103D CONGRESS 2D SESSION **H. R. 5300**

To improve access to health insurance and contain health care costs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 29, 1994

Mr. MICHEL introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, and the Judiciary

A BILL

To improve access to health insurance and contain health care costs, and for other purposes.

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

3 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

- 4 (a) SHORT TITLE.—This Act may be cited as the
- 5 "Affordable Health Care Now Act of 1994".
- 6 (b) TABLE OF CONTENTS OF TITLES AND SUB-
- 7 TITLES IN ACT.—The following are the titles and subtitles
- 8 contained in this Act:

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Increased Availability and Continuity of Health Coverage for Individuals and Their Families

Subtitle B—Reform of Health Insurance

Subtitle C—Preemption

Subtitle D—Health Deduction Fairness

Subtitle E—Improved Access to Community Health Services

Subtitle F—Improved Access to Rural Health Services

Subtitle G—Assistance in Enrolling Uninsured Children in Health Insurance

Subtitle H—Medicaid Reform

Subtitle I—Remedies and Enforcement with Respect to Group Health Plans

Subtitle J—Delivery of Health Care Services to Illegal Immigrants

TITLE II—HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

Subtitle A—Medical Malpractice Liability Reform

Subtitle B—Administrative Cost Savings and Fair Health Information Practices

Subtitle C—Deduction for Cost of Catastrophic Health Plan; Medical Savings Accounts

Subtitle D—Anti-Fraud

- Subtitle E—Increased Medicare Beneficiary Choice; Additional Medicare Reforms
- Subtitle F—Health Care Antitrust Improvements
- Subtitle G—Encouraging Enforcement Activities of Medical Self-Regulatory Entities

Subtitle H—Reform of Clinical Laboratory Requirements for Simple Tests Subtitle I—Miscellaneous Provisions

TITLE III—LONG-TERM CARE

Subtitle A—Tax Treatment of Long-term Care Insurance

Subtitle B—Establishment of Federal Standards for Long-term Care Insurance Subtitle C—Protection of Assets Under Medicaid Through Use of Qualified

Long-term Care Insurance

Subtitle D—Studies

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1 TITLE I—IMPROVED ACCESS TO

2 **AFFORDABLE HEALTH CARE**

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Subtitle A—Increased Availability 1 and Continuity of Health Cov-2 erage for Individuals and Their 3 **Families** 4 PART 1-REQUIRED COVERAGE OPTIONS FOR EL-5 6 **IGIBLE EMPLOYEES, SPOUSES, AND DEPEND-**7 ENTS 8 SEC. 1001. REQUIRING EMPLOYERS TO OFFER OPTION OF 9 **COVERAGE FOR ELIGIBLE INDIVIDUALS.** 10 (a) IN GENERAL.—Each employer shall make avail-11 able with respect to each eligible employee a group health 12 plan under which— (1) coverage of each eligible individual with re-13 14 spect to such an eligible employee may be elected on 15 an annual basis for each plan year, (2) subject to subsection (d), coverage is pro-16 17 vided for at least the required coverage specified in 18 subsection (c), and 19 (3) each eligible employee electing such cov-20 erage may elect to have any premiums owed by the 21 employee collected through payroll deduction. 22 An employer is not required under this subsection to make 23 any contribution to the cost of coverage under such a plan. 24 (b) SPECIAL RULES.—

1	(1) Exclusion of new employers and cer-
2	TAIN SMALL EMPLOYERS.—Subsection (a) shall not
3	apply to any employer for any plan year if, as of the
4	beginning of such plan year—
5	(A) such employer (including any prede-
6	cessor thereof) has been an employer for less
7	than 2 years,
8	(B) such employer has no more than 2 eli-
9	gible full-time employees, or
10	(C) there are no more than 2 full-time eli-
11	gible employees who both are not covered under
12	any group health plan and do not have health
13	insurance coverage.
14	(2) Exclusion of family members.—Under
15	such procedures as the Secretary may prescribe, any
16	relative of an employer may be, at the election of the
17	employer, excluded from consideration as an eligible
18	employee for purposes of applying the requirements
19	of subsection (a). In the case of an employer that is
20	not an individual, an employee who is a relative of
21	a key employee (as defined in section $416(i)(1)$ of
22	the Internal Revenue Code of 1986) of the employer
23	may, at the election of the key employee, be consid-
24	ered a relative excludable under this paragraph.

1 (3) OPTIONAL APPLICATION OF WAITING PE-2 RIOD.—A group health plan shall not be treated as 3 failing to meet the requirements of subsection (a) 4 solely because a period of service by an eligible em-5 ployee of not more than 60 days is required under 6 the plan for coverage under the plan of eligible indi-7 viduals with respect to such employee.

8 (c) REQUIRED COVERAGE.—

(1) IN GENERAL.—Except as provided in para-9 10 graph (2), the required coverage specified in this 11 subsection is standard coverage (consistent with sec-12 tion 1102(c)), including at least one option (either a fee-for-service option or a point-of-service option) 13 14 that permits covered individuals an unlimited choice 15 of the lawful providers for which covered benefits are made available. 16

17 (2) Special treatment of small employ-18 ERS NOT CONTRIBUTING TO EMPLOYEE COV-19 ERAGE.—In the case of a small employer (as defined 20 in section 1131(9)) that has not contributed during 21 the previous plan year to the cost of coverage for 22 any eligible employee under any group health plan, the required coverage specified in this subsection for 23 24 the plan year (with respect to each eligible employee) 25 is—

1	(A) MedAccess standard coverage, with a
2	fee-for-service option and, if available, a point-
3	of-service option and a managed care option (as
4	defined in section 1033);
5	(B) MedAccess catastrophic coverage; and
6	(C) if available, MedAccess medisave cov-
7	erage,
8	as such terms are defined in section $1102(a)(2)$.
9	(3) CONSTRUCTION.—Nothing in this section
10	shall be construed as limiting the group health
11	plans, or types of coverage under such a plan, that
12	an employer may offer to an employee.
13	(d) 5-Year Transition for Existing Group
14	Health Plans.—
15	(1) IN GENERAL.—The requirement of sub-
16	section (a)(2) shall not apply to a group health plan
17	for a plan year if—
18	(A) the group health plan is in effect in
19	the plan year in which July 1, 1994, occurs,
20	and
21	(B) the employer makes (or offers to
22	make), in such plan year and each subsequent
23	plan year through the plan year involved, a con-
24	tribution to the plan on behalf of each employee
25	who is eligible to participate in the plan.

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

5 PART 2—PORTABILITY AND
 6 NONDISCRIMINATION

7 SEC. 1011. NONDISCRIMINATION BASED ON HEALTH 8 STATUS.

9 (a) IN GENERAL.—A group health plan and an in-10 surer providing health insurance coverage may not deny 11 or impose (and an insurer may not require an employer 12 under a group health plan to impose or otherwise to impose through a waiting period for coverage under a plan 13 or similar requirement) a limitation or exclusion of bene-14 15 fits relating to treatment of a condition based on health status or based on the fact that the condition preexisted 16 the effective date of coverage of the individual under the 17 plan if— 18

(1) in the case of any individual eligible for
such coverage, such individual has such coverage at
the time at which such individual first becomes eligible;

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

1 (3) the limitation or exclusion relates to preg-2 nancy;

3 (4) the condition relates to a condition that was
4 not diagnosed or treated within 3 months (or 6
5 months in the case of coverage not under a group
6 health plan) before the date of such coverage; or

7 (5) the limitation or exclusion extends over
8 more than 6 months (or 12 months in the case of
9 coverage not under a group health plan) after the
10 date of such coverage.

11 In the case of an individual who is eligible for coverage 12 but for a waiting period imposed by the employer, in ap-13 plying paragraphs (4) and (5), the individual shall be 14 treated as having had such coverage as of the earliest date 15 of the beginning of the waiting period.

16 (b) ONE-TIME AMNESTY PERIOD.—

17 (1) IN GENERAL.—In the case of an individual
18 who, as of the first date of the amnesty period is—

(A) covered under a group health plan or
has health insurance coverage, such coverage
shall not be subject to pre-existing condition exclusions on and after such date; or

(B) not so covered, if the individual obtains coverage under a group health plan or
health insurance coverage during the next avail-

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able open enrollment period with respect to the 2 individual, coverage so obtained shall not be subject to pre-existing condition exclusions on and after the effective date of such coverage.

(2) AMNESTY PERIOD.—The amnesty period de-5 6 scribed in this paragraph, with respect to an individ-7 ual who is a resident of a State, is the 45-calendarday period beginning on the effective date of this 8 9 part (under section 1032(b)).

10 (3) ESTABLISHMENT OF SPECIAL ALLOCATION 11 OF RISK POOL FOR AMNESTY.—Each State shall es-12 tablish rules and requirements relating to the alloca-13 tion of risk among insurers with respect to addi-14 tional risks assumed as a result of the amnesty pe-15 riod under this subsection (including individuals pre-16 viously covered for whom a preexisting condition ex-17 clusion will be no longer applicable).

18 (c) Application of Rules by Certain Health MAINTENANCE ORGANIZATIONS.—A health maintenance 19 20 organization that provides health insurance coverage shall not be considered as failing to meet the requirements of 21 22 section 1301 of the Public Health Service Act notwith-23 standing that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provi-24

sions of this part so long as such exclusion is applied con sistent with the provisions of this part.

3 SEC. 1012. PORTABILITY.

4 (a) IN GENERAL.—Each group health plan and an 5 insurer providing health insurance coverage shall waive any period applicable to a preexisting condition for similar 6 7 benefits with respect to an individual to the extent that 8 the individual, immediately prior to the date of such indi-9 vidual's enrollment in such plan, had health insurance cov-10 erage for the condition, or was covered for the condition under a group health plan, that was in effect before such 11 date. 12

13 (b) CONTINUOUS COVERAGE REQUIRED.—

14 (1) IN GENERAL.—Subsection (a) shall no 15 longer apply if there is a continuous period of more 16 than 60 days (or, in the case of an individual de-17 scribed in paragraph (2), 6 months) for which the 18 individual did not have health insurance coverage for 19 the condition or was not covered under a group 20 health plan for the condition.

(2) JOB TERMINATION.—An individual is described in this paragraph if the individual loses coverage under a group health plan due to termination
of employment.

1 (3) EXCLUSION OF CASH-ONLY AND DREAD 2 DISEASE PLANS.—In this subsection, the term "group health plan" does not include any group 3 4 health plan which is offered primarily to provide— (A) coverage for a specified disease or ill-5 6 ness, or (B) a hospital or fixed indemnity policy, 7 unless the Secretary determines that such a 8 9 plan provides sufficiently comprehensive coverage of a benefit so that it should be treated 10 11 as a group health plan under this subsection. (c) TRANSITION FOR NON-CONFORMING POLICIES.— 12 Notwithstanding State law or the provision of any agree-13 ment to the contrary, effective January 1, 1997, an in-14 15 surer may cancel or refuse to renew health insurance coverage in a State prior to the application of this subtitle 16 to health insurance coverage issued in the State if the cov-17 erage does not provide for either standard or catastrophic 18 coverage, but only if the insurer offers the covered individ-19 20 ual affected the opportunity to obtain health insurance coverage that meets the applicable requirements of this 21

22 title.

23 (d) APPLICABILITY OF COVERAGE UNDER PUBLIC
24 INSURANCE.—In this section, an individual shall be con25 sidered to have health insurance coverage for a condition

without regard to whether such coverage is under a private
 or public plan.

3 SEC. 1013. REQUIREMENTS RELATING TO RENEWABILITY 4 GENERALLY.

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

10 (1) for nonpayment of contributions,

11 (2) for fraud or other misrepresentation by the12 employer,

(3) for noncompliance with plan provisions, or
(4) because the plan is ceasing to provide any
coverage in a geographic area.

16 (b) INSURERS.—

17 (1) IN GENERAL.—An insurer may not cancel
18 health insurance coverage or deny renewal of such
19 coverage other than—

20 (A) for nonpayment of premiums,

21 (B) for fraud or other misrepresentation22 by the insured,

23 (C) for noncompliance with plan provi-24 sions, or

1 (D) subject to paragraph (2), because the 2 insurer is ceasing to provide any health insur-3 ance coverage (or the same type of health insur-4 ance coverage in the same individual or small 5 employer insurance market) in a State, or, in 6 the case of a health maintenance organization 7 or other network plan, in a geographic area.

8 (2)NOTICE REQUIREMENT FOR MARKET 9 EXIT.—Paragraph (1)(D) shall not apply to an in-10 surer ceasing to provide coverage unless the insurer 11 provides notice of such termination to employers and 12 individuals covered at least 180 days before the date of termination of coverage. 13

14 (3) LIMITATION ON REENTRY IN EMPLOYER 15 AND INDIVIDUAL MARKETS.—If an insurer ceases to 16 offer or provide health insurance coverage (or a type 17 of insurance coverage) in an area with respect to the 18 individual or small group market, the insurer may 19 not offer such health insurance coverage (or type of 20 coverage) in the area in such market until 5 years 21 after the date of the termination.

22 (4) Type of coverage and insurance mar23 KET DEFINED.—In this subsection—

24 (A) MedAccess standard coverage,
25 MedAccess catastrophic coverage, and

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1	MedAccess medisave coverage shall each be con-
2	sidered to be separate types of health insurance
3	coverage; and
4	(B) the term "small group market" means
5	the insurance market offered to individuals
6	seeking health care coverage on behalf of them-
7	selves (and their dependents) on the basis of
8	employment or other relationship with respect
9	to an employer or an association.
10	PART 3—STANDARDS FOR MANAGED CARE
11	ARRANGEMENTS
12	SEC. 1021. STANDARDS FOR MANAGED CARE ARRANGE-
13	MENTS.
14	(a) Requirement.—
15	(1) IN GENERAL.—Each group health plan, and
16	each insurer providing health insurance coverage, for
17	health care through a managed care arrangement
18	shall comply with the applicable requirements of this
19	section.
20	(2) DEFINITIONS.—In this section:
	(\mathcal{L}) DEFINITIONS. In this section.
21	(A) MANAGED CARE ARRANGEMENT DE-
21 22	
	(A) MANAGED CARE ARRANGEMENT DE-
22	(A) MANAGED CARE ARRANGEMENT DE- FINED.—The term "managed care arrange-

into an agreement under the arrangement
 under which such providers are obligated to
 provide items and services covered under the ar rangement to individuals covered under the
 plan or who have such coverage.

6 (B) PROVIDER NETWORK.—The term 7 "provider network" means, with respect to a 8 group health plan or health insurance coverage, 9 providers who have entered into an agreement 10 described in subparagraph (A) under a man-11 aged care arrangement.

12 (b) Scope of Arrangements With Providers.—

(1) IN GENERAL.—The entity providing for a 13 14 managed care arrangement on behalf of a group 15 health plan or under health insurance coverage shall 16 enter into such agreements with health care provid-17 ers (including primary and specialty providers for 18 children) or have such other arrangements as may 19 be necessary to assure that covered individuals have 20 reasonably prompt access through the entity's pro-21 vider network to all items and services contained in the package of benefits for which coverage is pro-22 23 vided (including access to emergency services on a 24 24-hour basis where medically necessary), in a man-

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ner that assures the continuity of the provision of
 such items and services.

(2) Access to centers of excellence.—

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4 (A) IN GENERAL.—The entity providing 5 for a managed care arrangement on behalf of a 6 group health plan or under health insurance 7 coverage shall demonstrate that covered individuals (including individuals with chronic dis-8 9 eases) have access through the entity's provider 10 network to specialized treatment expertise of 11 designated centers of excellence. Such entity 12 shall demonstrate such access according to 13 standards developed by the Secretary, including 14 requirements relating to arrangements with such centers and referral of patients to such 15 16 centers.

17 (B) DESIGNATION OF CENTERS OF EXCEL-18 LENCE.—The Secretary shall establish a proc-19 ess for the designation of facilities, including 20 children's hospitals and other pediatric facili-21 ties, as centers of excellence for purposes of this 22 paragraph. A facility may not be designated un-23 less the facility is determined—

(i) to provide specialty care,

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1	(ii) to deliver care for complex cases
2	requiring specialized treatment and for in-
3	dividuals with chronic diseases, and
4	(iii) to meet other requirements that
5	may be established by the Secretary relat-
6	ing to specialized education and training of
7	health professionals, participation in peer-
8	reviewed research, or treatment of patients
9	from outside the geographic area of the fa-
10	cility.
11	(3) No referral required for obstetrics
12	AND GYNECOLOGY.—An entity providing for a man-
13	aged care arrangement may not require an individ-
14	ual to obtain a referral from a physician in order to
15	obtain covered items and services within the network
16	of the arrangement from a physician who specializes
17	in obstetrics and gynecology.
18	(c) Provision of Emergency and Urgent Care
19	Services.—
20	(1) IN GENERAL.—The entity providing for a
21	managed care arrangement on behalf of a group
22	health plan or under health insurance coverage must
23	cover medically necessary emergency and urgent
24	care services provided to covered individuals (includ-
25	ing trauma services provided by designated trauma

1	centers), without regard to whether or not the pro-
2	vider furnishing such services has a contractual (or
3	other) arrangement with the entity to provide items
4	or services to covered individuals and, in the case of
5	services furnished for the treatment of an emergency
6	medical condition (as defined in section $1867(e)(1)$
7	of the Social Security Act), without regard to prior
8	authorization.
9	(2) Designated trauma centers de-
10	FINED.—In paragraph (1), the term ''designated
11	trauma center"—
12	(A) has the meaning given such term in
13	section 1231 of the Public Health Service Act,
14	and
15	(B) includes (for years prior to 2001) a
16	trauma center that—
17	(i) is located in a State that has not
18	designated trauma centers under section
19	1213 of such Act, and
20	(ii) the Secretary finds meets the
21	standards under such section to be a des-
22	ignated trauma center.
23	(d) Due Process Standards Relating to Pro-
24	vider Networks.—

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

(A) ESTABLISHMENT.—The entity provid-3 4 ing for a managed care arrangement on behalf of a group health plan or under health insur-5 6 ance coverage shall establish standards to be 7 used by the entity for contracting with health care providers with respect the entity's provider 8 network. Such standards shall be established in 9 consultation with providers who are members of 10 11 the network.

(B) DISTRIBUTION OF INFORMATION.—
Descriptive information regarding these standards shall be made available upon request to enrollees, providers who are members of the network, and prospective enrollees and prospective
participating providers.

18 (2) NOTICE REQUIREMENT.—

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

4 (B) TIMING OF NOTIFICATION.—The en-5 tity shall provide the notification required under 6 subparagraph (A) at least 45 days prior to the 7 effective date of the termination or expiration of the agreement (whichever is applicable). The 8 9 previous sentence shall not apply if failure to 10 terminate the agreement prior to the deadline would adversely affect the health or safety of a 11 12 covered individual.

13 (3) REVIEW PROCESS.—

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14 (A) IN GENERAL.—The entity shall provide 15 a process under which the provider may request 16 a review of the entity's decision to terminate or 17 refuse to renew the provider's participation 18 agreement. Such review shall be conducted by a 19 group of individuals the majority of whom are 20 health care providers who are members of the entity's provider network or employees of the 21 22 entity, and who are members of the same profession as the provider who requests the review. 23

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

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

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

6 (4) CONSTRUCTION.—Nothing in this sub-7 section shall be construed to affect any other provi-8 sion of law that provides an appeals process or other 9 form of relief to a provider of health care services.

10 SEC. 1022. UTILIZATION REVIEW.

(a) REQUIRING REVIEW TO MEET STANDARDS.—A
group health plan or insurer 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.

17 (b) ESTABLISHMENT OF STANDARDS ΒY SEC-RETARY.—The Secretary shall establish standards for uti-18 lization review programs, consistent with subsection (c), 19 and shall periodically review and update such standards 20 to reflect changes in the delivery of health care services. 21 22 The Secretary shall establish such standards in consultation with appropriate parties, including representatives of 23 24 health care providers, specialists, insurers, plan adminis-25 trators, and other experts.

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

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

6 (2) negative determinations of the medical ne-7 cessity or appropriateness of services or the site at 8 which services are furnished may be made only by 9 clinically qualified personnel;

10 (3) the utilization review program shall provide
11 for a process under which an enrollee or provider
12 may obtain timely review of a denial of coverage;

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

17 (5) providers shall participate in the develop-18 ment of the utilization review program.

19 (d) PREEMPTION.—For provision preempting State20 laws relating to utilization review, see section 1203(a)(3).

21 **PART 4—ENFORCEMENT; EFFECTIVE DATES;**

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DEFINITIONS

23 **SEC. 1031. ENFORCEMENT.**

24 (a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR25 EMPLOYERS AND GROUP HEALTH PLANS.—

1 (1) IN GENERAL.—For purposes of part 5 of 2 subtitle B of title I of the Employee Retirement In-3 come Security Act of 1974, the provisions of parts 4 1 and 2 of this subtitle and part 1 of subtitle B shall be deemed to be provisions of title I of such 5 6 Act irrespective of exclusions under section 4(b) of 7 such Act. (2) REGULATORY AUTHORITY.—With respect to 8 9 the regulatory authority of the Secretary of Labor 10 under this subtitle pursuant to subsection (a), sec-11 tion 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply. 12 13 (b) ENFORCEMENT BY PENALTY FOR INSURERS.— 14 (1) IN GENERAL.—Chapter 43 of the Internal 15 Revenue Code of 1986 (relating to qualified pension, 16 etc., plans) is amended by adding at the end thereof 17 the following new section: 18 "SEC. 4980C. FAILURE OF INSURER TO COMPLY WITH 19 HEALTH INSURANCE STANDARDS. 20 "(a) Imposition of Penalty.— "(1) IN GENERAL.—There is hereby imposed a 21 22 tax on the failure of an insurer to comply with the 23 requirements applicable to the insurer under parts 2 24 and 3 of subtitle A of title I and subtitle B of the 25 Affordable Health Care Now Act of 1994.

1	"(2) EXCEPTION.—Paragraph (1) shall not
2	apply to a failure by an insurer in a State if the Sec-
3	retary of Health and Human Services determines
4	that the State has in effect a regulatory enforcement
5	mechanism that provides adequate sanctions with re-
6	spect to such a failure by such an insurer.
7	"(b) Amount of Penalty.—
8	"(1) IN GENERAL.—Subject to paragraph (2),
9	the amount of the tax imposed by subsection (a)
10	shall be \$100 for each day during which such failure
11	persists for each individual to which such failure re-
12	lates. A rule similar to the rule of section
13	4980B(b)(3) shall apply for purposes of this section.
14	"(2) LIMITATION.—The amount of the tax im-
15	posed by subsection (a) for an insurer with respect
16	to health insurance coverage shall not exceed 25 per-
17	cent of the amounts received for such coverage dur-
18	ing the period such failure persists.
19	"(c) LIABILITY FOR PENALTY.—The penalty imposed
20	by this section shall be paid by the insurer.
21	"(d) EXCEPTIONS.—
22	"(1) Corrections within 30 days.—No tax
23	shall be imposed by subsection (a) by reason of any
24	foilung if

24 failure if—

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1	"(A) such failure was due to reasonable
2	cause and not to willful neglect, and
3	"(B) such failure is corrected within the
4	30-day period beginning on the earliest date the
5	insurer knew, or exercising reasonable diligence
6	would have known, that such failure existed.
7	"(2) WAIVER BY SECRETARY.—In the case of a
8	failure which is due to reasonable cause and not to
9	willful neglect, the Secretary may waive part or all
10	of the tax imposed by subsection (a) to the extent
11	that payment of such tax would be excessive relative
12	to the failure involved.
13	((e) DEFINITIONS.—For purposes of this section, the
14	terms 'health insurance coverage' and 'insurer' have the
15	respective meanings given such terms in section 1033 of
16	the Affordable Health Care Now Act of 1994.".
17	(2) CLERICAL AMENDMENT.—The table of sec-
18	tions for chapter 43 of such Code is amended by
19	adding at the end thereof the following new items:
	"Sec. 4980C. Failure of insurer to comply with health insurance standards."
20	SEC. 1032. EFFECTIVE DATES.
21	(a) PART 1.—The requirements of part 1 shall apply
22	to plans years beginning after December 31, 1996.

23 (b) PARTS 2 AND 3.—The requirements of parts 224 and 3 shall apply with respect to—

1	(1) group health plans and employers shall
2	apply to plans years beginning after December 31,
3	1996, and
4	(2) insurers shall take effect on January 1,
5	1997.
6	SEC. 1033. DEFINITIONS AND SPECIAL RULES.
7	(a) IN GENERAL.—For purposes of this subtitle:
8	(1) DEPENDENT.—The term "dependent"
9	means, with respect to any individual, any person
10	who is—
11	(A) the spouse or surviving spouse of the
12	individual, or
13	(B) under regulations of the Secretary, a
14	child (including an adopted child) of such indi-
15	vidual and—
16	(i) under 19 years of age, or
17	(ii) under 25 years of age and a full-
18	time student.
19	(2) ELIGIBLE EMPLOYEE.—The term ''eligible
20	employee'' means, with respect to an employer, an
21	employee who normally performs on a monthly basis
22	at least 10 hours of service per week for that em-
23	ployer. Such term shall not include any employee
24	who is not reasonably expected as of the 1st day of
25	a month to be employed by the employer for a period

of 120 consecutive days during any 365-day period
 that includes such 1st day.

3 (3) ELIGIBLE INDIVIDUAL.—The term "eligible 4 individual" means, with respect to an eligible em-5 ployee, such employee, and any dependent of such 6 employee.

7 (4) EMPLOYER.—The term "employer" shall
8 have the meaning applicable under section 3(5) of
9 the Employee Retirement Income Security Act of
10 1974.

11 (5) EXEMPTED MULTIPLE EMPLOYER HEALTH PLAN.—The term "exempted multiple employer 12 health plan" means a multiple employer welfare ar-13 14 rangement treated as an employee welfare benefit 15 plan by reason of an exemption under part 7 of sub-16 title B of title I of the Employee Retirement Income 17 Security Act of 1974 (as added by part 2 of subtitle 18 C of this title).

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

the definition of a health insurance coverage under 1 2 section 1131(4)(B). (B) The term "plan" means a group health 3 4 plan (including any such plan which is a multiem-5 ployer plan) and an exempted multiple employer health plan. 6 7 (7) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" shall have the meaning 8 9 applicable under section 1131(4). 10 (8) FULLY INSURED.—The term "fully in-11 sured' shall have the meaning applicable under sec-12 tion 701(9) of Employee Retirement Income Security Act of 1974 (as added by section 1211 of this 13 title). 14 15 (9) INSURER.—The term "insurer" has the 16 meaning given such term in section 1131(6). 17 (10)MULTIPLE EMPLOYER WELFARE AR-18 RANGEMENT.—The term "multiple employer welfare 19 arrangement" shall have the meaning applicable 20 under section 3(40) of the Employee Retirement Income Security Act of 1974. 21 22 (11) Options.— 23 (A) FEE-FOR-SERVICE OPTION.—Standard 24 coverage is considered to provide a "fee-forservice option" if benefits with respect to the 25

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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.

5 (B) MANAGED CARE OPTION.—Standard 6 coverage is considered to provide a "managed care option" if benefits with respect to the cov-7 8 ered items and services in the coverage are 9 made available exclusively through a managed 10 arrangement (as defined in section care 11 1021(a)(2), except in the case of emergency 12 and urgent services and as otherwise required under law. 13

14 (C) POINT-OF-SERVICE OPTION.—Standard 15 coverage is considered to provide a "point-of-16 service option" if the benefits with respect to 17 covered items and services in the coverage are 18 made available principally through a managed 19 care arrangement, with the choice of the en-20 rollee to obtain such benefits for items and 21 services provided through any lawful provider of 22 such covered items and services. The coverage 23 may provide for different cost sharing schedules based on whether the items and services are 24

provided through such an arrangement or out side such an arrangement.

3 (b) APPLICATION OF ERISA DEFINITIONS.—Except 4 as otherwise provided in this subtitle, terms used in this 5 subtitle shall have the meanings applicable to such terms 6 under section 3 of the Employee Retirement Income Secu-7 rity Act of 1974 (29 U.S.C. 1002).

8 (c) SECRETARY.—Except with respect to references 9 specifically to the Secretary of Labor, the term "Sec-10 retary" means the Secretary of Health and Human 11 Services.

Subtitle B—Reform of Health Insurance

14 PART 1—MARKETPLACE FOR SMALL BUSINESS

15 SEC.1101.REQUIREMENTFORINSURERSTOOFFER16MEDACCESS COVERAGE.

17 (a) REQUIREMENT.—

(1) IN GENERAL.—Each insurer (as defined in
section 1131(6)) that makes available any health insurance coverage (as defined in section 1131(4)) to
a small employer (as defined in section 1131(9)) in
a State—

23 (A) shall make available to each small employer in the State MedAccess standard coverage (as defined in section 1102(a)(2)), with a

1	fee-for-service option and, if available, a point-
2	of-service option and a managed care option (as
3	defined in section 1033),
4	(B) shall make available to each small em-
5	ployer in the State MedAccess catastrophic cov-
6	erage (as defined in section $1102(a)(2)$), and
7	(C) may make available to each small em-
8	ployer in the State MedAccess medisave cov-
9	erage (as defined in section $1102(a)(2)$).
10	(2) Special rule for health maintenance
11	ORGANIZATIONS.—The requirements of paragraph
12	(1)(A) (with regard to requiring a fee-for-service op-
13	tion), and paragraphs $(1)(B)$ and $(1)(C)$ shall not
14	apply with respect to a health insurance coverage
15	that—
16	(A) is provided by a Federally qualified
17	health maintenance organization (as defined in
18	section 1301(a) of the Public Health Service
19	Act), or
20	(B) is not provided by such an organiza-
21	tion but is provided by an organization recog-
22	nized under State law as a health maintenance
23	organization or managed care organization or a
24	similar organization regulated under State law
25	for solvency.

1	(3) Exception if state provides for guar-
2	ANTEED AVAILABILITY (RATHER THAN GUARANTEED
3	ISSUE).—Paragraph (1) shall not apply to an insurer
4	in a State if the State is providing—
5	(A) access to each small employer in the
6	State to MedAccess standard coverage, to
7	MedAccess catastrophic coverage, and to a
8	MedAccess medisave coverage, and
9	(B) a risk allocation mechanism described
10	in subsection (c).
11	(b) Guaranteed Issue of MedAccess Cov-
12	ERAGE.—Subject to subsection (c)—
13	(1) IN GENERAL.—Subject to paragraphs (2)
14	and (3), each insurer that offers MedAccess cov-
15	erage to a small employer in a State—
16	(A) must accept every small employer in
17	the State that applies for such coverage; and
18	(B) must accept for enrollment under such
19	coverage every eligible individual (as defined in
20	paragraph (5)) who applies for enrollment on a
21	timely basis (consistent with paragraph (4))
22	and may not place any restriction on the eligi-
23	bility of an individual to enroll so long as such
24	individual is an eligible individual.

1	(2) Special rules for health mainte-
2	NANCE ORGANIZATIONS.—In the case of coverage of-
3	fered by a health maintenance organization or other
4	network plan, the organization may—
5	(A) limit the employers that may apply for
6	such coverage to those with eligible individuals
7	residing in the service area of the plan;
8	(B) limit the individuals who may be en-
9	rolled under such coverage to those who reside
10	in the service area for such organization; and
11	(C) within the service area of such organi-
12	zation, deny such coverage to such employers if
13	the organization demonstrates that—
14	(i) it will not have the capacity to de-
15	liver services adequately to enrollees of any
16	additional groups because of its obligations
17	to existing group contract holders and en-
18	rollees,
19	(ii) it is applying this subparagraph
20	uniformly to all employers without regard
21	to the health status, claims experience, or
22	duration of coverage of those employers
23	and their employees, and
24	(iii) it will not offer coverage to such
25	employers within such service area for a

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1	period of at least 180 days after such cov-
2	erage is denied.
3	In this paragraph, the term ''health maintenance or-
4	ganization'' includes an organization recognized
5	under State law as a health maintenance organiza-
6	tion or managed care organization or a similar orga-
7	nization regulated under State law for solvency.
8	(3) Special rule for financial capacity
9	LIMITS.—In the case of coverage offered by an in-
10	surer other than a health maintenance organization
11	or network plan, the insurer may deny such coverage
12	to small employers if the organization demonstrates
13	that—
14	(A) it does not have the financial reserves
15	necessary to underwrite additional coverage,
16	(B) it is applying this paragraph uniformly
17	to all employers without regard to the health
18	status, claims experience, or duration of cov-
19	erage of those employers and their employees,
20	and
21	(C) it shall not offer coverage to such em-
22	ployers within such service area for a period of

24 (4) CLARIFICATION OF TIMELY ENROLL25 MENT.—

at least 180 days after such coverage is denied.

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1	(A) GENERAL INITIAL ENROLLMENT RE-
2	QUIREMENT.—Except as provided in this para-
3	graph, enrollment of an eligible individual for
4	MedAccess coverage may be considered not to
5	be timely if the eligible employee or dependent
6	fails to enroll under such coverage during an
7	initial enrollment period, if such period is at
8	least 30 days long.
9	(B) Enrollment due to loss of pre-
10	VIOUS COVERAGE.—Enrollment under
11	MedAccess coverage is considered to be timely
12	in the case of an eligible individual who—
13	(i) was covered under a group health
14	plan or had other health insurance cov-
15	erage at the time of the individual's initial
16	enrollment period,
17	(ii) stated at the time of the initial en-
18	rollment period that coverage under a
19	group health plan or other health insur-
20	ance coverage was the reason for declining
21	enrollment,
22	(iii) lost coverage under a group
23	health plan or other health insurance cov-
24	erage (as a result of the termination of the

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1	coverage, termination or reduction of em-
2	ployment, or other reason), and
3	(iv) requests enrollment within 30
4	days after termination of the coverage.
5	(C) Requirement applies during open
6	ENROLLMENT PERIODS.—Each insurer and
7	each group health plan providing MedAccess
8	coverage shall provide for at least one period (of
9	not less than 30 days) each year during which
10	enrollment under such coverage shall be consid-
11	ered to be timely.
12	(D) Exception for court orders.—
13	Enrollment of a spouse or minor child of an
14	employee shall be considered to be timely if—
15	(i) a court has ordered that coverage
16	be provided for the spouse or child under
17	a covered employee's group health plan,
18	and
19	(ii) a request for enrollment is made
20	within 30 days after the date the court is-
21	sues the order.
22	(E) ENROLLMENT OF SPOUSES AND DE-
23	PENDENTS.—
24	(i) IN GENERAL.—Enrollment of the
25	spouse (including a child of the spouse)

	TI
1	and any dependent child of an eligible em-
2	ployee shall be considered to be timely if a
3	request for enrollment is made either—
4	(I) within 30 days of the date of
5	the marriage or of the date of the
6	birth or adoption of a child, if family
7	coverage is available as of such date,
8	or
9	(II) within 30 days of the date
10	family coverage is first made avail-
11	able.
12	(ii) COVERAGE.—If available coverage
13	includes family coverage and enrollment is
14	made under such coverage on a timely
15	basis under clause (i)(I), the coverage shall
16	become effective not later than the first
17	day of the first month beginning after the
18	date of the marriage or the date of birth
19	or adoption of the child (as the case may
20	be).
21	(5) DEFINITIONS.—In this subsection, the
22	terms ''eligible individual'' and ''group health plan''
23	have the meanings given such terms in section
24	1023(a).

1 (c) STATE OPTION OF GUARANTEED AVAILABILITY 2 Risk THROUGH ALLOCATION OF (RATHER THAN 3 THROUGH GUARANTEED ISSUE).—The requirements of 4 subsection (b) shall not apply in a State if the State has provided (in accordance with standards established under 5 this part) a mechanism under which— 6

(1) each insurer offering health insurance coverage to a small employer in the State must participate in a program for assigning high-risk small employer groups (or individuals within such a group)
among some or all such insurers, and

(2) the insurers to which such high-risk small
employer groups or individuals are so assigned comply with the requirements of subsection (b).

15 SEC. 1102. MEDACCESS COVERAGE DEFINED.

16 (a) MEDACCESS COVERAGE DEFINED.—In this sub-17 title:

(1) IN GENERAL.—The term "MedAccess coverage" means a health insurance coverage (whether
under a managed-care plan, indemnity plan, or other
plan) that meets the following requirements:

22 (A) The coverage—

23 (i) is designed to provide standard
24 coverage (consistent with subsection (c))
25 with substantial cost-sharing,

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1	(ii) is designed to provide only cata-
2	strophic coverage (consistent with sub-
3	section (d)), or
4	(iii) is designed to provide medisave
5	coverage (consistent with subsection (e)).
6	(B) The coverage includes only services, in-
7	cluding (but not limited to) medical, surgical,
8	hospital, and preventive services, which are es-
9	sential and medically necessary; except that no
10	specific procedure or treatment, or classes
11	thereof, is required to be included in such cov-
12	erage, by this Act or through regulations.
13	(C) The coverage meets the applicable re-
14	quirements of section 1101(b) (relating to guar-
15	anteed issue).
16	(D) The coverage meets the consumer pro-
17	tection standards established under section
18	1103(a)(1)(B).
19	(2) Medaccess standard, catastrophic,
20	AND MEDISAVE COVERAGE.—The terms "MedAccess
21	standard coverage", "MedAccess catastrophic cov-
22	erage'', ''MedAccess medisave coverage'' mean
23	MedAccess coverage that provides for at least stand-
24	ard coverage (referred to in paragraph $(1)(A)(i)$),
25	for only catastrophic coverage (referred to in para-

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graph (1)(A)(ii)), or medisave coverage (referred to
 in paragraph (1)(A)(iii)), respectively.

3 (b) Set of Rules of Actuarial Equivalence.—

4 (1) INITIAL DETERMINATION.—The NAIC is 5 requested to submit to the Secretary, within 6 6 months after the date of the enactment of this Act. 7 a set of rules, including an appropriate set of safe-8 harbors, which the NAIC determines is sufficient for 9 determining, in the case of any health insurance cov-10 erage and for purposes of this section, the actuarial 11 value of the coverage offered.

(2) CERTIFICATION.—If the Secretary deter-12 13 mines that the NAIC has submitted a set of rules 14 that comply with the requirements of paragraph (1), 15 the Secretary shall certify such set of rules for use 16 under this part. If the Secretary determines that 17 such a set of rules has not been submitted or does 18 not comply with such requirements, the Secretary 19 shall promptly establish a set of rules that meets such requirements. 20

21 (c) STANDARD COVERAGE.—

(1) IN GENERAL.—For purposes of this Act,
health insurance coverage is considered to provide
standard coverage consistent with this subsection if
the benefits are specified in a written instrument

1 providing for such coverage as essential and medi-2 cally necessary services described in subsection (a)(1)(B) and determined, in accordance with the set 3 4 of actuarial equivalence rules certified under sub-5 section (b), to have a value that is within 5 percent-6 age points of the applicable target actuarial value 7 for standard coverage established under paragraph (2).8

9 (2) INITIAL DETERMINATION OF APPLICABLE 10 TARGET ACTUARIAL VALUE FOR STANDARD COV-11 ERAGE.—

(A) INITIAL DETERMINATION.—The NAIC 12 13 is requested to submit to the Secretary, within 14 6 months after the date of the enactment of this Act, a procedure for determining the appli-15 16 cable target actuarial value for standard cov-17 erage (which may vary by geographic area). 18 Such value shall be equal to the average actuar-19 ial value of a representative range of the dif-20 ferent types of health benefits provisions (which include cost-sharing) typically offered as stand-21 ard coverage in the small employer health cov-22 23 erage market. In determining the actuarial 24 value, the benefits considered should be suffi-25 cient to cover only services, including (but not

1 limited to) medical, surgical, hospital, and pre-2 ventive services, which are essential and medi-3 cally necessary; except that no specific proce-4 dure or treatment, or classes thereof, is re-5 quired to be considered in such determination 6 by this Act or through regulations. The deter-7 mination of such value shall be based on a representative distribution of the population of eli-8 9 gible employees offered such coverage and a single set of standardized utilization and cost 10 11 factors (which may vary by geographic area).

12 (B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a proce-13 14 dure for determining the applicable target actu-15 arial value for standard coverage that complies 16 with the requirements of subparagraph (A), the 17 Secretary shall certify such procedure for use 18 under this part. If the Secretary determines 19 that such a procedure has not been submitted or does not comply with such requirements, the 20 Secretary shall promptly prescribe such a proce-21 22 dure that meets such requirements.

23 (d) CATASTROPHIC COVERAGE.—

24 (1) IN GENERAL.—For purposes of subsection25 (a)(1)(B), health insurance coverage is considered to

provide catastrophic coverage consistent with this
 subsection if—

(A) benefits are available under such coverage for a year only to the extent that expenses for covered services in a year exceed a
deductible amount that is consistent with the
dollar amounts specified in section 220(c)(2)(A)
of the Internal Revenue Code of 1986, as added
by section 2202, and

10 (B) the benefits are determined, in accord-11 ance with the set of actuarial equivalence rules 12 certified under subsection (b), to have a value 13 that is within 5 percentage points of the target 14 actuarial value for catastrophic coverage estab-15 lished under paragraph (2).

16 (2) INITIAL DETERMINATION OF TARGET ACTU17 ARIAL VALUE FOR CATASTROPHIC COVERAGE.—

18 (A) INITIAL DETERMINATION.—The NAIC 19 is requested to submit to the Secretary, within 20 6 months after the date of the enactment of 21 this Act, a target actuarial value for cata-22 strophic coverage equal to the actuarial value 23 that would have been computed under sub-24 section (c)(2)(A) if a deductible that represents 25 the midpoint of the range of deductibles per1

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mitted consistent with subsections (b)(2) and (c)(2)(A) of section 220 of the Internal Revenue Code of 1986 were used in place of any deductible that otherwise would be applicable.

(B) CERTIFICATION.—If the Secretary de-5 termines that the NAIC has submitted a target 6 actuarial value for catastrophic coverage that 7 8 comply with the requirements of subparagraph 9 (A), the Secretary shall certify such value for 10 use under this part. If the Secretary determines 11 that such a value has not been submitted or 12 does not comply with such requirements, the 13 Secretary shall promptly determine such a tar-14 get actuarial value that meets such require-15 ments.

16 (e) MEDISAVE COVERAGE.—

17 (1) IN GENERAL.—For purposes of subsection
18 (a)(1)(C), health insurance coverage is considered to
19 provide medisave coverage consistent with this sub20 section if such coverage consists of—

21 (A) coverage under a catastrophic health
22 plan (within the meaning of section 220(c)(2)
23 of the Internal Revenue Code of 1986, as in24 serted by section 2202 of this Act), and

1(B) a medical savings account described in2section 220(d)(1)(B) of such Code.

3 (f) SUBSEQUENT REVISIONS.—

4 (1) NAIC.—The NAIC may submit from time 5 to time to the Secretary revisions of the set of rules 6 of actuarial equivalence previously established or de-7 termined under this section if the NAIC determines 8 such revision necessary to take into account changes 9 in the relevant types of health benefits provisions, in 10 deductible levels for catastrophic coverage, or in de-11 mographic conditions which form the basis for such 12 set of rules. The provisions of subsection (b)(2) shall 13 apply to such a revision in the same manner as they 14 apply to the initial determination of the set of rules.

(2) SECRETARY.—The Secretary may by regulation revise such set or rules and values from time
to time if the Secretary determines such revision
necessary to take into account changes described in
paragraph (1).

20 SEC. 1103. ESTABLISHMENT OF OTHER MEDACCESS STAND-

21 **ARDS.**

22 (a) ESTABLISHMENT OF GENERAL STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 9 months after
the date of the enactment of this Act, model regula-

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1	tions that specify standards with respect to each of
2	the following:
3	(A)(i) The requirement, under section
4	1101(a), that insurers make available
5	MedAccess coverage.
6	(ii) The requirements of guaranteed avail-
7	ability of MedAccess coverage to small employ-
8	ers under section 1101(b).
9	(B) The requirements of section 1104 (re-
10	lating to use of modified community rating, uni-
11	form marketing materials, and miscellaneous
12	consumer protections).
13	If the NAIC develops recommended regulations
14	specifying such standards within such period, the
15	Secretary shall review the standards. Such review

15 Secretary shall review the standards. Such review 16 shall be completed within 60 days after the date the 17 regulations are developed. Unless the Secretary de-18 termines within such period that the standards do 19 not meet the requirements, such standards shall 20 serve as the standards under this section, with such 21 amendments as the Secretary deems necessary.

(2) 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 de-

1	scribed in paragraph (1), the Secretary shall specify,
2	within 15 months after the date of the enactment of
3	this Act, standards to carry out those requirements.
4	(3) EFFECTIVE DATE.—The MedAccess stand-
5	ards and consumer protection standards (as defined
6	in paragraph (5)) shall apply to MedAccess coverage
7	and health insurance coverage provided in a State
8	on or after the respective date the standards are im-
9	plemented in the State under subsections (b) and
10	(c).
11	(4) PREEMPTION OF STATE LAW.—
12	(A) IN GENERAL.—Except as provided in
13	subparagraph (B), a State may not establish or
14	enforce standards for health insurance coverage
15	made available to small employers and individ-
16	uals that are different from the standards es-
17	tablished under this part.
18	(B) GRANDFATHER.—In the case of a
19	State that, as of August 1, 1994, required that
20	premiums in the individual and small group
21	market sectors be community-rated and not
22	vary based on age, the State continue such
23	standards (and reasonable modifications there-
24	of) in force.
25	(5) DEFINITIONS.—In this section:

(A) 1 CONSUMER PROTECTION STAND-ARDS.—The term "consumer protection stand-2 ards" means the standards established under 3 4 paragraph (1)(B). (B) MEDACCESS STANDARDS.—The term 5 6 "MedAccess standards" means the standards 7 established under paragraph (1)(A) (relating to the requirements of section 1101), and includes 8 9 the consumer protection standards insofar as they relate to MedAccess coverage. 10 11 (b) APPLICATION **S**TANDARDS THROUGH OF STATES.— 12 13 (1)APPLICATION OF **MEDACCESS** STAND-14 ARDS.— 15 (A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified 16 17 in subparagraph (B), a report on steps the 18 State is taking to implement and enforce the 19 consumer protection standards with respect to 20 insurers, and MedAccess coverage offered, not 21 later than such deadline. 22 (B) DEADLINE FOR REPORT.—

23 (i) 1 YEAR AFTER STANDARDS ESTAB24 LISHED.—Subject to clause (ii), the dead25 line under this subparagraph is 1 year

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1	after the date the MedAccess standards
2	are established under subsection (a).
3	(ii) Exception for legislation.—
4	In the case of a State which the Secretary
5	identifies, in consultation with the NAIC,
6	as—
7	(I) requiring State legislation
8	(other than legislation appropriating
9	funds) in order for insurers and plans
10	providing MedAccess coverage offered
11	to meet the MedAccess standards es-
12	tablished under subsection (a), but
13	(II) having a legislature which is
14	not scheduled to meet in 1995 in a
15	legislative session in which such legis-
16	lation may be considered,
17	the date specified in this subparagraph is
18	the first day of the first calendar quarter
19	beginning after the close of the first legis-
20	lative session of the State legislature that
21	begins on or after January 1, 1996. For
22	purposes of the previous sentence, in the
23	case of a State that has a 2-year legislative
24	session, each year of such session shall be

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deemed to be a separate regular session of the State legislature.

3 (2) FEDERAL ROLE.—If the Secretary deter-4 mines that a State has failed to submit a report by 5 the deadline specified under paragraph (1) or finds that the State has not implemented and provided 6 7 adequate enforcement of the MedAccess standards under such paragraph, the Secretary shall notify the 8 9 State and provide the State a period of 60 days in which to submit such report or to implement and en-10 11 force such standards under such paragraph. If, after 12 such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall 13 provide for such mechanism for the implementation 14 and enforcement of such standards in the State as 15 16 the Secretary determines to be appropriate. Such 17 implementation and enforcement shall take effect 18 with respect to insurers, and plans providing 19 MedAccess coverage offered or renewed, on or after 20 3 months after the date of the Secretary's finding under the previous sentence, and until the date the 21 22 Secretary finds that such a failure has been cor-23 rected. In exercising authority under this subpara-24 graph, the Secretary shall determine whether the use 25 of a risk-allocation mechanism, described in section 1101(c), would be more consistent with the small
 employer group health coverage market in the State
 than the guaranteed availability provisions of section
 1101(b).

5 (3) APPLICATION OF CONSUMER PROTECTION
6 STANDARDS.—

7 (A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified 8 9 in subparagraph (B), a report on steps the State is taking to implement and enforce the 10 11 MedAccess standards with respect to insurers, 12 and health insurance coverage (other than MedAccess coverage) offered, not later than 13 14 such deadline.

15 (B) DEADLINE FOR REPORT.—

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

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

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1	(I) requiring State legislation
2	(other than legislation appropriating
3	funds) in order for insurers and plans
4	providing health insurance coverage
5	offered to meet the consumer protec-
6	tion standards established under sub-
7	section (a), but
8	(II) having a legislature which is
9	not scheduled to meet in 1995 in a
10	legislative session in which such legis-
11	lation may be considered,
12	the date specified in this subparagraph is
13	the first day of the first calendar quarter
14	beginning after the close of the first legis-
15	lative session of the State legislature that
16	begins on or after January 1, 1996. For
17	purposes of the previous sentence, in the
18	case of a State that has a 2-year legislative
19	session, each year of such session shall be
20	deemed to be a separate regular session of
21	the State legislature.
22	(4) FEDERAL ROLE.—If the Secretary deter-
23	mines that a State has failed to submit a report by
24	the deadline specified under paragraph (1) or finds
25	that the State has not implemented and provided

1 adequate enforcement of the consumer protection 2 standards under such paragraph, the Secretary shall notify the State and provide the State a period of 3 4 60 days in which to submit such report or to implement and enforce such standards under such para-5 6 graph. If, after such 60-day period, the Secretary 7 finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the 8 9 implementation and enforcement of such standards in the State as the Secretary determines to be ap-10 11 propriate. Such implementation and enforcement 12 shall take effect with respect to insurers, and health 13 insurance coverage (other than MedAccess coverage) offered or renewed, on or after 3 months after the 14 15 date of the Secretary's finding under the previous 16 sentence, and until the date the Secretary finds that 17 such a failure has been corrected. 18 SEC. 1104. USE OF MODIFIED COMMUNITY RATING, UNI-19 FORM MARKETING MATERIALS, AND MIS-20 **CELLANEOUS CONSUMER PROTECTIONS.**

21 (a) Use of Modified Community Rating.—

(1) IN GENERAL.—As a standard under section
1103(a)(1)(B), subject to paragraph (2), the premium rate established by an insurer for coverage

1	may not vary within a type of product except by the
2	following:
3	(A) AGE.—By age, based on classes of age
4	established by a State.
5	(B) GEOGRAPHIC AREA.—By geographic
6	area, based on 3-digit zip code or counties, as
7	identified by a State.
8	(C) FAMILY SIZE.—Family size, based on
9	a classification of individual, individual with one
10	or more children, married couple without chil-
11	dren, and married couple with children.
12	(2) DISCOUNT FOR EMPLOYER WELLNESS PRO-
13	GRAM.—An insurer may provide for a group dis-
14	count with respect to an employer that provides for
15	a wellness program for employees.
16	(b) Full Disclosure of Rating Practices.—At
17	the time an insurer offers health insurance coverage to
18	a small employer, the insurer shall fully disclose to the
19	employer rating practices for health insurance coverage,
20	including rating practices for different plan designs.
21	(c) ACTUARIAL CERTIFICATION.—Each insurer that
22	offers health insurance coverage to a small employer in
23	a State shall file annually with the State commissioner of
24	insurance a written statement by a member of the Amer-
25	ican 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 insurer
and methods used by the insurer in establishing premium
rates for applicable health insurance coverage—

6 (1) the insurer is in compliance with the appli-7 cable provisions of this section, and

8 (2) the rating methods are actuarially sound.
9 Each such insurer shall retain a copy of such statement
10 for examination at its principal place of business.

11 (d) REGISTRATION AND REPORTING.—Each insurer 12 that issues any health insurance coverage to a small em-13 ployer in a State shall be registered or licensed with the 14 State commissioner of insurance and shall comply with 15 any reporting requirements of the commissioner relating 16 to such coverage.

17 (e) MARKETING MATERIAL.—Each insurer that issues any health insurance coverage to a small employer 18 19 in a State shall file with the State those marketing materials relating to the offer and sale of health insurance cov-20 erage to be used for distribution before the materials are 21 22 used. Such materials shall be in a uniform format speci-23 fied under the standards established under section 1101. 24 Such materials (including information on plan designs of-25 fered by different insurers) shall be distributed to employers that do not contribute to health insurance coverage
 for their employees, in order to distribute such informa tion to their employees as part of the offer of coverage
 under section 1001(a).

5 SEC. 1105. MONITORING AND RESPONSE TO ADVERSE SE-6 LECTION; RISK ADJUSTMENT PROGRAMS.

7 (a) MONITORING.—The Secretary of Labor shall 8 monitor the prevalence and impact of adverse risk selec-9 tion in the fully insured plans made available to small em-10 ployers resulting from the decision of small employers to 11 self insure. State insurance commissioners may submit to 12 the Secretary such information on such adverse risk selec-13 tion as they determine to be appropriate.

14 (b) RESPONSE.—If the Secretary of Labor determines, on the basis of such information or otherwise, that, 15 due to decisions of small employers to self-insure, there 16 has been substantial or significant favorable selection with 17 respect to self-insured plans or unfavorable selection with 18 19 respect to fully insured plans in a State, the Secretary shall develop a risk adjustment program under subsection 20 21 (c) that responds to such a pattern in the State. The Secretary shall request the NAIC to submit to the Secretary 22 recommendations regarding the structure and operation of 23 such a program. 24

(c) ESTABLISHMENT OF RISK ADJUSTMENT PRO-1 2 GRAM.—The risk adjustment program applied in a State under this subsection— 3 (1) shall be designed to be operated on a non-4 governmental basis, 5 6 (2) shall require participation of each small em-7 ployer in the State that is self-insured, (3) shall require the imposition of such assess-8 9 ments on self-insured plans offered by such employ-10 ers as may be appropriate to prevent further adverse 11 or favorable selection, and 12 (4) shall provide for the distribution of such assessments to the State involved for purposes of mak-13 14 ing payments to insurers to stabilize the small group 15 insurance market. The amounts of the assessments under paragraph (3) for 16 individual employers may take into account the number 17 of lives covered under the plans of such employers and 18 the area of residence of the lives covered. 19 20 SEC. 1106. ESTABLISHMENT OF REINSURANCE OR ALLOCA-21 TION OF RISK MECHANISMS FOR HIGH RISK 22 INDIVIDUALS IN MARKETPLACE FOR SMALL 23 **BUSINESS AND MARKETPLACE FOR INDIVID-**24 UALS. 25 (a) ESTABLISHMENT OF STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall re-1 2 quest the NAIC to develop, within 9 months after the date of the enactment of this Act. models for re-3 insurance or allocation of risk mechanisms (each in 4 this section referred to as a "reinsurance or alloca-5 6 tion of risk mechanism") for health insurance cov-7 erage made available to small employers and for whom an insurer is at risk of incurring high costs 8 9 in providing such coverage. If the NAIC develops 10 such models within such period, the Secretary shall 11 review such models to determine if they provide for 12 an effective reinsurance or allocation of risk mechanism. Such review shall be completed within 30 days 13 14 after the date the models are developed. Unless the 15 Secretary determines within such period that such a model is not an effective reinsurance or allocation of 16 17 risk mechanism, such remaining models shall serve 18 as the models under this section, with such amend-19 ments as the Secretary deems necessary.

20 (2) CONTINGENCY.—If the NAIC does not de21 velop such models within such period or the Sec22 retary determines that all such models do not pro23 vide for an effective reinsurance or allocation of risk
24 mechanism, the Secretary shall specify, within 15

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months after the date of the enactment of this Act, 1 2 models to carry out this section. 3 (b) IMPLEMENTATION OF REINSURANCE OR ALLOCA-4 TION OF RISK MECHANISMS.— 5 (1) BY STATES.—Each State shall establish 6 and maintain one or more reinsurance or allocation 7 of risk mechanisms that are consistent with a model established under subsection (a) by not later than 8 9 the deadline specified in section 1103(b)(1)(B). A State may establish and maintain such a mechanism 10 11 jointly with one or more other States. 12 (2) FEDERAL ROLE.— 13 (A) IN GENERAL.—If the Secretary determines that a State has failed to establish or 14 15 maintain a reinsurance or allocation of risk 16 mechanism in accordance with paragraph (1), 17 the Secretary shall establish and maintain such 18 a reinsurance or allocation of risk mechanism 19 meeting the requirements of this paragraph. 20 **REINSURANCE** MECHANISM.—Unless (B) the Secretary determines under subparagraph 21 22 (C) that an allocation of risk mechanism is the 23 appropriate mechanism to use in a State under 24 this paragraph, the Secretary shall establish

and maintain for use under this section for

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each State an appropriate reinsurance mechanism.

(C) Allocation of risk mechanism.—If 3 4 the Secretary determines that, due to the na-5 ture of the health coverage market in the State 6 (including a relatively small number of plans of-7 fered providing health insurance coverage or a relatively small number of uninsurable small 8 employers), an allocation of risk mechanism 9 would be a better mechanism than a reinsur-10 11 ance mechanism, the Secretary shall establish 12 and maintain for use under this section for a 13 State an allocation of risk mechanism under 14 which small employers with employees who are at higher risk of significantly higher claims 15 16 would be equitably assigned among insurers of-17 fering health insurance coverage to small em-18 ployers.

19 (c) CONSTRUCTION.—Nothing in this section shall be 20 construed to prohibit reinsurance or allocation of risk ar-21 rangements relating to health insurance coverage, whether 22 on a State or multi-State basis, not required under this 23 section.

1 PART 2—MARKETPLACE FOR INDIVIDUALS

2 SEC. 1111. APPLICATION OF SIMILAR REQUIREMENTS.

3 (a) IN GENERAL.—Except as provided in subsection 4 (c)—

5 (1) the provisions of part 1 of this subtitle shall 6 apply to insurers offering health insurance coverage 7 to individuals in the individual market (as defined in 8 subsection (b)) in the same manner as such provi-9 sions apply to insurers offering health insurance cov-10 erage to employers, and

(2) the standards established under section
1103 shall apply under this part in the same manner
as they apply under part 1.

14 For purposes of this subsection, any reference to an em-15 ployee or eligible employee is deemed a reference to such16 an individual.

17 (b) INDIVIDUAL MARKET DEFINED.—In subsection 18 (a), the term "individual market" means the insurance 19 market offered to individuals seeking health care coverage 20 on behalf of themselves (and their dependents) and not 21 seeking coverage on the basis of employment, membership 22 in a organization, or through another group purchasing 23 arrangement.

24 (c) EXCEPTION AND SPECIAL RULE.—

(1)1 WELLNESS DISCOUNTS.—Section 2 1104(a)(2)(relating to discounts for employer 3 wellness programs) shall not apply under this part. 4 (2) SEPARATE APPLICATION OF RISK ADJUST-5 MENT TO INDIVIDUAL MARKET SECTOR.—Section 6 1105 (relating to monitoring and response to ad-7 verse selection; risk adjustment programs) shall be 8 applied under this part in a manner that is separate 9 from its application under part A. 10 (3) SEPARATE AGE RATING FACTOR FOR THE 11 INDIVIDUAL MARKET.—The provisions regarding age under section 1104(a)(1)(A) shall be determined 12 13 separately for each year of age and not by the class-14 es of age referred to in such section. 15 (4) CONVERSION OF PERMANENT HEALTH IN-

16 SURANCE POLICIES.—The provisions of section 1104 17 shall not apply in connection with a permanent pol-18 icy of health insurance existing on the effective date, 19 if each individual covered under the policy is given 20 the option to convert the policy to a policy of health 21 insurance subject to this part.

(d) APPLICATION OF REQUIREMENTS.—Coverage offered by an insurer shall not be treated as MedAccess coverage under this part unless the insurer complies with the
requirements of part 3 of subtitle A (relating to standards)

for managed care arrangements and essential community 1 2 providers) in the same manner as such requirements apply to a group health plan. 3

4 PART 3-VOLUNTARY HEALTH PURCHASING 5

ARRANGEMENTS

SEC. 1121. ESTABLISHMENT AND ORGANIZATION. 6

7 (a) IN GENERAL.—Voluntary health purchasing arrangements (in this part referred to as "purchasing ar-8 9 rangements") may be established in accordance with this 10 part. Each purchasing arrangement shall be chartered under State law and operated as a not-for-profit corpora-11 12 tion. An insurer may not form, underwrite, or possess a majority vote of a purchasing arrangement, but may ad-13 14 minister such an arrangement.

15 (b) BOARD OF DIRECTORS.—

16 (1) IN GENERAL.—Each purchasing arrange-17 ment shall be governed by a Board of Directors. 18 Such Board shall initially be appointed under proce-19 dures established by the State in which it operates. 20 Subsequently, the Board shall be elected by the 21 members of the arrangement in accordance with 22 paragraph (3). Such Board shall be composed of in-23 dividuals who are small employers (or representa-24 tives of small employers), eligible employees of small 25 employers (or representatives of such employees),

and eligible individuals in the area in which the ar rangement operates.
 (2) MEMBERSHIP.—A purchasing arrangement

shall accept all small employers, eligible employees,
and eligible individuals residing within the area
served by the arrangement as members if such employers, employees or individuals request such membership.

9 (3) VOTING.—Members of a purchasing ar-10 rangement shall have voting rights consistent with 11 the rules established under the bylaws governing the 12 arrangement.

13 (c) DUTIES OF PURCHASING ARRANGEMENTS.—

14 (1) IN GENERAL.—Subject to paragraph (2),
15 each purchasing arrangement shall—

16 (A) market MedAccess coverage to mem17 bers throughout the entire area served by the
18 arrangement;

(B) enter into agreements with insurers offering MedAccess coverage under section 1122;
(C) enter into agreements with small employers under section 1123;

23 (D) enroll individuals in MedAccess cov24 erage, only in accordance with section 1124;
25 and

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1	(E) carry out other functions provided for
2	under this part.
3	(2) LIMITATION ON ACTIVITIES.—A purchasing
4	arrangement shall not—
5	(A) perform any activity (including review,
6	approval, or enforcement) relating to payment
7	rates for providers;
8	(B) perform any activity (including certifi-
9	cation or enforcement) relating to compliance of
10	insurers or coverage with the requirements of
11	parts 1 or 2;
12	(C) assume financial risk in relation to any
13	such coverage; or
14	(D) perform other activities identified by
15	the State as being inconsistent with the per-
16	formance of its duties under paragraph (1).
17	(3) Characteristics of service area.—A
18	purchasing arrangement need not serve areas that
19	are contiguous, but the geographic boundaries of
20	such areas shall be consistent with the boundaries
21	established for geographic areas used in establishing
22	premium rates in the individual and small group
23	marketplace. If a purchasing arrangement serves a
24	part of a metropolitan statistical area the arrange-
25	ment shall serve the entire area.

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

3 (1) that a purchasing arrangement be estab4 lished in each area of a State in which it operates;
5 and

6 (2) that there be only one purchasing arrange-7 ment established with respect to any area.

8 SEC. 1122. AGREEMENTS WITH INSURERS.

9 (a) AGREEMENTS.—

10 (1) IN GENERAL.—Except as provided in para-11 graph (3), each purchasing arrangement for an area 12 shall enter into an agreement under this section with 13 each insurer that desires to make MedAccess cov-14 erage available through the purchasing arrangement 15 (consistent with any procedures established by the 16 State).

17 (2) TERMINATION OF AGREEMENT.—An agree-18 ment under paragraph (1) shall remain in effect for 19 a 12-month period, except that the purchasing ar-20 rangement may terminate an agreement under para-21 graph (1) if the insurer's license or certification 22 under State law is terminated or for other good 23 cause shown.

24 (3) LIMITATION ON RENEWAL OF AGREE25 MENTS.—Subsequent to the 12-month period de-

scribed in paragraph (2), a purchasing arrangement
 may—

3 (A) refuse to enter into a subsequent 4 agreement with an insurer if the arrangement 5 determines that the enrollment or premium is 6 too low, and

7 (B) if a previous agreement with an in-8 surer was terminated for good cause and the 9 arrangement determines appropriate actions 10 have not been taken to correct the problems, 11 refuse to enter into a subsequent agreement 12 with the insurer.

13 (4) NO PROHIBITION ON OFFERING OF COV-14 ERAGE.—Nothing in this subsection shall be construed as prohibiting an insurer that does not enter 15 16 into an agreement under paragraph (1) from offer-17 ing health insurance coverage to small employers 18 and eligible individuals within any area, so long as 19 the premium rates charged outside such arrange-20 ment are the same as those charged within the ar-21 rangement (subject to reasonable differences in pre-22 miums that only reflect savings in administrative 23 costs under such an arrangement).

24 (b) RECEIPT OF PREMIUMS ON BEHALF OF 25 Plans.— 1 (1) IN GENERAL.—Under an agreement under 2 this section between a purchasing arrangement and 3 an insurer—

4 (A) premiums shall be payable, and
5 (B) payment of premiums may be made by
6 individuals (or employers on their behalf) di7 rectly to the purchasing arrangement for the
8 benefit of the insurer.

9 (2) TIMING OF PAYMENT OF PREMIUMS.—Pre-10 miums may be payable on a monthly basis (or, at 11 the option of an eligible employee or individual, on 12 a quarterly basis). The purchasing arrangement may 13 provide for reasonable penalties and grace periods 14 for late payment.

15 (3) QUALIFIED HEALTH PLANS RETAIN RISK OF 16 NONPAYMENT.—Nothing in this subsection shall be 17 construed as placing upon a purchasing arrangement 18 any risk associated with the failure of individuals 19 and employers to make prompt payment of pre-20 miums to the purchasing arrangement (other than 21 the portion of the premium representing the purchasing arrangement administrative fee under sec-22 tion 1125). Each small employer and eligible individ-23 24 ual who enrolls with an insurer through the purchasing arrangement is liable to the insurer for pre miums.

3 (c) Forwarding of Premiums.—

(1) IN GENERAL.—If, under an agreement 4 under subsection (a), premium payments for an in-5 6 surer are made to the purchasing arrangement, the 7 purchasing arrangement shall forward to the insurer 8 the amount of the premiums and the purchasing ar-9 rangement (and not the employer or individual) shall 10 be liable for the premium payment collected under 11 such arrangement.

(2) PAYMENTS.—Payments shall be made by
the purchasing arrangement under this subsection
within a period of days (specified by the Secretary
and not to exceed 7 days) after receipt of the premium from the small employer of the eligible employee or the eligible individual, as the case may be.
SEC. 1123. PROVISION OF INFORMATION.

(a) IN GENERAL.—Each purchasing arrangement for
an area shall provide, upon request, to each small employer that employs individuals in the area and to each
eligible individual who resides in the area—

(1) information provided to the purchasing ar-rangement by the State or insurers in accordance

with rules by the State in which such arrangement
 is located, and

3 (2) the opportunity to enter into an agreement
4 with the arrangement for the purchase of coverage
5 through the insurer.

6 (b) FORWARDING INFORMATION AND PAYROLL DE-7 DUCTIONS.—As part of an agreement entered into under 8 this section, a small employer shall forward the informa-9 tion and make the payroll deductions required under sec-10 tion 1001.

11 SEC. 1124. ENROLLING ELIGIBLE EMPLOYEES AND ELIGI12 BLE INDIVIDUALS THROUGH A PURCHASING
13 ARRANGEMENT.

A purchasing arrangement shall offer, on behalf of each insurer with which an agreement was entered into under section 1122 and in accordance with the enrollment procedures of such insurers, enrollment in health insurance coverage only to—

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

22 (2) all eligible individuals residing in such area.
23 SEC. 1125. RESTRICTION ON CHARGES.

24 (a) IN GENERAL.—A purchasing arrangement may25 impose an administrative fee with respect to an eligible

employee or eligible individual obtaining coverage through
 the purchasing arrangement.

3 (b) FEE.—A purchasing arrangement that elects to 4 impose a fee under subsection (a) shall ensure that such 5 fee is set as a percentage of the premium for such coverage 6 and is imposed uniformly with respect to all coverage pro-7 vided through the arrangement.

8 PART 4—DEFINITIONS AND MISCELLANEOUS 9 PROVISIONS

10 SEC. 1131. DEFINITIONS.

11 Except as otherwise specifically provided, for pur-12 poses of this subtitle:

(1) DEPENDENT CHILD.—The term "dependent
child" means a child (including an adopted child)
who is under 19 years of age or who is a full-time
student and under 25 years of age.

17 (2) ELIGIBLE EMPLOYEE.—The term "eligible
18 employee" means, with respect to an employer, an
19 employee who—

20 (A) normally performs on a monthly basis
21 at least 10 hours of service per week for that
22 employer; or

(B) is reasonably expected as of the 1st
day of such month to be employed by the employer for a period of 120 consecutive days dur-

1	ing any 365-day period that includes such 1st
2	day.
3	(3) EMPLOYER.—The term ''employer'' shall
4	have the meaning applicable under section $3(5)$ of
5	the Employee Retirement Income Security Act of
6	1974.
7	(4) Health insurance coverage.—
8	(A) IN GENERAL.—Except as provided in
9	subparagraph (B), the term ''health insurance
10	coverage" means any hospital or medical service
11	policy or certificate, hospital or medical service
12	plan contract, or health maintenance organiza-
13	tion group contract offered by an insurer.
14	(B) EXCEPTION.—Such term does not in-
15	clude any of the following:
16	(i) Coverage only for accident, dental,
17	vision, disability income, or long-term care
18	insurance, or any combination thereof.
19	(ii) Medicare supplemental health in-
20	surance.
21	(iii) Coverage issued as a supplement
22	to liability insurance.
23	(iv) Liability insurance, including gen-
24	eral liability insurance and automobile li-
25	ability insurance.

1	(v) Worker's compensation or similar
2	insurance.
3	(vi) Automobile medical-payment in-
4	surance.
5	(vii) Coverage for a specified disease
6	or illness.
7	(viii) A hospital or fixed indemnity
8	policy.
9	(5) NETWORK PLAN.—The term ''network
10	plan'' includes, as defined in standards established
11	under section 1103, an organization that provides
12	health insurance coverage which meets specified
13	standards and under which health services are of-
14	fered to be provided on an at-risk basis primarily
15	through a defined set of providers.
16	(6) INSURER.—The term ''insurer'' means a li-
17	censed insurance company, an entity offering pre-
18	paid hospital or medical services, and a health main-
19	tenance organization offering such services to an
20	employer, and includes a similar organization regu-
21	lated under State law for solvency.
22	(7) NAIC.—The term "NAIC" means the Na-
23	tional Association of Insurance Commissioners.
24	(8) SECRETARY.—The term "Secretary" means
25	the Secretary of Health and Human Services.

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1	(9) SMALL EMPLOYER.—The term "small em-
2	ployer" means, with respect to a calendar year, an
3	employer that normally employs more than 1 but
4	less than 51 eligible employees on a typical business
5	day. For the purposes of this paragraph, the term
6	"employee" includes a self-employed individual. For
7	purposes of determining if an employer is a small
8	employer, rules similar to the rules of subsection (b)
9	and (c) of section 414 of the Internal Revenue Code
10	of 1986 shall apply.
11	(10) STATE.—The term "State" means the 50
12	States, the District of Columbia, Puerto Rico, the
13	Virgin Islands, Guam, and American Samoa.
14	(11) STATE COMMISSIONER OF INSURANCE.—
15	The term "State commissioner of insurance" in-
16	cludes a State superintendent of insurance.
17	SEC. 1132. ENFORCEMENT.
18	For enforcement of requirements of this subtitle, see
19	section 1031.
20	SEC. 1133. PROHIBITION OF IMPROPER INCENTIVES.
21	(a) Limitation on Financial Incentives.—No in-
22	surer that offers health insurance coverage may vary the
23	commission or financial or other remuneration to a person
24	based on the claims experience or health status of individ-

25 uals enrolled by or through the person.

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

5 SEC. 1134. ANNUAL REPORTS.

6 (a) IN GENERAL.—The Secretary shall submit to 7 Congress an annual report on the implementation of this 8 subtitle and the need for additional reforms to assure and 9 expand coverage.

10 (b) INFORMATION REGARDING IMPACT OF RE11 FORMS.—Each annual report shall include information
12 concerning at least the following:

(1) Implementation and enforcement of the applicable MedAccess standards and consumer protection standards under this subtitle by the States and
by the Secretary.

(2) An evaluation of the impact of the reforms
under this subtitle on the availability of affordable
health coverage for individuals and for small employers that purchase group health coverage and for
their employees, and, in particular, the impact of—
(A) guaranteed availability of health coverage,

24 (B) limitations of restrictions from cov-25 erage of preexisting conditions,

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1	(C) requirement for continuity of coverage,
2	(D) risk-management mechanisms for
3	health coverage,
4	(E) limits on premium variations, and
5	(F) preemption of State benefit mandates.
6	In performing such evaluation, the Secretary shall
7	seek to discount the effect of the insurance cycle on
8	health insurance premiums.
9	(3) An assessment of the implications of the re-
10	forms on adverse selection among health insurance
11	plans and the distribution of risk among health in-
12	surance plans.
13	(c) Information Regarding Coverage of the
14	UNINSURED.—The report submitted under this section 5
15	years after the date of the enactment of this Act also shall
16	include findings and recommendations regarding each of
17	the following:
18	(1) Characteristics of the insured and unin-
19	sured, including demographic characteristics, work-
20	ing status, health status, and geographic distribu-
21	tion.
22	(2) Steps which should be taken to improve ac-
23	cess to health care and increase health insurance
24	coverage of the chronically uninsured.

(3) Effectiveness of efforts to measure and im prove health care outcomes in the public and private
 sectors.

4 (4) Effectiveness of initiatives targeted to im5 proving access of underserved urban and rural popu6 lations to health care services.

7 (5) Effectiveness of new Federal subsidy pro8 grams, including recommendations to restrain future
9 growth of such programs.

 10
 SEC. 1135. RESEARCH AND DEMONSTRATION PROJECTS;

 11
 DEVELOPMENT OF A HEALTH RISK POOLING

 12
 MODEL.

(a) RESEARCH AND DEMONSTRATIONS.—The Secretary is authorized, directly, by contract, and through
grants and cooperative agreements within the Department
of Health and Human Services and outside the Department—

(1) to conduct research on the impact of this
subtitle on the availability of affordable health coverage for employees and dependents in the small employers group and individual health care coverage
market and other topics described in section
1134(b), and

24 (2) to conduct demonstration projects relating25 to such topics.

1	(b) Development of Methods of Measuring
2	Relative Health Risk.—
3	(1) IN GENERAL.—The Secretary shall develop
4	methods for measuring, in terms of the expected
5	costs of providing benefits under health insurance
6	plans and, in particular, MedAccess plans, the rel-
7	ative health risks of eligible individuals.
8	(2) METHODOLOGY.—The methods—
9	(A) shall rely on diagnosis or other health-
10	related information that is predictive of individ-
11	ual health care needs,
12	(B) may rely upon information routinely
13	collected in the process of making payments
14	under group health plans, and
15	(C) may provide for such random, sample
16	audits of records as may be necessary to verify
17	the accuracy of measurements.
18	(c) Development of a Health Risk Pooling
19	Model.—
20	(1) IN GENERAL.—The Secretary shall develop
21	a model, based on the methods of measuring risks
22	under subsection (b), for equitably distributing
23	health risks among insurers and group health plans
24	

25 erage market.

1 (2) REDISTRIBUTION OF RISK.—Under such 2 model, insurers and group health plans with below 3 average health risks would be required to contribute 4 to a common fund for payment to insurers and 5 group health plans with above average health risks, 6 each in relation to the degree of their favorable or 7 adverse risk selection.

8 (3) INCENTIVES.—Such model shall include in-9 centives to encourage continuous coverage of individ-10 uals and eligible individuals and small employers.

(d) CONSULTATION.—The methods and model underthis section shall be developed in consultation with theNAIC.

14 (e) REPORT.—By not later than January 1, 1996, the Secretary shall submit to Congress a report on the 15 methods and model developed under this section (as well 16 as on research and demonstration projects conducted 17 under subsection (a)). The Secretary shall include in the 18 report such recommendations respecting the application of 19 20 the model to insurers and group health plans (and, in particular, to MedAccess plans) under this subtitle as the Sec-21 22 retary deems appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There
are authorized to be appropriated to carry out this section,
\$5,000,000 in each of fiscal years 1995 through 1999.

Subtitle C—Preemption 1 2 **PART 1—SCOPE OF STATE REGULATION** 3 SEC. 1201. PROHIBITION OF STATE BENEFIT MANDATES 4 FOR GROUP HEALTH PLANS. 5 In the case of a group health plan, no provision of State or local law shall apply that requires the coverage 6 of one or more specific benefits, services, or categories of 7 health care, or services of any class or type of provider 8 of health care. 9 10 SEC. 1202. PROHIBITION OF PROVISIONS PROHIBITING EM-11 **PLOYER** GROUPS FROM PURCHASING 12 HEALTH INSURANCE. 13 No provision of State or local law shall apply that 14 prohibits 2 or more employers from obtaining coverage under a multiple employer welfare arrangement under 15 which all coverage consists of medical care described in 16 section 607(1) of the Employee Retirement Income Secu-17 18 rity Act of 1974 and is fully insured. 19 SEC. 1203. PREEMPTION OF STATE ANTI-MANAGED CARE 20 LAWS. 21 (a) PREEMPTION OF STATE LAW PROVISIONS.—Subject to subsection (c), the following provisions of State law 22

are preempted and may not be enforced: 23

24 (1) RESTRICTIONS ON REIMBURSEMENT RATES 25 OR SELECTIVE CONTRACTING.—Any law that re-

1	stricts the ability of a group health plan or insurer
2	to negotiate reimbursement rates with providers or
3	to contract selectively with one provider or a limited
4	number of providers.
5	(2) Restrictions on differential finan-
6	CIAL INCENTIVES.—Any law that limits the financial
7	incentives that a group health plan or insurer may
8	require a beneficiary to pay when a non-plan pro-
9	vider is used on a non-emergency basis.
10	(3) Restrictions on utilization review
11	METHODS.—Any law that—
12	(A) prohibits utilization review of any or
13	all treatments and conditions,
14	(B) requires that such review be made (i)
15	by a resident of the State in which the treat-
16	ment is to be offered or by an individual li-
17	censed in such State, or (ii) by a physician in
18	any particular specialty or with any board cer-
19	tified specialty of the same medical specialty as
20	the provider whose services are being reviewed,
21	(C) requires the use of specified standards
22	of health care practice in such reviews or re-
23	quires the disclosure of the specific criteria used
24	in such reviews,

1	(D) requires payments to providers for the
2	expenses of responding to utilization review re-
3	quests,
4	(E) imposes liability for delays in perform-
5	ing such review, or
6	(F) requires standards in addition to or in-
7	consistent with standards established under sec-
8	tion 1022(b).
9	Nothing in subparagraph (B) shall be construed as
10	prohibiting a State from (i) requiring a licensed phy-
11	sician or other health care professional be available
12	at some time in the review or appeal process, or (ii)
13	requiring that any decision in an appeal from such
14	a review be made by a licensed physician.
15	(b) GAO STUDY.—
16	(1) IN GENERAL.—The Comptroller General
17	shall conduct a study of the benefits and cost effec-
18	tiveness of the use of managed care in the delivery
19	of health services.
20	(2) REPORT.—By not later than 4 years after
21	the date of the enactment of this Act, the Comptrol-
22	ler General shall submit a report to Congress on the
23	study conducted under paragraph (1) and shall in-
24	clude in the report such recommendations (including

whether the provisions of subsection (a) should be
 extended) as may be appropriate.

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

6 SEC. 1204. DEFINITIONS.

13

For purposes of this part, the terms "dependent", 8 "employee", "employer", "fully insured", "group health 9 plan", "health insurance plan", "multiple employer wel-10 fare arrangement", and "State" have the meanings given 11 such terms in section 1023(a).

12 PART 2—MULTIPLE EMPLOYER HEALTH

BENEFITS PROTECTIONS

14 SEC. 1211. LIMITED EXEMPTION FROM CERTAIN RESTRIC-

15TIONS ON ERISA PREEMPTION OF STATE LAW16FOR HEALTH PLANS MAINTAINED BY MUL-17TIPLE EMPLOYERS SUBJECT TO CERTAIN18FEDERAL 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:

22 "Part 7—Multiple Employer Health Plans

23 **"SEC. 701. DEFINITIONS.**

24 "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.

5 "(2) PARTICIPATING EMPLOYER.—The term 6 'participating employer' means, in connection with a 7 multiple employer welfare arrangement, any em-8 ployer if any of its employees, or any of the depend-9 ents of its employees, are or were covered under 10 such arrangement in connection with the employ-11 ment of the employees.

"(3) EXCESS/STOP LOSS COVERAGE.—The term 12 'excess/stop loss coverage' means, in connection with 13 14 a multiple employer welfare arrangement, a contract 15 under which an insurer provides for payment with 16 respect to claims under the arrangement, relating to 17 participants or beneficiaries individually or other-18 wise, in excess of an amount or amounts specified in 19 such contract.

20 "(4) QUALIFIED ACTUARY.—The term 'quali21 fied actuary' means an individual who is a member
22 of the American Academy of Actuaries or meets
23 such reasonable standards and qualifications as the
24 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.

5 "(6) STATE INSURANCE COMMISSIONER.—The 6 term 'State insurance commissioner' means the in-7 surance commissioner (or similar official) of a State.

(7) Domicile state.—The term 'domicile 8 9 State' means, in connection with a multiple employer 10 welfare arrangement, the State in which, according 11 to the application for an exemption under this part, most individuals to be covered under the arrange-12 13 ment are located, except that, in any case in which 14 information contained in the latest annual report of the arrangement filed under this part indicates that 15 16 most individuals covered under the arrangement are 17 located in a different State, such term means such 18 different State.

19 "(8) FULLY INSURED.—Coverage under a mul20 tiple employer welfare arrangement is 'fully insured'
21 if one or more insurers, health maintenance organi22 zations, similar organizations regulated under State
23 law for solvency, or any combination thereof are lia24 ble under one or more insurance policies or contracts
25 for all benefits under the arrangement (irrespective

of any recourse they may have against other par ties).

3 "(9) EXEMPTED MULTIPLE EMPLOYER HEALTH
4 PLAN.—The term 'exempted multiple employer
5 health plan' means a multiple employer welfare ar6 rangement treated as an employee welfare benefit
7 plan by reason of an exemption under this part.

8 ''(10) COMMUNITY HEALTH NETWORK.—The
9 term 'community health network' has the meaning
10 given such term in section 1421 of the Affordable
11 Health Care Now Act of 1994.

 12 "SEC. 702. EXEMPTED MULTIPLE EMPLOYER HEALTH

 13
 PLANS RELIEVED OF CERTAIN RESTRIC

 14
 TIONS ON PREEMPTION OF STATE LAW AND

 15
 TREATED AS EMPLOYEE WELFARE BENEFIT

 16
 PLANS.

17 "(a) IN GENERAL.—Subject to subsection (b), a mul-18 tiple employer welfare arrangement under which coverage 19 is not fully insured and with respect to which there is in 20 effect an exemption granted by the Secretary under this 21 part (or with respect to which there is pending a complete 22 application for such an exemption and the Secretary deter-23 mines that provisional protection under this part is appro-24 priate)— "(1) shall be treated for purposes of subtitle A
 and the preceding parts of this subtitle as an em ployee welfare benefit plan, irrespective of whether
 such arrangement is an employee welfare benefit
 plan, and

6 ''(2) shall be exempt from section 7 514(b)(6)(A)(ii).

8 "(b) BENEFITS MUST CONSIST OF MEDICAL 9 CARE.—Subsection (a) shall apply to a multiple employer welfare arrangement only if the benefits provided there-10 under consist solely of medical care described in section 11 12 607(1) (disregarding such incidental benefits as the Secretary shall specify by regulation). 13

14 "(c) Restriction on Commencement of New Ar-RANGEMENTS.—A multiple employer welfare arrangement 15 providing benefits which consist of medical care described 16 in section 607(1) which has not commenced operations as 17 of January 1, 1995, may commence operations only if an 18 19 exemption granted to the arrangement under this part is 20 in effect (or there is pending with respect to the arrange-21 ment a complete application for such an exemption and 22 the Secretary determines that provisional protection under this part is appropriate). 23

1 "SEC. 703. EXEMPTION PROCEDURE.

2 "(a) IN GENERAL.—The Secretary shall grant an ex3 emption described in section 702(a) to a multiple employer
4 welfare arrangement if—

5 "(1) an application for such exemption with re-6 spect to such arrangement, identified individually or 7 by class, has been duly filed in complete form with 8 the Secretary in accordance with this part,

9 "(2) such application demonstrates compliance 10 with the requirements of section 704 with respect to 11 such arrangement, and

12 "(3) the Secretary finds that such exemption
13 is—

14 "(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.

20 "(b) NOTICE AND HEARING.—Before granting an ex-21 emption under this section, the Secretary shall publish no-22 tice in the Federal Register of the pendency of the exemp-23 tion, shall require that adequate notice be given to inter-24 ested persons, including the State insurance commissioner 25 of each State in which covered individuals under the ar-26 rangement are, or are expected to be, located, and shall

afford interested persons opportunity to present views. 1 2 The Secretary may not grant an exemption under this section unless the Secretary affords an opportunity for a 3 4 hearing and makes a determination on the record with re-5 spect to the findings required under subsection (a)(3). The Secretary shall, to the maximum extent practicable, make 6 7 a final determination with respect to any application filed under this section in the case of a newly established ar-8 9 rangement within 90 days after the date which the Sec-10 retary determines is the date on which such application is filed in complete form. 11

12 "SEC. 704. ELIGIBILITY REQUIREMENTS.

13 "(a) APPLICATION FOR EXEMPTION.—

14 "(1) IN GENERAL.—An exemption may be
15 granted by the Secretary under this part only on the
16 basis of an application filed with the Secretary in
17 such form and manner as shall be prescribed in reg18 ulations of the Secretary. Any such application shall
19 be signed by the operating committee and the spon20 sor 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

1	sole purpose of administering the exemption proce-
2	dures under this part.
3	"(3) INFORMATION INCLUDED.—An application
4	filed under this section shall include, in a manner
5	and form prescribed in regulations of the Secretary,
6	at least the following information:
7	"(A) Identifying information.—The
8	names and addresses of-
9	''(i) the sponsor, and
10	''(ii) the members of the operating
11	committee of the arrangement.
12	"(B) STATES IN WHICH ARRANGEMENT IN-
13	TENDS TO DO BUSINESS.—The States in which
14	individuals covered under the arrangement are
15	to be located and the number of such individ-
16	uals expected to be located in each such State.
17	"(C) BONDING REQUIREMENTS.—Evidence
18	provided by the operating committee that the
19	bonding requirements of section 412 will be met
20	as of the date of the application.
21	"(D) PLAN DOCUMENTS.—A copy of the
22	documents governing the arrangement (includ-
23	ing any bylaws and trust agreements), the sum-
24	mary plan description, and other material de-
25	scribing the benefits and coverage that will be

provided to individuals covered under the ar-1 2 rangement. "(E) AGREEMENTS WITH SERVICE PROVID-3 4 ERS.—A copy of any agreements between the arrangement and contract administrators and 5 6 other service providers. 7 "(F) FUNDING REPORT.—A report setting 8 forth information determined as of a date with-9 in the 120-day period ending with the date of 10 the application, including the following: 11 "(i) RESERVES.—A statement, cer-12 tified by the operating committee of the ar-13 rangement, and a statement of actuarial 14

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.

18 "(ii) Adequacy of contribution 19 RATES.—A statement of actuarial opinion, 20 signed by a qualified actuary, which sets 21 forth a description of the extent to which 22 contribution rates are adequate to provide for the payment of all obligations and the 23 24 maintenance of required reserves under the arrangement for the 12-month period be-25

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1 ginning with such date within such 120-2 day period, taking into account the ex-3 pected coverage and experience of the arrangement. If the contribution rates are 4 not fully adequate, the statement of actu-5 6 arial opinion shall indicate the extent to 7 which the rates are inadequate and the 8 changes needed to ensure adequacy.

"(iii) 9 Current AND PROJECTED 10 VALUE OF ASSETS AND LIABILITIES.—A 11 statement of actuarial opinion signed by a 12 qualified actuary, which sets forth the cur-13 rent value of the assets and liabilities accu-14 mulated under the arrangement and a projection of the assets, liabilities, income, 15 16 and expenses of the arrangement for the 17 12-month period referred to in clause (ii). 18 The income statement shall identify sepa-19 rately the arrangement's administrative ex-20 penses and claims.

21 "(iv) Costs of coverage to be 22 CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be 23 24 charged, including an itemization of 25 amounts for administration, reserves, and

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1 other expenses associated with the operation of the arrangement. 2 "(v) 3 OTHER INFORMATION.—Any 4 other information which may be prescribed 5 in regulations of the Secretary as nec-6 essary to carry out the purposes of this 7 part. "(b) OTHER REQUIREMENTS.—A complete applica-8 9 tion for an exemption under this part shall include infor-10 mation which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following 11 requirements are met with respect to the arrangement: 12 13 "(1) Sponsor.— 14 "(A) IN GENERAL.—Except in a case to 15 which subparagraph (B) or (C) applies, the 16 sponsor is, and has been (together with its im-17 mediate predecessor, if any) for a continuous 18 period of not less than 3 years before the date 19 of the application, organized and maintained in 20 good faith, with a constitution and bylaws spe-21 cifically stating its purpose, as a trade associa-22 tion, an industry association, a professional as-23 sociation, or a chamber of commerce (or similar 24 business group), for substantial purposes other

than that of obtaining or providing medical care

1 described in section 607(1), and the applicant 2 demonstrates to the satisfaction of the Sec-3 retary that the sponsor is established as a per-4 manent entity which receives the active support of its members. 5 6 "(B) Special rule for community 7 HEALTH NETWORKS.—In the case of an ar-8 rangement that is a community health network 9 (as defined in section 701(11)), the sponsor is 10 the operating committee of the network. 11 ((C) Special rule for employers in 12 THE SAME TRADE OR BUSINESS.—In the case 13 of an arrangement under which all participating 14 employers are engaged in a common type of 15 trade or business, the sponsor is the operating 16 committee of the arrangement. 17 "(2) Operating committee.— 18 "(A) IN GENERAL.—Except as provided in 19 subparagraph (B), the arrangement is operated, 20 pursuant to a trust agreement, by an operating 21 committee which has complete fiscal control 22 over the arrangement and which is responsible 23 for all operations of the arrangement, and the 24 operating committee has in effect rules of oper-

ation and financial controls, based on a 3-year

1 plan of operation, adequate to carry out the 2 terms of the arrangement and to meet all re-3 quirements of this title applicable to the ar-4 rangement. The members of the committee are individuals selected from individuals who are 5 6 the owners, officers, directors, or employees of 7 the participating employers or who are partners 8 in the participating employers and actively par-9 ticipate in the business. No such member is an 10 owner, officer, director, or employee of, or part-11 ner in, a contract administrator or other service 12 provider to the arrangement, except that offi-13 cers or employees of a sponsor which is a serv-14 ice provider (other than a contract adminis-15 trator) to the arrangement may be members of 16 the committee if they constitute not more than 17 25 percent of the membership of the committee 18 and they do not provide services to the arrange-19 ment other than on behalf of the sponsor. The 20 committee has sole authority to approve appli-21 cations for participation in the arrangement 22 and to contract with a service provider to ad-23 minister the day-to-day affairs of the arrange-24 ment.

1	"(B) Special rule for community
2	HEALTH NETWORKS.—In the case of an ar-
3	rangement that is a community health network
4	(as defined in section 701(11)), the operating
5	committee is the board of the entity that is the
6	network.
7	"(3) Contents of governing instru-
8	MENTS.—The instruments governing the arrange-
9	ment include a written instrument, meeting the re-
10	quirements of an instrument required under section
11	1212(a)(1), which—
12	"(A) provides that the committee serves as
13	the named fiduciary required for plans under
14	section $1212(a)(1)$ and serves in the capacity of
15	a plan administrator (referred to in section
16	3(16)(A)),
17	"(B) provides that the sponsor is to serve
18	as plan sponsor (referred to in section
19	3(16)(B)),
20	"(C) incorporates the requirements of sec-
21	tion 707, and
22	''(D) provides that, effective upon the
23	granting of an exemption under this part—
24	''(i) all participating employers must
25	be members or affiliated members of the

	-
1	sponsor, except that, in the case of a spon-
2	sor which is a professional association or
3	other individual-based association, if at
4	least one of the officers, directors, or em-
5	ployees of an employer, or at least one of
6	the individuals who are partners in an em-
7	ployer and who actively participates in the
8	business, is a member or affiliated member
9	of the sponsor, participating employers
10	may also include such employer, and
11	"(ii) all individuals thereafter com-
12	mencing coverage under the arrangement
13	must be—
14	"(I) active or retired owners, offi-
15	cers, directors, or employees of, or
16	partners in, participating employers,
17	or
18	"(II) the beneficiaries of individ-
19	uals described in subclause (I).
20	"(4) CONTRIBUTION RATES.—The contribution
21	rates referred to in subsection $(a)(3)(F)(ii)$ are
22	adequate.
23	"(5) Regulatory requirements.—Such
24	other requirements as the Secretary may prescribe

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by regulation as necessary to carry out the purposes
 of this part.

3 "(c) TREATMENT OF PARTY SEEKING EXEMPTION
4 WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

5 "(1) IN GENERAL.—In the case of any applica-6 tion for an exemption under this part with respect to a multiple employer welfare arrangement, if the 7 8 Secretary determines that the sponsor of the ar-9 rangement or any other person associated with the 10 arrangement is subject to disqualification under 11 paragraph (2), the Secretary may deny the exemption with respect to such arrangement. 12

13 "(2) DISQUALIFICATION.—A person is subject
14 to disqualification under this paragraph if such per15 son—

16 ''(A) has intentionally made a material
17 misstatement in the application for exemption;
18 ''(B) has obtained or attempted to obtain
19 an exemption under this part through misrepre20 sentation or fraud;

21 "(C) has misappropriated or converted to
22 such person's own use, or improperly withheld,
23 money held under a plan or any multiple
24 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 arrange ment 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 an exemption
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.

19 "(d) FRANCHISE NETWORKS.—In the case of a mul-20 tiple employer welfare arrangement established and main-21 tained by a franchisor for a franchise network consisting 22 of its franchisees, such franchisor shall be treated as the 23 sponsor referred to in the preceding provisions of this sec-24 tion, such network shall be treated as an association re-25 ferred to in such provisions, and each franchisee shall be

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treated as a member (of the association and the sponsor)
 referred to in such provisions, if all participating employ ers are such franchisees and the requirements of sub section (b)(1) with respect to a sponsor are met with
 respect to the network.

6 "(e) CERTAIN COLLECTIVELY BARGAINED ARRANGE-7 MENTS.—In applying the preceding provisions of this sec-8 tion in the case of a multiple employer welfare arrange-9 ment which would be described in section 3(40)(A)(i) but 10 for the failure to meet any requirement of section 11 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

15 "(2) the joint board of trustees shall be consid-16 ered the operating committee of the arrangement.

17 "(f) CERTAIN ARRANGEMENTS NOT MEETING SIN-18 GLE EMPLOYER REQUIREMENT.—

19 "(1) IN GENERAL.—In any case in which the
20 majority of the employees covered under a multiple
21 employer welfare arrangement are employees of a
22 single employer (within the meaning of clauses (i)
23 and (ii) of section 3(40)(B)), if all other employees
24 covered under the arrangement are employed by em-

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ployers who are related to such single employer, sub section (b)(3)(D) shall be disregarded.

3 "(2) RELATED EMPLOYERS.—For purposes of
4 paragraph (1), employers are 'related' if there is
5 among all such employers a common ownership in6 terest or a substantial commonality of business oper7 ations based on common suppliers or customers.

8 "SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO 9 EXEMPTED MULTIPLE EMPLOYER HEALTH 10 PLANS.

11 "(a) NOTICE OF MATERIAL CHANGES.—In the case of any exempted multiple employer health plan, descrip-12 tions of material changes in any information which was 13 required to be submitted with the application for the ex-14 emption granted under this part shall be filed in such form 15 and manner as shall be prescribed in regulations of the 16 17 Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified mat-18 ters which might serve as the basis for suspension or rev-19 ocation of the exemption. 20

"(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 an exempted multiple employer health plan in the same manner

and to the same extent as such requirements apply to em-1 ployee welfare benefit plans, irrespective of whether such 2 exemption continues in effect. The annual report required 3 under section 103 for any plan year in the case of any 4 such multiple employer welfare arrangement shall also in-5 clude information described in section 704(a)(3)(F) with 6 7 respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after 8 9 the close of the plan year.

"(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The 10 operating committee of each multiple employer welfare ar-11 rangement which is or has been an exempted multiple em-12 ployer health plan shall engage, on behalf of all covered 13 individuals, a qualified actuary who shall be responsible 14 for the preparation of the materials comprising informa-15 tion necessary to be submitted by a qualified actuary 16 under this part. The qualified actuary shall utilize such 17 assumptions and techniques as are necessary to enable 18 such actuary to form an opinion as to whether the con-19 tents of the matters reported under this part— 20

21 "(1) are in the aggregate reasonably related to
22 the experience of the arrangement and to reasonable
23 expectations, and

24 "(2) represent such actuary's best estimate of25 anticipated experience under the arrangement.

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The opinion by the qualified actuary shall be made with 1 respect to, and shall be made a part of, the annual report. 2 3 "(d) FILING NOTICE OF EXEMPTION WITH 4 STATES.—An exemption granted to a multiple employer 5 welfare arrangement under this part shall not be effective unless written notice of such exemption is filed with the 6 7 State insurance commissioner of each State in which at least 5 percent of the individuals covered under the ar-8 9 rangement are located. For purposes of this paragraph, an individual shall be considered to be located in the State 10 in which a known address of such individual is located or 11 in which such individual is employed. The Secretary may 12 by regulation provide in specified cases for the application 13 of the preceding sentence with lesser percentages in lieu 14 15 of such 5 percent amount.

16 "SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY

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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—

22 "(1) a document equivalent to the summary23 plan description required of plans under part 1,

24 "(2) information describing the contribution25 rates applicable to participating employers, and

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1	"(3) a statement indicating—
2	''(A) that the arrangement is not a li-
3	censed insurer under the laws of any State,
4	''(B) whether coverage under the arrange-
5	ment is fully insured, and
6	"(C) if coverage under the arrangement if
7	not fully insured, (i) whether the arrangement
8	is (or has ceased to be) an exempted multiple
9	employer health plan, and (ii) if such an ar-
10	rangement is an exempted multiple employer
11	health plan, that such arrangement is treated
12	as an employee welfare benefit plan under this
13	title.
14	"(b) TIME FOR DISCLOSURE.—Such information
15	shall be issued to employers within such reasonable period
16	of time before becoming participating employers as may
17	be prescribed in regulations of the Secretary.
18	"SEC. 707. MAINTENANCE OF RESERVES.
19	''(a) IN GENERAL.—Each multiple employer welfare

arrangement which is or has been an exempted multiple
employer health plan and under which coverage is not fully
insured shall establish and maintain reserves, consisting
of—

24 "(1) a reserve for unearned contributions,

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

5 "(3) a reserve, in an amount recommended by 6 the qualified actuary, for any other obligations of 7 the arrangement.

8 "(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.— 9 The total of the reserves described in subsection (a)(2) 10 shall not be less than an amount equal to 25 percent of 11 expected incurred claims and expenses for the plan year.

12 "(c) REQUIRED MARGIN.—In determining the 13 amounts of reserves required under this section in connec-14 tion with any multiple employer welfare arrangement, the 15 qualified actuary shall include a margin for error and 16 other fluctuations taking into account the specific 17 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 considers appropriate. Such requirements may be provided,
by regulation or otherwise, with respect to any arrangement or any class of arrangements.

24 "(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COV-25 ERAGE.—The Secretary may provide for adjustments to 1 the levels of reserves otherwise required under subsections 2 (a) and (b) with respect to any arrangement or class of 3 arrangements to take into account excess/stop loss cov-4 erage provided with respect to such arrangement or ar-5 rangements.

6 "(f) Alternative Means of Compliance.—The 7 Secretary may permit an arrangement (including a com-8 munity health network) to substitute, for all or part of 9 the reserves required under subsection (a), such security, 10 guarantee, or other financial arrangement as the Sec-11 retary determines to be adequate to enable the arrange-12 ment to fully meet all its financial obligations on a timely 13 basis.

14 "SEC. 708. CORRECTIVE ACTIONS.

"(a) 15 ACTIONS TO AVOID DEPLETION Re-OF SERVES.—A multiple employer welfare arrangement with 16 17 respect to which there is or has been in effect an exemption granted under this part shall continue to meet the 18 19 requirements of section 707, irrespective of whether such exemption continues in effect. The operating committee of 20 such arrangement shall determine semiannually whether 21 the requirements of section 707 are met. In any case in 22 which the committee determines that there is reason to 23 24 believe that there is or will be a failure to meet such re-25 quirements, or the Secretary makes such a determination

and so notifies the committee, the committee shall imme-1 diately notify the qualified actuary engaged by the ar-2 rangement, and such actuary shall, not later than the end 3 of the next following month, make such recommendations 4 5 to the committee for corrective action as the actuary determines necessary to ensure compliance with section 707. 6 7 Not later than 10 days after receiving from the actuary recommendations for corrective actions, the committee 8 9 shall notify the Secretary (in such form and manner as 10 the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, to-11 gether with a description of the actions (if any) that the 12 13 committee has taken or plans to take in response to such recommendations. The committee shall thereafter report 14 to the Secretary, in such form and frequency as the Sec-15 retary may specify to the committee, regarding corrective 16 action taken by the committee until the requirements of 17 section 707 are met. 18

19 "(b) TERMINATION.—

"(1) NOTICE OF TERMINATION.—In any case in
which the operating committee of a multiple employer welfare arrangement which is or has been an
exempted multiple employer health plan determines
that there is reason to believe that the arrangement
will terminate, the committee shall so inform the

1	Secretary, shall develop a plan for winding up the
2	affairs of the arrangement in connection with such
3	termination in a manner which will result in timely
4	payment of all benefits for which the arrangement is
5	obligated, and shall submit such plan in writing to
6	the Secretary. Actions required under this paragraph
7	shall be taken in such form and manner as may be
8	prescribed in regulations of the Secretary.
9	"(2) Actions required in connection with
10	TERMINATION.—In any case in which—
11	"(A) the Secretary has been notified under
12	subsection (a) of a failure of a multiple em-
13	ployer welfare arrangement which is or has
14	been an exempted multiple employer health plan
15	to meet the requirements of section 707 and
16	has not been notified by the operating commit-
17	tee of the arrangement that corrective action
18	has restored compliance with such require-
19	ments, and
20	"(B) the Secretary determines that the
21	continuing failure to meet the requirements of
22	section 707 can be reasonably expected to result
23	in a continuing failure to pay benefits for which
24	the arrangement is obligated,

1 the operating committee of the arrangement shall, at the direction of the Secretary, terminate the ar-2 3 rangement and, in the course of the termination, take such actions as the Secretary may require as 4 5 necessary to ensure that the affairs of the arrange-6 ment will be, to the maximum extent possible, wound 7 up in a manner which will result in timely payment 8 of all benefits for which the arrangement is 9 obligated.

10"SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF11EXEMPTION.

12 "(a) EXPIRATION AND RENEWAL OF EXEMPTION.— 13 An exemption granted to a multiple employer welfare ar-14 rangement under this part shall expire 3 years after the 15 date on which the exemption is granted. An exemption 16 which has expired may be renewed by means of application 17 for an exemption in accordance with section 704.

18 "(b) SUSPENSION OR REVOCATION OF EXEMPTION
19 BY SECRETARY.—The Secretary may suspend or revoke
20 an exemption granted to a multiple employer welfare
21 arrangement under this part—

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

25 "(2) if the Secretary finds that—

1	''(A) the arrangement, or the sponsor
2	thereof, in the transaction of business while
3	under the exemption, has used fraudulent, coer-
4	cive, or dishonest practices, or has dem-
5	onstrated incompetence, untrustworthiness, or
6	financial irresponsibility,
7	''(B) the arrangement, or the sponsor
8	thereof, is using such methods or practices in
9	the conduct of its operations, so as to render its
10	further transaction of operations hazardous or
11	injurious to participating employers, or covered
12	individuals,
13	''(C) the arrangement, or the sponsor
14	thereof, has refused to be examined in accord-
15	ance with this part or to produce its accounts,

17 with this part, or

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"(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.

records, and files for examination in accordance

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

5 "(c) Suspension or Revocation of Exemption UNDER COURT PROCEEDINGS.—An exemption granted to 6 7 a multiple employer welfare arrangement under this part 8 may be suspended or revoked by a court of competent ju-9 risdiction in an action by the Secretary brought under 10 paragraph (2), (5), or (6) of section 502(a), except that the suspension or revocation under this subsection shall 11 be effective only upon notification of the Secretary of such 12 13 suspension or revocation.

14 "(d) NOTIFICATION OF PARTICIPATING EMPLOY-ERS.—All participating employers in a multiple employer 15 welfare arrangement shall be notified of the expiration, 16 suspension, or revocation of an exemption granted to such 17 arrangement under this part, by such persons and in such 18 form and manner as shall be prescribed in regulations of 19 the Secretary, not later than 20 days after such expiration 20or after receipt of notice of a final decision requiring such 21 22 suspension or revocation.

23 "(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS,
24 AND REVOCATIONS.—The Secretary shall publish all expi-

rations of, and all final decisions to suspend or revoke,
 exemptions granted under this part.

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

"(a) IN GENERAL.—Any decision by the Secretary 4 5 which involves the denial of an application by a multiple employer welfare arrangement for an exemption under this 6 part or the suspension or revocation of such an exemption 7 8 shall contain a statement of the specific reason or reasons 9 supporting the Secretary's action, including reference to 10 the specific terms of the exemption and the statutory provision or provisions relevant to the determination. 11

12 "(b) DENIALS OF APPLICATIONS.—In the case of the 13 denial of an application for an exemption under this part, the Secretary shall send a copy of the decision to the appli-14 cant by certified or registered mail at the address specified 15 in the records of the Secretary. Such decision shall con-16 17 stitute the final decision of the Secretary unless the arrangement, or any party that would be prejudiced by the 18 decision, files a written appeal of the denial within 30 days 19 after the mailing of such decision. The Secretary may af-20 firm, modify, or reverse the initial decision. The decision 21 on appeal shall become final upon the mailing of a copy 22 by certified or registered mail to the arrangement or party 23 24 that filed the appeal.

1 "(c) Suspensions or Revocations of Exemp-TION.—In the case of the suspension or revocation of an 2 3 exemption granted under this part, the Secretary shall 4 send a copy of the decision to the arrangement by certified 5 or registered mail at its address, as specified in the records of the Secretary. Upon the request of the arrange-6 ment, or any party that would be prejudiced by the sus-7 pension or revocation, filed within 15 days of the mailing 8 9 of the Secretary's decision, the Secretary shall schedule 10 a hearing on such decision by written notice, sent by certified or registered mail to the arrangement or party 11 requesting such hearing. Such notice shall set forth— 12

"(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 shallconstitute the final decision of the Secretary, unless suchdecision is reversed in such hearing.".

1 (b) CONFORMING AMENDMENT TO DEFINITION OF PLAN SPONSOR.—Section 3(16)(B) of such Act (29) 2 U.S.C. 1002(16)(B)) is amended by adding at the end the 3 following new sentence: "Such term also includes the spon-4 sor (as defined in section 701(5)) of a multiple employer 5 welfare arrangement which is or has been an exempted 6 multiple employer health plan (as defined in section 7 701(10)).". 8

9 (c) ALTERNATIVE MEANS OF DISTRIBUTION OF 10 SUMMARY PLAN DESCRIPTIONS.—Section 110 of such 11 Act (29 U.S.C. 1030) is amended by adding at the end 12 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 8 607(1), a means of distribution of such descriptions by participating employers.".

20 (d) CLERICAL AMENDMENT.—The table of contents
21 in section 1 of the Employee Retirement Income Security
22 Act of 1974 is amended by inserting after the item relat23 ing to section 608 the following new items:

"Part 7—Multiple Employer Health Plans" Sec. 701. Definitions.

- "Sec. 702. Exempted multiple employer health plans relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.
- "Sec. 703. Exemption procedure.
- "Sec. 704. Eligibility requirements.
- "Sec. 705. Additional requirements applicable to exempted 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 exemption.
- "Sec. 710. Review of actions of the secretary."

1 SEC. 1212. CLARIFICATION OF SCOPE OF PREEMPTION

RULES.

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3 (a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the Employee Retirement Income Security Act of 1974 (29 4 5 U.S.C. 1144(b)(6)(A)(ii) is amended by inserting ", but only, in the case of an arrangement which provides medi-6 cal care described in section 607(1) and with respect to 7 which an exemption under part 7 is not in effect," before 8 "to the extent not inconsistent with the preceding sections 9 10 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:

14 "(E) For additional rules relating to exemption from
15 subparagraph (A)(ii) of multiple employer welfare ar16 rangements providing medical care, see part 7.".

1 SEC. 1213. CLARIFICATION OF TREATMENT OF SINGLE EM-2 **PLOYER ARRANGEMENTS.** 3 Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is 4 amended— 5 (1) in clause (i), by inserting "for any plan year 6 7 of any such plan, or any fiscal year of any such other arrangement," after "single employer", and by 8 inserting "during such year or at any time during 9 the preceding 1-year period" after "common con-10 11 trol"; 12 (2) in clause (iii), by striking "common control 13 shall not be based on an interest of less than 25 percent" and inserting "an interest of greater than 25 14 percent may not be required as the minimum inter-15 16 est necessary for common control", and by striking "and" at the end, 17 18 (3) by redesignating clause (iv) as clause (v), 19 and 20 (4) by inserting after clause (iii) the following 21 new clause:

"(iv) in determining, after the application of 22 23 clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall 24 25 be treated as having only 1 participating employer 26 if, at the time the determination under clause (i) is •HR 5300 IH

1	made, the number of individuals who are employees			
2	and former employees of any one participating em-			
3	ployer and who are covered under the arrangement			
4	is greater than 95 percent of the aggregate number			
5	of all individuals who are employees or former em-			
6	ployees of participating employers and who are			
7	covered under the arrangement.".			
8	SEC. 1214. CLARIFICATION OF TREATMENT OF CERTAIN			
9	COLLECTIVELY BARGAINED ARRANGE-			
10	MENTS.			
11	(a) IN GENERAL.—Section $3(40)(A)(i)$ of the Em-			
12	ployee Retirement Income Security Act of 1974 (29			
13	U.S.C. 1002(40)(A)(i)) is amended to read as follows:			
14	''(i) under or pursuant to one or more collective			
15	bargaining agreements,".			
16	(b) LIMITATIONS.—Section $3(40)$ of such Act (29)			
17	U.S.C. $1002(40)$) is amended by adding at the end the			
18	following new subparagraphs:			
19	"(C) Clause (i) of subparagraph (A) shall			
20	apply only if—			
21	''(i) the plan or other arrangement,			
22	and the employee organization or any other			
23	entity sponsoring the plan or other ar-			
24	rangement, do not—			

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1	''(I) utilize the services of any li-
2	censed insurance agent or broker for
3	soliciting or enrolling employers or in-
4	dividuals as participating employers or
5	covered individuals under the plan or
6	other arrangement, or
7	''(II) pay a commission or any
8	other type of compensation to a per-
9	son that is related either to the vol-
10	ume or number of employers or indi-
11	viduals solicited or enrolled as partici-
12	pating employers or covered individ-
13	uals under the plan or other arrange-
14	ment, or to the dollar amount or size
15	of the contributions made by partici-
16	pating employers or covered individ-
17	uals to the plan or other arrangement,
18	"(ii) not less than 85 percent of the
19	covered individuals under the plan or other
20	arrangement are individuals who—
21	''(I) are employed within a bar-
22	gaining unit covered by at least one of
23	the collective bargaining agreements
24	with a participating employer (or are
25	covered on the basis of an individual's

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employment in such a bargaining unit), or

"(II) are present or former em-3 4 ployees of the sponsoring employee organization, of an employer who is or 5 was a party to at least one of the col-6 7 lective bargaining agreements, or of the plan or other arrangement or a 8 9 related plan or arrangement (or are covered on the basis of such present 10 11 or former employment),

"(iii) the plan or other arrangement 12 does not provide benefits to individuals 13 (other than individuals described in clause 14 15 (ii)(II)) who work outside the standard 16 metropolitan statistical area in which the 17 employee organization repsponsoring 18 resents employees (or to individuals (other 19 described than individuals in clause 20 (ii)(II)) on the basis of such work by others), except that in the case of a sponsor-21 22 ing employee organization that represents employees who work outside of any stand-23 24 ard metropolitan statistical area, this clause shall be applied by reference to the 25

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1	State in which the sponsoring organization
2	represents employees,
3	''(iv) the employee organization or
4	other entity sponsoring the plan or other
5	arrangement certifies to the Secretary each
6	year, in a form and manner which shall be
7	prescribed in regulations of the Sec-
8	retary—
9	''(I) that the plan or other ar-
10	rangement meets the requirements of
11	clauses (i), (ii), and (iii), and
12	''(II) if, for any year, 10 percent
13	or more of the covered individuals
14	under the plan are individuals not de-
15	scribed in subclause (I) or (II) of
16	clause (ii), the total number of cov-
17	ered individuals and the total number
18	of covered individuals not so de-
19	scribed.
20	"(D)(i) Clause (i) of subparagraph (A)
21	shall not apply to a plan or other arrangement
22	that is established or maintained pursuant to
23	one or more collective bargaining agreements
24	which the National Labor Relations Board de-
25	termines to have been negotiated or otherwise

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agreed	to	in	а	manr	ner	or	thro	ugh	cor	nduct
which	viola	ites	se	ction	8(a	ı)(2)	of	the	Nat	ional
Labor	Rela	tion	s A	Act (2	9 U	J.S.C	2. 15	8(a)	(2)).	
"((ii) (T) W	'n	never	2	Stat	o ins	ura	100	com-

4 (11)(1) Whenever a State insurance com missioner has reason to believe that this sub-5 6 paragraph is applicable to part or all of a plan 7 or other arrangement, the State insurance com-8 missioner may file a petition with the National 9 Labor Relations Board for a determination under clause (i), along with sworn written testi-10 11 mony 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).

17 "(III) The Board shall determine, upon 18 the petition and any response, whether, on the 19 facts before it, the plan or other arrangement 20 was negotiated, created, or otherwise agreed to in a manner or through conduct which violates 21 22 section 8(a)(2) of the National Labor Relations 23 Act (29 U.S.C. 158(a)(2)). Such determination 24 shall constitute a final determination for purposes of this subparagraph and shall be binding 25

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in all Federal or State actions with respect to the status of the plan or other arrangement under this subparagraph.

4 "(IV) A person aggrieved by the determination of the Board under subclause (III) 5 6 may obtain review of the determination in any United States court of appeals in the circuit in 7 8 which the collective bargaining at issue oc-9 curred. Commencement of proceedings under 10 this subclause shall not, unless specifically or-11 dered by the court, operate as a stay of any 12 State administrative or judicial action or pro-13 ceeding related to the status of the plan or 14 other arrangement, except that in no case may 15 the court stay, before the completion of the re-16 view, an order which prohibits the enrollment of 17 new individuals into coverage under a plan or 18 arrangement.".

19sec. 1215. Employee leasing healthcare arrange-20ments.

(a) EMPLOYEE LEASING HEALTHCARE 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) Employee Leasing Healthcare Arrange Ment.—

"(A) IN GENERAL.—Subject to subparagraph
(B), the term 'employee leasing healthcare 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 (herein-9 after in this paragraph referred to as the 'les-10 11 see'), under a lease or other arrangement en-12 tered into with any other business or other en-13 tity (hereinafter in this paragraph referred to as the 'lessor'), receives from the lessor the 14 15 services of individuals to be performed under 16 such lease or other arrangement, and

17 ''(ii) benefits consisting of medical care de18 scribed in section 607(1) are provided to such
19 individuals or such individuals and their de20 pendents as participants and beneficiaries.

"(B) EXCEPTION.—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 in-

dividuals 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.".

6 (b) TREATMENT EMPLOYEE OF LEASING 7 HEALTHCARE ARRANGEMENTS AS MULTIPLE EMPLOYER 8 WELFARE ARRANGEMENTS.—Section 3(40) of such Act 9 (29 U.S.C. 1002(40)) (as amended by the preceding provi-10 sions of this title) is further amended by adding at the end the following new subparagraph: 11

12 ''(E) The term 'multiple employer welfare arrange13 ment' includes any employee leasing healthcare arrange14 ment.''.

15 (c) Special Rules for Employee Leasing16 Healthcare Arrangements.—

17 (1) IN GENERAL.—Part 7 of subtitle B of title
18 I of such Act (as added by the preceding provisions
19 of this Act) is amended by adding at the end the fol20 lowing new section:

21 "SEC. 711. SPECIAL RULES FOR EMPLOYEE LEASING
22 HEALTHCARE ARRANGEMENTS.

23 "(a) IN GENERAL.—The requirements of paragraphs
24 (1), (2), and (3) of section 704(b) shall be treated as satis25 fied in the case of a multiple employer welfare arrange-

ment that is an employee leasing healthcare arrangement
 if the application for exemption includes information
 which the Secretary determines to be complete and accu rate and sufficient to demonstrate that the following
 requirements are met with respect to the arrangement:

6 "(1) 3-YEAR TENURE.—The lessor has been in
7 operation for not less than 3 years.

8 "(2) SOLICITATION RESTRICTIONS.—Employee 9 leasing services provided under the arrangement are 10 not solicited, advertised, or marketed through li-11 censed insurance agents or brokers acting in such 12 capacity.

13 "(3) CREATION OF EMPLOYMENT RELATION-14 SHIP.—

15 "(A) DISCLOSURE STATEMENT.—Written 16 notice is provided to each applicant for employ-17 ment subject to coverage under the arrange-18 ment, at the time of application for employment 19 and before commencing coverage under the ar-20 rangement, stating that the employer is the les-21 sor under the arrangement.

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

1	"(C) INFORMED RECRUITMENT OF LES-
2	SEE'S EMPLOYEES.—In any case in which the
3	lessor offers employment to an employee of a
4	lessee under the arrangement, the lessor in-
5	forms each employee in writing that his or her
6	acceptance of employment with the lessor is vol-
7	untary and that refusal of such offer will not be
8	deemed to be resignation from or abandonment
9	of current employment.
10	"(4) Requisite employer-employee rela-
11	TIONSHIP UNDER ARRANGEMENT.—Under the em-
12	ployer-employee relationship with the employees of
13	the lessor—
14	"(A) the lessor retains the ultimate author-
15	ity to hire, terminate, and reassign such em-
16	ployees,
17	"(B) the lessor is responsible for the pay-
18	ment of wages, payroll-related taxes, and em-
19	ployee benefits, without regard to payment by
20	
20	the lessee to the lessor for its services,
20 21	the lessee to the lessor for its services, ''(C) the lessor maintains the right of di-
21	"(C) the lessor maintains the right of di-

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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

9 "(E) no owner, officer, or director of, or 10 partner in, a lessee is an employee of the lessor, 11 and not more than 10 percent of the individuals 12 covered under the arrangement consist of own-13 ers, officers, or directors of, or partners in, 14 such a lessee (or any combination thereof).

15 "(b) DEFINITIONS.—For purposes of this section—
16 "(1) LESSOR.—The term 'lessor' means the
17 business or other entity from which services of indi18 viduals are obtained under an employee leasing
19 healthcare arrangement.

20 ''(2) LESSEE.—The term 'lessee' means a busi21 ness or other entity which receives the services of in22 dividuals provided under an employee leasing
23 healthcare arrangement.''.

24 (2) CLERICAL AMENDMENT.—The table of con25 tents in section 1 of such Act (as amended by the

1	preceding provisions of this title) is further amended
2	by inserting after the item relating to section 710
3	the following new item:
	"Sec. 711. Employee leasing healthcare arrangements.".
4	SEC. 1216. ENFORCEMENT PROVISIONS RELATING TO MUL-
5	TIPLE EMPLOYER WELFARE ARRANGEMENTS
6	AND EMPLOYEE LEASING HEALTHCARE AR-
7	RANGEMENTS.
8	(a) Enforcement of Filing Requirements.—
9	Section 502 of the Employee Retirement Income Security
10	Act of 1974 (29 U.S.C. 1132) is amended—
11	(1) in subsection (a)(6), by striking "subsection
12	(c)(2) or (i) or (l)" and inserting "paragraph (2) or
13	(4) of subsection (c) or subsection (i) or (l)"; and
14	(2) by adding at the end of subsection (c) the
15	following new paragraph:
16	"(4) The Secretary may assess a civil penalty against
17	any person of up to \$1,000 a day from the date of such
18	person's failure or refusal to file the information required
19	to be filed with the Secretary under section 101(e).".
20	(b) Actions by States in Federal Court.—Sec-
21	tion 502(a) of such Act (29 U.S.C. 1132(a)) is amended—
22	(1) in paragraph (5), by striking ''or'' at the
23	end;
24	(2) in paragraph (6), by striking the period and
24	(ω) in puragraph (0) , by striking the period and

1 (3) by adding at the end the following: "(7) by a State official having authority under 2 the law of such State to enforce the laws of such 3 4 State regulating insurance, to enjoin any act or 5 practice which violates any provision of part 7 which 6 such State has the power to enforce under part 7.". 7 (c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL 8 MISREPRESENTATIONS.—Section 501 of such Act (29) U.S.C. 1131) is amended— 9 (1) by inserting "(a)" after "SEC. 501."; and 10 11 (2) by adding at the end the following new sub-12 section: "(b) Any person who, either willfully or with willful 13 blindness, falsely represents, to any employee, any employ-14 ee's beneficiary, any employer, the Secretary, or any State, 15 an arrangement established or maintained for the purpose 16 of offering or providing any benefit described in section 17 18 3(1) to employees or their beneficiaries as— 19 "(1) being an exempted multiple employer wel-20 fare arrangement (as defined in section 701(10)), "(2) being an employee leasing healthcare ar-21 22 rangement under an exemption granted under part 23 7, or

"(3) having been established or maintained
 under or pursuant to a collective bargaining agree ment,

4 shall, upon conviction, be imprisoned not more than five5 years, be fined under title 18, United States Code, or6 both.".

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

10 "(m)(1) Subject to paragraph (2), upon application 11 by the Secretary showing the operation, promotion, or 12 marketing of a multiple employer welfare arrangement 13 providing benefits consisting of medical care described in 14 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 an exemption granted by the Secretary
under part 7,

21 a district court of the United States shall enter an order22 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(9),

"(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

9 "(C) with respect to each such State, it is oper-10 ating in accordance with applicable State insurance 11 laws that are not superseded under section 514.

12 "(3) The court may grant such additional equitable 13 or remedial relief, including any relief available under this 14 title, as it deems necessary to protect the interests of the 15 public and of persons having claims for benefits against 16 the arrangement.".

17 Responsibility for Claims Procedure.— (e) Section 503 of such Act (29 U.S.C. 1133) is amended by 18 adding at the end (after and below paragraph (2)) the fol-19 lowing new sentence: "The terms of each multiple em-20 21 ployer welfare arrangement to which this section applies 22 and which provides benefits consisting of medical care de-23 scribed in section 607(1) shall require the operating com-24 mittee or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection
 with claims filed under the arrangement.".

3 SEC. 1217. SOLVENCY REQUIREMENTS FOR CERTAIN SELF 4 INSURED GROUP HEALTH PLANS.

5 (a) IN GENERAL.—The Secretary of Labor shall prescribe by regulation provisions described in subsection (b) 6 7 applicable to group health plans which are not multiple 8 employer health plans, which offer coverage with respect 9 to employees of small employers (as defined in section 10 1131), and under which some or all coverage is not fully insured (within the meaning of section 701(9) of the Em-11 ployee Retirement Income Security Act of 1974)), for the 12 purpose of promoting adequate funding of such plans. 13

14 (b) REQUIREMENTS.—

(1) GENERAL RULE.—Except as provided in
paragraph (2), the provisions described in subsection
(a) shall require the group health plan to establish
and maintain reserves, consisting of—

19 (A) a reserve for unearned contributions,20 and

(B) 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.

1 (2) EXCEPTION.—The Secretary may in such 2 regulations permit a group health plan to substitute, 3 for all or part of the reserves required under paragraph (1), such security, guarantee, or other finan-4 5 cial arrangement as the Secretary determines to be 6 adequate to enable the plan to fully meet all its fi-7 nancial obligations on a timely basis. (c) CRITERIA FOR COMPLIANCE.—The criteria that 8 9 the Secretary shall take into account in determining com-10 pliance with the requirements described in subsection (b) shall include— 11 12 (1) the size of the employer involved; (2) the benefit package provided under the 13 14 plan; 15 (3) whether the coverage provided under the 16 plan is in the form of a fee-for-service arrangement, 17 a health maintenance organization, or any other type 18 of coverage; 19 (4) the extent to which excess/stop loss coverage 20 is maintained for the plan; and (5) the nature of any security, guarantee, or 21 other financial arrangement described in subsection 22 23 (b)(2) obtained for the plan.

Title I, Subtitle C

1	SEC. 1218. FILING REQUIREMENTS FOR MULTIPLE EM-
2	PLOYER WELFARE ARRANGEMENTS PROVID-
3	ING HEALTH BENEFITS.
4	Section 101 of the Employee Retirement Income Se-
5	curity Act of 1974 (29 U.S.C. 1021) is amended—
6	(1) by redesignating subsection (e) as sub-
7	section (f); and
8	(2) by inserting after subsection (d) the follow-
9	ing new subsection:
10	"(e)(1) Each multiple employer welfare arrangement
11	shall file with the Secretary a registration statement de-
12	scribed in paragraph (2) within 60 days before commenc-
13	ing operations (in the case of an arrangement commencing
14	operations on or after January 1, 1995) and no later than
15	February 15 of each year (in the case of an arrangement
16	in operation since the beginning of such year), unless, as
17	of the date by which such filing otherwise must be made,
18	such arrangement provides no benefits consisting of medi-
19	cal care described in section 607(1).
20	"(2) Each registration statement—
21	"(A) shall be filed in such form, and contain
22	such information concerning the multiple employer
23	welfare arrangement and any persons involved in its
24	operation (including whether coverage under the ar-
25	rangement is fully insured), as shall be provided in

1	regulations which shall be prescribed by the Sec-
2	retary, and
3	"(B) if coverage under the arrangement is not
4	fully insured, shall contain a certification that copies
5	of such registration statement have been transmitted
6	by certified mail to—
7	"(i) in the case of an arrangement which
8	is an exempted multiple employer health plan
9	(as defined in section 701(10)), the State insur-
10	ance commissioner of the domicile State of such
11	arrangement, or
12	''(ii) in the case of an arrangement which
13	is not an exempted multiple employer health
14	plan, the State insurance commissioner of each
15	State in which the arrangement is located.
16	"(3) The person or persons responsible for filing the
17	annual registration statement are—
18	"(A) the trustee or trustees so designated by
19	the terms of the instrument under which the mul-
20	tiple employer welfare arrangement is established or
21	maintained, or
22	''(B) in the case of a multiple employer welfare
23	arrangement for which the trustee or trustees can-
24	not be identified, or upon the failure of the trustee
25	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.

8 "(4) Any agreement entered into under section 9 506(c) with a State as the primary domicile State with 10 respect to any multiple employer welfare arrangement 11 shall provide for simultaneous filings of reports required 12 under this subsection with the Secretary and with the 13 State insurance commissioner of such State.".

14SEC. 1219. COOPERATION BETWEEN FEDERAL AND STATE15AUTHORITIES.

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:

19 "(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE20 Employer Welfare Arrangements.—

21 "(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

1 502 and 504 to enforce the provisions of this 2 title applicable to multiple employer welfare ar-3 rangements which are or have been exempted 4 multiple employer health plans (as defined in section 701(10)). The Secretary shall enter into 5 6 the agreement if the Secretary determines that the delegation provided for therein would not 7 result in a lower level or quality of enforcement 8 9 of the provisions of this title.

"(B) department, 10 DELEGATIONS.—Any 11 agency, or instrumentality of a State to which 12 authority is delegated pursuant to an agree-13 ment entered into under this paragraph may, if authorized under State law and to the extent 14 consistent with such agreement, exercise the 15 16 powers of the Secretary under this title which 17 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.

24 "(D) RECOGNITION OF PRIMARY DOMICILE
25 STATE.—In entering into any agreement with a

1	State under subparagraph (A), the Secretary
2	shall ensure that, as a result of such agreement
3	and all other agreements entered into under
4	subparagraph (A), only one State will be recog-
5	nized, with respect to any particular multiple
6	employer welfare arrangement, as the primary
7	domicile State to which authority has been dele-
8	gated pursuant to such agreements.
9	"(2) Assistance to states.—The Secretary
10	shall—
11	"(A) provide enforcement assistance to the
12	States with respect to multiple employer welfare
13	arrangements, including, but not limited to, co-
14	ordinating Federal and State efforts through
15	the establishment of cooperative agreements
16	with appropriate State agencies under which
17	the Pension and Welfare Benefits Administra-
18	tion keeps the States informed of the status of
19	its cases and makes available to the States in-
20	formation obtained by it,
21	"(B) provide continuing technical assist-
22	ance to the States with respect to issues involv-
23	ing multiple employer welfare arrangements
24	and this Act,
21	"(B) provide continuing technical

"(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 sub paragraph (B), and

6 ''(D) distribute copies of all advisory opin-7 ions described in subparagraph (C) to the State 8 insurance commissioner of each State.''.

9 SEC. 1220. EFFECTIVE DATE; TRANSITIONAL RULES.

10 (a) EFFECTIVE DATE.—The amendments made by 11 this part shall take effect January 1, 1995, except that 12 the Secretary of Labor may issue regulations before such 13 date under such amendments. The Secretary shall issue 14 all regulations necessary to carry out the amendments 15 made by this title before the effective date thereof.

(b) TRANSITIONAL RULES.—If the sponsor of a mul-16 tiple employer welfare arrangement which, as of January 17 1, 1995, provides benefits consisting of medical care de-18 scribed in section 607(1) of the Employee Retirement In-19 come Security Act of 1974 (29 U.S.C. 1167(1)) files with 20 21 the Secretary of Labor an application for an exemption 22 under part 7 of subtitle B of title I of such Act within 23 180 days after such date and the Secretary has not, as 24 of 90 days after receipt of such application, found such 25 application to be materially deficient, section 514(b)(6)(A)

of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply 1 2 with respect to such arrangement during the 18-month period following such date. If the Secretary determines, at 3 4 any time after the date of enactment of this Act, that any 5 such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such Act of a multiple employer 6 7 welfare arrangement would be detrimental to the interests 8 of individuals covered under such arrangement, such ex-9 clusion shall cease as of the date of the determination. 10 Any determination made by the Secretary under this subsection shall be in the Secretary's sole discretion. 11

12 PART 3-ENCOURAGEMENT OF MULTIPLE EM-

13 PLOYER ARRANGEMENTS PROVIDING BASIC

14 **HEALTH BENEFITS**

15 SEC. 1221. ELIMINATING COMMONALITY OF INTEREST OR

16 **GEOGRAPHIC LOCATION REQUIREMENT FOR**

17 TAX EXEMPT TRUST STATUS.

18 (a) IN GENERAL.—Paragraph (9) of section 501(c)
19 of the Internal Revenue Code of 1986 (relating to exempt
20 organizations) is amended—

- 21 (1) by inserting "(A)" after "(9)"; and
- 22 (2) by adding at the end the following:

23 "(B) Any determination of whether a multiple
24 employer health plan (as defined in section 701(10)
25 of the Employee Retirement Income Security Act of

1	1974) or an insured multiple employer health plan
2	(as defined in section $701(11)$ of such Act) is a vol-
3	untary employees' beneficiary association meeting
4	the requirements of this paragraph shall be made
5	without regard to any determination of commonality
6	of interest or geographic location if—
7	''(i) such plan provides at least standard
8	coverage (consistent with section 102(c) of the
9	Affordable Health Care Now Act of 1994), and
10	''(ii) in the case of an insured multiple em-
11	ployer health plan, it meets the requirements
12	enforceable under section 514(b)(6)(B)(i) of the
13	Employee Retirement Income Security Act of
14	1974 to the extent not preempted by section
15	1202 of the Affordable Health Care Now Act of
16	1994.''.
17	(b) EFFECTIVE DATE.—The amendments made by
18	subsection (a) shall apply with respect to determinations
19	made on or after January 1, 1995.
20	SEC. 1222. SINGLE ANNUAL FILING FOR ALL PARTICIPAT-
21	ING EMPLOYERS.
22	(a) IN GENERAL.—Section 110 of the Employee Re-
23	tirement Income Security Act of 1974 (29 U.S.C. 1030),
24	as amended by section 1211(c) of this subtitle, is amended
25	by adding at the end the following new subsection:

"(d) The Secretary shall prescribe by regulation or 1 otherwise an alternative method providing for the filing 2 3 of a single annual report (as referred to in section 4 104(a)(1)(A) with respect to all employers who are participating employers under a multiple employer welfare ar-5 rangement under which all coverage consists of medical 6 7 care (described in section 607(1)) and is fully insured (as 8 defined in section 701(9)).".

9 (b) EFFECTIVE DATE.—The amendment made by 10 subsection (a) shall take effect on the date of the enact-11 ment of this Act. The Secretary of Labor shall prescribe 12 the alternative method referred to in section 110(d) of the 13 Employee Retirement Income Security Act of 1974, as 14 added by such amendment, within 90 days after the date 15 of the enactment of this Act.

16 SEC. 1223. COMPLIANCE WITH COVERAGE REQUIREMENTS

- 17 THROUGH MULTIPLE EMPLOYER HEALTH AR-
- 18 RANGEMENTS.

(a) COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH MULTIEMPLOYER PLANS.—In any case in which an eligible employee is, for any plan year, a participant in a group health plan which is a multiemployer plan, the requirements of section 1001(a) shall be deemed to be met with respect to such employee for such plan year if the employer requirements of subsection (c) are met

with respect to the eligible employee, irrespective of wheth er, or to what extent, the employer makes employer con tributions on behalf of the eligible employee.

4 (b) COMPLIANCE WITH APPLICABLE REQUIREMENTS
5 THROUGH OTHER MULTIPLE EMPLOYER HEALTH AR6 RANGEMENTS.—

7 (1) IN GENERAL.—In any case in which an employer is, for any plan year, a participating employer 8 9 (as defined in paragraph (3)) in an exempted mul-10 tiple employer health plan or in a multiple employer 11 welfare arrangement under which all coverage consists of medical care (described in section 607(1) of 12 13 the Employee Retirement Income Security Act of 14 1974) and is fully insured (as defined in section 15 701(9) of such Act), the requirements of section 16 1001(a) shall be deemed to be met (and the ERISA 17 requirements of paragraph (2) shall be deemed to be 18 met by the employer) with respect to an eligible em-19 ployee of the employer if—

20 (A) the employer requirements of sub21 section (c) are met with respect to the eligible
22 employee, and

(B) the applicable ERISA requirements of
paragraph (2) are met by the plan or arrangement with respect to the plan or arrangement,

1	irrespective of whether, or to what extent, the em-
2	ployer makes employer contributions on behalf of the
3	eligible employee.
4	(2) Applicable erisa requirements.—The
5	applicable ERISA requirements of this paragraph
6	are the requirements of—
7	(A) part 1 of subtitle B of title I of the
8	Employee Retirement Income Security Act of
9	1974 (relating to reporting and disclosure),
10	(B) section 503 of such Act (relating to
11	claims procedure), and
12	(C) part 6 of subtitle B of such title I (re-
13	lating to group health plans),
14	to the extent that such requirements relate to em-
15	ployers as plan sponsors or plan administrators.
16	(3) Participating employer.—In this sub-
17	section, the term ''participating employer'' means, in
18	connection with an exempted multiple employer
19	health plan or a multiple employer welfare arrange-
20	ment under which all coverage consists of medical
21	care (described in section 607(1) of the Employee
22	Retirement Income Security Act of 1974) and is
23	fully insured (as defined in section 701(9) of such
24	Act), any employer if any of its employees, or any
25	of the dependents of its employees, are or were cov-

ered under such plan or arrangement in connection
 with the employment of the employees.

3 (c) EMPLOYER REQUIREMENTS.—The employer re4 quirements of this subsection are met under a plan or ar5 rangement with respect to an eligible employee if—

6 (1) the employee is eligible under the plan or 7 arrangement to elect coverage on an annual basis 8 and is provided a reasonable opportunity to make 9 the election in such form and manner and at such 10 times as are provided by the plan or arrangement,

(2) subject to section 1001(c), such coverage includes at least the standard coverage (consistent
with section 1102(c)),

(3) the employer facilitates collection of any
employee contributions under the plan or arrangement and permits the employee to elect to have employee contributions under the plan or arrangement
collected through payroll deduction, and

(4) in the case of a plan or arrangement to
which part 1 of subtitle B of title I of the Employee
Retirement Income Security Act of 1974 does not
otherwise apply, the employer provides to the employee a summary plan description described in section 102(a)(1) of such Act in the form and manner

1	and at such times as are required under such part
2	1 with respect to employee welfare benefit plans.
3	Subtitle D—Health Deduction
4	Fairness
5	SEC. 1301. PERMANENT EXTENSION AND INCREASE IN
6	HEALTH INSURANCE TAX DEDUCTION FOR
7	SELF-EMPLOYED INDIVIDUALS.
8	(a) Permanent Extension of Deduction.—
9	(1) IN GENERAL.—Subsection (1) of section 162
10	of the Internal Revenue Code of 1986 (relating to
11	special rules for health insurance costs of self-em-
12	ployed individuals) is amended by striking paragraph
13	(6).
14	(2) EFFECTIVE DATE.—The amendment made
15	by this subsection shall apply to taxable years begin-
16	ning after December 31, 1993.
17	(b) Increase in Amount of Deduction; Insur-
18	ance Purchased Must Meet Certain Standards.—
19	(1) Increase in amount of deduction.—
20	Paragraph (1) of section 162(l) of such Code is
21	amended by striking ''25 percent of'' and inserting
22	"100 percent (25 percent in the case of taxable
23	years beginning in 1994 or 1995 and 50 percent in
24	the case of taxable years beginning in 1996 or 1997)
25	of".

1 (2) INSURANCE PURCHASED MUST MEET CER-2 TAIN STANDARDS.—Paragraph (2) of section 162(l)of such Code is amended by adding at the end there-3 of the following new subparagraph: 4 "(C) TREATMENT OF GROUP HEALTH 5 6 PLANS.—For purposes of this subsection, an amount paid into a multiple employer health 7 plan (as defined in section 701(10) of the Em-8 9 ployee Retirement Income Security Act of 1974) shall be deemed to be an amount paid for 10 11 insurance which constitutes medical care.". (3) EFFECTIVE DATE.—The amendments made 12 by this subsection shall apply to taxable years begin-13 14 ning after December 31, 1994. 15 SEC. 1302. DEDUCTION OF HEALTH INSURANCE PREMIUMS 16 FOR CERTAIN PREVIOUSLY UNINSURED INDI-17 VIDUALS. 18 (a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., ex-19 penses) is amended by adding at the end thereof the fol-20 21 lowing new subsection: 22 "(f) DEDUCTION FOR CERTAIN HEALTH INSURANCE 23 COSTS DETERMINED WITHOUT REGARD TO ADJUSTED

24 GROSS INCOME THRESHOLD.—

1	"(1) IN GENERAL.—Subsection (a) shall be ap-
2	plied without regard to the limitation based on ad-
3	justed gross income in the case of the applicable per-
4	centage of the amounts paid for insurance referred
5	to in section $162(l)(2)(C)$ (and including payments
6	referred to in section 162(l)(2)(D)).
7	"(2) Applicable percentage.—For purposes
8	of paragraph (1), the term 'applicable percentage'
9	means—
10	"(A) 25 percent for taxable years begin-
11	ning in 1994 or 1995,
12	''(B) 50 percent for taxable years begin-
13	ning in 1996 or 1997, and
14	"(C) 100 percent for taxable years begin-
15	ning after 1997.
16	"(3) Deduction not allowed to individ-
17	UALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COV-
18	ERAGE.—
19	"(A) IN GENERAL.—Paragraph (1) shall
20	not apply to any individual—
21	"(i) who is eligible to participate in
22	any subsidized health plan maintained by
23	an employer of such individual or the
24	spouse of such individual, or

"(ii) who is (or whose spouse is) a 1 2 member of a subsidized class of employees of an employer of such individual or 3 4 spouse. "(B) SUBSIDIZED CLASS.—For purposes of 5 subparagraph (A), an individual is a member of 6 7 a subsidized class of employees of an employer if, at any time during the 3 calendar years end-8 9 ing with or within the taxable year, any member of such class was eligible to participate in 10 11 any subsidized health plan maintained by such employer. 12 13 "(C) Special rules.— 14 "(i) CONTROLLED GROUPS.—All persons treated as a single employer under 15 subsection (a) or (b) of section 52 or sub-16 17 section (m) or (o) of section 414 shall be 18 treated as a single employer for purposes 19 of subparagraph (B).

20 "(ii) CLASSES.—Classes of employees
21 shall be determined under regulations pre22 scribed by the Secretary based on such fac23 tors as the Secretary determines appro24 priate to carry out the purposes of this
25 subsection.

1 "(4) COORDINATION WITH DEDUCTION FOR 2 OTHER AMOUNTS.—Amounts allowable as a deduc-3 tion under subsection (a) by reason of this sub-4 section shall not be taken into account in determin-5 ing the deduction under subsection (a) for other 6 amounts.

"(5) SUBSECTION NOT TO APPLY TO INDIVIDUALS ELIGIBLE FOR MEDICARE.—This subsection
shall not apply to amount paid for insurance covering an individual who is eligible for benefits under
title XVIII of the Social Security Act.".

(b) DEDUCTION ALLOWED WHETHER OR NOT INDI13 VIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
14 of section 62 of such Code is amended by inserting after
15 paragraph (15) the following new paragraph:

16 "(16) COSTS OF CERTAIN HEALTH INSUR17 ANCE.—The deduction allowed by section 213 to the
18 extent allowable by reason of section 213(f).".

19 (c) EFFECTIVE DATE.—The amendments made by20 this section shall apply to taxable years beginning after21 December 31, 1994.

Subtitle E—Improved Access to
 Community Health Services
 PART 1—INCREASED AUTHORIZATION FOR
 COMMUNITY AND MIGRANT HEALTH CENTERS
 SEC. 1401. GRANT PROGRAM TO PROMOTE PRIMARY
 HEALTH CARE SERVICES FOR UNDERSERVED
 POPULATIONS.

8 (a) AUTHORIZATION.—The Secretary of Health and 9 Human Services shall provide for a program of grants to 10 migrant and community health centers (receiving grants 11 or contracts under section 329, 330, or 340 of the Public 12 Health Service Act) in order to promote the provision of 13 primary health care services for underserved individuals. 14 Such grants may be used—

(1) to promote the provision of off-site services(through means such as mobile medical clinics);

17 (2) to improve birth outcomes in areas with18 high infant mortality and morbidity;

19 (3) to establish primary care clinics in areas20 identified as in need of such clinics; and

21 (4) for recruitment and training costs of nec22 essary providers and operating costs for unreim23 bursed services.

(b) CONDITIONS.—(1) Grants under this subsection
 shall only be made upon application, approved by the Sec retary.

4 (2) The amount of grants made under this section5 shall be determined by the Secretary.

6 (c) AUTHORIZATION OF APPROPRIATIONS.—There7 are authorized to be appropriated—

8 (1) in fiscal year 1995, \$100,000,000,

9 (2) in fiscal year 1996, \$200,000,000,

10 (3) in fiscal year 1997, \$300,000,000,

11 (4) in fiscal year 1998, \$400,000,000, and

12 (5) in fiscal year 1999, \$500,000,000,

to carry out this section. Of the amounts appropriated 13 each fiscal year under this section, at least 10 percent 14 15 shall be used for grants described in subsection (a)(1) and at least 10 percent shall be used for grants described in 16 subsection (a)(2). The Secretary may use not to exceed 17 50 percent of the amounts appropriated to carry out this 18 19 section for the purpose of making new grants or contracts under sections 329, 330, and 340 of the Public Health 20 21 Service Act.

(d) STUDY AND REPORT.—The Secretary shall conduct a study of the impact of the grants made under this
section to migrant and community health centers on access to health care, birth outcomes, and the use of emer-

gency room services. Not later than 2 years after the date
 of the enactment of this Act, the Secretary shall submit
 to Congress a report on such study and on recommenda tions for changes in the programs under this section in
 order to promote the appropriate use of cost-effective out patient services.

7 **PART 2—GRANTS FOR PROJECTS FOR** 8 **COORDINATING DELIVERY OF SERVICES** 9 SEC. 1411. PROJECTS FOR COORDINATING DELIVERY OF 10 **OUTPATIENT PRIMARY HEALTH SERVICES.** 11 Part D of title III of the Public Health Service Act 12 (42 U.S.C. 254b et seq.) is amended by adding at the end 13 the following new subpart: 14 "Subpart VII—Delivery of Services 15 "PROJECTS FOR COORDINATING DELIVERY OF SERVICES 16 "Sec. 340E. (a) Authority for Grants.— 17 "(1) IN GENERAL.—The Secretary may make 18 grants to public and nonprofit private entities to 19 carry out demonstration projects for the purpose of 20 increasing access to outpatient primary health serv-21 ices in geographic areas described in subsection (b) through coordinating the delivery of such services 22 23 under Federal, State, local, and private programs.

1	"(2) Requirement regarding plan.—The
2	Secretary may make a grant under paragraph (1)
3	only if—
4	''(A) the applicant involved has received a
5	grant under subsection (l) and the Secretary
6	has approved the plan developed with such
7	grant; and
8	''(B) the applicant agrees to carry out the
9	project under paragraph (1) in accordance with
10	the plan.
11	"(b) Qualified Health Service Areas.—
12	"(1) IN GENERAL.—A geographic area de-
13	scribed in this subsection is a geographic area
14	that—
15	"(A) is a rational area for the delivery of
16	health services;
17	"(B) has a population of not more than
18	500,000 individuals; and
19	"(C)(i) has been designated by the Sec-
20	retary as an area with a shortage of personal
21	health services; or
22	''(ii) has a significant number of individ-
23	uals who have low incomes or who have insuffi-
24	cient insurance regarding health care.

"(2) AUTHORITY REGARDING MULTIPLE POLIT-1 2 ICAL SUBDIVISIONS.—The Secretary shall make a determination of whether a geographic area is a geo-3 4 graphic area described in paragraph (1) without re-5 gard to whether the area is a political subdivision, 6 without regard to whether the area is located in 2 7 or more political subdivisions or States, and without 8 regard to whether the area encompasses 2 or more 9 political subdivisions.

10 "(c) PREFERENCES IN MAKING GRANTS.—In making 11 grants under subsection (a), the Secretary shall give pref-12 erence to applicants demonstrating that, with respect to 13 the outpatient primary health services that will be the sub-14 ject of the project conducted by the applicant under such 15 subsection—

"(1)(A) the project will result in the reduction
of administrative expenses associated with such services by increasing the efficiency of the administrative
processes of the providers participating in the
project, and

21 "(B) the resulting savings will be expended for
22 the direct provision of such services for the des23 ignated population; or

"(2) the services that will be the subject of the
 project will be provided in facilities that are
 underutilized.

4 "(d) ACTIVITIES OF PROJECT MUST SERVE DES-5 IGNATED POPULATION.—The Secretary may make a 6 grant under subsection (a) to an applicant only if the ap-7 plicant demonstrates that carrying out the project under 8 such subsection will increase access to outpatient primary 9 health services for a significant segment of the designated 10 population.

11 "(e) MATCHING FUNDS.—

"(1) IN GENERAL.—With respect to the costs of 12 the project to be carried out under subsection (a) by 13 14 an applicant, the Secretary may make a grant under 15 such subsection only if the applicant agrees to make available (directly or through donations from public 16 17 or private entities) non-Federal contributions toward 18 such costs in an amount that is not less than 50 19 percent of such costs.

"(2) Determination of amount contrib-20 UTED.—Non-Federal contributions required in para-21 22 graph (1) may be in cash or in kind, fairly evaluincluding plant, 23 ated, equipment, or services. 24 Amounts provided by the Federal Government, or 25 services assisted or subsidized to any significant extent by the Federal Government, may not be in cluded in determining the amount of such non-Fed eral contributions.

4 "(f) CERTAIN LIMITATIONS REGARDING GRANTS.—
5 "(1) PROVISION OF HEALTH SERVICES; CON6 STRUCTION OF FACILITIES.—The Secretary may
7 make a grant under subsection (a) only if the appli8 cant involved agrees that the grant will not be ex9 pended for the direct provision of any health service
10 or for the construction or renovation of facilities.

11 "(2) DURATION AND AMOUNT OF GRANT.—The 12 period during which payments are made for a 13 project under subsection (a) may not exceed 4 years, 14 and the aggregate amount of such payments for the 15 period may not exceed \$200,000. The provision of 16 such payments shall be subject to annual approval 17 by the Secretary of the payments and subject to the 18 availability of appropriations for the fiscal year in-19 volved to make the payments.

"(3) FINANCIAL CAPACITY FOR CONTINUATION
OF PROJECT AFTER TERMINATION OF GRANT.—The
Secretary may make a grant under subsection (a)
only if the Secretary determines that there is a reasonable basis for believing that, after termination of
payments under such subsection pursuant to para-

graph (2), the project under such subsection will
 have the financial capacity to continue operating.

3 "(g) Agreements Among Participants in4 Projects.—

5 "(1) REQUIRED PARTICIPANTS.—The Secretary 6 may make a grant under subsection (a) only if the 7 applicant for the grant has, for purposes of carrying 8 out a project under such subsection, entered into 9 agreements with—

"(A) the chief public health officers, and 10 the chief health officers for the elementary and 11 secondary schools, of each of the political sub-12 divisions of the qualified health service area in 13 14 which the project under such subsection is to be 15 carried out (or, in the case of a political subdivision that does not have such an official, 16 17 with another appropriate official of such sub-18 division);

19 "(B) each hospital in the qualified health20 service area;

21 "(C) representatives of entities in such
22 area that provide outpatient primary health
23 services under Federal, State, local, or private
24 programs;

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"(D) representatives of businesses in such 1 2 area, including small businesses; and "(E) representatives of nonprofit private 3 4 entities in such area. "(2) Optional participants.—With respect 5 6 to compliance with this section, a grantee under subsection (a) may, for purposes of carrying out a 7 8 project under such subsection, enter into such agree-9 ments with public and private entities in the quali-10 fied health service area involved (in addition to the 11 entities specified in paragraph (1)) as the grantee 12 may elect. "(h) EXPENDITURES OF GRANT.—With respect to a 13

project under subsection (a), the purposes for which a 14 15 grant under such subsection may be expended include (but are not limited to) expenditures to increase the efficiency 16 of the administrative processes of providers participating 17 in the project, paying the costs of hiring and compensating 18 19 staff, obtaining computers and other equipment (including 20 vehicles to transport individuals to programs providing 21 outpatient primary health services), and developing and 22 operating provider networks.

23 "(i) MAINTENANCE OF EFFORT.—In the case of serv24 ices and populations that are the subject of a project
25 under subsection (a), the Secretary may make such a

grant for a fiscal year only if the applicant involved agrees 1 that the applicant, and each entity making an agreement 2 under subsection (g), will maintain expenditures of non-3 4 Federal amounts for such services and populations at a level that is not less than the level of such expenditures 5 maintained by the applicant and the entity, respectively, 6 7 for the fiscal year preceding the first fiscal year for which 8 the applicant receives such a grant.

9 "(j) REPORTS TO SECRETARY.—The Secretary may 10 make a grant under subsection (a) only if the applicant 11 involved agrees to submit to the Secretary such reports 12 on the project carried out under such subsection as the 13 Secretary may require.

14 "(k) EVALUATIONS AND DISSEMINATION OF INFOR-15 MATION.—The Secretary shall provide for evaluations of 16 projects carried out under subsection (a), and for the col-17 lection and dissemination of information developed as a 18 result of such projects and as a result of similar projects.

19 "(I) PLANNING GRANTS.—

"(1) IN GENERAL.—The Secretary may make
grants to public and nonprofit private entities for
the purpose of developing plans to carry out projects
under subsection (a). Such a grant may be made
only if the applicant involved submits to the Secretary information—

1	''(A) providing a detailed statement of the
2	proposal of the applicant for carrying out the
3	project;
4	''(B) identifying the geographic area in
5	which the project is to be carried out; and
6	''(C) demonstrating that the area is a
7	qualified health service area and that the pro-
8	posal otherwise is in accordance with the re-
9	quirements established in this section for the
10	receipt of a grant under subsection (a).
11	"(2) DURATION AND AMOUNT OF GRANT.—The
12	period during which payments are made under para-
13	graph (1) for the development of a plan under such
14	paragraph may not exceed 1 year, and the amount
15	of such payments may not exceed \$100,000.
16	"(m) Application for Grant.—The Secretary may
17	make a grant under subsection (a) or (l) only if the appli-
18	cant for the grant submits an application to the Secretary
19	that—
20	"(1) contains any agreements, assurances, and
21	information required in this section with respect to
22	the grant; and
23	"(2) is in such form is made in such manner

and contains such other agreements, assurances, and
information as the Secretary determines to be nec-

1	essary to carry out the purpose for which the grant
2	is to be provided.
3	"(n) DEFINITIONS.—For purposes of this section:
4	''(1) The term 'designated population' means
5	individuals described in subsection $(b)(1)(C)(ii)$.
6	"(2) The term 'primary health services' includes
7	preventive health services.
8	''(3) The term 'qualified health service area'
9	means a geographic area described in subsection (b).
10	"(0) AUTHORIZATION OF APPROPRIATIONS.—
11	"(1) PLANNING FOR PROJECTS.—For the pur-
12	pose of grants under subsection (l), there is author-
13	ized to be appropriated \$5,000,000 for fiscal year
14	1995, to remain available until expended.
15	"(2) OPERATION OF PROJECTS.—For the pur-
16	pose of grants under subsection (a), there is author-
17	ized to be appropriated an aggregate \$10,000,000
18	for the fiscal years 1996 through 1999.".
19	PART 3—COMMUNITY HEALTH NETWORKS
20	SEC. 1421. QUALIFICATIONS FOR COMMUNITY HEALTH
21	NETWORKS.
22	(a) Community Health Network Defined.—For
23	purposes of part 7 of subtitle B of title I of Employee
24	Retirement Income Security Act of 1974 and this Act,

added by section 1211(a) of this title, the term "commu nity health network" means an arrangement that—

3	(1) is organized by health care providers (in-
4	cluding medical practitioners), community groups, or
5	both, and such other organizations as may be des-
6	ignated by the arrangement, to provide health care
7	services to an enrolled population in a service area,
8	(2) provides to its enrollees at least the benefits
9	included in standard coverage (consistent with sec-
10	tion 1102(c)),
11	(3) receives payment for such services on a pro-
12	spective capitated basis, which may vary only by
13	family composition, geographic area, and age,
14	(4) meets the requirements of subsection (b)
15	(relating to public accountability),
16	(5) meets the requirements of subsection (c)
17	(relating to coordination and integration of care),
18	(6) meets the requirements of subsection (d) to
19	the extent the arrangement is organized as a non-
20	profit entity, and
21	(7) meets the requirements of section 707 of
22	the Employee Retirement Income Security Act of
23	1974 (relating to maintenance of reserves), added by
24	section 1211.

1	(b) Public Accountability Requirements.—The
2	public accountability requirements of this subsection, with
3	respect to a network, are as follows:
4	(1) Performance measures.—The network
5	must establish and implement procedures for devel-
6	oping, compiling, evaluating, and reporting perform-
7	ance measures, statistics, and other information
8	on—
9	(A) the cost and financial performance of
10	network operations,
11	(B) the service utilization patterns of en-
12	rollees,
13	(C) the availability, accessibility, and ac-
14	ceptability of health care services to enrollees,
15	(D) ownership and governance of the net-
16	work, and
17	(E) demographic characteristics of enroll-
18	ees.
19	Such information shall be published annually and
20	disseminated to enrollees and the public.
21	(2) QUALITY ASSURANCE PROGRAM.—The net-
22	work must have an organizational arrangement for
23	an ongoing quality assurance program for all health
24	services it provides which—
25	(A) stresses health outcomes,

1	(B) to the maximum extent possible, relies
2	primarily on evaluating and comparing practice
3	patterns (rather than routine case-by-case re-
4	view) to identify problems,
5	(C) provides review by physicians and
6	other health professionals of the outcomes and
7	process followed in the provision of health serv-
8	ices, and
9	(D) makes the coverage and utilization re-
10	view requirements of the plan, and the stand-
11	ards applied for such review, available to pro-
12	viders and the public.
13	(3) ENROLLMENT.—The network does not expel
14	or refuse to enroll any applicant or limit coverage of
15	services included in standard coverage for any appli-
16	cant because of the health status or requirements for
17	health services.
18	(4) CREDENTIALING.—The network must de-
19	velop and implement a process for the credentialing
20	(and renewal of credentials) of network providers
21	(including practitioners).
22	(5) GRIEVANCE PROCESS.—The network must
23	have an enrollee complaint and grievance resolution
24	process which shall meet any requirements of appli-
25	cable law.

(c) COORDINATION AND INTEGRATION OF CARE RE QUIREMENTS.—The coordination and integration of care
 requirements of this subsection, with respect to a network,
 are as follows:

5 (1) COORDINATION AND INTEGRATION OF 6 CARE.—The network must establish and implement 7 mechanisms for coordinating the delivery of care 8 across provider settings and over time, including at 9 least mechanisms for—

10 (A) linking patient registration and medi-11 cal record information so that it is accessible to 12 all parts of the network and, consistent with 13 State law, assures the confidentiality of patient 14 information,

(B) assisting enrollees to obtain necessarycare, including preventive services, and

17 (C) coordinating the services furnished to
18 an enrollee when more than one practitioner or
19 provider is involved.

20 (2) OUT-OF-AREA COVERAGE.—The network
21 must provide care within a defined service area es22 tablished by the arrangement and must provide for
23 reimbursement for standard coverage (consistent
24 with section 1102(c)) for enrollees who are tempo25 rarily outside such area.

1 (3) COMMON MALPRACTICE POLICY.—Providers 2 (including practitioners) that provide standard cov-3 erage to network enrollees must be covered for mal-4 practice in accordance with documented criteria es-5 tablished by the arrangement.

6 (4) RECORD KEEPING.—The network must use
7 a unified patient registration system and medical
8 records system that is accessible to all parts of the
9 network and assures confidentiality of patient infor10 mation, consistent with State law.

(d) REQUIREMENTS FOR NETWORKS ORGANIZED AS
NONPROFIT ENTITIES.—The requirements of this subsection, with respect to a network, are as follows:

(1) COMMUNITY HEALTH STATUS IMPROVEMENT PROCESS.—The network develops and implements a community health status improvement process, in cooperation with other existing networks and
community organizations from the same service
area, that—

20 (A) provides for an assessment of commu21 nity health status that identifies important
22 health status problems in such area,

23 (B) implements measures to address such24 problems, and

(C) evaluates the efficiency and effective-1 2 ness of such measures in addressing such problems. 3 The results of evaluations made pursuant to sub-4 paragraph (C) shall be made publicly available on at 5 6 least an annual basis. (2) ENROLLMENT.—The network enrolls indi-7 viduals who are broadly representative of the various 8 age, social, and income groups within the area it 9 10 serves. Subtitle F—Improved Access to 11 **Rural Health Services** 12 **1-ESTABLISHMENT OF RURAL** 13 EMER-PART 14 GENCY ACCESS CARE HOSPITALS UNDER 15 **MEDICARE** SEC. 1501. RURAL EMERGENCY ACCESS CARE HOSPITALS 16 17 **DESCRIBED.** (a) IN GENERAL.—Section 1861 of the Social Secu-18 rity Act (42 U.S.C. 1395x) is amended by adding at the 19 20 end the following new subsection:

	1.0
1	"Rural Emergency Access Care Hospital; Rural
2	Emergency Access Care Hospital Services
3	``(oo)(1) The term 'rural emergency access care hos-
4	pital' means, for a fiscal year, a facility with respect to
5	which the Secretary finds the following:
6	''(A) The facility is located in a rural area (as
7	defined in section 1886(d)(2)(D)).
8	''(B) The facility was a hospital under this title
9	at any time during the 5-year period that ends on
10	the date of the enactment of this subsection.
11	"(C) The facility is in danger of closing due to
12	low inpatient utilization rates and negative operating
13	losses, and the closure of the facility would limit the
14	access of individuals residing in the facility's service
15	area to emergency services.
16	"(D) The facility has entered into (or plans to
17	enter into), with a hospital with a participation
18	agreement in effect under section 1866(a), and
19	under such agreement the hospital shall accept pa-
20	tients transferred to the hospital from the facility
21	and receives data from and transmits data to the fa-
22	cility.
23	''(E) There is a practitioner who is qualified to

provide advanced cardiac life support services (as de-

1	termined by the State in which the facility is lo-
2	cated) on-site at the facility on a 24-hour basis.
3	''(F) A physician is available on-call to provide
4	emergency medical services on a 24-hour basis.
5	"(G) The facility meets such staffing require-
6	ments as would apply under section 1861(e) to a
7	hospital located in a rural area, except that—
8	"(i) the facility need not meet hospital
9	standards relating to the number of hours dur-
10	ing a day, or days during a week, in which the
11	facility must be open, except insofar as the fa-
12	cility is required to provide emergency care on
13	a 24-hour basis under subparagraphs (E) and
14	(F); and
15	"(ii) the facility may provide any services
16	otherwise required to be provided by a full-time,
17	on-site dietitian, pharmacist, laboratory techni-
18	cian, medical technologist, or radiological tech-
19	nologist on a part-time, off-site basis.
20	"(H) The facility meets the requirements appli-
21	cable to clinics and facilities under subparagraphs
22	(C) through (J) of paragraph (2) of section
23	1861(aa) and of clauses (ii) and (iv) of the second
24	sentence of such paragraph (or, in the case of the
25	requirements of subparagraph (E), (F), or (J) of

such paragraph, would meet the requirements if any 1 2 reference in such subparagraph to a 'nurse practi-3 tioner' or to 'nurse practitioners' was deemed to be 4 a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'), except that in deter-5 6 mining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of 7 that paragraph shall be applied as if any reference 8 9 to a 'physician' is a reference to a physician as de-10 fined in section 1861(r)(1). 11 "(2) The term 'rural emergency access care hospital services' means the following services provided by a rural 12 13 emergency access care hospital: 14 "(A) An appropriate medical screening exam-15 ination (as described in section 1867(a)). "(B) Necessary stabilizing examination and 16 17 treatment services for an emergency medical condi-18 tion and labor (as described in section 1867(b)).". 19 (b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING RE-20 21 QUIREMENTS.—Section 1867(e)(5) of such Act (42 U.S.C.

22 1395dd(e)(5)) is amended by striking "1861(mm)(1))"

23 and inserting "1861(mm)(1)) and a rural emergency ac-

24 cess care hospital (as defined in section 1861(00)(1))".

1 SEC. 1502. COVERAGE OF AND PAYMENT FOR SERVICES. 2 (a) COVERAGE UNDER PART B.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is 3 4 amended— (1) by striking "and" at the end of subpara-5 graph (I); 6 7 (2) by striking the period at the end of subparagraph (J) and inserting "; and"; and 8 9 (3) by adding at the end the following new sub-10 paragraph: "(K) rural emergency access care hospital 11 12 services (as defined in section 1861(00)(2)).". (b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT 13 RURAL PRIMARY CARE HOSPITAL SERVICES.— 14 15 (1) IN GENERAL.—Section 1833(a)(6) of the Social Security Act (42 U.S.C. 1395l(a)(6)) is 16 17 amended by striking "services," and inserting "serv-18 ices and rural emergency access care hospital serv-19 ices,". 20 (2)PAYMENT METHODOLOGY DESCRIBED.— 21 Section 1834(g) of such Act (42 U.S.C. 1395m(g)) 22 is amended— (A) in the heading, by striking "SERV-23 ICES" and inserting "SERVICES AND RURAL 24 EMERGENCY ACCESS CARE HOSPITAL SERV-25 ICES'': and 26

1	(B) in paragraph (1), by striking ''during
2	a year before 1993" and inserting "during a
3	year before the prospective payment system de-
4	scribed in paragraph (2) is in effect'';
5	(C) in paragraph (1), by adding at the end
6	the following:
7	"The amount of payment shall be determined under
8	either method without regard to the amount of the
9	customary or other charge.";
10	(D) in paragraph (2), by striking ''Janu-
11	ary 1, 1993," and inserting "January 1,
12	1996,''; and
13	(E) by adding at the end the following new
14	paragraph:
15	"(3) Application of methods to payment
16	FOR RURAL EMERGENCY ACCESS CARE HOSPITAL
17	SERVICES.—The amount of payment for rural emer-
18	gency access care hospital services provided during
19	a year shall be determined using the applicable
20	method provided under this subsection for determin-
21	ing payment for outpatient rural primary care hos-
22	pital services during the year.".

1 SEC. 1503. EFFECTIVE DATE.

2 The amendments made by sections 1501 and 1502 3 shall apply to fiscal years beginning on or after October 4 1, 1994.

5 PART 2—RURAL MEDICAL EMERGENCIES AIR 6 TRANSPORT

7 SEC. 1511. GRANTS TO STATES REGARDING AIRCRAFT FOR
 8 TRANSPORTING RURAL VICTIMS OF MEDICAL

9 **EMERGENCIES.**

Part E of title XII of the Public Health Service Act
(42 U.S.C. 300d–51 et seq.) is amended by adding at the
end thereof the following new section:

13 "SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL
 14 VICTIMS OF MEDICAL EMERGENCIES.

15 "(a) IN GENERAL.—The Secretary shall make grants 16 to States to assist such States in the creation or enhance-17 ment of air medical transport systems that provide victims 18 of medical emergencies in rural areas with access to treat-19 ments for the injuries or other conditions resulting from 20 such emergencies.

21 "(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

1	a State plan as required in paragraph (2), as the
2	Secretary determines to be necessary to carry out
3	this section.
4	"(2) STATE PLAN.—An application submitted
5	under paragraph (1) shall contain a State plan that
6	shall—
7	"(A) describe the intended uses of the
8	grant proceeds and the geographic areas to be
9	served;
10	''(B) demonstrate that the geographic
11	areas to be served, as described under subpara-
12	graph (A), are rural in nature;
13	"(C) demonstrate that there is a lack of
14	facilities available and equipped to deliver ad-
15	vanced levels of medical care in the geographic
16	areas to be served;
17	''(D) demonstrate that in utilizing the
18	grant proceeds for the establishment or en-
19	hancement of air medical services the State
20	would be making a cost-effective improvement
21	to existing ground-based or air emergency medi-
22	cal service systems;
23	"(E) demonstrate that the State will not
24	utilize the grant proceeds to duplicate the capa-
25	bilities of existing air medical systems that are

180 effectively meeting the emergency medical needs 1 of the populations they serve; 2 "(F) demonstrate that in utilizing the 3 grant proceeds the State is likely to achieve a 4 reduction in the morbidity and mortality rates 5 of the areas to be served, as determined by the 6 7 Secretary; 8 "(G) demonstrate that the State, in utilizing the grant proceeds, will— 9 "(i) maintain the expenditures of the 10 State for air and ground medical transport 11 systems at a level equal to not less than 12 the level of such expenditures maintained 13 by the State for the fiscal year preceding 14 the fiscal year for which the grant is re-15 ceived: and 16 17 "(ii) ensure that recipients of direct 18 financial assistance from the State under 19 such grant will maintain expenditures of 20 such recipients for such systems at a level at least equal to the level of such expendi-21 22 tures maintained by such recipients for the fiscal year preceding the fiscal year for 23

which the financial assistance is received:

24

1	''(H) demonstrate that persons experienced
2	in the field of air medical service delivery were
3	consulted in the preparation of the State plan;
4	and
5	''(I) contain such other information as the
6	Secretary may determine appropriate.
7	"(c) Considerations in Awarding Grants.—In
8	determining whether to award a grant to a State under
9	this section, the Secretary shall—
10	"(1) consider the rural nature of the areas to
11	be served with the grant proceeds and the services
12	to be provided with such proceeds, as identified in
13	the State plan submitted under subsection (b); and
14	"(2) give preference to States with State plans
15	that demonstrate an effective integration of the pro-
16	posed air medical transport systems into a com-
17	prehensive network or plan for regional or statewide
18	emergency medical service delivery.
19	"(d) State Administration and Use of
20	Grant.—
21	"(1) IN GENERAL.—The Secretary may not
22	make a grant to a State under subsection (a) unless
23	the State agrees that such grant will be adminis-
24	tered by the State agency with principal responsibil-
25	ity for carrying out programs regarding the provi-

sion of medical services to victims of medical emer gencies or trauma.

3 "(2) PERMITTED USES.—A State may use
4 amounts received under a grant awarded under this
5 section to award subgrants to public and private en6 tities operating within the State.

7 "(3) Opportunity for public comment.— The Secretary may not make a grant to a State 8 9 under subsection (a) unless that State agrees that, 10 in developing and carrying out the State plan under 11 subsection (b)(2), the State will provide public notice 12 with respect to the plan (including any revisions 13 thereto) and facilitate comments from interested 14 persons.

15 "(e) NUMBER OF GRANTS.—The Secretary shall
16 award grants under this section to not less than 7 States.
17 "(f) REPORTS.—

18 "(1) REQUIREMENT.—A State that receives a
19 grant under this section shall annually (during each
20 year in which the grant proceeds are used) prepare
21 and submit to the Secretary a report that shall con22 tain—

23 "(A) a description of the manner in which
24 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 Sec-

5 retary may require.

6 "(2) TERMINATION OF FUNDING.—In reviewing 7 reports submitted under paragraph (1), if the Sec-8 retary determines that a State is not using amounts 9 provided under a grant awarded under this section 10 in accordance with the State plan submitted by the 11 State under subsection (b), the Secretary may termi-12 nate the payment of amounts under such grant to 13 the State until such time as the Secretary deter-14 mines that the State comes into compliance with such plan. 15

''(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.

20 "(h) AUTHORIZATION OF APPROPRIATIONS.—There 21 are authorized to be appropriated to make grants under 22 this section, \$15,000,000 for fiscal year 1994, and such 23 sums as may be necessary for each of the fiscal years 1996 24 and 1997.".

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1	PART 3—EMERGENCY MEDICAL SERVICES
2	AMENDMENTS
3	SEC. 1521. ESTABLISHMENT OF OFFICE OF EMERGENCY
4	MEDICAL SERVICES.
5	Title XII of the Public Health Service Act (42 U.S.C.
6	300d et seq.) is amended—
7	(1) in the heading for the title, by striking
8	"TRAUMA CARE" and inserting "EMERGENCY
9	MEDICAL SERVICES";
10	(2) in the heading for part A, by striking
11	"GENERAL" and all that follows and inserting
12	"General Authorities and Duties"; and
13	(3) by amending section 1201 to read as fol-
14	lows:
15	"SEC. 1201. ESTABLISHMENT OF OFFICE OF EMERGENCY
16	MEDICAL SERVICES.
17	''(a) IN GENERAL.—The Secretary shall establish an
18	office to be known as the Office of Emergency Medical
19	Services, which shall be headed by a director appointed
20	by the Secretary. The Secretary shall carry out this title
21	acting through the Director of such Office.
22	"(b) General Authorities and Duties.—With
23	respect to emergency medical services (including trauma
24	care), the Secretary shall—
25	"(1) conduct and support research, training,

26 evaluations, and demonstration projects;

1	(100)
	"(2) foster the development of appropriate,
2	modern systems of such services through the sharing
3	of information among agencies and individuals in-
4	volved in the study and provision of such services;
5	"(3) sponsor workshops and conferences;
6	''(4) as appropriate, disseminate to public and
7	private entities information obtained in carrying out
8	paragraphs (1) through (4);
9	"(5) provide technical assistance to State and
10	local agencies;
11	"(6) coordinate activities of the Department of
12	Health and Human Services; and
13	''(7) as appropriate, coordinate activities of
14	such Department with activities of other Federal
15	agencies.
16	"(c) Certain Requirements.—With respect to
17	emergency medical services (including trauma care), the
18	Secretary shall ensure that activities under subsection (b)
19	are carried out regarding—
20	"(1) maintaining an adequate number of health
21	professionals with expertise in the provision of the
22	services, including hospital-based professionals and
23	prehospital-based professionals;
24	"(2) developing, periodically reviewing, and re-
25	vising as appropriate, in collaboration with appro-

priate 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);

6 ''(3) the appropriate use of available tech7 nologies, including communications technologies; and
8 ''(4) the unique needs of underserved inner-city
9 areas and underserved rural areas.

10 "(d) GRANTS, COOPERATIVE AGREEMENTS, AND 11 CONTRACTS.—In carrying out subsections (b) and (c), the 12 Secretary may make grants and enter into cooperative 13 agreements and contracts.

14 "(e) DEFINITIONS.—For purposes of this part:

15 "(1) The term 'hospital-based professional' 16 means a health professional (including an allied 17 health professional) who has expertise in providing 18 one or more emergency medical services and who 19 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 med-

1	ical emergency or during transport to a medical fa-
2	cility.".
3	SEC. 1522. STATE OFFICES OF EMERGENCY MEDICAL SERV-
4	ICES.
5	(a) Technical Amendments To Facilitate Es-
6	tablishment of Program.—
7	(1) IN GENERAL.—Title XII of the Public
8	Health Service Act (42 U.S.C. 300d et seq.) is
9	amended—
10	(A) by redesignating section 1239 as sec-
11	tion 1235;
12	(B) by redesignating sections 1231 and
13	1233 as sections 1236 and 1237, respectively;
14	and
15	(C) by redesignating sections 1211 through
16	1222 as sections 1221 through 1232, respec-
17	tively.
18	(2) Modifications in format of title
19	XII.—Title XII of the Public Health Service Act, as
20	amended by paragraph (1) of this subsection, is
21	amended—
22	(A) by striking "PART B" and all that fol-
23	low through "STATE PLANS" and inserting the
24	following:

	100
1	"Subpart II—Formula Grants With Respect to
2	Modifications of State Plans";
3	(B) by striking "PART C—GENERAL PRO-
4	VISIONS" and inserting the following:
5	"Subpart III—General Provisions";
6	(C) by redesignating sections 1202 and
7	1203 as sections 1211 and 1212, respectively;
8	and
9	(D) by inserting before section 1211 (as so
10	redesignated) the following:
11	"Part B—Trauma Care
12	"Subpart I—Advisory Council; Clearinghouse".
13	(b) STATE OFFICES.—Title XII of the Public Health
14	Service Act, as amended by subsection (a) of this section,
15	is amended by inserting after section 1201 the following
16	new section:
17	"SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL
18	SERVICES.
19	"(a) Program of Grants.—The Secretary may
20	make grants to States for the purpose of improving the
21	availability and quality of emergency medical services
22	through the operation of State offices of emergency medi-
23	cal services.
24	"(b) Requirement of Matching Funds.—

	100
1	"(1) IN GENERAL.—The Secretary may not
2	make a grant under subsection (a) unless the State
3	involved agrees, with respect to the costs to be in-
4	curred by the State in carrying out the purpose de-
5	scribed in such subsection, to provide non-Federal
6	contributions toward such costs in an amount that—
7	"(A) for the first fiscal year of payments
8	under the grant, is not less than \$1 for each \$3
9	of Federal funds provided in the grant;
10	"(B) for any second fiscal year of such
11	payments, is not less than \$1 for each \$1 of
12	Federal funds provided in the grant; and
13	"(C) for any third fiscal year of such pay-
14	ments, is not less than \$3 for each \$1 of Fed-
15	eral funds provided in the grant.
16	"(2) Determination of amount of non-
17	FEDERAL CONTRIBUTION.—
18	''(A) Subject to subparagraph (B), non-
19	Federal contributions required in paragraph (1)
20	may be in cash or in kind, fairly evaluated, in-
21	cluding plant, equipment, or services. Amounts
22	provided by the Federal Government, or serv-
23	ices assisted or subsidized to any significant ex-
24	tent by the Federal Government, may not be in-

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1	cluded in determining the amount of such non-
2	Federal contributions.
3	"(B) The Secretary may not make a grant
4	under subsection (a) unless the State involved
5	agrees that—
6	"(i) for the first fiscal year of pay-
7	ments under the grant, 100 percent or less
8	of the non-Federal contributions required
9	in paragraph (1) will be provided in the
10	form of in-kind contributions;
11	"(ii) for any second fiscal year of such
12	payments, not more than 50 percent of
13	such non-Federal contributions will be pro-
14	vided in the form of in-kind contributions;
15	and
16	"(iii) for any third fiscal year of such
17	payments, such non-Federal contributions
18	will be provided solely in the form of cash.
19	"(c) Certain Required Activities.—The Sec-
20	retary may not make a grant under subsection (a) unless
21	the State involved agrees that activities carried out by an
22	office operated pursuant to such subsection will include—
23	"(1) coordinating the activities carried out in
24	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.

14 "(e) CERTAIN USES OF FUNDS.—

15 "(1) RESTRICTIONS.—The Secretary may not
16 make a grant under subsection (a) unless the State
17 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

22 "(B) the grant will not be expended to pro23 vide emergency medical services (including pro24 viding cash payments regarding such services).

"(2) ESTABLISHMENT OF OFFICE.—Activities
 for which a State may expend a grant under sub section (a) include paying the costs of establishing
 an office of emergency medical services for purposes
 of such subsection.

6 "(f) REPORTS.—The Secretary may not make a 7 grant under subsection (a) unless the State involved 8 agrees to submit to the Secretary reports containing such 9 information as the Secretary may require regarding activi-10 ties carried out under this section by the State.

11 "(g) REQUIREMENT OF APPLICATION.—The Sec-12 retary may not make a grant under subsection (a) unless 13 an application for the grant is submitted to the Secretary 14 and the application is in such form, is made in such man-15 ner, and contains such agreements, assurances, and infor-16 mation as the Secretary determines to be necessary to 17 carry out this section.".

18 SEC. 1523. PROGRAMS FOR RURAL AREAS.

19 (a) IN GENERAL.—Title XII of the Public Health20 Service Act, as amended by section 1522, is amended—

21 (1) by transferring section 1204 to part A;

(2) by redesignating such section as section1203;

24 (3) by inserting such section after section 1202;25 and

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1	(4) in section 1203 (as so redesignated)—
2	(A) by redesignating subsection (c) as sub-
3	section (d); and
4	(B) by inserting after subsection (b) the
5	following new subsection:
6	"(c) Demonstration Program Regarding Tele-
7	COMMUNICATIONS.—
8	"(1) LINKAGES FOR RURAL FACILITIES.—
9	Projects under subsection (a)(1) shall include dem-
10	onstration projects to establish telecommunications
11	between rural medical facilities and medical facilities
12	that have expertise or equipment that can be utilized
13	by the rural facilities through the telecommuni-
14	cations.
15	"(2) Modes of communication.—The Sec-
16	retary shall ensure that the telecommunications
17	technologies demonstrated under paragraph (1) in-
18	clude interactive video telecommunications, static
19	video imaging transmitted through the telephone
20	system, and facsimiles transmitted through such
21	system.".
22	(b) Conforming Amendment.—Section 1203 of the
23	Public Health Service Act as redesignated by subsection

23 Public Health Service Act, as redesignated by subsection24 (a)(2) of this section, is amended in the heading for the

PROGRAMS FOR RURAL AREAS.". Public Health Service Act, as amend- provisions of this title, is amended— signating parts C through F as parts spectively;	2 3 4 5 6 7
provisions of this title, is amended— bignating parts C through F as parts spectively;	4 5 6
provisions of this title, is amended— bignating parts C through F as parts spectively;	5 6
aignating parts C through F as parts spectively;	6
spectively;	
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ting after subpart III of part B the	
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rt C—Funding'';	10
sferring section 1239 to part C (as	11
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section, by striking subsections (a)	13
rting the following:	14
NCY MEDICAL SERVICES GEN-	15
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NERAL.—For the purpose of carry-	1/
NERAL.—For the purpose of carry- 201 other than with respect to trau-	17
201 other than with respect to trau-	18
201 other than with respect to trau- are authorized to be appropriated	18 19
201 other than with respect to trau- are authorized to be appropriated fiscal year 1995, and such sums as	18 19 20
201 other than with respect to trau- are authorized to be appropriated fiscal year 1995, and such sums as	18 19 20 21
201 other than with respect to trau- are authorized to be appropriated fiscal year 1995, and such sums as by for each of the fiscal years 1996	 18 19 20 21 22
rting the following:	13 14 15 16

such sums as may be necessary for each of the fiscal
 years 1996 and 1997.

"(3) CERTAIN TELECOMMUNICATIONS DEMONSTRATIONS.—For the purpose of carrying out section 1203(c), there are authorized to be appropriated \$10,000,000 for fiscal year 1995 and such
sums as may be necessary for each of the fiscal
years 1996 and 1997.

9 "(b) TRAUMA CARE AND CERTAIN OTHER ACTIVI-10 TIES.—

11 "(1) IN GENERAL.—For the purpose of carry-12 ing out part B, section 1201 with respect to trauma 13 care, and section 1203 (other than subsection (c) of 14 such section), there are authorized to be appro-15 priated \$60,000,000 for fiscal year 1995, and such 16 sums as may be necessary for each of the fiscal 17 years 1996 and 1997.

18 "(2) Allocation of funds by secretary.— 19 "(A) For the purpose of carrying out sub-20 part I of part B, section 1201 with respect to 21 trauma care, and section 1203 (other than sub-22 section (c) of such section), the Secretary shall 23 make available 10 percent of the amounts ap-24 propriated for a fiscal year under paragraph 25 (1).

1	"(B) For the purpose of carrying out sec-
2	tion 1203 (other than subsection (c) of such
3	section), the Secretary shall make available 10
4	percent of the amounts appropriated for a fiscal
5	year under paragraph (1).
6	"(C)(i) For the purpose of making allot-
7	ments under section 1221(a), the Secretary
8	shall, subject to subsection (c), make available
9	80 percent of the amounts appropriated for a
10	fiscal year under paragraph (1).
11	"(ii) Amounts paid to a State under sec-
12	tion 1221(a) for a fiscal year shall, for the pur-
13	poses for which the amounts were paid, remain
14	available for obligation until the end of the fis-
15	cal year immediately following the fiscal year
16	for which the amounts were paid.".
17	SEC. 1525. CONFORMING AMENDMENTS.
18	Title XII of the Public Health Service Act, as amend-
19	ed by the preceding provisions of this title, is amended—
20	(1) in section 1203(b), by striking $``1214(c)(1)''$
21	and inserting "1224(c)(1)";
22	(2) in section 1211(b)(3), by striking ''1213(c)''
23	and inserting "1223(c)";
24	(3) in section 1221—
25	(A) in subsection (a)—

1	(i) by striking ''1218'' and inserting
2	''1228''; and
3	(ii) by striking ''1217'' and inserting
4	''1227''; and
5	(B) in subsection (b)—
6	(i) by striking ''1233'' and inserting
7	''1237''; and
8	(ii) by striking ''1213'' and inserting
9	·'1223'';
10	(4) in section 1222—
11	(A) in subsection (a)—
12	(i) in paragraph (1), by striking
13	"1211(a)" and inserting "1221(a)"; and
14	(ii) in paragraph (2)(A), by striking
15	"1211(c)" and inserting "1221(c)"; and
16	(B) in subsection (b), by striking
17	"1211(a)" and inserting "1221(a)";
18	(5) in section 1223—
19	(A) in subsection (a), by striking
20	"1211(b)" and inserting "1221(b)";
21	(B) in subsection (b)—
22	(i) in paragraph (1), by striking
23	"1211(a)" and inserting "1221(a)"; and
24	(ii) in paragraph (3), by striking
25	"1211(a)" and inserting "1221(a)"; and

1	(C) in subsection (d), by striking
2	"1211(a)" and inserting "1221(a)";
3	(6) in section 1224—
4	(A) in each of subsections (a) through (c),
5	by striking ''1211(a)'' and inserting ''1221(a)'';
6	and
7	(B) in subsection (b), by striking
8	"1213(a)(7)" and inserting "1223(a)(7)";
9	(7) in section 1225—
10	(A) in subsection (a)—
11	(i) by striking ''1211(a)'' and insert-
12	ing ''1221(a)''; and
13	(ii) by striking ''1233'' and inserting
14	''1237''; and
15	(B) in subsection (b), by striking
16	"1211(b)" and inserting "1221(b)";
17	(8) in section 1226, in each of subsections (a)
18	through (c), by striking "1211(a)" and inserting
19	''1221(a)'';
20	(9) in section 1227—
21	(A) by striking ''1211(a)'' and inserting
22	"1221(a)"; and
23	(B) by striking ''1214'' and inserting
24	"1224";
25	(10) in section 1228—

1	(A) in each of subsections (a) through (c),
2	by striking ''1211(a)'' each place such term ap-
3	pears and inserting ''1221(a)'';
4	(B) in subsection (b), in each of para-
5	graphs (2)(A) and (3)(A), by striking
6	"1232(a)" and inserting "1239(a)"; and
7	(C) in subsection $(c)(2)$ —
8	(i) by striking ''1232(b)(3)'' and in-
9	serting ''1239(b)(3)''; and
10	(ii) by striking ''1217'' and inserting
11	·'1227'';
12	(11) in section 1229(a), by striking ''1211(a)''
13	each place such term appears and inserting
14	''1221(a)'';
15	(12) in section 1230(a), by striking ''1211(a)''
16	each place such term appears and inserting
17	''1221(a)'';
18	(13) in section 1231—
19	(A) in each of subsections (a) and (b), by
20	striking ''1211(a)'' each place such term ap-
21	pears and inserting ''1221(a)''; and
22	(B) in each of subsections (a) and (b), by
23	striking ''1211(b)'' and inserting ''1221(b)'';
24	(14) in section 1232, by striking ''1211'' and
25	inserting ''1221'';

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1	(15) in section 1236—
2	(A) in the matter preceding paragraph (1),
3	by striking ''this title'' and inserting ''this
4	part''; and
5	(B) in paragraph (1), by striking ''1213''
6	and inserting ''1223'';
7	(16) in section 1237—
8	(A) in each of subsections (a) and (b), by
9	striking ''1211'' each place such term appears
10	and inserting "1221";
11	(B) in subsection (b)—
12	(i) by striking ''part B'' and inserting
13	"subpart II"; and
14	(ii) by striking $(1214(c)(1))$ and in-
15	serting ''1224(c)(1)''; and
16	(C) in subsection (c), by striking "1213"
17	and inserting ''1223''; and
18	(17) in section 1239(c)(1)—
19	(A) by striking ''1211(a)'' and inserting
20	''1221(a)'';
21	(B) by striking "1218(a)(2)" and inserting
22	"1228(a)(2)"; and
23	(C) by striking ''part B'' and inserting
24	''subpart II''.

1 SEC. 1526. EFFECTIVE DATE.

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2 The amendments made by this part shall take effect3 October 1, 1994, or upon the date of the enactment of4 this Act, whichever occurs later.

5 **PART 4—ADDITIONAL RURAL HEALTH CARE**

PROVISIONS

7 SEC. 1531. DEVELOPMENT OF COMMUNITY-OPERATED
8 HEALTH PLANS IN RURAL AND FRONTIER
9 AREAS.

10 (a) COMMUNITY-OPERATED HEALTH PLANS.—The 11 Secretary of Health and Human Services (in this part re-12 ferred to as the "Secretary") may make grants to public 13 and nonprofit private entities for the purpose of carrying 14 out projects to develop health plans to provide services ex-15 clusively in rural and frontier areas.

(b) COMMUNITY INVOLVEMENT.—The Secretary may
make a grant under subsection (a) only if the applicant
involved meets the following conditions:

19 (1) In developing the proposal of the applicant 20 for a project under such subsection, the applicant 21 has consulted with the local governments of the geo-22 graphic area to be served by the health plan devel-23 oped through the project, with individuals who reside 24 in the area, and with a reasonable number and vari-25 ety of health professionals who provide services in 26 the area.

1	(2) The applicant agrees that the principal legal					
2	authority over the operation of the health plan will					
3	be vested in individuals who reside in such geo-					
4	graphic area.					
5	(3) In the proposal the applicant specifies how					
6	a full continuum of services will be provided.					
7	(4) In the proposal the applicant specifies how					
8	the proposed health plan will utilize existing health					
9	care facilities in a manner that avoids unnecessary					
10	duplication.					
11	(c) Use of Funds.—					
12	(1) IN GENERAL.—Funds made available under					
13	this section may be used for the following:					
14	(A) To develop integrated health networks,					
15	utilizing existing local providers and facilities					
16	where appropriate, with community involve-					
17	ment.					
18	(B) For information systems, including					
19	telecommunications.					
20	(C) For transportation services.					
21	(D) To develop rural emergency access					
22	care hospitals (as defined in section					
23	1861(00)(1) of the Social Security Act, as					
24	added by section 1501).					

1 (2) LIMITATIONS.—Funds made available under 2 this section shall not be used for the following: 3 (A) For a telecommunications system, unless the system is coordinated with, and does 4 not duplicate, such a system existing in the 5 6 area. 7 (B) For paying off existing debt. 8 (d) AUTHORIZATION OF APPROPRIATIONS.—There 9 are authorized to be appropriated \$25,000,000 in each of 10 fiscal years 1996, 1997, and 1998 to carry out this 11 section. 12 SEC. 1532. PRIMARY HEALTH CARE FOR MEDICALLY UN-13 DERSERVED RURAL **COMMUNITIES:** IN-14 **CREASED CAPACITY OF HOSPITALS AND OUT-**15 PATIENT FACILITIES. 16 (a) IN GENERAL.—The Secretary may make grants 17 to public and nonprofit private hospitals in medically underserved rural communities, and to public and nonprofit 18 outpatient facilities in such communities, for the purpose 19 20 of carrying out projects to develop or increase the capacity 21 of the hospitals and facilities to provide primary health

22 services.

(b) MEDICALLY UNDERSERVED RURAL COMMUNITY.—For purposes of this section, the term "medically
underserved rural community" means—

1 (1) a rural area that has a substantial number 2 of individuals who are members of a medically un-3 derserved population, as defined in section 330 of 4 the Public Health Service Act; or

5 (2) a rural area a significant portion of which
6 is a health professional shortage area designated
7 under section 332 of such Act.

8 (c) CERTAIN EXPENDITURES.—The purposes for 9 which the Secretary may authorize a grant under sub-10 section (a) to be expended include the renovation of facili-11 ties, the purchase of equipment, and the training of per-12 sonnel.

13 (d) AUTHORIZATION OF APPROPRIATIONS.—

(1) HOSPITALS.—There are authorized to be
appropriated \$50,000,000 in each of fiscal years
1996, 1997, and 1998 for the purpose of making
grants to hospitals under subsection (a).

18 (2) OUTPATIENT FACILITIES.—There are au-19 thorized to be appropriated \$25,000,000 in each of 20 fiscal years 1996, 1997, and 1998 for the purpose 21 of making grants to outpatient facilities under sub-22 section (a).

1SEC. 1533. INNOVATIVE APPROACHES TO DELIVERY OF2HEALTH SERVICES IN RURAL AREAS.

3 (a) IN GENERAL.—The Secretary, acting through the 4 Administrator for Health Care Policy and Research, may 5 make grants to public and nonprofit private entities for 6 the purposes of conducting research and carrying out dem-7 onstration projects to develop innovative approaches to the 8 delivery of health care in rural areas, such as the use of 9 telemedicine and the use of mobile delivery units.

(b) AUTHORIZATION OF APPROPRIATIONS.—There
are authorized to be appropriated \$15,000,000 in each of
fiscal years 1996 through 2000 to carry out this section.
SEC. 1534. TRAINING OF RURAL HEALTH PROFESSIONALS
OTHER THAN PHYSICIANS.

15 FUNDING FOR PROGRAMS UNDER PUBLIC (a) HEALTH SERVICE ACT.—With respect to programs of 16 title VII or VIII of the Public Health Service Act that 17 provide for the training of individuals as health profes-18 sionals other than physicians, there are authorized to be 19 20 appropriated, in addition to amounts otherwise authorized to be appropriated, \$50,000,000 in each of fiscal years 21 22 1996 through 2000 for the purpose of the Secretary carry-23 ing out such programs through entities described in sub-24 section (b).

1 (b) ELIGIBILITY.—With respect to a program re-2 ferred to in subsection (a), an entity described in this sub-3 section is an entity—

4 (1) that is eligible to receive grants or contracts
5 under the program (as provided in the applicable
6 provisions of title VII or VIII of the Public Health
7 Service Act); and

8 (2) a substantial number of whose designated 9 graduates are providing health services in a rural 10 area.

11 (c) DEFINITION OF DESIGNATED GRADUATE.—For 12 purposes of this section, the term "designated graduate", 13 with respect to an entity, means an individual completing 14 the training involved during the 5-year period preceding 15 the fiscal year for which the entity is applying to receive 16 a grant or contract under the applicable program referred 17 to in subsection (a).

18 (d) RELATIONSHIP TO OTHER FUNDS.—The 19 amounts made available in subsection (a) for carrying out 20 programs referred to in such subsection are in addition 21 to any other amounts that are available for carrying out 22 the programs.

23 SEC. 1535. GENERAL PROVISIONS.

24 (a) APPLICATION FOR GRANT.—The Secretary may 25 make a grant under any section of this part only if 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 informa tion as the Secretary determines to be necessary to carry
 out the program involved.

6 (b) TECHNICAL ASSISTANCE.—The Secretary may 7 provide technical assistance to recipients of grants or con-8 tracts under this part with respect to the planning, devel-9 opment, and operation of activities under the grants or 10 contracts.

Subtitle G—Assistance in Enrolling Uninsured Children in Health Insurance

14 SEC. 1601. ESTABLISHMENT OF STATE PROGRAMS.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section
16 1902(a) of the Social Security Act (42 U.S.C. 1396a(a))
17 is amended—

18 (1) by striking "and" at the end of paragraph19 (61);

20 (2) by striking the period at the end of para-21 graph (62) and inserting "; and"; and

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

1 "(63) provide for a State program furnishing 2 premium subsidies for needy children in accordance with section 1931.". 3 4 (b) STATE PROGRAMS FOR PREMIUM SUBSIDIES FOR NEEDY CHILDREN.—Title XIX of the Social Security Act 5 (42 U.S.C. 1396 et seq.) is amended by redesignating sec-6 tion 1931 as section 1932 and by inserting after section 7 8 1930 the following new section: 9 "STATE PREMIUM SUBSIDY PROGRAMS FOR NEEDY 10 **CHILDREN** "Sec. 1931. (a) Requirement To Operate State 11 12 PROGRAM.— "(1) IN GENERAL.—A State with a State plan 13 14 approved under this title shall have in effect a premium subsidy program for furnishing premium sub-15 16 sidy under subsection (b) to premium subsidy eligi-17 ble children in the State in fiscal years beginning 18 with fiscal year 1997. 19 ⁽⁽²⁾ DESIGNATION OF STATE AGENCY.—A 20 State may designate any appropriate State agency to administer the program under this section. 21 22 "(b) Assistance With Premiums for Standard HEALTH COVERAGE.— 23 24 "(1) ELIGIBILITY.—An eligible individual who has been determined by a State to be a premium 25 26 subsidy eligible child (as defined in paragraph (2))

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1	shall be entitled to premium subsidies in the amount
2	determined under subsection (c).
3	"(2) Premium subsidy eligible child.—For
4	purposes of this section, the term 'premium subsidy
5	eligible child' means an individual who is provided
6	certified standard health coverage (as defined in
7	subsection (j)(1)) and—
8	''(A) who is under 20 years of age,
9	"(B) whose family has a family income de-
10	termined under this section which does not ex-
11	ceed 240 percent (or such lesser percent as the
12	Secretary shall specify so that the total Federal
13	payments to States under this section for the
14	fiscal year do not exceed the amount specified
15	for the fiscal year under subsection $(i)(1)$ of
16	the poverty line, and
17	"(C) except as provided in paragraph (3),
18	who is not otherwise eligible for medical assist-
19	ance under the State plan (or would be eligible
20	for such assistance on the basis of the plan in
21	effect as of the date of the enactment of the Af-
22	fordable Health Care Now Act of 1994).
23	"(3) Eligibility of children becoming eli-

GIBLE FOR MEDICAID.—At the option of the State,a premium subsidy eligible child may include an in-

1	dividual who meets the requirements of subpara-
2	graphs (A) and (B) of paragraph (2) and is eligible
3	for medical assistance under the State plan if the in-
4	dividual was formerly a premium subsidy eligible
5	child under paragraph (2). The exercise of such op-
6	tion shall not diminish the benefits to which such a
7	child is otherwise entitled under the State plan.
8	"(4) Additional children using state-
9	ONLY FUNDS.—Nothing in this section shall be con-
10	strued as preventing a State, using its own funds
11	and without any Federal financial participation,
12	from covering additional children as premium sub-
10	
13	sidy eligible children.
13 14	sidy eligible children. "(c) Amount of Premium Subsidy.—
14	"(c) Amount of Premium Subsidy.—
14 15	"(c) Amount of Premium Subsidy.— "(1) In general.—
14 15 16	"(c) Amount of Premium Subsidy.— "(1) In general.— "(A) In general.—The premium subsidy
14 15 16 17	"(c) Amount of Premium Subsidy.— "(1) IN GENERAL.— "(A) IN GENERAL.—The premium subsidy amount determined under this paragraph is a
14 15 16 17 18	"(c) AMOUNT OF PREMIUM SUBSIDY.— "(1) IN GENERAL.— "(A) IN GENERAL.—The premium subsidy amount determined under this paragraph is a monthly amount equal to the subsidy percent-
14 15 16 17 18 19	"(c) AMOUNT OF PREMIUM SUBSIDY.— "(1) IN GENERAL.— "(A) IN GENERAL.—The premium subsidy amount determined under this paragraph is a monthly amount equal to the subsidy percent- age of 1/12th of the lesser of—
14 15 16 17 18 19 20	"(c) AMOUNT OF PREMIUM SUBSIDY.— "(1) IN GENERAL.— "(A) IN GENERAL.—The premium subsidy amount determined under this paragraph is a monthly amount equal to the subsidy percentage of 1/12th of the lesser of— "(i) the annual premium for certified
14 15 16 17 18 19 20 21	"(c) AMOUNT OF PREMIUM SUBSIDY.— "(1) IN GENERAL.— "(A) IN GENERAL.—The premium subsidy amount determined under this paragraph is a monthly amount equal to the subsidy percent- age of 1/12th of the lesser of— "(i) the annual premium for certified standard health coverage provided the
 14 15 16 17 18 19 20 21 22 	 "(c) AMOUNT OF PREMIUM SUBSIDY.— "(1) IN GENERAL.— "(A) IN GENERAL.—The premium subsidy amount determined under this paragraph is a monthly amount equal to the subsidy percent- age of 1/12th of the lesser of— "(i) the annual premium for certified standard health coverage provided the child, or

1	available under chapter 89 of title, United
2	States Code for the year, adjusted to re-
3	flect a premium for a single child of the
4	age involved and adjusted to reflect the rel-
5	ative cost of premiums for health coverage
6	of premium subsidy eligible children in the
7	geographic area in which the child resides
8	compared to the national average and ad-
9	justed to reflect the reduction in cost-shar-
10	ing effected under subsection (j)(4).
11	"(B) SUBSIDY PERCENTAGE.—For pur-
12	poses of paragraph (1), an individual's 'subsidy

14not below zero percent) by 1.8 percentage15points for each percentage point (or portion16thereof) such individual's income equals or ex-17ceeds 185 percent of the poverty line.

percentage' means 100 percent reduced (but

18 "(d) PAYMENTS.—

13

19 "(1) IN GENERAL.—The amount of the pre-20 mium subsidy available to a premium subsidy eligi-21 ble child under subsection (b) shall be paid by the 22 State in which the individual resides directly to the 23 insurer that provides the coverage for the premium 24 subsidy eligible child. Payments under the preceding 25 sentence shall commence in the first month during

which the individual is provided coverage and deter-1 2 mined under this section to be a premium subsidy eligible child. 3 "(2) Administrative errors.—A State is fi-4 5 nancially responsible for premium subsidy paid 6 based on an eligibility determination error to the extent the State's error rate for eligibility determina-7 tions exceeds a maximum permissible error rate to 8 9 be specified by the Secretary. "(e) ELIGIBILITY DETERMINATIONS.— 10 "(1) IN GENERAL.—The Secretary shall pro-11 mulgate regulations specifying requirements for 12 State programs under this section with respect to 13 14 determining eligibility for premium subsidy, includ-15 ing requirements with respect to— "(A) application procedures; 16 17 "(B) information verification procedures; 18 "(C) timeliness of eligibility determina-19 tions; "(D) procedures for applicants to appeal 20 21 adverse decisions; and "(E) any other matters determined appro-22 priate by the Secretary. 23

24 "(2) SPECIFICATIONS FOR REGULATIONS.—The
25 regulations promulgated by the Secretary under

1	paragraph	(1)	shall	include	the	following	require-
2	ments:						

3 "(A) FREQUENCY OF APPLICATIONS.—A
4 State program shall provide that an individual
5 may file an application for assistance with an
6 agency designated by the State at any time, in
7 person or by mail.

8 "(B) APPLICATION FORM.—A State pro-9 gram shall provide for the use of an application 10 form developed by the Secretary under this sec-11 tion.

12 "(C) DISTRIBUTION OF APPLICATIONS.—A
13 State program shall distribute applications for
14 assistance through employers and appropriate
15 public agencies.

"(D) REQUIREMENT TO SUBMIT REVISED 16 17 APPLICATION.—A State program shall, in ac-18 cordance with regulations promulgated by the 19 Secretary, require individuals to submit revised 20 applications during a year to reflect changes in estimated family incomes, including changes in 21 22 employment status of family members, during the year. The State shall revise the amount of 23 24 any premium subsidy based on such a revised application. 25

VERIFICATION.—A State program "(E) 1 shall provide for verification of the information 2 supplied in applications under this section. 3 4 Such verification may include examining return information disclosed to the State for such pur-5 6 pose under section 6103(l)(15) of the Internal 7 Revenue Code of 1986. 8 "(f) Administration of State Programs.— "(1) IN GENERAL.—The Secretary shall estab-9 lish standards for States operating programs under 10 11 this section which ensure that such programs are op-12 erated in a uniform manner with respect to application procedures, data processing systems, and such 13 14 other administrative activities as the Secretary de-15 termines to be necessary. (2)FORMS.—The 16 Application Secretary 17 shall develop an application form for assistance 18 which shall— 19 "(A) be simple in form and understandable 20 to the average individual; "(B) require the provision of information 21 22 necessary to make a determination as to whether an individual is a premium subsidy eligible 23 child including a declaration of estimated in-24

1	come by the individual based, at the election of
2	the individual—
3	''(i) on multiplying by a factor of 4
4	the individual's family income for the 3-
5	month period immediately preceding the
6	month in which the application is made, or
7	"(ii) on estimated income for the en-
8	tire year for which the application is sub-
9	mitted; and
10	''(C) require attachment of such docu-
11	mentation as deemed necessary by the Sec-
12	retary in order to ensure eligibility for assist-
13	ance.
14	"(3) OUTREACH ACTIVITIES.—A State operat-
15	ing a program under this section shall conduct such
16	outreach activities as the Secretary determines ap-
17	propriate.
18	"(4) Effectiveness of eligibility for pre-
19	MIUM SUBSIDIES.—A determination by a State that
20	an individual is a premium subsidy eligible child
21	shall be effective for the calendar year for which
22	such determination is made unless a revised applica-
23	tion submitted under paragraph (2) indicates that
24	an individual is no longer eligible for premium sub-
25	sidies.

"(5) PENALTIES FOR MATERIAL MISREPRESEN TATIONS.—

"(A) IN GENERAL.—Any individual who 3 4 knowingly makes a material misrepresentation of information in an application for assistance 5 6 under this section shall be liable to the Federal 7 Government for the amount of any premium subsidy received by individual on the basis of a 8 9 misrepresentation and interest on such amount 10 at a rate specified by the Secretary, and shall, 11 in addition, be liable to the Federal Government for \$2,000 or, if greater, 3 times the amount 12 any premium subsidy received by individual on 13 14 the basis of a misrepresentation.

"(B) 15 COLLECTION OF PENALTY AMOUNTS.—A State which receives an applica-16 17 tion for assistance with respect to which a ma-18 terial misrepresentation has been made shall 19 collect the penalty amount required under sub-20 paragraph (A) and submit 50 percent of such amount to the Secretary in a timely manner. 21

22 "(g) END-OF-YEAR RECONCILIATION FOR PREMIUM23 SUBSIDY.—

24 "(1) IN GENERAL.—

1	"(A) Requirement to file state-
2	MENT.—An individual who received premium
3	subsidies under this section from a State for
4	any month in a calendar year shall file with the
5	State an income reconciliation statement to ver-
6	ify the individual's family income for the year.
7	Such a statement shall be filed at such time,
8	and contain such information, as the State may
9	specify in accordance with regulations promul-
10	gated by the Secretary.
11	"(B) NOTICE OF REQUIREMENT.—A State
12	shall provide a written notice of the require-
13	ment under subparagraph (A) at the end of the
14	year to an individual who received premium
15	subsidies under this part from such State in
16	any month during the year.
17	"(2) Reconciliation of premium subsidy
18	BASED ON ACTUAL INCOME.—
19	"(A) IN GENERAL.—Based on and using
20	the income reported in the reconciliation state-
21	ment filed under paragraph (1) with respect to
22	an individual, the State shall compute the
23	amount of premium subsidy that should have
24	been provided under this section with respect to
25	the individual for the year involved.

"(B) OVERPAYMENT OF ASSISTANCE.—If 1 2 the total amount of the premium subsidy pro-3 vided was greater than the amount computed 4 under subparagraph (A), the individual is liable to the State to pay an amount equal to the 5 6 amount of the excess payment. Any amount collected by a State under this subparagraph shall 7 8 be submitted to the Secretary in a timely man-9 ner. "(C) UNDERPAYMENT OF ASSISTANCE.—If 10

11 the total amount of the premium subsidy pro-12 vided was less than the amount computed under 13 subparagraph (A), the State shall pay to the in-14 dividual an amount equal to the amount of the 15 deficit.

"(D) STATE OPTION.—A State may, in ac-16 17 cordance with regulations promulgated by the 18 Secretary, establish a procedure under which 19 any overpayments or underpayments of pre-20 mium subsidy determined under subparagraphs (A) and (B) with respect to an individual for a 21 22 year may be collected or paid, as appropriate, through adjustments to the premium subsidy 23 24 furnished to such individual in the succeeding 25 year.

"(3) VERIFICATION.—Each State may use such
 information as it has available to verify income of in dividuals with applications filed under this section,
 including return information disclosed to the state
 for such purpose under section 6103(l)(15) of the
 internal revenue code of 1986.

7 "(4) PENALTIES FOR FAILURE TO FILE.—In the case of an individual who is required to file a 8 9 statement under this subsection in a year who fails to file such a statement by such date as the Sec-10 11 retary shall specify in regulations, the entire amount 12 of the premium subsidy provided in such year shall be considered an excess amount under paragraph 13 14 (2)(A) and such individual shall not be eligible for 15 premium subsidy assistance under this section until 16 such statement is filed. A State, using rules estab-17 lished by the Secretary, shall waive the application 18 of this paragraph if the individual establishes, to the 19 satisfaction of the State under such rules, good 20 cause for the failure to file the statement on a timely 21 basis.

"(5) PENALTIES FOR FALSE INFORMATION.—
Any individual who provides false information in a
statement filed under paragraph (1) is subject to the
same penalties as are provided under subsection

1	(f)(5) for a misrepresentation of material fact de-
2	scribed in such section.
3	"(h) Special Rules on Federal Financial Par-
4	TICIPATION.—
5	"(1) PREMIUM SUBSIDY.—In applying section
6	1903(a)(1) with respect to expenditures for premium
7	subsidy (other than administrative expenses) under
8	this section—
9	''(A) such expenditures shall be considered
10	to be expenditures on medical assistance;
11	"(B) in the case of assistance for a pre-
12	mium subsidy eligible child not described in
13	subsection (b)(3), the Federal medical assist-
14	ance percentage is deemed to be 100 percent;
15	and
16	"(C) the total amount of Federal financial
17	participation with respect to any State for quar-
18	ters in any fiscal year (with respect to premium
19	subsidy eligible children not described in sub-
20	section (b)(3)) shall not exceed the State allot-
21	ment under subsection $(i)(2)$ for that year.
22	"(2) Administration expenses.—The
23	amount of expenditures that may be taken into ac-
24	count in computing amounts that are payable to a
25	State under section 1903(a) (other than paragraph

1	(1)) with respect to the administration of the pro-
2	gram under this section may not exceed 3 percent of
3	the total expenditures.
4	"(i) Total Federal Budget for Program; Al-
5	LOTMENTS TO STATES.—
6	"(1) Total federal budget.—
7	"(A) FISCAL YEARS 1997 THROUGH 2004.—
8	Subject to subparagraph (E)(iii), for purposes
9	of this section, the total Federal payments to
10	States under this section may not exceed the
11	following:
12	''(i) For fiscal year 1997, \$4.7 billion.
13	''(ii) For fiscal year 1998, \$5.2 bil-
14	lion.
15	''(iii) For fiscal year 1999, \$6.5 bil-
16	lion.
17	"(iv) For fiscal year 2000, \$9.8 bil-
18	lion.
19	"(v) For fiscal year 2001, \$12.3 bil-
20	lion.
21	''(vi) For fiscal year 2002, \$15.3 bil-
22	lion.
23	''(vii) For fiscal year 2003, \$20.0 bil-
24	lion.

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1	"(viii) For fiscal year 2004, \$24.4 bil-
2	lion.
3	"(B) SUBSEQUENT FISCAL YEARS.—For
4	purposes of this section, the total Federal budg-
5	et for State plans under this part for each fiscal
6	year after fiscal year 2004 is the total Federal
7	budget under this subsection for the preceding
8	fiscal year multiplied by the Secretary's esti-
9	mate of the percentage increase in private sec-
10	tor health expenditures for the year.
11	"(2) Allotments to states.—
12	"(A) IN GENERAL.—The amount of a
13	State's allotment under this section for a fiscal
14	year shall be equal to the product of—
15	"(i) the limit on the total amount of
16	Federal payments for the year under para-
17	graph (1)(A); and
18	"(ii) the State's allotment percentage
19	under subparagraph (B).
20	"(B) STATE ALLOTMENT PERCENTAGE.—
21	In subparagraph (A), a State's allotment per-
22	centage for a fiscal year is equal to the percent-
23	age of all premium subsidy eligible children in
24	the United States who are residents of the

1	State (as estimated by the Secretary prior to
2	the beginning of the fiscal year).
3	"(3) Limitation on premium payments for
4	ABORTION SERVICES.—Notwithstanding any other
5	provision of this title or the Affordable Health Care
6	Now Act of 1994, none of the funds appropriated to
7	carry out this section shall be expended to assist in
8	the purchase, in whole or in part, of a health benefit
9	package that includes abortion except in cases (A)
10	where the life of the mother would be endangered if
11	the fetus were carried to term, or (B) where the
12	pregnancy is the result of rape or incest.
13	"(j) Certified Standard Health Coverage De-
13 14	"(j) Certified Standard Health Coverage De- Fined.—
14	FINED.—
14 15	FINED.— "(1) IN GENERAL.—In this section, health in-
14 15 16	FINED.— "(1) IN GENERAL.—In this section, health in- surance coverage is considered to provide certified
14 15 16 17	FINED.— "(1) IN GENERAL.—In this section, health in- surance coverage is considered to provide certified standard health coverage if—
14 15 16 17 18	FINED.— "(1) IN GENERAL.—In this section, health in- surance coverage is considered to provide certified standard health coverage if— "(A) benefits under such coverage are pro-
14 15 16 17 18 19	FINED.— "(1) IN GENERAL.—In this section, health in- surance coverage is considered to provide certified standard health coverage if— "(A) benefits under such coverage are pro- vided within at least each of the required cat-
 14 15 16 17 18 19 20 	FINED.— "(1) IN GENERAL.—In this section, health in- surance coverage is considered to provide certified standard health coverage if— "(A) benefits under such coverage are pro- vided within at least each of the required cat- egories of benefits described in subparagraph
 14 15 16 17 18 19 20 21 	FINED.— "(1) IN GENERAL.—In this section, health in- surance coverage is considered to provide certified standard health coverage if— "(A) benefits under such coverage are pro- vided within at least each of the required cat- egories of benefits described in subparagraph (A) of paragraph (2) and consistent with such

1	"(C) the benefits comply with the mini-
2	mum requirements specified in paragraph (4).
3	"(2) Required categories of covered ben-
4	EFITS.—
5	"(A) IN GENERAL.—The categories of cov-
6	ered benefits described in this subparagraph are
7	the types of benefits specified in subparagraphs
8	(A), (B), (C), (D), and (F) of paragraph (1),
9	and subparagraphs (E) and (F) of paragraph
10	(2), of section 8904(a) of title 5, United States
11	Code (relating to types of benefits required to
12	be in health insurance offered to Federal em-
13	ployees) and includes the category of preventive
14	benefits.
15	"(B) Coverage of off-label use.—An
16	off-label use for a drug that has been found to
17	be safe and effective under section 505 of the
18	Federal Food, Drug, and Cosmetic Act shall be
19	covered if the medical indication for which it is
20	used is listed in one of the following 3 compen-
21	dia: the American Hospital Formulary Service-
22	Drug Information, the American Medical Asso-
23	ciation Drug Evaluations, and the United
24	States Pharmacopeia-Drug Information.

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

"(3) STANDARD ACTUARIAL VALUE.—

"(A) IN GENERAL.—The actuarial value of 9 the benefits under standard coverage in a rat-10 11 ing area meets the requirements of this para-12 graph if such value is equivalent to the stand-13 ard actuarial value described in subparagraph 14 (B) for the area, as adjusted for inflation under 15 subparagraph (D). The actuarial value of bene-16 fits under standard coverage shall be deter-17 mined using the standardized population and 18 set of standardized utilization and cost factors 19 described in subparagraph (C). Such actuarial 20 value shall be adjusted to reflect the reduction in cost-sharing effected under paragraph (4). 21

"(B) STANDARD ACTUARIAL VALUE DESCRIBED.—The standard actuarial value described in this subparagraph for coverage in a
geographic area is the actuarial value of bench-

1	mark coverage during 1994 in such area. Such
2	actuarial value shall be determined using the
3	standardized population and set of standardized
4	utilization and cost factors described in sub-
5	paragraph (C) and shall be adjusted to reflect
6	the age of the population of premium subsidy
7	eligible children under this section.
8	"(C) Adjustments for standardized
9	POPULATION, STANDARDIZED UTILIZATION AND
10	COST FACTORS, AND GEOGRAPHIC AREA.—The
11	adjustment under this subparagraph—
12	''(i) for a standardized population
13	shall be made by not taking into account
14	individuals 65 years of age or older, em-
15	ployees of the United States Postal Serv-
16	ice, and retirees; and
17	''(ii) for a geographic area shall be
18	made in a manner that reflects the ratio of
19	the actuarial value of benchmark coverage
20	in such geographic area (as adjusted under
21	clause (i)) to such actuarial value for such
22	benchmark coverage for the United States
23	as a whole, taking into account standard-
24	ized actuarial utilization and cost factors.
25	"(D) ADJUSTMENT FOR INFLATION.—

1	"(i) IN GENERAL.—The adjustment
2	under this paragraph for a year (beginning
3	with 1995) is the FEHBP national rolling
4	increase percentage for the year involved,
5	compounded by such increase for each pre-
6	ceding year after 1994.
7	"(ii) FEHBP NATIONAL ROLLING IN-
8	CREASE PERCENTAGE.—For purposes of
9	this paragraph, the term 'FEHBP national
10	rolling increase percentage' means, for a
11	year, the 5-year average of the annual na-
12	tional percentage increase in the premiums
13	for health plans offered under the Federal
14	Employees Health Benefits Program
15	(under chapter 89 of title 5, United States
16	Code) for the period ending with the pre-
17	vious year. Such increase shall be deter-
18	mined by the Secretary in consultation
19	with the Director of Office of Personnel
20	Management based on the best information
21	available.
22	"(4) MINIMUM REQUIREMENTS.—Benefits of-
23	fered under standard coverage within any category
24	shall be not less than the narrowest scope and short-
25	est duration of benefits within that category, in an

1	approved health benefits plan under chapter 89 of
2	title 5, United States Code, except that under such
3	coverage—
4	"(A) no cost-sharing may be imposed for
5	preventive services (as specified by the Sec-
6	retary); and
7	"(B) with respect to individuals with fam-
8	ily income below 100 percent of the poverty
9	line, any cost-sharing imposed for other items
10	and services may only be nominal.
11	"(k) Definitions; Determinations of Income.—
12	For purposes of this part:
13	"(1) DETERMINATIONS OF INCOME.—
14	"(A) FAMILY INCOME.—The term 'family
15	income' means, with respect to an individual
16	who—
17	"(i) is not a dependent (as defined in
18	subparagraph (B)) of another individual,
19	the sum of the modified adjusted gross in-
20	comes (as defined in subparagraph (D))
21	for the individual, the individual's spouse,
22	and dependents of the individual; or
23	"(ii) is a dependent of another indi-
24	vidual, the sum of the modified adjusted
25	gross incomes for the other individual, the

	-
1	other individual's spouse, and dependents
2	of the other individual.
3	"(B) DEPENDENT.—The term 'dependent'
4	shall have the meaning given such term under
5	paragraphs (1) or (2) of section 152(a) of the
6	Internal Revenue Code of 1986.
7	"(C) Special rule for foster chil-
8	DREN.—For purposes of subparagraph (A), a
9	child who is placed in foster care by a State
10	agency shall not be considered a dependent of
11	another individual.
12	"(D) Modified adjusted gross in-
13	COME.—The term 'modified adjusted gross in-
14	come' means adjusted gross income (as defined
15	in section 62(a) of the Internal Revenue Code
16	of 1986)—
17	"(i) determined without regard to sec-
18	tions 135, 162(l), 911, 931, and 933 of
19	such Code, and
20	"(ii) increased by—
21	"(I) the amount of interest re-
22	ceived or accrued by the individual
23	during the taxable year which is ex-
24	empt from tax, and

1	"(II) the amount of the social se-
2	curity benefits (as defined in section
3	86(d) of such Code) received during
4	the taxable year to the extent not in-
5	cluded in gross income under section
6	86 of such Code.
7	The determination under the preceding sen-
8	tence shall be made without regard to any car-
9	ryover or carryback.
10	"(2) Eligible individual.—
11	"(A) IN GENERAL.—Except as provided in
12	subparagraph (B), the term 'eligible individual'
13	means any individual who is residing in the
14	United States.
15	"(B) EXCLUSION.—The term 'eligible indi-
16	vidual' does not include—
17	''(i) an alien who is ineligible for as-
18	sistance under this title pursuant to sec-
19	tion 2802 of the Affordable Health Care
20	Now Act of 1994; or
21	''(ii) an individual who is an inmate of
22	a public institution (except as a patient of
23	a medical institution).
24	"(3) POVERTY LINE.—The term 'poverty line"
25	means the income official poverty line (as defined by

1	the Office of Management and Budget, and revised
2	annually in accordance with section 673(2) of the
3	Omnibus Budget Reconciliation Act of 1981) that—
4	"(A) in the case of a family of less than
5	five individuals, is applicable to a family of the
6	size involved; and
7	"(B) in the case of a family of more than
8	four individuals, is applicable to a family of
9	four persons.
10	"(4) PREMIUM.—Any reference to the term
11	'premium' includes a reference to premium equiva-
12	lence for self-insured plans.
13	"(5) BENCHMARK COVERAGE.—The term
14	'benchmark coverage' means the standard option of
15	the Blue Cross-Blue Shield plan offered under the
16	Federal Employees Health Benefits Program under
17	chapter 89 of title 5, United States Code, as in ef-
18	fect during 1994.".

1	Subtitle H—Medicaid Reform
2	PART 1-STATE FLEXIBILITY IN THE MEDICAID
3	PROGRAM: THE MEDICAL HEALTH ALLOW-
4	ANCE PROGRAM
5	SEC. 1701. ESTABLISHMENT OF PROGRAM.
6	(a) IN GENERAL.—Title XIX of the Social Security
7	Act (42 U.S.C. 1396 et seq.), as amended by section 1601,
8	is further amended—
9	(1) by redesignating section 1932 as section
10	1933; and
11	(2) by inserting after section 1931 the following
12	new section:
13	"STATE HEALTH ALLOWANCE PROGRAMS
14	"Sec. 1932. (a) Treatment of Expenditures
15	Under Health Allowance Programs as Medical
16	Assistance Under State Plan.—
17	"(1) IN GENERAL.—Notwithstanding any other
18	provision of this title, for purposes of determining
19	the amount to be paid to a State under section
20	1903(a)(1) for quarters in any fiscal year, amounts
21	expended by an eligible State (as described in sub-
22	section (b)) during the fiscal year under a State
23	health allowance program (as described in subsection
24	(c)) shall be included in the total amount expended
25	during the fiscal year as medical assistance under

1	the State plan (except as provided under paragraphs
2	(2) and (3) and under subsection $(d)(1)(C)$.
3	"(2) Federal payment restricted to
4	ACUTE CARE SERVICES.—No amounts expended
5	under a State health allowance program that are at-

6 tributable to medical assistance described in para-7 graphs (4), (14), (15), (23), or (24) of section 8 1905(a) shall be included in the total amount ex-9 pended as medical assistance under the State plan.

10 "(3) AMOUNT OF FEDERAL PAYMENT BASED 11 UPON UNUSED PREMIUM SUBSIDY PROGRAM ALLOT-12 MENT.—In no case shall this subsection result in the 13 total Federal payments to the State under this title 14 (including payments attributable to this section and 15 section 1923) for quarters in a fiscal year exceeding 16 an amount equal to the difference between—

17 "(A) the State's allotment for the premium
18 subsidy program for children under section
19 1931(i)(2) for such fiscal year; and

20 "(B) the amount paid to the State for such21 program for such fiscal year.

"(4) LIMITATION ON PREMIUM PAYMENTS FOR
ABORTION SERVICES.—Notwithstanding any other
provision of this title or the Affordable Health Care
Now Act of 1994, none of the funds appropriated to

carry out this section shall be expended to assist in
the purchase, in whole or in part, of a health benefit
package that includes abortion except in cases (A)
where the life of the mother would be endangered if
the fetus were carried to term, or (B) where the
pregnancy is the result of rape or incest.

7 "(b) ELIGIBILITY OF STATE.—A State is eligible for purposes of subsection (a) if the State submits (at such 8 9 time and in such form as the Secretary may require) an 10 application to the Secretary containing such information and assurances as the Secretary may require, including 11 assurances that the State has adopted and is enforcing 12 standards regarding quality assurance for group health 13 plans participating in the State health allowance program, 14 15 including standards regarding—

"(1) uniform reporting requirements for such
plans relating to a minimum set of clinical data, patient satisfaction data, and other information that
may be used by individuals to compare the quality
of various plans; and

21 "(2) the establishment or designation of an en22 tity of the State government to collect the data de23 scribed in subparagraph (A) and to regularly report
24 such data to the Secretary.

1 "(c) STATE HEALTH ALLOWANCE PROGRAM DE-2 SCRIBED.—

3 "(1) ENROLLMENT OF PARTICIPATING INDIVID-4 UALS IN APPROVED GROUP HEALTH PLANS.—In this 5 section, a State health allowance program is a program in effect in all the political subdivisions of the 6 7 State (except as provided in (c)) under which the State makes payments to a group health plan (ap-8 9 proved under paragraph (2)) which provides cov-10 erage to the individual as an allowance towards the 11 costs of providing the individual with benefits under the plan. 12

"(2) APPROVED PLANS DESCRIBED.—For purposes of paragraph (1), a State shall approve group
health plans in accordance with such standards as
the State may establish, except that—

"(A) the State may not approve a plan for
a year unless the plan provides certified standard health coverage described in section
1931(j);

21 "(B) at least one of the plans approved by
22 the State shall be a health maintenance organi23 zation or other plan under which payments are
24 otherwise made on a capitated basis for provid-

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ing medical assistance to individuals enrolled in the State plan under this title; and

"(C) in the case of an individual who is en-3 4 titled to benefits under the State plan under this title as of the first month during which the 5 6 State health allowance program is in effect, an approved plan may not require the individual to 7 contribute a greater amount of cost-sharing 8 9 than the individual would have been required to 10 contribute under the State plan (except as may 11 be imposed on an individual described in sub-12 paragraph (B) or subparagraph (C) of sub-13 section (d)(1).

In applying subparagraph (A), in determining the standard actuarial value, instead of adjustments made to reflect the population under section 1931 there shall be adjustments made to reflect the population covered under this section.

"(3) WAIVER OF STATEWIDENESS REQUIREMENT.—At the request of a State, the Secretary
may waive for a period not to exceed 3 years (subject to one 3-year extension) the requirement under
paragraph (1) that the State health allowance program be in effect in all political subdivisions of the
State.

"(d) Eligibility of Individuals To Participate
 IN Allowance Program.—

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

10 "(2) MANDATORY ELIGIBILITY OF PREGNANT
11 WOMEN WITH INCOME UNDER 150 PERCENT OF THE
12 POVERTY LEVEL.—

"(A) IN GENERAL.—Subject to subsection 13 14 (e) and subparagraph (B), an individual law-15 fully residing in the State shall be eligible to 16 participate in the program if the individual is a 17 pregnant woman and the income of the individ-18 ual's family is equal to or less than 240 percent 19 of the official poverty line (as defined by the 20 Office of Management and Budget, and revised annually in accordance with section 673(2) of 21 22 the Omnibus Budget Reconciliation Act of 1991) applicable to a family of the size in-23 volved. 24

Title I, Subtitle H

	200
1	"(B) EXCEPTION.—If the application of
2	subparagraph (A) would result in—
3	''(i) the total State expenditures for a
4	quarter under this title (including expendi-
5	tures attributable to this section and sec-
6	tion 1923, but not including expenditures
7	under section 1931), exceeding
8	''(ii) the total State expenditures that
9	the Secretary estimates would have been
10	made under this title for the quarter if the
11	State did not have a program under this
12	section,
13	then there shall be substituted for 150 percent
14	in subparagraph (A) such percent as would re-
15	sult in the amount described in clause (i) equal-
16	ing the amount described in clause (ii).
17	"(C) Phasing out premium subsidy for
18	CERTAIN INDIVIDUALS.—
19	"(i) IN GENERAL.—In the case of an
20	individual eligible to participate in the pro-
21	gram pursuant to this paragraph who has
22	income equal to or greater than 185 per-
23	cent of the official poverty line applicable
24	to a family of the size involved, the amount
25	paid by the State under subsection $(c)(1)$

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1	with respect to the individual shall be
2	equal to the individual's subsidy percent-
3	age of the amount that would otherwise be
4	paid under such subsection with respect to
5	the individual but for this subparagraph.
6	"(ii) Subsidy percentage de-
7	FINED.—In clause (i), an individual's 'sub-
8	sidy percentage' means 100 percent re-
9	duced (but not below zero percent) by 1.8
10	percentage points for each percentage
11	point (or portion thereof) by which the in-
12	dividual's income equals or exceeds 185
13	percent of the official poverty line.
14	"(3) Optional eligibility of other indi-
15	VIDUALS WITH INCOME UP TO 150 PERCENT OF POV-
16	ERTY LEVEL.—
17	"(A) IN GENERAL.—Subject to subsection
18	(e), a State operating a State health allowance
19	program under this section may make an indi-
20	vidual lawfully residing in the State who is not
21	described in paragraph (2) eligible to partici-
22	pate in the program if the income of the indi-
23	vidual's family is not greater than 150 percent
24	of such official poverty line.

"(B) Contribution may be required.— 1 2 In the case of an individual who is participating 3 in the program under this paragraph and whose 4 family income is greater than 100 percent of 5 the official poverty line, the program may re-6 quire such an individual to contribute all (or a 7 portion) of the premiums for such a group health plan if the amount of such contribution 8 9 is determined in accordance with a sliding scale based on the individual's family income. 10

11 "(4) Restriction on eligibility of other 12 MEDICAID BENEFICIARIES.—An individual is not eli-13 gible to participate in the program pursuant to para-14 graph (2) or paragraph (3) if the individual is eligi-15 ble for medical assistance under the State plan 16 under this title (or would be eligible for such assist-17 ance on the basis of the plan in effect as of the date 18 of the enactment of the Affordable Health Care Now 19 Act of 1994).

20 "(e) Exclusion and Use of Resource Stand-21 ard.—

22 "(1) EXCLUSION OF ELDERLY MEDICARE-ELIGI23 BLE INDIVIDUALS.—No individual shall be eligible to
24 participate in the program if the individual is enti-

tled to benefits under title XVIII pursuant to section
 226.

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

8 "(f) CONSTRUCTION.—No provision of any Federal 9 law shall prevent a State from enrolling any employee or 10 other individual in accordance with this section. The pre-11 vious sentence shall not be construed as permitting a State 12 to require the employer of an individual participating in 13 the program to contribute toward the individual's pre-14 mium required for such participation.

15 "(g) EVALUATIONS AND REPORTS.—

"(1) EVALUATIONS.—Not later than 3 years 16 17 after the date of the enactment of this section (and 18 at such subsequent intervals as the Secretary consid-19 ers appropriate), the Secretary shall evaluate the ef-20 fectiveness of the State health allowance programs 21 for which Federal financial participation is provided 22 under this section, and the impact of such programs on increasing the number of individuals with health 23 24 insurance coverage in participating States and in 25 controlling the costs of health care in such States.

1	"(2) REPORTS.—Not later than 3 years after
2	the date of the enactment of this section (and at
3	such subsequent intervals as the Secretary considers
4	appropriate), the Secretary shall submit a report on
5	the program to Congress.".
6	(b) EFFECTIVE DATE.—The amendments made by
7	this section shall apply to calendar quarters beginning on
8	or after October 1, 1996.
9	SEC. 1702. OPTIONAL USE OF PROGRAM TO OFFER COV-
10	ERAGE TO SOME OR ALL STATE RESIDENTS.
11	Section 1932 of the Social Security Act, as inserted
12	by section 1701(a)(2), is amended—
13	(1) in subsection $(c)(2)(A)$, in the matter before
14	clause (i), by inserting '', except as provided in sub-
15	section $(d)(4)(B)(iii)$," after "unless", and
16	(2) by adding at the end of subsection (d) the
17	following new paragraphs:
18	"(4) Optional enrollment of other indi-
19	VIDUALS.—
20	"(A) IN GENERAL.—Subject to subsection
21	(e), a State operating a State health allowance
22	program under this section may make any indi-
23	vidual (or class of individuals) who is not de-
24	scribed in paragraph (1), (2), or (3) and who
25	is not offered coverage under an employer

group health plan eligible to participate in the program.

"(B) SPECIAL RULES.—

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"(i) 4 CONTRIBUTION MAY ΒE RE-QUIRED.—In the case of an individual who 5 6 is participating in the program under this 7 paragraph, the program may require such 8 an individual to contribute all (or a por-9 tion) of the premiums and cost-sharing of 10 such a group health plan.

11 "(ii) No federal matching pay-12 MENTS.—For purposes of payment to 13 States under section 1903(a), no amounts 14 expended by the State under the program 15 during a fiscal year on behalf of an indi-16 vidual enrolled under subparagraph (A) 17 may be included in the total amount ex-18 pended during the fiscal year as medical 19 assistance under the State plan.

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

23 "(A) does not operate a State health allow24 ance program under this section from assuring
25 that individuals in the State who are not of-

1	fered coverage under an employer group health
2	plan are offered coverage under a health plan,
3	or
4	''(B) does operate such a program from as-
5	suring that individuals in the State who are not
6	described in paragraph (1), (2), or (3) and who
7	are not offered coverage under an employer
8	group health plan are offered coverage under a
9	health plan other than through such program.".
10	PART 2—MEDICAID PROGRAM FLEXIBILITY
11	SEC. 1711. MODIFICATION OF FEDERAL REQUIREMENTS TO
12	ALLOW STATES MORE FLEXIBILITY IN CON-
13	TRACTING FOR COORDINATED CARE SERV-
14	ICES UNDER MEDICAID.
15	(a) IN GENERAL.—Section 1903(m) of the Social Se-
16	curity Act (42 U.S.C. 1396b(m)) is amended—
17	(1) by striking all that precedes paragraph (4)
18	and inserting the following:
19	"(m) Coordinated Care.—
20	"(1) Payment conditioned on compli-
21	ANCE.—
22	"(A) GENERAL RULE.—No payment shall
23	be made under this title to a State with respect
24	to expenditures incurred by it for payment to a
25	risk contracting entity or primary care case

1	management entity (as defined in subparagraph
2	(B)), or with respect to an undertaking de-
3	scribed in paragraph (6), unless the State and
4	the entity or undertaking meet the applicable
5	requirements of this subsection. For purposes
6	of determining whether payment may be made
7	under this section, the Secretary may reject a
8	State's determination of compliance with any
9	provision of this subsection.
10	"(B) GENERAL DEFINITIONS.—For pur-
11	poses of this title:
12	"(i) Risk contracting entity.—
13	The term 'risk contracting entity' means
14	an entity that has a contract with the
15	State agency under which the entity—
16	''(I) provides or arranges for the
17	provision of health care items or serv-
18	ices to individuals eligible for medical
19	assistance under the State plan under
20	this title, and
21	''(II) is at risk (as defined in
22	clause (iv)) for part or all of the cost
23	of such items or services furnished to
24	such individuals.

1	"(ii) Primary care case manage-
2	MENT PROGRAM.—The term 'primary care
3	case management program' means a State
4	program under which individuals eligible
5	for medical assistance under the State plan
6	under this title are enrolled with primary
7	care case management entities, and are en-
8	titled to receive specified health care items
9	and services covered under such plan only
10	as arranged for and approved by such enti-
11	ties.
12	''(iii) AT RISK.—An entity is 'at risk',
13	for purposes of this subparagraph, if it has

14 a contract with the State agency under which it is paid a fixed amount for provid-15 ing or arranging for the provision of speci-16 17 fied health care items or services to an in-18 dividual eligible for medical assistance and 19 enrolled with the entity, regardless of 20 whether such items or services are fur-21 nished to such individual, and is liable for all or part of the cost of furnishing such 22 items or services, regardless of whether or 23 the extent to which such cost exceeds such 24 25 fixed payment.

1	"(iv) Primary care case manage-
2	MENT ENTITY.—The term 'primary care
3	case management entity' means a health
4	care provider (whether an individual or an
5	entity) that, under a State primary care
6	case management program meeting the re-
7	quirements of paragraph (7), has a con-
8	tract with the State agency under which
9	the entity arranges for or authorizes the
10	provision of health care items and services
11	to individuals eligible for medical assist-
12	ance under the State plan under this title,
13	but is not at risk (as defined in clause (iv))
14	for the cost of such items or services pro-
15	vided to such individuals.
16	"(2) GENERAL REQUIREMENTS FOR RISK CON-
17	TRACTING ENTITIES.—
18	"(A) Federal or state qualifica-
19	TION.—Subject to paragraph (3), a risk con-
20	tracting entity meets the requirements of this
21	subsection only if it either—
22	''(i) is a qualified health maintenance
23	organization as defined in section 1310(d)
24	of the Public Health Service Act, as deter-

1	mined by the Secretary pursuant to section
2	1312 of that Act, or
3	''(ii) is an entity which the State
4	agency has determined—
5	''(I) affords, to individuals eligi-
6	ble for medical assistance under the
7	State plan and enrolled with the en-
8	tity, access to health care items and
9	services furnished by the entity, with-
10	in the area served by the entity, at
11	least equivalent to the access such in-
12	dividuals would have to such health
13	care items and services in such area if
14	not enrolled with the entity, and
15	"(II) has made adequate provi-
16	sion against the risk of insolvency,
17	and assures that individuals eligible
18	for medical assistance under this title
19	are not held liable for the entity's
20	debts in case of the entity's insol-
21	vency.
22	"(B) INTERNAL QUALITY ASSURANCE.—
23	Subject to paragraph (3), a risk contracting en-
24	tity meets the requirements of this subsection
25	only if it has in effect an internal quality assur-

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1	ance program that meets the requirements of
2	paragraph (9).
3	"(C) Contract with state agency.—
4	Subject to paragraph (3), a risk contracting en-
5	tity meets the requirements of this subsection
6	only if the entity has a written contract with
7	the State agency that provides—
8	''(i) that the entity will comply with
9	all applicable provisions of this subsection;
10	"(ii) for a payment methodology based
11	on experience rating or another actuarially
12	sound methodology approved by the Sec-
13	retary, which guarantees (as demonstrated
14	by such models or formulas as the Sec-
15	retary may approve) that payments to the
16	entity under the contract shall not exceed
17	100 percent of expenditures that would
18	have been made by the State agency in the
19	absence of the contract;
20	"(iii) that the Secretary and the State

20 "(iii) that the Secretary and the State
21 (or any person or organization designated
22 by either) shall have the right to audit and
23 inspect any books and records of the entity
24 (and of any subcontractor) that pertain—

"(I) to the ability of the entity to
bear the risk of potential financial
losses, or
"(II) to services performed or de-
terminations of amounts payable
under the contract;
''(iv) that in the entity's enrollment,
reenrollment, or disenrollment of individ-
uals eligible for medical assistance under
this title 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
their health status or requirements for
health care services;
"(v)(I) that individuals eligible for
medical assistance under the State plan
who have enrolled with the entity are per-
mitted to terminate such enrollment with-
out cause as of the beginning of the first
out cause as of the beginning of the first calendar month following a full calendar
calendar month following a full calendar

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1	"(II) for notification of each such in-
2	dividual, at the time of the individual's en-
3	rollment, of the right to terminate enroll-
4	ment;
5	"(vi) for reimbursement, either by the
6	entity or by the State agency, for medically
7	necessary services provided—
8	''(I) to an individual eligible for
9	medical assistance under the State
10	plan and enrolled with the entity, and
11	"(II) other than through the en-
12	tity because the services were imme-
13	diately required due to an unforeseen
14	illness, injury, or condition;
15	"(vii) for disclosure of information in
16	accordance with paragraph (4);
17	"(viii) in the case of an entity that
18	has entered into a contract with a Feder-
19	ally-qualified health center for the provi-
20	sion of services of such center—
21	''(I) that rates of prepayment
22	from the State are adjusted to reflect
23	fully the rates of payment specified in
24	section 1902(a)(13)(E), and

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1	"(II) that, at the election of such
2	center, payments made by the entity
3	to such center for services described
4	in section $1905(a)(2)(C)$ are made at
5	the rates of payment specified in sec-
6	tion 1902(a)(13)(E);
7	"(ix) that any physician incentive plan
8	that the entity operates meets the require-
9	ments of section 1876(i)(8);
10	"(x) for maintenance of sufficient pa-
11	tient encounter data to identify the physi-
12	cian who delivers services to patients; and
13	"(xi) that the entity complies with the
14	requirement of section 1902(w) with re-
15	spect to each enrollee.
16	"(3) Exceptions to requirements for risk
17	CONTRACTING ENTITIES.—The requirements of
18	paragraph (2) (other than subparagraph (C)(viii))
19	do not apply to an entity that—
20	''(A)(i) received a grant of at least
21	\$100,000 in the fiscal year ending June 30,
22	1976, under section $329(d)(1)(A)$ or $330(d)(1)$
23	of the Public Health Service Act, and for the
24	period beginning July 1, 1976, and ending on
25	the expiration of the period for which payments

1	are to be made under this title, has been the re-
2	cipient of a grant under either such section;
3	and
4	''(ii) provides to its enrollees, on a prepaid
5	capitation or other risk basis, all of the services
6	described in paragraphs (1), (2), (3), (4)(C),
7	and (5) of section 1905(a) and, to the extent
8	required by section 1902(a)(10)(D) to be pro-
9	vided under the State plan, the services de-
10	scribed in section 1905(a)(7);
11	"(B) is a nonprofit primary health care en-
12	tity located in a rural area (as defined by the
13	Appalachian Regional Commission)—
14	''(i) which received in the fiscal year
15	ending June 30, 1976, at least \$100,000
16	(by grant, subgrant, or subcontract) under
17	the Appalachian Regional Development Act
18	of 1965), and
19	''(ii) for the period beginning July 1,
20	1976, and ending on the expiration of the
21	period for which payments are to be made
22	under this title either has been the recipi-
23	ent of a grant, subgrant, or subcontract
24	under such Act or has provided services
25	under a contract (initially entered into dur-

1	ing a year in which the entity was the re-
2	cipient of such a grant, subgrant, or sub-
3	contract) with a State agency under this
4	title on a prepaid capitation or other risk
5	basis; or
6	"(C) which has contracted with the State
7	agency for the provision of services (but not in-
8	cluding inpatient hospital services) to persons
9	eligible for medical assistance under this title
10	on a prepaid risk basis prior to 1970.''; and
11	(2) by adding after paragraph (6) the following
12	new paragraphs:
13	"(7) GENERAL REQUIREMENTS FOR PRIMARY
14	CARE CASE MANAGEMENT.—A State that elects in
15	its State plan under this title to implement a pri-
16	mary care case management program under this
17	subsection shall include in the plan methods for the
18	selection and monitoring of participating primary
19	care case management entities to ensure that—
20	''(A) the numbers, geographic locations,
21	hours of operation, and other relevant charac-
22	teristics of such entities are sufficient to afford
23	individuals eligible for medical assistance rea-
24	sonable access to and choice among such enti-
25	ties;

1	''(B) such entities and their professional
2	personnel are qualified to provide health care
3	case management services, through methods in-
4	cluding ongoing monitoring of compliance with
5	applicable requirements for licensing of health
6	care providers, providing training and certifi-
7	cation of primary care case managers, and pro-
8	viding information and technical assistance; and
9	"(C) such entities are making timely and
10	appropriate decisions with respect to enrollees'
11	need for health care items and services, and are
12	giving timely approval and referral to providers
13	of adequate quality where such items and serv-
14	ices are determined to be medically necessary.
15	"(8) STATE OPTIONS WITH RESPECT TO EN-
16	ROLLMENT AND DISENROLLMENT.—
17	"(A) MANDATORY ENROLLMENT OP-
18	TION.—A State plan may require an individual
19	eligible for medical assistance under the State
20	plan (other than a medicare qualified bene-
21	ficiary) to enroll with a risk contracting entity
22	or primary care case management entity, with-
23	out regard to the requirement of section
24	1902(a)(1) (concerning statewideness), the re-
25	quirements of section 1902(a)(10)(B) (concern-

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1	ing comparability of benefits), or the require-
2	ments of section 1902(a)(23) (concerning free-
3	dom of choice of provider), if the individual is
4	permitted a choice—
5	''(i) between or among two or more
6	risk contracting entities,
7	''(ii) between a risk contracting entity
8	and a primary care case management en-
9	tity, or
10	"(iii) between or among two or more
11	primary care case management entities.
12	"(B)(i) Restrictions on disen-
13	rollment without cause.—A State plan
14	may restrict the period in which individuals en-
15	rolled with a qualifying risk contracting entity
16	(as defined in clause (ii)) may terminate such
17	enrollment without cause to the first month of
18	each period of enrollment (as defined in clause
19	(iii)), but only if the State provides notification,
20	at least once during each such enrollment pe-
21	riod, to individuals enrolled with such entity of
22	the right to terminate such enrollment and the
23	restriction on the exercise of this right. Such
24	restriction shall not apply to requests for termi-
25	nation of enrollment for cause.

1 "(ii) For purposes of this subparagraph
2 the term 'qualifying risk contracting entity
3 means a risk contracting entity that is—
4 "(I) a qualified health maintenance
5 organization as defined in section 1310(d)
6 of the Public Health Service Act;
7 "(II) an eligible organization with a
8 contract under section 1876;
9 "(III) an entity that is receiving (and
0 has received during the previous 2 years)
a grant of at least \$100,000 under section
2 329(d)(1)(A) or 330(d)(1) of the Public
3 Health Service Act;
4 "(IV) an entity that is receiving (and
5 has received during the previous 2 years)
6 at least \$100,000 (by grant, subgrant, or
7 subcontract) under the Appalachian Re-
8 gional Development Act of 1965;
9 "(V) a program pursuant to an under
taking described in paragraph (6) in which
at least 25 percent of the membership en-
rolled on a prepaid basis are individuals
who (I) are not insured for benefits under
part B of title XVIII or eligible for medica
assistance under this title, and (II) (in the

1	case of such individuals whose prepay-
2	ments are made in whole or in part by any
3	government entity) had the opportunity at
4	the time of enrollment in the program to
5	elect other coverage of health care costs
6	that would have been paid in whole or in
7	part by any governmental entity; or
8	''(VI) an entity that, on the date of
9	enactment of this provision, had a contract
10	with the State agency under a waiver
11	under section 1115 or 1915(b) and was
12	not subject to a requirement under this
13	subsection to permit disenrollment without
14	cause.
15	''(iii) For purposes of this subparagraph,
16	the term 'period of enrollment' means—
17	"(I) a period not to exceed 6 months
18	in duration, or
19	"(II) a period not to exceed one year
20	in duration, in the case of a State that, on
21	the effective date of this subparagraph,
22	had in effect a waiver under section 1115
23	of requirements under this title under
24	which the State could establish a 1-year

1	minimum period of enrollment with risk
2	contracting entities.
3	"(C) REENROLLMENT OF INDIVIDUALS
4	WHO REGAIN ELIGIBILITY.—In the case of an
5	individual who—
6	''(i) in a month is eligible for medical
7	assistance under the State plan and en-
8	rolled with a risk contracting entity with a
9	contract under this subsection,
10	''(ii) in the next month (or next 2
11	months) is not eligible for such medical as-
12	sistance, but
13	''(iii) in the succeeding month is again
14	eligible for such benefits,
15	the State plan may enroll the individual for
16	that succeeding month with such entity, if the
17	entity continues to have a contract with the
18	State agency under this subsection.
19	"(9) Requirements for internal quality
20	ASSURANCE PROGRAMS.—The requirements for an
21	internal quality assurance program of a risk con-
22	tracting entity are that program is written and the
23	program—
24	"(A) specifies a systematic process includ-
25	ing ongoing monitoring, corrective action, and

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other appropriate activities to achieve specified and measurable goals and objectives for quality of care, and including annual evaluation of the program;

5 "(B) identifies the organizational units re-6 sponsible for performing specific quality assur-7 ance functions, and ensure that they are ac-8 countable to the governing body of the entity 9 and that they have adequate supervision, staff, 10 and other necessary resources to perform these 11 functions effectively;

"(C) if any quality assistance 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;

"(D) includes methods to ensure that physicians and other health care professionals
under contract with the entity are qualified to
perform the services they provide, and that
these qualifications are ensured through appropriate credentialing and recredentialing procedures;

1	''(E) includes policies addressing enrollee
2	rights and responsibilities, including grievance
3	mechanisms and mechanisms to inform enroll-
4	ees about access to and use of services provided
5	by the entity;
6	''(F) provides for continuous monitoring of
7	the delivery of health care, including—
8	''(i) identification of clinical areas to
9	be monitored,
10	''(ii) use of quality indicators and
11	standards for assessing care delivered, in-
12	cluding availability and accessibility of
13	care,
14	''(iii) monitoring, through use of epi-
15	demiological data or chart review, the care
16	of individuals, as appropriate, and patterns
17	of care overall, and
18	"(iv) implementation of corrective ac-
19	tions; and
20	"(G) meets any other requirements pre-
21	scribed by the Secretary after consultation with
22	States.
23	"(10) INDEPENDENT REVIEW AND QUALITY AS-
24	SURANCE.—

1	"(A) STATE GRIEVANCE PROCEDURE.—A
2	State contracting with a risk contracting entity
3	or primary care case management entity under
4	this subsection shall provide for a grievance
5	procedure for enrollees of such entity with at
6	least the following elements:
7	"(i) A toll-free telephone number for
8	enrollee questions and grievances.
9	"(ii) A State-operated enrollee griev-
10	ance procedure.
11	"(iii) Periodic notification of enrollees
12	of their rights with respect to such entity
13	or program.
14	"(iv) Periodic sample reviews of griev-
15	ances registered with such entity or pro-
16	gram or with the State.
17	"(v) Periodic survey and analysis of
18	enrollee satisfaction with such entity or
19	program.
20	"(B) STATE MONITORING OF RISK CON-
21	TRACTING ENTITIES' QUALITY ASSURANCE PRO-
22	GRAMS.—A State contracting with a risk con-
23	tracting entity under this subsection shall peri-
24	odically review such entity's quality assurance

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program to ensure that it meets the requirements of paragraph (9).

"(C) EXTERNAL INDEPENDENT REVIEW 3 4 OF INTERNAL QUALITY ASSURANCE.—A State 5 contracting with a risk contracting entity under 6 this subsection shall provide for annual external independent review (by a utilization control and 7 8 peer review organization with a contract under section 1153, or another organization unaffili-9 10 ated with the State government approved by the 11 Secretary) of such entity's internal quality assurance activities. Such independent review 12 13 shall include—

14 "(i) review of the entity's medical
15 care, through sampling of medical records
16 or other appropriate methods, for indica17 tions of inappropriate utilization and treat18 ment,

19 "(ii) review of enrollee inpatient and
20 ambulatory data, through sampling of
21 medical records or other appropriate meth22 ods, to determine quality trends,

23 "(iii) review of the entity's internal24 quality assurance activities, and

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1	"(iv) notification of the entity and the
2	State, and appropriate followup activities,
3	when the review under this subparagraph
4	indicates inappropriate care or treat-
5	ment.''.
6	(b) State Option To Guarantee Medicaid Eli-
7	GIBILITY.—Section 1902(e)(2) of such Act (42 U.S.C.
8	1396a(e)(2)) is amended—
9	(A) in subparagraph (A), by striking all
10	that precedes ''(but for this paragraph)'' and
11	inserting "In the case of an individual who is
12	enrolled—
13	''(i) with a risk contracting entity (as
14	defined in section $1903(m)(1)(B)(i)$ re-
15	sponsible for the provision of inpatient hos-
16	pital services and any other service de-
17	scribed in paragraphs (2), (3), (4), (5),
18	and (7) of section 1905(a),
19	''(ii) with any risk contracting entity
20	(as so defined) in a State that, on the ef-
21	fective date of this provision, had in effect
22	a waiver under section 1115 of require-
23	ments under this title under which the
24	State could extend eligibility for medical
25	assistance for enrollees of such entity, or

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''(iii) with an eligible organization
with a contract under section 1876 and
who would", and
(B) in subparagraph (B), by striking ''or-
ganization or'' each place it appears.
(c) 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)(25)(A) of such Act (42
U.S.C. 1396a(a)(25)(A)), as amended by section
13622(a)(1) of the Omnibus Budget Reconciliation
Act of 1993, is amended by striking "health mainte-
nance organizations" and inserting "risk contracting
entities".
(3) Section 1902(a)(25)(H) of such Act (42
U.S.C. 1396a(a)(25)(H)), as added by section
13622(b)(3) of the Omnibus Budget Reconciliation
Act of 1993, is amended by striking "health mainte-
nance organization" and inserting "risk contracting
entity".
(4) Section 1902(a)(30)(C) of such Act (42
U.S.C. $1396a(a)(30)(C)$) is amended by striking all
that precedes "with the results" and inserting "pro-

1	vide for independent review and quality assurance of
2	entities with contracts under section 1903(m), in ac-
3	cordance with paragraph (10) of such section,".
4	(5) Section 1902(a)(57) of such Act (42 U.S.C.
5	1396a(a)(57)) is amended by striking ''or health
6	maintenance organization" and inserting "or risk
7	contracting entity".
8	(6) Section 1902(a) of such Act (42 U.S.C.
9	1396a(a)), as amended by sections 13623(a),
10	13625(a), and 13631(a) of the Omnibus Budget
11	Reconciliation Act of 1993, is amended—
12	(A) by striking ''and'' at the end of para-
13	graph (61);
14	(B) by striking the period at the end of
15	paragraph (62) and inserting ''; and''; and
16	(C) by adding at the end the following new
17	paragraph:
18	"(63) at State option, provide for a primary
19	care case management program in accordance with
20	section 1903(m)(7).".
21	(7) Section 1902(p)(2) of such Act (42 U.S.C.
22	1396a(p)(2)) is amended by striking ''health mainte-
23	nance organization" and inserting "risk contracting
24	entity''.

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1	(8) Section 1902(w) of such Act (42 U.S.C.
2	1396a(w)) is amended—
3	(A) in paragraph (1), by striking ''section
4	1903(m)(1)(A)" and inserting "section
5	1903(m)(2)(C)(xi)'', and
6	(B) in paragraph (2)(E), by striking
7	"health maintenance organization" and "the or-
8	ganization" and inserting "risk contracting en-
9	tity" and "the entity", respectively.
10	(9) Section 1903(k) of such Act (42 U.S.C.
11	1396b(k)) is amended by striking ''health mainte-
12	nance organization" and inserting "risk contracting
13	entity".
14	(10) Section 1903(m)(4)(A) of such Act (42
15	U.S.C. 1396b(m)(4)(A)) is amended—
16	(A) in the first sentence, by striking "Each
17	health maintenance organization" and inserting
18	"Each risk contracting entity",
19	(B) in the first sentence, by striking "the
20	organization" each place it appears and insert-
21	ing ''the entity'', and
22	(C) in the second sentence, by striking "an
23	organization" and "the organization" and in-
24	serting ''a risk contracting entity'' and ''the
25	risk contracting entity", respectively.

(11) Section 1903(m)(4)(B) of such Act (42
U.S.C. 1396b(m)(4)(B)) is amended by striking "organization" and inserting "risk contracting entity".
(12) Section 1903(m)(5) of such Act (42
U.S.C. 1396b(m)(5)) is amended in paragraphs
(A)(iii) and (B)(ii) by striking "organization" and
inserting "entity".

8 (13) Section 1903(o) (42 U.S.C. 1396b(o)), as 9 amended by section 13622(a)(2) of the Omnibus 10 Budget Reconciliation Act of 1993, is amended by 11 striking "health maintenance organization" and in-12 serting "risk contracting entity".

(14) 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 1903(m)".

(15) 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" the
first place it appears.

24 (16) Section 1908(b) of such Act, as added by25 section 13623(b) of the Omnibus Budget Reconcili-

1	ation Act of 1993, is amended by striking ''health
2	maintenance organization" and inserting "risk con-
3	tracting entity".
4	(17) Section 1916(b)(2)(D) of such Act (42
5	U.S.C. 1396o(b)(2)(D)) is amended by striking
6	''health maintenance organization'' and inserting
7	"risk contracting entity".
8	(18) Section 1925(b)(4)(D)(iv) of such Act (42
9	U.S.C. 1396r–6(b)(4)(D)(iv)) is amended—
10	(A) in the heading, by striking ''HMO'' and
11	inserting "RISK CONTRACTING ENTITY",
12	(B) by striking ''health maintenance orga-
13	nization" and inserting "risk contracting en-
14	tity'' each place it appears, and
15	(C) by striking ''section 1903(m)(1)(A)''
16	and inserting "section 1903(m)(1)(B)(i)".
17	(19) Paragraphs (1) and (2) of section 1926(a)
18	of such Act (42 U.S.C. 1396r–7(a)) are each amend-
19	ed by striking ''health maintenance organizations''
20	and inserting "risk contracting entities".
21	(20) Section 1927 of such Act (42 U.S.C.
22	1396s) is amended—
23	(A) in subsection $(c)(1)(C)(i)$, as amended
24	by section 13602(a)(1) of the Omnibus Budget
25	Reconciliation Act of 1993, by striking ''health

maintenance organization" and inserting "risk
 contracting entity", and
 (B) in subsection (j)(1), by striking "***

Health Maintenance Organizations, including
those organizations' and inserting ''risk contracting entities''.

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

10 SEC. 1712. PERIOD OF CERTAIN WAIVERS.

11 (a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended by striking 12 "No waiver" and all that follows through "unless the Sec-13 retary" and inserting "A waiver under this section (other 14 than under subsection (c), (d), or (e)) shall be for an ini-15 tial term of 3 years and, upon the request of a State, shall 16 be extended for additional 5 year periods unless the Sec-17 18 retary".

(b) EFFECTIVE DATE.—The amendment made by
subsection (a) shall apply to waivers pursuant to applications which are approved, and with respect to continuations of waivers for which requests are made, later than
30 days after the date of the enactment of this Act.

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1	SEC. 1713. ELIMINATION OF DUPLICATIVE PEDIATRIC IM-
2	MUNIZATION PROGRAM.
3	Effective as if included in the enactment of the 13621
4	of the Omnibus Budget Reconciliation Act of 1993, title
5	XIX of the Social Security Act is amended as follows:
6	(1) Section 1902(a) is amended—
7	(A) by adding ''and'' at the end of para-
8	graph (60),
9	(B) by striking ''; and'' at the end of para-
10	graph (61) and inserting a period, and
11	(C) by striking paragraph (62).
12	(2) Section 1928 is repealed.
13	(3) Section 1903(i) is amended—
14	(A) by inserting "or" at the end of para-
15	graph (12),
16	(B) by striking the semicolon at the end of
17	paragraph (13) and inserting a period, and
18	(C) by striking paragraphs (14) and (15).
19	(4) Section $1902(a)(32)(D)$ is amended by
20	striking ''before October 1, 1994''.
21	(5) Section 1902(a) is amended—
22	(A) in paragraph (11)(B)—
23	(i) by inserting ''and'' before ''(ii)'',
24	and
25	(ii) by striking ''to the individual
26	under section 1903, and

1	(iii) providing for coordination of in-
2	formation and education on pediatric vac-
3	cinations and delivery of immunization
4	services" and inserting "to him under sec-
5	tion 1903'';
6	(B) in paragraph (11)(C), by striking '',
7	including the provision of information and edu-
8	cation on pediatric vaccinations and the delivery
9	of immunization services," and
10	(C) in paragraph $(43)(A)$, by striking "and
11	the need for age-appropriate immunizations
12	against vaccine-preventable diseases".
13	(6) Section $1905(r)(1)$ is amended—
14	(A) in subparagraph (A)(i), by striking
15	"and, with respect to immunizations under sub-
16	paragraph (B)(iii), in accordance with the
17	schedule referred to in section $1928(c)(2)(B)(i)$
18	for pediatric vaccines''; and
19	(B) in subparagraph (B)(iii), by striking
20	"(according to the schedule referred to in sec-
21	tion $1928(c)(2)(B)(i)$ for pediatric vaccines)".

1 **PART 3—MEDICAID DISPROPORTIONATE SHARE** 2 ADJUSTMENT 3 SEC. 1721. 25 PERCENT REDUCTION IN AMOUNT OF PAY-4 MENT ADJUSTMENTS FOR DISPROPORTION-5 ATE SHARE HOSPITALS. 6 (a) IN GENERAL.—Section 1923 of the Social Security Act (42 U.S.C. 1396r-4) is amended by adding at 7 the end the following new subsection: 8 9 "(h) REDUCTION IN FEDERAL FINANCIAL PARTICI-10 PATION FOR DISPROPORTIONATE SHARE ADJUST-MENTS.—Notwithstanding any other provision of this sec-11 tion, the amount of payments under section 1903(a) with 12 13 respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year 14 shall not exceed— 15 "(1) for quarters in fiscal years 1995 and 1996, 16 17 88 percent of the amount otherwise determined under subsection (f); and 18 "(2) for quarters in fiscal year 1997 and each 19 succeeding fiscal year, 75 percent of the amount oth-20 21 erwise determined under subsection (f).".

(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, 1996.

4 Subtitle I—Remedies and Enforce5 ment With Respect to Group 6 Health Plans

7 SEC. 1801. CLAIMS PROCEDURE FOR GROUP HEALTH 8 PLANS.

9 (a) IN GENERAL.—Section 503 of the Employee Re10 tirement Income Security Act of 1974 (29 U.S.C. 1133)
11 is amended—

12 (1) by inserting "(a) IN GENERAL.—" after 13 "SEC. 503."; and

14 (2) by adding at the end the following new sub-15 section:

"(b) Special Rules for Group Health Plans.— 16 17 "(1) IN GENERAL.—In addition to meeting the 18 requirements of subsection (a), every group health 19 plan shall afford a reasonable opportunity to any 20 participant or beneficiary, whose request for a 21 preauthorization, an emergency preauthorization, a 22 utilization review determination, or an emergency 23 utilization review determination has been denied, for 24 a full and fair review by the appropriate fiduciary of the decision denying the request. 25

"(2) TIME LIMITS FOR DECIDING CLAIMS.—

"(A) INITIAL DECISIONS.—A group health
plan shall issue an initial approval or denial of
any claim for medical, surgical, or hospital benefits not later than 30 days after its filing completion date. Failure to approve or deny such a
claim within such 30-day period shall be treated
as a denial of the claim.

9 "(B) REVIEWS OF INITIAL DECISIONS.— Every review by a fiduciary required under 10 paragraph (1) of an initial denial under sub-11 paragraph (A) shall be completed not later than 12 30 days after the review filing date. Failure to 13 14 issue a decision affirming, reversing, or modify-15 ing the initial denial shall be treated as a final 16 decision denying the claim.

17 "(3) TIME LIMIT FOR DECIDING REQUESTS FOR
18 PREAUTHORIZATION.—

19 "(A) GENERAL RULE.—Except as provided20 in subparagraph (B):

21 "(i) INITIAL DECISIONS.—If a request
22 for preauthorization is required under the
23 terms of a group health plan, the plan
24 shall approve or deny any such request not
25 later than 30 days after its filing comple-

1	tion date. Failure to approve or deny such
2	a request within such 30-day period shall
3	be treated as a denial of the request.
4	"(ii) Reviews of initial deci-
5	SIONS.—Every review by a fiduciary re-
6	quired under paragraph (1) of an initial
7	denial under clause (i) shall be completed
8	not later than 30 days after the review fil-
9	ing date. Failure to issue a decision affirm-
10	ing, reversing, or modifying the initial de-
11	nial within such 30-day period shall be
12	treated as a final decision denying the re-
13	quest.
14	"(B) REQUESTS FOR EMERGENCY
15	PREAUTHORIZATION.—
16	"(i) INITIAL DECISIONS.—In any case
17	in which a request for preauthorization re-
18	quired under the terms of a group health
19	plan is a request for emergency
20	preauthorization, the plan shall approve or
21	deny any such request not later than 10
22	days after its filing completion date (24
23	hours after such date in cases involving
24	emergency medical care). Failure to ap-
25	prove or deny such a request within such

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10-da	y period (or	24-hour	period)	shall	be
treate	d as a denia	l of the r	equest.		

"(ii) 3 REVIEWS OF INITIAL DECI-4 SIONS.—Every review by a fiduciary required under paragraph (1) of an initial 5 denial under clause (i) shall be completed 6 7 not later than 10 days after the review filing date (24 hours after such date in cases 8 9 involving emergency medical care). Failure 10 to issue a decision affirming, reversing, or 11 modifying the initial denial within such 10day period (or 24-hour period) shall be 12 treated as a final decision denying the re-13 14 quest.

15 "(4) TIME LIMIT FOR DECIDING REQUESTS FOR
16 UTILIZATION REVIEW DETERMINATIONS.—

17 ''(A) GENERAL RULE.—Except as provided18 in subparagraph (B):

19 "(i) INITIAL DECISIONS.—If a request
20 for a utilization review determination is re21 quired under the terms of a group health
22 plan, the plan shall approve or deny any
23 such request not later than 30 days after
24 its filing completion date. Failure to ap25 prove or deny such a request within such

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30-day period shall be treated as a denial of the request.

"(ii) 3 REVIEWS OF INITIAL DECI-4 SIONS.—Every review by a fiduciary required under paragraph (1) of an initial 5 denial under clause (i) shall be completed 6 7 not later than 30 days after the review filing date. Failure to issue a decision affirm-8 9 ing, reversing, or modifying the initial de-10 nial within such 30-day period shall be 11 treated as a final decision denying the re-12 quest.

13 "(B) Requests for emergency utiliza14 TION REVIEW DETERMINATIONS.—

15 "(i) INITIAL DECISIONS.—In any case 16 in which a request for a utilization review 17 determination required under the terms of 18 a group health plan is a request for an 19 emergency utilization review determination, 20 the plan shall approve or deny any such re-21 quest not later than 10 days after its filing 22 completion date (24 hours after such date in cases involving emergency medical care). 23 24 Failure to approve or deny such a request within such 10-day period (or 24-hour pe-25

riod) shall be treated as a denial of the request.

"(ii) 3 REVIEWS OF INITIAL DECI-4 SIONS.—Every review by a fiduciary required under paragraph (1) of an initial 5 denial under clause (i) shall be completed 6 7 not later than 10 days after the review filing date (24 hours after such date in cases 8 9 involving emergency medical care). Failure 10 to issue a decision affirming, reversing, or 11 modifying the initial denial within such 10-12 day period (or 24-hour period) shall be 13 treated as a final decision denying the re-14 quest. 15 "(5) DEFINITIONS.—For purposes of this sub-

16 section:

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17 "(A) CLAIM FOR MEDICAL, SURGICAL, OR 18 HOSPITAL BENEFITS.—The term 'claim for 19 medical, surgical, or hospital benefits' means a 20 request for payment by a group health plan of such benefits made by or on behalf of a partici-21 22 pant or beneficiary after the expense for medi-23 cal, surgical, or hospital care has been incurred. 24 "(B) UTILIZATION REVIEW DETERMINA-

TION.—The term 'utilization review determina-

tion' means a determination under a group 1 2 health plan solely that proposed medical, sur-3 gical, or hospital care is medically necessary (as 4 defined in section 1131(7) of the Health Secu-5 rity Act). Unless otherwise expressly provided under the terms of the plan, any such deter-6 7 mination shall not by itself constitute a guarantee that benefits under the plan will be pro-8 vided. 9

"(C) PREAUTHORIZATION.—The 10 term 11 'preauthorization' means a determination under 12 a group health plan that proposed medical, surgical, or hospital care meets the plan's terms 13 14 and conditions of coverage. Such a determina-15 tion shall constitute a guarantee that benefits 16 under the plan will be provided.

17 "(D) REQUEST FOR PREAUTHOR-18 IZATION.—The for 'request term 19 for preauthorization' means а request 20 preauthorization by a group health plan of medical, surgical, or hospital benefits made by or on 21 22 behalf of a participant or beneficiary before the expense for such care has been incurred. 23

24 "(E) REQUEST FOR EMERGENCY25 PREAUTHORIZATION.—The term 'request for

emergency preauthorization' means a request for preauthorization.0 by a group health plan in any case in which the medical, surgical, or hospital benefits for which the expense is to be incurred constitutes urgent medical care or emergency medical care.

"(F) REQUEST FOR UTILIZATION REVIEW
DETERMINATION.—The term 'request for a utilization review determination' means a request
by or on behalf of a participant or beneficiary,
made before an expense for medical, hospital, or
surgical care has been incurred, for a utilization
review determination by a plan.

14 "(G) Request for emergency utiliza-15 TION REVIEW DETERMINATION.—The term 're-16 quest for an emergency utilization review deter-17 mination' means a request for a utilization re-18 view determination in any case in which the 19 medical, hospital, or surgical care to be in-20 curred constitutes urgent medical care or emer-21 gency medical care.

"(H) URGENT MEDICAL CARE.—The term
"urgent medical care' means medical, surgical,
or hospital care in any case in which a physician with appropriate expertise has certified in

1	writing that failure to provide the participant or
2	beneficiary with such care within 45 days will
3	result in either—
4	"(i) the death of the participant or
5	beneficiary within 120 days, or
6	"(ii) the immediate, serious, and irre-
7	versible deterioration of the health of the
8	participant or beneficiary within 120 days
9	which will significantly increase the reason-
10	able likelihood of death of the participant
11	or beneficiary.
12	"(I) Emergency medical care.—The
13	term 'emergency medical care' means medical,
14	surgical, or hospital care in any case in which
15	a physician with appropriate expertise has cer-
16	tified in writing—
17	"(i) that failure to immediately pro-
18	vide the care to the participant or bene-
19	ficiary could reasonably be expected to re-
20	sult in—
21	''(I) placing the health of such
22	participant or beneficiary (or, with re-
23	spect to such a participant or bene-
24	ficiary who is a pregnant woman, the

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1	health of the woman or her unborn
2	child) in serious jeopardy,
3	''(II) serious impairment to bod-
4	ily functions, or
5	"(III) serious dysfunction of any
6	bodily organ or part,
7	or
8	"(ii) that immediate provision of the
9	care is necessary because the participant
10	or beneficiary has made or is at serious
11	risk of making an attempt to harm himself
12	or herself or another individual.
13	"(J) FILING COMPLETION DATE.—The
14	term 'filing completion date' means, in connec-
15	tion with a group health plan, the date as of
16	which the plan is in receipt of all information
17	reasonably required to make an initial decision
18	to approve or deny a claim for medical, sur-
19	gical, or hospital benefits, a request for
20	preauthorization, a request for emergency
21	preauthorization, a request for a utilization re-
22	view determination or a request for an emer-
23	gency utilization review determination.
24	"(K) REVIEW FILING DATE.—The term
25	'review filing date' means, in connection with a

1 group health plan, the date as of which the ap-2 propriate fiduciary is in receipt of all informa-3 tion reasonably required to make a decision 4 upon a full and fair review of the denial, in whole or in part, of a claim for medical, sur-5 6 or hospital benefits, a request for gical, 7 preauthorization, a request for emergency preauthorization, a request for a utilization re-8 9 view determination or a request for an emer-10 gency utilization review determination.

11 "(L) APPROPRIATE FIDUCIARY.—The term 12 'appropriate fiduciary' means with respect to 13 any determination under a group health plan a 14 person designated by the plan to make such de-15 termination. One or more appropriate fidu-16 ciaries shall be designated under each group 17 health plan for making determinations under 18 the plan.".

19 (b) DEFINITION OF GROUP HEALTH PLAN.—

20 (1) IN GENERAL.—Section 3 of such Act (29
21 U.S.C. 1002) is amended by adding at the end the
22 following new paragraph:

23 "(42) The term 'group health plan' means an em24 ployee welfare benefit plan providing medical care (as de25 fined in section 213(d) of the Internal Revenue Code of

1	1986) to participants or beneficiaries directly or through
2	insurance, reimbursement, or otherwise.".
3	(2) Conforming Amendment.—Section 607
4	of such Act (29 U.S.C. 1167) is amended by striking
5	paragraph (1).
б	SEC. 1802. MEDIATION OF GROUP HEALTH PLAN CLAIMS.
7	(a) IN GENERAL.—Part 5 of subtitle B of title I of
8	the Employee Retirement Income Security Act of 1974 is
9	amended—
10	(1) by inserting below the heading for part 5
11	the following:
12	"Subpart A—In General";
13	and
14	(2) by adding at the end the following new sub-
15	part:
16	"Subpart B—Mediation of Group Health Plan Claims
17	"SEC. 521. ELIGIBILITY FOR SUBMISSION TO MEDIATION.
18	''(a) IN GENERAL.—The Secretary shall establish a
19	mediation program under this subpart (hereinafter in this
20	subpart referred to as the 'mediation program') for the
21	purpose of facilitating mediation of disputes meeting the
21 22	purpose of facilitating mediation of disputes meeting the requirements specified in subsection (b). At the time no-
22 23	requirements specified in subsection (b). At the time no-

in writing to the participant or beneficiary whose claim
 for benefits under the plan has been denied of the avail ability of mediation under this subpart at the election of
 either the claimant or the plan.

5 "(b) DISPUTE CRITERIA.—A dispute may be submit-6 ted for mediation under the mediation program only if the 7 following requirements are met with respect to such dis-8 pute:

"(1) PARTIES.—The dispute consists of an as-9 10 sertion by a participant, a beneficiary, or the duly 11 authorized representative of a participant or bene-12 ficiary (or, in the case of an assignment, the assignee) of one or more claims under a group health 13 14 plan, and a denial of such claims, or a denial of ap-15 propriate reimbursement based on such claims, by 16 such plan or an appropriate fiduciary.

17 "(2) NATURE OF CLAIM.—The claim consists of
18 a claim for benefits for medical, surgical, or hospital
19 expenses under a group health plan which consist of
20 benefits described in section 3(1).

21 "(3) SUBMISSION AFTER EXHAUSTION OF PLAN
22 REMEDIES.—The claimant has received a final deter23 mination regarding the claim under the plans' claims
24 procedure under section 503, or has otherwise ex-

hausted all remedies under the plan provided pursu ant to section 503.

3 "(4) APPROPRIATE FIDUCIARY.—For purposes
4 of this subpart, the term 'appropriate fiduciary' has
5 the meaning provided in section 503(b)(5)(K).

6 "SEC. 522. FACILITATORS.

"(a) ROSTER.—The Secretary shall maintain a list
of individuals with appropriate expertise to serve as
facilitators in proceedings under the mediation program.
"(b) CRITERIA.—In identifying individuals to serve
as facilitators, the Secretary shall consider the following:
"(1) The individual's experience in dispute resolution.

14 "(2) The individual's ability to act impartially.
15 "(3) The individual's ability to perform evalua16 tions quickly and to present them in nontechnical
17 terms.

18 ''(4) The individual's experience in employee19 medical, hospital, and surgical benefits.

"(c) APPOINTMENT OF FACILITATOR.—Within 15
days after either party files with the Secretary an election
of mediation with respect to a dispute, the Secretary shall
propose a facilitator, selected under a random selection
procedure prescribed in regulations, and notify the parties
of such selection. Within 10 days after receipt of the noti-

fication of the selection of a facilitator, either party may 1 reject the proposed facilitator. If neither party objects to 2 the Secretary's proposed facilitator within such 10-day pe-3 riod, the appointment shall become final. If either party 4 5 objects to the Secretary's proposed facilitator, the procedure set forth in the preceding provisions of this sub-6 7 section shall be repeated. Each party is limited to 1 objec-8 tion to the Secretary's proposed facilitator for each medi-9 ation.

10 "SEC. 523. ROLE OF ATTORNEYS.

11 "Parties may represent themselves or be represented12 by attorneys throughout the mediation process.

13 "SEC. 524. INITIATION OF MEDIATION.

14 "(a) Claimant Initiation.—A claimant may initiate mediation of a dispute under this subpart only if no 15 action has been commenced by the claimant under section 16 502 with respect to any claim involved. To initiate medi-17 ation, a claimant shall file an election for mediation with 18 the Secretary (and shall file a copy of the election with 19 20 the plan or the appropriate fiduciary) within 30 days after a final determination regarding the claim pursuant to sec-21 22 tion 503.

23 "(b) PLAN INITIATION.—A participant or beneficiary
24 may not commence an action under section 502 with re25 spect to any claim until the participant or beneficiary has

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provided to the plan or the appropriate fiduciary 10 days 1 advance notice of the filing of such action. Within the ear-2 lier of (1) 25 days after receipt of such a notice with re-3 spect to any claim or (2) the date preceding the date on 4 5 which such claim is filed in court, the plan or the appropriate fiduciary may elect mediation of a dispute under 6 this subpart involving such claim by filing an election for 7 mediation with the Secretary (and a copy of the election 8 9 with the claimant). Upon a timely election of mediation by the plan or the appropriate fiduciary, the claimant's 10 right to pursue the claim under section 502 shall be sus-11 pended until the earlier of 75 days after the date of the 12 filing of the election of mediation or the termination of 13 the mediation proceedings. 14

15 "(c) ELECTION FOR MEDIATION.—An election by any
16 party for mediation under this subpart shall be in such
17 form and manner as the Secretary shall prescribe by regu18 lation.

19 "(d) PARTICIPATION.—The claimant and the plan 20 shall participate in the mediation. Each party shall provide 21 the facilitator a written summary of its position with re-22 spect to the dispute accompanied by supporting docu-23 mentation.

24 "(e) FILING FEE.—The party initiating mediation25 under this section shall include with any election for medi-

ation under this subpart a reasonable nonrefundable filing
 fee payable to the Secretary. The filing fee shall be deter mined pursuant to regulations prescribed by the Sec retary.

"(f) Tolling of Statutes of Limitations.—The 5 applicable statute of limitations with respect to any claim 6 7 involved in a dispute subject to mediation proceedings 8 under this subpart shall be tolled for the period commenc-9 ing with the 10-day notice period required under sub-10 section (b) and ending with the termination of the mediation proceedings with respect to such dispute. In no event 11 shall the applicable statute of limitations be tolled beyond 12 the 60-day-time limit for completion of mediation provided 13 under section 526. 14

15 "SEC. 525. MEDIATION PROCEDURE.

16 "(a) IN GENERAL.—Mediation proceedings under 17 this subpart shall be conducted, at locations convenient 18 to complainants, by facilitators recruited and assigned by 19 the Secretary under section 522.

20 "(b) DUTIES OF FACILITATOR.—The Secretary shall 21 prescribe by regulation the duties and role of the 22 facilitator during the mediation process. Such regulations 23 may require the facilitator to identify parties, establish a 24 schedule, request position papers from the parties, and 25 evaluate positions of the parties. Such regulations shall 291

provide that the mediation will be informal, convenient,
 inexpensive, and expeditious for all parties.

3 "(c) NEUTRALITY OF FACILITATOR.—The facilitator4 shall maintain a neutral stance between the parties.

5 "SEC. 526. MEDIATION TIME LIMIT.

6 "Any mediation proceedings commenced under this
7 subpart shall be completed within 60 days from the final
8 appointment of a facilitator pursuant to section 522(c).
9 "SEC. 527. COST OF MEDIATION.

"All reasonable costs of the mediation process under 10 this subpart with respect to any dispute, including the cost 11 of the facilitator, shall be divided equally among the par-12 ties. Facilitators shall be compensated at a rate estab-13 lished by the Secretary by regulation. The Secretary shall 14 prescribe regulations specifying reasonable mediation costs 15 and alternative means of allocating the costs in cases of 16 hardship on the part of the claimant. 17

18 "SEC. 528. LEGAL EFFECT OF PARTICIPATION IN MEDI19 ATION PROGRAM.

"(a) NONBINDING MEDIATION.—The results of any
mediation under this subpart shall be treated as advisory
in nature and nonbinding. Except as provided in subsection (b), the rights of the parties shall not be affected
by participation in the mediation program.

1 "(b) RESOLUTION THROUGH SETTLEMENT AGREE-2 MENT.—If a dispute is settled through participation in the 3 mediation program, the facilitator shall, upon the request 4 of either party, assist the parties in drawing up a settle-5 ment agreement between the parties.

6 "SEC. 529. CONFIDENTIALITY AND ADMISSIBILITY.

7 "(a) IN GENERAL.—All documents and communica8 tions made during or generated in connection with the me9 diation program, as well as any settlement offers or agree10 ments made or entered into under such program—

"(1) shall be privileged and confidential, and
"(2) shall not be admissible as evidence in any
Federal or State judicial proceeding unless all parties to the mediation consent in writing.

15 "(b) EXECUTION OF PRIVILEGE.—Any individual or entity involved in the mediation (including any party or 16 17 facilitator or other individual who acts on behalf of a party or who provides information or an opinion in connection 18 with the mediation) receiving a subpoena or other lawful 19 process seeking disclosure of any information or docu-20 ments rendered privileged and confidential under sub-21 22 section (a) shall assert the privilege provided under sub-23 section (a) and promptly notify all parties to the mediation 24 proceedings of the request for disclosure. The privilege 25 provided for in this section shall be in addition to any attorney-client privilege or other privilege which may be as serted by a party and nothing in this section shall con stitute a waiver of such attorney-client privilege or other
 privilege.".

5 (b) CLERICAL AMENDMENTS.—The table of contents6 in section 1 of such Act is amended—

7 (1) by inserting after the item relating to the8 heading for part 5 of subtitle B of title I the follow-

9 ing new item:

"Subpart A—General Provisions";

- 10 and
- 11 (2) by inserting after the item relating to sec-
- 12 tion 514 the following new items:

"Subpart B-Mediation of Group Health Plan Claims

- "Sec. 521. Eligibility for submission to mediation.
- "Sec. 522. Facilitators.
- "Sec. 523. Role of attorneys.
- "Sec. 524. Initiation of mediation.
- "Sec. 525. Mediation procedure.
- "Sec. 526. Mediation time limit.
- "Sec. 527. Cost of mediation.
- $``Sec. \ 528. \ Legal \ effect \ of \ participation \ in \ mediation \ program.$
- "Sec. 529. Confidentiality and admissibility.".

13 SEC. 1803. AVAILABLE COURT REMEDIES.

14 (a) IN GENERAL.—Section 502(c) of the Employee

- 15 Retirement Income Security Act of 1974 (29 U.S.C. 1132)
- 16 is amended by adding at the end the following new para-
- 17 graphs:
- 18 "(5) In any action commenced under subsection (a)
- 19 by a participant or beneficiary with respect to a group

health plan in which the plaintiff alleges that a person, 1 in the capacity of a fiduciary and in violation of the terms 2 3 of the plan or this title, has taken an action resulting in 4 a failure to provide an item or service, or payment there-5 for, or has failed to take an action for which such person is responsible under the plan and which is necessary under 6 7 the plan for provision of such item or service, or payment therefor, upon finding in favor of the plaintiff, the court 8 9 shall cause to be served on the defendant an order requiring the defendant— 10

11 "(i) to cease and desist from the alleged action12 or failure to act,

13 "(ii) to provide the item or service, or payment
14 therefor, and to otherwise comply with the terms of
15 the plan and the applicable requirements of this
16 title,

17 "(iii) to pay to the plaintiff prejudgment inter18 est on the actual costs incurred in obtaining any
19 item or service, or payment therefor, at issue in the
20 complaint, and

21 "(iv) to pay to the plaintiff a reasonable attor22 ney's fee, reasonable expert witness fees, and other
23 reasonable costs relating to the action on the
24 charges on which the plaintiff prevails.

The remedies provided under this paragraph shall be in
 addition to remedies otherwise provided under this section.

3 (6)(A) The Secretary may assess a civil penalty 4 against the plan administrator of, or the appropriate fiduciary (as defined in section 503(b)(5)(K)) of, one or more 5 group health plans for any pattern or practice thereof of 6 7 repeated failures to provide benefits under the terms of 8 the plan or plans without any reasonable basis or repeated 9 violations thereby of the requirements of section 503 with 10 respect to such plan or plans. Such penalty shall be payable only upon proof by clear and convincing evidence of 11 such pattern or practice. 12

13 "(B) Such penalty shall be in an amount not to ex-14 ceed the lesser of—

15 "(i) 20 percent of the aggregate value of claims
16 shown by the Secretary to have been denied, or un17 lawfully delayed in violation of section 503, under
18 such pattern or practice, or

19 "(ii) \$1,000,000.

"(C) The plan administrator or the appropriate fiduciary of any group health plan or plans who has engaged
in any such pattern or practice with respect to such plans,
upon the petition of the Secretary, may be removed by
the court from that position, and from any other involve-

1 ment, with respect to such plan or plans, for a period of2 not less than 7 years.

3 "(D) For purposes of this paragraph, the phrase 4 'without any reasonable basis' means, in connection with 5 any denial of claims for benefits under a group health 6 plan, that such denial does not have any reasonable basis, 7 support, or justification under—

8 "(i) the facts regarding such claim which were 9 reasonably available to the plan administrator or the 10 appropriate fiduciary at the time the claim was de-11 nied, and

12 "(ii) the terms of the plan.".

13 (b) CONFORMING AMENDMENT.—Section 502(a)(6)
14 of such Act (29 U.S.C. 1132(a)(6)) is amended by insert15 ing "or (c)(6)" after "(c)(2)".

16 SEC. 1804. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect January 1, 1995, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this subtitle before the effective date thereof.

Subtitle J—Delivery of Health Care Services to Illegal Immigrants

3 SEC. 1901. STUDY ON THE DELIVERY OF HEALTH CARE 4 SERVICES TO ILLEGAL IMMIGRANTS.

5 (a) IN GENERAL.—As soon as practicable after the 6 date of the enactment of this Act, the Secretary of Health 7 and Human Services shall conduct a detailed study of 8 health care in the United States to populations of individ-9 uals immigrating to the United States illegally, including 10 the effect of illegal immigration on levels of health costs 11 and the shifting of health costs.

12 (b) MATTERS TO BE ANALYZED.—In conducting the13 study under this section, the Secretary shall analyze—

(1) the extent to which individuals illegally immigrating into the United States obtain health care
services in the United States,

17 (2) the costs of such services,

18 (3) the means currently used to finance such19 costs,

20 (4) the means currently used for identifying,
21 evaluating, preventing, and resolving health prob22 lems of populations comprised of such individuals,

(5) the extent of efforts currently being under-taken to prevent or resolve such health problems,

(6) the extent of efforts currently being under taken to educate populations comprised of such indi viduals concerning such health problems and to co ordinate such efforts,

5 (7) the programs currently in place for carrying 6 out the activities described in paragraphs (3) 7 through (6), and

8 (8) the extent of intergovernmental cooperation 9 currently in place between the United States and 10 other countries in dealing with health problems de-11 scribed in the preceding provisions of this sub-12 section.

13 SEC. 1902. REPORT.

14 Not later than one year after the date of the enact-15 ment of this Act, the Secretary of Health and Human 16 Services shall submit to each House of the Congress a 17 final report on the matters analyzed in the study con-18 ducted under section 1801. The Secretary shall include in 19 such report any recommendations derived by the Secretary 20 regarding appropriate means of—

(1) alleviating the health problems peculiar to
populations of individuals who have immigrated to
the United States illegally,

24 (2) financing health care provided to such pop-25 ulations, and

(3) increasing intergovernmental cooperation
 and coordination of efforts between the United
 States and other countries to alleviate such health
 problems and to finance such efforts.

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Subtitle A—Medical Malpractice Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 2001. FEDERAL REFORM OF MEDICAL MALPRACTICE

LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any medical malpractice liability claim and to any medical malpractice liability action brought in any State or Federal court, except that this subtitle shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(b) PREEMPTION.—The provisions of this subtitle 1 2 shall preempt any State law to the extent such law is in-3 consistent with the limitations contained in such provisions. The provisions of this subtitle shall not preempt any 4 5 State law that provides for defenses or places limitations on a person's liability in addition to those contained in 6 7 this subtitle, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes 8 9 greater restrictions than those provided in this subtitle. 10 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be 11

12 construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of
law;

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

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

20 (4) preempt State choice-of-law rules with re21 spect to claims brought by a foreign nation or a citi22 zen of a foreign nation; or

1 (5) affect the right of any court to transfer 2 venue or to apply the law of a foreign nation or to 3 dismiss a claim of a foreign nation or of a citizen 4 of a foreign nation on the ground of inconvenient 5 forum.

6 (d) FEDERAL COURT JURISDICTION NOT ESTAB-7 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in 8 this subtitle shall be construed to establish any jurisdiction 9 in the district courts of the United States over medical 10 malpractice liability actions on the basis of section 1331 11 or 1337 of title 28, United States Code.

12 SEC. 2002. DEFINITIONS.

13 As used in this subtitle:

14 (1) ALTERNATIVE DISPUTE RESOLUTION SYS15 TEM; ADR.—The term "alternative dispute resolution
16 system" or "ADR" means a system established
17 under this subtitle that provides for the resolution of
18 medical malpractice liability claims in a manner
19 other than through medical malpractice liability ac20 tions.

(2) CLAIMANT.—The term "claimant" means
any person who alleges a medical malpractice liability claim, and any person on whose behalf such a
claim is alleged, including the decedent in the case

of an action brought through or on behalf of an es tate.

(3) CLEAR AND CONVINCING EVIDENCE.—The 3 4 term "clear and convincing evidence" is that measure or degree of proof that will produce in the mind 5 6 of the trier of fact a firm belief or conviction as to 7 the truth of the allegations sought to be established, except that such measure or degree of proof is more 8 9 than that required under preponderance of the evidence, but less than that required for proof beyond 10 11 a reasonable doubt.

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

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

(6) HEALTH CARE PROVIDER.—The term
"health care provider" means any organization or
institution that is engaged in the delivery of health
care services in a State and that is required by the

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

4 (7) INJURY.—The term "injury" means any ill-5 ness, disease, or other harm that is the subject of 6 a medical malpractice liability action or a medical 7 malpractice liability claim.

8 (8) MEDICAL MALPRACTICE LIABILITY AC-TION.—The term "medical malpractice liability ac-9 tion" means a civil action brought in a State or Fed-10 11 eral court against a health care provider or health 12 care professional in which the plaintiff alleges a medical malpractice liability claim, but does not in-13 14 clude any action in which the plaintiff's sole allegation is an allegation of an intentional tort. 15

16 (9) MEDICAL MALPRACTICE LIABILITY 17 CLAIM.—The term "medical malpractice liability 18 claim" means a claim in which the claimant alleges 19 that injury was caused by the provision of (or the 20 failure to provide) health care services or the use of 21 a medical product.

(10) Medical product.—

23 (A) IN GENERAL.—The term "medical
24 product" means, with respect to the allegation
25 of a claimant, a drug (as defined in section

22

1	201(g)(1) of the Federal Food, Drug, and Cos-
	0
2	metic Act (21 U.S.C. $321(g)(1)$) or a medical
3	device (as defined in section 201(h) of the Fed-
4	eral Food, Drug, and Cosmetic Act (21 U.S.C.
5	321(h)) if—
6	(i) such drug or device was subject to
7	premarket approval under section 505,
8	507, or 515 of the Federal Food, Drug,
9	and Cosmetic Act (21 U.S.C. 355, 357, or
10	360e) or section 351 of the Public Health
11	Service Act (42 U.S.C. 262) with respect
12	to the safety of the formulation or per-
13	formance of the aspect of such drug or de-
14	vice which is the subject of the claimant's
15	allegation or the adequacy of the packag-
16	ing or labeling of such drug or device, and
17	such drug or device is approved by the
18	Food and Drug Administration; or
19	(ii) the drug or device is generally rec-
20	ognized as safe and effective under regula-
21	tions issued by the Secretary of Health
22	and Human Services under section 201(p)
23	of the Federal Food, Drug, and Cosmetic
24	Act (21 U.S.C. 321(p)).

1 (B) EXCEPTION IN CASE OF MISREPRE-2 SENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term "medical product" 3 4 shall not include any product described in such subparagraph if the claimant shows that the 5 6 product is approved by the Food and Drug Administration for marketing as a result of with-7 8 held information, misrepresentation, or an ille-9 gal payment by manufacturer of the product.

10 (11)Noneconomic DAMAGES.—The term 11 "noneconomic damages" means damages paid to 12 compensate an individual for physical and emotional 13 pain, suffering, inconvenience, physical impairment, 14 mental anguish, disfigurement, loss of enjoyment of 15 life, loss of consortium, and other nonpecuniary 16 losses, but does not include punitive damages.

17 (12) PUNITIVE DAMAGES; EXEMPLARY DAM-18 AGES.—The terms "punitive damages" and "exem-19 plary damages" mean compensation, in addition to 20 compensation for actual harm suffered, that is 21 awarded for the purpose of punishing a person for 22 conduct deemed to be malicious, wanton, willful, or 23 excessively reckless.

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

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

5 SEC. 2003. EFFECTIVE DATE.

6 (a) IN GENERAL.—Except as provided in subsection 7 (b) and section 2017(c), this subtitle shall apply with re-8 spect to claims accruing or actions brought on or after 9 the expiration of the 3-year period that begins on the date 10 of the enactment of this Act.

11 (b) EXCEPTION FOR STATES REQUESTING EARLIER12 IMPLEMENTATION OF REFORMS.—

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

17 (2) DECISION BY SECRETARY.—The Secretary 18 shall issue a response to a State's application under 19 paragraph (1) not later than 90 days after receiving 20 the application. If the Secretary determines that the State meets the requirements of this subtitle at the 21 22 time of submitting its application, the Secretary shall approve the State's application, and this sub-23 24 title shall apply with respect to actions brought in 25 the State on or after the expiration of the 90-day period that begins on the date the Secretary issues
the response. If the Secretary denies the State's application, the Secretary shall provide the State with
a written explanation of the grounds for the decision.

6 PART 2—MEDICAL MALPRACTICE AND PRODUCT 7 LIABILITY REFORM

8 SEC. 2011. REQUIREMENT FOR INITIAL RESOLUTION OF 9 ACTION THROUGH ALTERNATIVE DISPUTE 10 RESOLUTION.

11 (a) IN GENERAL.—

12 (1) STATE CASES.—A medical malpractice li-13 ability action may not be brought in any State court 14 during a calendar year unless the medical mal-15 practice liability claim that is the subject of the ac-16 tion has been initially resolved under an alternative 17 dispute resolution system certified for the year by 18 the Secretary under section 2032(a), or, in the case 19 of a State in which such a system is not in effect 20 for the year, under the alternative Federal system 21 established under section 2032(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.—

7 (A) ESTABLISHMENT OF PROCESS FOR 8 CLAIMS.—The Attorney General shall establish 9 an alternative dispute resolution process for the resolution of tort claims consisting of medical 10 11 malpractice liability claims brought against the United States under chapter 171 of title 28, 12 13 United States Code. Under such process, the resolution of a claim shall occur after the com-14 pletion of the administrative claim process ap-15 16 plicable to the claim under section 2675 of such 17 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 estab-

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lished by the Attorney General under such sub paragraph.

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

7 (1) the ADR reaches a decision on whether the
8 defendant is liable to the plaintiff for damages; and
9 (2) if the ADR determines that the defendant
10 is liable, the ADR reaches a decision on the amount
11 of damages assessed against the defendant.

12 (c) PROCEDURES FOR FILING ACTIONS.—

13 (1) NOTICE OF INTENT TO CONTEST DECI-SION.—Not later than 60 days after a decision is is-14 sued with respect to a medical malpractice liability 15 16 claim under an alternative dispute resolution system, 17 each party affected by the decision shall submit a 18 sealed statement to a court of competent jurisdiction 19 indicating whether or not the party intends to con-20 test the decision.

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

24 (A) the party has filed the notice of intent25 required by paragraph (1); and

1	(B) the party files the action in a court of
2	competent jurisdiction not later than 90 days
3	after the decision resolving the medical mal-
4	practice liability claim that is the subject of the
5	action is issued under the applicable alternative
6	dispute resolution system.
7	(3) Court of competent jurisdiction.—
8	For purposes of this subsection, the term "court of
9	competent jurisdiction'' means—
10	(A) with respect to actions filed in a State
11	court, the appropriate State trial court; and
12	(B) with respect to actions filed in a Fed-
13	eral court, the appropriate United States dis-
14	trict court.
15	(d) Legal Effect of Uncontested ADR Deci-
16	SION.—The decision reached under an alternative dispute
17	resolution system shall, for purposes of enforcement by a
18	court of competent jurisdiction, have the same status in
19	the court as the verdict of a medical malpractice liability
20	action adjudicated in a State or Federal trial court. The
21	previous sentence shall not apply to a decision that is con-
22	tested by a party affected by the decision pursuant to sub-
23	section $(c)(1)$.

1 SEC. 2012. CALCULATION AND PAYMENT OF DAMAGES.

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

10 (b) TREATMENT OF PUNITIVE DAMAGES.—

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

(2) NO AWARD AGAINST MANUFACTURER OF
MEDICAL PRODUCT.—In the case of a medical malpractice liability action in which the plaintiff alleges
a claim against the manufacturer of a medical product, no punitive or exemplary damages may be
awarded against such manufacturer.

24 (3) PAYMENTS TO STATE FOR MEDICAL QUAL25 ITY ASSURANCE ACTIVITIES.—

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1	(A) IN GENERAL.—Any punitive or exem-
2	plary damages awarded in a medical mal-
3	practice liability action shall be paid to the
4	State in which the action is brought or, in a
5	case brought in Federal court, in the State in
6	which the health care services that caused the
7	injury that is the subject of the action were
8	provided.
9	(B) ACTIVITIES DESCRIBED.—A State
10	shall use amounts paid pursuant to subpara-
11	graph (A) to carry out activities to assure the
12	safety and quality of health care services pro-
13	vided in the State, including (but not limited
14	to)—
15	(i) licensing or certifying health care
16	professionals and health care providers in
17	the State;
18	(ii) operating alternative dispute reso-
19	lution systems;
20	(iii) carrying out public education pro-
21	grams relating to medical malpractice and
22	the availability of alternative dispute reso-
23	lution systems in the State; and
24	(iv) carrying out programs to reduce
25	malpractice-related costs for retired provid-

1 ers or other providers volunteering to pro-2 vide services in medically underserved 3 areas. 4 (C) MAINTENANCE OF EFFORT.—A State 5 shall use any amounts paid pursuant to sub-6 paragraph (A) to supplement and not to replace 7 amounts spent by the State for the activities described in subparagraph (B). 8

(c) Periodic Payments for Future Losses.—

10 (1) GENERAL RULE.—In any medical mal-11 practice liability action in which the damages awarded for future economic loss exceeds \$100,000, a de-12 13 fendant may not be required to pay such damages 14 in a single, lump-sum payment, but shall be per-15 mitted to make such payments periodically based on 16 when the damages are found likely to occur, as such 17 payments are determined by the court.

18 (2) WAIVER.—A court may waive the applica-19 tion of paragraph (1) with respect to a defendant if 20 the court determines that it is not in the best inter-21 ests of the plaintiff to receive payments for damages 22 on such a periodic basis.

23 (d) MANDATORY OFFSETS FOR DAMAGES PAID BY
24 A COLLATERAL SOURCE.—

9

1	(1) IN GENERAL.—With respect to a medical
2	malpractice liability claim or action, the total
3	amount of damages received by an individual under
4	such claim or action shall be reduced, in accordance
5	with paragraph (2), by any other payment that has
6	been, or will be, made to an individual to com-
7	pensate such individual for the injury that was the
8	subject of such claim or action.
9	(2) AMOUNT OF REDUCTION.—The amount by
10	which an award of damages to an individual for an
11	injury shall be reduced under paragraph (1) shall
12	be—
13	(A) the total amount of any payments
14	(other than such award) that have been made
15	or that will be made to such individual to pay
16	costs of or compensate such individual for the
17	injury that was the subject of the claim or ac-
18	tion; minus
19	(B) the amount paid by such individual (or
20	by the spouse, parent, or legal guardian of such
21	individual) to secure the payments described in
22	subparagraph (A).

 1
 SEC. 2013. TREATMENT OF ATTORNEY'S FEES AND OTHER

 2
 COSTS.

3 (a) Limitation on Amount of Contingency4 Fees.—

5 (1) IN GENERAL.—An attorney who represents, 6 on a contingency fee basis, a claimant in a medical 7 malpractice liability claim may not charge, demand, 8 receive, or collect for services rendered in connection 9 with such claim in excess of the following amount re-10 covered by judgment or settlement under such claim: (A) 25 percent of the first \$150,000 (or 11 12 portion thereof) recovered, plus

13 (B) 10 percent of any amount in excess of14 \$150,000 recovered.

15 (2) CALCULATION OF PERIODIC PAYMENTS.—In 16 the event that a judgment or settlement includes 17 periodic or future payments of damages, the amount 18 recovered for purposes of computing the limitation 19 on the contingency fee under paragraph (1) shall be 20 based on the cost of the annuity or trust established 21 to make the payments. In any case in which an an-22 nuity or trust is not established to make such pay-23 ments, such amount shall be based on the present 24 value of the payments.

25 (b) REQUIRING PARTY CONTESTING ADR RULING
26 TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(1) IN GENERAL.—The court in a medical mal-1 2 practice liability action shall require the party that 3 (pursuant to section 2011(c)(1)) contested the ruling 4 of the alternative dispute resolution system with re-5 spect to the medical malpractice liability claim that 6 is the subject of the action to pay to the opposing 7 party the costs incurred by the opposing party under 8 the action, including attorney's fees, fees paid to ex-9 pert witnesses, and other litigation expenses (but not 10 including court costs, filing fees, or other expenses 11 paid directly by the party to the court, or any fees 12 or costs associated with the resolution of the claim 13 under the alternative dispute resolution system), but only if-14

(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 does not exceed the amount of
damages awarded to the party under the ADR
system by at least 10 percent; 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 not at least 10 per-

1	cent less than the amount of damages assessed
2	under the ADR system.
3	(2) EXCEPTIONS.—Paragraph (1) shall not
4	apply if—
5	(A) the party contesting the ruling made
6	under the previous alternative dispute resolu-
7	tion system shows that—
8	(i) the ruling was procured by corrup-
9	tion, fraud, or undue means,
10	(ii) there was partiality or corruption
11	under the system,
12	(iii) there was other misconduct under
13	the system that materially prejudiced the
14	party's rights, or
15	(iv) the ruling was based on an error
16	of law;
17	(B) the party contesting the ruling made
18	under the alternative dispute resolution system
19	presents new evidence before the trier of fact
20	that was not available for presentation under
21	the ADR system;
22	(C) the medical malpractice liability action
23	raised a novel issue of law; or
24	(D) the court finds that the application of
25	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 deci sion.

(3)5 REQUIREMENT FOR PERFORMANCE 6 BOND.—The court in a medical malpractice liability 7 action shall require the party that (pursuant to sec-8 tion 2011(c)(1) contested the ruling of the alter-9 native dispute resolution system with respect to the 10 medical malpractice liability claim that is the subject 11 of the action to post a performance bond (in such 12 amount and consisting of such funds and assets as 13 the court determines to be appropriate), except that 14 the court may waive the application of such require-15 ment to a party if the court determines that the 16 posting of such a bond is not necessary to ensure 17 that the party shall meet the requirements of this subsection to pay the opposing party the costs in-18 19 curred by the opposing party under the action.

(4) LIMIT ON ATTORNEY'S 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 (5) RECORDS.—In order to receive attorneys' 5 fees under paragraph (1), counsel of record in the 6 medical malpractice liability action involved shall 7 maintain accurate, complete records of hours worked 8 on the action, regardless of the fee arrangement 9 with the client involved.

10 (c) CONTINGENCY FEE DEFINED.—As used in this 11 section, the term "contingency fee" means any fee for pro-12 fessional legal services which is, in whole or in part, con-13 tingent upon the recovery of any amount of damages, 14 whether through judgment or settlement.

15 SEC. 2014. JOINT AND SEVERAL LIABILITY.

16 A defendant may be held severally but not jointly liable in a medical malpractice action. A person found liable 17 for damages in any such action may be found liable, if 18 at all, only for those damages directly attributable to the 19 person's proportionate share of fault or responsibility for 20 the injury, and may not be found liable for damages at-21 tributable to the proportionate share of fault or respon-22 sibility of any other person (without regard to whether 23 24 that person is a party to the action) for the injury, includ-25 ing any person bringing the action.

1 SEC. 2015. STATUTE OF LIMITATIONS.

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

9 SEC. 2016. UNIFORM STANDARD FOR DETERMINING NEG-10 LIGENCE.

11 A defendant in a medical malpractice liability action 12 may not be found to have acted negligently unless the de-13 fendant's conduct at the time of providing the health care 14 services that are the subject of the action was not reason-15 able.

16 SEC. 2017. SPECIAL PROVISION FOR CERTAIN OBSTETRIC 17 SERVICES.

18 (a) IMPOSITION OF HIGHER STANDARD OF PROOF.— 19 In the case of a medical malpractice liability claim relating to services provided during labor or the delivery of a baby, 20 if the health care professional against whom the claim is 21 22 brought did not previously treat the individual alleged to 23 have been injured for the pregnancy, the trier of fact may 24 not find that the defendant committed malpractice and 25 may not assess damages against the health care professional unless the malpractice is proven by clear and con vincing evidence.

3 (b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of sub-4 section (a), a health care professional shall be considered 5 to have previously treated an individual for a pregnancy 6 if the professional is a member of a group practice whose 7 8 members previously treated the individual for the preg-9 nancy or is providing services to the individual during 10 labor or the delivery of a baby pursuant to an agreement with another health care professional. 11

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

16 PART 3—REQUIREMENTS FOR STATE ALTER17 NATIVE DISPUTE RESOLUTION SYSTEMS
18 (ADR)

19 SEC. 2031. BASIC REQUIREMENTS.

20 (a) IN GENERAL.—A State's alternative dispute reso21 lution system meets the requirements of this section if the
22 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 re-
quired 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 (includ-
ing any fees paid to the individuals hearing and
resolving the claim), together with an appro-
priate 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 regula-
tions of the Secretary);
(4) is approved by the State or by local govern-
ments in the State;
(5) with respect to a State system that consists
of multiple dispute resolution procedures—

1 (A) permits the parties to a dispute to se-2 lect the procedure to be used for the resolution 3 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 par-6 ties:

(6) provides for the transmittal to the State 8 9 agency responsible for monitoring or disciplining health care professionals and health care providers 10 11 of any findings made under the system that such a 12 professional or provider committed malpractice, un-13 less, during the 90-day period beginning on the date 14 the system resolves the claim against the professional or provider, the professional or provider 15 16 brings an action contesting the decision made under 17 the system; and

18 (7) provides for the regular transmittal to the 19 Administrator for Health Care Policy and Research 20 of information on disputes resolved under the sys-21 tem, in a manner that assures that the identity of 22 the parties to a dispute shall not be revealed.

23 (b) APPLICATION OF MALPRACTICE LIABILITY 24 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.— The provisions of part 2 shall apply with respect to claims 25

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

5 SEC. 2032. CERTIFICATION OF STATE SYSTEMS; APPLICA-

6

BILITY OF ALTERNATIVE FEDERAL SYSTEM.

7 (a) CERTIFICATION.—

8 (1) IN GENERAL.—Not later than October 1 of 9 each year (beginning with 1995), the Secretary, in 10 consultation with the Attorney General, shall deter-11 mine whether a State's alternative dispute resolution 12 system meets the requirements of this part for the 13 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 2031.
(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

1	during a calendar year in States that do not have
2	in effect an alternative dispute resolution system
3	certified under subsection (a) for the year.
4	(2) REQUIREMENTS FOR SYSTEM.—Under the
5	alternative Federal ADR system established under
6	paragraph (1)—
7	(A) paragraphs (1), (2), (6), and (7) of
8	section 2031(a) shall apply to claims brought
9	under the system;
10	(B) if the system provides for the resolu-
11	tion of claims through arbitration, the claims
12	brought under the system shall be heard and
13	resolved by arbitrators appointed by the Sec-
14	retary in consultation with the Attorney Gen-
15	eral; and
16	(C) with respect to a State in which the
17	system is in effect, the Secretary may (at the
18	State's request) modify the system to take into
19	account the existence of dispute resolution pro-
20	cedures in the State that affect the resolution
21	of medical malpractice liability claims.
22	(3) TREATMENT OF STATES WITH ALTER-
23	NATIVE SYSTEM IN EFFECT.—If the alternative Fed-
24	eral ADR system established under this subsection is
25	applied with respect to a State for a calendar year—

1	(A) the State shall reimburse the United
2	States (at such time and in such manner as the
3	Secretary may require) for the costs incurred
4	by the United States during the year as a result
5	of the application of the system with respect to
6	the State; and
7	(B) notwithstanding any other provision of
8	law, no funds may be paid to the State (or to
9	any unit of local government in the State) or to
10	any entity in the State pursuant to the Public
11	Health Service Act.
12	SEC. 2033. REPORTS ON IMPLEMENTATION AND EFFEC-
13	TIVENESS OF ALTERNATIVE DISPUTE RESO-
14	LUTION SYSTEMS.
14 15	LUTION SYSTEMS. (a) IN GENERAL.—Not later than 5 years after the
15 16	(a) IN GENERAL.—Not later than 5 years after the
15 16 17	(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall pre-
15 16 17	(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
15 16 17 18	(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 op-
15 16 17 18 19	(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall pre- pare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems op- erated pursuant to this part and the alternative Federal
15 16 17 18 19 20 21	(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall pre- pare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems op- erated pursuant to this part and the alternative Federal system established under section 2032(b).
15 16 17 18 19 20 21	 (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 2032(b). (b) CONTENTS OF REPORT.—The Secretary shall in-

24 (1) information on—

1	(A) the effect of the alternative dispute
2	resolution systems on the cost of health care
3	within each State,
4	(B) the impact of such systems on the ac-
5	cess of individuals to health care within the
6	State, and
7	(C) the effect of such systems on the qual-
8	ity of health care provided within the State; and
9	(2) to the extent that such report does not pro-
10	vide information on no-fault systems operated by
11	States as alternative dispute resolution systems pur-
12	suant to this part, an analysis of the feasibility and
13	desirability of establishing a system under which
14	medical malpractice liability claims shall be resolved
15	on a no-fault basis.
16	PART 4-OTHER PROVISIONS RELATING TO
17	MEDICAL MALPRACTICE LIABILITY
18	SEC. 2041. PERMITTING STATE PROFESSIONAL SOCIETIES
19	TO PARTICIPATE IN DISCIPLINARY ACTIVI-
20	TIES.
21	(a) ROLE OF PROFESSIONAL SOCIETIES.—Notwith-
22	standing any other provision of State or Federal law, a
23	State agency responsible for the conduct of disciplinary
24	actions for a type of health care practitioner may enter
25	into agreements with State or county professional societies

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

8 (b) REQUIREMENTS OF AGREEMENTS.—Any agree-9 ment entered into under subsection (a) for licensing activi-10 ties or the review of any health care malpractice action, 11 health care malpractice claim or allegation, or other infor-12 mation concerning the practice patterns of a health care 13 practitioner shall provide that—

(1) the health care professional society conducts
such activities or review as expeditiously as possible;
(2) after the completion of such review, such society shall report its findings to the State agency
with which it entered into such agreement;

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

24 (4) no individual affiliated with such society is25 liable for any damages or injury directly caused by

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

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

7 (d) EFFECTIVE DATE.—This section shall take effect8 2 years after the date of the enactment of this Act.

9 SEC. 2042. STUDY OF INCENTIVES TO ENCOURAGE VOL-10 UNTARY SERVICE BY PHYSICIANS.

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

17 (b) REPORTS.—(1) Not later than 1 year after the 18 date of the enactment of this Act, the Secretary shall sub-19 mit an interim report to Congress on the study conducted 20 under subsection (a), together with the Secretary's rec-21 ommendations for actions to increase the number of physi-22 cians volunteering to provide health care services in medi-23 cally underserved areas.

24 (2) Not later than 5 years after the date of the enact-25 ment of this Act, the Secretary shall submit a final report

to the Congress on the study conducted under subsection
(a) (taking into account the effects of this subtitle on the
incidence and costs of medical malpractice), together with
the Secretary's recommendations for actions to increase
the number of physicians volunteering to provide health
care services in medically underserved areas.

7 SEC. 2043. REQUIREMENTS FOR RISK MANAGEMENT PRO8 GRAMS.

9 (a) REQUIREMENTS FOR PROVIDERS.—Each State 10 shall require each health care professional and health care 11 provider providing services in the State to participate in 12 a risk management program to prevent and provide early 13 warning of practices which may result in injuries to pa-14 tients or which otherwise may endanger patient safety.

(b) REQUIREMENTS FOR INSURERS.—Each State
shall require each entity which provides health care professional or provider liability insurance to health care professionals and health care providers in the State to—

(1) establish risk management programs based
on data available to such entity or sanction programs of risk management for health care professionals and health care providers provided by other
entities; and

24 (2) require each such professional or provider,25 as a condition of maintaining insurance, to partici-

pate in one program described in paragraph (1) at
 least once in each 3-year period.

3 (c) EFFECTIVE DATE.—This section shall take effect4 2 years after the date of the enactment of this Act.

5 SEC. 2044. GRANTS FOR MEDICAL SAFETY PROMOTION.

6 (a) RESEARCH ON MEDICAL INJURY PREVENTION7 AND COMPENSATION.

8 (1) IN GENERAL.—The Secretary shall make 9 grants for the conduct of basic research in the pre-10 vention of and compensation for injuries resulting 11 from health care professional or health care provider 12 malpractice, and research of the outcomes of health 13 care procedures.

14 (2) PREFERENCE FOR RESEARCH ON CERTAIN ACTIVITIES.—In making grants under paragraph 15 16 (1), the Secretary shall give preference to applica-17 tions for grants to conduct research on the behavior 18 of health care providers and health care profes-19 sionals in carrying out their professional duties and of other participants in systems for compensating in-20 21 dividuals injured by medical malpractice, the effects 22 of financial and other incentives on such behavior, the determinants of compensation system outcomes, 23 and the costs and benefits of alternative compensa-24 tion policy options. 25

1 (3) APPLICATION.—The Secretary may not 2 make a grant under paragraph (1) unless an appli-3 cant submits an application to the Secretary at such 4 time, in such form, in such manner, and containing 5 such information as the Secretary may require.

6 (b) GRANTS FOR LICENSING AND DISCIPLINARY AC-7 TIVITIES.—

8 (1) IN GENERAL.—The Secretary shall make 9 grants to States to assist States in improving the 10 State's ability to license and discipline health care 11 professionals.

12 (2) USES FOR GRANTS.—A State may use a 13 grant awarded under subsection (a) to develop and 14 implement improved mechanisms for monitoring the 15 practices of health care professionals or for conduct-16 ing disciplinary activities.

17 (3) TECHNICAL ASSISTANCE.—The Secretary 18 shall provide technical assistance to States receiving 19 grants under paragraph (1) to assist them in evalu-20 ating their medical practice acts and procedures and to encourage the use of efficient and effective early 21 22 warning systems and other mechanisms for detecting practices which endanger patient safety and for dis-23 24 ciplining health care professionals.

1	(4) Applications.—The Secretary may not
2	make a grant under paragraph (1) unless the appli-
3	cant submits an application to the Secretary at such
4	time, in such form, in such manner, and containing
5	such information as the Secretary shall require.
6	(c) Grants for Public Education Programs.—
7	(1) IN GENERAL.—The Secretary shall make
8	grants to States and to local governments, private
9	nonprofit organizations, and health professional
10	schools (as defined in paragraph (3)) for—
11	(A) educating the general public about the
12	appropriate use of health care and realistic ex-
13	pectations of medical intervention;
14	(B) educating the public about the re-
15	sources and role of health care professional li-
16	censing and disciplinary boards in investigating
17	claims of incompetence or health care mal-
18	practice; and
19	(C) developing programs of faculty train-
20	ing and curricula for educating health care pro-
21	fessionals in quality assurance, risk manage-
22	ment, and medical injury prevention.
23	(2) APPLICATIONS.—The Secretary may not
24	make a grant under paragraph (1) unless the appli-
25	cant submits an application to the Secretary at such

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1 time, in such form, in such manner, and containing such information as the Secretary shall require. 2 (3)3 HEALTH PROFESSIONAL SCHOOL DE-4 FINED.—In paragraph (1), the term "health professional school" means a school of nursing (as defined 5 in section 853(2) of the Public Health Service Act) 6 7 or a school or program under section 799(1) of such 8 Act. 9 (d) AUTHORIZATION OF APPROPRIATIONS.—There

10 are authorized to be appropriated not more than
11 \$15,000,000 for each of the first 5 fiscal years beginning
12 on or after the date of the enactment of this Act for grants
13 under this section.

14 Subtitle B—Administrative Cost 15 Savings and Fair Health Infor 16 mation Practices

17 PART 1—ADMINISTRATIVE COST SAVINGS

18 SEC. 2100. PURPOSE.

19 It is the purpose of this part to improve the efficiency 20 and effectiveness of the health care system, including the 21 medicare program under title XVIII of the Social Security 22 Act and the medicaid program under title XIX of such 23 Act, by encouraging the development of a health informa-24 tion network through the adoption of standards and the establishment of requirements for the electronic trans mission of certain health information.

3 SEC. 2101. DEFINITIONS.

4 For purposes of this part:

5 (1) CODE SET.—The term "code set" means 6 any set of codes used for encoding data elements, 7 such as tables of terms, medical concepts, medical 8 diagnostic codes, or medical procedure codes.

9 (2) COORDINATION OF BENEFITS.—The term 10 "coordination of benefits" means determining and 11 coordinating the financial obligations of plan spon-12 sors when health care benefits are payable by more 13 than one such sponsor.

14 (3) EMPLOYER.—The term "employer" has the
15 meaning given such term in section 3(5) of the Em16 ployee Retirement Income Security Act of 1974.

(4) 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.

24 (5) HEALTH INFORMATION NETWORK.—The
25 term "health information network" means the health

1	information system that is formed through the appli-
2	cation of the requirements and standards established
3	under this part.
4	(6) Health information network serv-
5	ICE.—The term ''health information network serv-
6	ice''—
7	(A) means a private entity or an entity op-
8	erated by a State that enters into contracts-
9	(i) to process or facilitate the process-
10	ing of nonstandard data elements of health
11	information into standard data elements;
12	(ii) to provide the means by which
13	persons are connected to the health infor-
14	mation network for purposes of meeting
15	the requirements of this part, including the
16	holding of standard data elements of
17	health information;
18	(iii) to provide authorized access to
19	health information through the health in-
20	formation network; or
21	(iv) to provide specific information
22	processing services, such as automated co-
23	ordination of benefits and claims trans-
24	action routing; and

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(B) includes a health information protec tion service.

3 (7) Health information protection serv-ICE.—The term "health information protection serv-4 ice" means a private entity or an entity operated by 5 6 a State that accesses standard data elements of 7 health information through the health information 8 network, processes such information into non-identi-9 fiable health information, and may store such infor-10 mation.

11 (8) HEALTH PROVIDER.—The term "health 12 provider" includes a provider of services (as defined 13 in section 1861(u) of the Social Security Act), a pro-14 vider of medical or other health services (as defined 15 in section 1861(s) of such Act), and any other per-16 son (other than a plan sponsor) furnishing health 17 care items or services.

(9) NON-IDENTIFIABLE HEALTH INFORMATION.—The term "non-identifiable health information" means health information that is not protected
health information (as defined in part 2).

22 (10) PLAN SPONSOR.—The term "plan spon23 sor" means—

24 (A) a plan (as defined in section 25 1033(6)(B));

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(as defined in section 1 (B) insurer an 2 1131(6)) providing health insurance coverage (as defined in section 1131(4)); and 3 4 (C) a State, or the Federal Government, 5 acting in a capacity as a provider of health benefits to eligible individuals that is equivalent to 6 7 that of an insurer. 8 (11) PURCHASING ARRANGEMENT.—The term "purchasing arrangement" means a voluntary health 9 purchasing arrangement described in part 3 of sub-10 title B of title I. 11 12 (12)SECRETARY.—The "Secretary" term means the Secretary of Health and Human Services. 13 (13) STANDARD.—The term "standard", when 14 15 used with reference to a transaction or to data elements of health information, means that the trans-16 17 action or data elements meet any standard adopted 18 by the Secretary under subpart A that applies to the 19 transaction or data elements. 20 Subpart A—Standards for Data Elements and 21 Transactions 22 SEC. 2103. GENERAL REQUIREMENTS ON SECRETARY. 23 (a) IN GENERAL.—The Secretary shall adopt stand-24 ards and modifications to standards under this part that 25 are1 (1) consistent with the objective of reducing the 2 costs of providing and paying for health care; and

3 (2) in use and generally accepted, developed, or
4 modified by the standard-setting organizations ac5 credited by the American National Standard Insti6 tute.

7 (b) INITIAL STANDARDS.—The Secretary may de8 velop an expedited process for the adoption of initial
9 standards under this subpart.

(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.

14sec. 2104. Standards for data elements of health15information.

16 (a) IN GENERAL.—The Secretary shall adopt stand-17 ards necessary to make uniform and compatible for elec-18 tronic transmission through the health information net-19 work the data elements of any health information that the 20 Secretary determines is appropriate for transmission in 21 connection with a transaction described in section 2111.

(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.

- 3 (c) CERTAIN DATA ELEMENTS.—
- 4 (1) UNIQUE HEALTH IDENTIFIERS.—The Sec5 retary shall establish a system to provide for a
 6 standard unique health identifier for each individual,
 7 employer, plan sponsor, and health provider for use
 8 in the health care system.
- 9 (2) CODE SETS.—

10(A) IN GENERAL.—The Secretary, in con-11sultation with experts from the private sector12and 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.

20 (B) DISTRIBUTION.—The Secretary shall
21 establish efficient and low-cost procedures for
22 distribution of code sets and modifications to
23 code sets.

1 SEC. 2105. INFORMATION TRANSACTION STANDARDS.

2 (a) IN GENERAL.—The Secretary shall adopt tech-3 nical standards that are consistent with part 2 relating 4 to the method by which standard data elements of health 5 information may be transmitted electronically, including 6 standards with respect to the format in which such data 7 elements may be transmitted.

8 (b) SPECIAL RULE FOR COORDINATION OF BENE-FITS.—Any standard adopted by the Secretary under 9 paragraph (1) that relates to coordination of benefits shall 10 provide that a claim for reimbursement for health services 11 furnished shall be tested, by an algorithm specified by the 12 Secretary, against all records of enrollment and eligibility 13 for the individual who received such services that are avail-14 able to the recipient of the claim through the health infor-15 mation network to determine any primary and secondary 16 obligors for payment. 17

18 (c) ELECTRONIC SIGNATURE.—The Secretary, in co-19 ordination with the Secretary of Commerce, shall promul-20 gate regulations specifying procedures for the electronic 21 transmission and authentication of signatures, compliance 22 with which shall be deemed to satisfy State and Federal 23 statutory requirements for written signatures with respect 24 to transactions described in section 2111 and written sig-25 natures on health records and prescriptions.

(d) STANDARDS FOR CLAIMS FOR CLINICAL LABORA-1 TORY TESTS.—The standards under this section shall pro-2 3 vide that claims for clinical laboratory tests for which ben-4 efits are payable by a plan sponsor shall be submitted di-5 rectly by the person or entity that performed (or supervised the performance of) the tests to the sponsor in a 6 7 manner consistent with (and subject to such exceptions 8 as are provided under) the requirement for direct submis-9 sion of such claims under the medicare program.

10 SEC. 2106. TIMETABLES FOR ADOPTION OF STANDARDS.

11 (a) INITIAL STANDARDS FOR DATA ELEMENTS.—
12 The Secretary shall adopt standards relating to—

(1) the data elements for the information described in section 2104(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

20 (2) any addition to a set of data elements, in21 conjunction with making such an addition.

(b) INITIAL STANDARDS FOR INFORMATION TRANSACTIONS.—The Secretary shall adopt standards relating
to information transactions under section 2105 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).

4 (c) MODIFICATIONS TO STANDARDS.—

5 (1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards 6 7 adopted under this subpart and shall adopt modified 8 standards as determined appropriate, but not more 9 frequently than once every 6 months. Any modification to standards shall be completed in a manner 10 11 which minimizes the disruption to, and costs of com-12 pliance incurred by, a plan sponsor, health provider, 13 or purchasing arrangement that is required to com-14 ply with subpart B.

15 (2) Special Rules.—

16 (A) MODIFICATIONS DURING FIRST 12-17 MONTH PERIOD.—Except with respect to addi-18 tions and modifications to code sets under sub-19 paragraph (B), the Secretary may not adopt any modification to a standard adopted under 20 21 this subpart during the 12-month period begin-22 ning on the date the standard is adopted, un-23 less the Secretary determines that the modifica-24 tion is necessary in order to permit a plan spon-

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1	sor, a health provider, or a purchasing arrange-
2	ment to comply with subpart B.
3	(B) Additions and modifications to
4	CODE SETS.—
5	(i) IN GENERAL.—The Secretary shall
6	ensure that procedures exist for the rou-
7	tine maintenance, testing, enhancement,
8	and expansion of code sets.
9	(ii) Additional Rules.—If a code
10	set is modified under this subsection, the
11	modified code set shall include instructions
12	on how data elements that were encoded
13	prior to the modification are to be con-
14	verted or translated so as to preserve the
15	value of the data elements. Any modifica-
16	tion to a code set under this subsection
17	shall be implemented in a manner that
18	minimizes the disruption to, and costs of
19	compliance incurred by, a plan sponsor,
20	health provider, or purchasing arrange-
21	ment that is required to comply with sub-
22	part B.
23	(d) EVALUATION OF STANDARDS.—The Secretary
•	

24 may establish a process to measure or verify the consist-25 ency of standards adopted or modified under this subpart.

Such process may include demonstration projects and
 analyses of the cost of implementing such standards and
 modifications.

4 Subpart B-Requirements With Respect to Certain 5 **Transactions and Information** SEC. 2111. STANDARD TRANSACTIONS AND INFORMATION. 6 7 (a) TRANSACTIONS BY SPONSORS.— TRANSACTIONS WITH PROVIDERS.-If a 8 (1)plan sponsor conducts any of the transactions de-9 scribed in paragraph (3) with a health provider— 10 11 (A) the transaction shall be a standard 12 transaction; and (B) the health information transmitted by 13 14 the sponsor to the provider or by the provider 15 to the sponsor in connection with the transaction shall be in the form of standard data ele-16 17 ments. 18 (2) TRANSACTIONS WITH SPONSORS.—If a plan 19 sponsor conducts any of the transactions described 20 in paragraph (3) with another plan sponsor— 21 (A) the transaction shall be a standard 22 transaction; and (B) the health information transmitted by 23 24 either sponsor in connection with the trans-

1	action shall be in the form of standard data ele-
2	ments.
3	(3) TRANSACTIONS.—The transactions referred
4	to in paragraphs (1) and (2) are the following:
5	(A) Verification of eligibility for benefits.
6	(B) Coordination of benefits.
7	(C) Claim submission.
8	(D) Claim attachment submission.
9	(E) Claim status notification.
10	(F) Claim status verification.
11	(G) Claim adjudication.
12	(H) Payment and remittance advice.
13	(I) Certification or authorization of a re-
14	ferral to a health provider who is not part of
15	the defined set of providers providing items and
16	services under a network plan (as defined in
17	section 1131(5)).
18	(b) Transactions by Purchasing Arrange-
19	MENTS.—
20	(1) IN GENERAL.—If a purchasing arrangement
21	conducts any of the transactions described in para-
22	graph (2) with a plan sponsor—
23	(A) the transaction shall be a standard
24	transaction; and

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1	(B) the health information transmitted by
2	the arrangement to the sponsor or by the spon-
3	sor to the arrangement in connection with the
4	transaction shall be in the form of standard
5	data elements.
6	(2) TRANSACTIONS.—The transactions referred
7	to in paragraph (1) are the following:
8	(A) Enrollment and disenrollment.
9	(B) Premium payment.
10	(c) Use of Health Information Network Serv-
11	ICES.—A plan sponsor, a health provider, or a purchasing
12	arrangement may comply with any provision of this sec-
13	tion by entering into an agreement or other arrangement
14	with a health information network service certified under
15	section 2121 pursuant to which the service undertakes the
16	duties applicable to the sponsor, provider, or arrangement
17	under the provision.
18	SEC. 2112. ACCESSING HEALTH INFORMATION FOR AU-
19	THORIZED PURPOSES.
20	(a) PROCUREMENT RULE FOR GOVERNMENT AGEN-
21	CIES.—
22	(1) IN GENERAL.—A health information protec-
23	tion service that is certified under section 2121 shall
24	make available to a Federal or State agency, pursu-
25	ant to a cost-type contract (as defined under the

1	Federal Acquisition Regulation), any non-identifiable
2	health information, including non-identifiable health
3	information that is derived from protected health in-
4	formation, that—
5	(A) is held by the service or may be ob-
6	tained by the service under paragraph (2) or
7	subsection (b);
8	(B) consists of data elements that are sub-
9	ject to a standard under subpart A; and
10	(C) is requested by the agency to fulfill a
11	requirement under this Act.
12	(2) Certain information available at low
13	COST.—If a health information protection service re-
14	quires health information consisting of data elements
15	that are subject to a standard under subpart A from
16	a plan sponsor or a health provider in order to com-
17	ply with a request made by a Federal or State agen-
18	cy under paragraph (1), the sponsor or provider
19	shall make such information available to such orga-
20	nization for a charge that does not exceed the rea-
21	sonable cost of transmitting the information.
22	(b) PROCUREMENT RULE FOR INFORMATION PRO-
23	TECTION SERVICES.—A health information protection
24	service that makes non-identifiable health information

25 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 informa tion protection service that—

5 (A) is certified under section 2121; and

6 (B) requests the information.

7 SEC. 2113. ENSURING AVAILABILITY OF INFORMATION.

8 The Secretary shall establish a procedure under 9 which a plan sponsor or health provider that does not have 10 the ability to transmit standard data elements directly, 11 and does not have access to a health information network 12 service certified under section 2121, may comply with the 13 provisions of this subpart.

14 SEC. 2114. TIMETABLES FOR COMPLIANCE WITH REQUIRE-

15

MENTS.

16 (a) INITIAL COMPLIANCE.—

17 (1) IN GENERAL.—Not later than 12 months 18 after the date on which standards are adopted under 19 subpart A with respect to a type of transaction, or 20 data elements for a type of health information, a 21 plan sponsor, health provider, or purchasing ar-22 rangement shall comply with the requirements of 23 this subpart with respect to such transaction or information. 24

1 (2) ADDITIONAL DATA ELEMENTS.—Not later 2 than 12 months after the date on which the Sec-3 retary adopts an addition to a set of data elements 4 for health information under section 2104, a plan 5 sponsor, health provider, or purchasing arrangement 6 shall comply with the requirements of this subpart 7 using such data elements.

8 (b) Compliance with Modified Standards.—

9 (1) IN GENERAL.—If the Secretary adopts a 10 modified standard under section 2106(c), a plan 11 sponsor, health provider, or purchasing arrangement 12 shall comply with the modified standard at such 13 time as the Secretary determines appropriate, taking 14 into account the time needed to comply due to the 15 nature and extent of the modification.

16 (2) SPECIAL RULE.—In the case of a modifica-17 tion to a standard that does not occur within the 12-18 month period beginning on the date the standard is 19 adopted, the time determined appropriate by the 20 Secretary under paragraph (1) may not be—

21 (A) earlier than the last day of the 90-day
22 period beginning on the date the modified
23 standard is adopted; or

(B) later than the last day of the 12 month period beginning on the date the modi fied standard is adopted.

Subpart C—Miscellaneous Provisions

5 SEC. 2121. STANDARDS AND CERTIFICATION FOR HEALTH

6

4

INFORMATION NETWORK SERVICES.

7 (a) STANDARDS FOR OPERATION.—The Secretary 8 shall establish standards with respect to the operation of 9 health information network services, including standards 10 ensuring that such services—

(1) develop, operate, and cooperate with one an-other to form the health information network;

13 (2) meet all of the requirements under part 2
14 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 part 2, 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 informa tion in a manner that prevents access to such infor mation by such larger organization.

4 (b) CERTIFICATION BY THE SECRETARY.—

ESTABLISHMENT.—Not 12 5 (1)later than 6 months after the date of the enactment of this Act. 7 the Secretary shall establish a certification proce-8 dure for health information network services which 9 ensures that certified services are qualified to meet 10 the requirements of this part and the standards es-11 tablished by the Secretary under this section. Such 12 certification procedure shall be implemented in a 13 manner that minimizes the costs and delays of operations for such services. 14

15 (2) APPLICATION.—Each entity desiring to be 16 certified as a health information network service 17 shall apply to the Secretary for certification in a 18 form and manner determined appropriate by the 19 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 part, part 2, and

the standards established by the Secretary under
 this section.

3 (4) RECERTIFICATION.—A health information
4 network service shall be recertified under this sub5 section at least every 3 years.

6 (c) Loss of Certification.—

7 (1)MANDATORY TERMINATION.—Except as provided in paragraph (2), if a health information 8 9 network service violates a requirement imposed on such service under part 2, its certification under this 10 11 section shall be terminated unless the Secretary de-12 termines that appropriate corrective action has been taken. 13

14 (2) CONDITIONAL CERTIFICATION.—The Sec-15 retary may establish a procedure under which a 16 health information network service may remain cer-17 tified on a conditional basis if the service is operat-18 ing consistently with a plan intended to correct any 19 violations described in paragraph (1). Such proce-20 dure may provide for the appointment of a trustee to continue operation of the service until the require-21 22 ments for full certification are met.

23 (d) CERTIFICATION BY PRIVATE ENTITIES.—The
24 Secretary may designate private entities to conduct the
25 certification procedures established by the Secretary under

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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.

4 (e) INFORMATION HELD BY HEALTH INFORMATION NETWORK SERVICES.—If a health information network 5 service certified under this section loses its certified status 6 7 or takes any action that would threaten the continued availability of the standard data elements of health infor-8 9 mation held by such service, such data elements shall be transferred to another health information network service 10 certified under this section that has been designated by 11 the Secretary. 12

13 SEC. 2122. IMPOSITION OF ADDITIONAL REQUIREMENTS.

14 (a) IN GENERAL.—Except as provided in subsection 15 (c), after the Secretary has established standards under section 2104 that are necessary to make uniform and com-16 patible for electronic transmission the data elements that 17 the Secretary determines are appropriate for transmission 18 in connection with a transaction described in subpart B, 19 20 an individual or entity may not require an individual or 21 entity, to provide in any manner any additional data ele-22 ment in connection with—

- 23 (1) the transaction; or
- 24 (2) an inquiry with respect to the transaction.

1 (b) TRANSMISSION METHOD.—Except as provided in subsection (c), after the Secretary has established stand-2 3 ards under section 2105 relating to the method by which 4 data elements that the Secretary determines are appro-5 priate for transmission in connection with a transaction described in subpart B may be transmitted electronically, 6 7 an individual or entity may not require an individual or 8 entity to transmit any data element in a manner inconsist-9 ent with the standards in connection with—

10 (1) the transaction; or

(2) an inquiry with respect to the transaction.
(c) EXCEPTION.—Subsections (a) and (b) do not
apply if—

14 (1) an individual or entity voluntarily agrees to15 provide the additional data element; or

16 (2) a waiver is granted under subsection (d) to17 permit the requirement.

18 (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).

23 (2) CONSIDERATION OF WAIVER REQUESTS.—A
24 waiver may not be granted under this subsection to
25 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.

7 (3) ANONYMOUS REPORTING.—If an individual 8 or entity attempts to impose on an individual or en-9 tity a requirement prohibited under subsection (a) or 10 (b), the individual or entity on whom the require-11 ment is being imposed may contact the Secretary. 12 The Secretary shall develop a procedure under which 13 an individual or entity that contacts the Secretary 14 under the preceding sentence shall remain anony-15 mous. The Secretary shall notify the individual or 16 entity imposing the requirement that the require-17 ment may not be imposed unless the other individual 18 or entity voluntarily agrees to such requirement or 19 a waiver is obtained under this subsection.

20 SEC. 2123. EFFECT ON STATE LAW.

(a) IN GENERAL.—Except as otherwise provided in
this section, a provision, requirement, or standard under
this part shall supersede any contrary provision of State
law.

1 (b) STATE "QUILL AND PEN" LAWS.—A State may not establish, continue in effect, or enforce any provision 2 of State law that requires medical or health plan records 3 (including billing information) to be maintained or trans-4 mitted in written rather than electronic form, except 5 where the Secretary determines that the provision is nec-6 7 essary to prevent fraud and abuse, with respect to controlled substances, or for other purposes. 8

9 (c) PUBLIC HEALTH REPORTING.—Nothing in this 10 part shall be construed to invalidate or limit the authority, 11 power, or procedures established under any law providing 12 for the reporting of disease or injury, child abuse, birth, 13 or death, public health surveillance, or public health inves-14 tigation or intervention.

(d) PUBLIC USE FUNCTIONS.—Nothing in this part
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 part 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.

1 SEC. 2124. GRANTS FOR DEMONSTRATION PROJECTS.

2 (a) IN GENERAL.—The Secretary may make grants 3 for demonstration projects to promote the development 4 and use of electronically integrated community-based clini-5 cal information systems and computerized patient medical 6 records.

7 (b) APPLICATIONS.—

8 (1) SUBMISSION.—To apply for a grant under 9 this section for any fiscal year, an applicant shall 10 submit an application to the Secretary in accordance 11 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:

17 (A) Use of existing technology.— Funds received under this section will be used 18 19 to apply telecommunications and information 20 systems technology that is in existence on the 21 date the application is submitted in a manner 22 that improves the quality of health care, re-23 duces the costs of such care, and protects the 24 privacy and confidentiality of information relat-25 ing to the physical or mental condition of an in-26 dividual.

1	(B) Use of existing information sys-
2	TEMS.—Funds received under this section will
3	be used—
4	(i) to enhance telecommunications or
5	information systems that are operating on
6	the date the application is submitted;
7	(ii) to integrate telecommunications or
8	information systems that are operating on
9	the date the application is submitted; or
10	(iii) to connect additional users to
11	telecommunications or information net-
12	works or systems that are operating on the
13	date the application is submitted.
14	(C) MATCHING FUNDS.—The applicant
15	shall make available funds for the demonstra-
16	tion project in an amount that equals at least
17	20 percent of the cost of the project.
18	(c) GEOGRAPHIC DIVERSITY.—In making any grants
19	under this section, the Secretary shall, to the extent prac-
20	ticable, make grants to persons representing different geo-
21	graphic areas of the United States, including urban and
22	rural areas.
23	(d) REVIEW AND SANCTIONS.—The Secretary shall
24	review at least annually the compliance of a person receiv-
25	ing a grant under this section with the provisions of this

section. The Secretary shall establish a procedure for de termining 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.

5 (e) ANNUAL REPORT.—The Secretary shall submit 6 an annual report to the President for transmittal to Con-7 gress containing a description of the activities carried out 8 under this section.

9 Subpart D—Assistance to the Secretary 10 SEC. 2131. GENERAL REQUIREMENT ON SECRETARY.

In complying with any requirements imposed on the Secretary under this part, the Secretary shall rely on recommendations of the Health Information Advisory Committee established under section 2132 and shall consult with appropriate Federal agencies.

16 SEC. 2132. HEALTH INFORMATION ADVISORY COMMITTEE.

17 (a) ESTABLISHMENT.—There is established a com18 mittee to be known as the Health Care Information Advi19 sory Committee.

- 20 (b) DUTY.—
- 21 (1) IN GENERAL.—The committee shall—

(A) provide assistance to the Secretary in
complying with the requirements imposed on
the Secretary under this part and part 2;

1	(B) be generally responsible for advising
2	the Secretary and the Congress on the status of
3	the health information network; and
4	(C) make recommendations to correct any
5	problems that may occur in the network's im-
6	plementation and ongoing operations and to re-
7	fine and improve the network.
8	(2) TECHNICAL ASSISTANCE.—In performing
9	its duties under this subsection, the committee shall
10	receive technical assistance from appropriate Federal
11	agencies.
12	(c) Membership.—
13	(1) IN GENERAL.—The committee shall consist
14	of 15 members to be appointed by the President not
15	later than 60 days after the date of the enactment
16	of this part. The President shall designate 1 member
17	as the Chair.
18	(2) EXPERTISE.—The membership of the com-
19	mittee shall consist of individuals who are of recog-
20	nized standing and distinction and who possess the
21	demonstrated capacity to discharge the duties im-
22	posed on the committee.
23	(3) TERMS.—Each member of the committee
24	shall be appointed for a term of 5 years, except that
25	the members first appointed shall serve staggered

1	terms such that the terms of no more than 3 mem-
2	bers expire at one time.
3	(4) VACANCIES.—
4	(A) IN GENERAL.—A vacancy on the com-
5	mittee shall be filled in the manner in which the
6	original appointment was made and shall be
7	subject to any conditions which applied with re-
8	spect to the original appointment.
9	(B) FILLING UNEXPIRED TERM.—An indi-
10	vidual chosen to fill a vacancy shall be ap-
11	pointed for the unexpired term of the member
12	replaced.
13	(C) EXPIRATION OF TERMS.—The term of
14	any member shall not expire before the date on
15	which the member's successor takes office.
16	(5) CONFLICTS OF INTEREST.—Members of the
17	committee shall disclose upon appointment to the
18	committee or at any subsequent time that it may
19	occur, conflicts of interest.
20	(d) MEETINGS.—
21	(1) IN GENERAL.—Except as provided in para-
22	graph (2), the committee shall meet at the call of
23	the Chair.
24	(2) INITIAL MEETING.—Not later than 30 days
25	after the date on which all members of the commit-

tee have been appointed, the committee shall hold its
 first meeting.

3 (3) QUORUM.—A majority of the members of
4 the committee shall constitute a quorum, but a less5 er number of members may hold hearings.

6 (e) POWER TO HOLD HEARINGS.—The committee 7 may hold such hearings, sit and act at such times and 8 places, take such testimony, and receive such evidence as 9 the committee considers advisable to carry out the pur-10 poses 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.

16 (g) REPORTS.—

17 (1) IN GENERAL.—The committee shall annu18 ally prepare and submit to Congress and the Sec19 retary a report including at least an analysis of—

20 (A) the status of the health information
21 network established under this part, including
22 whether the network is fulfilling the purpose de23 scribed in section 2100;

24 (B) the savings and costs of the network;

1	(C) the activities of health information net-
2	work services certified under section 2121,
3	health providers, and plan sponsors under this
4	part;
5	(D) the extent to which entities described
6	in subparagraph (C) are meeting the standards
7	adopted under this part and working together
8	to form an integrated network that meets the
9	needs of its users;
10	(E) the extent to which entities described
11	in subparagraph (C) are meeting the privacy
12	and security protections of part 2;
13	(F) whether the Federal Government and
14	State Governments are receiving information of
15	sufficient quality to meet their responsibilities
16	under this Act;
17	(G) any problems with respect to imple-
18	mentation of the network;
19	(H) the extent to which timetables under
20	this part for the adoption and implementation
21	of standards are being met; and
22	(I) any legislative recommendations related
23	to the health information network.
24	(2) AVAILABILITY TO THE PUBLIC.—Any infor-
25	mation 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.

6 PART 2—FAIR HEALTH INFORMATION 7 PRACTICES

8 SEC. 2140. DEFINITIONS.

9 (a) DEFINITIONS RELATING TO PROTECTED10 HEALTH INFORMATION.—For purposes of this part:

11 (1) DISCLOSE.—The term "disclose", when 12 used with respect to protected health information 13 that is held by a health information trustee, means 14 to provide access to the information, but only if such 15 access is provided by the trustee to a person other 16 than—

17 (A) the trustee or an officer or employee of18 the trustee;

(B) an affiliated person of the trustee; or
(C) a protected individual who is a subject
of the information.

22 (2) DISCLOSURE.—The term "disclosure"23 means the act or an instance of disclosing.

24 (3) PROTECTED HEALTH INFORMATION.—The25 term "protected health information" means any in-

1	formation, whether oral or recorded in any form or
2	medium—
3	(A) that is created or received in a State
4	by—
5	(i) a health care provider;
6	(ii) a health benefit plan sponsor;
7	(iii) a health oversight agency;
8	(iv) a health information service orga-
9	nization; or
10	(v) a public health authority;
11	(B) that relates in any way to the past,
12	present, or future physical or mental health or
13	condition or functional status of a protected in-
14	dividual, the provision of health care to a pro-
15	tected individual, or payment for the provision
16	of health care to a protected individual; and
17	(C) that—
18	(i) identifies the individual; or
19	(ii) with respect to which there is a
20	reasonable basis to believe that the infor-
21	mation can be used to identify the individ-
22	ual.
23	(4) PROTECTED INDIVIDUAL.—The term "pro-
24	tected individual" means an individual who, with re-
25	spect to a date—

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1	(A) is living on the date; or
2	(B) has died within the 2-year period end-
3	ing on the date.
4	(5) USE.—The term "use", when used with re-
5	spect to protected health information that is held by
6	a health information trustee, means—
7	(A) to use, or provide access to, the infor-
8	mation in any manner that does not constitute
9	a disclosure; or
10	(B) any act or instance of using, or provid-
11	ing access, described in subparagraph (A).
12	(b) Definitions Relating to Health Informa-
13	TION TRUSTEES.—For purposes of this part:
14	(1) CARRIER.—The term "carrier" means a li-
15	censed insurance company, a hospital or medical
16	service corporation (including an existing Blue Cross
17	or Blue Shield organization, within the meaning of
18	section $833(c)(2)$ of the Internal Revenue Code of
19	1986), a health maintenance organization, or other
20	entity licensed or certified by a State to provide
21	health insurance or health benefits.
22	(2) Health benefit plan.—The term
23	''health benefit plan'' means—
24	(A) any contract of health insurance, in-
25	cluding any hospital or medical service policy or

1 certificate, hospital or medical service plan con-2 tract, or health maintenance organization group 3 contract, that is provided by a carrier; and 4 (B) an employee welfare benefit plan or other arrangement insofar as the plan or ar-5 6 rangement provides health benefits and is fund-7 ed in a manner other than through the purchase of one or more policies or contracts de-8 9 scribed in subparagraph (A). 10 (3) HEALTH BENEFIT PLAN SPONSOR.—The term "health benefit plan sponsor" means a person 11 12 who, with respect to a specific item of protected 13 health information, receives, creates, uses, main-14 tains, or discloses the information while acting in 15 whole or in part in the capacity of— (A) a carrier providing a health benefit 16 17 plan; 18 (B) any other provider of a health benefit 19 plan, including any public entity that provides 20 payments for health care items and services under a health benefit plan that are equivalent 21 22 to payments provided by a private person under 23 such a plan; or 24 (C) an officer or employee of a person described in subparagraph (A) or (B). 25

1	(4) HEALTH CARE PROVIDER.—The term
2	"health care provider" means a person who, with re-
3	spect to a specific item of protected health informa-
4	tion, receives, creates, uses, maintains, or discloses
5	the information while acting in whole or in part in
6	the capacity of—
7	(A) a person who is licensed, certified, reg-
8	istered, or otherwise authorized by law to pro-
9	vide an item or service that constitutes health
10	care in the ordinary course of business or prac-
11	tice of a profession;
12	(B) a Federal or State program that di-
13	rectly provides items or services that constitute
14	health care to beneficiaries; or
15	(C) an officer or employee of a person de-
16	scribed in subparagraph (A) or (B).
17	(5) Health information service organiza-
18	TION.—The term ''health information service organi-
19	zation" means a person who, with respect to a spe-
20	cific item of protected health information, receives,
21	creates, uses, maintains, or discloses the information
22	while acting in whole or in part in the capacity of—
23	(A) a person, other than an affiliated per-
24	son, who performs specific functions for which
25	the Secretary has authorized (by means of a

1	designation or certification) the person to re-
2	ceive access to health care data in electronic or
3	magnetic form that are regulated by this Act;
4	or
5	(B) an officer or employee of a person de-
6	scribed in subparagraph (A).
7	(6) Health information trustee.—The
8	term ''health information trustee'' means—
9	(A) a health care provider;
10	(B) a health information service organiza-
11	tion;
12	(C) a health oversight agency;
13	(D) a health benefit plan sponsor;
14	(E) a public health authority;
15	(F) a health researcher;
16	(G) a person who, with respect to a spe-
17	cific item of protected health information, is not
18	described in subparagraphs (A) through (F) but
19	receives the information—
20	(i) pursuant to—
21	(I) section 2157 (relating to
22	emergency circumstances);
23	(II) section 2158 (relating to ju-
24	dicial and administrative purposes);

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1	(III) section 2159 (relating to
2	law enforcement); or
3	(IV) section 2160 (relating to
4	subpoenas, warrants, and search war-
5	rants); or
6	(ii) while acting in whole or in part in
7	the capacity of an officer or employee of a
8	person described in clause (i).
9	(7) Health oversight agency.—The term
10	"health oversight agency" means a person who, with
11	respect to a specific item of protected health infor-
12	mation, receives, creates, uses, maintains, or dis-
13	closes the information while acting in whole or in
14	part in the capacity of—
15	(A) a person who performs or oversees the
16	performance of an assessment, evaluation, de-
17	termination, or investigation relating to the li-
18	censing, accreditation, or certification of health
19	care providers;
20	(B) a person who—
21	(i) performs or oversees the perform-
22	ance of an audit, assessment, evaluation,
23	determination, or investigation relating to
24	the effectiveness of, compliance with, or
25	applicability of, legal, fiscal, medical, or

1	scientific standards or aspects of perform-
2	ance related to the delivery of, or payment
3	for, health care; and
4	(ii) is a public agency, acting on be-
5	half of a public agency, acting pursuant to
6	a requirement of a public agency, or carry-
7	ing out activities under a State or Federal
8	statute regulating the assessment, evalua-
9	tion, determination, or investigation; or
10	(C) an officer or employee of a person de-
11	scribed in subparagraph (A) or (B).
12	(8) HEALTH RESEARCHER.—The term "health
13	researcher" means a person who, with respect to a
14	specific item of protected health information, re-
15	ceives the information—
16	(A) pursuant to section 2156 (relating to
17	health research); or
18	(B) while acting in whole or in part in the
19	capacity of an officer or employee of a person
20	described in subparagraph (A).
21	(9) Public health authority.—The term
22	"public health authority" means a person who, with
23	respect to a specific item of protected health infor-
24	mation, receives, creates, uses, maintains, or dis-

1	closes the information while acting in whole or in
2	part in the capacity of—
3	(A) an authority of the United States, a
4	State, or a political subdivision of a State that
5	is responsible for public health matters;
6	(B) a person acting under the direction of
7	such an authority; or
8	(C) an officer or employee of a person de-
9	scribed in subparagraph (A) or (B).
10	(c) OTHER DEFINITIONS.—For purposes of this part:
11	(1) AFFILIATED PERSON.—The term "affiliated
12	person'' means a person who—
13	(A) is not a health information trustee;
14	(B) is a contractor, subcontractor, associ-
15	ate, or subsidiary of a person who is a health
16	information trustee; and
17	(C) pursuant to an agreement or other re-
18	lationship with such trustee, receives, creates,
19	uses, maintains, or discloses protected health
20	information.
21	(2) Approved health research project.—
22	The term "approved health research project" means
23	a biomedical, epidemiological, or health services re-
24	search or statistics project, or a research project on
25	behavioral and social factors affecting health, that

1	has been approved by a certified institutional review
2	board.
3	(3) Certified institutional review
4	BOARD.—The term "certified institutional review
5	board" means a board—
6	(A) established by an entity to review re-
7	search involving protected health information
8	and the rights of protected individuals con-
9	ducted at or supported by the entity;
10	(B) established in accordance with regula-
11	tions of the Secretary under section $2156(e)(1)$;
12	and
13	(C) certified by the Secretary under section
14	2156(e)(2).
15	(4) HEALTH CARE.—The term "health care"—
16	(A) means—
17	(i) any preventive, diagnostic, thera-
18	peutic, rehabilitative, maintenance, or pal-
19	liative care, counseling, service, or proce-
20	dure—
21	(I) with respect to the physical or
22	mental condition, or functional status,
23	of an individual; or
24	(II) affecting the structure or
25	function of the human body or any

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1	part of the human body, including
2	banking of blood, sperm, organs, or
3	any other tissue; or
4	(ii) any sale or dispensing of a drug,
5	device, equipment, or other item to an indi-
6	vidual, or for the use of an individual, pur-
7	suant to a prescription; but
8	(B) does not include any item or service
9	that is not furnished for the purpose of main-
10	taining or improving the health of an individual.
11	(5) Law enforcement inquiry.—The term
12	"law enforcement inquiry" means a lawful investiga-
13	tion or official proceeding inquiring into a violation
14	of, or failure to comply with, any criminal or civil
15	statute or any regulation, rule, or order issued pur-
16	suant to such a statute.
17	(6) PERSON.—The term "person" includes an
18	authority of the United States, a State, or a political
19	subdivision of a State.
20	Subpart A—Duties of Health Information Trustees
21	SEC. 2141. INSPECTION OF PROTECTED HEALTH INFORMA-
22	TION.
23	(a) IN GENERAL.—Except as provided in subsection
24	(b), a health information trustee described in subsection
25	(g)—

1 (1) shall permit a protected individual to in-2 spect any protected health information about the in-3 dividual that the trustee maintains, any accounting 4 with respect to such information required under sec-5 tion 2144, and any copy of an authorization re-6 quired under section 2152 that pertains to such in-7 formation;

8 (2) shall provide the protected individual with a 9 copy of the information upon request by the individ-10 ual and subject to any conditions imposed by the 11 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

17 (4) may offer to explain or interpret informa18 tion that is inspected or copied under this sub19 section.

(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:

24 (1) MENTAL HEALTH TREATMENT NOTES.—
25 The information consists of psychiatric, psycho-

logical, or mental health treatment notes about the 1 2 individual, the trustee determines in the exercise of 3 reasonable professional judgment that inspection or 4 copying of the notes would cause sufficient harm to 5 the protected individual so as to outweigh the desir-6 ability of permitting access, and the trustee does not 7 disclose the notes to any person not directly engaged 8 in treating the individual, except with the authoriza-9 tion of the individual or under compulsion of law.

10 (2) INFORMATION ABOUT OTHERS.—The infor-11 mation relates to an individual, other than the pro-12 tected individual or a health care provider, and the 13 trustee determines in the exercise of reasonable pro-14 fessional judgment that inspection or copying of the 15 information would cause sufficient harm to one or 16 both of the individuals so as to outweigh the desir-17 ability of permitting access.

(3) ENDANGERMENT TO LIFE OR SAFETY.—Inspection or copying of the information could reasonably 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

1	confidentiality to a health care provider concerning
2	a protected individual who is a subject of the infor-
3	mation.
4	(5) Administrative purposes.—The informa-
5	tion—
6	(A) is used by the trustee solely for admin-
7	istrative purposes and not in the provision of
8	health care to a protected individual who is a
9	subject of the information; and
10	(B) is not disclosed by the trustee to any
11	person.
12	(6) DUPLICATIVE INFORMATION.—The informa-
13	tion duplicates information available for inspection
14	under subsection (a).
15	(7) Information compiled in anticipation
16	OF LITIGATION.—The information is compiled prin-
17	cipally—
18	(A) in anticipation of a civil, criminal, or
19	administrative action or proceeding; or
20	(B) for use in such an action or proceed-
21	ing.
22	(c) INSPECTION AND COPYING OF SEGREGABLE POR-
23	TION.—A health information trustee shall permit inspec-
24	tion and copying under subsection (a) of any reasonably

segregable portion of a record after deletion of any portion
 that is exempt under subsection (b).

3 (d) CONDITIONS.—A health information trustee 4 may—

5 (1) require a written request for the inspection
6 and copying of protected health information under
7 this section; and

8 (2) charge a reasonable cost-based fee for—

9 (A) permitting inspection of information10 under this section; and

(B) providing a copy of protected healthinformation under this section.

13 (e) STATEMENT OF REASONS FOR DENIAL.—If a 14 health information trustee denies in whole or in part a 15 request for inspection or copying under this section, the 16 trustee shall provide the protected individual who made 17 the request with a written statement of the reasons for 18 the denial.

19 (f) DEADLINE.—A health information trustee shall 20 comply with or deny a request for inspection or copying 21 of protected health information under this section within 22 the 30-day period beginning on the date the trustee re-23 ceives the request.

24 (g) APPLICABILITY.—This section applies to a health
25 information trustee who is—

1 (1) a health benefit plan sponsor;

(2) a health care provider;

2

3

4

- (3) a health information service organization;
- (4) a health oversight agency; or
- 5 (5) a public health authority.

6 SEC. 2142. AMENDMENT OF PROTECTED HEALTH INFORMA7 TION.

8 (a) IN GENERAL.—A health information trustee de-9 scribed in subsection (f) shall, within the 45-day period 10 beginning on the date the trustee receives from a protected 11 individual about whom the trustee maintains protected 12 health information a written request that the trustee cor-13 rect or amend the information, complete the duties de-14 scribed in one of the following paragraphs:

15 (1) CORRECTION OR AMENDMENT AND NOTIFI-16 CATION.—The trustee shall—

17 (A) make the correction or amendment re-18 quested;

(B) inform the protected individual of theamendment 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 dis-

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1	closed of the correction or amendment that has
2	been made; and
3	(D) at the request of the individual, make
4	reasonable efforts to inform any known source
5	of the uncorrected or unamended portion of the
6	information about the correction or amendment
7	that has been made.
8	(2) Reasons for refusal and review pro-
9	CEDURES.—The trustee shall inform the protected
10	individual of—
11	(A) the reasons for the refusal of the trust-
12	ee to make the correction or amendment;
13	(B) any procedures for further review of
14	the refusal; and
15	(C) the individual's right to file with the
16	trustee a concise statement setting forth the re-
17	quested correction or amendment and the indi-
18	vidual's reasons for disagreeing with the refusal
19	of the trustee.
20	(b) Standards for Correction or Amend-
21	MENT.—A trustee shall correct or amend protected health
22	information in accordance with a request made under sub-
23	section (a) if the trustee determines that the information

poses for which the information may be used or disclosed
 by the trustee.

3 (c) STATEMENT OF DISAGREEMENT.—After a pro-4 tected individual has filed a statement of disagreement 5 under subsection (a)(2)(C), the trustee, in any subsequent 6 disclosure of the disputed portion of the information, shall 7 include a copy of the individual's statement and may in-8 clude a concise statement of the trustee's reasons for not 9 making the requested correction or amendment.

10 (d) CONSTRUCTION.—This section may not be con-11 strued to require a health information trustee to conduct 12 a hearing or proceeding concerning a request for a correc-13 tion or amendment to protected health information the 14 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—

25 (1) a health benefit plan sponsor;

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1	(2) a health care provider;
2	(3) a health information service organization;
3	(4) a health oversight agency; or
4	(5) a public health authority.
5	SEC. 2143. NOTICE OF INFORMATION PRACTICES.
6	(a) PREPARATION OF NOTICE.—A health information
7	trustee described in subsection (d) shall prepare a written
8	notice of information practices describing the following:
9	(1) The rights under this part of a protected in-
10	dividual who is the subject of protected health infor-
11	mation, including the right to inspect and copy such
12	information and the right to seek amendments to
13	such information, and the procedures for authorizing
14	disclosures of protected health information and for
15	revoking such authorizations.
16	(2) The procedures established by the trustee
17	for the exercise of such rights.
18	(3) The uses and disclosures of protected health
19	information that are authorized under this part.
20	(b) DISSEMINATION OF NOTICE.—A health informa-
21	tion trustee—
22	(1) shall, upon request, provide any person with
23	a copy of the trustee's notice of information prac-
24	tices (described in subsection (a)); and

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1	(2) shall make reasonable efforts to inform per-
2	sons in a clear and conspicuous manner of the exist-
3	ence and availability of such notice.
4	(c) MODEL NOTICES.—Not later than July 1, 1996,
5	the Secretary, after notice and opportunity for public com-
6	ment, shall develop and disseminate model notices of infor-
7	mation practices for use by health information trustees
8	under this section.
9	(d) APPLICABILITY.—This section applies to a health
10	information trustee who is—
11	(1) a health benefit plan sponsor;
12	(2) a health care provider;
13	(3) a health information service organization; or
14	(4) a health oversight agency.
15	SEC. 2144. ACCOUNTING FOR DISCLOSURES.
16	(a) IN GENERAL.—Except as provided in subsection
17	(b) and section 2154, each health information trustee shall
18	create and maintain, with respect to any protected health
19	information the trustee discloses, a record of—
20	(1) the date and purpose of the disclosure;
21	(2) the name of the person to whom the disclo-
22	sure was made;
23	(3) the address of the person to whom the dis-
24	closure was made or the location to which the disclo-
25	sure was made; and

(4) where practicable, a description of the infor mation disclosed.

3 (b) REGULATIONS.—Not later than July 1, 1996, the 4 Secretary shall promulgate regulations that exempt a 5 health information trustee from maintaining a record 6 under subsection (a) with respect to protected health in-7 formation disclosed by the trustee for purposes of peer re-8 view, licensing, certification, accreditation, and similar ac-9 tivities.

10 SEC. 2145. SECURITY.

11 (a) IN GENERAL.—Each health information trustee 12 who receives or creates protected health information that 13 is subject to this part shall maintain reasonable and ap-14 propriate administrative, technical, and physical safe-15 guards—

- 16 (1) to ensure the integrity and confidentiality of17 the information;
- 18 (2) to protect against any reasonably antici-19 pated—
- 20 (A) threats or hazards to the security or21 integrity of the information; and
- (B) unauthorized uses or disclosures of theinformation; and

1 (3) otherwise ensure compliance with this part 2 by the trustee and the officers and employees of the 3 trustee. 4 (b) GUIDELINES.—Not later than July 1, 1996, the 5 Secretary, after notice and opportunity for public comment, shall develop and disseminate guidelines for the im-6 7 plementation of this section. The guidelines shall take into 8 account— 9 (1) the technical capabilities of record systems 10 used to maintain protected health information; 11 (2) the costs of security measures; 12 (3) the need for training persons who have access to protected health information; and 13 (4) the value of audit trails in computerized 14 15 record systems. 16 Subpart B—Use and Disclosure of Protected Health 17 Information 18 SEC. 2151. GENERAL LIMITATIONS ON USE AND DISCLO-19 SURE. 20 (a) USE.—Except as otherwise provided under this 21 part, a health information trustee may use protected 22 health information only for a purpose— (1) that is compatible with and directly related 23 24 to the purpose for which the information— 25 (A) was collected; or

1

(B) was received by the trustee; or

2 (2) for which the trustee is authorized to dis-3 close the information under this part.

4 (b) DISCLOSURE.—A health information trustee may
5 disclose protected health information only as authorized
6 under this part.

7 (c) Scope of Uses and Disclosures.—

8 (1) IN GENERAL.—A use or disclosure of pro-9 tected health information by a health information 10 trustee shall be limited, when practicable, to the 11 minimum amount of information necessary to ac-12 complish the purpose for which the information is 13 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 2154 (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 part.

(e) Agreement to Limit Use or Disclosure.— 4 5 A health information trustee who receives protected health information from any person pursuant to a written agree-6 7 ment to restrict use or disclosure of the information to 8 a greater extent than otherwise would be required under 9 this part shall comply with the terms of the agreement, 10 except where use or disclosure of the information in violation of the agreement is required by law. A trustee who 11 12 fails to comply with the preceding sentence shall be subject to section 2191 (relating to civil actions) with respect to 13 such failure. 14

(f) NO GENERAL REQUIREMENT TO DISCLOSE.—
16 Nothing in this part shall be construed to require a health
17 information trustee to disclose protected health informa18 tion not otherwise required to be disclosed by law.

19sec. 2152. Authorizations for disclosure of pro-20Tected 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 individ-

ual who is the subject of the information, if each of the
 following requirements is satisfied:

3 (1) WRITING.—The authorization is in writing,
4 signed by the individual, and dated on the date of
5 such signature.

6 (2) SEPARATE FORM.—The authorization is not
7 on a form used to authorize or facilitate the provi8 sion of, or payment for, health care.

9 (3) TRUSTEE DESCRIBED.—The trustee is spe-10 cifically named or generically described in the au-11 thorization as authorized to disclose such informa-12 tion.

(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.

23 (6) INFORMATION DESCRIBED.—The informa-24 tion to be disclosed is described in the authorization.

(7) AUTHORIZATION TIMELY RECEIVED.—The
 authorization is received by the trustee during a pe riod described in subsection (c)(1).

4 (8) DISCLOSURE TIMELY MADE.—The disclo5 sure occurs during a period described in subsection
6 (c)(2).

7 (b) STATEMENT OF INTENDED USES AND DISCLO-8 SURES.—

(1) IN GENERAL.—A person who wishes to re-9 ceive from a health information trustee protected 10 11 health information about a protected individual pur-12 suant to an authorization executed by the individual shall supply the individual, in writing and on a form 13 14 that is distinct from the authorization, with a statement of the uses for which the person intends the 15 information and the disclosures the person intends 16 17 to make of the information. Such statement shall be 18 supplied before the authorization is executed.

19 (2) ENFORCEMENT.—If the person uses or dis-20 closes the information in a manner that is inconsist-21 ent with such statement, the person shall be subject 22 to section 2191 (relating to civil actions) with re-23 spect to such failure, except where such use or dis-24 closure is required by law.

1	(3) Model statements.—Not later than July
2	1, 1996, the Secretary, after notice and opportunity
3	for public comment, shall develop and disseminate
4	model statements of intended uses and disclosures of
5	the type described in paragraph (1).
6	(c) TIME LIMITATIONS ON AUTHORIZATIONS.—
7	(1) RECEIPT BY TRUSTEE.—For purposes of
8	subsection (a)(7), an authorization is timely received
9	if it is received by the trustee during—
10	(A) the 1-year period beginning on the
11	date that the authorization is signed under sub-
12	section (a)(1), if the authorization permits the
13	disclosure of protected health information to-
14	(i) a health benefit plan sponsor;
15	(ii) a health care provider;
16	(iii) a health oversight agency;
17	(iv) a public health authority;
18	(v) a health researcher; or
19	(vi) a person who provides counseling
20	or social services to individuals; or
21	(B) the 30-day period beginning on the
22	date that the authorization is signed under sub-
23	section (a)(1), if the authorization permits the
24	disclosure of protected health information to a

1	person other than a person described in sub-
2	paragraph (A).
3	(2) DISCLOSURE BY TRUSTEE.—For purposes
4	of subsection (a)(8), a disclosure is timely made if
5	it occurs before—
6	(A) the date or event (if any) specified in
7	the authorization upon which the authorization
8	expires; and
9	(B) the expiration of the 6-month period
10	beginning on the date the trustee receives the
11	authorization.
12	(d) Revocation or Amendment of Authoriza-
13	TION.—
14	(1) IN GENERAL.—A protected individual in
15	writing may revoke or amend an authorization de-
15 16	writing may revoke or amend an authorization de- scribed in subsection (a), in whole or in part, at any
16	scribed in subsection (a), in whole or in part, at any
16 17	scribed in subsection (a), in whole or in part, at any time, except insofar as—
16 17 18	scribed in subsection (a), in whole or in part, at any time, except insofar as— (A) disclosure of protected health informa-
16 17 18 19	scribed in subsection (a), in whole or in part, at any time, except insofar as— (A) disclosure of protected health informa- tion has been authorized to permit validation of
16 17 18 19 20	scribed in subsection (a), in whole or in part, at any time, except insofar as— (A) disclosure of protected health informa- tion has been authorized to permit validation of expenditures based on health condition by a
16 17 18 19 20 21	scribed in subsection (a), in whole or in part, at any time, except insofar as— (A) disclosure of protected health informa- tion has been authorized to permit validation of expenditures based on health condition by a government authority; or
 16 17 18 19 20 21 22 	scribed in subsection (a), in whole or in part, at any time, except insofar as— (A) disclosure of protected health informa- tion 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

1	mation in reliance on an authorization that has been
2	revoked shall not be subject to any liability or pen-
3	alty under this part if—
4	(A) the reliance was in good faith;
5	(B) the trustee had no notice of the rev-
6	ocation; and
7	(C) the disclosure was otherwise in accord-
8	ance with the requirements of this section.
9	(e) Additional Requirements of Trustee.—A
10	health information trustee may impose requirements for
11	an authorization that are in addition to the requirements
12	in this section.
13	(f) COPY.—A health information trustee who dis-
14	closes protected health information pursuant to an author-
15	ization under this section shall maintain a copy of the au-
16	thorization.
17	(g) CONSTRUCTION.—This section may not be con-
18	strued—
19	(1) to require a health information trustee to
20	disclose protected health information; or
21	(2) to limit the right of a health information
22	trustee to charge a fee for the disclosure or repro-
23	duction of protected health information.
24	(h) Subpoenas, Warrants, and Search War-
25	RANTS.—If a health information trustee discloses pro-

tected health information pursuant to an authorization in
 order to comply with an administrative subpoena or war rant or a judicial subpoena or search warrant, the author ization—

5 (1) shall specifically authorize the disclosure for
6 the purpose of permitting the trustee to comply with
7 the subpoena, warrant, or search warrant; and

8 (2) shall otherwise meet the requirements in9 this section.

10 SEC. 2153. TREATMENT, PAYMENT, AND OVERSIGHT.

11 (a) DISCLOSURES BY PLANS, PROVIDERS, AND 12 OVERSIGHT AGENCIES.—A health information trustee de-13 scribed in subsection (d) may disclose protected health in-14 formation to a health benefit plan sponsor, health care 15 provider, or health oversight agency if the disclosure is—

16 (1) for the purpose of providing health care and
17 a protected individual who is a subject of the infor18 mation has not previously objected to the disclosure
19 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

24 (B)(i) of section 2140(b)(7).

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1	(b) Disclosures by Certain Other Trustees.—
2	A health information trustee may disclose protected health
3	information to a health care provider if—
4	(1) the disclosure is for the purpose described
5	in subsection $(a)(1)$; and
6	(2) the trustee—
7	(A) is a public health authority;
8	(B) received protected health information
9	pursuant to section 2157 (relating to emergency
10	circumstances); or
11	(C) is an officer or employee of a trustee
12	described in subsection (B).
13	(c) USE IN ACTION AGAINST INDIVIDUAL.—A person
14	who receives protected health information about a pro-
15	tected individual through a disclosure under this section
16	may not use or disclose the information in any administra-
17	tive, civil, or criminal action or investigation directed
18	against the individual, except an action or investigation
19	arising out of and related to receipt of health care or pay-
20	ment for health care.
21	(d) APPLICABILITY.—A health information trustee
22	referred to in subsection (a) is any of the following:
23	(1) A health benefit plan sponsor.
24	(2) A health care provider.
25	(3) A health oversight agency.

1 (4) A health information service organization. 2 SEC. 2154. NEXT OF KIN AND DIRECTORY INFORMATION. 3 (a) NEXT OF KIN.—A health information trustee who is a health care provider, who received protected health 4 5 information pursuant to section 2157 (relating to emergency circumstances), or who is an officer or employee of 6 7 such a recipient may orally disclose protected health information about a protected individual to the next of kin of 8 the individual (as defined under State law), or to a person 9 with whom the individual has a close personal relationship, 10 if— 11 (1) the trustee has no reason to believe that the 12 individual would consider the information especially 13 14 sensitive: 15 (2) the individual has not previously objected to the disclosure: 16 17 (3) the disclosure is consistent with good medi-18 cal or other professional practice; and 19 (4) the information disclosed is limited to infor-20 mation about health care that is being provided to 21 the individual at or about the time of the disclosure. 22 (b) DIRECTORY INFORMATION.— 23 (1) IN GENERAL.—A health information trustee 24 who is a health care provider, who received protected 25 health information pursuant to section 2157 (relat-

1	ing to emergency circumstances), or who is an offi-
2	cer or employee of a such a recipient may disclose
3	to any person the information described in para-
4	graph (2) if—
5	(A) a protected individual who is a subject
6	of the information has not objected in writing
7	to the disclosure;
8	(B) the disclosure is otherwise consistent
9	with good medical and other professional prac-
10	tice; and
11	(C) the information does not reveal specific
12	information about the physical or mental condi-
13	tion or functional status of a protected individ-
14	ual or about the health care provided to a pro-
15	tected individual.
16	(2) INFORMATION DESCRIBED.—The informa-
17	tion referred to in paragraph (1) is the following:
18	(A) The name of an individual receiving
19	health care from a health care provider on a
20	premises controlled by the provider.
21	(B) The location of the individual on such
22	premises.
23	(C) The general health status of the indi-
24	vidual, described in terms of critical, poor, fair,

stable, satisfactory, or terms denoting similar
 conditions.

3 (c) NO ACCOUNTING REQUIRED.—A health informa-4 tion trustee who discloses protected health information 5 under this section is not required to maintain an account-6 ing of the disclosure under section 2144.

7 (d) RECIPIENTS.—A person to whom protected
8 health information is disclosed under this section shall not,
9 by reason of such disclosure, be subject to any require10 ment under this part.

11 SEC. 2155. 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—

15 (1) a public health authority for use in legallyauthorized—

- 17 (A) disease or injury reporting;
- 18 (B) public health surveillance; or
- 19 (C) public health investigation or interven-
- 20 tion; 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 publichealth 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.

7 (c) INDIVIDUAL RECIPIENTS.—An individual to 8 whom protected health information is disclosed under sub-9 section (a)(2) shall not, by reason of such disclosure, be 10 subject to any requirement under this part.

11 SEC. 2156. HEALTH RESEARCH.

(a) IN GENERAL.—A health information trustee described in subsection (d) may disclose protected health information to a person if—

15 (1) the person is conducting an approved health16 research project;

17 (2) the information is to be used in the project;18 and

19 (3) the project has been determined by a cer-20 tified 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

1 (B) impracticable to conduct without the 2 information.

3 (b) DISCLOSURES BY HEALTH INFORMATION SERV-ICE ORGANIZATIONS.—A health information service orga-4 nization may disclose protected health information under 5 subsection (a) only if the certified institutional review 6 7 board referred to in subsection (a)(3) has been certified as being qualified to make determinations under such sub-8 9 section with respect to disclosures by such organizations. 10 (c) LIMITATIONS ON USE AND DISCLOSURE; OBLIGA-TIONS OF RECIPIENT.—A health researcher who receives 11 protected health information about a protected individual 12

13 pursuant to subsection (a)—

14 (1) may use the information solely for purposes15 of an approved health research project;

16 (2) may not use or disclose the information in
17 any administrative, civil, or criminal action or inves18 tigation 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 re-

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1	tention of such identifiers and there is an adequate
2	plan to protect the identifiers from use and disclo-
3	sure that is inconsistent with this part.
4	(d) APPLICABILITY.—A health information trustee
5	referred to in subsection (a) is any health information
6	trustee other than a person who, with respect to the spe-
7	cific protected health information to be disclosed under
8	such subsection, received the information—
9	(1) pursuant to—
10	(A) section 2158 (relating to judicial and
11	administrative purposes);
12	(B) paragraph (1), (2), or (3) of section
13	2159(a) (relating to law enforcement); or
14	(C) section 2160 (relating to subpoenas,
15	warrants, and search warrants); or
16	(2) while acting in whole or in part in the ca-
17	pacity of an officer or employee of a person de-
18	scribed in paragraph (1).
19	(e) Requirements for Institutional Review
20	Boards.—
21	(1) REGULATIONS.—Not later than July 1,
22	1996, the Secretary, after opportunity for notice and
23	comment, shall promulgate regulations establishing
24	requirements for certified institutional review boards
25	under this part. The regulations shall be based on

1 regulations promulgated under section 491(a) of the 2 Public Health Service Act and shall ensure that cer-3 tified institutional review boards are qualified to as-4 sess and protect the confidentiality of research sub-5 jects. The regulations shall include specific require-6 ments for certified institutional review boards that 7 make determinations under subsection (a)(3) with respect to disclosures by health information service 8 9 organizations.

10 (2) CERTIFICATION.—The Secretary shall cer11 tify that an institutional review board satisfies the
12 requirements of the regulations promulgated under
13 paragraph (1).

14 SEC. 2157. 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 necessary to prevent or lessen a serious and imminent threat
to the health or safety of an individual.

20 (b) USE IN ACTION AGAINST INDIVIDUAL.—A person 21 who receives protected health information about a pro-22 tected individual through a disclosure under this section 23 may not use or disclose the information in any administra-24 tive, civil, or criminal action or investigation directed 25 against the individual, except an action or investigation 407

arising out of and related to receipt of health care or pay ment for health care.

3 SEC. 2158. JUDICIAL AND ADMINISTRATIVE PURPOSES.

4 (a) IN GENERAL.—A health information trustee de5 scribed in subsection (d) may disclose protected health in6 formation—

7 (1) pursuant to the Federal Rules of Civil Pro-8 cedure, the Federal Rules of Criminal Procedure, or 9 comparable rules of other courts or administrative 10 agencies in connection with litigation or proceedings 11 to which a protected individual who is a subject of 12 the information is a party and in which the individual has placed the individual's physical or mental 13 condition or functional status in issue: 14

15 (2) if directed by a court in connection with a16 court-ordered examination of an individual; or

17 (3) to assist in the identification of a dead indi-18 vidual.

(b) WRITTEN STATEMENT.—A person seeking protected health information about a protected individual held
by health information trustee under—

22 (1) subsection (a)(1)—

23 (A) shall notify the protected individual or
24 the attorney of the protected individual of the
25 request for the information;

1	(B) shall provide the trustee with a signed
2	document attesting—
3	(i) that the protected individual is a
4	party to the litigation or proceedings for
5	which the information is sought;
6	(ii) that the individual has placed the
7	individual's physical or mental condition or
8	functional status in issue; and
9	(iii) the date on which the protected
10	individual or the attorney of the protected
11	individual was notified under subparagraph
12	(A); and
13	(C) shall not accept any requested pro-
14	tected health information from the trustee until
15	the termination of the 10-day period beginning
16	on the date notice was given under subpara-
17	graph (A); or
18	(2) subsection (a)(3) shall provide the trustee
19	with a written statement that the information is
20	sought to assist in the identification of a dead indi-
21	vidual.
22	(c) USE AND DISCLOSURE.—A person to whom pro-
23	tected health information is disclosed under this section
24	may use and disclose the information only to accomplish

25 the purpose for which the disclosure was made.

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1	(d) APPLICABILITY.—A health information trustee
2	referred to in subsection (a) is any of the following:
3	(1) A health benefit plan sponsor.
4	(2) A health care provider.
5	(3) A health oversight agency.
6	(4) A person who, with respect to the specific
7	protected health information to be disclosed under
8	such subsection, received the information—
9	(A) pursuant to—
10	(i) section 2157 (relating to emer-
11	gency circumstances); or
12	(ii) section 2160 (relating to subpoe-
13	nas, warrants, and search warrants); or
14	(B) while acting in whole or in part in the
15	capacity of an officer or employee of a person
16	described in subparagraph (A).
17	SEC. 2159. LAW ENFORCEMENT.
18	(a) IN GENERAL.—A health information trustee,
19	other than a health information service organization, may
20	disclose protected health information to a law enforcement
21	agency, other than a health oversight agency—
22	(1) if the information is disclosed for use in an
23	investigation or prosecution of a health information
24	trustee;

1 (2) in connection with criminal activity commit-2 ted against the trustee or an affiliated person of the trustee or on premises controlled by the trustee; or 3 (3) if the information is needed to determine 4 whether a crime has been committed and the nature 5 of any crime that may have been committed (other 6 7 than a crime that may have been committed by the protected individual who is the subject of the infor-8 mation). 9 10 (b) Additional Authority of Certain Trust-EES.—A health information trustee who is not a health 11 information service organization, a public health author-12 ity, or a health researcher may disclose protected health 13 information to a law enforcement agency (other than a 14 15 health oversight agency)— (1) to assist in the identification or location of 16 17 a victim, fugitive, or witness in a law enforcement 18 inquiry; 19 (2) pursuant to a law requiring the reporting of 20 specific health care information to law enforcement 21 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 agen cy requests a health information trustee to disclose pro tected health information under subsection (a) or (b)(1),
 the agency shall provide the trustee with a written certifi cation that—

6 (1) is signed by a supervisory official of a rank
7 designated by the head of the agency;

8 (2) specifies the information requested; and

9 (3) states that the information is needed for a10 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.

1SEC. 2160. SUBPOENAS, WARRANTS, AND SEARCH WAR-2RANTS.

3 (a) IN GENERAL.—A health information trustee de-4 scribed in subsection (g) may disclose protected health in-5 formation if the disclosure is pursuant to any of the fol-6 lowing:

7 (1) A subpoena issued under the authority of a
8 grand jury and the trustee is provided a written cer9 tification by the grand jury that the grand jury has
10 complied with the applicable access provisions of sec11 tion 2171.

(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 complied with the applicable access provisions of section
2171 or 2173(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 2153 through 2159.

(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.—Pro-1 2 tected health information about a protected individual that is disclosed by a health information trustee pursuant to— 3 4 (1) subsection (a)(2) may not be otherwise used 5 or disclosed by the recipient unless the use or disclosure is necessary to fulfill the purpose for which the 6 7 information was obtained; and (2) subsection (a)(3) may not be used or dis-8 9 closed by the recipient unless the recipient complies 10 with the conditions and restrictions on use and disclosure with which the recipient would have been re-11 quired to comply if the disclosure by the trustee had 12 13 been made under the section referred to in subsection (a)(3) the conditions of which were met by 14 the disclosure. 15 (d) RESTRICTIONS ON GRAND JURIES.—Protected 16 health information that is disclosed by a health informa-17 tion trustee under subsection (a)(1)— 18 19 (1) shall be returnable on a date when the 20 grand jury is in session and actually presented to the grand jury; 21 22 (2) shall be used only for the purpose of considering whether to issue an indictment or report by 23

that grand jury, or for the purpose of prosecuting a 25 crime for which that indictment or report is issued,

24

or for a purpose authorized by rule 6(e) of the Fed eral Rules of Criminal Procedure or a comparable
 State rule;

4 (3) shall be destroyed or returned to the trustee
5 if not used for one of the purposes specified in para6 graph (2); and

7 (4) shall not be maintained, or a description of 8 the contents of such information shall not be main-9 tained, by any government authority other than in the sealed records of the grand jury, unless such in-10 11 formation has been used in the prosecution of a 12 crime for which the grand jury issued an indictment 13 or presentment or for a purpose authorized by rule 6(e) of the Federal Rules of Criminal Procedure or 14 15 a comparable State rule.

16 (e) Use in Action Against Individual.—A person who receives protected health information about a pro-17 tected individual through a disclosure under this section 18 may not use or disclose the information in any administra-19 20 tive, civil, or criminal action or investigation directed 21 against the individual, except an action or investigation 22 arising out of and directly related to the inquiry for which 23 the information was obtained:

(f) CONSTRUCTION.—Nothing in this section shall beconstrued 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 part.

4 (g) APPLICABILITY.—A health information trustee
5 referred to in subsection (a) is any trustee other than the
6 following:

7 (1) A health information service organization.

8 (2) A public health authority.

9 (3) A health researcher.

10sec. 2161. Health information service organiza-11tions.

12 A health information trustee may disclose protected 13 health information to a health information service organi-14 zation for the purpose of permitting the organization to 15 perform a function for which the Secretary has authorized 16 (by means of a designation or certification) the organiza-17 tion to receive access to health care data in electronic or 18 magnetic form that are regulated by this Act.

Subpart C—Access Procedures and Challenge Rights
 SEC. 2171. ACCESS PROCEDURES FOR LAW ENFORCEMENT
 SUBPOENAS, WARRANTS, AND SEARCH WAR-

22 RANTS.

(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about a protected individual from a health informa-

1 tion trustee under paragraph (1) or (2) of section 2160(a)
2 for use in a law enforcement inquiry unless there is prob3 able cause to believe that the information is relevant to
4 a legitimate law enforcement inquiry being conducted by
5 the government authority.

6 (b) WARRANTS AND SEARCH WARRANTS.—A govern-7 ment authority that obtains protected health information 8 about a protected individual from a health information 9 trustee under circumstances described in subsection (a) 10 and pursuant to a warrant or search warrant shall, not later than 30 days after the date the warrant was served 11 on the trustee, serve the individual with, or mail to the 12 last known address of the individual, a copy of the 13 14 warrant.

15 (c) SUBPOENAS.—Except as provided in subsection (d), a government authority may not obtain protected 16 health information about a protected individual from a 17 health information trustee under circumstances described 18 in subsection (a) and pursuant to a subpoena unless a 19 20 copy of the subpoena has been served by hand delivery upon the individual, or mailed to the last known address 21 22 of the individual, on or before the date on which the subpoena was served on the trustee, together with a notice 23 24 (published by the Secretary under section 2175(1)) of the individual's right to challenge the subpoena in accordance
 with section 2172, and—

3 (1) 30 days have passed from the date of serv4 ice, or 30 days have passed from the date of mailing,
5 and within such time period the individual has not
6 initiated a challenge in accordance with section
7 2172; or

8 (2) disclosure is ordered by a court under sec-9 tion 2172.

10 (d) Application for Delay.—

11 (1) IN GENERAL.—A government authority may 12 apply to an appropriate court to delay (for an initial 13 period of not longer than 90 days) serving a copy of 14 a subpoena and a notice otherwise required under 15 subsection (c) with respect to a law enforcement in-16 quiry. The government authority may apply to the 17 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,

1	the protected health information being sought if the
2	court finds that—
3	(A) the inquiry being conducted is within
4	the lawful jurisdiction of the government au-
5	thority seeking the protected health informa-
6	tion;
7	(B) there is probable cause to believe that
8	the protected health information being sought is
9	relevant to a legitimate law enforcement inquiry
10	being conducted by the government authority;
11	(C) the government authority's need for
12	the information outweighs the privacy interest
13	of the protected individual who is the subject of
14	the information; and
15	(D) there are reasonable grounds to believe
16	that receipt of a notice by the individual will re-
17	sult in—
18	(i) endangering the life or physical
19	safety of any individual;
20	(ii) flight from prosecution;
21	(iii) destruction of or tampering with
22	evidence or the information being sought;
23	or
24	(iv) intimidation of potential wit-
25	nesses.

1 (4) SERVICE OF APPLICATION ON INDIVID-2 UAL.—Upon the expiration of a period of delay of 3 notice under this subsection, the government author-4 ity shall serve upon the individual, with the service 5 of the subpoena and the notice, a copy of any appli-6 cations filed and approved under this subsection.

7 SEC. 2172. CHALLENGE PROCEDURES FOR LAW ENFORCE 8 MENT SUBPOENAS.

9 (a) MOTION TO QUASH SUBPOENA.—Within 30 days of the date of service, or 30 days of the date of mailing, 10 of a subpoena of a government authority seeking protected 11 health information about a protected individual from a 12 13 health information trustee under paragraph (1) or (2) of section 2160(a) (except a subpoena to which section 2173) 14 15 applies), the individual may file (without filing fee) a motion to quash the subpoena— 16

17 (1) in the case of a State judicial subpoena, in18 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

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1	(4) in the case of any other subpoena issued
2	under the authority of the United States, in—
3	(A) the United States district court for the
4	district in which the individual resides or in
5	which the subpoena was issued; or
6	(B) another United States district court of
7	competent jurisdiction.
8	(b) COPY.—A copy of the motion shall be served by
9	the individual upon the government authority by delivery
10	of registered or certified mail.
11	(c) Affidavits and Sworn Documents.—The gov-
12	ernment authority may file with the court such affidavits
13	and other sworn documents as sustain the validity of the
14	subpoena. The individual may file with the court, within
15	5 days of the date of the authority's filing, affidavits and
16	sworn documents in response to the authority's filing. The
17	court, upon the request of the individual, the government
18	authority, or both, may proceed in camera.
19	(d) PROCEEDINGS AND DECISION ON MOTION.—The
20	court may conduct such proceedings as it deems appro-
21	priate to rule on the motion. All such proceedings shall
22	be completed, and the motion ruled on, within 10 calendar

days of the date of the government authority's filing. 23

24 (e) EXTENSION OF TIME LIMITS FOR GOOD 25 CAUSE.—The court, for good cause shown, may at any 421

time in its discretion enlarge the time limits established
 by subsections (c) and (d).

(f) STANDARD FOR DECISION.—A court may deny a 3 4 motion under subsection (a) if it finds that there is prob-5 able cause to believe that the protected health information being sought is relevant to a legitimate law enforcement 6 inquiry being conducted by the government authority, un-7 8 less the court finds that the individual's privacy interest 9 outweighs the government authority's need for the information. The individual shall have the burden of dem-10 onstrating that the individual's privacy interest outweighs 11 the need established by the government authority for the 12 information. 13

(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 infor-mation was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy
of the individual;

24 (3) the effect of the disclosure on the individ-25 ual's future health care;

(4) the importance of the inquiry being con ducted by the government authority, and the impor tance of the information to that inquiry; and

4 (5) any other factor deemed relevant by the 5 court.

6 (h) ATTORNEY'S FEES.—In the case of any motion 7 brought under subsection (a) in which the individual has 8 substantially prevailed, the court, in its discretion, may as-9 sess against a government authority a reasonable attor-10 ney's fee and other litigation costs (including expert fees) 11 reasonably incurred.

12 (i) NO INTERLOCUTORY APPEAL.—A court ruling denying a motion to quash under this section shall not be 13 deemed a final order and no interlocutory appeal may be 14 taken therefrom by the individual. An appeal of such a 15 ruling may be taken by the individual within such period 16 of time as is provided by law as part of any appeal from 17 a final order in any legal proceeding initiated against the 18 individual arising out of or based upon the protected 19 20health information disclosed.

21 SEC. 2173. ACCESS AND CHALLENGE PROCEDURES FOR
22 OTHER SUBPOENAS.

(a) IN GENERAL.—A person (other than a government authority seeking protected health information under
circumstances described in section 2171(a)) may not ob-

1 tain protected health information about a protected indi2 vidual from a health information trustee pursuant to a
3 subpoena under section 2160(a)(2) unless—

(1) a copy of the subpoena has been served 4 upon the individual or mailed to the last known ad-5 6 dress of the individual on or before the date on 7 which the subpoena was served on the trustee, to-8 gether with a notice (published by the Secretary 9 under section 2175(2)) of the individual's right to challenge the subpoena, in accordance with sub-10 11 section (b); and

12 (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 individual has not initiated a challenge in accordance with subsection (b); or

18 (B) disclosure is ordered by a court under19 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 infor mation.

6 (c) STANDARD FOR DECISION.—The court shall 7 grant an individual's motion under subsection (b) if the 8 person seeking the information has not sustained the bur-9 den 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 informationoutweighs 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—

20 (1) the particular purpose for which the infor-21 mation was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy
of the individual;

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(3) the effect of the disclosure on the individ ual's future health care;

3 (4) the importance of the information to the4 lawsuit or proceeding; and

5 (5) any other factor deemed relevant by the 6 court.

7 (e) ATTORNEY'S FEES.—In the case of any motion 8 brought under subsection (b) by an individual against a 9 person in which the individual has substantially prevailed, 10 the court, in its discretion, may assess against the person 11 a reasonable attorney's fee and other litigation costs (in-12 cluding expert fees) reasonably incurred.

13 SEC. 2174. CONSTRUCTION OF SUBPART; SUSPENSION OF 14 STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Nothing in this subpart shall affect the right of a health information trustee to challenge
a request for protected health information. Nothing in this
subpart shall entitle a protected individual to assert the
rights of a health information trustee.

20 (b) EFFECT OF MOTION ON STATUTE OF LIMITA-21 TIONS.—If an individual who is the subject of protected 22 health information files a motion under this subpart which 23 has the effect of delaying the access of a government au-24 thority to such information, the period beginning on the 25 date such motion was filed and ending on the date on

which the motion is decided shall be excluded in computing 1 any period of limitations within which the government au-2 3 thority may commence any civil or criminal action in con-4 nection with which the access is sought.

5 SEC. 2175. RESPONSIBILITIES OF SECRETARY.

Not later than July 1, 1996, the Secretary, after no-6 tice and opportunity for public comment, shall develop and 7 disseminate brief, clear, and easily understood model 8 notices— 9

10 (1) for use under subsection (c) of section 11 2171, detailing the rights of a protected individual 12 who wishes to challenge, under section 2172, the dis-13 closure of protected health information about the individual under such subsection: and 14

15 (2) for use under subsection (a) of section 16 2173, detailing the rights of a protected individual 17 who wishes to challenge, under subsection (b) of 18 such section, the disclosure of protected health infor-19 mation about the individual under such section.

Subpart D—Miscellaneous Provisions 21 SEC. 2181. PAYMENT CARD AND ELECTRONIC PAYMENT 22 TRANSACTIONS.

23 (a) PAYMENT FOR HEALTH CARE THROUGH CARD OR ELECTRONIC MEANS.—If a protected individual pays 24 25 a health information trustee for health care by presenting

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a debit, credit, or other payment card or account number, 1 or by any other electronic payment means, the trustee may 2 3 disclose to a person described in subsection (b) only such 4 protected health information about the individual as is necessary for the processing of the payment transaction 5 or the billing or collection of amounts charged to, debited 6 7 from, or otherwise paid by, the individual using the card, 8 number, or other electronic payment means.

9 (b) TRANSACTION PROCESSING.—A person who is a 10 debit, credit, or other payment card issuer, is otherwise directly involved in the processing of payment transactions 11 involving such cards or other electronic payment trans-12 13 actions, or is otherwise directly involved in the billing or collection of amounts paid through such means, may only 14 15 use or disclose protected health information about a protected individual that has been disclosed in accordance 16 with subsection (a) when necessary for— 17

(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;

23 (2) the transfer of receivables, accounts, or in-24 terest therein;

(3) the audit of the credit, debit, or other pay ment card account information;

3 (4) compliance with Federal, State, or local law;
4 or

5 (5) a properly authorized civil, criminal, or reg6 ulatory investigation by Federal, State, or local
7 authorities.

8 SEC. 2182. ACCESS TO PROTECTED HEALTH INFORMATION 9 OUTSIDE OF THE UNITED STATES.

10 (a) IN GENERAL.—Notwithstanding the provisions of 11 subpart B, and except as provided in subsection (b), a 12 health information trustee may not permit any person who 13 is not in a State to have access to protected health infor-14 mation about a protected individual unless one or more 15 of the following conditions exist:

16 (1) SPECIFIC AUTHORIZATION.—The individual
17 has specifically consented to the provision of such
18 access outside of the United States in an authoriza19 tion that meets the requirements of section 2152.

20 (2) EQUIVALENT PROTECTION.—The provision 21 of such access is authorized under this part and the 22 Secretary has determined that there are fair infor-23 mation practices for protected health information in 24 the jurisdiction where the access will be provided 25 that provide protections for individuals and pro-

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1	tected health information that are equivalent to the
2	protections provided for by this part.
3	(3) Access required by LAW.—The provision
4	of such access is required under—
5	(A) a Federal statute; or
6	(B) a treaty or other international agree-
7	ment applicable to the United States.
8	(b) EXCEPTIONS.—Subsection (a) does not apply
9	where the provision of access to protected health informa-
10	tion—
11	(1) is to a foreign public health authority;
12	(2) is authorized under section 2154 (relating
13	to next of kin and directory information), 2156 (re-
14	lating to health research), or 2157 (relating to emer-
15	gency circumstances); or
16	(3) is necessary for the purpose of providing for
17	payment for health care that has been provided to
18	an individual.
19	SEC. 2183. STANDARDS FOR ELECTRONIC DOCUMENTS AND
20	COMMUNICATIONS.
21	(a) STANDARDS.—Not later than July 1, 1996, the
22	Secretary, after notice and opportunity for public com-
23	ment and in consultation with appropriate private stand-
24	ard-setting organizations and other interested parties,
25	shall establish standards with respect to the creation,

1 transmission, receipt, and maintenance, in electronic and 2 magnetic form, of each type of written document specifi-3 cally required or authorized under this part. Where a sig-4 nature is required under any other provision of this part, 5 such standards shall provide for an electronic or magnetic 6 substitute that serves the functional equivalent of a signa-7 ture.

8 (b) TREATMENT OF COMPLYING DOCUMENTS AND 9 COMMUNICATIONS.—An electronic or magnetic document 10 or communication that satisfies the standards established 11 under subsection (a) with respect to such document or 12 communication shall be treated as satisfying the require-13 ments of this part that apply to an equivalent written 14 document.

15 SEC. 2184. DUTIES AND AUTHORITIES OF AFFILIATED 16 PERSONS.

17 (a) REQUIREMENTS ON TRUSTEES.—

18 (1) PROVISION OF INFORMATION.—A health in-19 formation trustee may provide protected health in-20 formation to a person who, with respect to the trust-21 ee, is an affiliated person and may permit the affili-22 ated person to use such information, only for the 23 purpose of conducting, supporting, or facilitating an 24 activity that the trustee is authorized to undertake.

1	(2) NOTICE TO AFFILIATED PERSON.—A health
2	information trustee shall notify a person who, with
3	respect to the trustee, is an affiliated person of any
4	duties under this part that the affiliated person is
5	required to fulfill and of any authorities under this
6	part that the affiliated person is authorized to
7	exercise.
8	(b) DUTIES OF AFFILIATED PERSONS.—
9	(1) IN GENERAL.—An affiliated person shall
10	fulfill any duty under this part that—
11	(A) the health information trustee with
12	whom the person has an agreement or relation-
13	ship described in section $2140(c)(1)(C)$ is re-
14	quired to fulfill; and
15	(B) the person has undertaken to fulfill
16	pursuant to such agreement or relationship.
17	(2) Construction of other subparts.—
18	With respect to a duty described in paragraph (1)
19	that an affiliated person is required to fulfill, the
20	person shall be considered a health information
21	trustee for purposes of this part. The person shall
22	be subject to subpart E (relating to enforcement)
23	with respect to any such duty that the person fails
24	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 part.

5 (b) AUTHORITIES OF AFFILIATED PERSONS.—

6 (1) IN GENERAL.—An affiliated person may 7 only exercise an authority under this part that the 8 health information trustee with whom the person is 9 affiliated may exercise and that the person has been 10 given by the trustee pursuant to an agreement or re-11 lationship described in section 2140(c)(1)(C). With 12 respect to any such authority, the person shall be 13 considered a health information trustee for purposes 14 of this part. The person shall be subject to subpart 15 E (relating to enforcement) with respect to any act 16 that exceeds such authority.

17 (2) EFFECT ON TRUSTEE.—An agreement or
18 relationship with an affiliated person does not affect
19 the authority of a health information trustee under
20 this part.

21 SEC. 2185. 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 exer cise the rights of the individual or estate, may, to the ex tent authorized, exercise and discharge the rights of the
 individual or estate under this part.

6 (b) HEALTH CARE POWER OF ATTORNEY.—A person 7 who is authorized by law (on grounds other than an indi-8 vidual's minority), or by an instrument recognized under 9 law, to make decisions about the provision of health care 10 to an individual who is incapacitated may exercise and discharge the rights of the individual under this part to the 11 extent necessary to effectuate the terms or purposes of 12 the grant of authority. 13

14 (c) NO COURT DECLARATION.—If a health care pro-15 vider determines that an individual, who has not been declared to be legally incompetent, suffers from a medical 16 condition that prevents the individual from acting know-17 ingly or effectively on the individual's own behalf, the right 18 of the individual to authorize disclosure under section 19 2152 may be exercised and discharged in the best interest 20 of the individual by— 21

(1) a person described in subsection (b) with re-spect to the individual;

24 (2) a person described in subsection (a) with re25 spect to the individual, but only if a person de-

scribed in paragraph (1) cannot be contacted after 1 2 a reasonable effort: (3) the next of kin of the individual, but only 3 4 if a person described in paragraph (1) or (2) cannot be contacted after a reasonable effort; or 5 (4) the health care provider, but only if a per-6 7 son described in paragraph (1), (2), or (3) cannot be 8 contacted after a reasonable effort. 9 SEC. 2186. MINORS. 10 (a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPA-BLE.—In the case of an individual— 11 (1) who is 18 years of age or older, all rights 12 13 of the individual shall be exercised by the individual, 14 except as provided in section 2185; or (2) who, acting alone, has the legal capacity to 15 16 apply for and obtain health care and has sought 17 such care, the individual shall exercise all rights of 18 an individual under this part with respect to pro-19 tected health information relating to such care. 20 (b) INDIVIDUALS UNDER 18.—Except as provided in 21 subsection (a)(2), in the case of an individual who is— 22 (1) under 14 years of age, all the individual's rights under this part shall be exercised through the 23 24 parent or legal guardian of the individual; or

1 (2) 14, 15, 16, or 17 years of age, the right of 2 inspection (under section 2141), the right of amend-3 ment (under section 2142), and the right to author-4 ize disclosure of protected health information (under 5 section 2152) of the individual may be exercised 6 either by the individual or by the parent or legal 7 guardian of the individual.

8 SEC. 2187. MAINTENANCE OF CERTAIN PROTECTED 9 HEALTH INFORMATION.

(a) IN GENERAL.—A State shall establish a process 10 under which the protected health information described in 11 subsection (b) that is maintained by a person described 12 in subsection (c) is delivered to, and maintained by, the 13 State or an individual or entity designated by the State. 14 15 (b) INFORMATION DESCRIBED.—The protected health information referred to in subsection (a) is pro-16 tected health information that— 17

18 (1) is recorded in any form or medium;

- 19 (2) is created by—
- 20 (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

1	(3) relates in any way to the past, present, or
2	future physical or mental health or condition or
3	functional status of a protected individual or the
4	provision of health care to a protected individual.
5	(c) PERSONS DESCRIBED.—A person referred to in
6	subsection (a) is any of the following:
7	(A) A health care facility previously located
8	in the State that has closed.
9	(B) A professional practice previously op-
10	erated by a health care provider in the State
11	that has closed.
12	(C) A health benefit plan sponsor that—
13	(i) previously provided benefits in the
14	form of items and services to enrollees in
15	the State; and
16	(ii) has ceased to do business.
17	Subpart E—Enforcement
18	SEC. 2191. CIVIL ACTIONS.
19	(a) IN GENERAL.—Any individual whose right under
20	this part has been knowingly or negligently violated—
21	(1) by a health information trustee, or any
22	other person, who is not described in paragraph (2),
23	(3), (4), or (5) may maintain a civil action for actual
24	damages and for equitable relief against the health
25	information trustee or other person;

1 (2) by an officer or employee of the United 2 States while the officer or employee was acting with-3 in the scope of the office or employment may main-4 tain a civil action for actual damages and for equi-5 table relief against the United States;

6 (3) by an officer or employee of any government 7 authority of a State that has waived its sovereign 8 immunity to a claim for damages resulting from a 9 violation of this part while the officer or employee 10 was acting within the scope of the office or employ-11 ment may maintain a civil action for actual damages 12 and for equitable relief against the State govern-13 ment:

(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 part (other than
 subsection (c) or (d) of section 2151) shall be entitled to
 recover the amount of the actual damages demonstrated
 or \$5000, whichever is greater.

5 (c) ACTUAL DAMAGES.—For purposes of this section, 6 the term "actual damages" includes damages paid to com-7 pensate an individual for nonpecuniary losses such as 8 physical and mental injury as well as damages paid to 9 compensate for pecuniary losses.

10 (d) PUNITIVE DAMAGES; ATTORNEY'S FEES.—In any action brought under this section in which the com-11 plainant has prevailed because of a knowing violation of 12 a provision of this part (other than subsection (c) or (d) 13 of section 2151), the court may, in addition to any relief 14 15 awarded under subsections (a) and (b), award such punitive damages as may be warranted. In such an action, the 16 17 court, in its discretion, may allow the prevailing party a reasonable attorney's fee (including expert fees) as part 18 of the costs, and the United States shall be liable for costs 19 the same as a private person. 20

(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 rea-

sonable opportunity to discover the violation, whichever oc curs first.

3 (f) INSPECTION AND AMENDMENT.—If a health in-4 formation trustee has established a formal internal proce-5 dure that allows an individual who has been denied inspec-6 tion or amendment of protected health information to ap-7 peal the denial, the individual may not maintain a civil 8 action in connection with the denial until the earlier of—

9 (1) the date the appeal procedure has been ex-10 hausted; or

11 (2) the date that is 4 months after the date onwhich 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 part and not otherwise
prohibited by State or Federal statute shall not be liable
to the individual for the disclosure under common law.

19 (h) NO LIABILITY FOR INSTITUTIONAL REVIEW 20 BOARD DETERMINATIONS.—If the members of a certified 21 institutional review board have in good faith determined 22 that an approved health research project is of sufficient 23 importance so as to outweigh the intrusion into the privacy 24 of an individual pursuant to section 2156(a)(1), the mem-25 bers, the board, and the parent institution of the board shall not be liable to the individual as a result of such
 determination.

3 (i) GOOD FAITH RELIANCE ON CERTIFICATION.—A 4 health information trustee who relies in good faith on a 5 certification by a government authority or other person 6 and discloses protected health information about an indi-7 vidual in accordance with this part shall not be liable to 8 the individual for such disclosure.

9 SEC. 2192. CIVIL MONEY PENALTIES.

(a) VIOLATION.—Any health information trustee who 10 the Secretary determines has demonstrated a pattern or 11 practice of failure to comply with the provisions of this 12 part shall be subject, in addition to any other penalties 13 that may be prescribed by law, to a civil money penalty 14 15 of not more than \$10,000 for each such failure. In determining the amount of any penalty to be assessed under 16 the procedures established under subsection (b), the Sec-17 retary shall take into account the previous record of com-18 pliance of the person being assessed with the applicable 19 requirements of this part and the gravity of the violation. 20

(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.

3 SEC. 2193. ALTERNATIVE DISPUTE RESOLUTION.

4 (a) IN GENERAL.—Not later than July 1, 1996, the 5 Secretary shall, by regulation, develop alternative dispute 6 resolution methods for use by individuals, health informa-7 tion trustees, and other persons in resolving claims under 8 section 2191.

9 (b) EFFECT ON INITIATION OF CIVIL ACTIONS.—

10 (1) IN GENERAL.—Subject to paragraph (2), 11 the regulations established under subsection (a) may 12 provide that an individual alleging that a right of the individual under this part has been violated shall 13 14 pursue at least one alternative dispute resolution method developed under such subsection as a condi-15 tion precedent to commencing a civil action under 16 17 section 2191.

(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.

23 (3) SUSPENSION OF STATUTE OF LIMITA24 TIONS.—The regulations established by the Sec25 retary under subsection (a) may provide that a pe-

1	riod in which an individual described in paragraph
2	(1) pursues (as defined by the Secretary) an alter-
3	native dispute resolution method under this section
4	shall be excluded in computing the period of limita-
5	tions under section 2191(e).
6	(c) Methods.—The methods under subsection (a)
7	shall include at least the following:
8	(1) ARBITRATION.—The use of arbitration.
9	(2) MEDIATION.—The use of mediation.
10	(3) EARLY OFFERS OF SETTLEMENT.—The use
11	of a process under which parties make early offers
12	of settlement.
13	(d) Standards for Establishing Methods.—In
14	developing alternative dispute resolution methods under
15	subsection (a), the Secretary shall ensure that the meth-
16	ods promote the resolution of claims in a manner that—
17	(1) is affordable for the parties involved;
18	(2) provides for timely and fair resolution of
19	claims; and
20	(3) provides for reasonably convenient access to
21	dispute resolution for individuals.
22	SEC. 2194. AMENDMENTS TO CRIMINAL LAW.
23	(a) IN GENERAL.—Title 18, United States Code, is
24	amended by inserting after chapter 89 the following:

"CHAPTER 90—PROTECTED HEALTH

INFORMATION

"Sec.

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- "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.

3 **"§1831. Definitions**

"As used in this chapter— 4 5 "(1) the term 'health information trustee' has 6 the meaning given such term in section 2140(b)(6)7 of the Affordable Health Care Now Act of 1994: "(2) the term 'protected health information' has 8 9 the meaning given such term in section 2140(a)(3)10 of such Act: and 11 "(3) the term 'protected individual' has the 12 meaning given such term in section 2140(a)(4) of 13 such Act. 14 **"§1832. Obtaining protected health information** 15 under false pretenses "Whoever under false pretenses— 16 "(1) requests or obtains protected health infor-17 18 mation from a health information trustee; or "(2) obtains from a protected individual an au-19 20 thorization for the disclosure of protected health in-

formation about the individual maintained by a
 health information trustee;

3 shall be fined under this title or imprisoned not more than4 5 years, or both.

5 "§1833. Monetary gain from obtaining protected
health information under false pretenses
7 "Whoever under false pretenses—

8 "(1) requests or obtains protected health infor-9 mation from a health information trustee with the 10 intent to sell, transfer, or use such information for 11 profit or monetary gain; or

12 "(2) obtains from a protected individual an au-13 thorization for the disclosure of protected health in-14 formation about the individual maintained by a 15 health information trustee with the intent to sell, 16 transfer, or use such authorization for profit or 17 monetary gain;

and knowingly sells, transfers, or uses such informationor authorization for profit or monetary gain shall be finedunder this title or imprisoned not more than 10 years, orboth.

22 "§1834. Knowing and unlawful obtaining of pro23 tected health information

24 "Whoever knowingly obtains protected health infor-25 mation from a health information trustee in violation of

part 2 of subtitle B of title II of the Affordable Health
 Care Now Act of 1994, knowing that such obtaining is
 unlawful, shall be fined under this title or imprisoned not
 more than 5 years, or both.

5 "§1835. Monetary gain from knowing and unlawful obtaining of protected health information

"Whoever knowingly—

8 "(1) obtains protected health information from 9 a health information trustee in violation of part 2 of subtitle B of title II of the Affordable Health Care 10 11 Now Act of 1994, knowing that such obtaining is unlawful and with the intent to sell, transfer, or use 12 13 such information for profit or monetary gain; and 14 "(2) knowingly sells, transfers, or uses such in-15 formation for profit or monetary gain;

16 shall be fined under this title or imprisoned not more than17 10 years, or both.

18 **"§1836.** Knowing and unlawful use or disclosure of

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protected health information

"Whoever knowingly uses or discloses protected
health information in violation of part 2 of subtitle B of
title II of the Affordable Health Care Now 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.

1	"§1837. Monetary gain from knowing and unlawful
2	sale, transfer, or use of protected health
3	information
4	"Whoever knowingly sells, transfers, or uses pro-
5	tected health information in violation of part 2 of subtitle
6	B of title II of the Affordable Health Care Now Act of

7 1994, knowing that such sale, transfer, or use is unlawful,8 shall be fined under this title or imprisoned not more than9 10 years, or both.".

10 (b) CLERICAL AMENDMENT.—The table of chapters 11 for part I of title 18, United States Code, is amended by 12 inserting after the item relating to chapter 89 the 13 following:

"90. Protected health information 1831".

14 Subpart F—Amendments to Title 5, United States

15

Code

16SEC. 2195. AMENDMENTS TO TITLE 5, UNITED STATES17CODE.

18 (a) NEW SUBSECTION.—Section 552a of title 5,
19 United States Code, is amended by adding at the end the
20 following:

21 "(w) MEDICAL EXEMPTIONS.—The head of an agen-22 cy that is a health information trustee (as defined in sec-23 tion 2140(b)(6) of the Affordable Health Care Now Act 24 of 1994) shall promulgate rules, in accordance with the 25 requirements (including general notice) of subsections

(b)(1), (b)(2), (b)(3), (c), and (e) of section 553 of this 1 title, to exempt a system of records within the agency, to 2 the extent that the system of records contains protected 3 4 health information (as defined in section 2140(a)(3) of 5 such Act), from all provisions of this section except subsections (e)(1), (e)(2), subparagraphs (A) through (C) and 6 7 (E) through (I) of subsection (e)(4), and subsections (e)(5), (e)(6), (e)(9), (e)(12), (l), (n), (o), (p), (q), (r), and8 (u).". 9

(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;".

Subpart G—Regulations, Research, and Education;
 Effective Dates; Applicability; and Relationship
 to Other Laws

17 SEC. 2196. REGULATIONS; RESEARCH AND EDUCATION.

(a) REGULATIONS.—Not later than July 1, 1996, theSecretary shall prescribe regulations to carry out this part.

20 (b) RESEARCH AND TECHNICAL SUPPORT.—The21 Secretary may sponsor—

(1) research relating to the privacy and securityof protected health information;

24 (2) the development of consent forms governing25 disclosure of such information; and

(3) the development of technology to implement 1 2 standards regarding such information. 3 (c) EDUCATION.—The Secretary shall establish education and awareness programs— 4 5 (1) to foster adequate security practices by 6 health information trustees: 7 (2) to train personnel of health information trustees respecting the duties of such personnel with 8 9 respect to protected health information; and 10 (3) to inform individuals and employers who 11 purchase health care respecting their rights with respect to such information. 12 13 SEC. 2197. EFFECTIVE DATES. 14 (a) IN GENERAL.—Except as provided in subsection (b), this part, and the amendments made by this part, 15 shall take effect on January 1, 1997. 16 17 (b) PROVISIONS EFFECTIVE IMMEDIATELY.—A provision of this part shall take effect on the date of the en-18 actment of this Act if the provision— 19 (1) imposes a duty on the Secretary to develop, 20 21 establish, or promulgate regulations, guidelines, no-22 tices, statements, or education and awareness pro-23 grams; or 24 (2) authorizes the Secretary to sponsor research or the development of forms or technology. 25

1 SEC. 2198. APPLICABILITY.

(a) PROTECTED HEALTH INFORMATION.—Except as
provided in subsections (b) and (c), the provisions of this
part 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 January
1, 1997, regardless of whether the information existed or
was disclosed prior to such date.

9 (b) EXCEPTION.—

10 (1) IN GENERAL.—The provisions of this part 11 shall not apply to a trustee described in paragraph 12 (2), except with respect to protected health informa-13 tion that is received by the trustee on or after Janu-14 ary 1, 1997.

15 (2) APPLICABILITY.—A trustee referred to in
16 paragraph (1) is—

(A) a health researcher; or

(B) a person who, with respect to specific
protected health information, received the information—

21 (i) pursuant to—
22 (I) section 2157 (relating to
23 emergency circumstances);
24 (II) section 2158 (relating to ju25 dicial and administrative purposes);

Title II, Subtitle B

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1	(III) section 2159 (relating to
2	law enforcement); or
3	(IV) section 2160 (relating to
4	subpoenas, warrants, and search war-
5	rants); or
6	(ii) while acting in whole or in part in
7	the capacity of an officer or employee of a
8	person described in clause (i).
9	(c) AUTHORIZATIONS FOR DISCLOSURES.—An au-

10 thorization for the disclosure of protected health informa-11 tion about a protected individual that is executed by the 12 individual before January 1, 1997, and is recognized and 13 valid under State law on December 31, 1996, shall remain 14 valid and shall not be subject to the requirements of sec-15 tion 2152 until January 1, 1998, or the occurrence of the 16 date or event (if any) specified in the authorization upon 17 which the authorization expires, whichever occurs earlier.

18 SEC. 2199. 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 part.

(2) An authority of a health information trustee
 under this part to disclose protected health informa tion.

4 (3) A provision of subpart C (relating to access
5 procedures and challenge rights), subpart D (mis6 cellaneous provisions), or subpart (E) (relating to
7 enforcement).

8 (b) LAWS RELATING TO PUBLIC HEALTH AND MEN-9 TAL HEALTH.—This part does not preempt, supersede, or 10 modify the operation of any State law regarding public 11 health or mental health to the extent that the law prohibits 12 or regulates a disclosure of protected health information 13 that is permitted under this part.

14 (c) CRIMINAL PENALTIES.—A State may establish
15 and enforce criminal penalties with respect to a failure to
16 comply with a provision of this part.

17 (d) PRIVILEGES.—A privilege that a person has 18 under law in a court of a State or the United States or 19 under the rules of any agency of a State or the United 20 States may not be diminished, waived, or otherwise af-21 fected by—

(1) the execution by a protected individual of an
authorization for disclosure of protected health information under this part, if the authorization is ex-

ecuted for the purpose of receiving health care or
 providing for the payment for health care; or

3 (2) any provision of this part that authorizes
4 the disclosure of protected health information for the
5 purpose of receiving health care or providing for the
6 payment for health care.

7 (e) DEPARTMENT OF VETERANS AFFAIRS.—The limitations on use and disclosure of protected health informa-8 9 tion under this part shall not be construed to prevent any 10 exchange of such information within and among components of the Department of Veterans Affairs that deter-11 mine eligibility for or entitlement to, or that provide, bene-12 fits under laws administered by the Secretary of Veterans 13 Affairs. 14

(f) CERTAIN DUTIES UNDER STATE OR FEDERAL
LAW.—This part shall not be construed to preempt, supersede, or modify the operation of any of the following:

(1) Any law that provides for the reporting ofvital statistics such as birth or death information.

20 (2) Any law requiring the reporting of abuse or21 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).

1 (4) The Americans with Disabilities Act of 2 1990.

3 (5) Any Federal or State statute that estab4 lishes a privilege for records used in health profes5 sional peer review activities.

6 (g) SECRETARIAL AUTHORITY.—

7 (1) Secretary of health and human serv-8 ICES.—A provision of this part does not preempt, 9 supersede, or modify the operation of section 543 of 10 the Public Health Service Act, except to the extent 11 that the Secretary of Health and Human Services determines through regulations promulgated by such 12 13 Secretary that the provision provides greater protec-14 tion for protected health information, and the rights 15 of protected individuals, than is provided under such section 543. 16

17 (2) SECRETARY OF VETERANS AFFAIRS.—A 18 provision of this part does not preempt, supersede, 19 or modify the operation of section 7332 of title 38, 20 United States Code, except to the extent that the Secretary of Veterans Affairs determines through 21 22 regulations promulgated by such Secretary that the 23 provision provides greater protection for protected 24 health information, and the rights of protected indi-25 viduals, than is provided under such section 7332.

Subtitle C—Deduction for Cost of Catastrophic Health Plan; Medi cal Savings Accounts

4 SEC. 2201. INDIVIDUALS ALLOWED DEDUCTION FROM
5 GROSS INCOME FOR COST OF CATASTROPHIC
6 HEALTH PLAN.

7 (a) IN GENERAL.—Subsection (a) of section 62 of the
8 Internal Revenue Code of 1986, as amended by title I,
9 is amended by inserting after paragraph (16) the following
10 new paragraph:

11 "(17) MEDICAL EXPENSES ATTRIBUTABLE TO
12 CATASTROPHIC HEALTH PLAN COVERAGE.—

"(A) IN GENERAL.—The deduction allowed
by section 213 to the extent attributable to coverage under a catastrophic health plan (as defined in section 220(c)(2)).

17 ''(B) EXCEPTION.—Subparagraph (A)
18 shall not apply to coverage of an individual who
19 has coverage described in section
20 220(c)(1)(B)(i).''.

(b) COORDINATION WITH DEDUCTION FOR OTHER
MEDICAL EXPENSES.—Subsection (a) of section 213 of
such Code is amended to read as follows:

24 "(a) ALLOWANCE OF DEDUCTION.—There shall be25 allowed as a deduction the expenses paid during the tax-

able year, not compensated by insurance or otherwise, for
 medical care of the taxpayer, his spouse, or a dependent
 (as defined in section 152) in an amount equal to the sum
 of—

5 "(1) the portion of such expenses attributable
6 to coverage under a catastrophic health plan (as de7 fined in section 220(c)(2)), and

8 "(2) the excess of such expenses (other than ex-9 penses described in paragraph (1)) over 7.5 percent 10 of the adjusted gross income of the taxpayer."

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

14 SEC. 2202. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to
additional itemized deductions for individuals) is amended
by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

20 "SEC. 220. MEDICAL SAVINGS ACCOUNTS.

21 "(a) DEDUCTION ALLOWED.—

"(1) IN GENERAL.—In the case of an eligible
individual, there shall be allowed as a deduction the
applicable percentage of the amounts paid in cash
during the taxable year by or on behalf of such indi-

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vidual to a medical savings account for the benefit
of such individual and (if any) such individual's
spouse and dependents if such spouse and depend-
ents are eligible individuals.
"(2) Applicable percentage.—For purposes
of paragraph (1), the term 'applicable percentage'
means—
"(A) 25 percent for taxable years begin-
ning in 1994 or 1995,
"(B) 50 percent for taxable years begin-
ning in 1996 or 1997, and
"(C) 100 percent for taxable years begin-
ning after 1997.
"(b) LIMITATIONS.—
"(1) Only 1 account per family.—Except as
provided in regulations prescribed by the Secretary,
no deduction shall be allowed under subsection (a)
for amounts paid to any medical savings account for
the benefit of an individual, such individual's spouse,
or any dependent of such individual or spouse if
or any dependent of such individual or spouse if such individual, spouse, or dependent is a beneficiary
such individual, spouse, or dependent is a beneficiary

1	able year shall not exceed whichever of the following
2	is the least:
3	''(A) The lowest deductible under any cata-
4	strophic health plan providing coverage to any
5	beneficiary of the medical savings account.
6	"(B) \$2,500 (\$5,000 if the catastrophic
7	health plan covering the taxpayer provides cov-
8	erage for more than 1 individual).
9	"(C) The excess of—
10	''(i) the applicable target actuarial
11	value for standard coverage established
12	under section 1102(c)(2) of the Affordable
13	Health Care Now Act of 1994, over
14	"(ii) the deduction allowed by section
15	213 for the taxable year to the extent at-
16	tributable to coverage under a catastrophic
17	health plan.
18	Under rules of the Secretary, the target actuar-
19	ial value under subparagraph (C)(i) shall be
20	made applicable to individual and family cov-
21	erage. A beneficiary of such account who has
22	attained age 65 before the close of the taxable
23	year shall not be taken into account in deter-
24	mining the limitation under the preceding sen-
25	tence.

Title II, Subtitle C

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1	"(c) DEFINITIONS.—For purposes of this section—
2	"(1) ELIGIBLE INDIVIDUAL.—
3	''(A) IN GENERAL.—The term 'eligible in-
4	dividual' means any individual who is covered
5	under a catastrophic health plan throughout the
6	calendar year in which or with which the tax-
7	able year ends.
8	"(B) LIMITATIONS.—Such term does not
9	include—
10	''(i) an individual who is 65 years of
11	age or older, unless the individual is cov-
12	ered under a catastrophic health plan that
13	is a primary plan (within the meaning of
14	section 1862(b)(2)(A) of the Social Secu-
15	rity Act); and
16	''(ii) an individual who has coverage
17	under a group health plan or health insur-
18	ance plan (other than a plan described in
19	1131(4)(B) of the Affordable Health Care
20	Now Act of 1994) that has either a de-
21	ductible that is less than the minimum de-
22	ductible required under a catastrophic
23	health plan (as defined in paragraph (2))
24	or has an actuarial value that is greater
25	than the value for MedAccess catastrophic

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1	coverage (as provided in section 1102(d) of
2	such Act).
3	"(C) DEDUCTION NOT ALLOWED BEFORE
4	1999 TO INDIVIDUALS ELIGIBLE FOR EM-
5	ployer-subsidized coverage.—In the case
6	of any taxable year beginning before January 1,
7	1999, such term does not include an individ-
8	ual—
9	''(i) who is eligible to participate in
10	any subsidized health plan maintained by
11	an employer of such individual or the
12	spouse of such individual, or
13	"(ii) who is (or whose spouse is) a
14	member of a subsidized class of employees
15	of an employer.
16	The rules of subparagraphs (B) and (C) of sec-
17	tion 213(f)(3) shall apply for purposes of this
18	preceding sentence.
19	"(2) CATASTROPHIC HEALTH PLAN.—For pur-
20	poses of paragraph (1)—
21	''(A) IN GENERAL.—The term 'cata-
22	strophic health plan' means a health plan cover-
23	ing specified expenses incurred by an individual
24	for medical care for such individual and the

spouse and dependents (as defined in section

1	152) of such individual only to the extent such
2	expenses covered by the plan for any calendar
3	year exceed \$1,800 (\$3,600 if the catastrophic
4	health plan covering the taxpayer provides cov-
5	erage for more than 1 individual) or such high-
6	er amounts as may be specified by the plan.
7	"(B) Cost-of-living adjustment.—In
8	the case of any calendar year after 1994, each
9	dollar amount in subparagraph (A) shall be in-
10	creased by an amount equal to—
11	''(i) such dollar amount, multiplied by
12	''(ii) the cost-of-living adjustment de-
13	termined under section $1(f)(3)$ for such
14	calendar year.
15	If any increase under the preceding sentence is
16	not a multiple of \$50, such increase shall be
17	rounded to the nearest multiple of \$50.
18	"(d) Medical Savings Accounts.—For purposes
19	of this section—
20	"(1) Medical savings account.—
21	"(A) IN GENERAL.—The term 'medical
22	savings account' means a trust created or orga-
23	nized in the United States exclusively for the
24	purpose of paying the medical expenses of the
25	beneficiaries of such trust, but only if the writ-

2meets the following requirements:3"(i) Except in the case of a rollover4contribution described in subsection (e)(4),5no contribution will be accepted unless it is6in cash, and contributions will not be ac-7cepted in excess of the amount allowed as8a deduction under this section for the tax-9able year (or would be allowed as such a10deduction but for subsection (c)(1)(C)).11"(ii) The trustee is a bank (as defined12in section 408(n)) or another person who13demonstrates to the satisfaction of the Sec-14retary that the manner in which such per-15son will administer the trust will be con-16sistent with the requirements of this sec-17tion.18"(iii) No part of the trust assets will19be invested in life insurance contracts.20"(iv) The assets of the trust will not21be commingled with other property except23ment fund.	1	ten governing instrument creating the trust
4contribution described in subsection (e)(4), no contribution will be accepted unless it is in cash, and contributions will not be ac- cepted in excess of the amount allowed as a deduction under this section for the tax- able year (or would be allowed as such a deduction but for subsection (c)(1)(C)).11"(ii) The trustee is a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Sec- retary that the manner in which such per- son will administer the trust will be con- sistent with the requirements of this sec- tion.18"(iii) No part of the trust assets will be invested in life insurance contracts.20"(iv) The assets of the trust will not be commingled with other property except in a common trust fund or common invest-	2	meets the following requirements:
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7cepted in excess of the amount allowed as a deduction under this section for the tax- able year (or would be allowed as such a deduction but for subsection (c)(1)(C)).11"(ii) The trustee is a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Sec- retary that the manner in which such per- son will administer the trust will be con- sistent with the requirements of this sec- tion.18"(iii) No part of the trust assets will be invested in life insurance contracts.20"(iv) The assets of the trust will not be commingled with other property except in a common trust fund or common invest-	5	no contribution will be accepted unless it is
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 16 sistent with the requirements of this sec- 17 tion. 18 ''(iii) No part of the trust assets will 19 be invested in life insurance contracts. 20 ''(iv) The assets of the trust will not 21 be commingled with other property except 22 in a common trust fund or common invest- 	14	retary that the manner in which such per-
 tion. 17 tion. 18 ''(iii) No part of the trust assets will 19 be invested in life insurance contracts. 20 ''(iv) The assets of the trust will not 21 be commingled with other property except 22 in a common trust fund or common invest- 	15	son will administer the trust will be con-
 18 "(iii) No part of the trust assets will 19 be invested in life insurance contracts. 20 "(iv) The assets of the trust will not 21 be commingled with other property except 22 in a common trust fund or common invest- 	16	sistent with the requirements of this sec-
 be invested in life insurance contracts. "(iv) The assets of the trust will not be commingled with other property except in a common trust fund or common invest- 	17	tion.
 20 "(iv) The assets of the trust will not 21 be commingled with other property except 22 in a common trust fund or common invest- 	18	''(iii) No part of the trust assets will
be commingled with other property exceptin a common trust fund or common invest-	19	be invested in life insurance contracts.
in a common trust fund or common invest-	20	"(iv) The assets of the trust will not
	21	be commingled with other property except
23 ment fund.	22	in a common trust fund or common invest-
	23	ment fund.

1	''(v) The interest of an individual in
2	the balance in his account is nonforfeit-
3	able.
4	''(vi) Under regulations prescribed by
5	the Secretary, rules similar to the rules of
6	section 401(a)(9) shall apply to the dis-
7	tribution of the entire interest of bene-
8	ficiaries of such trust.
9	"(B) TREATMENT OF COMPARABLE AC-
10	COUNTS HELD BY INSURANCE COMPANIES.—
11	For purposes of this section, an account held by
12	an insurance company in the United States
13	shall be treated as a medical savings account
14	(and such company shall be treated as a bank)
15	if—
16	''(i) such account is part of a health
17	insurance plan that includes a catastrophic
18	health plan (as defined in subsection
19	(c)(2)),
20	''(ii) such account is exclusively for
21	the purpose of paying the medical expenses
22	of the beneficiaries of such account who
23	are covered under such catastrophic health
24	plan, and

1	''(iii) the written instrument govern-
2	ing the account meets the requirements of
3	clauses (i), (v), and (vi) of subparagraph
4	(A).
5	"(2) Medical expenses.—
6	"(A) IN GENERAL.—The term 'medical ex-
7	penses' means, with respect to an individual,
8	amounts paid or incurred by such individual
9	for—
10	"(i) medical care (as defined in sec-
11	tion 213), or
12	''(ii) long-term care (as defined in
13	paragraph (3)),
14	for such individual, the spouse of such individ-
15	ual, and any dependent (as defined in section
16	152) of such individual, but only to the extent
17	such amounts are not compensated for by in-
18	surance or otherwise.
19	"(B) Health plan coverage may not
20	BE PURCHASED FROM ACCOUNT.—
21	"(i) IN GENERAL.—Such term shall
22	not include any amount paid for coverage
23	under a health plan.
24	"(ii) Exception.—Clause (i) shall
25	not apply—

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1	''(I) in the case of coverage of an
2	individual under 65 years of age
3	under a catastrophic health plan or
4	under a long-term care insurance
5	plan, or
6	"(II) in the case of coverage of
7	an individual 65 years of age or older
8	under a medicare supplemental policy
9	or under a long-term care insurance
10	plan or for payment of premiums
11	under part A or part B of title XVIII
12	of the Social Security Act.
13	"(3) Long-term care.—
14	''(A) IN GENERAL.—The term 'long-term
15	care' means diagnostic, preventive, therapeutic,
16	rehabilitative, maintenance, or personal care
17	services which are required by, and provided to,
18	a chronically ill individual, which have as their
19	primary purpose the direct provision of needed
20	assistance with 1 or more activities of daily liv-

ing (or the alleviation of the conditions neces-

sitating such assistance) that the individual is

certified under subparagraph (B) as being un-

able to perform, and which are provided in a

setting other than an acute care unit of a hos-

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pital pursuant to a continuing plan of care pre-2 scribed by a physician or registered professional 3 nurse. Such term does not include food or lodging provided in an institutional or other setting, or basic living services associated with the 6 maintenance of a household or participation in community life, such as case management, transportation or legal services, or the perform-8 9 ance of home maintenance or household chores.

"(B) CHRONICALLY ILL INDIVIDUAL.—The 10 11 term 'chronically ill individual' means an indi-12 vidual who is certified by a physician or registered professional nurse as being unable to 13 perform at least 3 activities of daily living with-14 15 out substantial assistance from another individ-16 ual. For purposes of this paragraph, the term 17 'activities of daily living' means bathing, dress-18 ing, eating, toileting, transferring, and walking.

19 **(**(4) TIME WHEN CONTRIBUTIONS DEEMED 20 MADE.—A contribution shall be deemed to be made on the last day of the preceding taxable year if the 21 22 contribution is made on account of such taxable year and is made not later than the time prescribed by 23 24 law for filing the return for such taxable year (not including extensions thereof). 25

"(e) TAX TREATMENT OF DISTRIBUTIONS.— 1 2 "(1) IN GENERAL.—Any amount paid or distributed out of a medical savings account shall be in-3 4 cluded in the gross income of the individual for whose benefit such account was established unless 5 such amount is used exclusively to pay the medical 6 7 expenses of such individual. 8 "(2) Excess contributions returned be-9 FORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid 10 11 during a taxable year to a medical savings account 12 to the extent that such contribution exceeds the 13 amount allowable as a deduction under subsection (a) if— 14 "(A) such distribution is received by the 15 individual on or before the last day prescribed 16 17 by law (including extensions of time) for filing 18 such individual's return for such taxable year, 19 and 20 "(B) such distribution is accompanied by 21 the amount of net income attributable to such 22 excess contribution. Any net income described in subparagraph (B) shall 23 24 be included in the gross income of the individual for 25 the taxable year in which it is received.

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1"(3) PENALTY FOR DISTRIBUTIONS NOT USED2FOR MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by 3 this chapter for any taxable year in which there 4 is a payment or distribution from a medical 5 savings account which is not used to pay the 6 7 medical expenses of the individual for whose 8 benefit the account was established shall be increased by 10 percent of the amount of such 9 payment or distribution which is includible in 10 11 gross income under paragraph (1).

"(B) Account balance limitation.— If—

"(i) the tax imposed by this chapter is 14 15 required to be increased under subparagraph (A) by reason of a distribution, and 16 17 "(ii) after such distribution, the ag-18 gregate balance of all medical savings ac-19 counts established for the benefit of the in-20 dividual, is less than the amount of the deductible under the catastrophic health plan 21 22 covering such individual,

23 subparagraph (A) shall be applied by substitut24 ing '50 percent' for '10 percent'.

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1	"(4) ROLLOVERS.—Paragraph (1) shall not
2	apply to any amount paid or distributed out of a
3	medical savings account to the individual for whose
4	benefit the account is maintained if the entire
5	amount received (including money and any other
6	property) is paid into another medical savings ac-
7	count for the benefit of such individual not later
8	than the 60th day after the day on which he received
9	the payment or distribution.
10	"(5) Penalty for mandatory distribu-
11	TIONS NOT MADE FROM ACCOUNT.—
12	"(A) IN GENERAL.—If during any taxable
13	year—
14	"(i) there is a payment of a manda-
15	tory distribution expense incurred by a
16	beneficiary of a medical savings account,
17	and
18	''(ii) the person making such payment
19	is not reimbursed for such payment with a
20	distribution from such account before the
21	60th day after such payment,
22	the taxpayer's tax imposed by this chapter for
23	such taxable year shall be increased by 100 per-

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1	ment over the amount of reimbursement made
2	before such 60th day.
3	"(B) MANDATORY DISTRIBUTION EX-
4	PENSE.—For purposes of subparagraph (A),
5	the term 'mandatory distribution expense'
6	means—
7	"(i) any expense incurred which may
8	be counted towards a deductible, or for a
9	copayment or coinsurance, under the cata-
10	strophic health plan covering such bene-
11	ficiary, and
12	"(ii) in the case of a beneficiary who
13	has attained age 65, any expense for cov-
14	erage described in subsection
15	(d)(2)(B)(ii)(II) and any expense incurred
16	which may be counted toward a deductible,
17	or for a copayment or coinsurance, under
18	title XVIII of the Social Security Act.
19	"(f) Tax Treatment of Accounts.—
20	"(1) EXEMPTION FROM TAX.—Any medical sav-
21	ings account is exempt from taxation under this sub-
22	title unless such account has ceased to be a medical

title unless such account has ceased to be a medical
savings account by reason of paragraph (2) or (3).
Notwithstanding the preceding sentence, any such
account shall be subject to the taxes imposed by sec-

1	tion 511 (relating to imposition of tax on unrelated
2	business income of charitable, etc. organizations).
3	"(2) Account terminates if individual en-
4	GAGES IN PROHIBITED TRANSACTION.—
5	"(A) IN GENERAL.—If, during any taxable
6	year of the individual for whose benefit the
7	medical savings account was established, such
8	individual engages in any transaction prohibited
9	by section 4975 with respect to the account, the
10	account ceases to be a medical savings account
11	as of the first day of that taxable year.
12	"(B) Account treated as distributing
13	ALL ITS ASSETS.—In any case in which any ac-
14	count ceases to be a medical savings account by
15	reason of subparagraph (A) on the first day of
16	any taxable year, paragraph (1) of subsection
17	(e) shall be applied as if there were a distribu-
18	tion on such first day in an amount equal to
19	the fair market value (on such first day) of all
20	assets in the account (on such first day) and no
21	portion of such distribution were used to pay
22	medical expenses.
23	"(3) Effect of pledging account as secu-
24	RITY.—If, during any taxable year, the individual for
25	whose benefit a medical savings account was estab-

lished uses the account or any portion thereof as se curity for a loan, the portion so used is treated as
 distributed to that individual and not used to pay
 medical expenses.

5 "(g) CUSTODIAL ACCOUNTS.—For purposes of this 6 section, a custodial account shall be treated as a trust if—

"(1) the assets of such account are held by a
bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer
the account will be consistent with the requirements
of this section, and

13 "(2) the custodial account would, except for the
14 fact that it is not a trust, constitute a medical sav15 ings account described in subsection (d).

16 For purposes of this title, in the case of a custodial ac-17 count treated as a trust by reason of the preceding sen-18 tence, the custodian of such account shall be treated as 19 the trustee thereof.

20 "(h) REPORTS.—The trustee of a medical savings ac-21 count shall make such reports regarding such account to 22 the Secretary and to the individual for whose benefit the 23 account is maintained with respect to contributions, dis-24 tributions, and such other matters as the Secretary may 25 require under regulations. The reports required by this subsection shall be filed at such time and in such manner
 and furnished to such individuals at such time and in such
 manner as may be required by those regulations."

4 (b) DEDUCTION ALLOWED WHETHER OR NOT INDI5 VIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
6 of section 62 of such Code is amended by inserting after
7 paragraph (17) the following new paragraph:

8 "(18) MEDICAL SAVINGS ACCOUNTS.—The de9 duction allowed by section 220."

10 (c) DISTRIBUTIONS FROM MEDICAL SAVINGS AC-11 COUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUC-12 TION.—Section 213 of such Code is amended by adding 13 at the end thereof the following new subsection:

14 "(g) COORDINATION WITH MEDICAL SAVINGS AC-15 COUNTS.—The amount otherwise taken into account 16 under subsection (a) as expenses paid for medical care 17 shall be reduced by the amount (if any) of the distribu-18 tions from any medical savings account of the taxpayer 19 during the taxable year which is not includible in gross 20 income by reason of being used for medical care."

21 (d) EXCLUSION OF EMPLOYER CONTRIBUTIONS TO
22 MEDICAL SAVINGS ACCOUNTS FROM EMPLOYMENT
23 TAXES.—

24 (1) Social security taxes.—

(A) Subsection (a) of section 3121 of such 1 2 Code is amended by striking "or" at the end of paragraph (20), by striking the period at the 3 end of paragraph (21) and inserting "; or", and 4 by inserting after paragraph (21) the following 5 6 new paragraph: "(22) remuneration paid to or on behalf of an 7 8 employee if (and to the extent that) at the time of 9 payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable 10 11 under section 220." 12 (B) Subsection (a) of section 209 of the Social Security Act is amended by striking "or" 13 at the end of paragraph (17), by striking the 14 15 period at the end of paragraph (18) and inserting "; or", and by inserting after paragraph 16 17 (18) the following new paragraph: 18 "(19) remuneration paid to or on behalf of an 19 employee if (and to the extent that) at the time of 20 payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable 21 22 under section 220 of the Internal Revenue Code of 23 1986."

1 (2) RAILROAD RETIREMENT TAX.—Subsection 2 (e) of section 3231 of such Code is amended by adding at the end thereof the following new paragraph: 3 "(10) Employer contributions to medical 4 5 SAVINGS ACCOUNTS.—The term 'compensation' shall 6 not include any payment made to or on behalf of an 7 employee if (and to the extent that) at the time of 8 payment of such remuneration it is reasonable to be-9 lieve that a corresponding deduction is allowable 10 under section 220." 11 (3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking 12 "or" at the end of paragraph (15), by striking the 13 period at the end of paragraph (16) and inserting "; 14 15 or", and by inserting after paragraph (16) the following new paragraph: 16 17 "(17) remuneration paid to or on behalf of an 18 employee if (and to the extent that) at the time of 19 payment of such remuneration it is reasonable to be-20 lieve that a corresponding deduction is allowable 21 under section 220."

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking "or"
at the end of paragraph (19), by striking the period
at the end of paragraph (20) and inserting "; or",

and by inserting after paragraph (20) the following
 new paragraph:

"(21) remuneration paid to or on behalf of an
employee if (and to the extent that) at the time of
payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable
under section 220."

8 (e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 9 of such Code (relating to tax on excess contributions to 10 individual retirement accounts, certain section 403(b) con-11 tracts, and certain individual retirement annuities) is 12 amended—

13 (1) by inserting "MEDICAL SAVINGS AC14 COUNTS," after "ACCOUNTS," in the heading of
15 such section,

16 (2) by redesignating paragraph (2) of sub17 section (a) as paragraph (3) and by inserting after
18 paragraph (1) the following:

19 ''(2) a medical savings account (within the20 meaning of section 220(d)),'',

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

23 (4) by adding at the end thereof the following24 new subsection:

"(d) Excess Contributions to Medical Savings 1 ACCOUNTS.—For purposes of this section, in the case of 2 3 a medical savings account (within the meaning of section 4 220(d)), the term 'excess contributions' means the amount 5 by which the amount contributed for the taxable year to the account exceeds the amount excludable from gross in-6 7 come under section 220 for such taxable year. For purposes of this subsection, any contribution which is distrib-8 9 uted out of the medical savings account in a distribution to which section 220(e)(2) applies shall be treated as an 10 amount not contributed." 11

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

15 (1) by adding at the end of subsection (c) the16 following new paragraph:

17 "(4) Special rule for medical savings ac-18 COUNTS.—An individual for whose benefit a medical 19 savings account (within the meaning of section 220(d)) is established shall be exempt from the tax 20 21 imposed by this section with respect to any trans-22 action concerning such account (which would other-23 wise be taxable under this section) if, with respect 24 to such transaction, the account ceases to be a medical savings account by reason of the application of
 section 220(e)(2)(A) to such account.", and

3 (2) by inserting "or a medical savings account
4 described in section 220(d)" in subsection (e)(1)
5 after "described in section 408(a)".

6 (g) FAILURE TO PROVIDE REPORTS ON MEDICAL
7 SAVINGS ACCOUNTS.—Section 6693 of such Code (relat8 ing to failure to provide reports on individual retirement
9 account or annuities) is amended—

10 (1) by inserting "OR ON MEDICAL SAVINGS
11 ACCOUNTS" after "ANNUITIES" in the heading of
12 such section, and

(2) by adding at the end of subsection (a) the
following: "The person required by section 220(h) to
file a report regarding a medical savings account at
the time and in the manner required by such section
shall pay a penalty of \$50 for each failure unless it
is shown that such failure is due to reasonable
cause."

20 (h) CLERICAL AMENDMENTS.—

(1) 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:

"Sec. 220. Medical savings accounts. "Sec. 221. Cross reference."

1	(2) The table of sections for chapter 43 of such
2	Code is amended by striking the item relating to sec-
3	tion 4973 and inserting the following:
	"Sec. 4973. Tax on excess contributions to individual retirement accounts, medical savings accounts, certain 403(b) contracts, and certain individual retirement annu- ities."
4	(3) The table of sections for subchapter B of
5	chapter 68 of such Code is amended by inserting ''or
6	on medical savings accounts" after "annuities" in
7	the item relating to section 6693.
8	(i) EFFECTIVE DATE.—The amendments made by
9	this section shall apply to taxable years beginning after
	D 01 1000
10	December 31, 1993.
10 11	Subtitle D—Anti-Fraud
11	Subtitle D—Anti-Fraud
11 12	Subtitle D—Anti-FraudPART1—ESTABLISHMENTOFALL-PAYER
11 12 13	Subtitle D—Anti-Fraud PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL
11 12 13 14	Subtitle D—Anti-Fraud PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM
 11 12 13 14 15 	Subtitle D—Anti-Fraud PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM SEC. 2301. ALL-PAYER HEALTH CARE FRAUD AND ABUSE
 11 12 13 14 15 16 	Subtitle D—Anti-Fraud PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM SEC. 2301. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.
 11 12 13 14 15 16 17 	Subtitle D—Anti-Fraud PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM SEC. 2301. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM. (a) IN GENERAL.—Not later than January 1, 1996,
 11 12 13 14 15 16 17 18 	Subtitle D—Anti-Fraud PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM SEC. 2301. 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.
 11 12 13 14 15 16 17 18 19 	Subtitle D—Anti-Fraud PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM SEC. 2301. 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

1 (2) to conduct investigations, audits, evalua-2 tions, and inspections relating to the delivery of and 3 payment for health care in the United States, and (3) in consultation with the Inspector General 4 5 of the Department of Health and Human Services, to facilitate the enforcement of the provisions of sec-6 7 tions 1128, 1128A, and 1128B of the Social Secu-8 rity Act and other statutes applicable to health care fraud and abuse. 9

10 (b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under sub-11 section (a), the Attorney General shall consult with, and 12 arrange for the sharing of data and resources with Fed-13 eral, State and local law enforcement agencies, State Med-14 icaid Fraud Control Units, and State agencies responsible 15 for the licensing and certification of health care providers. 16 17 COORDINATION WITH THIRD PARTY INSUR-(c) ERS.—In carrying out the program established under sub-18 section (a), the Attorney General shall consult with, and 19 arrange for the sharing of data with representatives of pri-20 vate sponsors of health benefit plans and other providers 21 22 of health insurance.

23 (d) REGULATIONS.—

(1) IN GENERAL.—The Attorney General shall
 by regulation establish standards to carry out the
 program under subsection (a).

(2) INFORMATION STANDARDS.—

4

(A) IN GENERAL.—Such standards shall 5 6 include standards relating to the furnishing of 7 information by health insurers (including selfinsured health benefit plans), providers, and 8 9 others to enable the Attorney General to carry 10 out the program (including coordination with 11 law enforcement agencies under subsection (b) 12 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.

19 (C) QUALIFIED IMMUNITY FOR PROVIDING 20 INFORMATION.—The of provisions section 1157(a) of the Social Security Act (relating to 21 22 limitation on liability) shall apply to a person 23 providing information to the Attorney General 24 under the program under this section, with re-25 spect to the Attorney General's performance of 1duties under the program, in the same manner2as such section applies to information provided3to organizations with a contract under part B4of title XI of such Act, with respect to the per-5formance of such a contract.

6 SEC. 2302. AUTHORIZATION OF ADDITIONAL APPROPRIA7 TIONS FOR INVESTIGATORS AND OTHER PER8 SONNEL.

9 In addition to any other amounts authorized to be 10 appropriated to the Attorney General for health care antifraud and abuse activities for a fiscal year, there are au-11 thorized to be appropriated such sums as may be nec-12 essary to enable the Attorney General to conduct inves-13 tigations of allegations of health care fraud and otherwise 14 carry out the program established under section 2301 in 15 a fiscal year. 16

17 SEC. 2303. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE 18 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 pro-

vided in this part and section 1128A(f)(3) of the Social
 Security Act.

3 (b) MANAGEMENT.—

4 (1) IN GENERAL.—The Trust Fund shall be
5 managed by the Attorney General through a Manag6 ing Trustee designated by the Attorney General.

7 (2) INVESTMENT OF FUNDS.—It shall be the duty of the Managing Trustee to invest such portion 8 9 of the Trust Fund as is not, in the trustee's judg-10 ment, required to meet current withdrawals. Such 11 investments may be made only in interest-bearing 12 obligations of the United States or in obligations 13 guaranteed as to both principal and interest by the 14 United States. For such purpose such obligations 15 may be acquired on original issue at the issue price, 16 or by purchase of outstanding obligations at market 17 price. The purposes for which obligations of the 18 United States may be issued under chapter 31 of 19 title 31, United States Code, are hereby extended to 20 authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obliga-21 22 tions issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs 23 24 of the Trust Fund and shall bear interest at a rate 25 equal to the average market yield (computed by the

1 Managing Trustee on the basis of market quotations 2 as of the end of the calendar month next preceding the date of such issue) on all marketable interest-3 4 bearing obligations of the United States then forming a part of the public debt which are not due or 5 6 callable until after the expiration of 4 years from the 7 end of such calendar month, except that where such average is not a multiple of $\frac{1}{8}$ of 1 percent, the rate 8 9 of interest on such obligations shall be the multiple of 1/8 of 1 percent nearest such market yield. The 10 11 Managing Trustee may purchase other interest-bear-12 ing obligations of the United States or obligations 13 guaranteed as to both principal and interest by the 14 United States, on original issue or at the market 15 price, only where the Trustee determines that the 16 purchase of such other obligations is in the public 17 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.

24 (4) The interest on, and the proceeds from the25 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 At-3 4 torney General in the discharge of the functions of the Attorney General shall not be included in the to-5 6 tals of the budget of the United States Government. 7 For purposes of part C of the Balanced Budget and Emergency Deficit Control Act of 1985, the Attor-8 9 ney General and the Trust Fund shall be treated in 10 the same manner as the Federal Retirement Thrift 11 Investment Board and the Thrift Savings Fund, re-12 spectively. The United States is not liable for any obligation or liability incurred by the Trust Fund. 13

14 (c) USE OF FUNDS.—Of the amounts in the Trust15 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-payor fraud

and abuse control program established under section
 2301(a) in the fiscal year involved.

(d) Deposit of Federal Health Anti-Fraud 3 AND ABUSE PENALTIES INTO TRUST FUND.—Section 4 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a-5 7a(f)(3) is amended by striking "as miscellaneous re-6 7 ceipts of the Treasury of the United States" and inserting "in the Anti-Fraud and Abuse Trust Fund established 8 9 under section 2303(a) of the Affordable Health Care Now Act of 1994". 10

11 (e) Use of Federal Health Anti-Fraud and ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-12 SHARING.—Section 1128A(f) of the Social Security Act 13 (42 U.S.C. 1320a–7a(f)) is amended in the matter preced-14 ing paragraph (1) by striking "Secretary and disposed of 15 as follows:" and inserting the following: "Secretary. If the 16 person against whom such a penalty or assessment was 17 assessed collected a payment from an individual for pro-18 viding to the individual the service that is the subject of 19 the penalty or assessment, the Secretary shall pay a por-20 21 tion of the amount recovered to the individual in the na-22 ture of restitution in an amount equal to the payment so 23 collected. The Secretary shall dispose of any remaining amounts recovered under this section as follows:". 24

1	PART 2-REVISIONS TO CURRENT SANCTIONS
2	FOR FRAUD AND ABUSE
3	SEC. 2311. MANDATORY EXCLUSION FROM PARTICIPATION
4	IN MEDICARE AND STATE HEALTH CARE PRO-
5	GRAMS.
6	(a) Individual Convicted of Felony Relating
7	to Fraud.—
8	(1) IN GENERAL.—Section 1128(a) of the So-
9	cial Security Act (42 U.S.C. 1320a-7(a)) is amend-
10	ed by adding at the end the following new para-
11	graph:
12	"(3) Felony conviction relating to
13	FRAUD.—Any individual or entity that has been con-
14	victed, under Federal or State law, in connection
15	with the delivery of a health care item or service on
16	or after the date of the enactment of this paragraph,
17	or with respect to any act or omission on or after
18	such date in a program (other than those specifically
19	described in paragraph (1)) operated by or financed
20	in whole or in part by any Federal, State, or local
21	government agency, of a criminal offense consisting
22	of a felony relating to fraud, theft, embezzlement,
23	breach of fiduciary responsibility, or other financial
24	misconduct.".

1	(2) Conforming Amendment.—Section
2	1128(b)(1) of such Act (42 U.S.C. 1320a-7(b)(1))
3	is amended—
4	(A) in the heading, by striking "CONVIC-
5	TION" and inserting "MISDEMEANOR CONVIC-
6	TION''; and
7	(B) by striking "criminal offense" and in-
8	serting "criminal offense consisting of a mis-
9	demeanor''.
10	(b) Individual Convicted of Felony Relating
11	to Controlled Substance.—
12	(1) IN GENERAL.—Section 1128(a) of the So-
13	cial Security Act (42 U.S.C. 1320a–7(a)), as amend-
14	ed by subsection (a), is amended by adding at the
15	end the following new paragraph:
16	"(4) Felony conviction relating to con-
17	TROLLED SUBSTANCE.—Any individual or entity
18	that has been convicted, under Federal or State law,
19	of a criminal offense consisting of a felony relating
20	to the unlawful manufacture, distribution, prescrip-
21	tion, or dispensing of a controlled substance.".
22	(2) Conforming Amendment.—Section
23	1128(b)(3) of such Act (42 U.S.C. 1320a-7(b)(3))
24	is amended—

(A) in the heading, by striking "CONVIC TION" and inserting "MISDEMEANOR CONVIC TION"; and

4 (B) by striking "criminal offense" and in-5 serting "criminal offense consisting of a mis-6 demeanor".

7 SEC. 2312. ESTABLISHMENT OF MINIMUM PERIOD OF EX8 CLUSION FOR CERTAIN INDIVIDUALS AND
9 ENTITIES SUBJECT TO PERMISSIVE EXCLU10 SION FROM MEDICARE AND STATE HEALTH
11 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:

15 "(D) In the case of an exclusion of an individual or 16 entity under paragraph (1), (2), or (3) of subsection (b), 17 the period of the exclusion shall be 3 years, unless the 18 Secretary determines in accordance with published regula-19 tions that a shorter period is appropriate because of miti-20 gating circumstances or that a longer period is appro-21 priate 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.

4 "(F) In the case of an exclusion of an individual or
5 entity under subsection (b)(6)(B), the period of the exclu6 sion shall be not less than 1 year.".

7 SEC. 2313. REVISIONS TO CRIMINAL PENALTIES.

8 (a) CLARIFICATION OF DISCOUNT EXCEPTION TO
9 ANTI-KICKBACK PROVISIONS.—Section 1128B(b)(3)(A)
10 of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)(A))
11 is amended—

12 (1) by inserting "(regardless of its timing or13 availability)" after "in price"; and

14 (2) by striking "program;" and inserting "pro15 gram and is not paid in the form of currency or
16 coin;".

17 (b) EXEMPTION FROM ANTI-KICKBACK PENALTIES
18 FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section
19 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is
20 amended—

21 (1) by striking "and" at the end of subpara-22 graph (D);

23 (2) by striking the period at the end of sub24 paragraph (E) and inserting "; and"; and

(3) by adding at the end the following new sub paragraph:

"(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—

8 ''(i) the item or service is provided through
9 an organization described in section 1877(b)(3),
10 or

11 "(ii) the item or service is provided 12 through such an organization on behalf of an-13 other entity (including but not limited to a self-14 insured employer or indemnity plan) that as-15 sumes financial risk for the provision of the 16 item or service.".

17 (c) EXEMPTION FROM ANTI-KICKBACK PENALTIES
18 FOR CERTAIN PROTECTED FINANCIAL RELATIONSHIPS.—
19 Section 1128B(b)(3) of such Act (42 U.S.C. 1320a20 7b(b)(3)), as amended by subsection (b), is further amend21 ed—

(1) by striking "and" at the end of subpara-graph (E);

24 (2) by striking the period at the end of sub-25 paragraph (F) and inserting "; and"; and

(3) by adding at the end the following new sub-1 2 paragraph:

3 "(G) any amount in a financial relationship of a physician (or an immediate family member of such 4 5 physician) with an entity specified in section 1877(a)(2), if section 1877(a)(1) does not apply to 6 that amount or financial relationship.". 7

8 SEC. 2314. REVISIONS TO LIMITATIONS ON PHYSICIAN 9 SELF-REFERRAL.

10 (a) CLARIFICATION OF COVERAGE OF RADIOLOGY OR 11 DIAGNOSTIC SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by 12 striking subparagraph (D). 13

14 (b) New Exception for Shared Facility Serv-1877(b) of such Act (42 15 ICES.—Section U.S.C. 1395nn(b)) is amended— 16

17 (1) by redesignating paragraph (4) as para-18 graph (5); and

19 (2) by inserting after paragraph (3) the follow-20 ing new paragraph:

"(4) SHARED FACILITY SERVICES.— 21

22 "(A) IN GENERAL.—In the case of a shared facility service of a shared facility— 23 24

"(i) that is furnished—

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1	''(I) personally by the referring
2	physician who is a shared facility phy-
3	sician or personally by an individual
4	directly employed by such a physician,
5	''(II) by a shared facility in a
6	building in which the referring physi-
7	cian furnishes substantially all of the
8	services of the physician that are un-
9	related to the furnishing of shared fa-
10	cility services, and
11	"(III) to a patient of a shared fa-
12	cility physician; and
13	''(ii) that is billed by the referring
14	physician.
15	"(B) Shared facility related defini-
16	TIONS.—
17	"(i) Shared facility service.—
18	The term 'shared facility service' means,
19	with respect to a shared facility, a des-
20	ignated health service furnished by the fa-
21	cility to patients of shared facility physi-
22	cians.
23	"(ii) Shared facility.—The term
24	'shared facility' means an entity that fur-

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1	nishes shared facility services under a
2	shared facility arrangement.
3	"(iii) Shared facility physician.—
4	The term 'shared facility physician' means,
5	with respect to a shared facility, a physi-
6	cian who has a financial relationship under
7	a shared facility arrangement with the fa-
8	cility.
9	"(iv) Shared facility arrange-
10	MENT.—The term 'shared facility arrange-
11	ment' means, with respect to the provision
12	of shared facility services in a building, a
13	financial arrangement—
14	''(I) which is only between physi-
15	cians who are providing services (un-
16	related to shared facility services) in
17	the same building,
18	"(II) in which the overhead ex-
19	penses of the facility are shared, in
20	accordance with methods previously
21	determined by the physicians in the
22	arrangement, among the physicians in
23	the arrangement, and

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"(III) which, in the case of a cor-1 2 poration, is wholly owned and con-3 trolled by shared facility physicians.". 4 (c) REVISION TO RURAL PROVIDER EXCEPTION.— Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2)) 5 is amended by striking "substantially all" and inserting 6 7 "not less than 75 percent (as determined in accordance 8 with regulations of the Secretary)". 9 (d) CLARIFICATION OF Referrals BY NEPHROLOGISTS.—Section 1877(h)(5)(C) of such Act (42 10 U.S.C. 1395nn(H)(5)(C) is amended— 11 (1) by striking "and a request" and inserting 12 "a request"; 13 (2) by inserting after "radiation therapy," the 14 15 following: "and a request by a nephrologist for items or services related to renal dialysis,"; and 16 17 (3) by striking "or radiation oncologist" and in-18 serting "radiation oncologist, or nephrologist". 19 (e) REVISION OF REPORTING REQUIREMENTS.—Section 1877(f) of such Act (42 U.S.C. 1395nn(f)) is 20 amended— 21 22 (1) by striking "Each entity" and all that fol-23 lows through paragraph (2) and inserting the follow-24 ing: "The Secretary may require each entity (other than a physician or physician group practice) provid-25

ing designated health services to provide the Sec-1 2 retary with the following information concerning the 3 entity's ownership, investment, and compensation ar-4 rangements: "(1) the designated health services provided by 5 6 the entity; and "(2) the names and unique physician identifier 7 numbers of all physicians with an ownership or in-8 described in subsection 9 vestment interest (as 10 (a)(2)(A) or with a compensation interest (as de-11 scribed in subsection (a)(2)(B) in the entity, or 12 whose immediate relatives have such an ownership, 13 investment, or compensation interest in the entity."; 14 and 15 (2) by striking the fifth sentence. 16 (f) EXCEPTION FOR CERTAIN MANAGED CARE AR-RANGEMENTS.—Section 1877(b)(3) of such Act (42) 17 U.S.C. 1395nn(b)(3)) is amended— 18 19 (1) by striking "or" at the end of subparagraph (C); 20 (2) by striking the period at the end of sub-21 paragraph (D) and inserting a comma; and 22 23 (3) by adding at the end the following new sub-24 paragraphs:

1	''(E) with a contract with a State to pro-
2	vide services under the State plan under title
3	XIX (in accordance with section 1903(m)); or
4	"(F) which meets State regulatory require-
5	ments applicable to health maintenance organi-
6	zations and which—
7	''(i) provides designated health serv-
8	ices directly or through contractual ar-
9	rangements with providers;
10	"(ii) assumes financial risk for the
11	provision of services or provides services on
12	behalf of another individual or entity (in-
13	cluding but not limited to a self-insured
14	employer, indemnity plan, physician, or
15	physician group) that assumes financial
16	risk for the provision of the item or serv-
17	ice; and
18	''(iii) subjects the services to a pro-
19	gram of utilization review offered by an or-
20	ganization described in a preceding sub-
21	paragraph, an organization meeting State
22	regulatory requirements applicable to utili-
23	zation review, or an organization accred-
24	ited to perform utilization review consid-
25	ered 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:

4 "(6) PREEMPTION OF STATE LAW.—The provi5 sions of this section shall supersede any State law to
6 the extent State law prohibits a physician from mak7 ing a referral, or an entity from presenting a bill, for
8 the furnishing of a service which is not subject to
9 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);

21 "(B) section 1877(b)(4) of the Social Se22 curity Act (as in effect on the day before the
23 date of the enactment of this Act) shall apply;
24 "(C) the requirements of section
25 1877(c)(2) of the Social Security Act (as

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1	amended by this Act) shall not apply to any se-
2	curities of a corporation that meets the require-
3	ments of section 1877(c)(2) of the Social Secu-
4	rity Act (as in effect on the day before the date
5	of the enactment of this Act);
6	"(D) section 1877(e)(3) of the Social Secu-
7	rity Act (as amended by this Act) shall apply,
8	except that it shall not apply to any arrange-
9	ment that meets the requirements of subsection
10	(e)(2) or subsection (e)(3) of section 1877 of
11	the Social Security Act (as in effect on the day
12	before the date of the enactment of this Act);
13	"(E) the requirements of clauses (iv) and
14	(v) of section $1877(h)(4)(A)$, and of clause (i)
15	of section 1877(h)(4)(B), of the Social Security
16	Act (as amended by this Act) shall not apply;
17	and
18	"(F) section $1877(h)(4)(B)$ of the Social
19	Security Act (as in effect on the day before the
20	date of the enactment of this Act) shall apply
21	instead of section 1877(h)(4)(A)(ii) of such Act
22	(as amended by this Act).".
23	(i) EFFECTIVE DATE.—The amendments made by
24	this section shall apply to referrals made on or after Janu-
25	and 1 100° and that the ansarding state and her such

25 ary 1, 1995, except that the amendments made by sub-

section (h) shall apply as if included in the enactment of
 the Omnibus Budget Reconciliation Act of 1993.

3 SEC. 2315. MEDICARE HEALTH MAINTENANCE ORGANIZA 4 TIONS.

5 (a) STUDY ON COSTS OF PEER REVIEW CONTRACTS FOR MEDICARE HMOS.—The Comptroller General shall 6 7 conduct a study of the costs incurred by eligible organiza-8 tions with risk-sharing contracts under section 1876(b) of 9 the Social Security Act of complying with the requirement 10 of entering into a written agreement with an entity providing peer review services with respect to services provided 11 12 by the organization, together with an analysis of how information generated by such entities is used by the Sec-13 retary of Health and Human Services to assess the quality 14 15 of services provided by such eligible organizations.

16 (b) REPORT TO CONGRESS.—Not later than July 1, 17 1997, the Comptroller General shall submit a report to 18 the Committee on Ways and Means and the Committee 19 on Energy and Commerce of the House of Representatives 20 and the Committee on Finance and the Special Committee 21 on Aging of the Senate on the study conducted under sub-22 section (a).

23 SEC. 2316. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this part shall take effect January 1, 1996.

1 PART 3—AMENDMENTS TO CRIMINAL LAW

2 SEC. 2321. PENALTIES FOR HEALTH CARE FRAUD.

3 (a) IN GENERAL.—

4 (1) FINES AND IMPRISONMENT FOR HEALTH
5 CARE FRAUD VIOLATIONS.—Chapter 63 of title 18,
6 United States Code, is amended by adding at the
7 end the following:

8 "§1347. Health care fraud

9 "(a) Whoever knowingly executes, or attempts to exe-10 cute, a scheme or artifice—

"(1) to defraud any health care plan or other 11 12 person, in connection with the delivery of or pay-13 ment for health care benefits, items, or services; or 14 "(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the 15 16 money or property owned by, or under the custody 17 or control of, any health care plan, or person in connection with the delivery of or payment for health 18 19 care benefits, items, or services;

20 shall be guilty of a felony, and fined under this title or21 imprisoned not more than 5 years, or both.

22 "(b) In determining the amount or scope of any pen-23 alty or assessment, the court shall take into account—

24 "(1) the nature of the false or fraudulent
25 claims and the circumstances under which they are
26 presented;

1 "(2) the degree of culpability and history of 2 prior offenses by the convicted health care provider; "(3) the extent to which restitution is paid; and 3 4 "(4) such other matters as justice may require. 5 "(c) A principal is liable for penalties and assessments under this section for the acts of the principal's 6 7 agents acting within the scope of the agency. "(d) For purposes of this section, the term 'health 8 9 care plan' means a Federally-funded public program or 10 private program for the delivery of or payment for health care items or services.". 11 (2) CLERICAL AMENDMENT.—The table of sec-12 13 tions at the beginning of chapter 63 of title 18, 14 United States Code, is amended by adding at the 15 end the following:

"1347. Health care fraud.".

16 SEC. 2322. REWARDS FOR INFORMATION LEADING TO17PROSECUTION AND CONVICTION.

18 Section 3059 of title 18, United States Code, is 19 amended by adding at the end the following new sub-20 section:

"(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.

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"(2) A person is not eligible for a payment under

2	paragraph (1) if—
3	"(A) the person is a current or former officer
4	or employee of a Federal or State government agen-
5	cy or instrumentality who furnishes information dis-
6	covered or gathered in the course of government em-
7	ployment.
8	''(B) the person knowingly participated in the
9	offense;
10	"(C) the information furnished by the person
11	consists of allegations or transactions that have been
12	disclosed to the public—
13	"(i) in a criminal, civil, or administrative
14	proceeding;
15	''(ii) in a congressional, administrative or
16	General Accounting Office report, hearing,
17	audit or investigation; or
18	''(iii) by the news media, unless the person
19	is the original source of the information; or
20	''(D) when, in the judgment of the Attorney
21	General, it appears that a person whose illegal ac-
22	tivities are being prosecuted or investigated could
23	benefit from the award.
24	((3) For the purposes of paragraph $(2)(C)(iii)$, the
25	term 'original source' means a person who has direct and
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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 "(4) Neither the failure of the Attorney General to
5 authorize a payment under paragraph (1) nor the amount
6 authorized shall be subject to judicial review.".

7 SEC. 2323. BROADENING APPLICATION OF MAIL FRAUD
8 STATUTE.

9 Section 1341 of title 18, United States Code, is 10 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

15 (2) by inserting "or such carrier" after "causes16 to be delivered by mail".

17 PART 4—ADVISORY OPINIONS

18 SEC. 2331. AUTHORIZING THE SECRETARY OF HEALTH AND

19HUMAN SERVICES TO ISSUE ADVISORY OPIN-20IONS 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:

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"ADVISORY OPINIONS

2 "SEC. 1129. (a) ISSUANCE OF ADVISORY OPIN3 IONS.—The Secretary shall issue advisory opinions as pro4 vided in this section.

5 "(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—
6 The Secretary shall issue advisory opinions as to the fol7 lowing matters:

8 "(1) What constitutes prohibited remuneration
9 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).

23 "(5) Whether an arrangement, activity or pro24 posed arrangement or proposed activity violates any
25 other provision of this Act.

"(c) MATTERS NOT SUBJECT TO ADVISORY OPIN IONS.—Such advisory opinions shall not address the fol lowing matters:

4 "(1) Whether the fair market value shall be, or
5 was paid or received for any goods, services or prop6 erty.

"(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2)
of the Internal Revenue Code of 1986.

10 "(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—

22 "(1) the procedure to be followed by a party ap-23 plying for an advisory opinion;

1	"(2) the procedure to be followed by the Sec-
2	retary in responding to a request for an advisory
3	opinion;
4	"(3) the interval in which the Secretary shall
5	respond;
6	"(4) the reasonable fee to be charged to the
7	party requesting an advisory opinion; and
8	''(5) the manner in which advisory opinions will
9	be made available to the public.
10	"(f) Interval for Issuance of Advisory Opin-
11	IONS.—Under no circumstances shall the interval in which
12	the Secretary shall respond to a party requesting an advi-
13	sory opinion exceed 30 days.".
14	SEC. 2332. AUTHORIZING THE SECRETARY OF HEALTH AND
15	HUMAN SERVICES TO ISSUE ADVISORY OPIN-
16	IONS RELATING TO PHYSICIAN OWNERSHIP
17	AND REFERRAL.
18	Section 1877 of the Social Security Act (42 U.S.C.
19	1395nn) is amended by the addition of the following new
20	subsection:
21	"(i) Advisory Opinions.—
22	"(1) IN GENERAL.—The Secretary shall issue
23	advisory opinions on whether an arrangement or
24	proposed arrangement will result in a prohibited re-
25	ferral within the meaning of this section.

1	"(2) Effect of advisory opinions.—
2	"(A) Each advisory opinion issued by the
3	Secretary shall be binding as to the Secretary
4	and the party or parties requesting the opinion.
5	''(B) The failure of a party to seek an ad-
6	visory opinion may not be introduced into evi-
7	dence to prove that the party intended to vio-
8	late the provisions of this section.
9	"(3) REGULATIONS.—The Secretary within one
10	hundred and eighty days of the date of enactment,
11	shall issue regulations establishing a system for the
12	issuance of advisory opinions. Such regulations shall
13	provide for—
14	"(A) the procedure to be followed by a
15	party applying for an advisory opinion;
16	"(B) the procedure to be followed by the
17	Secretary in responding to a request for an ad-
18	visory opinion;
19	"(C) the interval in which the Secretary
20	shall respond;
21	"(D) the reasonable fee to be charged to
22	the party requesting an advisory opinion; and
23	"(E) the manner in which advisory opin-
24	ions will be made available to the public.

1 "(4) INTERVAL FOR ISSUANCE OF ADVISORY 2 OPINIONS.—Under no circumstances shall the inter-3 val in which the Secretary shall respond to a party 4 requesting an advisory opinion exceed thirty days.". 5 SEC. 2333. EFFECTIVE DATE. Unless otherwise specified, the amendments made by 6 7 this part shall be effective upon the enactment of this Act. **E**—Increased **Medicare** Subtitle 8 **Beneficiary Choice; Additional** 9 **Medicare Reforms** 10 11 PART 1-INCREASED MEDICARE BENEFICIARY 12 CHOICE 13 SEC. 2401. REQUIREMENTS FOR HEALTH MAINTENANCE 14 **ORGANIZATIONS UNDER MEDICARE.** 15 (a) Use of Metropolitan Statistical Areas to DETERMINE ADJUSTED AVERAGE PER CAPITA COST.— 16 of (42)U.S.C. 17 Section 1876(a)(4)such Act 1395mm(a)(4)) is amended by striking "in a geographic 18 area served by an eligible organization or in a similar 19 area" and inserting "in the metropolitan statistical area 20 (as defined by the Office of Management and Budget) in 21 22 which the individual resides, or in the entire portion of 23 the State in which the individual resides which is not lo-24 cated in a metropolitan statistical area in the case of an individual who does not reside in a metropolitan statistical
 area".

3 (b) DETERMINATION OF MODEL ADDITIONAL
4 HEALTH BENEFIT PACKAGES.—Section 1876(g) of such
5 Act (42 U.S.C. 1395mm(g)) is amended by inserting after
6 paragraph (3) the following new paragraph:

7 "(4) The Secretary shall develop the following model
8 packages of additional health benefits (referred to in para9 graph (3)(B)) which an eligible organization may provide
10 (at its option) under paragraph (2):

11 "(A) Coverage for catastrophic illness (subject
12 to a limit on out-of-pocket expenditures).

13 "(B) Coverage for prescription drugs.

14 "(C) Coverage for preventive services.".

15 (c) REVISION OF MEMBERSHIP LIMITATION.—Sec16 tion 1876(f) of the Social Security Act (42 U.S.C.
17 1395mm(f)) is amended—

18 (1) in paragraph (1), by striking "one-half"19 and inserting "25 percent"; and

20 (2) in paragraph (2)(A), by striking "50 per21 cent" and inserting "75 percent".

22 (d) ENROLLMENT PERIODS FOR MEDICARE HEALTH23 MAINTENANCE ORGANIZATIONS.—

24 (1) UNIFORM OPEN ENROLLMENT PERIOD.—
25 Section 1876(c)(3)(A)(i) of such Act (42 U.S.C.

1 1395mm(c)(3)(A)(i)) is amended by striking "must
2 have" and all that follows through "and including"
3 and inserting the following: "shall have open enroll4 ment during an annual uniform open enrollment pe5 riod established by the Secretary for all eligible orga6 nizations, together with".

7 (2)Open **ENROLLMENT** FOR CERTAIN 8 DISENROLLED INDIVIDUALS.—Section 9 1876(c)(3)(A)(ii)(I)of such Act (42) U.S.C. 10 1395 mm(c)(3)(A)(ii)(I)) is amended by adding at the end the following: "Each eligible organization 11 12 with a risk-sharing contract under this section shall 13 have an open enrollment period for individuals resid-14 ing in the organization's service area who disenroll 15 from another eligible organization with a risk-shar-16 ing contract under this section on the grounds that 17 the individual's primary care physician is no longer 18 a member of the organization's provider network or 19 for cause (in accordance with such standards, and as 20 demonstrated through an appeals process that meets 21 such requirements, as the Secretary may establish). 22 (e) EFFECTIVE DATE.—The amendments made by 23 this section shall apply to contracts entered into on or after the date of the enactment of this Act. 24

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 SEC. 2402. EXPANSION AND REVISION OF MEDICARE SE

 2
 LECT POLICIES.

3 (a) Permitting Medicare Select Policies in4 All States.—

5 (1) IN GENERAL.—Subsection (c) of section 6 4358 of the Omnibus Budget Reconciliation Act of 7 1990 (hereafter referred to as "OBRA–1990") is 8 hereby repealed.

9 (2) CONFORMING AMENDMENT.—Section 4358 10 of OBRA–1990 is amended by redesignating sub-11 section (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
16 1991 NAIC Model Regulation or 1991 Federal Regulation
17 and otherwise complies with the requirements of this sec18 tion 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

23 "(ii) in the case of a policy described in sub24 paragraph (C)(i)—

"(I) the benefits under such policy are not 1 2 one of the groups or packages of benefits described in subsection (p)(2)(A), 3 "(II) except for nominal copayments im-4 posed for services covered under part B of this 5 6 title, such benefits include at least the core 7 group of basic benefits described in subsection 8 (p)(2)(B), and "(III) an enrollee's liability under such pol-9 icy for physician's services covered under part 10 11 B of this title is limited to the nominal 12 copayments described in subclause (II), the policy shall nevertheless be treated as meeting those 13 standards if the policy meets the requirements of subpara-14 graph (B). 15 "(B) A policy meets the requirements of this sub-16 paragraph if— 17 18 "(i) full benefits are provided for items and 19 services furnished through a network of entities

21 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

which have entered into contracts or agreements

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1	and it is not reasonable given the circumstances to
2	obtain the services through the network,
3	''(iii) the network offers sufficient access,
4	''(iv) the issuer of the policy has arrangements
5	for an ongoing quality assurance program for items
6	and services furnished through the network,
7	((v)(I) the issuer of the policy provides to each
8	enrollee at the time of enrollment an explanation
9	of—
10	''(aa) the restrictions on payment under
11	the policy for services furnished other than by
12	or through the network,
13	"(bb) out of area coverage under the pol-
14	icy,
15	"(cc) the policy's coverage of emergency
16	services and urgently needed care, and
17	"(dd) the availability of a policy through
18	the entity that meets the 1991 Model NAIC
19	Regulation or 1991 Federal Regulation without
20	regard to this subsection and the premium
21	charged for such policy, and
22	"(II) each enrollee prior to enrollment acknowl-
23	edges receipt of the explanation provided under
24	subclause (I), and

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1	''(vi) the issuer of the policy makes available to
2	individuals, in addition to the policy described in this
3	subsection, any policy (otherwise offered by the is-
4	suer to individuals in the State) that meets the 1991
5	Model NAIC Regulation or 1991 Federal Regulation
6	and other requirements of this section without re-
7	gard to this subsection.
8	''(C)(i) A policy described in this subparagraph—
9	''(I) is offered by an eligible organization (as
10	defined in section 1876(b)),
11	''(II) is not a policy or plan providing benefits
12	pursuant to a contract under section 1876 or an ap-
13	proved demonstration project described in section
14	603(c) of the Social Security Amendments of 1983,
15	section 2355 of the Deficit Reduction Act of 1984,
16	or section 9412(b) of the Omnibus Budget Reconcili-
17	ation Act of 1986, and
18	"(III) provides benefits which, when combined
19	with benefits which are available under this title, are
20	substantially similar to benefits under policies of-
21	fered to individuals who are not entitled to benefits
22	under this title.
23	''(ii) In making a determination under subclause (III)
24	of clause (i) as to whether certain benefits are substan-
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 $25\;$ tially 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).".

7 (c) RENEWABILITY OF MEDICARE SELECT POLI8 CIES.—Section 1882(q)(1) of the Social Security Act (42
9 U.S.C. 1395ss(q)(1)) is amended—

10 (1) by striking "(1) Each" and inserting
11 "(1)(A) Except as provided in subparagraph (B),
12 each";

(2) by redesignating subparagraphs (A) and(B) as clauses (i) and (ii), respectively; and

15 (3) by adding at the end the following new sub-paragraph:

"(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

1	individual must be permitted to enroll in any medi-
	- · · ·
2	care supplemental policy offered by such issuer or
3	affiliate that provides benefits comparable to or less
4	than the benefits provided in the policy being can-
5	celed or nonrenewed. An individual whose coverage
6	is canceled or nonrenewed under this subparagraph
7	shall, as part of the notice of termination or
8	nonrenewal, be notified of the right to enroll in other
9	medicare supplemental policies offered by the issuer
10	or its affiliates.
11	''(iii) For purposes of this subparagraph, the
12	term 'affiliate' shall have the meaning given such
13	term by the 1991 NAIC Model Regulation.".
14	(d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of
15	the Social Security Act $(42 \text{ U.S.C. } 1395ss(t)(2))$ is
16	amended—
17	(1) by striking "(2)" and inserting "(2)(A)";
18	(2) by redesignating subparagraphs (A), (B),
19	(C), and (D) as clauses (i), (ii), (iii), and (iv), re-
20	spectively;
21	(3) in clause (iv), as so redesignated—
22	(A) by striking "paragraph $(1)(E)(i)$ " and
23	inserting "paragraph $(1)(B)(v)(I)$, and
24	(B) by striking ''paragraph (1)(E)(ii)'' and
25	inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking "the previous sentence" and in serting "this subparagraph"; and

3 (5) by adding at the end the following new sub-4 paragraph:

5 "(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a mis-6 7 representation to the Secretary or has provided the Secretary with false information regarding such policy, the 8 9 issuer is subject to a civil money penalty in an amount not to exceed \$100,000 for each such determination. The 10 provisions of section 1128A (other than the first sentence 11 of subsection (a) and other than subsection (b)) shall 12 apply to a civil money penalty under this subparagraph 13 in the same manner as such provisions apply to a penalty 14 15 or proceeding under section 1128A(a).".

16 (e) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months 17 18 after the date of the enactment of this Act, the Na-19 Association of Insurance Commissioners tional 20 (hereafter in this subsection referred to as the "NAIC") makes changes in the 1991 NAIC Model 21 22 Regulation (as defined in section 1882(p)(1)(A) of 23 the Social Security Act) to incorporate the additional 24 requirements imposed by the amendments made by 25 this section, section 1882(g)(2)(A) of such Act shall

be applied in each State, effective for policies issued 1 2 to policyholders on and after the date specified in 3 paragraph (3), as if the reference to the Model Reg-4 ulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) 5 6 as changed under this paragraph (such changed 7 Regulation referred to in this subsection as the "1994 NAIC Model Regulation"). 8

9 (2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model 10 11 Regulation (as so defined) within the 6-month period 12 specified in paragraph (1), the Secretary of Health 13 and Human Services (in this subsection as the "Sec-14 retary") shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be ap-15 plied in each State, effective for policies issued to 16 17 policyholders on and after the date specified in para-18 graph (3), as if the reference to the Model Regula-19 tion adopted in June 6, 1979, were a reference to 20 the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph 21 22 (such changed Regulation referred to in this subsection as the "1994 Federal Regulation"). 23

24 (3) DATE SPECIFIED.—

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1	(A) IN GENERAL.—Subject to subpara-
2	graph (B), the date specified in this paragraph
3	for a State is the earlier of—
4	(i) the date the State adopts the 1994
5	NAIC Model Regulation or the 1994 Fed-
6	eral Regulation; or
7	(ii) 1 year after the date the NAIC or
8	the Secretary first adopts such regulations.
9	(B) ADDITIONAL LEGISLATIVE ACTION RE-
10	QUIRED.—In the case of a State which the Sec-
11	retary identifies, in consultation with the NAIC,
12	as—
13	(i) requiring State legislation (other
14	than legislation appropriating funds) in
15	order for medicare supplemental policies to
16	meet the 1994 NAIC Model Regulation or
17	the 1994 Federal Regulation, but
18	(ii) having a legislature which is not
19	scheduled to meet in 1995 in a legislative
20	session in which such legislation may be
21	considered,
22	the date specified in this paragraph is the first
23	day of the first calendar quarter beginning after
24	the close of the first legislative session of the
25	State legislature that begins on or after Janu-

1	ary 1, 1995. For purposes of the previous sen-
2	tence, in the case of a State that has a 2-year
3	legislative session, each year of such session
4	shall be deemed to be a separate regular session
5	of the State legislature.
6	SEC. 2403. INCLUDING NOTICE OF AVAILABLE HEALTH
7	MAINTENANCE ORGANIZATIONS IN ANNUAL
8	NOTICE TO BENEFICIARIES.
9	Section 1804 of the Social Security Act (42 U.S.C.
10	1395b–2) is amended—
11	(1) by striking ''and'' at the end of paragraph
12	(2);
13	(2) by striking the period at the end of para-
14	graph (3) and inserting '', and''; and
15	(3) by inserting after paragraph (3) the follow-
16	ing new paragraph:
17	"(4) with respect to the area in which the indi-
18	vidual receiving the notice resides, a description of
19	the eligible organizations under section $1833(a)(1)$
20	or section 1876 and the carriers offering a medicare
21	supplemental policy described in section $1882(t)(1)$
22	which serve the area in which the individual receiv-
23	ing the notice resides.".

5211 SEC. 2404. LEGISLATIVE PROPOSAL ON ENROLLING MEDI-2 **CARE BENEFICIARIES IN QUALIFIED HEALTH** 3 PLANS. 4 (a) IN GENERAL.— 5 (1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the 6 7 Secretary shall develop and submit to Congress a 8 proposal for legislation which provides for the enroll-9 ment of medicare beneficiaries in private health in-10 surance plans (including medisave coverage de-11 scribed in section 1102(e)). 12 (2) MEDICARE BENEFICIARY.—For purposes of this section, the term "medicare beneficiary" means 13 14 an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is en-15 16 rolled under part B of such title. 17 (b) CONTENTS OF THE PROPOSAL.—A proposal for 18 legislation submitted under subsection (a) shall— 19 (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 26

(3) provide medicare beneficiaries with the op portunity to enroll in a private health insurance
 plan.

4 SEC. 2405. OPTIONAL INTERIM ENROLLMENT OF MEDICARE

5

BENEFICIARIES IN PRIVATE HEALTH PLANS.

6 (a) INTERIM ENROLLMENT OF MEDICARE BENE-7 FICIARIES IN QUALIFIED HEALTH PLANS.—

8 (1) IN GENERAL.—Notwithstanding title XVIII 9 of the Social Security Act, the Secretary shall pro-10 vide for a monthly payment as provided under sub-11 section (b)(1) to a private health insurance plan on 12 behalf of enrolled medicare beneficiaries who choose 13 to enroll in such a plan.

14 (2) MEDICARE BENEFICIARY.—For purposes of
15 this section, the term "medicare beneficiary" means
16 an individual who is eligible for benefits under part
17 A of title XVIII of the Social Security Act and is en18 rolled under part B of such title.

19 (b) PAYMENT SPECIFIED.—

20 (1) FEDERAL PAYMENT.—

21 (A) IN GENERAL.—The amount of pay22 ment specified in this paragraph for an individ23 ual who is enrolled in a private health insurance
24 plan is the lesser of—

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1	(i) the applicable rate specified in sec-
2	tion $1876(a)(1)(C)$ of the Social Security
3	Act; or
4	(ii) the monthly premium charged the
5	individual for coverage under the private
6	health insurance plan.
7	(B) SOURCE OF PAYMENT.—The payment
8	to a private health insurance plan under this
9	paragraph for individuals entitled to benefits
10	under part A and enrolled under part B of title
11	XVIII of the Social Security Act shall be made
12	from the Federal Hospital Insurance Trust
13	Fund and the Federal Supplementary Medical
14	Insurance Trust Fund, with the allocation to be
15	determined by the Secretary.
16	(2) INDIVIDUAL'S SHARE.—If the monthly pre-
17	mium for the private plan in which the individual is
18	enrolled is greater than the amount specified under
19	paragraph (1)(A)(i), the individual shall be respon-
20	sible for paying to the plan the difference between
21	the monthly premium charged the individual for cov-
22	erage under the plan and the amount specified in
23	paragraph (1)(A)(i).
24	(3) BUDGET-NEUTRALITY.—The total amount
25	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.

7 (c) PAYMENTS UNDER THIS SECTION AS SOLE MEDI-8 CARE BENEFITS.—Payments made under this section 9 shall be instead of the amounts that would otherwise be 10 payable, pursuant to sections 1814(b) and 1833(a) of the 11 Social Security Act, for services furnished to medicare 12 beneficiaries.

(d) INCLUSION IN ANNUAL NOTICE TO BENEFICIARIES.—Section 1804 of the Social Security Act (42
U.S.C. (42 U.S.C. 1395b-2), as amended by section 2403,
is amended

17 (1) by striking "and" at the end of paragraph18 (3);

(2) by striking the period at the end of para-graph (4) and inserting ", and"; and

21 (3) by inserting after paragraph (4) the follow-22 ing new paragraph:

23 "(5) a description of the option provided pursu24 ant to section 2405 of the Affordable Health Care
25 Now Act of 1994 for payment to be made by the

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1	Secretary on the individual's behalf for enrollment in
2	a private health insurance plan.''.
3	PART 2—MEDICARE PART B PREMIUM; OTHER
4	MEDICARE PAYMENT CHANGES
5	SEC. 2411. EXTENSION OF CURRENT RULES FOR COMPUT-
6	ING MEDICARE PART B PREMIUM.
7	Section 1839(e) of the Social Security Act (42 U.S.C.
8	1395r(e)) is amended—
9	(1) in paragraph (1)(A), by striking ''January
10	1999" and inserting "January 2005"; and
11	(2) in paragraph (2), by striking ''January
12	1998" and inserting "January 2004".
13	SEC. 2412. INCREASE IN MEDICARE PART B PREMIUM FOR
14	INDIVIDUALS WITH HIGH INCOME.
15	(a) IN GENERAL.—Subchapter A of chapter 1 of the
16	Internal Revenue Code of 1986 is amended by adding at
17	the end thereof the following new part:
18	"PART VIII—MEDICARE PART B PREMIUMS FOR
19	HIGH-INCOME INDIVIDUALS
	"Sec. 59B. Medicare part B premium tax.
20	"SEC. 59B. MEDICARE PART B PREMIUM TAX.
21	"(a) IMPOSITION OF TAX.—In the case of an individ-

21 "(a) IMPOSITION OF TAX.—In the case of an individ-22 ual to whom this section applies for the taxable year, there 23 is hereby imposed (in addition to any other tax imposed 24 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.

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

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

9 "(2) the modified adjusted gross income of the 10 taxpayer for such taxable year exceeds the threshold 11 amount.

12 "(c) MEDICARE PART B PREMIUM TAX FOR13 MONTH.—

14 "(1) IN GENERAL.—The Medicare part B pre15 mium tax for any month is ²/₃ the amount equal to
16 the excess of—

17 "(A) 150 percent of the monthly actuarial
18 rate for enrollees age 65 and over determined
19 for that calendar year under section 1839(b) of
20 the Social Security Act, over

21 "(B) the total monthly premium under sec22 tion 1839 of the Social Security Act (deter23 mined without regard to subsections (b) and (f)
24 of section 1839 of such Act).

1	"(2) PHASEIN OF TAX.—If the modified ad-
2	justed gross income of the taxpayer for any taxable
3	years exceeds the threshold amount by less than
4	\$50,000, the Medicare part B premium tax for any
5	month during such taxable year shall be an amount
6	which bears the same ratio to the amount deter-
7	mined under paragraph (1) (without regard to this
8	paragraph) as such excess bears to \$50,000. The
9	preceding sentence shall not apply to any individual
10	whose threshold amount is zero.
11	"(d) Other Definitions and Special Rules.—
12	For purposes of this section—
13	"(1) THRESHOLD AMOUNT.—The term 'thresh-
14	old amount' means—
14 15	old amount' means— ''(A) except as otherwise provided in this
15	"(A) except as otherwise provided in this
15 16	''(A) except as otherwise provided in this paragraph, \$100,000,
15 16 17	"(A) except as otherwise provided in this paragraph, \$100,000,"(B) \$125,000 in the case of a joint re-
15 16 17 18	''(A) except as otherwise provided in this paragraph, \$100,000,''(B) \$125,000 in the case of a joint return, and
15 16 17 18 19	 "(A) except as otherwise provided in this paragraph, \$100,000, "(B) \$125,000 in the case of a joint return, and "(C) zero in the case of a taxpayer who—
15 16 17 18 19 20	 "(A) except as otherwise provided in this paragraph, \$100,000, "(B) \$125,000 in the case of a joint return, and "(C) zero in the case of a taxpayer who— "(i) is married at the close of the tax-
 15 16 17 18 19 20 21 	 "(A) except as otherwise provided in this paragraph, \$100,000, "(B) \$125,000 in the case of a joint return, and "(C) zero in the case of a taxpayer who—

1	"(2) Modified adjusted gross income.—
2	The term 'modified adjusted gross income' means
3	adjusted gross income—
4	"(A) determined without regard to sections
5	135, 911, 931, and 933, and
6	"(B) increased by the amount of interest
7	received or accrued by the taxpayer during the
8	taxable year which is exempt from tax.
9	"(3) MEDICARE PART B COVERAGE.—An indi-
10	vidual shall be treated as covered under Medicare
11	part B for any month if a premium is paid under
12	part B of title XVIII of the Social Security Act for
13	the coverage of the individual under such part for
14	the month.
15	"(4) MARRIED INDIVIDUAL.—The determina-
16	tion of whether an individual is married shall be
17	made in accordance with section 7703."
18	(b) CLERICAL AMENDMENT.—The table of parts for
19	subchapter A of chapter 1 of such Code is amended by
20	adding at the end thereof the following new item:
	"Part VIII. Medicare Part B Premiums For High-Income Individ- uals."
21	(c) EFFECTIVE DATE.—The amendments made by
22	this section shall apply to months after December 1994

23 in taxable years ending after December 31, 1994.

SEC. 2413. IMPROVED EFFICIENCY THROUGH CONSOLIDA TION OF ADMINISTRATION OF PARTS A AND B.

4 (a) IN GENERAL.—The Secretary of Health and 5 Human Services shall take such steps as may be necessary 6 to consolidate the administration (including processing 7 systems) of parts A and B of the medicare program (under 8 title XVIII of the Social Security Act) including over a 9 5-year period.

10 (b) COMBINATION OF INTERMEDIARY AND CARRIER 11 FUNCTIONS.—In taking such steps, the Secretary shall 12 contract with a single entity that combines the fiscal 13 intermediary and carrier functions in each area except 14 where the Secretary finds that special regional or national 15 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.

21SEC. 2414. EXTENSION OF MEDICARE SECONDARY PAY-22MENT PROVISIONS.

23 (a) EXTENSION OF DATA MATCH.—

24 (1) Section 1862(b)(5)(C)(iii) of the Social Se25 curity Act (42 U.S.C. 1395y(b)(5)(C)(iii)) is amend26 ed by striking "1998" and inserting "2004".

1	(2) Section $6103(l)(12)(F)$ of the Internal Rev-
2	enue Code of 1986 is amended—
3	(A) in clause (i), by striking ''1998'' and
4	inserting ''2004'',
5	(B) in clause (ii)(I), by striking ''1997''
6	and inserting "2003", and
7	(C) in clause (ii)(II), by striking ''1998''
8	and inserting "2004".
9	(b) Extension of Medicare Secondary Payer
10	TO DISABLED BENEFICIARIES.—Section
11	1862(b)(1)(B)(iii) of such Act (42 U.S.C.
12	1395y(b)(1)(B)(iii)) is amended by striking "1998" and
13	inserting "2004".
14	(c) Extension of Period for End Stage Renal
15	DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) of such
16	Act (42 U.S.C. $1395y(b)(1)(C)$) is amended in the second
17	sentence by striking "1998" and inserting "2004".
18	Subtitle F—Health Care Antitrust
19	Improvements
20	SEC. 2501. PROTECTION FROM ANTITRUST LAWS FOR CER-
21	TAIN COMPETITIVE AND COLLABORATIVE
22	ACTIVITIES.
23	(a) PROTECTIONS DESCRIBED.—An activity relating
24	to the provision of health care services shall receive the
25	following protection from the antitrust laws:

1 (1) If the activity is within a safe harbor des-2 ignated by the Attorney General under section 2502, 3 the safe harbor shall be a defense to all antitrust 4 claims, except for claims for injunctive relief as-5 serted by the Attorney General or the Chair of the 6 Federal Trade Commission in extraordinary cir-7 cumstances.

8 (2) If the activity is specified in and in compli-9 ance with the terms of a certificate of review issued 10 by the Attorney General under section 2503 and the 11 activity occurs while the certificate is in effect, the 12 certificate shall be a defense to antitrust claims, 13 other than claims for injunctive relief.

14 (b) Award of Attorney's Fees and Costs of15 Suit.—

16 (1) IN GENERAL.—If any person brings an ac-17 tion alleging a claim under the antitrust laws and 18 the activity on which the claim is based is found by 19 the court to be protected from such laws under sub-20 section (a), the court shall, at the conclusion of the 21 action—

(A) award to a substantially prevailing
claimant the cost of suit attributable to such
claim, including a reasonable attorney's fee, or

1 (B) award to a substantially prevailing 2 party defending against such claim the cost of such suit attributable to such claim, including 3 4 reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the 5 6 claim. was frivolous, unreasonable, without 7 foundation, or in bad faith. 8 (2) OFFSET IN CASES OF BAD FAITH.—The 9 court may reduce an award made pursuant to paragraph (1) in whole or in part by an award in favor 10 11 of another party for any part of the cost of suit (in-

12 cluding a reasonable attorney's fee) attributable to
13 conduct during the litigation by any prevailing party
14 that the court finds to be frivolous, unreasonable,
15 without foundation, or in bad faith.

16 SEC. 2502. DESIGNATION OF SAFE HARBORS.

17 (a) IN GENERAL.—

(1) DESIGNATION BY ATTORNEY GENERAL.—
The Attorney General, in consultation with the Secretary of Health and Human Services and the Chair,
shall develop and designate pursuant to paragraph
(C) safe harbors for purposes of section 2501(a)(1)
relating to—

24 (A) each category of activities referred to25 in paragraph (2); and

1	(B) such other categories of activities as
2	the Attorney General may designate in accord-
3	ance with the process described in this section.
4	(2) Required categories of activities sub-
5	JECT TO SAFE HARBORS.—The categories of activi-
6	ties referred to in this paragraph are as follows:
7	(A) Joint purchasing of health care
8	SERVICES.—Providing the terms under which
9	consumers of health care services (patients or
10	others acting on their behalf) may jointly nego-
11	tiate and purchase health care services.
12	(B) SMALL HOSPITAL MERGERS.—Provid-
13	ing for small hospitals lawfully to merge under
14	the antitrust laws without undue delay or re-
15	view, taking into account the special needs and
16	circumstances of rural health care markets.
17	(C) NETWORK FORMATION AND OPER-
18	ATION.—Permitting activities related to the
19	startup and operation of collaborations between
20	State-licensed providers through partial or full
21	integration, including multi-provider networks,
22	hospital networks, physician-hospital organiza-
23	tions, and other efforts to provide health care
24	services more efficiently.

1 (D) ACTIVITIES OF MEDICAL SELF-REGU-2 LATORY ENTITIES.—Permitting standard set-3 ting and enforcement activities by medical self-4 regulatory entities (such as hospital boards and 5 medical societies) to promote health care qual-6 ity, except that a safe harbor under this paragraph may not provide protection for any activ-7 ity undertaken for financial gain or for anti-8 9 competitive reasons.

10 (E) PROVISION OF INFORMATION TO BUY-11 ERS AND CONSUMERS.—Permitting health care 12 providers collectively to supply non-price medical information to buyers and consumers relat-13 14 ing to the type, quality and efficiency of treat-15 ment, including joint views on procedures that 16 should be covered by purchasers and medical 17 protocols, except that a safe harbor under this 18 subparagraph may not provide protection for 19 any collective refusals to deal or collective at-20 tempts at coercion.

(F) PARTICIPATION IN SURVEYS.—Providing the terms under which health care providers
may lawfully participate in written surveys of
prices of services, reimbursements received, employee compensation, and other relevant areas.

1 (G) HIGH-TECHNOLOGY AND TERTIARY 2 CARE JOINT VENTURES.—Permitting activities 3 of health care joint ventures to purchase or use 4 new or existing high technology or costly equip-5 ment, or to provide advanced tertiary care 6 services.

7 (H) MARKET POWER SCREENS.—Providing 8 market power screens at appropriate levels 9 below which combinations of health care provid-10 ers are too small to pose a realistic antitrust 11 threat. There may be different levels for dif-12 ferent activities and markets, taking into ac-13 count the special needs of rural health care markets. 14

(I) JOINT PURCHASING ARRANGEMENTS.—
Providing the terms under which health care
providers may make joint purchases of products
and services.

(J) GOOD FAITH NEGOTIATIONS.—Providing the terms under which health care providers
may engage in discussions relating to legitimate
collaborative activities contemplated by the safe
harbors.

24 (b) PROCESS FOR DESIGNATION OF ADDITIONAL25 CATEGORIES OF ACTIVITIES.—

1 (1) SOLICITATION OF PROPOSALS.—Not later 2 than 30 days after the date of the enactment of this 3 Act, the Attorney General shall publish a notice in 4 the Federal Register soliciting proposals for safe 5 harbors.

6 (2) REVIEW OF PROPOSED SAFE HARBORS.— 7 Not later than 180 days after the date of the enact-8 ment of this Act, the Attorney General (in consulta-9 tion with the Secretary and the Chair) shall review 10 the proposed safe harbors submitted under para-11 graph (1) and include a description of the safe har-12 bors in the report under subsection (d).

(3) ADDITIONAL SAFE HARBORS.—After submitting the report under subsection (d), the Attorney General (in consultation with the Secretary and
the Chair) may from time to time add additional
safe harbors in accordance with the procedures described in this subsection.

19 (c) EFFECTIVE DATE OF SAFE HARBORS.—

(1) PUBLICATION.—Not later than 180 days
after the date of the enactment of this Act, the Attorney General shall publish in the Federal Register
for public comment the safe harbors proposed for
designation under this section. Not later than 180
days after publishing such proposed safe harbors in

the Federal Register, the Attorney General shall
 issue final rules establishing such safe harbors.

3 (2) EFFECTIVE DATE.—The safe harbors estab4 lished under the final rules issued under paragraph
5 (1) shall take effect 90 days after issuance, unless
6 disapproved by the Congress.

7 (d) REPORT ON PROPOSED SAFE HARBORS.—Not later than 180 days after the date of the enactment of 8 this Act, the Attorney General (in consultation with the 9 Secretary and the Chair) shall submit a report to Congress 10 describing the proposals from subsections (a) and (b)(1)11 to be included in the publication of safe harbors described 12 in subsection (c)(1) and the proposals from subsection 13 (b)(1) that are not to be so included, together with expla-14 15 nations therefor.

16 (e) MODIFICATION OR REMOVAL OF SAFE HAR-17 BORS.—The Attorney General (in consultation with the 18 Secretary and the Chair) may modify or remove a safe 19 harbor following notice and comment upon a determina-20 tion that the safe harbor does not meet the criteria of sub-21 section (f).

(f) CRITERIA FOR SAFE HARBORS.—In establishing
safe harbors under this section, the Attorney General shall
take into account the following:

1	(1) The extent to which a competitive or col-
2	laborative activity will accomplish any of the follow-
3	ing:
4	(A) An increase in access to health care
5	services.
6	(B) The enhancement of the quality of
7	health care services.
8	(C) The establishment of cost efficiencies
9	that will be passed on to consumers, including
10	economies of scale and reduced transaction and
11	administrative costs.
12	(D) An increase in the ability of health
13	care facilities to provide services in medically
14	underserved areas or to medically underserved
15	populations.
16	(E) An improvement in the utilization of
17	health care resources or the reduction in the in-
18	efficient duplication of the use of such re-
19	sources.
20	(2) Whether the designation of an activity as a
21	safe harbor will result in the following outcomes:
22	(A) Health plans and other health care in-
23	surers, consumers of health care services, and
24	health care providers will be better able to ne-

1	gotiate payment and service arrangements
2	which will reduce costs to consumers.
3	(B) Taking into consideration the charac-
4	teristics of the particular purchasers and pro-
5	viders involved, competition will not be unduly
6	restricted.
7	(C) Equally efficient and less restrictive al-
8	ternatives do not exist to meet the criteria de-
9	scribed in paragraph (1).
10	(D) The activity will not unreasonably
11	foreclose competition by denying competitors a
12	necessary element of competition.
13	SEC. 2503. CERTIFICATES OF REVIEW.
14	(a) ESTABLISHMENT OF PROGRAM.—In consultation
15	with the Secretary, the Attorney General shall (not later
16	than 180 days after the date of the enactment of this Act)
17	issue certificates of review in accordance with this section
18	for providers of health care services and advise and assist
19	any person with respect to applying for such a certificate
20	of review.
21	(b) PROCEDURES FOR APPLICATION FOR CERTIFI-
22	CATE.—
23	(1) SUBMISSION OF APPLICATION.—

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1	(A) FORM; CONTENT.—To apply for a cer-
2	tificate of review, a person shall submit to the
3	Attorney General a written application which—
4	(i) specifies the activities relating to
5	the provision of health care services which
6	satisfy the criteria described in section
7	2502(e) and which will be included in the
8	certificate; and
9	(ii) is in a form and contains any in-
10	formation, including information pertain-
11	ing to the overall market in which the ap-
12	plicant operates, required by rule or regu-
13	lation promulgated under section 2506.
14	(B) FILING FEE.—The Attorney General
15	may require a filing fee to be submitted with
16	the application to cover the cost of publication
17	and the cost of review required by this section.
18	The amount of the filing fee shall be deter-
19	mined on a sliding scale established by the At-
20	torney General (based on the monetary size of
21	the transaction involved), except that such fee
22	may not exceed \$5,000.
23	(2) Publication of notice in federal reg-
24	ISTER.—Within 10 days after an application submit-
25	ted under paragraph (1) is received by the Attorney

General, the Attorney General shall publish in the Federal Register a notice that announces that an application for a certificate of review has been submitted, identifies each person submitting the application, and describes the conduct for which the application is submitted.

7 (3) ESTABLISHMENT OF PROCEDURES FOR IS-8 SUANCE OF CERTIFICATE.—In consultation with the 9 Chair and the Secretary, the Attorney General shall 10 establish procedures to be used in applying for and 11 in determining whether to approve an application for a certificate of review under this title. Under such 12 13 procedures the Attorney General, in consultation 14 with the Secretary, shall approve an application if 15 the Attorney General determines that the activities 16 to be covered under the certificate will satisfy the 17 criteria described in section 2502(f) for safe harbors 18 designated under such section and that the benefits 19 of the issuance of the certificate will outweigh any 20 disadvantages that may result from reduced competition. If the Attorney General, with the concur-21 22 rence of the Secretary, determines that the require-23 ments for a certificate are met, the Attorney General 24 shall issue to the applicant a certificate of review. 25 The certificate of review shall specify—

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1	(i) the health care market activities to
2	which the certificate applies,
3	(ii) the person to whom the certificate
4	of review is issued, and
5	(iii) any terms and conditions the At-
6	torney General or the Secretary deems nec-
7	essary to assure compliance with the appli-
8	cable procedures described in paragraph
9	(3).
10	(4) TIMING FOR DECISION ON APPLICATION.—
11	Within 90 days after the Attorney General receives
12	an application for a certificate of review, the Attor-
13	ney General shall determine whether to grant or
14	deny the certificate.
15	(5) NOTIFICATION OF DECISION.—The Attor-
16	ney General shall notify the applicant of the Attor-
17	ney General's determination and if the application is
18	denied, the reasons for the denial.
19	(6) Fraudulent procurement.—A certifi-
20	cate of review shall be void ab initio with respect to
21	any health care market activities for which the cer-
22	tificate was procured by fraud.
23	(c) Amendment and Revocation of Certifi-
24	CATES.—

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1	(1) NOTIFICATION OF CHANGES.—Any appli-
2	cant who receives a certificate of review—
3	(A) shall promptly report to the Attorney
4	General any change relevant to the matters
5	specified in the certificate; and
6	(B) may submit to the Attorney General
7	an application to amend the certificate to re-
8	flect the effect of the change on the conduct
9	specified in the certificate.
10	(2) Amendment to certificate.—An appli-
11	cation for an amendment to a certificate of review
12	shall be treated as an application for the issuance of
13	a certificate. The effective date of an amendment
14	shall be the date on which the application for the
15	amendment is received by the Attorney General.
16	(3) REVOCATION.—
17	(A) GROUNDS FOR REVOCATION.—In ac-
18	cordance with this paragraph, the Attorney
19	General, in consultation with the Secretary,
20	may revoke in whole or in part a certificate of
21	review issued under this section. There shall be
22	considered as grounds for the revocation of a
23	certificate the fact that—
24	(i) after the expiration of the 2-year
25	period beginning on the date a person's

1	certificate is issued, the activities of the
2	person have not substantially accomplished
3	the purposes for the issuance of the certifi-
4	cate;
5	(ii) the person has failed to comply
6	with any of the terms or conditions im-
7	posed under the certificate by the Attorney
8	General or the Secretary under subsection
9	(b)(4); or
10	(iii) the activities covered under the
11	certificate no longer satisfy the criteria set
12	forth in section 2502(f).
13	(B) REQUEST FOR COMPLIANCE INFORMA-
14	TION.—If the Attorney General or the Sec-
15	retary has reason to believe that any of the
16	grounds for revocation of a certificate of review
17	described in subparagraph (A) may apply to a
18	person holding the certificate, the Attorney
19	General shall request such information from
20	such person as the Attorney General or the Sec-
21	retary deems necessary to resolve the matter of
22	compliance. Failure to comply with such request
23	shall be grounds for revocation of the certificate
24	under this paragraph.

1 (C) PROCEDURES FOR REVOCATION.—If 2 the Attorney General or the Secretary deter-3 mines that any of the grounds for revocation of 4 a certificate of review described in subparagraph (A) apply to a person holding the certifi-5 6 cate, or that such person has failed to comply 7 with a request made under subparagraph (B), the Attorney General shall give written notice of 8 9 the determination to such person. The notice shall include a statement of the circumstances 10 11 underlying, and the reasons in support of, the 12 determination. In the 60-day period beginning 13 30 days after the notice is given, the Attorney 14 General shall revoke the certificate or modify it 15 as the Attorney General or the Secretary deems 16 necessary to cause the certificate to apply only 17 to activities that meet the criteria set forth in 18 section 2502(f).

19 (D) INVESTIGATION AUTHORITY.—For 20 purposes of carrying out this paragraph, the Attorney General may conduct investigations in 21 22 the same manner as the Attorney General con-23 ducts investigations under section 3 of the Anti-24 trust Civil Process Act, except that no civil in-25 vestigative demand may be issued to a person

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1	to whom a certificate of review is issued if such
2	person is the target of such investigation.
3	(d) REVIEW OF DETERMINATIONS.—
4	(1) AVAILABILITY OF REVIEW FOR CERTAIN AC-
5	TIONS.—If the Attorney General denies, in whole or
6	in part, an application for a certificate of review or
7	for an amendment to a certificate, or revokes or
8	modifies a certificate pursuant to paragraph (3), the
9	applicant or certificate holder (as the case may be)
10	may, within 30 days of the denial or revocation,
11	bring an action in the United States District Court
12	for the District of Columbia to set aside the deter-
13	mination on the ground that such determination is
14	clearly erroneous.

(2) NO OTHER REVIEW PERMITTED.—Except
as provided in paragraph (1), no action by the Attorney General, the Chair, or the Secretary pursuant
to this subtitle shall be subject to judicial review.

(3) EFFECT OF REJECTED APPLICATION.—If
the Attorney General denies, in whole or in part, an
application for a certificate of review or for an
amendment to a certificate, or revokes or amends a
certificate, neither the negative determination nor
the statement of reasons therefore shall be admissible in evidence, in any administrative or judicial pro-

ceeding, concerning any claim under the antitrust
 laws.

3 (e) PUBLICATION OF DECISIONS.—The Attorney 4 General shall publish a notice in the Federal Register on 5 a timely basis of each decision made with respect to an 6 application for a certificate of review under this section 7 or the amendment or revocation of such a certificate, in 8 a manner that protects the confidentiality of any propri-9 etary information relating to the application.

10 (f) ANNUAL REPORTS.—Every person to whom a cer-11 tificate of review is issued shall submit to the Attorney 12 General an annual report, in such form and at such time 13 as the Attorney General may require, that contains any 14 necessary updates to the information required under sub-15 section (b) and a description of the activities of the holder 16 under the certificate during the preceding year.

17 (g) RESTRICTIONS ON DISCLOSURE OF INFORMA-18 TION.—

(1) WAIVER OF DISCLOSURE REQUIREMENTS
UNDER ADMINISTRATIVE PROCEDURE ACT.—Information submitted by any person in connection with
the issuance, amendment, or revocation of a certificate of review shall be exempt from disclosure under
section 552 of title 5, United States Code.

1	(2) Restrictions on disclosure of com-
2	MERCIAL OR FINANCIAL INFORMATION.—
3	(A) IN GENERAL.—Except as provided in
4	subparagraph (B), no officer or employee of the
5	United States shall disclose commercial or fi-
6	nancial information submitted in connection
7	with the issuance, amendment, or revocation of
8	a certificate of review if the information is priv-
9	ileged or confidential or if disclosure of the in-
10	formation would cause harm to the person who
11	submitted the information.
12	(B) EXCEPTIONS.—Subparagraph (A)
13	shall not apply with respect to information dis-
14	closed—
15	(i) upon a request made by the Con-
16	gress or any committee of the Congress,
17	(ii) in a judicial or administrative pro-
18	ceeding, subject to appropriate protective
19	orders,
20	(iii) with the consent of the person
21	who submitted the information,
22	(iv) in the course of making a deter-
23	mination with respect to the issuance,
24	amendment, or revocation of a certificate
25	of review, if the Attorney General deems

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disclosure of the information to be nec-
essary in connection with making the de-
termination,
(v) in accordance with any require-
ment imposed by a statute of the United
States, or
(vi) in accordance with any rule or
regulation promulgated under subsection
(i) permitting the disclosure of the infor-
mation to an agency of the United States
or of a State on the condition that the
agency will disclose the information only
under the circumstances specified in
clauses (i) through (v).
(3) PROHIBITION AGAINST USE OF INFORMA-
TION TO SUPPORT OR ANSWER CLAIMS UNDER ANTI-
TRUST LAWS.—Any information disclosed in an ap-
plication for a certificate of review under this section
shall only be admissible into evidence in a judicial or
administrative proceeding for the sole purpose of es-
tablishing whether a person is entitled to the protec-
tions provided by such a certificate.

1	SEC. 2504. NOTIFICATIONS PROVIDING REDUCTION IN CER-
2	TAIN PENALTIES UNDER ANTITRUST LAW
3	FOR HEALTH CARE JOINT VENTURES.
4	(a) NOTIFICATIONS DESCRIBED.—
5	(1) SUBMISSION OF NOTIFICATION BY VEN-
6	TURE.—Any party to a health care joint venture,
7	acting on such venture's behalf, may, not later than
8	90 days after entering into a written agreement to
9	form such venture or not later than 90 days after
10	the date of the enactment of this Act, whichever is
11	later, file with the Attorney General a written notifi-
12	cation disclosing—
13	(A) the identities of the parties to such
14	venture,
15	(B) the nature and objectives of such ven-
16	ture, and
17	(C) such additional information as the At-
18	torney General may require by regulation.
19	(2) FILING FEE.—The Attorney General may
20	require a filing fee to be submitted with the notifica-
21	tion to cover the cost of publication and the cost of
22	administering this section, except that the amount of
23	such fee shall not exceed \$250.
24	(3) SUBMISSION OF ADDITIONAL INFORMA-
25	TION.—

1	(A) Request of attorney general.—
2	At any time after receiving a notification filed
3	under paragraph (1), the Attorney General may
4	require the submission of additional information
5	or documentary material relevant to the pro-
6	posed health care joint venture.
7	(B) PARTIES TO VENTURE.—Any party to
8	a health care joint venture may submit such ad-
9	ditional information on the venture's behalf as
10	may be appropriate to ensure that the venture
11	will receive the protections provided under sub-
12	section (b).
13	(C) Required submission of informa-
14	tion on changes to venture.—A health
15	care joint venture for which a notification is in
16	effect under this section shall submit informa-
17	tion on any change in the membership of the
18	venture not later than 90 days after such
19	change occurs.
20	(4) PUBLICATION OF NOTIFICATION.—
21	(A) INFORMATION MADE PUBLICLY AVAIL-
22	ABLE.—Not later than 30 days after receiving
23	a notification with respect to a venture under
24	paragraph (1), the Attorney General shall pub-
25	lish in the Federal Register a notice with re-

spect to the venture that identifies the parties
to the venture and generally describes the purpose and planned activity of the venture. Prior
to its publication, the contents of the notice
shall be made available to the parties to the
venture.

7 (B) **Restriction** on DISCLOSURE OF 8 OTHER INFORMATION.—All information and 9 documentary material submitted pursuant to 10 this section and all information obtained by the 11 Attorney General in the course of any investiga-12 tion or case with respect to a potential violation of the antitrust laws by the health care joint 13 venture (other than information and material 14 15 described in subparagraph (A)) shall be exempt from disclosure under section 552 of title 5, 16 17 United States Code, and shall not be made pub-18 licly available by any agency of the United 19 States to which such section applies except in 20 a judicial proceeding in which such information 21 and material is subject to any protective order. 22 (5) WITHDRAWAL OF NOTIFICATION.—Any person who files a notification pursuant to this section 23 24 may withdraw such notification before a publication by the Attorney General pursuant to paragraph (4). 25

1 (6) NO JUDICIAL REVIEW PERMITTED.—Any 2 action taken or not taken by the Attorney General 3 with respect to notifications filed pursuant to this 4 subsection shall not be subject to judicial review.

5 (b) PROTECTIONS FOR VENTURES SUBJECT TO6 NOTIFICATION.—

7 (1) IN GENERAL.—

8 (A) PROTECTIONS DESCRIBED.—Except as 9 provided in subsection (c), the provisions of 10 paragraphs (2), (3), (4), and (5) shall apply 11 with respect to any action under the antitrust 12 laws challenging conduct within the scope of a 13 notification which is in effect pursuant to sub-14 section (a)(1).

15 (B) TIMING OF PROTECTIONS.—The pro-16 tections described in this subsection shall apply 17 to the venture that is the subject of a notifica-18 tion under subsection (a)(1) as of the earlier 19 of—

20 (i) the date of the publication in the
21 Federal Register of the notice published
22 with respect to the notification; or

(ii) if such notice is not published during the period required under subsection
(a) (4), the expiration of the 30-day period

1	that begins on the date the Attorney Gen-
2	eral receives any necessary information re-
3	quired to be submitted under subsection
4	(a)(1) or any additional information re-
5	quired by the Attorney General under sub-
6	section (a)(3)(A).

7 (2)APPLICABILITY RULE OF OF REASON 8 STANDARD.—In any action under the antitrust laws, 9 the conduct of any person which is within the scope 10 of a notification filed under subsection (a) shall not 11 be deemed illegal per se, but shall be judged on the 12 basis of its reasonableness, taking into account all 13 relevant factors affecting competition, including, but 14 not limited to, effects on competition in relevant 15 markets.

16 (3) LIMITATION ON RECOVERY TO ACTUAL 17 DAMAGES AND INTEREST.—Notwithstanding section 18 4 of the Clayton Act, any person who is entitled to 19 recovery under the antitrust laws for conduct that is within the scope of a notification filed under sub-20 21 section (a) shall recover the actual damages sus-22 tained by such person and interest calculated at the 23 rate specified in section 1961 of title 28, United 24 States Code, for the period beginning on the earliest 25 date for which injury can be established and ending

1	on the date of judgment, unless the court finds that
2	the award of all or part of such interest is unjust
3	under the circumstances.
4	(4) Award of attorney's fees and costs
5	OF SUIT.—
6	(A) IN GENERAL.—In any action under the
7	antitrust laws brought against a health care
8	joint venture for conduct that is within the
9	scope of a notification filed under subsection
10	(a), the court shall, at the conclusion of the ac-
11	tion—
12	(i) award to a substantially prevailing
13	claimant the cost of suit attributable to
14	such claim, including a reasonable attor-
15	ney's fee, or
16	(ii) award to a substantially prevailing
17	party defending against such claim the
18	cost of such suit attributable to such claim,
19	including a reasonable attorney's fee, if the
20	claim, or the claimant's conduct during
21	litigation of the claim, was frivolous, un-
22	reasonable, without foundation, or in bad
23	faith.
24	(B) OFFSET IN CASES OF BAD FAITH.—
25	The court may reduce an award made pursuant

to subparagraph (A) in whole or in part by an
award in favor of another party for any part of
the cost of suit (including a reasonable attor-
ney's fee) attributable to conduct during the
litigation by any prevailing party that the court
finds to be frivolous, unreasonable, without
foundation, or in bad faith.
(5) Restrictions on admissibility of in-
FORMATION.—
(A) IN GENERAL.—Any information dis-
closed in a notification submitted under sub-
section $(a)(1)$ and the fact of the publication of
a notification by the Attorney General under
subsection (a)(4) shall only be admissible into
evidence in a judicial or administrative proceed-
ing for the sole purpose of establishing whether
a party to a health care joint venture is entitled
to the protections described in this subsection.
(B) ACTIONS OF ATTORNEY GENERAL.—
No action taken by the Attorney General pursu-
ant to this section shall be admissible into evi-
dence in any judicial or administrative proceed-
ing for the purpose of supporting or answering
any claim under the antitrust laws.
(c) Exception for Certain Activities.—

1 (1) ACTIVITIES DESCRIBED.—The protections 2 described in subsection (b) shall not apply to con-3 duct which constitutes price-fixing, bid-rigging, or 4 market allocation, unless such conduct is related to 5 procompetitive aspects of a health care joint venture 6 (as determined in accordance with the process de-7 scribed in paragraph (2)).

8 (2) PROCESS.—If conduct of a health care joint 9 venture which is subject to a notification under subsection (a)(1) is challenged for price-fixing, bid-rig-10 11 ging, or market allocation, any party to the joint 12 venture shall be entitled to show the procompetitive aspects of such conduct. The protections described 13 in subsection (b) shall not apply to the conduct if 14 15 the party is unable to show that the conduct is not 16 mere price-fixing, bid-rigging, or market allocation. 17 SEC. 2505. REVIEW AND REPORTS ON SAFE HARBORS, CER-

18

TIFICATES OF REVIEW, AND NOTIFICATIONS.

(a) IN GENERAL.—The Attorney General, in consultation with the Secretary and the Chair, shall periodically review the safe harbors designated under section
2502, the certificates of review issued under section 2503,
and notification received under section 2504, and—

(1) with respect to the safe harbors, issue modi-fications to such safe harbors in such manner as the

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1 Attorney General considers appropriate in accord-2 ance with the requirements of section 2502, which 3 modifications shall take effect 90 days after issu-4 ance, unless disapproved by the Congress; and

5 (2) with respect to the certificates of review and 6 notifications, submit a report to Congress on the is-7 suance of such certificates and receipt of notifica-8 tions, including a description of the effect of such 9 certificates and notifications on increasing access to 10 high quality health care services at reduced costs.

11 (b) RECOMMENDATIONS FOR LEGISLATION.—The 12 Attorney General shall include in the reports submitted 13 under subsection (a)(2) any recommendations of the At-14 torney General for legislation to improve the programs for 15 the issuance of certificates of review and receipt of notifi-16 cations established under this subtitle.

17 SEC. 2506. RULES, REGULATIONS, AND GUIDELINES.

(a) SAFE HARBORS, CERTIFICATES, AND NOTIFICATIONS.—The Attorney General, in consultation with the
Secretary and the Chair, shall promulgate such rules, regulations, and guidelines as are necessary to carry out sections 2502, 2503, and 2504.

23 (b) GUIDANCE FOR PROVIDERS.—

24 (1) IN GENERAL.—To promote greater cer25 tainty regarding the application of the antitrust laws

1	to activities in the health care market, the Attorney
2	General, in consultation with the Secretary and the
3	Chair, shall (not later than 1 year after the date of
4	the enactment of this Act), taking into account the
5	criteria used to designate safe harbors under section
6	2502 and grant certificates of review under section
7	2503, publish guidelines—
8	(A) to define or provide assistance in de-
9	termining relevant geographic and product mar-
10	kets for health care services and providers of
11	health care services;
12	(B) to further collaborative activities which
13	may be helpful to enhance services in under-
14	served and geographically disadvantaged areas
15	such as rural markets and inner cities;
16	(C) to assist collaboration between provid-
17	ers (such as hospital networks, physician-hos-
18	pital organizations, and other groups of provid-
19	ers) which will help provide health care services
20	more efficiently;
21	(D) to further activities by which public
22	health clinics (including community health cen-
23	ters and migrant health centers under title III
24	of the Public Health Service Act) may partici-
25	pate in networks and other collaborative activi-

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1	ties in order to enhance services in underserved
2	areas;
3	(E) to assist providers of health care serv-
4	ices in analyzing whether the activities of such
5	providers may be subject to a safe harbor under
6	section 2502;
7	(F) to provide clarification for activities in
8	the general subject matter areas described in
9	the safe harbors in section 2502, but which fall
10	outside the safe harbors; and
11	(G) to describe specific types of activities
12	which would meet the requirements for issuance
13	of a certificate of review under section 2503,
14	and summarizing the factual and legal bases on
15	which the activities would meet the require-
16	ments.
17	(2) PERIODIC UPDATE.—The Attorney General
18	shall periodically update the guidelines published
19	under paragraph (1) as the Attorney General consid-
20	ers appropriate.
21	(3) Waiver of administrative procedure
22	ACT.—Section 553 of title 5, United States Code,
23	shall not apply to the issuance of guidelines under
24	paragraph (1).

1SEC. 2507. ESTABLISHMENT OF HHS OFFICE OF HEALTH2CARE COMPETITION POLICY.

3 (a) IN GENERAL.—There is established within the 4 Department of Health and Human Services an Office to 5 be known as the Office of Health Care Competition Policy 6 (hereafter in this section referred to as the "Office"). The 7 Office shall be headed by a director, who shall be ap-8 pointed by the Secretary.

9 (b) DUTIES.—The Office shall coordinate the respon-10 sibilities of the Secretary under this subtitle and otherwise 11 assist the Secretary in developing policies relating to the 12 competitive and collaborative activities of providers of 13 health care services.

14 SEC. 2508. DEFINITIONS.

15 In this subtitle:

- 16 (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
- 23 (B) includes any State law similar to the24 laws referred to in subparagraph (A).
- 25 (2) The term "Chair" means the Chair of the26 Federal Trade Commission.

(3) The term "health benefit plan" means any 1 2 hospital or medical expense incurred policy or certifi-3 cate, hospital or medical service plan contract, or 4 health maintenance subscriber contract, or a mul-5 tiple employer welfare arrangement or employee ben-6 efit plan (as defined under the Employee Retirement 7 Income Security Act of 1974) which provides benefits with respect to health care services. 8 (4) The term "health care joint venture" means 9 10 a joint venture of 2 or more persons formed for the 11 purpose of providing health care services, including attempts to enter into or perform a contract or 12 agreement to provide such services. 13 (5) The term "health care services" means any 14 services for which payment may be made under a 15 16 health benefit plan, including services related to the 17 delivery or administration of such services. 18 (6) The term "medical self-regulatory entity" 19 means a medical society or association, a specialty 20 board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, 21 22 employees, consultants, and volunteers or committees of such an entity. 23 (7) The term "person" includes a State or unit 24 of local government. 25

1	(8) The term "provider of health care services"
2	means any individual or entity that is engaged in the
3	delivery of health care services in a State and that
4	is required by State law or regulation to be licensed
5	or certified by the State to engage in the delivery of
6	such services in the State.
7	(9) The term "Secretary" means the Secretary
8	of Health and Human Services.
9	(10) The term "specialty group" means a medi-
10	cal specialty or subspecialty in which a provider of
11	health care services may be licensed to practice by
12	a State (as determined by the Secretary in consulta-
13	tion with the certification boards for such specialties
14	and subspecialties).
15	(11) The term "standard setting and enforce-
16	ment activities" means—
17	(A) accreditation of health care practition-
18	ers, health care providers, medical education in-
19	stitutions, or medical education programs,
20	(B) technology assessment and risk man-
21	agement activities,
22	(C) the development and implementation of
23	practice guidelines or practice parameters, or
24	(D) official peer review proceedings under-
25	taken by a hospital medical staff (or committee

thereof) or a medical society or association for
 purposes of evaluating the professional conduct
 or quality of health care provided by a medical
 professional.

5 Subtitle G—Encouraging Enforce6 ment Activities of Medical Self7 Regulatory Entities

8 PART 1—APPLICATION OF THE CLAYTON ACT TO 9 MEDICAL SELF-REGULATORY ENTITIES

 10
 SEC. 2601. ANTITRUST EXEMPTION FOR MEDICAL SELF

 11
 REGULATORY ENTITIES.

12 (a) IN GENERAL.—(1) Except as provided in paragraph (2), no damages, interest on damages, cost of suit, 13 or attorney's fee may be recovered under section 4, 4A, 14 or 4C of the Clayton Act (15 U.S.C. 15, 15a, 15c), or 15 under any State law similar to such section, from any 16 medical self-regulatory entity (including its members, offi-17 cers, employees, consultants, and volunteers or committees 18 thereof) as a result of engaging in standard setting or en-19 20 forcement activities that are—

21 (A) designed to promote the quality of health22 care provided to patients, and

23 (B) not conducted for purposes of financial24 gain.

1 (2) Paragraph (1) shall not prohibit the recovery of 2 actual damages, interest on damages, the cost of suit, or a reasonable attorney's fee under section 4 or 4A of the 3 4 Clayton Act (15 U.S.C. 15, 15a), or under any State law 5 similar to such section, by a State or the United States from a medical self-regulatory entity (including its mem-6 7 bers, officers, employees, consultants, and volunteers or committees thereof) for injury sustained as a result of en-8 9 gaging in the conduct described in such paragraph.

10 (b) FEES.—In any action under section 4, 4C, or 16 of the Clayton Act (15 U.S.C. 15, 15c, 26), or under a 11 similar State law, brought against any medical self-regu-12 latory entity (including its members, officers, employees, 13 consultants, and volunteers or committees thereof) as a 14 result of engaging in conduct described in subsection 15 (a)(1), the court shall award the cost of suit, including 16 a reasonable attorney's fee, to a substantially prevailing 17 defendant. 18

19 SEC. 2602. DEFINITIONS.

20 For purposes of this subtitle:

(1) The term "medical self-regulatory entity"
means a medical society or association, a specialty
board, a recognized accrediting agency, or a hospital
medical staff.

1	(2) The term "standard setting and enforce-
2	ment activities" means—
3	(A) accreditation of health care practition-
4	ers, health care providers, medical education in-
5	stitutions, or medical education programs,
6	(B) technology assessment and risk man-
7	agement activities,
8	(C) the development and implementation of
9	practice guidelines or practice parameters, or
10	(D) official peer review proceedings under-
11	taken by a hospital medical staff (or committee
12	thereof) or a medical society or association for
13	purposes of evaluating the quality of health care
14	provided by a medical professional.
15	PART 2-CONSULTATION BY FEDERAL AGENCIES
16	SEC. 2611. CONSULTATION WITH MEDICAL SELF-REGU-
17	LATORY ENTITIES RESPECTING MEDICAL
18	PROFESSIONAL GUIDELINES AND STAND-
19	ARDS.
20	Any Federal agency engaged in the establishment of
21	medical professional standards shall consult with appro-
22	priate medical societies or associations, specialty boards,
23	or recognized accrediting agencies, if available, in carrying

25 or standards relating to the practice of medicine.

24 out medical professional standard setting and guidelines

Subtitle H—Reform of Clinical Lab oratory Requirements for Sim ple Tests

4 SEC. 2701. ELIMINATING CLIA REQUIREMENT FOR CERTIFI-

5CATE OF WAIVER FOR SIMPLE LABORATORY6EXAMINATIONS AND PROCEDURES.

7 (a) IN GENERAL.—Section 353 of the Public Health
8 Service Act (42 U.S.C. 263a) is amended—

9 (1) in subsection (b), by inserting before the pe-10 riod at the end the following: "or unless the labora-11 tory is exempt from the certificate requirement 12 under subsection (d)(2)";

13 (2) by amending paragraph (2) of subsection14 (d) to read as follows:

15 "(2) EXEMPTION FROM CERTIFICATE REQUIRE16 MENT FOR LABORATORIES PERFORMING ONLY SIM17 PLE EXAMINATIONS AND PROCEDURES.—A labora18 tory which performs only laboratory examinations
19 and procedures described in paragraph (3) is not re20 quired to have in effect a certificate under this sec21 tion.";

22 (3) by striking paragraph (4) of subsection (d);23 and

(4) in subsection (m)(1), by striking ", except
 that the Secretary" and all that follows and insert ing a period.

4 (b) EFFECTIVE DATE.—The amendments made by
5 this section shall take effect on the first day of the first
6 month beginning after the date of the enactment of this
7 Act.

8 SEC. 2702. AMENDMENT RELATED TO SIMPLE LABORATORY 9 EXAMINATIONS.

Section 353(d) of the Public Health Service Act (42
U.S.C. 263) is amended by striking paragraph (3) and
inserting the following:

13 "(3) EXAMINATIONS AND PROCEDURES.—The
14 examinations and procedures identified in paragraph
15 (2) are simple laboratory examinations and proce16 dures which have an insignificant risk of an erro17 neous result and include those which—

18 "(A) have been approved by the Food and19 Drug Administration for home use,

20 "(B) employ methodologies that are so
21 simple and accurate as to render the likelihood
22 of erroneous results negligible,

23 "(C) the Secretary has determined pose no
24 reasonable risk of serious harm to the patient
25 if performed incorrectly, or

1	''(D)(i) are performed by or under the di-
2	rection or supervision of or in collaboration with
3	a doctor of medicine or osteopathy licensed to
4	practice medicine or osteopathy in the State in
5	which the laboratory is located, or by an indi-
6	vidual qualified to direct, supervise, or perform
7	examinations and procedures under State laws
8	or such standards as the Secretary may estab-
9	lish; and
10	''(ii) the patient is available for clinical ob-
11	servation; and
12	"(iii) prompt results are needed to evalu-
13	ate, diagnose, and treat the patient or to avoid
14	additional burdens on the patient that could re-
15	sult from not performing the test.
16	"(4) DEFINITION.—As used in this section, the
17	term 'simple laboratory examinations and proce-
18	dures' includes dipstick tests for total and allergen-
19	specific IgE; microscopic examination of nasal
20	smears (for cells and bacteria); mono spot tests;
21	testing for theophylline using the Accu-Level meth-
22	od; microscopic urinalysis; vaginal wet mount; KOH
23	prep, scabies prep; rapid strep antigen;
24	nonautomated qualitative and quantitative semen
25	analysis; pin worm; prostate smears; synovial fluid

1 analysis for inflammation and infection; post coital 2 test; fern test; occult blood; Gram stain; qualitative 3 drug screen; pulse oximetry; hemoglobin (by hand-4 held hemoglobinometer); ASO, CRP, RF, and mono screen; sickle cell screen; white blood cell count by 5 6 manual chamber count; peripheral blood smears; 7 sputum eosinophil; urine culture colony; urine sensitivities; microscopic examination of hair morphol-8 9 ogy; molluscum smear; fungal cultures, including dermatophyte test medium; Tzank smear; Darkfield 10 11 examination; agglutination pregnancy test; urethral 12 gram stains, and centrifigal hematology, including 13 white blood cell count, hematocrit, differential, and 14 platelet count.".

15 SEC. 2703. AMENDMENT RELATED TO STUDY.

16 (a) STUDY.—The Secretary of Health and Human Services, acting through the Centers for Disease Control 17 and Prevention, shall use existing appropriations to con-18 duct the study required by section 4 of the Clinical Lab-19 oratory Improvement Amendments of 1988 (42 U.S.C. 20 21 263a note). The Secretary shall report the results of such 22 study to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Rep-23 resentatives and the Committee on Finance and the Com-24

mittee on Labor and Human Resources of the Senate not
 later than May 1, 1996.

3 (b) SUNSET.—If the results of the study described 4 in subsection (a) are not reported to the committees of 5 Congress by May 1, 1996, section 353 of the Public 6 Health Service Act shall not be in effect after May 1, 7 1996.

8 SEC. 2704. AMENDMENTS RELATED TO THE CLINICAL LAB-9 ORATORY IMPROVEMENT ADVISORY COM-10 MITTEE.

11 The Secretary of Health and Human Services shall revise the membership of the Clinical Laboratory Improve-12 ment Advisory Committee established by the Secretary in 13 regulations to implement section 353 of the Public Health 14 15 Service Act (subpart T of part 493 of title 42 Code of Federal Regulations) to contain, in the membership which 16 does not include ex-officio members or officers or employ-17 ees of the Federal Government, a number of practicing 18 physicians which is proportionate to the number of physi-19 cian laboratories regulated under such section 353. For 20 purposes of this section, the term "practicing physician" 21 22 means a licensed doctor of medicine or osteopathy who spends at least 80 percent of the physician's professional 23 24 time in direct patient care and who directs an in-office 25 clinical laboratory for the physician's patients.

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Subtitle I—Miscellaneous Provisions

3 SEC. 2801. **REQUIREMENT THAT CERTAIN AGENCIES** 4 **PREFUND GOVERNMENT HEALTH BENEFITS** 5 **CONTRIBUTIONS FOR THEIR ANNUITANTS.** 6 (a) DEFINITIONS.—For the purpose of this section— 7 (1) the term "agency" means any agency or 8 other instrumentality within the executive branch of 9 the Government, the receipts and disbursements of which are not generally included in the totals of the 10 budget of the United States Government submitted 11 12 by the President; 13 (2) the term "health benefits plan" means, with 14 respect to an agency, a health benefits plan, estab-15 lished by or under Federal law, in which employees or annuitants of such agency may participate; 16 (3) the term "health-benefits coverage" means 17 coverage under a health benefits plan; 18 19 (4) an individual shall be considered to be an 20 "annuitant of an agency" if such individual is enti-21 tled to an annuity, under a retirement system estab-22 lished by or under Federal law, by virtue of— 23 (A) such individual's service with, and sep-24 aration from, such agency; or

1 (B) being the survivor of an annuitant 2 under subparagraph (A) or of an individual who died while employed by such agency; and 3 4 (5) the term "Office" means the Office of Per-5 sonnel Management. 6 (b) PREFUNDING REQUIREMENT.— 7 (1) IN GENERAL.—Effective as of October 1, 1994, each agency (or February 1, 1995, in the case 8 9 of the agency with the greatest number of employ-10 ees, as determined by the Office) shall be required 11 to prepay the Government contributions which are 12 or will be required in connection with providing 13 health-benefits coverage for annuitants of such agen-14 cy. 15 (2) REGULATIONS.—The Office shall prescribe 16 such regulations as may be necessary to carry out 17 this section. The regulations shall be designed to en-18 sure at least the following: 19 (A) Amounts paid by each agency shall be 20 sufficient to cover the amounts which would otherwise be payable by such agency (on a 21 22 "pay-as-you-go" basis), on or after the applicable effective date under paragraph (1), on be-23 half of— 24

Title II, Subtitle I

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1	(i) individuals who are annuitants of
2	the agency as of such effective date; and
3	(ii) individuals who are employed by
4	the agency as of such effective date, or
5	who become employed by the agency after
6	such effective date, after such individuals
7	have become annuitants of the agency (in-
8	cluding their survivors).
9	(B)(i) For purposes of determining any
10	amounts payable by an agency—
11	(I) this section shall be treated as if
12	it had taken effect at the beginning of the
13	20-year period which ends on the effective
14	date applicable under paragraph (1) with
15	respect to such agency; and
16	(II) in addition to any amounts pay-
17	able under subparagraph (A), each agency
18	shall also be responsible for paying any
19	amounts for which it would have been re-
20	sponsible, with respect to the 20-year pe-
21	riod described in subclause (I), in connec-
22	tion with any individuals who are annu-
23	itants or employees of the agency as of the
24	applicable effective date under paragraph
25	(1).

(ii) Any amounts payable under this sub paragraph for periods preceding the applicable
 effective date under paragraph (1) shall be pay able in equal installments over the 20-year pe riod beginning on such effective date.

6 (c) FASB STANDARDS.—Regulations under sub7 section (b) shall be in conformance with the provisions of
8 standard 106 of the Financial Accounting Standards
9 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.

16 SEC. 2802. INELIGIBILITY OF ALIENS FOR SSI AND MEDIC-

17

(a) IN GENERAL.—Notwithstanding any other provision of law and except as provided in subsections (b) and
(c), no alien shall be eligible for any program referred to
in subsection (d).

22 (b) EXCEPTIONS.—

AID.

(1) REFUGEE EXCEPTION.—Subsection (a)
shall not apply to an alien admitted to the United
States as a refugee under section 207 of the Immi-

1	gration and Nationality Act until 6 years after the
2	date of such alien's arrival into the United States.
3	(2) AGED EXCEPTION.—Subsection (a) shall
4	not apply to an alien who—
5	(A) has been lawfully admitted to the
6	United States for permanent residence;
7	(B) is over 75 years of age; and
8	(C) has resided in the United States for at
9	least 5 years.
10	(3) CURRENT RESIDENT EXCEPTION.—Sub-
11	section (a) shall not apply to the eligibility of an
12	alien for a program referred to in subsection (d)
13	until 1 year after the date of the enactment of this
14	Act if, on such date of enactment, the alien is resid-
15	ing in the United States and is eligible for the pro-
16	gram.
17	(c) Programs For Which Aliens May Be Eligi-
18	BLE.—The limitation under subsection (a) shall not apply
19	to medical assistance with respect to emergency services
20	(as defined for purposes of section $1916(a)(2)(D)$ of the
21	Social Security Act).
22	(d) Programs For Which Aliens Are Ineli-
23	GIBLE.—The programs referred to in this subsection are
24	the following:

(1) The program of medical assistance under
 title XIX of the Social Security Act, except emer gency services as provided in subsection (c).

4 (2) The supplemental security income program
5 under title XVI of the Social Security Act.

6 (e) NOTIFICATION OF ALIENS.—Any Federal agency
7 that administers a program referred to in subsection (d)
8 shall, directly or through the States, notify each alien re9 ceiving benefits under the program whose eligibility for the
10 program is or will be terminated by reason of this section.
11 SEC. 2803. LIMITATION ON SSI BENEFITS FOR DRUG AND
12 ALCOHOL ADDICTS.

13 (a) IN GENERAL.—

14 (1) LIMITATION DESCRIBED.—Section 1614(a)
15 of the Social Security Act (42 U.S.C. 1382c(a)) is
16 amended by adding at the end the following:

"(5)(A) The Secretary shall identify all recipients of
benefits under this title by reason of disability whose disability is a result of addiction to illegal drugs.

"(B) The Secretary shall periodically, on a random
basis, test each recipient identified under subparagraph
(A) to determine whether the recipient is using illegal
drugs.

24 "(C)(i) Notwithstanding any other provision of this25 title, any individual who is determined under subpara-

graph (B) to be using illegal drugs, or who refuses to sub mit to testing as provided for under subparagraph (B),
 shall not be eligible for benefits under this title for a pe riod of at least 1 year.

5 "(ii) The period of ineligibility under clause (i) shall 6 terminate (after the last day of such 1-year period) if the 7 individual has 2 tests (at least 2 months apart and not 8 paid for through Federal funds) which establish that the 9 recipient is not using illegal drugs.".

10 (2) EFFECTIVE DATE.—The amendment made 11 by paragraph (1) shall apply to quarters beginning 12 after the expiration of the 6-month period that be-13 gins on the date of the enactment of this Act.

14 (b) REPRESENTATIVE PAYEE REFORMS.—

15 (1) AUTHORITY OF GOVERNMENT AGENCIES TO 16 BECOME PAID REPRESENTATIVE PAYEES.—Section 17 1631(a)(2)(D)(ii) of (42)U.S.C. such Act 18 1383(a)(2)(D)(ii) is amended by adding at the end 19 the following: "The term 'qualified organization' also 20 includes any government agency that meets the requirements of items (aa) and (bb) of subclause 21 22 (II).".

(2) MAXIMUM FEE PAYABLE TO REPRESENTATIVE PAYEES.—Section 1631(a)(2)(D)(i) of such Act
(42 U.S.C. 1383(a)(2)(D)(i)) is amended by striking

- 1 "the lesser of—" and all that follows and inserting
- 2 "10 percent of the monthly benefit involved.".

3 TITLE III—LONG-TERM CARE

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Sec. 3101. Establishment of Federal standards for long-term care insurance.

"TITLE XXVII-LONG-TERM CARE INSURANCE STANDARDS

"Part A—Promulgation of Standards and Model Benefits

"Sec. 2701. Standards.

"Part B—Establishment and Implementation of Long-Term Care Insurance Policy Standards

- "Sec. 2711. Implementation of policy standards.
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Subtitle A—Tax Treatment of Long term Care Insurance

3 SEC. 3001. TREATMENT OF LONG-TERM CARE INSURANCE

OR PLANS.

4

5 (a) GENERAL RULE.—Subpart E of part I of sub-6 chapter L of chapter 1 of the Internal Revenue Code of 7 1986 is amended by inserting after section 818 the follow-8 ing new section:

9 "SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE

10 OR PLANS.

11 "(a) GENERAL RULE.—For purposes of this part, a
12 long-term care insurance contract shall be treated as an
13 accident or health insurance contract.

14 "(b) LONG-TERM CARE INSURANCE CONTRACT.—

- 15 "(1) IN GENERAL.—For purposes of this part,
 16 the term 'long-term care insurance contract' means
 17 any insurance contract issued if—
- 18 "(A) the only insurance protection pro-19 vided under such contract is coverage of quali-

1	fied long-term care services and benefits inci-
2	dental to such coverage,
3	"(B) the maximum benefit under the pol-
4	icy for expenses incurred for any day does not
5	exceed \$200,
6	"(C) such contract does not cover expenses
7	incurred for services or items to the extent that
8	such expenses are reimbursable under title
9	XVIII of the Social Security Act or would be so
10	reimbursable but for the application of a de-
11	ductible or coinsurance amount,
12	"(D) such contract is guaranteed renew-
13	able,
14	''(E) such contract does not have any cash
15	surrender value, and
16	"(F) all refunds of premiums, and all pol-
17	icyholder dividends or similar amounts, under
18	such contract are to be applied as a reduction
19	in future premiums or to increase future bene-
20	fits.
21	"(2) Special rules.—
22	"(A) PER DIEM, ETC. PAYMENTS PER-
23	MITTED.—A contract shall not fail to be treated
24	as described in paragraph (1)(A) by reason of
25	payments being made on a per diem or other

1	periodic basis without regard to the expenses
2	incurred during the period to which the pay-
3	ments relate.
4	"(B) Contract may cover medicare
5	REIMBURSABLE EXPENSES WHERE MEDICARE
6	IS SECONDARY PAYOR.—Paragraph (1)(C) shall
7	not apply to expenses which are reimbursable
8	under title XVIII of the Social Security Act
9	only as a secondary payor.
10	"(C) REFUNDS OF PREMIUMS.—Paragraph
11	(1)(F) shall not apply to any refund of pre-
12	miums on surrender or cancellation of the con-
13	tract.
14	"(c) Qualified Long-Term Care Services.—For
15	purposes of this section—
16	''(1) IN GENERAL.—The term 'qualified long-
17	term care services' means necessary diagnostic, pre-
18	ventive, therapeutic, and rehabilitative services, and
19	maintenance or personal care services, which—
20	''(A) are required by a chronically ill indi-
21	vidual in a qualified facility, and
22	"(B) are provided pursuant to a plan of
23	care prescribed by a licensed health care practi-
24	tioner.

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1	''(A) IN GENERAL.—The term 'chronically
2	ill individual' means any individual who has
3	been certified by a licensed health care practi-
4	tioner as—
5	''(i)(I) being unable to perform (with-
6	out substantial assistance from another in-
7	dividual) at least 2 activities of daily living
8	(as defined in subparagraph (B)) for a pe-
9	riod of at least 90 days due to a loss of
10	functional capacity, or
11	"(II) having a level of disability simi-
12	lar (as determined by the Secretary in con-
13	sultation with the Secretary of Health and
14	Human Services) to the level of disability
15	described in subclause (I), or
16	"(ii) having a similar level of disabil-
17	ity due to cognitive impairment.
18	"(B) ACTIVITIES OF DAILY LIVING.—For
19	purposes of subparagraph (A), each of the fol-
20	lowing is an activity of daily living:
21	"(i) MOBILITY.—The process of walk-
22	ing or wheeling on a level surface which
23	may include the use of an assistive device
24	such as a cane, walker, wheelchair, or
25	brace.

1	"(ii) DRESSING.—The overall complex
2	behavior of getting clothes from closets
3	and drawers and then getting dressed.
4	"(iii) TOILETING.—The act of going
5	to the toilet room for bowel and bladder
6	function, transferring on and off the toilet,
7	cleaning after elimination, and arranging
8	clothes or the ability to voluntarily control
9	bowel and bladder function, or in the event
10	of incontinence, the ability to maintain a
11	reasonable level of personal hygiene.
12	"(iv) TRANSFER.—The process of get-
13	ting in and out of bed or in and out of a
14	chair or wheelchair.
15	"(v) EATING.—The process of getting
16	food from a plate or its equivalent into the
17	mouth.
18	''(3) QUALIFIED FACILITY.—The term 'quali-
19	fied facility' means—
20	''(A) a nursing, rehabilitative, hospice, or
21	adult day care facility (including a hospital, re-
22	tirement home, nursing home, skilled nursing
23	facility, intermediate care facility, or similar in-
24	stitution)—

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1	"(i) which is licensed under State law,
2	or
3	''(ii) which is a certified facility for
4	purposes of title XVIII or XIX of the So-
5	cial Security Act, or
6	"(B) an individual's home if a licensed
7	health care practitioner certifies that without
8	home care the individual would have to be cared
9	for in a facility described in subparagraph (A).

10 "(4) MAINTENANCE OR PERSONAL CARE SERV-11 ICES.—The term 'maintenance or personal care serv-12 ices' means any care the primary purpose of which 13 is to provide needed assistance with any of the ac-14 tivities of daily living described in paragraph (2)(B).

⁽⁽⁵⁾ 15 LICENSED HEALTH CARE PRACTI-TIONER.—The term 'licensed health care practi-16 17 tioner' means any physician (as defined in section 18 1861(r) of the Social Security Act) and any reg-19 istered professional nurse, licensed social worker, or 20 other individual who meets such requirements as may be prescribed by the Secretary. 21

"(d) CONTINUATION COVERAGE EXCISE TAX NOT
TO APPLY.—This section shall not apply in determining
whether section 4980B (relating to failure to satisfy con-

tinuation coverage requirements of group health plans) ap plies.

3 "(e) Inflation Adjustment of \$200 Benefit
4 Limit.—

"(1) IN GENERAL.—In the case of a calendar 5 6 year after 1994, the \$200 amount contained in sub-7 section (b)(1)(B) shall be increased for such calendar year by the medical care cost adjustment for 8 such calendar year. If any increase determined 9 under the preceding sentence is not a multiple of 10 11 \$10, such increase shall be rounded to the nearest multiple of \$10. 12

13 "(2) MEDICAL CARE COST ADJUSTMENT.—For
14 purposes of paragraph (1), the medical care cost ad15 justment for any calendar year is the percentage (if
16 any) by which—

17 "(A) the medical care component of the
18 Consumer Price Index (as defined in section
19 1(f)(5)) for August of the preceding calendar
20 year, exceeds

"(B) such component for August of 1993."
(b) RESERVES.—Clause (iii) of section 807(d)(3)(A)
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 such subpart E 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."

4 SEC. 3002. EXCLUSION FOR BENEFITS PROVIDED UNDER 5 LONG-TERM CARE INSURANCE; INCLUSION 6 OF EMPLOYER-PROVIDED COVERAGE.

7 (a) IN GENERAL.—Subsection (a) of section 104 of 8 the Internal Revenue Code of 1986 (relating to compensa-9 tion for injuries or sickness) is amended by striking "and" 10 at the end of paragraph (4), by striking the period at the 11 end of paragraph (5) and inserting ", and", and by insert-12 ing after paragraph (4) the following new paragraph:

13 "(6) benefits under a long-term care insurance
14 contract (as defined in section 818A(b))."

15 (b) INCLUSION OF EMPLOYER-PROVIDED COV-16 ERAGE.—Section 106 of such Code (relating to contribu-17 tions by employer to accident and health plans) is amend-18 ed by adding at the end thereof the following sentence: 19 "The preceding sentence shall not apply to any plan pro-20 viding coverage for long-term care services."

21 SEC. 3003. QUALIFIED LONG-TERM SERVICES TREATED AS 22 MEDICAL CARE.

23 (a) GENERAL RULE.—Paragraph (1) of section
24 213(d) of the Internal Revenue Code of 1986 (defining
25 medical care) is amended by striking "or" at the end of
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subparagraph (B), by redesignating subparagraph (C) as
 subparagraph (D), and by inserting after subparagraph
 (B) the following new subparagraph:

4 "(C) for qualified long-term care services
5 (as defined in section 818A(c)), or".

6 (b) DEDUCTION FOR LONG-TERM CARE EXPENSES 7 FOR PARENT OR GRANDPARENT.—Section 213 of such 8 Code (relating to deduction for medical expenses) is 9 amended by adding at the end the following new sub-10 section:

11 "(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE 12 EXPENSES.—For purposes of subsection (a), the term 'de-13 pendent' shall include any parent or grandparent of the 14 taxpayer for whom the taxpayer has expenses for long-15 term care services described in section 818A(c), but only 16 to the extent of such expenses."

17 (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:

1	"In the case of a long-term care insurance contract
2	(as defined in section 818A), only eligible long-term
3	care premiums (as defined in paragraph (10)) shall
4	be taken into account under subparagraph (D)."
5	(B) Subsection (d) of section 213 is amended
6	by adding at the end the following new paragraph:
7	"(10) Eligible Long-Term Care Pre-
8	MIUMS.—
9	"(A) IN GENERAL.—For purposes of this
10	section, the term 'eligible long-term care pre-
11	miums' means the amount paid during a tax-
12	able year for any long-term care insurance con-
13	tract (as defined in section 818A) covering an
14	individual, to the extent such amount does not
15	exceed the limitation determined under the fol-
16	lowing 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\$200More than 40 but not more than 50375More than 50 but not more than 60750More than 60 but not more than 701,600More than 702,000.
17	"(B) INDEXING.—
18	''(i) IN GENERAL.—In the case of any
19	taxable year beginning in a calendar year
20	after 1993, each dollar amount contained
21	in paragraph (1) shall be increased by the

1	medical care cost adjustment of such
2	amount for such calendar year. If any in-
3	crease determined under the preceding sen-
4	tence is not a multiple of \$10, such in-
5	crease shall be rounded to the nearest mul-
6	tiple of \$10.
7	"(ii) Medical care cost adjust-
8	MENT.—For purposes of clause (i), the
9	medical care cost adjustment for any cal-
10	endar year is the percentage (if any) by
11	which—
12	"(I) the medical care component
13	of the Consumer Price Index (as de-
14	fined in section $1(f)(5)$ for August of
15	the preceding calendar year, exceeds
16	"(II) such component for August
17	of 1991.''
18	(3) Paragraph (6) of section 213(d) of such
19	Code is amended—
20	(A) by striking ''subparagraphs (A) and
21	(B)" and inserting "subparagraphs (A), (B),
22	and (C)", and
23	(B) by striking "paragraph (1)(C)" in sub-
24	paragraph (A) and inserting ''paragraph
25	(1)(D)".

(4) Paragraph (7) of section 213(d) of such 1 Code is amended by striking "subparagraphs (A) 2 and (B)" and inserting "subparagraphs (A), (B), 3 and (C)". 4 5 SEC. 3004. EFFECTIVE DATE. The amendments made by this subtitle shall apply to 6 taxable years beginning after December 31, 1994. 7 Subtitle B-Establishment of Fed-8 eral Standards for Long-term 9 **Care Insurance** 10 11 SEC. 3101. ESTABLISHMENT OF FEDERAL STANDARDS FOR 12 LONG-TERM CARE INSURANCE. 13 (a) IN GENERAL.—The Public Health Service Act is amended— 14 (1) by redesignating title XXVII (42 U.S.C. 15 300cc et seq.) as title XXVIII; and 16 17 (2) by inserting after title XXVI the following 18 new title: **"TITLE XXVII—LONG-TERM CARE** 19 **INSURANCE STANDARDS** 20 21 "Part A—Promulgation of Standards and Model 22 **BENEFITS** 23 "SEC. 2701. STANDARDS. "(a) Application of Standards.— 24

1	"(1) NAIC.—The Secretary shall request that
2	the National Association of Insurance Commis-
3	sioners (hereinafter in this title referred to as the
4	'NAIC')—
5	"(A) develop specific standards that incor-
6	porate the requirements of this title; and
7	"(B) report to the Secretary on such
8	standards,
9	by not later than 12 months after enactment of this
10	title. If the NAIC develops such model standards
11	that incorporate the requirements of this title within
12	such period and the Secretary finds that such stand-
13	ards implement the requirements of this title, such
14	standards shall be the standards applied under this
15	title.
16	"(2) DEFAULT.—If the NAIC does not promul-
17	gate the model standards under paragraph (1) by
18	the deadline established in that paragraph, the Sec-
19	retary shall promulgate, within 12 months after such
20	deadline, a regulation that provides standards that
21	incorporate the requirements of this title and such
22	standards shall apply as provided for in this title.
23	"(3) Relation to state law.—Nothing in
24	this title shall be construed as preventing a State
25	from applying standards that provide greater protec-

1	tion to policyholders of long-term care insurance
2	policies than the standards promulgated under this
3	title, except that such State standards may not be
4	inconsistent or in conflict with any of the require-
5	ments of this title.
6	"(b) Deadline for Application of Stand-
7	ARDS.—
8	"(1) IN GENERAL.—Subject to paragraph (2),
9	the date specified in this subsection for a State is—
10	"(A) the date the State adopts the stand-
11	ards established under subsection $(a)(1)$; or
12	"(B) the date that is 1 year after the first
13	day of the first regular legislative session that
14	begins after the date such standards are first
15	established under subsection $(a)(2)$;
16	whichever is earlier.
17	"(2) STATE REQUIRING LEGISLATION.—In the
18	case of a State which the Secretary identifies, in
19	consultation with the NAIC, as—
20	''(A) requiring State legislation (other than
21	legislation appropriating funds) in order for the
22	standards established under subsection (a) to be
23	applied; but
24	''(B) having a legislature which is not
25	scheduled to meet within 1 year following the

1	beginning of the next regular legislative session
2	in which such legislation may be considered;
3	the date specified in this subsection is the first day
4	of the first calendar quarter beginning after the
5	close of the first legislative session of the State legis-
6	lature that begins on or after January 1, 1994. For
7	purposes of the previous sentence, in the case of a
8	State that has a 2-year legislative session, each year
9	of such session shall be deemed to be a separate reg-
10	ular session of the State legislature.
11	"(c) ITEMS INCLUDED IN STANDARDS.—The stand-
12	ards promulgated under subsection (a) shall include—
13	"(1) minimum Federal standards for long-term
14	care insurance consistent with the provisions of this
15	title;
16	"(2) standards for the enhanced protection of
17	consumers with long-term care insurance;
18	"(3) procedures for the modification of the
19	standards established under paragraph (1) in a
20	manner consistent with future laws to expand exist-
21	ing Federal or State long-term care benefits or es-
22	tablish a comprehensive Federal or State long-term
23	care benefit program; and
24	''(4) other activities determined appropriate by
25	Congress.

1	"(d) CONSULTATION.—In establishing standards and
2	models of benefits under this section, the Secretary shall
3	provide for and consult with an advisory committee to be
4	chosen by the Secretary, and composed of—
5	"(1) three individuals who are representatives
6	of carriers;
7	''(2) three individuals who are representatives
8	of consumer groups;
9	"(3) three representatives who are representa-
10	tives of providers of long-term care services;
11	"(4) three other individuals who are not rep-
12	resentatives of carriers or of providers of long-term
13	care services and who have expertise in the delivery
14	and financing of such services; and
15	"(5) the Secretary of Veterans Affairs.
16	"(e) DUTIES.—The advisory committee established
17	under subsection (d) shall—
18	"(1) recommend the appropriate inflationary
19	index to be used with respect to the inflation protec-
20	tion benefit portion of the standards;
21	"(2) recommend the uniform needs assessment
22	mechanism to be used in determining the eligibility
23	of individuals for benefits under a policy;
24	"(3) recommend appropriate standards for ben-
25	efits under section 2715(c); and

1	"(4) perform such other activities as deter-
2	mined appropriate by the Secretary.
3	"(f) Administrative Provisions.—The following
4	provisions of section 1886(e)(6) of the Social Security Act
5	shall apply to the advisory committee chosen under sub-
6	section (d) in the same manner as such provisions apply
7	under such section:
8	"(1) Subparagraph (C) (relating to staffing and
9	administration).
10	"(2) Subparagraph (D) (relating to compensa-
11	tion of members).
12	"(3) Subparagraph (F) (relating to access to
13	information).
14	''(4) Subparagraph (G) (relating to use of
15	funds).
16	''(5) Subparagraph (H) (relating to periodic
17	GAO audits).
18	"(6) Subparagraph (J) (relating to requests for
19	appropriations).
20	"Part B—Establishment and Implementation of
21	Long-Term Care Insurance Policy Standards
22	"SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.
23	"(a) In General.—
24	"(1) REGULATORY PROGRAM.—No long-term
25	care policy (as defined in section (2721)) may be is-

1	sued, sold, or offered for sale as a long-term care in-
2	surance policy in a State on or after the date speci-
3	fied in section 2701(b) unless—
4	"(A) the Secretary determines that the
5	State has established a regulatory program
6	that—
7	"(i) provides for the application and
8	enforcement of the standards established
9	under section 2701(a); and
10	''(ii) complies with the requirements
11	of subsection (b);
12	by the date specified in section 2701(b), and
13	the policy has been approved by the State com-
14	missioner or superintendent of insurance under
15	such program; or
16	"(B) if the State has not established such
17	a program, or if the State's regulatory program
18	has been decertified, the policy has been cer-
19	tified by the Secretary (in accordance with such
20	procedures as the Secretary may establish) as
21	meeting the standards established under section
22	2701(a) by the date specified in section
23	2701(b).
24	For purposes of this subsection, the advertising or
25	soliciting with respect to a policy, directly or indi-

rectly, shall be deemed the offering for sale of the
 policy.

"(2) REVIEW OF STATE REGULATORY PRO-3 4 GRAMS.—The Secretary periodically shall review reg-5 ulatory programs described in paragraph (1)(A) to 6 determine if they continue to provide for the applica-7 tion and enforcement of the standards and proce-8 dures established under section 2701(a) and (b). If 9 the Secretary determines that a State regulatory 10 program no longer meets such standards and re-11 quirements, before making a final determination, the 12 Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the 13 14 program to continue to meet such standards and re-15 quirements. If the Secretary makes a final deter-16 mination that the State regulatory program, after 17 such an opportunity, fails to meet such standards 18 and requirements, the Secretary shall assume re-19 sponsibility under paragraph (1)(B) with respect to 20 certifying policies in the State and shall exercise full 21 authority under section 2701 for carriers, agents, or 22 associations or its subsidiary in the State plans in 23 the State.

24 "(b) Additional Requirements for Approval25 of State Regulatory Programs.—For purposes of

 section 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 non- compliance with such standards; and "(B) shall provide for notice in the annual report required under paragraph (5) to the Sec- retary of cases where such compliance is not se- cured within such 30-day period. "(2) PROCESS.—The enforcement process under each State regulatory program shall provide for— "(A) procedures for individuals and enti- ties 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 	1	subsection (a)(1)(A)(ii), the requirements of this sub-
 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 non- compliance with such standards; and "(B) shall provide for notice in the annual report required under paragraph (5) to the Sec- retary of cases where such compliance is not se- cured within such 30-day period. "(2) PROCESS.—The enforcement process under each State regulatory program shall provide for— "(A) procedures for individuals and enti- ties 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 	2	section for a State regulatory program are as follows:
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 19 "(B) responding on a timely basis to such 20 complaints; 21 "(C) the investigation of— 22 "(i) those complaints which have a 	17	ties to file written, signed complaints respecting
 20 complaints; 21 ''(C) the investigation of— 22 ''(i) those complaints which have a 	18	alleged violations of the standards;
 21 ''(C) the investigation of— 22 ''(i) those complaints which have a 	19	"(B) responding on a timely basis to such
22 "(i) those complaints which have a	20	complaints;
-	21	"(C) the investigation of—
23 reasonable probability of validity, and	22	''(i) those complaints which have a
	23	reasonable probability of validity, and

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1	''(ii) such other alleged violations of
2	the standards as the program finds appro-
3	priate; and
4	"(D) the imposition of appropriate sanc-
5	tions (which include, in appropriate cases, the
6	imposition of a civil money penalty as provided
7	for in section 2718) in the case of a carrier,
8	agent, or association or its subsidiary deter-
9	mined to have violated the standards.
10	"(3) Consumer access to compliance in-
11	FORMATION.—
12	"(A) IN GENERAL.—A State regulatory
13	program must provide for consumer access to
14	complaints filed with the State commissioner or
15	superintendent of insurance with respect to
16	long-term care insurance policies.
17	"(B) CONFIDENTIALITY.—The access pro-
18	vided under subparagraph (A) shall be limited
19	to the extent required to protect the confiden-
20	tiality of the identity of individual policyholders.
21	"(4) Process for approval of premiums.—
22	"(A) IN GENERAL.—Each State regulatory
23	program shall—
24	"(i) provide for a process for approv-
25	ing or disapproving proposed premium in-

1	creases or decreases with respect to long-
2	term care insurance policies; and
3	''(ii) establish a policy for receipt and
4	consideration of public comments before
5	approving such a premium increase or de-
6	crease.
7	"(B) Conditions for approval.—No
8	premium increase shall be approved (or deemed
9	approved) under subparagraph (A) unless the
10	proposed increase is accompanied by an actuar-
11	ial memorandum which—
12	''(i) includes a description of the as-
13	sumptions that justify the increase;
14	''(ii) contains such information as
15	may be required under the Standards; and
16	''(iii) is made available to the public.
17	"(C) APPLICATION.—Except as provided in
18	subparagraph (D), this paragraph shall not
19	apply to a group long-term care insurance pol-
20	icy issued to a group described in section
21	4(E)(1) of the NAIC Long Term Care Insur-
22	ance Model Act (effective January 1991), ex-
23	cept that such group policy shall, pursuant to
24	guidelines developed by the NAIC, provide no-

1	tice to policyholders and certificate holders of
2	any premium change under such group policy.
3	"(D) EXCEPTION.—Subparagraph (C)
4	shall not apply to—
5	''(i) group conversion policies;
6	''(ii) the group continuation feature of
7	a group policy if the insurer separately
8	rates employee and continuation coverages;
9	and
10	''(iii) group policies where the func-
11	tion of the employer is limited solely to col-
12	lecting premiums (through payroll deduc-
13	tions or dues checkoff) and remitting them
14	to the insurer.
15	"(E) CONSTRUCTION.—Nothing in this
16	paragraph shall be construed as preventing the
17	NAIC from promulgating standards, or a State
18	from enacting and enforcing laws, with respect
19	to premium rates or loss ratios for all, including
20	group, long-term care insurance policies.
21	"(5) ANNUAL REPORTS.—Each State regu-
22	latory program shall provide for annual reports to be
23	submitted to the Secretary on the implementation
24	and enforcement of the standards in the State, in-

1	cluding information concerning violations in excess
2	of 30 days.
3	"(6) Access to other information.—The
4	State regulatory program must provide for consumer
5	access to actuarial memoranda provided under para-
6	graph (4).
7	"(7) DEFAULT.—In the case of a State without
8	a regulatory program approved under subsection (a),
9	the Secretary shall provide for the enforcement ac-
10	tivities described in subsection (c).
11	"(c) Secretarial Enforcement Authority.—
12	"(1) IN GENERAL.—The Secretary shall exer-
13	cise authority under this section in the case of a
14	State that does not have a regulatory program ap-
15	proved under this section.
16	"(2) Complaints and investigations.—The
17	Secretary shall establish procedures—
18	"(A) for individuals and entities to file
19	written, signed complaints respecting alleged
20	violations of the requirements of this title;
21	"(B) for responding on a timely basis to
22	such complaints; and
23	"(C) for the investigation of—
24	"(i) those complaints that have a rea-
25	sonable probability of validity; and

1	''(ii) such other alleged violations of
2	the requirements of this title as the Sec-
3	retary determines to be appropriate.
4	In conducting investigations under this subsection,
5	agents of the Secretary shall have reasonable access
6	necessary to enable such agents to examine evidence
7	of any carrier, agent, or association or its subsidiary
8	being investigated.
9	"(3) Hearings.—
10	"(A) IN GENERAL.—Prior to imposing an
11	order described in paragraph (4) against a car-
12	rier, agent, or association or its subsidiary
13	under this section for a violation of the require-
14	ments of this title, the Secretary shall provide
15	the carrier, agent, association or subsidiary
16	with notice and, upon request made within a
17	reasonable time (of not less than 30 days, as
18	established by the Secretary by regulation) of
19	the date of the notice, a hearing respecting the
20	violation.
21	"(B) CONDUCT OF HEARING.—Any hear-
22	ing requested under subparagraph (A) shall be
23	conducted before an administrative law judge.
24	If no hearing is so requested, the Secretary's

1	imposition of the order shall constitute a final
2	and unappealable order.
3	"(C) AUTHORITY IN HEARINGS.—In con-
4	ducting hearings under this paragraph—
5	"(i) agents of the Secretary and ad-
6	ministrative law judges shall have reason-
7	able access necessary to enable such agents
8	and judges to examine evidence of any car-
9	rier, agent, or association or its subsidiary
10	being investigated; and
11	''(ii) administrative law judges, may,
12	if necessary, compel by subpoena the at-
13	tendance of witnesses and the production
14	of evidence at any designated place or
15	hearing.
16	In case of contumacy or refusal to obey a sub-
17	poena lawfully issued under this subparagraph
18	and upon application of the Secretary, an ap-
19	propriate district court of the United States
20	may issue an order requiring compliance with
21	such subpoena and any failure to obey such
22	order may be punished by such court as a con-
23	tempt thereof.
24	"(D) ISSUANCE OF ORDERS.—If an admin-
25	istrative law judge determines in a hearing

1	under this paragraph, upon the preponderance
2	of the evidence received, that a carrier, agent,
3	or association or its subsidiary named in the
4	complaint has violated the requirements of this
5	title, the administrative law judge shall state
6	the findings of fact and issue and cause to be
7	served on such carrier, agent, association, or
8	subsidiary an order described in paragraph (4).
9	"(4) Cease and desist order with civil
10	MONEY PENALTY.—
11	"(A) IN GENERAL.—Subject to the provi-
12	sions of subparagraphs (B) through (F), an
13	order under this paragraph—
14	"(i) shall require the agent, associa-
15	tion or its subsidiary, or a carrier—
16	"(I) to cease and desist from
17	such violations; and
18	''(II) to pay a civil penalty in an
19	amount not to exceed \$15,000 in the
20	case of each agent, and not to exceed
21	\$25,000 for each association or its
22	subsidiary or a carrier for each such
23	violation; and
24	"(ii) may require the agent, associa-
25	tion or its subsidiary, or a carrier to take

1	such other remedial action as is appro-
2	priate.
3	"(B) Corrections within 30 days.—No
4	order shall be imposed under this paragraph by
5	reason of any violation if the carrier, agent, or
6	association or its subsidiary establishes to the
7	satisfaction of the Secretary that—
8	''(i) such violation was due to reason-
9	able cause and was not intentional and was
10	not due to willful neglect; and
11	''(ii) such violation is corrected within
12	the 30-day period beginning on the earliest
13	date the carrier, agent, association, or sub-
14	sidiary knew, or exercising reasonable dili-
15	gence could have known, that such a viola-
16	tion was occurring.
17	"(C) WAIVER BY SECRETARY.—In the case
18	of a violation under this title that is due to rea-
19	sonable cause and not to willful neglect, the
20	Secretary may waive part or all of the civil
21	money penalty imposed under subparagraph
22	(A)(i)(II) to the extent that payment of such
23	penalty would be grossly excessive relative to
24	the violation involved and to the need for deter-

rence of violations.

"(D) 1 ADMINISTRATIVE APPELLATE RE-2 VIEW.—The decision and order of an administrative law judge under this paragraph shall be-3 4 come the final agency decision and order of the Secretary unless, within 30 days, the Secretary 5 6 modifies or vacates the decision and order, in 7 which case the decision and order of the Secretary shall become a final order under this 8 9 paragraph.

10 "(E) JUDICIAL REVIEW.—A carrier, agent, 11 or association or its subsidiary or any other in-12 dividual adversely affected by a final order is-13 sued under this paragraph may, within 45 days 14 after the date the final order is issued, file a pe-15 tition in the Court of Appeals for the appro-16 priate circuit for review of the order.

17 "(F) ENFORCEMENT OF ORDERS.-If a 18 carrier, agent, or association or its subsidiary 19 fails to comply with a final order issued under 20 this paragraph against the carrier, agent, asso-21 ciation or subsidiary after opportunity for judi-22 cial review under subparagraph (E), the Sec-23 retary shall file a suit to seek compliance with 24 the order in any appropriate district court of 25 the United States. In any such suit, the validity ممم

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1	and appropriateness of the final order shall not
2	be subject to review.
3	"(d) Demonstration Grant Program.—
4	"(1) IN GENERAL.—The Secretary may award
5	grants to States for the establishment of demonstra-
6	tion programs to improve the enforcement within
7	such States of long-term care insurance standards
8	applicable under this title.
9	"(2) APPLICATION.—To be eligible to receive a
10	grant under paragraph (1), a State shall prepare
11	and submit to the Secretary an application at such
12	time, in such manner, and containing such informa-
13	tion as the Secretary may require, including a de-
14	scription of the program for which the State intends
15	to use the amounts provided under the grant.
16	"(3) Minimum amount of grants.—The
17	amount of a grant awarded under this subsection
18	shall not be less than \$100,000.
19	"(4) EVALUATION.—A State that receives a
20	grant under this subsection shall comply with such
21	evaluation procedures as the Secretary shall by regu-
22	lation establish. The Secretary shall utilize such
23	evaluations to conduct an overall evaluation of the
24	results of the demonstration programs established

under this section. 25

"(5) AUTHORIZATION OF APPROPRIATIONS.—
 There are authorized to be appropriated to carry out
 this subsection, \$5,000,000 for each of the fiscal
 years 1996 through 2000.
 "SEC. 2712. REGULATION OF SALES PRACTICES. "(a) DUTY OF GOOD FAITH AND FAIR DEALING.—
 "(1) IN GENERAL.—Each agent (as defined in

section 2733) 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:

16 "(A) TWISTING.—

17 "(i) IN GENERAL.—Knowingly making 18 any misleading representation (including 19 the inaccurate completion of medical his-20 tories) or incomplete or fraudulent com-21 parison of any long-term care insurance 22 policy or insurers for the purpose of induc-23 ing, or tending to induce, any person to re-24 tain or effect a change with respect to a 25 long-term care insurance policy.

1 "(ii) Policy replacement form.— With respect to any person who elects to 2 replace or effect a change in a long-term 3 4 care insurance policy, the individual that is selling such policy shall ensure that such 5 person completes a policy replacement 6 7 form developed by the NAIC. A copy of such form shall be provided to such person 8 9 and additional copies shall be delivered by the selling individual to the old policy is-10 11 suer and the new issuer and kept on file 12 for inspection by the State regulatory 13 agency. 14 "(B) HIGH PRESSURE TACTICS.—Employ-15 ing any method of marketing having the effect 16 of, or intending to, induce the purchase of long-17 term care insurance policy through force, fright, 18 threat or undue pressure, whether explicit or

19 implicit.

20 "(C) COLD LEAD ADVERTISING.—Making
21 use directly or indirectly of any method of mar22 keting which fails to disclose in a conspicuous
23 manner that a purpose of the method of mar24 keting is solicitation of insurance and that con-

tact will be made by an insurance agent or in surance company.

3 "(D) OTHERS.—Engaging in such other
4 practices determined inappropriate under guide5 lines issued by the NAIC.

6 "(b) FINANCIAL STANDARDS.—The NAIC shall de-7 velop recommended financial minimum standards (includ-8 ing both income and asset criteria) for the purpose of ad-9 vising individuals considering the purchase of a long-term 10 care insurance policy.

11 "(c) PROHIBITION OF SALE OR ISSUANCE TO MEDIC-12 AID BENEFICIARIES.—An agent, an association, or a car-13 rier may not knowingly sell or issue a long-term care in-14 surance policy to an individual who is eligible for medical 15 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—

"(1) knowing that the policy provides for coverage that duplicates coverage already provided in
another service-benefit long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy); or

"(2) for the benefit of an individual unless the
 individual (or a representative of the individual) pro vides a written statement to the effect that the cov erage—

5 "(A) does not duplicate other coverage in 6 effect under a service-benefit long-term care in-7 surance policy; or

8 "(B) will replace another service-benefit
9 long-term care insurance policy.

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.

14 "(e) PROHIBITION BASED ON ELIGIBILITY FOR 15 OTHER BENEFITS.—A carrier may not sell or issue a 16 long-term care insurance policy that reduces, limits or co-17 ordinates the benefits provided under the policy on the 18 basis that the policyholder has or is eligible for other long-19 term care insurance coverage or benefits.

20 "(f) PROVISION OF OUTLINE OF COVERAGE.—No 21 agent, association or its subsidiary, or carrier may sell or 22 offer for a sale a long-term care insurance policy (or for 23 a certificate under a group long-term care insurance pol-24 icy) without providing to the purchaser or potential pur-25 chaser (or representative) an outline of coverage that complies with the standards established under section
 2701(a).

"(g) PENALTIES.—Any agent who sells, offers for 3 sale, or issues a long-term care insurance policy in viola-4 tion of this section may be imprisoned not more than 5 5 years, or fined in accordance with title 18, United States 6 Code, and, in addition, is subject to a civil money penalty 7 of not to exceed \$15,000 for each such violation. Any asso-8 9 ciation or its subsidiary or carrier that sells, offers for 10 sale, or issues a long-term care insurance policy in violation of this section may be fined in accordance with title 11 18, United States Code, and in addition, is subject to a 12 civil money penalty of not to exceed \$25,000 for each vio-13 14 lation.

15 "(h) AGENT TRAINING AND CERTIFICATION RE16 QUIREMENTS.—The NAIC, shall establish requirements
17 for long-term care insurance agent training and certifi18 cation that—

19 "(1) specify requirements for training insurance
20 agents who desire to sell or offer for sale long-term
21 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.

1 "SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CAR-2RIERS.

3 "(a) REFUND OF PREMIUMS.—If an application for a long-term care insurance policy (or for a certificate 4 under a group long-term care insurance policy) is denied 5 or an applicant returns a policy or certificate within 30 6 7 days of the date of its issuance pursuant to subsection 2717, the carrier shall refund directly to the applicant, 8 or in the case of an employer to whomever remits the pre-9 mium, and not by delivery by the agent, not later than 10 30 days after the date of the denial or return, any pre-11 miums paid with respect to such a policy (or certificate). 12

13 "(b) MAILING OF POLICY.—If an application for a 14 long-term care insurance policy (or for a certificate under 15 a group long-term care insurance policy) is approved, the 16 carrier shall provide the applicant, or in the case of a 17 group plan the employer, the policy (or certificate) of in-18 surance not later than 30 days after the date of the 19 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)—

25 "(1) provide a written explanation of the rea-26 sons for the denial; and

"(2) make available all medical and patient
 records directly relating to such denial.

3 Except as provided in subsection (e) of section 2715, no 4 claim under such a policy may be denied on the basis of 5 a failure to disclose a condition at the time of issuance 6 of the policy if the application for the policy failed to re-7 quest information respecting the condition.

"(d) REPORTING OF INFORMATION.—A carrier that 8 9 issues one or more long-term care insurance policies shall periodically (not less often than annually) report, in a 10 form and in a manner determined by the NAIC, to the 11 Commissioner, superintendent or director of insurance of 12 each State in which the policy is delivered, and shall make 13 available to the Secretary, upon request, information in 14 a form and manner determined by the NAIC concerning— 15

16 "(1) the long-term care insurance policies of the17 carrier that are in force;

18 "(2) the most recent premiums for such policies
19 and the premiums imposed for such policies since
20 their initial issuance;

21 "(3) the lapse rate, replacement rate, and re22 scission rates by policy;

23 "(4) the names of that 10 percent of its agents
24 that—

1 "(A) have the greatest lapse and replace-2 ment rate; and

3 "(B) have produced at least \$50,000 of
4 long-term care insurance sales in the previous
5 year; and

"(5) the claims denied (expressed as a number 6 7 and as a percentage of claims submitted) by policy. Information required under this subsection shall be re-8 9 ported in a format specified in the standards established under section 2701(a). For purposes of paragraph (3), 10 there shall be included (but reported separately) data con-11 cerning lapses due to the death of the policyholder. For 12 purposes of paragraph (4), there shall not be included as 13 a claim any claim that is denied solely because of the fail-14 15 ure to meet a deductible, waiting period, or exclusionary 16 period.

17 "(e) STANDARDS ON COMPENSATION FOR SALE OF18 POLICIES.—

19 "(1) IN GENERAL.—A carrier that issues one or 20 more long-term care insurance policies may provide 21 a commission or other compensation to an agent or 22 other representative for the sale of such a policy only 23 if the first year commission or other first year com-24 pensation to be paid does not exceed 200 percent of 25 the commission or other compensation paid for selling or servicing the policy in the second year, or if
the first year commission or other compensation to
be paid does not exceed 50 percent of the premium
paid on the first year policy, until the NAIC promulgates mandatory standards concerning compensation
for the sale of such policies.

7 "(2) SUBSEQUENT YEARS.—The commission or
8 other compensation provided for the sale of long9 term care insurance policies in years subsequent to
10 the first year of the policy shall be the same as that
11 provided in the second subsequent year and shall be
12 provided for no fewer than 5 subsequent years.

13 "(3) LIMITATION.—No carrier shall provide
14 compensation to its agents for the sale of a long15 term care insurance policy and no agent shall receive
16 compensation greater than the renewal compensation
17 payable by the replacing carrier on renewal policies
18 if an existing policy is replaced.

19 "(4) COMPENSATION DEFINED.—As used in 20 this subsection, the term 'compensation' includes pe-21 cuniary or nonpecuniary remuneration of any kind 22 relating to the sale or renewal of the policy, includ-23 ing but not limited to deferred compensation, bo-24 nuses, gifts, prizes, awards, and finders fees. "SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE,
 AND BASIS FOR CANCELLATION OF POLICIES.
 "(a) IN GENERAL.—No long-term care insurance pol icy may be canceled or nonrenewed for any reason other
 than nonpayment of premium, material misrepresentation
 or fraud.

7 "(b) CONTINUATION AND CONVERSION RIGHTS FOR8 GROUP POLICIES.—

9 "(1) IN GENERAL.—Each group long-term care 10 insurance policy shall provide covered individuals 11 with a basis for continuation or conversion in ac-12 cordance with this subsection.

"(2) BASIS FOR CONTINUATION.—For purposes 13 14 of paragraph (1), a policy provides a basis for con-15 tinuation of coverage if the policy maintains cov-16 erage under the existing group policy when such cov-17 erage would otherwise terminate and which is sub-18 ject only to the continued timely payment of pre-19 mium when due. A group policy which restricts pro-20 vision of benefits and services to or contains incen-21 tives to use certain providers or facility, may provide 22 continuation benefits which are substantially equiva-23 lent to the benefits of the existing group policy.

24 "(3) BASIS FOR CONVERSION.—For purposes of25 paragraph (1), a policy provides a basis for conver-

1	sion of coverage if the policy entitles each
2	individual—
3	''(A) whose coverage under the group pol-
4	icy would otherwise be terminated for any rea-
5	son; and
6	''(B) who has been continuously insured
7	under the policy (or group policy which was re-
8	placed) for at least 6 months before the date of
9	the termination;
10	to issuance of a policy providing benefits identical to,
11	substantially equivalent to, or in excess of, those of
12	the policy being terminated, without evidence of in-
13	surability.
14	"(4) Treatment of substantial equiva-
15	LENCE.—In determining under this subsection
16	whether benefits are substantially equivalent, consid-
17	eration should be given to the difference between
18	managed care and non-managed care plans.
19	"(5) Group replacement of policies.—If a
20	group long-term care insurance policy is replaced by
21	another long-term care insurance policy purchased
22	by the same policyholder, the succeeding issuer shall
23	offer coverage to all persons covered under the old
24	group policy on its date of termination. Coverage
25	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.—

4

5 "(A) GUARANTEE.—An agent, association 6 or carrier that sells or issues long-term care in-7 surance policies shall guarantee that such poli-8 cies shall be sold or issued to an individual, or 9 eligible individual in the case of a group plan, 10 if such individual meets the minimum medical 11 underwriting requirements of such policy.

12 "(B) PREMIUM FOR CONVERTED POL-ICY.—If a group policy from which conversion 13 14 is made is a replacement for a previous group policy, the premium for the converted policy 15 shall be calculated on the basis of the insured's 16 17 age at the inception of coverage under the 18 group policy from which conversion is made. 19 Where the group policy from which conversion 20 is made replaced previous group coverage, the 21 premium for the converted policy shall be cal-22 culated on the basis of the insured's age at in-23 ception of coverage under the group policy re-24 placed.

"(2) UPGRADE FOR CURRENT POLICIES.—The
 NAIC shall establish standards, including those pro viding guidance on medical underwriting and age
 rating, with respect to the access of individuals to
 policies offering upgraded benefits.

6 "(d) Effect of Incapacitation.—

"(1) In general.—

7

"(A) PROHIBITION.—Except as provided 8 in paragraph (2), a long-term care insurance 9 policy in effect as of the effective date of the 10 11 standards established under section 2701(a) 12 may not be canceled for nonpayment if the policy holder is determined by a long-term care 13 14 provider, physician or other health care pro-15 vider, independent of the issuer of the policy, to 16 be cognitively or mentally incapacitated so as to 17 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 insurer 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 termi-

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nation and shall allow for the collection of past
due premium.
"(2) PERMITTED CANCELLATION.—A long-term
care insurance policy may be canceled under para-
graph (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.

16 "SEC. 2715. BENEFIT STANDARDS.

17 "(a) USE OF STANDARD DEFINITIONS AND TERMI-18 NOLOGY, UNIFORM FORMAT, AND STANDARD BENE-19 FITS.—Each long-term care insurance policy shall, with 20 respect to services, providers or facilities, pursuant to 21 standards established under section 2701(a)—

"(1) use uniform language and definitions, except that such language and definitions may take
into account the differences between States with re-

1 spect to definitions and terminology used for long-2 term care services and providers; "(2) use a uniform format for presenting the 3 4 outline of coverage under such a policy; and "(3) provide coverage for at least one standard 5 benefits package (of those developed by the NAIC) 6 7 that shall include the limitations on the amount of payments per day and the lengths of covered stays 8 9 for nursing facility and home health care services; 10 as prescribed under guidelines issued by the NAIC and periodically updated. 11 12 "(b) DISCLOSURE.— 13 "(1) OUTLINE OF COVERAGE.— 14 "(A) REQUIREMENT.—Each carrier that sells or offers for sale a long-term care insur-15 16 ance policy shall provide an outline of coverage 17 under such policy that meets the applicable

and periodically updated.
"(B) CONTENTS.—The outline of coverage
for each long-term care insurance policy shall
include at least the following:

established pursuant to section

2701(a), complies with the requirements of sub-

paragraph (B), and is in a uniform format as

prescribed in guidelines issued by the NAIC

standards

18

19

20

	020
1	"(i) A description of the principal
2	benefits and coverage under the policy.
3	"(ii) A statement of the principal ex-
4	clusions, reductions, and limitations con-
5	tained in the policy.
6	"(iii) A statement of the terms under
7	which the policy (or certificate) may be
8	continued in force or discontinued, the
9	terms for continuation or conversion, and
10	any reservation in the policy of a right to
11	change premiums.
12	"(iv) A statement, in bold face type
13	on the face of the document in language
14	that is understandable to an average indi-
15	vidual, that the outline of coverage is a
16	summary only, not a contract of insurance,
17	and that the policy (or master policy) con-
18	tains the contractual provisions that gov-
19	ern, except that such summary shall sub-
20	stantially and accurately reflect the con-
21	tents of the policy or the master policy.
22	"(v) A description of the terms, speci-
23	fied in section 2717, under which a policy
24	or certificate may be returned and pre-
25	mium refunded.

1	"(vi) Information on national average
2	costs for nursing facility and home health
3	care and information (in graphic form) on
4	the relationship of the value of the benefits
5	provided under the policy to such national
6	average costs and State average costs,
7	where available.
8	"(vii) A statement of the percentage
9	limit on annual premium increases that is
10	provided under the policy pursuant to this
11	section.
12	"(2) CERTIFICATES.—A certificate issued pur-
13	suant to a group long-term care insurance policy
14	shall include—
15	"(A) a description of the principal benefits
16	and coverage provided in the policy;
17	"(B) a statement of the principal exclu-
18	sions, reductions, and limitations contained in
19	the policy; and
20	"(C) a statement that the group master
21	policy determines governing contractual provi-
22	sions.
23	"(3) Long-term care as part of life in-
24	SURANCE.—In the case of a long-term care insur-
25	ance policy issued as a part of, or a rider on, a life

1	insurance policy, at the time of policy delivery there
2	shall be provided a policy summary that includes—
3	''(A) an explanation of how the long-term
4	care benefits interact with other components of
5	the policy (including deductions from death
6	benefits);
7	"(B) an illustration of the amount of bene-
8	fits, the length of benefit, and the guaranteed
9	lifetime benefits (if any) for each covered per-
10	son; and
11	"(C) any exclusions, reductions, and limi-
12	tations on benefits of long-term care.
13	"(4) Additional information.—The NAIC
14	shall develop recommendations with respect to in-
15	forming consumers of the long-term economic viabil-
16	ity of carriers issuing long-term care insurance
17	policies.
18	"(c) Limiting Conditions on Benefits; Minimum
19	Benefits.—
20	"(1) IN GENERAL.—A long-term care insurance
21	policy may not condition or limit eligibility—
22	"(A) for benefits for a type of services to
23	the need for or receipt of any other services;
24	"(B) for any benefit on the medical neces-
25	sity for such benefit;

1	"(C) for benefits furnished by licensed or
2	certified providers in compliance with conditions
2	which are in addition to those required for li-
	-
4	censure or certification under State law, except
5	that if no State licensure or certification laws
6	exists, in compliance with qualifications devel-
7	oped by the NAIC; or
8	''(D) for residential care (if covered under
9	the policy) only—
10	''(i) to care provided in facilities
11	which provide a higher level of care; or
12	''(ii) to care provided in facilities
13	which provide for 24-hour or other nursing
14	care not required in order to be licensed by
15	the State.
16	"(2) Home health care or community-
17	BASED SERVICES.—If a long-term care insurance
18	policy provides benefits for the payment of specified
19	home health care or community-based services, the
20	policy—
21	"(A) may not limit such benefits to serv-
22	ices provided by registered nurses or licensed
23	practical nurses;
24	''(B) may not require benefits for such
25	services to be provided by a nurse or therapist

1	that can be provided by a home health aide or
2	licensed or certified home care worker, except
3	that if no State licensure or certification laws
4	exist, in compliance with qualifications devel-
5	oped by the NAIC;
6	''(C) may not limit such benefits to serv-
7	ices provided by agencies or providers certified
8	under title XVIII of the Social Security Act;
9	and
10	''(D) must provide, at a minimum, benefits
11	for personal care services (including home
12	health aide and home care worker services as
13	defined by the NAIC) home health services,
14	adult day care, and respite care in an individ-
15	ual's home or in another setting in the commu-
16	nity, or any of these benefits on a respite care
17	basis.
18	"(3) NURSING FACILITY SERVICES.—If a long-
19	term care insurance policy provides benefits for the
20	payment of specified nursing facility services, the
21	policy must provide such benefits with respect to all
22	nursing facilities (as defined in section 1919(a) of
23	the Social Security Act or until such time as subse-
24	quently provided for by the NAIC in establishing

uniform language and definitions under section
 2715(a)(1)) in the State.

"(4) Per diem policies.—

3

4 "(A) DEFINITION.—For purposes of this 5 title, the term 'per diem long-term care insur-6 ance policy' means a long-term care insurance 7 policy (or certificate under a group long-term 8 care insurance policy) that provides for benefit 9 payments on a periodic basis due to cognitive 10 impairment or loss of functional capacity with-11 out regard to the expenses incurred or services 12 rendered during the period to which the pay-13 ments relate.

''(B) LIMITATION.—No per diem long-term
care insurance policy (or certificate) may condition or otherwise exclude benefit payments
based on the receipt of any type of nursing facility, home health care or community-based
services.

20 "(d) PROHIBITION OF DISCRIMINATION.—A long-21 term care insurance policy may not treat benefits under 22 the policy in the case of an individual with Alzheimer's 23 disease, with any related progressive degenerative demen-24 tia of an organic origin, with any organic or inorganic 25 mental illness, or with mental retardation or any other cognitive or mental impairment differently from an indi vidual having another medical condition for which benefits
 may be made available.

4 "(e) Limitation on Use of Preexisting Condi-5 tion Limits.—

6 "(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.

13 "(B) 6-month limit.—

"(i) IN GENERAL.—No long-term care 14 insurance policy or certificate issued under 15 16 this title shall utilize a definition of 'pre-17 existing condition' that is more restrictive 18 than the following: The term 'preexisting 19 condition' means a condition for which 20 medical advice or treatment was rec-21 ommended by, or received from a provider 22 of health care services, within 6 months preceding the effective date of coverage of 23 an insured individual. 24

1	"(ii) Prohibition on exclusion of
2	COVERAGE.—No long-term care insurance
3	policy or certificate may exclude coverage
4	for a loss or confinement that is the result
5	of a preexisting condition unless such loss
6	or confinement begins within 6 months fol-
7	lowing the effective date of the coverage of
8	the insured individual.
9	"(2) REPLACEMENT POLICIES.—If a long-term
10	care insurance policy replaces another long-term
11	care insurance policy, the issuer of the replacing pol-
12	icy shall waive any time periods applicable to pre-
13	existing conditions, waiting period, elimination peri-
14	ods and probationary periods in the new policy for
15	similar benefits to the extent such time was spent
16	under the original policy.
17	"(f) Eligibility for Benefits.—
18	"(1) LONG-TERM CARE POLICIES.—Each long-
19	term care insurance policy shall—
20	"(A) describe the level of benefits available
21	under the policy; and
22	''(B) specify in clear, understandable
23	terms, the level (or levels) of physical, cognitive,
24	or mental impairment required in order to re-
25	ceive benefits under the policy.

"(2) FUNCTIONAL ASSESSMENT.—In order to 1 2 submit a claim under any long-term care insurance 3 policy, each claimant shall have a professional func-4 tional assessment of his or her physical, cognitive, and mental abilities. Such initial assessment shall be 5 6 conducted by an individual or entity, meeting the 7 qualifications established by the NAIC to assure the professional competence and credibility of such indi-8 9 vidual or entity and that such individual meets any 10 applicable State licensure and certification require-11 ments. The individual or entity conducting such as-12 sessment may not control, or be controlled by, the 13 issuer of the policy. For purposes of this paragraph 14 and paragraph (4), the term 'control' means the di-15 rect or indirect possession of the power to direct the 16 management and policies of a person. Control is pre-17 sumed to exist, if any person directly or indirectly, 18 owns, controls, holds with the power to vote, or 19 holds proxies representing 10 percent of the voting 20 securities of another person.

21 "(3) CLAIMS REVIEW.—Except as provided in
22 paragraph (4), each long-term care insurance policy
23 shall be subject to final claims review by the carrier
24 pursuant to the terms of the long-term care insur25 ance policy.

"(4) Appeals process.—

1

"(A) IN GENERAL.—Each long-term care 2 insurance policy shall provide for a timely and 3 4 independent appeals process, meeting standards established by the NAIC, for individuals who 5 dispute the results of the claims review, con-6 7 ducted under paragraph (3), of the claimant's 8 functional assessment, conducted under paragraph (2). 9

10 "(B) INDEPENDENT ASSESSMENT.—An 11 appeals process under this paragraph shall in-12 clude, at the request of the claimant, an inde-13 pendent assessment of the claimant's physical, 14 cognitive or mental abilities.

15 "(C) CONDUCT.—An independent assess-16 ment under subparagraph (B) shall be con-17 ducted by an individual or entity meeting the 18 qualifications established by the NAIC to as-19 sure the professional competence and credibility 20 of such individual or entity and any applicable State licensure and certification requirements 21 22 and may not be conducted—

23 "(i) by an individual who has a direct24 or indirect significant or controlling inter-

1	est in, or direct affiliation or relationship
2	with, the issuer of the policy;
3	''(ii) by an entity that provides serv-
4	ices to the policyholder or certificateholder
5	for which benefits are available under the
6	long-term care insurance policy; or
7	''(iii) by an individual or entity in con-
8	trol of, or controlled by, the issuer of the
9	policy.
10	"(5) STANDARD ASSESSMENTS.—Not later than
11	2 years after the date of enactment of this title, the
12	advisory committee established under section
13	2701(d) shall recommend uniform needs assessment
14	mechanisms for the determination of eligibility for
15	benefits under such assessments.
16	"(g) INFLATION PROTECTION.—
17	"(1) Option to purchase.—A carrier may
18	not offer a long-term care insurance policy unless
19	the carrier also offers to the proposed policyholder,
20	including each group policyholder, the option to pur-
21	chase a policy that provides for increases in benefit
22	levels, with benefit maximums or reasonable dura-
23	tions that are meaningful, to account for reasonably
24	anticipated increases in the costs of long-term care
25	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:

4 "(A) With respect to policies that provide 5 for automatic periodic increases in benefits, the 6 policy provides for an annual increase in bene-7 fits in a manner so that such increases are 8 computed annually at a rate of not less than 5 9 percent.

"(B) With respect to policies that provide 10 11 for periodic opportunities to elect an increase in 12 benefits, the policy guarantees that the insured individual will have the right to periodically in-13 14 crease the benefit levels under the policy with-15 out providing evidence of insurability or health 16 status so long as the option for the previous pe-17 riod was not declined. The amount of any such 18 additional benefit may not be less than the dif-19 ference between-

20 "(i) the existing policy benefit; and

21 "(ii) such existing benefit compounded
22 annually at a rate of at least 5 percent for
23 the period beginning on the date on which
24 the existing benefit is purchased and ex-

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637 tending until the year in which the offer of 1 2 increase is made. "(C) With respect to service benefit poli-3 4 cies, the policy covers a specified percentage of the actual or reasonable charges and does not 5 6 include a maximum specified indemnity amount 7 or limit. "(2) EXCEPTION.—The requirements of para-8 graph (1) shall not apply to life insurance policies or 9 riders containing accelerated long-term care benefits. 10 11 "(3) REQUIRED INFORMATION.—Carriers shall include the following information in or together with 12 the outline of coverage provided under this title: 13 "(A) A graphic comparison of the benefit 14 15 levels of a policy that increases benefits over the 16 policy period with a policy that does not in-17 crease benefits. Such comparison shall show 18 benefit levels over not less than a 20-year 19 period. 20 "(B) Any expected premium increases or additional premiums required to pay for any 21 22 automatic or optional benefit increases, whether the individual who purchases the policy obtains 23

the inflation protection initially or whether such

1

individual delays purchasing such protection 2 until a future time.

"(4) CONTINUATION OF PROTECTION.—Infla-3 4 tion protection benefit increases under this subsection under a policy that contains such protection 5 6 shall continue without regard to an insured's age, claim status or claim history, or the length of time 7 the individual has been insured under the policy. 8

"(5) CONSTANT PREMIUM.—An offer of infla-9 tion protection under this subsection that provides 10 11 for automatic benefit increases shall include an offer 12 of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous 13 14 manner that the premium may change in the future unless the premium is guaranteed to remain con-15 16 stant.

17 "(6) REJECTION.—Inflation protection under 18 this subsection shall be included in a long-term care 19 insurance policy unless a carrier obtains a written 20 rejection of such protection signed by the policyholder. 21

22 **"SEC. 2716. NONFORFEITURE.**

23 "(a) IN GENERAL.—Each long-term care insurance 24 policy (or certificate) shall provide that if the policy lapses 25 after the policy has been in effect for a minimum period (specified under the standards under section 2701(a)), the
 policy will provide, without payment of any additional pre miums, nonforfeiture benefits as determined appropriate
 by the NAIC.

5 "(b) ESTABLISHMENT OF STANDARDS.—The stand6 ards under section 2701(a) shall provide that the percent7 age or amount of benefits under subsection (a) must in8 crease based upon the policyholder's equity in the policy.
9 "SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND
10 RIGHT TO RETURN.

11 "(a) CONTESTABILITY.—A carrier may not cancel or 12 renew a long-term care insurance policy or deny a claim 13 under the policy based on fraud or material misrepresenta-14 tion relating to the issuance of the policy unless notice 15 of such fraud or material misrepresentation is provided 16 within a time period to be determined by the NAIC.

17 "(b) RIGHT TO RETURN.—Each applicant for a long-18 term care insurance policy shall have the right to return 19 the policy (or certificates) within 30 days of the date of 20 its delivery (and to have the premium refunded) if, after 21 examination of the policy or certificate, the applicant is 22 not satisfied for any reason.

1 "SEC. 2718. CIVIL MONEY PENALTY.

2 "(a) CARRIER.—Any carrier, association or its sub3 sidiary that sells or offers for sale a long-term care insur4 ance policy and that—

5 "(1) fails to make a refund in accordance with
6 section 2713(a);

7 ''(2) fails to transmit a policy in accordance
8 with section 2713(b);

9 ''(3) fails to provide, make available, or report 10 information in accordance with subsections (c) or (d) 11 of section 2713;

12 "(4) provides a commission or compensation in
13 violation of section 2713(e);

14 "(5) fails to provide an outline of coverage in
15 violation of section 2715(b)(1); or

16 ''(6) issues a policy without obtaining certain
17 information in violation of section 2715(f);

18 is subject to a civil money penalty of not to exceed \$25,00019 for each such violation.

20 "(b) AGENTS.—Any agent that sells or offers for sale21 a long-term care insurance policy and that—

22 "(1) fails to make a refund in accordance with23 section 2713(a);

24 "(2) fails to transmit a policy in accordance
25 with section 2713(b);

1	''(3) fails to provide, make available, or report
2	information in accordance with subsections (c) or (d)
3	of section 2713;
4	"(4) fails to provide an outline of coverage in
5	violation of section $2715(b)(1)$; or
6	"(5) issues a policy without obtaining certain
7	information in violation of section 2715(f);
8	is subject to a civil money penalty of not to exceed \$15,000
9	for each such violation.
10	"Part C—Long-Term Care Insurance Policies,
11	Definition and Endorsements
12	"SEC. 2721. LONG-TERM CARE INSURANCE POLICY DE-
12 13	"SEC. 2721. LONG-TERM CARE INSURANCE POLICY DE- FINED.
13	FINED.
13 14	FINED. "(a) IN GENERAL.—As used in this section, the term
13 14 15	FINED. "(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance pol-
13 14 15 16 17	FINED. "(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance pol- icy, rider or certificate advertised, marketed, offered or de-
13 14 15 16 17	FINED. "(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance pol- icy, rider or certificate advertised, marketed, offered or de- signed to provide coverage for not less than 12 consecutive
 13 14 15 16 17 18 	FINED. "(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance pol- icy, rider or certificate advertised, marketed, offered or de- signed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred,
 13 14 15 16 17 18 19 20 	FINED. "(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance pol- icy, rider or certificate advertised, marketed, offered or de- signed 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 nec-
 13 14 15 16 17 18 19 20 21 	FINED. "(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance pol- icy, rider or certificate advertised, marketed, offered or de- signed 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 nec- essary diagnostic, preventive, therapeutic, rehabilitative,
 13 14 15 16 17 18 19 20 21 22 	FINED. "(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance pol- icy, rider or certificate advertised, marketed, offered or de- signed 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 nec- essary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a set-

24 "(1) group and individual annuities and life in-25 surance policies, riders or certificates that provide

1	directly, or that supplement long-term care insur-
2	ance; and
3	"(2) a policy, rider or certificates that provides
4	for payment of benefits based on cognitive impair-
5	ment or the loss of functional capacity.
6	"(b) ISSUANCE.—Long-term care insurance policies
7	may be issued by—
8	"(1) carriers;
9	"(2) fraternal benefit societies;
10	''(3) nonprofit health, hospital, and medical
11	service corporations;
12	"(4) prepaid health plans;
13	"(5) health maintenance organizations; or
14	"(6) any similar organization to the extent they
15	are otherwise authorized to issue life or health insur-
16	ance.
17	"(c) Policies Excluded.—The term 'long-term
18	care insurance policy' shall not include any insurance pol-
19	icy, rider or certificate that is offered primarily to provide
20	basic Medicare supplement coverage, basic hospital ex-
21	pense coverage, basic medical-surgical expense coverage,
22	hospital confinement indemnity coverage, major medical
23	expense coverage, disability income or related asset-protec-
24	tion coverage, accident only coverage, specified disease or
25	specified accident coverage, or limited benefit health cov-

erage. With respect to life insurance, such term shall not 1 2 include life insurance policies, riders or certificates that accelerate the death benefit specifically for one or more 3 of the qualifying events of terminal illness, medical condi-4 tions requiring extraordinary medical intervention, or per-5 manent institutional confinement, and that provide the op-6 7 tion of a lump-sum payment for those benefits and in 8 which neither the benefits nor the eligibility for the bene-9 fits is conditioned upon the receipt of long-term care.

10 "(d) APPLICATIONS.—Notwithstanding any other 11 provision of this title, this title shall apply to any product 12 advertised, marketed or offered as a long-term insurance 13 policy, rider or certificate.

14 "SEC. 2722. CODE OF CONDUCT WITH RESPECT TO EN-15DORSEMENTS.

16 "Not later than 1 year after the date of enactment 17 of this title the NAIC shall issue guidelines that shall apply to organizations and associations, other than em-18 19 ployers and labor organizations that do not accept compensation, and their subsidiaries that provide endorse-20 21 ments of long-term care insurance policies, or that permit such policies to be offered for sale through the organiza-22 tion or association. Such guidelines shall include at mini-23 24 mum the following:

1 "(1) In endorsing or selling long-term care in-2 surance policies, the primary responsibility of an or-3 ganization or association shall be to educate their 4 members concerning such policies and assist such 5 members in making informed decisions. Such organi-6 zations and associations may not function primarily 7 as sales agents for insurance companies.

8 "(2) Organizations and associations shall pro-9 vide objective information regarding long-term care 10 insurance policies sold or endorsed by such organiza-11 tions and associations to ensure that members of 12 such organizations and associations have a balanced 13 and complete understanding of both the strengths 14 and weaknesses of the policies that are being en-15 dorsed or sold.

16 "(3) Organizations and associations selling or 17 endorsing long-term care insurance policies shall dis-18 close in marketing literature provided to their mem-19 bers concerning such policies the manner in which 20 such policies and the insurance company issuing 21 such policies were selected. If the organization or as-22 sociation and the insurance company have interlocking directorates, the organization or association shall 23 24 disclose such fact to their members.

1 "(4) Organizations and associations selling or 2 endorsing long-term care insurance policies shall dis-3 close in marketing literature provided to their mem-4 bers concerning such policies the nature and amount 5 of the compensation arrangements (including all 6 fees, commissions, administrative fees and other 7 forms of financial support that the organization or 8 association receives) from the endorsement or sale of 9 the policy to its members. 10 "(5) The Boards of Directors of organizations 11 and associations selling or endorsing long-term care 12 insurance policies, if such organizations and associa-13 tions have a Board of Directors, shall review and ap-14 prove such insurance policies, the compensation arrangements and the marketing materials used to 15 16 promote sales of such policies. 17 "PART D—MISCELLANEOUS PROVISIONS 18 "SEC. 2731. FUNDING FOR LONG-TERM CARE INSURANCE 19 INFORMATION, COUNSELING, AND ASSIST-20 ANCE. 21 "(a) IN GENERAL.—The Secretary, acting through 22 the Public Health Service, may award grants to States, 23 and national organizations with demonstrated experience 24 in long-term care insurance, for the establishment of pro-25 grams to provide information, counseling, and assistance

relating to the procurement of adequate and appropriate
 long-term care insurance.

3 "(b) APPLICATION.—To be eligible to receive a grant 4 under subsection (a), a State or national organization 5 shall prepare and submit to the Secretary an application 6 at such time, in such manner, and containing such infor-7 mation as the Secretary may require, including a descrip-8 tion of the program for which the State or organization 9 intends to use the amounts provided under the grant.

10 "(c) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be
appropriated for grants to States under subsection
(a), \$10,000,000 for each of the fiscal years 1996
through 1998.

15 "(2) NATIONAL ORGANIZATIONS.—There are
authorized to be appropriated for grants to national
organizations under subsection (a), \$1,000,000 for
each of the fiscal years 1996 through 1998.

19 **"SEC. 2732. DEFINITIONS.**

20 "As used in this title:

21 "(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

1	licensed or required to be licensed under State
2	law for such purpose; and
3	"(B) after the date referred to in subpara-
4	graph (A), an individual who meets the training
5	and certification requirements established under
6	section 2712(f).
7	"(2) Association.—The term 'association' in-
8	cludes the association and its subsidiaries.
9	"(3) CARRIER.—The term 'carrier' means any
10	person that offers a health benefit plan, whether
11	through insurance or otherwise, including a licensed
12	insurance company, a prepaid hospital or medical
13	service plan, a health maintenance organization, a
14	self-insured carrier, a reinsurance carrier, and a
15	multiple employer welfare arrangement (a combina-
16	tion of employers associated for the purpose of pro-
17	viding health benefit plan coverage for their employ-
18	ees).".
19	(b) Conforming Amendments.—
20	(1) Sections 2701 through 2714 of the Public
21	Health Service Act (42 U.S.C. 300cc through
22	300cc-15) are redesignated as sections 2801
23	through 2814, respectively.
24	(2) Sections $465(f)$ and 497 of such Act (42)
25	U.S.C. 286(f) and 289(f)) are amended by striking

"2701" each place that such appears and inserting
 "2801".

3 Subtitle C—Protection of Assets 4 Under Medicaid Through Use of 5 Qualified Long-term Care Insur 6 ance

7 SEC. 3201. PROTECTION OF ASSETS THROUGH USE OF
 8 QUALIFIED LONG-TERM CARE INSURANCE.

9 (a) IN GENERAL.—Title XIX of the Social Security 10 Act, as amended by sections 1601(a) and 1701(a), is 11 amended—

12 (1) by redesignating section 1933 as section13 1934; and

14 (2) by inserting after section 1932 the following15 new section:

16 "SPECIAL RULES FOR ASSET DISREGARD IN THE CASE OF

17 QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS

18 "SEC. 1933. (a) IN GENERAL.—Each State plan 19 under this title may provide, subject to subsection (d), that in determining the eligibility of an individual for medical 20 21 assistance under the plan with respect to such services 22 there shall be disregarded some or all of the individual's assets which are attributable (as determined under sub-23 section (c)(2) to coverage under a qualified long-term 24 care insurance contract (as defined in subsection (b)). 25

1 "(b) QUALIFIED LONG-TERM CARE INSURANCE 2 CONTRACT DEFINED.—In this section, the term 'qualified 3 long-term care insurance contract' means, with respect to 4 a State, a long-term care insurance contract (as defined 5 in section 818A(b) of the Internal Revenue Code of 1986) 6 which—

7 "(1) provides such protection against the costs
8 of receiving long-term care services as the State may
9 require by law;

10 "(2) provides that benefits under the contract
11 shall be paid without regard to eligibility for medical
12 assistance under this title; and

"(3) meets such other requirements (such as requirements relating to premiums, disclosure, minimum benefits, rights of conversion, and standards
for claims processing) as the State may determine to
be appropriate.

18 "(c) OTHER DEFINITIONS.—In this section:

"(1) LONG-TERM CARE SERVICES.—The term
'long-term care services' means nursing facility services, home health care services, and home and community-based services, and includes such other similar items and services described in section 1905(a)
as a State may specify.

"(2) ATTRIBUTION RULES.—An individual's as-1 2 sets are considered to be 'attributable' to a qualified 3 long-term care insurance contract to the extent spec-4 ified under the State plan. Such a plan shall provide for at least one of the following: 5 "(A) All assets are considered attributable 6 7 if the insurance contract provides coverage for at least a specified period of coverage (of not 8 9 less than 3 years and of not more than 6 years) 10 for long-term care services. "(B) An amount of assets, up to the dollar 11 12 limitation on benefits for long-term care serv-13 ices under the contract, is considered attributable to the contract. 14 "(d) LIMITATION.—In no case shall this section re-15 sult in (1) the total Federal payments to the State for 16 the quarter under this title (including payments attrib-17 utable to this section), exceeding (2) the total Federal pay-18 ments that the Secretary estimates would have been paid 19 under this title to the State for the quarter if the State 20 did not provide for the determination of eligibility in ac-21 22 cordance with subsection (a).". 23 (b) CONFORMING AMENDMENT.—Section

24 1902(a)(17)(A) of such Act (42 U.S.C. 1396a(a)(17)(A))

is amended by inserting "and section 1932" after "objec tives of this title".

3 (c) Effective Date.—

4 (1) IN GENERAL.—The amendments made by 5 this section shall apply (except as provided under 6 paragraph (2)) to payments to States under title XIX of the Social Security Act for calendar quarters 7 8 beginning on or after one year after the date of the 9 enactment of this Act, without regard to whether regulations to implement such amendment are pro-10 11 mulgated by such date.

12 (2) DELAY PERMITTED IF STATE LEGISLATION 13 REQUIRED.—In the case of a State plan for medical 14 assistance under title XIX of the Social Security Act 15 which the Secretary of Health and Human Services 16 determines requires State legislation (other than leg-17 islation authorizing or appropriating funds) in order 18 for the plan to meet the additional requirements im-19 posed by the amendments made by this section, the 20 State plan shall not be regarded as failing to comply with the requirements of such title solely on the 21 22 basis of its failure to meet these additional require-23 ments before the first day of the first calendar quar-24 ter beginning after the close of the first regular ses-25 sion of the State legislature that begins after the date of the enactment of this Act. 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.

Subtitle D—Studies

6

7 SEC. 3301. FEASIBILITY OF ENCOURAGING HEALTH CARE

8 PROVIDERS TO DONATE SERVICES TO HOME9 BOUND PATIENTS.

10 The Comptroller General of the United States shall 11 conduct a study on the feasibility of encouraging health 12 care providers to donate their services to homebound pa-13 tients. Such study shall include an examination of the ef-14 fects of qualifying such services as a charitable contribu-15 tion.

16SEC. 3302. FEASIBILITY OF TAX CREDIT FOR HEADS OF17HOUSEHOLDS WHO CARE FOR ELDERLY FAM-18ILY MEMBERS IN THEIR HOMES.

19 The Comptroller General of the United States shall 20 conduct a study on the feasibility of providing heads of 21 households who care for elderly family members in their 22 homes with a tax credit. Such study shall estimate the 23 cost of such a tax credit which would apply to expenses 24 incurred in the custodial care of such an elderly family member to the extent such expenses exceed 5 percent of
 adjusted gross income.

3 SEC. 3303. CASE MANAGEMENT OF CURRENT LONG-TERM 4 CARE BENEFITS.

5 (a) IN GENERAL.—The Secretary of Health and 6 Human Services shall conduct a study of the feasibility 7 of encouraging or requiring the use of a single designated 8 public or nonprofit agency (such as an area agency on 9 aging) to coordinate, through case management, the provi-10 sion of long-term care benefits under current Federal, 11 State, and local programs in a geographic area.

(b) REPORT.—The Secretary shall submit to Con-12 gress a report on the study conducted under subsection 13 (a) by not later than 1 year after the date of the enact-14 ment of this Act. Such report shall include such rec-15 ommendations regarding changes in legislation to encour-16 age or require the use (described in subsection (a)) of an 17 agency to coordinate long-term care benefits as may be 18 appropriate. 19

1	Subtitle E—Volunteer Service
2	Credit Demonstration Projects
3	SEC. 3401. AMENDMENT TO THE OLDER AMERICANS ACT
4	OF 1965.
5	(a) IN GENERAL.—Part B of title IV of the Older
6	Americans Act of 1965 (42 U.S.C. 3034–3035r) is amend-
7	ed by adding at the end the following:
8	"SEC. 429K. VOLUNTEER SERVICE CREDIT DEMONSTRA-
9	TION PROJECTS.
10	"(a) REQUIREMENTS.—The Commissioner shall—
11	"(1) establish and operate (directly, or through
12	the State agency on aging or one or more area agen-
13	cies on aging) a volunteer service credit demonstra-
14	tion project in all or part of each State;
15	"(2) establish criteria for selecting individuals
16	to whom volunteer services will be provided under
17	volunteer service credit demonstration projects oper-
18	ated under paragraph (1);
19	"(3) recruit and train (directly or through State
20	agencies on aging or area agencies on aging) individ-
21	uals who volunteer to provide services through such
22	projects;
23	"(4) establish a minimum standard for each
24	service to be provided by volunteers through such
25	projects;

"(5) monitor services provided by volunteers
 through such projects to ensure that standards es tablished under paragraph (4) are met; and

4 "(6) maintain (directly or through State agen-5 cies on aging or area agencies on aging) with respect 6 to each individual who provides services through a 7 volunteer service credit demonstration project oper-8 ated under paragraph (1) a separately identifiable 9 account showing the number of hours such individ-10 ual provided such services.

11 "(b) DEFINITION.—For purposes of subsection (a), 12 the term 'volunteer service credit demonstration project' 13 means a demonstration project through which homemaker 14 services, respite care for families, adult day care, and edu-15 cational, transportation, and home-delivery services are 16 provided by—

17 "(1) volunteer older individuals for the benefit18 of older individuals or low-income children; or

19 ''(2) volunteer individuals of any age for the20 benefit of older individuals;

in return for the receipt of similar services under any such
demonstration project (that is established under this section) at a time at which such volunteers are older individuals in need of such services.".

(b) EFFECTIVE DATE.—The amendment made by
 subsection (a) shall take effect October 1, 1995.

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