fund other than as established pursuant to paragraph (1).

''(f) In carrying out responsibilities under the Bipartisan Health Care Reform Act of 1994, a State (or a State-established entity)—

''(1) may not impose any standard or requirement on VA health coverage that is inconsistent with this section or any regulation prescribed under this section or other Federal laws regarding the operation of this section; and

''(2) may not deny certification of VA health coverage under the Bipartisan Health Care Reform Act of 1994 on the basis of a conflict between a rule of a State (or State-established entity) and this section or regulations prescribed under this section or other Federal laws regarding the operation of this section.

''(g) Notwithstanding any provision of the Bipartisan Health Care Reform Act of 1994 or this subchapter, any reference in this subchapter to 'qualified health coverage' under such Act shall, subject to section 1821(b) of this

title, be considered a reference to coverage of a standardized package of benefits established by the Secretary with an actuarial value not less than the actuarial value of qualified health coverage under such Act.

"§ 7342. Operation of health care facilities within States operating as single payer areas

''(a) In a State (or portion of a State) that operates as a single payer system, Department health care facilities in that State (or portion of a State) shall serve as providers to individuals residing in that State (or portion of a State) who would be eligible to enroll under chapter 18 of this title to obtain VA health coverage if they were residing in an area where qualified health coverage was offered under the Bipartisan Health Care Reform Act of 1994. Such facilities may provide those individuals any covered service in standard coverage.

''(b) A Department facility providing care to residents of a single payer area pursuant to subsection (a) shall be reimbursed for that care on the same basis as any other provider furnishing the same services in that area.

''(c) A veteran described in section 1831(b) of this title shall be exempt from any otherwise applicable charges for such care. Any other individual provided care pursuant to subsection (a) shall be subject to all applicable require-

ments respecting copayments, deductibles, and coinsurance. Notwithstanding the preceding sentence, section 1831(c)(3) of this title shall apply to any such charge.

"§ 7343. Health care resource agreements

''(a)(1) In accordance with policies established under subsection (b), an official specified in paragraph (2) may, without regard to any law or regulation specified in paragraph (3), enter into agreements with health care plans, with insurers, and with health care providers, and with any other entity or individual, to furnish or obtain any health-care resource.

''(2) An official specified in this paragraph is any of the following:

''(A) The head official offering VA health coverage.

''(B) The director of a Department health care facility that is providing service through VA health coverage.

''(C) The director of a Department health care facility that is operating in a State (or portion of a State) that is operating under a single payer system.

''(3) A law or regulation specified in this paragraph is any of the following:

''(A) Section 1703 of this title.

''(B) Any other law or regulation pertaining to—

''(i) competitive procedures;

''(ii) acquisition procedures or policies (other than contract dispute settlement procedures); or

''(iii) bid protests.

''(4) For purposes of this subsection, the term 'health-care resource' has the meaning given that term in section 8152 of this title.

''(b) Policies established by the Secretary under subsection (a) shall include appropriate provisions to ensure that procurements under that subsection are carried out in a manner consistent with (1) Federal acquisition policies regarding nondiscrimination, equal opportunity, business integrity, and safeguarding against fraud and abuse, and (2) the goal of a streamlined process for the acquisition of health-care resources.

''(c) Any proceeds to the Government received from an agreement under subsection (a) shall be credited to the Department of Veterans Affairs Health Coverage Fund established under section 1834 of this title and to funds that have been allotted to the facility that furnished the resource involved.

"§ 7344. Administrative and personnel flexibility

''(a) In order to carry out this subchapter, the Secretary may—

''(1) subject to section 1822(c) of this title, carry out administrative reorganizations of the Department without regard to those provisions of section 510 of this title following subsection (a) of that section; and

''(2) when the Secretary finds it is cost-effective or necessary in order to provide health care services in a timely manner—

''(A) enter into contracts for procurement of any commercially available item at a cost of under $100,000 without regard to any provision of law or regulation (i) requiring competitive procedures; (ii) mandating or giving priority to any source of supply; or (iii) pertaining to protests; and

''(B) enter into contracts without regard to section 8110(c) of this title for the performance of services previously performed by employees of the Department.

''(b)(1) The Secretary may establish alternative personnel systems or procedures for personnel at facilities offering qualified health coverage under this title, or for personnel at facilities operating in a State (or portion of a

State) that is operating under a single payer system, whenever the Secretary considers such action necessary, except that the Secretary shall provide for preference eligibles (as defined in section 2108 of title 5) in a manner comparable to the preference for such eligibles under subchapter I of chapter 33, and subchapter I of chapter 35, of such title.

''(2) In establishing alternative personnel systems or procedures under this subsection, the Secretary shall include the following:

''(A) A system that ensures that applicants for employment and employees are appointed, promoted, and assigned on the basis of merit and fitness.

''(B) An equal employment opportunity program.

''(C) Compensation systems which will be used to set rates of pay that are competitive with rates of pay paid by health-care providers other than the Department and that take into consideration the difficulty, responsibility, and qualification requirements of the work performed.

''(D) A formal performance appraisal system.

''(E) A system to address unacceptable conduct and performance by employees, including a general statement of violations, sanctions, and procedures

which shall be made known to all employees, and a dispute resolution procedure.

''(F) A formal policy regarding the accrual and use of sick leave and annual leave.

''(c) The Secretary may carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department offering qualified health coverage.

"§ 7345. Veterans Health Care Transition Fund

''(a) For each of fiscal years 1995 and 1996, the Secretary of the Treasury shall credit to a special fund (in this section referred to as the 'Fund') of the Treasury an amount equal to—

''(1) $1,200,000,000 for fiscal year 1995; and

''(2) $800,000,000 for fiscal year 1996.

''(b) Amounts in the Fund shall be available to the Secretary only for VA health coverage authorized under this chapter. Such amounts are available without fiscal year limitation for costs of commencing the offering of VA health coverage, including consulting services, equipment, marketing, and other costs, minor construction, and (subject to section 8104 of this title) major construction.

''(c) The Secretary shall submit to Congress, no later than March 1, 1996, a report concerning the operation of the Department of Veterans Affairs health care system

in preparing for, and operating under, national health care reform under the Bipartisan Health Care Reform Act of 1994 during fiscal years 1995 and 1996. The report shall include a discussion of—

''(1) the adequacy of amounts in the Fund for the offering of VA health coverage;

''(2) the quality of care provided by the Department; and

''(3) the ability of the Department to attract patients.

''§ 7346. Funding provisions: grants and other sources of assistance

''The Secretary may apply for and accept, if awarded, any grant or other source of funding that is intended to meet the needs of special populations and that but for this section is unavailable to facilities of the Department or to qualified health coverage offered by the Government if funds obtained through the grant or other source of funding will be used through a facility of the Department offering qualified health coverage.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by striking out the item relating to the heading for subchapter IV and inserting in lieu thereof the following:

''SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

''7341. Organization of health care facilities as facilities offering qualified health coverage
''7342. Operation of health care facilities within States operating as single payer areas.
''7343. Health care resource agreements.
''7344. Administrative and personnel flexibility.
''7345. Veterans Health Coverage Transition Fund.
''7346. Funding provisions: grants and other sources of assistance.

''SUBCHAPTER V—RESEARCH CORPORATIONS''.

SEC. 9003. ELIGIBILITY FOR CHAPTER 17 CARE.

(a) NURSING HOME CARE.—Section 1710(a)(1) of title 38, United States Code, is amended by inserting ''(or, in the case of a veteran described in subparagraph (A) or (D) below, shall furnish nursing home care)'' after ''may furnish nursing home care''.

(b) OUTPATIENT CARE FOR ENROLLED VETERANS.—Paragraph (1) of section 1712(a) of such title is amended—

(1) by striking out ''and'' at the end of subparagraph (C);

(2) by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon; and

(3) by adding at the end the following:

''(E) to any veteran described in section 1831(b) of this title who is enrolled under section 1811 of this title and the Bipartisan Health Care Reform Act of 1994 with VA health coverage (as de-

fined in section 1801 of this title), for any disability to the extent that care and treatment of that disability is not included within standard coverage (as defined in section 1801 of this title);''.

(c) OBVIATE-THE-NEED OUTPATIENT CARE.—(1) Paragraph (2) of such section is amended by striking out ''The Secretary'' and all that follows through ''this subsection—'' and inserting in lieu thereof ''Except as provided in subsection (b) of this section, the Secretary shall furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed—''.

(2) Paragraph (4) of such section is amended by striking out ''medical services for a purpose described in paragraph (5) of this subsection'' and inserting in lieu thereof '', to the extent that facilities are available, such medical services as the Secretary determines are needed''.

(3) Such section is further amended—

(A) by striking out paragraph (5); and

(B) by redesignating paragraphs (6) and (7) as paragraphs (5) and (6), respectively.

(d) CONFORMING AMENDMENTS.—(1) Section 1701(6)(A)(i) of such title is amended by striking out ''(except under the conditions described in section 1712(a)(5)(A) of this title)''.

(2) Section 1701(6)(B)(i)(II) of such title is amended by striking ''section 1712(a)(5)(B)'' and inserting in lieu thereof ''section 1712''.

(3) Section 1703(a)(2)(B) of such title is amended by striking out ''for a purpose described in section 1712(a)(5)(B) of this title'' and inserting in lieu thereof ''to complete treatment incident to hospital, nursing home, or domiciliary care that has been provided by the Department''.

(4) Section 1712A(b)(1) of such title is amended by striking out ''section 1712(a)(5)(B)'' and inserting in lieu thereof ''section 1703(a)(2)(B)''.

SEC. 9004. AUTHORITY TO PROVIDE HEALTH CARE FOR HERBICIDE AND RADIATION EXPOSURE.

(a) AUTHORIZED INPATIENT CARE.—Section 1710(e) of title 38, United States Code, is amended to read as follows:

''(e)(1)(A) Subject to paragraph (4), a herbicide-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for any disease specified in subparagraph (B).

''(B) The diseases referred to in subparagraph (A) are those for which the National Academy of Sciences, in a report issued in accordance with section 2 of the Agent Orange Act of 1991, has determined—

''(i) that there is sufficient evidence to conclude that there is a positive association between occurrence of the disease in humans and exposure to a herbicide agent;

''(ii) that there is evidence which is suggestive of an association between occurrence of the disease in humans and exposure to a herbicide agent, but such evidence is limited in nature; or

''(iii) that available studies are insufficient to permit a conclusion about the presence or absence of an association between occurrence of the disease in humans and exposure to a herbicide agent.

''(2) A radiation-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for—

''(A) any disease listed in section 1112(c)(2) of this title; and

''(B) any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

''(3) Subject to paragraph (4), a veteran who the Secretary finds may have been exposed while serving on active

duty in the Southwest Asia theater of operations during the Persian Gulf War to a toxic substance or environmental hazard is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability which becomes manifest before October 1, 1996, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

''(4) Hospital and nursing home care may not be provided under or by virtue of paragraph (1) after September 30, 1996, or, in the case of a veteran described in paragraph (3), after September 30, 1998.

''(5) For purposes of this subsection and section 1712 of this title—

''(A) the term 'herbicide-exposed veteran' means a veteran (i) who served on active duty in the Republic of Vietnam during the Vietnam era, and (ii) who the Secretary finds may have been exposed during such service to a herbicide agent;

''(B) the term 'herbicide agent' has the meaning given that term in section 1116(a)(4) of this title; and

''(C) the term 'radiation-exposed veteran' has the meaning given that term in section 1112(c)(4) of this title.''.

(b) AUTHORIZED OUTPATIENT CARE.—Section 1712 of such title is amended—

(1) in subsection (a)(1) (as amended by section 9003(b)), by adding at the end the following:

''(F) during the period before October 1, 1996, to any herbicide-exposed veteran for any disease listed in section 1710(e)(1)(B) of this title; and

''(G) to any radiation-exposed veteran for any disease covered under section 1710(e)(1)(C) of this title.''; and

(2) in subsection (i)(3)—

(A) by striking out ''(A)''; and

(B) by striking out '', or (B)'' and all that follows through ''title''.

(c) SAVINGS PROVISION.—The provisions of sections 1710(e) and 1712(a) of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, shall apply with respect to hospital care, nursing home care, and medical services in the case of any veteran furnished care or services before such date of enactment on the basis of presumed exposure to a substance or radiation under the authority of those provisions.

SEC. 9005. EXTENSION OF AUTHORITY TO PROVIDE PRIORITY OUTPATIENT HEALTH CARE FOR EXPOSURE TO ENVIRONMENTAL HAZARDS.

Section 1712(a)(1)(D) of title 38, United States Code, is amended by striking out ''December 31, 1994, for any disability'' and inserting in lieu thereof ''October 1, 1998, for any disability which becomes manifest before October 1, 1996,''.

SEC. 9006. REPORT ON WAIVING COST-SHARING FOR CERTAIN MEDICAL CARE FOR DEPENDENTS OF PERSIAN GULF VETERANS WHO MAY HAVE BEEN EXPOSED TO ENVIRONMENTAL HAZARDS.

(a) REPORT.—The Secretary of Veterans Affairs shall submit to Congress a report on the desirability and the feasibility of waiving any requirement for cost-sharing in the case of medical care described in subsection (b) that is provided through VA health coverage under chapter 18 of title 38, United States Code (as added by section 9001), to an individual who is a VA enrollee enrolled under family-member eligibility under section 1813 of that chapter.

(b) PERSIAN GULF WAR ILLNESS.—Medical care referred to in subsection (a) is medical care provided to a family member of a veteran described in subparagraph (C) of section 1710(e)(1) of title 38, United States Code, for any disease or disability occurring in that family member

which the Secretary finds may be related to the service of the veteran in the Southwest Asia theater of operations during the Persian Gulf War.

(c) MATTERS TO BE CONSIDERED.—In preparing the report under subsection (a), the Secretary shall consider relevant studies, including those that have been (or that are being) conducted by the Department of Veterans Affairs, the Department of Defense, the National Institutes of Health, the National Academy of Sciences, and private health care providers.

(d) SUBMISSION OF REPORT.—The report under subsection (a) shall be submitted not later than 60 days after the date of the enactment of this Act.

SEC. 9007. STUDY OF THE EFFECT OF TELEMEDICINE ON THE DELIVERY OF VA HEALTH CARE SERVICES.

(a) IN GENERAL.—During each of fiscal years 1995 through 1997, the Secretary of Veterans Affairs shall carry out a study of the effect of telemedicine on the delivery, accessibility, and quality of health care services available to individuals who are eligible for coverage through the Department of Veterans Affairs.

(b) REPORTS.—Not later than 120 days after the date of the enactment of this Act and annually thereafter through 1998, the Secretary shall submit to the Commit-

tees on Veterans' Affairs of the Senate and House of Representatives a report, including descriptions of the telemedicine applications benefiting veterans, relating to the study conducted under subsection (a).

(c) CONSULTATION.—Each study under subsection (a) shall be carried out in consultation with the Secretary of Health and Human Services, the Secretary of Defense, the Chair of the White House Information Infrastructure Task Force, and the Director of High Performance Computing and Communications in the Executive Office of the President.

SEC. 9008. LEGISLATIVE PROPOSAL ON VA HEALTH COVERAGE FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary, in consultation with the Secretary of Veterans Affairs, shall develop and submit to Congress a proposal for legislation which provides for obtaining VA health coverage for medicare beneficiaries who are veterans.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term ''medicare beneficiary'' means an individual who is eligible for benefits under part

A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) CONTENTS OF THE PROPOSAL.—A proposal for legislation submitted under subsection (a) shall—

(1) provide for an appropriate methodology by which the Secretary shall make payment to the Secretary of Veterans Affairs for the enrollment of medicare beneficiaries;

(2) provide individuals the opportunity to remain enrolled to obtain VA health coverage without an interruption in coverage upon becoming medicare beneficiaries; and

(3) provide medicare beneficiaries who are veterans with the opportunity to enroll to obtain VA health coverage as an individual or with family members.

SEC. 9009. OUTPATIENT CLINIC PILOT PROGRAM.

(a) PILOT PROGRAM.—The Secretary of Veterans Affairs shall carry out a pilot program to reduce waiting times for patients seeking health-care services in outpatient clinics of the Department of Veterans Affairs and the traveling distance to such clinics.

(b) ADDITIONAL CLINICS.—Under the pilot program, the Secretary shall provide for the operation of approximately 20 new outpatient clinics around 2 medical centers

of the Department of Veterans Affairs. The Secretary shall select the locations for the clinics so that veterans served by one of the clinics would be within a one-hour drive of such a clinic.

(c) SERVICES.—The Secretary shall ensure that the clinics provide a wide range of services, including x-ray, laboratory, physical therapy, respiratory therapy, pharmaceutical services, and psychological services, to be available at those clinics.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, for each of fiscal years 1998 through 2004, such sums are may be necessary to carry out this section.

TITLE X—MISCELLANEOUS SAVINGS PROVISIONS

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Subtitle B—Prefunding Government Health Benefits Contributions

Sec. 10101. Requirement that certain agencies prefund government health benefits contributions for their annuitants.

Subtitle A—Automobile Insurance Coordination

SEC. 10001. DEFINITIONS.

In this subtitle—

(1) INJURED INDIVIDUAL.—The term ''injured individual'' means an individual who has a bodily injury or illness sustained in an automobile accident and who is entitled to receive automobile insurance medical services from a health plan.

(2) AUTOMOBILE INSURANCE MEDICAL SERVICES.—The term ''automobile insurance medical services'' means services and items covered by automobile insurance that are medically necessary or appropriate for treatment of bodily injuries or illnesses sustained in automobile accidents and that are within the scope of the benefits to which an injured individual is entitled under his or her health plan.

(3) AUTOMOBILE INSURANCE CARRIER.—The term ''automobile insurance carrier'' means an insurance company, employer, or fund that is liable for payment for automobile insurance medical services based either on a direct contractual obligation to an injured individual or an obligation on behalf of a person responsible for causation of an injured individual's bodily injury or illness.

(4) HEALTH PLAN.—The term ''health plan'' means a plan or organization that pays for the services of health care providers and is subject to Federal or State regulation.

SEC. 10002. PROVISION OF AUTOMOBILE INSURANCE MEDICAL SERVICES THROUGH HEALTH PLANS.

(a) IN GENERAL.—An individual enrolled in a health plan shall receive automobile insurance medical services exclusively through the provision (or arrangement for the provision) of such services by the health plan. Such services shall be subject to all quality, cost containment, and anti-fraud and abuse provisions that apply generally to medical services provided by or through health plans.

(b) ALTERNATIVE PERMITTED.—

(1) BY AGREEMENT.—Subsection (a) shall not prevent an individual and an automobile insurance carrier from agreeing that treatment for bodily injury or illness sustained in an automobile accident shall be provided other than by or through the health plan in which the individual is enrolled. Notice of any such agreement shall be filed with the injured individual's health plan. Upon receipt of such notice, the health plan shall be absolved of all responsibility for payment of any services covered by the agreement.

(2) MEDICARE AND MEDICAID.—Subsection (a) shall not prevent a State from requiring automobile insurance carrier to make direct payment to health care providers for automobile insurance medical services that are covered both by (A) medicare or medicaid, and (B) and automobile insurance contract that is required by law and provides for direct payment of medical services regardless of fault. Payment for automobile insurance medical services in such circumstances shall be made to the extent of the automobile insurance carrier's liability under the applicable contract, in accordance with fee schedules prescribed under section 10003(d), and such services shall be subject to all quality, cost containment, and anti-fraud and abuse provisions that apply generally to medical services provided by or through health plans.

SEC. 10003. PAYMENT FOR AUTOMOBILE INSURANCE MEDICAL SERVICES.

(a) PAYMENT TO HEALTH PLANS.—Each automobile insurance carrier that is liable for payment for automobile insurance medical services provided to an injured individual by a health plan shall make payment to the health plan for such services to the extent of its obligations under the applicable automobile insurance contract. Any feder-

ally funded health care plan shall have first priority, over the right of any other person, to receive payment pursuant to any obligation under an automobile insurance policy covering automobile insurance medical services.

(b) REIMBURSEMENT FOR COST SHARING.—Each automobile insurance carrier shall remain liable, to the extent of its obligations under the applicable automobile insurance contract, for reimbursement of any deductibles or coinsurance paid by an injured individual for automobile insurance medical services.

(c) LIMITATION OF LIABILITY.—Except with respect to payments to health plans as required by subsection (a) and to reimbursement of deductibles and coinsurance in accordance with subsection (b), nothing in this subtitle or any other provision of law shall require an automobile insurance carrier or any person insured by such a carrier to make any payment to a health plan, health care provider, or any other person for (1) automobile insurance medical services, or (2) other health care services or items used to treat an injury or illness sustained in an automobile accident that are not medically necessary or appropriate.

(d) USE OF FEE SCHEDULES.—

(1) IN GENERAL.—Irrespective of the type of health plan providing automobile insurance medical

services, payment by automobile insurance carriers for such services shall be made to the plan in accordance with any fee schedule or schedules established for health care services generally. Each State shall develop or approve a fee schedule applicable to payment for any automobile insurance medical services that are not covered by a generally applicable fee schedule or schedules.

(2) ALTERNATIVE PAYMENT METHODOLOGIES.—Fee schedules shall not be required in any case in which an automobile insurance carrier and a health plan have agreed on an alternative payment arrangement.

(e) REIMBURSEMENT FOR PAYMENTS MADE.—Nothing in this subtitle or any other provision of law shall impair the right of a health plan or automobile insurance carrier to seek reimbursement from any person liable for a bodily injury or illness sustained in an automobile accident for payments made for automobile insurance medical services to treat such injury or illness.

(f) RIGHTS TO COVERAGE FOR ADDITIONAL TREATMENT.—Subject to the provisions of subsection (c), nothing in this subtitle shall impair any rights with respect to medically necessary or appropriate services and items to which an individual injured in an automobile accident

is entitled that are not automobile insurance medical services as defined in this subtitle.

SEC. 10004. PAYMENT FACILITATION.

(a) IN GENERAL.—In each State, an efficient and effective system shall be established for prompt payment for automobile insurance medical services by automobile insurance carriers to health plans. Such systems shall require automobile insurance carriers and health plans to interface effectively, including through the use of cost-effective computer data programs, in order to specify the automobile insurance carrier or carriers liable for payment for automobile insurance medical services. Such systems also shall include mechanisms for resolution, including arbitration, of any issues or disputes that may arise in connection with such payment. The results of the resolution of issues and disputes under the mechanisms prescribed pursuant to this subsection, including the use of any fee schedule under section 10003(d), shall be admissible in evidence only for purposes of recovery under section 10003(e).

(b) SANCTIONS.—In each State, appropriate sanctions shall be prescribed for the failure of a health plan, an automobile insurance carrier, or any other person to comply with the requirements established pursuant to subsection (a). Such sanctions shall include a penalty for late

payment, which shall be imposed on any automobile insurance carrier that delays payment to a health plan after the amount of reimbursement is established pursuant to the procedures prescribed under subsection (a).

SEC. 10005. PAYMENT OF STATE ADMINISTRATIVE EXPENSES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for payment to each State, from the allotment to the State provided under subsection (b), of an amount equal to the amount expended by the State for administrative expenses in carrying out this subtitle in the State. Such payments shall be made at a time and manner specified by the Secretary and shall be conditioned upon the State providing the Secretary with such information as the Secretary may require in order to compute the appropriate amount of payments to be made. This subsection constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide payments to States in accordance with the applicable provisions of this section.

(b) STATE ALLOTMENT.—

(1) IN GENERAL.—The Secretary shall establish a formula for allotting among the States for each fiscal year the total amount of funds made available under paragraph (2) for the fiscal year.

(2) FUNDS AVAILABLE.—The total amount of funds available under this paragraph—

(A) for fiscal year 1997 is $300,000,000, and

(B) for each succeeding fiscal year (through fiscal year 2004) is $100,000,000.

SEC. 10006. CONSTRUCTION.

(a) COORDINATION WITH OTHER PROVISIONS OF THIS ACT.—The provisions of this subtitle shall be construed to be consistent with and shall be implemented in accordance with the other provisions of this Act.

(b) EFFECT ON WORKERS' COMPENSATION LAW.—Nothing in this subtitle shall affect rights or obligations under workers' compensation law.

Subtitle B—Prefunding Government Health Benefits Contributions

SEC. 10101. REQUIREMENT THAT CERTAIN AGENCIES PREFUND GOVERNMENT HEALTH BENEFITS CONTRIBUTIONS FOR THEIR ANNUITANTS.

(a) DEFINITIONS.—For the purpose of this section—

(1) the term ''agency'' means any agency or other instrumentality within the executive branch of the Government, the receipts and disbursements of which are not generally included in the totals of the

budget of the United States Government submitted by the President;

(2) the term ''health benefits plan'' means, with respect to an agency, a health benefits plan, established by or under Federal law, in which employees or annuitants of such agency may participate;

(3) the term ''health-benefits coverage'' means coverage under a health benefits plan'';

(4) an individual shall be considered to be an ''annuitant of an agency'' if such individual is entitled to an annuity, under a retirement system established by or under Federal law, by virtue of—

(A) such individual's service with, and separation from, such agency; or

(B) being the survivor of an annuitant under subparagraph (A) or of an individual who died while employed by such agency; and

(5) the term ''Office'' means the Office of Personnel Management.

(b) PREFUNDING REQUIREMENT.—

(1) IN GENERAL.—Effective as of October 1, 1994, each agency (or February 1, 1995, in the case of the agency with the greatest number of employees, as determined by the Office) shall be required to prepay the Government contributions which are

or will be required in connection with providing health-benefits coverage for annuitants of such agency.

(2) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section. The regulations shall be designed to ensure at least the following:

(A) Amounts paid by each agency shall be sufficient to cover the amounts which would otherwise be payable by such agency (on a ''pay-as-you-go'' basis), on or after the applicable effective date under paragraph (1), on behalf of—

(i) individuals who are annuitants of the agency as of such effective date; and

(ii) individuals who are employed by the agency as of such effective date, or who become employed by the agency after such effective date, after such individuals have become annuitants of the agency (including their survivors).

(B)(i) For purposes of determining any amounts payable by an agency—

(I) this section shall be treated as if it had taken effect at the beginning of the

20-year period which ends on the effective date applicable under paragraph (1) with respect to such agency; and

(II) in addition to any amounts payable under subparagraph (A), each agency shall also be responsible for paying any amounts for which it would have been responsible, with respect to the 20-year period described in subclause (I), in connection with any individuals who are annuitants or employees of the agency as of the applicable effective date under paragraph (1).

(ii) Any amounts payable under this subparagraph for periods preceding the applicable effective date under paragraph (1) shall be payable in equal installments over the 20-year period beginning on such effective date.

(c) FASB STANDARDS.—Regulations under subsection (b) shall be in conformance with the provisions of standard 106 of the Financial Accounting Standards Board, issued in December 1990.

(d) CLARIFICATION.—Nothing in this section shall be considered to permit or require duplicative payments on behalf of any individuals.

(e) DRAFT LEGISLATION.—The Office shall prepare and submit to Congress any draft legislation which may be necessary in order to carry out this section.

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